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TEXAS MEDICAID

PROVIDER PROCEDURES MANUAL

Volume 2

PROVIDER HANDBOOKS

VISION AND HEARING SERVICES HANDBOOK

This manual is available for download at www.tmhp.com, and is also available on CD. There are many benefits to using the electronic manual, including easy navigation with bookmarks and hyperlinked cross-references, the ab lity to quickly search for specific terms or codes, and form printing on demand.

The Texas Medicaid & Healthcare Partnership (TMHP) is the claims administrator for Texas Medicaid under contract with the Texas Health and Human Services Commission.

VISION AND HEARING SERVICES HANDBOOK

TEXAS
Health and Human
Services Commission

VISION AND HEARING SERVICES HANDBOOK

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Note: *A comprehensive Index, including Volume 1 and all handbooks from Volume 2, is included at the end of Volume 1 (General Information).*

VISION AND HEARING SERVICES HANDBOOK

1. GENERAL INFORMATION

The information in this handbook is intended for optometrists (doctors of optometry) and hearing aid professionals (physicians, audiologists, and fitters and dispensers) who provide hearing evaluations or fitting and dispensing services. The handbook provides information about Texas Medicaid's benefits, policies, and procedures applicable to these providers.

Important: *All providers are required to read and comply with Section 1, Provider Enrollment and Responsibilities. In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide healthcare services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1* Texas Administrative Code *(TAC) §371.1617(a)(6)(A). Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure, at all times, to deliver healthcare items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: Section 1, Provider Enrollment and Responsibilities, (*Vol. 1, General Information*)

Subsection 8.1, "Medicaid Managed Care" in Section 8, "Managed Care" (*Vol. 1, General Information*)

2. HEARING AID PROFESSIONALS

2.1 Enrollment

To enroll in Texas Medicaid, hearing aid professionals (physicians, audiologists, and hearing aid fitters and dispensers) who provide hearing evaluations or fitting and dispensing services must be licensed by the licensing board of their profession to practice in the state where the service is performed. Hearing aid providers are eligible to enroll as individuals and facilities. Audiologists are eligible to enroll as individuals and groups. Audiologists may enroll as both audiologists and as hearing aid fitters and dispensers by completing an enrollment application for each type of provider (i.e., select "Audiologist" on one application and "Hearing Aid" on the other application).

Hearing services professionals who provide implantable hearing devices and services must also be appropriately enrolled according to their licensure and scope of practice.

Providers cannot be enrolled if their license is due to expire within 30 days. A current license must be submitted.

2.1.1 School Districts, State Agencies, and Inpatient Facilities

To be reimbursed for audiology and audiometry evaluation and diagnostic services for suspected and confirmed hearing loss (other than audiology evaluation and therapy services reimbursed to SHARS providers), audiologists employed by or contracted with school districts, state agencies, and inpatient hospitals must enroll as individual practitioners or group practitioners by choosing "Audiologist" on the enrollment application.

To be reimbursed for hearing aid devices and accessories and fitting and dispensing visits and revisits, audiologists and hearing aid fitters and dispensers employed by or contracted with school districts, state agencies, and inpatient hospitals must enroll as individual practitioners or facilities by choosing "Hearing Aid" on the enrollment application.

Appropriately-licensed providers who want to provide both audiology services and hearing aid fitting and dispensing services must complete applications for audiologist and for hearing aid fitter and dispenser for each program for which they want to enroll.

Note: *A SHARS TPI cannot be used to bill for these services.*

2.2 Services/Benefits, Limitations and Prior Authorization

Texas Medicaid clients of any age are eligible to receive medically necessary hearing aid devices and services through the hearing services benefit outlined in the following sections. The Texas Medicaid hearing services benefit includes a broad range of hearing services for clients of all ages and reimburses providers who are appropriately enrolled with Texas Medicaid in accordance with their licensure and scope of practice. Prior authorization is not necessary for benefits within program limitations.

The following hearing services are benefits of Texas Medicaid to appropriately-enrolled audiologists, hearing aid fitters and dispensers, and physicians according to their licensure, scope of practice, and enrollment as indicated:

- Audiologists and physicians may be reimbursed for audiology and audiometry evaluation and diagnostic services for suspected and confirmed hearing loss.
- Hearing aid fitters and dispensers may be reimbursed for hearing aid devices and accessories and fitting and dispensing visits and revisits.
- Physicians may be reimbursed for physician otology and otorhinolaryngology (ENT) services.

The following additional hearing services are benefits for Texas Medicaid clients, and are included in the reimbursement for the routine service or visit as indicated:

- As part of the hospital reimbursement, a hospital may be reimbursed for a routine newborn hearing screening that is performed before the infant is discharged from the hospital. The routine newborn hearing screening is included in the hospital reimbursement and is not reimbursed separately to audiologists, hearing aid fitters and dispensers, or physicians under the Texas Medicaid hearing services benefit.
- As part of the THSteps periodic medical checkup, a THSteps medical provider may be reimbursed for a routine THSteps medical checkup hearing screening. The routine THSteps medical checkup hearing screening is included in the reimbursement for the THSteps periodic medical checkups and is not reimbursed separately to audiologists, hearing aid fitters and dispensers, or physicians under the Texas Medicaid hearing services benefit.

Texas Medicaid clients whose jobs are contingent on their possessing a hearing aid or who appear to have vocational potential and who need a hearing aid may be referred to the Texas Department of Assistive and Rehabilitative Services (DARS) for hearing aids.

2.2.1 Limitations and Required Forms

All services provided to Texas Medicaid clients must be medically necessary. Unless otherwise specified, services may be reimbursed without prior authorization within the set limitations. In addition to services that always require prior authorization, providers may request prior authorization for medically necessary services that exceed benefit limitations.

Required forms, which are indicated in the specific sections below, are not required to be submitted with the claim, but the forms must be completed and maintained in the client's medical record and made available upon request by HHSC or TMHP for retrospective review.

2.2.2 Hearing Screenings

2.2.2.1 Routine Hearing Screenings

Routine hearing screenings that are required as part of the newborn hospital stay and as part of a THSteps periodic visit are included in the Texas Medicaid hearing services benefit. These routine screenings are not reimbursed to audiologists, hearing aid fitters and dispensers, or physicians. The newborn hearing screening is included in the reimbursement to the hospital for the newborn hospital stay, and the THSteps hearing screening is included in the reimbursement to the THSteps provider for the THSteps medical checkup.

Refer to: Subsection 6.3.1.8, "Newborn Examination" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about the newborn hearing screening.

2.2.2.2 Additional Hearing Screenings

Hearing screening provided by an audiologist, physician, nurse practitioner (NP), clinical nurse specialist (CNS), and physician assistant (PA) at the request of a client or parent or guardian or at the provider's discretion is a benefit for Texas Medicaid clients of all ages when rendered by a provider who is enrolled with Texas Medicaid and licensed to perform these services.

A hearing screening requested outside of a routine newborn or THSteps medical checkup may be reimbursed as medically necessary without prior authorization using procedure code 92551. Procedure code 92551 may be reimbursed to audiologists, physicians, NPs, CNSs, or PAs in the office or outpatient hospital setting.

Further diagnostic testing may also be reimbursed using the appropriate procedure code as indicated in the Audiology and Audiometry Evaluation and Diagnostic Services section of this article.

2.2.2.3 Abnormal Hearing Screening Results

If the screening returns abnormal results, the client must be referred to a Texas Medicaid provider who is a licensed audiologist or physician who provides audiology services. Clients who are birth through 20 years of age must be referred to a Texas Medicaid provider who is an audiologist or physician who is experienced with the pediatric population and who offers auditory services.

The referring physician who performs the screening must complete the Physician's Examination Report, which is maintained in the client's medical record. A new Physician's Examination Report must be completed whenever there is a change in the client's hearing or a new hearing aid is needed. Retrospective review may be performed to ensure documentation supports the medical necessity of the service.

In addition to being referred to an appropriate provider for further testing, clients who are 35 months of age or younger with suspected hearing loss must be referred to Early Childhood Intervention (ECI) within 2 working days of the abnormal hearing screening.

Refer to: Subsection 3.1, "Early Childhood Intervention (ECI) (CCP)" in the *Children's Services Handbook* (*Vol. 2 Providers Handbooks*) for more information about ECI.

2.2.3 Audiology and Audiometry Evaluation and Diagnostic Services

Physicians must recommend hearing evaluations based on examination of the client. Only physicians or licensed audiologists will be reimbursed for hearing evaluations. Hearing aid fitters and dispensers are not reimbursed for hearing evaluations.

2.2.3.1 Diagnostic Hearing Services

The Hearing Evaluation, Fitting, and Dispensing Report (Form 3503) must be completed by the physician or audiologist conducting the diagnostic testing. The provider who signs the report must maintain it in the client's file. The report includes audiometric assessment results of the hearing evalu-

ation and must provide objective documentation that amplification improves communication ability. Retrospective review may be performed to ensure documentation supports the medical necessity of the service.

Hearing screening and testing services do not require prior authorization. Documentation of medical necessity must be maintained by the provider in the client's medical record. Retrospective review may be performed to ensure that the documentation supports medical necessity for the service.

The following audiometry survey procedure codes may be reimbursed once per day:

Procedure Codes						
92550	92551	92552	92553	92555	92556	92557
92563	92567	92568*	92570	92579	92582	
* Limited to specific diagnosis codes.						

Procedure codes 92550 and 92570 may be reimbursed once each per day.

Procedure code 92568 may be reimbursed when billed with one of the following diagnosis codes:

Diagnosis Codes									
2251	3510	3511	3518	3519	38600	38601	38602	38603	38604
38610	38611	38612	38619	3862	38630	38631	38632	38633	38634
38635	38640	38641	38642	38643	38648	38650	38651	38652	38653
38654	38655	38656	38658	3868	3869	3870	3871	3872	3878
3879	3882	38830	38831	38832	38840	38841	38842	38843	38844
38845	3885	38905	38906	38913	38915	38916	38917	38920	38921
38922	7443	7804							

Procedure codes 92551, 92552, 92553, 92555, and 92556 are not reimbursed on the same day by any provider as procedure code 92557. If three or more of these procedure codes are billed for the same date of service, they are denied with instructions to bill with the more appropriate, comprehensive audiometry procedure code (92557).

Tympanometry (procedure code 92567) must be limited to selected individual cases where its use demonstrably adds to the provider's ability to establish a diagnosis and provide appropriate treatment. Tympanometry is limited to 4 services per year by the same provider and is based on medical necessity, which must be documented in the client's medical record.

The following evoked potential and otoacoustic emissions screening procedure codes may be reimbursed once per day:

Procedure Codes			
92585	92586	92587	92588

Hearing screening services with the use of auditory brainstem response (ABR) and otoacoustic emissions (OAE) audiometry are a benefit of Texas Medicaid for newborns as part of the newborn hearing screening. ABR and OAE are benefits for clients of all ages when performed to identify and diagnose hearing loss.

Evoked response testing (procedure codes 92585, 92586, 92587, and 92588) is considered a bilateral procedure. If separate charges are billed for left- and right-sided tests of the same type, the tests are combined and reimbursed as a quantity of one.

An electroencephalogram (EEG) may be reimbursed for the same date of service as evoked response testing by any provider.

Procedure code 95920 may be reimbursed in addition to each evoked potential test. Procedure code 95920 is limited to a maximum of 2 hours per day, per client, per provider, without documentation of medical necessity.

Procedure code 92591 (hearing aid examination) and procedure code V5010 (hearing aid assessment) may be reimbursed as medically necessary.

2.2.3.2 Physician Diagnostic Hearing Services

Providers must maintain documentation of medical necessity in the client's medical record. Retrospective review may be performed to ensure that the documentation supports medical necessity for the service.

No other forms are required and authorization is not required.

Texas Medicaid reimburses physicians for ear and throat examination procedure codes 92502, 92504, and 92540.

Important: *Procedure codes 92502, 92504, and 92540 are not reimbursed to audiologists*

2.2.3.3 SHARS Audiology Services

Audiology evaluation and therapy services procedure codes 92506, 92507, and 92508 may be reimbursed to school districts and state agencies that are enrolled with Texas Medicaid as School Health and Related Services (SHARS) providers.

Refer to: Section 4, "School Health and Related Services (SHARS)" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about SHARS services.

Other hearing evaluation, diagnostic, and hearing aid services may be reimbursed to appropriately-enrolled audiologists, hearing aid fitters and dispensers, and physicians as outlined in this section.

