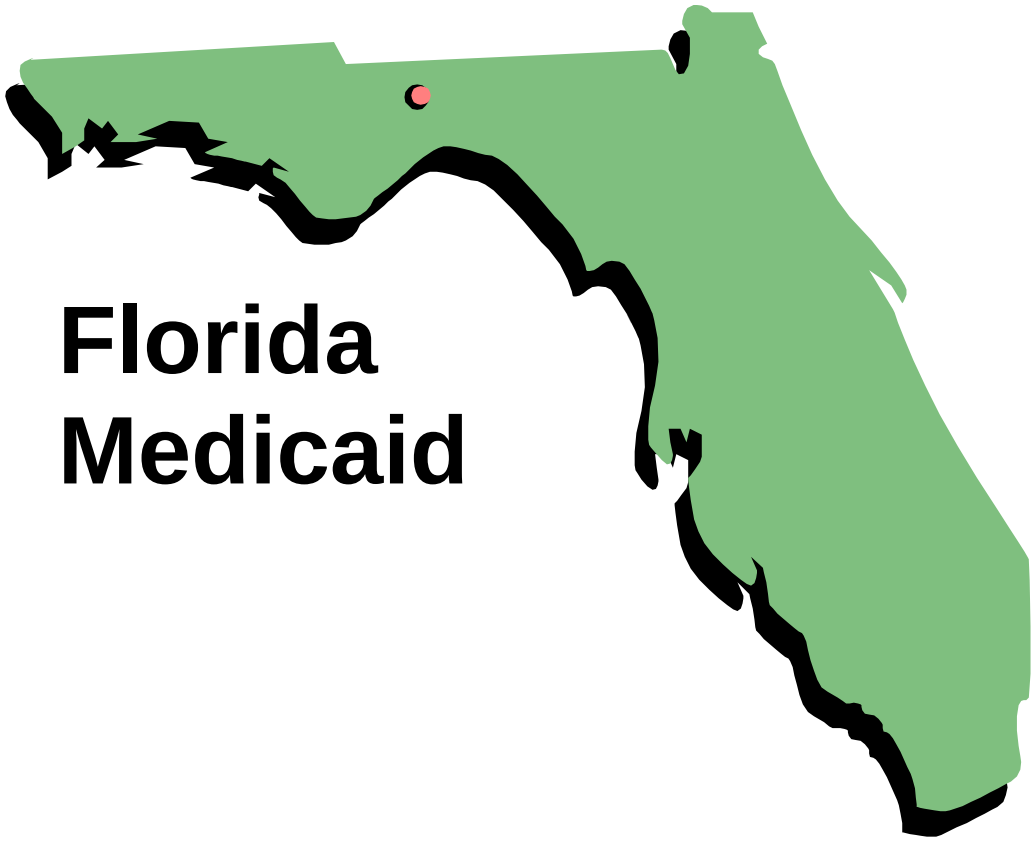

Florida Medicaid

VISUAL SERVICES COVERAGE AND LIMITATIONS HANDBOOK

Agency for Health Care Administration

FLORIDA MEDICAID
A Division of the Agency for Health Care Administration

FLORIDA MEDICAID
A Division of the Agency for Health Care Administration

CHARLIE CRIST
GOVERNOR

Better Health Care for all Floridians

THOMAS W. ARNOLD
SECRETARY

<DATE>

Dear Medicaid Visual Services Provider:

The Visual Services Coverage and Limitations Handbook, January 2010, Section 59G- 4.340 is amended to implement changes to the handbook that include:

- Changes in fiscal agent references.
- A reduction in Medicaid coverage for eyeglass frames and lenses for recipients age 21 and older.
- Clarification of Visual Services policy.

Please contact your local Medicaid area office if you have any questions. The Medicaid area offices' phone numbers and addresses are listed on our Web site at www.ahca.myflorida.com. All of the Medicaid handbooks are available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select *Public Information for Providers*, then *Provider Support*, and then *Provider Handbooks*.

We appreciate the services you provide to Florida's Medicaid recipients.

Sincerely,

Beth Kidder, Chief
Bureau of Medicaid Services

UPDATE LOG
VISUAL SERVICES
COVERAGE AND LIMITATIONS HANDBOOK

How to Use the Update Log

Introduction

The current Medicaid provider handbooks are posted on the Medicaid fiscal agent's Web site at mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks. Changes to a handbook are issued as handbook updates. An update can be a change, addition, or correction to policy. An update may be issued as either replacement pages in an existing handbook or a completely revised handbook.

It is very important that the provider read the updated material and if he maintains a paper copy, file it in the handbook. It is the provider's responsibility to follow correct policy to obtain Medicaid reimbursement.

Explanation of the Update Log

Providers can use the update log to determine if they have received all the updates to the handbook.

Update is the month and year that the update was issued.

Effective Date is the date that the update is effective.

Instructions

When a handbook is updated, the provider will be notified by a notice. The notification instructs the provider to obtain the updated handbook from the Medicaid fiscal agent's Web site at mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks.

Providers who are unable to obtain an updated handbook from the Web site may request a paper copy from the Medicaid fiscal agent's Provider Support Contact Center at 800-289-7799.

UPDATE	EFFECTIVE DATE
Revised Handbook	January 2000
Revised Handbook	May 2001
Replacement Pages	January 2002
Replacement Pages	March 2003
Revised Handbook	January 2004
Errata	January 2004
Remove Appendix A	January 2005
Revised Handbook	January 2006
Replacement Pages	January 2007
Revised Handbook	January 2007
Revised Handbook	January 2010

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VISUAL SERVICES
COVERAGE AND LIMITATIONS HANDBOOK

Table of Contents

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INTRODUCTION TO THE HANDBOOK

Overview

Introduction

This chapter introduces the format used for the Florida Medicaid handbooks and tells the reader how to use the handbooks.

Background

There are three types of Florida Medicaid handbooks:

Provider General Handbook describes the Florida Medicaid Program.
Coverage and Limitations Handbooks explain covered services, their limits, who is eligible to receive them, and the fee schedules.
Reimbursement Handbooks describe how to complete and file claims for reimbursement from Medicaid.

Exception: For Prescribed Drugs, the coverage and limitations handbook and the reimbursement handbook are combined into one.

Legal Authority

The following federal and state laws govern Florida Medicaid:

Title XIX of the Social Security Act.
Title 42 of the Code of Federal Regulations.
Chapter 409, Florida Statutes.
Chapter 59G, Florida Administrative Code.

