MAA Support Letter SB 795 20260304.pdf
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Maryland Academy of Audiology

P.O. Box 710

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https://maaudiology.org/

Senator Pamela Beidle, Chair
Senate Finance Committee
3 East Miller Senate Office Building
Annapolis, MD 21401

RE: **SB 795 Health Insurance – Vision Benefits – Regulation of Insurers and Vision Benefit Managers**
Position: **FAVORABLE**

March 04, 2026

Madam Chair Beidle, Vice Chair Hayes, and Committee Members,

On behalf of the Maryland Academy of Audiology (MAA), I write to express our **strong support** for Senate Bill 795, state legislation that establishes meaningful consumer protections, increases transparency in vision care and eyeglass/contact contracts, and promotes fair and ethical participation by licensed vision care professionals.

The MAA represents nearly 600 licensed audiologists who practice in the state of Maryland and the patients we serve. Our mission is to enhance the ability of members to achieve career and practice objectives by fostering professional autonomy, providing quality continuing education, and increasing public and consumer awareness of hearing, tinnitus (audiologic), and balance (vestibular) disorders and the value of these services. Audiologists in Maryland work closely with federal, state, and private third-party payers/administrators (TPPs and 3PAs) to optimize coverage of services provided for the evaluation, diagnosis, management, and treatment of patients in our care.

SB 795 clarifies that only covered items and services may be subject to plan-established fees, while preserving the ability of licensed optometrists to charge usual and customary (U&C) fees for non-covered services, with full disclosure consistent with the federal No Surprises Act requirements. These provisions promote fairness, sustainability, and ethical care delivery without limiting consumer choice.

SB 795 aligns with efforts by MAA and national audiology associations to reform problematic managed care practices in hearing health care, including:

- Clear distinctions between insurance benefits and discount programs;
- Fair reimbursement for professional audiologic and vestibular services;
- Transparency regarding third-party administrator (3PA) and manufacturer involvement; and
- Protection against coercive contracting practices.

This legislation reflects principles advanced at both state and federal levels and serves as a model for balanced regulation that protects consumers while respecting licensed professionals. Disclosure of manufacturer ownership and product limitations is especially important to maintaining patient trust and preventing conflicts of interest that could compromise clinical decision-making.

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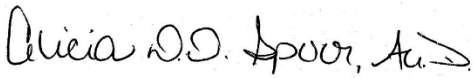
SB 795 represents thoughtful, well-balanced legislation that protects Maryland consumers, supports ethical vision health care delivery, and increases accountability within the vision care plan marketplace. The MAA appreciates the opportunity to provide input and stands ready to serve as a resource on healthcare policy matters.

The MAA requests a ***favorable*** committee report on SB 795 and looks forward to replicating the optometrist's success in the near future.

Sincerely,



Alicia D.D. Spoor, Au.D.
Doctor of Audiology
Legislative Chair, MAA

CatCarterTestimonySupportSB 795.pdf
Uploaded by: Catherine Carter
Position: FAV

Testimony in Support of SB 795

Senate Finance Committee
Maryland General Assembly

Submitted by:
Cat Carter
Small Business Owner, Former English Teacher, Lions Club Member, Mother of Five
March 4, 2026

Main Testimony

My name is Cat Carter. I am a small cybersecurity business owner, a former English teacher, a Lions Club member, and a mother of five. I purchase my family's vision insurance on the open market. I am here today as a patient and as a parent in strong support of SB 795.

All five of my children and I wear glasses and/or contact lenses. Vision care in our household is not occasional — it is constant. When coverage fails, the impact does not happen once. It happens six times.

My daughter Belleadora is currently in active myopia management treatment to slow the progression of her nearsightedness. Progressive myopia significantly increases the lifetime risk of retinal tears and retinal detachment. This is not cosmetic care — it is preventive medical care intended to protect her eyesight for decades to come.

There was a period when her prescription was changing rapidly. Each change required new lenses. Our vision plan allows only a short window for prescription-change remakes. When her eyes changed outside that window — which they did — the plan would not cover replacement lenses, even though the change was medically necessary. We paid out of pocket to keep her vision corrected because waiting was not an option.

Vision plans typically cover glasses or contact lenses — not both. But children in myopia management and patients who rely on contacts must maintain a current pair of glasses to avoid overwear and protect eye health. When prescriptions change, families are forced to choose which to update through insurance and which to pay for themselves. What should be a medical decision becomes a financial one.

Low reimbursement also affects what happens inside the exam room. When plans reimburse very little for comprehensive eye exams, providers must schedule higher patient volumes to remain financially viable. That means less time per patient. As a mother managing progressive myopia in

one child and corrective needs for five others, I value time in the exam room. When reimbursement pressures compress appointment time, patient care inevitably feels the strain.

This issue is deeply personal to me.

My son, Atticus, struggled with double vision that went undiagnosed for far too long. Watching your child try to read when the words will not stay still is heartbreaking. He worked twice as hard just to keep up — not because he lacked ability, but because he could not see clearly enough to learn.

Because of children like Atticus, the Atticus Act was passed in Maryland in 2018 to improve access to eye care so students can see in order to learn. That same year, Maryland passed a vision screening reporting bill after data showed that only 35% of parents followed up after their child failed a school vision screening.

That means most children identified as needing help were not getting to an eye doctor.

On average, school vision screenings cost Maryland counties approximately $5 million annually, and follow-up efforts cost schools approximately $1.9 million annually. We are investing millions of dollars to identify students with vision problems. But identification without access to treatment does not solve the problem.

When I served as project manager for the Howard County Beyond 2020 Outreach program, our parent survey found that the number one barrier to care was simply finding a provider.

Just last week, I received a call from a high school administrator asking for help for students who were struggling and needed eye exams and glasses. The VSP voucher system that school nurses relied on for years is gone. Fewer providers are participating in certain plans. Access points are shrinking.

As a Lions Club member, I refer families to our LASH (Lions Affordable Sight & Hearing) program and have organized numerous community vision screenings. I strongly believe in what Helen Keller charged the Lions to do when she called us to be “knights of the blind in this crusade against darkness.” We can identify children who need help. But identification is not treatment.

Meanwhile, through the Blueprint for Maryland’s Future, significant Concentration of Poverty funds are being invested in school-based eye exam programs to address vision barriers to learning.

That investment acknowledges how serious this issue is. But school-based programs alone cannot solve it.

The Vision for Baltimore Study (2021) showed that while there was improvement at one year, the impact was not sustained over time. The study emphasized that long-term success requires connection to community eye care clinicians for ongoing monitoring and updated prescriptions.

Providing glasses once is not enough.

If reimbursement structures make it difficult for providers to participate in insurance plans, the network shrinks. When the network shrinks, students lose continuous care. We end up spending public dollars on identification and short-term solutions without strengthening the long-term treatment infrastructure.

This bill helps ensure that students not only receive glasses once — but have sustained access to the doctors who can care for them over time.

I cannot overstate how deeply I value and trust my optometrist. Quite frankly, I trust her with something as precious as my family's sight — there is nothing more important. She has already had to drop one vision plan because it was not financially sustainable.

As a small business owner who purchases my family's vision insurance on the open market, I would wholeheartedly accept a modest premium increase — likely no more than $50 per year — if it meant she is reimbursed fairly and can continue participating with my plan. Supporting her ability to provide the exceptional care I rely on is more than worth that cost.

I do not want to lose access to the doctor who has cared for my children for years. I do not want her to be forced to drop my plan because the reimbursement structure no longer works.

SB 795 helps protect patient access — especially for the students who need to see in order to learn.

For my family of seven, and for thousands of Maryland children trying to learn without being able to see clearly, this is deeply personal.

Thank you for your consideration.

Supplemental Patient Perspective

Practical Impact of Vision Plan Structures

The following reflects my personal experience navigating our family's vision coverage:

- During a period when my daughter's prescription was changing rapidly, our plan would not cover replacement lenses outside a narrow remake window, even though her prescription had medically changed. We paid out of pocket to keep her vision corrected.
- Vision plans typically provide benefits for glasses or contact lenses, not both. However, patients who wear contact lenses must maintain a current pair of glasses to protect eye health. When prescriptions change, families are often forced to pay out of pocket for one or the other.
- The version of Davis Vision our family carries functions largely as a basic discount plan. We pay premiums while still paying significant out-of-pocket costs for frames and medically necessary lens upgrades.
- Low reimbursement for comprehensive eye exams forces higher patient volume, reducing available appointment time and sometimes requiring additional visits to address medical concerns.
- Many families are told their vision plan "covers" exams and glasses, but most plans provide only a limited frame allowance and do not cover medically necessary lens upgrades.
- Reimbursement for certain services, such as vision therapy, is often so low that many practices do not participate with insurance, limiting access further.

When reimbursement does not adequately support the cost of delivering care, providers must make difficult decisions about insurance participation. When providers leave plans, families lose access.

SB 795 addresses that structural problem and supports sustainable patient access to care.

Heather Atcherson - SB 795 Oral Testimony .docx.pd
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March 4, 2026

The Honorable Pamela Beidle
Senate Finance Committee
Miller Senate Office Building, 3 East Wing
11 Bladen St., Annapolis, MD 21401 - 1991

Re: SUPPORT SB 795 "Health Insurance - Vision Benefits - Regulation of Insurers and Vision Benefit Managers"

Dear Chair Beidle & Committee Members,

My name is Dr. Heather Atcherson, and I own and operate a second-generation private Optometry practice in District 33 in Annapolis. For years, my father and I debated whether we could afford to continue accepting vision insurance. I wanted to serve as many patients as possible. He had grown discouraged after decades of financial strain from these plans.

The reality is simple: reimbursement rates for comprehensive eye exams have not increased in over 20 years. Today, it costs my practice about $260 per hour just to keep our doors open. We schedule 45 minutes for each patient because that's what a thorough, comprehensive exam requires. Yet vision plans reimburse only $40 to $60 per exam. That does not cover the cost of providing care.

Because of this, independent practices are forced to rely on the sale of glasses or contact lenses to remain financially viable. We strictly follow each patient's insurance benefits, charging only the copays and allowances outlined in their plan to keep costs competitive. But the exam itself—the core medical service we provide—is significantly undervalued.

Vision plans are not traditional insurance. They do not assume unpredictable risk. They offer one routine exam per year and fixed product allowances, while maintaining control over reimbursements. The main plans have become vertically integrated, owning a piece in almost every touchpoint in the industry. Independent doctors have little to no ability to negotiate fair rates.

While premiums have likely adjusted to inflation over time, reimbursements to doctors have remained stagnant. Corporate profits have grown, while small community practices struggle to keep the lights on.

We want to continue delivering high-quality, comprehensive care to our patients. But without meaningful change, sustaining independent practice becomes increasingly difficult.

Thank you for your time and consideration.

Very truly yours,

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Practice: Bay Hills Eye Care

Opposition Arguments & The Facts.docx.pdf

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March 4, 2026

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Re: SUPPORT SB 795 "Health Insurance - Vision Benefits - Regulation of Insurers and Vision Benefit Managers"

The Opposition's Arguments and the Facts

***VBM Argument:* VBMs claim insurance premiums could go up as much as 30% if this bill passes:**

Facts:

1. Texas, Oklahoma, Nevada, and Arkansas have recently passed similar legislation and there have been no reported premium increases while expanding provider networks and patient access.
2. Absolute worst case scenario – if an insurance plan premium is roughly $10-12/month, a 30% increase is less than $50 total for the entire year. That amount won't be a massive make or break for the average consumer.
3. The real cost driver is vertical integration allowing monopoly pricing. The threat of increased premiums is a red herring to scare legislators away from market reform. When major medical centers refuse to participate in VBM plans due to untenable contract terms, patients with complex conditions are forced to seek fragmented care across multiple uncoordinated locations, leading to duplicate testing, delayed diagnoses, and worse outcomes that cost the healthcare system far more than coordinated care would.
    a. This bill doesn't increase premiums - it removes anti-competitive practices in an 85% concentrated market that fragments care, restricts patient access to quality providers, and drives up total healthcare spending through inefficiency.
4. It's ultimately up to the VBM how they want to absorb or pass on these costs. They have enough alternative business ventures that there should be ways for them to absorb some of the costs, but if they opt to pass the entirety onto their customers, that's their business decision. Optometrists haven't had a pay raise in the last 30 years while the Corporate entities have been massively profiting.

***VBM Argument:* VBMs state there is no reason that they shouldn't be able to be transparent about which practices/doctors provide discounts or better rates for their consumers on their Provider directories.**

Facts: The online provider directories/doctor locators rank their doctors **not** by in-network/out-of-network and **not** by quality of care standards, but by how much you purchase annually into their company's other business ventures. All of the in-network providers have agreed to provide a certain subset of services, at a quality standard and can be kicked out of the network if not upholding, yet are underrecognized for not purchasing a certain separate line of services that is owned by the VBM.

Example: VSP has a "premier" status for providers, which ranks them higher on their doctor provider directory page. Doctors achieve this "premier provider" status PURELY by spending $12,000 annually on the frame lines they own and using VSP's brand of lenses, Unity.

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To rank a doctor as “premier” by only how much they’ve “paid to play” in support of that particular vertically integrated company is misleading to consumers about why they would choose one provider over another and decreases choice/competition as doctors are having to funnel patients to a certain subset of products just to continue being ranked higher by that plan.

This is equivalent to having a neighborhood “Best Of” ranking based on community votes, but allowing people to bypass the voting system and buy their way to the top spots.

VBM Argument: **Providers can simply opt out of VBM networks.**

Facts: Unlike other markets, providers cannot “just walk away.” In many Maryland communities, VBMs dominate the market. Patients have no alternative plan. Providers face ‘take it or leave it’ contracts. Providers have no realistic ability to negotiate or drop these plans without losing the majority of their patients. Opting out means patients lose access to local care. Rural clinics become financially unsustainable. This is why legislation is needed — to level the playing field and protect both patients and providers.

VBM Argument: **VBMs reduce costs for patients and employers. VBMs negotiate lower prices, control utilization, and help keep premiums affordable for employers and consumers.**

Facts: VBMs do not reduce the cost of care. They shift costs from insurers to providers; and from plans to patients who have copays, non-covered services and forced materials. There is no evidence that VBM savings are passed on to patients or employers in the form of lower premiums. In practice, VBMs:

- Restrict patient choice
- Mandate pricing below market value
- Increase administrative burdens and waste. SB795 streamlines contracting and communication.

Maryland employers already pay premiums; VBMs add middlemen costs, not savings. VBMs don’t lower costs – they redistribute them away from insurers and onto patients and small medical practices.

VBM Argument: **Regulation will drive insurers/VBMs out of Maryland.**

Facts: VBMs continue operating in states like Oklahoma, Texas, Nevada and Arkansas that have already passed legislation. Marylanders deserve the same protections.

VBM Argument: **Vision care isn’t essential medical care. Vision benefits are ancillary or optional.**

Facts: Vision exams detect diabetes, hypertension, glaucoma, and neurologic disease. Loss of vision directly impacts ability to work, safety, and independence. Medicare and Maryland Medicaid already recognize optometric services as “physician services” part of essential healthcare.

VBM Argument: **VBMs already operate under sufficient regulation. Existing insurance laws are adequate.”**

Facts: VBMs exploit regulatory gaps. They are neither insurers nor providers. Oversight is fragmented or absent. SB795 closes a known loophole. Transparency requirements exist in other benefit manager sectors.

VBM Argument: SB795 limits negotiation and removes discounts for patients.

Facts: SB795 protects open negotiation and bans deceptive ‘discounts’ only. It restores honest pricing and fair negotiations. Patients get honest, upfront pricing and more freedom of choice. SB795 doesn’t eliminate contracts – it ensures contracts don’t harm patients.

VBM Argument: **SB795 eliminates data for claims.**

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Facts: It only restricts unnecessary or invasive data collection. It actually protects privacy while maintaining claim efficiency.

VBM Argument: SB795 limits tiering and flexibility.

Facts: SB795 stops anti-competitive steering, not benefit design. It ensures fairness and employers keep flexibility.

VBM Argument: **VBMs ensure quality and standardization. They improve care quality by setting uniform standards."**

Facts: VBMs do not set medical standards – licensing boards and medical guidelines do. VBMs:

- Restrict exam time
- Dictate materials and labs
- Incentivize volume over quality

There is no evidence that VBM oversight improves clinical outcomes. Quality healthcare is delivered by licensed professionals, not benefit managers.

VBM Argument: **VBMs protect against fraud and abuse. Their oversight prevents overutilization and unnecessary services.**

Facts: Fraud prevention already exists through state licensing boards, insurance audits and federal Medicaid oversight. VBMs use "fraud" language to justify denials, retroactive clawbacks, and arbitrary documentation demands. These practices burden compliant providers and do not target bad actors.

VBM Argument: **Restricts removing poor providers.**

Facts: SB795 allows removal for material breach with due process. It protects integrity and fairness.

Truly yours,

Dr. Heather Atcherson, OD

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Audiology-Physical-Occupational-Speech-and-Vision-

Uploaded by: Jennifer Cohen

Position: FAV

MARYLAND DEPARTMENT OF HEALTH
COMAR 10.09.23.01-1
MEDICAL ASSISTANCE PROGRAM

Early Periodic Screening, Diagnosis, and Treatment (EPSDT)
For
Audiology, Physical, Occupational, Speech & Vision Services
Provider Manual

Effective January 2025

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PROVIDER MANUAL OVERVIEW

In this manual, you will find billing and reimbursement information for the following Medicaid services: Acupuncture, Chiropractic, Speech Language Pathology, Occupational Therapy, Nutrition Therapy, Physical Therapy, Audiology, and Vision Services. The information provided is related to services rendered to Medicaid participants who are 20 years of age or younger, except for audiology and physical therapy services which are covered for Medicaid participants of all ages. Please refer to the table of contents to find information specific to each of the covered services.

Occupational therapy, speech language pathology, and physical therapy services are "carved-out" from the HealthChoice Managed Care Organization (MCO) benefits package for participants *who are 20 years of age and* younger and must be billed directly to the Fee-for-Service (FFS) Medicaid Program.

