
# Handbook for Providers of Optometric Services

# Chapter O-200 Policy and Procedures for Optometric Services

**Illinois Department of Healthcare and Family Services**

**Issued March 2017**

# Chapter O-200

# Optometric Services

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# Foreword

## Purpose

This handbook, along with recent provider notices, will act as an effective guide to participation in the Department's Medical Programs. It contains information that applies to fee-for-service Medicaid providers. It also provides information on the Department's requirements for enrollment and provider participation, as well as information on which services require prior approval and how to obtain prior approval.

Limited guidance is contained in this handbook for the provision of medical diagnostic and therapeutic services for the eyes. Additional guidance for such medical services, whether provided by optometrists or by physicians, can be found in the Handbook for Practitioners Rendering Medical Services, Chapter A-200.

It is important that both the provider of services and the provider's billing personnel read all materials prior to initiating services to ensure a thorough understanding of the Department's Medical Programs policy and billing procedures. Revisions and supplements to the handbook are released as necessary based on operational need and State or federal laws requiring policy and procedural changes. Updated handbooks are posted on the Provider Handbooks page of the website.

Providers are held responsible for compliance with all policy and procedures contained herein. Providers should register to receive e-mail notification, when new provider information has been posted by the Department.

Providers should always verify a participant's eligibility before providing services, both to determine eligibility for the current date and to discover any limitations to the participant's coverage. It is imperative that providers check HFS electronic eligibility systems regularly to determine eligibility. The Recipient Eligibility Verification (REV) System, the Automated Voice Response System (AVRS) at 1-800-842-1461, and the Medical Electronic Data Interchange (MEDI) systems are available.

Inquiries regarding coverage of a particular service or billing issues may be directed to the Bureau of Professional and Ancillary Services at 1-877-782-5565.

# Acronyms and Definitions

**CPT:** Current Procedural Terminology, as defined and published by the American Medical Association.

**Department of Healthcare and Family Services (HFS) or (Department):** The Department of Healthcare and Family Services (HFS) or (Department) is the agency that administers Illinois' Medical Assistance (Medicaid) Program, as well as other public healthcare programs, including All Kids, FamilyCare, Veterans Care, and Health Benefits for Workers with Disabilities (HBWD)

**Document Control Number (DCN):** A fifteen-digit number assigned by the Department to identify each claim that is submitted by a provider. The format is CCYYDDDLLSSSSSS.

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|---|---|
| CC | First 2 digits of the century claim was received. |
| YY | Last 2 digits of year claim was received. |
| DDD | Julian date (pdf) claim was received. |
| LL | Document Control Line Number (most commonly 13 for OPO and HFS 1443, Provider Invoice claim form, 15 for paper, 16 for paper with attachment, 17 for paper with override, 22 for electronic, 23 for electronic Medicare crossover). |
| SSSSSS | Sequential Number. |

**Early Intervention (EI):** Illinois' Early Intervention program's mission is to assure that families who have infants and toddlers, birth to three years of age, with diagnosed disabilities, development delays or substantial risk of significant delays, receive resources and support that assist them in maximizing their infants' and toddlers' development. EI services must be sought first for children in this age group.

Providers billing for EI covered items or services must bill the EI Central Billing Office (CBO) for payment. Contact Early Intervention at 1-800-634-8540 for service questions, and 217-782-1981 for billing questions.

**Fee-for-Service:** A payment methodology in which reimbursement is considered for each service provided.

**HCPCS:** Healthcare Common Procedure Coding System.

**HFS 1443:** The Department of Healthcare and Family Services Provider Invoice.

**HFS 2360:** The Department of Healthcare and Family Services Health Insurance Claim Form.

**HFS 2432:** The Split Billing Transmittal for MANG Spenddown Program Form issued by the Department of Human Services.

**HFS 3797:** The Department of Healthcare and Family Services Medicare Crossover Invoice.

**Identification Card or Notice:** The card issued by the Department to each person or family who is eligible under Medical Assistance, All Kids, FamilyCare, Veterans Care, Health Benefits for Workers with Disabilities (HBWD) and Qualified Medicare Beneficiaries (QMB) who are not eligible for Medical Assistance, but are eligible for Department consideration of Medicare coinsurance and deductibles.

**National Provider Identifier (NPI):** The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated the adoption of standard unique identifiers for healthcare providers and health plans. For healthcare providers, this identifier is referred to as the National Provider Identifier (NPI).

**Participant:** A term used to identify an individual receiving coverage under one of the Department's medical programs. It is interchangeable with the term "recipient".

**Practitioner:** For purposes of this handbook, a practitioner is a health care professional or entity who is rendering medical services and is enrolled with HFS as one of the following provider types: physician, advanced practice nurse, imaging center, portable X-ray company, school-based linked health center, local health department, independent laboratory, fee-for-service hospital or optometrist or dentist providing medical services.

**Procedure Code:** The appropriate codes from the American Medical Association Current Procedural Terminology (CPT) or appropriate HCPCS Codes.

**Provider Enrollment Services (PES):** The section of the Department of Healthcare and Family Services that is responsible for maintaining provider enrollment records.

