

BILLING AND REIMBURSEMENT

Claim Submission Standards

All encounters for AlohaCare members must be submitted as a claim, regardless of whether the services are covered under a capitation or fee-for-service payment arrangement.

Paper claims should be typed or printed legibly. Initial submissions must be on original claim forms; no "Xeroxed" or copied forms are accepted for initial claim submission. Electronic submission of claims can be arranged by contacting AlohaCare's Provider Relations Department.

Mail claims to:

AlohaCare
Claims Department
1357 Kapiolani Blvd., Suite 1250
Honolulu, HI 96814

All claims must contain required information and all data must be consistent and valid. Omission of required information will result in a denied claim. Missing information should be provided via claim resubmission.

Filing Deadlines

All claims must be submitted within the AlohaCare filing deadlines, which are set based on our requirements to submit encounter data to the State of Hawaii Med-QUEST Division within specific time limits:

- Claims where AlohaCare is the primary payer must be received **within 120 days of date of service**. Claim resubmissions must be received within one year of date of service.
- Third Party Liability (TPL) claims must be received within 150 days from the date of service, with the Explanation of Benefits (EOB) from other insurance carriers attached. If the EOB from the other carrier has not been received by your office, a claim should be filed to AlohaCare within the 120 day deadline to document the services. Under these circumstances, the claim will be denied for lack of EOB. However, if the claim was filed in a timely manner, providers have up to one year from date of service to resubmit the claim with the EOB attached.
- For facilities billing for inpatient stays, the filing deadlines are from date of admission. Interim billings, using appropriate bill types, are encouraged for lengthy confinements.
- Exceptions to the filing deadlines will be granted only for unusual circumstances. Requests for waiver of the deadline should be sent with details regarding the circumstances for the filing delay. These requests will be reviewed on a case-by-case basis. These requests should be sent to:

AlohaCare
Attention: Customer Service Manager
1357 Kapiolani Blvd., Suite 1250
Honolulu, HI 96814

Procedure and Diagnosis Codes

Current, valid ICD-9, CPT and HCPCS and modifiers must be used. A detailed description of the service provided must be included when using "unclassified or unspecified" codes. Prior to using HCPCS temporary (C, Q or S) codes, check with AlohaCare as to our ability to accept these codes and/or discuss alternative coding.

Coding to the appropriate specificity (using the CPT 4th or 5th digits, depending on the diagnosis) is required, and incomplete codes will not be accepted.

Claim Forms

Claims submitted on the incorrect claim form will not be accepted for processing.

- The CMS 1500 is the standard claim form used to bill professional services, including those of individual practitioner and non-hospital outpatient clinics, and suppliers of medical equipment.
- The UB04 is the standard claim form used to bill institutional or facility claims such as inpatient, outpatient hospital, residential/outpatient treatment centers and skilled nursing facility.

Med-QUEST reporting guidelines require reporting of a CPT or HCPCS code when billing with the revenue codes listed below. When there are multiple CPT/HCPCS codes for the same revenue code, the revenue code must be repeated as a separate line item for each CPT/HCPCS code. Absence of a valid CPT/HCPCS code with these revenue codes will result in denial of the line item.

027X	Medical/Surgical Supplies
029X	Durable Medical Equipment (Except Renal)
030X	Laboratory
031X	Laboratory – Pathological
032X	Radiology – Diagnostic
033X	Radiology – Therapeutic
034X	Nuclear Medicine
035X	CT Scan
040X	Other Imaging Services
042X	Physical Therapy
043X	Occupational Therapy
044X	Speech-Language Pathology
046X	Pulmonary Function
047X	Audiology
048X	Cardiology
049X	Ambulatory Surgical Care
062X	Medical/Surgical Supplies (cont. from 27X)
073X	EKG/ECG
074X	EEG
092X	Other Diagnostic Services

Prior Authorization/Referral Information

When billing for services, the prior authorization/notification or referral number assigned by AlohaCare should be entered on the claim form in order to expedite payment. On the CMS 1500 form, the number should be entered in box 23; on the UB04 form, the number should be entered in box 63.

