WYOMING MEDICAID VISION SERVICES 2017

April Wickham- Medicaid Vision Services Manager

Elisa Mauch- Provider Relations Supervisor

Chapter 24.22 Vision Services

- Vision and dispensing services are benefits for client's ages 0-20.
- Vision services for clients 21 and older are **only** reimbursable for the treatment of eye disease or eye injury based on the appropriate ICD diagnosis code and client records must support billing of any vision services.
- Routine eye exams and/or glasses are **not** a covered benefit for clients 21 and older.

  NOTE: Wyoming Medicaid will pay the deductible and/or coinsurance due on Medicare crossover claims for post-surgical contact lenses and/or eyeglasses, up to the Medicaid allowable.

- A licensed ophthalmologist, optometrist, or optician, within the Scope of the Practice Act within their respective profession, may provide vision services and dispensing services.

EYE EXAMS

For children, ages 0-20:

Eye exams determine visual acuity and refraction, binocular vision, and eye health.

92002-92004 - New patient eye exams are a covered benefit for clients who are new to the provider's practice.

92012-92015 - Established patient eye exams are a covered benefit once in a 365 day period unless there is medical necessity to support an additional exam.

EYE EXAMS

For adults, 21 years and older:

Eye exams to diagnose an eye disease or eye injury <u>ONLY</u>.

92002-92004 - New patient eye exams are a covered benefit for clients who are new to the provider's practice.

92012-92014 - Established patient eye exams are a covered benefit once in a 365 day period unless there is medical necessity to support an additional exam.

*Routine eye exam are not covered for adult clients. Do not bill for routine eye exams for clients 21 years and older. Exam codes may pay, and then upon audit, be taken back as Medicaid abuse recovery. These codes are not limited by diagnosis at this time and should only be billed when medical necessity can be documented to show an eye disease or injury.

EYE EXAMS

Office visits for the treatment of eye disease or eye injury.

99201-99215 – May be billed by ophthalmologists for office exams.

Documentation: Eye care provider records must reflect medical necessity and include interpretation and report, as appropriate, of the procedure.

92018-92065, 92081-92226, 92230-92287 - Special Ophthalmological Services should be performed only when medically necessary. (92283 requires a PA)

EYEGLASSES/MATERIALS

For Children ages 0-20:

- One (1) pair of eyeglasses is covered per 365 days
- **V2020** – Standard frames are covered up to $73.49. The provider may not "balance bill" the client for frames that cost more than the allowable amount.

NOTE: Balancing billing example – When the client selects $120 frames and Medicaid allows up to $73.49 then the optometrist should either, mutually agree in writing with the client that the client is responsible for the payment of the frames ($120), or, the provider may bill Medicaid for $73.49 and accept this payment as payment in full for the frames.

COVERED LENSES

- **V2100-V2121** (**V2199** requires prior authorization) – Single lenses
- **V2200-V2221** (**V2299** requires prior authorization) – Bifocal lenses
- **V2300-V2321** (**V2399** requires prior authorization) – Trifocal lenses
- **V2410-V2430** (**V2499** requires prior authorization) –High Index Aspheric lenses
- **V2784** – Polycarbonate lens (billed as an add on to a standard C-39 lens)

HIGH INDEX ASPHERIC LENSES

Aspheric lenses will only be covered when medically necessary and when they meet the following guidelines listed below:

- When the power in the highest meridian is - (minus) 6 diopters or more. For example:

  A spectacle prescription of -2.00 -4.00 x 180 -4.00 + -2.00 = -6.00. This Rx would qualify

  A spectacle prescription of -2.00 +5.00 x 180 -2.00 + +5.00 = +3.00. This Rx would not qualify for high index aspheric material

- When the power in the highest meridian is + (plus) 4.00 diopters or more. For example:

  A spectacle prescription of -2.00 -4.00 x 180 -4.00 + -2.00 = -6.00. This Rx would qualify

  A spectacle prescription of -2.00 + +5.00 = +3.00.
  This Rx would not qualify for a high index aspheric material

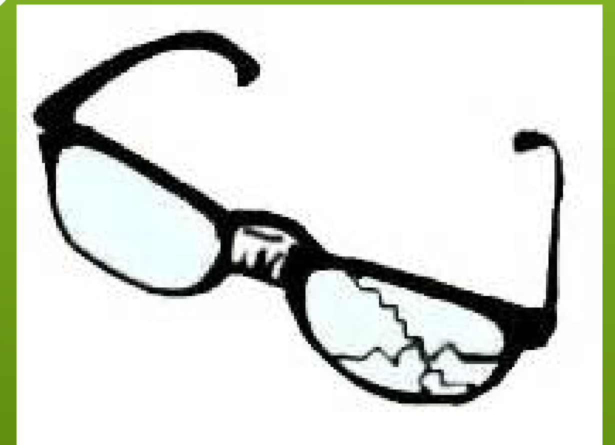
REPLACEMENTS

Medicaid will allow one (1) replacement of lenses and frames within the 12 month period if:

- There is a change in the prescription for the lenses, (please use the existing frames if possible).
- Eyeglasses are lost or broken beyond repair – This will require documentation stating it was not due to blatant abuse or neglect

NOTE: The provider needs to submit an electronic claim and attach necessary documentation of medical necessity to substantiate why the replacement glasses are needed. The claim will then be reviewed and processed if criteria is met.