2.2.3.4 Noncovered Services

Texas Medicaid does not reimburse for hearing screening completed for day care, Head Start, or school. Separate procedure codes should not be billed for these services.

2.2.4 Hearing Aid Devices and Accessories (Non-Implantable)

Reimbursement for a hearing aid device requires that the following also be provided:

- An individual client assessment to identify the appropriate type of device
- The fitting of the device
- The re-assessment to determine whether the device allows for adequate hearing
- Expendable supplies that are necessary to keep the device functioning properly, such as batteries and accessories

TMHP does not supply the hearing aid devices, supplies, and accessories. Providers must purchase equipment directly from manufacturers and vendors of their choice and submit claims to TMHP for reimbursement using the appropriate procedure codes.

Texas Medicaid reimburses hearing aid fitters and dispensers for the following services:

Service	Procedure Code(s)	Limitation
Hearing aid devices	See below	1 per ear every 5 years (monaural codes = bill quantity of 1) (binaural codes = bill quantity of 1)
Hearing aid assessment	V5010	As medically necessary
Hearing aid accessories*	V5267	Prior authorization required
Fitting and dispensing visit	Refer to the online fee lookup (OFL) or the hearing aid fee schedule for payable codes.	1 per hearing aid procedure code
Ear impression Ear mold	V5275 V5264	1 each per hearing aid device (monaural codes = bill quantity of 1) (binaural codes = bill quantity of 2)
Revisit (as necessary)**	92592 92593	2 per calendar year when billed by any provider
Batteries (replacement only)	V5266	As medically necessary when a hearing aid device has been previously reimbursed **Note:** *If a hearing aid has not been reimbursed by Texas Medicaid in the last 5 years, the replacement batteries may be reimbursed upon appeal with a statement documenting medical necessity.*
Additional hearing aids within a 5-year period	The appropriate hearing aid procedure code	Prior authorization required
Hearing aid repair or modification	V5014	1 per year after the 1-year warranty period has lapsed

*** Hearing aid accessories including but not limited to chin straps, clips, boots, and headbands for clients who are birth through 20 years of age.**
**** Procedure code 92592 may be reimbursed for the first and second revisits for monaural fittings. Procedure code 92593 may be reimbursed for the first and second revisits for binaural fittings.**

2.2.4.1 Hearing Aid Devices

To file claims after providing the services, providers must use the appropriate electronic format or the appropriate CMS paper claim form. No other forms are required.

Texas Medicaid may reimburse monaural and binaural procedure codes. One monaural procedure code with modifier LT and 1 monaural procedure code with modifier RT may be reimbursed once every 5 years from the dispensing month without prior authorization, or one binaural procedure code may be reimbursed once every 5 years from the dispensing month without prior authorization. Exceptions are considered on a case-by-case basis through the prior authorization process.

Note: *Hearing services provided to clients who are birth through 20 years of age will not be reimbursed when the services are performed in the skilled nursing facility (SNF), intermediate care facility (ICF), or extended care facility (ECF) setting.*

The reimbursement for the monaural and binaural procedure codes includes the required hearing aid package as follows:

- Acquisition cost of the hearing aid (the actual cost or net cost of the hearing aid after any discounts have been deducted)
- Manufacturer's postage and handling charges
- All necessary hearing aid accessories or supplies
- Instructions for care and use
- A 1-month supply of batteries

Prior authorization is not required for hearing aids that are within benefit limitations. Prior authorization is required for additional medically necessary hearing aid devices within a 5-year period.

Refer to: Subsection 2.2.4.7, "Prior Authorization Requirements" in this handbook for details about submitting prior authorization requests.

For clients who are birth through 20 years of age, if the authorization request is denied because it does not meet benefit criteria, the TMHP Special Medical Prior Authorization (SMPA) Department will refer the request to the TMHP Coordinated Care Program (CCP) Department for consideration under CCP. The provider is not required to complete additional forms or request referral to the TMHP CCP Department.

Texas Medicaid may reimburse the following monaural hearing aid procedure codes:

Monaural Hearing Aid Procedure Codes									
V5030	V5040	V5170	V5180	V5244	V5245	V5246	V5247	V5254	V5255
V5256	V5257	V5298*							
* Prior authorization required.									

Monaural hearing aid procedure codes must be billed with modifier LT (left ear) or modifier RT (right ear) to indicate which ear is fitted with the hearing aid device.

Texas Medicaid may reimburse the following binaural procedure codes:

Binaural Hearing Aid Procedure Codes									
V5100	V5210	V5220	V5249	V5250	V5251*	V5252	V5253	V5258	V5259
V5260	V5261	V5298*							
* May be reimbursed with prior authorization for clients who are birth through 20 years of age only.									

Binaural procedure codes must be billed with a quantity of 1. The reimbursement for one binaural procedure code includes the set of hearing aid devices (i.e., 2 devices).

For clients who are birth through 20 years of age, providers may request prior authorization for hearing aids that are medically necessary but are not currently benefits of Texas Medicaid using procedure code V5298. Prior authorization must be requested through the TMHP SMPA Department. Procedure code V5298 may be reimbursed to hearing aid fitters and dispensers in the office, home, and other location settings.

Procedure code V5251 may be reimbursed to hearing aid fitters and dispensers in the office, home, and other location settings.

2.2.4.2 Medical Necessity

Monaural hearing aids may be reimbursed for clients who have no medical contraindication for using a hearing aid and who have documentation of medical necessity. The following documentation of medical necessity must be maintained in the client's medical record:

- Hearing loss in the better ear of 35 dBHL or greater for the pure tone average of 500, 1000, and 2000 Hz.
- A spondee threshold in the better ear of 35 dBHL or greater when pure tone thresholds cannot be established.
- Hearing loss in each ear is less than 35 dBHL at the frequencies below 2000 Hz and thresholds in each ear are greater than 40 dBHL at 2000 Hz and higher.
- Documentation of communication need and a statement that the patient is alert and oriented and able to use the device appropriately by themselves or with assistance.

Clients meet the criteria for binaural aids if they meet the conditions for a monaural hearing aid and have at least a 35-dBHL hearing loss in both ears.

Providers must also include the model number, serial number, and warranty dates of the purchased hearing aid device in the client's medical record.

Refer to: Subsection 6.3.1.1, "Place of Service (POS) Coding" in *Claims Filing* (*Vol. 1, General Information*) for more information about coding place of service for "other locations."

2.2.4.3 Replacement of Hearing Aid Devices

Replacement devices must be prior authorized. Replacement is considered for prior authorization when loss or irreparable damage has occurred. A copy of the police or fire report, when appropriate, and measures to be taken to prevent reoccurrence must be submitted with the prior authorization request. Replacements will not be authorized when the equipment has been abused or neglected by the client, the client's family, or the caregiver.

2.2.4.4 Supplies and Accessories

To file claims after providing services, providers must use the appropriate electronic format or the appropriate CMS paper claim form. No other forms are required.

Providers must dispense each hearing aid reimbursed through Texas Medicaid with all necessary hearing aid accessories and supplies, including a 1-month supply of batteries. Batteries may be replaced as medically necessary without prior authorization.

Supplies and accessories that are included in the hearing aid package are included in the reimbursement of the hearing aid procedure code and are not reimbursed separately.

Replacement hearing aid batteries- Replacement hearing aid batteries (procedure code V5266) may be reimbursed as medically necessary without prior authorization and are limited to clients with a previously billed hearing aid. Replacement batteries for clients who did not receive the hearing aid through Texas Medicaid are considered for reimbursement on appeal with a physician's statement documenting medical necessity.

Children's hearing aid accessories-For clients who are birth through 20 years of age, Texas Medicaid may also reimburse children's hearing aid accessories, including, but not limited to, chin straps, clips, boots, and headbands with prior authorization using procedure code V5267. Providers may purchase the accessories from a vendor of their choice and submit a claim to TMHP for reimbursement. Children's hearing aid accessories must be prior authorized.

Refer to: Subsection 2.2.4.7, "Prior Authorization Requirements" in this handbook for details about submitting prior authorization requests.

2.2.4.5 Hearing Aid Warranty: Repairs and Modifications

After the warranty period has lapsed, repair or modification of a hearing aid may be reimbursed once per year if repair or modification is a better alternative than a new purchase using procedure code V5014.

To file claims after providing services, providers must use the appropriate electronic format or the appropriate CMS paper claim form. No other forms are required.

Additional repairs beyond 1 per year may be reimbursed with prior authorization if medical necessity can be demonstrated. Requests for prior authorization must include documentation that supports the need for the requested repair.

Refer to: Subsection 2.2.4.7, "Prior Authorization Requirements" in this handbook for details about submitting prior authorization requests.

A hearing aid dispensed through Texas Medicaid must meet the following criteria:

- Be a new and current model
- Meet the performance specifications indicated by the manufacturer
- Include, at minimum, a standard 12-month warranty that begins on the dispensing date of the hearing aid.

During the warranty period, Texas Medicaid may reimburse providers for a replacement hearing aid and replacement hearing aid batteries. Texas Medicaid will not reimburse hearing aid repair during the 12-month manufacturer's warranty period. Providers must follow the manufacturer's repair process as outlined in their warranty contract.

2.2.4.6 Fitting and Dispensing Visits and Revisits

The forms and documentation required for the fitting and dispensing visits are as follows:

- Hearing Evaluation, Fitting, and Dispensing Report (Form 3503)
- Client acknowledgement statement (created by the provider)
- 30-day trial period certification statement (created by the provider)
- Additional necessary documentation

Hearing Evaluation, Fitting, and Dispensing Report (Form 3503)—The Hearing Evaluation, Fitting, and Dispensing Report (Form 3503) must be completed by the fitter/dispenser that conducts the fitting and dispensing visit. The provider who signs the report must maintain it in the client's file. The report includes audiometric assessment results of the hearing evaluation and must provide objective documentation that amplification improves communication ability. Retrospective review may be performed to ensure documentation supports the medical necessity of the device, service, or supply.

Client Acknowledgement Statement (created by the provider)—At the time the hearing aid device and supplies are dispensed, the client must sign a client acknowledgement statement to verify the client was evaluated and offered an appropriate hearing aid that meets the client's hearing need. The acknowledgement statement must include language that indicates the client is responsible for paying any hearing aid rental fees if charged. The provider must obtain the signed acknowledgment statement before dispensing the hearing aid device and supplies and must keep the signed acknowledgment statement in the client's file. Retrospective review may be performed to ensure documentation supports the medical necessity of the device, service, or supply.

30-Day Trial Period Certification Statement (created by the provider)—Providers must inform clients in writing of the trial period lasting 30 consecutive days. The statement, which must be created by the provider and signed by the client, must contain the beginning and ending dates of the trial period, all charges and fees associated with the trial period, an acknowledgment that the client accepts responsibility for any assessed rental fees, and the name, address, and telephone number of the State Board of Examiners for Speech-Language Pathology and Audiology. The client must receive a copy of this agreement.

After at least 30 days and the successful completion of the trial period, the provider must update the statement to indicate that the trial was successful and the client accepted the dispensed hearing aid device. The updated statement must be maintained in the client's file. Retrospective review may be performed to ensure documentation supports the medical necessity of the device, service, or supply.

Medical record documentation must be maintained in the client's medical record.

Authorization for fitting and dispensing visits and revisits is not required.

Hearing services provided to clients who are birth through 20 years of age will not be reimbursed when the services are performed in the SNF, ICF, or ECF setting.

Hearing aid visits are comprised of:

- The fitting and dispensing visit
- The first revisit
- The second revisit (as needed)

The fitting and dispensing visit includes the fitting, dispensing, and post-fitting check of the hearing aid. The licensed audiologist or fitter/dispenser must perform a post-fitting check of the hearing aid within 5 weeks of the initial fitting. The post-fitting check is part of the dispensing procedure and is not reimbursed separately.

> ***Note:*** *Providers may use procedure code V5011 or refer to the Texas Medicaid fee schedules on or after September 1, 2009 for payable procedure codes.*

The first and second revisits are available if additional visits are required after the post-fitting check, 2 additional revisits may be reimbursed as medically necessary. The first revisit must include a hearing aid check. The second revisit must include either a real ear measurement or aided sound field testing according to the guidelines specified for the hearing evaluation. If the aided sound field test scores suggest a decrease in hearing acuity, the provider must include puretone and speech audiometry readings from the first evaluation.

The second revisit is available as needed after the post-fitting check and first revisit.