Resubmissions

If a claim is being resubmitted, it must be clearly marked "**RESUBMISSION**" and must be received by AlohaCare within one year from the date of service (or date of admission for facilities resubmitting inpatient claims). Claims resubmitted after one year will generally not be considered for payment. All resubmissions must be submitted on paper with any corrections or additional information required to reprocess the claim. Any attachments required on the original submission should be sent with the resubmitted claim. To expedite research and reprocessing, a copy of the remittance advice, with the original claim denial circled, should be attached along with an explanation regarding the reason for resubmission. Mail or fax resubmissions to the AlohaCare Customer Service Department.

Claims Review

AlohaCare claims review guidelines reference Medicaid guidelines in determining the appropriateness of the coding of the services billed. In the absence of Medicaid guidelines, AlohaCare refers to Medicare guidelines. AlohaCare claims examiners also reference CPT and "National Correct Coding Initiative" guidelines and handbooks and the "Medicare Billing Guide" with regard to bundling/unbundling, global surgical packages and correct modifier use. AlohaCare will deny service lines that are coded inappropriately (example: one of the submitted codes is defined in such a way as it should not be separately reported when submitted with another code on the claim). Such denials are not a determination that the procedure/service was not medically necessary; it means that according to generally accepted coding practices, the procedure/service should not be coded separately under this circumstance.

Additional types of claims review may be performed for purposes including, but not limited to:

- Determination and verification of medical necessity and appropriateness of billed services
- Confirmation of appropriateness of the place of service and level of care
- Accuracy of coding
- Compliance with the QUEST program and AlohaCare plan benefits
- Preparation and analysis of grievance, appeal, and reconsideration cases
- Utilization trending
- Quality Improvement review for data collection
- Review of services performed on emergent or urgent basis without prior authorization
- Investigation of complaints or reports of potential fraud and abuse

Certain facility claims undergo claims review and may require reports, itemization, progress notes, physician orders, and discharge summary.

Reimbursement

Reimbursement for covered services is determined according to the provider contract. Non-contracted providers are reimbursed at standard AlohaCare's standard Fee Schedule amounts. **Because AlohaCare is a Medicaid Managed Care plan, payments made must be considered payment in full, and members cannot be balance billed.**

In accordance with Section 1932 (b)(2) of the Social Security Act (42 U.S.C 1396u-2(b)(3)); any provider of emergency services that does not have in effect a contract with a Medicaid managed care entity that establishes payment amounts for services furnished to a beneficiary enrolled in the entity's Medicaid managed care plan must accept as payment in full no more than the amounts (less any payments for indirect costs of medical education and direct costs of graduate medical education) that it could collect if

the beneficiary received medical assistance under this title other than through enrollment in such an entity. In a State where rates paid to hospital under the State plan are negotiated by contract and not publicly released, the payment amount applicable under this subparagraph shall be the average contract rate that would apply under the State plan for general acute care hospitals or the average contract rate that would apply under such plan for tertiary hospitals effective January 1, 2007.

AlohaCare's reimbursement policies and methodologies include:

- **Bilateral Surgical Procedures:** when a CPT/HCPCS code describes a unilateral procedure, and the provider performs the service on both sides of the body in the same session, the provider should bill the appropriate unilateral code with modifier "50" for both procedures performed. This should be billed on a single claims line. Payment is made at 150 percent of the applicable fee schedule amount for the unilateral procedure. CPT/HCPCS codes defined as bilateral should not be billed with modifier "50."
- **Assistant Surgeon Claims:** the assistant surgeon should bill the appropriate procedure code, appending modifier "80." Payment is made at 20% of the applicable fee scheduled amount for the procedure. AlohaCare follows Medicare guidelines for which procedures are eligible for assistant surgeon reimbursement. The assistant surgeon claims will be denied if the procedure code billed does not match that billed by the primary surgeon, or if there is no primary surgeon's bill on file. Assistant surgeon's claims for services provided at a teaching hospital must be submitted with documentation verifying the non availability of a qualified resident. Correct use of modifier "82" is acceptable.
- **Anesthesia:** ASA codes must be used, followed by any applicable anesthesia modifier. All anesthesia claims must be billed with anesthesia time. Reimbursement is calculated on base ASA units plus time units. Time units are calculated as one (1) unit for each 15 minute period. Any minutes beyond a whole unit will be rounded up or down to the nearest whole unit.
- **Facility Inpatient Late Charges:** claims for late charges (bill type 115) will be processed but will not affect payment on claims paid on a per diem basis. Late charges may affect reimbursement of an outlier claim, but in order to be considered the charge must be filed within the claims filing deadline, and the entire claim must be resubmitted for the full service period.

