Texas Medicaid

Provider Procedures Manual

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Provider Handbooks

Vision and Hearing Services Handbook

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

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1 General Information

The information in this handbook is intended for optometrists (doctors of optometry), ophthalmologists, and opticians who render services related to the eye and vision and for hearing aid professionals (fitters and dispensers, physicians, and audiologists) 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 subsection 4.1, "Enrollment" in this handbook. 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) §371.1659. 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*).

This handbook contains information about Texas Medicaid fee-for-service benefits. For information about managed care benefits, refer to the *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*).

Managed care carve-out services are administered as fee-for-service benefits. A list of all carve-out services is available in section 8, "Carve-Out Services" in the *Medicaid Managed Care Handbook* (*Vol. 2, Provider Handbooks*).

1.1 Payment Window Reimbursement Guidelines for Services Preceding an Inpatient Admission

According to the three-day and one-day payment window reimbursement guidelines, most professional and outpatient diagnostic and nondiagnostic services that are rendered within the designated timeframe of an inpatient hospital stay and are related to the inpatient hospital admission will not be reimbursed separately from the inpatient hospital stay if the services are rendered by the hospital or an entity that is wholly owned or operated by the hospital.

These reimbursement guidelines do not apply in the following circumstances:

- The professional services are rendered in the inpatient hospital setting.
- The hospital and the physician office or other entity are both owned by a third party, such as a health system.
- The hospital is not the sole or 100-percent owner of the entity.

Refer to: Subsection 3.7.4.17, "Payment Window Reimbursement Guidelines" in the *Inpatient and Outpatient Hospital Services Handbook* (*Vol. 2, Provider Handbooks*) for additional information about the payment window reimbursement guidelines.

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2 Nonimplantable Hearing Aid Devices and Related Services

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.

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 School Health and Related Services [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 post-fitting follow-up visits, 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.

2.2 Services, Benefits, Limitations, and Prior Authorization

The Texas Medicaid hearing services benefit includes those services that are medically necessary for clients of any age who have suspected or identified hearing loss that can be improved or ameliorated using a hearing aid device. Such services may be reimbursed to audiologists or hearing aid fitters and dispensers.

> ***Note:*** *Hearing-related services that are medically necessary because of a medical condition that cannot be improved or ameliorated using a nonimplantable hearing aid device are not considered part of the Texas Medicaid hearing services benefit. Providers may refer to the other Texas Medicaid Provider Procedures Manual Handbooks for benefit and limitation information about other hearing-related services.*

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 unless specifically addressed in the sections below.

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 post-fitting follow-up visits.
- Physicians may be reimbursed for physician otology and otorhinolaryngology (ENT) services.

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 Workforce Commission (TWC) for hearing aids.

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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 the Texas Health and Human Services Commission (HHSC) or the Texas Medicaid & Healthcare Partnership (TMHP) for retrospective review.

2.2.2 Hearing Screenings

Hearing screening provided due to client concern, or at the provider's discretion, is a benefit for clients of any age when the client is referred by a Medicaid-enrolled physician, and the screening is provided by a Medicaid-enrolled provider licensed to perform these services.

Note: *A nurse practitioner, clinical nurse specialist, or a physician assistant under physician supervision and delegation may also refer the client for hearing screening.*

Routine newborn hearing screenings and Texas Health Steps (THSteps) medical checkup hearing screenings are benefits for Texas Medicaid clients, and are included in the reimbursement for the routine service or visit.

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 medical checkup are included in the Texas Medicaid hearing services benefit. These routine screenings are not reimbursed to audiologists, hearing aid fitters and dispensers, or physicians.

Newborn Hearing Screen

The newborn hearing screening is included in the reimbursement to the hospital for the newborn hospital stay and is not reimbursed separately. A newborn hearing screening must be offered to each newborn by the facility where the birth occurs, through a program mandated by the Texas State Legislature and certified by the Texas Department of State Health Services (DSHS). The screening is covered as part of the newborn delivery. An infant born outside a birthing facility and not admitted to a birthing facility shall be referred to a facility that provides newborn hearing screening. If a facility is not required by legislative mandate to perform newborn hearing screening, a referral must be made to a facility that offers the screening.

Refer to: Subsection 4.3.10, "Newborn Examination" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about the newborn hearing screening.

THSteps Medical Checkup Hearing Screen

Hearing screening is a required component of the THSteps medical checkup, and a standardized audiometric hearing screening is required at specific ages according to the periodicity schedule.

Refer to: The THSteps Medical Checkups Periodicity Schedule including the footnotes, which is available on the Texas HHS website, for coverage criteria when performed as part of a THSteps medical checkup.

Subsection 4.3.12.2.3, "Hearing Screening" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for more information on THSteps checkup hearing screening.

2.2.2.2 Additional Hearing Screenings

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.

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Further diagnostic testing may also be reimbursed using the appropriate procedure code as indicated in subsection 2.2.3, "Audiology and Audiometry Evaluation and Diagnostic Services" in this handbook.

2.2.2.3 Abnormal Hearing Screening Results

If the screening returns abnormal results, the client must be referred to a Texas Medicaid-enrolled provider who is a licensed audiologist or physician who provides audiology services. Clients who are 20 years of age or younger and have abnormal screening results must be referred to a Texas Medicaid-enrolled 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 and younger and have suspected hearing loss must be referred to Early Childhood Intervention (ECI) as soon as possible but no longer than 7 days after identification, even if the client was referred to an appropriate provider for further testing.

The client's responsible adult may refuse to permit the referral or decline ECI services at any time. The provider must document the client's responsible adult's decision in the client's medical record.

Refer to: Subsection 2.9, "Early Childhood Intervention (ECI) Services" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about ECI.

2.2.3 Audiology and Audiometry Evaluation and Diagnostic Services

Audiometry is a benefit of Texas Medicaid for clients of any age. 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.

Important: *The date of service for audiology and audiometry evaluations and diagnostic services is the date the service is rendered to the client. The date of service that is billed on the claim must match the date of service that is documented in the client's medical record.*

The following audiometry procedure codes are benefits of Texas Medicaid for a basic comprehensive audiometry survey:

Procedure Codes									
92550	92551	92552	92553	92555	92556	92557			

The following additional procedure codes may be benefits for audiometric testing:

Procedure Codes									
92558	92563	92565	92567	92568	92570	92571	92572	92575	92576
92578	92579	92582	92583	92584	92587	92588	92650	92651	92652
92653									

Refer to: The appropriate Texas Medicaid fee schedule on the TMHP web site at www.tmhp.com for procedure codes that may be reimbursed to individual types of providers.

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Automated auditory brainstem response (AABR) and otoacoustic emissions (OAE) are benefits for clients of any ages when performed to identify and diagnose hearing loss and for newborns when performed for the purpose of a newborn hearing screening.

Note: *AABR and OAE tests performed as part of the newborn hearing screen are reimbursed as part of the hospital visit and are not reimbursed separately.*

2.2.3.1 Otological Examinations

Otological examinations are a benefit when medically necessary and provided by a Medicaid-enrolled physician licensed to perform this service.

Procedure codes 92504 and 92505 are benefits for otological examinations.

An otological examination may also include physician evaluation and management (E/M) services provided to diagnose or treat medical conditions.

Refer to: Subsection 9.2.60.3, "Group Clinical Visits" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for information about medically necessary physician E/M services.

2.2.3.2 Vestibular Evaluations

Vestibular evaluations are a benefit when medically necessary and provided by a Medicaid-enrolled physician or nonphysician provider licensed to perform this service.

The following procedure codes for vestibular evaluations are benefits:

Procedure Codes									
92531	92532	92533	92534	92537	92538	92540	92541	92542	92544
92545	92546	92547							

2.2.3.3 Evaluative and Therapeutic Services

The following procedure codes may be reimbursed for evaluative and therapeutic services:

Procedure Codes									
92620	92621	92625							

Audiology providers may be reimbursed for services rendered in the office setting for procedure code 92621.

2.2.3.4 Intraoperative Neurophysiology Monitoring (IONM)

Audiology providers may be reimbursed for performing intraoperative neurophysiology monitoring (IONM) with the following procedure codes:

Procedure Codes									
95940	95941								

Refer to: Section 9.2.28.3, "Evoked Potential Testing" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for more information about intraoperative neurophysiology monitoring.

2.2.3.5 Forms and Documentation

Providers of hearing evaluations must have a report in the client's record. Providers must include in the report hearing evaluation test data. The Hearing Evaluation and Fitting and Dispensing Report (Form 3503) must be completed by the physician or audiologist who conducts the diagnostic testing. The provider who signs the report must maintain it in the client's file. The report includes audiometric

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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 service.

For physician diagnostic hearing services (procedure codes 92502, 92504, 92540, 95940, and 95941), 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.

2.2.3.6 Prior Authorization

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.

Prior authorization requests may be submitted to the TMHP Prior Authorization Department via mail, fax, or the electronic portal. Prescribing or ordering providers, dispensing providers, clients' responsible adults, and clients may sign prior authorization forms and supporting documentation using electronic or wet signatures.

Providers should use the Special Medical Prior Authorization (SMPA) Request Form for all prior authorization requests.

2.2.3.7 Limitations

Newborn hearing screenings provided during the birth admission are considered part of the newborn delivery payment to the facility and are not reimbursed as separate procedures.

An otological examination is a benefit of Texas Medicaid when medically necessary and provided by a Medicaid-enrolled physician licensed to perform this service.

An otological examination may also include physician E/M services provided to diagnose or treat medical conditions.

Refer to: Subsection 9.2.60.3, "Group Clinical Visits" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for information about medically necessary physician E/M services.

Audiometry survey procedure codes and evoked potential and otoacoustic emissions screening procedure codes may be reimbursed once per day.

Procedure codes 92551, 92552, and 92553 for pure tone audiometry are limited to one of any of these procedure codes per day, same provider, same client.

Procedure codes 92553 and 92556 are not reimbursed on the same day by the same provider for the same client. If both procedure codes are billed for the same date of service, same provider, and same client, they are denied with instructions to bill with the more appropriate, comprehensive audiometry procedure code 92557.

Procedure codes 92558, 92587, 92588, 92650, 92651, 92652, and 92653 may be reimbursed once per day, same provider, same client, assuming testing is done in both ears and must be billed with modifier 52 if the testing is only performed on one ear.

Procedure codes 92620, 92621, and 92625 may be reimbursed to the same provider four times each per rolling year. Providers must submit a prior authorization request for additional reimbursement of either procedure code.

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2.2.3.7.1 Tympanometry

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 three services per rolling year when billed by any provider and is based on medical necessity, which must be documented in the client's medical record.

2.2.3.7.2 Electrical Testing

Electrical testing may be reimbursed for services rendered to clients of any age.

Electrical testing (procedure code 92547) must be billed with the same date of service by the same provider as procedure codes 92540, 92541, 92542, 92544, 92545, or 92546.

2.2.3.7.3 Vestibular Evaluation

Vestibular evaluation is a benefit of Texas Medicaid when medically necessary and provided by a provider who is licensed to provide this service.

Hearing pathway tests such as audiometry, AABR, and electrocochleography (ECoG) can also be used for the same purpose and are frequently combined with vestibular tests.

2.2.3.7.4 AABR and OAE Hearing Screening Services

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

Texas Medicaid may reimburse physicians for ear and throat examination procedure codes 92502 and 92504. Physicians and non-physician providers licensed to perform this service may be reimbursed for procedure code 92540.

Refer to: Subsection 9.2.60, "Physician Evaluation and Management (E/M) Services" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for more information about these services.

Procedure codes 95940 and 95941 may be reimbursed in addition to each evoked potential test. Procedure codes 95940 and 95941 are limited to a maximum of 2 hours per day, per client, any provider, without documentation of medical necessity. Procedure codes 95940 and 95941 cannot be reported by the surgeon or anesthesiologist.

2.2.3.8 SHARS Audiology Services

Audiology services may be reimbursed to school districts and state agencies that are enrolled with Texas Medicaid as SHARS providers.

Refer to: Subsection 2.3.1, "Audiology Services" in the *School Health and Related Services (SHARS) 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.

2.2.3.9 Noncovered Services

Texas Medicaid does not reimburse for a hearing screening completed in a day care, Head Start location, or a school, unless it is performed in a school-based health clinic as follow-up to an acute care medical visit. Separate procedure codes must not be billed for these services.

