CATEGORICALLY NEEDY

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists= Services

Services are limited to two (2) visits per State Fiscal Year (July 1 through June 30). The benefit limit for State Fiscal Year 1992 will be calculated beginning with services provided on or after December 1, 1991. **Beneficiaries** in the Child Health Services (EPSDT) Program are not benefit limited.

b. Optometrists= Services

Examination of eyes and provision of glasses and/or contact lens and other diagnostic screening, preventive and rehabilitative services and treatment of conditions found for eligible persons. The following limits are imposed:

(1) One eye exam every **twelve (12)** months for eligible **beneficiaries** 21 years of age and older.

12. Prescribed drugs, dentures and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist (Continued)

d. Eyeglasses

For the provision of glasses and/or contact lens for eligible **beneficiaries,** the following limits are imposed:

(1) One pair of glasses every **twelve (12)** months for eligible **beneficiaries** 21 years of age and over. **Repairs to glasses or professional service for repairing glasses are covered for eligible beneficiaries 21 years of age and over. Replacement of glasses is covered for post cataract patients with prior authorization.**

(2) One pair of glasses every twelve (12) months for eligible **beneficiaries** under 21 years of age in the Child Health Services (EPSDT) Program. **One replacement pair of glasses every twelve (12) months for eligible beneficiaries under 21 years of age in the Child Health Services (EPSDT) Program. Repairs to glasses or professional service for repairing glasses are covered for eligible beneficiaries under 21 years of age.** Under special circumstances, additional glasses may be authorized.

(3) Contact **lenses** are covered for **beneficiaries** of all ages if either of the following conditions are exhibited by the patient:

a. Medical necessity
b. Cataract patients

Prior authorization is required by the Medical Assistance Section. Lens replacement for all **beneficiaries** is allowed as medically necessary.

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatrists= Services

Services are limited to two (2) visits per State Fiscal Year (July 1 through June 30). The benefit limit for State Fiscal Year 1992 will be calculated beginning with services provided on or after December 1, 1991. **Beneficiaries** in the Child Health Services (EPSDT) Program are not benefit limited.

b. Optometrists= Services

Examination of eyes and provision of glasses and/or contact lens and other diagnostic screening, preventive and rehabilitative services and treatment of conditions found for eligible persons. The following limits are imposed:

(1) One eye exam every **twelve (12)** months for eligible **beneficiaries** 21 years of age and older.

12. Prescribed drugs, dentures and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist (Continued)

d. Eyeglasses

For the provision of glasses and/or contact lens for eligible **beneficiaries,** the following limits are imposed:

(1) One pair of glasses every **twelve (12)** months for eligible **beneficiaries** 21 years of age and over. **Repairs to glasses or professional service for repairing glasses are covered for eligible beneficiaries 21 years of age and over. Replacement of glasses is covered for post cataract patients with prior authorization.**

(2) One pair of glasses every twelve (12) months for eligible **beneficiaries** under 21 years of age in the Child Health Services (EPSDT) Program. **One replacement pair of glasses every twelve (12) months for eligible beneficiaries under 21 years of age in the Child Health Services (EPSDT) Program. Repairs to glasses or professional service for repairing glasses are covered for eligible beneficiaries under 21 years of age.** Under special circumstances, additional glasses may be authorized.

(3) Contact **lenses** are covered for **beneficiaries** of all ages if either of the following conditions are exhibited by the patient:

a. Medical necessity
b. Cataract patients

Prior authorization is required by the Medical Assistance Section. Lens replacement for all **beneficiaries** is allowed as medically necessary.

5. Physicians' Services

Reimbursement is based on the lesser of the amount billed or the maximum Title XIX (Medicaid) charge allowed. Reimbursement rates (payments) shall be as ordered by the United States District Court for the Eastern District of Arkansas in the case of Arkansas Medical Society v. Reynolds.

For dates of service occurring July 1, 1994 through March 31, 2004, reimbursement rates are set at 66% of the Arkansas Physician's Blue Cross/Blue Shield (BC/BS) Fee Schedule dated October 1, 1993.

For dates of service occurring April 1, 2004 and after:

A. Reimbursement rates are increased by 10% up to a maximum or benchmark rate of 80% of the 2003 Arkansas Blue Cross/Blue Shield (BC/BS) fee schedule. For rates that as of March 31, 2004, are equal to or greater than 80% of the 2003 BC/BS fee schedule rate, no increase will be given. A minimum rate or floor amount of 45% of the 2003 BC/BS fee schedule rate will be reimbursed. For those rates that after the 10 % increase is applied are still less than the floor amount, an additional increase will be given to bring these rates up to the floor amount.

B. Reimbursement rates are capped at 100% of the 2003 BC/BS rate. Rates that as of March 31, 2004, exceed the cap shall be reduced in order to bring the rates in line with the cap by making four equal annual reductions beginning July 1, 2005.

C. Adjustments to payment rates that are comprised of two components, e.g., a professional component and a technical services component, shall be calculated based on a combined payment rate that includes both components. After determining the increase or decrease applicable to the combined rate, the payment rate adjustment for each rate component shall be apportioned as follows:

(1) Increases: If one component rate, either technical or professional, exceeds the cap, the entire increase shall be apportioned to the other component. If neither rate component exceeds the cap, the increase shall be applied in proportion to the component's ratio to the combined rate (i.e., if the technical component rate is 30% of the combined rate then 30% of the increase shall be applied to the technical component payment rate), up to the benchmark. Once a component rate is increased to the benchmark, any remaining increase shall be applied to the other component.

