

CHAPTER 62

VISION CARE SERVICES MANUAL

Authority

N.J.S.A. 30:4D-6a(5), b(6), (7); 7a, b, and c; 30:4D-12; 42 CFR 440.50, 440.120.

Source and Effective Date

R.1994 d.6, effective December 7, 1993.
See: 25 N.J.R. 3907(a), 26 N.J.R. 225(a).

Executive Order No. 66(1978) Expiration Date

Chapter 62, Vision Care Services Manual, expires on December 7, 1998.

Chapter Historical Note

Chapter 62, Vision Care Services Manual, became effective October 18, 1971 as R.1971 d.142. See: 3 N.J.R. 25(c), 3 N.J.R. 178(e).

1973 Revisions: Amendments became effective September 1, 1973 as R.1973 d.197. See: 5 N.J.R. 44(a), 5 N.J.R. 281(b).

1974 Revisions: Amendments became effective August 30, 1974 as R.1974 d.181. See: 6 N.J.R. 65(b), 6 N.J.R. 312(c).

1975 Revisions: Amendments became effective September 1, 1975 as R.1975 d.261. See: 7 N.J.R. 316(c), 7 N.J.R. 465(b).

1979 Revisions: Amendments became effective February 14, 1979 as R.1979 d.60. See: 10 N.J.R. 539(b), 11 N.J.R. 132(c).

1981 Revisions: Amendments became effective July 9, 1981 as R.1981 d.249. See: 13 N.J.R. 293(a), 13 N.J.R. 417(a). Further amendments became effective September 10, 1981 as R.1981 d.331. See: 13 N.J.R. 413(a), 13 N.J.R. 575(a).

1983 Revisions: Subchapters 1, 2 and 4 were readopted pursuant to Executive Order 66(1978) effective December 19, 1983 as R.1983 d.620. See: 15 N.J.R. 1731(a), 16 N.J.R. 144(b).

1986 Revisions: Subchapter 4 was repealed and a new subchapter became effective March 3, 1986 as R.1986 d.52. See: 17 N.J.R. 1519(b), 18 N.J.R. 478(a). Subchapter 3 was readopted pursuant to Executive Order 66(1978) effective March 6, 1986 as R.1986 d.90. See: 17 N.J.R. 2731(b), 18 N.J.R. 689(a). Amendments became effective June 16, 1986 (operative July 1, 1986) as R.1986 d.236. See: 18 N.J.R. 803(a), 18 N.J.R. 1287(a).

1987 Revisions: Subchapter 3 was substantially amended and recodified effective October 5, 1987 as R.1987 d.408. See: 19 N.J.R. 1155(a), 19 N.J.R. 1800(a).

1988 Revisions: Pursuant to the provisions of N.J.S.A. 30:4D-2, 3, 5, 6 and 7 and the New Jersey Appropriation Act (P.L. 1988 c.47), maximum fee allowance increases for routine visit in 4.3 for August 1, 1988 and May 1, 1989 and also for vision care appliances effective August 1, 1988 and May 1, 1989. See: 20 N.J.R. 2101(a). Subchapters 1, 2 and 3 were repealed and new subchapters 1, 2 and 3 of the "Vision Care Services Manual" became effective December 19, 1988 as R.1988 d.580. See: 20 N.J.R. 956(c), 20 N.J.R. 3147(a).

Pursuant to Executive Order No. 66(1978), Chapter 62 was readopted as R.1994 d.6. See: Source and Effective Date. As a part of R.1994 d.6, existing Subchapter 3, Billing Procedures, and Subchapter 4, referencing HCPCS, were repealed and a new Subchapter 3, HCFA Common Procedure Coding System (HCPCS), was adopted, effective January 3, 1994. See: 25 N.J.R. 3907(a), 26 N.J.R. 225(a). See, also, section annotations for specific rulemaking activity.

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SUBCHAPTER 1. EYE CARE: PROFESSIONAL SERVICES

10:62-1.1 Scope

This subchapter delineates the New Jersey Medicaid program's standards for examinations and care for vision defects and/or eye diseases for the purpose of maintaining or improving the health of New Jersey Medicaid recipients.

Amended by R.1994 d.6, effective January 3, 1994.
See: 25 N.J.R. 3907(a), 26 N.J.R. 225(a).

10:62-1.2 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings unless the context clearly indicates otherwise.

“Ophthalmologist” means a fully licensed medical doctor who has been recognized by the New Jersey Medicaid program as a specialist in ophthalmology.

“Optometrist” means any person who is licensed by the New Jersey State Board of Optometry to engage in the practice of optometry, or licensed to engage in the practice of optometry in the state in which he or she performs such functions.

“Practitioner” means a licensed ophthalmologist or optometrist, acting within the scope of licensure.