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2.2.4 Hearing Aid Devices and Accessories (Nonimplantable)

Texas Medicaid may reimburse hearing aid fitters and dispensers for the following devices and accessories:

Service	Limitation
Hearing aid devices	**Limitation:** • For clients who are 20 years of age and younger, 1 hearing aid device per ear may be reimbursed every 5 rolling years from the month it is dispensed. • For clients who are 21 years of age and older, if the client has at least a 35 dB hearing loss in both ears, 1 hearing aid device may be reimbursed every 5 years from the month it is dispensed. Either the left or the right may be reimbursed, but not both in the same 5 year period. ***Refer to:*** Subsection 2.2.4.1, "Forms and Documentation" in this handbook for additional medical necessity criteria. Replacement hearing aid devices that are required within the same 5-year period must be prior authorized. Repairs or modifications may be reimbursed without prior authorization once per rolling year after the 1-year warranty period has lapsed if the requested repair or modification is a better alternative than a new purchase. **Procedure codes:** See below for monaural and binaural procedure codes. Procedure code V5014 may be reimbursed for repairs and modifications. **Date of service:** The date of service for the initial hearing aid device is the date the client successfully completes the 30-day trial period and accepts the hearing aid device. ***Note:*** *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 repairs or modifications that are rendered during the 12-month manufacturer's warranty period. Providers must follow the manufacturer's repair process as outlined in their warranty contract.*
Hearing aid accessories	**Limitation:** As often as is medically necessary for clients who are 20 years of age and younger with prior authorization. ***Note:*** *Hearing aid accessories include, but are not limited to, chin straps, clips, boots, and headbands.* **Procedure code:** V5267 **Date of service:** The date of service is the date the client successfully completes the 30-day trial period and accepts the hearing aid device or the date the client receives the replacement accessory item.
Ear impression	**Limitation:** 1 each per hearing aid device as follows: • For one impression, bill a quantity of 1. • For two impressions, bill a quantity of 2. **Procedure codes:** V5275 **Date of service:** The date of service for the ear impression is the date the ear impression is taken.

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Service	Limitation
Ear mold	**Limitation:** As medically necessary for clients who are 20 years of age and younger. For clients who are 21 years of age and older: • 3 ear molds per rolling year for custom ear molds • 4 ear molds per 30 days for disposable ear molds Ear molds must be billed using the appropriate LT or RT modifier. Replacement ear molds may be reimbursed as often as is medically necessary without prior authorization. Documentation of medical necessity must be maintained in the client's medical record. **Procedure codes:** V5264 and V5265 **Date of service:** The date of service for the ear mold is the date the ear mold is dispensed to the client.
Batteries (Replacement only)	**Limitation:** Replacement batteries may be reimbursed as often as is medically necessary when a hearing aid device has been previously reimbursed by Texas Medicaid. ***Note:*** *If a hearing aid has not been reimbursed by Texas Medicaid in the last 5 years, the replacement batteries may be reimbursed on appeal with a statement that documents medical necessity.* **Procedure code:** V5266 **Date of service:** The date of service is the date the client receives the replacement batteries.

The following monaural procedure codes may be reimbursed for medically necessary hearing aid devices and replacements that are rendered to clients of any age when they are billed with the appropriate modifier LT or RT to indicate for which ear the hearing aid device was purchased and fitted:

Procedure Codes									
V5030	V5040	V5244	V5245	V5246	V5247	V5254	V5255	V5256	V5257
V5298									

Procedure codes V5171, V5172, and V5181 may be reimbursed for monaural hearing aids that are rendered to clients who are 20 years of age and younger only.

The following binaural procedure codes may be reimbursed for medically necessary hearing aid devices and replacements that are rendered to clients who are 20 years of age and younger:

V5100	V5211	V5212	V5213	V5214	V5215	V5221	V5249	V5250	V5251
V5252	V5253	V5258	V5259	V5260	V5261				

Binaural hearing aid procedure codes must be submitted with a quantity of 1 per procedure code. Providers can refer to the Online Fee Lookup (OFL) or the applicable fee schedule on the TMHP website at www.tmhp.com for reimbursement rates.

Refer to: Subsection 2.4.2, "Reimbursement" in this handbook for more information about manual pricing.

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2.2.4.1 Forms and Documentation

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 dB or greater for the pure tone average of 500, 1000, 1500, and 2000 Hz, or a spondee threshold in the better ear of 35 dB or greater when pure tone thresholds cannot be established
- 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 who are 21 years of age and older must meet the medical necessity criteria outlined above and have at least a 35 dB hearing loss in both ears to qualify for the purchase of a monaural hearing aid device.

Clients who are 20 years of age and younger must meet the medical necessity criteria outlined above and have at least a 35 dB hearing loss in both ears to qualify for the purchase of binaural hearing aid devices.

Claims for non-implantable hearing aid devices must be submitted with a manufacturer invoice showing the net acquisition cost of the non-implantable hearing aid device.

An invoice printed from an email or the Internet will not be accepted and should not be submitted with the claim as documentation to show the net acquisition cost of the hearing aid device unless the invoice reflects the actual price the provider paid for the hearing aid device.

Note: *The requirement to submit the net acquisition cost of the hearing aid device applies only to non-implantable monaural and binaural hearing aid devices including, but not limited to, procedure code V5298.*

Refer to: Subsection 6.3.1.1, "Place of Service (POS) Coding" in "Section 6: Claims Filing" (*Vol. 1, General Information*) for more information about coding place of service for other locations.

2.2.4.2 Prior Authorization

Prior authorization is not required for medically necessary hearing aid devices and supplies that are provided within the limitations outlined in the table above.

Prior authorization is required for the following:

- *Replacement hearing aid devices that are required within the same 5-year period.* A replacement hearing aid device may be 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.
- Hearing aid repair in excess of one per rolling year. The prior authorization request must include documentation supporting the need for the requested repair.
- *Hearing aid accessories for clients who are birth through 20 years of age.* Requests for prior authorization for children's hearing aid accessories including, but not limited to, chin straps, clips, boots, and headbands 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.
- *Hearing aid devices that are not currently a benefit of Texas Medicaid but that are medically necessary for clients who are birth through 20 years of age (using procedure code V5298).*

  The prior authorization request must include:

  - The medical necessity for the requested hearing aid device.

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  - The name of the manufacturer.
  - The model number, serial number, and the dates that the warranty is in effect for the requested hearing aid.
- Additional medically necessary repairs or modifications beyond 1 per year.
  For additional repairs or modifications, requests for prior authorization must include documentation that supports the need for the requested repair.

For services that require prior authorization, prior authorization must be obtained before the services are rendered. The prior authorization number must be included on the claim form when the claim is submitted to TMHP.

Prior authorization requests must be submitted to the TMHP Special Medical Prior Authorization (SMPA) Department with documentation that supports medical necessity for the requested device, service, or supply. Authorization may be submitted on the TMHP website at www.tmhp.com or by fax to 1-512-514-4213.

Important: *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 SMPA Department will refer the request to the TMHP Comprehensive 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.*

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

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

2.2.4.3 Limitations

The following services and supplies must be provided to Texas Medicaid clients if a nonimplantable hearing aid device is medically necessary:

- An individual client assessment to identify the appropriate type of device
- The fitting/implantation 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

Hearing devices are a benefit for clients of any age. Some types of hearing devices are age restricted.

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.

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. The reimbursement for monaural and binaural procedure codes includes the required hearing aid package as follows, and no separate reimbursement will be made for these items:

- Acquisition cost of the hearing aid (the actual cost or net cost of the hearing aid after any discounts or rebates have been deducted)

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- Manufacturer's postage and handling charges, including shipping insurance
- All necessary hearing aid accessories or supplies
- Instructions for care and use
- A 1-month supply of batteries

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

Claims for procedure code 92628 will be denied when submitted by any provider on the same date of service if performed on the same ear as procedure code 92622, 92623, 92626, 92627, 92634, 92635, 92636, 92637, or V5010.

Procedure code 92629 is an add-on procedure and must be billed on the same claim as the primary procedure code 92628 for reimbursement.

Claims for procedure code 92631 will be denied when submitted by any provider on the same date of service if performed on the same ear as procedure codes 92622, 92623, 92626, 92627, 92636, and 92637.

Procedure code 92632 is an add-on procedure and must be billed on the same claim as the primary procedure code 92631 for reimbursement.

One hearing aid fitting service (either procedure code 92634 or V5011) per hearing aid is allowed within a rolling five-year period by any provider.

Claims for procedure code 92634 will be denied when submitted by any provider on the same date of service as procedure code 92636, 92637, or V5011.

Clients should have one follow-up fitting visit within five weeks following the hearing aid fitting visit and is included as part of the hearing aid fitting service (procedure code 92634).

Procedure code 92635 is an add-on procedure and must be billed on the same claim as the primary procedure code 92634 for reimbursement.

Claims for procedure code 92636 will be denied when submitted by any provider on the same date of service as procedure code 92628, 92629, 92631, 92632, 92634, or 92635.

Claims for procedure code 92636 are limited to a total of two visits per hearing aid, per calendar year, by any provider. Additional services for procedure code 92636 may be reimbursed with prior authorization.

Procedure code 92637 is an add-on procedure and must be billed on the same claim as the primary procedure code 92636 for reimbursement.

Procedure code 92638 is an add-on procedure and must be billed on the same claims that include the primary procedure code 92634 or 92636 for reimbursement.

Providers may perform hearing aid measurement services (procedure code 92639) and hearing device verification services (procedure code 92641) for clients who are:

- 20 years of age or younger for unilateral or bilateral services.
- 21 years of age or older for only unilateral services.

Providers must submit claims for procedure code 92639 and 92641 with modifier 52 if the service is performed on only one ear.

Procedure code 92639 is an add-on procedure and must be billed on the same claims that include primary procedure code 92634 or 92636 for reimbursement.

Procedure code V5298 may be reimbursed with prior authorization for hearing aid devices that are not currently a benefit of Texas Medicaid but that are medically necessary for clients who are birth through 20 years of age.

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Services for residents in a skilled nursing facility (SNF), intermediate care facility (ICF), or extended care facility (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.

2.2.5 Hearing Aid Services

The following additional hearing aid related procedures are benefits for services that are rendered to clients of any age:

Procedure Codes									
92628	92629	92631	92632	92634	92635	92636	92637	92638	92639
92641	V5010	V5011	V5264	V5265	V5266	V5275			

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

Service	Limitation
Fitting and dispensing visits	**Limitation:** 1 fitting per hearing aid procedure code per 5 rolling year period, regardless of the number of times a device is returned as unacceptable during a 30-day trial period **Procedure code:** 92634 or V5011 **Limitation:** 1 dispensing fee each time a hearing aid is dispensed and a new 30-day trial period begins **Procedure codes:** V5090 and V5241 (for clients of any age) and V5110, V5160, V5200, and V5240 (for clients who are 20 years of age and younger) The dispensing fee may be reimbursed separately from the fitting of the hearing aid. A fitting follow-up visit should occur within five weeks of the fitting and dispensing visit and is included in the reimbursement for the fitting and dispensing procedure and is not reimbursed separately.
Post-fitting follow-up services	**Limitation:** 2 per calendar year when billed by any provider **Procedure codes:** 92636 (monaural and binaural) first 30 minutes; 92637 (monaural and binaural) each additional 15 minutes Post-fitting follow-up services are limited to a total of two per calendar year by any provider. Additional hearing aid checks may be reimbursed with prior authorization.

2.2.5.1 Forms and Documentation

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

- Physician's Examination Report—The referring physician who performs the screening must complete the Physician's Examination Report, which is maintained in the client's medical record.

  Note: *An advanced practice registered nurse (APRN) or a physician assistant (PA) under physician supervision and delegation may also complete the Physician's Examination Report.*

- Hearing Evaluation and Fitting and Dispensing Report (Form 3503)—The Hearing Evaluation and 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 to support improved communication ability with amplification. Retrospective review may be performed to ensure documentation supports the medical necessity of the device, service, or supply.

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- 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.
- Prior to dispensing a hearing instrument, a provider must enter into a written contract with the client that meets the Texas Department of Licensing and Regulation (TDLR) rule requirements in 16 TAC §112.140. The signed contract should verify that:
  - The client has a 30-day trial period for the hearing aid.
  - If the client is not satisfied with the purchased hearing aid, the client may return it to the provider within the 30-day trial period. If the device is returned within the 30-day trial period, the provider may charge the client a rental fee not to exceed $2.00 per day. This fee is not a benefit of Texas Medicaid. The 30-day trial period and any charged rental fee must meet TDLR rule requirements in 16 TAC §112.140.
  - The contract must be executed prior to dispensing and must be maintained in the client's file.
  - The client must receive a copy of the executed contract.
  - All charges and fees associated with the trial period must be stated in the contract, which shall also include the name, address, and telephone number of TDLR.

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.

For hearing aids that are dispensed in a provider's office, if a client fails to return by the end date of the trial period, the provider must contact the client. After 3 attempts have been made, if the client does not return to the provider's office, the provider must document all attempts to contact the client and must maintain this documentation in the client's file. Retrospective review may be performed to ensure documentation supports the contact attempts and the client's failure to return to the provider's office. This requirement does not apply for services that are rendered to clients who receive hearing aids in other places of service (i.e., nursing homes).

2.2.5.2 Prior Authorization

Prior authorization is not required for fitting and dispensing visits and the first two post-fitting follow-up service visits.

2.2.5.3 Limitations

The following hearing aid visits may be reimbursed by Texas Medicaid:

- The fitting and dispensing visits that encompass a 30-day trial period and include a hearing aid fitting follow-up five weeks after the trial period has been successfully completed
- A first post-fitting follow-up visit as needed after the hearing aid fitting follow-up
- A second post-fitting follow-up as needed after the first post-fitting follow-up visit
- Additional hearing aid checks may be reimbursed within a period of six months after a second post-fitting follow-up visit. Providers must submit a prior authorization request and documentation of medical necessity for the additional hearing aid checks.