Acupuncture, chiropractic, nutrition, and vision services are covered by the HealthChoice MCO benefits package for participants *who are 21 years of age and* older.

Effective July 1, 2018, audiology services are covered by the HealthChoice MCO benefits package *for participants of all ages*.

EPSDT refers to Early Periodic, Screening, Diagnosis, and Treatment services for participants under the age of 21.

Some services described in this manual are both EPSDT services (covered under age 21) and covered services for adults. Some services for adults described in this manual are only covered in certain settings. Most Medical Assistance (Medicaid) participants are enrolled in MCOs. Certain services for children are not part of the MCO benefit package; instead, they are carved out and must be billed to Fee-for-Service (FFS) Medicaid as described in this manual.

EPSDT services covered by the MCO are described in COMAR 10.67.06.20. When a participant under the age of 21 is enrolled in an MCO, contact the MCO unless the service is carved out.

When a participant aged 21 and older is enrolled in an MCO, the services described in this manual that are covered for adults are the responsibility of the MCO. These services are described in COMAR 10.67.06. Providers must contact the MCO for further details.

Until a participant is enrolled in an MCO, services can be billed to Fee-for-Service (FFS) Medicaid.

When a participant aged 21 and older is not enrolled in an MCO, the services that can be billed to FFS are audiology and physical therapy unless the participant is in the REM program. Covered services for participants in the REM program are described in COMAR 10.09.69.10. For questions, providers may contact 410-767-3998.

Patient Eligibility & Eligibility Verification System (EVS)

The EVS is a telephone inquiry system that enables health care providers to quickly and efficiently verify a Medicaid participant's current eligibility status. Medicaid eligibility should be verified on EACH DATE OF SERVICE *prior* to rendering services. Although Medicaid eligibility validation via the Program's EVS system is not required, it is to your advantage to do so to prevent claims from being denied for services rendered to a canceled/non-eligible participant. ***Before*** **rendering services to a Medicaid-eligible participant, verify the participant's eligibility** ***on the date of service*** **via the Program's Eligibility Verification System (EVS) 1-866-710-1447.**

If you need additional EVS information, please call the Provider Relations Unit at 410-767-5503 or 800-445-1159. EVS is an invaluable tool that is fast and easy to use.

For providers enrolled in eMedicaid, Web EVS - a web-based eligibility application, is now available at *www.emdhealthchoice.org*. The provider must be enrolled in eMedicaid in order to access the web EVS system.

Provider Verification System (PVS)

The Provider Verification System (PVS) is an internally built , public-facing search engine for Maryland Medicaid FFS provider enrollment. The PVS can be used to search for a provider's Medicaid FFS enrollment status to determine if the provider was active or inactive on a specified date. Additionally, the PVS can also be used to:

- Check group status.
- Check revalidation dates; and
- Look up provider numbers.

Before **rendering a service covered by Medicaid, providers should verify their eligibility** ***for the date of service.***

The PVS can be accessed at https://encrypt.emdhealthchoice.org/searchableProv/main.action

Billing Medicare

The Program will authorize payment on Medicare claims if:

- The provider accepts Medicare assignments,
- Medicare makes direct payment to the provider,
- Medicare has determined that services were medically justified,
- The services are covered by the Program; and
- Initial billing is made directly to Medicare according to Medicare guidelines.

If the participant has insurance or other coverage such as Medicare, or if any other person is obligated, either legally or contractually, to pay for, or to reimburse the participant for the services in these guidelines, the provider should seek payment from that source first. If an insurance carrier rejects the claim or pays less than the amount allowed by Medicaid the provider should submit a claim to the Program. A copy of the insurance carrier's notice or remittance advice should be kept on file and available upon request by the Program. In this instance, the CMS-1500 must reflect the letter K (services not covered) in box 11 of the claim form.

Specifically, when a provider bills Medicare Part B for services rendered to a Medicaid participant and the provider accepts assignment on the claim, the payments should be made automatically. However, if payment is not received within 30 days, the claim may not have successfully crossed over and the claim should be submitted to the Program on a CMS-1500 along with the Medicare Explanation of Benefits (EOB).

Note: When dropping claims to paper, the CMS-1500 and EOB should match the Medicare claim line for line

Providers should only submit claims to Medicare for services rendered to patients who are dually eligible for both Medicare and Medicaid. The Program must receive Medicare/Medicaid crossover claims within 120 days of the Medicare payment date. This is the date on Medicare's EOB form. The Program recognizes the billing time limitations of Medicare and will not make payment when Medicare has rejected a claim due to late billing. In general, the Program does not pay Medicare Part B coinsurance or copayments on claims where Medicare payment exceeds the Medicaid fee schedule.

Contact Medicaid's Professional Provider Relations Unit at 410-767-5503 or 800-445-1159 if you have questions about completing the CMS-1500 claims form or Medicare crossover claims.

Managed Care Organization – (MCO) Billing

Other than the carve-out services of PT, OT, and speech language pathology for children under the age of 21, claims for participants who are enrolled in an MCO must be submitted to the MCO for payment. Contact the MCO for information regarding their billing and preauthorization procedures.

Acupuncture, nutrition, and chiropractic services are a covered benefit through the MCO system for participants who are 20 years old and younger. Audiology services are a covered benefit.
through the MCO system for participants of all ages. Contact the MCO for information regarding their billing and preauthorization procedures.

Fee-for-Service (FFS) Billing

Providers must bill the Maryland Medicaid Program on the CMS-1500 claims form and attach any requested documentation. Maryland Medicaid specific procedure codes are required for billing purposes. Please refer to the procedure code and fee schedule that is included at the end of this manual.

The Program reserves the right to return to the provider, before payment, all invoices not properly signed, completed, and accompanied by properly completed forms required by the Department.

The provider shall charge the Program their usual and customary charge to the public for similar services. The Program will pay for covered services, based upon the lower of the following:

- The provider's customary charge to the public; or
- The Department's fee schedule

The Provider may <u>not</u> bill the Program or participants for:

- Services rendered by mail or telephone,
- Services delivered via telehealth if requirements established in COMAR 10.09.49 are not met,
- Completion of forms and reports; or
- Broken or missed appointments

To ensure payment by Maryland Medicaid, check Maryland Medicaid's EVS for ***every Medicaid patient*** on the date of service.

Under Medicaid's FFS Program, services are reimbursed on a per visit basis under the procedure code that is listed on Maryland Medicaid's established procedure code and fee schedule. The schedule will indicate the maximum units allowed for the service and the reimbursement amount for each unit of service. The maximum units are the total number of units that can be billed on the same day of service. Maryland Medicaid will reject claims that exceed the maximum units of service.
PLEASE NOTE: All paper claims must include the MA number and NPI for the rendering provider.

Medical Assistance Payments

You must accept payment from Medicaid as ***payment in full*** for a covered service. You ***cannot*** bill a Medicaid participant under the following circumstances:

- For a covered service for which you have billed Medicaid,
- When you bill Medicaid for a covered service and Medicaid denies your claims because of billing errors you made, such as: wrong procedure codes, lack of preauthorization, invalid consent forms, unattached necessary documentation, incorrectly completed forms, filing after the time limitations, or other provider errors,
- When Medicaid denies your claim because Medicare or another third party has paid up to or exceeded what Medicaid would have paid,
- For the difference between your charges and the amount Medicaid has paid,
- For transferring the participant's medical records to another health care provider; and/or
- When services were determined to not be medically necessary.

You ***can*** bill the participant under the following circumstances:

- If the service provided is not covered by Medicaid and you have notified the participant prior to providing the service that the service is not covered; or
- If the participant is not eligible for Medicaid on the date you provided the service.

The Health Insurance Portability & Accountability Act (HIPAA)

HIPAA of 1996 requires that standard electronic health transactions be used by health plans, including private, commercial, Medicaid and Medicare, health care clearinghouses, and health care providers.

More information on HIPAA may be obtained from:
https://health.maryland.gov/iac/HIPAA/Pages/About-HIPAA.aspxryland.gov/hipaa/Pages/Home.aspx.

National Provider Identifier (NPI)

The National Provider Identifier (NPI) is mandated by the Health Information Portability and Accountability Act (HIPAA), which requires a standard unique identifier for health care providers. Administered by the Centers of Medicare and Medicaid Services (CMS), the NPI is a unique, 10-digit, numeric identifier that does not expire or change. NPI's are assigned to improve the efficiency and effectiveness of the electronic transmission of health information.

To apply for an NPI, visit the CMS website at https://nppes.cms.hhs.gov/.

Ordering, Rendering, and Prescribing (ORP) Providers

CMS requires State Medicaid agencies to enroll all ordering, rendering, or prescribing (ORP) providers with Maryland Medicaid. Services ordered, rendered, or prescribed to a Medicaid participant by a provider who is not enrolled in Medicaid will be denied.

Providers who render billable services and who intend to be reimbursed for patient care should be enrolled in the Medicaid Program as the provider type corresponding to their license. Providers who are only prescribing medications and who do not intend to bill Medicaid (typically interns, residents, and trainees) have the option to enroll as an Ordering, Referring, or Prescribing (ORP) only provider type. For additional enrollment assistance, please go to:
https://health.maryland.gov/mmcp/provider/Pages/enrollment.aspx

Fraud and Abuse

It is illegal to submit reimbursement requests for:

- Amounts greater than your usual and customary charge for the service. If you have more than one charge for a service, the amount billed to Maryland Medicaid should be the lowest amount billed to any person, insurer, health alliance or other payer,

- Services which are not provided, or not provided in the manner described on the request for reimbursement. In other words, you must accurately describe the service performed, correctly define the time and place where the service was provided and identify the professional status of the person providing the service,

Fraud and Abuse, cont.

- Any procedures other than the ones you provide,
- Multiple, individually described, or coded procedures if there is a comprehensive procedure that could be used to describe the group of services provided,
- Unnecessary, inappropriate, non-covered or harmful services, even if you actually provided the service; or
- Services for which you have received full payment by another insurer or party.

You are required to refund all overpayments received from Medicaid within 30 days. Providers must not rely on Department requests for the repayments of overpayments. Retention of overpayments is also illegal.

A provider who is suspended or removed from the Medicaid Program, or who voluntarily withdraws from Medicaid, must inform participants ***before*** rendering services that they are no longer a Medicaid provider, and the participant is therefore financially responsible for the services.

Appeal Procedures

Appeals related to Medicaid services are conducted under the authorization of COMAR 10.09.36.09 and in accordance with COMAR 10.01.03. Providers that wish to initiate an appeal must file the appeal within 30 days of the date of a notice of administrative decisions in accordance with COMAR 10.09.36.09.

Code of Maryland Annotated Regulations (COMAR)

Regulations governing EPSDT services described in this manual are established in:

COMAR	Title
10.09.14	Vision Care Services
10.09.17	Physical Therapy Services
10.09.23	Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services
10.09.36	General Medical Assistance Provider Participation Criteria
10.09.49	Telehealth Services
10.09.51	Audiology Services

COMAR regulations can be found on the following webpage:
https://dsd.maryland.gov/Pages/COMARHome.aspx

- Select “Search COMAR”;
- Select title number 10 – Maryland Department of Health;
- Select Subtitle 09 - Medical Care Programs; and
- Select the appropriate chapter number (i.e., 51- Audiology Services).

Provider Requirements

The provider must meet requirements as set forth in COMAR 10.09.36, General Medical Assistance Provider Participation Criteria.

EPSDT OVERVIEW

This section of the manual addresses occupational therapy, speech language pathology, and physical therapy services for children when the services are not part of home health services or an inpatient hospital stay. These services are "carved-out" from the HealthChoice MCO benefits package for participants *who are 20 years of age and younger* and must be billed directly to the FFS Medicaid Program. Services provided by other providers (i.e., pediatricians, internists, family practitioners, general practitioners, nurse practitioners, neurologists, and/or other physicians) to determine whether a child has a need for occupational therapy, physical therapy, or speech language pathology services are the responsibility of the MCO and must be billed to the participant's MCO. When therapy services are provided to participants under the age of 21 as part of home health or an inpatient hospital stay, they become the responsibility of the MCO. In addition, MCOs reimburse for community-based rehabilitation, including physical and occupational therapy and speech language pathology services for adult enrollees. Contact the MCO for their preauthorization and billing policy and procedures for participants 21 years of age and older.

Acupuncture, chiropractic, and nutrition services addressed in this manual are limited to Maryland Medicaid's EPSDT population (participants who are 20 years of age and younger). These services are not generally covered for adults. When a participant under the age of 21 is enrolled in a HealthChoice MCO, the MCO is responsible for covering these services.

The following chart outlines the payer for these services when the participant is **enrolled in an MCO**:

Service	Bill the MCO	Bill Fee-for-Service (FFS) Medicaid
Occupational Therapy	21 + older	0-20
Physical Therapy	21 + older	0-20
Speech Language Pathology	21 + older	0-20
Acupuncture	0-20	------
Chiropractic	0-20	------
Nutrition	0-20	------
Home Health Therapy	0-99	------
Inpatient Therapy	0-99	------
Audiology	0-99	------
Vision Care Services	21 + older	0-20

If a participant who is 21 or older is **not enrolled** in an MCO, the provider should bill FFS for audiology and physical therapy services.

Regardless of age, if a participant is part of the REM program, the provider should bill FFS for occupational therapy, physical therapy, speech-language pathology, chiropractic, nutrition, and vision services. The covered services for REM participants are listed in 10.09.69.10.

Therapy services provided by a hospital, home health agency, inpatient facility, nursing home, Residential Treatment Center (RTC), local lead agency, school or in accordance with an IEP/IFSP, model waiver, etc., are not specifically addressed in this manual.

Covered Services

EPSDT Acupuncture, Occupational Therapy, Speech Language Pathology & Chiropractic Services

For occupational therapy and speech language pathology services rendered to participants under the age of 21, bill FFS Medicaid. Contact the MCO for preauthorization requirements for participants 21 years of age and older. Acupuncture and chiropractic services for participants under the age of 21 are covered through the MCO.

Services are covered for participants who are 20 years of age and younger when the services are:

- Necessary to correct or ameliorate defects and physical illnesses and/or conditions discovered during an EPSDT screen,
- Provided upon the referral and order of a screening provider,
- Rendered in accordance with accepted professional standards and when the condition of a participant requires the judgment, knowledge, and skills of a licensed acupuncturist, licensed occupational therapist, licensed speech language pathologist or licensed chiropractor,
- Delivered in accordance with the plan of treatment,
- Limited to one initial evaluation per condition; and
- Delivered by a licensed acupuncturist, licensed chiropractor, licensed occupational therapist, licensed speech language pathologist, or a speech language pathologist clinical fellow*.
- *PLEASE NOTE: services rendered by a SLP Clinical Fellow must be billed under the NPI of the fully licensed supervising SLP who is enrolled with Maryland Medicaid. This applies to school, community, and inpatient/outpatient settings. Only the fully licensed supervising SLP is eligible to enroll with Maryland Medicaid via ePREP. SLP Clinical Fellows are not eligible to enroll with Maryland Medicaid. See EPSDT Transmittal No. 50 for more information.

In order to participate as an EPSDT-referred services provider, the provider shall:

- Obtain approval by the screening provider every six (6) months or as authorized by the Department for continued treatment of a participant. Approval must be documented by the screening provider and the therapist, acupuncturist, or chiropractor in the participant's medical record,

- Have experience with rendering services to individuals ages birth through 20 years,
- Submit a quarterly progress report to the participant's primary care provider, and
- Maintain medical documentation for each visit.

PLEASE NOTE: Services provided in an institution for mental disease, a hospital, a residential treatment center, or nursing home facility, or by a group where reimbursement is covered by another part of Medicaid **are not covered**.

Physical Therapy

Providers of physical therapy services should bill FFS Medicaid for participants under 21 years of age. Contact the MCO for preauthorization for participants 21 years of age and older.

If a participant who is 21 or older is **not enrolled** in an MCO, the provider should bill FFS for physical therapy services.

Medically necessary physical therapy services ordered in writing by a physician, nurse practitioner, physician assistant, nurse midwife, Doctor of Dental Surgery or of dental medicine or podiatrist are covered when:

- Provided by a licensed physical therapist or by a licensed physical therapist assistant under direct supervision of the licensed physical therapist,
- Rendered in the provider's office, the participant's home, domiciliary level facility, or via telehealth in accordance with 10.09.49,
- Diagnostic, rehabilitative, or therapeutic in nature and directly related to the written treatment order,
- Of sufficient complexity and sophistication, or the condition of the patient is such, that the services of a physical therapist are required,
- Rendered pursuant to a written treatment order that is signed and dated by the prescriber,
- The treatment order is kept on file by the physical therapist as part of the participant's permanent record,
- Not altered in type, amount, frequency, or duration by the therapist unless medically indicated. The physical therapist shall make necessary changes and sign the treatment order, advising the prescriber of the change and noting it in the patient's record,
- Limited to one initial evaluation per condition; and
- A new order is requested from the prescriber, for continued therapy, if the order exceeds 30 days.

Services are to be recorded in the patient's permanent record, which shall include:

- The treatment order of the prescriber,
- The initial evaluation by the therapist and significant past history,

- All pertinent diagnoses and prognoses,
- Contraindications, if any; and

Physical Therapy, cont.

- Progress notes documented in accordance with the requirements listed in COMAR 10.38.03.02-1.

The following physical therapy services are not covered:

- Services provided in a facility or by a group, where reimbursement for physical therapy is covered by another part of the Medicaid Program,
- Services performed by licensed physical therapy assistants, when not under the direct supervision of a licensed physical therapist,
- Services performed by physical therapy aides,
- Experimental treatment; and/or
- More than one initial evaluation per condition.

EPSDT Nutrition Services

Nutrition Services are covered for participants who are 20 years of age and younger when the services are:

- Medically necessary and provided by a licensed dietician nutritionist,
- Rendered in accordance with accepted professional standards and when the condition of a participant requires the judgment, knowledge, and skills of a licensed dietician nutritionist.

