



Benefits Collaborative FAQs: Vision

This FAQ document summarizes:

- Frequently asked questions regarding Department efforts to define the existing vision benefit through the Benefits Collaborative Process; and
- Suggestions made within the Benefits Collaborative Process, and supported by more than one stakeholder, for how to improve the draft Vision Services Benefits Coverage Standard.

Below each item, the Department has provided an *interim* response.

Important Note: The development of the Vision Services Benefit Coverage Standard is ongoing; there are many stages of the Benefits Collaborative Process that the draft has yet to complete. This FAQ document is a snap-shot of the Department position as of 12/15/2015 and should not be read as a final policy determination

Item 1

What *was* the vision services policy proposed by the Department as of October 22, 2015?

- On October 22, 2015, the Department shared a draft Benefit Coverage Standard that outlined the proposed amount, scope and duration of the vision services benefit. To view the draft standard, follow the link below:

<https://www.colorado.gov/pacific/sites/default/files/Benefits%20Collaborative%20Vision%20Services%20Coverage%20Standard%20October%2022%2C%202015.pdf>

Item 2

How can I learn more about the Department's proposal?

- To learn more about what the Department proposed at the start of the 2015 Vision Services Benefits Collaborative Process – and why, you may view slides 25-27 of the



Power Point presentation dated October 22, 2015, located on the Benefits Collaborative Meeting Schedule webpage at the link bellow.

<https://www.colorado.gov/pacific/sites/default/files/Benefits%20Collaborative%20Vision%20Services%20Presentation%20October%2022%2C%202015.pdf>

Item 3

How do you define medically necessary glasses?

- The Department is currently revising the definition of medical necessity found in Colorado Medical Assistance Program rule at 8.076.1.8. A link to the FAQ about this process can be found below. When this process is complete, rule 8.076.1.8 will be updated.

<https://www.colorado.gov/pacific/sites/default/files/Benefits%20Collaborative%20Medicaid%20Necessity%20FAQs%20January%202013%2C%202015.pdf>

- The section of Colorado Medical Assistance Program rule (8.280) that outlines the Early and Periodic, Screening, Diagnostic, and Treatment (EPSDT) benefit for children 20 years of age and younger, will refer to revised rule 8.076.1.8 and include additional language specific to the pediatric population. Information about this change is also included in the above link.

Item 4

What coverage is there for eyewear outside of eyeglasses and contacts, e.g. low vision aids?

- Medically necessary low vision aids are an available benefit for Colorado Medicaid members 20 years and younger. This information will be included in the revised Benefit Coverage Standard.
 - The Department is planning to require that service code V2615, which is used for complex devices reimbursed at a significantly higher rate than other low-vision aids, be prior-authorized. Prior authorization will help assure appropriate utilization of these expensive devices.



- Low vision aids are not a covered service for adults 21 years and older. Coverage is subject to the same legal constraints as adult eyeglasses (*See second bullet under Item 5 below*).

Item 5

Adults currently have access to exams, how can adults access material benefits, e.g. glasses and contacts?

- The Department recognizes the need to address the overall health of our members. We are currently able to offer eyeglasses to adults once per 24-month period after eye surgery.
- Expanding the adult vision benefit, even with proven cost-neutrality, would require state legislative authority for budgetary action and federal authority for benefit expansion. These processes can take several years.

How does Colorado compare to other states regarding this coverage?

- Colorado's coverage for adult eyeglasses is comparable to other states, including a 24-month or greater limitation. For more information, visit the link below:

<http://kff.org/medicaid/state-indicator/eyeglasses/>

Item 6

Can adults receive glasses before the 24 month frequency limitation if they have a significant change in prescription?

- The Department has reviewed this proposal and has determined that enriching this benefit for the small number of adults eligible (after surgery) would decrease parity among the adult Medicaid population as a whole.



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Item 7

Can this Benefit Coverage Standard include policy about vision telehealth?

- The Department is developing a comprehensive telehealth policy. An ophthalmologist has been involved in early stages of this process. Interested stakeholders can continue to engage the Department in this area.
- The Department plans to develop a single telehealth policy, rather than develop telehealth options among the various benefits.

Item 8

Will this benefit cover vision therapy?

- Yes, vision therapy for convergence insufficiency (ICD 10 H51.11) will be added as a covered service for those 20 years and younger.
- The Department plans to require prior authorization for this service, in compliance with our CMS contract.

For which providers?

- The Department is exploring the most appropriate providers for this service, including researching anecdotal reports of physical and occupational therapists providing the service under other codes.