



Florida Medicaid

Visual Aid Services Coverage Policy

Agency for Health Care Administration

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1.0 Introduction

1.1 Description

Visual aid services provide visual aids to recipients to alleviate visual impairments.

1.1.1 Florida Medicaid Policies

This policy is intended for use by visual aid services providers that render services to eligible Florida Medicaid recipients. It must be used in conjunction with Florida Medicaid's general policy and any applicable service-specific and claim reimbursement policies with which providers must comply .

Note: Policies are available on the Florida Medicaid fiscal agent's Web site at <http://portal.flmmis.com/flpublic>. All policies are incorporated by reference in Rule Division 59G, Florida Administrative Code (F.A.C.).

1.1.2 Statewide Medicaid Managed Care Plans

This Florida Medicaid policy provides the minimum requirements for all providers of visual aid services. This includes providers who contract with Florida Medicaid managed care plans (i.e., provider service networks and health maintenance organizations). Providers must comply with the coverage requirements outlined in this policy, unless otherwise specified in the Agency for Health Care Administration's (AHCA) contract with the Florida Medicaid managed care plan. The provision of services to recipients in a Florida Medicaid managed care plan must not be subject to more stringent coverage than specified in Florida Medicaid policies.

1.2 Legal Authority

Visual aid services are authorized by the following:

- Title XIX, section 1905, of the Social Security Act (SSA)
- Title 42, Code of Federal Regulations (CFR), 440.335
- Section 409.906, Florida Statutes (F.S.)
- Rule 59G-4.340, F.A.C.

1.3 Definitions

1.3.1 Claim Reimbursement Policy

A policy document that provides instructions on how to bill for services.

1.3.2 Coverage and Limitations Handbook or Coverage Policy

A policy document that contains coverage information about a Florida Medicaid service.

1.3.3 Eyeglasses

Glasses that include a frame and lenses (also referred to as a "pair").

1.3.4 Factory Repair

Any repair that exceeds the provider's expertise and must be performed in a manufacturer or factory setting to restore the frame or lenses to a usable state.

1.3.5 General Policy

A collective term for Florida Medicaid policy documents found in Rule Chapter 59G-1 containing information that applies to all providers including all basic requirements of the Florida Medicaid program.

1.3.6 Long-term Care Plan

A managed care plan that provides services in accordance with section 409.908, F.S., for the long-term care program of the Statewide Medicaid Managed Care program.

1.3.7 Managed Medical Assistance Plan

A managed care plan that provides services in accordance with section 409.973, F.S., for the medical assistance program of the Statewide Medicaid Managed Care program.

1.3.8 Medically Necessary/Medical Necessity

In accordance with Rule 59G-1.010, F.A.C., “[T]he medical or allied care, goods, or services furnished or ordered must:

(a) Meet the following conditions:

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

“(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a medical necessity or a covered service.”

1.3.9 Provider

The term used to describe any entity, facility, person, or group that has been approved for enrollment or registered with Florida Medicaid.

1.3.10 Recipient

For the purpose of this coverage policy, the term used to describe an individual enrolled in Florida Medicaid (including managed care plan enrollees).

2.0 Eligible Recipient

2.1 General Criteria

An eligible recipient must be enrolled in the Florida Medicaid program on the date of service and meet the criteria provided in this policy.

Provider(s) must verify each recipient’s eligibility each time a service is rendered.

2.2 Who Can Receive

Florida Medicaid recipients requiring medically necessary visual aid services. Some services may be subject to additional coverage criteria as specified in section 4.0.

2.3 Coinsurance, Copayment, or Deductible

There is no coinsurance, copayment, or deductible for this service.

3.0 Eligible Provider

3.1 General Criteria

To be reimbursed for services rendered to eligible recipients, providers must meet at least one of the following:

- Directly enrolled with Florida Medicaid if providing services through a fee-for-service delivery system

- Registered with Florida Medicaid if providing services through a managed care plan

3.2 Who Can Provide

- Optometrist and certified optometrist licensed in accordance with Chapter 463, F.S.
- Ophthalmologist licensed in accordance with Chapter 458, F.S.
- Optician licensed in accordance with Chapter 484, F.S.

4.0 Coverage Information

4.1 General Criteria

Florida Medicaid reimburses services that:

- Are determined medically necessary.
- Do not duplicate another service.
- Meet the criteria as specified in this policy.

4.2 Specific Criteria

4.2.1 Eyeglasses

Florida Medicaid reimburses for two pairs per 365 days for recipients under the age of 21 years.