PLEASE NOTE: Nutrition services are covered through the HealthChoice Program. Contact the MCO for preauthorization information, if serving an MCO enrollee.

Preauthorization

Contact the MCO for information regarding their billing and preauthorization procedures for acupuncture, chiropractic, nutrition, and therapy services for participants who are under the age of 21, or who are receiving home health and inpatient services.

Preauthorization is not required under FFS Medicaid; however, it is expected that a quarterly care plan be shared with the participant's primary care provider.

Provider Enrollment

PLEASE NOTE: Under Maryland Medicaid, acupuncturists, therapists, and chiropractors who are part of a physician's group are not considered physician extenders. Services rendered by these providers cannot be billed under the supervising physician's rendering number. These providers must complete an enrollment application in ePREP and obtain a Maryland Medicaid provider number that has been specifically assigned to them under their individual name. The number must be used when billing services directly to FFS Maryland Medicaid.

Therapists, acupuncturists, nutrition ,dietitians and chiropractors ***must be*** licensed to practice their specialties in the jurisdictions where they practice. (Chiropractors must be licensed and enrolled as a physical therapist in order to bill for physical therapy services.)

When a provider application has been approved for participation in the Maryland Medicaid Program, a nine-digit provider identification number will be issued. Applicants enrolling as a renderer in a group practice must be associated with a new or existing group practice of the same Medicaid provider type (i.e., a PT can enroll as a renderer in a therapy group practice, but not in a physician group practice).

PLEASE NOTE: All claims submitted to Medicaid, must include the MA number and NPI for the rendering provider.

Changes to the practice must be brought to the attention of the Program.

Provider Type	Type of Practice	Specialty Codes
AC - Acupuncture	35 (group) or 30 (individual or renderer in a group practice)	
12 - Vision Care Providers	35 (group) or 30 (individual or renderer in a group practice) 99 (facility/other)	Optician (177) Optometric Center (178 - facilities/TOP 99 only) Optometrist (179)
13 - Chiropractor	35 (group) or 30 (individual or renderer in a group practice)	EPSDT – Chiropractor (106)
16 - Physical Therapist	35 (group) or 30 (individual or renderer in a group practice)	Physical Therapy (189)

Provider Type	Type of Practice	Specialty Codes
17 - Speech Language Pathologist	35 (group) or 30 (individual or renderer in a group practice)	EPSDT – Speech Language Pathology (209)
18 - Occupational Therapist	35 (group) or 30 (individual or renderer in a group practice)	EPSDT – Occupational Therapy (173)
19 - Audiology Providers	35 (group) or 30 (individual or renderer in a group practice) 99 (facility/other)	Audiologist (103) Audiology Centers (104) Hearing Aid Dealers (143)
28 - Therapy Group	35 (group)	Must be comprised of at least two different specialties: OT (173), PT (189), SLP (209)
85 – Nutritionist	35 (group) or 30 (individual or renderer in a group practice)	EPSDT Nutrition Counseling (124) Healthy Start Nutrition (141)

EPSDT Population

Under 21 years of age – EPSDT Population

Speech language pathology, occupational therapy, and physical therapy services provided to participants who are 20 years of age or younger are part of Maryland Medicaid's FFS Program when not provided as a home health or inpatient service. Home health and inpatient care are covered by the MCO. Therapy providers who are enrolled as a Maryland Medicaid provider may render the prescribed therapy services and bill the Program directly on the CMS-1500 form using his/her Maryland Medicaid assigned provider identification number.

Acupuncture, nutrition, and chiropractic services continue as a covered benefit under the HealthChoice Program; these services must be billed to the MCO for MCO enrollees. Contact the MCO for preauthorization and treatment procedures for acupuncture, nutrition, and chiropractic services.

21 years of age and older

Most Maryland Medicaid participants are enrolled in an MCO. It is customary for the MCO to refer their enrollees to therapists in their own provider network for this age group. If a participant is 21 or older and is enrolled in an MCO, preauthorization may be required by the MCO before treating the patient. Contact the participant's MCO for their authorization and treatment procedures.

Under Medicaid's FFS Program, coverage for community-based therapy services for the 21 and over age population is limited to physical therapy services unless coverable under a different Maryland Medicaid Program that is not specifically addressed in this manual (i.e., hospital services, home health services, etc.)

Procedure Codes and Fee Schedules Effective January 1, 2025

Acupuncture Services

Procedure Code	Description	Requires Pre-Auth	Maximum Number of Units	Maximum Payment
97810	Acupuncture, 1 or more needles; without electrical stimulation, initial 15-minutes of personal one-on-one contact with the patient	N	1	$28.37
97811	Acupuncture without electrical stimulation, each additional 15-minutes of personal one-on-one contact with the patient, with re-insertion of needle(s)	N	1	$21.11
97813	Acupuncture with electrical stimulation, initial 15-minutes of personal one-on one contact with the patient	N	1	$30.27
97814	Acupuncture with electrical stimulation, initial 15-minutes of personal one-on one contact with the patient, with re-insertion of needle(s)	N	1	$23.86

EPSDT Chiropractic Services

Procedure Code	Description	Requires Pre-Auth	Maximum Number of Units	Maximum Payment
98940	Chiropractic Manipulative Treatment Spinal, 1 to 2 regions	N	1	$22.00
98941	Chiropractic Manipulative Treatment Spinal, 3 to 4 regions	N	1	$31.51
98942	Chiropractic Manipulative Treatment Spinal, 5 regions	N	1	$41.04
98943	Chiropractic Manipulative Treatment Extra spinal, 1 or more regions	N	1	$21.18

Physical Therapy

Procedure Code	Description	Requires Pre-Auth	Maximum Number of Units	Maximum Payment
97161	Physical Therapy Evaluation, Low complexity, 20 minutes	N	1	$69.20
97162	Physical Therapy Evaluation, Moderate complexity, 30 minutes	N	1	$69.20
97163	Physical Therapy Evaluation, High complexity, 45 minutes	N	1	$69.20
97164	Physical Therapy Re-Evaluation, Established plan of care	N	1	$47.19
97010	Application of modality to 1 or more Areas; hot or cold packs (supervised)	N	10	$4.77
97012	Mechanical Traction (supervised)	N	1	$12.67
97014	Electrical Stimulation (unattended)	N	1	$12.52
97016	Vasopneumatic Devices	N	2	$12.29
97018	Paraffin Bath	N	10	$6.06
97022	Whirlpool	N	10	$16.49
97024	Diathermy (e.g., microwave)	N	10	$5.34
97026	Infrared	N	10	$4.77
97028	Ultraviolet Light	N	10	$5.87
97032	Attended Electrical Stimulation, each 15 minutes	N	4	$14.95
97033	Iontophoresis, each 15 minutes	N	4	$17.48
97034	Contrast Bath, each 15-minutes	N	4	$14.17
97035	Ultrasound, each 15-minutes	N	4	$9.90
97036	Hubbard Tanks, each 15-minutes	N	4	$26.01
97110	Therapeutic Procedure, each 15-minutes	N	6	$29.03
97112	Neuromuscular Reeducation	N	4	$26.58
97113	Aquatic Therapy	N	4	$33.98
97116	Gait Training	N	4	$22.08
97124	Therapeutic Massage	N	4	$20.46

97140	Manual Therapy Techniques, each 15 minutes	N	6	$23.45
97530	Therapeutic Activities, each 15 minutes (Age limit 0-20 yrs.)	N	4	$30.56
97597	Selective Debridement (for wounds ≤ 20 sq. cm.)	N	1	$59.82
97598	Selective Debridement (For each additional 20 sq. cm wound)	N	1	$25.68
97605	Negative pressure wound therapy	N	1	$32.38
97606	Total wound surface area ≥ 50 sq.cm.	N	1	$38.27
97607	Negative pressure wound therapy ≤ 50 sp. cm	N	1	$37.79
97608	Negative pressure wound therapy > 50 sq. cm.	N	1	$44.97
97750	Physical performance test or measurement, each 15 minutes	N	8	$25.72
97755	Assistive Technology Assessment, each 15 minutes	N	8	$27.68

EPSDT Occupational Therapy

Procedure Code	Description	Requires Pre-Auth	Maximum Number of Units	Maximum Payment
97110	Therapeutic exercise to develop strength, endurance, range of motion, and flexibility, each 15 minutes	N	6	$29.03
97112	Therapeutic procedure to re-educate brain-to-nerve-to-muscle function, each 15 minutes	N	4	$26.58
97165	Occupational Therapy Evaluation, Low complexity, 30 minutes	N	1	$67.01
97166	Occupational Therapy Evaluation, Moderate complexity, 45 minutes	N	1	$67.01
97167	Occupational Therapy Evaluation, High Complexity, 60 minutes	N	1	$67.01
97168	Occupational Therapy Re-Evaluation, Established plan of care	N	1	$44.34
97530	Therapeutic Activities, each 15 minutes	N	6	$30.56

EPSDT Speech Language Pathology

Procedure Code	Description	Requires Pre-Auth	Maximum Number of Units	Maximum Payment
92507	Individual	N	1	$ 63.99
92508	Group	N	1	$24.918
92521	Evaluation of speech fluency	N	1	$ 91.35
92522	Evaluation of speech sound production	N	1	$74.00
92523	Evaluation of speech sound production with evaluation of language comprehension and expression	N	1	$153.97
92524	Behavioral and qualitative analysis of voice and resonance	N	1	$77.40
92526	Treatment of swallowing dysfunction and/or oral function for feeding	N	1	$80.85
92607	Evaluation for prescription for speech-generating augmentative and alternative communication device, face to-face with patient, first hour	N	1	$121.74

92608	Evaluation for prescription for speech-generating augmentative and alternative communication device, face to-face with patient, each additional 30 minutes	N	4	$41.53
92609	Therapeutic services for the use of speech-generating device, including programming and modification	N	1	$86.26
92610	Evaluation of oral and pharyngeal swallowing function	N	1	$81.43
92626	Evaluation of auditory rehabilitation status	N	1	$70.21
92627	Evaluation of auditory rehabilitation	N	6	$17.37
92630	Auditory rehabilitation; pre lingual hearing loss	N	1	$63.99
92633	Auditory rehabilitation; post lingual hearing loss	N	1	$63.99

EPSDT Nutrition Services

Procedure Code	Description	Requires Pre-Auth	Telehealth Allowance	Maximum Number of Units	Maximum Payment
97802	Nutrition Assessment and intervention	N	Y	12	$30.03
97803	Nutrition Re- assessment and intervention	N	Y	11	$26.35
97804	Group Nutrition Service	N	Y	6	$13.55

PLEASE NOTE: Services are reimbursed up to the maximum units as indicated on this schedule. Providers enrolled as a Therapy Group (Provider Type 28) may bill the per visit charge for each ***enrolled*** discipline participating in the group. Please refer to the fee schedule for maximum reimbursement.

Claims must reflect the above referenced procedure codes for proper reimbursement. These codes are specific to services outlined in the Provider Manual for EPSDT services, and they are specific to the Maryland Medicaid FFS system of payment.

AUDIOLOGY SERVICES

Overview

As of July 1, 2018, audiology services for the EPSDT population will be provided through the participant's MCO, as these services were placed back into the MCO system of payment. Effective July 1, 2018, audiology services are a covered Medicaid benefit for all Medicaid participants when determined to be medically necessary. The participant may have to obtain a pre-authorization or referral from the MCO before visiting an audiologist for evaluation and/or treatment. FFS Medicaid may also require preauthorization on certain services. In order to determine which service requires preauthorization, review the attached fee schedule for audiology services.

If a participant who is 21 or older is **not enrolled** in an MCO, the provider should bill FFS for audiology services.

Covered Services

All services for which reimbursement is sought must be provided in accordance with the regulations for Medicaid's Audiology Services (COMAR 10.09.51).

The Program covers the following medically necessary services:

1. Audiology services, as follows:
    a. Audiology assessments using procedures appropriate for the participant's developmental age and abilities; and
    b. Hearing-aid evaluations and routine follow-up for participants with an identified hearing impairment, who currently use or are being considered for hearing aids;
2. Hearing amplification services, as follows:
    a. Unilateral or bilateral hearing aids which are:
        1. Not used or rebuilt, and which meet the current standards set forth in 21 CFR §§801.420 and 801.421, which are incorporated by reference,
        2. Recommended and fitted by an audiologist when in conjunction with written medical clearance from a physician who has performed a medical examination within the past 6 months,
        3. Sold on a 30-day trial basis; and
        4. Fully covered by a manufacturer's warranty for a minimum of 2 years at no cost to the Program.

Covered Services cont.

b. Hearing aid accessories and services, as listed below:

    1. Ear molds,

    2. Batteries,

    3. Routine follow-ups and adjustments,

    4. Repairs after all warranties have expired,

    5. Replacement of unilateral or bilateral hearing aids every 5 years when determined to be medically necessary; and

    6. Other hearing aid accessories are determined to be medically necessary.

c. Cochlear implants and related services, as listed below:

    1. Unilateral or bilateral implantation of cochlear implant or implants which are medically necessary including the cost of the device,

    2. Post-operative evaluation and programming of the cochlear implant or implants,

    3. Aural rehabilitation services; and

    4. Repair or replacement of cochlear implant device components subject to the limitations in COMAR 10.09.51.05.

d. Auditory osseointegrated device or devices and related services, as listed below:

    1. Unilateral or bilateral implantation of auditory osseointegrated devices which are medically necessary including the cost of the device,

    2. Non-implantable or soft band device or devices,

    3. Evaluation and programming of the auditory osseointegrated device or devices; and

    4. Repair or replacement, or both of auditory osseointegrated device components subject to the limitations in COMAR 10.09.51.05.

Limitations

A. Covered audiology services including hearing aids, cochlear implants and auditory osseointegrated devices are limited to:

1. One audiology assessment per year, unless the time limitation is waived by the Department,

2. The initial coverage of unilateral or bilateral hearing aids, cochlear implants, or auditory osseointegrated devices when the Department's medical necessity criteria have been met,

3. Replacement of unilateral or bilateral hearing aids once every 5 years unless the Program approves more frequent replacement,

4. Replacement of hearing aids, cochlear implants and auditory osseointegrated device components that have been lost, stolen, or damaged beyond repair, after all warranties policies have expired,

5. Repairs and replacements that take place after all warranties have expired,

6. A maximum of 76 batteries per participant per 12-month period for a unilateral hearing aid or osseointegrated devices, or 152 batteries per participant per 12-month period for a bilateral hearing aid or osseointegrated devices purchased from the Department not more frequently than every 6 months, and in quantities of 38 or fewer for a unilateral hearing aid or osseointegrated, or 76 or fewer for a bilateral hearing aid or osseointegrated device,

7. A maximum of 238 disposable batteries for a unilateral cochlear implant per participant per 12-month period or 476 disposable batteries per 12-month period for a bilateral cochlear implant purchased not more frequently than every 6 months, and in quantities of 119 or fewer for a unilateral cochlear implant, or 238 or fewer for a bilateral cochlear implant,

8. Four replacement cochlear implant component rechargeable batteries per 12-month period for bilateral cochlear implants, and a maximum of two replacement rechargeable batteries per 12-month period for a unilateral cochlear implant,

9. Two cochlear implant replacement transmitter cables per 12-month period for bilateral cochlear implants, and a maximum of one replacement transmitter cable per 12-month period for a unilateral cochlear implant,

10. Two cochlear implant replacement headset cables per 12-month period for bilateral cochlear implants, and a maximum of one replacement headset cable per 12- month period for a unilateral cochlear implant,

11. Two cochlear implant replacement transmitting coils per 12-month period for bilateral cochlear implants, and a maximum of one replacement transmitting coil per 12-month period for a unilateral cochlear implant,

12. Charges for routine follow-ups and adjustments which occur more than 60 days after the dispensing of a new hearing aid: and

13. A maximum of two unilateral earmolds or four bilateral earmolds per 12-month period unless a larger amount is determined to be medically necessary.

B. Services which are not covered are:

1. Services not medically necessary,

2. Hearing aids and accessories not medically necessary,

3. Cochlear implant services and external components not medically necessary,

4. Cochlear implant services and external components provided less than 90 days after the surgery which are covered through the initial reimbursement,

5. Spare or backup cochlear implant components,

6. Spare or backup auditory osseointegrated device components,

7. Replacement of hearing aids, equipment, cochlear implant components, and auditory osseointegrated device components if the existing devices are functional, repairable, and appropriately correct or ameliorate the problem or condition,

8. Spare or backup hearing aids, equipment, or supplies,

9. Repairs to spare or backup hearing aids, cochlear implants, auditory osseointegrated devices, equipment, or supplies,

10. Investigational or experimental services or devices, or both,

11. Replacement of improperly fitted ear mold or ear molds unless the:

    a. Replacement service is administered by someone other than the original provider; and

    b. Replacement service has not been claimed before,

12. Additional professional fees and overhead charges for a new hearing aid when a dispensing fee claim has been made to the Program; and

13. Loaner hearing aids.

Preauthorization Requirements

The following information details the Department's preauthorization requirements for providers billing under Medicaid FFS. The Department's clinical criteria for medical necessity can be found at the link below.
https://mmcp.health.maryland.gov/Pages/Provider-Information.aspx

Please note that MCOs may have different requirements and criteria. Contact the MCOs directly for more information about their policies. MCO contact information can be found at: https://health.maryland.gov/mmcp/healthchoice/pages/home.aspx.

A. The Department requires preauthorization for the following services:

   1. All hearing aids,

   2. Certain hearing aid accessories,

   3. All cochlear implant devices and replacement components except microphone, transmitter cables and transmitting coils,

   4. All auditory osseointegrated devices; and

   5. Repairs for hearing aids, cochlear implants, and auditory osseointegrated components exceeding $500.

B. Preauthorization is valid:

   1. For services rendered or initiated within 6 months from the date the preauthorization was issued; and

   2. If the patient is an eligible participant at the time the service is rendered.

C. Telligen is the Department's designee responsible for pre-authorizing all hearing aids, certain hearing aid accessories, all cochlear implant devices, all auditory osseointegrated devices, repairs exceeding $500, and other cochlear implant and auditory osseointegrated components exceeding $500.

