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20.1 Eye Examinations/Vision Services

20.1.1 Description

Medicaid covers eye and vision services provided by qualified optometry/ophthalmology professionals within certain limits based on recipient age. For information on glasses and contact lenses see the section about Vision Eyewear later in this chapter.

20.1.2 Amount, Duration and Scope

- a) Emergency eye care, which meets the definition of an emergency medical condition, is covered for all recipients. Vision examinations and the provision of prescription lenses are covered. Cataract removal is covered for all eligible recipients.
- b) An ophthalmologic exam with refraction includes:
 - Determination of visual acuity
 - Tonometry (routine and serial)
 - Gross visual fields
 - Muscle balance
 - Slit lamp microscopy
- c) Ophthalmoscopy is payable as a separate procedure. If done within a pre-op period, it is considered a pre-operative examination.
- d) Eye examinations are considered bilateral and should be coded as a single procedure code. Right and left or bilateral modifiers will not be paid.

20.1.3 Exclusions

- a) Excluded vision services include:
 - Orthoptic training
 - Prescription fee
 - Progress exams
 - Radial keratotomy

- Visual training
- Lasik procedures

b) All charges for drugs and supplies used in the office for testing are included in the fee for the specific procedure; no additional allowance for the drugs will be made.

20.1.4 Limitations

20.1.4.1 Screening

Limited to once in a 12-month period for individuals under age 21 and once in a 24-month period for adults age 21 and older. Visits done more frequently are payable when indicated by symptoms or medical condition.

20.1.4.2 Cataracts

a) Cataract removal is a covered service when the cataract is visible by exam, ophthalmoscopic or slit lamp, and any of the following apply:

- Visual acuity that cannot be corrected by lenses better than 20/70 and is reasonably attributable to the cataract; or
- In the presence of complete inability to see the posterior chamber, vision is confirmed by potential acuity meter (PAM) reading, or
- For eligible recipients who have corrected visual acuity between 20/50 and 20/70, a second opinion by an ophthalmologist is obtained.

b) Cataract surgery is covered only when there is a reasonable expectation by the operating ophthalmic surgeon that the recipient will achieve improved visual functional ability when visual rehabilitation is complete.

c) Cataract surgeries are generally done on an outpatient basis, but an inpatient stay may be required due to the need for complex medical and nursing care, multiple ocular conditions or procedures or the recipient's medical status.

d) The global period covers 45 days post-operative follow-up and one pre-operative day on the day of surgery. A separate professional fee will be allowed for evaluation prior to the procedure.

20.1.4.3 Corneal Transplants

a) Indications for penetrating keratoplasty are:

- Corneal opacification that sufficiently obscures vision through the anterior segment of the eye with at least light perception present. Causes for this problem include:
 - 1) Corneal injury and scarring;
 - 2) Corneal degeneration (from Fuch's or other dystrophy or from previous cataract and/or intraocular lens implantation);
 - 3) Corneal degeneration from keratoconus or familial causes;
 - 4) Corneal infection (e.g., herpes)
- Therapeutic graft for relief of pain is needed and the patient has at least light perception vision present or the patient has corneal degeneration due to an eye inflammation resulting in pain however useful vision is still present.

b) Indications for lamellar keratoplasty include:

- Superficial layer corneal scarring and deformity due to trauma, degeneration, infection, or congenital deformity (anterior);
- Aphakia
- High myopia
- High refractive error
- Keratoconus
- Recurrent pterygium

c) Additional conditions and limitations for corneal transplants are:

- There is no intractable glaucoma in the eye under consideration.
- There is no active eye infection at the time of surgery.
- There are no general medical contraindications to surgery or anesthesia.

- There is an informed consent obtained from the patient or patient's representative.
- There is no age restriction.

20.1.5 Authorization

Prior authorization is not required.

20.1.6 Claims Submittal

Claims for vision services must be billed on a CMS (formerly HCFA) 1500 form. The Vision Care claim form 205A is no longer accepted.

20.2 Vision Eyewear

20.2.1 Description

The charges incurred in dispensing visual aids prescribed by ophthalmologists or optometrists are covered by the Medicaid program. These include costs for the lens, frames, or other parts of the glasses, as well as fittings and adjustments.

