OPTOMETRIC AND OPTICAL SERVICES

ELIGIBLE PROVIDERS

In order to receive payment, all eligible servicing and billing provider's National Provider Identifiers (NPI) must be enrolled with South Dakota Medicaid. Servicing providers acting as a locum tenens provider must enroll in South Dakota Medicaid and be listed on the claim form. Please refer to the provider enrollment chart for additional details on enrollment eligibility and supporting documentation requirements.

South Dakota Medicaid has a streamlined enrollment process for eligible ordering, referring, and attending providers that may require no action on the part of the provider as submission of claims constitutes agreement to the South Dakota Medicaid Provider Agreement.

Optometric and optical services are reimbursable for an optometrist licensed to practice optometry as defined in SDCL 36-7-1, an individual licensed to practice optometry under the laws of another state, or an enrolled optical supply company.

ELIGIBLE RECIPIENTS

Providers are responsible for checking a recipient's Medicaid ID card and verifying eligibility before providing services. Eligibility can be verified using South Dakota Medicaid's online portal.

The following recipients are eligible for medically necessary services covered in accordance with the limitations described in this chapter:

Coverage Type	Coverage Limitations
Medicaid/CHIP Full Coverage	Medically necessary services covered in accordance with the limitations described in this chapter.
Qualified Medicare Beneficiary – Coverage Limited (73)	Coverage restricted to copay, coinsurance, and deductibles on Medicare A and B covered services.

Refer to the Recipient Eligibility manual for additional information regarding eligibility including information regarding limited coverage aid categories.

COVERED SERVICES AND LIMITS

General Coverage Principles
Providers should refer to the General Coverage Principles manual for basic coverage requirements all services must meet. These coverage requirements include:

- The provider must be properly enrolled;
- Services must be medically necessary;

- The recipient must be eligible; and
- If applicable, the service must be prior authorized.

The manual also includes non-discrimination requirements providers must abide by.

Covered Optometric Services
Optometric services are a covered service for both children and adults eligible for South Dakota Medicaid. There is no age restriction for eye examinations and/or refractions. Recipients in a Care Management Program are not required to obtain a referral for these services. Covered services are limited to the services and supplies listed on the department's Vision fee schedule.

Eye Examinations
Intermediate Eye Exam
An intermediate eye exam is covered under CPT code 92002 for new patients and 92012 for established patients. Providers must follow the guidelines in the CPT codebook for distinguishing between new and established patients. An intermediate examination is an examination of a new or existing condition complicated with a new diagnostic or management problem not necessarily relating to the primary diagnosis. An intermediate eye examination must meet the description provided in the CPT codebook.

Comprehensive Eye Exam
A comprehensive eye exam is covered under CPT code 92004 for new patients and CPT code 92014 for established patients. Providers must follow the guidelines set in the CPT codebook for distinguishing between new and established patients. A comprehensive examination is a general evaluation of the complete visual system. It must meet the description provided in the CPT codebook and the requirements established in ARSD 20:50:07:01.

EM Codes
Providers may code examinations in which counseling and coordination of care are the dominant services with the appropriate evaluation and management (E/M) code.

Refractions
If medically necessary, a test to determine refractive state is covered under CPT code 92015 if services include specification of lens type (monofocal, bifocal or other), lens power, axis, prism, impact resistance and other factors for a prescription of lenses. In cases when a third-party payer requires tests for refractions to be included in an examination code, providers are allowed to include 92015 on the claim to Medicaid. The provider must note on the explanation of benefits that the primary insurer does not allow 92015 to be separately billed. The total billed charges for the examination and refraction should match the total billed charges on the explanation of benefits for the examination.

Contact Lenses
- Initial contact lenses are covered if necessary, for the correction of irregular astigmatism, anisometropia in excess of four diopters, or refractive error in excess of six diopters in one meridian of either eye.
- Contact lenses are also covered for therapeutic use.

Replacement Contact Lenses

- Replacement contact lenses are covered for standard rigid gas permeable or standard annual replacement, daily wear soft contact lenses are limited to two lenses a year which may consist of two lenses for one eye or one lens for each eye. Recipients fitted with planned replacement daily wear soft contact lenses must be provided with a year's supply of lenses at the initial fitting and no other replacement lenses may be covered during that year.

Lenses

- Single vision, bifocal, and trifocal lenses are covered.
- Progressive lenses are covered but may not be billed with any other lenses (V2299 or V2399).
- Polycarbonate lenses are covered for children age 20 or younger. Polycarbonate lenses are only covered for adults if the recipient has a prosthetic eye, monocular vision, or the recipient's corrected visual acuity is 20/50 or less in one eye because of amblyopia or injury.
- High index lenses are only covered if the recipient has at least plus or minus 7.00 diopters in the meridian of greatest power when placed on an optical cross.
- Aspheric single vision and multifocal lenses greater than 6 D effective power are covered when medically necessary due to cataract surgery or other eye disease without replacement of the interocular lens and may not be billed with a 22 modifier.

