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8.310.6 VISION CARE SERVICES

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TITLE 8 SOCIAL SERVICES
CHAPTER 310 HEALTH CARE PROFESSIONAL SERVICES
PART 6 VISION CARE SERVICES

8.310.6.1 ISSUING AGENCY: New Mexico Human Services Department. (HSD)
[2/1/95; 8.310.6.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 12/1/03; A, 5/14/10]

8.310.6.2 SCOPE: The rule applies to the general public.
[2/1/95; 8.310.6.2 NMAC - Rn, 8 NMAC 4.MAD.000.2, 12/1/03]

8.310.6.3 STATUTORY AUTHORITY: The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act as amended or by state statute. See Section 27-2-12 et seq. NMSA 1978.
[2/1/95; 8.310.6.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 12/1/03; A, 5/14/10]

8.310.6.4 DURATION: Permanent
[2/1/95; 8.310.6.4 NMAC - Rn, 8 NMAC 4.MAD.000.4, 12/1/03]

8.310.6.5 EFFECTIVE DATE: February 1, 1995, unless a later date is cited at the end of a section.
[2/1/95; 8.310.6.5 NMAC - Rn, 8 NMAC 4.MAD.000.5, 12/1/03; A, 5/14/10]

8.310.6.6 OBJECTIVE: The objective of this rule is to provide instruction for the service portion of the New Mexico medical assistance programs.
[2/1/95; 8.310.6.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 12/1/03; A, 5/14/10]

8.310.6.7 DEFINITIONS: [RESERVED]

8.310.6.8 MISSION STATEMENT: To reduce the impact of poverty on people living in New Mexico and to assure low income and disabled individuals in New Mexico equal participation in the lives of their communities.
[2/1/95; 8.310.6.8 NMAC - Rn, 8 NMAC 4.MAD.002, 12/1/03; A, 5/14/10]

8.310.6.9 VISION CARE SERVICES: The medical assistance division (MAD) pays for medically necessary health services furnished to eligible recipients. To help New Mexico MAD eligible recipients receive medically necessary services, MAD pays for covered vision services.
[2/1/95; 8.310.6.9 NMAC - Rn, 8 NMAC 4.MAD.715, 12/1/03; A, 5/14/10]

8.310.6.10 ELIGIBLE PROVIDERS:

A. Health care to New Mexico MAD eligible recipients is furnished by a variety of providers and provider groups. The reimbursement and billing for these services is administered by MAD. Upon approval of a New Mexico MAD provider participation agreement by MAD or its designee, licensed practitioners, facilities and other providers of services that meet applicable requirements are eligible to be reimbursed for furnishing covered services to eligible recipients. A provider must be enrolled before submitting a claim for payment to the MAD claims processing contractors. MAD makes available on the HSD/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HSD or its authorized agents, including program rules, billing instructions, utilization review instructions, and other pertinent materials. When enrolled, a provider receives instruction on how to access these documents. It is the provider's responsibility to access these instructions, to understand the information provided and to comply with the requirements. The provider must contact HSD or its authorized agents to obtain answers to questions related to the material or not covered by the material. To be eligible for reimbursement, a provider must adhere to the provisions of the MAD provider participation agreement and all applicable statutes, regulations, and executive orders. MAD or its selected claims processing contractor issues payments to a provider using electronic funds transfer (EFT) only. Providers must supply necessary information in order for payment to be made. Eligible providers include:

(1) individuals licensed to practice medicine in New Mexico, who limit their practice to ophthalmology (ophthalmologists) and the groups, corporations, and professional associations they form;

(2) individuals licensed to practice optometry in New Mexico and the groups, corporations, and professional associations they form;

(3) individuals licensed as opticians; opticians are eligible to participate as providers of eyeglasses, contact lenses, supplies, and other vision-related materials; and

(4) IHS or tribal facilities operating under Public Law 93-638.

B. Once enrolled, a provider receives a packet of information, including MAD program policies, billing instructions, utilization review instructions, and other pertinent materials from MAD. A provider is responsible for ensuring that he has received and understands these materials and for updating his knowledge as new materials are provided by MAD.