For recipients age 21 years and older, Florida Medicaid reimburses for the following:

- One frame every two years
- Two lenses every 365 days

Florida Medicaid also reimburses the following:

- Polycarbonate or thermoplastic lens materials for a recipient's safety or documented medical condition (when necessary)
- Metal frames when plastic frames are medically inappropriate

Florida Medicaid may reimburse for additional frames, lenses, pairs of glasses, and special order frames with prior authorization.

4.2.2 Fitting, Dispensing, and Adjustment of Eyeglasses Services

Florida Medicaid reimburses for services for new Medicaid-provided glasses and after factory repairs.

4.2.3 Eyeglass Repair Services

Florida Medicaid reimburses for repairs when performed in an office or by a licensed authorized dealer.

Only elements of the frames or lenses that are damaged beyond repair may be replaced.

4.2.4 Contact Lenses

Florida Medicaid reimburses for the following when the recipient has a documented medical condition where eyeglasses would not provide any benefit for their visual impairment:

- Rigid or soft contact lenses
- Extended wear (if the recipient cannot wear normal soft lenses)

Contact lens services include all of the following:

- Fitting
- The contact lens and required care kits
- Instructions on insertion, removal, and proper care of the lenses

- A 90 day follow-up visit period that includes acuities, assessment of corneal physiology, biomicroscopy examination, and other procedures required (as necessary)

4.2.5 Prosthetic Eyes

Florida Medicaid reimburses for evaluating, measuring, fitting, and dispensing of the prosthetic eye(s). The evaluation must be completed no more than three months prior to the provision of the prosthetic eye.

Florida Medicaid reimburses for replacement of prosthetic eyes when the eye(s) are damaged or no longer the appropriate size. Prosthetic eyes may also be reimbursed through Florida Medicaid's durable medical equipment and medical supply services benefit.

5.0 Exclusion

5.1 General Non-Covered Criteria

Services related to this policy are not reimbursed when:

- The service does not meet the medical necessity criteria listed in section 1.0.
- The recipient does not meet the eligibility requirements listed in section 2.0.
- The service unnecessarily duplicates another provider's service.

5.2 Specific Non-Covered Criteria

Florida Medicaid does not reimburse for:

- Aspheric spectacle lenses below plus or minus 7.00 Diopters.
- Ultraviolet (UV) coating for lenses in combination with polycarbonate lenses.
- Low-vision therapy or devices.
- Progressive lenses.
- Transition lenses.
- Glass lenses (including clear, absorptive tint, photogrey, photogrey extra, photosun, photochromic, or any glass lens product).
- Orthoptics or visual training.
- Simple, one-step adjustments or realignment of the frame or temples.
- Contact lenses for cosmetic purposes.
- Fitting, dispensing and adjustment services, upon initial dispensing, when a recipient chooses to privately pay for the eyeglasses, frame, or lenses.
- Repairs when the cost exceeds that of new glasses.

6.0 Documentation

6.1 General Criteria

For information on general documentation requirements, please refer to the Florida Medicaid's general policy.

6.2 Specific Criteria

There is no coverage-specific documentation requirement for this service.

7.0 Authorization

7.1 General Criteria

As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the SSA, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of

21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary.

For recipients enrolled in a managed care plan, providers should request authorization through the recipient's managed care plan. For recipients receiving services through the fee-for-service delivery system, providers should request authorization through the Quality Improvement Organization.

7.2 Specific Criteria

The authorization information described below is applicable to the fee-for-service delivery system, unless otherwise specified.

Providers must obtain authorization when the following applies:

- Exceeding coverage specified in this policy
- For special order frames or special base curves
- For contact lenses

8.0 Reimbursement

8.1 General Criteria

The reimbursement information below is applicable to the fee-for-service delivery system, unless otherwise specified.

8.2 Specific Criteria

The provider must forward the claim for reimbursement only after the fitting and dispensing is complete and the recipient has received the eyeglasses. The provider must enter the date when the eyeglasses were dispensed as the date of service on the claim form. An exception can be made to this whereby a provider may use the order date on the claim form if the recipient loses eligibility from one month to the next.

8.3 Claim Type

Professional (CMS-1500/837P)

8.4 Billing Code, Modifier, and Billing Unit

Providers must report the most current and appropriate billing code(s), modifier(s), and billing unit(s) for the service rendered, as incorporated by reference in Rule 59G-4.002, F.A.C.

8.5 Diagnosis Code

Providers must report the most current and appropriate diagnosis code to the highest level of specificity that supports medical necessity, as appropriate for this service.

8.6 Rate

For a schedule of rates, as incorporated by reference in Rule 59G-4.002, F.A.C., visit the Florida Medicaid fiscal agent's Web site at <http://portal.flmmis.com/flpublic>.