

**KENTUCKY MEDICAID
VISION PROGRAM MANUAL**

TABLE OF CONTENTS

| | PAGE NO. |
|---|-----------------|
| I. INTRODUCTION | 1.1 |
| A. Introduction | 1.1 |
| B. Fiscal Agent | 1.1 |
| C. General Information | 1.1 |
| II. KENTUCKY MEDICAID PROGRAM | 2.1 - 2.3 |
| A. Policy | 2.1 - 2.2 |
| B. Timely Submission of Claims | 2.2 – 2.3 |
| C. Kentucky Patient Access and Care System (KenPAC) | 2.3 |
| D. Lock-In Program | 2.3 |
| III. CONDITIONS OF PARTICIPATION | 3.1 - 3.4 |
| A. General Information | 3.1 |
| B. Licensure | 3.1 |
| C. Clinics and Professional Service Corporations (P.S.C.) | 3.1 - 3.2 |
| D. Freedom of Choice Concept | 3.2 |
| E. Medical Records | 3.2 - 3.3 |
| F. Medicaid Participation Overview | 3.3 |
| G. Overview of Required Procedures | 3.4 |
| IV. PROGRAM COVERAGE | 4.1 - 4.12 |
| A. Eligibility Guidelines | 4.1 |
| B. Examination, Diagnostic and Treatment Services | 4.1 - 4.5 |
| C. Eyeglasses | 4.5 - 4.7 |
| D. Eyeglasses Coverage Limitations | 4.7 – 4.8 |
| E. Dispensing of Eyeglasses | 4.9 – 4.10 |
| F. Professional Services for Dispensing and Repairing Eyeglasses | 4.10 |
| G. Eyeglass Procedure Codes | 4.10 |
| H. Provider - Patient Contacts | 4.11 |
| I. Consultation Services | 4.11 - 4.12 |
| V. REIMBURSEMENT | 5.1 - 5.4 |
| A. Optometrists | 5.1 |
| B. Ophthalmic Dispensers | 5.1 - 5.2 |
| C. Laboratory Services | 5.2 |
| D. Reimbursement in Relation to Medicare | 5.2 - 5.3 |
| E. Fees-Duplicate or Inappropriate | 5.3 – 5.4 |
| F. Fee Payment by Recipient | 5.4 |

INTRODUCTION

SECTION I

SECTION I - INTRODUCTION

A. Introduction

The Kentucky Medicaid Vision Program Manual provides Medicaid providers with a tool to be used when providing services to qualified Medicaid recipients. This manual contains basic information concerning coverage and policy. Precise adherence to policy shall be imperative.

B. Fiscal Agent

The Department for Medicaid Services contracts with a fiscal agent for the operation of the Kentucky Medicaid Management Information System (MMIS). The fiscal agent receives and processes all claims for medical services provided to Kentucky Medicaid recipients.

C. General Information

The Department for Medicaid Services shall be bound by both Federal and State statutes and regulations governing the administration of the State Plan. The state shall not be reimbursed by the federal government for monies improperly paid to providers for non-covered, unallowable medical services. Therefore, Kentucky Medicaid may request a return of any monies improperly paid to providers for non-covered services.

KENTUCKY MEDICAID PROGRAM

SECTION II

SECTION II – KENTUCKY MEDICAID PROGRAM

SECTION II – KENTUCKY MEDICAID PROGRAM

A. Policy

The basic objective of the Kentucky Medicaid Program shall be to ensure the availability and accessibility of quality medical care to eligible program recipients. The Medicaid Program shall be the payor of last resort. If the patient has an insurance policy, veteran's coverage, or other third party coverage of medical expenses, that party shall be primarily liable for the patient's medical expenses. Accordingly, the provider of service shall seek reimbursement from the third party groups for medical services provided prior to billing Medicaid. If a provider receives payment from a recipient, payment shall not be made by Medicaid. If a payment is made by a third party, Medicaid shall not be responsible for any further payment above the Medicaid maximum allowable charge.

In addition to statutory and regulatory provisions, several specific policies have been established through the assistance of professional advisory committees. Principally, some of these policies are as follows:

All participating providers shall agree to provide medical treatment according to standard medical practice accepted by their professional organization and to provide Medicaid services in compliance with federal and state statutes regardless of age, color, creed, disability, ethnicity, gender, marital status, national origin, race, religion, or sexual orientation.

Providers shall comply with the Americans with Disabilities Act and any amendments, rules and regulations of this act.

Each medical professional shall be given the choice of whether or not to participate in the Kentucky Medicaid Program. From those professionals who have chosen to participate, recipients may select the provider from whom they wish to receive their medical care.

If the Department makes payment for a covered service and the provider accepts this payment in accordance with the Department's fee structure, the amounts paid shall be considered payment in full; a bill for the same services shall not be tendered to the recipient, and a payment for the same service shall not be accepted from the recipient. The provider may bill the recipient for services not covered by Kentucky Medicaid.

The provider's adherence to the application of policies in this manual shall be monitored through either post-payment review of claims by the Department, or

SECTION II – KENTUCKY MEDICAID PROGRAM

computer audits or edits of claims. When computer audits or edits fail to function properly, the application of policies in this manual shall remain in effect. Therefore, claims shall be subject to post-payment review by the Department.

All providers shall be subject to rules, laws, and regulations issued by appropriate levels of federal and state legislative, judiciary and administrative branches.

All services provided to eligible Medicaid recipients shall be on a level of care that is equal to that extended private patients, and on a level normally expected of a person serving the public in a professional capacity.