20.2.2 Amount, Duration and Scope

The following are covered:

a) Eyeglasses

- Refractive correction criteria for an original prescription is (+) or (-) 0.50 diopter, sphere or cylinder, or 1 vertical or 5 horizontal prism diopters for each eye.
- Refractive correction of a change in prescription is (+) or (-) 0.50 diopter, sphere or cylinder, or 6 degrees in cylinder axis for both eyes.
- Glass or plastic lenses may be used. Glass must conform to standard Z-80 (National Bureau of Standards) as it existed on September 15, 1983. Polycarbonate lenses must be prior authorized.
- Nose pads and rocking pads are considered as part of the technical servicing for the complete glasses. Replacement of the pads is considered a repair and is payable. Frame adjustment, verification of prescription and dispensing of eyeglasses and technical servicing is included in the servicing of the entire glasses.
- Frames – covered. Recipients may not pay the difference between the maximum Medicaid allowance for frames and higher-priced frames. Recipients desiring more

expensive frames must pay the entire charge for the frame including technical servicing of the frames. Providers may bill Medicaid only those charges pertaining to the lenses.

b) Contact lenses

- Keratoconus in one or both eyes where corrected vision by glasses is less than 20/40 and the vision is further improved by contact lenses;
- Corneal astigmatism in one or both eyes greater than 4.00 diopter correctable by contact lenses and the astigmatism correctable by contact lenses;
- Irregular astigmatism due to corneal imperfection where corrected vision by glasses is less than 20/40 and vision is further improved by contact lenses;
- Anisometropia due to aphakia or other causes where the vision corrected by glasses in the non-affected eye is less than 20/50, the problem either will last for at least six months or is permanent, and the person requires binocular vision for educational or job purposes;
- Bilateral aphakia when a person becomes ill using spectacle glasses or when the person's occupation makes the wearing of glasses hazardous;
- Certain inflammatory conditions of the cornea for which therapeutic contact lenses are indicated with the recommendation of an ophthalmologist.

c) Miscellaneous Vision Supplies

- Prosthetic eyes are covered. A global fee includes payment for all visits, materials, costs, modifications or replacement because of poor fit or unacceptable defect within 90 days from the initial visit for fitting. Neighbor Island recipients requiring a prosthesis should be referred to a provider who can complete the prosthesis in one series of daily visits.
- Subnormal visual aids are covered.

d) Repairs

Minor repairs are covered.

20.2.3 *Exclusions*

- Blended bifocals
- Bifocal contact lenses

- Spare pair of glasses or contacts
- Repairs on glasses that no longer meet a recipient's needs are not payable
- Tinted lenses for cosmetic reasons, recipient must pay for all expenses (technical and material)
- Oversized lenses unless authorized for cosmetic reasons
- Contact lenses for:
 - 1) Elderly persons beyond the working age with aphakia where the corrected vision in the non-aphakia eye with glasses is 20/50 or better and the addition of a contact lens will not make the person economically productive; and
 - 2) Solely cosmetic purposes such as obscuring an opaque pupil.
- Contact Lens Care Kit and Accessories (Aseptron)
- All services or material not in compliance with the restrictions in this Chapter

20.2.4 *Limitations*

a) Eyeglasses

- New lenses are limited to once in a 24-month period for adults and once in a 12-month period for individuals under the age of 21 years. A new pair within the 24-month period for adults (12 months for children) is payable if the change in prescription meets the guidelines described above under "Eyeglasses". The 24-month period will begin again from the date of the most recent dispensed glasses. The claim for the new glasses, however, must have both the old and new prescriptions to confirm the prescription change and avoid processing delays.
- Tinted or color-coated corrective lenses or "clip-ons" are payable only for persons with aphakia, albinism, glaucoma or other medical conditions excluding photophobia not associated with such conditions. The tint or coat should allow use of the lenses indoors and at night. These lenses must be prior authorized.
- Bilateral plano glasses are payable as safety glasses for persons with one remaining functioning eye.
- Balance lenses are payable if the other eye has a prescription that meets the criteria for lenses.

- Persons with presbyopia who require minimal or no distance correction are to be fitted with ready made half-glasses
- When unusual complications affect normal recovery, ready-made temporary glasses should be rented or purchased following cataract extraction (with or without insertion of an intra-ocular prosthetic lens) until the eyes have healed and refractive error has stabilized. Authorization on Form 1144 is required except when prescribed by an ophthalmologist whose full name must appear on the claim. No additional allowance for plastic cataract lenses is payable. Payment will be made at the level for standard cataract lenses.
- Providers may designate a selection of frames for Medicaid recipients to choose from and recipients desiring more expensive frames will be required to pay the entire charge for the frame including technical servicing of the frames. Medicaid would then only pay for those charges pertaining to the lenses. Recipients may not pay the difference between the maximum Medicaid allowance for frames and higher-priced frames.
- Repairs are payable only for current eyewear.

b) Contact lenses

See section above.