Replacement Lenses and Frames

General Replacement Criteria

- Replacement frames and/or both lenses are covered if:
    - A minimum of 15 months has passed since the present eyeglasses were received and a lens change is medically necessary;
    - There is a change in correction to one or both eyes of at least .50 diopters; or
    - The eyeglasses are broken beyond repair and the broken eyeglasses are returned to the provider.
    - The provider must enter “Lost”, “Stolen”, or “Broken” in box 19 of the CMS 1500 claim form the and into loop 2300 for 837P claim form for replacement lenses and/or frames.
    - Recipients aged 20 or younger who have outgrown their glasses and no longer fit the recipient without pain or discomfort.
        - Documentation clarifying the recipient has outgrown the current frames, must accompany the claim.

Stolen Eyeglasses

- Replacement of stolen eyeglasses are covered for recipients aged 20 or younger. For recipients, age 21 or older a police report must be submitted with the claim. The date on the police report must align with the date of theft in order to be considered valid.

Broken Eyeglasses

- Damaged eyeglasses should always be repaired if possible.
- Replacement of eyeglasses that are broken beyond repair is covered for recipients of all ages.

Monitoring of Replacements

South Dakota Medicaid monitors replacements and may contact recipients if the number of replacements appears to be excessive.

Prosthesis

- Permanent prosthesis is covered for aphakia.

Lens Modification

- Slab-off prism or Bi-centric grinding is covered when medically necessary. Documentation must be submitted with the claim that supports medical necessity.
- Fresnel or Press-on Prism is covered when medically necessary. Documentation must be submitted with the claim that supports medical necessity.

Fundus Photography

- Fundus photography is covered when indicated to document abnormalities related to disease processes affecting the eye or to follow the progress of the disease.
- Fundus photographs are only considered medically necessary where the results may influence the management of the patient. Such conditions include: macular degeneration, retinal neoplasms, choroid disturbances and diabetic retinopathy, or to identify glaucoma, multiple sclerosis, and other central nervous system abnormalities.

NON-COVERED SERVICES

General Non-Covered Services

Providers should refer to ARSD 67:16:01:08 or the General Coverage Principles manual for a general list of services that are not covered by South Dakota Medicaid. Due to EPSDT, coverage limits contained in ARSD 67:16:08:04 do not apply to children under the age of 21 if items or services are medically necessary.

Non-Covered Optometric/Optical Services

South Dakota Medicaid does not cover the following items or services:

- Extended wear or daily disposable contact lenses;
- Regular eyeglasses or contact lenses when used to supplement another pair of corrective vision lenses;
- Athletic glasses;
- Tinting, additional charges for photochromic lenses, lens decoration, or special lens coating;
- Frames if a lens change is not medically necessary;
- LASIK surgery; and
- Consultation services.

DOCUMENTATION REQUIREMENTS

General Requirements

Providers must keep legible medical and financial records that fully justify and disclose the extent of services provided and billed to South Dakota Medicaid. These records must be retained for at least 6

years after the last date a claim was paid or denied. Please refer to the Documentation and Record Keeping manual for additional requirements.

REIMBURSEMENT AND BILLING

Timely Filing
South Dakota Medicaid must receive a provider's completed claim form within 6 months following the month the service was provided. Requests for reconsiderations will only be considered if they are received within the timely filing period or within 3 months of the date a claim was denied. The time limit may be waived or extended by South Dakota Medicaid in certain circumstances. Providers should refer to the General Claim Guidance manual for additional information.

Third-Party Liability
Medicaid recipients may have one or more additional source of coverage for health services. South Dakota Medicaid is generally the payer of last resort. Providers must pursue the availability of third-party payment sources and should use the Medicare Crossover or Third-Party Liability billing instructions when applicable. Providers should refer to the General Claim Guidance manual for additional information.

Reimbursement
A claim must be submitted at the provider's usual and customary charge. Payment is the lesser of the provider's usual and customary charge or the fee listed on the Vision fee schedule. After South Dakota Medicaid has made payment on any procedure(s) the provider may not bill the recipient for any part of the charge. Therefore, if a recipient chooses a more expensive frame or lenses, the provider may either accept South Dakota Medicaid's payment in full or bill the recipient for the entire amount.