All recipients shall be entitled to the same level of confidentiality afforded persons NOT eligible for Medicaid benefits.

Providers of medical service or authorized representative attest by their signatures (not facsimiles) on the claim form submitted, that the presented claims are valid and in good faith. Fraudulent claims shall be punishable by fine, imprisonment, or both. Stamped or computer generated signatures shall be not acceptable.

Claims shall not be allowed for services outside the scope of allowable benefits within a particular program specialty. Likewise, claims shall not be paid for services that required and were not granted prior authorization by the Kentucky Medicaid Program. In addition, providers are subject to provisions in 907 KAR 1:671, 907 KAR 1:672, and 907 KAR 1:673.

Claims shall not be paid for medically unnecessary items, services, or supplies. The recipient may be billed for non-covered items and services. Providers shall notify recipients in advance of their liability for the charges for non-medically necessary and non-covered services.

If a recipient makes payment for a covered service, and that payment is accepted by the provider as either partial payment or payment in full for that service, responsibility for reimbursement shall not be attached to the Department and a bill for the same service shall not be paid by the Department. However, a recipient with spenddown coverage may be responsible for a portion of the medical expenses they have incurred.

B. Timely Submission of Claims

According to Federal regulations, claims shall be billed to Medicaid within twelve (12) months of the date of service or six (6) months from the adjudication date of the Medicare payment date or other insurance. Federal regulation define

SECTION II – KENTUCKY MEDICAID PROGRAM

“Timely submission of claims” as received by Medicaid “no later than twelve (12) months from the date of service.” Received is defined in 42 CFR 447.45(d) (5) as follows, “The date of receipt is the date the agency receives the claim, as indicated by its date stamp on the claim.” To consider those claims twelve (12) months past the service date for processing, the provider shall attach documentation showing RECEIPT by Medicaid, the fiscal agent and documentation showing subsequent billing efforts. Claim copies alone shall not be acceptable documentation of timely billing. ONLY twelve (12) months shall elapse between EACH RESUBMISSION of the claim by the Program.

C. Kentucky Patient Access and Care System (KenPAC)

KenPAC is a statewide patient care system which provides Medicaid recipients with a primary physician or family doctor. The primary physician shall be responsible for providing or arranging for the recipient’s primary care and for referral of other medical services.

Optometry and ophthalmology services shall not be affected by KenPAC. You should continue to bill as usual for any covered services provided to patients in KenPAC.

D. Lock-In Program

The Department shall monitor and review utilization patterns of Medicaid recipients to ensure that benefits received are at an appropriate frequency and are medically necessary given the condition presented by the recipient. The Department shall investigate all complaints concerning recipients who are believed to be over-utilizing the Medicaid Program.

The Department shall assign one (1) physician to serve as a case manager and one (1) pharmacy. The recipient shall be required to utilize only the services of these providers, except in cases of emergency services and appropriate referrals by the case manager. In addition, provider and recipients shall comply with the provision set forth in 907 KAR 1:677, Medicaid Recipient Lock-In.

Providers who are not designated as lock-in case managers or pharmacies shall not receive payment for services provided to a recipient assigned to the lock-in program, unless the case manager has pre-approved a referral or for emergency services.

CONDITIONS OF PARTICIPATION

SECTION III

SECTION III– CONDITIONS OF PARTICIPATION

SECTION III– CONDITIONS OF PARTICIPATION

A. General Information

For purposes of participation in the Kentucky Medicaid Program, a Medicaid provider number shall be assigned to each provider. Optometry provider numbers have a prefix of "77". Optician provider numbers have a prefix of "52". Failure to report the correct provider number on the claim submitted for services provided may result in incorrect or nonpayment of claims. If a provider is terminated or suspended from Kentucky Medicaid participation, services provided to Kentucky Medicaid recipients after the effective date shall not be payable. (Please note: Any new provider number issued after June 4th, 2007 will be a non-intelligent number beginning with a "71" no matter what the provider type.)

B. Licensure

All optometrists shall be certified by the Kentucky Board of Optometric Examiners or in the state in which they practice and be required to submit proof of licensure. Annual proof of licensure renewal (which includes effective date and expiration date) shall be required and submitted to the Kentucky Medicaid Program, Individual Provider Services Branch for providers who desire to remain actively enrolled.

All opticians shall hold a current license in the Commonwealth of Kentucky as ophthalmic dispensers and conduct business in accordance with KRS Chapter 326. Out-of-Kentucky opticians shall be required to submit proof of licensure and license renewal as dictated by their respective state boards. Annual proof of licensure renewal (which includes effective date and expiration date) shall be required and submitted to the Kentucky Medicaid Program, Provider Enrollment Section for providers who desire to remain actively enrolled.

NOTE: Non-submission of proof of current licensure shall result in loss of eligibility of the provider and denial of claims submitted for payment.

C. Clinics and Professional Service Corporations (P.S.C.)

Kentucky Medicaid shall permit a group of optometrists and ophthalmic dispensers to enroll in the Program as a clinic or a Professional Service Corporation (P.S.C.) under certain conditions. A clinic shall be defined by Kentucky Medicaid as a group of several providers who practice cooperatively and collaboratively, and who perform a majority of their services in the primary care setting.

SECTION III– CONDITIONS OF PARTICIPATION

Optometrists and ophthalmic dispensers who are employed and salaried by a clinic or professional service corporation may request that payment for their individual services provided to eligible Kentucky Medicaid Program recipients be made directly to the clinic or professional service corporation. Each optometrist and ophthalmic dispenser employed in these settings shall be required to sign and submit a Statement of Authorization Form, (MAP-347).