In This Chapter

This chapter contains:

Handbook Use and Format

Purpose	The purpose of the Medicaid handbooks is to provide the Medicaid provider with the policies and procedures needed to receive reimbursement for covered services provided to eligible Florida Medicaid recipients. The handbooks provide descriptions and instructions on how and when to complete forms, letters or other documentation.
Provider	The term “provider” is used to describe any entity, facility, person or group who is enrolled in the Medicaid program and provides services to Medicaid recipients and bills Medicaid for services.
Recipient	The term “recipient” is used to describe an individual who is eligible for Medicaid.
General Handbook	General information for providers regarding the Florida Medicaid Program, recipient eligibility, provider enrollment, fraud and abuse policy, and important resources are included in the Florida Medicaid Provider General Handbook. This general handbook is distributed to all enrolled Medicaid providers and is updated as needed.
Coverage and Limitations Handbook	Each coverage and limitations handbook is named for the service it describes. A provider who provides more than one type of service will have more than one coverage and limitations handbook.
Reimbursement Handbook	Each reimbursement handbook is named for the claim form that it describes.
Chapter Numbers	The chapter number appears as the first digit before the page number at the bottom of each page.
Page Numbers	Pages are numbered consecutively throughout the handbook. Page numbers follow the chapter number at the bottom of each page.
White Space	The "white space" found throughout a handbook enhances readability and allows space for writing notes.

Characteristics of the Handbook

Format	The format styles used in the handbooks represent a short and regular way of displaying difficult, technical material.
Information Block	Information blocks replace the traditional paragraph and may consist of one or more paragraphs about a portion of the subject. Blocks are separated by horizontal lines. Each block is identified or named with a label.
Label	Labels or names are located in the left margin of each information block. They identify the content of the block in order to help scanning and locating information quickly.
Note	Note is used most frequently to refer the user to important material located elsewhere in the handbook. Note also refers the user to other documents or policies contained in other handbooks.
Topic Roster	Each chapter contains a list of topics on the first page, which serves as a table of contents for the chapter, listing the subjects and the page number where the subject can be found.

Handbook Updates

Update Log	The first page of each handbook will contain the update log. Every update will contain a new updated log page with the most recent update information added to the log. The provider can use the update log to determine if all updates to the current handbook have been received. Each update will be designated by an “Update” and the “Effective Date.”
How Changes Are Updated	The Medicaid handbooks will be updated as needed. Changes may be: 1. Replacement handbook—Major changes will result in the entire handbook being replaced with a new effective date throughout and it will be a clean copy. 2. Revised handbook – Changes will be highlighted in yellow and will be incorporated within the appropriate chapter. These revisions will have an effective date that corresponds to the effective date of the revised handbook..

Handbook Updates, continued

Effective Date of New Material	The month and year that the new material is effective will appear at the bottom of each page. The provider can check this date to ensure that the material being used is the most current and up to date.
Identifying New Information	New material will be identified by yellow highlighting. The following information blocks give examples of how new labels, new information blocks, and new or changed material within an information block will be indicated.
New Label and New Information Block	A new label and a new information block will be identified with yellow highlight to the entire section.
New Material in an Existing Information Block or Paragraph	New or changed material within an existing information block or paragraph will be identified by yellow highlighting to the sentence and/or paragraph affected by the change.

CHAPTER 1
VISUAL SERVICES
PROVIDER QUALIFICATIONS AND REQUIREMENTS

Overview

Introduction

This chapter describes the Medicaid Visual Services Program and the provider qualifications.

Legal Basis

Visual services are authorized by Title XIX of the Social Security Act and Code of Federal Regulations (C.F.R.), Title 42, Part 440. The Florida Medicaid Visual Services Program was implemented through Chapter 409.906, Florida Statutes (F.S.) and Chapter 59G, Florida Administrative Code (F.A.C.).

In This Chapter

This chapter contains:

Purpose and Description

Purpose

The purpose of visual services is to provide medically necessary eyeglasses, contact lenses, eyeglasses repair services, and prosthetic eyes to Medicaid recipients.

Purpose of This Handbook

This handbook is intended for use by currently enrolled ophthalmologists, optometrists, and opticians who provide visual services to Medicaid recipients. It must be used in conjunction with the Florida Medicaid Provider General Handbook, which contains information about the Medicaid program in general, and the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, which contains the specific procedures for submitting claims for payment.

Note: All Medicaid Provider Handbooks are available on the Medicaid Web site at mymedicaid-florida.com. Select Public Information for Providers, Provider Support, and Provider Handbooks.

Purpose and Description, continued

Description

Visual services include the medically necessary provision of eyeglasses, prosthetic eyes, and contact lenses; the fitting, dispensing, and adjusting of eyeglasses; and eyeglass repair services.

Provider Qualifications

Licensure

To enroll as a Medicaid visual service provider, the applicant must be currently licensed as an:

- Ophthalmologist as defined in Chapter 458, F.S.;
- Optometrist as defined in Chapter 463, F.S.; or
- Optician as defined in Chapter 484, Part I, F.S.

Note: See Chapter 2 in the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for additional information regarding out-of-state providers and services. All Medicaid Provider Handbooks are available on the Medicaid Web site at mymedicaid-florida.com. Select Public Information for Providers, Provider Support, and Provider Handbooks.

Fully Operational at Time of Enrollment

Visual services providers must meet all the provider requirements and qualifications and their practices must be fully operational before they can be enrolled as Medicaid providers.

Note: See Chapter 2 of this handbook for the definition of fully operational.

Provider Enrollment

General Enrollment Requirements

Visual services providers must meet the general Medicaid provider enrollment requirements that are contained in Chapter 2 of the Florida Medicaid Provider General Handbook. In addition, visual services providers must follow the specific enrollment requirements that are listed in this section.

Ophthalmologists and optometrists providing visual services must request that Category of Service code 62 be added to their provider files, to become eligible for the reimbursement of visual services.

Physicians must also be currently licensed as ophthalmologists to be eligible for a Category of Service code 62 to be added to their provider files.

Group Providers

Two or more Medicaid-enrolled providers whose practice is incorporated under the same tax identification number must enroll as a Medicaid provider group. In order to receive payment from Medicaid, each member of the group must also enroll as an individual treating provider within the group.

Provider Enrollment, continued

Multiple Locations

Both individual and group providers who have practices at more than one physical office location, i.e., satellite offices, must notify the Medicaid fiscal agent of additional practice locations. See Chapter 2 of the Florida Medicaid Provider General Handbook for instructions on notifying the fiscal agent of additional practice locations.

Any closure of a practice location must also be reported to the Medicaid fiscal agent, in writing on office letterhead stationery, along with the effective date of the closure or the anticipated date of closure.

Note: See Definitions in Chapter 2 of this handbook for additional information regarding physical location

Provider Requirements

General Requirements

In addition to the general requirements and responsibilities that are contained in Chapter 2 of the Florida Medicaid Provider General Handbook, visual services providers are also responsible for complying with the provisions contained in this section.

Note: All Medicaid Provider Handbooks are available on the Medicaid Web site at mymedicaid-florida.com. Select Public Information for Providers, Provider Support, and Provider Handbooks.

Provider Responsibility

Florida Medicaid has implemented all of the requirements contained in the federal legislation known as the Health Insurance Portability and Accountability Act (HIPAA). As trading partners with Florida Medicaid, all Medicaid providers, including their staff, contracted staff and volunteers, must comply with HIPAA privacy requirements effective April 14, 2003. Providers who meet the definition of a covered entity according to HIPAA must comply with HIPAA Electronic Data Interchange (EDI) requirements effective October 16, 2003. This coverage and limitations handbook includes information regarding changes in procedure codes mandated by HIPAA. The Florida Medicaid Provider Reimbursement Handbooks contain the claims processing requirements for Florida Medicaid, including the changes necessary to comply with HIPAA.