(2) Decreases: If one component rate, either technical or professional, is at the floor, the entire decrease shall be apportioned to the other component. If one component rate is above the cap, the entire decrease shall be apportioned to that component. If both component rates are above the cap, each component shall be reduced to the cap.

For dates of service beginning September 28, 2006, the maximum reimbursement rate for fitting of spectacles (procedure code 92340) is $51.22. The rate is based on 80% of the $64.02 2006 Arkansas Physician's Blue Cross/Blue Shield fee schedule rate.

6. Medical Care and any other type of remedial care recognized under State Law, furnished by licensed practitioners within the scope of their practice as defined by State Law.

b. Optometrist's Services

Reimbursement is based on the lesser of the amount billed or the Title XIX (Medicaid) maximum allowed. Effective for claims with dates of services on or after March 1, 1997, the Title XIX (Medicaid) maximum reimbursement for optometrist services is the same as the physician rates for applicable services.

For dates of service beginning September 28, 2006, the maximum reimbursement rate for a routine eye examination including refraction (procedure codes S0620 and S0621) is $60.23. The rate is based on 40% of the $150.57 2006 Arkansas Physician's Blue Cross/Blue Shield fee schedule rate for procedure code 92014.

c. Chiropractors' Services

Reimbursement is based on the lesser of the amount billed or the Title XIX (Medicaid) maximum charge allowed.

Effective for dates of service on or after June 1, 1998, the current Arkansas Medicaid maximum of $23.58 for procedure code A2000 (Manipulation of the Spine by Chiropractor) will be used to establish the reimbursement rate for each CPT procedure code for Chiropractic care. This care will be covered as described in the following procedure codes established by the American Medical Association (AMA) and published in their 1997 Physician=s Current Procedural Terminology (CPT) Manual, or such procedure codes as AMA (or it=s successor) shall declare are replacements for, and successor= to the following:

98940 Chiropractic manipulative treatment (CMT); spinal, one to two
98941 Chiropractic manipulative treatment (CMT); spinal, three of four regions
98942 Chiropractic manipulative treatment (CMT); spinal, five regions

Effective for dates of service on or after July 1 of each year, Arkansas Medicaid will apply an adjustment factor to the Medicaid maximum. To determine the adjustment factor, a comparison between the previous and current year=s Medicare rates will be made. The adjustment factor will be equal to the average adjustment made to the Medicare payment rates for all of the above CPT procedure codes as reflected in the current Medicare Physician=s Fee Schedule.

d. Other Practitioners' Services
(l) Hearing Aid Dealers - Refer to Attachment 4.19-B, Item 4.b. (10).
(2) Audiologist - Refer to Attachment 4.19-B, Item 4.b. (11).
(3) Optical Labs - Based on contract price. Established through competitive bidding.
(4) Nurse Anesthetists - Reimbursement is based on 80% of the Medicaid Physician Fee Schedule.
(a) Additional Reimbursement for Nurse Anesthetists Associated with UAMS – Refer to Attachment 4.19-B, item 5.

Arkansas Department Of Health and Human Services

Division of Medical Services

P.O. Box 1437, Slot S-295
Little Rock, AR 72203-1437

Fax: 501-682-2480 **TDD: 501-682-6789** **Internet Website: www.medicaid.state.ar.us**

TO: **Arkansas Medicaid Health Care Providers – Visual Care**

DATE: **December 1, 2006**

SUBJECT: **Provider Manual Update Transmittal #82**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
201.000	3-1-06	201.000	12-1-06
—	—	201.110	12-1-06
—	—	201.120	12-1-06
201.200	10-13-03	201.200	12-1-06
202.000	3-1-06	202.000	12-1-06
203.000	10-13-03	203.000	12-1-06
204.000	10-13-03	204.000	12-1-06
211.000	10-13-03	211.000	12-1-06
212.000	10-13-03	212.000	12-1-06
213.200	2-1-06	213.200	12-1-06
213.300	10-13-03	213.300	12-1-06
214.100	10-13-03	214.100	12-1-06
214.200	2-1-06	214.200	12-1-06
214.300	10-13-03	214.300	12-1-06
216.000	10-13-03	216.000	12-1-06
232.000	10-13-03	232.000	12-1-06
241.000	10-13-03	241.000	12-1-06
242.110	7-1-06	242.110	12-1-06
242.410	10-13-03	242.410	12-1-06
243.150	10-13-03	243.150	12-1-06

Explanation of Updates

Section 201.000 has been updated to include the statement that Visual Care providers must adhere to all applicable professional standards of care and conduct. This statement has been removed from section 202.000. Also language from this section has been removed and placed in a new section.

Section 201.110 is a new section which outlines the Visual Care Providers in Arkansas and Bordering States. This information was originally a part of section 201.000.

Section 201.120 is a new section which outlines the Visual Care Providers in states not bordering Arkansas.

Section 201.200 along with several other sections within this update has been included to replace the word *recipient* with *beneficiary.*

Section 202.000 is included to show that part G number 5 has been removed and placed in section 201.000.

Section 212.000 is included to add planned replacement lens, disposable lens and toric lens to the list of contact lenses that are provided. Part E of this section has been revised and reference has been made to form DMS-0101. Obsolete information has been removed from the section.

