Fee-for-Service Vision
Agenda

- Reference materials
- IHCP Provider Healthcare Portal
- Coverage
- Secondary claims on the IHCP Provider Healthcare Portal
- Reminder
- Helpful tools
- Questions
Reference materials
Reference materials

Stay informed…

- *Banner Pages and Bulletins*
- News and Announcements
- Email notifications
- Code sets
- Professional Fee Schedule
- *Medical Policy Manual*
- *Vision Services provider reference module*
IHCP MAKES PROVIDER RESOURCES AND INFORMATION EASY TO ACCESS

The Indiana Health Coverage Programs (IHCP) offers providers easy access to the resources and tools needed to conduct business with Indiana Medicaid. Provider updates and announcements, important reference materials, and general program information are all available through links and web pages located on this website. The Provider Healthcare Portal, which serves as the primary online interface for provider business transactions with the IHCP and the State’s CoreMMIS Information processing system, is also accessible from this site.

NEWS AND ANNOUNCEMENTS

- **08/27/2019** - Based on Centers for Disease Control and Prevention (CDC) influenza vaccine recommendations, the IHCP will reimburse for live attenuated influenza vaccine (LAIV) in the 2018-2019 flu season. This reimbursement policy change applies to all IHCP programs, subject to limitations established for certain benefit packages. The change applies to LANV (FluMist) vaccines billed as a medical service or a pharmacy service.

- **Temporary change in scheduling NEMT services applies ONLY to designated facility provider types**

  08/31/2019 - The IHCP recently released BT201945 concerning a temporary return to nonbrokered NEMT services for FFs members in specific types of facilities. Affected facilities are still required to contact Southeasterns to receive a Trip Leg ID during this temporary period. The IHCP encourages providers to carefully read the entire bulletin.

- **DXC email addresses changing from @HPE to @DXC September 18, 2018**

  08/30/2018 - By September 18, 2018, all HPE email addresses (123456@hpe.com) will change to DXC email addresses
Reference materials
Vision Services provider reference module

Reimbursement Requirements for Vision Services
Prior Authorization for Vision Services
Coverage and Billing for Vision Services
  Vision Procedures Limited to One Unit
  Eye Examinations
  Orthoptic or Pleoptic Training, Vision Training, and Therapies
  Lenses
  Frames
  Replacement Eyeglasses
  Corneal Tissue
  Intraocular Lenses
  Triamcinolone Acetonide
  Intraocular Stents
  Retisert

Vision Benefit Limits
  Written Correspondence
  Billing a Member for Services that Exceed Benefit Limits
Reference materials
Vision code sets

Table 1 – Vision Services Code Set for Opticians (Specialty 190)
Table 2 – Vision Services Code Set for Optometrists (Specialty 180)
Table 3 – ICD-10 Diagnosis Codes for Optometrist Billing of Visual Evoked Potential (VEP) Testing
Table 4 – Procedure Codes for Billing Intraocular Stents Inserted in Conjunction with Cataract Surgery
### IHCP Professional Fee-For-Service Fee Schedule - Search

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Mod 1</th>
<th>Mod 2</th>
<th>Mod 3</th>
<th>Mod 4</th>
<th>Service Category</th>
<th>Service Category Desc</th>
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IHCP Provider Healthcare Portal
What can you do in the Portal?

- Submit, copy, edit, and void claims
- Check status of claims
- Verify eligibility
- View and print Remittance Advises
- Request prior authorization
- Provider enrollment and revalidation
- Secure correspondence
• 6195 – Frames initial or repair/replacement 21 yrs older
• 6196 – Frames initial/replacement, member 21 yrs younger
• 6271 – Lenses initial/replacement, member 21 yrs younger
• 6272 – Lenses initial repair/replacement, member 21 yrs older
• 6297 – Routine vision exam limit to 1/12 months age 0-20
• 6298 – Routine vision exam limit 1/24 months age 21-999

Benefit limitations the member has already met appear on the eligibility screen. If the limitation does not appear, the member is still eligible to receive that service (based on fee-for-service claim data only).
Vision service providers may not have the most current information available about services previously rendered to a member and paid by the IHCP.

- This situation can result in reduced reimbursement or no reimbursement for rendered services.
- Providers may submit secure correspondence through the Portal or write to the Written Correspondence Unit to inquire whether particular members have exceeded their service limitations.
  - Providers should allow up to four business days for a response.
The IHCP provides reimbursement for routine vision services, subject to the following restrictions:

- One routine vision care examination and refraction is covered for members 20 years old and younger, per rolling 12-month period.
- One routine vision care examination and refraction is covered for members 21 years old and older, per rolling 24-month period.