20.2.5 *Authorization*

a) Eyeglasses

- Polycarbonate lenses must be prior authorized.
- Bifocal lenses for recipients under 40 years of age must have medical justification. No additional payment is made for blended bifocals.
- Trifocals are payable only for recipients currently wearing them for specific job requirements
- Replacement of children's glasses that are lost, stolen or severely damaged within 12 months of the last pair must be approved before being dispensed.
- Replacement of an adult's glasses within two years must be approved before being dispensed. The information should include one or more of the following information:
 - 1) The date and circumstances of loss;

- 2) The date the previous glasses were made; and
 - 3) The visual acuity without and with corrections; or
 - 4) The refractive prescription and the previous prescription, if a change is being requested.
- Replacement of lens or frames or any other part of the glasses does not require authorization.
 - Tinted, absorptive or color-coated corrective lenses or clip ons must be prior authorized.
 - Ready-made glasses not prescribed by an ophthalmologist after cataract extraction.
- b) Contact lenses
- A sterilization unit for soft contact lenses must be medically justified.
 - All contact lenses must be authorized except for those with a change in prescription during the 24 month period in which the last pair was received do not require authorization. Dispensing of the lenses from the new prescription begins a new 24-month period.
- c) Miscellaneous vision supplies
- Initial and replacement prosthetic eyes must be prior-authorized.
 - Subnormal visual aids costing more than \$50

20.3 Hearing Services

20.3.1 Description

Services for individuals with hearing disorders means diagnostic, screening, preventive, or corrective services/equipment/supplies provided by, or under the direction of, a physician or an audiologist, to whom a patient is referred by a physician.

20.3.2 Amount, Duration and Scope

- a) A physician may prescribe services for patients with hearing disorders who are expected to improve in a reasonable period of time with therapy.
- b) All recommended therapy shall require prior authorization by the department's medical consultants according to the following procedures:
 - For therapy, information including:
 - 1) The evaluation and results of standardized objective tests; and
 - 2) A plan of therapy with goals and time frames.
- c) If a reasonable doubt exists that an individual requires therapy or continuation of therapy, a board of experienced therapists may be asked to review the medical consultants' findings and make recommendations to the department's medical consultants.

20.3.3 Exclusions

Hearing aid insurance premiums for children above 12 years of age and adults are not covered.

20.3.4 Limitations

- a) **Audiology.** Services must be prescribed by a physician and provided by an audiologist authorized to participate in the Medicaid Program. Prior authorization for an evaluation for and request for approval of a hearing aid is required and must be requested by an otolaryngologist. Hearing aid rental and purchase requires prior authorization. The authorization request must be accompanied with the results of a hearing aid evaluation.
- b) **Ear Plugs.** Custom-made earplugs must be prescribed by ENT specialists for individuals with recurrent middle ear infections and approved on Form 1144.
- c) **Hearing Aids**

The following conditions and limitations shall apply:

- Persons requesting hearing aids shall have a hearing evaluation by a physician who is an ear, nose, and throat specialist who has determined that the otologic disorders are associated with hearing loss. Hearing Aid Suppliers will not be paid for a hearing evaluation.
- Only one hearing evaluation is payable every twelve months.

- Hearing aids purchased by the Medicaid program shall be of the unilateral type except for children under the age of 12 years.
- Miniaturized or “all in the ear” hearing aids are excluded. Special models or modifications shall require justification with documentation of medical necessity.
- Hearing aid purchase requests shall be approved initially for one month of rental at \$25 per month to determine the appropriateness of the hearing aid; if it is significantly damaged or lost during the rental period, payment will be made in full. The molded earpiece will be purchased.
- If purchase of the hearing aid is recommended based on the re-evaluation following the 1-month rental period, a new authorization form, Form 1144, shall be submitted by the ENT physician for approval. The form must have hearing aid cost information from the hearing aid supplier. The hearing aid evaluation with aided and unaided results must be submitted with the purchase request. The evaluation should consider the patient’s motivation to wear the hearing aid and capability of caring for it or having a responsible party care for it. The maximum reimbursement for a hearing aid is \$300.00.
- If the hearing aid purchase is not recommended and/or the recipient returns the hearing aid, a factory reconditioning charge of no more than \$50 may be paid when supported by a copy of the manufacturer’s invoice; then any payment by Medicaid for the hearing aid must be returned. Instructions for refunding Medicaid can be found in Chapter 4: Claim Forms.
- Repair of hearing aids shall be itemized and the problem with the aid clearly stated on the Form 1144 (i.e., damage versus routine wear and tear) submitted for approval.
- Patients requiring batteries should pick them up in person; if the patient is a resident in a SNF or ICF, the batteries should be mailed by the supplier and the postage will be paid. Service calls are not covered and not reimbursable.
- Hearing aid replacements may be purchased every two years with authorization.
- Insurance Premiums to cover hearing aid losses or repair shall be covered only for children under twelve years of age.
- A maximum fee for monaural hearing aids is payable. If the cost is greater than the maximum fee then an invoice from the laboratory or supplier showing the cost must be attached to the authorization form for consideration by the medical consultant.

20.3.5 Authorization

- a) All hearing aid rentals, purchases, or repairs shall require medical approval by the Medical Consultant on Form 1144.
- b) Prior authorization is required for binaural hearing aids for children older than 12 years of age. ENT results and audiological test results must be submitted with the request.

20.3.6 Claims Submittal

Claims for hearing exams must be billed on a CMS (formerly HCFA) 1500 form.