A Professional Service Corporation shall be defined by Kentucky Medicaid as it is defined specifically according to Commonwealth of Kentucky Revised Statutes, Chapter 274 (KRS 274.990). Out-of-state Professional Service Corporations shall be defined by their individual state law.

D. Freedom of Choice Concept

The freedom of choice concept has always been a fundamental principle governing the Kentucky Medicaid Program. Providers shall have the freedom to decide whether or not to accept eligible Medicaid recipients and to bill the program for the medical care provided.

E. Medical Records

907 KAR 1:672, Section 4. Required provider documentation.

Each provider shall maintain documentation of:

- (a) Care, services, or supplies provided to an eligible beneficiary
- (b) The recipient's medical record or other provider file, as appropriate, which shall demonstrate that the care, services or supplies billed for, were actually performed or delivered;
- (c) The diagnostic condition necessitating the service performed or supplies provided;
- (d) Medical necessity as substantiated by appropriate documentation including an appropriate medical order.

All documentation required by this section shall be maintained by the provider for a minimum of six (6) years from the latter of:

- (a) The date of final payment for services;
- (b) The date of final cost settlement for cost reports; or
- (c) The date of final resolution of disputes, if any.

SECTION III– CONDITIONS OF PARTICIPATION

If any litigation, claim, negotiation, audit, investigation, or other action involving the records has been started before the expiration of the six (6) year period, the records shall be retained until the latter of:

- (a) The completion of the action and resolution of all issues which arise from it, or
- (b) The end of the regular six (6) year period.

F. Medicaid Participation Overview

Any optometrist or ophthalmic dispenser licensed in Kentucky or another state may participate in the Kentucky Medicaid Program by enrolling in the Program and requesting payment for covered services provided to eligible program recipients. A copy of this licensure or any renewal of licensure shall be submitted by the provider and maintained on file in Kentucky Medicaid. The provider shall complete the Provider Application (MAP-811) Form. All participating providers shall comply with the requirements specified in 907 KAR 1:671, 907 KAR 1:672, and 907 KAR 1:673. One (1) copy of each completed form shall be returned to the Department, whereupon a provider number shall be assigned to the provider. The number serves to identify statements submitted to the Program, and shall be utilized in the preparation of all payment records.

Optometrists and ophthalmic dispensers who choose to enroll in the Kentucky Medicaid Program as a clinic or a Professional Service Corporation (PSC) shall complete the MAP-343 and Map-344 forms as referenced above, and sign and submit a Statement of Authorization Form (MAP-347). Return these forms to the Department, whereupon a provider number shall be assigned to the clinic or PSC.

If a provider enrolls in Kentucky Medicaid and chooses to submit claims electronically, the provider shall complete and submit a Provider Agreement Addendum (MAP-380). If a third party computer billing agency is used to prepare the media for the provider, the electronic media billing agency shall also complete and submit an agreement (MAP-246). One (1) copy of each completed form shall be returned to the Department for Medicaid Services.

Optometry providers located outside the United States and its territories shall not be granted enrollment in the Kentucky Medicaid Program.

Notification in writing shall be made to the Medicaid Program regarding any change in Program participation status (e.g., change of ownership, address change, closing).

SECTION III– CONDITIONS OF PARTICIPATION

G. Overview of Required Procedures

The Medicaid Program shall use several investigative and screening methods to detect any abuse on the part of the provider or recipient. Computer print-outs shall be reviewed periodically (e.g., quarterly). Data shall be compared against norms of the specific medical service areas for number of medical services per recipient, cost per service and cost per recipient. If the figures show significant deviations from the norms, the provider shall be identified as needing an in-depth review. Records shall be more thoroughly examined and provider and recipient contact shall be initiated to determine the cause for the unusual pattern or care.

PROGRAM COVERAGE

SECTION IV

SECTION IV– PROGRAM COVERAGE

SECTION IV - PROGRAM COVERAGE

A. Eligibility Guidelines

Medical Assistance Identification (MAID) cards shall be issued to all recipients eligible for program benefits. The ten (10) digit MAID number which appears on the identification card shall be entered in Field 9a on the HCFA-1500 claim form submitted for payment. It is recommended that the provider or provider's staff correctly identify the recipient whose name appears on the card at the time of service delivery and carefully note the period of eligibility to validate that the recipient is eligible for benefits on the date of service. A second form of recipient identification may be requested by the provider in order to verify the identity of the recipient. Kentucky Medicaid shall not reimburse for services provided to ineligible recipients.

B. Examination, Diagnostic and Treatment Services

Effective June 2007, the CMS-1500 claim form shall be used to report vision services provided to eligible Medicaid recipients. This specific form shall be submitted completely, accurately, and legibly to the Kentucky Medicaid fiscal agent within twelve (12) months from the date of service or within six (6) months of the Medicare or other insurance adjudication date. Specific guidelines for completion of the HCFA-1500 shall be available through the fiscal agent. Actual signatures of the provider or authorized others shall be required on claims submitted for payment.

The Kentucky Medicaid Program shall provide reimbursement to optometrists for vision examinations and limited diagnostic and treatment services provided for eligible Kentucky Medicaid recipients of all ages according to the Physicians' Current Procedural Terminology/Health Care Financing Administration Common Procedural Coding System (CPT codes) reported on claims and ONLY as the descriptors of the codes allow. Kentucky Medicaid shall announce occasions when code descriptors are not recognized or are altered for Kentucky Medicaid reimbursement purposes. If protocols in the CPT are more stringent than limits stated in this Section, the protocols in the CPT will take precedence.

