Montana Healthcare Programs

Optometric, Optician, and Eyeglass Providers

Frequently Asked Questions
Revised December 2019

How often can a Montana Medicaid/HMK-Plus, & HMK/CHIP member receive eyeglasses?

A Montana Medicaid/HMK-Plus member is eligible for one pair of eyeglasses for adults (21 & older) and children (20 & under) every 730 days. Medicaid/HMK-Plus members (20 and under) may exceed these limits if medically necessary under Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services outlined below.

An HMK/CHIP (18 & under) member is eligible for one pair of eyeglasses every 365 days.

What is EPSDT?

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services program is the federally sponsored, comprehensive healthcare benefits package for Medicaid-enrolled children through age 20. It helps families get early identification and treatment of medical, dental, vision, mental health, and developmental problems for their children. If prior authorization is indicated for a Medicaid/HMK-Plus member (20 and under), the Eyeglass Additional Feature and Contact Lens Prior Authorization request form must be used. The Eyeglass Additional Feature and Contact Lens Prior Authorization request form can be found on-line at: http://medicaidprovider.mt.gov/forms.

What lenses styles are covered under the Department's Contract?

For all eligibility groups:

- Plastic and Glass lenses are covered materials.
- Polycarbonate material is covered for members that are monocular. Polycarbonate material requires a prior authorization (PA).
- Single Vision, Bifocals (FT25, Ft28, FT35), Round Bifocal (22 & 24), Trifocals (7x25, 7x28 & 8x35), Executive style bifocals, Slab Off and Aphakic lenses.

Under EPSDT, Medicaid/HMK-Plus members (20 and under) are eligible to receive medically necessary specialty lenses with an approved prior authorization.

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Are Montana Medicaid members allowed replacements?

Under EPSDT, Medicaid/HMK-Plus members (20 & under) can have a one-time, complete frame and lens replacement, within the 365-day period if they lose or break their eyeglasses, without needing to obtain a prior authorization. If Medicaid/HMK-Plus members (20 & under) require an additional (beyond the one-time replacement), and the replacement falls in the 365 days after the initial prescription was issued, the Department must Prior Authorize any additional replacement eyeglasses.

To order replacements from Classic Optical for Medicaid/HMK-Plus members (20 & under), the EPSDT box needs to be checked on the order form. In the box marked "Special Instructions", the statement "One replacement per 365 days" needs to be included.

Adults (21 & older) can have a one-time lens replacement in the 730-day period if the lenses are broken or unusable. The member would only be eligible for lenses not a complete pair of eyeglasses.

For adults age 21 and over, only replacement lenses will be covered. The member shall present their damaged lenses to the optometric provider to ensure lens replacement is necessary. If the member needs to order a new frame along with the lenses the order will need to be placed as a Lenses Only order and put in special instructions to bill providers account for the frame.

Medicaid will not cover lens add-on's unless it was previously Prior Authorized. Items that will need Prior Authorization are:

- Photochromic lenses (i.e. transition)
- Polycarbonate lenses
- Tints other than Rose 1 or 2 which also require Prior Authorization.
- Ultra violet coating
- Scratch resistant coating
- Deluxe frames

If an adult member loses or damages the pair of glasses that were issued within the last 365 days, a new order can be completed and sent to Classic Optical. The member would be responsible for payment of the frame and any additional add-ons that were not previously authorized. Order as

usual and check the box "Non covered items – bill to provider". The provider then collects from the member the contract price or their usual and customary charge.

Are Montana Medicaid/HMK-Plus, & HMK/CHIP members allowed replacements?

HMK/CHIP (18 & under) members CAN NOT have a replacement pair of eyeglasses in the 365-day period. However, if there is a prescription change as outlined below, only the lenses will be replaced. For replacements due to loss or breakage, HMK members may purchase eyeglasses through Classic Optical by placing a retail order on the Classic website or providers can fax the order to Classic at 888-522-2022 noting the providers account should be billed. The contract or usual and customary charges will apply.