**Recipient Identification Number (RIN):** The nine-digit identification number unique to the individual receiving coverage under one of the Department's Medical Programs. It is vital that this number be correctly entered on billings for services rendered.

**Remittance Advice:** A document issued by the Department which reports the status of claims (invoices) and adjustments processed. It may also be referred to as a voucher.

# Chapter O-200

# Optometric Services

## O-200 Basic Provisions

For consideration of payment by the Department for optometric services, such services must be provided by a provider enrolled for participation in the Department's Medical Programs via the web-based system known as Illinois Medicaid Program Advanced Cloud Technology (IMPACT). Services provided must be in full compliance with applicable federal and State laws, the general provisions contained in the Chapter 100, Handbook for Providers of Medical Services, General Policy and Procedures, and the policy and procedures contained in this handbook. Exclusions and limitations are identified in specific topics contained herein.

The billing instructions contained within this handbook are specific to the Department's paper forms and apply to patients enrolled in traditional fee-for-service and **do not apply to patients** enrolled in Managed Care Organizations (MCOs) and Managed Care Community Networks (MCCNs). Further information can be found at the HFS Care Coordination website.

Providers submitting X12 electronic transactions must refer to Chapter 300, Handbook for Electronic Processing. Chapter 300 identifies information that is specific to conducting Electronic Data Interchange (EDI) with the Illinois Medical Assistance Program and other health care programs funded or administered by the Illinois Department of Healthcare and Family Services.

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# O-201 Provider Enrollment

## O-201.1 Enrollment Requirements

An optometrist who holds a valid Illinois (or state of practice) license to practice optometry is eligible to be considered for enrollment to participate in the Department's Medical Programs.

- Optometrists holding non-teaching administrative or staff positions in schools or other institutions may be approved for participation in the provision of direct services if they maintain a private practice.
- Teaching optometrists who provide direct services may be approved for participation provided that salaries paid by schools or other institutions do not include a component for treatment services.

No license is required for enrollment as an optician or optical company, but the provider must be in compliance with relevant state laws in the state in which he or she is doing business.

Participation requirements for ophthalmologists are covered in Chapter A-200, the Handbook for Practitioners Rendering Medical Services.

To comply with the Federal Regulations at 42 CFR Part 455 Subpart E - Provider Screening and Enrollment, Illinois has implemented a new electronic provider enrollment system. The web-based system is known as Illinois Medicaid Program Advanced Cloud Technology (IMPACT).

Under the IMPACT system, category of service/s (COS) is replaced with Specialties and Subspecialties. When enrolling in IMPACT, a Provider Type Specialty must be selected. A provider type subspecialty may or may not be required.

Refer to the IMPACT Provider Types, Specialties and Subspecialties document for additional information.

## O-201.2 Enrollment Approval

When enrollment is approved, the provider will receive a computer-generated notification, the Provider Information Sheet, listing certain data on the Department's computer files. The provider is to review this information for accuracy immediately upon receipt. For an explanation of the data entries on the Provider Information Sheet, see Appendix O-4.

If all information is correct, the provider is to retain the Provider Information Sheet for subsequent use in completing claims (billing statements) to ensure that all identifying information required is an exact match to that in the Department files. If any of the information is incorrect, refer to Topic O-201.4.

Enrollment of a provider is subject to a provisional period and shall be conditional for one year unless otherwise specified by the Department. During the period of conditional enrollment, the Department may terminate or disenroll the provider from the Medical Assistance Program without cause.

## O-201.3 Enrollment Denial

When enrollment is denied, the provider will receive written notification of the reason for denial.

Within ten calendar days after the date of this notice, the provider may request a hearing. The request must be in writing and must contain a brief statement of the basis upon which the Department's action is being challenged. If such a request is not received within ten calendar days, or is received, but later withdrawn, the Department's decision shall be a final and binding administrative determination.

Department rules concerning the basis for denial of enrollment are in 89 Ill. Adm. Code 140.14. Department rules concerning the administrative hearing process are in 89 Ill. Adm. Code 104 Subpart C

## O-201.4 Provider File Maintenance

The information carried in the Department's files for participating providers must be maintained on a current basis. The provider and the Department share responsibility for keeping the file updated.

### Provider Responsibility

The information contained on the Provider Information Sheet is the same as in the Department's files. Each time the provider receives a Provider Information Sheet, it is to be reviewed carefully for accuracy. The Provider Information Sheet contains information to be used by the provider in the preparation of claims. Any inaccuracies found are to be corrected and the Department notified immediately via IMPACT.

Failure of a provider to properly update the IMPACT with corrections or changes may cause an interruption in participation and payments

## Department Responsibility

When there is a change in a provider's enrollment status or the provider submits a change, the Department will generate an updated Provider Information Sheet reflecting the change and the effective date of the change. The updated sheet will be sent to the provider and to all payees listed if the payee address is different from the provider address.

## O-202 Provider Reimbursement

The Department uses the Illinois Department of Corrections (DOC) for fabrication of eyeglasses for participants who are enrolled in traditional fee-for-service. Although other plans may contract with DOC to fabricate eyeglasses for its members, this handbook policy does not apply to those participants, and the plan should be contacted for its policy on ordering eyeglasses. See the Care Coordination webpage for information.