Procedure code 92592 may be used for the first and second revisit for a monaural fitting. Procedure code 92593 may be used for the first and second revisit for a binaural fitting.

2.2.4.6.1 30-Day Trial Period

Providers must allow each Texas Medicaid client a 30-consecutive-day trial period that begins with the dispensing date. This trial period gives the client time to determine whether the hearing aid device meets the client's needs. If the client is not satisfied with the purchased hearing aid, the client may return it to the provider, who must accept it. If the device is returned within 30 days of the date it was dispensed, the provider may charge the client a rental fee not to exceed $2 per day. This fee is not a benefit of Texas Medicaid and will not be reimbursed. The client is responsible for paying the hearing aid rental fees if the provider chooses to charge a fee for the rental of returned hearing aid devices.

During the trial period, providers may dispense additional hearing aids as medically necessary until either the client is satisfied with the results of the hearing aid or the provider determines that the client cannot benefit from the dispensing of another hearing aid. The dispensing date of each additional hearing aid starts a new trial period.

2.2.4.6.2 Facility Visits and Home Visits

Home visit hearing evaluations and fittings are permitted only with the physician's written recommendation.

For clients who are birth through 20 years of age, hearing services provided to clients who are birth through 20 years of age will not be reimbursed when the services are performed in the SNF, ICF, or ECF setting.

For clients who are 21 years of age or older, services for residents in a SNF, ICF, or ECF must be ordered by the attending physician. The order must be on the client's chart, must state the condition that necessitates the hearing aid services, and must be signed by the attending physician.

2.2.4.7 Prior Authorization Requirements

Providers may use the form of their choice to submit the required information.

> ***Note:*** *Unless otherwise indicated, Texas Medicaid does not require prior authorization for hearing aid devices and services that are medically necessary and that are provided within the limitations outlined in this article. See below for those services that require prior authorization.*

For services that require prior authorization, prior authorization must be obtained before the services are provided. Prior authorization may also be requested for medically necessary services required beyond benefit limitations. The prior authorization number must be included on the claim form when the claim is submitted to TMHP.

Prior authorization is required only for the following devices and services:

- Additional devices and services that exceed benefit limitations (Providers may refer to the specific sections of this handbook for information about submitting the prior authorization requests for devices and services beyond benefit limitations.)
- Replacement of hearing aids within a 5-year period

For clients who are birth through 20 years of age, prior authorization is also required for the following services:

- Hearing aids that are medically necessary but are not currently benefits of Texas Medicaid.
- Children's hearing aid accessories including but not limited to chin straps, clips, boots, and headbands

The following table summarizes the documentation requirements for the items that require prior authorization:

Procedure Code	Description	Prior Authorization Requirements
V5298*	Hearing aids that are medically necessary for clients who are birth through 20 years of age but are not currently benefits of Texas Medicaid	The prior authorization request must include: • The medical necessity for the requested hearing aid device. • The name of the manufacturer. • The MSRP or AWP or the provider's documented invoice cost. • The model number, serial number, and the dates that the warranty is in effect for the requested hearing aid.
V5251	Analog hearing aid not reimbursed for clients who are 21 years of age or older	Medical necessity documentation is required.
*** Procedure codes V5298 and V5267 are benefits for clients who are birth through 20 years of age only.**		

Procedure Code	Description	Prior Authorization Requirements
Appropriate hearing aid device procedure code	Replacement of hearing aids within a 5-year period	Requests for prior authorization must include documentation that supports medical necessity, which may include documentation that loss or irreparable damage has occurred, a copy of the police or fire report (if applicable), and measures to be taken to prevent reoccurrence.
V5267*	Children's hearing aid accessories including, but not limited to, chin straps, clips, boots, and headbands.	Requests for prior authorization for hearing aid supplies will be considered when the requests are submitted with documentation that shows that the client is birth through 20 years of age and that the requested supply is medically necessary for the proper use or functioning of the hearing aid device.
* Procedure codes V5298 and V5267 are benefits for clients who are birth through 20 years of age only.		

Providers must submit requests for prior authorization to the TMHP SMPA Department with documentation that supports medical necessity for the requested device, service, or supply. Authorizations may be submitted on the TMHP website at www.tmhp.com or by fax to 1-512-514-4213.

Providers may use the form of their choice to submit the required information to the TMHP SMPA Department. No specific request form is required.

Important: *For clients who are birth through 20 years of age, if the authorization request is denied because it does not meet criteria as outlined in this article, the TMHP SMPA Department will refer the request to the TMHP CCP Department for consideration under CCP. The provider is not required to complete additional forms or request referral to the TMHP CCP Department.*

Refer to: Section 6, Claims Filing (*Vol 1, General Information*) for more information about the authorizations and claims filing processes.

Providers can refer to the Online Fee Lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com for procedure codes that may be reimbursed.

2.2.4.8 Noncovered Services

The following hearing aid procedure codes are not reimbursed by Texas Medicaid:

Procedure Codes									
V5050	V5060	V5070	V5080	V5120	V5130	V5140	V5150	V5190	V5230
V5242	V5243	V5248	V5262	V5263					

2.2.5 Implantable Hearing Devices for Clients of All Ages

Implantable hearing devices, including the cochlear implant device, the auditory brainstem implant (ABI), and the bone anchored hearing aid (BAHA), are benefits of Texas Medicaid for clients of all ages.

The following implantable hearing devices and services require prior authorization:

- Cochlear implant surgery, device, and replacement parts
- ABI surgery and device
- BAHA implant surgery and device
- Sound processor repair or replacement

- Replacement batteries beyond the limitations outlined in this article

Requests for prior authorization must be submitted to the SMPA Department with documentation supporting the medical necessity for the requested device, service, or supply.

2.2.5.1 Cochlear Implants

A cochlear implant device is an electronic instrument, part of which is implanted surgically into the cochlea to stimulate auditory nerve fibers and part of which is worn externally to capture and amplify sound. These devices are available in single- and multi-channel models.

Cochlear implants are used to provide awareness and identification of sound and to facilitate communication for persons who are profoundly hearing impaired.

The cochlear implant device is a benefit for clients who are 12 months of age or older.

The device must be approved by the Food and Drug Administration (FDA) and be age-appropriate for the client. The device can be billed separately from the surgical implantation procedure.

Speech therapy is a benefit of Texas Medicaid and can be billed separately from the surgical fee for the cochlear implant as follows:

For clients who are 12 months through 20 years of age, speech therapy is provided through the Comprehensive Care Program (CCP).

For clients who are 21 years of age or older, speech therapy is payable through Texas Medicaid when billed by the hospital or the physician.

The service is considered to be included in the inpatient DRG payment when provided in an inpatient facility or inpatient rehabilitation setting.

The following procedure codes may be submitted for the cochlear implant device, separate components, and services:

Procedure Codes									
69930*	L7368	L8499	L8614	L8615	L8616	L8617	L8618	L8619	L8621
L8622	L8623	L8624	L8627	L8628	L8629				

*** Unilateral cochlear implantation must be billed using procedure code 69930 with the appropriate LT or RT modifier. Bilateral cochlear implantation performed simultaneously must be billed using procedure code 69930 with modifier 50 to indicate a bilateral procedure.**

Note: *The cochlear implant device and the surgery to implant the device may be reimbursed separately.*

Procedure codes L8627, L8628, and L8629 for the cochlear implant device and components may be reimbursed for clients who are one year of age or older. One per day may be reimbursed with prior authorization.

Diagnostic analysis of the cochlear implant must be billed using procedure code 92601, 92602, 92603, or 92604.

2.2.5.1.1 Prior Authorization Requirements for Cochlear Implants

Prior authorization is required for the cochlear implant surgery, device, and replacement parts. Documentation submitted for review must indicate who will be providing the cochlear implant device (i.e., the facility or the DME/medical supplier). The National Provider Identifier (NPI) or Texas Provider Identifier (TPI) of the supplier of the device must be included on the prior authorization request.

Prior authorization for a unilateral or bilateral cochlear implant may be granted for clients who are 12 months of age or older with documentation of all of the following criteria:

- Cognitive ability to use auditory cues and written documentation of agreement by the client or the client's parent or guardian that the client will participate in a program of post-implantation aural rehabilitation. This documentation must be maintained in the client's medical record.
- Postlingual deafness or prelingual deafness.
- Freedom from middle-ear infection, an accessible cochlear lumen that is structurally suited to implantation, and freedom from lesions in the auditory nerve and acoustic areas of the central nervous system.
- No contraindications to surgery.
- Diagnosis of severe-to-profound bilateral sensorineural hearing loss with documentation of poor speech discrimination and a recommendation for cochlear implant candidacy.
- Inability to derive benefit from appropriately fitted hearing aid devices.

Covered diagnosis codes are limited to the following:

Diagnosis Codes						
38910	38911	38912	38914	38916	38918	38922

2.2.5.1.2 Replacement Batteries for Cochlear Implants

Replacement batteries for the cochlear implant device include non-rechargeable and rechargeable batteries as follows:

Replacement Batteries	Prior Authorization	Procedure Code	Limitation
Non-rechargeable*	Not required	L8621 (Zink air)	Maximum of 50 per month
Non-rechargeable*	Not required	L8622 (Alkaline)	Maximum of 31 per month
Rechargeable*	Not required	L8623 (Lithium ion)	2 batteries per calendar year
Rechargeable*	Not required	L8624 (Lithium ion)	2 batteries per calendar year
Battery recharger unit**	Required	L7368	one replacement unit per five-rolling-year period

*** Additional batteries beyond these limitations may be benefits with prior authorization based on medical necessity. Documentation must be submitted with the prior authorization request to support the need for the additional batteries.**
**** Additional recharger units for lithium ion rechargeable batteries beyond these limitations may be benefits through prior authorization with documentation of the medical necessity for the requested replacement.**

Replacement batteries for clients with bilateral cochlear implants and two sound processors must be billed using a left (LT) and a right (RT) modifier with the appropriate battery procedure code.

Replacement batteries for the cochlear device are limited to clients with a previously billed cochlear implant procedure, device, or supply.

Replacement batteries for clients who did not receive the cochlear implant through Texas Medicaid will be considered for reimbursement on appeal with a physician's statement documenting medical necessity.

Frequency modulated (FM) system services are not benefits of Texas Medicaid.

2.2.5.2 Auditory Brainstem Implant (ABI)

ABI is a benefit for clients who are 12 years of age or older. Prior authorization is required for the ABI surgery, device, and replacement parts. The following procedure codes must be used for the ABI and related components:

Procedure Codes				
S2235	L8499	L8614	L8621*	L8622*
* Replacement batteries				

Diagnostic analysis of the ABI (procedure code 92640) is limited to 2 hours per day, any provider.

Prior authorization requests and claims for ABI must be submitted with diagnosis code 23772.

2.2.5.3 Bone-Anchored Hearing Aid (BAHA)

The BAHA procedure, device, and replacement parts are benefits for clients who are 5 years of age or older with prior authorization.

The following procedure codes must be submitted for the BAHA and related components:

Procedure Codes							
L8690	L8691	L8692	69714	69715	69717	69718	V5266

Prior authorization requests may be granted for clients who are 5 years of age or older with all of the following:

- Documentation of previous attempts at hearing aid devices and why these devices are inadequate or have failed.
- Documentation of scores on hearing tests for bone conduction thresholds and on maximum speech discrimination.
- Documentation of audiological testing showing good inner ear function.
- Documentation of a multidisciplinary assessment including physical, cognitive, communicative, and behavioral limitations describing the client's auditory disability and expected benefit with use of the BAHA implant.
- Documentation of an appropriate diagnosis. Covered diagnoses may include, but are not limited to:

Diagnosis Codes							
38901	38902	38906	38908	38915	74401	74402	7560

Replacement batteries for the BAHA (procedure code V5266) do not require prior authorization. The replacement batteries are limited to clients with a previously billed hearing device. Replacement batteries for clients who did not receive the hearing device through Texas Medicaid will be considered for reimbursement on appeal with a physician's statement documenting the medical necessity.

Bilateral BAHA procedures are not benefits of Texas Medicaid.

Procedure codes L8691 and L8692 will be denied as part of another service when billed by any provider with the same date of service as procedure code L8690.

Procedure code L8692 for the bone-anchored hearing aid (BAHA) device and components may be reimbursed for clients who are five years of age or older. One per day may be reimbursed with prior authorization.