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The fitting visit includes the fitting, dispensing, and post-fitting check of the hearing aid. A trial period of up to 30 days is authorized by *Texas Occupations Code* §402.401. The 30-day trial period, and any charged rental fee, must meet the Texas Department of Licensing and Regulation (TDLR) rule requirements in 16 TAC §112.140.

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.

A fitting follow-up check should be performed within 5 weeks of the initial hearing aid fitting visit. This evaluation is considered part of the hearing aid fitting visit and is not reimbursed separately.

The first and second post-fitting follow-up visits are available if additional visits are required after the post-fitting check.

- *First post-fitting follow-up visit (procedure code 92636).* The first post-fitting follow-up visit must include a hearing aid check.
- *Second post-fitting follow-up visit (procedure code 92636).* The second post-fitting follow-up visit is available as needed after the fitting follow-up visit and the first post-fitting follow-up visit. The second post-fitting follow-up visit 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 pure tone and speech audiometry readings from the first evaluation.

Services for residents in an 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.

Home visit hearing evaluations and fittings are permitted only with documentation of client need in the physician's, advanced practice registered nurse (APRN) or a physician assistant (PA) written order.

Note: *APRN or a PA under physician supervision and delegation may also perform the evaluation.*

2.3 Documentation Requirements

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

Required forms for nonimplantable 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.

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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.

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

Subsection 1.7.12, "Billing Clients" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General 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 Paper 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.

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

Exception: *Claims for non-implantable hearing aid devices must be submitted on the CMS-1500 paper claim form because electronic claim submissions do not allow for the submission of attachments.*

Claims must include the following information:

- The most appropriate *International Classification of Diseases,* Tenth Revision, Clinical Modification (ICD-10-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.)

Note: *For Texas Medicaid managed care clients, all hearing aid benefits and otology, and audiometry services are administered by the client's Medicaid managed care organization (MCO).*

2.4.1.1 Non-implantable Hearing Aid Devices

To be reimbursed for a non-implantable hearing aid device, providers must submit documentation with the paper claim showing their cost for the hearing aid device. The Texas Health and Human Services Commission (HHSC) requires providers to submit non-implantable hearing aid claims using the CMS-1500 paper claim form because electronic claim submissions do not allow for the submission of attachments.

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Providers must use the net acquisition cost as the amount billed on the claim. The net acquisition cost is the actual price the provider paid for the device, including the wholesale cost plus sales tax, shipping and handling, and any reductions resulting from discounts or rebates. Providers must not use usual and customary fees as the amount billed.

The documentation submitted with the claim must be a manufacturer invoice showing the net acquisition cost of the non-implantable hearing aid device. An original invoice that includes the manufacturer name, model number, serial number, and warranty expiration date must be submitted. Invoice templates will not be accepted.

An invoice printed from an email or the Internet will not be accepted and should not be submitted with the claim as documentation to show the net acquisition cost of the hearing aid device unless the invoice reflects the actual price the provider paid for the hearing aid device.

2.4.1.2 Third Party Liability

Standard third party liability (TPL) rules apply to all hearing services claims.

Refer to: "Section 8: Third Party Liability (TPL)" (*Vol. 1, General Information*).

2.4.2 Reimbursement

Hearing aid devices and all hearing and audiological services are reimbursed in accordance with 1 TAC §355.8141. 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."

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 MSRP less 18 percent or based on the provider's documented invoice cost if there is no MSRP available.

Manually priced items are indicated with "Note Code 5" in the Texas Medicaid fee schedule.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/resources/rate-and-code-updates/rate-changes.

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

2.4.2.1 National Correct Coding Initiative (NCCI) and Medically Unlikely Edit (MUE) Guidelines

The HCPCS and CPT codes included in the *Texas Medicaid Provider Procedures Manual* are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manuals. Providers should refer to the CMS NCCI web page for correct coding guidelines and specific applicable code combinations.

In instances when Texas Medicaid limitations are more restrictive than NCCI MUE guidance, Texas Medicaid limitations prevail.

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3 Implantable Hearing Devices and Related Services

3.1 Enrollment

To enroll in Texas Medicaid, hearing services professionals who provide implantable hearing devices and services must 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.

3.2 Services, Benefits, Limitations and Prior Authorization

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

The following services and supplies must be provided to Texas Medicaid clients if an implantable hearing aid device is medically necessary:

- An individual client assessment to identify the appropriate type of device
- The fitting of the device
- The reassessment 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

Hearing devices are a benefit for clients of any age. Some types of hearing devices are age restricted.

3.2.1 Cochlear Implants

The following procedure codes may be reimbursed 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				

The following procedure codes may be reimbursed for diagnostic analysis of the cochlear implant:

Procedure Codes									
92601	92602	92603	92604						

Note: *ASCs are paid based on a global fee, with the exception that certain pieces of equipment may be reimbursed separately from the ASC or HASC global rate.*

3.2.1.1 Prior Authorization

Prior authorization is required for the following:

- Cochlear implant surgery, device, and replacement parts
- Sound processor repair or replacement
- Battery recharger unit
- Replacement batteries beyond the limitations outlined in the sections below

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

Note: *Requests for clients who are 20 years of age or younger who do not meet the medical necessity criteria may be considered through Comprehensive Care Program (CCP).*

Documentation submitted for review must indicate who will be providing the cochlear implant device (i.e., the facility or the Durable Medical Equipment (DME) or medical supplier). The supplier's provider number must be included on the prior authorization request.

Prior authorization for a unilateral or bilateral cochlear implant may be granted for clients who are 9 months of age and 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 auditory 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.
- Inability to derive benefit from appropriately fitted hearing aid devices.
- Documentation of poor speech discrimination and a recommendation for cochlear implant candidacy and the most appropriate ICD-10-CM diagnoses for severe-to-profound bilateral sensorineural hearing loss.

The initial lithium-ion battery recharger unit, additional medically necessary units, and additional replacement batteries beyond the limitations indicated in the following sections may be reimbursed with prior authorization. Documentation must be submitted with the prior authorization request to support medical necessity for the request.

Refer to: Subsection 3.2.4, "Sound Processor Replacement and Repair" in this handbook for more information about sound processor repair or replacement.

Prior authorization requests may be submitted to the TMHP Prior Authorization Department by mail, fax, or the electronic portal. Prescribing or ordering providers, dispensing providers, clients' responsible adults, and clients may sign prior authorization forms and supporting documentation using electronic or wet signatures.

3.2.1.2 Limitations

Surgery

Procedure code 69930 with the appropriate modifier LT or RT may be reimbursed for unilateral cochlear implantation. Procedure code 69930 with modifier 50 may be reimbursed for bilateral cochlear implantation performed simultaneously.

Device and Components

Procedure codes L8627, L8628, and L8629 for the cochlear implant device and components may be reimbursed for clients who are 9 months of age and older as follows:

- The device must be approved by the Food and Drug Administration (FDA) and be age-appropriate for the client.
- One per day may be reimbursed with prior authorization.

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

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Replacement Batteries and Related Items

Replacement batteries and related items for the cochlear implant device include non-rechargeable batteries, rechargeable batteries, and recharger units as follows:

Procedure Code	Prior Authorization	Limitation
L8621 (Zinc air non-rechargeable)	Not required	Maximum of 50 per month
L8622 (Alkaline non-rechargeable)	Not required	Maximum of 31 per month
L8623 (Lithium-ion rechargeable)	Not required	2 batteries per calendar year
L8624 (Lithium-ion rechargeable)	Not required	2 batteries per calendar year
L7368 (Battery recharger unit for lithium-ion rechargeable batteries)	Required	1 replacement unit every 5 rolling years

Replacement batteries for clients with bilateral cochlear implants and two sound processors may be reimbursed when billed with the applicable battery procedure code and the appropriate LT or RT modifier.

Replacement batteries for the cochlear device are limited to clients with a cochlear implant procedure, device, or supply that has been billed within the past five rolling years. 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.

Additional batteries and lithium-ion battery recharger units beyond these limitations may be reimbursed with prior authorization.

3.2.1.3 Auditory Rehabilitation

Auditory rehabilitation is a benefit of Texas Medicaid when it is medically necessary for clients who have received a surgically implanted hearing device, or who have prelingual or postlingual hearing loss when the treating physician has determined that auditory rehabilitation would be beneficial.

The following procedure codes may be reimbursed for auditory rehabilitation:

Procedure Codes									
92626	92627	92630	92633						

One auditory rehabilitation evaluation and 12 visits per 180 day period may be reimbursed without prior authorization. Additional visits during a six rolling month period for clients who are 12 months of age through 20 years of age require prior authorization.

Procedure code 92627 is an add-on procedure and must be billed with the primary procedure code 92626 to be considered for reimbursement.

Procedure code 92627 may be reimbursed up to four times per day to the same provider.

Note: *Additional therapy services may be a benefit through the Texas Medicaid speech therapy benefit.*

Refer to: The *Physical Therapy, Occupational Therapy, and Speech Therapy Services Handbook* (*Vol. 2, Provider Handbooks*) for information about speech therapy.

Personal frequency modulated (FM) systems are not benefits of Texas Medicaid.

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3.2.2 Auditory Brainstem Implant (ABI)

The following procedure codes may be reimbursed for the ABI, related components, and services:

Procedure Codes									
92640	L8499	L8614	L8621	L8622	S2235				

3.2.2.1 Prior Authorization

The following implantable hearing devices and services require prior authorization:

- ABI surgery, device, and replacement parts
- Sound processor repair or replacement
- Replacement batteries beyond the limitations outlined in the sections below

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

Prior authorization requests and claims for ABI is limited to clients with a condition of neurofibromatosis, type II or Schwannomatosis.

Refer to: Subsection 2.2.1, "Limitations and Required Forms" in this handbook for additional information about replacement batteries.

Subsection 3.2.4, "Sound Processor Replacement and Repair" in this handbook for more information about sound processor repair or replacement.

3.2.2.2 Limitations

ABI is a benefit for clients who are 12 years of age and older.

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

Zinc air batteries (procedure code L8621) are limited to a maximum of 50 per month. Alkaline batteries (procedure code L8622) are limited to a maximum of 31 per month.

Non-rechargeable batteries (procedure codes L8621 and L8622) do not require prior authorization. Procedure codes L8621 and L8622 must be billed using a left (LT) or right (RT) modifier. Since the ABI is not ear-specific, procedure codes L8621 and L8622 may be billed using either the LT or RT modifier.

Replacement batteries for the ABI are limited to clients with an ABI surgical procedure, device, or replacement part that has been billed within the past 5 rolling years. Replacement batteries for clients who did not receive their ABI through Texas Medicaid are considered for reimbursement on appeal with a physician's statement documenting medical necessity.

3.2.3 Bone-Anchored Hearing Device (BAHD)

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

Procedure Codes										
69714	69716	69717	69719	69726	69727	69728	69729	69730	92622	92623
L8625	L8690	L8691	L8692	L8693	L8694	V5266				

3.2.3.1 Prior Authorization

The following implantable hearing devices and services require prior authorization:

- BAHD implant surgery, revision, device, and replacement parts
- Sound processor repair or replacement

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

Providers should use the Special Medical Prior Authorization (SMPA) Request Form for all prior authorization requests.

Prior authorization requests may be granted for clients who are 5 years of age and 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 BAHD implant
- Documentation of an appropriate diagnosis.

Benefit-eligible conditions may include, but are not limited to the following:

- Conductive hearing loss
- Sensorineural hearing loss
- Other anomalies of external ear with impairment of hearing
- Anomalies of skull and face bones

Refer to: Subsection 3.2.4, "Sound Processor Replacement and Repair" in this handbook for more information about sound processor repair or replacement.

3.2.3.2 Limitations

Implanted BAHDs are a benefit for clients who are 5 years of age and older.

A BAHD sound processor that is specifically worn on a soft headband is a benefit for clients five years old or younger. If chosen by a client, a BAHD sound processor worn on a soft headband is also a benefit for clients who are five years of age or older. The BAHD sound processor is not implanted. A BAHD sound processor worn on a soft headband may be reimbursed using procedure code L8692.

Replacement batteries for the BAHD (procedure code V5266) do not require prior authorization. The replacement batteries are limited to clients with a hearing device that has been billed within the past five rolling years. 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.

Procedure codes L8691, L8692, L8693, and L8694 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 BAHD device and components may be reimbursed once per day with prior authorization.

Bilateral BAHD procedures are not benefits of Texas Medicaid.

3.2.4 Sound Processor Replacement and Repair

3.2.4.1 Prior Authorization

Replacement and repair of a sound processor require prior authorization.

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Documentation by the provider must explain the need for the replacement of the sound processor. The processor must be used for a minimum of 12 months before 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. 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.

3.2.4.2 Limitations

Procedure code L8499 with modifier RB may be reimbursed for sound processor repair.

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

Procedure code 92623 is an add-on procedure and must be billed with the primary procedure code (92622) on the same day, by the same provider to be considered for reimbursement.

3.2.5 Electromagnetic Bone Conduction Hearing Device - Removal Only

The removal of the electromagnetic bone conduction hearing aid may be reimbursed by Texas Medicaid using procedure code 69711.

