Medicaid, as authorized by Title XIX of the Social Security Act, is a federal and state program of medical assistance to qualified individuals. Each state designates a state agency as the single state agency for the administration of Medicaid. State law has designated the Division of Medicaid, Office of the Governor, as the single state agency to administer the Medicaid program in Mississippi.

Vision service is an optional benefit under the state's Medicaid program. Paragraph (11) of Section 43-13-117 of the Mississippi Medical Assistance Act (Medicaid) provides financial assistance as follows:

> "Eyeglasses for all Medicaid beneficiaries who have (a) had surgery on the eyeball or ocular muscle that results in a vision change for which eyeglasses is medically indicated within six (6) months of the surgery and is in accordance with policies established by the division, or (b) one (1) pair every five (5) years and in accordance with policies established by the the division. In either instance, the eyeglasses must be prescribed by a physician skilled in diseases of the eye or an optometrist, whichever the beneficiary may select."

EXCEPTION: Beneficiaries in the pregnancy only category (COE 88) and the Family Planning Waiver (COE 29) are **not** eligible for vision benefits.

As required by Title XIX of the Social Security Act, Mississippi's Medicaid program provides EPSDT services for Medicaid eligible beneficiaries less than 21 years of age. Eligible beneficiaries may receive one (1) complete pair of eyeglasses per fiscal year. Replacement glasses are covered if medically necessary.

A provider's participation in the Mississippi Medicaid program is entirely voluntary. However, if a provider does choose to participate in Medicaid, the provider must accept the Medicaid payment as payment in full for those services covered by Medicaid. The provider cannot charge the beneficiary the difference between the usual and customary charge and Medicaid's payment. The provider cannot accept payment from the beneficiary, bill Medicaid, and then refund Medicaid's payment to the beneficiary. Services not covered under the Medicaid program can be billed directly to the Medicaid beneficiary.

The Mississippi Medicaid program purchases needed health care services for beneficiaries as determined under the provision of the Mississippi Medical Assistance Act. DOM is responsible for formulating program policy. DOM staff is directly responsible for the administration of the program. Under the direction of DOM, the fiscal agent is responsible for processing claims, issuing payments to providers, and for notifications regarding billing. DOM initiates Medicaid policy as it relates to these factors.

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.

DOM policy does not permit providers of optometric services to charge a beneficiary an additional amount for services or supplies (i.e., frames) above the fee established by DOM. Example: The provider cannot dispense a more expensive frame than is covered under the Medicaid program and collect the difference from the beneficiary. Medicaid payment for covered services is considered payment in full.

A beneficiary may purchase non-covered services (i.e., scratch resistant lens coating). The provider may bill non-covered services to the beneficiary. The provider should not include charges for non-covered services when billing Medicaid.

Providers may not bill Medicaid and hold the eyeglasses or contacts until Medicaid pays the provider. Providers may not bill Medicaid for replacement costs associated with provider error or poor workmanship.

Section 1902(a) (14) of the Social Security Act permits states to require certain beneficiaries to share some of the costs of receiving Medicaid services.

Co-Payment Amounts for Vision Services

Physician (any setting)	$3.00 per visit
Eyeglasses	$3.00 per pair

Vision Services Co-Payment Exceptions

Co-payment, by federal law, cannot be collected in certain instances. The following groups of beneficiaries are excluded from co-payment for vision services:

C Children
N Nursing facility residents
P Pregnant Women **(Reminder: The pregnancy-only eligibility category, COE 88, is excluded from vision service coverage)**

When the beneficiary is co-pay exempt, one of the exception codes **must** be indicated on the claim in the Medicaid ID number field as a suffix to the Medicaid number. Otherwise, co-payment will be deducted from the claim payment amount.

Collection of Co-Payment

In the absence of knowledge or indication to the contrary, the provider may accept the beneficiary's assertion that he/she cannot afford to pay the cost sharing co-payment amount. The provider may not deny services to any eligible Medicaid individual due to the individual's inability to pay the cost of the co-payment. However, the individual's inability to pay the co-payment does not alter the Medicaid reimbursement amount for the claim, unless the beneficiary or service is excluded from the co-payment policy as listed.

Collecting the co-payment amount from the beneficiary is the responsibility of the provider. In cases of claim adjustments, the responsibility of refunding or collecting the additional cost sharing co-payments from the beneficiary remains the responsibility of the provider.