C. When services are billed to and paid by a coordinated services contractor authorized by HSD, the provider must also enroll as a provider with the coordinated services contractor and follow that contractor's instructions for billing and for authorization of services.

[2/1/95; 8.310.6.10 NMAC - Rn, 8 NMAC 4.MAD.715.1 & A, 12/1/03; A, 5/14/10]

8.310.6.11 PROVIDER RESPONSIBILITIES:

A. A provider who furnishes services to medicaid or other health care program eligible recipients must comply with all federal and state laws, regulations and executive orders relevant to the provision of services as specified in the MAD provider participation agreement. A provider also must conform to MAD program rules and instructions as specified in the provider rules manual and its appendices, and program directions and billing instructions, as updated. A provider is also responsible for following coding manual guidelines and CMS correct coding initiatives, including not improperly unbundling or upcoding services. When services are billed to and paid by a coordinated services contractor authorized by HSD, the provider must follow that contractor's instructions for billing and for authorization of services.

B. A provider must verify that individuals are eligible for a specific health care program administered by the HSD and its authorized agents, and must verify the eligible recipient's enrollment status at the time services are furnished. A provider must determine if an eligible recipient has other health insurance. A provider must maintain records that are sufficient to fully disclose the extent and nature of the services provided to an eligible recipient. See 8.302.1 NMAC, *General Provider Policies*.

C. A provider must ensure that prescriptions for eyeglasses or contact lenses are accurate to the extent that the prescription corrects the eligible recipient's vision to the degree of acuity indicated on the vision examination record.

D. An eyeglass and contact lens supplier is responsible for verifying that the correct prescription is provided.

(1) If a prescription is inaccurate and an eligible recipient is unable to use their eyeglasses or contact lenses, payment for both the eye examination and the eyeglasses or contact lenses is subject to recoupment.

(2) If the eyeglasses or contact lenses are not ground to the correct prescription, payment for the eyeglasses or contact lenses is subject to recoupment.

[2/1/95; 8.310.6.11 NMAC - Rn, 8 NMAC 4.MAD.715.2 & A, 12/1/03; A, 5/14/10]

8.310.6.12 COVERED SERVICES: MAD covers specific vision care services that are medically necessary for the diagnosis of and treatment of eye diseases. MAD pays for the correction of refractive errors, as required by the condition of the eligible recipient. All services must be furnished within the limits of MAD benefits, within the scope and practice of the medical professional as defined by state law and in accordance with applicable federal, state and local laws and regulations.

A. **Exam:** MAD covers routine eye exams. Coverage for an eligible adult recipient over 21 years of age is limited to one routine eye exam in a 36-month period. An exam for an existing medical condition, such as cataracts, diabetes, hypertension, and glaucoma, will be covered for required follow-up and treatment. The medical condition must be clearly documented on the visual examination record and indicated by diagnosis on the claim. Exam coverage for an eligible recipient under 21 years of age is limited to one routine eye exam in a 12-month period.

B. **Corrective lenses:** MAD covers one set of corrective lenses for an eligible adult recipient age 21 years or older not more frequently than once in a 36-month period. For an eligible child recipient under the age of 21 years, one set of corrective lenses is covered no more frequently than once every 12 months. For either age group, MAD covers corrective lenses more frequently when an ophthalmologist or optometrist recommends a change in prescription due to a medical condition, including but not limited to cataracts, diabetes, hypertension, glaucoma or treatment with certain systemic medications affecting vision. The vision prescription must be appropriately recorded on the visual examination record and indicated by a diagnosis on the claim.

(1) For the purchase of eyeglasses, the diopter correction must meet or exceed one of the following diopter correction criteria:

(a) -1.00 myopia (nearsightedness);

(b) + 1.00 for hyperopia (farsightedness);

(c) 0.75 astigmatism (distorted vision), the combined refractive error of sphere and cylinder to equal 0.75 will be accepted;

(d) ±1.00 for presbyopia (farsightedness of aging); or

(e) diplopia (double vision) - prism lenses.