Note: For additional information regarding HIPAA privacy in Florida Medicaid, see Chapter 2 in the Florida Medicaid Provider General Handbook. For information regarding changes in EDI requirements for Florida Medicaid because of HIPAA, contact the Medicaid fiscal agent EDI help desk at 1-866-586-0961, or 1-800-289-7799 (option 3). All Medicaid Provider Handbooks are available on the Medicaid Web site at mymedicaid-florida.com. Select Public Information for Providers, Provider Support, and Provider Handbooks.

CHAPTER 2
VISUAL SERVICES
COVERED SERVICES, LIMITATIONS AND EXCLUSIONS

Overview

Introduction

This chapter describes the services covered under the Florida Medicaid Visual Services Program, the requirements for service provision, and the service limitations, and exclusions.

In This Chapter

This chapter contains:

Covered and Excluded Services

Introduction

Medicaid may reimburse for the covered visual services described in this handbook and listed in the current Visual Services Fee Schedule. The services must be provided to currently eligible Medicaid recipients and be medically necessary as described below.

Covered and Excluded Services, *continued*

Covered Services

Only those services designated in this chapter and listed in the Vision Services Fee Schedule can be reimbursed by Medicaid to a currently enrolled optometrist, ophthalmologist, and optician.

Note: All Medicaid Provider Handbooks are available on the Medicaid Web site at mymedicaid-florida.com. Select Public Information for Providers, Provider Support, and Provider Handbooks.

The Medicaid Visual Services Program reimburses the following services, within maximum limitations and when medically necessary:

- Fitting, dispensing, and adjustment of eyeglasses;
- Eyeglasses;
- Contact lenses;
- Eyeglasses repair services; and
- Prosthetic eyes.

Residents of Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) do not qualify for Medicaid Visual Services. The ICF/DD resident's visual services are included in the facility's per diem rate.

Note: See Intermediate Care Facilities for the Developmentally Disabled (ICF/DD) in this chapter and section for additional per diem information.

Limitations

Certain services are designated with limitations by diagnosis or other limitations listed on the Vision Services Fee Schedule. Additional limitations specified in this handbook also apply.

Visual Exams

Medicaid reimburses medically necessary visual exams through the physician and optometric services programs.

In accordance with Chapter 484.013, Florida Statutes, it is unlawful for an optician to perform visual examinations.

Note: See the Florida Medicaid Physician Coverage and Limitations Handbook or the Optometric Services Coverage and Limitations Handbook for the visual examination procedure codes, fees, and provider enrollment qualifications. All Medicaid Provider Handbooks are available on the Medicaid Web site at mymedicaid-florida.com. Select Public Information for Providers, Provider Support, and Provider Handbooks.

Covered and Excluded Services, *continued*

Medically Necessary

Medicaid reimburses services that are determined medically necessary and do not duplicate another provider's service. In addition, the services must meet the following criteria:

- Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
- Be individualized, specific, consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;
- Be consistent with generally accepted professional standards as determined by the Medicaid program, and not be experimental or investigational;
- Reflect the level of services that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
- Be furnished in a manner not primarily intended for the convenience of the recipient,the recipient's caretaker, or the provider.

The fact that a provider has prescribed, recommended, or approved medical or allied care, good(s), or service(s) does not, in itself, make such care, good(s) or service(s) medically necessary or a covered service.

Note: See the Glossary in the Florida Medicaid Provider General Handbook for the definition of medically necessary. All Medicaid Provider Handbooks are available on the Medicaid Web site at mymedicaid-florida.com. Select Public Information for Providers, Provider Support, and Provider Handbooks.

Prescription for Eyeglasses or Contact Lenses

Eyeglasses and contact lenses must be prescribed by a currently licensed ophthalmologist or optometrist currently enrolled in Medicaid. (If you do not know if the prescribing provider is enrolled in Medicaid, contact your area Medicaid office to confirm the provider's enrollment.)

The prescribing provider must indicate on the recipient's eyeglass or contact lens prescription the diagnosis code that best described the medical need for the service. The visual services provider must maintain a copy of the prescription in the recipient's medical record.

The visual services provider must also enter the diagnosis code on the Medicaid claim.

Note: See the Provider Reimbursement-CMS 1500 Handbook, for additional information regarding instructions for the completion of a claim form. All Medicaid Provider Handbooks are available on the Medicaid Web site at mymedicaid-florida.com. Select Public Information for Providers, Provider Support, and Provider Handbooks.

Covered and Excluded Services, *continued*

Central Optical Laboratory

The state of Florida has a Central Optical Laboratory that is managed by Prison Rehabilitative Industries and Diversified Enterprises (PRIDE). The Central Optical Laboratory maintains a supply of frames, fills prescriptions for eyeglasses, and may provide special order items.

Visual services providers may choose to use the Central Optical Laboratory for services provided to Medicaid recipients.

The address and phone number of the laboratory are:

PRIDE Optical
20421 Sheridan Street
Fort Lauderdale, Florida 33332
Phone: 800-523-1766
Fax: 813-890-2103

Excluded Services

The Medicaid Visual Services Program does not reimburse:

- Visual examinations;
- Orthoptics or visual training;
- Low-vision therapy;
- Low-vision devices;
- Procedures related to providing eyeglasses that are performed in a nursing facility, a custodial care facility, or a recipient's home unless the conditions described on the next page are met;
- Progressive lenses;
- Transition lenses; and
- Glass lenses.

Note: See Criteria for Providing Eyeglasses in a Nursing Facility, Custodial Care Facility, or Recipient's Home in this chapter for specific requirements.

Note: See the Optometric Services Handbook regarding visual examinations reimbursed through Medicaid. All Medicaid Provider Handbooks are available on the Medicaid Web site at mymedicaid-florida.com. Select Public Information for Providers, Provider Support, and Provider Handbooks.

Covered and Excluded Services, *continued*

Criteria For Providing Eyeglasses in a Nursing Facility, Custodial Care Facility, or Recipient's Home	Only when all of the following criteria are met, will visual services be reimbursed when performed in: 1) the recipient's home, 2) a nursing home, or 3) other custodial care facility: • The recipient is given the right to choose his visual service provider; • The visual services provided in the facility or recipient's home are qualitatively comparable to visual services rendered in the provider's office; • Transportation to the provider's office would require an ambulance or stretcher van or moving the recipient out of his home or nursing facility room would pose an unacceptable health risk, due to the recipient's current and documented medical condition; • The recipient's primary care physician, or facility physician, specifically orders medically necessary visual services to be performed in the recipient's home or residential facility; ➢ The physician's order (documentation of medical necessity) is valid up to 90 days after the order is signed and dated by the referring physician. ➢ If additional visual services are required, the medical necessity for the service must be re-determined by the recipient's primary care physician. ➢ Pursuant to Chapter 59A-4. 107, F.A.C.; verbal treatment orders shall be countersigned by the primary care physician on the next visit to the residential facility and must be filed in the recipient's medical record at both the facility and the visual services provider's office. • When visual services are provided in the recipient's home, documentation of medical necessity, as described above, and services received must be maintained in the recipient's medical record in the provider's office. • When visual services are provided in the recipient's residential facility the documentation of medical necessity and documentation of services received must be maintained in both the facility and the provider's office. The appropriate place of service must be entered on the provider's claim form. Visual services performed in a recipient's home or recipient's residential facility must not be billed with a place of service code that is designated for an office, inpatient, outpatient or health clinic setting. Note: Refer to Chapter 3 of the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, regarding prior authorization and a list of all place of service codes and code descriptions. All Medicaid Provider Handbooks are available on the Medicaid Web site at mymedicaid-florida.com. Select Public Information for Providers, Provider Support, and Provider Handbooks.

