Connecticut interChange MMIS

Provider Manual

Chapter 7 - Vision Care

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REGULATIONS OF CONNECTICT STATE AGENCIES
DEPARTMENT OF SOCIAL SERVICES
Concerning
Requirements for Payment of Vision Care Services

Section 1. Sections 17b-262-559 to section 17b-262-571, inclusive, of the Regulations of Connecticut State Agencies are amended to read as follows:

Sec. 17b-262-559. Scope
Sections 17b-262-559 through 17b-262-571, inclusive, set forth the Department of Social Services requirements for payment of accepted methods of treatment provided by an ophthalmologist, optometrist, or optician for clients who are determined eligible to receive services under Connecticut's Medical Assistance Program pursuant to section 17b-262 of the Connecticut General Statutes (CGS).

Sec. l7b-262-560. Definitions
For the purposes of sections 17b-262-559 through 17b-262-571 the following definitions shall apply:

(1) **"Acute"** means having rapid onset, severe symptoms, and a short course.
(2) **"Client"** means a person eligible for goods or services under the department's Medical Assistance Program.
(3) **"Commissioner"** means the Commissioner of Social Services appointed pursuant to subsection (a) of section 17b-1 of the Connecticut General Statutes.
(4) **"Department"** means the Department of Social Services or its agent.
(5) **"Doctor of Osteopathy"** means a doctor of osteopathy licensed pursuant to section 20-17 of the Connecticut General Statutes.
(6)**"Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT)"** means the services described in subsection (r) of section 1905 of the Social Security Act.
(7) **"Emergency"** means a medical condition, including labor and delivery, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the client's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.
(8) **"Fees"** means the rates for services, treatments, and drugs administered by ophthalmologists, optometrists, and opticians which shall be established by the commissioner of the department and contained in the department's fee schedules.
(9) **"Incomplete Eye Exam"** means an annual eye exam which is not completed since the preliminary findings reveal that visual analysis is not indicated.
(10) **"Interperiodic Encounter"** means any medically necessary visit to a Connecticut Medical Assistance provider, other than for the purpose of performing a periodic comprehensive health screening. Such encounters include, but are not limited to, physician's office visits, clinic visits, and other primary care visits.

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(11) **"Licensed Practitioner of the Healing Arts"** means a professional person providing health care pursuant to a license issued by the Department of Public Health (DPH).
(12) **"Medical Appropriateness or Medically Appropriate"** means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate medical setting; and is the least costly of multiple, equally-effective, alternative treatments or diagnostic modalities.
(13) **"Medical Assistance Program"** means the medical assistance provided pursuant to Chapter 319v of the Connecticut General Statutes (CGS) and authorized by Title XIX of the Social Security Act. The program is also referred to as Medicaid.
(14) **"Medical Necessity or Medically Necessary"** means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or prevent a medical condition from occurring.
(15) **"Medical Record"** means the definition contained in section 19a-14-40 of the Regulations of Connecticut State Agencies, which is also the Public Health Code.
(16) **"Modified Lens Prescription"** means a prescription given to a client because of:
(A) a radical change in the prescription;
(B) a large initial prescription; or
(C) amblyopia, latent hyperopia, or inadequate care previously received.
(17) **"Ophthalmologist"** means a physician licensed pursuant to Chapter 370 of the Connecticut General Statutes, who within his or her scope of practice as defined by state law, specializes in the branch of medicine dealing with the structure, functions, pathology, and treatment of the eyes. The practice includes the use of surgery, x-ray, photocoagulation, ionizing radiation, and drugs for examination of the eyes.
(18) **"Optician"** means an individual licensed pursuant to section 20-145 of the Connecticut General Statutes having a knowledge of optics and is skilled in the technique of producing and reproducing ophthalmic lenses and kindred products and who, within his or her scope of practice as defined by state law, prepares and dispenses ophthalmic lenses and products to correct visual defects.
(19) **"Optometrist"** means an individual licensed pursuant to Chapter 380 of the Connecticut General Statutes to practice optometry as delineated in subsections (a) (1) and (2) of section 20-127 of the Connecticut General Statutes.
(20) **"Physician"** means a physician licensed pursuant to section 20-10 of the Connecticut General Statutes.
(21) **"Prior Authorization"** means approval for the provision of a service or delivery of goods from the department before the provider actually provides the service or delivers the goods.
(22) **"Progressive Myopia"** means a known progressive myopia, changing .75 diopters in the past six months.