- Practitioners may be reimbursed for professional services; a fitting fee for eyeglasses; and certain optical supplies
- Optical companies may be reimbursed for the fitting fee for eyeglasses, and certain optical supplies

Providers will not be reimbursed for the actual fabrication or sale of eyeglasses unless prior approval was obtained to fabricate the eyeglasses in a private lab.

All services for which charges are made are to be coded with specific procedure codes as identified in the Optometric Fee Schedule or Practitioner Fee Schedule. No other procedure codes are acceptable. Reimbursement will not be made for services provided when the claim has been completed with invalid procedure codes.

When billing for services or materials or both, the claim submitted for payment must include a description of the actual services provided or the materials dispensed. Any payment received from a third-party payer must be reflected as a credit on any claim submitted to the Department for covered services. A provider is not to charge a participant a copayment when dispensing optical materials. Other Department co-payments, when applicable, are not to be reflected on the claim.

If a patient has a third party insurance and chooses to order eyewear through a private lab, the Department will not reimburse the patient or the provider any balance due from the cost of that eyewear.

Providers participating in the Chicago Public School district vision program bill the Department or child's MCO for services and eyeglasses; however, eyeglasses are not fabricated through DOC. See Topic O-235 for more information.

### O-202.1 Charges

Charges billed to the Department must be the provider's usual and customary charge billed to the general public for the same service or item.

Providers may charge only for services they personally provide, or which are provided under their direct supervision in their offices by their staff, e.g., fitting done by a technician in a provider's employ.

A provider may not charge, however, for services provided by another provider, even though one may be in the employ of the other. Providers may not charge for services provided outside their offices by anyone other than themselves.

**Allowable Charges By Teaching Optometrists**

Teaching optometrists who provide direct patient care may submit charges for the services provided, if the salary paid them by the school or other institution does not include a component for treatment services.

Charges are to be submitted only when the teaching optometrist seeking reimbursement has been personally involved in the services being provided. This means presence in the room performing or supervising the major phases of the services, with full and immediate responsibility for all actions performed as a part of the testing or examination. The patient's record must be documented to show these requirements have been met. All such entries must be signed and dated by the optometrist seeking reimbursement.

## O-202.2 Electronic Claim Submittal

Any claims that do not require attachments or accompanying documentation may be billed electronically using the X-12 837 Professional Standard. Refer to Chapter 300, Handbook for Electronic Processing.

Providers may also submit claims directly to the Department via the Internet through the MEDI IEC system. Further information regarding MEDI IEC can be found on the Department's website.

Providers billing electronically should take note of the requirement that Form HFS 194-M-C (Billing Certification Form) must be signed and retained by the provider for a period of three years from the date of the voucher. Failure to do so may result in revocation of the provider's right to bill electronically, recovery of monies or other adverse actions. Refer to Chapter 100 for further details. Form HFS 194-M-C is included as the last page for each Remittance Advice that reports the disposition of electronic claims.

Please note that the specifications for electronic claims billing are not the same as those for paper claims. Please follow the instructions for the medium being used. If a problem occurs with electronic billing, providers should contact the Department in the same manner as would be applicable to a paper claim. It may be necessary for providers to contact their software vendor if the Department determines that the service rejections are being caused by the submission of incorrect or invalid data.

## O-202.3 Paper Claim Preparation and Submittal

For general information on policy and procedures regarding claim submittal, and billing for Medicare covered services and submittal of claims for participants eligible for Medicare Part B, refer to Chapter 100.

Form HFS 1443, Provider Invoice, is to be used to submit charges for optometric services covered primarily by the Department or secondary to TPL. Detailed instructions for its completion and mailing are included in Appendix O-1.

Form HFS 2803, Optical Prescription Order, must be submitted with the paper HFS 1443 when submitting a charge for a fitting service. Do not staple the claim and OPO together.

Form HFS 2360, Health Insurance Claim Form, is to be used to submit charges for professional services covered primarily by the Department or secondary to TPL. Refer to the Handbook for Practitioner Services for completion and mailing instructions.

Form HFS 3797, Medicare Crossover Invoice, is to be used to submit charges for Medicare cost-sharing when services are allowed primarily by Medicare. Detailed instructions for its completion and mailing are included in Appendix O-2.

Do not attach prior approval notification letters, eyeglass delivery slips, or EOMB to claim forms. Do not staple documentation.

Providers who wish to request review and override of a previous claim rejection that is now past timely filing must submit the paper claim form, an HFS 1624 Override Request Form, and any other documentation to:

Illinois Department of Healthcare and Family Services
Bureau of Professional and Ancillary Services
Attn: Billing Consultant
P.O. Box 19115
Springfield, Illinois 62794-9115

The Department uses a claim imaging system for scanning paper claims. The imaging system allows efficient processing of paper claims and also allows attachments to be scanned. Refer to Appendix O-1 for technical guidelines to assist in preparing paper claims for processing. The Department offers a claim scanability/imaging evaluation. Turnaround on a claim scanability/imaging evaluation is approximately 7-10 working days and providers are notified of the evaluation results in writing. Please send sample claims with a request for evaluation to the following address.