Covered and Excluded Services, *continued*

Intermediate Care Facilities for the Developmentally Disabled (ICF/DD)	Eyeglasses are included in the ICF/DD per diem rate. Visual service providers cannot bill Medicaid for eyeglasses for a recipient who resides in an ICF/DD. Claims for eyeglasses provided to a resident of an ICF/DD facility must be submitted directly to the facility for payment. Note: See the Florida Medicaid Intermediate Care Facility for the Developmentally Disabled (ICF-DD) Coverage and Limitations Handbook for more information on this type of facility. All Medicaid Provider Handbooks are available on the Medicaid Web site at mymedicaid-florida.com . Select Public Information for Providers, Provider Support, and Provider Handbooks.

Fitting, Dispensing, and Adjustment of Eyeglasses

Description	The fitting, dispensing and adjustment of eyeglasses may be provided for both new eyeglasses and eyeglasses that need major factory repairs, such as replacement of the frame, temple, or lens(es).
Service Components	The visual services provider may submit a claim to receive reimbursement for the fitting, dispensing, and adjustment of eyeglasses, only when all of the following components are provided: • Assisting the recipient in selecting the frame style, color, and size; • Ordering the eyeglasses; • Verifying the prescription; and • Dispensing, fitting, and adjusting the eyeglasses for the recipient. The order for the eyeglasses must be dated and signed by the recipient, Medicaid cannot reimburse the provider for the fitting, dispensing and adjustment of eyeglasses if the recipient chooses to purchase the frames or the lenses, or both the frames with the lenses, privately. Note: See Recipient Options under the Eyeglasses and Lenses section of this chapter.

Fitting, Dispensing, and Adjustment of Eyeglasses, *continued*

Billing Date

The provider must not submit a claim for fitting, dispensing, and adjustment of eyeglasses or any other procedure code for eyeglasses, until the recipient has been satisfactorily fitted and has taken possession of the eyeglasses.

The provider must use the date that the eyeglasses were dispensed as the date of service on the claim when billing for the eyeglasses (frames, lenses, and add-ons. The provider may only use the date the eyeglasses were ordered as the date of service on the claim, if the recipient has become ineligible for Medicaid after the order date and before the date the eyeglasses are dispensed.

Service Exclusions

Provision of the same service for the same recipient on the same date of service cannot be reimbursed as both a physician service and a visual service.

Dually-Eligible Medicare and Medicaid Recipients

Providers must follow special claim procedures when submitting claims for visual services furnished to dually-eligible Medicare and Medicaid recipients.

- Services related to cataract surgery that are reimbursable by Medicare must be billed to Medicare.
- Claims for services that are not covered by Medicare must be submitted directly to Medicaid.
- If the visual services are for diagnoses other than for refractive error and fall outside the refractive error diagnosis range of 367.0-367.9, then these claims must be submitted to the area Medicaid office to be force paid.

Note: See Chapter 4 in the Florida Medicaid Provider General Handbook for additional information on Medicare crossovers claims.

All Medicaid Provider Handbooks are available on the Medicaid Web site at mymedicaid-florida.com. Select Public Information for Providers, Provider Support, and Provider Handbooks.

Eyeglasses and Lenses

Description

Eyeglasses include the frame and lenses and are referred to as a “pair” within this section of the handbook.

Eyeglasses and Lenses, *continued*

Description	Eyeglasses include the frame and lenses and are referred to as a "pair" within this section of the handbook.
Service Limitations for Recipients Ages 20 and Younger	Eyeglasses for recipients age 20 years and younger are limited to two pairs (two frames, four lenses), per recipient, per 365 days. If a recipient requires a second pair of eyeglasses to replace the first pair within the 365-day period, a replacement pair may be provided without prior authorization if the replacement is for one of the medically necessary reasons that are listed in Appendix A in this handbook. When the recipient cannot tolerate using multifocal lenses, the provider may dispense a second pair of eyeglasses to the recipient already having a functional pair, (i.e., one pair to be used for near vision and the second pair to be used for distance vision.) In this instance the provider must document a specific reason for the recipient's intolerance of multifocal lenses in the recipient's medical record. A claim override by the area Medicaid office will be needed for the second pair, if it is dispensed on the same date of service as the first pair. Medically necessary reasons for replacing eyeglasses, frames, or lenses must be documented in the recipient's medical record. The second and subsequent prescription is by medical necessity only. It must be documented in the clinical record with significant, clinically relevant and sufficient reasons for the second pair and subsequent pairs of spectacles (full pair, lenses only, or frame only). Eyeglass replacement service cannot be automatic or ordered as a routine for every recipient where the recipient is rescheduled at known intervals in order to change the spectacles.
Service Limitations for Recipients Ages 21 and Older (Effective January 1, 2010)	Eyeglass frames for recipients ages 21 and older are limited to one pair every two years. A second eyeglass frame may be prior approved during the two-year time-period, through the prior authorization process. Eyeglass lenses for recipients ages 21 and older are limited to one pair every 365 days. A second pair prescription is by medical necessity only and may be prior approved during the 365-day time period, through the prior authorization process. It must be documented in the clinical record with significant, clinically relevant and sufficient reasons for the second pair of spectacles (full pair, lenses only, or frame only). Reasons for replacing eyeglasses, frames, or lenses must be one of the medically necessary reasons listed in Appendix A in this handbook and must be documented in the recipient's medical record.

Eyeglasses and Lenses, *continued*

Authorization for a Third Pair of Eyeglasses (For Recipients Ages 20 and Younger)

If the recipient age 20 and younger needs a third pair of eyeglasses within the 365-day period, the provider must obtain prior authorization from Medicaid.

Documentation of the medical necessity must be submitted with the prior authorization request. All procedure codes required for the prescribed eyeglasses, and the provider's fees for each code, must be included on the prior authorization request.

If replacement eyeglasses will be provided by the Central Optical Laboratory (PRIDE), the provider must include the prior authorization number on the prescription sent to the lab and must indicate on the order form that the prescription being submitted is for a third pair of eyeglasses.

Note: See Chapter 2 in the Florida Medicaid Provider Reimbursement Handbook, CMS-1500 for prior authorization procedures and form. All Medicaid Provider Handbooks are available on the Medicaid Web site at mymedicaid-florida.com. Select Public Information for Providers, Provider Support, and Provider Handbooks.

