Mississippi Question of the Month April 2025

A provider called the MOA office and said a claim submitted to Ambetter for a diabetic eye exam was denied with Ambetter stating the examination was a routine vision exam. The provider was confused about why this happened.

Response: The provider was asked to send in the original claim copy and explanation of benefits (EOB) for review – with all the patient identifying information removed.

Upon review, the determination was made that the claim was indeed not denied but that the EOB had been misread. The claim for the medical visit with the diagnosis of diabetes was appropriately paid. However, the refraction had been appropriately denied with the explanation that the patient did not have the adult vision rider and thus the refraction was not covered but the patient could be billed.

Every provider can misread an EOB, particularly any denial reasons. Anytime a provider or staff thinks a claim was inappropriately denied, the first step is a careful review of the EOB to ensure it was properly interpreted. If, indeed, a claim has seemingly been inappropriately denied, the provider should ensure the original claim contained the appropriate information, examination code, diagnosis codes appropriate and linked to the correct procedure code. If an error was made, a corrected claim can be submitted. The MOA is always ready to aid any provider with a claims process to ensure proper reimbursement is received.

A few other tips for claims AmBetter commercial (not Medicaid claims) in particular:

1. For medical claims do not point the refraction to anything other than a routine ICD-10-CM code (i.e. Z01.01).
2. Ambetter will only pay a refraction pointed to a routine code.
3. For routine exams you can use an S code (which includes a refraction) or a 92- code plus a refraction. The reimbursement will be the same.
4. All materials and contact lens fit(s) also need routine, well vision ICD-10-CM and procedure codes.
5. If a denial states an unpaid premium issue, the provider should bill the patient. While the ACA allows beneficiaries to be delinquent for up to 90 days and still use their insurance. However, after 90 days, if they do not catch up with premium payments, all claims during that grace period will be denied.
6. For any denials that were appropriately billed, an appeal with records should be sent along with a short letter validating the appeal.