Illinois Department of Healthcare and Family Services
201 South Grand Avenue East
Second Floor - Data Preparation Unit
Springfield, Illinois 62763-0001
Attention: Vendor/Scanner Liaison

All routine paper claims, including those with an Optical Prescription Order (OPO) Form attached, are to be submitted in a pre-addressed mailing envelope, Form HFS 1444, Provider Invoice Envelope, provided by the Department for this purpose. Routine claims with an OPO attached, and routine claims with no OPO attached, should be mailed in separate envelopes. Use of the pre-addressed envelope should ensure that billing statements arrive in their original condition and are properly routed for processing. Do not staple documentation.

For a non-routine claim submittal, use Form HFS 2248, Special Handling Envelope. A non-routine claim is a claim with an attachment, such as an EOB or HFS 2432 Split Billing Transmittal.

## O-202.4 Payment

Payment made by the Department for allowable services will be made at the lower of the provider's usual and customary charge, or the maximum rate as established by the Department. Refer to Chapter 100 for payment procedures utilized by the Department and explanations of Remittance Advice detail provided to providers.

### Reimbursement for Vision Examinations

The reimbursement made for the vision examination, to determine the condition of the eye, includes all services provided during the examination and associated vision care services provided as a result of examination findings, such as the writing of a prescription for eyeglasses.

### Reimbursement for Medical Services

When a therapeutic procedure is performed, reimbursement will be made for either the visit or the procedure, but not for both, unless it is an initial visit. On subsequent medical visits, when a procedure is performed the same day, the provider may bill both, but the Department’s total payment will be capped. In calculating the cap, the Department compares the maximum rate payable for each service billed and selects the highest amount payable. Further reimbursement information may be found in the Handbook for Practitioner Services and the Practitioner Fee Schedule and key.

### Reimbursement for Optical Supplies

The Optometric Fee Schedule identifies the Department's maximum reimbursement amounts and identifies if an item requires prior approval, or if the item is hand-priced.

Coverage of contact lenses is subject to prior approval. However, contact lenses for children under the age of three who have an aphakic diagnosis do **not** require prior approval. Refer to Topic O-212.2.

## O-202.5 Fee Schedule

Fee schedules of allowable procedure codes by provider type are on the Department's website.

The Optometric Fee Schedule identifies the fitting fee and service fee codes, as well as other HCPCS codes related to optical equipment and supplies.

For all other medical procedure codes, optometrists and physicians must refer to the Practitioner Fee Schedule.

The Department will notify providers regarding major policy and procedural changes via a provider notice posted to the website. Provider notices will not be released for minor updates such as error corrections or the addition of newly created HCPCS or CPT codes.

Providers should sign up to receive electronic notification of new releases, including fee schedule updates, on the Department's website. Please mark "All Medical Assistance Providers" as well as each specific provider type for which notification is requested.

# O-203 Covered Services

A covered service is a service for which payment can be made by the Department in accordance with 89 Ill. Adm. Code 140.3. The services covered in the Medical Assistance Program are limited and include only those reasonably necessary medical and remedial services that are recognized as standard medical care required for immediate health and well-being because of illness, disability, infirmity or impairment.

Optical services and materials are covered only when provided in accordance with the limitations and requirements described in the individual topics within this handbook.

The provision of glasses and other materials that are required to restore and conserve vision are a covered service. All lenses and frames are to be obtained from the Department of Corrections (DOC) laboratory.

Optometrists, physicians, and optical companies may bill for the eyeglasses fitting fee and also provide frame parts, frame repairs, contact lenses, artificial eyes and low vision devices. Some of these services are subject to prior approval, as described in Topic O-211. **Only optometrists and physicians may bill for examinations.**

Any question a provider may have about coverage of a particular service is to be directed to the Department prior to provision of the service. Providers may call the Bureau of Professional and Ancillary Services at 1-877-782-5565.

If services are to be provided to a participant enrolled in Care Coordination, prior authorization and payment must be obtained from the Care Coordination entity.

## O-203.1 Examination to Determine the Condition of the Eye Including the Refractive State

The Department will reimburse for more than one examination per year only when the optometrist or physician documents the need for the additional examination. If more frequent care is medically necessary because of an unusual circumstance, the patient's record must be documented and dated with an explanation of the special circumstances, and the services provided.

The eye examination must be conducted in accordance with rules promulgated by the Illinois Department of Financial and Professional Regulation at 68 Ill. Admin. Code Part 1320 implementing the Illinois Optometric Practice Act. Those rules list the procedures comprising a minimum eye examination.

## O-203.2 Fitting Fee

A fitting fee must be charged to initiate the fabrication process of eyeglasses or products through DOC. The charge is to be no more than that made by the provider to private pay patients, and is to cover the fitting and subsequent adjustment services. The Department will reimburse up to the allowable listed in the Optometric Fee Schedule.

## O-203.3 Service Fee

A service fee may be charged when the fitting fee is not applicable, e.g., when replacement parts are provided.

A service fee is not to be charged in combination with a fitting fee.

## O-203.4 Early Intervention Services

Early Intervention (EI) services are covered only for children up to the age of three years, who are eligible for Part H Services under the Individuals with Disabilities Education Act, and when those services are included in the child's Individualized Family Service Plan. Procedure codes for EI services must be billed to the EI Central Billing Office (CBO) for payment. In order to receive payment from the CBO, a provider must apply for, and obtain, an Early Intervention Credential, enroll as a provider with the CBO, and have prior authorization to provide services.