Newborn Claims

AlohaCare will pend claims received for newborns until eligibility verification and QUEST ID number is received from Med-QUEST. Generally, but not always, Med-QUEST will assign the newborn to AlohaCare when the mother is eligible with AlohaCare on the date of birth. Once the newborn's eligibility and QUEST ID number is established, AlohaCare will process the claim provided that all other claim processing requirements are fulfilled.

Member Direct Billing

In accordance with the Hawaii QUEST Program guidelines, providers cannot bill or make any attempt to collect payment, directly or through a collection agency, from a person claiming to be QUEST eligible except in the following circumstances:

- Individual was not eligible for QUEST Program on date of service.
- No-show fees for QUEST-Net or QUEST-ACE adult members. Provider shall inform the member in advance of imposing the fee, or the intent to impose such a fee and what the member must do to avoid such assessment.
- Non-covered services from unauthorized non-participating provider or member self-referral to a specialist or other provider without following plan procedure. Provider shall inform member of non-covered status of such services before receiving the non-covered service and document

each such event with a clear statement by the provider and the member's signed acceptance of payment responsibility. Documentation must be placed in the member's medical record.

- QUEST-Net or QUEST-ACE adult members can be billed for services exceeding benefit limitations.
- AlohaCare does not pay for services if the patient had primary coverage through a prepaid benefits plan (examples include: HMSA Health Plan Hawaii, Kaiser Health Plan) but did not go to a primary payer's designated facility for treatment. The member can be billed if AlohaCare denies these types of service, but the expectation is that such denials will be rare due to the responsibility of providers to check for eligibility and TPL coverage in advance of providing services. AlohaCare may pay for QUEST covered services if the service is excluded from coverage under the prepaid benefits plan.

Third Party Liability (TPL)/Coordination of Benefits

As a Medicaid Managed Care health plan, AlohaCare is always considered the payer of last resort when a member has other insurance coverage. If any other insurance carrier is liable for incurred charges, that carrier must reimburse the provider to the limits of its coverage before AlohaCare will be responsible for its share of the payment.

After the primary carrier has processed a claim and if AlohaCare is responsible for payment of a portion of health services rendered to the member, the servicing provider must submit the claim to AlohaCare to process. The provider must submit the following information to ensure accurate and timely processing:

- A completed claim form
- If a facility is billing or where applicable, an itemized bill
- The matching explanation of benefits (EOB) statement from the insurance carrier who processed the claim first

Professional: For all covered professional services, AlohaCare will coordinate up to AlohaCare's reimbursement allowance for the billed procedure. Provided that all claim submission requirements have been met, AlohaCare will calculate payment using AlohaCare's reimbursement allowance for the billed procedure less the primary carrier's payment as shown on the explanation of benefits. Provider adjustment amounts made by the primary carrier will not be factored into coordination of benefit payments. No additional payment will be made if the primary carrier's payment is greater than AlohaCare's standard reimbursement allowance for the billed procedure.

If the primary carrier denied a service which is a covered benefit under AlohaCare, the service may be payable. Payment will be determined based on AlohaCare benefits, the clinical appropriateness of the service according to the claim diagnosis and administrative requirements, not on the primary carrier's benefits.

Facility UB04: For all covered facility services, AlohaCare will coordinate payment based on the lesser of:

1. The difference between AlohaCare standard reimbursement allowance and the primary carrier payment, or
2. The member co-payment, co-insurance and deductible amounts.