The removal or repair of an electromagnetic bone conduction hearing device is limited to two procedures per lifetime when billed by any provider.

The implantation of the device is not a benefit of Texas Medicaid.

3.3 Documentation Requirements

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

3.4 Claims Filing and Reimbursement

3.4.1 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.

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

Subsection 1.7.12, "Billing Clients" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General 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 Paper 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.

Note: *For Texas Medicaid managed care clients, all implantable hearing devices and services are administered by the client's Medicaid MCO.*

3.4.1.1 Third Party Liability

Standard TPL rules apply to all hearing services claims.

Refer to: "Section 8: Third Party Liability (TPL)" (*Vol. 1, General Information*).

3.4.2 Reimbursement

Implantable hearing aids and related services are reimbursed in accordance with 1 TAC §355.8141.

Implantable 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 MSRP less 18 percent 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.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/resources/rate-and-code-updates/rate-changes.

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

3.4.2.1 NCCI and MUE Guidelines

The HCPCS and CPT codes included in the *Texas Medicaid Provider Procedures Manual* are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manuals. Providers should refer to the CMS NCCI web page for correct coding guidelines and specific applicable code combinations.

In instances when Texas Medicaid limitations are more restrictive than NCCI MUE guidance, Texas Medicaid limitations prevail.

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4 Vision Care Professionals

4.1 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.

4.2 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).
- Check the client's eligibility
- Visit TexMedConnect or access the Medicaid Client Portal for providers to determine whether eyeglasses have been reimbursed by Texas Medicaid within the last 24 months. Providers should ask clients if they recently received vision care services that may not be documented in My Account yet.
- Submit claims for eyewear services as soon as possible so the client's record indicates that eyewear or eyeglasses have been dispensed.
- Have the client, parent, or guardian sign and date the Medicaid Vision Eyewear Client Certification Form and retain it in their records. When a client chooses an eyeglass or contact lens option beyond the program limitations, or if eyeglasses or contact lenses are replaced because of loss or destruction, the client must acknowledge their choice and his/her liability for the cost difference by signing the Medicaid Vision Eyewear Client Certification Form. The form must remain in the provider's 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 eyeglasses were dispensed.

4.3 Services, Benefits, Limitations, and Prior Authorization

Examination and treatment of eye conditions, including prescribing and dispensing of medically necessary eyeglasses or contact lenses, are benefits of Texas Medicaid and may be reimbursed to optometrist, ophthalmologist, and optician providers within the scope of practice for each.

The following services are included in other services and will not be considered for separate reimbursement:

- Vision screening conducted to meet State screening requirements, such as the DSHS School Vision and Hearing Screening Program.

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- 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.

Note: *Medicaid clients 22 years old and younger who have been determined by their provider to have a vision impairment that may require intensive or comprehensive vision impaired related services should be referred to the Texas Health and Human Services Commission (HHSC) Blind Children's Vocational Discovery and Development Program. Adults, youths and students who have been determined by their provider to have a vision impairment that may require intensive or comprehensive vision impaired related services should be referred to the Texas Workforce Commission (TWC).*

Note: *Vision Services requests for clients birth through 20 years of age who do not meet criteria as outlined in this handbook may be considered through the Texas Health Steps (THSteps)-Comprehensive Care Program (CCP).*

Ophthalmologist and Optometrist

Examination and treatment services rendered by an ophthalmologist or optometrist are not limited to the procedure codes included in this handbook.

Refer to: The Texas Medicaid fee schedules on the TMHP web site at www.tmhp.com for a complete list of procedure codes that may be reimbursed by Texas Medicaid.

Optician

Services rendered by an optician are limited to fitting and dispensing of medically necessary eyeglasses and contact lenses.

Note: *In accordance with the Omnibus Reconciliation Act 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.*

4.3.1 Services Performed in Long-Term Care Facilities

Ophthalmological, optometric, and eyeglass or contact lens services provided in a skilled or intermediate care facility may be reimbursed when the client's attending physician has ordered the service and the signed order is included in the client's medical record at the nursing facility.

The ordering physician's name and National Provider Identifier (NPI) and taxonomy code must be documented on the claim when ophthalmological, optometric, and eyeglasses or contact lenses services are performed in a skilled or intermediate care facility.

4.3.2 Services Performed in Federally Qualified Healthcare Centers (FQHC)

Vision services rendered by FQHC providers may be reimbursed based on an all-inclusive rate per visit.

Refer to: Subsection 2.2, "Services, Benefits, Limitations, and Prior Authorization" in the *Clinics and Other Outpatient Facility Services Handbook* (*Vol. 2, Provider Handbooks*) for information about vision services that may be reimbursed to FQHC providers.

4.3.3 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 an optometrist or ophthalmologist who is experienced with the pediatric population and who can perform further testing, diagnosis, and treatment.

Refer to: Subsection 4.3.12.2.4, "Vision Screening" in the *Children's Services Handbook* (*Vol. 2, Provider Handbooks*) for information about THSteps medical checkup vision screenings.

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4.3.3.1 Vision Screening Outside of a THSteps Preventive Care Medical Checkup

Vision screening for clients who are birth through 20 years of age may be completed at any primary care provider's office visit upon the following:

- Request from a parent
- Referral from a school vision screening program
- Referral from a school nurse

Clients who are birth through 20 years of age must be screened for eye abnormalities by history, observation, and physical exam. Clients who are identified as high risk must be referred to a Medicaid-enrolled optometrist or ophthalmologist.

4.3.4 Noncovered Services

The following services and supplies are not a benefit of Texas Medicaid:

- Artificial eyes for clients who are 21 years of age and older.

  Note: *Artificial eyes for clients who are birth through 20 years may be considered under Texas Health Steps-Comprehensive Care Program (THSteps-CCP).*

- Eyeglasses for residents of institutions where the reimbursement formula and vendor reimbursement include this service.
- Eyeglasses or contact lenses prescribed or dispensed to clients at a hospital or nursing facility without documented orders of the attending physician in the client's medical records.
- Low vision aids.

  Note: *Clients may be referred to TWC for low vision aids.*

- Optional eyeglass features that are requested by the client but that do not increase visual acuity (e.g., lens tint, industrial hardening, and decorative accessories or lettering).
- Plano sunglasses.
- Extended color vision examination, dark adaptation examination, and vision screening.
- Spectacle (eyeglass) fitting services when billed separately.

Clients may be billed for noncovered frames and other items beyond Medicaid benefits. Providers must have the client sign and date the Medicaid Vision Eyewear 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 $32.55 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 ($172.07) 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

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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 Medicaid Vision Eyewear Client Certification Form and retain it in the provider's records.

4.3.5 Vision Testing

Vision testing and examination and treatment of eye conditions are benefits of Texas Medicaid and may be reimbursed to ophthalmologist or optometrist providers.

Routine eye examinations with refraction testing may be reimbursed using the following procedure codes:

Procedure Codes									
S0620	S0621								

Medical evaluation and examination may be reimbursed when accompanied by a medical condition other than refractive error using the following procedure codes:

Procedure Codes									
92002	92004	92012	92014	92015					

Procedure codes 92002, 92004, 92012, and 92014 are limited to one service per day by any provider.

Procedure codes 92002 and 92004 are limited to one new client visit every three years when no other professional services have been billed by the physician, or another physician of the same specialty in the same group practice, within the past three years.

A new client is defined as one who has not received any professional services from a physician or physician within the same group practice, of the same specialty, within the past three years.

An established client is one who has received professional services from a physician or physician within the same group practice, of the same specialty, within the past three years.

Refer to: Subsection 9.2.60.1.1, "New and Established Patient Services" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for information about new patient and established patient E/M services.

Vision testing procedure codes are subject to the CMS NCCI relationships. Claims that are submitted by physicians with the same specialty who are in the same group practice are processed as if they were the same provider. Providers should refer to the *Current Procedural Terminology (CPT) Manual* for additional information about intermediate and comprehensive ophthalmological services.

4.3.5.1 Routine Vision Testing

Procedure codes S0620 and S0621 are considered routine eye examinations and are limited to diagnosis codes Z0100 or Z0101.

Procedure codes S0620 and S0621 will be denied if billed with the same date of service as procedure codes 92020, 92265, 92270, 92273, 92274, 92285, 92286, and 92287.

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Clients who are birth through 20 years of age are eligible for a routine eye examination with refraction testing for the purpose of obtaining eyeglasses or contact lenses once every 12 months. The limitation for refraction testing can be exceeded for clients who are birth through 20 years of age only when:

- The parent, teacher, or school nurse requests the refraction testing and it is medically necessary.
- There is a significant change in vision, and documentation supports a diopter (d) change of 0.5 or greater in the sphere, cylinder, prism measurements, or axis changes.

Clients who are 21 years of age and older are eligible for a routine eye examination with refraction testing for the purpose of obtaining eyeglasses or contact lenses once every 24 months. The limitation for refraction testing can be exceeded for clients who are 21 years of age and older only when there is a significant change in vision, and documentation supports a diopter change of 0.5 or more in the sphere, cylinder, prism measurements, or axis changes.

4.3.5.2 Medically Necessary Eye Examinations

An eye examination with or without refraction (procedure code 92002, 92004, 92012, 92014, or 92015) may be reimbursed for medical evaluations and examinations of the eye. Procedure codes 92002, 92004, 92012, 92014, and 92015 will not be reimbursed for routine exams.

Documentation in the client's medical record must support the medical necessity of the service performed.

Procedure codes 92002, 92004, 92012, and 92014 may be reimbursed when it is medically necessary to ophthalmologist or optometrist providers for medically necessary eye examinations without refraction.

Procedure code 92015 may be reimbursed to ophthalmologist or optometrist providers for refraction in addition to the eye examination procedure code 92002, 92004, 92012, or 92014. A refractive state (procedure code 92015) will be denied as part of another service if it is billed with the same date of service by any provider as procedure code S0620 or S0621.

4.3.6 Special Ophthalmological Services and Diagnostic Testing

4.3.6.1 Ophthalmological Examination and Evaluation with General Anesthesia

An ophthalmological examination and evaluation under general anesthesia (procedure codes 92018 and 92019) performed by an ophthalmologist may be medically necessary when a client has significant injury or cannot otherwise tolerate the procedure while conscious.

Procedure codes 92018 and 92019 may be reimbursed once per service, per day, when billed by any provider.

4.3.6.2 Ophthalmic Ultrasound

Ophthalmic ultrasound is a diagnostic test that uses high frequency sound waves to provide additional information about the interior of the eye and surrounding areas. The following procedure codes may be reimbursed for ophthalmic ultrasound services:

Procedure Codes									
76510	76511	76512	76513	76514	76516	76519	76529	76999	

Procedure codes 76510, 76511, 76512, 76513, 76516, are limited to two services per calendar year by any provider.

Corneal pachymetry (procedure code 76514) is used to determine the corneal thickness. Procedure code 76514 (unilateral or bilateral code) may be reimbursed once per lifetime, when billed by any provider, and is restricted to the following diagnosis codes:

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Diagnosis Codes							
H1811	H1812	H1813	H1820	H18211	H18212	H18213	H18221
H18222	H18223	H18231	H18232	H18233	H18461	H18462	H18463
H18511	H18512	H18513	H18521	H18522	H18523	H18531	H18532
H18533	H18541	H18542	H18543	H18551	H18552	H18553	H18591
H18592	H18593	H18601	H18602	H18603	H18611	H18612	H18613
H18621	H18622	H18623	H21551	H21552	H21553	H40001	H40002
H40003	H40011	H40012	H40013	H40021	H40022	H40023	H40031
H40032	H40033	H40041	H40042	H40043	H40051	H40052	H40053
H40061	H40062	H40063	H4010X0	H4010X1	H4010X2	H4010X3	H4010X4
H401110	H401111	H401112	H401113	H401114	H401120	H401121	H401122
H401123	H401124	H401130	H401131	H401132	H401133	H401134	H401210
H401211	H401212	H401213	H401214	H401220	H401221	H401222	H401223
H401224	H401230	H401231	H401232	H401233	H401234	H401310	H401311
H401312	H401313	H401314	H401320	H401321	H401322	H401323	H401324
H401330	H401331	H401332	H401333	H401334	H401410	H401411	H401412
H401413	H401414	H401420	H401421	H401422	H401423	H401424	H401430
H401431	H401432	H401433	H401434	H40151	H40152	H40153	H4020X0
H4020X1	H4020X2	H4020X3	H4020X4	H40211	H40212	H40213	H402210
H402211	H402212	H402213	H402214	H402220	H402221	H402222	H402223
H402224	H402230	H402231	H402232	H402233	H402234	H40231	H40232
H40233	H40241	H40242	H40243	H4031X0	H4031X1	H4031X2	H4031X3
H4031X4	H4032X0	H4032X1	H4032X2	H4032X3	H4032X4	H4033X0	H4033X1
H4033X2	H4033X3	H4033X4	H4041X0	H4041X1	H4041X2	H4041X3	H4041X4
H4042X0	H4042X1	H4042X2	H4042X3	H4042X4	H4043X0	H4043X1	H4043X2
H4043X3	H4043X4	H4051X0	H4051X1	H4051X2	H4051X3	H4051X4	H4052X0
H4052X1	H4052X2	H4052X3	H4052X4	H4053X0	H4053X1	H4053X2	H4053X3
H4053X4	H4061X0	H4061X1	H4061X2	H4061X3	H4061X4	H4062X0	H4062X1
H4062X2	H4062X3	H4062X4	H4063X0	H4063X1	H4063X2	H4063X3	H4063X4
H40811	H40812	H40813	H40821	H40822	H40823	H40831	H40832
H40833	H40841	H40842	H40843	H4089	H409	H42	H44511
H44512	H44513	T868401	T868402	T868403	T868411	T868412	T868413
Q150	Q8788	Z947					

The one per lifetime limitation for procedure code 76514 does not apply when submitted with the following diagnosis codes:

Diagnosis Codes							
H1811	H1812	H1813	H18211	H18212	H18213	H18231	H18232
H18233	H18511	H18512	H18513	H21551	H21552	H21553	T868401
T868402	T868403	T868411	T868412	T868413	Z947		

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When billing for two or more services, providers must bill with one of the diagnosis listed as an exception to the limit.

