

907 KAR 1:631. Vision Program reimbursement provisions and requirements.

RELATES TO: KRS 205.520, 42 C.F.R. 440.40, 440.60, 447 Subpart B, 42 U.S.C. 1396a-d
STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3)

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed, or opportunity presented, by federal law to qualify for federal Medicaid funds. This administrative regulation establishes Medicaid Program reimbursement provisions and requirements for vision services provided to a Medicaid recipient who is not enrolled in a managed care organization.

Section 1. Definitions. (1) "CPT code" means a code used for reporting procedures and services performed by medical practitioners and published annually by the American Medical Association in Current Procedural Terminology.

(2) "Department" means the Department for Medicaid Services or its designee.

(3) "Enrollee" means a recipient who is enrolled with a managed care organization.

(4) "Federal financial participation" is defined by 42 C.F.R. 400.203.

(5) "Healthcare Common Procedure Coding System" or "HCPCS" means a collection of codes acknowledged by the Centers for Medicare and Medicaid Services (CMS) that represents procedures or items.

(6) "Managed care organization" means an entity for which the Department for Medicaid Services has contracted to serve as a managed care organization as defined in 42 C.F.R. 438.2.

(7) "Medically necessary" or "medical necessity" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.

(8) "Ophthalmic dispenser" means an individual who is qualified to engage in the practice of ophthalmic dispensing in accordance with KRS 326.030 or 326.040.

(9) "Optometrist" means an individual who is licensed as an optometrist in accordance with KRS Chapter 320.

(10) "Provider" is defined by KRS 205.8451(7).

(11) "Recipient" is defined by KRS 205.8451(9).

(12) "Usual and customary charge" means the uniform amount the provider charges in the majority of cases for the service or item.

Section 2. General Requirements. (1) For the department to reimburse for a vision service or item, the requirements established in 907 KAR 1:632 and this administrative regulation shall be met.

(2)(a) If a procedure is part of a comprehensive service, the department shall:

1. Not reimburse separately for the procedure; and

2. Reimburse one (1) payment representing reimbursement for the entire comprehensive service.

(b) A provider shall not bill the department multiple procedures or procedural codes if one (1) CPT code or HCPCS code is available to appropriately identify the comprehensive service provided.

(3)(a) If a provider receives any duplicate payment or overpayment from the department, regardless of reason, the provider shall return the payment to the department.

(b) Failure to return a payment to the department in accordance with paragraph (a) of this subsection may be:

1. Interpreted to be fraud or abuse; and

2. Prosecuted in accordance with applicable federal or state law.

(4) The department shall not reimburse for:

(a) A service with a CPT code that is not listed on the Department for Medicaid Services Vision Program Fee Schedule; or

(b) An item with an HCPCS code that is not listed on the Department for Medicaid Services Vision Program Fee Schedule.

Section 3. Reimbursement for Covered Procedures and Materials for Optometrists. (1) Except for a clinical laboratory service, the department's reimbursement for a covered service or covered item provided by a participating optometrist shall be the lesser of the:

(a) Optometrist's usual and customary charge for the service or item; or

(b) Reimbursement established on the Department for Medicaid Services Vision Program Fee Schedule for the service or item.

(2) The department shall reimburse for a covered clinical laboratory service in accordance with 907 KAR 1:028.

Section 4. Maximum Reimbursement for Covered Procedures and Materials for Ophthalmic Dispensers. The department's reimbursement for a covered service or covered item provided by a participating ophthalmic dispenser shall be the lesser of the:

(1) Ophthalmic dispenser's usual and customary charge for the service or item; or

(2) Reimbursement established on the Department for Medicaid Services Vision Program Fee Schedule for the service or item.

Section 5. Reimbursement Limitations. (1) The department shall not reimburse for:

(a) A telephone consultation;

(b) Contact lenses, except as established in 907 KAR 1:632, Section 5(1);

(c) Safety glasses unless proof of medical necessity is documented;

(d) A press-on prism; or

(e) A service with a CPT code or item with an HCPCS code that is not listed on the Department for Medicaid Services Vision Program Fee Schedule.

(2)(a) The department shall reimburse for no more than one (1) pair of eyeglasses per recipient per calendar year unless:

1. The recipient's eyeglasses are broken or lost during the calendar year; or

2. The eyeglass prescription for the recipient is changed during the calendar year.

(b) If an event referenced in paragraph (a)1 or 2 of this subsection occurs within the calendar year, the department shall reimburse for one (1) additional pair of eyeglasses for the recipient during the calendar year.

(3) A prism, if medically necessary, shall be included in the cost of lenses.

Section 6. Third Party Liability. (1) Nonduplication of payments and third-party liability shall be in accordance with 907 KAR 1:005.

(2) A provider shall comply with KRS 205.622.

Section 7. Not Applicable to Managed Care Organizations. A managed care organization shall not be required to reimburse the same amount as established in this administrative regulation for an item or service reimbursed by the department via this administrative regulation.

Section 8. Federal Approval and Federal Financial Participation. The department's reimbursement for services pursuant to this administrative regulation shall be contingent upon:

- (1) Receipt of federal financial participation for the reimbursement; and
- (2) Centers for Medicare and Medicaid Services' approval for the reimbursement.

Section 9. Appeal Rights. A provider may appeal a department decision as to the application of this administrative regulation in accordance with 907 KAR 1:671.

Section 10. Incorporation by Reference. (1) "Department for Medicaid Services Vision Program Fee Schedule", May 13, 2014, is incorporated by reference.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky, Monday through Friday, 8 a.m. to 4:30 p.m. or online at the department's Web site at <http://www.chfs.ky.gov/dms/incorporated.htm>. (21 Ky.R. 218; eff. 9-21-1994; 23 Ky.R. 4015; 24 Ky.R. 120; eff. 6-18-1997; 27 Ky.R. 1105; eff. 12-21-2000; 34 Ky.R. 1847; 2121; eff. 4-4-2008; 40 Ky.R. 1991; 2524; 2749; eff. 7-7-2014; Crt eff. 12-6-2019.)