- For credential and enrollment information, contact Provider Connections at 1-800-701-0995.

- For questions about the service authorization and billing processes, contact the Early Intervention CBO Cornerstone Call Center at 1-800-634-8540.

## O-204 Non-Covered Services

Services for which medical necessity is not clearly established are not covered by the Department's Medical Programs. Refer to 89 Ill. Adm. Code 140.6 for a general list of non-covered services.

In addition, the following optometric services are excluded from coverage in the Department's Medical Programs, and payment will not be made for the provision of these services:

- Examination required for the determination of disability or incapacity. Local Department of Human Services offices (Family Community Resource Centers) may request that such examinations be provided, with payment authorized from nonmedical funds. Optometrists are to follow specific billing instructions given in these cases.
- Services provided in federal or state institutions.

## O-205 Record Requirements

The Department regards the maintenance of adequate records essential for the delivery of quality medical care. In addition, providers should be aware that medical records are key documents for post-payment audits. Refer to Chapter 100 for record requirements applicable to all providers.

Providers must maintain an office record for each patient. The office record should include all office visits and dispensing/fitting information and dates. In group practices, partnerships and other shared practices, one record is to be kept with chronological entries by the individual optometrist, physician or optician rendering services.

The record maintained by the provider is to include the essential details of the patient's condition and of each service or material provided. The signature of the provider is required for the record of the service/visit to be complete. If there is no signature, then the record is incomplete.

All entries must include the date, must be legible and be written in English. Records that are unsuitable because of illegibility or because they are written in a language other than English, may result in sanctions if an audit is conducted. Any services provided to a patient by the provider outside the provider's office setting are to be documented in the medical record maintained in the provider's office.

For patients who are in a nursing facility, the primary medical record indicating the patient's condition, and the treatment and services ordered and provided during the period of institutionalization, may be maintained as a part of the facility chart; however, an abstract of the facility record, including diagnosis, treatment program, and dates and times services were provided, is to be maintained by the rendering provider as an office record to show continuity of care. The chart must have a dated referral with the name of the practitioner who referred the patient for eye care.

Opticians and optical companies must maintain dated records adequate to document items dispensed, services provided, and to document that eyeglasses and other eye care materials are dispensed only in accordance with a prescription written by a physician or an optometrist.

The Department, and its professional advisors, regard the preparation and maintenance of adequate medical records as essential for the delivery of quality medical care. In addition, providers should be aware that medical records are a key document for post-payment audits.

**In the absence of proper and complete medical records, no payment will be made, and payments previously made will be recouped. Lack of records or falsification of records may also be cause for a referral to the appropriate law enforcement agency for further action.**

# O-211 Prior Approval

Prior to the provision of certain services, approval must be obtained from the Department. If charges are submitted for services that require prior approval and approval was not obtained, payment will not be made for services as billed. See Chapter 100 for a general discussion of prior approval provisions.

The Department will not give prior approval for an item or service if a less expensive item or service is considered appropriate to meet the patient's need or if the item is not considered medically necessary.

**Prior approval to provide services does not include any determination of the patient's eligibility. When prior approval is given, it is the provider's responsibility to verify the patient's eligibility on the date of service.**

The Optometric Fee Schedule documents procedure codes requiring prior approval. Although an item may not be listed as covered, a prior approval for an item that is "Not Elsewhere Classified" may be submitted for review.

If a participant becomes enrolled in an MCO or MCCN during a period of time for which a prior approval has been previously granted, the prior approval will no longer be applicable effective with the participant's managed care enrollment date. Prior approval requests for participants in an MCO or MCCN should be directed to the individual plan.

## O-211.1 Prior Approval Requests

***Revised Effective August 18, 2017***

Prior approval requests must contain enough information for Department staff to make a decision on medical necessity, appropriateness and anticipated patient benefits of the service.

**The single most common reason for a delay in processing of prior approval requests is lack of adequate information upon which to make an informed decision.**

The following services and materials may be provided only with prior approval of the Department:

- Additional eyeglasses within a two-year period for adults after eye surgery
- Contact lens/lenses and related service
- Custom-made artificial eye
- Low vision devices
- Polycarbonate eyeglass lenses for adults, age 21 and over (see Appendix O-2a for specific information)
- Eyeglasses fabricated by suppliers other than DOC
- Service/materials not otherwise identified on the schedule of procedures for optical services and supplies

Refer to the Optometric Fee Schedule on the Department's website for the billing codes of the vision care services that require prior approval. If the code is hand-priced, the Department requires an invoice from the supplier verifying the cost.

**Procedure**:
Prior approval to dispense or provide the above described service or material is to be requested by submitting the following:

- Form HFS 1409, Prior Approval Request (see Appendix O-2 for instructions for completing Form HFS 1409)
- A letter to justify medical necessity of an item
- The patient's best spectacle lens prescription with and without eyeglasses/contacts
- Visual acuities with and without eyeglasses/contacts
- A cost invoice of the item, if the item is hand-priced

Requests for prior approval for eye protection do not require a spectacle prescription or visual acuity.

