Connecticut Medical Assistance Program
Policy Transmittal 2020-45

Provider Bulletin 2020-64
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Contact: Catherine.Holt@ct.gov

TO: Ophthalmologists, Optometrists and Opticians

RE: Clarifying Guidance Pertaining to the Coverage of Eyeglasses and Contact Lenses

This provider bulletin provides clarifying guidance pertaining to the CMAP vision policy for eyeglasses for adults ages 21 and older, the vision policy for children under the age of 21, as well as coverage rules for contact lenses. This policy transmittal supersedes and replaces previously posted PB 2011-74 "Information Concerning Vision Policy and Prior Authorization (PA) Requests".

Coverage of Eyeglasses for Adults 21 Years of Age and Older:

As previously communicated, pursuant to Section 1 of Public Act 11-48, effective for dates of service on and after July 1, 2011, the Department of Social Services (DSS) updated the vision policy to reimburse enrolled providers for **one pair** of eyeglasses per HUSKY Health member, 21 years of age or older, every **two** rolling years (24 month period measured backward from the date of service), unless a new pair is medically necessary due to a change in the HUSKY Health member's medical condition. This policy applies regardless of medical necessity for a second pair of eyeglasses or for 2 pairs prescribed in lieu of bifocals. Examples of a change in the member's medical condition include, but are not limited to: cataract surgery, tumors, stroke, diabetes or a change of vision acuity by at least 1 diopter since the last prescribed pair.

Prior authorization (PA) is not required for eyeglasses that are medically necessary due to a change in the HUSKY Health member's medical condition. The HUSKY Health member is eligible to receive a new pair of frames and new lenses if the above criteria are met. The provider may bill the CMAP for such medically necessary eyeglasses without the need for PA. Documentation must be kept on file for review by DSS and shall include information regarding details of the condition supporting the medical necessity for the need for a new pair of eyeglasses within the two-year period. Any claims paid by CMAP for a new pair of eyeglasses that are not medically necessary within the two-year period will be subject to post payment audit adjustments by DSS.

No exceptions will be made to replace broken, lost or stolen eyeglasses until the two-year limitation is met. Please note if a HUSKY Health member elects to only upgrade their lenses and not the frames or vice versa on the same date of service for which they were allowed to receive a new pair of glasses, this will be treated as having exhausted the full benefit, and the member will **not** be eligible for a new set of frames or lenses until the following two year rolling period has been exhausted and/or is over.

Vision providers must verify that no other provider has submitted a claim for a pair of eyeglasses in the previous 2 rolling years by logging into their secure Web portal account from the www.ctdssmap.com Web site and selecting Claims > Claim History for Specific Services > Eyeglass Vision Services.

Coverage of Eyeglasses for Children under the Age of 21 (HUSKY A, C and D):

DSS will pay for only one (1) pair of eyeglasses per HUSKY Health member per two rolling year period, unless a replacement pair of eyeglasses during the two-year time period is medically necessary because of a change in the member's medical condition **or** if the previous pair is lost, stolen, or broken.

Documentation must be kept on file for review by DSS and shall include information regarding details of the condition supporting the medical necessity for the replacement pair of eyeglasses within the two-year period.

For HUSKY Health members under the age of 21 who have broken lenses but have no change in vision, the member is eligible to receive a new pair of lenses and frame, even if the new lenses can be accommodated in the existing frame. **PLEASE NOTE, this does not apply to "Deluxe Frames" [*refer to section below on Deluxe Frames*].**

In addition, a spare pair of glasses is not a covered service.

HUSKY B Children:

HUSKY Health members enrolled in HUSKY B have a $100.00 allowance toward eyeglasses every two calendar years.

As a reminder, HUSKY Health members covered under HUSKY B have $15.00 copays outside of the COVID Public Health Emergency period. Please see PB 2020-15 for additional details.

Deluxe Frames for HUSKY A, B, C and D:

For guidance concerning the coverage of deluxe frames, please refer to policy transmittal *PB 2015-102, "New Coverage Guidelines for CPT Code V2025 Deluxe Frames*". Providers are reminded that deluxe frames are considered medically necessary for clinical circumstances for children 0-5 years of age and those members who are 6 years old and over must include one or more correlating diagnosis codes. Please refer to PB 2015-102 for additional details.

If HUSKY Health members, under the age of 21 have broken lenses that are in a deluxe frame and they have no change in vision, the member shall receive a new pair of lenses that can be accommodated in the existing deluxe frame unless, the deluxe frame has been compromised. Deluxe frames will be replaced only if medically necessary due to a change in the member's medical condition, which results in the need to provide a new lens that cannot be accommodated in the existing frame. Eyeglasses with deluxe frames that are lost or stolen will be replaced for HUSKY Health members under 21 and require the same documentation as indicated above.

Documentation of the medical necessity for the deluxe frames should be entered in the HUSKY Health members' medical record.