If medical necessity dictates more frequent examinations, documentation of such medical necessity must be maintained in the provider’s office, and prior authorization must be obtained.
Coverage
Routine vision versus medical examinations

When a patient is seen for a medical and routine vision service on the same date, the primary reason for the encounter should be used to determine whether the service falls under the routine or medical benefit.

Example: If the primary reason for the visit was swelling or mass of the eye, but a routine vision exam and refraction were performed, the exam should be coded with the swelling and mass of the eye (medical) diagnosis, and the refraction should be coded with the routine diagnosis.
The prescribing of lenses, when required, is included in the procedure code 92015 – Determination of refractive state:

- It includes specification of lens type, such as:
  - Monofocal
  - Bifocal
  - Lens power, axis, and prism
  - Absorptive factor
  - Impact resistance

- The IHCP does not provide coverage for all lenses:
  - If a member chooses to upgrade to progressive lenses, transitional lenses, anti-reflective coating, or tint numbers other than 1 or 2, the basic lens V code can be billed to the IHCP.
  - The upgrade portion can be billed to the member only if the member was given an appropriate advance notification (signed waiver) of the noncovered service, and if a separate procedure code for the service exists.
Coverage
Frames

Reimbursement is available for frames using V2020 – *Frames, purchase.* Maximum reimbursement for frames is $20, unless medical necessity requires more expensive frames.

Providers that receive payment from the IHCP for frames may not bill the member for any additional cost that exceeds the maximum IHCP reimbursement.
Coverage
Frames

All claims for more expensive frames are billed with V2025 and must be accompanied by:

• Documentation supporting medical necessity – examples:
  – Special frames to accommodate a facial deformity or anomaly
  – Frames with special modifications, such as a ptosis crutch
  – Allergy to standard frame materials
  – Frames for an infant or child where special-size frames that are unavailable for $20 or less must be prescribed

• Manufacturer’s suggested retail price (MSRP) or cost invoice
  – Frames are reimbursed at 75% of the MSRP or 120% of the cost invoice
Coverage
Replacement eyeglasses

- Members younger than 21 years of age may be eligible for a replacement pair of eyeglasses one year from the date their previous eyeglasses were provided.
- Members 21 years old and older may be eligible for a replacement pair of eyeglasses five years from the date their previous eyeglasses were provided.
- If a member needs replacement eyeglasses due to loss, theft, or damage beyond repair, prior to the established limitations, use the U8 modifier to bill for the replacement lenses or frames.

Replacement glasses are based on medical necessity.
Coverage
Replacement eyeglasses

Replacement frames and lenses are covered only when medically necessary:

- Replacement eyeglasses due to a change in the prescription that are needed prior to the established limitations require the modifier **SC** – *Medically necessary service or supply* on the claim.

- The minimum prescription or change meets the following criteria:
  - A change of 0.75 diopters for members six to 42 years old
  - A change of 0.50 diopters prescription or change for members more than 42 years old
  - An axis change of at least 15 degrees
Secondary claims on the Provider Healthcare Portal
When is the primary EOB required for Other Insurance (TPL)?

- When the TPL has **DENIED** the service as noncovered
  - *Exception* – If the **TPL primary EOB contains an acceptable denial ARC code**, the secondary windows can be completed with the ARC code, and no EOB is required.
- When TPL has applied the amount to the copay, coinsurance, or deductible

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Services that are **NONCOVERED** by the primary insurance are **NOT** filed as a secondary claim. The secondary windows may be completed to bypass the need for the primary EOB attachment for **TPL CLAIMS only**.
When is the primary EOB for *Other Insurance* information (TPL) *NOT* needed?

The primary insurance *COVERS* the service and has *PAID* on the claim.

- Actual dollars were received.
When is the primary Medicare or Medicare Replacement Plan EOB required?

When Medicare or the Medicare Replacement Plan DENIES the service

When a Replacement Plan EOB is required, write MEDICARE REPLACEMENT PLAN on the EOB.
When is the primary EOB for Medicare or Medicare replacement plans NOT required?

The Medicare or Medicare Replacement Plan **COVERS** the service:

- Actual dollars were received.
- Entire or partial amount was applied to deductible, coinsurance, or copay.
If the primary insurance covers the service, check the box.
Verify that the carrier name shows the correct insurance. Remove any insurance that should not be listed. Click on the 1 by the carrier name to complete the information.
Other Insurance (TPL) – header

Paid amount on the ENTIRE claim
**Other Insurance (TPL) – header**

**Other Insurance Details**

Enter the carrier and policy holder information below.

