MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Distribution: Practitioner 01-03
Vision 01-03

Issued: April 1, 2001

Subject: Uniform Billing

Effective: August 1, 2001

Programs Affected: Medicaid, Children's Special Health Care Services

Effective for services rendered on and after August 1, 2001, the Michigan Department of Community Health (MDCH) is implementing changes in coverage and reimbursement policies, and claim submission requirements for all vision providers (i.e., optometrists, ophthalmologists, optical companies, and vision hardware contractor). These changes will help align MDCH requirements with those of other major health insurers and are a step toward HIPAA (Health Insurance Portability and Accountability Act of 1996) compliance.

This bulletin contains information about specific changes being implemented for vision providers. You should also refer to Medicaid bulletin MSA 01-01 (revised Chapter IV) issued January 1, 2001, for additional information regarding claim completion requirements. Copies of all draft and final policy bulletins, the electronic claim transaction set, and other information related to changes being made are available on the MDCH website at www.mdch.state.mi.us, click on Medical Services Administration, Information for Medicaid Providers.

The following changes will be implemented August 1, 2001:

All vision providers must begin using:

- Current Procedural Terminology (CPT) procedure codes and modifiers,
- Health Care Financing Administration Common Procedure Coding System (HCPCS) procedure codes and modifiers,
- International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis codes, and
- claim formats: National Electronic Data Interchange Transaction Set Health Care Claim: Professional 837 (ASC X12N 837, version 3051) for electronic submission; HCFA 1500 (12-90) for paper claim submission.

For many vision providers, this means a change of claim form used as well as coding structures. In addition, some coverage changes are being made to bring Medicaid coverage closer to that of other insurance carriers. Attachment 1 of this bulletin presents procedure code parameters.

POLICY CHANGES/IMPACTS

All vision services will be subject to editing for Medicare coverage.

Vision procedures and services provided must be within the provider's scope of practice. Examples: When prescribing medication for treatment of a glaucoma patient, an optometrist must possess a Therapeutic Pharmaceutical Agent (TPA) certificate. When providing follow-up services after cataract surgery, a properly certified optometrist bills the MDCH by using the surgery code with modifier 55. If an optometrist who is not properly certified bills a procedure requiring certification, the claim will be rejected.

Whenever a vision Evaluation and Management CPT procedure code is billed, a medical diagnosis must be indicated in the appropriate area for the claim format selected.

There will no longer be a differentiation made between the maximum allowable amount paid to an ophthalmologist and the maximum allowable amount paid to an optometrist for a given service. For example, if an optometrist with TPA certification billed Procedure Code 92313 for a beneficiary and an ophthalmologist billed Procedure Code 92313 for a different beneficiary, the same maximum allowable amount would be available for each provider.

Each date of service must be billed on a separate claim line (i.e., services may not be "series billed").

Copayments

A $2 beneficiary copayment is required for each routine ophthalmological examination (i.e., Procedure Codes S0620 or S0621) performed by an **optometrist or ophthalmologist** if the beneficiary is 21 years of age or older and does not reside in a nursing facility. HOWEVER, a copayment is not required if the examination is covered by Medicare.

A $2 beneficiary copayment is required for each dispensing service for spectacles or contact lenses billed by **Provider Types 86 and 94** if the beneficiary is 21 years of age or older and does not reside in a nursing facility. HOWEVER, a copayment is not required if the service is covered by Medicare.

Attachment 1 of this bulletin indicates the procedure codes that require copayments.

Chapter IV (distributed by bulletin MSA 01-01, issued January 1, 2001) explains how claims are completed to correctly reflect copayments.

Examinations

Optometrists AND ophthalmologists must use Procedure Codes S0620 "Routine ophthalmological examination including refraction; new patient" or S0621 "Routine ophthalmological examination including refraction; established patient" to bill a routine examination.

An eye examination is considered "routine" if it is provided solely for any of the following diagnoses: ametropia, anisometropia, astigmatism, emmetropia, hypermetropia, hyperopia, myopia, "no pathology," presbyopia, or refractive error.