Kentucky Medicaid shall not provide separate payment for procedures that are part of a more comprehensive service; therefore, two (2) or more procedure codes shall not be reported or reimbursed separately if one (1) code is available to appropriately identify the comprehensive service provided.

SECTION IV– PROGRAM COVERAGE

1. Covered Services

Following is a list of procedure codes corresponding to covered optometry vision examination, diagnostic and treatment services by Kentucky Medicaid. These codes listed in numerical order are more specifically identified in the AMA Physicians' Current Procedural Terminology (CPT) book.

| | | | | | | |
|-------|-------|--------|-------|-------|-------|-------|
| 65205 | 81000 | 87081 | 92120 | 92313 | 99205 | 99254 |
| 65210 | 82947 | 87082 | 92130 | 92499 | 99211 | 99255 |
| 65220 | 82948 | 87083 | 92135 | 92531 | 99212 | 99301 |
| 65222 | 82951 | 87084 | 92140 | 92532 | 99213 | 99302 |
| 65430 | 82952 | 87085 | 92225 | 92533 | 99214 | 99303 |
| 65435 | 85002 | 87205 | 92226 | 92534 | 99215 | 99304 |
| 67820 | 85007 | 90901 | 92230 | 95930 | 99221 | 99305 |
| 68761 | 85009 | 92002 | 92235 | 95999 | 99222 | 99306 |
| 68801 | 85014 | 92004 | 92250 | 96111 | 99223 | 99307 |
| 68810 | 85018 | 92012 | 92260 | 96116 | 99231 | 99321 |
| 76511 | 85021 | 92014 | 92265 | 97110 | 99232 | 99322 |
| 76512 | 85022 | 92015 | 92270 | 97112 | 99233 | 99323 |
| 76514 | 85023 | 92020 | 92275 | 97139 | 99241 | 99331 |
| 76516 | 85024 | 92060 | 92283 | 97530 | 99242 | 99332 |
| 76529 | 85025 | 92065 | 92284 | 99050 | 99243 | 99333 |
| 76999 | 85031 | 92070* | 92285 | 99178 | 99244 | 99341 |
| 80002 | 85041 | 92081 | 92286 | 99201 | 99245 | 99342 |
| 80003 | 85048 | 92082 | 92310 | 99202 | 99251 | 99343 |
| 80004 | 86490 | 92083 | 92311 | 99203 | 99252 | 99351 |
| 80005 | 86510 | 92100 | 92312 | 99204 | 99253 | 99352 |
| 80006 | 99308 | 99309 | 99353 | | | |

NOTE: Optometry claims submitted for the above referenced covered CPT procedures shall reflect the usual and customary billed charge to the general public. These procedures are covered for recipients of all ages.

*Procedure code 92070 shall be used to bill the therapeutic bandage lens used in the treatment of diseases, (e.g., bullous keratopathy or non-healing corneal ulcers).

Contact lenses are non-covered and shall not be substituted as eyeglasses.

SECTION IV– PROGRAM COVERAGE

2. Limitations on Covered Examination, Diagnostic and Treatment Services

Effective 12-01-93, new patient Evaluation and Management office or other outpatient services codes 99201, 99202, 99203, 99204 and 99205 shall be limited to one (1) per recipient, per provider, per three (3) year period.

Effective 12-01-93, new patient Evaluation and Management home services codes 99321, 99322, 99323, 99342, 99342, and 99343 shall be limited to one (1) per recipient, per provider, per three (3) year period. Established Evaluation and Management home service code 99353 shall be limited to one (1) per recipient, per provider, per twelve (12) month period.

Effective 12-01-93, new patient ophthalmological procedure codes 92002 and 92004 shall be limited to one (1) per recipient, per provider, per three (3) year period.

Established patient ophthalmological procedure codes 92012 and 92014 shall be limited to one (1) per recipient, per provider, per twelve (12) month period.

Coverage for an evaluation and management service with a corresponding CPT code of 99214 or 99215 shall be limited to two (2) per recipient, per year, per diagnosis, per provider. Additionally, whenever any of these two codes are submitted after the limit has been met, they will be automatically down-coded to a CPT 99213.

Procedure codes 92002, 92004, 92012, and 92014 shall NOT be reported and billed with the following procedure codes: 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, and 99215.

Procedure codes 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, and 99215 shall not be reported and billed with the following procedure codes: 99241, 99242, 99243, 99244, 99245, 99251, 99252, 99253, 99254, and 99255.

Evaluation and management service code 99211 shall not be payable unless there is actual physician-patient contact during the visit.

Application of these policies shall be subject to enforcement by both computer audits and edits and the postpayment review of claims.

SECTION IV– PROGRAM COVERAGE

3. Limitations on Covered Visual Fields and Ophthalmoscopy Services

Visual field examinations (procedure codes 92081, 92082, and 92083) shall be limited to one (1) examination per recipient, per provider, per date of service. These procedure codes shall not be billed together on the same date of service.

Ophthalmoscopy examination procedure codes (92230, 92235, 92250 and 92260) shall be limited to one (1) examination per recipient, per provider, per date of service. These procedure codes shall not be billed together.

4. Limitations on Covered Laboratory Services

The Clinical Laboratory Improvement Amendments (CLIA) requirements became effective September 1, 1992. For Kentucky Medicaid to provide reimbursement for laboratory services after this date, all providers who perform any laboratory test shall apply for and be issued CLIA certification, and possess a CLIA identification number this includes commonly performed tests (e.g., rapid strep, nasal smears, etc.) with CPT procedure codes 80002-89399.