Category of Eligibility Exclusions

Beneficiaries in the following categories of eligibility are **not** eligible for vision benefits:

- COE 88 – Pregnancy only
- COE 29 – Family Planning Waiver

General Vision Program Exclusions

Services and items **not** covered by the Division of Medicaid include, but are not limited to, the following:

- Eyeglasses used solely for protective, fashion, cosmetic, sports, occupational or vocational purposes
- Spare pair of eyeglasses
- Single vision eyeglasses in addition to multifocal eyeglasses
- No-line/invisible bifocals
- Hi-index/polycarbonate (high prescription) lenses for beneficiaries age twenty-one (21) and older
- Sunglasses
- Upgraded frames (i.e., Medicaid only covers standard frames)
- Eyeglass cases
- Engraving
- Contact lens supplies/solutions
- Eyeglass or contact lens insurance
- Low vision aids for beneficiaries age twenty-one (21) and older
- Ocular prosthesis (Artificial Eye) for beneficiaries age twenty-one (21) and older
- Lens Coating except as specified in Section 29.07
- Orthoptics
- Dispensing fees
- Contact lenses except as specified in Section 29.08

- Refractive surgery including, but not limited to, Lasik surgery, radial keratotomy, photorefractive keratectomy, and astigmatic keratotomy
- Services and items requiring prior authorization for which authorization has been either denied or not requested
- Replacement of lenses or frames due to provider error in prescribing, frame selection, or measurement
- Replacement of lenses or frames due to poor workmanship and/or materials
- Any exclusion listed elsewhere in the Mississippi Medicaid Provider Manual, bulletins, or other Mississippi Medicaid publications

Eye examinations must be performed by an Optometrist or Ophthalmologist.

Examination for Determination of Refractive State

Refractive errors generally occur in otherwise healthy eyes. The shape of the eye does not refract light properly causing the visual image to be blurred. There are four basic types of refractive errors: Myopia, Hyperopia, Astigmatism, and Presbyopia.

DOM covers examination for refractive errors as follows:

Benefit	Limitations	Prior Authorization
Exam for Determination of Refractive State (CPT 92015)	**Beneficiary Age 21 And Over:** Allowed one (1) eye exam every fiscal year. The exam counts toward the twelve (12) office visits.	NO
	Beneficiary Under Age 21: Allowed one (1) eye exam every fiscal year. The exam counts toward the twelve (12) office visits.	NO

Fiscal year is defined as July 1 through June 30.

Providers must use CPT 92015 to bill for examinations performed to determine refractive state.

Medically Necessary Diagnostic Services

Medically necessary diagnostic services that aid in the evaluation, diagnosis, and or treatment of ocular disease or injury are covered for all beneficiaries regardless of age. **Coverage is limited to the eye examination**. The exam counts toward the twelve (12) office visits. Providers must bill using the appropriate Ophthalmology CPT codes for new and established patients.

Screening Services for Children Under Age Twenty-One

Vision screening services for beneficiaries under age twenty-one (21) are available through the Early and Periodic, Diagnosis and Treatment (EPSDT) Program. Refer to the EPSDT Manual.

Coverage Criteria

DOM covers eyeglasses prescribed by an Ophthalmologist or Optometrist when documentation supports the following:

- Eyeglasses are medically necessary, **and**
- Eyeglasses are prescribed to significantly improve vision or correct a medical condition, **and**
- Eyeglasses meet eyeglass program specifications for frames and lenses.

Coverage Benefits/ Limitations

Benefit	Limitations	Prior Authorization
Eyeglass Lenses and Frames	**Beneficiary Age 21 And Over:** Allowed one (1) complete pair of eyeglasses every five (5) years.	NO **Exception**: Manually priced codes
	Beneficiary Under Age 21: Allowed one (1) complete pair of eyeglasses every fiscal year.	NO **Exception**: Manually priced codes
Eyeglass Repair and/or Replacement	**Beneficiary Age 21 And Over:** Repairs/Replacements are **not** covered	Not Applicable
	Beneficiary Under Age 21: Repairs/Replacements within the fiscal year are covered when medically necessary.	First pair of replacement glasses does not require PA; any additional pairs require PA. **Exception**: Manually priced codes

Prescriptions

Prescriptions for eyeglass lenses must include lens specifications such as lend, type power, axis, prism, absorptive power, and impact resistance.

Prescriptions for lens coating must include ICD-9 diagnosis and/or narrative diagnosis. Coverage for lens coating is limited. Refer to Lens Coating section in this manual section.

Lenses

Lenses may be glass or plastic. All lenses must meet FDA impact resistant regulations.

Frames

Only standard frames (V2020) are covered. Deluxe frames (V2025) are **not** covered. Eyeglass frames should be durable ZYL frames (plastic) constructed to be normally resistant to damage or breakage. Wire frames are **not** covered.