“Transfer” means the relinquishing of responsibility for the continuing care of the recipient by one practitioner and the assumption of such responsibility by another practitioner.

Amended by R.1994 d.6, effective January 3, 1994.
See: 25 N.J.R. 3907(a), 26 N.J.R. 225(a).

10:62-1.3 Providers of professional services

(a) Within the restrictions of their respective licensure, the following are eligible providers of eye care upon fulfilling the enrollment process requirements in N.J.A.C. 10:49-3.2:

1. Ophthalmologists or optometrists licensed in the State of New Jersey;
2. Ophthalmologists or optometrists in another state who are duly licensed in that state;
3. Independent clinics approved by the New Jersey Medicaid program to render eye care services; and
4. Hospitals meeting the definition of “approved hospital” as described in N.J.A.C. 10:52-1.1 of the Hospital Services Manual.

Amended by R.1994 d.6, effective January 3, 1994.
See: 25 N.J.R. 3907(a), 26 N.J.R. 225(a).

10:62-1.4 Covered services

Professional services include office visits for evaluation and management, comprehensive eye examinations, low vision examinations, low vision work-ups, vision training work-ups, vision training program visits as well as other specific procedures as listed at N.J.A.C. 10:62-3.2. Payment is made subject to the limitations specified under each type of service. If a service requires prior authorization, see N.J.A.C. 10:62-1.11.

Amended by R.1994 d.6, effective January 3, 1994.
See: 25 N.J.R. 3907(a), 26 N.J.R. 225(a).

Amended by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).
See: 30 N.J.R. 1060(a).

Substituted a reference to N.J.A.C. 10:62-1.11 for a reference N.J.A.C. 10:62-1.10 at the end.

10:62-1.5 Comprehensive eye examination

(a) A comprehensive eye examination may include cycloplegics and a post cycloplegic visit. All findings and data, including positive and negative, shall be clearly recorded. A comprehensive eye examination shall include the following, as a minimum, where possible unless contraindicated:

1. Detailed case history;
2. Complete visual acuity findings;
3. External and internal (ophthalmoscopic) examination including slit lamp;
4. Refraction (objective and subjective);
5. Extra-ocular measurement (EOM);
6. Gross visual fields (central and peripheral);
7. Tonometry (when indicated for patients under 35; mandatory for all patients over 35). The specific method used should be identified and recorded (the finger palpation test is not acceptable);
8. Binocular coordination testing (distance and near), fusion, stereopsis, and color vision;
9. The diagnosis (ocular deficiency or deformity, visual or muscular anomaly, and so forth); and
10. Recommendations.

10:62-1.6 Personal contribution to care requirements for NJ KidCare-Plan C

(a) General policies regarding the collection of personal contribution to care for or NJ KidCare-Plan C service are set forth at N.J.A.C. 10:49-9.

(b) Personal contribution to care for NJ KidCare-Plan C services is \$5.00 a visit for office visits, except when the service is provided for preventive care.

1. An office visit is defined as a face-to-face contact with a vision care professional, which meets the documentation requirements in this subchapter and N.J.A.C. 10:62-4.
2. Office visits include eye care professional services provided in the office, patient’s home, or any other site, excluding hospital, where the child may have been examined by the vision care professional. Generally, these procedure codes are set forth in N.J.A.C. 10:62-3.2 and 3.3.

(c) Vision care professionals shall not charge a personal contribution to care provided to newborns, who are covered under fee-for-service for Plan C; or preventive services.

New Rule, R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).

See: 30 N.J.R. 1060(a).

Former N.J.A.C. 10:62-1.6, Low vision examination, recodified to N.J.A.C. 10:62-1.7.

10:62-1.7 Low vision examination

A low vision examination as defined in N.J.A.C. 10:62-3.3 may be performed following a comprehensive eye examination when the vision in the better eye is 20/70 or less with the best correction.

Recodified from 10:62-1.7 and amended by R.1994 d.6, effective January 3, 1994.

See: 25 N.J.R. 3907(a), 26 N.J.R. 225(a).

Prior text at 10:62-1.6, Routine office visit or follow-up visit, repealed.

Recodified from N.J.A.C. 10:62-1.6 by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).

See: 30 N.J.R. 1060(a).

Former N.J.A.C. 10:62-1.7, Low vision work-up, recodified to N.J.A.C. 10:62-1.8.

10:62-1.8 Low vision work-up

A low vision work-up as defined in N.J.A.C. 10:62-3.3 requires prior authorization (see N.J.A.C. 10:62-1.10). For purposes of the New Jersey Medicaid program, a low vision work-up consists of certain testing techniques and procedures to determine what optical aids and devices can be prescribed for an individual to increase range of vision. A low vision work-up requires a written report and is much more detailed than the low vision examination that follows a complete comprehensive examination.

Recodified from 10:62-1.8 and amended by R.1994 d.6, effective January 3, 1994.