2.2.5.4 Sound Processor Replacement and Repair Guidelines for Implantable Hearing Devices

Procedure codes L8619 and L8499 must be used for sound processor replacement and repair.

Replacement of a sound processor requires prior authorization.

Documentation by the physician must explain replacement of the unit will be considered.

The prior authorization request must include evidence of the purchase, such as the manufacturer's warranty.

Repair of a sound processor will be considered for prior authorization with documentation of medical necessity for the requested repair. Modifier RB must be used with procedure code L8499 when submitting a claim for a prior authorized sound processor repair.

Repair of a sound processor will be manually priced at the time the prior authorization is reviewed and granted. If the actual cost of the repair differs from the prior authorized fee, the provider must contact the SMPA Department to update the authorization before filing a claim for the repair services.

Repair or replacement of a sound processor is not a benefit during the manufacturer's warranty period.

2.3 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including hearing services. Hearing services are subject to retrospective review and recoupment if documentation does not support the service billed.

Required forms for non-implantable hearing devices and services, which are indicated in the specific sections above, are not submitted with the claim to TMHP, but the forms must be completed and maintained in the client's medical record and made available upon request by HHSC or TMHP for retrospective review.

2.4 Claims Filing and Reimbursement

2.4.1 Claims Filing

Hearing services must be submitted to TMHP in an approved electronic format or on the CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 paper claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Providers supplying hearing aid devices for STAR+PLUS Medicaid Qualified Medicare beneficiary (MQMB) clients must submit claims to TMHP, not the STAR+PLUS Health Maintenance Organization (HMO), for the hearing aid devices.

Refer to: Subsection 2.2, "Reimbursement Methodology" in Section 2, *Texas Medicaid Reimbursement* (*Vol. 1, General Information*) for more information about reimbursement.

Subsection 1.4.9, "Billing Clients" in Section 1, *Provider Enrollment and Responsibilities* (*Vol. 1, General Information*) for more information.

Section 3, TMHP Electronic Data Interchange (EDI) (*Vol. 1, General Information*) for information on electronic claims submissions.

Subsection 6.1, "Claims Information" in Section 6, "Claims Filing" (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, "CMS-1500 Claim Filing Instructions" in Section 6, "Claims Filing" (*Vol. 1, General Information*). Blocks that are not referenced are not required for processing by TMHP and may be left blank.

2.4.1.1 Hearing Devices (Non-Implantable)

To be reimbursed for both audiology services and hearing aid fitting and dispensing services, audiologists must enroll with Texas Medicaid as audiologists and also as hearing aid fitters and dispensers. Audiology services must be billed using the audiologist provider number and benefit code (for electronic claims only) as indicated on the provider enrollment letter that indicates "Audiologist", and hearing aid and fitting and dispensing services must be billed with the hearing aid provider number and benefit code (for electronic claims only) as indicated on the provider enrollment letter that indicates "Hearing Aid."

Providers must file all claims electronically or on the appropriate Centers for Medicare & Medicaid Services (CMS) paper claim form after providing the services. Claims must include the following information:

- The most appropriate 3- to 5-digit *International Classification of Diseases*, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis code that represents the purpose for the service.
- The most appropriate Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) procedure code(s) that represent the service(s) provided.
- The appropriate information as indicated on the provider enrollment letter (Electronic claims must also include the most appropriate attested taxonomy code.)

2.4.1.2 Hearing Services Claims for Clients with Medicaid HMOs

All hearing services claims for clients who are birth through 20 years of age must be submitted to TMHP regardless of the clients' Medicaid managed care plans.

For clients who are 21 years of age or older, the claim for hearing services must be submitted to TMHP for fee-for-service clients or to the appropriate Medicaid managed care plan, either to TMHP for Primary Care Case Management (PCCM) clients or to the appropriate health maintenance organization (HMO) for clients with another Medicaid managed care plans.

2.4.1.3 Third Party Resource

Standard third-party resource (TPR) rules apply to all hearing services claims.

2.4.2 Reimbursement

Hearing aids and audiological services are reimbursed in accordance with 1 TAC §355.8141.

Hearing aids and related services are reimbursed at the lesser of the billed charges or the published Texas Medicaid fee. Unless otherwise indicated, providers may not make additional charges to the client for covered services; such charges constitute a breach of the Texas Medicaid contract.

Requested items that are not represented by a specific procedure code must be prior authorized and are priced manually during the authorization process. Manually priced items for clients who are birth through 20 years of age require prior authorization that must be obtained through the TMHP SMPA Department. The reimbursement will be determined based on either the manufacturer's suggested retail price (MSRP) less 18 percent or average wholesale price (AWP) less 10.5 percent (whichever is applicable) or based on the provider's documented invoice cost. Manually priced items are indicated with "MP" in the reimbursement rate table at the end of this article.

Providers may refer to the online fee lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com.

Refer to: The TMHP - Providers web page at www.tmhp.com/Providers/default.aspx for more information about the transition of the hearing services benefit from DSHS to TMHP.

3. VISION CARE PROFESSIONALS

3.1 Enrollment

To enroll in Texas Medicaid, optometrists (doctors of optometry [ODs]) and ophthalmologists must be licensed by the licensing board of their profession to practice in the state where the service is performed, at the time the service is performed, and be enrolled as Medicare providers.

An optometrist or ophthalmologist cannot be enrolled if their license is due to expire within 30 days; a current license must be submitted.

3.2 Provider Responsibilities

Suppliers of eyewear must comply with all Medicaid provider responsibilities and adhere to the following guidelines:

- Do not delay the ordering of eyewear or the dispensing of eyeglasses to the client while payment is pending from TMHP.
- Deliver the eyewear in a reasonable amount of time (usually two or three weeks from the date the order is placed by the client).
- Obtain the required eligibility information from the client's Medicaid Identification Form (Form H3087).
- Refer to the Eyeglasses column of the Medicaid Identification Form (Form H3087) to determine whether eyeglasses have been reimbursed by Texas Medicaid within the last 24 months. Providers are advised to ask clients if they have recently received vision care services that may not appear on the Medicaid Identification Form (Form H3087) because of the delay in updating form information.
- Update the Eyeglasses column of the Medicaid Identification Form (Form H3087) to indicate that eyewear was dispensed. Initial, date, and mark the form to indicate that the service was performed. Temporary cataract lenses or glasses are payable during the four-month convalescent period even if the Medicaid Identification Form (Form H3087) does not have a check mark under the Eyeglasses column. However, the Medicaid Identification Form (Form H3087) must not have a check mark under the Eyeglasses column if nonprosthetic eyeglasses are to be obtained for use in conjunction with cataract contact lenses.
- Have the client or parent/guardian sign and date the Vision Care Eyeglass Patient (Medicaid Client) Certification Form and retain it in the provider's records if the client selects eyewear that is not covered or if the client's eyewear is lost or destroyed.
- Have the client or parent/guardian sign and date the Vision Care Eyeglass Patient (Medicaid Client) Certification Form and retain it in their records.
- Do not charge a Medicaid client more than a patient not enrolled in Texas Medicaid for noncovered services (e.g., tints, oversized lenses, or frames).
- Keep invoices on file for a minimum of five years.
- Submit claims using the date eyeglasses were ordered as the date of service (DOS) (the start of the 95-day filing period), not the date the eyewear was dispensed.

3.3 Services/Benefits, Limitations and Prior Authorization

Optometric services may be reimbursed to optometrists.

Vision care benefits including prosthetic and non-prosthetic eyewear may be reimbursed to optometrists and ophthalmologists with specific limitations.

Note: *In accordance with the* Omnibus Reconciliation Act *(OBRA) of 1986, Section 9336, a Doctor of Optometry is considered a physician, with respect to the provision of any item or service the optometrist is authorized to perform by state law or regulation.*

Expenses for medical supplies, equipment, and other items that are not specifically made-to-order for the client are considered to have been incurred on the date the item is delivered and no reimbursement can be made to the provider.

3.3.1 Services Performed in Long-Term Care Facilities

Vision care services performed in long-term care facilities (SNF or ICF) must be ordered by the attending physician. The physician's name and address or nine-character Texas Provider Identifier (TPI) must be documented on the claim.

Optometrist services provided in a skilled nursing facility (SNF) or intermediate care facility for persons with mental retardation (ICF-MR) may be reimbursed by Texas Medicaid if the client's attending physician has ordered the service and the order is included in the client's medical records at the facility. Providers must document the physician's name and address or provider identifier in Block 17 of the CMS-1500 claim form. Claims submitted without this information are listed on the R&S as incomplete and must be corrected and resubmitted for consideration of payment. Electronic claims of this nature will be rejected. Attending physician information for electronic claims must be noted in the appropriate field of an approved electronic claims format.

3.3.2 THSteps Medical Checkup Vision Screening

A vision screening must be completed during each THSteps medical checkup with standardized screenings performed at specific ages, as listed in the THSteps Periodicity Schedule. Providers may perform a vision screening during an acute care visit with the appropriate screening tools or refer at-risk infants and children to a provider who can perform further testing, diagnosis, and treatment.

Refer to: Subsection 6.3.2.4.1, "Vision Screening" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for information about THSteps medical checkup vision screenings.

3.3.3 Noncovered Services and Supplies

The following services and supplies are not covered by Texas Medicaid:

- Vision services for clients who are 21 years of age or older that exceed the limitation of one examination of the eyes by refraction, per client, per 24 months.
- All metal frames.
- Replacements of lost or destroyed eyewear or contact lenses for clients who are 21 years of age or older.
- Artificial eyes for clients 21 years of age or older. (Note: artificial eyes may be reimbursed for clients who are birth through 20 years of age through CCP.)
- Plano sunglasses.
- Eyewear prescribed or dispensed to clients at a hospital or nursing facility without orders of the attending physician documented in the clients' medical records.
- Eyeglasses for residents of institutions where the reimbursement formula and vendor payment include this service.
- Optional eyeglass features requested by the client that do not increase visual acuity including, but not limited to, lens tint, industrial hardening, decorative accessories, or lettering.
- Prisms that are ground into the lenses.

Clients may be billed for noncovered frames and other items beyond Medicaid benefits. Providers must have the client sign and date the Vision Care Eyeglass Patient (Medicaid Client) Certification Form and retain it in the provider's records. The client payment amount is not considered other insurance and must not be entered as a credit amount in the electronic field.

Example: *Texas Medicaid may reimburse providers a total of $30.36 for eyeglass frames that are within the provider's selection for Medicaid reimbursement plus the allowed cost per lens. If the client chooses a pair of frames (such as $200 frames) that are outside of the provider's selections for Medicaid reimbursement and if the client chooses other items or services that are not a benefit of Texas Medicaid (such as tinted lenses for an extra $10 charge), the client is responsible for and may be billed for the balance of the cost of the frames ($169.64) and the other items that are not a benefit of Medicaid ($10 for tinted lenses).*

The provider may withhold the noncovered eyewear, contacts, or eyeglasses until the client pays for those items. If the client fails to pay for the noncovered items or has not returned for finished eyewear within a reasonable length of time (two to three months), the provider may return any reusable items to stock. Any payment made by TMHP for frames or lenses must be refunded to Texas Medicaid. If a client requests eyewear that is beyond program benefits (for example, scratch-resistant coating), Medicaid allows reimbursement up to the maximum fee. The provider may charge the client the difference between the Medicaid payment and the customary charge for the eyewear requested, when the client has been shown the complete selection of Medicaid-covered eyewear and when the following conditions are met:

- The client rejects the Medicaid-covered eyewear and wants eyewear that complies with Texas Medicaid specifications, but is not included in the selection of Medicaid-covered eyewear.
- The client indicates a willingness to pay the difference between the Medicaid payment and the actual charge. The provider must have the client sign the Vision Care Eyeglass Patient (Medicaid Client) Certification Form and retain it in the provider's records.

3.3.4 Ophthalmological Services

Ophthalmological services include medical services, surgical services, and consultations.

Bilateral ophthalmological services must be billed with a quantity of one. Unless specifically defined by description as a unilateral procedure code, all ophthalmological services listed are considered bilateral and should not be billed with a quantity of two.

Providers are to use the eye exam procedure codes in this section with a diagnosis code of ophthalmological disease or injury.

3.3.4.1 Complete Eye Examinations

The following E/M procedure codes include refraction:

Procedure Codes									
99201	99202	99203	99204	99205	99211	99212	99213	99214	99215

When an ophthalmologist sees a client for a minor condition that does not require a complete eye exam (such as conjunctivitis), providers are to use the appropriate office E/M procedure code.

