Mississippi Specific Information

This document contains information specific to the State of Mississippi. Please refer to the Provider Reference Guide for general information regarding plan administration.

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1.1 Covered Benefits – Molina Healthcare of Mississippi – MississippiCAN

Benefit	Benefit Limitations/Criteria
Routine Exam	▪ 2 exams every calendar year beginning July 1st ages 20 and under. ▪ 1 exam every calendar year beginning July 1st ages 21 and older. ▪ Additional exams covered when medically necessary ages 20 and under.

Frame and Lenses	▪ 1 pair of frame and lenses ($136 value) from the March frame kit and contracted lab every fiscal year beginning July 1st.
	  ▪ Single vision, bifocal or trifocal lenses.
	  ▪ Polycarbonate and/or reflective coating are also covered at no charge to the member.
	▪ **Frame must be selected from the March frame kit.**
	▪ **Lenses must be provided by the March lab. Please refer to Exhibit C in the Provider Reference Guide for lab information.**
	▪ Frame and lenses are in lieu of contact lenses.

Frame and Lens Replacement	▪ 1 pair or frame and lenses every fiscal year beginning July 1st due to vision change, loss or damage ages 20 and under. ▪ **Frame must be selected from the March frame kit.** ▪ **Lenses must be provided by the March lab. Please refer to Exhibit C in the Provider Reference Guide for lab information.** ▪ **To identify replacement frame and lenses, please bill using modifier code RA in conjunction with the current and appropriate HCPCS code(s) for frame and lenses.**
Contact Lenses	▪ $100 allowance for contact lenses every fiscal year beginning July 1st. ▪ Contact lenses are in lieu of frame and lenses. ▪ Contact lenses **MUST** be supplied by the provider.

Eyewear After Cataract Surgery	▪ One pair of eyeglasses (standard frame and lenses) after each surgery on the eyeball or ocular muscle when the following criteria are met:
	  ▪ Surgery results in a vision change,
	  ▪ Eyeglasses are medically indicated within six (6) months of the surgery, and
	  ▪ Eyeglasses are prescribed by an optometrist or ophthalmologist.
	▪ **Frame must be selected from the March frame kit.**
	▪ **Lenses must be provided by the March lab. Please refer to Exhibit C in the Provider Reference Guide for lab information.**
	▪ **To identify eyewear after cataract surgery, please bill with the appropriate diagnosis code for cataract surgery.**

Non-Covered Services	▪ Medical eye care. ▪ Surgical eye care.

1.2 Covered Benefits – Molina Healthcare of Mississippi – Mississippi CHIP

Benefit	Benefit Limitations/Criteria
Routine Exam	▪ 1 exam every calendar year beginning January 1st.

Frame and Lenses	▪ 1 pair of frame and lenses ($136 value) from the March frame kit and contracted lab every calendar year beginning January 1st.
	  ▪ Single vision, bifocal or trifocal lenses.
	  ▪ Polycarbonate and/or reflective coating are also covered at no charge to the member.
	▪ **Frame must be selected from the March frame kit.**
	▪ **Lenses must be provided by the March lab. Please refer to Exhibit C in the Provider Reference Guide for lab information.**

Necessary Contact Lenses	▪ 2 units (1 pair) every calendar year beginning January 1st when vision cannot be corrected with eyeglasses. ▪ Contact lenses are in lieu of frame and lenses. ▪ Contact lenses **MUST** be supplied by the provider.
Non-Covered Services	▪ Medical eye care. ▪ Surgical eye care.

1.3 Covered Benefits - UnitedHealthcare Community Plan – MississippiCAN

Benefit	Benefit Limitations/Criteria
Routine Exam	▪ 2 exams every calendar year beginning January 1st ages 20 and under. ▪ 1 exam every calendar year beginning January 1st ages 21 and older.
Routine Exam Replacement	▪ Covered as needed ages 20 and under if glasses are lost or stolen and it is not possible to return to or obtain the prescription from the previous provider.
Necessary Medical Services	▪ Covered as needed when services are performed by an optometrist and are within the scope of licensure.