The Department generates a letter, to both the provider and the patient, of the Department approval or disapproval of the prior approval request. The approval letter does include the amount approved for the item.

When billing for a service or material that has been approved for a patient, the provider can submit the claim to the Department as a routine claim on the HFS 1443 Provider Invoice, or bill electronically. The actual prior approval notification letter is not required to be attached to a paper claim.

## O-211.2 Timelines

The Department is obligated to make a decision on optometric prior approval requests within 30 days of the Department's receipt date, as specified in accordance with 89 Illinois Administrative Code 140.Table E, Time Frames for Processing Prior Approval Request. Decisions must be made within the time frame established with exceptions as described below. If the Department fails to make a decision within the specified time frame, the item or service is automatically approved, but for a minimum time period. If an item or service has been automatically approved, reimbursement will be made at the provider's charge or the Department's maximum rate, whichever is less.

If the request is incomplete or requires further information to be properly considered, the Department may request additional information from either the supplying provider or the provider who ordered the service. If additional information is requested within fourteen (14) days of receipt of the prior approval request, the thirty (30) day period stops. When the required information is received, a new thirty (30) day period begins. An HFS 3701 will be generated when additional information is required.

The provider can request status of a prior approval after thirty (30) days from the Department's receipt date. This can be done by calling the optometric prior approval unit at 1-877-782-5565.

# O-212 Limitations and Considerations on Specific Items

***Revised Effective August 18, 2017***

All eyeglasses and materials to repair eyeglasses must be ordered through the DOC laboratory.

Lenses available through the DOC laboratory are:

- Glass
- Plastic – no limits
- Polycarbonate
    - Polycarbonate lenses are available for all children through age 20, and adults with prior approval and a prescription of ± 2.5.
    - Single vision, maximum is +8.50 and bifocal maximum is +8.0. Minus has no upper limit.
- Prisms

Materials not available through the DOC laboratory:

- Slab off lenses
- Miroflex frames
- Transition lenses

## O-212.1 Lenses

Eyeglasses are not a yearly benefit. Eyeglasses are to be replaced when medically necessary and when the minimum prescription change has been met. If an exam determines a participant's prescription has not changed and new eyeglasses are not required, it is not appropriate to order new glasses.

### Single Vision Lenses

Lenses are covered only if the power is at least ± 0.75 diopters, in either the sphere **or** cylinder component.

A change of lenses is a covered service only when there is a change of at least ± 0.75 diopters, in either the sphere **or** cylinder component.

### Bifocal Lenses

Bifocal lenses are covered only if the power of the bifocal addition is ± 1.00 diopter or more. A change in lenses is covered if the distance power meets the minimum change requirements (± 0.75 diopters), or if the power of the bifocal addition is changed by at least ± 0.50 diopters.

**Change From Single Vision to Bifocal or Bifocal to Single Vision**
When changing from a single vision to bifocal, the distance component must meet the minimum prescription requirement (± 0.75 diopters), **or** the resultant total power of the new prescription must meet the requirement for a change in prescription (± 0.75 diopters).

When changing from bifocal to single vision, the new prescription must meet the requirement for a change in prescription (± 0.75 diopters) figured from the resultant total power of the bifocal prescription, **and** the new prescription must meet the minimum prescription power requirement (± 0.75 diopters).

Prisms meeting the minimum power requirements do not require prior approval and may be obtained through DOC. The requirements are met only when the combined vertical prism power is at least ± 2 prism diopters, or the combined horizontal prism power is at least ± 5 prism diopters.

## O-212.2 Contact Lenses

Contact lenses require prior approval, except when provided to children age 0 to 3 who have aphakia. Consideration will be given to approving contact lenses only when there is a documented medical need or when useful vision cannot be obtained with glasses.

Although aphakic contacts do not require prior approval for children age 0 to 3, the prior approval process must be followed in order to price the lenses.

Requests for approval of contact lenses must include information explaining why the patient cannot be satisfactorily fitted with conventional lenses, a report of the patient's best spectacle lens prescription, and the visual acuity achieved with contacts and with eyeglasses.

The Department will accept prior approval requests for the contact lens prescription and fitting service, whenever the provider believes it is medically necessary for the patient to receive this service. The prescription and fitting service must meet the criteria as set forth in *Current Procedural Terminology (CPT®), Fourth Edition.*

## O-212.3 Custom-Made Artificial Eyes

Custom-made artificial eyes are subject to prior approval and are covered only when the patient is unable to wear a stock plastic eye. All prior approval requests must include information as to why a stock artificial eye is not appropriate to meet the patient's need.

## O-212.4 Low Vision Devices

Low vision devices other than eyeglasses and prisms are covered only with prior approval. Requests for prior approval to dispense low vision corrective devices must include information explaining in detail the patient's need for the device. Additionally, the request is to include the cost of the device, the life expectancy of the device, and the manufacturer. Convenience and duplicate items will not be covered.

## O-212.5 Fabrication of Glasses by Supplier Other Than DOC

Fabrication of glasses by a supplier other than the Department of Corrections is covered only with prior approval. Requests for prior approval must include sufficient detail on the type of lens or frame, to determine that DOC cannot manufacture them. The request must also include information explaining why a standard pair of glasses is not medically appropriate to meet the patient’s need.