Procedure code 76999 is limited to one service per day, same procedure, same provider, and may be reimbursed with prior authorization.

Ophthalmic ultrasounds may be reimbursed when they are billed with the same date of service by the same provider as an eye examination visit or consultation.

Ophthalmic ultrasounds (procedure codes 76514 and 76516) are limited to one service, per day, by any provider.

Ophthalmic coherence biometry with intraocular lens power calculation will be considered medically necessary when the measurements are used to calculate the intraocular lens power prior to cataract extraction.

Ophthalmic biometry procedure codes 76519 and 92136 are duplicative tests and cannot be performed together. Procedure codes 76519 and 92136 are limited two services per lifetime, any provider, any combination.

Procedure code 76519 is defined as a bilateral service for the technical component and unilateral service for the professional component. The professional component is only billed when a decision to remove the cataract has been made by the patient and surgeon.

- Two services per day are allowed when the professional component is performed on both eyes on the same date.
- One physician may do the technical component and another physician the professional component. Each will need to use the appropriate modifier. The professional component should also have the anatomic modifier (LT or RT) appended.

When the scan is performed with a calculation done on the first eye, the provider must bill the total component for procedure code 76519 with modifier LT or RT to identify the eye on which the service was performed, or bill procedure code 76519 with total component plus procedure code 76519 with professional component and modifier LT or RT.

When the calculation is performed on the second eye, the provider must only bill procedure code 76519 with professional component and modifier LT or RT to identify the eye on which the service was performed.

If the technical and professional components are performed on both eyes on the same date, the provider must bill procedure code 76519 with the LT or RT modifier and procedure code 76519 with professional component and the corresponding LT or RT modifiers.

Ophthalmic biometry may be repeated after 12 months if the patient decides to have the surgery later or the procedure is performed by a different provider. Requests for a second ophthalmic biometry in less than 12 months will not be payable without documentation of significant change in vision. Documentation must include at least one of the following changes:

- A change of 0.50 diopters or more in any corresponding meridian.
- A cylinder axis change of at least 20 degrees for a cylinder power of 0.50-0.62 diopters.
- A cylinder axis change of at least 15 degrees for a cylinder power of 0.75-0.87 diopters.
- A cylinder axis change of at least 10 degrees for a cylinder power of 1.00-1.87 diopters.
- A cylinder axis change of at least 5 degrees for a cylinder power of 2.00 diopters or greater.

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Prior Authorization Requirements

Procedure code 76999 requires prior authorization. Prior Authorization requests must be submitted on the SMPA Request Form and must include the following documentation:

- A clear, concise description of the ophthalmic ultrasound being performed.
- Reason for recommending this particular procedure.
- A statement confirming that a CPT or HCPCS code is not available for the procedure requested.
- The client's diagnosis.
- Documentation that this procedure is not investigational or experimental.
- The physician's intended fee for this procedure, including a comparable CPT or HCPCS code.

Note: *Services and procedures that are investigational or experimental are not a benefit of Texas Medicaid.*

4.3.6.3 Gonioscopy

Gonioscopy is an eye examination to look at the front part of the eye (anterior chamber) between the cornea and the iris. A microscope (slit lamp) is used to look inside the eye.

Procedure code 92020 will be denied as part of another service if billed on the same date of service by the same provider as procedure codes S0620 and S0621.

Procedure code 92020 may be reimbursed for gonioscopy when billed with one of the diagnosis codes in the following table:

Diagnosis Codes							
H20011	H20012	H20013	H20021	H20022	H20023	H20031	H20032
H20033	H20041	H20042	H20043	H20051	H20052	H20053	H2010
H2011	H2012	H2021	H2022	H2023	H20811	H20812	H20813
H20821	H20822	H20823	H209	H2101	H2102	H2103	H211X1
H211X2	H211X3	H21211	H21212	H21213	H21221	H21222	H21223
H21231	H21232	H21233	H21241	H21242	H21243	H21251	H21252
H21253	H21261	H21262	H21263	H21271	H21272	H21273	H2129
H21301	H21302	H21303	H21311	H21312	H21313	H21321	H21322
H21323	H21331	H21332	H21333	H21341	H21342	H21343	H21351
H21352	H21353	H2141	H2142	H2143	H21501	H21502	H21503
H21511	H21512	H21513	H21521	H21522	H21523	H21531	H21532
H21533	H21541	H21542	H21543	H21551	H21552	H21553	H21561
H21562	H21563	H2181	H2182	H22	H31401	H31402	H31403
H31411	H31412	H31413	H31421	H31422	H31423	H3411	H3412
H3413	H348110	H348111	H348112	H348120	H348121	H348122	H348130
H348131	H348132	H348310	H348311	H348312	H348320	H348321	H348322
H348330	H348331	H348332	H35031	H35032	H35033	H35051	H35052
H35053	H3521	H3522	H3523	H3582	H36821	H36822	H36823
H36829	H3689	H47231	H47232	H47233	H40001	H40002	H40003
H40011	H40012	H40013	H40021	H40022	H40023	H40031	H40032
H40033	H40041	H40042	H40043	H40051	H40052	H40053	H40061

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Diagnosis Codes							
H40062	H40063	H4010X0	H4010X1	H4010X2	H4010X3	H4010X4	H401110
H401111	H401112	H401113	H401114	H401120	H401121	H401122	H401123
H401124	H401130	H401131	H401132	H401133	H401134	H401210	H401211
H401212	H401213	H401214	H401220	H401221	H401222	H401223	H401224
H401230	H401231	H401232	H401233	H401234	H401310	H401311	H401312
H401313	H401314	H401320	H401321	H401322	H401323	H401324	H401330
H401331	H401332	H401333	H401334	H401410	H401411	H401412	H401413
H401414	H401420	H401421	H401422	H401423	H401424	H401430	H401431
H401432	H401433	H401434	H40151	H40152	H40153	H4020X0	H4020X1
H4020X2	H4020X3	H4020X4	H40211	H40212	H40213	H402210	H402211
H402212	H402213	H402214	H402220	H402221	H402222	H402223	H402224
H402230	H402231	H402232	H402233	H402234	H40231	H40232	H40233
H40241	H40242	H40243	H4031X0	H4031X1	H4031X2	H4031X3	H4031X4
H4032X0	H4032X1	H4032X2	H4032X3	H4032X4	H4033X0	H4033X1	H4033X2
H4033X3	H4033X4	H4041X0	H4041X1	H4041X2	H4041X3	H4041X4	H4042X0
H4042X1	H4042X2	H4042X3	H4042X4	H4043X0	H4043X1	H4043X2	H4043X3
H4043X4	H4051X0	H4051X1	H4051X2	H4051X3	H4051X4	H4052X0	H4052X1
H4052X2	H4052X3	H4052X4	H4053X0	H4053X1	H4053X2	H4053X3	H4053X4
H4061X0	H4061X1	H4061X2	H4061X3	H4061X4	H4062X0	H4062X1	H4062X2
H4062X3	H4062X4	H4063X0	H4063X1	H4063X2	H4063X3	H4063X4	H40811
H40812	H40813	H40821	H40822	H40823	H40841	H40842	H40843
H4089	H409	H42	Q150				

4.3.6.4 Corneal Topography

Corneal topography is a computer assisted diagnostic tool that creates a three-dimensional map of the shape and curvature of the cornea. Procedure code 92025 may be reimbursed for corneal topography. Procedure code 92025 is considered medically necessary to diagnose, monitor, and treat various visual conditions such as, the following:

- Pre-operatively for evaluation of irregular astigmatism prior to cataract surgery
- Monocular diplopia
- Bullous keratopathy
- Post-surgical or post traumatic astigmatism, measuring at a minimum of 3.5 diopters
- Post penetrating keratoplasty surgery
- Corneal dystrophy
- Complications of transplanted cornea
- Post traumatic corneal scarring
- Keratoconus
- Pterygium and/or corneal ectasia that cause visual impairment

Corneal topography may be reimbursed when it is billed with the same date of service by the same provider as an eye examination visit or consultation.

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Corneal topography (procedure code 92025) is limited to one service, per day, and two services per calendar year, by any provider.

4.3.6.5 Sensorimotor Examination

A sensorimotor examination is an evaluation of the function of the ocular neuro-muscular system. This exam consists of interpretation and reporting of multiple ocular deviation measurements, including:

- Visual motor integration
- Reversal frequency (letters and numbers)
- Motor speed and precision
- Visual memory
- Visualization to test eye movement and control
- Focusing ability
- Eye teaming ability
- Depth perception
- Visual perception skills

Sensorimotor examination (procedure code 92060) is limited to one service per day and two services per calendar year by any provider. Procedure code 92060 may be reimbursed in addition to an eye examination visit.

4.3.6.6 Orthoptic Training

Orthoptics, a component of vision training or vision therapy, are exercises designed to improve the function of the eye muscles with an emphasis on binocular vision and eye movements.

Procedure codes 92065 and 92066 may be reimbursed for orthoptic training when it is billed with one of the following diagnosis codes:

Diagnosis Codes							
H50011	H50012	H50021	H50022	H50031	H50032	H50041	H50042
H5005	H5006	H5007	H5008	H50111	H50112	H50121	H50122
H50131	H50132	H50141	H50142	H5015	H5016	H5017	H5018
H5021	H5022	H50311	H50312	H5032	H50331	H50332	H5034
H50411	H50412	H5042	H5043	H5051	H5052	H5053	H5054
H5055	H50611	H50612	H5069	H50811	H50812	H5089	H5111
H5112	H518	H53011	H53012	H53013	H53021	H53022	H53023
H53031	H53032	H53033	H5501	H5502	H5503	H5504	H5509
H5581	H5582	H5589					

Orthoptic training is limited to 12 services per lifetime per client, when it is billed with one of the diagnosis codes in the above diagnosis table.

Providers must document in the medical record a diagnosis, treatment plan, and the reason for continuous treatment if the client attends multiple training sessions.

Procedure codes 92065 and 92066 may be reimbursed in addition to an eye examination visit.

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4.3.6.7 Visual Field Examinations

The following procedure codes may be reimbursed for visual field examinations:

Procedure Codes		
92081	92082	92083

Procedure codes 92081, 92082, and 92083 may be reimbursed once per day and twice per calendar year by any provider, for any combination of visual field examinations.

Procedure codes 92081, 92082 and 92083 are considered medically necessary under the following conditions:

- Disorder of the eyelids potentially affecting the visual field.
- A documented diagnosis of glaucoma.
- A suspected diagnosis of glaucoma with supporting evidence documented.
- A documented disorder of the optic nerve, the neurologic visual pathway, or retina.
- A recent intracranial hemorrhage, an intracranial mass or a recent measurement of increased intracranial pressure with or without visual symptomatology.
- A recently documented occlusion and/or stenosis of cerebral and precerebral arteries, a recently diagnosed transient cerebral ischemia or giant cell arteritis.
- A history of a cerebral aneurysm, pituitary tumor, occipital tumor or other condition potentially affecting the visual fields.
- A visual field defect demonstrated by gross visual field testing (e.g., confrontation testing).
- An initial workup for buphthalmos, congenital anomalies of the posterior segment or congenital ptosis.
- A disorder of the orbit, potentially affecting the visual field (e.g., orbital tumor, thyroid disease, etc.).
- A significant eye injury.
- A pale or swollen optic nerve documented by a recent examination.
- New functional limitations which may be due to visual field loss (i.e., reports by family that patient is running into things).
- Medication treatment (e.g., hydroxychloroquine) which has a high risk of potentially affecting the visual system.
- Initial evaluation for macular degeneration related to central vision loss or has experienced such loss resulting in vision measured at or below 20/70.

4.3.6.8 Serial Tonometry

Serial tonometry is used to determine the pressure of intraocular fluid in the diagnosis of certain conditions, such as glaucoma. Serial tonometry includes a series of pressure checks over the course of a day to measure peaks and acute elevations in intraocular pressure (diurnal curve).

Procedure code 92100 may be reimbursed once per day and twice per calendar year by any provider.