Note: See the Visual Services Fee Schedule for a list and description of procedure codes and fees. All Medicaid Fee Schedules are available on the Medicaid Web site at mymedicaid-florida.com. Select Public Information for Providers, Provider Support, and Fee Schedules.

Service Requirements for Frame

If the provider dispenses the eyeglasses himself, he must offer either a frame that is available from the Central Optical Laboratory or a frame of equal or better quality, at no additional cost to the recipient. Medicaid does not reimburse for a frame that is of lesser quality than Central Optical Laboratory frames. Plastic frames are primarily used for Medicaid reimbursed eyeglasses.

When dispensing a plastic (zylonite, zyl or equivalent non-metal) frame, providers must bill using the procedure code with the description, " Frames, purchases (new or replacement; plastic)".

Only if a plastic frame is not available or there is medical necessity documentation in the recipient's medical record to justify why the recipient cannot be fitted with a plastic frame can the provider bill Medicaid for a metal frame. Providers may bill for metal frames using the procedure code with the description "Deluxe frame (new or replacement; metal)".

Eyeglasses and Lenses, *continued*

Service Requirements for Lenses

All lenses must meet the following requirements:

- All lenses must meet existing Food and Drug Administration (FDA) impact resistant regulations (American National Standard Institute Z-80.1 and Z-80.3).
- Bifocals should be flat top 28, which is the standard lens for the bifocals that are available from the Central Optical Laboratory.
- Any deviation from the flat top 28 bifocal must be documented in writing on the visual services recipient chart or on the laboratory order form with a valid reason for non-standard bifocal.

Glass Lenses

Glass lenses are not reimbursed through Medicaid.

This includes clear, absorptive tint, photogrey, photogrey extra, photosun, photocromactic, and any glass lens product.

Multifocal Lenses

The standard bifocal is flat top-28. The standard trifocal is flat top-7X28. Any deviation from this standard must be documented in the recipient's chart with significant, clinically relevant and sufficient data to warrant a change from the standard.

Routine usage of oversize bifocals or trifocals is prohibited. Progressive addition lenses are not reimbursable.

Bifocal or trifocal additions over +3.25 Diopters must have sufficient reasons:

- Delineated and written in the recipient's chart;
- Substantiated with decipherable ophthalmic data; and
- Clinically relevant to the case and necessary for the improvement of the recipient, without the increased additional power.

Variable Asphericity Lenses

Aspheric spectacle lenses cannot be used below plus or minus 7.00 Diopters, any meridian either eye. These codes cannot be used routinely.

Documentation in the recipient's chart must accompany the use of this code with significant, clinically relevant and sufficient data to warrant its use.

Eyeglasses and Lenses, *continued*

Polycarbonate Lenses

Polycarbonate or equivalent (thermoplastic) lens material may be used for the safety of an individual recipient meeting a specific criterion.

Medicaid may reimburse for polycarbonate lenses, instead of the routinely used cast molded plastic lenses, only for a recipient with one or more of the following conditions:

- The recipient is monocular; the corrected sight in the poor eye being 20/50 or worse.
- The recipient has significant amblyopia.
- The recipient has had a retinal detachment or is significantly at risk for retinal detachment, e.g., lattice degeneration, history of retinal detachment in the family, posterior vitreous detachment, retinal holes.
- The recipient has a seizure disorder.
- The recipient has Marfan's Syndrome, an ocular prosthesis, or keratoplasty.
- The recipient is involved in an occupation or physical exercise sport where there is high risk of eye trauma and the eyes must be protected beyond the usual plastic lens spectacle correction.

The condition(s) rendering the recipient eligible for polycarbonate lenses must be sufficiently documented and maintained in the recipient's medical record.

Reimbursement Information for Polycarbonate Lenses

To receive reimbursement for polycarbonate lenses, the provider must use the following procedure codes on the claim form:

- The same procedure code(s) used for plastic lenses; and
- The appropriate procedure code for polycarbonate single vision, bifocal or trifocal lens fees.

Note: See the Visual Services Fee Schedule for a list of covered procedure codes, code descriptions and associated fees. All Medicaid Fee Schedules are available on the Medicaid Web site at mymedicaid-florida.com. Select Public Information for Providers, Provider Support, and Fee Schedules.

Documentation

The provider must maintain the following documentation in the recipient's medical record:

- The prescription used for the eyeglasses furnished;
- Documentation for each service provided, including replacement and repair of eyeglasses, frames or lenses;
- Documentation of referral and required criteria for services provided in recipient's home, nursing home or custodial care facility; and,
- Documentation of the recipient's condition that meets the criterion for provision of specific eyeglass or lens types

Eyeglasses and Lenses, *continued*

Recipient Options

Medicaid recipients have the option of:

- Selecting eyeglasses in one of the frame styles and colors offered by the Central Optical Laboratory;
- Selecting eyeglasses from the provider, if the provider accepts the Medicaid fee as payment in full (the eyeglasses must be of equal or better quality than the Central Optical Laboratory's eyeglasses);
- Selecting eyeglasses from the provider that are priced higher than the Medicaid fee, and privately paying the total cost; or
- Selecting to privately pay for lenses not covered by Medicaid, (i.e. transitional or progressive lenses).

If the recipient pays for the frames, Medicaid may reimburse for the lenses or vice versa. In either of these two circumstances the visual services provider will not qualify for, and must not bill Medicaid for, the fitting, dispensing and adjustment fees.

Oversized Lenses

The procedure code for oversized lenses may be reimbursed only when the following criteria are met:

- The lenses are 56mm and greater or there is a large effective diameter.
- Measurements apply to the actual dispensed eyeglasses, demanding an oversized lens blank by calculation;
- The recipient requires oversized lenses; or
- Eyeglasses with oversized lenses (made with frames appropriate to accommodate the size and weight of the oversized lenses) are actually dispensed.

Oversize lens usage must have documentation clearly explained on the lab order form and in the recipient's chart with:

- Eye size;
- Interpupillary distance;
- Oversize blank used; or
- Sufficient data to calculate that an oversize lens is needed, including:
  - Eye size;
  - Bridge size; interpupillary distance;
  - Effective diameter; and
  - Oversized blank used.

It is not sufficient to state the lab used an oversize lens blank when one was not called for. A 56 eye size is not an automatic use of this code when:

- An oversize lens blank must be necessary based on the factors; and
- The oversize blank size must be stated on the lab order form, or in the chart.

The effective diameter, complete frame dimensions, and distance and near interpupillary measurements must be documented in the recipient's medical record.

Eyeglasses and Lenses, *continued*

Special Base Curves

Special base curves are reimbursed only when the curves are prescribed by an optometric physician or ophthalmologist for the purpose of anisekonia, anisometropia or other sufficient reason. Visual services providers are required to submit a prior authorization request for special base curves.

Prior authorization requests should include all procedure codes being used for the eyeglass prescription as well as the provider's fees for these codes.