## O-212.6 Items Not Otherwise Identified

Services or materials that are not identified on the Optometric or Practitioner Fee Schedules require prior approval. Information must be submitted describing in detail the material or service to be provided. A history of past treatment provided is required. Additionally, the request for approval must show why the material or service is better than any other commonly used to deal with similar diagnoses or conditions. All items or services requested must be medically necessary.

## O-212.7 Frequency of Services

### O-212.7.1 Adult Services

***Revised Effective August 18, 2017***

Eyeglasses for adults are covered if medically necessary. Adult participants who are 21 years of age and older are limited to one pair of eyeglasses in a two-year (730 day) period; however, the limitation does not apply to an individual who needs different eyeglasses following a surgical procedure such as cataract surgery. Providers must submit a prior approval request for an adult in these circumstances. Refer to Topic O-211 for information regarding prior approval and Topic O-212.1 for the minimum lens prescription changes required.

This policy for adults does not limit medically necessary eye examinations, or claims for repair/refitting of eyeglasses.

### O-212.7.2 Children’s Services

For children through age 20, eyeglasses are replaced as needed through the DOC laboratory, with no prior approval required. Documentation of new eyeglass orders must be maintained in the provider file. Refer to Topic O-205 - Record Requirements.

## O-220 Office Services

If billing on the paper claim format, optometrists and physicians bill all professional services, except the fitting fee and any other supply, on the HFS 2360 claim form. The fitting fee and supplies are billed on the HFS 1443 paper claim form.

Providers should follow the CPT definitions of services, and bill the code for the level of service rendered.

The Handbook for Practitioners Rendering Medical Services delineates general coverage, coding and documentation requirements and coverage restrictions for medical, diagnostic and treatment services provided in the office.

When an optometrist shares a partnership or group practice with another optometrist or a physician, the same policies and billing limitations apply to all members in the same group practice. For example, a patient may be designated as a new medical patient for billing purposes only once collectively for all practitioners in the partnership or group, regardless of how many practitioners in the group practice eventually see the patient.

## O-222 Surgical Services

Reimbursement to a physician for certain surgical services includes the presurgical examination and complete postoperative care for a period of 30 days.

**Example:** If a surgeon performs cataract surgery and refers a patient to an optometrist for follow-up care, the postoperative care by the optometrist is not covered.

Other practitioners, including optometrists, may bill for medical visits during this period only for conditions or diagnoses unrelated to the surgery. To submit a claim within 30 days of surgery for an unrelated diagnosis, submit the paper HFS 2360, Health Insurance Claim Form with notes for consideration of payment.

A narrative explanation of the medical necessity for such care must be submitted with each paper claim to document the visit is not related to the surgery or the claim will reject. Please refer to the Handbook for Practitioners Rendering Medical Services and the Practitioner Fee Schedule Key for additional information.

# O-235 Provision of Eyeglasses and Optical Materials

The Department utilizes the Department of Corrections (DOC) laboratory at Dixon Correctional Facility for fabrication of eyeglasses.

A patient may utilize any participating optometrist or physician for an examination. If eyewear is needed as a result of that examination, the optometrist or physician must supply the patient with the prescription (16 CFR Part 456.2). The patient may choose to order eyewear from that same optometrist or physician, or may take the prescription to a participating optician or optical company.

**The patient may choose to order eyewear from any participating optometrist, physician, optician or optical company.**

The Chicago Public Schools (CPS) has a distinct program available to all children in the district to obtain exams and eyeglasses. CPS partners with a vendor to manufacture eyeglasses for participating students in its district who are eligible through the Department's medical programs, as well as for students who are uninsured. Other contracted providers render eye exams in the CPS setting and are responsible for dispensing the eyeglasses to students. The CPS exams, dispensing fees, and eyeglasses are billed to the Department or MCO. Questions regarding this program should be directed to CPS at 773-535-8675.

## O-235.1 Ordering of Frame Boards

DOC supplies a display board to providers of the available eyeglass frames. To obtain a display board, the provider must contact DOC directly.

**Procedure**: Contact DOC at the following address and telephone number:

Dixon Correctional Facility Industries
Post Office Box 809
Dixon, Illinois 61021
Phone: 1-800-523-1487 (toll free)

The DOC has a contract with the Department to fabricate eyeglasses for the Department's participants. DOC provides its own policies regarding the use of the lab.

## O-235.2 Ordering of Eyeglasses

The process of ordering eyeglasses is initiated when a provider submits a claim for a fitting code with an Optical Prescription Order (OPO).

**It is important for providers to submit the claim and OPO as soon as possible after the patient has been seen to initiate the processing of the eyeglasses order. Delaying the claim and OPO submission only adds to the time the patient must wait for the eyewear.**

The Optical Prescription Order (OPO), Form HFS 2803, is to be used to order lenses or frames or both. The OPO is to be submitted with the paper HFS 1443 claim form to the Department. The claim must show charges for the fitting fee, not the actual lenses and frames. Upon receipt, the Department will scan the claim into the Claims Processing System, and forward the OPO for fabrication of eyeglasses to DOC. When the claim has completed editing for patient eligibility and for previous eyeglasses utilization, the Department will authorize DOC to fabricate the eyeglasses. DOC will mail the eyeglasses directly to the ordering provider.

