MISSISSIPPI DIVISION OF
MEDICAID

Administrative Code

Title 23: Medicaid
Part 217
Vision Services

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Title 23: Division of Medicaid

Part 217: Vision Services

Part 217 Chapter 1: General

Rule 1.1: Vision Services

Vision service is an optional benefit under the state's Medicaid program and financial assistance is provided as follows:

A. Eyeglasses for all Medicaid beneficiaries who have had surgery on the eyeball or ocular muscle that results in a vision change for which eyeglasses are medically indicated within six (6) months of the surgery and is in accordance with rules established by Medicaid, or

B. One (1) pair of eyeglasses every five (5) years and in accordance with rules established by Medicaid. In either instance, the eyeglasses must be prescribed by a physician skilled in diseases of the eye or an optometrist, whichever the beneficiary selects.

C. Eye exams for all eligible beneficiaries are covered.

Source: Miss. Code Ann. § 43-13-121; 43-113-117(11); 42 CFR 441.30

Rule 1.2: Provider Enrollment

A. Providers of vision services, and those who dispense optical items such as eyeglasses and contacts must satisfy all requirements set forth in Part 200, Chapter 4, Rule 4.8 in addition to the following provider type specific requirements:

    1. National Provider Identifier (NPI), verification from National Plan and Provider Enumeration System (NPPES),

    2. Copy of licensure card or letter from the appropriate board stating current certification. Card or letter must be from state of servicing location, and

    3. Verification of social security number using a social security card, driver's license if it notes the social security number, military ID or a notarized statement signed by the provider noting the social security number. The name noted on verification must match the name noted on the W-9.

B. Written confirmation from the IRS confirming the provider's tax identification number and legal name.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 455, Subpart E

Rule 1.3: Reimbursement

A. Medicaid covers vision services under 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 the actual acquisition cost (AAC) for the frames and lenses. Medicaid will cover the frames and lenses based on the lower of AAC or the maximum fee as determined by Medicaid.

B. Medicaid does not permit providers of optometric services to charge a beneficiary an additional amount for services or supplies, like frames, above the fee established. The provider cannot dispense a more expensive frame than is covered under the Medicaid program and collect the difference from the beneficiary.

C. A beneficiary may purchase non-covered services, like scratch resistant lens coating. Providers cannot 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.

Source: Miss. Code Ann. § 43-13-121

Rule 1.4: Non-Covered Services

A. The Division of Medicaid does not cover vision services including, but not limited to, eye exams, eyeglasses, frames, lenses, and/or contact lenses, for beneficiaries enrolled in the Family Planning Waiver (FPW).

B. The Division of Medicaid does not cover the following including, but not limited to:

1. Eyeglasses solely for protective, fashion, cosmetic, sports, occupational or vocational purposes,

2. More than one (1) pair of eyeglasses every five (5) years,

3. Single vision eyeglasses in addition to multifocal eyeglasses,

4. Progressive bifocals,

5. Sunglasses,

6. Upgraded frames,

7. Eyeglass cases,

8. Engraving,

9. Contact lens supplies and/or solutions,

10. Eyeglass or contact lens insurance,

11. Lens coating, unless specified by a Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid, or designated entity,

12. Orthoptics,

13. Dispensing fees,

14. Contact lenses, unless specified by a UM/QIO, the Division of Medicaid, or designated entity,

15. Refractive surgery including, but not limited to, Lasik surgery, radial keratotomy, photorefractive keratectomy, and/or astigmatic keratotomy,

16. Services and items requiring prior authorization for which authorization has been either denied or not requested, or

17. Replacement of lenses or frames due to:

    a) Provider error in prescribing, frame selection, or measurement, or

    b) Poor workmanship and/or materials.

Source: 42 CFR §§ 435.116, 441.30; Miss. Code Ann. §§ 43-13-117, 43-13-121; SPA 13-0019; Healthier Mississippi Waiver.

History: Revised to correspond with SPA 13-0019 (eff. 01/01/14) and Healthier Mississippi Waiver (HMW) Renewal (eff. 07/24/2015) eff. 04/01/2016.

Rule 1.5: Eye Examinations/Refractions

A. Medicaid requires eye examinations/refractions to be performed by an optometrist or an ophthalmologist. Medicaid covers for one (1) refraction every five (5) years. No prior authorization is required. The appropriate procedure code must be billed.

B. Medicaid covers medically necessary diagnostic services that aid in the evaluation, diagnosis, and or treatment of ocular disease or injury 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 procedure codes for new and established patients.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 441.30

Rule 1.6: Lacrimal Punctum Plugs

A. Medicaid covers medically necessary insertion of collagen and silicone punctum plugs when there is a documented diagnosis consistent with moderately severe to severe dry eye syndrome. A signed treatment/surgical consent form, specific to plug insertion, is required.

