Vision

Provider Manual
Volume II

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Change Log

The Change Log is used to track all changes within this manual. Changes are approved by the State of NH. The column titles and descriptions include:

Date Change to the Manual	Date the change was physically made to the manual.
Effective Date	Date the change goes into effect. This date may represent a retroactive, current or future date.
Section	Section/Sub-Section number(s) to which the change(s) are made.
Change Description	Description of the change(s).
Reason	A brief explanation for the change (including rule number if applicable).
Related Communication	References any correspondence that relates to the change (ex: Bulletin, Provider Notice, CSR, etc.).

Date Change to Manual	Effective Date	Section	Change Description	Reason	Related Communication

1. NH Medicaid Provider Billing Manuals Overview

New Hampshire (NH) Medicaid Provider Billing Manuals include two volumes, which must be used in conjunction with each other. Policies and requirements detailed in these manuals are established by the NH Department of Health and Human Services (DHHS), also referred to as the Department.

It is critical that the provider and the provider's staff be familiar with, and comply with, all information contained in the General Billing Manual – Volume I, and this Provider Specific Billing Manual – Volume II.

- The **General Billing Manual – Volume I:** Applies to every enrolled NH Medicaid provider (hereinafter referred to as the provider) who submits bills to NH Medicaid for payment. It includes *general policies and procedures* applicable to the NH Medicaid Program such as provider responsibilities, verification of member eligibility, covered and non-covered services, service authorizations, medical necessity, third party liability, surveillance and utilization review/program integrity, access to fee schedules, claims processing, and obtaining reimbursement for providing services. This manual also includes general information on how to enroll as a NH Medicaid provider. The General Billing Manual – Volume I Appendices section encompasses a range of supplemental materials such as Contact Information, Common Acronyms, and general information.

- The **Provider Specific Billing Manual – Volume II:** Specific to a provider type and designed to guide the provider through *specific policies applicable to the provider type*.

1.1 Intended Audience

The General Billing Manual - Volume I, and the Provider Specific Billing Manual – Volume II, are designed for all Medicaid enrolled health care providers, their staff, and provider-designated billing agents. All providers who work with members of a Medicaid plan, whether Medicaid Fee-for-Service or a managed care health plan, are required to fulfill the fundamental obligations as outlined in the general Billing Manual Section 4: Provider Participation and Responsibilities. Additionally, it is imperative that all providers maintain up-to-date information in the Medicaid Management Information System (MMIS) to ensure receipt of all important Medicaid Programmatic updates.

The specific billing requirements outlined in this manual pertain specifically to members of the Medicaid Fee-for-Service Program. The billing requirements pertaining to members of Managed Care Health Plans can be found in the specific managed care health plan's provider manual.

Fee-for-Service Member eligibility should be confirmed by providers prior to billing for covered services. Please refer to Section 12: Member Eligibility of the General Billing Manual - Volume I for instructions on confirming member eligibility.

These manuals are ***not*** designed for use by NH Medicaid members (hereinafter referred to as members).

1.2 Provider Accountability

Participating providers must know the content of both billing manuals, make them available to their staff and authorized billing agents, and be aware of all policies and procedures, as well as any changes to policies and procedures, that relate directly or indirectly to the provision of services and the billing of services for members.

1.3 Document Disclaimer/Policy Interpretation

It is the Department's intention that the provider billing manuals, as well as the information furnished to providers by the staff of the Department's fiscal agent, be accurate and timely. However, in the event of inconsistencies between the fiscal agent and the Department regarding policy interpretation, the Department's interpretation of the policy language in question will control and govern.

1.4 Notifications & Updates

Providers are notified of NH Medicaid Program changes and any other changes applicable to participating providers through several types of media, including provider bulletins, provider notices, memos, letters, website updates, newsletters and/or updated pages to the General Billing Manual – Volume I, and/or the Provider Specific Billing Manual – Volume II. It is important that providers share these documents with their service providers, billing agents and staff.

Billing Manual updates are distributed jointly by the Department and the fiscal agent. Providers receive notification of manual updates through email distributions based on the contact information stored in the MMIS. It is imperative that providers keep up to date contact information so that these various messages and updates are received in a timely manner. It is highly recommended that providers include an email address in their MMIS profile for effective communication. Providers should log into their MMIS accounts routinely and ensure that all provider information is up to date and accurate. All notifications distributed to providers and all billing manuals are saved in the MMIS and are accessible to providers at any time.

1.5 Description of Change Log

All changes made to this manual are under change control management and are approved by the Department and/or its associated organizations. The change log is located at the front of this document.

1.6 Contacts for Billing Manual Inquiries

Billing manual inquiries may be directed to the fiscal agent's Provider Relations Unit (refer to General Billing Manual – Volume I Appendices Section for all Contact Information).