Date of Service Documentation for the Fitting Fee Associated with Eyeglasses and Contact Lenses for Adults and Children on All HUSKY Benefit Plans:

The date of service to be used on the claim for the fitting fee and eyeglasses or contact lenses should be the order date, as this date represents the date the service was provided. Please note that this guidance applies to both children and adults.

If the HUSKY Health member never returns to pick up the glasses or contact lenses, providers must reverse the charges for the hardware; however, the provider is allowed to keep the fitting fee.

Balance Billing of Members Not Allowed:

Per Section 17b-262-570(m) of the Regulations of Connecticut State Agencies, "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." In addition, the payment in full provision applies to all CMAP covered services, as defined in Section 17-262-526(2) of the Regulations of Connecticut State Agencies.

Polycarbonate Lens:

Polycarbonate lenses are covered when medically necessary and require an order from an enrolled physician, Physician Assistant (PA), Advanced Practice Registered Nurse (APRN) or Optometrist. The order must clearly document the medical necessity. The DSS Optician/Eyeglasses fee schedule includes procedure code S0580 (Polycarbonate lens) rather than code V2784 (Lens, polycarbonate or equal, any index, per lens). Providers should bill with S0580 and not V2784, since the latter will deny.

Tints and Photochromatic Lenses:

Tints and photo chromatic lenses are covered when medically necessary under procedure code V2744 (Tint, photo chromatic, per lens) and do not require PA.

High-Index Lenses and Progressive Bifocal Lenses:

High-index; anti-reflective lenses and progressive bifocal lenses are not covered unless medically necessary and require prior authorization (PA). Procedure code V2799 must be used when requesting PA, and the cost of these lenses will be paid at the actual acquisition cost (AAC).

Contact Lenses:

As specified in Sec. 17b-262-570 of the Regulations of Connecticut State Agencies, contact lenses are only 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 diagnoses of Unilateral Aphakia, Keratoconus, Corneal Transplant and High Anisometropia.

Any claims for contact lenses which are not medically necessary will be subject to post payment audit adjustments by DSS.

Miscellaneous Procedure Code V2799:

Procedure code V2799 (Vision services, miscellaneous) may be used when requesting prior authorization (PA) for any medically necessary miscellaneous vision service not listed on the optician fee schedule. This code requires PA and is paid at Actual Acquisition Cost (AAC). The use of miscellaneous code V2799 is not allowed to be used as a dispensing fee. Code V2799 may be used when requesting authorization for services such as a keratoconus lens.

Please note that coverage for services billed under procedure code V2799 will require PA and must be medically necessary. Items that are not covered by Medicaid under procedure code V2799 may include eyeglass cleaners, cords, chains, eyewear retainers, etc. as these are not considered medically necessary.

Prior Authorization:

When submitting a Prior Authorization (PA), please select Vision Care Services on the Prior Authorization form. An Outpatient PA form can be found at https://www.huskyhealthct.org/providers/provider_postings/provider_forms/Outpatient_Auth_Request_Form.pdf. Click "***For Providers***," "***Prior Authorization***," then "***Prior Authorization Forms and Manuals***." For questions regarding the PA process, please contact Community Health Network of CT (CHNCT) at 1-800-440-5071.

Non-Covered Services

Pursuant to section 17b-262-531(l) of the Regulations of Connecticut State Agencies, providers are reminded that if a HUSKY Health member requests eyeglasses within the two-year period of receiving a previous pair that is not medically necessary, or if the HUSKY Health member requests non-covered services, the provider may bill the member under the following conditions:

> "[A] provider shall only charge an eligible Medical Assistance Program client, or any financially responsible relative or representative of that individual, for goods or services which are not coverable under the Medical Assistance Program, when the client knowingly elects to receive the goods or

services and enters into an agreement in writing to pay for such goods or services prior to receiving them."

Any claims paid by CMAP for non-covered services or services that are not medically necessary will be subject to recoupment on post payment audit.

Optometrist/Ophthalmologist Professional Services:

Professional services of Optometrists and Ophthalmologists, for example, CPT code 92012 – Ophthalmological services: medical examination and evaluation) are paid according to the rules on the Physician Office and Outpatient fee schedule. These professional services are not subject to the provision of the eyeglasses limit of one per every two years; however, other limitations may apply.

Professional services provided following a surgical procedure should be billed with the appropriate evaluation and management or ophthalmology service code. Providers should not bill with the surgery procedure code and modifier -55 (*post-operative management only*). Please note that when submitting a PA request form for vision-related surgical procedures, you should check "Professional /Surgical Services" on the PA form. **Do not** check off the box labeled "Vision Care Services" for surgical procedure codes.

Posting Instructions: Policy transmittals can be downloaded from the Web site at www.ctdssmap.com.

Distribution: This policy transmittal is being distributed to providers of the Connecticut Medical Assistance Program by DXC Technology.

Responsible Unit: DSS, Division of Health Services, Medical Policy Section; Catherine Holt, Medical Policy Consultant or email at Catherine.Holt@ct.gov.

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