See: 25 N.J.R. 3907(a), 26 N.J.R. 225(a).

Recodified from N.J.A.C. 10:62-1.7 and amended by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).

See: 30 N.J.R. 1060(a).

Substituted a reference to N.J.A.C. 10:62-1.10 for a reference to N.J.A.C. 10:62-1.9 at the end of the first sentence. Former N.J.A.C. 10:62-1.8, Vision training program, recodified to N.J.A.C. 10:62-1.9.

10:62-1.9 Vision training program

(a) Vision training requires prior authorization (see N.J.A.C. 10:62-1.10). For purposes of the New Jersey Medicaid program, vision training is the use of certain procedures and modalities for the development of and/or increase in the vision capacity of the eye(s) with poor and/or inconsistent or distorted vision localization.

(b) Vision training is limited to orthoptics, with its acceptable procedures and/or modalities, and further limited to the following types of conditions to be treated by private physicians approved for such training by the respective peer group:

1. Strabismus;

2. Amblyopia;
3. Heterophoria; and
4. Accommodative and/or convergence anomalies.

(c) If vision training is required following the initial comprehensive eye examination, the practitioner shall submit a written request (form FD-358) to Vision Care Unit for prior authorization (see N.J.A.C. 10:62-1.10) for a vision training work-up. This request shall include the preliminary findings, detailed reason(s) why it is believed a further evaluation is needed, and any history of previous vision training with the dates and the results. Upon receiving approval for a vision training work-up, the practitioner shall then submit, within 30 days of receipt of authorization, the work-up report to the Vision Care Unit. The vision training work-up report shall consist of, but not be limited to:

1. Diagnosis;
2. Findings;
3. Interpretation;
4. Recommendations;
5. Outline of training procedures and frequency of sessions with estimated duration of treatment; and
6. Prognosis.

(d) The decision of the Vision Care Unit to approve or deny vision training will be transmitted to the practitioner by the fiscal agent.

(e) Upon completion of an approved training program, the practitioner shall submit a detailed progress report, listing the status of all parameters indicated in the original evaluation. No treatment plan shall exceed a period of 90 days or a total of 30 training visits, commencing with the inception of the treatment plan. An additional prior authorization is required for any extension of treatment and requires submission of a detailed progress report to the Vision Care Unit.

(f) Vision training may be provided by a practitioner when found medically necessary. This service can be performed in the office or in an independent clinic approved by the New Jersey Medicaid program.

Recodified from 10:62-1.9 and amended by R.1994 d.6, effective January 3, 1994.

See: 25 N.J.R. 3907(a), 26 N.J.R. 225(a).

Recodified from N.J.A.C. 10:62-1.8 and amended by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).

See: 30 N.J.R. 1060(a).

In (a) and (c), substituted references to N.J.A.C. 10:62-1.10 for references to N.J.A.C. 10:62-1.9, Professional services requiring prior authorization, recodified to N.J.A.C. 10:62-1.10.

10:62-1.10 Professional services requiring prior authorization

(a) Form FD-358 (Request for Prior Authorization for Vision Care Services) shall be used to request prior authorization for professional services. Instructions for completing the form are provided in the Fiscal Agent Billing Supplement. The completed form, clearly indicating the reasons for requesting the service requiring prior authorization, shall be submitted to the Vision Care Unit, Division of Medical Assistance and Health Services, Mail Code # 16, PO Box 712, Trenton, New Jersey 08625-0712. When a request for prior authorization is approved or denied, the provider shall receive a letter of notification from the fiscal agent.

(b) Items requiring prior authorization should not be provided to the Medicaid recipient until the authorization is received by the provider from the fiscal agent.

(c) The following professional services require prior authorization:

1. Low vision work-up;
2. Vision training program;
3. Vision training work-up; and
4. All other services not specified as a covered service under N.J.A.C. 10:62-1.4.

(d) Vision care provider services rendered to Medicaid recipients who are enrolled in a health maintenance organization which includes these services in its benefits package must be prior authorized by the HMO/physician case manager. (See N.J.A.C. 10:49-19 and 10:49-20 for specifics on prepaid health plans, the Garden State Health Plan, which serves the Medicaid population, and the Fiscal Agent Billing Supplement, for details for obtaining prior authorization.

Recodified from 10:62-1.10 and amended by R.1994 d.6, effective January 3, 1994.

See: 25 N.J.R. 3907(a), 26 N.J.R. 225(a).

Recodified from N.J.A.C. 10:62-1.9 by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998). See: 30 N.J.R. 1060(a).

Former N.J.A.C. 10:62-1.10, Prescription policies, recodified to N.J.A.C. 10:62-1.11.

10:62-1.11 Prescription policies

(a) Upon request, a recipient must be provided with his or her prescription for an optical appliance. The following information shall be indicated on the prescription: Name, address, HSP (Medicaid) Case Number, date of examination, and diagnosis code(s).