- Repair of eyeglasses may be billed upon expiration of the warranty



REIMBURSEMENT

Obtain eligibility information from Medicaid prior to placing order for eyewear

- Verify with client and Provider Relations (1-800-251-1268) if the benefit has been used in the past year
- Deliver glasses in a reasonable amount of time (typically within a week or two from the order date)
- Verify client eligibility for the date of delivery
- Bill Medicaid on the delivery date of the glasses. The date of delivery must be used as the date of service on a claim.
- If the client does not return to receive their glasses, the glasses should be mailed to the client and the mail date used as the date of service.

NOTE: If the client is not eligible on the delivery date, does not return for the delivery, or the mailed glasses are returned to the provider, the provider may only bill the glasses on the order date if they have a signed "Order vs Delivery Date Exception Form" from Medicaid.

ORDER VS DELIVERY DATE EXCEPTION FORM (EFFECTIVE 4/1/17)

Wyoming Medicaid will allow a provider to bill using the order date of glasses only if one of the following conditions are present:

1. Client is not eligible on the delivery date but were eligible on the order date
2. Client does not return to the office for pick-up of glasses **AND** the glasses were mailed but have been returned to sender for "not deliverable"

A provider may use the order date as the date of service only if they have obtained a sign exception form from the State. Below is the required process:

1. Print the "Order vs Delivery Date Exception From" from http://wyequalitycare.acs-inc.com
2. Complete the form and fax or mail the form to the address at the bottom of the form
3. Once the form is signed by the State, it will be returned to the provider and must be a part of the client's permanent, clinical, record.
4. The provider may then bill the claim using the order date as the date of service.

NOTE: If an audit of clinical records is performed, and it is found that the provider billed on the order date but does not have a signed "Order vs Delivery Date Exception Form" for the client and DOS, the money paid will be recovered.

CONTACT LENSES

For Children, ages 0-20:

- **V2500-V2599** – Contact lenses require prior authorization (PA) and documentation provided must show medical necessity and state why the client's vision cannot be corrected with eyeglasses. (6.14 Prior Authorizations)
- Contact lenses will be reimbursed at the cost of invoice, plus shipping and handling, plus 15% (6.15, Submitting Attachments for Electronic Claims).
- **92072** – Fitting of contact lens does not require PA, however, should only be billed when PA has been obtained for the lens.

▶ PA FORM

Prior Authorization Request
To Avoid Delays – Please fill out Completely

☐ ADD
☐ MODIFY
☐ CANCEL

PATIENT INFORMATION

1. DOB	2. AGE	3. MEDICAID ID #
Enter Date of Birth	Enter Age	Enter Medicaid ID #

4. PATIENT NAME (Last, First, MI): Enter Last Name, First Name, MI

PROVIDER INFORMATION

5. PAY-TO PROVIDER NPI #	6. TAXONOMY
Enter Provider NPI	Enter Provider Taxonomy

7. PAY-TO PROVIDER NAME: Enter Pay-to Provider Name

8. STREET ADDRESS: Enter Physical Address

9. CITY, STATE, ZIP CODE: Enter City, State, Zip Code

10. TELEPHONE	11. CONTACT NAME
Enter Phone Number	Enter Contact Name

SERVICE INFORMATION

12. PROPOSED DATES OF SERVICE	12a. FROM	12b. TO
	Enter Service "From" Date	Enter Service "To" Date

13. SERVICE DESCRIPTION	14. PROC CODE	15. MODIFIER(S)	16. UNITS	17. ESTIMATED COST	18. TREATING PROVIDER NPI NUMBER
Enter Service Description					Enter Treating Provider NPI Number
Enter Service Description					Enter Treating Provider NPI Number
Enter Service Description					Enter Treating Provider NPI Number
Enter Service Description					Enter Treating Provider NPI Number

19. PLEASE ATTACH SUPPORTING DOCUMENTATION SHOWING MEDICAL NECESSITY
Applicable documentation must be supplied in sufficient detail to satisfy the medical necessity for the prescribed service. Additional documentation may be attached when necessary.

20. PLEASE NOTE BELOW WHICH MODIFICATIONS ARE REQUESTED

21. TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS TRUE, ACCURATE AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND NECSSARY TO THE HEALTH OF THE PATIENT.