Section 213.200 is included to make changes in the coverage and limitations of the Adult Program. Effective for dates of service on and after September 28, 2006, beneficiaries may receive one visual examination, one pair of eyeglasses and one prescription services fee every *twelve (12)* months from the last date of service. Also *polycarbonate* lenses are now covered in the Arkansas Medicaid Program. Trifocals, progressive lenses and contact lenses are covered if medically necessary with a prior authorization.

Section 214.200 is included to add polycarbonate lenses to the list of coverage and limitations of the under age 21 program and to revise Part A for clarity.

Section 214.300 has been revised for clarity.

Section 232.000 is included to change the Department of Human Services to the *Department of Health and Human Services* and to change the acronym from DHS to *DHHS.*

Section 242.110 is included to add procedure code ***S0500 (Disposable lens)*** to the list of contact lenses. Effective for dates of service on or after September 28, 2006, disposable contact lenses are covered for all ages with a prior authorization. Also the following procedure codes are now payable for beneficiaries under age 21 with a prior authorization for dates of service on or after December 1, 2006: **92065, 92060 and 96111**. Procedure code 92396 has been replaced with **92326**. Procedure code 92396 was deleted in the 2006 CPT Manual and became non-payable for dates of service on or after March 1, 2006.Paper versions of this update transmittal have updated pages attached to file in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes will be automatically incorporated.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-6789.

If you have questions regarding this transmittal, please contact the EDS Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

Arkansas Medicaid provider manuals (including update transmittals), official notices and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.

_____

Roy Jeffus, Director

TOC required

201.000 Arkansas Medicaid Participation Requirements for Visual Care Providers 12-1-06

Visual Care Program providers meeting the following criteria are eligible for participation in the Arkansas Medicaid Program:

A. Provider must be licensed by the State Board of Optometry to practice in his or her state. A current copy of the optometrist's license must be submitted with the provider application for participation. Subsequent licensure must be provided when issued.

1. Subsequent license renewal must be forwarded to Provider Enrollment within 30 days of issue. If the renewal documents have not been received within the 30-day deadline, the provider will have an additional and final 30 days to comply.
2. Failure to ensure that current licensure is on file with Provider Enrollment will result in termination from the Arkansas Medicaid Program.

B. Provider must be enrolled in the Title XVIII (Medicare) Program.

C. Provider must complete a provider application (form DMS-652), a Medicaid contract (form DMS-653) and a Request for Taxpayer Identification Number and Certification (Form W-9). **View or print the provider application (form DMS-652), the Medicaid contract (form DMS-653) and the Request for Taxpayer Identification Number and Certification (Form W-9).**

D. Enrollment as a Medicaid provider is conditioned upon approval of a completed provider application and the execution of a Medicaid provider contract. Persons and entities that are excluded or debarred under any state or federal law, regulation or rule are not eligible to enroll, or to remain enrolled, as Medicaid providers.

E. The Visual Care provider must adhere to all applicable professional standards of care and conduct.

201.110 Visual Care Providers in Arkansas and Bordering States 12-1-06

Visual Care Program providers in Arkansas and the bordering states of Louisiana, Mississippi, Missouri, Oklahoma, Tennessee and Texas will be enrolled as routine services providers.

Routine Services Providers

A. Provider will be enrolled in the program as a regular provider of routine services.

B. Reimbursement will be available for all visual care services covered in the Arkansas Medicaid Program.

C. Claims must be filed according to Section 240.000 of this manual. This includes assignment of ICD-9-CM and HCPCS codes for all services rendered.

201.120 Visual Care Providers in States Not Bordering Arkansas 12-1-06

A. Visual Care providers in states not bordering Arkansas are called closed-end providers because they may enroll in Arkansas Medicaid only after they have furnished services to an Arkansas Medicaid beneficiary and have a claim to file. **View or print Provider Enrollment Unit contact information.**

A non-bordering state provider may download the provider manual and provider application materials from the Arkansas Medicaid website, **www.medicaid.state.ar.us/InternetSolution/Provider/Provider.aspx**, and then submit the application and claim to the Medicaid Provider Enrollment Unit.

B. Closed-end providers remain enrolled for one year.

1. If a closed-end provider treats another Arkansas Medicaid beneficiary during the year of enrollment and bills Medicaid, the enrollment may continue for one year past the newer claim's last date of service, if the provider keeps the enrollment file current.
2. During this enrollment period, the provider may file any subsequent claims directly to the Arkansas Medicaid fiscal agent.
3. Closed-end providers are strongly encouraged to submit claims through the Arkansas Medicaid website because the front-end processing of web-based claims ensures prompt adjudication and facilitates reimbursement.

201.200 Services to Beneficiaries with Refraction 12-1-06

Visual care providers who accept a Medicaid beneficiary for an eye examination with refraction must follow these guidelines:

A. The provider will advise the beneficiary, prior to performing the exam, that he or she will not provide the glasses.

B. The beneficiary will be given the choice to select a provider who will provide both services.

C. If the beneficiary elects to have the examination, a written prescription for the glasses will be given or offered to the beneficiary post-examination.

D. The prescriber cannot withhold the prescription pending Medicaid payment for the refraction.

E. If the beneficiary is not satisfied with the frame selection or services provided, the provider will offer the beneficiary "freedom of choice" and give the beneficiary the prescription for glasses.