Frame	▪ 2 units every calendar year beginning January 1st ages 20 and under
	▪ 1 unit every 3 calendar years beginning January 1st ages 21 and older.
	▪ Documentation must support the following:
	  ▪ Eyeglasses are medically necessary,
	  ▪ Eyeglasses are prescribed to significantly improve vision or correct a medical condition, and
	  ▪ Eyeglasses meet eyeglass program specifications for frames and lenses.
	  ▪ Frame must be selected from the March frame kit.
	  ▪ No coverage for a non-March frame.
	▪ Prior confirmation is required after the 1st pair per plan year for ages 20 and under.
	▪ **Frame must be selected from the March frame kit.**

Frame Replacement	▪ Covered as needed if lost or stolen ages 20 and under. ▪ The provider should only replace the part that is lost. ▪ **To identify replacement frames, please bill using modifier code RA in conjunction with the current and appropriate HCPCS code(s) for frames.**

Benefit	Benefit Limitations/Criteria

Lens (Single, Bifocal, Trifocal, Lenticular)	▪ 4 units (2 pairs) every calendar year beginning January 1st ages 20 and under.
	▪ 2 units (1 pair) every 3 calendar years beginning January 1st ages 21 and older.
	▪ Documentation must support the following:
	  ▪ Eyeglasses are medically necessary,
	  ▪ Eyeglasses are prescribed to significantly improve vision or correct a medical condition, and
	  ▪ Eyeglasses meet eyeglass program specifications for frames and lenses.
	  ▪ Glass or plastic single, bifocal, trifocal or lenticular lenses are covered.
	  ▪ Tinted lenses, photochromatic lenses, or UV protected lenses are covered when medically necessary for the following medical diagnoses:
	  ▪ Other disturbances of aromatic amino-acid metabolism,
	  ▪ Degeneration of macula and posterior pole,
	  ▪ Pigmentary retinal dystrophy,
	  ▪ Cataracts,
	  ▪ Keratitis,
	  ▪ Corneal opacity and other disorders of cornea,
	  ▪ Disorders of conjunctiva,
	  ▪ Aphakia,
	  ▪ Congenital Aphakia,
	  ▪ Aniridia, and
	  ▪ Pseudophakos.
	  ▪ Polycarbonate lenses are covered for ages 20 and under.
	▪ **Lenses must be provided by the March lab. Please refer to Exhibit C in the Provider Reference Guide for lab information.**

Lens Replacement	▪ Covered as needed if lost or stolen ages 20 and under. ▪ The provider should only replace the part that is lost. ▪ **To identify replacement lenses, please bill using modifier code RA in conjunction with the current and appropriate HCPCS code(s) for lenses.**

Necessary Contact Lenses	▪ Covered when medically necessary for the treatment of the following diseases or injury to the eye:
	  ▪ Keratoconus,
	  ▪ Keratoglobus,
	  ▪ Irregular cornea astigmatism,
	  ▪ Nystagmus,
	  ▪ Progressive myopia over 6 diopters, where contact lenses will improve visual acuity or retard the progressive myopia and lessen the frequency of prescription changes,
	  ▪ Hyperopia over 3.5 diopters, where contact lenses will improve visual acuity,
	  ▪ Anisometropia greater than 3 diopters or greater than 2.5, if there is documented intolerance to glasses as a result of anisometropia,
	  ▪ Disease or deformity of the nose, skin, or ears that precludes the wearing of eyeglasses,
	  ▪ Post-operative cataract surgery, or
	  ▪ Treatment as a result of eye surgery, other than cataracts, which must be provided within six (6) months of the surgery to be covered.
	▪ Prior confirmation is required for all contact lenses. The request must properly document that one (1) of the diagnoses listed above is involved, and it must reflect that conventional eyeglasses are not an acceptable method of correction.
	▪ **Contact lenses must be supplied by the provider.**

Benefit	Benefit Limitations/Criteria
Eyeglasses After Cataract/Ocular Surgery	▪ One pair of eyeglasses (standard frame and lenses) after each surgery on the eyeball or ocular muscle when the following criteria are met: ▪ Surgery results in a vision change, ▪ Eyeglasses are medically indicated within six (6) months of the surgery, and ▪ Eyeglasses are prescribed by an optometrist or ophthalmologist. ▪ **Frame must be selected from the March frame kit.** ▪ **Lenses must be provided by the March lab. Please refer to Exhibit C in the Provider Reference Guide for lab information.** ▪ **To identify eyewear after cataract surgery, please bill with the appropriate diagnosis code for cataract surgery.**
Repairs	▪ Repair of damaged lenses and/or frames is covered ages 20 and under. ▪ The provider must document a description of the damage in the medical record. The provider must repair only the part that is damaged. ▪ Damage cannot be repaired or repair costs exceed the Medicaid allowable amount for new frames and lenses, the provider must dispense new eyeglasses.
Non-Covered Services	▪ Surgical eye care.

