

**APPENDIX: PLAN SPECIFICS
MAGNOLIA HEALTH PLAN
MississippiCAN and Mississippi CHIP Programs**

The provisions outlined in these Plan Specifics shall prevail over any provision in the Centene Vision Provider Manual that may conflict or appear inconsistent with any provision contained in this document.

Envolve Vision, doing business as Centene Vision Services, administers the vision benefit for Magnolia Health. Members are eligible for routine and medical vision services within the scope of Mississippi’s fee-for-service Medicaid and CHIP programs, as detailed below.

We provide vision services for the following Magnolia Health member eligibility categories:

- MississippiCAN Adults
- MississippiCAN Children
- Mississippi CHIP Children

For specific individual member benefits and eligibility, log into our provider portal [Eye Health Manager](https://centenevision.com/logon) (centenevision.com/logon) or call Customer Service at 888-241-0663.

PLAN BENEFITS:

BENEFIT	BENEFIT CRITERIA/LIMITATIONS
Preventive Eye Exams with Refraction/*Value Add Benefits	<p>MS CAN Members 21 & over: *One routine eye exam every state fiscal year (July 1 – June 30). MS CAN Members under 21: *Two routine eye exams every state fiscal year (July 1 – June 30). EPSDT-eligible members are eligible for more services if determined to be medically necessary.</p> <p>MS CHIP: One complete eye exam every calendar year.</p> <ul style="list-style-type: none"> • Eligible diagnoses for preventive vision exams can be found on our website at centenevision.com/forms. Navigate to the Eligible ICD Codes for all other States (PDF). • Report refraction (92015) separately when billing the exam with a 92XXX code. • Regardless of final diagnosis, a member who presents for a routine exam with no complaint must be reported as a preventive exam, using a routine diagnosis code as the primary diagnosis. Additional diagnoses identified during the examination should be reported following the initial routine diagnosis that corresponds with the chief complaint. Providers are required

	<p>to code all claims to the highest level of specificity and report and submit all diagnoses that impact the patient’s evaluation, care and treatment; reason for the visit; co-existing acute conditions; chronic conditions or relevant past conditions.</p> <ul style="list-style-type: none"> • CPT II codes 2022F-2033F and 3072F are separately reimbursable when reported for evaluation of diabetic retinopathy. Submit 2022F-2033F for results corresponding to current year findings, or 3072F to report no retinopathy in the prior year.
<p>Medical Services, Surgical Services, and Injectable Ocular Drugs</p>	<p>Medically necessary eye care services are covered for members of all ages as indicated in the evidence of coverage.</p> <ul style="list-style-type: none"> • No prior authorization is required for most services performed by participating providers in participating facilities. Please refer to the “Prior Authorization” section in this document for more information. • All medical and surgical services are subject to Centene Vision Utilization Management policies and procedures. Policies and procedures can be found by logging into Eye Health Manager (centenevision.com/logon). • All claims for medically necessary eye care services, ocular injectable drugs, and facility services should be directed to Centene Vision. • Providers should comply with Magnolia Health Plan’s drug formulary or preferred drug list when prescribing medications for a member. This information can be found at magnoliahealthplan.com/for-members/pharmacy.
<p>Copayments</p>	<p>None</p>
<p>Covered Eyewear/*Value Add Benefits</p>	<p>MS CAN Members 21 and over: *One pair of eyeglasses every state fiscal year (July 1 – June 30). MS CAN Members under 21: *Two pairs of eyeglasses every state fiscal year (July 1 – June 30). EPSDT-eligible members are eligible for more services if determined to be medically necessary.</p> <p>MS CHIP: One pair of eyeglasses every calendar year. Eligible diagnoses for routine eyeglasses can be found on the <i>Eligible ICD Codes for all other States (PDF)</i>.</p> <p>Dispensing Requirements (adult/child) Providers must have a selection of at least 30 standard-size frames available at no cost to the member. Frames must meet the following requirements:</p> <ul style="list-style-type: none"> • Only standard frames are covered. Deluxe frames are not covered. Providers may not dispense a more expensive frame than is covered under the Medicaid Program and bill the member for the difference.