B. Medicaid does not cover the following:

1. Insertion of silicone plugs less than ten (10) days following collagen plug insertion,

2. Insertion of plugs for the treatment of any condition other than dry eye syndrome, contact lens intolerance, refractive correction, glaucoma, or sinus maladies,

3. Repetitive use of temporary or dissolvable collagen plugs when semi-permanent or permanent treatment is indicated,

4. Repetitive use of semi-permanent or non-dissolvable silicone plugs when there is an absence of documentation to support the need, such as plug fell out, and/or when permanent treatment is indicated, or

5. Separate reimbursement for the plug itself or when the cost of the plug is included in payment for the insertion.

C. Medicaid covers up to two (2) collagen or silicone plugs per office visit. In most cases, placement of one (1) plug in each lower punctum is sufficient to alleviate symptoms. Up to two (2) additional plugs may be performed for a total of four (4), but documentation must reflect that the additional plugs were medically necessary. There must be a period of no less than ten (10) days between the insertion of collagen plugs and the insertion of silicone plugs.

D. Providers must use the appropriate procedure code in conjunction with the appropriate and applicable modifier for each plug is placed into a punctum.

E. There may be both a diagnostic occlusion with a temporary dissolvable collagen plug and a therapeutic occlusion with a semi-permanent, non-dissolvable silicone, plug performed on the same beneficiary within a short amount of time. Medicaid does not cover if the length of time between insertion of collagen and silicone plugs is less than ten (10) days.

F. Medicaid requires documentation of the following for insertion of lacrimal punctum plugs:

1. Symptoms, including dryness, scratchiness, itching, redness, burning, foreign body sensation,

2. Comorbidities that might be related to ophthalmic disease,

3. Diagnostic tests and results, including visual acuity exam, slit lamp exam, tear film break-up time (BUT), Schirmer's tear test, and/or staining procedures,

4. Signed treatment/surgical consent form(s) specific to insertion of the plug,

5. Specific treatments rendered, including conservative treatments, and the results, and

6. Operative report(s).

G. Documentation must be sufficient to support the type, either temporary or semi-permanent, and the number of plugs inserted. Documentation must reflect a minimum of ten (10) days between insertion of temporary plugs and the insertion of semi-permanent plugs.

Source: Miss. Code Ann. § 43-13-121

Rule 1.7: Documentation

Records must be documented and maintained in accordance with Part 200, Chapter 1, Rule 1.3. The vision medical record documentation must contain the following on each beneficiary:

A. Date(s) of service,

B. Demographic information,

C. Current medical history,

D. Examination and/or treatment rendered,

E. Specific name/type of all diagnostic studies, and the result/finding of the studies,

F. Specific order for all lenses, lens coating, and ocular prosthetics, and

G. Provider's signature.

Source: Miss. Code Ann. § 43-13-121; 43-13-117; 43-13-118; 43-13-129

Rule 1.8: Dual Eligibles

A. Medicare covers vision services provided to dual eligible beneficiaries, in accordance with the rules outlined in this Part, for services not covered by Medicare when the reason for the Medicare denial is other than medical necessity.

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

C. Providers must adhere to the rules for Third Party billing outlined in Part 306.

Source: Miss. Code Ann. § 43-13-121

Rule 1.9: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of Title 23, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121

Part 217 Chapter 2: Contact Lenses

Rule 2.1: Coverage Criteria

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

B. Medicaid covers contact lenses prescribed by an ophthalmologist or an optometrist when there is documentation that supports the following criteria:

1. Conventional eyeglasses will not result in acceptable visual correction, and

2. Contact lenses are medically necessary for the treatment of the following diseases or injury to the eye:

a) Keratoconus,

b) Keratoglobus,

c) Irregular cornea astigmatism,

d) Nystagmus,

e) Progressive myopia over 6 diopters, where contact lens will improve visual acuity or retard the progressive myopia and lessen the frequency of prescription changes,

f) Hyperopia over 3.5 diopters, where contact lenses will improve visual acuity,

g) Anisometropia greater than 3 diopters or greater than 2.5, if there is documented intolerance to glasses as a result of anisometropia,

h) Disease or deformity of the nose, skin, or ears that precludes the wearing of eyeglasses,

i) Post-operative cataract surgery, or -

j) Treatment as a result of eye surgery, other than cataracts, which must be provided within six (6) months of the surgery to be covered.