Standard curves of a manufactured lens ordered without specification by the physician does not qualify as special base curves if the prescribing physician has not used cognitive skills to arrive at the curves and thicknesses with sufficient data in the chart to substantiate said curves for an optical, optometric, or medical reason.

Note: See Chapter 2 in the Florida Medicaid Provider Reimbursement Handbook, CMS-1500 for the prior authorization procedures and form.

Special Order Frame and Lenses

If for specifically stated and written medical reasons the recipient is unable to use the available frames or requires special lenses, the provider must obtain prior authorization from Medicaid before providing the alternative frames or special lenses.

The provider must submit sufficient cost information, necessary for pricing the items, with the prior authorization request. Documentation must include:

- Documentation of medical necessity for the alternative frames or special lenses requested;
- The wholesale cost of each item, or a written estimate from the Central Optical Laboratory;
- The name of the product manufacturer; and
- The product name of the special frame or type of lenses requested.

Note: See Chapter 2 in the Florida Medicaid Provider Reimbursement Handbook, CMS-1500 for the prior authorization procedures and form. All Medicaid Provider Handbooks are available on the Medicaid Web site at mymedicaid-florida.com. Select Public Information for Providers, Provider Support, and Provider Handbooks.

Eyeglasses and Lenses, continued

Lab Order Form

The provider must include the following information on the lab order form for each eyeglass prescription dispensed:

- Eye size;
- Bridge size;
- Temple length;
- Name or number of frame;
- Color of frame;
- Manufacturer of frame;
- Metal or plastic frame;
- Use of tint;
- Use of UV 400 coating; and
- Plastic or polycarbonate lenses.
- Prescriptive data; and
- Whether this order is new, second or third, etc, being ordered within the 365-day period.

Lab order forms must be retained in the recipient's medical record.

Note: "Service Limitations for Recipients Ages 21 and Older (Effective January 1, 2010)" and "Service Limitations for Recipients Ages 20 and Younger ", in this section.

Note: See Central Optical Laboratory, under the Covered and Excluded Services section of this chapter, for PRIDE contact information.

Contact Lenses

Description

Medicaid reimburses for rigid or soft contact lenses. Medicaid may reimburse for continuous-wear lenses when the recipient cannot wear normal soft lenses. All contact lenses require prior authorization by Medicaid. The Contact Lens Prior Authorization form must be completed and submitted with the Florida Medicaid Authorization Request form.

Note: See the Contact Lens Prior Authorization form, attached as Appendix B of this handbook.

Note: The Florida Medicaid Authorization Request form can be accessed from the Medicaid Web site at mymedicaid-florida.com/. Select Public Information for Providers, Provider Support, Forms, and Prior Authorization Request (to the right of the General Information category).

Contact Lenses, *continued*

Who May Receive Contact Lenses

Medicaid reimburses for contact lenses only for recipients who have the following conditions:

- Unilateral aphakia or bilateral aphakia, but not pseudophakia;
- Keratoconus (conical cornea);
- Irregular cornea or irregular astigmatism (does not apply if the recipient has had previous refractive surgery);
- Significant, symptomatic anisometropia;
- Refractive errors that are + or – 7.00D and over, any meridian, either eye, spectacle prescription; or
- Nystagmus, congenital or acquired but not latent monocular, where there is significant improvement of the visual acuity with contact lens wear regardless of the refractive error, astigmatic status, or natural lens status.

Service Exclusions

Medicaid does not reimburse for contact lenses for cosmetic purposes.

Prior Authorization

To be reimbursed by Medicaid for contact lenses, the provider must obtain prior authorization from Medicaid. A vision consultant reviews the prior authorization request to determine if the recipient is being fitted with the proper type of lenses. If either soft or rigid lenses could be used, Medicaid will approve the least expensive type, which may result in updates being made to the request.

For pediatric aphakic recipients, providers may request up to four lenses, using the procedure code describing, " contact lens, other type", on a single prior authorization form, accompanied by a Contact Lens Information form .

Note: See Chapter 2 in the Florida Medicaid Provider Reimbursement Handbook, CMS-1500 for prior authorization procedures and form instructions. The Florida Medicaid Authorization Request form can be accessed from the Medicaid Web site at mymedicaid-florida.com/. Select Public Information for Providers, Provider Support, Forms, and Prior Authorization Request (to the right of the General Information category). All Medicaid Provider Handbooks are available on the Medicaid Web site at mymedicaid-florida.com. Select Public Information for Providers, Provider Support, and Provider Handbooks.

Contact Lenses, *continued*

Documentation Required for Prior Authorization of Contact Lenses

The provider must submit the following information with the prior authorization request, which is included in the Contact Lens Information form:

- Recipient's condition making them eligible for contact lenses;
- Indicate if the recipient is aphakic or not aphakic;
- The eyeglasses prescription for each eye;
- Substantiation for special fittings (e.g., Keratoconus);
- All appropriate procedure codes;
- The provider's total fee that includes professional fitting services (excluding initial examination), the contact lenses, the required care kits, and follow-up visits for 90 days; and
- A statement as to whether:
  - This is an original fitting (or refitting) or for replacement lenses;
  - This is for unilateral or bilateral lenses;
  - The lenses are spherical or toric;
  - The lenses are rigid (PMMA or gas permeable) or soft lenses; and
  - The lenses are daily wear or extended wear.

Prior authorization requests submitted without all items listed above will be returned to the provider for more information, causing unnecessary delays in the overall review process.

Contact Lenses, continued

Required Professional Services

In order to receive Medicaid reimbursement, the provider must perform the following professional services:

- Trial fitting and the design of the lenses;
- The dispensing visit, which includes:
  - Fitting of the finished contact lenses;
  - Evaluation of the fitting; and
  - Instructions on insertion, removal, and proper care of the lenses; and
- Follow-up visits that include acuities, assessment of corneal physiology, biomicroscopy examination, and other procedures required as necessary.

The number of follow-up visits is dictated by the number of times necessary for the provider to determine if the lenses are functioning as expected and that the eyes have fully adapted to the lenses without insult.

All follow-up visits related to the provision of contact lenses are included in the total reimbursement for contact lenses and are considered a 90-day global fitting period, meaning that additional visits related to contact lenses may not be billed through the physician or optometric services program.

Reimbursement Information

Reimbursement for contact lenses represents all professional services, including:

- Fittings;
- Follow-up visits;
- The contact lenses; and
- The required care kits.

The procedure codes used for reimbursement of contact lenses include the V code for the type of lens needed and the procedure code with the description "integral lens service, miscellaneous services reported separately", additional contact lens services (includes fitting and follow-up visits). These codes represent all services associated with the provision of contact lenses and are a per lens fee.

Examinations to determine the prescription for contact lenses are reimbursed through the physician and optometric services programs, and are not a part of the prior authorization required for contact lenses through the visual services program.

Eyeglasses Repair Services

Description

Repairs may be done in the provider's office or by the Central Optical Laboratory (PRIDE).

Eyeglasses Repair Services, continued

Central Optical Laboratory Repairs

The Central Optical Laboratory is required to repair all eyeglasses that were purchased from their laboratory.