(2) When an eligible recipient's existing prescription is updated and the frequency of replacement lenses meets the requirements in Subsection B of 8.310.6.12 NMAC, the lenses may be replaced when there is a minimum 0.75 diopter change in the prescription. The combined refractive error of sphere and cylinder to equal 0.75 will be accepted. An exception is considered for the following:

(a) an eligible recipient over 21 years of age with cataracts;

(b) an ophthalmologist or optometrist recommends a change due to a medical condition; or

(c) an eligible recipient under 21 years of age.

C. **Bifocal lenses:** MAD covers bifocal lenses with a correction of 0.25 or more for distance vision and 1 diopter or more for added power (bifocal lens correction).

D. **Tinted lenses:** MAD covers tinted lenses with filtered or photochromic lenses if the examiner documents one or more of the following disease entities, injuries, syndromes or anomalies in the "comments" section of the visual examination record, and the prescription meets the dioptic correction purchase criteria:

(1) aniridia;

(2) albinism, ocular;

(3) traumatic defect in iris;

(4) iris coloboma, congenital;

(5) chronic keratitis;

(6) sjogren's syndrome;

(7) aphakia, U.V. filter only if intraocular lens is not U.V. filtered;

(8) rod monochromaly;

(9) pseudophakia; and

(10) other diagnoses confirmed by ophthalmologist or optometrist that is documented on visual examination form.

E. **Polycarbonate lenses**: MAD covers polycarbonate lenses for:

(1) an eligible recipient for medical conditions which require prescriptions for high power lenses;

(2) an eligible recipient with monocular vision;

(3) an eligible recipient who works in a high-activity physical job.

F. **Balance lenses:** MAD covers balance lenses for an eligible recipient under 21 years of age without a prior authorization in the following situations:

(1) lenses used to balance an aphakic eyeglass lens; or

(2) an eligible recipient under 21years of age is blind in one eye and the visual acuity in the eye requiring correction meets the diopter correction purchase criteria.

G. **Frames:** MAD covers frames for corrective lenses. Coverage for an eligible recipient 21 years of age or older is limited to one frame in a 36-month period and coverage for an eligible recipient under 21 years of age is limited to one frame in a 12-month period unless:

(1) an ophthalmologist or optometrist has documented a medical condition that requires replacement; or

(2) other situations that will be reviewed on a case-by-case basis.

H. **Contact lenses:** MAD covers contact lenses, either the original prescription or replacement, only with a prior authorization. Coverage for an eligible adult recipient over 21 years of age or older is limited to one pair of contact lenses in a 24-month period, unless an ophthalmologist or an optometrist recommends a change in prescription due to a medical condition affecting vision. A request for prior authorization will be evaluated on dioptic criteria or visual acuity, the eligible recipient's social or occupational need for contact lenses, and special medical needs. The criteria for authorization of contact lenses are as follows:

(1) the eligible recipient must have a diagnosis of keratoconus or diopter correction of +/- -6.00 or higher in any meridian or at least 3.00 diopters of anisometropia;

(2) monocular aphakics may be provided with one contact lens and a pair of bifocal glasses.

I. **Replacement:** Eyeglasses or contact lenses that are lost, broken or have deteriorated to the point that, in the examiner's opinion, they have become unusable to the eligible recipient, may be replaced for the following:

(1) the eligible recipient is under 21 years of age; or

(2) the eligible recipient is 21 years of age or older and has a developmental disability.

(3) Documentation for replacement:

(a) the eyeglasses or contact lens (or lenses) must meet the diopter correction purchase criterion and must be recorded on the visual examination record; and

(b) the loss, deterioration or breakage must be documented on the visual examination record.

J. **Prisms:** Prisms are covered if medically indicated to prevent diplopia (double vision). Documentation is required on the visual examination record.

K. **Lens tempering:** MAD covers lens tempering on new glass lenses only.

L. **Lens edging:** MAD covers lens edging and lens insertion.

M. **Minor repairs:** MAD covers minor repairs to eyeglasses.

N. **Dispensing fee:** MAD pays a dispensing fee to an ophthalmologist, optometrist, or optician for dispensing a combination of lenses and new frames. This fee is not paid when contact lenses are dispensed. The prescription and fitting of contact lenses is paid to dispensing ophthalmologists and optometrists. Independent technicians are not covered by MAD to prescribe and fit contact lenses.