D. Since July 1, 2018, providers have been required to submit pre-authorization requests electronically through Telligen's web-based provider portal, Qualitrac. Qualitrac is a web-based application that allows healthcare providers to submit review requests for consideration. All of the audiology items on the fee schedule with a (Y) after the reimbursement amount, will require preauthorization. All providers who submit requests for hearing aids, cochlear implant devices and components, and auditory osseointegrated devices and components must complete a security registration for Telligen's Qualitrac provider portal. Please visit Telligen's website at: http://www.telligenmd.qualitrac.com/document-library.

Once in Qualitrac, download the Security Administrator Registration Form and view the guide for completion. All providers must complete the security registration prior to submitting a preauthorization request for audiology services. Sections 3, 4, and 5 of the packet will need to be completed and sent to Telligen for processing. Section 5 needs to be notarized. If notarization cannot be completed in a timeframe to meet the deadline, the forms can be faxed to Telligen, and the notarized form may be mailed within 30 days. Once completed documentation is received by Telligen, please allow 3-5 days for processing. Additionally, training is available on how to submit pre-authorization requests. To view the trainings, please visit: http://www.telligenmd.qualitrac.com/education-training.

E. The following written documentation shall be submitted by the provider to Telligen with each request for preauthorization of hearing aids, cochlear implants, or auditory osseointegrated devices:

1. Audiology report documenting medical necessity of the hearing aids, cochlear implants or auditory osseointegrated devices,

2. Interpretation of the audiogram,

3. Medical evaluation by a physician supporting the medical necessity of the initial hearing aids, cochlear implants or auditory osseointegrated devices within 6 months of the preauthorization request. (Only required for the **initial** request of the hearing aids, cochlear implants, or auditory osseointegrated device); and

4. Invoice for the cost of service, minus any discounts, for services reimbursed at acquisition cost (A/C).

A pre-authorization request for hearing aids, cochlear implants, and auditory osseointegrated device components must be submitted through Telligen's web-based provider portal, Qualitrac. The provider must complete, sign (signature from the audiologist or hearing aid dispenser is required) and submit the request electronically *prior* to rendering the service to the participant to ensure coverage. It is imperative that correct procedure codes be entered with the request. Omitted information will result in a rejected request.

Determination of authorization is issued via a letter from Telligen after the review of the request has been completed. A copy of the notification letter is sent to the provider as well as to the participant.

Payment Procedures

A. To obtain compensation from the Department for covered services, the provider shall submit a request for payment on the form designated by the Department.

B. Audiology services are reimbursed in accordance with COMAR 10.09.23.01-1.

C. The provider shall be paid the lesser of:

1. The provider's customary charge to the public; and

2. The rate in accordance with the Department's fee schedule.

D. The provider may not bill the Department or participant for:

1. Completion of forms and reports,

2. Broken or missed appointments; or

3. Professional services rendered by mail or telephone.

E. Audiology centers licensed as a part of a hospital may charge for and be reimbursed according to rates approved by the Health Services Cost Review Commission (HSCRC), set forth in COMAR 10.37.03.

F. The provider shall refund to the Department payment for hearing aids, supplies, or both, that have been returned to the manufacturer within the 30-day trial period.

G. The provider shall give the Department the full advantage of all manufacturer's warranties and trade-ins offered on hearing aids, equipment, or both.

H. Unless preauthorization has been granted by the Department or its designee, the Department is not responsible for any reimbursement to a provider for any service which requires preauthorization.

I. For audiology services reimbursed at acquisition cost (A/C), the provider must complete and submit a preauthorization request to Telligen, including an invoice for their cost for the service, minus any discount offered to them (if applicable).

J. For services covered by Medicare and when Medicare is the primary payer, the provider must submit a Medicare Explanation of Benefits (EOB) to the Department with their claim. An EOB is not required if the service is not covered by Medicare.

Audiology Procedure Codes & Fee Schedule Effective January 1, 2025

Audiology Services Fee Schedule

Procedure Code	Description	Requires Pre-Auth	Maximum Fee
92517	Vestibular evoked myogenic potential testing, with interpretation and report; cervical (cVEMP) (Do not report in conjunction with 92270, 92518, 92519)	N	$74.74
92518	Vestibular evoked myogenic potential testing, with interpretation and report; ocular (oVEMP) (Do not report in conjunction with 92270, 92517, 92519)	N	$69.57
92519	Vestibular evoked myogenic potential testing, with interpretation and report; cervical (cVEMP) and ocular (cVEMP) (Do not report in conjunction with 92270, 92517, 92518)	N	$116.00
92550	Tympanometry and reflex threshold measurements (do not report 92550 in conjunction with 92567, 92568)	N	$22.08
92551	Screening test, pure tone, air only	N	$9.72
92552	Pure tone audiometry (threshold); air only	N	$25.40
92553	Pure tone audiometry (threshold); air and bone	N	$30.25
92555	Speech audiometry threshold	N	$18.85
92556	Speech audiometry threshold; with speech recognition	N	$30.53
92557	Comprehensive audiometry-pure tone, air and bone, and speech threshold and discrimination - annual audiology assessment (annual limitation may be waived if medically necessary and appropriate)	N	$36.60
92560	Bekesy audiometry; screening	N	$5.50
92561	Bekesy audiometry; diagnostic	N	$31.14
92562	Loudness balance test; alternate binaural or monaural	N	$37.37
92563	Tone decay test	N	$24.83
92564	Short increment sensitivity index (SISI)	N	$21.98
92565	Stenger test, pure tone	N	$13.22

92567	Tympanometry (impedance testing) (do not report 92550 or 92568 in addition to 92567)	N	$16.44
92568	Acoustic reflex testing: threshold (do not report 92550 or 92567 in addition to 92568)	N	$15.22
92570	Acoustic immittance testing (includes tympanometry, acoustic reflex threshold, and acoustic reflex decay testing)	N	$32.59
92571	Filtered speech test	N	$21.98
92572	Staggered spondaic word test	N	$25.44
92575	Sensorineural acuity level test	N	$47.10
92576	Synthetic sentence identification test	N	$29.39
92577	Stenger test, speech	N	$15.26
92579	Visual reinforcement audiometry	N	$35.55
92582	Conditioning play audiometry	N	$53.94
92583	Select picture audiometry	N	$40.51
92584	Electrocochleography	N	$70.26
92587	Distortion product evoked otoacoustic emissions; limited evaluation (single stimulus level, either transient or distortion products)	N	$22.16
92588	Evoked otoacoustic emissions; comprehensive (comparison of transient and/or distortion product otoacoustic emissions at multiple levels and frequencies)	N	$33.99
92590	Hearing aid examination and selection; monaural	N	$78.00
92591	Hearing aid examination and selection; binaural	N	$78.00
92592	Hearing aid check; monaural	N	$42.00
92593	Hearing aid check; binaural	N	$42.00
92594	Electroacoustic evaluation for hearing aid; monaural	N	$11.00
92595	Electroacoustic evaluation for hearing aid; binaural	N	$13.00
92596	Ear protector attenuation measurements	N	$33.42
92601	Diagnostic analysis of cochlear implant, patient under 7 years of age; with programming	N	$140.40

92602	Subsequent reprogramming (do not report 92602 in addition to 92601)	N	$ 96.30
92603	Diagnostic analysis of cochlear implant, age 7 years or older, with programming	N	$118.62
92604	Subsequent reprogramming (do not report 92604 in addition to 92603)	N	$70.49

Procedure Code	Description	Requires Pre-Auth	Maximum Fee
92620	Evaluation of central auditory function, with report; initial 60 minutes	N	$73.76
92621	Evaluation of central auditory function, with report; each additional 15 minutes	N	$17.33
92622	Analysis, programming, and verification of sound processor for bone-anchored inner ear implant, first hour - New	N	$65.87
92623	Analysis, programming, and verification of sound processor for bone-anchored inner ear implant, each additional 15 minutes -New	N	$16.96
92626	Evaluation of auditory rehabilitation status; first hour (can be used pre-op and post-op)	N	$70.21
92627	Evaluation of auditory rehabilitation status; each additional 15 minutes	N	$17.37
92630	Auditory rehabilitation; pre-lingual hearing loss	N	$63.99
92633	Auditory rehabilitation; post-lingual hearing loss	N	$63.99
92650	Auditory evoked potentials; screening of auditory potential with broadband stimuli, automated analysis	N	$23.68
92651	Auditory evoked potentials; screening of auditory potential for hearing status determination, broadband stimuli, with interpretation and report	N	$78.07
92652	Auditory evoked potentials; screening of auditory potential for threshold estimation at multiple frequencies with interpretation and report (Do not report 92652 in conjunction with 92651)	N	$102.00
92653	Auditory evoked potentials; screening of auditory potential, neurodiagnostic, with interpretation and report	N	$74.63
V5299	Hearing service, miscellaneous (procedure not listed; service not typically covered, request for consideration. Documentation demonstrating medical necessity required – to be submitted with pre-authorization request.)	Y	A/C

Hearing Aid, Cochlear Implant, Auditory Osseointegrated Devices and Accessories & Supplies Fee Schedule

Procedure Code	Description	Requires Pre-Auth	Maximum Fee
L7510	Repair of prosthetic device/repair or replace minor parts	N	$184.42
L7520	Repair prosthetic device, labor component	N	$24.57 per unit, maximum 12 units
L8614	Cochlear device, includes all internal and external components	Y	$18,853.31
L8615	Cochlear implant device headset/headpiece, replacement	N	$428.08
L8616	Cochlear implant device microphone, replacement	N	$99.71
L8617	Cochlear implant device transmitting coil, replacement	N	$87.09
L8618	Cochlear implant or auditory osseointegrated device transmitter cable, replacement	N	$24.89
L8619	Cochlear implant external speech processor and controller, integrated system, replacement	Y	$8,093.59
L8621	Zinc air battery for use with cochlear implant device and auditory osseointegrated sound processors, replacement, each	N	$0.59
L8622	Alkaline battery for use with cochlear implant device, any size, replacement, each; maximum 180 for unilateral or 360 per 12 month period for bilateral	N	$0.30
L8623	Lithium-ion battery for use with cochlear implant device speech processor, other than ear level, replacement, each	N	$61.39
L8624	Lithium ion battery for use with cochlear implant or auditory osseointegrated device speech processor, ear level, replacement, each	N	$153.07
L8625	External recharging system for battery for use with cochlear implant or auditory osseointegrated device, replacement only, each	N	$179.25
L8627	Cochlear implant, external speech processor, component, replacement	Y	$6,914.53

L8628	Cochlear implant, external controller component, replacement	Y	$1,179.04
L8629	Transmitting coil and cable, integrated, for use with cochlear implant device, replacement	N	$169.95
L8690	Auditory osseointegrated device, includes all internal and external components	Y	$4,515.27
L8691	Auditory osseointegrated device, external sound processor, excludes transducer/actuator, replacement only, each	Y	$1,634.56
L8692	Auditory osseointegrated device, external sound processor, used without osseointegration, body worn, includes headband or other means of external attachment	Y	$2,503.41
L8693	Auditory osseointegrated device, abutment, any length, replacement only	Y	$1,439.22
L8694	Auditory osseointegrated device, transducer/actuator, replacement only, each	Y	$896.34
V5014	Repair/Modification of Hearing Aid	N	$250.00
V5160	Dispensing fee, binaural	N	$175.00
V5171	Hearing aid, contralateral routing device, monaural. ITE	Y	$1,190.00
V5172	Hearing aid, contralateral routing device, monaural. ITC	Y	$1,190.00
V5181	Hearing aid, contralateral routing device, monaural. BTE	Y	$1,190.00
V5211	Hearing aid, contralateral routing device, binaural. ITE/ITE	Y	$1,190.00
V5212	Hearing aid, contralateral routing device, binaural. ITE/ITC	Y	$1,190.00
V5213	Hearing aid, contralateral routing device, binaural. ITE/BTE	Y	$1,190.00
V5214	Hearing aid, contralateral routing device, binaural. ITC/ITC	Y	$1,190.00
V5215	Hearing aid, contralateral routing device, binaural. ITC/BTE	Y	$1,190.00
V5221	Hearing aid, contralateral routing device, binaural. BTE/BTE	Y	$1,190.00

V5200	Dispensing fee, contralateral, monaural	N	$106.00
V5240	Dispensing fee, contralateral routing system, binaural	N	$175.00
V5254	Digital, monaural, CIC	Y	$1,400.00
V5255	Digital, monaural, ITC	Y	$1,400.00
V5256	Digital, monaural, ITE	Y	$1,400.00
V5257	Digital, monaural, BTE	Y	$1,400.00
V5258	Digital, binaural, CIC	Y	$2,800.00
V5259	Digital, binaural, ITC	Y	$2,800.00
V5260	Digital, binaural, ITE	Y	$2,800.00
V5261	Digital, binaural, BTE	Y	$2,800.00
V5241	Dispensing fee, monaural	N	$106.00
V5264	Ear mold, not disposable, (limitation = up to 2 per monaural/4 per binaural per 12 month period)	N	$27.00
V5266	Replacement battery for use in hearing device maximum 76 per year for monaural maximum 152 per 12-month period for binaural	N	$0.58
V5267	Hearing aid supplies /accessories (medically necessary and effective services. Note: prophylactic ear protection - a copy of the signed prescription from the primary care doctor, and a documented history of tympanostomy tube must be on file.)	Y	A/C
99002	Handling/conveyance service for devices	N	$15.00

KEY:

A/C Acquisition cost

VISION CARE SERVICES

Overview

Vision screening and treatment services are included in the comprehensive EPSDT program for children and adolescents under 21 years of age. At a minimum, EPSDT must include age-appropriate vision assessments and services to correct or ameliorate vision problems, including eyeglasses.

Covered Services

All services for which reimbursement is sought must be provided in accordance with the regulations for Maryland Medicaid's Vision Care Services (COMAR 10.09.14).

Medicaid covers the following vision care services:

1. A maximum of one optometric examination to determine the extent of visual impairment or the correction required to improve visual acuity, every two years for participants 21 years and older, and a maximum of one optometric examination a year for participants younger than 21 years old, unless the time limitations are waived by the Program, based upon medical necessity.

2. A maximum of one pair of eyeglasses a year for participants younger than 21 years old (unless the time limitations are waived by the Program, based on medical necessity), which have first quality, impact resistant lenses (except in cases where prescription requirements cannot be met with impact resistant lenses) and frames which are made of fire-resistant, first quality material, when at least one of the following conditions are met:

    a. The participant requires a diopter change of at least 0.50,

    b. The participant requires a diopter correction of less than 0.50 based on medical necessity and preauthorization has been obtained from the Program,

    c. The participant's present eyeglasses have been damaged to the extent that they affect visual performance and cannot be repaired to effective performance standards, or are no longer usable due to a change in head size or anatomy; or

    d. The participant's present eyeglasses have been lost or stolen.

3. Examination and eyeglasses for a participant with a medical condition, other than normal physiological change necessitating a change in eyeglasses (before the normal time limits have been met) when a pre-authorization has been obtained from the Program.

4. Visually necessary optometric care rendered by an optometrist when these services are:
    a. Provided by the optometrist or his/her licensed employee,
    b. Related to the patient's health needs as diagnostic, preventative, curative, palliative,

Covered Services, cont.

    c. or rehabilitative services; and
    d. Adequately described in the patient's record; and
5. Optician services when they are:
    a. Provided by the optician or optometrist, or by an employee under their supervision and control,
    b. Adequately described in the patient's record; and
    c. Ordered or prescribed by an ophthalmologist or optometrist.

Service Limitations

A. The Vision Care Program does not cover the following services:
    1. Services not medically necessary,
    2. Investigational or experimental drugs or procedures,
    3. Services prohibited by the State Board of Examiners in Optometry,
    4. Services denied by Medicare as not medically justified,
    5. Eyeglasses, ophthalmic lenses, optical aids, and optician services rendered to participants 21 years or older,
    6. Eyeglasses, ophthalmic lenses, optical aids, and optician services rendered to participants younger than 21 years old which were not ordered as a result of a full or partial EPSDT screen,
    7. Repairs, except when repairs to eyeglasses are cost effective compared to the cost of replacing with new glasses,
    8. Repairs for participants 21 or older,
    9. Combination or metal frames except when required for proper fit,
    10. Cost of travel by the provider,
    11. A general screening of the Medicaid population,
    12. Visual training sessions which do not include orthoptic treatment; and
    13. Routine adjustments.

B. The optometrist may not bill the Program or the participant for:

1. Completion of forms and reports,
2. Broken or missed appointments,

Service Limitations, cont.

3. Professional services rendered by mail or telephone,
4. Services which are provided at no charge to the general public; and
5. Providing a copy of a participant's record when requested by another licensed provider on behalf of the participant.

C. An optometrist certified by the Board as qualified to administer diagnostic pharmaceutical agents may use the following agents in strengths not greater than the strengths indicated:

1. Agents directly or indirectly affecting the pupil of the eye including the mydriatics and cycloplegics listed below:
   a. Phenylephrine hydrochloride (2.5%),
   b. Hydroxyamphetamine hydrobromide (1.0%),
   c. Cyclopentolate hydrochloride (0.5 - 2.0%),
   d. Tropicamide (0.5 and 1.0%),
   e. Cyclopentolate hydrochloride (0.2%) with Phenylephrine hydrochloride (1.0%),
   f. Dapiprazole hydrochloride (0.5%); and
   g. Hydroxyamphetamine hydrobromide (1.0%) and Tropicamide (0.25%);
2. Agents directly or indirectly affecting the sensitivity of the cornea including the topical anesthetics listed below:
   a. Proparacaine hydrochloride (0.5%); and
   b. Tetracaine hydrochloride (0.5%),
3. Diagnostic topical anesthetic and dye combinations listed below:
   a. Benoxinate hydrochloride (0.4%) - Fluorescein sodium (0.25%); and
   b. Proparacaine hydrochloride (0.5%) - Fluorescein sodium (0.25%).