Each CLIA identification number submitted to Kentucky Medicaid is entered into the corresponding provider record and cross-referenced with the provider number in the computer system. Effective December 1, 1992, any provider billing laboratory codes without an appropriate CLIA number on file, shall have any uncertified laboratory code payments reclaimed by Kentucky Medicaid. Monitoring for CLIA numbers was initiated on January 1, 1993.

Providers who perform any laboratory tests may request information or apply for CLIA certification at the following address:

ATTN CLIA LABORATORY INQUIRY
HEALTH CARE FINANCING ADMINISTRATION
PO BOX 26689
BALTIMORE MD 21207-0489

Upon receipt of CLIA certification and issuance of a CLIA number, individual optometrists providing laboratory services shall provide a copy of the CLIA certification of approval and the CLIA number to Department for Medicaid Services; Individual Provider Services Branch; 275 East Main; Frankfort, KY 40621. The individual optometrist shall report his

SECTION IV– PROGRAM COVERAGE

Kentucky Medicaid eight (8) digit provider number at the same time to facilitate cross-referencing.

All optometrists enrolled in Kentucky Medicaid who are CLIA certified and have registered their CLIA certification numbers with Kentucky Medicaid Provider Enrollment may bill and receive reimbursement for the following laboratory procedures performed for Kentucky Medicaid recipients:

A complete blood count (CBC) shall be billed when three (3) or more of the following tests are performed: 85007 or 85009, 85014, 85018, 85041, or 85048. When a CBC is performed and billed to Kentucky Medicaid separate payment for any one (1) of these components shall not be allowed.

Reimbursement for both culture and smear for bacteria shall not be allowed by Kentucky Medicaid for the same diagnosis of a recipient, on the same date of service by the same provider.

Application of policy related to laboratory services shall be subject to enforcement by computer audits, edits and the postpayment review of claims.

C. Eyeglasses

1. Conditions of coverage

The following criteria shall be met for Kentucky Medicaid Program coverage of eyeglasses.

(a) Recipient's Age

The costs of eyeglasses or eyeglass parts and the appropriate dispensing fee for services provided are eligible for reimbursement for eligible Kentucky Medicaid Program recipients under twenty-one (21) years of age.

(b) Diagnosis

Coverage of eyeglasses is dependent upon a diagnosed visual condition that (1) requires eyeglasses and (2) is included in one (1) of the following four (4) categories:

SECTION IV– PROGRAM COVERAGE

- (1) Amblyopia
- (2) Post surgical eye condition
- (3) Diminished or subnormal vision
- (4) Other diagnosis which indicates need for eyeglasses

(c) Minimum Prescription

Visual conditions requiring prescriptions for correction shall contain power in the stronger lens no weaker than the following:

- +0.50 or 0.50 sphere +0.50 or 0.50 cylinder
- 0.50 diopter of vertical prism
- A total of 2 diopter of lateral prism

(d) Frame and Lenses Requirement

(1.) Frame

All frames shall be first quality and free of defects. Each pair of frames dispensed must carry a minimum of a one-year manufacturer's guarantee.

To enable replacement of lenses and frame parts, all frames shall have imprinted on them the following information: Eye size, bridge size, temple length, and the manufacturer's name or trademark.

The provider shall allow the recipient to try on and select from an adequate selection of appropriate, approved frame styles. The recipient shall be permitted to use his own frame, if he chooses. If the recipient selects frames non-approved by the Medicaid Program, the recipient shall be responsible for the payment of the frames. The Medicaid Program shall not pay the difference in costs for designer frames or non-approved frames.

(2.) Lenses

Only first quality lens shall be used. The lens shall be available in a complete range of corrected curves. The lens shall be free of defects, packaged in the manufacturer's original envelope or box, and meet the requirements of inspection, tolerance, and testing procedures as outlined in the American Standard Prescription Requirements.

SECTION IV– PROGRAM COVERAGE

All lenses shall meet the current Food and Drug Administration (FDA) standards of impact resistance. All lenses shall be polycarbonate and scratch coated.

NOTE: Supplies and materials other than eyeglasses and visual aids used in a diagnostic service (e.g., eye drops, cotton swabs, etc.) shall be considered to be part of the service provided; therefore, Program payment for the service shall be all inclusive of costs of these items. Separate charges for these items shall not be allowed by Kentucky Medicaid and the recipient shall not be billed for these items.

D. Eyeglasses Coverage Limitations

1. Reimbursement for eyeglasses and hardware shall be in accordance with the upper limits specified in the Medicaid Vision Fee Schedule with total payments not to exceed:
 - (A) \$200 per calendar year for a recipient who is under age twenty-one (21) and a member of the Global Choices benefit plan; and
 - (b) \$400 per calendar year for a recipient who is under age twenty-one (21) and a member of the:
 1. Family Choices benefit plan;
 2. Comprehensive Choices benefit plan; or
 3. Optimum Choices benefit plan.

If medical necessity is established, these reimbursement caps do not apply to Early Periodic Screening, Diagnostic and Treatment (EPSDT) eligible children in accordance with 1905(r)(5) of the Social Security Act.