202.000 Visual Care Records Providers are Required to Keep 12-1-06

Visual care providers are required to keep the following records and, upon request, must immediately furnish the records to authorized representatives of the Division of Medical Services, the state Medicaid Fraud Control Unit, representatives of the Department of Health and Human Services and the Centers for Medicare and Medicaid Services:

A. History and visual care examination on initial visit.

B. Chief complaint on each visit.

C. Tests and results.

D. Diagnosis.

E. Treatment, including prescriptions.

F. Signature or initials of visual care provider after each visit.

G. Copies of hospital and/or emergency room records that are available to disclose services.

1. All records must be kept for five (5) years from the ending date of service or until all audit questions, appeal hearings, investigations or court cases are resolved, whichever is longer. Failure to furnish these records upon request may result in sanctions being imposed.
2. All documentation must be immediately made available to representatives of the Division of Medical Services at the time of an audit by the Medicaid Field Audit Unit. All documentation must be available at the provider's place of business. When a recoupment is necessary, no more than thirty (30) days will be allowed after the date of the recoupment notice in which additional documentation will be accepted. Additional documentation will not be accepted after the 30 days allowed after recoupment.
3. Visual Care providers furnishing any Medicaid-covered good or service for which a prescription is required by law, by Medicaid rule, or both, must have a copy of the prescription for such good or service. The Visual Care provider must obtain a copy of the prescription within five (5) business days of the date the prescription is written.
4. The Visual Care provider must maintain a copy of each relevant prescription in the Medicaid beneficiary's records and follow all prescriptions and care plans.

203.000 Monitoring Performance of the Medicaid Optical Equipment Supplier 12-1-06

The Arkansas Medicaid Program uses a single optical laboratory selected through a competitive bid process to furnish eyeglasses for eligible Medicaid beneficiaries. The Medicaid Program's Medical Assistance Unit depends on visual care providers to assist in monitoring the performance of the contractor both in quality of product and timeliness of delivery. The following procedures must be followed:

A. The Medical Assistance Unit welcomes positive and negative comments regarding the optical laboratory's performance. All comments regarding the optical laboratory's performance must be made on the Vendor Performance Report. **View or print the Vendor Performance Report**. The provider will complete the Vendor Performance Report at any time a beneficiary verbally expresses dissatisfaction with their eyeglasses.

B. Vendor Performance Reports should be mailed to the Division of Medical Services, Medical Assistance Unit. **View or print the Division of Medical Services, Medical Assistance Unit contact information**.

C. The Medical Assistance Unit, upon receipt of the Vendor Performance Report, will log and investigate the complaint.

D. A copy of the report is kept on file and may be a factor in awarding future contracts.

To assist the Medical Assistance Unit in investigating your report, the following guidelines are suggested when submitting a Vendor Performance Report::

A. Agency and address - enter your name, address and phone number

B. Vendor and address - enter name and address of optical laboratory

C. Include the date the patient was examined and the date the claim and prescription were submitted

D. Indicate the date the eyewear was delivered

E. Describe specific problems, e.g., poor quality (explain in detail), failure to deliver in a timely manner, unauthorized frame substitution, etc.

F. Give name of the Medicaid beneficiary and ID number

G. If your staff has previously contacted the optical lab about a problem, note the date of contact, the name of the person who made the contact and the name of the persons contacted. Include any pertinent information related to the contact.

Copies of the Vendor Performance Report may be obtained by calling the Division of Medical Services, Medical Assistance Unit. **View or print the Division of Medical Services, Medical Assistance Unit contact information**.

204.000 The Visual Care Provider's Role in the Child Health Services (EPSDT) Program 12-1-06

The Arkansas Medical Assistance Program includes a Child Health Service, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program for eligible individuals less than 21 years of age. The purpose of this program is to detect and treat health problems in their early stages.

If you are a Child Health Services (EPSDT) provider, please refer to the Child Health Services (EPSDT) provider manual for additional information.

Visual care providers interested in enrolling in the Child Health Services (EPSDT) Program should contact the Central Child Health Services Office. **View or print contact information for the Central Child Health Services Office.**

Visual care providers must bill Child Health Services (EPSDT) on the DMS-694 claim form using the proper Child Health Services (EPSDT) procedure codes found in the Child Health Services (EPSDT) provider manual. Ancillary charges, such as lab and X-ray, associated with Child Health Services (EPSDT) should be listed on the DMS-694. **View a DMS-694 sample form**.

Any enrolled Arkansas Medicaid provider rendering services not covered by the Arkansas Medicaid Program to a participant in the Child Health Services (EPSDT) Program who has been referred for services as a result of an EPSDT screen will be reimbursed for the services rendered if the services are medically necessary and permitted under federal Medicaid regulations.

Any Arkansas Medicaid provider may bill for non-covered services if the services are provided to a participant in the Child Health Services (EPSDT) Program who has been referred due to an EPSDT screen. The services must be medically necessary and permitted under federal Medicaid regulations.

When a provider performs a Child Health Services (EPSDT) screen and refers the patient to another provider for services **not covered** by Arkansas Medicaid, the referring provider must give the beneficiary a prescription for the non-covered services. The prescription must indicate the services being prescribed and state the services are being prescribed due to an EPSDT screen. **In order for the non-covered service to be eligible for Medicaid payment, the referral** documentation must be available for review. A provider who performs a Child Health Services (EPSDT) screen may also provide services resulting from the screen, if appropriate.