Fitting

Fitting is a separate service. Fitting includes measurement of anatomical facial characteristics, the writing of laboratory specifications, and the final adjustment of spectacles to the visual axes and anatomical topography.

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 **not** covered for beneficiaries 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.

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

Prior Authorization

Beneficiaries age twenty-one (21) and over: Prior authorization is **not** required, **except** when billing codes that are manually priced. Replacement and/or repairs are **not** covered.

Beneficiaries under age twenty-one (21): Prior authorization is **not** required for the initial pair of eyeglasses, or the first replacement pair, **except** when billing codes are manually priced. Any additional eyeglasses within the same fiscal year will require prior authorization. Prior authorization is **not** required for repairs.

Information regarding codes that are manually priced may be found by accessing 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.

Providers must submit prior authorization requests on the Eyeglass/Hearing Aid Authorization Form. See the Eyeglass/Hearing Aid Authorization Form section of this manual section.

Documentation

Refer to Section 29.13 Documentation of this manual section.

Definitions

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

DOM will cover tinted lenses, photochromatic lenses, or UV protected lens when medically necessary for the following medical diagnoses and ICD-9 codes only:

- Other disturbances of aromatic amino-acid metabolism: 270.2
- Degeneration of macula and posterior pole: 362.5 – 362.57
- Pigmentary retinal dystrophy: 362.74
- Cataract: 366.0 – 366.9
- Keratitis: 370.0 – 370.9
- Corneal opacity and other disorders of cornea: 371.0-371.9
- Disorders of conjunctiva: 372.0-372.9
- Aphakia: 379.31
- Congenital Aphakia: 743.35
- Aniridia: 743.45

- Pseudophakos: V43.1

Coverage Exclusions

- Scratch resistant coating
- Antireflective coating
- Mirror coating
- Polarized coating
- ICD-9 diagnoses other than those listed under 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 29.13 Documentation, of this manual section.

The Division of Medicaid does not cover contact lenses when prescribed for routine correction of refractive errors.

Coverage Criteria

The Division of Medicaid will cover contact lenses prescribed by an ophthalmologist or an optometrist when there is documentation that supports the following criteria:

- Conventional eyeglasses will not result in acceptable visual correction, **and**
- Contact lenses are medically necessary for the treatment of disease or injury to the eye as specified in the table below.

Diagnosis/Condition	Beneficiary Under Age 21	Beneficiary Age 21 and Older
Keratoconus	Covered	Covered
Keratoglobus	Covered	Covered
Irregular cornea astigmatism	Covered	Covered
Regular cornea astigmatism, 3.5 dopters or greater	Covered	Not Covered
Nystagmus	Covered	Covered
Progressive myopia over 3 .5 diopters where contact lens will improve visual acuity or retard the progressive myopia and lessen the frequency of prescription change.	Covered	Covered
Hyperopia over 3.5 diopters where contact lenses will improve visual acuity.	Covered	Covered
Anisometropia greater than 3 diopters or greater than 2.5 if there is documented intolerance to glasses as a result of anisometropia.	Covered	Covered
Post-operative cataract surgery. Refer to section 29.09.	Covered	Covered
Treatment as a result of eye surgery, other than cataract, when provided within six (6) months of the surgery	Covered	*Covered

Corneal Bandages

DOM does not cover separate reimbursement for lenses used as corneal bandages. The cost of the lenses is included in the payment for the physician and/or facility's service. Providers should bill using CPT 92070. Prior authorization is required.

Prescriptions

Prescriptions for contact lenses must include lens specifications such as power, size, curvature, flexibility, and gas-permeability.

Prescriptions for lens coating must include ICD-9 diagnosis and/or narrative diagnosis. Coverage for lens coating is limited. See Section 29.07.

Lost or Stolen Lenses

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

Replacement of lost or stolen contact lenses is covered for beneficiaries under age twenty-one (21).

Prior Authorization

Prior authorization is required for all contact lenses. Providers must submit prior authorization requests on the Eyeglass/Hearing Aid Authorization Form. See Section 29.11. The request must properly document that one of the diagnoses listed under coverage criteria is involved, and it must reflect that conventional eyeglasses would not be an acceptable method of correction.

Documentation

Refer to Section 29.13 Documentation of this manual section.