The following procedure codes may be reimbursed for eye examinations:

Procedure Codes						
92002	92004	92012	92014	92015	S0620	S0621
Procedure codes 92002, 92004, 92012, and 92014 may be reimbursed for eye examinations with refraction used in evaluating a client with ocular disease. **Procedure codes S0620 and S0621 may be reimbursed when evaluating a client only for refractive purposes.**						

When an E/M office visit or consultation is billed in addition to the eye examination, the most inclusive code may be reimbursed and the other will be denied.

Procedure codes 92015, S0620, and S0621 are considered part of the office visit/eye examination and will not be reimbursed when billed with the same date of service as an office visit/eye examination.

For clients with both Medicare and Medicaid, the following exceptions apply to procedure codes 92015, S0620, and S0621:

- Procedure code 92015 may be reimbursed separately if it is used to bill for the refractive portion of an examination.
- Procedure codes 92015, S0620, and S0621 may be reimbursed in addition to procedure codes 92002, 92004, 92012, and 92014.

Eye refractions may be reimbursed as follows:

- Eye refractions for clients who are birth through 20 years of age are limited to one per state fiscal year (September 1 through August 31).
- Eye refractions for clients who are 21 years of age or older are limited to one every 24 months, when done for refractive errors only (S0620 and S0621).
- Refractions done for medical reasons (procedure codes 92002, 92004, 92012, 92014, and 92015) may be reimbursed as medically necessary.

Eye examinations for aphakia and disease or injury to the eye are not subject to any of the limitations listed in this section and are payable even if the Medicaid ID form does not have a checkmark under the Eye Exam column.

New Patient vs. Established Patient Visits

A new patient eye examination visit (procedure code 92002 or 92004) is defined as a visit with a client who is new to the physician and whose medical and administrative records need to be established. An established patient eye examination visit (procedure code 92012 or 92014) is defined as a visit with a client whose medical and administrative records are available to the physician.

A new patient eye examination for a particular client is limited to once every 2 years per provider. A new patient eye examination visit in any place of service will be denied if history shows that the same provider has furnished a medical, surgical, or consultation service to the client within two years of the date of service.

A new patient or established patient office visit or eye examination visit will be denied as part of an ophthalmoscopy service performed on the same day.

3.3.4.2 Ophthalmoscopy Services

The following procedure codes may be reimbursed for ophthalmoscopy services:

Procedure Codes						
92225	92226	92230	92235	92240	92250	92260

Procedure codes 92225, 92226, 92230, and 92235 are unilateral procedure codes. A quantity of two may be reimbursed if both left and right eyes are evaluated. If two services are billed for the same date of service, one may be reimbursed at 100 percent, and the other may be reimbursed at 50 percent.

Procedure code 92230 will not be reimbursed if billed with procedure code 92235.

A new or established patient office visit or ophthalmological medical examination is denied if billed with any of these ophthalmoscopy services.

3.3.4.3 Special Ophthalmological Services

The following procedure codes may be reimbursed for special ophthalmological services:

Procedure Codes						
92018	92019	92020	92025	92060	92081	92082
92083	92100	92120	92135	92140		

These special ophthalmological services will be denied if billed the same day as an intermediate or comprehensive new patient or established patient office visit or eye examination visit.

Special ophthalmological service procedure codes 92018, 92019, 92025, 92081, 92082, 92083, 92120, 92135, and 92140 may be reimbursed in addition to the general eye examination visit procedure codes 92002, 92004, 92012, and 92014.

Procedure codes 92020, 92060, and 92100 are considered part of the office visit/eye examination and will not be reimbursed when billed with the same date of service as an office visit/eye examination.

3.3.4.4 Other Ophthalmological Services

The following procedure codes may be reimbursed for other ophthalmological services:

Procedure Codes						
92265	92270	92275	92285	92286	92287	95930

A new patient or established patient office visit or eye examination visit will be denied if any of these ophthalmological services are performed on the same day.

3.3.4.5 Corneal Transplants

Corneal transplants may be reimbursed by Texas Medicaid and are subject to global surgery fee guidelines. The following procedure codes may be reimbursed this surgery:

Procedure Codes					
65710	65730	65750	65755	65756	65757

Bioengineered cornea transplants remain investigational at this time and are not reimbursed by Texas Medicaid.

3.3.4.6 Services Not Reimbursed Separately

Orthoptic or pleoptic training (procedure code 92065) is considered part of a client visit or eye exam and will not be reimbursed separately.

Ophthalmological services will not be reimbursed if billed only for a cataract, as they are not routinely medically indicated.

3.3.5 Optometric Services

The following procedure codes may be reimbursed for optometric services:

Procedure Codes						
Surgical Procedure						
65205	65210	65220	65222	65286	65430	67820
67938	68530	68761	68801	68810	68840	
Eye Examinations						
92002	92004	92012	92014	92015	92020	92025
92060	92065	92081	92082	92083	92100	92120
92135	92140	92225	92226	92230	92235	92240
92250	92260	92265	92270	92275	92285	92286
92287	92326	95060	95933	99000	99050	99056
S0620	S0621					
Procedure codes S0620 and S0621 may be reimbursed when billed with a diagnosis of refractive error only. Providers may refer to Diagnosis Limitations in this handbook for the appropriate diagnosis codes. Procedure code 92015 will not be reimbursed when billed with the same date of service as procedure code S0620 or S0621. If an office evaluation and management (E/M) service or consultation is billed in addition to the eye exam, the E/M service or consultation will be denied as part of the eye exam.						
Evaluation and Management (E/M) and Consultation Procedure Codes						
99201	99202	99203	99204	99205	99211	99212
99213	99214	99215	99221	99222	99223	99231
99232	99233	99234	99235	99236	99238	99239
99241	99242	99243	99244	99245	99251	99252
99253	99254	99255	99281	99282	99283	99284
99285	99304	99305	99306	99307	99308	99309
99310	99315	99316	99318	99324	99325	99326
99327	99328	99334	99335	99336	99337	99339
99340	99341	99342	99343	99344	99345	99347
99348	99349	99350				

A visual acuity screening will not be reimbursed separately when billed with the same date of service as a THSteps medical visit or an E/M visit. The reimbursement for the visual acuity screening is considered part of the reimbursement for the visit.

3.3.5.1 Diagnosis Limitations

Optometric services including evaluation and management (E/M) services and consultations may be reimbursed when billed with the following diagnosis codes:

Diagnosis Codes									
05320	05321	05322	05329	05440	05441	05442	05443	05444	05449
0760	0761	0769	0770	0771	0772	0773	0774	0778	0903
0905	0906	0907	0909	09150	09151	09152	09840	09841	09842
09843	09849	11502	11512	11592	1301	1302	1900	1901	1902

Diagnosis Codes									
1903	1904	1905	1906	1907	1908	1909	2240	2241	2242
2243	2244	2245	2246	2247	2248	2249	2340	23981	24900
24901	24910	24911	24920	24921	24930	24931	24940	24941	24950
24951	24960	24961	24970	24971	24980	24981	24990	24991	25000
25001	25002	25003	25010	25011	25012	25013	25020	25021	25022
25023	25030	25031	25032	25033	25040	25041	25042	25043	25050
25051	25052	25053	25060	25061	25062	25063	25070	25071	25072
25073	25080	25081	25082	25083	25090	25091	25092	25093	36000
36001	36002	36003	36004	36011	36012	36013	36014	36019	36020
36021	36023	36024	36029	36030	36031	36032	36033	36034	36040
36041	36042	36043	36044	36050	36051	36052	36053	36054	36055
36059	36060	36061	36062	36063	36064	36065	36069	36081	36089
3609	36100	36101	36102	36103	36104	36105	36106	36107	36110
36111	36112	36113	36114	36119	3612	36130	36131	36132	36133
36181	36189	3619	36201	36202	36203	36204	36205	36206	36207
36210	36211	36212	36213	36214	36215	36216	36217	36218	36220
36221	36222	36223	36224	36225	36226	36227	36229	36230	36231
36232	36233	36234	36235	36236	36237	36240	36242	36243	36250
36251	36252	36253	36254	36255	36256	36257	36260	36261	36262
36263	36264	36265	36266	36482	36752	36753	36789	36800	36801
36802	36803	36810	36811	36812	36813	36814	36815	36816	3682
36830	36831	36832	36833	36834	36840	36841	36842	36843	36844
36845	36846	36847	36851	36852	36853	36854	36855	36859	36860
36861	36862	36863	36869	3688	3689	36900	36901	36902	36903
36904	36905	36906	36907	36908	36910	36911	36912	36913	36914
36915	36916	36917	36918	36920	36921	36922	36923	36924	36925
3693	3694	36960	36961	36962	36963	36964	36965	36966	36967
36968	36969	36970	36971	36972	36973	36974	36975	36976	3698
3699	37000	37001	37002	37003	37004	37005	37006	37007	37020
37021	37022	37023	37024	37031	37032	37033	37034	37035	37040
37044	37049	37050	37052	37054	37055	37059	37060	37061	37062
37063	37064	3708	3709	37100	37101	37102	37103	37104	37105
37110	37111	37112	37113	37114	37115	37116	37120	37121	37122
37123	37124	37130	37131	37132	37133	37140	37141	37142	37143
37144	37145	37146	37148	37149	37150	37151	37152	37153	37154
37155	37156	37157	37158	37160	37161	37162	37170	37171	37172
37173	37181	37182	37189	3719	37200	37201	37202	37203	37204
37205	37206	37210	37211	37212	37213	37214	37215	37220	37221
37222	37230	37231	37233	37234	37239	37240	37241	37242	37243
37244	37245	37250	37251	37252	37253	37254	37255	37256	37261

Diagnosis Codes									
37262	37263	37264	37271	37272	37273	37274	37275	37281	37289
3729	37300	37301	37302	37311	37312	37313	3732	37331	37332
37333	37334	3734	3735	3736	3738	3739	37400	37401	37402
37403	37404	37405	37410	37411	37412	37413	37414	37420	37421
37422	37423	37430	37431	37432	37433	37434	37441	37443	37444
37445	37446	37450	37451	37452	37453	37454	37455	37456	37481
37482	37483	37484	37485	37486	37487	37489	3749	37500	37501
37502	37503	37511	37512	37513	37514	37515	37516	37520	37521
37522	37530	37531	37532	37533	37541	37542	37543	37551	37552
37553	37554	37555	37556	37557	37561	37569	37581	37589	37600
37601	37602	37603	37604	37610	37611	37612	37613	37621	37622
37630	37631	37632	37633	37634	37635	37636	37640	37641	37642
37643	37644	37645	37646	37647	37650	37651	37652	3766	37681
37682	37689	3769	37700	37701	37702	37703	37704	37710	37711
37712	37713	37714	37715	37716	37721	37722	37723	37724	37730
37731	37732	37733	37734	37739	37741	37742	37743	37749	37751
37752	37753	37754	37761	37762	37763	37771	37772	37773	37775
3779	37800	37801	37802	37803	37804	37805	37806	37807	37808
37810	37811	37812	37813	37814	37815	37818	37817	37818	37820
37821	37822	37823	37824	37830	37831	37832	37833	37834	37835
37840	37841	37842	37843	37844	37845	37850	37851	37852	37853
37854	37855	37856	37860	37861	37862	37863	37871	37872	37873
37881	37882	37883	37884	37885	37886	37887	3789	37900	37901
37902	37903	37904	37905	37906	37907	37909	37911	37912	37913
37914	37915	37916	37919	37921	37922	37923	37924	37925	37926
37929	37931	37932	37933	37934	37939	37940	37941	37942	37943
37945	37946	37949	37950	37951	37952	37953	37954	37955	37956
37957	37958	37959	37960	37961	37962	37963	3798	37990	37991
37992	37993	37999	74300	74303	74306	74310	74311	74312	74320
74321	74322	74330	74331	74332	74333	74334	74335	74336	74337
74339	74341	74342	74343	74344	74345	74346	74347	74348	74349
74351	74352	74353	74354	74355	74356	74357	74358	74359	74361
74362	74363	74364	74365	74366	74369	7438	7439	8700	8701
8702	8703	8704	8708	8709	8710	8711	8712	8713	8714
8715	8716	8717	8719	9180	9181	9182	9189	9210	9211
9212	9213	9219	9300	9301	9302	9308	9309	9400	9401
9402	9403	9404	9405	9409					

Procedure codes S0620 and S0621 may be reimbursed when billed with one of the following diagnosis codes:

Diagnosis Codes									
3670	3671	36720	36721	36722	36731	3674	36751	36752	36753
36781	36789	3679	37182	V720					

3.3.6 Corneal Topography

Optometrists must receive prior authorization for procedure code 92025.