The prescription for services must be dated by the referring provider. The prescription for the non-covered service is acceptable if services were prescribed and the prescription is dated within the applicable periodicity schedule, not to exceed a maximum of 12 months.

211.000 Introduction 12-1-06

The Arkansas Medicaid Program covers visual care services of Medicaid beneficiaries within restrictions set in federal and state guidelines. The following paragraphs are a general summary of the program coverage. Detailed coverage, prior authorization, reference information and other requirements may be found in those specific sections within this manual.

212.000 Contact Lens 12-1-06

The Visual Care Program makes contact lenses available to eligible beneficiaries under the following guidelines:

A. All requests for contact lenses require prior authorization by the Medical Assistance Unit. (Refer to Section 220.000 of this manual for prior authorization procedures).

B. Contact lenses are covered if either of the following conditions are exhibited by the patient:

1. Medically necessary
2. Cataract (aphakia) patients

C. The following types of contact lenses are provided:

1. Soft lens
2. Hard lens
3. Toric lens to correct astigmatism
4. Monocular lens
5. Lenses for cataract patients
6. Gas Permeable
7. Keratoconus lens
8. Planned replacement lens
9. Disposable lens

D. Bifocal lenses are not covered.

E. Upon completion of the visual analysis, the provider will forward a letter containing the following information to the Division of Medical Services, Medical Assistance Unit. **View or print form DMS-0101.**

1. Patient's name, date of birth and Medicaid ID number
2. Date of service
3. Patient's complaint
4. Diagnosis and pathology
5. Visual acuities without correction, with present correction and with best correction
6. Power of patient's most recent prior prescription
7. Medical justification for prescribing contacts
8. Type of contacts requested, lens specifications, K reading, hard or soft conventional daily-wear contacts, disposable or planned replacement contacts
9. Provider name, address and Medicaid provider number

F. The visual analysis is reimbursable even if the contact lenses are not authorized. All other services should be billed as a package deal and should include the following services:

1. Prescription services
2. Supply and fitting of contact lens
3. Contact lens care kit, including sterilizer
4. Up to four follow-up visits to achieve maximum wearing time up to a period of six months. The patient will be responsible for payment of all other office visits after the four initial visits or six months, whichever comes first.

G. A patient receiving contact lenses should have a pair of conventional glasses. If the current prescription of the patient's glasses is adequate, Medicaid will not furnish another pair. When the patient does not have a pair of conventional glasses or the current prescription is inadequate, a new pair will be furnished. If a new pair is needed, the provider must complete and submit Form DMS-26-V with a request for contact lens invoice. **View a DMS-26-V sample form**. The prescribing doctor will be paid one time for prescribing and verifying the prescription. At the time of the contact lens request, the provider should furnish the power of the patient's old prescription, if available.

H. Neither insurance nor service contracts are provided by Medicaid. This is the beneficiary's responsibility.

I. If the patient cannot wear the lens, it is the responsibility of the provider to notify Medicaid and reimburse the program 50 percent of Medicaid's payment for the contact lens package deal. Refund checks will be made payable to DHHS Accounts Receivable. **View or print the DHHS Accounts Receivable contact information**. An explanation of refund should be enclosed with the check identifying the patient name, Medicaid number, date of service and date of Medicaid payment. Even if the patient cannot wear the lens, once the billing has been submitted, the service will count against the patient's benefit limit.

J. For beneficiaries age 21 and over, lens replacement will be covered for post-operative cataract (aphakia) patients only and will require prior authorization. For beneficiaries under age 21, lens replacement will be covered as needed. For these beneficiaries, prior authorization is required except for post-operative cataract (aphakia) patients. Medicaid will reimburse the lower of the amount billed or the Medicaid maximum allowable for each procedure. When billing, the provider should submit the charge for lens replacement only and should not include charges for professional service.

K. Refer to Section 240.000 of this manual for the procedure codes, description of services and billing instructions for contact lens.

L. Any questions regarding approval or denial of contact lens should be forwarded to the Division of Medical Services, Medical Assistance Unit, attention Visual Care Services. **View or print Division of Medical Services, Medical Assistance Unit contact information**.

213.200 Coverage and Limitations of the Adult Program 12-1-06

A. One visual examination and one pair of glasses are available to eligible Medicaid beneficiaries every twelve (12) months.

1. If repairs are needed, the eyeglasses must have been originally purchased through the Arkansas Medicaid Program in order for repairs to be made.

2. All repairs will be made by the optical laboratory.

B. One prescription services fee every 12 months from the last date of service

C. Lens replacement as medically necessary with prior authorization

D. Lens power for single vision must be a minimum of:

1. +1.00 OR -0.75 sphere
2. -0.75 axis 90 or 0.75 axis 180 cylinder or at any axis

E. Tinted lenses, photogray lenses or sunglasses are limited to post-operative cataract or albino patients

F. Bifocals for presbyopia must have a power of +1.00 and any changes in bifocals must be in increments of at least +0.50

G. Bifocal lenses are limited to:

1. D-28 and
2. Kryptok

H. For beneficiaries who are eligible for both Medicare and Medicaid, see Section I for coinsurance and deductible information.