HMK-Plus (20 & under) members CAN have one replacement pair of eyeglasses in the 365-day period, without needing to obtain a prior authorization. To order replacements from Classic Optical for HMK-Plus children age 20 and under:

- the EPSDT box needs to be checked on the order form
- the box marked "Special Instructions", include "One replacement per 365 days".
- when the replacement is beyond the one-time issuance of the original prescription (a 2nd or 3rd pair) and is within the 365 days from initial prescription, the Department will review and issue a Prior Authorization.

Montana Medicaid/HMK-Plus, & HMK/CHIP members (adult or child) can have a lens only replacement if any of the following apply:

(a) .50 diopter change in the sphere
(b) .75 diopter change in the cylinder
(c) .5 prism diopter change in vertical prism
(d) .50 diopter change in the near reading power
(e) A minimum of a 5-degree change in the axis of any cylinder less than or equal to 3.00 diopters
(f) A minimum of a 3-degree change in axis of any cylinder greater than 3.00 diopters
(g) Any 1 prism diopter or more change in lateral prism

From Dec. 1, 2016 through Nov. 30, 2017, the previous lens prescription will have to be obtained and provided to Classic showing where one of the criteria has been met. From December 1, 2017 forward, if an order was placed with Classic Optical, the prescription numbers are on file with Classic Optical and will not need to be provided. To order a lens or lenses, complete the Classic Optical paper order form with the new prescription information and attach the previous prescription information. Fax the order to Classic at (888) 522-2022.

When an order error occurs, what is the procedure with Classic Optical for a provider to follow?

When an error in an eyeglass prescription is found after its production by Classic Optical, and the error was considered made by the ordering provider, Classic Optical will remake an order and the cost transaction will be worked out between the Contractor (Classic Optical) and the providers. Examples of common scenarios are below:

#1 Original Order	**#1 redo order**
Standard frame	same frame
SV sphere only	SV spherocylinder

In the order #1 scenario, Classic would bill the provider for the remake of the lenses to a spherocylinder at the Medicaid contracted rate for the lenses.

#2 Original Order	**#2 redo order**
Standard frame	same frame
lined bifocals	progressive lenses
transition material	transition material

In the order #2 scenario, Classic would bill the provider for the remake of the lenses into a progressive type at the Medicaid contracted price.

#3 Original Order	**#3 redo order**
Deluxe frame Pt. Pd.	same frame
Progressive lens	Pt. Pd. lined bifocal (non-adapt to progressive)
Transition Pt. Pd.	transition Pt. Pd.

In the order #3 scenario, Classic would need the original progressive lens returned and the lined bifocals would be made at no charge. The original progressive lenses were paid by the member and Classic will not refund that cost to the provider/member. Classic will remake the order with bifocal lenses at no cost to the provider/member. The member would be responsible for the cost of the transition material in the re-order as they were in the original.

The Prior Authorization process has changed with Classic Optical, how?

The Prior Authorization process is as follows:

1.) Complete the Departments Prior Authorization request form found at: http://medicaidprovider.mt.gov/forms
2.) Fax the request into the number on the form
3.) The Department will review and issue a Prior Authorization number or contact the provider for more information
4.) The Department will fax back to the provider, the computer screen shot of the Prior Authorization number that will be need to be attached to the order and faxed to Classic Optical.

The next step is to order the requested items from Classic Optical. Do this by completing the *Blank Medicaid form* and include the returned screen shot of the Prior Authorization from the Department. Fax the order form and the Departments screen shot of the Prior Authorization to the Classic fax number: (888) 522-2022. All orders that have a prior authorization must be faxed in or mailed to Classic with a copy of the order and the prior authorization.

Do Round bifocals 22 or 24 need to have Prior Authorization?

The Round bifocal feature does not require Prior Authorization and can be ordered as a lens type with Classic's online ordering system. It is listed as RD 22 and RD 24 on the order form.

Does Montana Medicaid/HMK-Plus, & HMK/CHIP cover Tints?

Yes, but only Rose 1 or Rose 2 tints are covered for both children and adults and they require Prior Authorization. Any other tint would either require a Prior Authorization or the provider's account can be billed from Classic Optical and the cost passed on to the member.