Questions relating to policy issues outlined in this manual may be directed to the fiscal agent's Provider Relations Unit for referral to the appropriate Department contact.

2. Provider Participation & Ongoing Responsibilities

Providers of health care and other NH Medicaid reimbursable services must enroll in the NH Medicaid Program in order to be participating providers. There are also ongoing responsibilities that participating providers must meet, these responsibilities are outlined in the Section 4 of the General Billing Manual – Volume I.

In order to participate in the New Hampshire Medicaid Program, the following requirements must be met:

1. Ophthalmologists, optometrists and opticians shall be New Hampshire enrolled Medicaid providers;

2. Ophthalmologists and optometrists shall be licensed by the state in which they practice;

3. Opticians practicing in NH shall be registered in accordance with RSA 327-A:2, or, if practicing in another state, meet the requirements of the state in which they practice; and

4. Opticians who fit contact lenses shall have a statement of delegation from an ophthalmologist or optometrist in accordance with RSA 327-A:2.

The Department has contracted with an ophthalmic laboratory. Vision care providers must order all lenses and frames from this provider. Contact information for the current ophthalmic provider may be obtained by contacting the Department's fiscal agent.

3. Covered Services & Requirements

Services covered by the NH Medicaid Program fall into broad coverage categories as specified in the federal regulations. Reference should be made to this individual Provider Specific Billing Manual - Volume II and the Department's rules for coverage details. (See Contact Information in the General Billing Manual for Department Rules website).

Some of the medical services covered by the NH Medicaid Program require that the provider obtain a service authorization ***prior to*** service delivery in order to be reimbursed by the NH Medicaid Program. Information about specific services which require service authorizations prior to service delivery and for the details regarding how to submit theserequests can be found in this Provider Specific Billing Manual - Volume II.

Vision care services covered under the NH Medicaid Program shall include:

1. Eye examination procedures to diagnose and monitor medical conditions of the eye, including:
    a. Complete eye examinations which shall include:
        i. Visual acuity testing;
        ii. Gross visual fields;
        iii. Muscle balance;
        iv. Slit lamp examinations, and
        v. Ophthalmoscopy and tonometry.
    b. Interior extended testing of visual fields only;
    c. Ophthalmoscopy, fundoscopy only, and
    d. Routine tonometry;
2. Eye examinations, performed in:
    a. A provider's office;
    b. A member's home; or
    c. A nursing facility in which the member resides;
3. One refraction to determine the need for glasses, no more frequently than every 12 months;
4. One pair of single vision lenses with frames, provided that the refractive error is at least plus or minus .50 diopter according to the type of refractive error, in each eye;
5. One pair of glasses with bifocal corrective lenses or one pair of glasses with corrective lenses for close vision and one pair of glasses with corrective lenses for distant vision if there is a refractive error of at least .50 diopter for both close and distant vision;
6. Transition lenses for members with ocular albinism;
7. Contact lenses for ocular pathology in cases where the visual acuity is not correctable to 20/70 or better without contact lenses, or when required to correct aphakia or to treat corneal disease;
8. Replacement of the component eyeglasses parts due to breakage or damage, subject to the following:

a. Replacements may be in the form of a single lens, both lenses, frame only or a complete pair of corrective lenses;

b. Each component part or complete pair of corrective lenses may only be replaced one time within a 12-month period; and

c. when the recipients has 2 pairs of eyeglasses in lieu of bifocals as allowed in (5) above, each pair of eyeglasses is subject to replacement in accordance with (a) and (b) above

9. Only one replacement of lost eyeglasses per lifetime for recipients under 21 years of age;
10. Trifocal lenses provided that the member:
    a. Is employed and the trifocal lenses are required for the work involved in the member's employment;
    b. Is a full time student and the trifocal lenses are required for the work involved in the member's education; or
    c. Currently has trifocals;
11. Ocular prostheses including:
    a. Artificial eyes, and
    b. Replacing the lens of an eye, and
12. Replacement of nickel frames after 12 months, if the member has a documented allergy to nickel demonstrated by skin irritation and wearing down of the frame in the affected area.

The Department has contracted with an ophthalmic laboratory. Vision care providers must order all lenses and frames from this provider. Contact information for the current ophthalmic contractor may be obtained by contacting the Department's fiscal agent.

Vision providers may obtain, at their own expense, from the contracted ophthalmic laboratory, an eyeglass kit that contains sample frames from which members may choose. Please contact the ophthalmic contractor to determine if frames may be viewed on their website.

3.1 Service Limits

Vision care services shall be limited as follows:

1. One refraction to determine the need for glasses, no more frequently than every 12 months;
2. Replacement of lenses or at the discretion of the member, lenses and frames, when the refractive error changes .50 diopter or more in both eyes;
3. Replacement of nickel frames after 12 months, if the member has a documented allergy to nickel demonstrated by skin irritation and wearing down of the frame in the affected area;
4. One repair of glasses every 12 months, including replacement of the broken part(s) only;
5. Contact lens orders are limited to a 60-day supply at a time.