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4.3.6.9 Computerized Ophthalmic Diagnostic Imaging

The following procedure codes are a benefit of Texas Medicaid when medically indicated and may be reimbursed for Computerized Ophthalmic Diagnostic Imaging (CODI):

Procedure Codes									
92132	92133	92134	92137						

Procedure codes 92132, 92133, 92134, and 92137 are limited to one service per day, and two services per calendar year, any provider.

Procedure code 92132 will be denied as part of another service if billed on the same date of service by any provider as procedure code 76513.

Additional services may be requested for procedure codes 92134 and 91237, with prior authorization, for a total of 12 services per calendar year.

Prior authorization requests must be submitted on a SMPA Request Form and must include documentation of medical necessity for the following circumstances:

- Monitoring patients with conditions affecting the optic nerve (e.g., optic neuropathy) or retinal disease (e.g., macular degeneration, diabetic retinopathy) and in the evaluation and treatment of certain macular abnormalities (e.g., macular edema, atrophy associated with degenerative retinal diseases) including:
- Patients being treated with bevacizumab, aflibercept, pegaptanib sodium, dexamethasone, or ranibizumab for either diabetic retinopathy or macular degeneration.
- Patients being treated with chloroquine (CQ) and/or hydroxychloroquine (HCQ) for the development of retinopathy.

4.3.6.10 Ophthalmic Coherence Biometry

Ophthalmic coherence biometry with intraocular lens power calculation will be considered medically necessary when the measurements are used to calculate the intraocular lens power prior to cataract extraction.

Ophthalmic biometry procedure codes 76519 and 92136 are duplicative tests and cannot be performed together. Procedure codes 76519 and 92136 are limited two services per lifetime, any provider, any combination.

Procedure code 76519 is defined as a bilateral service for the technical component and unilateral service for the professional component. The professional component is only billed when a decision to remove the cataract has been made by the patient and surgeon.

- Two services per day are allowed when the professional component is performed on both eyes on the same date.
- One physician may do the technical component and another physician the professional component. Each will need to use the appropriate modifier. The professional component should also have the anatomic modifier (LT or RT) appended.

When the scan is performed with a calculation done on the first eye, the provider must bill the total component for procedure code 76519 with modifier LT or RT to identify the eye on which the service was performed, or bill procedure code 76519 with total component plus procedure code 76519 with professional component and modifier LT or RT.

When the calculation is performed on the second eye, the provider must only bill procedure code 76519 with professional component and modifier LT or RT to identify the eye on which the service was performed.

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If the technical and professional components are performed on both eyes on the same date, the provider must bill procedure code 76519 with the LT or RT modifier and procedure code 76519 with professional component and the corresponding LT or RT modifiers.

Ophthalmic biometry may be repeated after 12 months if the patient decides to have the surgery later or the procedure is performed by a different provider. Requests for a second ophthalmic biometry in less than 12 months will not be payable without documentation of significant change in vision. Documentation must include at least one of the following changes:

- A change of 0.50 diopters or more in any corresponding meridian.
- A cylinder axis change of at least 20 degrees for a cylinder power of 0.50-0.62 diopters.
- A cylinder axis change of at least 15 degrees for a cylinder power of 0.75-0.87 diopters.
- A cylinder axis change of at least 10 degrees for a cylinder power of 1.00-1.87 diopters.
- A cylinder axis change of at least 5 degrees for a cylinder power of 2.00 diopters or greater.

4.3.6.11 Ophthalmoscopy, Extended Ophthalmoscopy, and Fluorescein Angiography

Ophthalmoscopy, extended ophthalmoscopy, and fluorescein angiography may be reimbursed using the following procedure codes:

Procedure Codes									
92201	92202	92227	92228	92229	92230	92235	92240	92242	92250
92260									

Procedure codes 92201, 92202, 92227, 92229, 92230, and 92260 are reimbursed for the total component only.

Routine ophthalmoscopy is part of a general and special ophthalmologic service whenever indicated. It is a non-itemized service and is not reported separately.

Extended ophthalmoscopy (procedure codes 92201 and 92202) is a method of examining the posterior portion of the eye when the level of examination requires a complete view of the back of the eye and documentation is greater than that required during routine ophthalmoscopy. Extended ophthalmoscopy must add information not available from the standard evaluation services and/or information that will demonstrably affect the treatment plan.

Extended ophthalmoscopy is considered medically necessary for the following conditions:

- Infants (0-24 months) undergoing treatment and/or monitoring of retinopathy of prematurity
- Histoplasmosis
- Choroidal neoplasms
- Glaucoma
- Optic nerve pathology
- Diabetic retinopathy
- Hypertensive retinopathy
- Vascular occlusion
- Retinal neovascularization
- Macular pathology
- Retinal tear, thinning, schisis or detachment
- Hereditary retinal dystrophies

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- Other visible retinal disorders requiring detailed imaging for adequate documentation

Extended ophthalmoscopy is not medically necessary under the following situations:

- Routine replacement of standard ophthalmoscopy with extended ophthalmoscopy to document the appearance of healthy retinal anatomy.
- Duplicative documentation of retinal pathology with extended ophthalmoscopy in conjunction with fundus photography, fluorescein angiography, etc., unless the additional diagnostic procedures provide new information to assist in clinical decision-making.
- Repeated performance in the presence of controlled and/or stable disease.

Repeat extended ophthalmoscopy is medically necessary when there is a change in signs, symptoms or specific condition. The frequency for providing extended ophthalmoscopy depends upon the medical necessity in each client which relates to the diagnosis. While most clients will require up to two services per year, in some cases, additional services may be reimbursed up to 12 services per year.

The client's medical record must contain documentation that fully supports the medical necessity for extended ophthalmoscopy. Retinal drawings must meet the following specifications:

- Must be a separate detailed sketch, minimal size of 3-4 inches
- All items must be identified and labeled
- Drawings in four-six standard colors are preferred. However, non-colored drawings are acceptable, if clearly labeled
- All abnormalities should be included in drawing

Procedure codes 92201 and 92202 are limited to one service per day and 12 services per calendar year by any provider.

Remote retinal imaging (procedure codes 92227, 92228, and 92229) is a benefit of Medicaid when the images are obtained by a provider at one facility, and then transmitted electronically, to be reviewed and interpreted at another site by an ophthalmologist or other qualified health care professional under the direction of a retinal specialist.

Procedure codes 92227, 92228, 92229, 92235, 92240, 92242, 92250 and 92260 are limited to one service per day and two services per calendar year by any provider.

Procedure code 92230 must be billed with modifier LT or RT to identify the eye on which the service was performed.

Procedure codes S0620 and S0621 will be denied if billed on the same date of service as procedure codes 92227, 92228, 92229, 92230, 92235, 92240, 92242, 92250 or 92260.

Fundus photography (procedure code 92250) is considered medically necessary when an existing clinical condition is subject to change in extent, appearance or size with potential direct impact on and the management of client care. These conditions include, but are not limited to the following:

- Macular degeneration
- Glaucoma
- Neoplasms of the retina or choroid
- Chorioretinal inflammation, scars, and other disorders of choroid
- Retinal hemorrhages
- Ischemia
- Retinal detachment

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- Diabetic retinopathy
- Assessment of recently performed retinal laser surgery
- Lupus erythematosus
- Hypertension
- Multiple sclerosis
- Rheumatoid arthritis
- Sickle-cell anemia

Note: *Fundus photography performed for a routine screen of a normal eye, in the absence of a clinical condition, that is subject to change in extent, appearance or size is not a benefit of Texas Medicaid.*

4.3.6.12 Other Specialized Vision Services

The following procedure codes may be reimbursed by Texas Medicaid when the services are medically necessary:

Procedure Codes									
92265	92270	92273	92274	92285	92286	92287			

Procedure code 92265 is performed to evaluate nerve and muscle function of the eye muscles and considered medically necessary when performed for the diagnosis and evaluation of myasthenia gravis as well as other neuromuscular conditions effecting eye movement.

Procedure code 92273 is an acceptable alternative adjunctive modality useful in establishing loss of retinal function and distinguishing retinal from optic nerve lesions.

Procedure code 92274 is considered medically necessary for detecting chloroquine (Aralen) and hydroxychloroquine (Plaquenil) toxicity.

Procedure code 92285 may be indicated when photo-documentation is required to track the progression or lack of progression of an eye condition, or to document the progression of a particular course of treatment. This procedure should not be used to simply document the existence of a condition in order to enhance the medical record.

Procedure codes 92286 and 92287 are performed to evaluate the integrity of the cornea, iris and other anterior segment structures.

Texas Medicaid considers procedure code 92286 medically necessary for patients who meet one or more of the following criteria:

- Slit lamp evidence of endothelial dystrophy
- Slit lamp evidence of corneal edema
- Are about to undergo a secondary intraocular lens implantation
- Previous intraocular surgery requiring cataract surgery
- Are about to undergo a surgical procedure associated with a higher risk to corneal endothelium, i.e., phacoemulsification or refractive surgery
- Evidence of posterior polymorphous dystrophy of the cornea or iridocorneal-endothelium syndrome
- Will be fitted with extended wear contact lenses after intraocular surgery

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Procedure codes 92265, 92270, 92273, 92274, 92285, 92286, and 92287 may each be reimbursed once per day and twice per calendar year by any provider.

Procedure codes S0620 and S0621 will be denied if billed on the same date of service as procedure codes 92265, 92270, 92273, 92274, 92285, 92286, or 92287.

For other professional services, fitting services are included in the reimbursement for prosthetic eyeglasses or contact lenses.

Microfluidic analysis of tear osmolarity is a CLIA-waived lab test and may be performed by optometrists in the office setting.

Refer to: Subsection 2.2.13, "Urinalysis and Chemistry" in the *Radiology and Laboratory Services Handbook* (*Vol. 2, Provider Handbooks*) for information about microfluidic analysis (procedure code 83861).

4.3.7 Eyeglasses

Eyeglasses are a benefit of Texas Medicaid when the following criteria are met:

- Medically necessary
- Prescribed by a doctor of medicine, optometry, or osteopathy
- Prescribed to significantly improve vision or correct a medical condition
- In compliance with eyeglass program specifications for frames and lenses as stated in 1 Texas Administrative Code (TAC) §354.1017 and §363.503, Specifications for Eyewear

Eyeglasses may be provided to clients of any age when there is no other option available to correct or ameliorate a visual defect.

Eyeglasses are limited to once every 24 months. Additional services within the 24-month period may be considered when documentation in the client's medical record supports medical necessity for a diopter change of 0.5 or more in the sphere, cylinder, prism measurement(s), or axis changes. A new 24-month benefit period for eyewear begins with the placement of the new eyewear.

The prescription for eyeglasses must be given to the client upon request. A provider may not withhold a prescription for eyeglasses from a client even if Medicaid reimbursement for the eye examination has not been received.

The fitting of eyeglasses is considered part of the dispensing procedure and is not separately reimbursed.

4.3.7.1 Frames

The following procedure codes may be reimbursed for eyeglass frames:

Procedure Codes									
V2020	V2025								

Frames are limited to one per 24 calendar months by any provider.

4.3.7.2 Eyeglass Lenses

The following eyeglass lens procedure codes may be reimbursed for single vision lenses:

Procedure Codes									
V2100	V2101	V2102	V2103	V2104	V2105	V2106	V2107	V2108	V2109
V2110	V2111	V2112	V2113	V2114	V2115	V2118	V2121		

The following eyeglass lens procedure codes may be reimbursed for bifocal lens:

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Procedure Codes									
V2200	V2201	V2202	V2203	V2204	V2205	V2206	V2207	V2208	V2209
V2210	V2211	V2212	V2213	V2214	V2215	V2218	V2219	V2220	V2221

The following eyeglass lens procedure codes may be reimbursed for trifocal lenses:

Procedure Codes									
V2300	V2301	V2302	V2303	V2304	V2305	V2306	V2307	V2308	V2309
V2310	V2311	V2312	V2313	V2314	V2315	V2318	V2319	V2320	V2321

The following eyeglass lens procedure codes may be reimbursed for variable asphericity lenses:

Procedure Codes	
V2410	V2430

Eyeglass lenses are limited to one pair per 24 calendar months, any provider.

Providers must bill a quantity of two when billing for bilateral lenses with the same prescription.

4.3.7.3 Add-On Lenses

The following procedure codes may be reimbursed for add-on services:

Procedure Codes									
V2700	V2710	V2715	V2718	V2730	V2755	V2770	V2780		

Add-on procedure codes will not be reimbursed unless they are billed with the appropriate lens procedure code by the same provider for the same date of service.

Procedure code V2755 may be reimbursed for ultraviolet (U-V) protection when billed with one of the following diagnosis codes:

Diagnosis Codes							
H2701	H2702	H2703	H27111	H27112	H27113	H27121	H27122
H27123	H27131	H27132	H27133	Q123	Z961		

Procedure code V2755 will be denied when billed for the same date of service by the same provider as procedure code V2784.