2. Telephone contacts shall be excluded from payment by Kentucky Medicaid.
3. Contact lenses shall be excluded from Kentucky Medicaid payment and shall not be substituted as eyeglasses. Procedure code 92070 shall be used to bill for the therapeutic bandage lens used in the treatment of diseases, (e.g., bullous keratopathy, or non-healing corneal ulcers). The fitting of contact lenses shall be payable ONLY when any one (1) of the following criteria is met:
 - (a) The CORRECTED acuity in the recipient's best eye is 20/50 and shall be improved with use of contact lenses;
 - (b) The visual prescription of ± 8.00 diopter or greater;

SECTION IV– PROGRAM COVERAGE

- (c) The recipient diagnosis is 4.00 diopter anisometropia (difference in power between eyes); or
 - (d) The words **MEDICALLY INDICATED OR MEDICALLY NECESSARY** shall be written or typed on the claim form. If this is not done, the provider must attach to the claim form a written or typed note or a formal attachment (e.g., the invoice or recipient medical record) stating that this method of correction is **MEDICALLY INDICATED OR MEDICALLY NECESSARY**. Documentation in the recipient's medical record shall substantiate why this method of correction was medically necessary or medically indicated.
4. Tint shall be payable by Kentucky Medicaid **ONLY** if the prescription specifically states the diagnosis of photophobia. Include the tint cost within the cost of the lenses. This policy shall be subject to enforcement by postpayment review of claims.
 5. Kentucky Medicaid Program reimbursement for frames and lenses shall be considered payment in full. The cost of both laboratory materials and dispensing fees may be billed to either the program or the recipient. If any portion of this fee for covered services is paid by the recipient, Kentucky Medicaid shall not assume responsibility for payment of the same service and a claim shall not be submitted to Kentucky Medicaid for additional payment. A claim for the same service may, however, be submitted to Kentucky Medicaid for payment if the provider refunds the amount paid by the recipient for the Kentucky Medicaid Program covered service before billing the program.
 6. Plano safety glasses shall be payable only when medically indicated or medically necessary. The rationale for prescribing safety glasses shall be reported on the claim form, (e.g., recipient is blind in one (1) eye or has only one (1) eye); therefore, he requires additional protection for the remaining eye.
 7. Tints, photochromics, anti-reflective coatings and other lens options that are not medically necessary are non-covered services and may be paid by the recipient.
 8. The cost of prism(s) when medically necessary shall be included within the cost of the lenses.
 9. Low-Vision Services shall be excluded from Kentucky Medicaid payment.

SECTION IV– PROGRAM COVERAGE

E. Dispensing of Eyeglasses

The dispensing of eyeglasses shall include:

- single vision prescriptions
 - bifocal vision prescriptions
 - multifocal vision prescriptions
 - services to frames
 - delivery of completed glasses
1. **SINGLE VISION PRESCRIPTIONS** - The lens selection and design shall meet the recipient's physical, occupational, and recreational needs and requirements. The prescriber shall verify that the finished prescription lens power is correct as ordered and that lens specifications have been met. The prescriber shall be responsible for ascertaining that only first-quality eyeglass materials approved by the Kentucky Medicaid Program have been provided for the Kentucky Medicaid Program recipients, and that the fabrication conforms to the standards.

THE PRESCRIBER SHALL BE RESPONSIBLE AT NO ADDITIONAL COST TO THE KENTUCKY MEDICAID PROGRAM OR THE RECIPIENT, FOR THE REPLACEMENT OF INACCURATELY FILLED PRESCRIPTIONS, DEFECTIVE MATERIALS, OR IMPROPERLY FITTING LENSES.

2. **BIFOCAL AND MULTIFOCAL EYEGLASSES** - prescriptions shall have the same requirements as single vision prescriptions except when contraindicated.
3. **SERVICES TO FRAMES.** Services to frames shall include selecting frames, measuring the recipient's face for fitting, and fulfilling the recipient's occupational and recreational requirements. The provider shall allow the recipient to try on and select from an adequate number of appropriate, approved frame styles. The recipient shall be permitted to use his frame if he chooses. The provider shall verify that the finished prescriptions meet the frame specifications ordered and that only first-quality materials, approved by Kentucky Medicaid, have been provided for recipients. Each pair of frames dispensed must carry at least a one-year manufacturer's guarantee. THE PROVIDER SHALL BE RESPONSIBLE AT NO ADDITIONAL COST TO THE KENTUCKY MEDICAID PROGRAM OR THE RECIPIENT, FOR INACCURATELY FILLED PRESCRIPTIONS, DEFECTIVE MATERIALS, OR IMPROPERLY FITTING FRAMES.

SECTION IV– PROGRAM COVERAGE

4. DELIVERY OF COMPLETED EYEGLOSS PRESCRIPTION - Delivery of the completed glasses shall include instruction of the recipient in the use of the glasses, any adjustment of the glasses, and any subsequent minor adjustments for a period of one (1) year. These services shall be performed by the provider at no additional cost to the Kentucky Medicaid Program or the recipient.

F. Professional Services for Dispensing and Repairing Eyeglasses

Procedure codes for dispensing and repairing eyeglasses are contained in the American Medical Association Physicians' Current Procedural Terminology (CPT) Book. Codes from this source that are reimbursable by Kentucky Medicaid shall include 92340, 92341, 92352, 92353, for the dispensing of new frames and 92370 or 92371 as applicable for repair, refitting or replacement of frames under warranty.

Optometrists and opticians shall report their usual and customary charges for professional dispensing procedures when submitting claims to Kentucky Medicaid. Reimbursement shall be provided by Kentucky Medicaid only for recipients under twenty-one (21) years of age.