Procedure code 92025 may be reimbursed to ophthalmologists for corneal topography without prior authorization when billed with one of the following diagnosis codes:

Diagnosis Codes						
37000	37001	37002	37003	37004	37005	37006
37007	37100	37101	37102	37103	37104	37120
37121	37122	37123	37140	37142	37146	37148
37149	37160	37161	37162	37170	37171	37172
37173	37234	37240	37241	37242	37243	37244
37245	37281	37289	8710	8711	9402	9403
9404	99651	V425	V4561	V4569		

Only a quantity of one may be billed by any provider per eye, per day.

An initial- or established-patient visit or consultation may be reimbursed when billed with the same date of service as corneal topography. Corneal topography is subject to global surgery fee guidelines. If procedure code 92025 is performed within the global surgical pre-/post-care days of the following procedure codes, the corneal topography will be denied as part of the procedure:

Procedure Codes						
65270*	65272	65273	65275	65280	65285	65286
65400	65420	65426	65430*	65435*	65436*	65450
65600	65710	65730	65750	65755	65756**	65757**
65880	66600	66605	66625	66630	66635	66820
66821	66830	66840	66850	66852	66920	66930
66940	66983	66984**	66985**	66986		

*** Ophthalmologists may be reimbursed separately for procedure code 92025 when billed within the global surgical pre-/post-care days of procedure codes 65270, 65430, 65435, and 65436.**

**** Procedure code 92025 will be denied if billed within the global surgical pre-/post-care days of procedure codes 65756, 65757, 66984, and 66985 when billed by optometrists.**

3.3.6.1 Authorization Requirements

Corneal topography requires prior authorization when used for the fitting of contact lenses. The prior authorization request must include diagnosis code 36720, 36722, or 74341. Prior authorization criteria must be met for both the corneal topography and the contact lenses.

Prior authorization requests must be submitted to the TMHP Special Medical Prior Authorization unit at:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727
Fax: 1-512-514-4213

Refer to: Subsection 3.3.9.2.3, "Non-Prosthetic Contact Lenses" in this handbook for contact lens authorization requirements.

3.3.7 Ophthalmic Ultrasound, Sonography, and Echography Services

Ultrasound ophthalmic procedure codes 76510, 76511, 76512, 76513, and 76999 may be reimbursed when billed with any of the following diagnosis codes:

Diagnosis Codes						
1900	1901	1984	2240	2241	2340	2388
23981	24950	24951	25050	25051	25052	25053
36050	36051	36052	36053	36054	36055	36059
36060	36061	36062	36063	36064	36065	36069
36100	36101	36102	36103	36104	36105	36106
36107	36110	36111	36112	36113	36114	36119
3612	36130	36131	36132	36133	36181	3619
36201	36202	36203	36204	36205	36206	36207
36210	36211	36212	36213	36214	36215	36216
36217	36218	36220	36221	36222	36223	36224
36225	36226	36227	36229	36230	36231	36232
36233	36234	36235	36236	36237	36240	36241
36242	36243	36250	36251	36252	36253	36254
36255	36256	36257	36260	36261	36262	36263
36264	36265	36266	36270	36271	36272	36273
36274	36275	36276	36277	36281	36282	36283
36284	36285	36289	36340	36341	36342	36343
36361	36362	36363	36370	36371	36372	36441
36481	36482	36489	36641	37921	37926	37992

A-scan ophthalmic ultrasound procedure codes 76511, 76516, and 76519 may be reimbursed when billed with any of the following procedure codes:

Diagnosis Codes						
36600	36601	36602	36603	36604	36609	36610
36611	36612	36613	36614	36615	36616	36617
36618	36619	36620	36621	36622	36623	36630
36631	36632	36633	36634	36641	36642	36643
36644	36645	36646	36650	36651	36652	36653

Diagnosis Codes						
3668	3669	37100	37101	37102	37103	37104
37105	37110	37111	37112	37113	37114	37115
37116	37120	37121	37122	37123	37124	37130
37131	37132	37133	37140	37141	37142	37143
37144	37145	37146	37148	37149	37150	37151
37152	37153	37154	37155	37156	37157	37158
37160	37161	37162	37170	37171	37172	37173
37181	37182	37189	3719	37931	37932	37933
37934	37939	74330	74331	74332	74333	74334
74335	74336	74337	74339			

Ophthalmic A-scan procedure code 76511, 76516, or 76519 may be reimbursed on the same day as ophthalmic B-scan procedure code 76512 when each meet the diagnosis criteria listed in the appropriate table above.

Ophthalmic ultrasound foreign body localization procedure code 76529 may be reimbursed when billed with any of the following diagnosis codes:

Diagnosis Codes						
3766	8704	8715	8716	9300	9301	9302
9308	9309					

3.3.8 Vision Services for Prosthetic Eyewear

Definition: Prosthetic eyewear is prescribed for post-cataract surgery, congenital absence of the eye lens, or loss of an eye lens because of trauma. Providers may refer to TAC §354.1015 for more information.

Limitation: Eye examinations for aphakia (including congenital aphakia) and disease or injury to the eye may be reimbursed as medically necessary.

One pair of permanent contact lenses or eyeglasses, or both, may be reimbursed per lifetime, unless a replacement is required due to a significant change in visual acuity, loss, theft, or damage that is beyond repair.

Prosthetic lenses are those lenses that replace the function of the eye's organic lens. Replacement of the eye's organic lens may be necessary for the following reasons, including, but not limited to:

- A defect or trauma resulting in aphakia.
- Surgical cataract extraction.

Procedure codes for prosthetic eyewear may be reimbursed when billed with a diagnosis of aphakia (diagnosis code 37931 or 74335). Providers should use modifier VP when billing for services for clients with a diagnosis of aphakia.

The date of cataract surgery is not required on the claim for permanent prosthetic eyewear.

3.3.8.1 Prosthetic Eyewear Dispensing Requirements

Both contact lenses and eyeglasses can be prosthetic. Providers must be able to dispense standard size frames at no cost to the eligible client. Providers must also show each eligible client a minimum of three styles of zylonite frames for male, female, child, or adult, in a choice of three colors. The provider may also show combination frames of zylonite and metal.

Clients must acknowledge their choice of eyewear beyond program limitations by signing the Vision Care Eyeglass Patient (Medicaid Client) Certification Form.

Refer to: Vision Care Eyeglass Patient (Medicaid Client) Certification Form in this handbook.

Note: *Providers who advertise "two-for-one" eyeglass special promotions without restrictions must not refuse the offer to clients with Medicaid coverage.*

3.3.8.2 Replacement and Repair of Prosthetic Eyewear

One pair of permanent contact lenses or eyeglasses, or both, may be reimbursed per lifetime, unless a replacement is required due to a significant change in visual acuity, loss, theft, or damage that is beyond repair. The provider must maintain in the client's record documentation that supports the need for replacement eyewear.

Replacement of lost or destroyed prosthetic eyewear is a benefit for clients regardless of age and does not require prior authorization when billed with a diagnosis of aphakia (diagnosis code 37931 or 74335).

Procedure code V2799 may be reimbursed with prior authorization for major eyeglass repairs. This procedure code may be manually priced.

3.3.8.3 Prosthetic Eyeglass Frames and Lenses

The following procedure codes may be reimbursed for prosthetic lenses when billed with a diagnosis of aphakia (diagnosis code 37931 or 74335):

Prosthetic Eyeglass Lens Procedure Codes									
V2410	V2430	V2102	V2105	V2106	V2109	V2110	V2111	V2112	V2113
V2114	V2202	V2205	V2206	V2209	V2210	V2211	V2212	V2213	V2214
V2302	V2305	V2306	V2309	V2310	V2311	V2312	V2313	V2314	V2700
V2710	V2715	V2718	V2730	V2755	V2770	V2780			

Frame Procedure Codes	
V2020	V2025

For bilateral lenses, a quantity of 2 unilateral lens procedure codes may be reimbursed.

When temporary eyeglasses are necessary for a client after cataract surgery, the most appropriate lens and frame procedure codes may be reimbursed when billed with diagnosis code V431 (lens organ or tissue replacement). The procedure code for the frames may be reimbursed in addition to the lens procedure code(s) when medically necessary.

Temporary eyeglasses for these clients may be reimbursed up to four months after surgery until the client is ready for their permanent lenses. The date of surgery is required to determine the convalescence period for temporary prosthetic eyewear. There are no limitations on the number of necessary temporary prosthetic lenses during the postsurgical convalescence period. Temporary lenses are not payable if dispensed after the four-month convalescence period.

Ultraviolet protection (procedure code V2755) may be reimbursed only for clients with a diagnosis of aphakia (diagnosis code 37931 or 74335).

The frames must be made in America unless foreign-made frames are comparable in quality and are less expensive. The frames must also be serviceable and able to meet statutory quality standards.

3.3.8.4 Prosthetic Contact Lenses

Prosthetic contact lenses require prior authorization unless the medical necessity meets one of the following exceptions:

- The client has a diagnosis of aphakia (diagnosis code 37931 or 74335).
- The lenses are used as corneal bandages in an emergency. The emergency condition must be documented on the claim.
- The contact lenses are required as a postsurgical or congenital prosthetic.

Refer to: Subsection 3.3.9.2.3, "Non-Prosthetic Contact Lenses" in this handbook for prior authorization requirements for contact lenses.

The following procedure codes may be reimbursed for prosthetic contact lenses:

Permanent Contact Lens Procedure Codes									
V2500	V2501	V2502	V2510	V2511	V2512	V2513	V2520	V2521	V2522
V2523	V2530	V2531	V2599						

Providers may refer to the online fee lookup (OFL) or the applicable Texas Medicaid fee schedules on the TMHP website at www.tmhp.com for contact lens procedure codes.

3.3.8.4.1 Temporary Contact Lenses

When temporary contact lenses are necessary for a client after cataract surgery, the most appropriate lens procedure code may be reimbursed with prior authorization when billed with diagnosis code V431 (lens organ or tissue replacement).

Temporary contact lenses may be considered for reimbursement up to four months after surgery until the client is ready for their permanent lenses. The date of surgery is required to determine the convalescence period for temporary prosthetic eyewear. There are no limitations on the number of necessary temporary prosthetic lenses during the postsurgical convalescence period. Temporary lenses are not payable if dispensed after the four-month convalescence period.

3.3.8.4.2 Permanent Contacts Lenses

Permanent contact lenses must be prior authorized.

3.3.8.4.3 Medicare Coverage

Postsurgical prosthetic cataract lenses are also a benefit of Medicare. If the client is eligible for Medicare coverage, the provider must bill Medicare first. Medicaid pays any deductible or coinsurance due. The provider must not require the client to pay the deductible or coinsurance.

3.3.8.5 Corneal Bandage

A corneal bandage (procedure code 92070) may be reimbursed with prior authorization when needed for eye protection due to a disease process to prevent blindness.

Prior authorization is not required if placement is an emergency. The emergency condition must be documented on the claim.

Refer to: Subsection 3.3.9.2.3, "Non-Prosthetic Contact Lenses" in this handbook for prior authorization requirements.

3.3.8.6 Intraocular Lens (IOL) and Additional Eyewear

Intraocular lenses are benefits of Texas Medicaid. If conventional eyewear is medically necessary in addition to the IOL, the IOL is considered the prosthetic device, and the eyewear and any replacements are considered non-prosthetic.

Refer to: Subsection 6.3.41.4, "Intraocular Lens (IOL)" *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Volume 2, Provider Handbooks*) for more information about IOL benefits.

Subsection 3.3.9, "Vision Services for Non-Prosthetic Eyewear" in this handbook for more information about non-prosthetic eyewear.

3.3.8.7 Medicare Coverage for Prosthetic Eyewear

Postsurgical prosthetic cataract lenses are also a benefit of Medicare. If the client is eligible for Medicare coverage, the provider must bill Medicare first. Medicaid pays any deductible or coinsurance due. The provider must not require the client to pay the deductible or coinsurance.

3.3.9 Vision Services for Non-Prosthetic Eyewear

Definition: Non-prosthetic eyewear is medically necessary to correct defects in vision. Providers may refer to TAC §354.1015 for more information.