AlohaCare will apply our internal policies for "global" procedure codes, and will combine component code payments and coordinate up to the AlohaCare eligible reimbursement, which may not necessarily cover 100 percent of any co-pay, deductible, or other patient responsibility amount indicated by the primary payer. AlohaCare's payment, in this regard, must be considered payment in full, and the member cannot be balance billed.

An explanation of benefits (EOB) from the primary carrier must be attached to each claim submitted when other insurance coverage for the member exists. If the primary carrier has denied the claim for any reason, an EOB or letter of denial is required. If an EOB is not attached to the claim upon submission to AlohaCare, the claim will be denied.

Claims denied by the primary carrier, with the exception of claims rejected for eligibility or non-covered services, will require the provider to appeal the primary carrier's initial decision. Documentation of the original denial and results of the appeal will be required before AlohaCare can review for payment.

Contact AlohaCare's Customer Service Department in the event that the member's Med-QUEST third party liability information used by AlohaCare is not valid. Information provided will be forward to Med-QUEST.

Benefits Coordination when Medicare is Primary Carrier

For all covered services, AlohaCare will coordinate payment based on the lesser of:

- The difference between AlohaCare standard reimbursement allowance and the primary carrier payment, or
- The member co-payment, co-insurance and deductible amounts.

Benefits Coordination for Motor Vehicle Incidents

- Where AlohaCare members have purchased their own motor vehicle insurance, claims should be submitted to the member's motor vehicle insurance carrier. If the member is injured while in a vehicle belonging to another person and that person is insured by a standard motor vehicle insurance policy, bill the vehicle owner's insurance carrier.
- When motor vehicle insurance benefits have been exhausted, a letter from the no-fault carrier indicating that benefits have been exhausted must be attached to the claim. This letter must reference the specific services being billed as non-payable.
- When the AlohaCare member has the insurance provided at no cost to public assistance recipients who meet certain criteria, this coverage does not provide medical coverage. AlohaCare is the primary payer for members injured in accidents involving vehicles covered in this manner. Documentation of this type of coverage, from the insurance carrier, should be attached to the claim form in order to expedite processing.
- AlohaCare may be billed as the primary carrier if the involved vehicle was not insured and there is no avenue to pursue other liable parties, Claims must clearly note that the vehicle was uninsured, and documentation of this information may be requested on a case-by-case basis.

AlohaCare will recover reimbursements when payment was made for services that should have been billed to another payer.

Claim Adjustments and Recoveries

When AlohaCare makes an adjustment on a previously paid claim, or recoups a claim that was paid inappropriately, the recovery will appear on the next remittance advice as a negative payment amount. When posting payment of the other claims on the remittance advice, you will need to also post any recoveries as payment reversals in your accounting systems in order for your totals to match the check amount.

AlohaCare may recoup any payments for services made to the Provider due to member eligibility or TPL adjustments, audit findings that show such payments to be inappropriate, lack of clinical documentation, provider's failure or refusal to submit copies of requested medical records, or non-covered services.

Recoupments based on audit findings may be recovered from a future payment after giving the provider a 30-day written notice of the findings or through other repayment arrangements made with the provider. Recoupments based on eligibility and TPL adjustments may be made on the provider's next payment or through other repayment arrangements made with the provider.

Pharmacy Claim Submission Standard

The TelePAID System sets pricing, eligibility, and other information that must be used by AlohaCare's Participating Pharmacy Network. AlohaCare's participating providers will transmit drug claims with all required fields using the most current NCPDP standards, which are incorporated in Medco Health's Version 5.1 Payer Sheet. The most current Payer Sheet can be obtained through AlohaCare's website at www.AlohaCareHawaii.org

Pharmacies must submit all claims through the TelePAID System and will comply with all information communicated via the TelePAID System or otherwise by AlohaCare and/or Medco. Refer to your Medco Pharmacy Services Manual for further details.