G. Eyeglass Procedure Codes

The following laboratory procedure codes and descriptions for eyeglasses and eyeglass parts contained in the current year AMA HCPCS Level II Code book shall be reimbursable by the Kentucky Medicaid Program and used when submitting claims for reimbursement for covered services.

| | |
|---------------|---------------|
| V2100 – V2199 | Single Vision |
| V2200 – V2299 | Bifocal |
| V2300 – V2499 | Multifocal |

The fee schedule above shall be adjusted annually in accordance with the GII.

If vision supplies are ordered from the manufacturer, the invoice or associated information from the current Frames Data Price Book shall be maintained in the recipient's medical record. Listing the frame number and the list price from the current Frames Data Price Book in the patient record will serve as proof of acquisition cost.

SECTION IV– PROGRAM COVERAGE

H. Provider - Patient Contacts

Pursuant to 907 KAR 1:009 Section I, the Kentucky Medicaid Program shall provide reimbursement to a physician for service(s) provided for a recipient ONLY when there is actual physician-patient contact except as provided for herein. The provider shall bill Kentucky Medicaid only for services actually performed. Charges shall not be submitted for recipients who visit the office when the provider does not actually see and examine, treat or diagnose the recipient. Additionally, charges shall not be submitted to Kentucky Medicaid when services are performed or recipient contacts are made exclusively by assistants to the provider, employees, nurses, etc.

Telephone contacts with the recipients shall not be recognized or payable as visits. Therefore, the Program shall not be billed for a visit when telephone contact is the only service provided. Similarly, contacts between providers, or provider employees, and the recipients for the sole purpose of obtaining a prescription or prescription refills shall not be considered visits and the Program shall not be billed. Covered services provided by licensed medical professionals under the direct, personal supervision of a participating Kentucky Medicaid provider shall be billed to the Kentucky Medicaid Program only when the licensed professional is employed on a continuing basis by the Kentucky Medicaid participating provider. The Kentucky Medicaid provider under whose number the claim is submitted shall have provider-patient contact at some point during each treatment session billed. The professional shall be licensed in the state where he actively practices and the services provided shall be within the scope of that license.

The Kentucky Medicaid provider may not serve merely as a billing agent for a licensed medical professional or any agency that cannot otherwise be paid by the Kentucky Medicaid Program.

I. Consultation Services

Requests for consultation services from the attending provider and the need for consultation shall be documented in the recipient's medical record. The consultant's assessment, opinion, and any services ordered or performed shall also be documented in the recipient's medical record. This information shall be communicated in writing to the referring provider.

After an initial consultation in the consultant's office or other outpatient facility, follow-up visits initiated by the consultant shall be reported using office visit codes for established patients.

SECTION IV– PROGRAM COVERAGE

Initial inpatient consultations shall be limited to ONE (1) initial consultation per consultant provider, per recipient, per hospitalization.

If a consultant assumes responsibility for management of a portion or all of a recipient's healthcare, consultation codes shall not be used. In the hospital inpatient setting, the provider receiving the recipient for partial or complete transfer of care shall use the appropriate subsequent hospital care codes. In the office setting, the appropriate established patient codes shall be used.

The application of this policy shall be subject to enforcement by the postpayment review of claims.

REIMBURSEMENT

SECTION V

SECTION V– REIMBURSEMENT

SECTION V - REIMBURSEMENT

A. Optometrists

1. For purposes of determination of payment, "usual and customary charge" shall refer to the uniform amount the individual provider charges in the majority of cases for a specific procedure or service. Charges submitted to the Kentucky Medicaid Program for payment shall not in any case exceed the amount charged to private pay patients or third party payers for identical procedures or services. Kentucky Medicaid Program payment for covered services, except eyeglass materials and laboratory services shall be the optometrists' usual and customary actual billed charges up to the fixed upper limit per procedure established by the department using a Kentucky Medicaid Fee Schedule developed from a resource-based relative value scale (RBRVS) on parity with physicians. If there is no RBRVS based fee the department shall set a reasonable fixed upper limit for the procedure consistent with the general rate setting methodology. Fixed upper limits not determined in accordance with the principle shown in this section due to consideration of other factors (e.g., recipient access) shall be specified herein.
2. Reimbursement for frames or parts of frames (not lenses) for eligible Kentucky Medicaid Program recipients under age twenty-one (21), plus taxes, postage and postal insurance if applicable, shall not exceed upper limits for materials as set by the Department.

B. Ophthalmic Dispensers

1. For purposes of determination of payment, "usual and customary charge" shall refer to the uniform amount the individual provider charges in the majority of cases for a specific procedure or service. Charges submitted to the Kentucky Medicaid Program for payment shall not in any case exceed the amount charged to private pay patients or third party payers for identical procedures or services established by the department using a Kentucky Medicaid Fee Schedule developed from a resource-based relative value scale (RBRVS). If there is no RBRVS based fee the department shall set a reasonable fixed upper limit for the procedure consistent with the general rate setting methodology. Fixed upper limits not determined in accordance with the principle shown in this section due to consideration of other factors (e.g., recipient access) shall be specified herein.

SECTION V– REIMBURSEMENT

2. Reimbursement for eyeglasses or parts of eyeglasses for eligible Kentucky Medicaid Program recipients under age twenty-one (21), plus taxes, postage and postal insurance if applicable, shall not exceed upper limits for materials as set by the Department.