SIGNATURE OF PROVIDER: **DATE:**

22. PENDING AUTHORIZATION GIVEN BY	22a. DATE	22b. PRIOR AUTHORIZATION #
Enter Who Provided Pending PA Number	Enter Date	Prior Authorization #

AUTHORIZATION (FOR FISCAL AGENT USE ONLY)

AUTHORIZATION IS VALID FOR SERVICES	FROM DATE	TO DATE	PRIOR AUTHORIZATION #

COMMENTS / EXPLANATION

WYOMING MEDICAID Attn: MEDICAL POLICY • PO BOX 667• CHEYENNE, WY 82003-0667
1-800-251-1268 •• FAX: (307) 772-8405

Rev. 7/2014

VISION THERAPY

Procedure Code: 92065, 99070

Vision therapy is a sequence of activities individually prescribed and monitored by the doctor to develop efficient visual skills and processing. It is prescribed after a comprehensive eye examination has been performed and has indicated that vision therapy is an appropriate treatment option. The vision therapy program is based on the results of standardized tests, the needs of the patient, and the patient's signs and symptoms.

Research has demonstrated vision therapy can be an effective treatment option for individuals under the age of 21 or individuals with Acquired Brain Injury:

- Ocular motility dysfunctions (eye movement disorders)
- Non-strabismic binocular disorders (inefficient eye teaming)
- Strabismus (misalignment of the eyes)
- Amblyopia (poorly developed vision)
- Accommodative disorders (focusing problems)
- Visual information processing disorders, including visual-motor integration and integration with other sensory modalities.

VISION THERAPY

92065 – Vision Therapy can be billed for clients under the age of 21 and clients eligible for the Acquired Brain Injury Waiver benefit plan with a qualifying medical diagnosis (See manual for diagnosis codes)

- When administered in the office under the guidance of a practitioner.
- It requires a number of office visits and depending on the severity of the diagnosed conditions
- The length of the program typically ranges from several weeks to several months
- Activities paralleling in-office techniques are typically taught to the patient to be practiced at home to reinforce the developing visual skills
- Vision therapy visits are capped at 32 per 365-days for treatment of ICD diagnosis

*Additional visits or exceptions to these diagnosis codes will be considered on a case by case basis only

99070 - Vision Therapy training aids will be reimbursed at cost of invoice. Invoices must be submitted with documentation of medical necessity to Medial Policy (2.1, Quick Reference) for consideration (6.15, Submitting Attachments for Electronic Claims)

ADDITIONAL SERVICES

- **V2627** – Scleral cover shell requires prior authorization all ages(6.14 Prior Authorizations)
- **V2623, V2629** - Prosthetic eye requires prior authorization all ages (6.14 Prior Authorizations)

RESOURCES

- Provider Manuals and Bulletins
  - Click on Provider / Provider Manuals and Bulletins / Select Provider Type
- Fee Schedule
  - Click on Provider / Fee Schedules / Accept / Procedure Code Search Page
    - CMS NCCI Tables
    - Procedure Code Searches
    - Dental Fee Schedule
    - OPPS/APC-Base Fee Schedule
- IVR Navigation Tips
  - Helps to direct providers to the appropriate options for each department
  - Click on Provider / Contact Us / Click here for helpful Provider IVR Navigation Tips
- Remittance Advice Retrieval
  - From the Secure Provider Web Portal
- Medicaid State Healthcare Benefit Plan Document
  - Click on Provider / Provider Manuals and Bulletins / Additional Links
- IVR 1.800.251.1268
  - 24 Hours a day / 7 days per week
  - NPI is required

RESOURCES CONTINUED

IVR Functionality

- Verify client eligibility
  - Client ID or client SSN and date of service is required
  - Benefit plan
    - Covered Services
    - Limitations
  - Cap Limits
  - Lock-in
  - TPL / Medicare Buy-in
- Verify claim status
- Verify payment
- Opt out to agent

Provider Relations 1.800.251.1268 (Option 1, 5, 0)

- 9-5 MST Monday – Friday
- Bulletin/Manual inquiries
- Cap Limits
- Claim inquiries
- Claim submission problems
- Client eligibility
- Questions on completing forms
- Payment inquiries
- Verifying validity of procedure codes

RESOURCES CONTINUED

Fax Number

- 307.772.8405

EDI Services 1.800.672.4959 (Option 3)

- 9-5 MST Monday – Friday
- EDI Enrollment Form
- Trading Partner Agreement
- WINASAP Software & Technical Support for WINASAP
- Technical Support for Vendors, Billing Agents, and Clearinghouses
- Provider Web Portal Registration
- Technical Support for Provider Web Portal & Password Resets

QUESTIONS?