Improving Claim Submissions/Correcting Common Errors

Use the correct ID number

Errors seen:

- Using the ID number of another family member
- Member ID number with additional or missing numerals

How to prevent errors:

- Copy the number carefully from the member ID card

Validate date of birth

Errors seen:

- Patient's date of birth does not match the information provided to AlohaCare by Med-QUEST

How to prevent errors:

- When possible, request additional ID to verify patient identity

Call AlohaCare for assistance in correcting any inaccurate information

Use valid and current ICD-9 diagnosis codes, revenue codes, CPT and HCPCS procedure codes

Errors seen:

- Missing or incomplete diagnosis, procedure, or revenue codes
- Using deleted, invalid codes
- Using temporary codes not accepted by AlohaCare
- Using NDC codes without current CPT or HCPCS code

How to prevent errors:

- Include diagnosis, procedure, and revenue codes where required
- Use current ICD-9 diagnosis codes, CPT and HCPCS procedure codes and revenue codes

Submit claims only for eligible patients

Errors seen:

- Services rendered after member's disenrollment date
- Services rendered during break in member's coverage
- Claims submitted for patients that are not enrolled in AlohaCare

How to prevent errors:

- Ask member for the AlohaCare ID card to verify he/she is a member of AlohaCare's plan
- Call the AlohaCare Customer Service Department or check eligibility on AlohaCare's on-line eligibility system
- Call Med-QUEST Enrollment Call Center to determine QUEST plan and eligibility

Submit original claims within the filing deadline (120 days from the date of service, or 150 days with EOB if there is TPL) and resubmissions within one year from date of service

Errors seen:

- Claims that appear to be original submissions are submitted past the filing deadline

How to prevent claim denials:

- Submit claims within the filing deadline. Consider submitting claims involving TPL within 120 days without an EOB from the primary payer. Claims can then be resubmitted with the primary payer EOB from the primary carrier within the resubmission deadline
- If submitting a follow-up or corrected claim, include documentation of previous submissions and indicate "RESUBMISSION" on claim form

Provide applicable CPT or HCPCS codes for selected revenue codes

Errors seen:

- Revenue codes are submitted without applicable CPT or HCPCS code describing the service or item provided
- Revenue codes are submitted with a procedure code that does not match the revenue code category (e.g. CPT procedure code billed with Supplies revenue code)

How to prevent errors:

- Review list of revenue codes that require CPT/HCPCS codes
- Match up CPT/HCPCS codes with the applicable revenue code
- Use current, valid CPT, HCPCS and revenue codes

Complete box 10 and box 14 of the CMS 1500 claim form for pregnancy and accident claims

Errors seen:

- Claims related to pregnancy or accidents, with box 10 and/or box 14 left blank on the CMS 1500 claim form

How to prevent errors:

- Always complete box 10 and box 14 on the CMS 1500 claim form when billing for pregnancy or accident-related services

Provide complete accident information for accident claims when billing accident-related services on a UB04 form

Errors seen:

- Accident occurrence codes are used but no accident diagnosis code given
- Accident diagnosis code used but no accident occurrence code given
- Wrong accident occurrence codes are used to describe accident (e.g., occurrence code for work-related injury used on claims for children and infants)

How to prevent errors:

- Use accident diagnosis codes in 800-999 range of codes whenever an accident occurrence code is used (01-05)
- Review UB-04 processing manual to be sure the correct definitions are associated with usage of the occurrence codes

Referral/Prior Authorization

Errors seen:

- Date of services billed not same as on referral or prior authorization notification
- Signature on referral form is other than the PCP (or authorized signatory) or signature omitted
- Units billed not consistent or exceed the number of units authorized
- Invalid authorization number in box 23 of CMS 1500 or box 63 of UB04
- No prior authorization, or no referral on file

How to prevent errors:

- Provide correct referral or authorization number in appropriate boxes on claim forms
- Match up Date of Service on referral form or prior authorization notification with billed services
- Ensure all required information and signatures are included on referral forms or prior authorization requests
- Follow AlohaCare's policies for prior authorizations, notifications and referrals
- Ensure that billed services do not exceed the number of units assigned

Attachments Missing

Errors seen:

- Explanation of Benefits missing on claims where there is TPL

How to prevent errors:

- Attach Explanation of Benefits to TPL claims

Anesthesia

Errors seen:

- No anesthesia time
- Missing or invalid ASA codes

How to prevent errors:

- Always include anesthesia time
- Bill with valid ASA codes

Charge Amount Discrepancies

Errors seen:

- Service line charges do not match total charge

How to prevent errors:

- Carefully check that the total amount showing on the claim matches the total of the service line charges
- When billing multi-page claims, do not total each page but total on last page only; mark other pages as “page 1 of 2,” etc.

