REIMBURSEMENT

The Fiscal Intermediary (FI) accepts standardized professional 837P electronic transactions if the Software Vendor, Billing Agent, or Clearinghouse (VBC) used by the provider has tested and been approved by the FI. Providers billing hard copy claims will continue to bill on the CMS-1500 (see Appendix C for sample CMS 1500 form and instructions). All information, whether handwritten or computer generated, must be legible and completely contained in the designated area of the claim form.

In order for a claim to be paid by Medicaid for services that require prior authorization, the request must have been approved and the dates of service must fall between the dates listed on the prior authorization. The actual date that the service was delivered should be used as the date of service when filing a claim for payment.

After prior authorization approval is received and the eye wear is delivered to the recipient, the provider should bill for all of the services rendered. All eye wear services, regardless of whether prior authorization is required, may be billed on the same claim form.

Billing Information

All claims submitted must contain LA Medicaid approved Healthcare Common Procedure Coding System **(**HCPCS**)** eye wear codes. Refer to the eye wear fee schedule located in Appendix A of this chapter.

All claims for payment should be submitted with the procedure code(s) that are identified in Appendix A for lens and frames and must include the appropriate number of units (quantity) for each item. Additionally, all claims must include the appropriate place of service (POS) code.

Reimbursement Fee

A flat fee has been established for each code listed in the Eye Wear Fee Schedule with the exception of the “non-specific” codes listed as “manually priced”.

These non-specific codes require PA and the reimbursement fee will be determined at the time of PA based on invoice cost. A copy of the invoice must be submitted with the PA request in order to determine the amount of reimbursement. Use of these codes should be limited to the instance when there is no established code available to describe the service being rendered.

Modifiers Required

The following modifiers should be used for PA and claims for payment *ONLY* in conjunction with procedure code V2102 when the lens is over 12.00 D spheres:

- RT-indicates right eye; and
- LT-indicates left eye.

These modifiers should not be used when billing procedure code V2102 when the lens is plus or minus 7.12 to plus or minus 12.00D sphere or with any other procedure code.

The attending provider number in item 24J of the CMS-1500 must match the provider number previously included on the PA-01 Form (field 6) of the PA form.

When billing for an approved service, the 9-digit PA number must be entered in item 23 of the CMS 1500 form or in the appropriate field of the electronic 837P.

Electronic Claims Status Inquiry

Providers who wish to check the status of claims submitted to Louisiana Medicaid should use the electronic claims status inquiry (e-CSI) application. Once enrolled on the Medicaid website, all active providers, with the exception of "prescribing only" providers, have authorization to utilize the e-CSI application. Refer to the General Information and Administration, or the Louisiana Medicaid website for more information on e-CSI.

Adjustment/Void Claims

An adjustment or void may be submitted electronically or by using the CMS-1500 (02/12) form. Refer to Appendix C for a sample adjustment and void form and instructions as related to vision services.

Adjustments for a Medicare/Medicaid Claims

When a provider has filed a claim with Medicare, Medicare pays, then the claim becomes a “crossover” to Medicaid for consideration of payment of the Medicare deductible or co-payment.

If, at a later date, it is determined that Medicare has overpaid or underpaid, the provider should rebill Medicare for a corrected payment. These claims may “crossover” from Medicare to Medicaid, but cannot be automatically processed by Medicaid (as the claim will appear to be a duplicate claim, and therefore must be denied by Medicaid).

In order to receive an adjustment, it is necessary for the provider to file a hard copy claim using the CMS 1500 (see Appendix C for adjustment/void form and instructions) to Medicaid. A copy of both the most recent Medicare Explanation of Benefits (EOMB) and the original Explanation of Benefits must be attached to the adjustment form and should be mailed to the Fiscal Intermediary (FI).

The provider should write "2X7" at the top of the CMS 1500 to indicate the adjustment is for a Medicare/Medicaid claim.