1.4 Covered Benefits - UnitedHealthcare Community Plan – MS CHIP

Benefit	Benefit Limitations/Criteria
Routine Exam	▪ 1 exam every calendar year beginning January 1st.
Necessary Medical Services	▪ Covered as needed when services are performed by an optometrist and are within the scope of licensure. ▪ $5 copay may apply. Please refer to the Patient Benefit Summary in eyeSynergy® or contact Customer Service at 844-606-2724 to determine if the member has a copay.
Frame	▪ 1 unit every calendar year beginning January 1st. ▪ **Frame must be selected from the March frame kit**. ▪ 20% discount* toward the purchase of additional complete pairs of prescription glasses (lenses, lens options, and frames) from the provider's selection.
Lens (Single, Bifocal, Trifocal, Lenticular, Polycarbonate)	▪ 2 units (1 pair) every calendar year beginning January 1st. ▪ Plastic single, bifocal, trifocal or lenticular lenses are covered. ▪ Polycarbonate lenses are covered. ▪ Scratch resistant coating is covered. ▪ **Lenses must be provided by the March lab. Please refer to Exhibit C in the Provider Reference Guide for lab information.** ▪ 20% discount* toward the purchase of additional complete pairs of prescription glasses (lenses, lens options, and frames) from the provider's selection.
Necessary Contact Lenses	▪ 2 units (1 pair) in lieu of frame and lenses every plan year beginning January 1st when vision cannot be corrected with eyeglasses. ▪ **Contact lenses must be supplied by the provider.**
Non-Covered Services	▪ Surgical eye care.

*Discount available at select locations.

1.5 Covered Benefits - UnitedHealthcare Dual Complete® HMO D-SNP (Medicare) H5008-011

Benefit	Benefit Limitations/Criteria
Exam	▪ 1 service date every calendar year.
Necessary Medical Services	▪ Covered as needed when services are performed by an optometrist and are within the scope of licensure.
Eyewear	▪ $350 allowance every calendar year. ▪ Allowance may be used toward frames, lenses, lens extras and contact lenses. ▪ In-house frame and lenses **MUST** be used.
Eyewear After Cataract Surgery	▪ One pair of eyeglasses (standard frame and lenses) OR one pair of contact lenses following cataract surgery with an intraocular lens. Allowance does not apply. ▪ **To identify eyewear after cataract surgery, please bill with the appropriate diagnosis code for cataract surgery.**
Glaucoma Screening	▪ 1 service date every calendar year when member is considered "at-risk" according to the following Medicare definitions of "at-risk": ▪ Individuals with a family history of glaucoma ▪ Individuals with diabetes mellitus ▪ African-Americans ages 50 and older ▪ Hispanic-Americans ages 65 and older
Non-Covered Services	▪ Surgical eye care

1.6 Molina Reimbursement Procedures

The Molina Healthcare benefits afford members the opportunity to:

- Select eyeglasses using a $136 allowance that covers one frame from the March frame kit, single vision, bifocal or trifocal lenses and polycarbonate and/or anti-reflective coating OR
- Select contact lenses in lieu of frame and lenses using a $100 allowance (MississippiCAN only).

The following examples illustrate reimbursement for each scenario. These examples are for illustrative purposes only and may not reflect actual amounts unless stated otherwise.

March Frame Kit and March Lab

Providers must bill the current and appropriate service code for the fitting of spectacles when using the frame kit. Reimbursement for the fitting of spectacles will be at the lesser amount of billed charges or the provider's contracted rate. Frame and lens codes are not reimbursable and should not be billed as materials are provided by the March lab.

The following example assumes a contracted rate of $24.00 for the fitting of monofocal spectacles.

Service Code	Description	Modifier	Billed Charges	Paid Amount
92340	Fitting of Spectacles		$ 50.00	$ 24.00
Total			**$ 50.00**	**$ 24.00**

Retail Allowance – Contact Lenses (MississippiCAN only)

Providers must bill the current and appropriate HCPCS code(s) for contact lenses and CPT code for contact lens fitting. Reimbursement will be the lesser of billed charges or the contracted rate of $90.

Example 1

Service Code	Description	Modifier	Billed Charges	Paid Amount
V2500	Contact Lenses	75	$ 75.00	$ 75.00
92310	Contact Lens Fitting	75	$ 25.00	$ 0.00
Total			**$ 100.00***	**$ 75.00**

*Member is responsible for charges exceeding their benefit allowance ($100). In this example, there is no member responsibility.

Example 2

Service Code	Description	Modifier	Billed Charges	Paid Amount
V2500	Contact Lenses	75	$ 150.00	$ 85.00
92310	Contact Lens Fitting	75	$ 25.00	$ 0.00
Total			**$ 175.00***	**$ 85.00**

*Member is responsible for charges exceeding their benefit allowance ($100). In this example, the member is responsible for $75.