A routine examination may be performed once every two years and includes history, visual acuity determination, external exam of the eye, binocular measure, ophthalmoscopy with or without tonometry, with plotting of visual fields, with or without biomicroscopy (slit lamp), and with or without refraction. Exceptions to this frequency require documentation of medical necessity in the "Remarks" area of the claim (i.e., Item 19 on the paper format; 2300 NTE02 for the electronic format), including the visual acuities from both examinations. It is not sufficient to say "two or more line reduction in visual acuity" or "acuity of 20/50 or less with spectacles."

Special note to all optometrists and ophthalmologists: Procedure Code 92015 "Determination of refractive state" is not separately reimbursable by the MDCH.

Vision Services Approval/Order form (DCH-0893)

Beginning August 1, 2001, both ophthalmologists and optometrists must use the DCH-0893 for hardware orders and prior approval requests. A facsimile of the DCH-0893, along with instructions for completion, mailing, and obtaining a supply of the DCH-0893 are contained in Attachment 2.

If an ophthalmologist (Provider Type 10, 11, or 77) wishes to obtain the ordered hardware and dispense the items to Medicaid beneficiaries, he/she must also enroll with the MDCH as Provider Type 86.

NOTE: If polycarbonate, high index, or industrial thickness lenses are ordered, the appropriate modifier must be indicated in Item 21 of the DCH-0893 along with the procedure code.

Spectacles

The policies for spectacles and lenses remain unchanged.

Normally, the date of service for dispensing hardware is the actual date dispensing occurs. However, if the beneficiary loses eligibility between the date an order is submitted to the hardware contractor and the date the provider receives the hardware, or if the beneficiary moves from a fee-for-service status to being enrolled with a qualified health plan or a Children's Special Health Care Services special health plan during that time frame, the order date must be used as the date of service.

If spectacles are undeliverable (e.g., the beneficiary moves and leaves no forwarding address and you have exhausted all attempts to locate him/her), the dispensing provider must send the spectacles to the local Family Independence Agency within 90 days of placing the order with the hardware contractor. To bill for dispensing, the provider must:

- use the date the spectacles were sent to the local Family Independence Agency as the date of service,
- put the date the spectacles were ordered in "Remarks" area of the claim, along with an explanation of the circumstances making the spectacles undeliverable, and
- if the spectacles were not sent to the local Family Independence Agency within 90 days of the order, the claim must reflect the reason in the "Remarks" area of the claim.

INVOICE

The HCFA 1500 (12-90) paper claim form will be accepted and processed for dates of service on and after August 1, 2001. However, providers are encouraged to bill electronically using the National Electronic Data Interchange Transactions Set Health Care Claim: Professional 837 (ASC X12N 837, version 3051) to receive faster payments and fewer pends and rejections.

Chapter IV (issued January 1, 2001 by bulletin MSA 01-01) contains a facsimile of the paper HCFA-1500 form that Medicaid will accept and presents claim completion instructions and a crosswalk to the electronic format. Providers are urged to review this Chapter very carefully, as there are a number of data items that are much different than those on the previously used Medicaid invoice.

CODING STRUCTURES

For dates of service on and after August 1, 2001, providers must use ICD-9-CM diagnosis codes and CPT/HCPCS procedure codes in addition to any appropriate modifiers for billing services provided or items ordered from the hardware contractor. **NOTE:** When using ICD-9-CM codes, the provider must use the code reflecting the greatest specificity for the diagnosis.

Provider types 86 and 94 are restricted to the following place of service codes (the appropriate code must appear in the “Place of Service” area on the claim):

11	office
12	home
21	inpatient hospital
22	outpatient hospital
23	emergency room - hospital
24	ambulatory surgical center
31	skilled nursing facility
32	nursing facility
33	custodial care facility
35	adult living care facility

The hardware contractor is limited to place of service 11 (office) for all Medicaid billing.