The Central Optical Laboratory may also repair eyeglasses that were not obtained from them, if not too costly or too difficult to obtain the needed parts. If the laboratory cannot repair the eyeglasses, the provider will be notified within three days of the lab's receipt of the order for repair.

Temple Replacement

If the temple is the only part of the eyeglass frame requiring repair, and the eyeglasses were obtained from the Central Optical Laboratory, the provider may send a prescription to the laboratory for a new temple in the required style, color and length. In this circumstance the eyeglasses will not need to be returned to the laboratory.

Repair Cost Exceeds New Eyeglasses

If the cost of the needed repair exceeds the cost of new eyeglasses, Medicaid may reimburse for new eyeglasses. Medicaid will not reimburse for both the cost of the repair to the recipient's damaged eyeglasses and the cost of the new replacement eyeglasses.

Office Repairs

Office repair is defined as work performed in the provider's office that is necessary to restore the frame or lenses to a usable state. An office repair includes any detailed repair that requires the use of an optical tool and the provider's expertise. Office repairs must be documented in the recipient's medical record.

Reimbursable office repairs include:

- Replacing lens(es) that have fallen out of the frame;
- Correcting lens rotation due to slippage;
- Turning bent or broken frame eyewire;
- Shrinking frame to tighten lens;
- Inserting lens washer to tighten the frame;
- Reshaping or modification of the frame;
- Repairing hinge including riveting, shrinking of the frame around the hinge, replacement of the hinge or repair of the hinge or barrels;
- Tightening screws with riveting, peening or special screws with hex nuts;
- Gluing any part of the frame;
- Repairing cracked parts with acetone;
- Eyewire repair of any type including gluing, stapling, or heating;
- Re-edging lenses for fit;
- Reshaping pad arms and replacing pads; and
- Soldering.

Eyeglasses Repair Services, continued

Office Repair Exclusions

Medicaid does not reimburse a visual services provider for simple, one-step adjustments or realignment of the frame or temples.

Medicaid does not reimburse for the fitting, dispensing and adjustment of eyeglasses) on the same date of service as an office repair procedure for the same recipient.

Prosthetic Eyes

Description

Medicaid reimburses physicians, optometrists, and opticians for the provision of prosthetic eyes through the Visual Services Program.

Medicaid reimbursement for prosthetic eyes includes all costs related to the measuring, fitting, and dispensing of the eye.

Prosthetic eyes may also be reimbursed through the Medicaid Durable Medical Equipment and Medical Supplies Program.

Note: See Durable Medical Equipment and Medical Supplies Coverage and Limitations Handbook, for additional information regarding that program's prosthetic eye coverage. All Medicaid Provider Handbooks are available on the Medicaid Web site at mymedicaid-florida.com. Select Public Information for Providers, Provider Support, and Provider Handbooks.

Service Requirements

If the recipient is enrolled in MediPass, prosthetic eye services must be authorized by the recipient's MediPass primary care provider.

If the recipient is enrolled in a Provider Service Network (PSN), prosthetic eye services must be authorized by the PSN. To obtain authorization, providers should call the PSN at the telephone number listed on the recipient's PSN Enrollee Identification Card.

Note: See Chapter 1 in the Florida Medicaid Provider General Handbook for information on MediPass and PSNs. All Medicaid Provider Handbooks are available on the Medicaid Web site at mymedicaid-florida.com. Select Public Information for Providers, Provider Support, and Provider Handbooks.

Documentation

The provider must obtain and maintain a physician or optometrist's patient evaluation in the recipient's medical record. The evaluation must have been completed not more than three months prior to the provision of the prosthetic eye.

Prosthetic Eyes, *continued*

Reimbursement Information	The provider may not bill Medicaid for the prosthetic eye until it has been satisfactorily fitted and the recipient has taken possession of the prosthetic eye. The provider must use the date that the prosthetic eye was fitted as the date of service on the claim. The provider may only use the date the prosthetic eye was ordered as the date of service when submitting the claim if the recipient becomes ineligible for Medicaid after the order was placed and before the date the prosthetic eye is fitted.

CHAPTER 3
VISUAL SERVICES
COVERED SERVICES, LIMITATIONS AND EXCLUSIONS

Overview

Introduction

This chapter describes the procedure codes and maximum fees for services covered by the Visual Services Program.

In This Chapter

This chapter contains:

Note: All Medicaid Provider Handbooks are available on the Medicaid Web site at mymedicaid-florida.com. Select Public Information for Providers, Provider Support, and Provider Handbooks.

Reimbursement Information

Procedure Codes

The procedure codes listed in the Vision Services Fee Schedule are Healthcare Common Procedure Coding System (HCPCS) codes, Level 1 and Level 2. The codes are part of the standard code set described in the Physician's Current Procedure Terminology (CPT) book. Please refer to the current CPT book for complete descriptions of the standard codes. CPT codes and descriptions are copyrighted 2006 by the American Medical Association. All rights reserved.

Level 1 procedure codes (CPT) are a systematic listing and coding of procedures and services performed by providers. Each procedure or service is identified by a five digit numeric code.

Level 2 procedure codes are national codes used to describe medical services and supplies. They are distinguished from Level 1 codes by beginning with a single letter (A through V) followed by four numeric digits.

Reimbursement Information, continued

Dually-Eligible Medicare and Medicaid Recipients

Providers must follow special claim procedures when submitting claims for visual services furnished to dually-eligible Medicare and Medicaid recipients.

- Services related to cataract surgery that are reimbursable by Medicare must be billed to Medicare.

Note: See Chapter 4 in the Florida Medicaid Provider General Handbook for additional information on Medicare crossovers. All Medicaid Provider Handbooks are available on the Medicaid Web site at mymedicaid-florida.com. Select Public Information for Providers, Provider Support, and Provider Handbooks.

MediPass Authorization Exemptions

Visual services providers are not required to obtain MediPass authorization, except for prosthetic eye services.

How to Read the Vision Services Fee Schedule

Introduction

Specific CPT codes are reimbursed by Medicaid to optometrists, opticians, and ophthalmologists. These CPT codes are listed on the Vision Services Fee Schedule.

Note: All Medicaid Fee Schedules are available on the Medicaid Web site at mymedicaid-florida.com. Select Public Information for Providers, Provider Support, and Fee Schedules

Code

This column identifies the five-digit procedure codes associated with the covered services. The codes are listed in ascending order.

Mod

This column identifies the two-digit modifier associated with the covered services.

Note: See Procedure Code Modifiers in this chapter for additional information.

Description

The information in this column describes the service or procedure associated with the procedure code. Medicaid providers are instructed to refer to the current CPT or HCPCS Level II books for a complete description for billing purposes. The CPT book and HCPCS Level II books include identifying codes and descriptions for reporting medical services and procedures.