Service Limitations, cont.

D. An optometrist certified by the Board as qualified to administer and prescribe topical therapeutic pharmaceutical agents is limited to:

   1. Ocular antihistamines, decongestants, and combinations thereof, excluding steroids,

   2. Ocular anti-allergy pharmaceutical agents,

   3. Ocular antibiotics and combinations of ocular antibiotics, excluding specially formulated or fortified antibiotics,

   4. Anti-inflammatory agents, excluding steroids,

   5. Ocular lubricants and artificial tears,

   6. Tropicamide,

   7. Homatropine,

   8. Nonprescription drugs that are commercially available; and

   9. Primary open-angle glaucoma medications, in accordance with a written treatment plan developed jointly between the optometrist and an ophthalmologist.

E. The Program will only pay for lenses to be used in frames purchased by the Program or to replace lenses in the participant's existing frames, which are defined as those which have been fitted with lenses and previously worn by the participant for the purpose of correcting that patient's vision.

F. Providers may not sell a frame to a participant as a private patient and bill the Program for the lenses only.

G. Providers may not bill the Program for lenses when the participant presents new, unfitted frames which were purchased from another source.

H. Providers may not bill the Program for the maximum allowed fee for frames and collect supplemental payment from the participant to enable that participant to purchase a desired frame that exceeds Program limits.

I. If after the provider has fully explained the extent of Program coverage, the participant knowingly elects to purchase the desired frames and lenses, the provider may sell a complete pair of eyeglasses (frames and lenses) to a participant as a private patient without billing the Program.

Preauthorization Requirements

A. The following services require written preauthorization:

1. Optometric examinations to determine the extent of visual impairment or the correction required to improve visual acuity before expiration of the normal time limitations,
2. Replacement of eyeglasses due to medical necessity or because they were lost, stolen, or damaged before expiration of the normal time limitations,
3. Contact lenses,
4. Subnormal vision aid examination and fitting,
5. Orthoptic treatment sessions,
6. Plastic lenses costing more than equivalent glass lenses unless there are six or more diopters of spherical correction or three or more diopters of astigmatic correction,
7. Absorptive lenses, except cataract; and
8. Ophthalmic lenses or optical aids when the diopter correction is less than:

   a. 0.50 D. sphere for myopia in the weakest meridian,

   b. + 0.75 D. sphere for hyperopia in the weakest meridian,

   c. + 0.75 additional for presbyopia,

   d. ± 0.75 D. cylinder for astigmatism,

   e. A change in axis of 5 degrees for cylinders of 1.00 diopter or more; and

   f. A total of 4 prism diopters laterals or a total of 1 prism diopter vertical.

B. Preauthorization is issued when the provider submits to the Program adequate documentation demonstrating that the service to be preauthorized is medically necessary. "Medically necessary means that the service or benefit is directly related to diagnostic, preventive, curative, palliative, rehabilitative or ameliorative treatment of an illness, injury, disability, or health condition; consistent with current accepted standards of good medical practice; the most cost-efficient service that can be provided without sacrificing effectiveness or access to care; and not primarily for the convenience of the consumer, their family or the provider.

C. Preauthorization is valid only for services rendered or initiated within 60 days of the date the preauthorization is issued.

D. Preauthorization must be requested in writing. A Preauthorization Request Form for Vision Care Services (DHMH 6326) must be completed and submitted to:

Medical Care Operations Administration
Division of Claims Processing
P.O. Box 17058
Baltimore, MD 21203

Preauthorization Requirements, cont.

E. Documentation substantiating medical necessity must be attached to the preauthorization request. A copy of the patient record report and/or notes describing the service must be included with the request. If available, include a copy of the laboratory invoice at this time. Otherwise, a copy of the invoice must be attached to the claim for proper pricing of the item after the service has been authorized by the Program.

F. Procedure codes followed by a "**Y**" in this manual require written preauthorization.

G. The Program will cover medically justified contact lenses for participants younger than 21 years old. The following criteria are used when reviewing written preauthorization requests for contact lenses:

1. Monocular Aphakia:

    a. When visual acuity of the two eyes is equalized within two lines (standard Snellen designation),

    b. When no secondary condition or disease exists that could adversely alter the acuity of either eye or contra-indicate such usage; and

    c. When tests conclude that disrupted binocular function will be restored and enhanced when compared to alternative treatment.

2. Anisometropia:

    a. When the prescriptive difference between the two eyes exceeds 4.00 diopters (S.E.) and visual acuity of the two eyes is equalized within two lines,

    b. When no secondary condition or disease exists that could adversely alter the acuity of either eye or contra-indicate such usage; and

    c. When tests conclude that disrupted binocular function will be restored and enhanced when compared to alternative treatment.

3. Keratoconus/Corneal Dyscrasias:

    a. When contact lenses are accepted as the treatment of choice relative to the phase of a particular condition,

    b. When the best spectacle correction in the best eye is worse than 20/60 and when the contact lens can improve visual acuity to better than 20/40 or four lines better than the best spectacle acuity; and

    c. When no secondary condition or disease exists that could adversely alter the acuity of either eye or contra-indicate such usage.

Provider Enrollment

PLEASE NOTE: Under Maryland Medicaid, optometrists and optical centers that are part of a physician's group cannot bill under the physician's provider number. Services rendered by the optometrist or optical center cannot be billed under the physician's provider number. These providers must complete an enrollment application and receive a Medicaid provider number that has been specifically assigned to them. The number will be used when billing directly to FFS Medicaid for optometric or optical center services**.**

Please visit eprep.health.maryland.gov to enroll as a Medicaid provider for vision services (Provider Type 12). Ophthalmologists are enrolled as a physician (Provider Type 20) and should follow the regulations and manual specific to that particular provider type.

Payment Procedures

The provider shall submit requests for payment for vision services as stated in COMAR 10.09.36.

The request for payment must include any required documentation, such as, preauthorization number, need for combination or metal frame, patient record notes, and laboratory invoices, when applicable.

Medicaid has established a fee schedule for covered vision care services provided by optometrists and optical centers. The fee schedule lists all covered services by CPT and national HCPCS codes and the maximum fee allowed for each service. Vision care providers must bill their usual and customary charge to the general public for similar professional services.

The provider shall submit a request for payment on the CMS-1500 billing form. The request for payment must include any required documentation, such as preauthorization number, need for combination or metal frame, patient record notes, and laboratory invoices, when applicable.
Maryland Medicaid Billing Instruction for the CMS-1500 form can be found https://health.maryland.gov/mmcp/Pages/Provider-Information.aspx

The Program will pay professional fees for covered services at the lower of the provider's usual and customary charge or the Program's fee schedule. For professional services, providers must bill their usual and customary charges. The Program will pay for materials at acquisition costs not to exceed the maximum established by the Program. For materials, providers must bill their acquisition costs.

Where a **"By Report" (B/R)** status is indicated on the schedule, attach a copy of the lab invoice to the claim for pricing purposes as well as the records to substantiate medical necessity (record report/notes describing the service).

Payment Procedures, cont.

When the fee for a vision care procedure is listed as "**Acquisition Cost"** (**A/C**) in this manual, the value of the procedure is based on acquisition cost. Providers must bill the FFS Program the acquisition cost for the item. The lab invoice substantiating the charge as well as other records must remain on file for a 6-year period and be made available upon request by the Program.

Procedures with a pre authorization requirement **(Y)** must be authorized prior to treating the patient. If the procedure is authorized, the preauthorization number must appear on the claim.

The provider must select the procedure code that most accurately identifies the service performed. Any service rendered must be adequately documented in the patient record. The records must be retained for 6 years. Lack of acceptable documentation may cause the Program to deny payment or if payment has already been made, to request repayment, or to impose sanctions, which may include withholding of payment or suspension or removal from the Program. Payment for services is based upon the procedure(s) selected by the provider. Although some providers delegate the task of assigning codes, the accuracy of the claim is solely the provider's responsibility and is subject to audit.

The **NFAC** (Non-Facility) fee is paid for place of service 11, 12, and 62.

The **FAC** (facility) fee is paid for all other places of service.

Payments for lenses, frames, and the fitting and dispensing of spectacles include any routine follow-up and adjustments for 60 days. No additional fees will be paid. Providers must bill and will be paid for the supply of materials at acquisition costs not to exceed the maximum established by the Program. If a maximum has not been established, the provider must attach laboratory documentation to the invoice.

Fitting includes facial measurements, frame selection, prescription evaluation and verification and subsequent adjustments. The maximum fee for lenses includes the cost for FDA hardening, testing, edging, assembling, and surfacing. The maximum fee for frames includes the cost of a case.

1. Use the following procedure codes for the billing of frames:
    a. **V2020** for a child/adult ZYL frame,
    b. **V2025** for a metal or combination frame when required for a proper fit; and
    c. **V2799** (preauthorization required) for a special or custom frame when necessary and appropriate.
2. Use procedure codes **92340 - 92342** for the fitting of spectacles.

3. Use procedure code **92370** and attach a copy of the lab invoice to the claim when billing for a repair. **PLEASE NOTE**: Repair charges not traditionally billed to the general public cannot be billed to Maryland Medicaid. (Review the regulations for coverage of eyeglass repairs.)

Payment Procedures, cont.

Contact lens services require preauthorization and include the prescription of contact lenses (specification of optical and physical characteristics), the proper fitting of contact lenses (including the instruction and training of the wearer, incidental revision of the lens and adaptation), the supply of contact lenses, and the follow-up of successfully fitted extended wear lenses. Use the following procedure codes for the billing of these services:

1. **92310 - 92326** for the professional services of prescription, fitting, training, and adaptation,
2. **V2500 - V2599, S0500** for contact lenses,
3. **V2784** for polycarbonate lenses; and
4. **92012** for follow-up after a proper fitting.

Vision care claims must be received within **12** months of the date that services were rendered. If a claim is received within the 12-month limit but rejected due to erroneous or missing data, resubmission will be accepted within 60 days of rejection or within 12 months of the date that the service was rendered, whichever is later. If a claim is rejected because of late receipt, the participant may not be billed for that claim.

Medicare/Medicaid crossover claims must be received within **120** days of the date that payment was made by Medicare. This is the date of Medicare's Explanation of Benefits (EOB) form. The Program recognizes the billing time limitations of Medicare and will not make payment when Medicare has rejected a claim due to late billing.

Medicaid is always the payer of last resort. Whenever a Medicaid participant is known to be enrolled in Medicare, Medicare must be billed first. Claims for Medicare/Medicaid participants must be submitted on the CMS-1500 directly to the Medicare Intermediary.

For additional information about the Maryland Medicaid, go to the following link:

https://health.maryland.gov/mmcp/pages/provider-information.aspx

A copy of the regulations (COMAR 10.09.14) can be viewed at:

https://dsd.maryland.gov/Pages/COMARSearch.aspx

Preauthorization Required Prior to Treatment

When the fee for a vision care procedure is listed with a "Y", a request for preauthorization must be submitted on form DHMH 6326. A copy of the patient record report and/or notes describing the services must be submitted to the Program prior to rendering the service.

Professional Services/Materials Reimbursements for Vision Care Providers (Provider Type 12 Non-facility & Facility Included) Effective January 1, 2025

Procedure Code	Description	Requires Pre-Auth	Maximum Payment NFAC	Maximum Payment FAC
65205	Removal of foreign body from eye	N	$ 28.94	$ 29.29
65210	Removal of foreign body embedded in eye	N	$ 38.83	$ 36.39
65220	Removal of foreign body w/o lamp	N	$ 45.98	$ 33.43
65222	Removal of foreign body w/ lamp	N	$ 52.46	$ 40.76
92002	Eye exam w/new patient	N	$ 63.71	$ 37.21
92004	Eye exam w/new patient comprehensive	N	$ 116.51	$ 77.48
92012	Eye exam and treatment of established patients	N	$ 67.09	$ 41.13
92014	Eye Exam and treatment of establish patients, comprehensive	N	$ 96.99	$ 62.27
92015	Determination of Refractive state	N	$ 19.02	$15.03
92020	Special Eye Evaluation - Gonioscopy	N	$ 21.00	$16.43
92025	Computerized Corneal Topography	N	$ 29.90	$ 29.90
92060	Sensorimotor exam with multiply measure. Ocular deviation	N	$ 51.21	$ 51.21
92065	Orthoptic/pleoptic training	Y	$ 40.24	$ 32.57
92071	Fitting contact lens for treatment of ocular surface disease	N	$ 31.59	$28.02
92072	Fitting contact lens for management of keratoconus initial fitting	N	$ 104.54	$ 79.97
92081	Visual field exam(s) limited	N	$ 33.37	$ 33.37
92082	Visual field exam(s) Intermediate	N	$ 48.22	$ 48.22
92083	Visual field exam(s) extended	N	$ 56.74	$ 56.74
92100	Serial Tonometry exam(s)	N	$ 63.33	$32.13

Procedure Code	Description	Requires Pre-Auth	Maximum Payment NFAC	Maximum Payment FAC
92132	Scanning Computerized ophthalmic diagnostic imaging anterior segment, with interpretation and report	N	$ 30.41	$ 30.41
92133	Scanning Computerized ophthalmic diagnostic imaging posterior segment, with interpretation and report unilateral or bilateral; optic nerve	N	$ 31.65	$ 31.65
92134	Scanning Computerized ophthalmic diagnostic imaging posterior segment, with interpretation and report unilateral or bilateral; retina	N	$ 33.37	$ 33.37
92201	Ophthalmoscopy, ext., with retinal drawing and scleral depression of peripheral retinal disease, with interpretation and report.	N	$ 21.63	$ 19.75
92202	Ophthalmoscopy, ext., with drawing of optic nerve or macula, with interpretation and report.	N	$ 13.68	$ 12.74
92250	Fundus photography w/ interpretation and report	N	$ 37.76	$ 37.76
92260	Ophthalmodynamometry	N	$ 14.48	$ 8.49
92283	Color vision examination extended, e.g., anomaloscope or equivalent	N	$ 44.78	$ 44.78
92284	Dark adaptation examination w/ interpretation and report	N	$ 31.81	$ 31.81
92285	External ocular photography w/ interpretation and report for documentation of medical progress (e.g., close-up photography, slit lamp photography, goniophotography, stereo-photography)	N	$ 24.12	$ 24.12
92286	Special anterior segment photography w/interpretation and report; with specular endothelial microscopy and cell count	N	$ 39.85	$ 39.85
92310	Contact lenses fitting	Y	$ 75.28	$ 46.22
92311	Contact lens fitting - 1/aphakia	Y	$ 79.33	$ 43.16

Procedure Code	Description	Requires Pre-Auth	Maximum Payment NFAC	Maximum Payment FAC
92312	Contact lens fitting - 1/aphakia	Y	$ 92.38	$ 49.89
92313	Contact lens fitting - 1/aphakia	Y	$ 75.89	$ 36.58
92314	Fitting Special Contact lens	N	$ 62.97	$ 27.33
92325	Modification of contact lens	Y	$ 33.95	$ 33.95
92326	Replacement of contact lens	Y	$ 36.82	$ 36.82
92340	Fitting of spectacles, monofocal	N	$ 27.88	$ 14.48
92341	Fitting of spectacles, bifocal	N	$ 31.71	$ 18.60
92342	Fitting of spectacles, multifocal	N	$ 34.16	$ 20.77
92354	Fitting of spectacle mounted low vision aid; single element system	Y	$ 14.28	$ 14.28
92370	Repair & refitting spectacles	N	$ 24.26	$12.59

Professional Services/Materials Reimbursements for Vision Care Providers (Provider Type 12 Facility Only)
Effective January 1, 2025

Procedure Code	Description	Requires Pre-Auth	Maximum Payment FAC
92499	Unlisted eye service or procedure	N	B.R.
S0500	Disposable contact lens, per lens	Y	A.C.
V2020	Adult/child ZYL frames w /case	N	$ 20.00
V2025	Metal or combination frame	N	$ 25.00
V2100	Lens sphere single plano 4.00, per lens	N	$ 12.00
V2101	Single vision sphere 4.12 - 7.00, per lens	N	$ 7.20
V2102	Single vision sphere 7.12 - 20.00, per lens	N	$ 22.15
V2103	Spherocylinder, SV, 4.00d/.12-2.00, per lens	N	$ 15.00
V2104	Spherocylinder, SV, 4.00d/2.12-4d, per lens	N	$ 15.00
V2105	Spherocylinder, SV,4.00d/4.25-6d, per lens	N	$ 7.30
V2106	Spherocylinder, SV,4.00d/over6.00d, per lens	N	A.C.
V2107	Spherocylinder, SV,+-4.25d/.12-2d, per lens	N	$ 15.00
V2108	Spherocylinder, SV,+-4.25d/2.12-4d, per lens	N	$ 15.00
V2109	Spherocylinder, SV,+-4.25d/4.25-6d, per lens	N	$ 9.20
V2110	Spherocylinder, SV,+-4.25d/over 6d, per lens	N	B.R.
V2111	Spherocylinder, SV,+-7.25d/.25-2.25d, per lens	N	$ 22.15
V2112	Spherocylinder, SV,+-7.25d/2.25-4d, per lens	N	$ 19.00
V2113	Spherocylinder, SV,+-7.25d/4.25-6d, per lens	N	A.C.
V2114	Spherocylinder, SV, over +-12.00d, per lens	N	$ 36.00
V2115	Lenticular (myodisc), SV, per lens	N	B.R.
V2118	Aniseikonic lens, SV	Y	A.C.
V2121	Lenticular lens, Per Lens, Single, per lens	N	A.C.
V2199	Not otherwise classified, SV lens	Y	A.C.
V2200	Sphere, bifcl, plano +-4.00d, per lens	N	$ 21.00
V2201	Sphere, bifcl,+-4.12/+-7.00d, per lens	N	$ 13.00
V2202	Sphere, bifcl,+-7.12/+-20d, per lens	N	A.C.

