

Adult Vision Services

Definition: Adult Vision Services are included in the MR/RD Waiver as an extension to the vision services included in the State Plan. In the State Plan, specified vision services are only available to Medicaid recipients who are under age 21. The MR/RD Waiver removes the age restriction making the same vision services available to those who are over age 21 and enrolled in the Waiver.

Vision Care Services are defined as those services which are reasonable and necessary for the diagnosis and treatment of conditions related to the optical system.

The State Plan covers one comprehensive eye exam for all Medicaid recipients (both under 21 and over 21) and additional exams during the 365 day period if medically necessary.

The MR/RD Waiver provides the following vision services to enrolled adults:

- One complete set of glasses every 365 days (\$65.00)
- Replacement lenses when the recipient's prescription changes at least one half diopter during the 365 day period. (\$65.00)
- Other vision services when medically justified.

Please refer to the South Carolina Department of Health and Human Services Medicaid Vision Provider Manual for a complete listing of all covered services and payment rates. Please contact the vision representative at the SCDHHS with additional questions.

Providers: Adult Vision Services are provided by Optometrists, Ophthalmologists or Opticians licensed to practice in South Carolina and who are enrolled with SCDHHS to provide Vision Services.

Arranging for the Services: One eye exam every 365 days is a service that is available to all Medicaid recipients, regardless of age, through the State Plan. If it is determined through this exam that additional vision services are needed and the need is clearly documented in the recipient's plan, you must offer the recipient or his/her family a choice of provider of the service and document this offering.

After documenting the need, the amount and frequency of the service, and the offering of provider choice, you must update the Waiver Tracking System (S43) to reflect the anticipated cost of the additional services and receive approval.

The recipient must present his/her Medicaid card to the enrolled provider as authorization for payment. No additional paperwork is required. The provider will in turn bill Medicaid directly for these services.

Please note that in some circumstances the Service Coordinator will not be notified by the individual/legal guardian/residential staff that an individual needs vision services. They will simply present their Medicaid Card to their vision provider when they need services.

In order to ensure that the Single Plan supports these services (as mandated by the MR/RD Waiver document and CMS Protocol), you should plan for these services when completing the Single Plan. In order to plan for vision services, the team that is assembled to complete the Single plan should discuss any upcoming vision services that will be needed during the year. The Service Coordinator should include information in the plan about vision services for the upcoming year.

Monitoring the Services: You must monitor the effectiveness, frequency, duration, benefits, and usefulness of the service along with the recipient's/family's satisfaction with the service. Information gathered during monitoring may lead to a change in the service, such as an increase/decrease in units authorized, change of provider, change to a more appropriate service, etc. The following criteria should be followed when monitoring Adult Vision Services:

- Within two weeks of completion or notification of service by consumer

This service may be monitored during a contact with the individual/family or service provider. It may also be monitored during a review of medical assessment/notes regarding treatment provided. Some items to consider during monitorship include:

- Has the individual's medical status changed since your last contact?
- Are all applicable services being provided as discussed?
- Is the individual satisfied with the result of this service (i.e. glasses, examination, etc.)
- Does the individual feel that the provider is responsive to their needs?
- Does the individual feel that there is a good relationship with the provider?

Reduction, Suspension, or Termination of Services: If services are to be reduced, suspended, or terminated, a written notice must be forwarded to the consumer or his/her legal guardian including the details regarding the change(s) in service, allowance for appeal, and a ten (10) calendar day waiting period before proceeding with the reduction, suspension, or termination of the waiver service(s). The general termination form that has been used in the past for all waiver services is no longer used. See *Chapter 9* for specific details and procedures regarding written notification and the appeals process.