How to Read the Vision Services Fee Schedule

Max Fee	The amount that appears in this column is the maximum allowable amount Medicaid will pay for the complete procedure.
Units	The number in this column indicates the maximum units for the procedure.
Spec	An alphabetic code in this column indicates special requirements for submission of a claim for the procedure listed on the same line. The alphabetic codes are described below
L/R	A"L/R" in the Spec column instructs the provider to enter a modifier LT or RT on the claim, to indicate whether the service is being billed for the left or for the right eye.
PA	A "PA" in the Spec Column identifies a procedure code for which services performed in a setting outside of the inpatient hospital require authorization from the AHCA Medicaid headquarters office, prior to performing the service. Note: The Florida Medicaid Authorization Request form can be accessed from the Medicaid Web Site at mymedicaid-florida.com/. Select Public Information for Providers, Provider Support, Forms, and Prior Authorization Request (to the right of the General Information category). Note: See Prior Authorization in Chapter 2 of the Florida Medicaid Provider Reimbursement Handbook, CMS-1500 for additional information on the prior authorization process. All Medicaid Provider Handbooks are available on the Medicaid Web site at mymedicaid-florida.com. Select Public Information for Providers, Provider Support, and Provider Handbooks.

Procedure Code Modifiers

Definition of Modifier

A code modifier is a two-digit code that helps further describe a procedure code without changing the definition of the code, so that an accurate payment may be made.

The modifiers are entered in the field directly to the right of the procedure code field in item 24D, under Modifier on the CMS-1500 claim form.

There are two different types of modifiers used by Visual Services providers: pricing modifiers and local-code modifiers. The two types of modifiers are described below.

Note: See Chapter 1 in the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for additional information on entering modifiers on the claim form. All Medicaid Provider Handbooks are available on the Medicaid Web site at mymedicaid-florida.com. Select Public Information for Providers, Provider Support, and Provider Handbooks.

Pricing Modifiers

A pricing modifier is a two-digit code that is used with a procedure code listed in the fee schedule to affect the procedure code's fee or cause a claim to suspend for review.

The provider is required to use pricing modifiers under certain circumstances described in Chapter 2 of this handbook, or in the pricing modifiers' definitions in this section.

The provider is required to use pricing modifiers LT or RT to indicate whether the service is for the left eye or the right eye.

Local-Code Modifiers

Visual services providers use "local-code modifiers" with certain visual services procedure codes listed on the Visual Services Fee Schedule, i.e., TS, SC and TG. Local-code modifiers can only be used with the procedure codes they are paired with on the Visual Services Fee Schedule. Use of local-code modifiers with any other procedure codes will cause the claim to deny or pay incorrectly.

Entering More than One Modifiers on the Claim Form

The modifier is entered in the field next directly to the right of the procedure code field in item 24D, Modifier, on the CMS-1500 claim form.

Entering pricing modifiers: Enter the pricing modifier in the first Modifier field on the claim form. If more than one pricing modifier is applicable, enter the multiple pricing modifier 99.

Entering a pricing modifier and local-code modifier: If a situation requires both a pricing modifier and local-code modifier, enter the pricing modifier in the first modifier field on the claim form, and enter the local-code modifier in the second modifier field

APPENDIX A
MEDICALLY NECESSARY REASONS FOR A SECOND PAIR OF EYEGLASSES WITHIN TIME LIMIT PERIOD

1. **CHANGES IN THE PRESCRIPTION** for the following or similar reasons:

Cataracts	**Paralysis or Paresis of Accommodation**
Retinopathy of Prematurity	**Contact Lens Induced**
Diabetes	**Post-Ocular Trauma**
Myopia Progression	**Post-Surgical Aphakia, Pseudophakia**
Astigmatism Shift or increase	**Keratoconus**
Latent Hyperopia increase	**Treatment with Miotics**
Pterygium	**Adies Tonic Syndrome**
Orbital Tumor	**Systemic Drug Reaction**
Post-Refractive Surgery	

2. **DAMAGED FRAMES OR LENSES**:*

a) The lenses are significantly scratched (pitted, scarred, chipped, cracked, broken) or damaged beyond repair.
b) The frame is broken or damaged beyond repair; the frame is too small (outgrown).

3. **LOST EYEGLASSES** – one or more of the following medically necessary replacement criteria must be present:

a) The loss is related to an event with a medical condition such as Down's Syndrome, seizure disorder, or mental retardation.
b) The loss is the result of victimization such as a mugging, beating, robbery, spousal abuse, house fire, nursing home loss, or loss by a third party, e.g., family member, caretaker, nurse, or teacher.
c) Presence of factors that would endanger life, career, or schooling such as the recipient cannot pass a driver's license test, cannot function at employment, or cannot function in the classroom.
d) Presence of related ocular or visual factors whereby not having the glasses may cause one or more of the following to occur:

- Symptoms of hurt, pain, discomfort, irritation, accommodative spasms, headache, or asthenopia;
- Headache;
- Diplopia;
- Strabismus or ocular motility problem;
- Significant, symptomatic anisometropia or aniseikonia exists and needs correction;
- Significant heterophoria and a need for correcting spectacle prism or near prescription;
- Central visual acuity is compromised because of a visual field defect;
- Protection for the good eye is needed in a monocular patient (amblyopia or organic loss in poorer eye);
- Specific learning disability is present and correction is necessary; or
- Binocular vision anomaly is present and a correction is necessary.

*If the recipient has damaged lenses only, the original frame must be used when replacing the lenses. If the recipient has a broken frame and no damage to the lenses, only the frame may be replaced.

APPENDIX B

FLORIDA MEDICAID
AUTHORIZATION REQUEST SUPPLEMENT

CONTACT LENS INFORMATION FORM

Appendix B
Florida Medicaid
Authorization Request Supplement
Contact Lens Information Form

This form must be completed and submitted with a completed Florida Medicaid Authorization Request form PA01. A determination for payment cannot be made without the information requested on this form.

Recipient Name: _____ Recipient ID #: _____

Date of Service: _____ Provider: _____

Spectacle Prescription: **OD** _____ **OS** _____

Please check ONE appropriate response for each numbered item

1. Is this a request for a □ New fitting □ Refit fitting □ Replacement lens(es)?
2. Is this contact request for □ One eye □ Two eyes? (i.e. unilateral or bilateral)
3. Is this request for □ Spherical contact lens □ Toric/Prism type contact lens?
4. Is the contact lens material □ PMMA □ Rigid gas permeable □ Hydrophilic?
5. Is this contact to be used for □ Daily wear □ Extended wear?
6. Is this contact request □ For aphakia □ Not for aphakia?
7. Is this a special contact lens fitting (i.e., Keratoconus, Corneal transplant, trauma, nystagmus, anisometropia, or other)? □ Yes □ No

If Yes, please provide diagnostic data, bilateral Rx, signs and symptoms and any other data relevant to this case:

_____

Pricing Information (*excluding examination*)**:**

***Please refer to the current Visual Services Handbook and Visual Services Fee Schedule to ensure the appropriate procedure codes are being used for this request.*

Procedure Code	**Quantity**	**Total Fee** (*in dollars*)
		$
		$
		$

***** All Medicaid program handbooks and current fee schedules are available on the Medicaid fiscal agent's website at mymedicaid-florida.com/. Select Public Information for Providers, Provider Support, "Handbooks" or "Fees".

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