4. Non-Covered Services

Non-covered services are services for which NH Medicaid will not make payment.

There may be non-covered services directly associated with your provider type (such as those for which there is no medical need), but some non-covered services cannot be directly associated with a specific provider category. Therefore, providers should review the list of other examples of non-covered services in the "Non-Covered Services" section of the General Billing Manual – Volume I.

If a non-covered service is provided to a member, the provider must inform the member, **prior to** delivery of the service, that it is non-covered by NH Medicaid, and that should the member still choose to receive the service, then the member will be responsible for payment. If this occurs, the Department suggests that you maintain in your files a statement signed and dated by the member that they understand that the service is non-covered and that they agree to pay for the service.

Non-Covered vision services shall include:

1. Replacement of lost eyeglasses for recipients age 21 and over
2. Replacement of lost eyeglasses more than once per lifetime for recipients under age 21, except in accordance with He-W 546.06;
3. Progressive lenses;
4. Photochromatic lenses ,including Transition lenses, except for members diagnosed with ocular albinism;
5. Contact lenses, except as described in the covered services section;
6. Orthopics and visual therapy, such as muscle training;
7. Low vision aids, such as magnifying glasses;
8. Sunglasses and eyeglass tinting;
9. Polarized lenses and anti-reflective coatings;
10. High-index lenses;
11. Lasiks surgery;
12. Titanium frames,
13. Items or services for which a less costly alternative is available; and
14. Any other item or service not listed in the Covered Services Section.

5. Service Authorizations (SA)

A service authorization (SA), also known as a prior authorization (PA), is an advance request for authorization for a specific item or service.

A service authorization does not guarantee payment. Claims must be correctly completed, the Medicaid provider must be actively enrolled, and the recipient must be Medicaid eligible, on the date(s) of service.

The provider is responsible for determining that the member is Medicaid eligible on the date of service and if any applicable service limits have been reached. Providers may monitor the number of services used by a member based on claims paid.

Service authorizations are reviewed by the Department. The Contact Information in the Appendices of the General Billing Manual or on the SA form itself should be consulted for the name and method of contact.

Service authorizations are required for contact lenses, trifocal lenses, ocular prostheses, and for any vision service or item over the service limits.

6. Documentation

Providers must maintain clinical records to support claims submitted for reimbursement for a period of at least six years from the date of service or until the resolution of any legal action(s) commenced in the six year period, whichever is longer. See the "Record Keeping" section of the General Billing Manual – Volume I, for documentation requirements.

7. Surveillance and Utilization Review – (SURS) – Program Integrity

The purpose of a Medicaid Surveillance and Utilization Review (SURS) program which, in NH, is administered by the Department's Medicaid Program Integrity Unit is to perform utilization review activities to identify, prevent, detect, and correct potential occurrences of fraud, waste and abuse and to ensure that federal and state taxpayer dollars are spent appropriately on delivering quality, necessary care. These activities are carried out in accordance with state and federal rules, statutes, regulations CMS transmittals, provider fee schedules, and provider participation agreements. Reviews ensure that accurate and proper reimbursement has been made for the care, services or supplies provided to NH Medicaid members.

Utilization review activities may be done prior to payment, following payment, or both. Provider reviews may be selected at random, or generated from member complaints, from other providers, from anonymous calls, or from the Electronic Fraud and Abuse Detection system that is in place.

For additional information regarding utilization review, please refer to the SURS – Program Integrity section of the General Billing Manual – Volume 1.

8. Adverse Actions

An adverse action may be taken by the Department due to a provider's non-compliance with Federal regulations, State laws, Department rules, policies or procedures. See the "Adverse Actions" section of the General Billing Manual – Volume I – regarding the types of adverse actions the Department is authorized to take against non-compliant providers.

9. Medicare/Third Party Coverage

Under federal law, the Medicaid Program is the ***payer of last resort***. All third party obligations must be exhausted before claims can be submitted to the fiscal agent in accordance with 42 CFR 433.139, except for exclusions as outlined in the Medicare/Third Party Insurance Coverage Section of the General Billing Manual – Volume 1. Providers who receive payment in full from a third party are not required to file zero-payment claims with the NH Medicaid Program.

Detailed Medicare/Third Party Coverage guidelines are found in the General Billing Manual – Volume I.

10. Payment Policies

NH Medicaid pays enrolled providers through various reimbursement methodologies for covered services provided to eligible members.

Reimbursement is based on fees or rates established by the Department of Health and Human Services. The maximum reimbursement for services rendered will not exceed the usual and customary charges or the Medicaid maximum allowances.