Procedure Code	Description	Requires Pre-Auth	Maximum Payment FAC
V2203	Spherocylinder, BF, 4.00d/.12-2.00d, per lens	N	$ 21.00
V2204	Spherocylinder, BF, 4.00d/2.12-4, per lens	N	$ 14.50
V2205	Spherocylinder, BF, 4.00d/4.25-6, per lens	N	$ 16.50
V2206	Spherocylinder, BF, 4.00d/over 6, per lens	N	B.R.
V2207	Spherocylinder, BF, 4.25-7/.12 to 2, per lens	N	$ 14.50
V2208	Spherocylinder, BF, 4.25+-7/2.12 to 4, per lens	N	$ 15.50
V2209	Spherocylinder, BF, 4.25+-7/4.25-6, per lens	N	$ 17.50
V2210	Spherocylinder, BF, 4.25+-7/over 6, per lens	N	A.C.
V2211	Spherocylinder, BF, 7.25+-12/.25-2.25, per lens	N	A.C.
V2212	Spherocylinder, BF, 7.25+-12/2.25-4, per lens	N	A.C.
V2213	Spherocylinder, BF, 7.25+-12/4.25-6, per lens	N	A.C.
V2214	Spherocylinder, BF, sphere over +-12.00d, per lens	N	A.C.
V2215	Lenticular (myodisc) bifocal, per lens	N	B.R.
V2218	Aniseikonic, bifocal, per lens	Y	A.C.
V2219	Bifocal seg width over 28 mm	Y	A.C.
V2220	Bifocal add over 3.25d	Y	A.C.
V2221	Lenticular lens, bifocal, per lens	N	$ 24.00
V2299	Specialty bifocal	Y	A.C.
V2300	Sphere, trifcl, pl+-4.00d, per lens	N	$ 16.50
V2301	Sphere, trifcl +-4.12/-7.00d, per lens	N	$ 19.00
V2302	Sphere, trifcl +-7.12/+-20.00, per lens	N	A.C.
V2303	Spherocylinder, trifcl, pl+-4/.12-2, per lens	N	$ 18.00
V2304	Spherocylinder, trifcl, p+-4/2.25-4, per lens	N	$ 20.50
V2305	Spherocylinder, trifcl, p+-4/4.25-6, per lens	N	$ 24.00
V2306	Spherocylinder, trifcl, p+-4/over 6, per lens	N	A.C.
V2307	Spherocylinder, trifcl, +-4.25/…2d, per lens	N	$ 20.50
V2308	Spherocylinder, trifcl, +-4.25/…4d, per lens	N	$ 22.00
V2309	Spherocylinder, trifcl, +-4.25/…6d, per lens	N	$ 25.00
V2310	Spherocylinder, trifcl, +-4.25/over 6d, per lens	N	A.C.
V2311	Spherocylinder, trifcl, +-7.25/…2.25d, per lens	N	A.C.
V2312	Spherocylinder, trifcl ,+-7.25/…4.00d, per lens	N	A.C.

Procedure Code	Description	Requires Pre-Auth	Maximum Payment FAC
V2313	Spherocylinder, trifcl, +-7.25/…6.00d, per lens	N	A.C.
V2314	Spherocylinder, trifcl, over p-12.00d, per lens	N	A.C.
V2315	Lenticular (myodisc), trifocal, per lens	N	A.C.
V2318	Aniseikonic lens, trifocal	Y	A.C.
V2319	Trifocal seg width over 28 mm	Y	A.C.
V2320	Trifocal add over 3.25d	Y	A.C.
V2321	Lenticular lens, trifocal, per lens	N	A.C.
V2399	Specialty trifocal (by report)	Y	A.C.
V2410	Variable asph, SV, full fld,gl/pl	Y	A.C.
V2430	Variable asph, bifcl, full fld,gl/pl	Y	A.C.
V2499	Variable sphericity, other type	Y	A.C.
V2500	Contact lens, PMMA spherical	Y	A.C.
V2501	Contact lens PMMA toric/prism	Y	A.C.
V2502	Contact lens PMMA bifocal	Y	A.C.
V2503	Contact lens PMMA color vision def	Y	A.C.
V2510	Contact lens, gas permeable, spherical, per lens	Y	A.C.
V2511	Contact lens, gas permeable, toric, prism ballast, per lens	Y	A.C.
V2512	Contact lens, gas permeable, bifocal, per lens	Y	A.C.
V2513	Contact lens, gas permeable, extended wear, per lens	Y	A.C.
V2520	Contact lens, hydrophilic, spherical, per lens	Y	A.C.
V2521	Contact lens, hydrophilic, toric, or prism ballast, per lens	Y	A.C.
V2522	Contact lens, hydrophilic, bifocal, per lens	Y	A.C.
V2523	Contact lens, hydrophilic, extended wear, per lens	Y	A.C.
V2530	Contact lens, scleral, gas imperm, per lens	Y	A.C.
V2599	Contact lens, other type	Y	A.C.
V2600	Handheld low vision aids	Y	A.C.
V2610	Single lens spectacle mount low vision aids	Y	A.C.
V2615	Telescopic & another compound lens	Y	A.C.
V2700	Balance lens	N	A.C.
V2715	Prism lens	Y	A.C.
V2718	Press-on lens, Fresnel prism	Y	A.C.

Procedure Code	Description	Requires Pre-Auth	Maximum Payment FAC
V2745	Add. tint, any color/solid/grad	N	B.R.
V2784	Polycarbonate lens, any index (Greater than 6 Diopters or other medically necessary condition)	N	$6.50
V2799	Vision service, miscellaneous	Y	A.C.

Professional Services/Materials Reimbursements for Vision Care Providers (Provider Type 12 Non-Facility & Facility Included) Rate Changes Effective January 1, 2025

Procedure Code	Description	Requires Pre-Auth	Maximum Payment NFAC	Maximum Payment FAC
99202	Office/Outpatient visit new 15-29 mins	N	$75.41	$48.59
99203	Office/Outpatient visit new 30-44 mins	N	$116.38	$84.27
99204	Office/Outpatient visit new 45-59 mins	N	$174.01	$136.96
99212	Office/Outpatient visit established pt 10-19 mins	N	$59.11	$36.18
99213	Office/Outpatient visit established pt 20-29 mins	N	$94.62	$67.45
99214	Office/Outpatient visit established pt 30-39 mins	N	$133.26	$99.39

ATTACHMENT A: MARYLAND MEDICAID FREQUENTLY REQUESTED CONTACT INFORMATION

Audiology Policy/Coverage Issues	**(410) 767-3998**
Vision Policy/Coverage Issues	**(410) 767-3998**
Healthy Start/Family Planning Coverage	**(800) 456-8900**
Maryland Medicaid Children's Services	**(410) 767-1903**
Rare and Expensive Case Management Program (REM)	**(800) 565-8190** https://health.maryland.gov/mmcp/Pages/remprogram.aspx
Eligibility Verification System (EVS)	**(866) 710-1447**
Board of Audiologists/Hearing Aid Dispensers/Speech Language Pathologists	**(410) 764-4725** https://health.maryland.gov/boardsahs/Pages/Index.aspx
Maryland Board of Acupuncture	**(410) 764-4766** https://health.maryland.gov/bacc/Pages/index.aspx
Maryland Board of Examiners in Optometry	**(410) 764-4710** https://health.maryland.gov/optometry/Pages/index.aspx
Maryland Board of Chiropractic Examiners	**(410) 764-4738** https://health.maryland.gov/chiropractic/Pages/index.aspx
Maryland Board of Dietetic Practice	**(410) 764-4733** https://health.maryland.gov/dietetic/Pages/Index.aspx
Maryland Board of Occupational Therapy Practice	**(410) 402-8556** https://health.maryland.gov/botp/Pages/home.aspx
Maryland Board of Physical Therapy Examiners	**(410) 764-4718** https://health.maryland.gov/bphte/Pages/index.aspx

Provider Enrollment	**(410) 767-5340** **mdh.providerenrollment@maryland.gov**
Electronic Provider Revalidation and Enrollment Portal (ePREP)	**(844) 463-7768** **https://health.maryland.gov/mmcp/provider/Pages/enrollment.aspx**
Provider Relations **P.O. Box 22811** **Baltimore, MD 21203**	**(410) 767-5503** **(800) 445-1159**
Missing Payment Voucher/Lost or Stolen Check	**(410) 767-5503**
Third Party Liability/Other Insurance	**(410) 767-1771**
Recoveries	**(410) 767-1783**

ATTACHMENT B: HEALTH INSURANCE CLAIM FORM

(SEE NEXT PAGE)

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL

15. OTHER DATE QUAL MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

MARYLAND STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE
PREAUTHORIZATION REQUEST FORM
VISION CARE SERVICES

SECTION I - Patient Information

Medical Number | | | | | | | | | | | |

Last Name _____ **First Name** _____ **MI**__

DOB _____ **Sex** _____ **Telephone** _____

Address _____

SECTION II - Preauthorization General Information

Pay to Provider Number | | | | | | | | | |

Name _____ **Date Service**

Address _____ **Requested by**

Contact _____ **Provider** _____

Provider's Signature _____ **Telephone** (__)_____

SECTION III – Additional Preauthorization Information

Give Reason(s) for Requested Service _____

_____

_____

SECTION IV – Preauthorization Line Item Information

*** Required fields - Do not leave any blanks**

*DESCRIPTION OF SERVICE	*PROCEDURE CODE	*REQUESTED *UNITS	*REQUESTED *AMOUNT	*AUTHORIZED UNITS	*AUTHORIZED AMOUNT
			$		$
			$		$
			$		$
			$		$
			$		$

PREAUTHORIZATION NUMBER

DOCUMENT CONTROL NUMBER
(STAMP HERE)

SUBMIT TO: **Program Systems and Operations Administration**
Division of Claims Processing
P.O. Box 17058
Baltimore, Maryland 21203

SECTION V – Specific Preauthorization Information

New Prescription: **O.D.**_____ **Best Visual Activity** _____

_____

O.D._____ **Best Visual Activity** _____

CONTACT LENS REQUESTS:

Health Condition of each eye: **O.D.**_____ **O.S.**_____

Date of Surgery: **O.D.**_____ **O.S.**_____

Best visual acuity with contact lenses: **O.D.**_____ **O.S.**_____

Advantage of contact lenses over glasses:_____

_____

SECTION VI (DHMH Only)

_____**Approved** _____**Denied** _____**Returned**

Reason(s)_____

Medical Consultant's Signature_____**Date**_____

Comer Letter to DOJ 11-18-24.pdf
Uploaded by: Jennifer Cohen
Position: FAV

JAMES COMER, KENTUCKY
CHAIRMAN

ONE HUNDRED EIGHTEENTH CONGRESS

JAMIE RASKIN, MARYLAND
RANKING MINORITY MEMBER

Congress of the United States
House of Representatives
COMMITTEE ON OVERSIGHT AND ACCOUNTABILITY
2157 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–6143
MAJORITY (202) 225–5074
MINORITY (202) 225–5051
https://oversight.house.gov

November 18, 2024

The Honorable Merrick Garland
Attorney General
U.S. Department of Justice
950 Pennsylvania Ave, NW
Washington, D.C. 20530

Dear Attorney General Garland:

The Committee on Oversight and Accountability is continuing its oversight of the impact consolidation in vision care markets has had on consumers. Consolidation in the vision insurance market raises concerns about the potential for increased costs to patients and fewer choices. We request a staff-level briefing and certain documents and information related to the Department of Justice's (DOJ) work to ensure consolidation in the vision care market does not detrimentally impact patients.

According to reports, two companies control 85 percent of the market share of the stand-alone vision insurance plans.[1] In fact, in 42 states one company controls at least a plurality of the vision insurance plan market.[2] In 28 states, a single company controls more than 75 percent of the vision insurance plan market.[3] Concerns over consolidation in the vision insurance market are extensive and raise serious questions over their potential impact on patients. Vision benefit managers (VBMs) own, operate or affiliate with, eyeglass and lens manufacturers, laboratories, and retail locations that employ eye care providers. Through these ownership and affiliation agreements VBMs have fully integrated the vertical supply chain of vision care. The vertical integration has allowed VBMs to provide favorable copays to steer patients to stores they own while simultaneously charging plan sponsors higher rates.[4]

Furthermore, it appears that the consolidation in the market is not finished. In October of this year, a major VBM, VSP Vision Care (VSP) announced its plans to purchase Eyemart Express, a retailer that operated stores in 42 states.[5] VSP already provides vision insurance for 82 million Americans nationwide.[6] This includes a reported 1.4 million covered lives in the Federal Employees Dental and Vision Insurance Program (FEDVIP).[7] VSP has also provided financial

[1] Stephanie Guinan, *What Are the Largest Vision Insurance Companies?*, VALUEPENGUIN, (Jul. 6, 2023).
[2] *Id*.
[3] *Id*.
[4] David Lazarus, *Column: Vision insurers have rigged the market to get you to buy their glasses*, LOS ANGELES TIMES, (Mar. 19, 2019).
[5] *VSP Vision Enters into Definitive Agreement to Acquire Eyemart Express*, Vision Monday, (Oct. 9, 2024).
[6] *About VSP*, VSP VISION CARE, (2024).
[7] *Highly-Concentrated Vision Insurance Market Increasing*, MARK FARRAH ASSOCIATES, (Jan. 12, 2023).

incentives to providers who push frames that VSP has owns or has affiliations with without consumer's knowledge.[8]

This type of consolidation and anticompetitive practices are similar to those found by the Committee in its investigation into Pharmacy Benefit Managers (PBMs).[9] The Committee identified several examples of PBMs utilizing their position as middlemen and vertical integration to steer patients to entities they own, drive competitors out of business, increase costs for patients, and utilize market opacity to prevent oversight of their actions.[10] The Committee is concerned that these same practices are being used by VBMs to the detriment of patients.

To understand the impacts consolidation of vision insurance plans and their vertical integration with manufacturers have had on consumers, please make arrangements to schedule a briefing with Committee staff on this matter as soon as possible, but no later than November 25, 2024. Additionally, please provide the following documents and information as soon as possible, but no later than, December 2, 2024:

1) All documents and communications related to the DOJ's review of consolidation in vision care markets;

2) All documents and communications related to the potential acquisition of Eyemart Express by VSP; and

3) All documents and communications related to the DOJ's review of anticompetitive practices by any entity within vision care markets.

To schedule the briefing or to ask any related follow-up questions, please contact the Committee on Oversight and Accountability Majority staff at 202-225-5074. Attached are instructions for producing the documents and information to the Committee.

The Committee on Oversight and Accountability is the principal oversight committee of the U.S. House of Representatives and has broad authority to investigate, "any matter" at "any time" under House Rule X. Thank you for your attention to this important matter.

Sincerely,

James Comer
Chairman
Committee on Oversight and Accountability

cc: The Honorable Jamie B. Raskin, Ranking Member
Committee on Oversight and Accountability

[8] *Id.*
[9] *The Role of Pharmacy Benefit Managers in Prescription Drug Markets*, H. Comm. On Oversight and Accountability, (Jul. 23, 2024).
[10] *Id.*

FTC-2024-0022-1786_Steven Reed Letter to DOJ.pdf
Uploaded by: Jennifer Cohen
Position: FAV

AMERICAN OPTOMETRIC ASSOCIATION

May 30, 2024

Grace Lee
Competition Policy and Advocacy Section
Antitrust Division
U.S. Department of Justice
950 Pennsylvania Ave., N.W., Suite 3337
Washington, D.C., 20530

Dear Ms. Lee,

The American Optometric Association (AOA) appreciates the opportunity to provide comment on the Department of Justice's Antitrust Division, the Federal Trade Commission and the Department of Health and Human Services "Request for Information on Consolidation in Health Care Markets." The AOA is especially concerned about transactions made by private payers in the vision care market and the impact that consolidation has on doctors and their patients.

Each year, millions of American families rely on local doctors of optometry for their comprehensive vision and eye health care needs. While many patients have coverage for medical eye care through a health plan, roughly 200 million Americans have supplemental preventive eye exam and materials (glasses/contact lenses) benefits through a vision benefit manager (VBM). The two most dominant vision benefit managers provide coverage to roughly 2/3 of Americans with this benefit. In addition to the dominance of these companies, VBMs typically enjoy special legal treatment and are not regulated as health insurers. Recently, the House Oversight Committee raised concerns with the impact of this market dominance noting:

> One company, VSP Vision Care (VSP), provides vision insurance for 82 million Americans nationwide. This includes a reported 1.4 million covered lives in the Federal Employees Dental and Vision Insurance Program (FEDVIP). Several vision insurers have also sought to vertically consolidate, creating their own brick-and-mortar retail stores providing favorable copays and pricing to steer consumers to their stores and away from their competitors. Additionally, many of these insurers own lens and frame manufacturers enabling them to mark up prices by as much as 1,000 percent. VSP has also provided financial incentives to providers who push frames that VSP owns or has affiliations with without consumer's knowledge.[1]

The AOA often receives concerns from member doctors regarding the incentive programs that payers put into place. These incentive programs often will encourage doctors to utilize certain lens or frame types that are owned by the payer. Doctors who utilize the recommended lenses and frames are in turn provided with priority placement on the payer's doctor locator. More recently, one incentive program has offered increased reimbursement for comprehensive eye exams as a benefit of meeting the incentive program

[1] Letter-to-FTC-Khan-on-Consolidation-of-Vision-Care-Plans.pdf (house.gov)

requirements. This creates an extremely challenging situation for doctors of optometry as reimbursement rates from VBMs have remained stagnant for many years. An AOA analysis found 70% of doctors reported not receiving an increase in the fee schedule for the largest vision plan they accept in their practice in at least five years, and, thinking back to that last increase, 69% of doctors reported that it had been at least six years or more since the previous increase. In other words, most doctors of optometry have had no increase or just one increase in payment from the largest vision plan they accept in their practice in the last decade even as cost of providing high quality eye health and vision care steadily rose (as evidenced by a 40% increase in the Medicare Economic Index since 2000).[2]

Essentially, a situation has been created wherein doctors have not received an increase in reimbursement in decades even as the cost of doing business has increased drastically, especially in recent years. In order to receive *any* reimbursement increase from certain VBMs, doctors are encouraged to take part in incentive programs. These programs are grounded in encouraging the use of certain lens and frame companies that the VBM owns. The combination of keeping reimbursement flat and incentivizing the use of VBM-owned frames and lens companies in order to obtain higher reimbursement has created a complete imbalance of power between the doctors who are working to care for their patients and the VBMs who typically own the VBM, frame companies, lens companies, labs where glasses are manufactured and more.