Limitation for Eye Examination: Clients are eligible for one examination with refraction for the purpose of obtaining non-prosthetic eyewear during each state fiscal year (i.e., September 1 to August 31 according to the vision care annual periodicity schedule) with the following exceptions:

- Clients who are birth through 20 years of age may be eligible for additional exams as outlined in the Eye Examinations section below.
- Eye examinations for aphakia (including congenital aphakia) and disease or injury to the eye may be reimbursed as medically necessary.

Limitation for Eyewear: One pair of eyewear may be reimbursed every 24 months unless the recipient experiences a visual acuity change of 0.5 diopters or more. A new 24-month benefit period for eyewear begins with the replacement of non-prosthetic eyewear due to a change in visual acuity of 0.5 diopters or more.

One pair of conventional eyewear (contact lenses or glasses) may be reimbursed every 24 months for clients who have had cataract surgery with insertion of an intraocular lens (IOL).

The Texas Medicaid vision services benefit includes serviceable non-prosthetic eyeglasses, contact lenses that are medically necessary and prior authorized, necessary major repairs to eyeglasses for clients who are birth through 20 years of age, and replacement of lost or destroyed eyeglasses and contact lenses for clients who are birth through 20 years of age.

Note: *Providers who advertise "two-for-one" eyeglass special promotions without restrictions must not refuse the offer to clients with Medicaid coverage.*

3.3.9.1 Eye Examinations for the Purpose of Prescribing Eyewear

One eye examination with refraction for the purpose of obtaining eyewear (procedure codes 92004, 92014, S0620, and S0621) may be reimbursed each state fiscal year (September 1 to August 31) when billed with an appropriate diagnosis code. More than one eye examination may be reimbursed per year for clients who are birth through 20 years of age in the following situations:

- A school nurse, teacher, or parent requests another medically necessary eye examination.
- An additional eye exam is medically necessary.

The medical necessity of the additional eye exam must be included on the claim.

For clients who are 21 years of age or older, a new patient eye examination may be reimbursed once every 24 months per client per provider. A new patient eye examination in any place of service will be denied if the same provider has furnished a medical service, a surgical service, or a consultation within the previous two years.

Refer to: Subsection 3.3.2, "THSteps Medical Checkup Vision Screening" in this handbook for more information about the vision screening for THSteps clients.

Subsection 3.3.5, "Optometric Services" and Subsection 3.3.4, "Ophthalmological Services" in this handbook for more information about eye exams, including a list of appropriate diagnosis codes.

3.3.9.2 Non-Prosthetic Eyewear: Frames, Lenses, and Contact Lenses

Clients of any age are eligible for new eyewear every 24 months or whenever there is a diopter (d) change of 0.5d or more in the sphere, cylinder, or prism measurement(s). The old and new prescription must be included on the claim.

Providers may not withhold from a client a prescription for eyeglasses if the eye examination is pending Texas Medicaid payment. Prescriptions for eyeglasses must be given to the client on request.

Note: *A client who experiences difficulty with daily living activities or employment related to vision may be referred to the Texas Commission for the Blind (TCB). TCB can evaluate the client and may provide resources for assistance, as appropriate.*

Eyewear must meet the following criteria:

- Be medically necessary.
- Be prescribed by a doctor of medicine, optometry, or osteopathy.
- Be prescribed to significantly improve vision or correct a medical condition.
- Comply with eyewear program specifications for frames and lenses as included in the sections that follow.

3.3.9.2.1 Non-Prosthetic Eyeglass Frames

Frames composed of new materials and all zylonite components may be reimbursed by Texas Medicaid.

If the client chooses frames composed of a combination of zylonite and metal components, the frames may be reimbursed to the maximum allowable amount for a zylonite frame. The client may be billed for the difference between the reimbursed amount and the actual cost, as the metal portion is not a benefit of Texas Medicaid.

Refer to: Subsection 3.3.3, "Noncovered Services and Supplies" in this handbook for more information.

The frames must be made in America unless foreign-made frames are comparable in quality and are less expensive. The frames must also be serviceable and able to meet statutory quality standards.

The following procedure codes may be reimbursed for eyeglass frames in combination with the most appropriate lens procedure codes:

Frame Procedure Codes	
V2020	Single vision eyeglasses, procedure code V2020, should be billed with the lens codes in the table in "Eyeglass Lenses" following this section.
V2025	Single vision eyeglasses, with deluxe frames, procedure code V2025, should be billed with the lens codes in the table in "Lenses" following this section. Procedure code V2025 must be used for nonprosthetic eyewear that is beyond program benefits.

3.3.9.2.2 Non-Prosthetic Eyeglass Lenses

Eyeglass lenses must be clear glass or plastic, and must be composed of new materials. The lenses must be heat or chemically treated dress eyewear able to meet standards of the American Standard Prescription Requirements for first quality glass and plastic lenses.

Note: *Plastic lenses may include, but are not limited to, high-index plastic such as polycarbonate lenses. Reimbursement for the high-index plastic is included in the reimbursement for the lens and is not reimbursed separately.*

Single vision lenses may be reimbursed using the following procedure codes:

Single Vision Lens Procedure Codes						
V2100	V2101	V2103	V2104	V2107	V2108	V2121

Bifocal lenses must be a minimum kryptoc or 22 mm flat top lens or equivalent. Bifocal lenses may be reimbursed using the following procedure codes:

Bifocal Lens Procedure Codes						
V2200	V2201	V2203	V2204	V2207	V2208	V2221

Trifocal lenses must be a minimum flat top 7/25 lens or equivalent. Trifocal lenses may be reimbursed using the following procedure codes:

Trifocal Lens Procedure Codes						
V2300	V2301	V2303	V2304	V2307	V2308	V2321

High-powered lenses are benefits of Texas Medicaid. Prior authorization is not required. High-powered lenses are defined by Texas Medicaid as those with a sphere greater than 7.00d or a cylinder greater than 4.00d and may be reimbursed using the following procedure codes:

High-Powered Lens Procedure Codes									
V2102	V2105	V2106	V2109	V2110	V2111	V2112	V2113	V2114	V2202
V2205	V2206	V2209	V2210	V2211	V2212	V2213	V2214	V2302	V2305
V2306	V2309	V2310	V2311	V2312	V2313	V2314			

Note: *For clients who are birth through 20 years of age, high-powered lenses are benefits through CCP.*

Variable Asphericity Lenses may be reimbursed using the following procedure codes:

Procedure Codes	
V2410	V2430

The following miscellaneous lens procedure codes may also be used:

Miscellaneous Lens Procedure Codes						
V2700	V2710	V2715	V2718	V2730	V2755	V2770
V2780						

The invoice is required and must be maintained in the provider's files. When billing on paper for these services, the invoice must be submitted with the claim and providers are to include a copy of the prescription and manufacturer's suggested retail price. Providers are to use the invoice cost as the billed

amount and list the prescription on the claim form, indicating the power is greater than plus or minus 7 diopters or the cylinder is greater than plus or minus 4 diopters. The billed amount should not exceed the invoice amount.

A pair of eyeglasses may be reimbursed using the most appropriate frame procedure code (quantity of 1) and the most appropriate lens procedure code (quantity of 2).

For clients who are birth through 20 years of age, modifier RB must be used for replacement lenses.

3.3.9.2.3 Non-Prosthetic Contact Lenses

Contact lenses may be reimbursed when no other option is available to correct a visual defect. Contact lenses prescribed as non-prosthetic eyewear require prior authorization that must be obtained before the lenses are dispensed. The following contact lens procedure codes may be reimbursed with prior authorization:

Permanent Contact Lens Procedure Codes									
V2500	V2501	V2502	V2510	V2511	V2512	V2513	V2520	V2521	V2522
V2523	V2530	V2531	V2599						

Aspheric contact lenses may be reimbursed using the appropriate contact lens procedure code and procedure code V2410.

The prior authorization request for contact lenses must be submitted with the following documentation:

- The client's name and Medicaid number, as they appear on the Texas Medicaid card.
- The diagnosis that caused the refractive error (such as keratoconus).
- The current prescription and the previous prescription if the request is because of a significant change in vision (equal to or greater than 0.5d).
- The eye(s) to be treated (right, left, or bilateral).
- The procedure code requested.
- A brief statement addressing the medical need for vision correction by contact lenses. Specify why eyeglasses are inappropriate or contraindicated for this client.
- The provider identifier.
- The signature of the physician or optometrist requesting prior authorization.

Requests lacking this information will be denied. Mail or fax the request to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727
Fax: 1-512-514-4213

Exception: *Contact lenses for a diagnosis of aphakia do not require prior authorization.*

Providers can refer to the online fee lookup (OFL) or the applicable Texas Medicaid fee schedules on the TMHP website at www.tmhp.com for contact lens procedure codes.

3.3.9.3 Replacement of Non-Prosthetic Eyewear

The replacement of lost or destroyed non-prosthetic eyewear may not be reimbursed for clients who are 21 years of age or older. New eyewear may be reimbursed once every 24 months.

The replacement of lost or destroyed non-prosthetic eyewear may be reimbursed with prior authorization for clients who are birth through 20 years of age. There are no limitations on the number of replacements that may be reimbursed for clients who are birth through 20 years of age. If the eyewear is lost or destroyed, the provider must request prior authorization with documentation of medical necessity that includes the following:

- The most appropriate procedure code for the replacement.
- Modifier RB to signify replacement lenses.
- The Vision Care Eyeglass Patient (Medicaid Client) Certification Form signed by the client or the client's parent or guardian.

The eyewear may be reimbursed even if the client's Medicaid Identification Form (Form H3087) does not have a check mark in the services already rendered.

3.3.9.4 Undeliverable Eyewear

For custom-made items only: If a client cancels an order for eyeglasses prior to their completion and delivery, or if the eyeglasses become unusable prior to completion and delivery because the client dies or the prescription changes, the provider may be reimbursed for the services furnished and materials used up to the time of the cancellation or the time provider learned that the eyeglasses had become usable. The provider may be reimbursed for lenses only, not for the frames.

3.3.9.5 Medicare Coverage for Non-Prosthetic Eyewear

Eye examinations for the purpose of prescribing, fitting, or changing eyeglasses/contact lenses because of refractive errors are not a benefit of Medicare. These services must be filed directly to Texas Medicaid when performed for a Medicare/Medicaid client. Medicare coverage is limited to eye examinations for treatment of eye disease or injury and for a diagnosis of aphakia. When performing an eye examination with refraction for a Medicare/Medicaid client diagnosed with aphakia or disease or injury to the eye, the following procedures must be followed:

- Procedure code 92015 must be used to bill Texas Medicaid for the refractive portion of the examination and is payable with a diagnosis of aphakia or ocular disease only.
- The medical portion of the eye examination (procedure code 92002, 92004, 92012, or 92014) is covered by Medicare and must be billed to Medicare first. Medicare forwards this portion of the examination automatically to TMHP for payment of coinsurance or deductible.

Important: Providers performing eye exams for refractive errors on STAR+PLUS clients (Medicaid Qualified Medicare Beneficiary [MQMB]) must bill TMHP, not the STAR+PLUS health plan. Do not send the refraction (procedure code 92015) to Medicare first. Texas Medicaid will not waive the 95-day filing deadline if the claim is billed to Medicare in error, nor will Medicare transfer the refraction to Texas Medicaid for payment.

Medicare allows payment of one pair of conventional eyewear (contact lens or glasses) for clients who have had cataract surgery with insertion of an intraocular lens (IOL). Medicare considers the IOL the prosthetic device. Texas Medicaid providers must bill Medicare for the conventional (nonprosthetic) eyewear provided following an IOL insertion and bill Texas Medicaid for any replacements of the conventional (nonprosthetic) eyewear using the procedure codes in Subsection 3.3.9, "Vision Services for Non-Prosthetic Eyewear" in this handbook.

3.4 Documentation Requirements

All services require documentation to support the medical necessity of the service rendered, including vision services. Vision services are subject to retrospective review and recoupment if documentation does not support the service billed.

The client must sign and date the Vision Care Eyeglass Patient (Medicaid Client) Certification Form, and the provider must retain it in the provider's records.

The current and previous prescriptions must be documented in the client's medical record.

3.5 Claims Filing and Reimbursement

3.5.1 Claims Filing

Vision care service claims must be submitted to TMHP in an approved electronic format or on a CMS-1500 paper claim form. Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms. When completing a CMS-1500 claim form, all required information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

When submitting the client's old and new prescriptions to show a diopter change of .5 or more, enter the new prescription in Block 24D, line 5, and the old prescription in Block 24D, line 6 of the CMS-1500 claim form.