Does Montana Medicaid/HMK-Plus, & HMK/CHIP cover Deluxe-Durable and Special Needs Frames for members?

Yes if medically necessary. Deluxe-Durable frames and Special Needs frames are available and require a Prior Authorization from the Department for all members. If not medically necessary,

Deluxe-Durable frames and Special Needs frames can be purchased and the cost passed on to the member.

Does Montana Medicaid/HMK-Plus, & HMK/CHIP cover Safety Frames for members?

No, safety frames are not covered but can be purchased as a deluxe frame and the cost passed on to the member. For HMK-Plus (age 20 & under) or for HMK/CHIP (age 18 & under), safety frames would require a Prior Authorization request for a deluxe frame.

Will Montana Medicaid/HMK-Plus, & HMK/CHIP cover the cost of Lens Add-Ons?

Some lens add-ons may be covered with a Prior Authorization (PA) when medically necessary and prescribed by the provider. The prior authorization criteria can be found in the Optometric and Eyeglass Services provider manual on the provider website at http://medicaidprovider.mt.gov/47. Requested add–ons not meeting medical necessity criteria or those not included on the Department's fee schedule are available with the cost passed on to the member.

When a provider is requesting an item that has been determined to be not covered by Montana Medicaid and does not have a Prior Authorization, Classic Optical would do a split bill on the order. Example of lens order with a non-covered item, Classic will bill MT Medicaid for the base lens and bill the provider the contract cost of the add-on item.

What are the items that may be covered by a Prior Authorization or Private Pay?

Add-on items such as transition, polycarbonate, tints other than Rose 1 or 2, ultraviolet and scratch resistant coatings are lens features that may be covered if a Prior Authorization request is initiated by the provider and approved by the Department. Deluxe frames also require a Prior Authorization

Any lens style, lens material, tint, coating lens enhancement (polished edge, etc.) not specifically noted below will be billed to the dispensing provider at Classic Optical's wholesale price list, found at: https://www.classicoptical.com

The table below features items that require Prior Authorization. Find the Prior Authorization request form on the Medicaid Provider website at: http://medicaidprovider.mt.gov/forms titled "Eyeglass Additional Feature and Contact Lens Prior Authorization Request".

Lens Feature	Children age 20 & under	Adults age 21 & over
Photochromic/transition (plastic or glass material)	Yes – if medically necessary	No
Progressive	No	No
Polycarbonate	Yes–if monocular	Yes- if monocular
Tints Rose 1 & 2	Yes - with PA	Yes - with PA
Tints other than Rose 1 & 2	Yes – if medically necessary	No
UV or Scratch resistant	Yes-if medically necessary	No
Deluxe Frames (no safety frames)	Yes-if medically necessary	No

How can a provider submit an order to Classic?

Classic accepts orders over the internet, via fax or mail. The easiest way to place an order is online. This can be done directly at www.classicoptical.com. Call Classic at 888-522-2020 for a login and password. Orders can be faxed to 888-522-2022. Providers can mail orders to: Classic Optical Laboratories, Inc., 3710 Belmont Ave., P.O. Box 1341 (44501), Youngstown, OH 44505. Phone orders cannot be accepted.

Where can a provider obtain a paper order form?

Order forms can be downloaded from the Classic website at www.classicoptical.com or requested by calling a Classic customer service representative at 888-522-2020.

What is the warranty on frames and lenses?

Classic Optical covers frames and lenses under a one-year warranty from manufacturing defect.

Can Classic's customer service verify eligibility based on benefit/eyewear frequency?

Yes, based on order history supplied to Classic Optical by Montana Medicaid.

Does Classic Optical check Medicaid eligibility on Medicaid orders?

Yes, before Classic processes any Medicaid orders, Classic will send the order out for an eligibility check using HIPAA compliant eligibility transactions offered to enrolled providers. If the Department sends back a response that the member is eligible and they have not exceeded their frequency of frames or lenses, Classic will process the order.

If the Department sends back a response to Classic that the member is not eligible or the member has exceeded their benefit frequency of frames or lenses, the order will not be processed. The provider will be notified by email using the order confirmation number if the order was placed on Classic's website or by mail if the order was faxed or mailed to Classic.