The following procedure codes, which conform to the standard coding convention, have been created to allow providers to obtain replacement parts for frames:

Z3002	Replacement of front, including insertion of lenses
Z3003	Replacement of temples
Z3004	Replacement of adjustable nose pads

If a frame style is discontinued from the Medicaid selection of frames and the provider has that particular style frame in his/her sample kit, the provider may dispense that frame using Procedure Code V2799. Lenses must be ordered from the hardware contractor. If the provider sends the sample frame to the hardware contractor for lens insertion, this fact must be indicated in Item 29 of the DCH-0893. When billing the MDCH, the "Remarks" area of the claim must reflect the frame name, acquisition cost, and postage/shipping costs.

There are no CPT/HCPCS codes specific to a low vision evaluation. Providers must select an appropriate Evaluation and Management code for these evaluations.

Attachment 1 of this bulletin contains a list of the CPT/HCPCS procedure codes most likely to be used when billing for vision services, ordering items from the hardware contractor, and the hardware contractor bills the MDCH for ordered items.

Providers should refer to the CPT/HCPCS coding manuals for the complete lists of procedure codes.

Procedure code S4027 (spectacle case) is used only by the **hardware contractor** when billing the MDCH.

Attachment 3 of this bulletin presents a list of modifiers most frequently used with vision CPT/HCPCS procedure codes. Providers should refer to the CPT/HCPCS coding manuals for complete lists of modifiers.

MANUAL UPDATE

The pages attached to this bulletin are not in manual format. As a temporary measure, you may file them in the Medical Assistance Program Manual until such time as updated pages are issued.

The following bulletins are obsolete and may be discarded: Vision 00-03, Vision 00-01, Vision 93-01, Vision 92-01, and MSA 96-06 (Vision 96-01, Practitioner 96-02)

QUESTIONS

Any questions regarding this bulletin should be directed to: Provider Inquiry, Medical Services Administration, P. O. Box 30479, Lansing, Michigan 48909-7979, or e-mail at ProviderSupport@state.mi.us. Providers may phone toll free 1-800-292-2550.

APPROVAL

James K. Haveman, Jr.
Director

Robert M. Smedes
Deputy Director for
Medical Services Administration

CROSSWALK
VISION CPT/HCPCS PROCEDURE CODES

1. Codes requiring prior approval are designated with a Y in the "PA" column.
2. Codes requiring the optometrist to have an expanded scope of practice via therapeutic pharmaceutical agent (TPA) certification are designated with a Y in the "Cert." column. These codes may also be restricted to specific diagnosis codes.
3. Codes that must be used with a specific modifier indicate the modifier in the "Modifier" column.
4. The vision hardware contractor (Provider Type 95) must use certain modifiers to further designate types of hardware provided (i.e., VC [polycarbonate lens], VH [high index lens], VI [industrial thickness lens], and VG [industrial thickness polycarbonate lens]). These modifiers determine the reimbursement amount for the contractor and are indicated in the "Modifier" column by a Y.
5. Copayments apply to each routine ophthalmological examination performed by an ophthalmologist or optometrist if the beneficiary is 21 years of age or older and does not reside in a nursing facility.
   NOTE: A copayment is NOT required if the examination is covered by Medicare.
6. Copayments apply to each dispensing service for spectacles or contact lenses billed by Provider Types 86 and 94 if the beneficiary is 21 years of age or older and does not reside in a nursing facility.
   NOTE: A copayment is NOT required if the service is covered by Medicare.

CODES THAT ARE NOT SEPARATELY REIMBURSABLE BY THE DEPARTMENT OF COMMUNITY HEALTH OR THOSE STRICTLY FOR USE BY OPHTHALMOLOGISTS ARE NOT INCLUDED IN THIS LIST.

Code	PA	Cert	Prov Types	Modifier	Comments	Old Codes
65205		Y	94			41039
65220		Y	94			N/A
65222		Y	94			41039
65430		Y	94			41039
65435		Y	94			N/A
66821		Y	94	55		N/A
66840			94	55		N/A
66850			94	55		N/A
66852			94	55		N/A
66920			94	55		N/A
66930			94	55		N/A
66940			94	55		N/A
66983			94	55		N/A
66984			94	55		N/A
66985			94	55		N/A
66986			94	55		N/A
67820		Y	94			41039
67938		Y	94			41007
68761		Y	94			41039
68801		Y	94			N/A
76511			94			N/A
76512			94			N/A
76516			94			N/A

