



Mississippi Medicaid
Provider Reference Guide
For Part 217
Vision

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Reimbursement

Reimbursement for vision services is from a statewide uniform fixed fee schedule for the professional services of the optometrist or ophthalmologist plus actual acquisition cost for eyeglass frames and lenses. The provider of eyeglasses must bill actual acquisition cost (AAC) for the frames and lenses. Reimbursement for frames and lenses is based on the lower of AAC or the maximum fee as determined by DOM.

Eyeglasses

Lost or Stolen Lenses and Frames

Replacement of lost or stolen lenses and/or frames is **not** covered for beneficiaries age twenty-one (21) and over.

Replacement of lost or stolen lenses and/or frames is covered for beneficiaries under age twenty-one (21). The provider should only replace the part that is lost (Example: If a lens falls out and is lost, replace only the lens).

Damaged Lenses and Frames

Repair of damaged lenses and/or frames is covered for beneficiary's age twenty-one (21) and over. Repair of damaged lenses and/or frames is covered for beneficiaries under age twenty-one (21). The provider must document a description of the damage in the medical record. The provider must repair only the part that is damaged.

Damage cannot be repaired or repair costs exceed the Medicaid allowable amount for new frames and lenses, the provider must dispense new eyeglasses.

Lens Coating

Antireflective-coating applied to a lens to reduce the amount of reflected light and glare that reaches the eye.

Mirror - coating applied to a lens that allows the lens to take on the properties of a two-way mirror.

Scratch Resistant - coating applied to a lens that helps retard crazing of the lens, thus extending

the product life.

Tint - opaque or transparent color coating applied to a lens. The parts of the light spectrum that are absorbed by the lens are determined by the color of the tint.

Photochromatic - coating applied to a lens that allows the lens to adjust to the amount of available light.

Polarized - coating applied to a lens that filters out reflected light and glare.

UV - coating applied to a lens to filter out ultraviolet light.

Coverage Criteria

Prior Approval

Prior approval will not be required for lens coating.

Prescriptions

Prescriptions for lens coating must include the ICD-9 diagnosis code and/or a narrative diagnosis.

Billing

All claims must be submitted with the appropriate ICD-9 diagnosis code.

A beneficiary may purchase non-covered lens coating services. Non-covered services may be billed to the beneficiary. The provider should not include the charges for non-covered services when billing Medicaid.

Documentation

Refer to Section 200 of the Administrative Code

Ocular Prosthesis (Artificial Eye)

Coverage

An ocular prosthesis is not covered for beneficiaries' age twenty-one (21) and above. An ocular prosthesis is covered for children under age twenty-one (21) regardless of the cause of the loss of the eyeball. Services related to the prosthesis are covered as follows:

- Medically necessary polishing/resurfacing is covered one (1) time per year. If the beneficiary requires more frequent service, the provider must submit a prior authorization request (Eyeglass/Hearing Aid Authorization Form).
- One (1) medically necessary enlargement or reduction of the prosthesis within five (5) years of the fitting date is covered without prior authorization. Additional enlargements or reductions are rarely medically necessary and are therefore covered only when prior approved.

Prior Authorization

Prior authorization is not required except as noted above.

Documentation Requirements

Medical necessity must be documented in the beneficiary medical record.

Eyeglasses/Hearing Aid Authorization Form

The Eyeglass/Hearing Aid Authorization Request Form (DOM - 210) must be completed and submitted to DOM for all services requiring prior authorization. Forms must contain the preprinted authorization number in the appropriate field. Forms are available through the fiscal agent. The Eyeglass/Hearing Aid Authorization Form is a multi-copy form. All copies must be legible.

Mail all three completed copies to the following address:

Division of Medicaid
Vision Program
Walter Sillers Building
550 High Street, Suite 1000
Jackson, MS 39201

Medicaid staff will render a decision to approve or deny services, write the decision on the form, and mail a copy back to the provider. The provider must send an invoice along with the prior authorization request when billing codes that require manual pricing. Invoices must be itemized. Codes that require manual pricing are listed on the Hearing and Vision Services fee schedule. Providers may access the fee schedule from the DOM website at www.dom.state.ms.us. Use the drop down and click on Fee Schedules for Medicaid Provider Services. Go to the Hearing and Vision Services Fee Schedule.