Other Claims Tips

Avoid duplicate claim submissions. Contact our Customer Service Department or use the AlohaCare on-line claims status system to check on the status of your claim. Duplicate claim submissions slow down claims processing by adding unnecessary volume. Additionally, state and federal auditors have identified duplicate claims submission as a trigger for fraud and abuse investigations (see Fraud and Abuse section of this manual for further details).

If you do not understand a claims denial, or have received multiple denials, contact our Customer Service Department for assistance. Continuing to resubmit a claim without correcting the specific error causing the denial may cause further delay in processing the claim.

VISION SERVICES

AlohaCare administers vision benefits of the AlohaCare QUEST plan. As with other professional services, vision claims should be submitted to AlohaCare on the CMS-1500 claim form.

Prior authorization or referral is not required for members seeing participating providers for routine vision services (eye exam, refraction, glasses) that are within the QUEST Plan guidelines and limits. Referrals will be required if the patient is seeing a vision provider for non-routine vision care.

AlohaCare Vision Guidelines

The following guidelines are based on Medicaid guidelines and criteria for vision benefits and vision-related medical conditions (version dates 10/18/02) with a few AlohaCare modifications.

1. Eye Examination/Vision Services

A. Description

Program covers eye and vision services provided by qualified optometry/ ophthalmology professionals within certain criteria based on the member's age. For information on glasses and contact lenses, see the section about Vision Eyewear later in this chapter.

B. Amount, Duration, and Scope

- 1) Emergency eye care, which meets the definition of an emergency medical condition, is covered for all AlohaCare members. Vision examination and the provision of prescription lenses are covered. Cataract removal is covered for all eligible members.
- 2) An ophthalmologic exam with refraction includes:
 - Determination of visual acuity
 - Tonometry (routine and serial)

- Gross visual fields
 - Muscle balance
 - Slit lamp microscopy
- 3) Ophthalmoscope is payable as a separate procedure. If done within a pre-op period, it is considered a pre-operative examination.
 - 4) Eye examinations are considered bilateral and should be coded as a single procedure code. Right and left or bilateral modifiers will not be paid.

C. Exclusions

- 1) Excluded vision services include:
 - Orthoptic training
 - Prescription fee
 - Progress exams
 - Radial keratotomy
 - Visual training
 - Lasik procedures
 - All charges for drugs and supplies used in the office for testing are included in the fee for the specific procedure; no additional allowance for the drugs will be made.

D. Limitations

- 1) Screening Limited to:
 - a) Once in a 12-month period for individuals under age 21
 - b) Once in a 24-month period for adults age 21 and olderVisits done more frequently are payable when indicated by symptoms or medical condition, but are subject to prior authorization.
- 2) Cataracts
 - a) Cataract removal is a covered service (under Medical) when the cataract is visible by exam, ophthalmoscope or slit lamp, and any of the following apply:
 - Visual acuity that cannot be corrected by lenses better than 20/70 and is reasonably attributable to the cataract; or
 - In the process of complete inability to see the posterior chamber, vision is confirmed by potential acuity meter (PAM) reading, or
 - For eligible members who have corrected visual acuity between 20/50 and 20/70, a second opinion by an ophthalmologist is obtained.
 - b) Cataract surgery is covered only when there is a reasonable expectation by the operating ophthalmic surgeon that the recipient will achieve visual functional ability when visual rehabilitation is complete.
- 3) Cataract surgeries are generally done on an outpatient basis, but an inpatient stay may be required due to the need for complex medical and nursing care, multiple ocular conditions or procedures and the member's medical status.