Code	PA	Cert	Prov Types	Modifier	Comments	Old Codes
76519		Y	94			41039
92002			94			41000 – 41006
92004		Y	94			41006
92012			94			41000 – 41006
92014		Y	94			41006
92020			94			41039
92060			94			41170
92065	Y		94		PA required for age 21 and older	41171
92070		Y	94			41175 – 41178
92081			94			41020
92082			94			41020
92083			94			41020
92100			94			41022
92120			94			41024
92135		Y	94			N/A
92225			94			41039
92226			94			41039
92250		Y	94			41007
92283			94			41039
92284			94			41039
92310			86,94		Cannot bill with modifier VP Copayment applies	41176 – 41178
92311			86,94	VP	Must bill with modifier VP Copayment applies	41177 – 41178
92312			86,94	VP	Must bill with modifier VP Copayment applies	41176, 41178
92313			86,94		Copayment applies	41176 – 41178
92326	Y		86,94		Copayment applies	41179
92330			10,11,94		Copayment applies	41150 – 41155
92340			86,94		Cannot bill with modifier VP Copayment applies	41260
92341			86,94		Cannot bill with modifier VP Copayment applies	41261
92342			86,94		Cannot bill with modifier VP Copayment applies	41261
92352			86,94	VP	Must bill with modifier VP Copayment applies	41262 – 41263
92353			86,94	VP	Must bill with modifier VP Copayment applies	41262 – 41263
92370			86,94		Cannot bill with modifier VP	41263
92371			86,94	VP	Must bill with modifier VP	41263
92391	Y		86,94		Bill with modifier 26 for the service of fitting without supply	41179

Code	PA	Cert	Prov Types	Modifier	Comments	Old Codes
92396	Y		86,94		Bill with modifier 26 for the service of fitting without supply	41179
92499			94			41159, 41169, 41173, 41199
95060		Y	94			N/A
97112			94			41181
97116			94			41181
97530			94			41181
99201			94			41000 – 41003, 41006 – 41007, 41010
99202			94			41000, 41010
99203			94			41006
99204		Y	94			41007
99205		Y	94			41180
99211			94			41007, 41010
99212			94			41007, 41010
99213			94			41000 – 41003, 41006 – 41007, 41010
99214		Y	94			41007
99215		Y	94			41180
99221		Y	94			N/A
99222		Y	94			N/A
99223		Y	94			N/A
99231		Y	94			N/A
99232		Y	94			N/A
99233		Y	94			N/A
99241		Y	94			N/A
99242		Y	94			N/A
99243		Y	94			N/A
99244		Y	94			N/A
99245		Y	94			N/A
99251		Y	94			N/A
99252		Y	94			N/A
99253		Y	94			N/A
99254		Y	94			N/A
99255		Y	94			N/A
99261		Y	94			N/A
99262		Y	94			N/A
99263		Y	94			N/A
99281		Y	94			N/A
99282		Y	94			N/A

Code	PA	Cert	Prov Types	Modifier	Comments	Old Codes
99283		Y	94			N/A
99284		Y	94			N/A
99285		Y	94			N/A
99311			94			N/A
99312			94			N/A
99313			94			N/A
99321			94			N/A
99322			94			N/A
99323			94			N/A
99331			94			N/A
99332			94			N/A
99333			94			N/A
99341			94			N/A
99342			94			N/A
99343			94			N/A
99344			94			N/A
99345			94			N/A
99347			94			N/A
99348			94			N/A
99349			94			N/A
99350			94			N/A
S0620			94		Copayment applies	41000 – 41003, 41006
S0621			94		Copayment applies	41000 – 41003, 41006
S4027			95			41256
V2020			95			41250, 41253, 41256
V2100			86,94,95 94	Y	Billable by PT95 only	41200 – 41202
V2101			86,94,95	Y	Billable by PT95 only	41200 – 41202
V2102			86,94,95	Y	Billable by PT95 only	41200 – 41202
V2103			86,94,95	Y	Billable by PT95 only	41200 – 41202
V2104			86,94,95	Y	Billable by PT95 only	41200 – 41202
V2105			86,94,95	Y	Billable by PT95 only	41200 – 41202
V2106			86,94,95	Y	Billable by PT95 only	41200 – 41202
V2107			86,94,95	Y	Billable by PT95 only	41200 – 41202
V2108			86,94,95	Y	Billable by PT95 only	41200 – 41202
V2109			86,94,95	Y	Billable by PT95 only	41200 – 41202
V2110			86,94,95	Y	Billable by PT95 only	41200 – 41202
V2111			86,94,95	Y	Billable by PT95 only	41200 – 41202
V2112			86,94,95	Y	Billable by PT95 only	41200 – 41202