Place of Service Site Differential
Effective for claims with dates of service on and after July 1, 2026, South Dakota Medicaid's maximum allowable reimbursement rate for physicians' services in some instances differs depending on if the service is provided in a facility or non-facility settings. For applicable procedure codes, the place of service is derived from the Place of service (POS) code entered in Block 24 of the CMS 1500 claim form. Non-Facility and Facility place of service code designations are provided in the General Coverage Principles manual. The rate for facility or non-facility services is published on the Departments' Fee Schedule website at https://dss.sd.gov/medicaid/providers/feeschedules/.

Claim Instructions
Claims must be submitted on a CMS 1500 claim form or on an 837P. Detailed instructions for completing a claim for are provided in the Billing Manuals.

A claim for optical supplies may not be submitted until after the item is delivered to the recipient. Refer to the 837P instructions for electronic claims.

High Index Lenses

When billing for high index lenses, providers must document the prescription strength in box 19 of the CMS 1500 or the 837p equivalent field or submit a copy of the prescription with the claim using one of the following CPT codes:

- V2782 – Lens, 1.54-1.65 P/160-1.79G
- V2783 – Lens, >= 1.66 P/> = 1.80 G

Replacement Lenses and/or Frames

In box 19 of the CMS 1500 claim form the provider must enter “Lost”, “Stolen”, or “Broken”. For 837P claims this information should be entered in loop 2300. Verify the segment with your electronic clearinghouse. If glasses are stolen, the provider must attach a police report with the CMS 1500 claim form. The date on the police report must align with the date of theft in order to be considered valid.

Postoperative Management Only Services

When providers perform postoperative management only for procedures performed by another physician/ophthalmologist, the 55 modifier must be applied to the claim. The maximum allowable rate is is 25% of the established rate.

DEFINITIONS

1. "Amblyopia," the condition that exists when there is reduced vision in an eye because it did not receive adequately focused retinal stimulus during early childhood;

2. "Anisometropia," the difference in the refractive power of the two eyes;

3. "Aphakia," the absence of an eye's lens;

4. "Diopter," the unit of refractive power of lenses;

5. "Irregular astigmatism," the condition in which the curvature in different parts of the same meridian of the eye varies or in which successive meridians differ irregularly in refraction;

6. "Myopia," that error of refraction in which rays of light entering the eye parallel to the optic axis are brought to focus in front of the retina;

7. "Optician," a supplier of eyeglasses as prescribed by an optometrist;

8. "Optometric and optical care services," prescriptive, diagnostic, dispensing, or therapeutic services provided by an optometrist, optician, or optical company;

9. "Optometrist," an individual who practices optometry as defined in SDCL 36-7-1 or an individual licensed to practice optometry under the laws of another state; and

10. "Therapeutic," healing, curative.

REFERENCES

- Administrative Rule of South Dakota (ARSD)
- South Dakota Medicaid State Plan
- Code of Federal Regulations

QUICK ANSWERS

1. **Does South Dakota Medicaid's replace children's glasses that are lost, stolen or broken?**

   South Dakota Medicaid will replace glasses that are lost, stolen, or broken beyond repair for recipients under the age of 21. In box 19 of the CMS 1500 claim form the provider must enter "Lost", "Stolen", or "Broken". For 837P claims this information should be entered in loop 2300. Verify the segment with your electronic clearinghouse.

2. **A replacement pair of glasses are ordered for a child that lost their glasses. The recipient finds the glasses before the new pair is dispensed. Are the replacement glasses covered?**

   If the lost glasses have been found, the replacement glasses are not covered.

3. **Are replacement glasses covered if an adult has their glasses stolen?**

   If glasses are stolen, the provider must attach a police report with the CMS 1500 claim form.

4. **Are replacement glasses covered for an adult that has lost their glasses?**

   No, South Dakota Medicaid does not cover this item for adults aged 21 or older.

5. **Are replacement glasses covered for an adult that has broken their glasses?**

   Yes, if the eyeglasses are broken beyond repair and the broken glasses are returned to the provider. In box 19 of the CMS 1500 claim form the provider must enter "Broken". For 837P claims this information should be entered in loop 2300. Verify the segment with your electronic clearinghouse.

6. **Can I bill for a baseline fundus photography on every recipient?**

   Fundus photographs are only considered medically necessary where the results may influence the care management of the patient. If the recipient has a disease process affecting the eye, the fundus photographs may be used to follow the disease progression.

7. **Do I have to be enrolled as an optical supply company to bill optical supplies such as contacts and eyeglasses?**

   Providers enrolled as optometrists or optical supply companies can bill for these supplies.

8. **Can I charge the recipient an amount in addition to the Medicaid payment?**

No, South Dakota Medicaid payment is considered payment in full per ARSD 67:16:01:07. If a recipient wants a more expensive frame or lenses, the provider may choose to accept South Dakota Medicaid's payment as payment in full. Alternatively, the recipient may choose to pay the full cost of the lenses/frames out of pocket if the provider does not accept Medicaid payment for the item.