This imbalance of power is further aggravated as VBMs are now increasingly purchasing practices across the country. The AOA is following a California-based lawsuit, brought by Total Vision, which supports a group of independent optometric practices there, that accuses the country's largest vision benefits manager, VSP, of using its huge leverage to "strong arm" and bully it into accepting business conditions that threaten its very survival. The allegations mirror alarms raised by the AOA regarding VSP and other VBMs anticompetitive practices in the insurance marketplace.

The lawsuit was filed Sept. 26, 2023 in the U.S. District Court in the Central District of California.[3] "This case concerns a vision insurance company that seeks to wield its monopoly power to drive an innovative competitor out of business to the detriment of competition and patients," says Total Vision's lawsuit, which lays out VSP's related business interests (vertical integration) including its own independent optometry services, glasses frames and lenses, and optometric software. The suit adds: "The problem this has created is that VSP uses the power it derives from its vision insurance business mercilessly to force optometry practices to purchase glasses frames and lenses from its subsidiaries at supra-competitive prices for lower-quality products, purchase its back-office software regardless of whether they want it or not, and, perhaps most insidiously, prevent independent optometry practice groups from growing because VSP wants to dominate those services just as it does vision insurance." The suit seeks damages and an injunction barring VSP from limiting Total Vision's growth by refusing to deal with it, for instance, by removing it from VSP's network or "to force tying and other harmful anticompetitive arrangements on Total Vision."

In the lawsuit, Total Vision describes itself as providing the 59 independent practices affiliated with it with centralized nonclinical, back-office and administrative support, allowing doctors to focus on patient care and their practices and Total Vision to "achieve economies of scale." According to the suit, VSP is the largest vision insurer in the country. That ubiquity not only gives VSP "enormous leverage" over independent practices, but also makes it a "must have" for those in-network practices that want to compete for patients in the marketplace, the suit says.

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[2] HPI_Stagnation_in_Vision_Plan_Fee_Schedules.pdf (aoa.org)

[3] https://www.aoa.org/AOA/Documents/Advocacy/state/C.D.%20Cal.%2023-cv-01805%20dckt%20000001_000%20filed%202023-09-26.pdf

Total Vision alleges that when it balked at VSP's practices, their relationship turned tense under the terms of the 2019 agreement, which the suit says required Total Vision to purchase a "substantial number" of glasses frames and lenses made and sold by VSP using the VBM's practice management software. Without those restrictions, Total Vision might have negotiated better prices on materials or for labs to the benefit of its patients. The suit claims, "VSP was able to foist these anticompetitive terms on Total Vision because it controls so much of the vision insurance market that companies like Total Vision have no choice but to acquiesce to its demands, lest they risk thousands of their patients losing access to vision insurance."[4]

Similar to the Total Vision lawsuit, doctors of optometry have reported how the VBMs use their power over inclusion in the provider network to encourage and discourage certain business behaviors. It has been reported to AOA, anecdotally, that if a doctor who has operated as a sublease holder of a practice owned by a VBM tries to leave that sublease to begin their own practice, the VBM will make it difficult or impossible to remain on the VBMs network panel. Given the sheer market dominance of the two largest VBMs and as noted in the Total Vision lawsuit, to be out of network can threaten the viability of new private practices and can overall limit competition.

We understand that following recent practice acquisitions by VBMs, FTC has conducted outreach to individuals and doctors in the communities impacted by the acquisitions to assess how competition may have been impacted. The AOA would like to serve as a resource to the FTC as these acquisitions increasingly occur in the eye care industry and many of these acquisitions are small enough to not garner significant FTC attention.

We appreciate the FTC's exploration of the impact of increasing acquisitions in health care. As the FTC continues its work, we welcome the opportunity to provide the perspective of doctors of optometry and their patients. If additional information is needed, please contact Kara Webb at [redacted]

Sincerely,

Steven T. Reed, O.D.
AOA President

[4] ibid

SB 795-MOA Testimony.pdf
Uploaded by: Jennifer Cohen
Position: FAV

Maryland Optometric Association
P.O. Box 350, Stevenson, MD 21153 ◆ T: (410) 486-9662 ◆ F: (443) 378-8845 ◆ www.marylandoptometry.org

March 4, 2026

The Honorable Pamela Beidle
Senate Finance Committee
Miller Senate Office Building, 3 East Wing
11 Bladen St., Annapolis, MD 21401 - 1991

Re: SUPPORT SB 795 "Health Insurance - Vision Benefits - Regulation of Insurers and Vision Benefit Managers"

Dear Chair Beidle & Committee Members,

On behalf of the Maryland Optometric Association (MOA), we appreciate and value your role in providing oversight and regulation of the insurance industry in Maryland. MOA represents state-licensed doctors of optometry and their patients, and we respectfully urge you to support Senate Bill 795.

More than 200 million Americans receive vision care benefits. While some of these benefits are covered and administered by traditional medical insurance companies, the majority are covered or administered by managed vision care plans, also known as Vision Benefit Managers (VBMs). Unfortunately, in many states these managed vision care companies have been permitted to operate and grow outside of the regulatory framework that traditional insurers must follow.

Today, market concentration in the vision benefit industry is significant. Although there are roughly 20 managed vision care companies nationally, four control the vast majority of covered lives:

- VSP Global – 84.4 million lives
- EyeMed – 52 million lives
- Versant Health – 33 million lives
- UnitedHealthcare/Spectera – 20 million lives

The size of these plans is concerning not only nationally, but locally. The two largest managed vision care companies are also vertically integrated conglomerates that dominate the national markets for spectacle lenses and frames. These companies administer the patient's benefits, manufacture frames and lenses, designate preferred products on plan formularies, and steer patients toward retail and e-commerce locations they own and operate.

Most patients assume their insurance plan simply processes claims. In reality, the same company may control the insurance network, the supply chain, and competing retail outlets. Consumers are often unaware of these conflicts of interest. This level of consolidation reduces transparency, limits patient choice, and risks interference with the doctor–patient relationship.

For independent optometry practices, the impact is significant. Reimbursement rates have remained largely stagnant for years, even as rent, staff wages, equipment, and medical supply costs continue to rise. In some cases, higher reimbursement is tied to participation in incentive programs that favor products owned by the VBM. Independent doctors are placed in the difficult position of either absorbing increased costs or aligning purchasing decisions with the insurer's corporate interests.

Beyond market dominance, there are serious concerns regarding business practices that have developed in the absence of clear regulatory oversight. Compared to traditional medical insurers, managed vision care companies may:

• Administer medical and surgical eye care benefits without being subject to the same patient protection requirements as medical insurers;
• Facilitate discriminatory network participation practices by requiring optometrists to contract with affiliated managed vision care plans instead of directly with medical insurers;
• Establish misleading network tiers based largely on sales volume and profit margins rather than quality-of-care measures, without adequate disclosure to consumers or regulators;
• Market unfunded discounts for services or materials not reimbursed by the plan;
• Recoup payments from providers years after claims were paid, well beyond timelines commonly permitted under state insurance laws;
• Fail to provide adequate administrative or financial relief during public health emergencies such as COVID-19;
• Execute contracts with indefinite terms that avoid application of new state laws; and
• Maintain stagnant fee schedules for decades without meaningful negotiation, often failing to provide transparent reimbursement schedules to participating doctors.

Additionally, many vision plans increasingly shift administrative responsibilities onto doctors and their staff, while retaining control over benefit design, data, and marketing representations made to patients and employer clients. This lack of accountability further disadvantages providers and creates confusion for consumers.

When two companies control approximately 85% of the vision benefit market and simultaneously own key segments of the supply chain and competing practices, the leverage is enormous. Exclusion from a dominant network can threaten the viability of a small practice. That dynamic limits fair negotiation and ultimately reduces meaningful patient choice.

Independent optometry practices serve communities across Maryland. We want to compete based on quality of care, accessibility, and patient relationships—not on vertically integrated corporate leverage.

Senate Bill 795 represents an important step toward appropriate oversight, transparency, and consumer protection in the vision care marketplace. Even addressing one of the concerns outlined above would have a meaningful impact on patients and providers alike.

We respectfully ask for your favorable vote on SB 795 and welcome the opportunity to partner with you in protecting Maryland consumers.

Thank you for your time, consideration, and leadership.

Sincerely,

Jennifer Cohen
MOA Executive Director

SB795 Background & Summary.pdf
Uploaded by: Jennifer Cohen
Position: FAV

Vision Benefit Manager (VBM) Bill (SB 785) Summary

Maryland Optometric Association

Contact: Jennifer Cohen, MOA Executive Director
P: (410) 949-7006 | **E:** jcohen@marylandoptometry.org

Background

Through vertical integration, and consolidation, vision benefit managers (VBMs) increasingly influence how patients access eye care. VBMs limit patient choice, distort competition, and erode the independent doctor–patient relationship. This model legislation establishes clear definitions, transparency standards, fair-contracting and credentialing requirements, prohibitions on coercive or deceptive practices, and strong enforcement tools to ensure patients have access to eye care in their communities. It ensures providers can practice without undue corporate control.

Outline of Bill Provisions

- **Definitions and scope**
  - Defines relevant terms for the eye care industry and applies the Act to appropriate entities including affiliates, subcontractors, and third-party administrators involved in vision benefits.
- **Transparency and disclosure**
  - Requires insurers/VBMs to publicly disclose ownership, legal status, regulators, litigation history, and formal complaints.
  - Requires submission of plan, contract, and marketing materials to state regulators upon request; misleading or deceptive marketing is treated as a deceptive trade practice.
- **Covered services, materials, and fee schedules** (*see MD Insurance Code § 15-112.2* - enacted 2013)
  - Prohibits setting fees for services or materials unless they are clearly defined and reimbursed as covered.
  - Requires use of standard HCPCS/CPT codes and prohibits re-defining or altering those code meanings by contract or policy.
  - Prohibits labeling a service or material as “covered” or “included” if plan reimbursement is nominal, de minimis, or consists solely of the enrollee’s out-of-pocket payment.
  - Requires itemized fee schedules showing allowed amounts, plan payments, and enrollee cost-sharing for each covered service and material.
  - Prohibits arrangements that require providers to furnish covered services or materials at a financial loss.
- **Tiering, steering, and self-dealing**
  - Prohibits tiering, ranking, or otherwise differentiating in-network providers based on discounts on non-covered items, product volume, or specific brands/sources of materials.
  - Prohibits varying deductibles, copays, coinsurance, rebates, gift cards, or other incentives to steer patients to plan-owned or affiliated retail locations or affiliated online channels.
  - Prohibits advertising that services or materials are “free,” “no charge,” or “complimentary” when the plan does not contribute payment to the provider.
- **Access to plan information and claims practices**
  - Requires direct, electronic access to complete in-network and out-of-network benefit information for providers and enrollees.

- Requires payment of contracted amounts when eligibility was verified using customary methods on the date of service.
- Prohibits altering, downcoding, bundling, or otherwise changing provider-submitted codes/modifiers in ways that reduce payment or harm providers/enrollees.

- **Provider autonomy, labs, suppliers, and technology**
  - Prohibits varying reimbursement related to a provider's choice of optical labs, suppliers, equipment, EHR/practice-management systems, or clearinghouse/claim-filing services.
  - Prohibits controlling or attempting to control the professional judgment or manner of practice of eye care providers.
- **Credentialing, network access, and anti-coercion protections** (*see MD Insurance Code § 15-112.2*)
  - Requires an online method to apply for network participation and mandates objective, reasonable, non-discriminatory credentialing standards, and sets timelines for decisions.
  - Prohibits excluding qualified providers solely due to "panel size," geography, time/distance, professional designation, or participation status in other plans.
  - Prohibits "all-products" clauses or making participation in one plan contingent on participation in another health or vision plan.
- **Contract changes, payment methods, and retaliation**
  - Requires at least 90 days' notice of proposed contract, fee schedule, or policy changes, and an opportunity for meeting and written response.
  - Prohibits unilateral amendment-by-silence; if the provider does not affirmatively agree, the existing agreement remains in force.
  - Prohibits requiring reimbursement via virtual credit cards or other payment methods that impose processing/administrative fees as a condition of payment.
  - Prohibits retaliation against providers for negotiating contract terms or filing complaints with regulators, and authorizes sanctions and remedies if retaliation occurs.
- **Audits and extrapolation**
  - Prohibits the use of extrapolation to determine audit overpayments or underpayments; any recoupment must be based on actual claims reviewed, after full appeal opportunities.
- **Private right of action and enforcement**
  - Grants providers a private right of action for injunctive relief, damages, and attorney's fees/costs, consistent with state consumer-protection frameworks.
  - Gives the insurance commissioner and attorney general authority to investigate, adopt rules, seek injunctions, and impose penalties for unfair or deceptive trade practices.
- **Severability and effective date**
  - Includes a severability clause to preserve the remainder of the Act if any provision is held invalid.
  - Applies to new and renewed policies and provider agreements, requires that provider manuals and referenced policies be supplied with agreements.

Written Testimonial.pdf
Uploaded by: Katia Carpio
Position: FAV

Visionary Eye Doctors
Advanced technology with a loving touch

March 4, 2026

The Honorable Pamela Beidle
Senate Finance Committee
Miller Senate Office Building, 3 East Wing
11 Bladen St., Annapolis, MD 21401 - 1991

Re: SUPPORT SB 795 "Health Insurance - Vision Benefits - Regulation of Insurers and Vision Benefit Managers"

Dear Chair Beidle & Committee Members

As a Maryland-licensed doctor of optometry and business private practice owner who wishes to better serve my patients, I respectfully ask you to support Senate Bill 795. This legislation addresses the anti-competitive practices of Vision Benefit Managers, which restrict patient choice and threaten patient access to care. I want to share what consolidation in the vision care market looks like from the ground level.

Most of my patients receive their vision benefits through a Vision Benefit Manager, or VBM. Today, two companies control the majority of that market (85%). That concentration matters because these same companies increasingly own not only the vision plan, but the frame brands, the lens labs, the retail stores, the software systems we use to run our practices — and in many cases, they own or employ competing practices.

Reimbursement rates from these plans have remained largely flat for years, even as rent, staff wages, equipment costs, and medical supplies continue to rise. In some cases, the only way to receive slightly better reimbursement is to participate in incentive programs that favor frames or lenses owned by the VBM. That puts independent doctors in a difficult position: either absorb rising costs or align purchasing decisions with the insurer's business interests.

When a company controls both the insurance network and the supply chain, it has enormous leverage. Being excluded from a dominant network can threaten the viability of a small practice. That reality limits our negotiating power and, ultimately, limits patient choice.

My patients often assume their insurance plan is simply paying claims. In reality, the same company may also be steering them toward certain products, certain labs, or even certain retail locations it owns. That reduces transparency and shifts focus away from what should matter most — the patient's clinical needs.

Independent optometry practices serve communities across this country. We want to compete based on quality of care, not on vertically integrated corporate leverage. I urge careful scrutiny of consolidation in the vision care market to ensure fair competition and protect patient choice. Please vote favorably on SB 795.

Very truly yours,

Babak Hosseini, OD
11300 Rockville Pike, Suite 1202
Rockville, MD 20852
301-896-0890

committe letter March 2026.pdf
Uploaded by: Michelle May
Position: FAV

ADVANCED FAMILY VISION CARE

Complete Family Eye Care and Optical
Vision Development and Rehabilitation Center
Michelle May, OD, FOVDR

March 4, 2026

The Honorable Pamela Beidle
Senate Finance Committee
Miller Senate Office Building, 3 East Wing
11 Bladen St., Annapolis, MD 21401 - 1991

Re: SUPPORT SB 795 "Health Insurance - Vision Benefits - Regulation of Insurers and Vision Benefit Managers"

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Reimbursement rates from these plans have remained largely flat for years, even as rent, staff wages, equipment costs, and medical supplies continue to rise. In some cases, the only way to receive slightly better reimbursement is to participate in incentive programs that favor frames or lenses owned by the VBM. That puts independent doctors in a difficult position: either absorb rising costs or align purchasing decisions with the insurer's business interests.

When a company controls both the insurance network and the supply chain, it has enormous leverage. Being excluded from a dominant network can threaten the viability of a small practice. That reality limits our negotiating power and, ultimately, limits patient choice. I recently made the difficult decision to terminate my participation with one of the VBMs, largely due to the continuously poor reimbursement rates. This impacted a large number of my patients, many of whom have now chosen to re-establish their care elsewhere (and also expressed frustration and disappointment in having to do so). Those who have chosen to stay either pay out of pocket or have purchased a second vision plan, increasing their cost for being able to see the provider of their choice.

My patients often assume their insurance plan is simply paying claims. In reality, the same company may also be steering them toward certain products, certain labs, or even certain retail locations it owns. That reduces transparency and shifts focus away from what should matter most — the patient's clinical needs.
Independent optometry practices serve communities across this country. We want to compete based on quality of care, not on vertically integrated corporate leverage. I urge careful scrutiny of consolidation in the vision care market to ensure fair competition and protect patient choice. Please vote favorably on SB 795.