Code	PA	Cert	Prov Types	Modifier	Comments	Old Codes
V2113			86,94,95	Y	Billable by PT95 only	41200 – 41202
V2114			86,94,95	Y	Billable by PT95 only	41200 – 41202
V2115			86,94,95	Y	Billable by PT95 only	41241
V2117			86,94,95	Y	Billable by PT95 only	41230
V2199	Y		86,94,95	Y	Billable by PT95 only	41240
V2200			86,94,95	Y	Billable by PT95 only	41206 – 41208, 41212 – 41213, 41215 – 41216
V2201			86,94,95	Y	Billable by PT95 only	41206 – 41208, 41212 – 41213, 41215 – 41216
V2202			86,94,95	Y	Billable by PT95 only	41206 – 41208, 41212 – 41213, 41215 – 41216
V2203			86,94,95	Y	Billable by PT95 only	41206 – 41208, 41212 – 41213, 41215 – 41216
V2204			86,94,95	Y	Billable by PT95 only	41206 – 41208, 41212 – 41213, 41215 – 41216
V2205			86,94,95	Y	Billable by PT95 only	41206 – 41208, 41212 – 41213, 41215 – 41216
V2206			86,94,95	Y	Billable by PT95 only	41206 – 41208, 41212 – 41213, 41215 – 41216
V2207			86,94,95	Y	Billable by PT95 only	41206 – 41208, 41212 – 41213, 41215 – 41216
V2208			86,94,95	Y	Billable by PT95 only	41206 – 41208, 41212 – 41213, 41215 – 41216
V2209			86,94,95	Y	Billable by PT95 only	41206 – 41208, 41212 – 41213, 41215 - 41216
V2210			86,94,95	Y	Billable by PT95 only	41206 – 41208, 41212 – 41213, 41215 – 41216
V2211			86,94,95	Y	Billable by PT95 only	41206 – 41208, 41212 – 41213, 41215 – 41216
V2212			86,94,95	Y	Billable by PT95 only	41206 – 41208, 41212 – 41213, 41215 – 41216
V2213			86,94,95	Y	Billable by PT95 only	41206 – 41208, 41212 – 41213, 41215 – 41216
V2214			86,94,95	Y	Billable by PT95 only	41206 – 41208, 41212 – 41213, 41215 – 41216
V2217			86,94,95	Y	Billable by PT95 only	41231 – 41232
V2219			86,94,95	Y	Billable by PT95 only	41214, 41217 – 41218
V2220			86,94,95	Y	Billable by PT95 only	41214, 41217 – 41218, 41244
V2299	Y		86,94,95	Y	Billable by PT95 only	41240, 41285
V2300			86,94,95	Y	Billable by PT95 only	41220 – 41221
V2301			86,94,95	Y	Billable by PT95 only	41220 – 41221
V2302			86,94,95	Y	Billable by PT95 only	41220 – 41221
V2303			86,94,95	Y	Billable by PT95 only	41220 – 41221
V2304			86,94,95	Y	Billable by PT95 only	41220 – 41221
V2305			86,94,95	Y	Billable by PT95 only	41220 – 41221
V2306			86,94,95	Y	Billable by PT95 only	41220 – 41221
V2307			86,94,95	Y	Billable by PT95 only	41220 – 41221
V2308			86,94,95	Y	Billable by PT95 only	41220 – 41221