C. Corneal bandages when used as lenses are not covered as a separate reimbursement. The cost of the lenses is included in the payment for the physician and/or facility's service. Providers should bill using the appropriate procedure code. Prior authorization is required.

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

E. Medicaid does not cover for replacement of lost or stolen contact lenses.

F. Prior authorization is required for all contact lenses**.** The request must properly document that one (1) of the diagnoses listed under coverage criteria is involved, and it must reflect that conventional eyeglasses is not an acceptable method of correction.

Source: Miss. Code Ann. § 43-13-121

Rule 2.2: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of Title 23, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121

Part 217 Chapter 3: Eyeglasses

Rule 3.1: Coverage Criteria

A. Medicaid covers eyeglasses prescribed by an ophthalmologist or optometrist when documentation supports the following:

    1. Eyeglasses are medically necessary,

    2. Eyeglasses are prescribed to significantly improve vision or correct a medical condition, and

    3. Eyeglasses meet eyeglass program specifications for frames and lenses.

B. Coverage benefits/limitations include:

    1. Beneficiaries are allowed one (1) complete pair of eyeglasses every five (5) years. Prior authorization is not required unless manually priced codes are used. This includes eyeglass lenses and frames.

    2. Repairs and replacements are not covered.

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

D. Prescriptions for lens coating must include the appropriate diagnosis codes and/or narrative diagnosis.

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

F. Only standard frames with the appropriate code are covered. Deluxe frames are not covered. Eyeglass frames should be durable and constructed to be normally resistant to damage or breakage to minimize the need for replacement.

G. Fitting is a separate service and is covered. 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.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(1)

Rule 3.2: Lens Coating

A. For purposes of this rule the following definitions will apply:

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

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

    3. Scratch resistant coating is applied to a lens that helps retard crazing of the lens, thus extending the product life.

    4. Tint is an 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.

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

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

    7. UV coating is applied to a lens to filter out ultraviolet light.

B. Medicaid covers tinted lenses, photochromatic lenses, or UV protected lens when medically necessary for the following medical diagnoses:

    1. Other disturbances of aromatic amino-acid metabolism,

2. Degeneration of macula and posterior pole,

3. Pigmentary retinal dystrophy,

4. Cataracts,

5. Keratitis,

6. Corneal opacity and other disorders of cornea,

7. Disorders of conjunctiva,

8. Aphakia,

9. Congenital Aphakia,

10. Aniridia, and

11. Pseudophakos.

C. Non-covered services include:

1. Scratch resistant coating,

2. Antireflective coating,

3. Mirror coating,

4. Polarized coating, and

5. Diagnoses other than those listed under coverage criteria.

D. Prescriptions for lens coating must include the appropriate diagnosis code and/or a narrative diagnosis.

E. A beneficiary may purchase non-covered lens coating services. Charges for non-covered services must not be billed to Medicaid.

F. Documentation must comply with the requirements for maintenance of records set forth in Part 200, Chapter 1, Rule 1.3 in addition to following documentation specific to lenses and lens coating:

1. Orders and prescriptions for eyeglass lenses must include lens specifications such as lens type, power, axis, prism, absorptive factor, and impact resistance.

2. Orders and prescriptions for contact lenses must include lens specifications such as power,

size, curvature, flexibility, and gas permeability.

3. Orders and prescriptions for lens coating must include appropriate diagnosis and/or narrative diagnosis.

Source: Miss. Code Ann. § 43-13-121; 43-13-117; 43-13-118; 43-13-129

Rule 3.3: Cataract/Ocular Surgery

A. Medicaid covers eyeglasses, including the 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:

   1. Surgery results in a vision change,

   2. Eyeglasses are medically indicated within six (6) months of the surgery, and

   3. Eyeglasses are prescribed by an optometrist or ophthalmologist.

B. Beneficiaries who undergo multiple surgeries will be eligible for the benefit following each surgery if all criteria is met.

C. Beneficiaries who experience refractive changes after the six (6) month post-surgical period are subject to the eyeglass benefit limitations.

D. Medicaid does not cover refractive surgery including, but not limited to:

   1. Lasik surgery,

   2. Radial keratotomy,

   3. Photorefractive keratectomy, or

   4. Astigmatic keratotomy.

E. Beneficiaries who undergo the procedures listed in Rule 3.3 D above cannot receive the surgical benefit. Beneficiaries who need eyeglasses following any of these surgeries are subject to the eyeglass benefit limitations.

Source: Miss. Code Ann. § 43-13-121; 43-13-117(11)

Rule 3.4: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of Title 23, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121