907 KAR 1:632. Vision Program coverage 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, 45 C.F.R. 147.126
STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 42 C.F.R. 441.30, 42 C.F.R. 441.56(c)(1)
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 the Kentucky Medicaid Program provisions and requirements regarding the coverage of vision services.

Section 1. Definitions. (1) "Current procedural terminology code" or "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 Servicers 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) "Medicaid basis" means a scenario in which:
(a) A provider provides a service to a recipient as a Medicaid-participating provider in accordance with:
1. 907 KAR 1:671; and
2. 907 KAR 1:672;
(b) The Medicaid Program is the payer for the service; and
(c) The recipient is not liable for payment to the provider for the service other than any cost sharing obligation owed by the recipient to the provider.
(8) "Medically necessary" or "medical necessity" means that a covered benefit is determined to be needed in accordance with 907 KAR 3:130.
(9) "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.
(10) "Optometrist" means an individual who is licensed as an optometrist in accordance with KRS Chapter 320.
(11) "Provider" is defined by KRS 205.8451(7).
(12) "Recipient" is defined by KRS 205.8451(9).

Section 2. General Requirements and Conditions of Participation. (1)(a) For the department to reimburse for a vision service or item, the service or item shall be:
1. Provided:
a. To a recipient; and
b. By a provider who is:
(i) Enrolled in the Medicaid Program pursuant to 907 KAR 1:672;
(ii) Except as provided in paragraph (b) of this subsection, currently participating in the Medicaid Program pursuant to 907 KAR 1:671; and

(iii) Authorized by this administrative regulation to provide the given service or item;
2. Covered in accordance with this administrative regulation;
3. Medically necessary;
4. A service or item authorized within the scope of the provider's licensure; and
5. A service or item listed on the Department for Medicaid Services Vision Program Fee Schedule.
(b) In accordance with 907 KAR 17:015, Section 3(3), a provider of a service to an enrollee shall not be required to be currently participating in the fee-for-service Medicaid Program.
(2)(a) To be recognized as an authorized provider of vision services, an optometrist shall:
1. Be licensed by the:
a. Kentucky Board of Optometric Examiners; or
b. Optometric examiner board in the state in which the optometrist practices if the optometrist practices in a state other than Kentucky;
2. Submit to the department proof of licensure upon initial enrollment in the Kentucky Medicaid Program; and
3. Annually submit to the department proof of licensure renewal including the expiration date of the license and the effective date of renewal.
(b)1. To be recognized as an authorized provider of vision services, an in-state optician shall:
a. Hold a current license in Kentucky as an ophthalmic dispenser;
b. Comply with the requirements established in KRS Chapter 326;
c. Submit to the department proof of licensure upon initial enrollment in the Kentucky Medicaid Program; and
d. Annually submit to the department proof of licensure renewal including the expiration date of the license and the effective date of renewal.
2. To be recognized as an authorized provider of vision services, an out-of-state optician shall:
a. Hold a current license in the state in which the optician practices as an ophthalmic dispenser;
b. Submit to the department proof of licensure upon initial enrollment in the Kentucky Medicaid Program; and
c. Annually submit to the department proof of licensure renewal including the expiration date of the license and the effective date of renewal.
(c) A physician shall be an authorized provider of vision services.
(3) A provider shall comply with:
(a) 907 KAR 1:671;
(b) 907 KAR 1:672;
(c) All applicable state and federal laws; and
(d) The confidentiality of personal records pursuant to 42 U.S.C. 1320d to 1320d-8 and 45 C.F.R. Parts 160 and 164.
(4)(a) A provider shall:
1. Have the freedom to choose whether to provide services to a recipient; and
2. Notify the recipient referenced in paragraph (b) of this subsection of the provider's decision to accept or not accept the recipient on a Medicaid basis prior to providing any services to the recipient.
(b) A provider may provide a service to a recipient on a non-Medicaid basis:
1. If the recipient agrees to receive the service on a non-Medicaid basis; and
2. Whether or not the:
a. Provider is a Medicaid-participating provider; or
b. Service is a Medicaid-covered service.

Section 3. Vision Service Coverage. (1) Vision service coverage shall be limited to a service

listed with a CPT code or item with an HCPCS code on the Department for Medicaid Services Vision Program Fee Schedule.

(2) Vision service limits shall be as established on the Department for Medicaid Services Vision Program Fee Schedule.

Section 4. Coverage of Eyeglasses and Frames. (1) To be eligible for eyeglasses covered by the department, a recipient shall:

(a) Be under the age of twenty-one (21) years, including the month in which the recipient becomes twenty-one (21) years of age; and

(b) Have a diagnosed visual condition that:

1. Requires the use of eyeglasses;

2. Is within one (1) of the following categories:

a. Amblyopia;

b. Post surgical eye condition;

c. Diminished or subnormal vision; or

d. Other diagnosis which indicates the need for eyeglasses; and

3. Requires a prescription correction in the stronger lens no weaker than:

a. +0.50, 0.50 sphere +0.50, or 0.50 cylinder;

b. 0.50 diopter of vertical prism; or

c. A total of two (2) diopter of lateral prism.