Code	PA	Cert	Prov Types	Modifier	Comments	Old Codes
V2309			86,94,95	Y	Billable by PT95 only	41220 – 41221
V2310			86,94,95	Y	Billable by PT95 only	41220 – 41221
V2311			86,94,95	Y	Billable by PT95 only	41220 – 41221
V2312			86,94,95	Y	Billable by PT95 only	41220 – 41221
V2313			86,94,95	Y	Billable by PT95 only	41220 – 41221
V2314			86,94,95	Y	Billable by PT95 only	41220 – 41221
V2320			86,94,95	Y	Billable by PT95 only	41244
V2399	Y		86,94,95	Y	Billable by PT95 only	N/A
V2410			86,94,95	Y	Billable by PT95 only	41233
V2430			86,94,95	Y	Billable by PT95 only	41234 – 41235
V2499	Y		86,94,95	Y	Billable by PT95 only	N/A
V2500	Y		86,94			41179
V2501	Y		86,94			41179
V2510	Y		86,94			41179
V2511	Y		86,94			41179
V2520	Y		86,94			41179
V2521	Y		86,94			41179
V2599	Y		86,94	VP if for aphakia		41179
V2600	Y		86,94			41185 – 41186
V2610	Y		86,94			41185 – 41186
V2615	Y		86,94			41185 – 41186
V2623			86			41150 – 41155
V2624			86,94			41150 – 41155
V2625	Y		86,94			41150 – 41155
V2626	Y		86,94			41150 – 41155
V2627			86,94			41153 – 41155
V2628			86,94			41150 – 41155
V2629	Y		86,94			41150 – 41155
V2700			86,94,95	Y	Billable by PT95 only	41238
V2710			86,94,95		Billable by PT95 only	41245
V2715			86,94,95		Billable by PT95 only	41242
V2718			86,94,95		Billable by PT95 only	41246 – 41247
V2740	Y		86,94,95		Billable by PT95 only	41280
V2741	Y		86,94,95		Billable by PT95 only	41280
V2742	Y		86,94,95		Billable by PT95 only	41280
V2743	Y		86,94,95		Billable by PT95 only	41280
V2744	Y		86,94,95		Billable by PT95 only Covered for glass lens only	41281 – 41282

Code	PA	Cert	Prov Types	Modifier	Comments	Old Codes
V2755	Y		86,94,95		Billable by PT 95 only Covered for plastic lens only	41283
V2799	Y		86,94,95		Billable by PT95 only	41259

Procedure Code	PA	Description	Provider Types	Old Codes
Z3002		Replacement of front, including insertion of lenses	86,94,95	41134
Z3003		Replacement of temples	86,94,95	41135
Z3004		Replacement of adjustable nose pads	86,94,95	41136

DCH-0893 COMPLETION INSTRUCTIONS

The printed DCH-0893 is a four-part snap-out form. A facsimile of the DCH-0893 is at the end of this attachment. Many items need no explanation for completion; the following instructions should assist you in completing the remainder of the form.

Also in the attachment you will find mailing instructions and information on how to obtain the DCH-0893.

Completion Instructions

Items 1 – 6 must remain blank.

If you are submitting the DCH-0893 to request prior approval (PA) and it is approved, the PA number will appear in Item 1 when the form is returned to you. You must use this PA number when you bill.

Items 7 – 13 are related to you and/or your employer.

Item 11 (Provider Signature) requires a hand written signature (i.e., a stamped signature is unacceptable).

Item 13 (Date of Order) should reflect the examination date.

Items 14 – 18 contain beneficiary information, which can be obtained from the Medicaid ID Card or for Children's Special Health Care Services (CSHCS) enrollees, from the Provider Authorization Notice (form MG-041) or the Client Eligibility Notice (form MG-040).

Item 19 (Diagnosis) must contain the diagnosis(es) code(s) reflecting the greatest specificity for the diagnosis(es) from the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM). If appropriate, each eye's diagnosis(es) must be included.

Items 20 – 23 relate to services and materials being requested and applicable charges.

Lines 01 and 02 of Item 20 are preprinted. Lines 03 through 06 are available for special characteristics (e.g., prisms, high adds) or other services (e.g., contact lens, orthoptics), if applicable. **NOTE:** Each date of service must be billed on a separate line on the claim form; therefore, each date of service must be entered on a separate line of the DCH-0893 if the service requires PA.