All third party obligations must be exhausted before claims can be submitted to the fiscal agent. Medicaid is the payer of last resort. Providers must pursue any other health benefit resources prior to filing a claim with NH Medicaid. If a third party does not pay at or in excess of the applicable NH Medicaid reimbursement amount, a provider may submit a claim to NH Medicaid.

Per 42 CFR 447.15, providers rendering service to eligible members must agree to accept the payment made by the Medicaid Program as payment in full and make no additional charge to the members or others on the members' behalf except for NH Medicaid coinsurance, if applicable.

Payment cannot be made directly to a member or entities other than the provider of service.

Additional Payment Policy guidelines are found in the General Billing Manual – Volume I.

Payment for vision care services which include examinations and fitting fees, shall be made in accordance with rates established by the Department.

Vision frames and lenses shall be ordered from, and billed by, the Department's contracted ophthalmic laboratory provider.

Sample frame kits are not eligible for reimbursement.

11. Claims

All providers participating in NH Medicaid must submit claims in accordance with NH Medicaid guidelines. NH Medicaid claim completion requirements may be different than those for other payers, previous NH fiscal agents, or fiscal agents in other states.

Regardless of the method through which claims are submitted, information submitted on the claim by the provider represents a legal document. Neither the fiscal agent nor State staff can alter any data on a submitted claim.

Additional claims guidelines are found in the General Billing Manual – Volume I.

The vision care provider shall submit claims for payment to the Department's fiscal agent.
Vision frames and lenses shall be ordered from and billed by the Department's sole source vision provider.

11.1 Diagnosis & Procedure Codes

All NH Medicaid services must be billed using the appropriate industry-standard diagnosis, revenue and procedure codes. One procedure or revenue code must be provided for each charge billed.

For medical services, the NH Medicaid Program requires the Health Care Financing Administration Common Procedure Coding System (HCPCS) codes and modifiers.

The most current version of the ICD-CM diagnosis code series should be utilized. Claims without the required diagnosis or procedure codes will be denied.

11.2 Service Authorizations (SAs)

Providers must obtain pre-approval and a corresponding service authorization number when outlined as required in this manual. The claim form allows the entry of a service authorization number. However, NH Medicaid does not require the service authorization number on the claim form. If providers choose to enter the SA number on the claim, the SA number must be an exact match of the number stored in the MMIS.

11.3 Claim Completion Requirements for Vision

Vision providers are required to submit claims to NH Medicaid using the CMS1500 paper form or the electronic version, an 837P. Paper claims are imaged and will then go through the OCR process as the first steps in claim processing and payment. You can prevent delays to your anticipated payment date by following these suggestions:

1. DO NOT submit laser printed red claim forms.
2. DO NOT use highlighters on any claim form(s) or adjustments(s). Highlighted area show up as black lines, just as they do when highlighted forms are photocopied or faxed.
3. DO NOT use staples.
4. DO submit only RED UB-04 or HCFA claims forms. Fixed claims or claim copies will not be accepted.
5. DO use typewritten (BLOCK lettering) print when filling out claim forms; handwritten or script claims can cause delays and errors in processing.
6. DO ensure that your printers are properly aligned, and that your print is dark and legible, if you are using a printer to create claim forms.
7. DO use only black or blue ink on ALL claims or adjustment that you submit to the fiscal agent. The fiscal agent imaging/OCR system reads blue and black ink.
8. DO make all appropriate corrections prior to re-submitting the claim(s) or adjustment(s).
9. DO call the NH Medicaid Provider Relations Unit at (603) 223-4774 or 1 (866) 291-1674 if you have questions.

The CMS1500 form must be both signed and dated, on or after the last date of service on the claim, in box 31. Acceptable forms of signature are an actual signature, signature stamp, typed provider name, or signature or file.

Please note that the person authorized by the provider or company who is allowed to sign the form is based on the company's own policy for authorized signers.

Paper claims and other documents can be mailed to:

NH Medicaid Claims Unit
PO Box 2003
Concord, NH 03302-2003

12. Terminology

Department means the New Hampshire department of health and human services.

Medicaid means the Title XIX and Title XXI programs administered by the department, which makes medical assistance available to eligible individuals.

Ophthalmologist means a physician who specializes in the diagnosis and treatment of disorders of the eye.

Optometrist means a doctor of optometry (OD), a primary health care provider who diagnoses, manages, and treats conditions and diseases of the eye.

Optician means "optician" as defined in RSA 327-A:1,VII, namely "anyone who sells or dispenses, upon prescription, spectacles, eyeglasses or contact lenses."

Recipient means any individual who is eligible for and receiving medical assistance under the medicaid program.

Title XIX means the joint federal-state program described in Title XIX of the Social Security Act and administered in New Hampshire under the medicaid program.

Title XXI means the joint federal-state program described in Title XXI of the Social Security Act and administered in New Hampshire by the department under the medicaid program.