Claims for eye examination services require a diagnosis. If eyeglasses are not prescribed, diagnosis code V720 may be used. Diagnosis code V720 must not be used on claims for eyewear. If the diagnosis is not known by the supplier of the eyewear, diagnosis code 3689 is acceptable. Claims for eye examinations that lack a diagnosis are listed as an incomplete claim on the Remittance and Status (R&S) report and must be resubmitted for payment consideration. Electronic claims that lack a diagnosis will be rejected. A letter with the reason for rejection and instructions for resubmission will be mailed the following business day.

When the eye exam limitation is exceeded for clients 20 years of age or younger, identify one of the following situations in Block 19 of the CMS-1500 paper claim form:

- A school nurse, teacher, or parent requests the eye examination.
- The eye examination is medically necessary.

3.5.2 Reimbursement

Professional services by an optometrist for contact lenses and prosthetic eyewear are reimbursed in accordance with 1 TAC, §§355.8001, 355.8081, and 355.8085.

Federally qualified health centers (FQHCs) are paid an all-inclusive rate per visit for payable services in accordance with 1 TAC, §355.8261.

Suppliers of non-prosthetic lenses and frames are reimbursed the lesser of their billed amount or of the established maximum allowable fee in accordance with 1 TAC, §355.8001. See the online fee lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com.

Refer to: Subsection 2.2, "Reimbursement Methodology" in Section 2, *Texas Medicaid Reimbursement* (*Vol. 1, General Information*) for more information about reimbursement.

Form VH.6, "Vision" in Section 6 of this handbook for a claim form example.

4. CLAIMS RESOURCES

Refer to the following sections and forms when filing claims:

Resource	Location
Acronym Dictionary	Appendix F (*Vol. 1, General Information*)
Automated Inquiry System (AIS)	TMHP Telephone and Address Guide (*Vol. 1, General Information*)

Resource	Location
CMS-1500 Claim Filing Instructions	Subsection 5.5 (*Vol. 1, General Information*)
Hearing Aid Assessments Claim Form Example	Form VH.5, Section 7 of this handbook
Hearing Evaluation, Fitting, and Dispensing Report (Form 3503)	Form VH.1, Section 6 of this handbook
Physician's Examination Report	Form VH.2, Section 6 of this handbook
State and Federal Offices Communication Guide	Appendix A (*Vol. 1, General Information*)
TMHP Electronic Data Interchange (EDI)	Section 3 (*Vol. 1, General Information*)
TMHP Electronic Claims Submission	Subsection 5.2 (*Vol. 1, General Information*)
Vision Care Eyeglass Patient (Medicaid Client) Certification Form	Form VH.3, Section 6 of this handbook
Vision Care Eyeglass Patient (Medicaid Client) Certification Form (Spanish)	Form VH.4, Section 6 of this handbook
Vision Claim Form Example	Form VH.6, Section 7 of this handbook

5. CONTACT TMHP

The TMHP Contact Center at 1-800-925-9126 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time.

6. FORMS

VH.1 Hearing Evaluation, Fitting, and Dispensing Report (Form 3503)

Name (Last, First, Middle Initial)		Client No.	Age	Birth Date
Address (Street, City, State, ZIP Code)				
Date of Examination	Place of Examination		Puretone Audiometry: ANSI 2004 ❑ Yes ❑ No	
Date of Audiometer Calibration	Ambient Noise** _____dBa_____dBc	**Ambient noise level measurements MUST be made at the time of EACH evaluation not conducted in a commercial sound treated test booth. Testing must follow the ambient noise guidelines as stated in the provider's licensure rules.		

Indicate with an asterisk (*) by Recorded Threshold when masking is used

PURETONE TEST RESULT IN DECIBELS
(Completed by physicians and audiologist only)

	500 Hz	1000 Hz	2000 Hz	4000 Hz
LE				
RE				
Masking Level LE				
Masking Level RE				

BONE CONDUCTION

	500 Hz	1000 Hz	2000 Hz	4000 Hz
LE				
RE				
Masking Level LE				
Masking Level RE				

SPEECH AUDIOMETRY

	SRT	PB Quiet	PB Level	Thres. Disc.
LE				
RE				
Masking Level LE				
Masking Level RE				

FITTING AND DISPENSING RESULTS

Results are _____Real ear measurement in Sound Pressure Level (SPL)
_____Soundfield Function gain in decibels (dB)
Acquisition Cost: Left aid:_____ Right aid:_____

Fill in results below for ear(s) fitted:

Manufacturer:			Model		
	500 Hz	1000 Hz	2000 Hz	3000 Hz	4000 Hz
Left ear aided					
Right ear aided					

Comments:

Is report of Physician's Examination attached? ❑ Yes ❑ No

FITTER AND DISPENSER: The fitter and dispenser must sign below.

_____
Name of Fitter and Dispenser (please type or print)

_____
Signature – Fitter and Dispenser Date

This is to certify that the foregoing information is true, accurate, and complete. I understand that payment and satisfaction of this claim will be from federal and state funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State Laws.

I, _____ do hereby certify that I am _____ and that
(Signature of Physician or Audiologist) (Title of Person Certifying)

I am duly authorized to make this certification for and on behalf of _____
(Name of Payee Company Claimant)

I further certify that the attached invoice is correct and that it corresponds in every particular with the supplies and/or services contracted for. I further certify that the account is true, correct and unpaid.

_____
(Signature of Physician or Audiologist) Date

_____

Effective date December 2, 2008 Revision date December 2, 2008

VH.2 Physician's Examination Report

Client Name (Last, First, M)	Client No.	Date of Birth
Address (Street, City, State, ZIP Code)		

1. Date Of Examination*

2. Ear Examination:

a. Within Normal Limits ❑ Yes ❑ No

b. Cerumen Removed ❑ Yes ❑ No

c. Describe Ear Abnormalities:

_____

_____

3. Is more otolaryngological examination/treatment required to provide medical clearance for the fitting of a hearing aid? ❑ Yes ❑ No

If yes, refer this patient for consultation and completion of this form.

4. Are there any medical contradictions to hearing aid usage in either ear? ❑ Yes ❑ No

If yes, a hearing aid is medically prohibited in ❑ Right Ear ❑ Left Ear

5. Is the above-named individual a candidate for a hearing aid evaluation? ❑ Yes ❑ No

Signature* - Physician	Physician's Name (please type or print)	Medical Specialty
Address		Telephone No.

***NOTE PLEASE FURNISH THE PATIENT WITH THE SIGNED AND DATED ORIGINAL AND ONE COPY OF THIS FORM**

To be reimbursed for the examination, you must submit this completed form along with a claim for physician's services to the following address:

Texas Medicaid & Healthcare Partnership
12357-B Riata Trace Parkway
Suite 150
Austin, TX 78727

VH.3 Vision Care Eyeglass Patient (Medicaid Client) Certification Form

I, _____ , certify that:

Printed name of Medicaid client

(Check all that apply:)

☐ I was offered a selection of serviceable glasses at no cost to me, but I desired a type or style of eyewear beyond Medicaid program benefits. *I will be responsible for any balance for eyewear beyond Medicaid program benefits.*

My selection(s) beyond Medicaid benefits were:

1. _____
2. _____
3. _____
4. _____

☐ The glasses that are being replaced were unintentionally lost or destroyed.

☐ I picked up/received the eyewear.

_____ _____

Medicaid client signature Witness signature

_____ _____

Date Date

_____

Client Medicaid number

_____

Provider TPI

_____

Provider NPI

Effective Date_01152008/Revised Date_08072007

VH.4 Vision Care Eyeglass Patient (Medicaid Client) Certification Form (Spanish)

Yo, _____ , declaro que:
Nombre del cliente de Medicaid

(Marque todos los que apliquen)

☐ Yo necesito reemplazar los lentes que tengo. Me ofrecieron una selección de lentes gratis, pero deseo otro tipo que no está incluido en el programa de Medicaid. *Yo entiendo que tendré que pagar por la diferencia.*

La selección(es) de lentes que escogí fue:

1. _____
2. _____
3. _____
4. _____

☐ Los lentes que van a ser reemplazados no fueron perdidos o destruidos intencionadamente.

☐ Yo recibí los lentes.

_____ _____
Firma del Cliente Firma de Testigos

_____ _____
Fecha Fecha

_____
Número de identificación de Medicaid del Cliente

_____
Número de identificación del proveedor (TPI)

_____
Número de identificación del proveedor (NPI)

Effective Date_01152008/Revised Date_08082007

7. CLAIM FORM EXAMPLES

VH.5 Hearing Aid Assessments

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) CHAMPUS [ ] (Sponsor s SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 123456789

2. PATIENT S NAME (Last Name, First Name, Middle Initial): Jackson, Robert K.

3. PATIENT S BIRTH DATE MM DD YY: 10 26 1999 SEX M [X] F [ ]

4. INSURED S NAME (Last Name, First Name, Middle Initial):

5. PATIENT S ADDRESS (No., Street): 460 Jennings Lane

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED S ADDRESS (No., Street):

CITY: Palestine | STATE: TX

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY | STATE

ZIP CODE: 75801 | TELEPHONE (Include Area Code): (409) 555-1234

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT S CONDITION RELATED TO:

11. INSURED S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER S NAME OR SCHOOL NAME:

c. EMPLOYER S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT S OR AUTHORIZED PERSON S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED **Signature on File** DATE

13. INSURED S OR AUTHORIZED PERSON S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Charles Sotos, M.D.

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 9876543-21

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [X] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 389.9
2. ____.__
3. ____.__
4. ____.__

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 01 01 2010	01 01 2010	1	R	V5010		1	62.12	1				
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT S ACCOUNT NO.: 123456

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE $ 62.12

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Tom White

SIGNED 01 10 2010 DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN S, SUPPLIER S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

The Hearing Aid Store/Service Ctr.
432 New Pines
Palestine, TX 75801

PIN# GRP# 9876543-21

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)

VH.6 Vision

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) TRICARE CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED S I.D. NUMBER (For Program in Item 1): 512345678

2. PATIENT S NAME (Last Name, First Name, Middle Initial): Doe, Jane

3. PATIENT S BIRTH DATE MM DD YY: 01 01 2001 SEX M [ ] F [X]

4. INSURED S NAME (Last Name, First Name, Middle Initial):

5. PATIENT S ADDRESS (No., Street): 1234 N. Main Street

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED S ADDRESS (No., Street):

CITY: Anytown STATE: TX

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]

CITY: STATE:

ZIP CODE: 77123 TELEPHONE (Include Area Code): (123) 555-1234

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: TELEPHONE (Include Area Code): ( )

9. OTHER INSURED S NAME (Last Name, First Name, Middle Initial): Doe, John

10. IS PATIENT S CONDITION RELATED TO:

11. INSURED S POLICY GROUP OR FECA NUMBER: 412345678A

a. OTHER INSURED S POLICY OR GROUP NUMBER: 123456789

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. OTHER INSURED S DATE OF BIRTH MM DD YY: 05 01 1966 SEX M [X] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER S NAME OR SCHOOL NAME:

c. EMPLOYER S NAME OR SCHOOL NAME: ABCD, Inc. Prudential

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT S OR AUTHORIZED PERSON S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: Signature on File DATE:

13. INSURED S OR AUTHORIZED PERSON S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: Signature on File

14. DATE OF CURRENT: MM DD YY: 05 01 2010 ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY:

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: Dr. Dan Smith

17a.

17b. NPI: 8819004002

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 367.1

2. 367.9

3.

4.

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 05 01 2010	05 01 2010	1		V2020		1, 2	175.00			NPI	
2 05 01 2010	05 01 2010	1		V2100		1,2	10.00			NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT S ACCOUNT NO.: 123456

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 175.00

29. AMOUNT PAID: $ 20.00

30. BALANCE DUE: $ 155.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Dr. Dan Smith, MD 05 01 2010

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

Eyecare Clinic
124 S. First Street
Anytown, TX 77123

a. NPI b.

33. BILLING PROVIDER INFO & PH # (111)222-3333

Dr. Dan Smith, M.D.
1234 S. First Street
Anytown, TX 77123

a. 1234567089 b. 1234567-01

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

TMHP
TEXAS MEDICAID & HEALTHCARE PARTNERSHIP
12357 - B RIATA TRACE PARKWAY STE 150
AUSTIN, TX 78727
A STATE MEDICAID CONTRACTOR