I. Plastic or polycarbonate lenses only are covered under the Arkansas Medicaid Program.

J. Low vision aids are covered on a prior authorization basis.

K. Medicaid eligible beneficiaries with the exception of nursing home residents, who are 21 or older, will pay a $2.00 co-payment to the visual care provider for prescription services.

L. Adult diabetics are eligible (with prior authorization) to receive a second pair of eyeglasses within the twelve month period if their prescription changes more than one diopter.

M. One visual prosthetic device every 24 months from the last date of service

N. Eye prosthesis and polishing services are covered with a prior authorization.

O. Trifocals are covered if medically necessary with a prior authorization.

P. Progressive lenses are covered if medically necessary with a prior authorization.

Q. Contact lenses are covered if medically necessary with a prior authorization. Please refer to section 212.000 for contact lens guidelines.

213.300 Exclusions in the Adult Program 12-1-06

A. The Medicaid Program will not reimburse for replacement glasses, with the exception of post-cataract patients, which will require prior authorization.

B. Lenses may not be purchased separately from the frames. If the beneficiary desires frames other than the frames approved by Medicaid, he or she will be responsible for the lenses also. Medicaid will reimburse the provider for the examination in these situations.

C. Medicaid will not pay the prescription service charges in situations where the patient buys the eyeglasses.

D. Medicaid does not cover charges incurred due to errors made by doctors or optical laboratories.

E. Tinted lenses for cosmetics purposes are not covered.

F. Glass lenses are NOT covered by Medicaid.

214.100 Scope of the Under Age 21 Program 12-1-06

The primary purpose of this program is for the screening, examination, diagnosis and treatment of conditions of the eye for the prescribing and fitting of eyeglasses, contact lenses and low vision aids for eligible beneficiaries under 21 years of age.

214.200 Coverage and Limitations of the Under Age 21 Program 12-1-06

A. One examination and one pair of glasses are available to eligible Medicaid beneficiaries every twelve months.

1. If repairs are needed, the eyeglasses must have been originally purchased through the Arkansas Medicaid Program in order for repairs to be made.
2. If the glasses are lost or broken beyond repair within the twelve month benefit limit period, one additional pair will be available through the optical laboratory without a prior authorization requirement from the Division.
3. All repairs and/or replacements will be made by the optical laboratory.

B. Prescriptive and acuity minimums must be met before glasses will be furnished. Glasses should be prescribed only if the following conditions apply:

1. The strength of the prescribed lens (for the poorer eye) should be a minimum of -.75D + 1.00D spherical or a minimum of .75 cylindrical or the unaided visual acuity of the poorer eye should be worse than 20/30 at a distance.
2. Reading glasses may be furnished based on the merits of the individual case. The doctor should indicate why such corrections are necessary. All such requests will be reviewed on a prior approval basis.

C. Plastic or polycarbonate lenses only are covered under the Arkansas Medicaid Program.

D. When the prescription has met the prescriptive and acuity minimum qualifications, Medicaid will purchase eyeglasses through a negotiated contract with an optical laboratory.

E. The eyeglasses will be forwarded to the doctor's office where he or she will be required to verify the prescription and fit or adjust them to the patient's needs.

F. Eye prosthesis and polishing services require a prior authorization.

G. Contact lenses are covered if medically necessary with a prior authorization. Please refer to section 212.000 for contact lens guidelines.

H. Eyeglasses for children diagnosed as having the following diagnoses must have a surgical evaluation in conjunction with supplying eyeglasses:

1. Ptosis (droopy lid)
2. Congenital cataracts
3. Exotropia or vertical tropia
4. Children between the ages of twelve (12) and twenty-one (21) exhibiting exotropia

214.300 Exclusions in the Under Age 21 Program 12-1-06

A. Tinted or plastic lenses for cosmetic purposes

B. Frames other than the ones on contract

C. Contact lenses for cosmetic purposes

D. Contact lenses or eyeglasses obtained by means other than Medicaid

E. Glass lenses

216.000 Medical Procedures Billable by Optometrists 12-1-06

Optometrists are allowed to bill for certain procedures for office medical services and special services previously payable only to physicians.

The office medical services provided by an optometrist will be limited to twelve visits per state fiscal year for individuals age 21 and over. The benefit limit will be used in conjunction with four other programs. These programs are physicians' services, medical services provided by dentists, rural health clinic services and certified nurse-midwife services. Beneficiaries will be allowed twelve visits per state fiscal year for office medical services furnished by an optometrist, medical services furnished by a dentist, physicians' services, rural health clinic services, certified nurse-midwife services or a combination of the five. Extensions beyond the twelve-visit limit may be provided if medically necessary. Office medical services for beneficiaries under age 21 in the Child Health Services (EPSDT) Program are not benefit limited. Procedure codes, description of services and special billing instructions are located in Section 240.000 of this manual.

All beneficiaries of vision and medical eye care may have direct access to optometrists as primary eye care providers, independent of the primary care provider (e.g., physician, Federally Qualified Health Center (FQHC), etc.).

232.000 Rate Appeal Process 12-1-06

A provider may request reconsideration of a program decision by writing to the Assistant Director, Division of Medical Services. This request must be received within 20 calendar days following the application of policy and/or procedure or the notification of the provider of its rate. Upon receipt of the request for review, the Assistant Director will determine the need for a program/provider conference and will contact the provider to arrange a conference if needed. Regardless of the program decision, the provider will be afforded the opportunity for a conference, if he or she so wishes, for a full explanation of the factors involved and the program decision. Following review of the matter, the Assistant Director will notify the provider of the action to be taken by the Division within 20 calendar days of receipt of the request for review or the date of the program/provider conference.