Emergency Situations

In emergency situations, providers may call the Bureau of Medical Services, telephone number (601)359-5683, for instructions.

Dual Eligibles

Providers may file a claim with Medicaid for services not covered by Medicare if the reason for the Medicare denial is other than for medical necessity. The provider must submit a hard copy of the HCFA -1500 (CMS 1500), using Medicaid specific codes, and a copy of the Medicare EOB denial.

The six (6) month timely limitation for filing crossover claims is applicable with no exceptions.

Encounter Services

An encounter rate is paid for services provided by physicians, physician assistants, nurse practitioners, clinical psychologists, dentists, optometrists, ophthalmologists and clinical social workers. A clinic's encounter rate covers the beneficiary's visit to the clinic, including all services and supplies (drugs and biologicals that are not usually self-administered by the patient) furnished as an incident to a professional service. When services, supplies, drugs or biologicals are included in the clinic's encounter rates, the clinic cannot send the beneficiary to another provider that will bill Medicaid for the covered service, supply, drug or biological.

When a beneficiary sees more than one provider type (medical, dental, optometry, or mental health) at the same Federally Qualified Health Center on the same date the clinic will be reimbursed as charted below. The exception is a case in which the patient, subsequent to the first encounter, suffers illness or injury requiring an additional diagnosis or treatment. For example, a beneficiary has a visit in the morning with a physician for a medical illness and has to return in

the afternoon due to an injury which resulted in a lacerated hand. In such case, a medical encounter is paid for both visits. If the beneficiary receives an EPSDT screening only or an EPSDT screening with a medical visit on the same date, only one (1) medical encounter is paid to the clinic.

Provider Type	Encounter Allowance
Physician, Nurse Practitioner, and/or Nurse Midwife	Only one medical encounter per day
Dentist	Only one dental encounter per day
Optometrist	Only one optometry encounter per day
Clinical Psychologist and/or Clinical Social Worker	Only one mental health encounter per day

Examples are:

Service	Maximum Daily Encounter Allowance
EPSDT screening in the morning, child later becomes ill on same date, and is examined by physician in the afternoon	Two (2) medical encounters
EPSDT screening and covered dental services on same date	One (1) medical encounter and one (1) dental encounter
Physician examination for an illness and EPSDT screening during same visit	One (1) medical encounter
Exam by optometrist and dentist on same date	One(1) optometry encounter and one (1) dental encounter
Physician visit and clinical psychologist visit on same date	One (1) medical encounter and one (1) mental health encounter

The maximum number of encounters that can be paid to the same FQHC for the same beneficiary on the same date is four (4). The only exception is an instance where the beneficiary has visits with all the core service types on the same day, and in addition, the beneficiary has to return to the clinic for an injury or illness requiring additional diagnosis or treatment. In such case, the FQHC may be paid another medical encounter.

For an encounter to be paid, the service must be covered in accordance with the policies of the Mississippi Medicaid Program. All limitations and exclusions are applicable. If a service requires prior authorization, the provider must satisfy the prior authorization requirements.

Claims submitted to the fiscal agent for the same beneficiary will pay one encounter rate for each date of service and provider type (medical, dental, optometry, or mental health). A separate claim must be submitted for medical, dental, optometry, or mental health services. Claims for visits requiring additional diagnosis or treatment must be submitted to the fiscal agent as a paper claim with documentation justifying the medical necessity for the additional visit on the same date. Providers may refer to the DOM website at www.medicaid.ms.gov for a list of procedure codes which generate an encounter.

Approved Places of Service

All ambulatory services performed by a center employee or contractual worker for a center patient must be billed as an FQHC claim. This includes services provided in the clinic, skilled nursing facility, nursing facility or other institution used as a patient's home. The program will pay for visits at multiple places of service for a patient. Services performed for clinic patients by an outside lab should be billed to Medicaid by the outside lab. However, claims for in-house lab services must be billed with the same place of service code as the visit. In-house lab services are covered in the visit payment.