4.3.7.4 * Polycarbonate Lenses

Polycarbonate lenses (procedure code V2784) may be reimbursed when billed with one of the diagnosis codes in the following table:

[Revised] Diagnosis Codes							
D8984	E083521	E083522	E083523	E083531	E083532	E083533	E083541
E083542	E083543	E093521	E093522	E093523	E093531	E093532	E093533
E093541	E093542	E093543	E103521	E103522	E103523	E103531	E103532
E103533	E103541	E103542	E103543	E113521	E113522	E113523	E113531
E113532	E113533	E113541	E113542	E113543	E133521	E133522	E133523
E133531	E133532	E133533	E133541	E133542	E133543	F840	F842
F843	F845	F848	F849	F951	G20A1	G20A2	G20B1

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[Revised] Diagnosis Codes							
G20B2	G20C	G2111	G2119	G213	G214	G218	G3180
G3183	G3184	G3186	G35A	G35B0	G35B1	G35B2	G35C0
G35C1	G35C2	G35D	G3781	G3789	G40001	G40009	G40011
G40019	G40101	G40109	G40111	G40119	G40201	G40209	G40211
G40219	G40301	G40309	G40311	G40319	G40A01	G40A09	G40A11
G40A19	G40B01	G40B09	G40B11	G40B19	G40C01	G40C09	G40C11
G40C19	G40401	G40409	G40411	G40419	G40501	G40509	G40801
G40802	G40803	G40804	G40811	G40812	G40813	G40814	G40821
G40822	G40823	G40824	G40841	G40842	G40843	G40844	G4089
G40901	G40909	G40911	G40919	G7100	G7101	G7102	G7109
G7111	G7112	G7113	G7114	G7119	G7120	G7121	G71220
G71228	G7129	G713	G718	G719	G720	G721	G722
G723	G7241	G7249	G7281	G7289	G729	G737	G800
G801	G802	G803	G804	G808	G809	G90B	G9342
G9344	G9345	H33001	H33002	H33003	H33011	H33012	H33013
H33021	H33022	H33023	H33031	H33032	H33033	H33041	H33042
H33043	H33051	H33052	H33053	H33191	H33192	H33193	H3321
H3322	H3323	H33301	H33302	H33303	H33311	H33312	H33313
H33321	H33322	H33323	H33331	H33332	H33333	H3341	H3342
H3343	H338	H53001	H53002	H53003	H53011	H53012	H53013
H53021	H53022	H53023	H53031	H53032	H53033	H53041	H53042
H53043	H540X33	H540X34	H540X35	H540X43	H540X44	H540X45	H540X53
H540X54	H541131	H541132	H541141	H541142	H541151	H541152	H541213
H541214	H541215	H541223	H541224	H541225	H542X12	H542X21	H542X22
H54413A	H54414A	H5442A3	H5442A4	H54512A	H5452A2	H8101	H8102
H8103	H8109	H8110	H8111	H8112	H8113	H8120	H8121
H8122	H8123	H81311	H81312	H81313	H81319	H81391	H81392
H81393	H81399	H814	H8301	H8302	H8303	H8309	H8311
H8312	H8313	H8319	H832X1	H832X2	H832X3	H832X9	I69012
I69112	I69212	I69312	I69812	I69912	P100	P101	P104
P108	P109	P112	P119	P524	P526	P528	P529
Q8740	Q87410	Q87418	Q8742	Q8743	Q8782	Q8783	Q8784
Q8785	Q8786	Q8787	Q8788	Q87A	Q8981	Q8989	Q900
Q901	Q902	Q909	Q9352	Q99811	Q99812	Q99813	Q99818
Q99819	QA00101	QA00139	QA00141	QA00142	QA00149	QA00151	R4185
S061X0A	S061X1A	S061X2A	S061X3A	S061X4A	S061X5A	S061X6A	S061X7A
S061X8A	S061X9A	S061XAA	S061XAD	S061XAS	S06305A	S06305D	S06305S
S06306A	S06306D	S06306S	S06307A	S06308A	S0630AA	S0630AD	S0630AS
S06371A	S06371D	S06371S	S06372A	S06372D	S06372S	S06373A	S06373D
S06373S	S06374A	S06374D	S06374S	S06375A	S0637AA	S0637AD	S0637AS

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[Revised] Diagnosis Codes							
S06890A	S06890D	S06890S	S06891A	S06891D	S06891S	S06892A	S06892D
S06892S	S06893A	S06893D	S06893S	S06894A	S06894D	S06894S	S06895A
S06895D	S06895S	S06896A	S06896D	S06896S	S06897A	S06898A	S06899A
S06899D	S06899S	S0689AA	S0689AD	S0689AS	S069X0A	S069X0D	S069X0S
S069X1A	S069X1D	S069X1S	S069X2A	S069X2D	S069X2S	S069X3A	S069X3D
S069X3S	S069X4A	S069X4D	S069X4S	S069X5A	S069X5D	S069X5S	S069X6A
S069X6D	S069X6S	S069X7A	S069X8A	S069X9A	S069X9D	S069X9S	S069XAA
S069XAD	S069XAS	T8521XA	T8521XD	T8521XS	T8522XA	T8522XD	T8522XS
T8529XA	T8529XD	T8529XS	T85310A	T85310D	T85310S	T85311A	T85311D
T85311S	T85318A	T85318D	T85318S	T85320A	T85320D	T85320S	T85321A
T85321D	T85321S	T85328A	T85328D	T85328S	T85390A	T85390D	T85390S
T85391A	T85391D	T85391S	T85398A	T85398D	T85398S	T8579XA	T8579XD
T8579XS	T85890A	T85890D	T85890S	T85898A	T85898D	T85898S	

In addition to the diagnoses listed in the table, polycarbonate lenses also may be reimbursed when the client meets the following criteria:

- Lens power in at least one meridian of -5.25/+4.00 diopters or more and the eyeglasses are not functional in regular standard glass or plastic lens materials due to weight, thickness, or aberration
- Monocular vision with functional vision in one eye
- Retinal detachment or risk for retinal detachment (e.g., lattice degeneration, history of retinal detachment in the family, posterior vitreous detachment)

Polycarbonate lens claims must include a lens procedure code with lens power in one meridian of -5.25/+4.00d or more.

If the eyeglass lenses are not functional in regular standard glass or plastic due to weight, thickness, or aberration or for diagnosis not listed, providers must submit documentation of medical necessity. If documentation is not submitted with the claim, the polycarbonate lenses will be denied.

Procedure code V2755 will be denied when billed for the same date of service by the same provider as polycarbonate lenses.

4.3.7.5 Dispensing of Eyeglasses

Dispensing of eyeglasses includes the design, verification, fitting, adjustment, sale, and delivery to the client of (1) fabricated and finished spectacle lenses, (2) frames, or (3) other ophthalmic devices, prescribed by and dispensed in accordance with a prescription from a licensed physician or optometrist.

Providers must be able to dispense standard size frames at no cost to the eligible client.

Providers must offer each client the following frame options:

- 20 years of age or younger: a choice of six styles in three colors for each type of frame.
- 21 years of age or older: a choice of three styles in three colors for each type of frameA cylinder axis change of at least 15 degrees for a cylinder power of 0.75-0.87 diopters.

The type of frame choices that are a benefit are:

- Metal
- Zylonite

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- Combination of metal and zylonite

When a client chooses eyeglass options beyond the program limitations, the client must be informed their choice is not a benefit of Texas Medicaid and acknowledge his or her liability for the cost difference by signing the Medicaid Vision Eyewear Client Certification form.

4.3.7.6 Repair of Eyeglasses

The eyeglass supplier is required to perform minor repairs on request (without charge) on eyeglasses that they have dispensed regardless of the client's age.

A repair costing $2.00 or less is considered a minor repair and is included in the eyeglass reimbursement.

Repair of eyeglasses is not a benefit for clients 21 years of age and older.

Repair of prosthetic eyeglasses, when the actual cost of materials exceeds $2.00 is a benefit for all ages.

Eyeglass repair costing $2.00 or more may be reimbursed using procedure code V2799 and requires the following:

- The cost of repair supplies cannot exceed the cost of replacement eyeglasses.
- All eyeglass repair materials must be new and at least equivalent to the original item.
- The provider must maintain the following in the client's medical record:
  - An itemized list of repairs
  - The replacement cost to determine whether criteria are met for repair

4.3.7.7 Replacement of Eyeglasses

Replacement of lost or destroyed eyeglasses is a benefit of Texas Medicaid for clients from birth through 20 years of age. If the eyeglasses are lost, stolen, or damaged beyond repair, the provider must have the client sign the Medicaid Vision Eyewear Client Certification Form and the signed form must be maintained in the client's medical record.

Claims for replacement lenses must be submitted with the RB modifier to ensure accurate processing. Prior authorization is not required for the replacement of eyeglasses.

Replacement of eyeglasses within the 24-month period is a benefit only when medically necessary due to a significant change in visual acuity. A new prescription must document at least one of the following changes:

- A change of 0.50 diopters or more in any corresponding meridian.
- A cylinder axis change of at least 20 degrees for a cylinder power of 0.50-0.62 diopters.
- A cylinder axis change of at least 15 degrees for a cylinder power of 0.75-0.87 diopters.
- A cylinder axis change of at least 10 degrees for a cylinder power of 1.00-1.87 diopters.
- A cylinder axis change of at least 5 degrees for a cylinder power of 2.00 diopters or greater.

4.3.7.8 Undeliverable Eyeglasses

If a client cancels an order for eyeglasses prior to their completion and delivery or if the eyeglasses become unusable because the client dies or his prescription changes prior to completion and delivery of the eyeglasses, the provider is still entitled to reimbursement based on the services furnished and the materials used, up to the time the provider learned of the cancellation of the eyeglasses or the fact that the eyeglasses would not be usable. This applies to lenses only, not to the frames.

4.3.8 Contact Lenses

Contact lenses may be considered for clients of any age if there is no other option available to correct or ameliorate a visual defect.

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Contact lenses are limited to once every 24 months. Additional services within the 24-month period may be considered when documentation in the client's medical record supports medical necessity for a diopter change of 0.5 or more in the sphere, cylinder, prism measurement(s), or axis changes. A new 24-month benefit period for eyewear begins with the placement of the new non-prosthetic eyewear.

Prior authorization is required for all contact lenses unless provided in a medical emergency. Prior authorization decisions are based on the provider's written documentation supporting the need for contact lenses as the only means of correcting the vision defect.

The following procedure codes may be reimbursed for contact lenses:

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

Therapeutic soft (hydrophilic) contact lenses (procedure codes V2520, V2521, V2522, V2523) or gas-permeable fluid ventilated scleral lenses (procedure codes V2530 and V2531) are considered medically necessary prosthetics when used as moist corneal bandages for the treatment of severe ocular surface diseases.

4.3.8.1 Dispensing of Contact Lenses

Dispensing of contact lenses include the fabrication, ordering, adjustment, dispensing, sale, and delivery to the client of the contact lens(es) prescribed by and dispensed in accordance with a prescription from a licensed physician or optometrist.

When a client chooses contact lens options beyond the program limitations, the client must be informed their choice is not a benefit of Texas Medicaid and acknowledge his or her liability for the cost difference by signing the Medicaid Vision Eyewear Client Certification Form.

4.3.8.2 Contact Lens Fitting and Modification

The following procedure codes may be reimbursed for the fitting and modification of a contact lens:

Procedure Codes							
92310	92311	92312	92313	92314	92315	92316	92317
92325	92326						

Procedure codes 92310, 92325, and 92326 are limited to one service per day, any provider.

4.3.8.3 Contact Fitting for Corneal Bandage Lens

A contact lens fitting for placement of a corneal bandage lens may be medically necessary for eye protection and pain control due to a disease or injury.

The following procedure codes may be reimbursed for corneal bandage fitting:

Procedure Codes							
92071	92072						

The emergency condition necessitating a corneal bandage must be documented on the claim.

Procedure code 92071 is limited to one service per eye, per day, by any provider.

Modifier LT or RT must be included on the claim to identify the eye on which the service was performed. When procedure code 92071 is performed on both eyes on the same date of service, one procedure may be reimbursed at the full rate and the second procedure may be reimbursed at half rate.

Procedure code 92072 is limited to one service per lifetime by the same provider.

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Procedure code 92072 will be denied if billed on the same date of service by the same provider as procedure code 92071.

Procedure codes 92071 or 92072 must be billed on the same date of service as one of the following procedure codes V2511, V2512, V2513, V2520, V2521, V2522, and V2523.

4.3.8.4 Prior Authorization Requirements

Prior authorization for contact lenses must be submitted on a SMPA Request Form, signed and dated by the prescribing physician or optometrist and must include the following documentation:

- Diagnosis causing the refractive error (such as keratoconus)
- Current and new prescriptions supporting a diopter change of 0.5 or more in the sphere, cylinder, prism measurement(s), or axis changes
- Which eye(s) need to be treated
- The procedure code(s) requested
- A brief statement addressing the medical necessity for vision correction by contact lens(es) and specifying why eyeglasses are inappropriate or contraindicated for this client

Note: *Additional contact lenses may be considered more frequently than the limitations previously outlined in this handbook, when documentation in the client's medical record supports medical necessity for a diopter change of 0.5 or more in the sphere, cylinder, prism measurement(s), or axis changes.*

Note: *Non-prosthetic contact lenses for emergency placement do not require prior authorization. The emergency condition necessitating a corneal bandage must be documented on the claim.*

Authorization for contact lenses may be considered for 60 days.