	<ul style="list-style-type: none"> • Eyeglass frames should be durable and constructed to be normally resistant to damage or breakage to minimize the need for replacement. <p>Lenses must meet the following requirements:</p> <ul style="list-style-type: none"> • Polycarbonate lenses are covered for all members. • All lenses must meet FDA impact-resistant regulations. <p>A member may purchase non-covered lens features such as scratch resistant or anti-reflective coating. If a member chooses to purchase non-covered services, the member must be properly advised in advance and documentation must be maintained in the member’s medical records of such election. Additionally, a provider may collect these charges directly from the member. It is recommended that providers obtain and retain a signed Non-covered Services Liability Acknowledgment form from the member indicating their agreement to pay for such services. This form is available at centenevision.com/forms under the section titled <i>All State Providers</i>.</p>
<p>Medically Indicated Eyewear</p>	<p>Prior authorization is not required for medically necessary eyewear; however, it is subject to retrospective review. Please maintain documentation in the member’s file of the necessity of the eyewear and/or services provided.</p> <p>Medically Indicated Contact Lenses Medically indicated contact lenses are covered when:</p> <ul style="list-style-type: none"> • Conventional glasses will not result in acceptable vision correction. • Contact lenses are medically indicated to treat disease or injury to the eye. • Contact lenses for illness or injury must be billed in accordance with the Mississippi Division of Medicaid (DOM) Provider Policy Manual. <p>Low Vision Aids Covered when medically indicated for members under age 21. Prior authorization is not required. All services will be reviewed post claim payment to ensure that services were provided in accordance with state or Centene Vision policy.</p> <p>Lens Coating Tinted, photochromatic, or UV protected lenses will be covered when medically indicated for the following medical diagnoses as defined in the Mississippi DOM Provider Policy Manual: other disturbances of aromatic amino-acid metabolism, degeneration of macula and posterior pole,</p>

	<p>pigmentary retinal dystrophy, cataracts, keratitis, corneal opacity and other disorders of cornea, disorders of conjunctiva, aphakia, congenital aphakia, aniridia, and pseudophakos.</p> <p>High-index Covered when medically indicated for members under age 21.</p> <p>Post-cataract Eyewear Members who have undergone cataract surgery are entitled to one additional pair of eyeglasses when medically indicated and prescribed by an optometrist or ophthalmologist within six months of the cataract surgery.</p> <ul style="list-style-type: none"> • This benefit is allowed for members who have had surgery on the eyeball or ocular muscle. • Members who undergo multiple surgeries will be eligible for the benefit following each surgery if all criteria is met. • This benefit is in addition to the eyewear benefits described in the Eyewear section above. • Eyewear must meet the same requirements as those listed under the Eyewear section. • Post cataract eyewear must be billed with Z96.1.
Frequency Exceptions	<p>Members under age 21 may receive additional exams per benefit year (7/1-6/30) based on medical necessity.</p> <ul style="list-style-type: none"> • No prior approval is required. • Provider should retain documentation for the additional exams in the member’s medical record. • There are no frequency exceptions for members age 21 and over.
Eyeglasses Replacement	<p>Members under age 21 may obtain replacements of frames and lenses due to loss or theft.</p> <ul style="list-style-type: none"> • Only the part that is lost may be replaced. For example, if a lens falls out and is lost, only the lens may be replaced. • Providers should bill replaced components utilizing the appropriate RA or RB modifiers. • Members age 21 and over are not eligible for replacement eyeglasses due to loss or destruction.
Eyeglasses Repair	<p>Repair of damaged lenses and/or frame is covered for members under age 21.</p> <ul style="list-style-type: none"> • The provider must maintain a description of the damage in the medical record and must repair only the part that is damaged. • If the cost of repair supplies exceeds the Medicaid allowable amount for a new frame and lenses, the provider must dispense new eyeglasses. • Members age 21 and over are not eligible for repair services.