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(23) **"Provider"** means a licensed ophthalmologist, optometrist, or optician.
(24) **"Provider Agreement"** means the signed, written, contractual agreement between the department and the provider of services or goods.
(25) **"State Plan"** means the document which contains the services covered by the Connecticut Medical Assistance Program in compliance with Part 430, Subpart B, of Title 42 of the Code of Federal Regulations (CFR).
(26) **"Usable Lens"** means a lens which is not scratched or otherwise defective so as to impair use or endanger the wearer.
(27) **"Usual and Customary Charge"** means the amount that the provider charges for the service or procedure in the majority of non-Medicaid cases. If the provider varies the charges so that no one amount is charged in the majority of cases, usual and customary shall be defined as the median charge. When calculating the median charge, token charges for charity patients and other exceptional charges are to be excluded.

Sec. 17b-262-561. Provider Participation
In order to enroll in the Medical Assistance Program and receive payment from the department, providers shall:
(a) meet and maintain all applicable licensing, accreditation, and certification requirements;
(b) meet and maintain all departmental enrollment requirements; and
(c) have a valid provider agreement on file which is signed by the provider and the department upon application for enrollment into the Medical Assistance Program. This agreement, which shall be periodically updated, shall continue to be in effect for the duration of the agreement or for the stated period in the agreement. The provider agreement specifies the conditions and terms which govern the program and to which the provider is mandated to adhere in order to participate in the program.

Sec. 17b-262-562. Eligibility
Payment for vision care services shall be available on behalf of all persons eligible for the Medical Assistance Program subject to the conditions and limitations which apply to these services.

Sec. 17b-262-563. Services Covered and Limitations
(a) Except for the limitations and exclusions listed below, the department shall pay for the professional services of a licensed ophthalmologist, optometrist, or optician which conform to accepted methods of diagnosis and treatment, but shall not pay for anything of an unproven, educational, social, research, experimental, or cosmetic nature; for services in excess of those deemed medically necessary and medically appropriate by the department to treat the client's condition; or for services not directly related to the client's diagnosis, symptoms, or medical history.

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(b) The department shall pay providers for:

(1) only those procedures listed in the provider's fee schedule and within the scope of the provider's practice;

(2) services provided in the provider's office, client's home, hospital, nursing facility, rest home, intermediate care facility for the mentally retarded (ICF/MR), chronic disease hospital, boarding home, state-owned or state-operated institution, or home for the aged;

(3) two pairs of eyeglasses, distance and near, permitted in lieu of bifocals, when need for same is substantiated in the client's medical record by clinical data from the provider; and

(4) Early periodic screening, diagnostic and treatment services.

Sec. 17b-262-564. Services Not Covered

The department shall not pay for the following:

(a) information or services provided to a client by a provider over the telephone;

(b) cancelled office visits and appointments not kept;

(c) a spare pair of eyeglasses; and

(d) visual analysis within forty-two consecutive days from the date of an eye examination.

Sec. 17b-262-565. Need for Service

The department shall pay for medically necessary and medically appropriate vision care services for Medical Assistance Program eligible clients, in relation to the diagnosis for which care is required, provided that:

(a) the services are within the scope of the provider's practice;

(b) the services are made part of the client's medical record; and

(c) for contact lenses, glasses, or vision training, only when prescribed by a physician, doctor of osteopathy, or optometrist.

Sec. 17b-262-566. Early Periodic Screening, Diagnostic and Treatment Services

(a) Prior authorization for EPSDT services not on the Vision Care fee schedule or which are on such fee schedule but for which there are limitations in the amount, frequency or circumstances under which such services can be used, either in the fee schedule or in the Regulations of Connecticut State Agencies published by the department, may be obtained using the following procedures:

(1) Services not on the fee schedule, or for which there are limitations on their use, may be authorized on a case-by-case basis. Requests for prior authorization to provide services shall be made on forms and in a manner as specified by the department.

(2) Providers requesting prior authorization to provide services shall be required to provide pertinent medical or social information adequate for evaluating the client's medical need for services. This information shall include: (A) a written statement from the prescribing physician, or other practitioner of the healing arts, performing such services within such practitioner's respective scope of practice as defined under state law, justifying the need for

the item or service requested; (B) a description of the outcomes of any alternative measures tried; and (C) if applicable and requested by the department, any other documentation required in order to render a decision.