C Laboratory Services

Providers who bill for clinical laboratory codes must comply with the requirements set forth in the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88). A copy of the CLIA certification must be sent to the Department for Medicaid Services, so that the CLIA number can be placed on the provider's file. Reimbursement for clinical laboratory services shall be based on the lesser of the providers' usual and customary billed charges, or Medicare allowable payment rates. For laboratory codes which have no Medicare allowable fee on file, reimbursement shall be based on sixty-five (45) percent of the usual and customary actual billed charges.

D. Reimbursement in Relation to Medicare

1. Deductible and Coinsurance

Medicaid Program recipients who are also eligible for benefits under Title XVIII-Parts A and B (Medicare Hospital Insurance and Supplementary Medical Insurance) shall be required to utilize their benefits under Title XVIII (Medicare) prior to the availability of benefits under the Medicaid (Title XIX) Program. Title XVIII accepts primary liability for all payment sought.

Deductibles are those medical expenses which the recipient shall initially pay on an annual basis to qualify for subsequent Medicare reimbursement. Coinsurance is a cost-sharing requirement which provides that a recipient shall assume a portion or percentage of the costs of covered services. Medicaid shall pay the Medicare deductible and coinsurance amounts for all Medicare covered services submitted on cross-over claims for eligible recipients.

The Medicaid Program shall make payments on behalf of those Title XIX recipients who are also entitled to benefits under Medicare Title XVIII-Part A of Public Law 89-97. The Medicaid Program shall pay the deductible and coinsurance amounts as determined by Medicare.

SECTION V– REIMBURSEMENT

2. Qualified Medicare Beneficiary

Effective February 1, 1989, Section 301 of the Medicare Catastrophic Coverage Act of 1988 requires states to provide Medicaid coverage to certain Medicare beneficiaries in order to pay Medicare cost-sharing expenses (premium, deductible coinsurance amounts). Individuals entitled to Medicare Part A and who do not exceed federally-established income and resource standards may be eligible to receive Medicaid benefits as Qualified Medicare Beneficiaries (QMB's). Reimbursable services for QMB recipients shall be limited to coinsurance and deductibles for all Medicare (Parts A and B) covered services or items regardless of whether the services or items are routinely covered by Kentucky Medicaid.

3. Dual Eligibility for QMB and Medicaid

The Technical and Miscellaneous Revenue Act of 1988 (TAMRA) further provides that specified individual meeting income and resource standards for QMB and also meeting Medicaid eligibility criteria shall have dual eligibility for OMB benefits and Medicaid benefits.

NOTE: On April 1, 1990, OBRA legislation mandated that assignment be accepted on all Medicare/Medicaid claims. This includes Qualified Medicare Beneficiary (QMB) claims. Unassigned claims submitted for coinsurance and deductible payments shall be denied for medical services provided on or after this April 1, 1990, date.

The Medicaid Program shall make payment for all Medicare deductible and coinsurance amounts for the time period any recipient is QMB or dually eligible.

E. Fees - Duplicate or Inappropriate

Effective July 1, 1994, the Kentucky Medicaid Program implemented a comprehensive, computerized auditing system for provider claims submitted for payment. The auditing system was designed to evaluate billing information and coding accuracy on claims submitted for payment to prevent duplicate or inappropriate payment. Based on coding criteria and protocols in the Physician's Current Procedural Terminology (CPT) code book introduced and published annually by the American Medical Association, this automated system of checking claims shall be utilized to detect miscoding and irregularities, i.e., unbundling which involves billing two (2) or more individual CPT codes that may be combined under a single code and charge, mutually exclusive procedures, incidental or integral procedures, etc. The logic of this oversight system shall supersede any Kentucky Medicaid audits or edits previously implemented. As

SECTION V– REIMBURSEMENT

complex developments in medical technology are introduced and require more specific coding, this automated claim checking system shall be updated to assist in the processing and payment of claims for Kentucky Medicaid providers in a way more consistent with CPT and International Classification of Diseases (ICD-9) criteria.

Any duplicate or inappropriate payments issued by Kentucky Medicaid, whether due to erroneous billing or payment system faults, shall be refunded to Kentucky Medicaid. Refund checks shall be made payable to “Kentucky State Treasurer” and sent to the fiscal agent.

Failure to refund a duplicate or inappropriate payment shall be interpreted as fraud or abuse, and therefore, subject to prosecution.

F. Fee Payment By Recipient

Participants in the program shall report ALL payments or deposits made toward a recipient's account, regardless of the source of payment. If the provider receives payment from an eligible Medicaid Program recipient for a Medicaid covered service, the Medicaid Program regulations preclude payment being made by the program for that service unless documentation is received that the payment has been refunded to the recipient. This policy shall not apply to payments made by recipients for spenddown or non-covered services.

Recipients approved for Medicaid benefits on a spend down basis shall be obligated to pay fees to health care providers as assigned by their local Department for Social Insurance where eligibility is established. These fees shall be paid to the providers by the recipients and shall satisfy the excess income for the period of eligibility. These fee payments by the recipients shall be reported by the providers on the claim form as payments from other sources.

Any item(s) or service(s) provided for Medicaid recipients non-covered by Kentucky Medicaid may be billed to the recipient or any other responsible party. Providers shall not collect fees from recipients for covered item(s) or service(s) for which Kentucky Medicaid shall be accepted by the provider as payment in full for a service.

If a recipient has retroactive eligibility in which the individual receives a back-dated Medicaid card, the provider of service shall maintain the option to accept the Kentucky Medicaid card. If the provider agrees to accept the card, any payments made to the provider by the recipient for services during the retroactive eligible period will require a 100 percent refund to the recipient before the program may be billed.