



State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

MEDICAID ALERT

April 1992

TO: Providers of Vision Care Services

SUBJECT: Clarification of Billing Instructions for Optical Appliances

This Medicaid Alert is to identify for providers of vision care services certain problems which have caused a significant number of claims to suspend or deny. When completing an MC-9 form (Request for Authorization and Payment - Optical Appliances), carefully follow the instructions provided in this Medicaid Alert. Failure to do so may result in continued claims suspension or denial.

NOTE: The revised Medicaid Request for Authorization and Payment-Optical Appliances Claim Form - MC-9 (REV. 9/91) is a two-ply form. Each ply has a fixed purpose. The plies are not interchangeable, i.e., they can be used only for the one intended purpose. The top page of this two-ply form is entitled Optical Appliances Prior Authorization - MC-9(A) (REV.9/91) - Part 1 of 2. The second page of the two-ply form is entitled Optical Appliances Claim Form - MC-9 (REV.9/91)-Part 2 of 2.

When submitting for prior authorization to the Vision Care Unit, send only the completed top page MC-9(A) Prior Authorization Form. Retain page 2 (Claim Form) with your recipient's records. When you receive your approval letter from Unisys/Paramax, you may complete the service.

NOTE: The Prior Authorization number, as indicated in the notification letter from Unisys/Paramax, must be entered on the top right hand corner of the MC-9 Claim Form, Part 2 of 2, before submitting it to the Fiscal Agent for payment.

When submitting for payment to Unisys/Paramax for those services which do not require prior authorization, fill out the second page of the MC-9 Claim Form, Part 2 of 2, only. Do not send the top page, Part 1 of 2, (MC-9(A) Prior Authorization Form).

The information submitted on the form must be legible, complete, correct and filled in by means of a typewriter, printer, or ball-point pen (BLACK INK ONLY).

All dates must be in month, day, and year sequence (MM/DD/YY) format.

For example: September 6, 1955 is written 09/06/55.

All blocks must be filled in. The most commonly omitted blocks have been Block 12 (Primary and Secondary Diagnosis Codes), Block 17 (Prescribing Practitioner), and Block 25K (Place of Service). These should be completed as follows:

1. Block 12 (Primary and Secondary Diagnosis Codes):

Enter valid and appropriate ICD-9-CM diagnosis codes for the primary diagnosis and any secondary diagnosis(es). Opticians may obtain the diagnosis codes from the prescribing practitioner.

2. Block 17 (Prescribing Practitioner):

If the provider (Block 10) and the prescribing practitioner (Block 17) are the same, DO NOT use the word same. Enter the prescribing practitioner's name and seven-digit provider number. If the prescription for the appliance comes from a hospital or an eye clinic, the name of such hospital or clinic should be clearly printed or typed. If the prescribing practitioner is a non-participant in the New Jersey Medicaid program, enter seven (5's) for out-of-state providers, or seven (6's) for in-state providers.

3. Block 19 (Remarks):

When requesting prior authorization for an optical appliance, use this block for any explanation.

For example: Previous RX, glasses lost or stolen, medical exceptions.

NOTE: If requesting prior authorization for more than one optical appliance, each must have a separate MC-9(A) Prior Authorization Form.

4. Block 25 (Claim Services Detail):

If each lens is a different HCPCS procedure code, the codes should be listed on 2 separate lines. If both Right lens & Left lens are the same HCPCS procedure code, the provider may put them on the same line. Mark "2" in Block 25D (Units Requested) and enter the provider's usual and customary charge for the total of two units in Block 25I (Total Fee Requested).

The provider must use the HCPCS procedure codes as listed in the Vision Care Services Manual in Block 25B (Procedure & Modifier Code Requested).

For frame repair or replacement use HCPCS procedure code Y9787. No prior authorization is required if charge is \$15.00 or less.

When requesting a fee greater than the Medicaid maximum allowable, use modifier "22" with the base code and enclose a copy of the invoice.

For example: V2114-22 Spherocylinder, single vision, sphere over plus or minus 12.00D, invoice attached for \$24.00. Medicaid maximum for V2114 is \$19.50. Medicaid will reimburse \$24.00.

NOTE: The Optician provider should always use "9" (other) in Block 25K (Place of Service).

5. Block 26 (Patient's Certification):

It is acceptable to indicate "Recipient signature on file", in lieu of patient signature.

6. Block 27 (Provider's Certification):

The providers signature and provider number must be legible.

If there are any questions regarding this Medicaid Alert, please contact Vision Care Consultant, Division of Medical Assistance and Health Services, at 1-609-588-2745.

RETAIN THIS MEDICAID ALERT AT THE END OF YOUR FISCAL AGENT BILLING SUPPLEMENT