(b) If a recipient requests a duplicate prescription, the duplicate prescription shall clearly indicate: "THIS IS A DUPLICATE". The date of the original prescription shall

also be included. The dispensing provider shall retain the original prescription.

Recodified from 10:62-1.11 and amended by R.1994 d.6, effective January 3, 1994.

See: 25 N.J.R. 3907(a), 26 N.J.R. 225(a).

Recodified from N.J.A.C. 10:62-1.10 by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998). See: 30 N.J.R. 1060(a).

Former N.J.A.C. 10:62-1.11, Recordkeeping policies, recodified to N.J.A.C. 10:62-1.12.

10:62-1.12 Recordkeeping policies

(a) Providers shall keep such legible individual records as are necessary to fully disclose the kind and extent of services provided, as well as the medical necessity for those services. Data shall include such quantitative positive and negative findings as will be meaningful in a subsequent review. Check marks are not acceptable. The information shall be readily available to representatives of the New Jersey Medicaid program, or its agents, as required.

(b) Records shall be kept and maintained by the provider for a period of at least five years from the date the service was rendered.

Recodified from 10:62-1.12 and amended by R.1994 d.6, effective January 3, 1994.

See: 25 N.J.R. 3907(a), 26 N.J.R. 225(a).

Recodified from N.J.A.C. 10:62-1.11 by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998). See: 30 N.J.R. 1060(a).

Former N.J.A.C. 10:62-1.12, Reimbursement policies, recodified to N.J.A.C. 10:62-1.13.

10:62-1.13 Reimbursement policies

(a) Instructions for submitting claims for payment of vision care services are provided in the Fiscal Agent Billing Supplement.

(b) Vision care services shall be identified by means of procedure codes, utilizing the Health Care Financing Administration's (HCFA) Common Procedure Coding System (HCPCS). The codes and maximum fee allowance schedule are listed in N.J.A.C. 10:62-3.

(c) The provider shall use his or her usual and customary charge when submitting a claim for vision care services. Reimbursement for covered services furnished under the New Jersey Medicaid program shall be made on the basis of the provider's customary charge, not to exceed an allowance determined to be reasonable by the Commissioner of the Department of Human Services, and further limited by federal policy (policy 42 CFR 447 Subpart B) relative to payment of practitioners and other individual providers.

1. In no event shall the charge to the New Jersey Medicaid program exceed the charge by the provider for identical services to other governmental agencies, private nonprofit agencies, trade unions or other individuals in the community.

2. If a recipient receives care from more than one member of a partnership or corporation in the same discipline for the same service, the maximum payment allowance shall be the same as that of a single provider. For purposes of reimbursement, optometrist and/or physician, optometrist and physician groups, shared health care facility, or optometrist and physician sharing a common record shall be considered a single provider.

3. Reimbursement shall not be made for, and recipients may not be asked to pay for, broken appointments.

(d) For reimbursement purposes, when the practitioner submits a claim for services, the services shall have been performed personally by the practitioner submitting the claim.

(e) To qualify as documentation that the service was rendered by the practitioner during an inpatient stay, the recipient's medical record must contain the practitioner's notes indicating that he or she personally:

1. Reviewed the recipient's medical history with the recipient and/or his or her family, depending upon the medical situation;
2. Performed an eye examination, or other procedure;
3. Established, confirmed or revised the diagnosis; and
4. Visited and examined the recipient on the day(s) for which a claim for reimbursement is made.

Recodified from 10:62-1.13 and amended by R.1994 d.6, effective January 3, 1994.

See: 25 N.J.R. 3907(a), 26 N.J.R. 225(a).
Recodified from N.J.A.C. 10:62-1.12 by R.1998 d.154, effective February 27, 1998 (operative March 1, 1998; to expire August 31, 1998).
See: 30 N.J.R. 1060(a).

SUBCHAPTER 2. OPTICAL APPLIANCES AND SERVICES

10:62-2.1 Scope

This subchapter covers the provision of optical appliances necessary for the correction of any eye vision defects.

Amended by R.1994 d.6, effective January 3, 1994.
See: 25 N.J.R. 3907(a), 26 N.J.R. 225(a).

10:62-2.2 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings unless the context clearly indicates otherwise:

"Ocularist" means a provider of artificial eyes.

"Optical appliances" mean those items, devices or appliances prescribed by a practitioner in order to aid or improve vision, or to replace the eye.

"Optician" means an individual licensed by the New Jersey State Board of Examiners of Ophthalmic Dispensers and Ophthalmic Technicians, or licensed to practice as an optician in the state in which he or she performs such functions.

Amended by R.1994 d.6, effective January 3, 1994.
See: 25 N.J.R. 3907(a), 26 N.J.R. 225(a).