(2) Provisions regarding any limit on the number of eyeglasses covered shall be as established in 907 KAR 1:631.

(3) For the department to cover:

(a) A frame, the frame shall be:

1. First quality;

2. Free of defects; and

3. Have a warranty of at least one (1) year; or

(b) A lens, the lens shall be:

1. First quality;

2. Free of defects;

3. Meet the United States Food and Drug Administration's impact resistance standards; and

4. Polycarbonate and scratch coated.

(4) The dispensing of eyeglasses shall include:

(a) Single vision prescriptions;

(b) Bi-focal vision prescriptions;

(c) Multi-focal vision prescriptions;

(d) Services to frames; or

(e) Delivery of the completed eyeglasses which shall include:

1. Instructions in the use and care of the eyeglasses; and

2. Any adjustment, minor or otherwise, for a period of one (1) year.

(5) A provider shall be responsible, at no additional cost to the department or the recipient, for:

(a) An inaccurately filled prescription;

(b) Defective material; or

(c) An improperly fitted frame.

Section 5. Contact Lenses, Tint, and Plano Safety Glasses. (1) The department shall not reimburse for contact lenses substituted for eyeglasses unless:

(a) The corrected acuity in a recipient's stronger eye is twenty (20)/fifty (50) and shall be improved with the use of contact lenses;

(b) The visual prescription is of + 8.00 diopter or greater; or
(c) The recipient's diagnosis is 4.00 diopter anisometropia.
(2) The department shall not reimburse for tint unless the prescription specifically indicates a diagnosis of photophobia.
(3) The department shall not reimburse for plano safety glasses unless the glasses are medically indicated for the recipient.

Section 6. Noncovered Services or Items. The department shall not reimburse for:
(1) Tinting if not medically necessary;
(2) Photochromics if not medically necessary;
(3) Anti-reflective coatings if not medically necessary;
(4) Other lens options which are not medically necessary;
(5) Low vision services;
(6) A press-on prism; or
(7) 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.

Section 7. Required Provider Documentation. (1)(a) In accordance with 42 C.F.R. 431.17, a provider shall maintain medical records of a service provided to a recipient for the period of time currently required by the United States Health and Human Services Secretary unless the department requires a retention period, pursuant to 907 KAR 1:671, longer than the period required by the United States Health and Human Services Secretary.
(b) If, pursuant to 907 KAR 1:671, the department requires a medical record retention period longer than the period required by the United States Health and Human Services Secretary, the medical record retention period established in 907 KAR 1:671 shall be the minimum record retention period.
(c) A provider shall maintain medical records of a service provided to a recipient in accordance with:
1. 45 C.F.R. 164.316; and
2. 45 C.F.R. 164.306.
(2) A provider shall maintain the following documentation in a recipient's medical record:
(a) Any covered service or covered item provided to the recipient;
(b) For each covered service or covered item provided to the recipient:
1. A signature by the individual who provided the service or item signed on the date the service or item was provided;
2. The date that the service or item was provided; and
3. Demonstration that the covered service or covered item was provided to the recipient;
(c) The diagnostic condition necessitating the service or item; and
(d) The medical necessity as substantiated by an appropriate medical order.

Section 8. No Duplication of Service. (1) The department shall not reimburse for a service provided to a recipient by more than one (1) provider of any program in which the service is covered during the same time period.
(2) For example, if a recipient is receiving a speech-language pathology service from a speech-language pathologist enrolled with the Medicaid Program, the department shall not reimburse for the same service provided to the same recipient during the same time period via the physician services program.

Section 9. Third Party Liability. A provider shall comply with KRS 205.622.

Section 10. Auditing Authority. The department shall have the authority to audit any claim, medical record, or documentation associated with the claim or medical record.

Section 11. Use of Electronic Signatures. (1) The creation, transmission, storage, and other use of electronic signatures and documents shall comply with the requirements established in KRS 369.101 to 369.120.

(2) A provider that chooses to use electronic signatures shall:

(a) Develop and implement a written security policy that shall:

1. Be adhered to by each of the provider's employees, officers, agents, or contractors;

2. Identify each electronic signature for which an individual has access; and

3. Ensure that each electronic signature is created, transmitted, and stored in a secure fashion;

(b) Develop a consent form that shall:

1. Be completed and executed by each individual using an electronic signature;

2. Attest to the signature's authenticity; and

3. Include a statement indicating that the individual has been notified of his or her responsibility in allowing the use of the electronic signature; and

(c) Provide the department, immediately upon request, with:

1. A copy of the provider's electronic signature policy;

2. The signed consent form; and

3. The original filed signature.

Section 12. Federal Approval and Federal Financial Participation. The department’s coverage of services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the coverage; and

(2) Centers for Medicare and Medicaid Services’ approval for the coverage.

Section 13. Appeal Rights. An appeal of a department decision regarding a Medicaid recipient who is:

(1) Enrolled with a managed care organization shall be in accordance with 907 KAR 17:010; or

(2) Not enrolled with a managed care organization shall be in accordance with 907 KAR 1:563.

Section 14. 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. (40 Ky.R. 2034; 2536; 2757; eff. 7-7-2014; Crt eff. 12-6-2019.)