[~~N.~~] O. **Eye prosthesis:** MAD covers eye prostheses (artificial eyes). Refer to 8.324.8 NMAC, *Prosthetics and Orthotics*.

[2/1/95; 8.310.6.12 NMAC - Rn, 8 NMAC 4.MAD.715.3 & A, 12/1/03; A, 7/1/04; A, 5/14/10]

8.310.6.13 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: All MAD services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See 8.302.5 NMAC, *Prior Approval and Utilization Review*. The provider must contact HSD or its authorized agents to request utilization review instructions. It is the provider's responsibility to access these instructions or ask for paper copies to be provided, to understand the information provided, to comply with the requirements, and to obtain answers to questions not covered by these materials. When services are billed to and paid by a coordinated services contractor authorized by HSD, the provider must follow that contractor's instructions for authorization of services.

A. **Prior authorization:** Certain procedures or services may require prior authorization from MAD or its designee. Contact lenses, either the original prescription or replacement, require prior authorization. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

B. **Eligibility determination:** The prior authorization of a service does not guarantee that an individual is eligible for medicaid or other health care programs. A provider must verify that an individual is eligible for a specific program at the time the service is furnished and must determine if the eligible recipient has other health insurance.

C. **Reconsideration:** A provider who disagrees with a prior authorization denial or another review decision may request a re-review and a reconsideration. See 8.350.2 NMAC, *Reconsideration of Utilization Review Decisions* [MAD-953].

[2/1/95; 8.310.6.13 NMAC - Rn, 8 NMAC 4.MAD.715.4 & A, 12/1/03; A, 5/14/10]

8.310.6.14 NONCOVERED SERVICES: Vision services are subject to the limitations and coverage restrictions that exist for other MAD services. See 8.301.3 NMAC, *General Noncovered Services* and 8.302.1 NMAC, *General Provider Policies*. MAD does not cover the following specific vision services:

A. orthoptic assessment and treatment;

B. photographic procedures, such as fundus or retinal photography and external ocular photography;

C. polycarbonate lenses other than for prescriptions for high acuity;

D. ultraviolet (UV) lenses;

E. trifocals;

F. progressive lenses;

G. tinted or photochromic lenses, except in cases of documented medical necessity. See Subsection D of 8.310.6.12 NMAC above;

H. oversize frames and oversize lenses;

I. low vision aids;

J. eyeglass cases;
K. eyeglass or contact lens insurance; and
L. anti-scratch, anti-reflective, or mirror coating.
[2/1/95; 8.310.6.14 NMAC - Rn, 8 NMAC 4.MAD.715.5 & A, 12/1/03; A, 7/1/04; A, 5/14/10]

8.310.6.15 REIMBURSEMENT:
A. A vision service provider, except an IHS facility, must submit claims for reimbursement on the CMS 1500 claim form or its successor. See 8.302.2 NMAC, *Billing for Medicaid Services.* Once enrolled, a provider receives instructions on documentation, billing, and claims processing. Reimbursement to a provider for covered services is made at the lesser of the following:
(1) the provider's billed charge; or
(2) the MAD fee schedule for the specific service or procedure.
B. The provider's billed charge must be his usual and customary charge for services.
C. "Usual and customary charge" refers to the amount which the individual provider charges the general public in the majority of cases for a specific procedure or service.
[2/1/95; 8.310.6.15 NMAC - Rn, 8 NMAC 4.MAD.715.6 & A, 12/1/03; A, 5/14/10]

HISTORY OF 8.310.6 NMAC:
Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
ISD 310.1000, Vision Care Services, filed 2/13/80.
ISD 310.1000, Vision Care Services, filed 7/8/82.
ISD Rule 310.1000, Vision Care Services, filed 2/28/83.
ISD Rule 310.1000, Vision Care Services, filed 8/23/84.
MAD Rule 310.10, Vision Care Services, filed 12/15/87.
MAD Rule 310.10, Vision Care Services, filed 10/26/88.
MAD Rule 310.10, Vision Care Services, filed 4/20/92.

History of Repealed Material:
MAD Rule 310.10, Vision Care Services, filed 4/20/92 - Repealed effective 2/1/95.