Enter other carrier Remittance Advice details here for the claim or with each service line. Enter adjusted payment details, such as reason codes, in the Claim Adjustment Details section.

Click the Remove link to remove the entire row.

<table>
<thead>
<tr>
<th>#</th>
<th>Carrier Name</th>
<th>Carrier ID</th>
<th>Group ID</th>
<th>TPL/Medicare Paid Amount</th>
<th>Paid Date</th>
<th>Action</th>
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<tbody>
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</tbody>
</table>

**Carrier Name**

*Policy Holder Last Name
Policy Holder Address
City
*First Name
State
ZIP Code
Country
SSN
*Claim Filing Code
Policy Name
Paid Date
Authorization Number

**Carrier ID**

*Policy ID
*Relationship to Patient
Group ID
TPL/Medicare Paid Amount
Claim ID
Referral Number

How the member is related to the person that holds the insurance

Always **CI** for TPL

16-Health Maintenance Organization (HMO)
17-Dental Maintenance Organization
AM-Automobile Medical
BL-Blue Cross/Blue Shield
CH-Champus
CI-Commercial Insurance Co.
DS-Disability
FI-Federal Employees Program
Claim adjustment details are **NOT** completed for TPL, unless there is an acceptable denial ARC code.
Other Insurance (TPL) – detail

Paid amount for this detail only

Repeat process for *all* service details.
If Medicare or the Medicare Replacement Plan covers the service, check the box.
Verify that the carrier name shows Medicare or the Medicare Replacement Plan. Remove any insurance that should not be listed. Click on the 1 by Medicare or the Medicare Replacement Plan to complete the information.
Paid amount on the ENTIRE claim
**Medicare/Medicare Replacement Plan – header**

### Other Insurance Details

Enter the carrier and policy holder information below.

Enter other carrier Remittance Advice details here for the claim or with each service line. Enter adjusted payment details, such as reason codes, in the Claim Adjustment Details section.

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Click to add a new other insurance.

### Claim Adjustment Details

You can enter up to five unique group codes. You can repeat six combinations of reason code and adjustment amount with each group code.

Click the Remove link to remove the entire row.

<table>
<thead>
<tr>
<th>#</th>
<th>Claim Adjustment Group Code</th>
<th>Reason Code</th>
<th>Adjustment Amount</th>
<th>Units</th>
<th>Action</th>
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</thead>
</table>

**Adjustment amount is the patient responsibility on ENTIRE claim.**

PR – Patient responsibility

1 – Deductible amount
2 – Coinsurance amount
3 – Copayment amount

Click to collapse.

[Add]  [Cancel]

Click to add a new other insurance.

Back to Step 1  [Continue]  Cancel
### Medicare/Medicare Replacement Plan – detail

#### Service Details

Select the row number to edit the row. Click the Remove link to remove the entire row.

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<th>#</th>
<th>From Date</th>
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<th>Place of Service</th>
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<th>Charge Amount</th>
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<td>99213-OFFICE/OUTPATIENT VISIT EST</td>
<td>$100.00</td>
<td>1.00 Unit</td>
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#### Other Insurance for Service Detail

Click the row number to edit the row. Click the Remove link to remove the entire row.

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Paid amount for this detail only
Medicare/Medicare Replacement Plan – detail

### Other Insurance Details
Enter the carrier and policy holder information below.

Enter other carrier Remittance Advice details here for the claim or with each service line. Enter adjusted payment details, such as reason codes, in the Claim Adjustment Details section.

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<th>Action</th>
</tr>
</thead>
</table>

1 – Deductible amount
2 – Coinsurance amount
3 – Copayment amount

PR – Patient responsibility

Adjustment amount is the patient responsibility

ON JUST THIS DETAIL

Repeat process for all service details.
Add claim attachments

When the primary EOB is required, use the “Attachments” feature.

Submit electronically through file transfer.

Search for the file from the documents saved on the computer
- Attachment file size limit is 5 MB, and valid file types for upload include .bmp, .gif, .jpg, .jpeg, .pdf, .png, .tif and .tiff.
### Add claim attachments

<table>
<thead>
<tr>
<th>Attachments</th>
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<tbody>
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<td>Click the Remove link to remove the attachment.</td>
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<tr>
<td></td>
<td>BT-Blanket Test Results</td>
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<td>CB-Chiropractic Justification</td>
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<td>CK-Consent Form(s)</td>
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<td></td>
<td>CT-Certification</td>
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<tr>
<td></td>
<td>D2-Drug Profile Document</td>
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<td>DA-Dental Models</td>
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<td>DB-Durable Medical Equipment Prescription</td>
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<tr>
<td></td>
<td>DG-Diagnostic Report</td>
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<tr>
<td></td>
<td>DJ-Discharge Monitoring Report</td>
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<td>DS-Discharge summary</td>
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**Transmission Method**

- EB-Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer)

**Attachment Type**

- EB-Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer)

**Claim Note Information**

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40
Submit the claim

Attachments may cause the claim to be Pending in Process.
Reminder
Claim filing limit

The IHCP will mandate a 180-day filing limit for fee-for-service (FFS) claims, effective January 1, 2019. Refer to BT201829, published on June 19, 2018, for additional details.