Very truly yours,

Michelle May, OD
252 Charring Ct. Riva, MD 21140
443-340-3043

insurance discounting-slides_slide 7 adjusted_3.20
Uploaded by: Nutaporn Natalie Sukontasup
Position: FAV

VISION PLANS

Optometrists' Collections

versus

Optometrists' Losses

Avesis Advantage Plan

COVERED --- EXAM AND ONE PAIR OF GLASSES OR SUPPLY OF CONTACTS

NON-COVERED --- 20% MANDATED DISCOUNT BY INSURANCE COMPANY

Material	Cost	Optometrist Collects	Optometrist Losses
Additional Glasses	$300	$240	- $60
Additional Contact Lens Services	$100	$80	- $20
Additional Contact Lens Materials	$100	$80	- $20
Total	**$500**	**$400**	**- $100**

Based on 2013 fees and collections

Davis Vision Hybrid Affinity –CareFirst Bluechoice, CareFirst BlueCross BlueShield Vision Plus

COVERED --- EXAM ONLY

NON-COVERED --- MANDATED DISCOUNTS BY INSURANCE COMPANIES

Material	Discount	Cost	Optometrist Collects	Optometrist Losses
Frame U&C*	10% over $70	$200	$180	- $20
Lenses U&C*		$100	$65	- $35
Add'l Glasses	20%	$300	$240	- $60
Add'l Contact Lens Services	15% off U&C	$100	$85	- $15
Add'l Contact Lens Materials	10-20% U&C	$200	$160	- $40
Total		**$900**	**$730**	**- $170**

Based on 2013 fees and collections

* U & C = Usual & Customary

EyeMed: Humana Optimum Select

COVERED --- EXAM AND ONE PAIR OF GLASSES OR SUPPLY OF CONTACTS

NON-COVERED --- 40% MANDATED DISCOUNT BY INSURANCE COMPANY

Material	Cost	Optometrist Collects	Optometrist Losses
Additional Glasses	$300	$180	- $120
Additional Contact Lens Services & Materials	$200	$120	- $80
Total	**$500**	**$300**	**- $200**

Based on 2013 fees and collections

EyeMed: Anthem Access Plan C

COVERED --- EXAM ONLY				
NON-COVERED --- MANDATED DISCOUNTS BY INSURANCE COMPANY				
Material	**Discount**	**Cost**	**Optometrist Collects**	**Optometrist Losses**
Frame U&C*	35%	$200	$130	- $70
Lenses U&C*		$100	$40	- $60
AND MAY PURCHASE CONTACT LENS WITH GLASSES				
Add'l Glasses	20%	$300	$240	- $60
Add'l Contact Lens Services	15% off U&C*	$100	$100	0
Add'l Contact Lens Materials	15% U&C*	$200	$170	- $30
Total		**$900**	**$680**	**- $220**

Based on 2013 fees and collections

* U & C = Usual & Customary

VSP: Signature, Choice, Indemnity Plan

COVERED --- EXAM AND ONE PAIR OF GLASSES OR SUPPLY OF CONTACTS
(May require 15% discount on professional service contact lens evaluation fees)

NON-COVERED --- MANDATED DISCOUNTS BY INSURANCE COMPANIES

Material	Discount	Cost	Optometrist Collects	Optometrist Losses
Additional Glasses	20%	$300	$240	- $60
Additional Contact Lens Services	15%	$100	$85	- $15
Total		**$400**	**$325**	**- $75**

Based on 2013 fees and collection data

Bluechoice: Medical HMO

COVERED --- Medical Only

NON-COVERED --- MANDATED AMOUNT BY INSURANCE COMPANY

Material	Cost	Optometrist Collects	Optometrist Losses
Routine Vision Service	$35	$22.19	- $12.81
Total	**$35**	**$22.19**	**- $12.81**

Based on 2013 fees and collection data

Superior Vision Discount Features Plan

COVERED --- EXAM AND ONE PAIR OF GLASSES AND/OR SUPPLY OF CONTACTS

NON-COVERED --- MANDATED DISCOUNTS BY INSURANCE COMPANY

Material	Discount	Cost	Optometrist Collects	Optometrist Losses
Exam U&C*	30%	$194	$135.80	- $58.20
Frame U&C*	30%	$200	$140	- $60
Lenses U&C*	20%	$100	$80	- $20
AND MAY PURCHASE CONTACT LENS WITH GLASSES				
Additional Contact Lens Services	30%	$100	$70	- $30
Additional Contact Lens Materials	10% off U&C*	$200	$190	- $10
Total		**$794**	**$615.80**	**- $178.20**

Based on 2013 fees and collection data

* U & C = Usual & Customary

Vision Benefits of America

COVERED --- EXAM AND ONE PAIR OF GLASSES AND/OR SUPPLY OF CONTACTS			
NON-COVERED --- VARIABLE MANDATED DISCOUNT BY INSURANCE COMPANY			
Material	**Cost**	**Optometrist Collects**	**Optometrist Losses**
Contact Lens Services	$100	$70	- $30
Contact Lenses	$200	$180	- $20
Total	**$300**	**$250**	**- $50**

Based on 2013 fees and collection data

Vision Plans

NON-COVERED --- OPTOMETRISTS LOSSES BY INSURANCE COMPANY

Vision Plan	Cost	Optometrist Collects	Optometrist Losses
Avesis Advantage Plan	$500	$400	- $100
Davis Vision Hybrid Affinity	$900	$730	- $170
EyeMed: Humana Optimum	$500	$300	- $200
EyeMed: Anthem Access Plan C	$900	$680	- $220
VSP	$400	$325	- $75
Bluechoice	$35	$22.19	- $12.81
Superior Vision	$794	$615.80	- $178.20
Vision Benefits	$300	$250	- $50
Cumulative Total	**$4,329**	**$3,322.99**	**- $1006.01**

Based on 2013 fees and collection data

WrittenTestimony_SB795_Signed.pdf
Uploaded by: Nutaporn Natalie Sukontasup
Position: FAV

firstSight VISION CARE

March 4, 2026

The Honorable Pamela Beidle
Senate Finance Committee
Miller Senate Office Building, 3 East Wing
11 Bladen St., Annapolis, MD 21401 – 1991

Re: SUPPORT SB 795 "Health Insurance - Vision Benefits - Regulation of Insurers and Vision Benefit Managers"

Dear Chair Beidle & Committee Members,

My name is Dr. Natalie Sukontasup. I am a practicing optometrist and small business owner in Fulton, Maryland. I also represent the Maryland Optometric Association.

I am writing in support of strengthening oversight and adding clearer regulations for vision benefit managers. Except for one vision plan, vision benefit managers currently operate without regulatory oversight in Maryland. As a result, these entities have been able to grow rapidly and vertically integrate, dominating the vision care market. Vertical integration reduces competition, limits patient choice, and ultimately increases costs for the very members they are supposed to serve.

In 2013, legislation was passed in Maryland to address certain vision plan abuses. However, that law proved ineffective because many vision plans claimed they were not insurers but discount plans, allowing them to avoid compliance. SB795 clarifies and strengthens the language so that the law clearly applies to vision benefit managers and includes additional safeguards to ensure they operate in the best interest of patients and providers.

One of the primary ways vision benefit managers exert their control is by imposing unfair contract terms that make it extremely difficult for providers to operate a sustainable business.

For example:

- **Providers are required to discount non-covered services and materials, often at a loss, with no ability to negotiate.**

Non-covered services and materials frequently include new technologies and innovative treatments. As with any advancement, there are real costs involved: staff training, new equipment, updated workflows, and the technology itself.

First Sight Vision Care LLC
8115 Maple Lawn Blvd, Suite 135 Fulton, Maryland 20759 • Phone: (301) 490-3036 • Fax: (443) 535-1844
www.firstsightvisioncare.com

firstSight VISION CARE

Just as the newest generation smartphone costs more than the first model, new lens technologies, including those recently approved to slow the progression of nearsightedness in children, require significant investment.

For services and materials not covered by the plan, providers should have the ability to set their own fees and determine whether to offer a discount. This flexibility allows small businesses to account for the true cost of delivering care.

• Provider contracts often restrict our choice of labs and suppliers for both covered and non-covered materials.

In many cases, glasses must be sent to out-of-state to contracted labs, which increases both turnaround time and costs. Many optometry practices, including mine, have in-office finishing labs that allow us to provide faster turnaround time and negotiate better pricing for private-pay patients.

However, for vision plan patients, we are required to use designated labs. I currently send our vision care orders to Tennessee, New York and Texas while there are three full service optical manufacturing labs right here in Maryland. By allowing providers to choose their labs will strengthen local businesses and support Maryland's economy.

In closing, SB795 restores fairness and transparency to the vision care marketplace.
It bans deceptive discount practices, ensures fair provider contracts and protects patient choice.

Very truly yours,

Nutaporn Natalie Sukontasup, O.D.
8315 Academy Rd,
Ellicott City, MD 21043
443.804.1173

SB0795 Testimony_ Health Insurance - Vision Benefi
Uploaded by: Phylicia Porter
Position: FAV

City of Baltimore

Room 527, City Hall
100 N. Holliday Street, Baltimore, Maryland 21202
Telephone: (410) 396-4822
Email: Phylicia.Porter@baltimorecity.gov

Councilwoman Phylicia R. L. Porter, District 10
CHAIR: Public Health and Environment
MEMBER:
Labor and Workforce
Public Safety
Transportation and Land Use

February 26, 2026

Bill Title: SB0795: Health Insurance - Vision Benefits - Regulation of Insurers and Vision Benefit Managers
Position: Favorable
To: Chair Beidle, Vice Chair Hayes, Finance Committee

Dear Chair Beidle and Members of the Committee,

I respectfully submit this testimony in strong support of SB0795, a bill that strengthens accountability and transparency within Maryland's vision benefit plans and ensures patient care remains the priority.

Families navigating financial hardship should not face additional barriers when accessing medical care. How insurers and vision benefit managers administer and communicate benefits directly affects communities. Where transparency is deficient, vulnerable patients bear the burden. Eye care goes far beyond prescribing glasses; routine optometric visits detect early signs of diabetes, high blood pressure, and high cholesterol, conditions that disproportionately affect minority and low-income communities. Black and Latino residents are twice as likely to be uninsured, limiting access to preventive care and early intervention. When vision care is inaccessible, early diagnoses are missed, leading to more severe health outcomes.

SB0795 establishes clear standards for transparency, contracting, and reimbursement. It ensures fairness and consistency, reduces administrative burdens, and allows providers to focus on delivering quality care. Strengthened oversight protects both providers and patients from unnecessary barriers. This legislation complements the Child Health Equity Act I passed in 2025, which expanded access to healthcare for children and strengthened services in schools. Financial hardship should never determine health outcomes, and SB0795 advances equitable access to preventive care for all patients.

At its core, SB0795 is about fairness, transparency, and access. By setting clear expectations and reinforcing accountability, we can strengthen our healthcare system and improve health outcomes across Maryland.

I respectfully urge the favorable passage of this important legislation.

Sincerely,

Councilwoman Phylicia Porter, MPH, MSL
Phylicia.Porter@baltimorecity.gov
Chair, Public Health and Environment Committee
Baltimore City Council - District 10

SB0795_FWA_MSEPS_HI - Vision Benefits - Regulation

Uploaded by: Danna Kauffman

Position: FWA

Senate Finance Committee
March 4, 2026
Senate Bill 795 – *Health Insurance – Vision Benefits – Regulation of Insurers and Vision Benefit Managers*
POSITION: SUPPORT WITH AMENDMENT

The Maryland Society of Eye Physicians and Surgeons (MSEPS) is the professional organization of ophthalmologists in Maryland. Maryland is a world-renowned center for the training of ophthalmologists, including the Wilmer Eye Institute at Johns Hopkins University. MSEPS **supports with amendment** Senate Bill 795, which seeks to regulate the practice of vision benefit managers.

Like pharmacy benefit managers, regulating vision benefit managers is important to ensure fair reimbursement, transparent contracting, and protection from policies that disadvantage optometrists and ophthalmologists. Oversight prevents corporate interference in clinical decision-making, safeguards patient choice, and preserves access to quality eye care.

In supporting the bill, MSEPS respectfully requests one amendment – that references to optometrists and physicians be listed separately rather than collectively as "eye care provider(s)."

On page 2, in line 26, strike "EYE CARE PROVIDER" and substitute "OPTOMETRIST"; in line 27, strike beginning with "OR" down through "ARTICLE" in line 29.

On page 2, after line 29, insert:

"(C) PHYSICIAN MEANS AN INDIVIDUAL LICENSED TO PRACTICE MEDICINE UNDER TITLE 14 OF THE HEALTH OCCUPATION ARTICLE."

With this amendment, the subsection will need to be renumbered, and throughout the bill, wherever "EYE CARE PROVIDER" or "EYE CARE PROVIDERS" are referenced, it will need to be changed to "OPTOMETRIST AND PHYSICIAN".

For more information call:
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Position: UNF

March 4, 2025

Via E-mail: pamela.beidle@senate.maryland.gov

The Honorable Pam Beidle
Senate Finance Committee
3 East Miller Senate Office Building
Annapolis, MD 21401

Re: Senate Bill 795 – Regulation of Insurers and Vision Benefit Managers

Dear Chair Beidle and Committee Members:

The League of Life & Health Insurers of Maryland (the "League") and the American Council of Life Insurers (the "ACLI") are writing to respectfully express our ***opposition to Senate Bill 795*** ("SB 795"), which would have significant consequences for Maryland residents who rely on affordable, high-quality vision care. While the bill aims to strengthen consumer protections, several provisions would ultimately raise costs, restrict access, and create compliance and administrative challenges that do not benefit patients. For the reasons outlined below, we oppose this legislation and ask that it be reported unfavorably from this Committee.

First, this bill would include limitations on how vision plans may communicate benefit and discount information to members. The requirements outlined in this bill are so extensive that they would make it extremely difficult to share basic, accurate information that consumers depend on when choosing care. Recent court decisions in other states have already found similar restrictions to be inconsistent with constitutional protections for truthful communication, which raises additional concerns for Maryland.

This legislation would also add new disclosure obligations that would significantly increase administrative workload without improving patient understanding. These requirements would apply only to plans, not providers, leading to an uneven regulatory structure. They may also conflict with federal health-privacy rules, which could place plans in an impossible position—obey state law or follow federal requirements. The increased costs associated with these mandates would inevitably fall on employers and families.

In addition, SB 795 would create new contracting rules that would be difficult, and in some cases impossible, for plans to follow. The bill would require lengthy waiting periods before any contract updates can take effect—even when those updates are needed to comply with new state or federal

laws. It would also restrict a plan's ability to remove providers who fail to meet performance, quality, or regulatory standards. These restrictions could reduce care quality and limit the ability of plans to protect consumers. Some provisions would also require plans to give individualized legal interpretations to providers during contract discussions, which is not feasible and exposes plans to unnecessary liability.

The customer-service requirements proposed in this bill—such as mandatory live call-backs within short timeframes, including weekends and holidays—also do not reflect how healthcare administrative systems function. These rules would require substantial staffing increases and significantly drive up administrative costs without delivering meaningful improvements to patient experience.

This legislation would eliminate common tools used to maintain high-value, efficient networks. For example, it requires plans to accept any provider who meets basic credentialing requirements, even in areas that already have more than enough providers. It also restricts modern employment models and requires the use of outdated billing codes that cannot accurately capture certain conditions or support employer reporting needs. These changes would weaken network quality and increase costs for consumers.

Finally, the bill expands opportunities for lawsuits while narrowing the tools plans may use to prevent fraud, waste, and abuse. This combination makes the system more vulnerable to inappropriate billing while simultaneously exposing plans—and therefore employers and families—to higher costs.

For these reasons, SB 795 would make vision coverage more expensive, less flexible, and less able to protect consumers. The bill would impose extensive obligations on plans while providing little benefit to patients, and in some cases directly limiting their access to accurate information and high-quality care.

We respectfully urge you to ***oppose SB 795*** and ask that it be given an unfavorable report.

Sincerely,

MATTHEW CELENTANO
Executive Director
League of Life & Health Insurers of Maryland

VINCENT J. RYAN
Regional Vice President – State Relations
American Council of Life Insurers

SB795_UNF_ MABE.pdf
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BILL: Senate Bill 795
TITLE: Health Insurance – Vision Benefits – Regulation of Insurers and Vision Benefit Managers.
DATE: March 4, 2026
POSITION: UNFAVORABLE
COMMITTEE: Senate Finance Committee
CONTACT: Milton Nagel, Executive Director, MABE Health

The Maryland Association of Boards of Education (MABE) submits this testimony in **opposition** to Senate Bill 795. MABE Health manages a health insurance pool consisting of six school systems and one county government representing over 15,000 insured lives. Year over year cost increases for health insurance benefits, to include vision benefits, continues to outpace inflation and appropriation increases from the local government and the State of Maryland.

Contains an Effective "Gag Order" on Truthful Communication about Consumer Discounts
Senate Bill 795 would impose extensive verification requirements that would make communicating truthful benefit information practically impossible.

Unprecedented and Burdensome Mandatory Disclosure Requirements
Senate Bill 795 would mandate needless paperwork that provides no value to consumers and will create unnecessary administrative expense for vision care plans. The costs associated with this requirement will certainly be passed on to the consumer, our members, who cannot afford yet another cost increase that doesn't directly correlate with an increase in benefit.

Contains Unreasonable Contracting Restrictions
Senate Bill 795 would prevent the removal of a non-compliant provider unless a "material breach" has occurred which would potentially harm our members by forcing the retention of providers who fail to meet quality, access, or care standards. The bill also specifically would allow individual providers to negotiate with vision care plans even if a group contract is in place for which the individual provider is already a member, essentially undermining the integrity of the existing group contract and potentially increasing costs to our members outside of the normal annual contract renewal process. Furthermore, the bill would also prohibit plans from altering any provider-submitted code if doing so would reduce their payment, essentially eliminating standard fraud prevention and claims accuracy tools used throughout the industry.

Decreases Network Efficiency, Driving Up Consumer Costs
Senate Bill 795 would force plans to add any provider that meets credentialing requirements, which eliminates employers and plan sponsors ability to effectively and efficiently manage the network and provide value based contracting.

Conclusion
For these reasons, MABE Health requests an **unfavorable** report to Senate Bill 795.