If the decision of the Assistant Director, Division of Medical Services is unsatisfactory, the provider may then appeal the question to a standing Rate Review Panel established by the Director of the Division of Medical Services, which will include one member of the Division of Medical Services, a representative of the provider association and a member of the Department of Health and Human Services (DHHS) Management Staff, who will serve as chairman.

The request for review by the Rate Review Panel must be postmarked within 15 calendar days following the notification of the initial decision by the Assistant Director, Division of Medical Services. The Rate Review Panel will meet to consider the question(s) within 15 calendar days after receipt of a request for such appeal. The question(s) will be heard

by the panel and a recommendation will be submitted to the Director of the Division of Medical Services.

241.000 Introduction to Billing 12-1-06

Visual care providers use the Visual Care DMS-26-V claim form or the CMS-1500 form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid beneficiaries. Each claim may contain charges for only one beneficiary.

Section III of this manual contains information about Provider Electronic Solutions (PES) and other available options for electronic claim submission.

242.110 Visual Procedure Codes 12-1-06

The following services are covered under the Arkansas Medicaid Program.

Procedure Code	Required Modifier	Description	Coverage	
			Under 21	Over 21
DIAGNOSTIC AND ANCILLARY SERVICES				
S0620	—	ROUTINE OPTHALMOLOGICAL EXAMINATION INCLUDING REFRACTION; NEW PATIENT This service must include the following: case history, general health observation, external exam of the eye and adnexa, ophthalmoscopic examination, determination of refractive state, basic sensorimotor and binocularity examination. It may also include initiation of diagnostic and treatment programs or referral.	yes	yes
S0621		ROUTINE OPTHALMOLOGICAL EXAMINATION INCLUDING REFRACTION; ESTABLISHED PATIENT This service must include the following: case history, general health observation, external exam of the eye and adnexa, ophthalmoscopic examination, determination of refractive state, basic sensorimotor and binocularity examination. It may also include initiation of diagnostic and treatment programs or referral.	yes	yes

Procedure Code	Required Modifier	Description	Coverage	
			Under 21	Over 21
92340	—	FITTING OF SPECTACLES, EXCEPT FOR APHAKIA: MONOFOCAL Fitting includes measurement of anatomical facial characteristics, the writing of laboratory specifications, and the final adjustment of the spectacles to the visual axes and anatomical topography.	yes	yes
92370	—	REPAIR AND REFITTING OF SPECTACLES Repair and refitting spectacles; except for aphakia	yes	yes
99173	UB	SCREENING TEST OF VISUAL ACUITY, QUANTITATIVE, BILATERAL This procedure must include at minimum three of the services listed under procedure code V0100. This code may not be billed in conjunction with procedure code V0100.	yes	yes
CONTACT LENS SERVICES				
S0592	—	COMPREHENSIVE CONTACT LENS EVALUATION This service must include the following: biomicroscopy, multiple ophthalmometry, case history, tear flow, measurement of ocular adnexa, initial tolerance evaluation, and may include other tests. This procedure does not include contact lens and should be billed in conjunction with other contact lens procedure codes. If billing this code, **DO NOT** bill S0620 or S0621. Contacts and glasses may be ordered using this code.	yes	yes
S0512	—	SUPPLYING AND FITTING OF CONTACT LENS (SOFT) Spherical, aphakic, lenticular, toric, hydrophilic (per lens)	yes W/PA	yes W/PA
S0512	—	SUPPLYING AND FITTING OF CONTACT LENS (GAS PERMEABLE) Spherical, aphakic, lenticular, toric, prism ballast (per lens)	yes W/PA	yes W/PA
V2501	UA	SUPPLYING AND FITTING OF KERATOCONUS LENS (HARD OR GAS PERMEABLE) - per lens	yes W/PA	yes W/PA

Procedure Code	Required Modifier	Description	Coverage	
			Under 21	Over 21
S0512	—	SUPPLYING AND FITTING OF MONOCULAR LENS (HARD OR GAS PERMEABLE) - per lens	yes W/PA	yes W/PA
V2501	U1	SUPPLYING AND FITTING OF MONOCULAR LENS (SOFT LENS) - per lens	yes W/PA	yes W/PA
S0512	—	SUPPLYING AND FITTING OF CONTACT LENS (SOFT) Spherical, aphakic, lenticular, toric, hydrophilic (per lens)	yes W/PA	yes W/PA
S0500	---	DISPOSABLE CONTACTS (PER LENS)	Yes W/PA	Yes W/PA
LOW VISION SERVICES				
92002	UB	LOW VISION EVALUATION	yes W/PA	yes W/PA
SUPPLEMENTAL PROCEDURES				
92081	—	VISUAL FIELD - Electronic or Goldmann	yes	yes
92081	—	VISUAL FIELD - Confrontation Perimetry	yes	yes
MISCELLANEOUS SERVICES				
92100	UB	TONOMETRY This procedure will only be covered when medically necessary. These conditions include, but are not limited to, diabetes, hypertension and age of the patient.	yes	yes
V2623	—	EYE PROSTHESIS Prosthetic eye, plastic, custom	yes W/PA	yes W/PA
V2624	—	POLISHING OF PROSTHESIS Polishing/resurfacing of ocular prosthesis	yes W/PA	yes W/PA
92065		ORTHOPTIC AND PLEOPTIC TRAINING WITH CONTINUING MEDICAL DIRECTION AND EVALUATION	yes W/PA	no
92060		SENSORIMOTOR EXAMINATION With multiple measurements of ocular deviation (eg, restrictive or paretic muscle with diplopia) with interpretation and report (separate procedure).	yes W/PA	no