(3) Except in emergency situations, or when authorization is being requested for more than one visit in the same day, approval shall be received before services are rendered. In an emergency situation which occurs after working hours or on a weekend or holiday, the provider shall secure verbal approval on the next working day for the services provided.

(b) In order to receive payment from the department a provider shall comply with all prior authorization requirements. The department, in its sole discretion determines what information is necessary in order to approve an authorization request. Prior authorization does not, however, guarantee payment unless all other requirements for payment are met.

Sec. 17b-262-567. Billing Procedures

(a) Claims from providers shall be submitted on the department's designated form or electronically submitted to the department's fiscal agent and shall include all information required by the department to process the claim for payment.

(b) Claims for a full or partial eye examination in a nursing facility or a state-owned or state-operated institution shall contain the name of the prescribing practitioner.

(c) The amount billed to the department shall represent the provider's usual and customary charge for the services delivered.

Sec. 17b-262-568. Payment

(a) Payment rates shall be the same for in-state and out-of-state providers.

(b) Payment for professional services shall be made at the lowest of:

(1) the provider's usual and customary charge;

(2) the lowest Medicare rate;

(3) the amount in the applicable fee schedule as published by the department; or

(4) the amount billed by the provider.

(c) Payment for supplies and equipment shall be made at the lowest of:

(1) the provider's usual and customary charge;

(2) the lowest Medicare rate;

(3) the amount in the applicable fee schedule as published by the department; or

(4) the amount billed by the provider.

(d) The department shall pay for lenses for clients who own their own frames and are eligible for lenses.

Sec. 17b-262-569. Payment Rate

The commissioner establishes the fees contained in the department's fee schedule pursuant to section 4-67c of the Connecticut General Statutes.

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Sec. 17b-262-570. Payment Limitations

(a) Contact lenses shall be covered, when such lenses provide better management of a visual or ocular condition than can be achieved with spectacle lenses, including, but not limited to the diagnosis of: Unilateral Aphakia, Keratoconus, Corneal Transplant, and High Anisometropia.
(b) Prescription sunglasses shall be covered when light sensitivity which will hinder driving or seriously handicap the outdoor activity of a client is evident.
(c) Trifocals shall be covered only when the client has a special need due to a job training program or extenuating circumstances.
(d) Oversize lens shall be covered only when needed for physiological reasons, and not for cosmetic reasons.
(e) Services and materials covered shall be limited to those listed in the department's fee schedule.
(f) Extended wear contact lenses shall be covered for aphakia and for clients whose coordination or physical condition makes daily usage of contact lenses impossible.
(g) When the preliminary findings of an eye examination reveal that a visual analysis cannot or should not be completed, payment shall be made only for an incomplete eye exam.
(h) Providers shall be limited to a maximum of six full or partial eye examinations in a chronic disease hospital, boarding home, home for the aged, nursing facility, ICF/MR, or state-owned or state-operated institution in any one day, in any one home or institution.
(i) A written request shall be provided by the provider from the prescribing practitioner of a nursing facility and state-owned or state-operated institution, for a full or partial eye examination, to be performed on a client in the facility or institution.
(j) Payment for ocular prosthesis shall be made only to the provider performing the actual fitting.
(k) The payment limitations set forth in section 17b-262-448 of the department's regulations governing physicians' services are hereby incorporated by reference and made applicable to services provided by ophthalmologists.
(l) The department shall pay for eyeglasses for a client, as long as the client was eligible on the date the eyeglasses were ordered or requested by the client.
(m) The department shall pay for eyeglass frames when the client meets all eligibility requirements. The Medical Assistance Program published fee shall be considered maximum payment in full. A provider shall not bill the Medical Assistance Program for eyeglass frames and receive payment from the client for the difference in cost.

Sec. 17b-262-571. Documentation

(a) Vision care providers shall maintain a specific record for all services and supplies received for each client eligible for Medical Assistance Program payment including, but not limited to: name, address, birth date, Medical Assistance Program identification number, pertinent diagnostic information, a current treatment plan signed by the provider, documentation of services and supplies provided, and the dates the services or supplies were provided.

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(b) All required documentation in its original form shall be maintained for at least five years in the vision care provider's file subject to review by authorized department personnel. In the event of a dispute concerning a service or supply provided, documentation shall be maintained until the end of the dispute or five years, whichever is greater.
(c) Failure to maintain all required documentation shall result in the disallowance and recovery by the department of any amounts paid to the vision care provider for which the required documentation is not maintained and not provided to the department upon request.