Federally Qualified Health Center services are not covered when performed in a hospital (inpatient or outpatient). Physicians employed by an FQHC and rendering services to Medicaid beneficiaries in a hospital will be reimbursed fee-for-service. The physician must obtain a provider number from the Division of Medicaid and bill using the CMS 1500 claim form.

Fee-for-Service

No services (same or separate dates) will be reimbursed to the clinic at a fee-for-service rate. All ambulatory services provided in an FQHC will be reimbursed an encounter rate on a per visit basis.

Drugs Purchased Under a Veterans Health Care Act Discount Agreement

The Veterans Health Care Act applies to FQHCs and allows centers to sign an agreement with drug companies to purchase drugs at a discount price. DOM is not allowed to file for a rebate on drugs purchased through a discount agreement. Therefore, all drugs purchased at a discounted price through a discount agreement must not be billed through the Medicaid pharmacy program. The reimbursement for the drugs is included in the encounter rate.

Obstetrical

Providers must utilize CPT evaluation and management codes 99201 through 99215, 59425, and 59426 to bill antepartum visits as listed below.

- (A) Providers must bill CPT codes in the 99201 through 99215 range for antepartum visits 1 or 2 or 3. Bill one code per visit.
- (B) Providers must bill CPT code 59425 for antepartum visits 4, 5, or 6. Bill one code per visit.
- (C) Providers must bill CPT code 59426 for antepartum visits 7 or over. Bill one code per visit.

The number of the antepartum visit is defined as to the number of the visit(s) that the beneficiary has been to one physician. For example, if a beneficiary goes to Dr. A for antepartum visit 1, 2, 3, and 4 and then moves and goes to Dr. B, Dr. A will bill the appropriate evaluation and management code for each antepartum visit 1 or 2 or 3 and CPT code 59425 for antepartum visit 4. Dr. B will then bill for his antepartum visits starting with antepartum visit number 1, etc.

CPT codes 59410, 59515, 59614, and 59622 will be used to reimburse deliveries and postpartum care as of October 1, 2003. The postpartum care is inclusive of both hospital and office visits following vaginal and cesarean section deliveries. These codes must be billed under the individual physician's Medicaid provider number.

CPT code 59430 can only be billed for postpartum visits when the clinic physician was not the delivering physician.

Modifier TH identifies "obstetrical treatment/services, prenatal and postpartum" and must be reported with each code for antepartum visits and deliveries and postpartum care. The Division of Medicaid will utilize this modifier to track data and to bypass the physician visit limitation of twelve (12). Antepartum office visits will not be applied to this limitation.

Refer to the Maternity Services, Part 222, and Chapter 1 of the Administrative Code.

Subdermal Implant

The cost of a subdermal implant is included in the encounter rate and will not be reimbursed separately.

Vision (Eye Glasses)

All Medicaid policy related to vision services is applicable. Vision services performed in an FQHC are reimbursed at an encounter rate. All vision services for the same date of service must be billed on one claim form.

Refer to Part 217 of the Administrative Code for policy related to vision services.

Dental

All Medicaid policy related to dental services is applicable. Dental services performed in an FQHC are reimbursed at an encounter rate. All dental services for the same date of service must be billed on one claim form.

Refer to Part 204, Dental Services, of the Administrative Code.

Solid Organ/Tissue Transplant

Refer Part 202, Chapter 4, Organ Transplant of the Administrative Code.

Hospital Services

Federally Qualified Health Center services are covered when provided in outpatient settings only, including a patient's place of residence, which may be a skilled nursing facility or a nursing facility or other institution used as a patient's home.

“Physician services” are professional services that are performed by a physician at the clinic or away from the clinic by a physician whose agreement with the clinic provides that he or she will be paid by the clinic for such services.

If a physician employed by a FQHC provides physician services at the hospital, inpatient or outpatient, the CMS 1500 claim form must be billed under the individual physician's Medicaid provider number and will be reimbursed fee-for-service. Payment will be made directly to the physician, and a 1099 form will be provided to the physician for tax purposes. The financial arrangement between the physician and the FQHC should be handled through the agreement.