Upon receipt of the eyeglasses from DOC, the provider must notify the participant that the eyeglasses have been received. The materials must be fitted and the provider ensures that the items meet the patient's medical needs before dispensing.

If the eyeglasses **are** fabricated but the fitting fee is rejected, the provider should submit an HFS 1443, Provider Invoice **without** an OPO attached. Mail the form to the address below with an HFS 1624, Override Request Form, selecting a D78 override for payment only.

Illinois Department of Healthcare and Family Services
P.O. Box 19115
Springfield, Illinois 62794-9115
Attn: Optometric Billing Consultant

If the eyeglasses **are not** being fabricated and the claim rejects due to a correctable error, the provider should submit a new Provider Invoice **with** an OPO attached. Do not staple the OPO to the claim.

## O-235.3 Quality Assurance

The agreement between the Department and DOC provides that DOC is responsible for monitoring the quality of the finished product. Therefore, if the ordering provider finds that the eyeglasses received from DOC do not conform to the prescription order the provider submitted, or the finished product is defective, this is to be reported directly to DOC for resolution and refabrication of the eyeglasses, if necessary.

Dixon Correctional Facility Industries
Post Office Box 809
Dixon, Illinois 61021
Telephone: 1-800-523-1487 (toll-free)

The ordering or dispensing provider will not be held accountable for the cost of replacement eyeglasses or parts, when the error is attributable to DOC or to the Department.

If the ordering provider or the patient finds that the eyeglasses are not usable due to error in how the prescription was written, the ordering provider must arrange for fabrication of new eyeglasses at his or her own expense. Additionally, neither the Department nor the patient is to be billed.

### O-235.4 Replacement of Broken Lenses

If one or both lenses are broken, but the frame is still usable, the lens or lenses are to be ordered from DOC by completing an OPO and a claim containing a charge for the service fee, and sending both documents to the Department. The OPO must identify the frame for which DOC is being asked to fabricate a new lens or lenses. The new lens or lenses will be sent directly to the provider for insertion into the frame.

### O-235.5 Frames and Repairs

Only DOC frames are covered by the Department unless the participant received prior approval for eyeglasses outside of the normal DOC process. A replacement frame may be covered only when the present frame is broken, and is non-repairable, or has been lost.

If the frame that has a broken frame front or temple is a DOC frame, the replacement frame is to be ordered from DOC by completing the OPO and the claim for a service fee charge, and sending both to the Department.

If the frame that has a broken frame front or temple is not a DOC frame but the provider can furnish the replacement part, the provider completes the service and bills both the part and the service fee on the claim. No OPO is completed or attached to the claim.

If the frame that has a broken frame front or temple is not a DOC frame and the provider cannot furnish the replacement part, new eyeglasses (complete glasses) may be ordered from DOC by completing the OPO and the claim, and sending both documents to the Department.

# O-270 Home and Long Term Care Facility Services

A provider may provide a covered service to a patient in the patient's place of residence (private home or long-term care facility), when the patient is physically unable to go to the provider's office.

Charges may be made for the examination, or for the services the provider provided at the time of a home visit, in accordance with policy and procedures applicable to office services, and within the limitations and requirements specified in this section for services provided in long-term care facilities.

No charges may be made for services provided to residents in a long-term care facility by a provider who derives a direct or indirect profit from total or partial ownership (or from other types of financial investment for profit) of such facility, except:

1. for emergency services provided for acute illness, or
2. when essential treatment facilities are not available in the vicinity for short-term care pending transfer, or
3. when there is not a comparable facility in the area.

Charges may not be made for services to residents in a long-term care facility by a provider who receives reimbursement from the facility for direct patient care services.

## O-270.1 Long Term Care Facility Limitations and Requirements – Vision Examinations and Refractions

To be considered for reimbursement, vision examinations and refractions performed in a long-term care facility must meet the requirements conducted in accordance with rules promulgated by the Illinois Department of Financial and Professional Regulation at 68 Ill. Admin. Code Part 1320 implementing the Illinois Optometric Practice Act.

Non-essential visits to residents in long-term care facilities are not allowed, and payment will not be made for such care. Such care includes screening services.

All services provided by the provider to residents in long-term care facilities are to be documented by the provider in the resident's record, which is maintained by the facility. The provider must maintain a patient record at the main provider office and it must be dated and documented with the reason for the visit, including the name of the individual requesting the service in addition to the ordering and referring physician. See also Topic O-205.

## O-270.2 Long Term Care Facility Limitations and Requirements – Medical Services Provided by an Optometrist

Except for emergency services provided when the attending physician is not available, an optometrist may not charge for medical services to a resident in a long-term care facility, unless the attending physician has made a referral with the resident's knowledge and permission. Charges are not to be submitted for routine visits that are made without individual referrals by the attending physician. Referrals must be specific to the medical condition or need of the resident.

Visits made to residents eligible for Medicare benefits will be disallowed if determined not medically necessary by Medicare.