Item 21 (Procedure Code) must reflect the appropriate CPT/HCPCS **procedure code and applicable modifier.**

Item 22 (Quantity) must present the appropriate quantity for each procedure code.

Each spectacle lens procedure code represents one lens. When requesting approval for or ordering a pair of spectacle lenses using the same procedure, use a quantity of "2."

Item 23 (Charge) is completed for only items requiring prior approval. Enter your usual and customary charge.

Item 24 (Reason) requires you to enter an X in only one box.

Initial Glasses: Enter an X if the prescription is for the **first spectacles ever worn** by the beneficiary. Both lenses and the frame must be provided.

Replacement: Enter an X if an **identical** (complete) pair of spectacles is provided because the previous pair was lost, stolen, or broken beyond repair. **NOTE:** If the identical style of frame is no longer available, a new **Medicaid-approved** frame style may be selected.

Diopter Change: Enter an X if the reason for a new pair of spectacles is due to a sufficient diopter change according to Medicaid's published policy.

Items 25 – 27 relate to the type/style of lenses and frame requested.

Items 28 – 29 reflect the lens specifications.

Enter all lens specifications in Item 28. **NOTE:** The width and style must be consistent with the procedure code appearing in Item 21 of the DCH-0893.

Item 29 must contain any additional instructions to the hardware contractor necessary for proper fabrication.

Item 30 must contain the specifications from the beneficiary's previous lens(es). This is applicable for diopter changes or replacements, as well as when requesting frames only. If this information is missing, the form will be returned to the provider unless documentation is submitted with a reason why this is not complete. **NOTE:** The only time this item is left blank is for initial spectacles.

Item 31 must remain blank. If you are requesting PA, this area will be completed before the DCH-0893 form is returned to you.

Mailing Instructions

Prior Approval

REMINDER: PA requests should be postmarked no more than 30 calendar days from the date of examination. If beyond the 30 days, the provider must include a detailed explanation of why the submission was delayed.

When requesting prior approval, the provider should make a photocopy of the completed form for its file because the entire four-part DCH-0893 must be sent to:

VISION CONTRACT MANAGER
6TH FLOOR, CAPITOL COMMONS CENTER
PO BOX 30479
LANSING MI 48909-7979

Upon completion of the PA process, one copy of the DCH-0893 is returned to the provider.

Order

REMINDER: Orders placed with the hardware contractor must be postmarked no more than 30 days after the date of examination. If beyond the 30 days, the hardware contractor will return the order to the provider, who must explain to Medicaid why submission was delayed and request an exception from the time limit.

When placing an order with the hardware contractor, the provider should retain the bottom copy of the completed form for its file and send the remaining pages of the DCH-0893 to:

CLASSIC OPTICAL LABORATORIES
3710 BELMONT AVE
PO BOX 1341
YOUNGSTOWN OH 44501-1341

To Obtain a Template of the DCH-0893

You may obtain a copy of the DCH-0893 electronically to use as a template. The DCH-0893 may be found at www.mdch.state.mi.us, scroll down to Health Legislation and Policy Development, click on Administrative Tribunal, click on Policy & Procedures, click on DCH-0893 Vision Services Approval/Order. **NOTE:** If a template is used to electronically complete the form, you need to photocopy the completed form or generate the appropriate number of copies to allow you to send the original and the three copies for PA or an order, keeping a copy for your files.

To Order a Supply of the DCH-0893

A letter detailing the form name, number, quantity desired, and shipping address may be sent to:

BUREAU OF HUMAN RESOURCES/ADMIN SERVICES DIV
FORMS MANAGEMENT SECTION/CASS BUILDING 1 SOUTH
320 SOUTH WALNUT
LANSING MI 48913

Orders may also be faxed to (517) 241-4719.

VISION SERVICES APPROVAL / ORDER

Michigan Department of Community Health

For MDCH Consultant Use Only

1. Prior Authorization Number

2 3 4 5 6

NOTE: Approval refers to services and does NOT guarantee beneficiary eligibility.