What is the Eyeglass Fee Schedule and why is it important to Optometrist?

The Eyeglass Fee Schedule is the contracted reimbursement amount the Department pays for the items under contract with Classic Optical. If an item on the fee schedule requires a prior authorization, the Department will only pay for the item if it is found medically necessary, and allowed for the age group. If the Prior Authorization criteria are not met the item will be considered an add-on and a dispensing provider may bill the member the contracted price listed on the Fee Schedule or their usual and customary price. The items/codes that require Prior Authorization are noted under the column PA with a letter "Y" for Yes. The Eyeglass Fee Schedule provides information of contracted prices to Optometrist and Opticians for covered items. The fee schedule can be found on the Department's Provider Website at: http://medicaidprovider.mt.gov/47

There are many non-covered add-on features beyond those listed on the Department's Eyeglass Fee Schedule. The wholesale price list is available on Classic Optical website: www.classicoptical.com. Non-covered items ordered by the provider will appear on the line of credit invoice sent to the provider from Classic Optical each month.

What can a Provider charge a member for add-ons and non-covered items?

In accordance with the administrative rules of Montana, a provider may bill a member for a non-covered service or item if the provider has informed the member in advance of providing the service that Medicaid will not cover the services and that the member will be required to pay privately for the services. The member must also agree to pay privately for the services. The agreement to pay privately must be based upon definite and specific information given by the provider to the member indicating that the service will not be paid by Medicaid. The non-covered services or items can be charged to the member at the provider's usual and customary charge.

SPECIFIC QUESTIONS RELATED TO INFORMATION ABOVE

What is the process for prescription changes?

Until November 30, 2017, when ordering a new prescription for a member meeting the replacement lens criteria, please include a copy of the old prescription along with the new prescription information. Classic Optical will ensure the replacement criteria outlined above is met. The old prescription information will need to be provided because Classic may not have this information in their database until after November 30, 2017.

A child broke frames what do I do?

The member's eligibility plan needs to be established first. Determine if frame is under warranty. If so, refer to the Provider Notice issued 11/28/2016 found at: http://medicaidprovider.mt.gov/47

> ***For Medicaid/HMK-Plus***; the member will choose a Classic Optical frame and the provider will order with the current lens prescription. If the breakage occurs within 365 days from their last exam and the provider determines a new prescription is needed, refer to the section regarding prescription changes.

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Frame upgrades, do they ask for the contract price or U&C?

When a member requests an "upgrade" to Classic Optical's group of Deluxe frames that is not medically necessary, the provider may bill the member as stated above in "What can a Provider charge a member for add-ons and non-covered items?."

How fast is the order turn-around?

The turn-around for orders submitted since the beginning of the contract on December 1, 2016 has shown that approximately 95% of the orders were processed and sent back to providers in the first 5 days after receipt of the order. The Department requires that 95% of properly submitted orders will be returned within 10 working days of receipt by Classic Optical and that 99% of properly submitted orders are returned within 15 working days of receipt.

HELP Co-pay?

Providers may not bill members for co-pays at the time of service beginning June 1, 2016. A Provider Notice titled "Changes to Member Cost Share" was issued by the Department and can be found under Provider Notices at the Optometric Provider website: http://medicaidprovider.mt.gov/21. The Department directs providers to the latest issuance of this provider notice dated July 19, 2016. The HELP and Medicaid member's co-pays fall into one of two types of co-pays.

- A $4.00 co-pay/cost share will be assessed for each visit or date of service when the claim is processed. This does not include the member's return for the final fitting of the eyewear. That service is considered inclusive to the initial fitting service done at the time the eyeglasses were ordered.
- For members with annual household incomes above 100% of the Federal Poverty Level (FLP), a 10% of the providers reimbursed amount for any Medicaid covered service will be assessed when the claim is processed.

Specific questions not addressed in this document?

For an eye exam or eyeglass situation or question not covered above, please contact the appropriate Program Officer. For Medicaid, HMK-Plus, and HMK/CHIP contact: Rena Steyaert at (406) 444- 4066.