Procedure Code	Required Modifier	Description	Coverage	
			Under 21	Over 21
96111	__	DEVELOPMENTAL TESTING Extended (includes assessment of motor, language, social, adaptive and/or cognitive functioning by standardized developmental instruments) with interpretation and report.	Yes W/PA	no
CONTACT LENS REPLACEMENT				
92326	—	HARD LENS (PER LENS) This procedure code does not include a professional fee.	yes W/PA	no
92326	—	SOFT LENS (PER LENS) This procedure code does not include a professional fee.	yes W/PA	no
92326	—	GAS PERMEABLE (PER LENS) This procedure code does not include a professional fee.	yes W/PA	no
92326	—	APHAKIC LENS Post-operative cataract.	Yes W/PA	yes W/PA
V2799	—	UNSPECIFIED PROCEDURE	yes	yes

242.410 Billing for Medicare/Medicaid Dually-Eligible Beneficiaries 12-1-06

If Medicare denies a claim for services provided to a beneficiary eligible for both Medicare and Medicaid, the claim will not cross over to Medicaid automatically. Therefore, the Visual Care claim form DMS-26-V should be submitted to EDS along with the Explanation of Medicare Benefits (EOMB) explaining the reason for Medicare's denial.

NOTE: A copy of the Medicare EOMB must be attached to the claim and must match the dates of service on the claim form.

Medicare/Medicaid crossover claims are discussed in Section III of this manual.

243.150 Office Medical Services 12-1-06

The office medical services provided by an optometrist are limited to twelve (12) visits per state fiscal year (July 1 through June 30) for beneficiaries age 21 and older. The benefit limit will be used in conjunction with four other programs: physicians' services, medical services provided by dentists, rural health clinic services and certified nurse-midwife services. Beneficiaries will be allowed twelve visits per state fiscal year for office medical services furnished by an optometrist, medical services furnished by a dentist, physicians' services, rural health clinic services and certified nurse-midwife services or a combination of the five. Extensions beyond the twelve-visit limit may be provided if medically necessary. Office medical services for beneficiaries under age 21 in the Child Health Services (EPSDT) Program are not benefit limited.

Office medical services covered in the Visual Care Program are limited to the following procedure codes:

92002	92004	92012	92014
99201	99202	99203	99204
99205	99211	99212	99213
99214	99215		

Arkansas Department of Health and Human Services

Division of Medical Services

P.O. Box 1437, Slot S-295
Little Rock, AR 72203-1437

Fax: 501-682-2480 **TDD: 501-682-6789** **Internet Website: www.medicaid.state.ar.us**

TO: **Arkansas Medicaid Health Care Providers**

DATE: **December 1, 2006**

SUBJECT: **Section V Provider Manual Update Transmittal**

Provider Manual	Transmittal Number
Alternatives for Adults with Physical Disabilities Waiver	46
Ambulatory Surgical Center	79
ARKids First-B	46
Certified Nurse-Midwife	81
Child Health Management Services	79
Child Health Services/Early and Periodic Screening, Diagnosis and Treatment	86
Children's Services Targeted Case Management	30
Chiropractic	74
DDS Alternative Community Services Waiver	71
Dental	97
Developmental Day Treatment Clinic Services	82
Developmental Rehabilitation Services	30
Division of Youth Services and Division of Children and Family Services Targeted Case Management	22
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Nurse Practitioner	76
Occupational, Physical, Speech Therapy Services	71
Personal Care	84
Pharmacy	96
Physician/Independent Lab/CRNA/Radiation Therapy Center	125

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
—	—	DMS-0101	12/2006

Explanation of Updates

This update is included to add a new form titled, “Contact Lens Prior Authorization Request Form”.

Paper versions of this update transmittal have updated pages attached to file in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-6789.

If you have questions regarding this transmittal, please contact the EDS Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

Arkansas Medicaid provider manuals (including update transmittals), official notices and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.

Roy Jeffus, Director

Arkansas Department of Health and Human Services

Division of Medical Services

Medical Assistance Section

Visual Unit

P.O. Box 1437, Slot S-410 Little Rock, AR 72203-1437 • 501-682-8342 • Fax: 501-682-8304 • TDD: 501-682-6789

Contact Lens Prior Authorization Request Form

1. Patient Name, Date of Birth and Medicaid ID Number:

2. Date of Service:

3. Patient Complaint:

4. Diagnosis and Pathology:

5. Visual Acuities Without Correction:

6. Power of Patient's Most Recent Spectacle Prescription:

7. Medical Justification for Prescribing Contact Lenses:

8. Type of Contacts Requested:
   PGR/SDW/SES/PR/DISP/OTHER_____

   a. Lens Specification:

   b. K Readings:

9. Provider Name, Address, Phone Number and Medicaid Provider Number:

DMS-0101 (12/06)