7. **PROVIDER** Name (Last, First, Middle Initial)			9. Phone No. ( )	10. Provider ID Number
8. Address (No. & Street, Etc.)			11. Provider Signature.	12. Provider Type
City	State	ZIP Code		13. Date of Order

14. **BENEFICIARY** Name (Last, First, Middle Initial)			16. Sex ☐ **FEMALE** ☐ **MALE**	
15. Address (No. & Street, Etc.)			17. Birth Date	18. Beneficiary ID Number
City	State	ZIP Code	19. DIAGNOSIS:	

	20. DESCRIPTION OF SERVICE(S)	21. PROC. CODE	22. QUANTITY	23. CHARGE
01	Spectacle Lens(es)			
02	Frame			
03				
04				
05				
06				

24. Reason: ***Note:*** *If prior authorization is required, attach documentation of medical necessity pursuant to Vision Services Manual.*
☐ **INITIAL GLASSES** ☐ **REPLACEMENT** ☐ **DIOPTER CHANGE**

25. Lens Type:
☐ **PLASTIC** ☐ **GLASS** ☐ **POLYCARBONATE** ☐ **LENS(ES) ONLY** ☐ **FRAME ONLY**

26. Lens Style:
☐ **SINGLE VISION** ☐ **BIFOCAL** ☐ **TRIFOCAL** ☐ **HI INDEX** ☐ **CATARACT**

27. FRAME Name		Manufacturer	
Color	Eye Size	Bridge Size	Temple Style & Length

LENS SPECIFICATIONS

28.	SPHERE	CYLINDER	AXIS	PRISM POWER & BASE DIRECTION	MRP HORIZONTAL	MRP HEIGHT
R						
L						

	ADD	SEGMENT HEIGHT	WIDTH & STYLE	SEGMENT INSET	TOTAL INSET	PD
R						Far:
L						Near:

29. Special Instructions to Laboratory:

PREVIOUS LENS SPECIFICATIONS

30.	SPHERE	CYLINDER	AXIS	ADD	PRISM / DIRECTION	LENS STYLE
R						
L						

31. ***For Consultant Use Only*** — Initials and Date

☐ **Approved** ☐ **Disapproved -** Exceeds Frequency ☐ **NO ACTION**
☐ **Amended** ☐ **Disapproved -** Criteria Not Met ☐ **Insufficient Documentation**

Authority: Title XIX of the Social Security Act
Completion: Is Voluntary, but is required if Medical Assistance program payment is desired.

The Department of Community Health is an equal opportunity employer, services, and programs provider.

DCH-0893(E) (Rev. 2/00) (W) Replaces MSA-0893, which is Obsolete

VISION MODIFIERS

Complete listings of modifiers are located in the CPT and HCPCS coding books. The following list indicates the modifiers that will be used most frequently by vision providers. **NOTE:** The last section of this attachment presents modifiers, based on standard coding convention, established for use on prior approval requests, orders, and on Medicaid billings submitted by the vision contractor.

modifiers for use with CPT procedure codes

-50 bilateral procedure
-52 reduced services
-55 postoperative management only

modifiers for use with HCPCS procedure codes

AP determination of refractive state was not performed in the course of diagnostic ophthalmological examination
CC procedure code change (use "CC" when the procedure code submitted was changed either for administrative reasons or because an incorrect code was filed)
E1 upper left, eyelid
E2 lower left, eyelid
E3 upper right, eyelid
E4 lower right, eyelid
LS FDA-monitored intraocular lens implant
LT left side (used to identify procedures performed on the left side of the body)
RT right side (used to identify procedures performed on the right side of the body)
VP aphakic patient

Michigan modifiers for use with HCPCS procedure codes

THESE MODIFIERS DO NOT APPEAR IN THE CPT OR HCPCS CODING BOOKS BUT MUST BE USED ON THE DCH-0893 AND THE CONTRACTOR MUST USE THEM WHEN BILLING MEDICAID

VC polycarbonate lens
VH high index lens
VI industrial thickness lens
VG industrial thickness polycarbonate lens