- 4) The global period covers 45 days post-operative follow-up and one pre-operative day on the day of surgery. A separate professional fee will be allowed for evaluation prior to the procedure.
- 5) Corneal Transplants
 - A) Indications for penetrating keratoplasty are:
 - Corneal opacification that sufficiently obscures vision through the anterior segment of the eye with at least light perception present. Causes for this problem include:
 - Corneal injury and scarring;
 - Corneal degeneration (from Fuch's or other dystrophy or from previous cataract and/or intraocular lens implantation);
 - Corneal degeneration from keratoconus or familial causes;
 - Corneal infection (e.g., herpes)
 - Therapeutic graft for relief of pain is needed and the patient has at least light perception vision present or the patient has corneal degeneration due to an eye inflammation resulting in pain, however useful vision is still present.
 - B) Indications for lamellar keratoplasty include:
 - Superficial layer corneal scarring and deformity due to trauma, degeneration, infection, or congenital deformity (anterior)
 - Aphakia
 - High myopia
 - High refractive error
 - Keratoconus
 - Recurrent pterygium
 - C) Additional conditions and limitations for corneal transplants are as follows:
 - There is no intractable glaucoma in the eye under consideration
 - There is no active eye infection at the time of surgery
 - There are no general medical contraindications to surgery or anesthesia
 - There is an informed consent obtained from the patient or patient's representative
 - There is no age restriction
 - D) Prior Authorization
 - Prior authorization is required by AlohaCare for the performance of corneal transplants as per our policy and procedure on elective surgery performed in the non-office setting.

Vision Eyewear

A. Description

The charges incurred in dispensing visual aids prescribed by ophthalmologists or optometrists are covered by the AlohaCare Vision program. These include costs for the lens, frames, or other parts of the glasses, as well as fittings and adjustments.

B. Amount, Duration, and Scope

The following are covered:

1. Eyeglasses

- Refractive corrections criteria for an original prescription is (+) or (-) 0.50 diopter, sphere or cylinder, or 1 vertical or 5 horizontal prism diopters for each eye.
- Refractive correction of a change in prescription is (+) or (-) 0.50 diopter, sphere or cylinder, or 6 degrees in cylinder axis for both eyes.
- Glass or plastic lenses may be used. Glass must conform to standard Z-80 (National Bureau of Standards) as it existed on September 15, 1983.
Polycarbonate lenses must be prior authorized.
- Nose pads and rocking pads are considered as part of the technical servicing for the complete glasses. Replacement of the pads is considered a repair and is payable. Frame adjustment, verification or prescription and dispensing of eyeglasses and technical servicing are included in the servicing of the entire glasses.
- Frames: please refer to limitations later in this chapter.
- Frames: **covered at a capped amount of \$30.** The provider must provide a selection of frames from which the member may choose. This selection will be reimbursed by AlohaCare at the fee amount stated above and there should be no co-payment or balance billing to the AlohaCare member.

AlohaCare members are allowed to pick frames outside of the AlohaCare selection. However, the provider must inform the member that AlohaCare will only pay the fee schedule amount and the member will be responsible for the balance up to the actual cost of the frames. The provider should obtain the member's agreement to be balance billed in writing to protect the provider.

PLEASE NOTE that this differs from the Medicaid requirement that there be no balance billing to members. In the Medicaid program, a member who chooses to select frames outside of the selection that is paid in full by Medicaid results in NO BENEFIT for the frames from the Medicaid program. The Medicaid member is then required to pay in full for the more expensive frames, as well as the cost of the technical servicing of the frames. Providers may only bill Medicaid for the charges pertaining to the lenses. It is for this reason that we advise providers to show the AlohaCare frame selection and obtain written agreement from the member with regards to balance billing in the event that frames outside of the AlohaCare set is selected.

2. Contact Lenses

- Keratoconus in one or both eyes where corrected vision by glasses is less than 20/40 and the vision is further improved by contact lenses.
- Corneal astigmatism in one or both eyes greater than 4.00 diopter correctable by contact lenses and the astigmatism correctable by contact lenses.
- Irregular astigmatism due to corneal imperfection where corrected vision by glasses is less than 20/40 and vision is further improved by contact lenses.

- Anisometropia due to aphakia or other causes where the vision corrected by glasses in the non-affected eye is less than 20/50, the problem either will last for at least 6 months or is permanent, and the person requires binocular vision for educational or job purposes.
- Bilateral aphakia when a person becomes ill using spectacle glasses or when the person's occupation makes the wearing of glasses hazardous.
- Certain inflammatory conditions of the cornea for which therapeutic contact lenses are indicated with the recommendation of an ophthalmologist.