• The 180-day filing limit will be effective based on date of service:
  – Any services rendered on or after January 1, 2019, will be subject to the 180-day filing limit.
  – Dates of service before January 1, 2019, will be subject to the 365-day filing limit.

*Watch for additional communications!*
Helpful tools
### Helpful tools

Provider Relations Consultants

<table>
<thead>
<tr>
<th>REGION</th>
<th>FIELD CONSULTANT</th>
<th>EMAIL</th>
<th>TELEPHONE</th>
<th>COUNTIES SERVED</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Jean Downs</td>
<td><a href="mailto:INXIXRegion1@dxc.com">INXIXRegion1@dxc.com</a></td>
<td>(317) 488-5071</td>
<td>Dekalb, Elkhart, Fulton, Jasper, Kosciusko, LaGrange, Lake, LaPorte, Marshall, Newton, Noble, Porter, Pulaski, St. Joseph, Starke, Steuben, Whitley Chicago, Watseka Sturgis</td>
</tr>
<tr>
<td>Illinois</td>
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</tr>
<tr>
<td>Michigan</td>
<td>Shari Galbreath</td>
<td><a href="mailto:INXIXRegion2@dxc.com">INXIXRegion2@dxc.com</a></td>
<td>(317) 488-5080</td>
<td>Allen, Adams, Benton, Blackford, Cass, Carroll, Clinton, Delaware Founta in Grant, Howard, Hunting, Jay, Madison, Miami, Montgomery, Randolph, Tippecanoe, Tipton, Wabash, Warren, Wells, White Danville</td>
</tr>
<tr>
<td>Illinois</td>
<td>Crystal Woodson</td>
<td><a href="mailto:INXIXRegion3@dxc.com">INXIXRegion3@dxc.com</a></td>
<td>(317) 488-5324</td>
<td>Boonem Hamilton, Hendricks, Johnson, Marion, Morgan</td>
</tr>
<tr>
<td>3</td>
<td>Ken Guth</td>
<td><a href="mailto:INXIXRegion4@dxc.com">INXIXRegion4@dxc.com</a></td>
<td>(317) 488-5153</td>
<td>Clay, Crawford, Daviess, Dubois, Gibson, Greene, Knox, Lawrence, Martin, Orange, Owen, Parke, Perry, Pike, Posey, Putnam, Spencer, Sullivan, Vanderburgh, Vermillion, Vigo, Warrick Owensboro</td>
</tr>
<tr>
<td>Kentucky</td>
<td>Virginia Hudson</td>
<td><a href="mailto:INXIXRegion5@dxc.com">INXIXRegion5@dxc.com</a></td>
<td>(317) 488-5186</td>
<td>Bartholomew, Brown, Clark, Dearborn, Decatur, Fayette, Hancock, Henry, Jackson, Jennings, Monroe, Ohio, Ripley, Rush, Scott, Shelby, Switzerland, Union, Washington, Wayne Louis ville Cincinnati, Harrison, Hamilton, Oxford</td>
</tr>
<tr>
<td>Kentucky</td>
<td></td>
<td></td>
<td>(317) 488-5026</td>
<td>All other out of state areas not previously listed</td>
</tr>
<tr>
<td>Ohio</td>
<td>Judy Green</td>
<td></td>
<td>(317) 488-5032</td>
<td></td>
</tr>
<tr>
<td>Team Lead</td>
<td>Jenny Atkins</td>
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</table>
Helpful tools

IHCP website at indianamedicaid.com:
- IHCP Provider Reference Modules
- Medical Policy Manual
- Contact Us – Provider Relations Field Consultants

Customer Assistance available:
- Monday – Friday, 8 a.m. – 6 p.m. Eastern Time
- 1-800-457-4584

Secure Correspondence:
- Via the Provider Healthcare Portal
- Written Correspondence:
  DXC Technology Provider Written Correspondence
  P.O. Box 7263
  Indianapolis, In 46207-7263
Questions

Following this session, please review your schedule for the next session you are registered to attend