Temporary contact lenses after cataract surgery may be prior authorized for diagnosis code Z961 when medically necessary.

4.3.8.5 Replacement of Contact Lenses

Replacement of lost or destroyed contact lenses is a benefit of Texas Medicaid for clients from birth through 20 years of age. If the contact lenses are lost, stolen, or damaged beyond repair, the provider must have the client sign the Medicaid Vision Eyewear Client Certification Form and the signed form must be maintained in the client's medical record.

Replacement of contacts within the 24-month period is a benefit only when medically necessary due to a significant change in visual acuity. A new prescription must document at least one of the following changes:

- A change of 0.50 diopters or more in any corresponding meridian.
- A cylinder axis change of at least 20 degrees for a cylinder power of 0.50-0.62 diopters.
- A cylinder axis change of at least 15 degrees for a cylinder power of 0.75-0.87 diopters.
- A cylinder axis change of at least 10 degrees for a cylinder power of 1.00-1.87 diopters.
- A cylinder axis change of at least 5 degrees for a cylinder power of 2.00 diopters or greater.

Prior authorization is required for replacement of contact lenses.

The appropriate eyeglass and frame or contact lens procedure codes must be billed with modifier RB to indicate replacement.

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4.3.9 Eyeglasses and Contact Lenses

4.3.9.1 Medicare Coverage for Eyewear

Eye examinations for the purpose of prescribing, fitting, or changing eyeglasses or 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 Medicaid Qualified Medicare Beneficiary (MQMB) 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 an MQMB 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 deductible and coinsurance payment consideration according to current guidelines.

Refer to: Section 2.7, "Medicare Crossover Claim Reimbursement" in the *Section 2: Texas Medicaid Fee-for-Service Reimbursement* (*Vol. 2, Provider Handbooks*) for more information about current coinsurance and deductible payment guidelines.

Important: *Providers performing eye exams for refractive errors on Medicaid Qualified Medicare Beneficiary (MQMB) clients must bill TMHP. 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 Section 4.3.7, "Eyeglasses" in the *Vision and Hearing Services Handbook* (*Vol. 2, Provider Handbooks*)and Section 4.3.8, "Contact Lenses" in the *Vision and Hearing Services Handbook* (*Vol. 2, Provider Handbooks*).

4.3.9.2 Prosthetic Eyeglasses or Contact Lenses

Prosthetic eyeglasses or contact lenses are lenses that replace the eye's organic lens when it is absent due to congenital or acquired aphakia. Aphakia may be the result of a congenital abnormality or defect, or an acquired condition as a result of trauma, or cataract removal without IOL insertion.

Prosthetic eyeglasses or contact lenses may be provided based on medical necessity. Prosthetic contact lenses may be provided, with prior authorization, for clients of any age with congenital or acquired aphakia. Eye examinations for aphakia (including congenital aphakia) and disease or injury to the eye may be reimbursed as often as is medically necessary.

Note: *Fitting services are included in the reimbursement for prosthetic eyeglasses.*

One pair of prosthetic eyeglasses or contact lens(es) is a benefit during a client's lifetime.

The following aphakia diagnosis codes must be used when billing for prosthetic eyeglasses:

Diagnosis Codes							
H2701	H2702	H2703	Q123				

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Replacement of prosthetic eyeglasses or contact lens(es) is a benefit of Texas Medicaid regardless of age under the following circumstances:

- Loss or destruction
- Significant change in visual acuity with a diopter change of 0.5 or more in the sphere, cylinder, prism measurement(s), or axis changes

The provider must maintain documentation in the client's medical record supporting the medical necessity for the replacement eyeglasses or contact lens(es).

If the prosthetic eyewear is lost, stolen, or damaged beyond repair, the provider must have the client sign the Medicaid Vision Eyewear Client Certification Form and the signed form must be maintained in the client's medical record.

The appropriate eyeglass and frame or contact lens procedure codes must be billed with modifier RB to indicate replacement.

Refer to: Section 4.3.7, "Eyeglasses" in the *Vision and Hearing Services Handbook* (*Vol. 2, Provider Handbooks*) and Section 4.3.8, "Contact Lenses" in the *Vision and Hearing Services Handbook* (*Vol. 2, Provider Handbooks*)for the eyeglass lens, frame, contact lens procedure codes and dispensing requirements that apply to eyewear.

4.3.9.3 Eyeglasses or Contact Lenses following Cataract Surgery

4.3.9.3.1 Temporary Eyewear

Temporary eyeglasses or contact lenses after cataract surgery may be reimbursed when they are billed with the appropriate lens and frame procedure codes and diagnosis code Z961.

Temporary eyeglasses or contact lens(es) for these clients may be considered up to four months after surgery until the client is ready for permanent eyeglasses or contact lens(es) when medically necessary. The date of surgery is used to determine the convalescence period for temporary eyeglasses or contact lens(es). There are no limitations on the number of temporary contact lens(es) during the postsurgical convalescence period. Temporary eyeglasses or contact lens(es) will be denied if dispensed more than four months after the date of surgery.

4.3.9.3.2 Permanent Eyewear

Permanent eyeglasses or contact lens(es) following cataract surgery may be provided based on medical necessity for clients of any age. Permanent contact lenses require prior authorization.

Note: *Fitting services are included in the reimbursement for permanent eyeglasses.*

One pair of permanent eyeglasses or contact lens(es) is a benefit during a client's lifetime.

Providers must use diagnosis code Z961 to indicate the presence of an IOL when billing for permanent eyewear following cataract surgery.

Replacement of permanent eyeglasses or contact lens(es) is a benefit of Texas Medicaid regardless of age under the following circumstances:

- Loss or destruction
- Significant change in visual acuity with a diopter change of 0.5 or more in the sphere, cylinder, prism measurement(s), or axis changes

The provider must maintain documentation in the client's medical record supporting the medical necessity for the replacement eyeglasses or contact lens(es).

If the permanent eyewear is lost, stolen, or damaged beyond repair, the provider must have the client sign the Medicaid Vision Eyewear Client Certification Form and the signed form must be maintained in the client's medical record.

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The date of cataract surgery is not required on the claim for:

- Permanent contact lens(es) or eyeglasses after surgery
- Prosthetic contact lens(es) or eyeglasses after cataract surgery without IOL insertion

Providers must include diagnosis code Z961 to indicate the presence of an IOL on the claim.

4.3.9.4 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 nonprosthetic.

Refer to: Section 9.2.49.4, "Intraocular Lens (IOL)" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for more information about IOL benefits.

Section 4.3.7, "Eyeglasses" in the *Vision and Hearing Services Handbook* (*Vol. 2, Provider Handbooks*)and Section 4.3.8, "Contact Lenses" in the *Vision and Hearing Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about nonprosthetic eyewear

4.3.9.5 Artificial Eyes

For clients who are birth through 20 years of age, artificial eyes may be considered under CCP.

4.3.10 Surgical Vision Services

Refer to: Subsection 6.55, "Fluocinolone Acetonide (Retisert)" in the *Outpatient Drug Services Handbook* (*Vol. 2, Provider Handbooks*) for more information about fluocinolone acetonide benefits.

Subsection 9.2.49, "Ophthalmology" in the *Medical and Nursing Specialists, Physicians, and Physician Assistants Handbook* (*Vol. 2, Provider Handbooks*) for more information about surgical vision services.

4.3.11 Prior Authorization

Prior authorization is required for:

- Unlisted ultrasound procedures.
- Computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; retina, beyond the maximum limits outlined in this handbook.
- All contact lenses, except corneal bandage lens(es) for emergency placement.
- All services requested through THSteps-CCP.

Requests for prior authorization must be received and approvals must be obtained before services are rendered. Requests received after the service date will be denied.

Prior authorization requests may be submitted to the TMHP Special Medical Prior Authorization Department via mail, fax, or the electronic portal. The electronic signature technology must meet all applicable federal and state statutes and administrative rules. Electronically-signed documents must have an electronic date on the same page as the signature, Electronic signatures that are generated through an electronic medical record (EMR) or electronic health record (EHR) system that complies with applicable federal and state statutes and rules are acceptable. All electronically-signed transactions and electronically-signed documents must be kept in the client's medical record. Prescribing and dispensing providers that utilize electronic signatures must provide a certification that the electronic signature technology that they use complies with all applicable federal and state statutes and administrative rules. Providers who submit a prior authorization request must also attest that electronic

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signatures included in the request are true and correct to the best of their knowledge. A hard copy of electronic transactions and signed documents must be available upon request. Stamped signatures and images of wet signatures will not be accepted. Prescribing or ordering providers, dispensing providers, clients' responsible adults, and clients may sign prior authorization forms and supporting documentation using electronic or wet signatures.

To complete the prior authorization process by paper, the provider must fax or mail the completed Special Medical Prior Authorization (SMPA) Request Form to the TMHP-SMPA department and retain a copy of the signed and dated prior authorization form in the client's medical record.

To complete the prior authorization process electronically, the provider must complete the prior authorization requirements through any approved electronic methods and retain a copy of the signed and dated prior authorization form in the client's medical record.

The SMPA form must be signed and dated within 60 days before the date of service. Services will not be authorized prior to the ordering provider's signature date.

To facilitate determination of medical necessity and avoid unnecessary denials, the physician must provide correct and complete information, including documentation for medical necessity for the equipment or supplies requested. The physician must maintain documentation of medical necessity in the client's medical record.

The requesting provider may be asked for additional information to clarify or complete a request.

Retrospective review may be performed to ensure documentation supports the medical necessity of the requested equipment or supplies.

4.4 Documentation Requirements

In addition to documentation requirements outlined in the prior authorization sections of this handbook, all services require documentation to support the medical necessity of the service rendered. Vision services are subject to retrospective review and recoupment if documentation does not support the service billed.

The client must sign and date the Medicaid Vision Eyewear Client Certification Form, and the provider must retain it in the provider's records.

When a client chooses an eyeglasses or contact lens option beyond the program limitations, eyeglasses or contact lenses are replaced because of loss or destruction the client must acknowledge their choice and liability for the cost difference by signing the Medicaid Vision Eyewear Client Certification Form and retain it in the provider's records.

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

The provider must make the client's medical record available for review upon request by the following:

- HHSC
- Office of the Attorney General
- TMHP

4.5 Claims Filing and Reimbursement

4.5.1 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 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.

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When submitting the client's old and new prescriptions to show an axis change or 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 paper claim form.

Claims for eye examination services require a diagnosis. 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 who are 20 years of age and 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.

4.5.2 Reimbursement

Providers must reflect the highest level of specificity for vision related diagnoses on claims or other documentation. Professional services by an optometrist for contact lenses and prosthetic eyewear are reimbursed in accordance with 1 TAC §355.8001 and §355.8085.

Procedure codes described as bilateral are inclusive codes, and right and left studies billed on the same day will be reimbursed at a quantity of one.

Procedure codes described as "unilateral or bilateral" will be reimbursed for the same amount whether one or both sides are tested.

FQHCs are paid an all-inclusive rate per visit for payable services in accordance with 1 TAC, §355.8261.

Suppliers of 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 OFL or the applicable fee schedule on the TMHP website at www.tmhp.com.

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

Vision Services on the TMHP website at www.tmhp.com for a claim form example.

Texas Medicaid implemented mandated rate reductions for certain services. The OFL and static fee schedules include a column titled "Adjusted Fee" to display the individual fees with all mandated percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/resources/rate-and-code-updates/rate-changes.

4.5.2.1 NCCI and MUE Guidelines

The HCPCS and CPT codes included in the *Texas Medicaid Provider Procedures Manual* are subject to NCCI relationships, which supersede any exceptions to NCCI code relationships that may be noted in the manuals. Providers should refer to the CMS NCCI web page for correct coding guidelines and specific applicable code combinations.

In instances when Texas Medicaid limitations are more restrictive than NCCI MUE guidance, Texas Medicaid limitations prevail.

If applicable and consistent with CMS billing guidelines, procedure codes must be billed with modifier LT (left side) or RT (right side) to identify the eye on which the service was performed.

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5 Claims Resources

Refer to the following sections and forms when filing claims:

Resource	Location
Acronym Dictionary	"Appendix C: Acronym Dictionary" (*Vol. 1, General Information*)
Automated Inquiry System (AIS)	Subsection A.10, "TMHP Telephone and Fax Communication" in "Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*)
CMS-1500 Paper Claim Filing Instructions	Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*)
State, federal, and TMHP contact information	"Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*)
TMHP electronic claims submission information	Subsection 6.2, "TMHP Electronic Claims Submission" in "Section 6: Claims Filing" (*Vol. 1, General Information*)
TMHP Electronic Data Interchange (EDI) information	"Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*)

6 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.

7 Forms

The following linked forms can also be found on the Forms page of the Provider section of the TMHP website at www.tmhp.com:

Forms
Physician's Examination Report
Medicaid Vision Eyewear Client Certification Form
Medicaid Vision Eyewear Client Certification Form (Spanish)

8 Claim Form Examples

The following linked claim form examples can also be found on the Claim Form Examples page of the Provider section of the TMHP website at www.tmhp.com:

Claim Form Examples
Hearing Aid Assessments
Vision Services

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