Prosthetics	<p>Prosthetic eyes are a covered service for members under 21.</p> <ul style="list-style-type: none"> • Prior authorization is not required; however, providers are instructed to attach the invoice when submitting a claim for prosthetics.
Non-covered Services	<ul style="list-style-type: none"> • Eyeglasses used solely for protective, fashion, cosmetic, sports, occupational, or vocational purposes. • Replacements for members age 21 and over. • Spare pair of glasses or single vision glasses in addition to multifocal glasses. • Deluxe frames. • No-line/invisible bifocals. • Hi-index lenses for members age 21 and older. • Lens coating except as noted above for medical necessity. • Sunglasses, eyeglass cases, engraving, eyeglass or contact lens insurance. • Contact lenses except as noted above for medical necessity. • Contact lens supplies or solutions. • Dispensing fees. • Low vision evaluations, services, and hardware for members 21 and older. • Vision therapy (orthoptics and pleoptics). • Prosthetics for members 21 and over. • Cosmetic, experimental, or investigative services. • LASIK and other elective refractive procedures.

UTILIZATION MANAGEMENT REQUIREMENTS:

<p>Prior authorization</p>	<p>Prior authorization is required for the following services:</p> <ul style="list-style-type: none"> • Non-emergent surgeries: CPT codes 15822, 15823, 67900, 67904, and 67908. Blepharoplasty procedures must include original photographs and can be sent via secure email to visionauthorizations@centene.com. All procedures must be performed at a participating facility. Non-emergency services performed without prior authorization will be denied and the member cannot be held liable for payment of benefits normally covered under their benefit plan. • Anti-VEGF injectable drugs, excluding Avastin. Avastin does not require prior authorization. Requests for prior authorizations for ocular injectables must be sent using Prior Authorization Request for Anti-VEGF Injectables (PDF) located on our website at centenevision.com/forms. <p>Prior authorization requests should be submitted to centenevision.com/logon or via fax at 877-865-1077. Detailed instructions for submitting prior authorization requests can be found at centenevision.com/logon. Click on <i>Online Forms</i> and <i>Prior Authorization Request Form</i>.</p> <ul style="list-style-type: none"> • For more information, please call Centene Vision Utilization Management at 800-465-6972 or by fax at 877-865-1077.
<p>Documentation</p>	<p>Medical records must support medical necessity as applicable.</p> <ul style="list-style-type: none"> • Eyeglass documentation includes lens specifications such as lens type, power, axis, prism, absorptive power, and impact resistance. • Contact lens documentation includes lens specifications such as power, size, curvature, flexibility, and gas permeability. • Prescriptions for lens coating must include diagnosis code and/or narrative as defined by the state. • Centene Vision conducts retrospective review of medical records to ensure that documentation requirements are satisfied.

CODING INFORMATION:

Description	Code
Routine Ophthalmological Examination	92002, 92004, 92012, 92014
Refraction	92015
Frames	V2020
Fitting of spectacles	92340 – 92342
Repair and refitting spectacles	92370
Category II CPT Codes for Diabetic Retinal Exam (DRE) Measure	2022F-2033F, or 3072F for prior year findings
Replacement of optical hardware	RA Modifier
Replacement of a part of optical hardware furnished as a part of a repair	RB Modifier
CLAIMS SUBMISSION	
<p>All claims should be submitted within 180 days from the date of service. No reimbursement will be made for claims received beyond this date. Claims received after the 180-day filing deadline will be considered a provider liability and members may not be billed for services. All corrected claims, requests for reconsideration or claim disputes must be received within 90 calendar days from the date of notification of payment or denial.</p>	
<p>Eye Health Manager (available 24/7)</p> <ul style="list-style-type: none"> • Verify member eligibility and benefits. • File claims. • Review claims status. • Use audit tools. • Download, research, and reprint EOPs. • Request secure HIPAA compliant prior authorization requests. 	<p>To access <i>Eye Health Manager</i>:</p> <ol style="list-style-type: none"> 1. Go to centenevision.com/logon. 2. Log in with your username and password. 3. Please contact Network Management at 800-531-2818 if you have misplaced your username/password or if you would like to have access to the Eye Health Manager.
Electronic Claims Submission:	Change Healthcare Payor ID# 56190
Paper Claims Submission:	Centene Vision, Inc. PO Box 7548 Rocky Mount, NC, 27804
Contacting Us	
Member Eligibility and Claims Inquiries	888-241-0663
Provider Participation and Credentialing Inquiries	800-531-2818
Member Identification Card	
Please find Member ID Card examples for your state at Where We Are (centenevision.com/mystate) .	