Coverage Criteria

The Division of Medicaid covers eyeglasses (frames and lenses) for beneficiaries who have had surgery on the eyeball or ocular muscle. The surgical benefit will be applied regardless of whether the beneficiary has received eyeglasses during the benefit period when all of the following criteria are met:

- Surgery results in a vision change, **AND**
- Eyeglasses are medically indicated within six (6) months of the surgery, **AND**
- Eyeglasses are prescribed by an Optometrist or Ophthalmologist.

Beneficiaries who undergo multiple surgeries (Example: cataract surgery) will be eligible for the benefit following each surgery if all criteria is met.

Beneficiaries who experience refractive changes **after** the six (6) month post surgical period are subject to the eyeglass benefit limitations set forth in Section 29.06.

Exclusions

The Division of Medicaid does **not** cover refractive surgery including, but not limited to, Lasik surgery, radial keratotomy, photorefractive keratectomy, and astigmatic keratotomy. Beneficiaries who undergo these procedures will **not** receive the surgical benefit described above. Beneficiaries who need eyeglasses following any of these surgeries are subject to the eyeglass benefit limitations set forth in Section 29.06.

Providers must adhere to policies found in other sections of this manual.

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.

Prior Authorization

Prior authorization is **not** required.

Documentation Requirements

Refer to Section 29.13 Documentation of this manual section.

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
Suite 801, Robert E. Lee Bldg.
239 N. Lamar St.
Jackson, MS 39201-1399

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.

Medicare generally does not cover routine examination, eyeglasses, or contact lens. However, Medicare does cover some preventive eye tests and screening. In addition, Medicare reimburses for cataract glasses, contact lenses, or intraocular lenses following cataract surgery. Providers should refer to Medicare policy for coverage information.

Mississippi law requires providers participating in the Medicaid program to determine if a beneficiary is covered by a third party source, and to file and collect all third party coverage prior to billing Medicaid. This includes beneficiaries who are Medicare/Medicaid (dual) eligible. Refer to Section 6.03 of the Provider Policy Manual.

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.

Dual eligible beneficiaries may not be billed the balance between standard and deluxe frames as the Medicare and Medicaid payment is considered payment in full.

All professional and institutional providers participating in the Medicaid program are required to maintain legible, accurate, and complete records that disclose and justify the services rendered and billed under the program and upon request, make these records available to representatives of DOM for substantiation of any or all claims. Documentation supporting the medical necessity of Medicaid claims should be maintained a minimum of five (5) years in compliance with state and federal regulations and laws.

In order for DOM to fulfill its obligation to verify services rendered to Medicaid beneficiaries and those paid for by Medicaid, the provider must maintain auditable records that will substantiate the claim submitted to Medicaid. DOM, the UM/QIO, and/or the fiscal agent have the authority to request patient records at any time to conduct a random review and/or documentation of services billed by the provider.

General Documentation Requirements

At a minimum, Vision medical record documentation must contain the following on each patient:

- Date(s) of service
- Demographic information (Example: name, Medicaid number, date of birth, etc.);
- Current medical history;
- Examination and/or treatment rendered;
- Specific name/type of all diagnostic studies (Example: laboratory, radiology, etc.) and the result/finding of the studies;
- Provider's signature or initials.

Medical Necessity Documentation Requirements

In addition to the general requirements, documentation must support medical necessity based on the criteria in individual coverage sections of this manual.

Lenses/Lens Coating Documentation Requirements

In addition to the general requirements, documentation must support medical necessity based on the criteria in individual coverage sections of this manual.

- Orders and prescriptions for eyeglasses lenses must include lens specifications such as lens type, power, axis, prism, absorptive factor, and impact resistance.
- Orders/prescriptions for contact lenses must include lens specifications such as power, size, curvature, flexibility, and gas permeability.
- Orders and prescriptions for lens coating must include ICD-9 diagnosis and/or narrative diagnosis.

If the provider rendering the service is other than the ordering/referring provider, the provider rendering the service must maintain hard copy documentation of the ordering/referring provider's prescription for a minimum of five (5) years. The prescription must include all specifications noted above.

Nonsubstantiated Services

DOM, the UM/QIO, and/or the fiscal agent have the authority to request any patient records at any time to conduct a random sampling review and/or document any services billed by the vision provider. If the provider's records do not substantiate services paid for under the Mississippi Medicaid program, as previously noted, the provider will be asked to refund is not received within thirty (30) days, a sum equal to the amount paid for such services will be deducted from any future payments that are deemed to be due the provider.

A vision provider who knowingly or willfully makes or causes to be made, a false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments may be prosecuted under federal and state criminal laws. A false attestation can result in civil monetary penalties as well as fines, and may automatically disqualify the provider as a provider of Medicaid services.