3. Miscellaneous Vision Supplies

- Prosthetic eyes are covered. A global fee includes payment for all visits, materials, costs, modifications or replacement because of poor fitting or unacceptable defect within 90 days from the initial visits for fitting. Members on the Neighbor islands requiring prosthesis should be referred to a provider who can complete the prosthesis in one series of daily visits.
- Subnormal visual aids are covered.

4. Repairs

- Minor repairs are covered.

5. Exclusions

- Blended bifocals
- Bifocal contact lenses
- Spare pair of glasses or contacts
- Repairs on glasses that no longer meet the member's needs are not payable
- Tinted lenses for cosmetic reasons. Members must pay for all expenses, both technical and material.
- Oversized lenses unless authorized
- Contact lenses solely for cosmetic purposes such as obscuring an opaque pupil
- Contact lens care kit and accessories
- All services or material not in compliance with the restrictions in these guidelines

6. Limitations

a. Eyeglasses are limited to:

- 1) Once in a 24-month period for adults age 21 and older
- 2) Once in a 12-month period for individuals under the age of 21 years

A new pair within the 24-month period for adults or the 12 month period for under 21 year old members is payable if the change in prescription meets the guidelines described above under "Eyeglasses." The 24-month period (Or 12 months for under 21) will begin again from the date of the most recently dispensed glasses. The claim for the new glasses, however, must have both the old and new prescriptions to confirm the prescription change and avoid processing delays.

Exams or visual aids (glasses) that exceed the limitation require Prior Authorization.

- Tinted or color-coated corrective lenses or “clip-ons” are payable for persons with aphakia, albinism, glaucoma, or other medical conditions excluding photophobia not associated with such conditions. The tint or coat should allow use of the lenses indoors and at night. **These lenses must be prior authorized.**
- Bilateral Plano glasses are payable as safety glasses for persons with one remaining functioning eye.
- Balance lenses are payable if the other eye has a prescription that meets the criteria for lenses.
- Persons with presbyopia who require minimal or no distance correction are to be fitted with ready made half-glasses.
- When unusual complications affect normal recovery, ready-made temporary glasses should be rented or purchased following cataract extraction (with or without insertion of an intra-ocular prosthetic lens) until the eyes have healed and refractive error has stabilized. Prior authorization is required except when prescribed by an ophthalmologist who must be identified on the claim. No additional allowance is payable for plastic cataract lenses. Payment will be made at the level of standard cataract lenses.
- Repairs are payable for the current eyewear only.

b. Contact lenses

- See section above

c. Prior Authorization

1. Eyeglasses

- Polycarbonate lenses must be prior authorized.
- Bifocal lenses for AlohaCare members under 40 years of age must have medical justification. No additional payment is made for blended bifocals.
- Trifocals are payable only for members currently wearing them for specific job requirements.
- Replacement of children’s glasses that are lost, stolen or severely damaged within 12 months of the last pair must be approved before being dispensed.
- Replacement of an adult’s glasses within 2 years must be pre-approved before being dispensed. The information should include one or more of the following information:
 - a. The date and circumstances of loss
 - b. The date the previous glasses were made
 - c. The refractive prescription and the previous prescription, if a change is being requested
- Replacement of lens or frames or any part of the glasses does not require authorization. However, replacement of the entire glasses within the time limits as defined by member age requires prior authorization.
- Tinted, absorptive or color-coated corrective lenses or clip-ons must be prior authorized.

- Ready-made glasses not prescribed by an ophthalmologist after cataract extraction requires prior authorization.

2. Contact Lenses

- A sterilization unit for soft contact lenses must be medically justifiable.
- All contact lenses must be prior authorized including those with a change of prescription during the 24 month period in which the last pair was received or within 12 months for members under 21. Dispensing of the lenses from the new prescription begins a new 24-month period.

3. Miscellaneous vision supplies

- Initial and replacement prosthetic eyes must be prior authorized.