

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO <i>Singleton</i>	DATE <i>2-20-14</i>
------------------------	------------------------

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER <i>000289</i>	<input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR <i>CC: Mr. Keck</i> <i>Cleared 3/13/14, letter</i> <i>attached.</i>	<input checked="" type="checkbox"/> Prepare reply for appropriate signature DATE DUE <i>3-4-14</i>
	<input type="checkbox"/> FOIA DATE DUE _____
	<input type="checkbox"/> Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			



A. DOUGLAS MARION, M.D.
Physician's Office Building
1 Medical Park Drive
Chester, S.C. 29706
(803) 581-2020

Feb. 11, 2014

Anthony Keck
Director
SCDHHS
P.O. Box # 100101
Columbia, S.C. 29202

RECEIVED

FEB 20 2014

Department of Health & Human Services
OFFICE OF THE DIRECTOR

Dear Mr. Keck,

I am writing to express my frustration with and enlist your aid in getting details on the new Medicaid glasses program which began on Jan. 1 2014. Despite the fact that this program has been in effect for over a month, I cannot get any information on how the program works. I would have preferred to contact a representative whose job it is to answer these questions, but have had no luck in locating a person who knows anything about the program. I have been in business for 27 years and have dealt with Medicaid glasses since that time. In the past, Nathan Zavala has been in charge of the vision program and has been able to answer questions. Apparently, there is no such person anymore, or if there is, no one knows who they are or how to contact them.

When I received the Medicaid bulletin in early Dec. 2013 stating that the program would change at the first of the year, I began calling the Medicaid help center and requesting information on the new program. Unfortunately, no one I spoke to, including supervisors, were able to answer the most basic questions as to what codes were to be used, who would be reimbursed (labs or providers) and what the reimbursements would be. They simply took my name and telephone number and said they would email someone who would get back to me. Despite multiple calls, this information was not forthcoming, even after the January 1, 2014 date had passed.

After six weeks without a return call to my initial inquiry, I called back and was told that my answer was still pending. No one could tell me when to expect an answer or how to proceed in order to get an answer. When I asked to speak to someone in the vision department, I was told that Medicaid had done away with "specialists" and they were all now "generalists." But none of the generalists could find an answer. I was told that all they could do was to email someone. When I asked to speak to that person, I was told that I was not allowed to do so. After hours on the phone, I finally got a supervisor who said she would answer my questions. She wrote down my questions and said that she would get back to me.

This did not occur until I repeatedly called her back asking for information. She was unable to tell me anything until the fee schedule came out near the end of January 2013. Still, the information is fragmented and many questions remain.

I emailed my questions to Medicaid and was given answers which did not address the questions that I asked. I was mostly told to check my manual, which did not address the specific questions. I enclose copies of these emails.

The main questions that I have are:

1. Do I use the U8 and U9 modifiers on every service (frames, lenses, etc.) when replacing a broken or lost frame? If so, is there a different reimbursement for the service with this modifier? (There is a different reimbursement for the frame with the modifier, but none is listed for the lenses.) Are the lenses filed with these modifiers, or just the frames.
2. The reimbursement for the original frame V2020 is \$50.00. The reimbursement for a V2020-U8 (broken frame) is only \$15.00. And the reimbursement for a lost frame (V2020-U9) is only \$5.00. I cannot understand how I am expected to provide a duplicate frame to the original for such a low reimbursement and how the reimbursement is less for a frame which is completely gone than for one which is broken. The logic for this escapes me. The least expensive package wholesale cost that I can get for a frame and polycarbonate lenses, with no astigmatism and low power, is \$36.15 plus tax. If I can only get \$5.00 for the frame, \$5.00 for each lens, with no reimbursement for polycarbonate, and a \$15.00 fitting fee, that is a total of \$30.00. This is less than the cost of the frame and lenses to me. From past experience, I can tell you that most every child who has Medicaid will lose or claim to have lost their glasses during the one year period if this service is offered. If my reimbursement is less than my cost, I will go broke participating in this program.
3. The cost of a polycarbonate lens is much greater than a plastic lens. The manual states that all recipients under 21 will be required to have polycarbonate lenses. Since only children under 21 are eligible for glasses, this is 100% of those who get glasses. There is a V code for this service – V2784, but I am told that even though this service is required, that this is a non-covered service. How does this make sense?

Mostly, I am frustrated that I cannot get anyone at Medicaid to answer a direct question about this new glasses program. Your employees have not been taught how to handle these questions. When I am told to consult the manual, and the manual does not address these questions, I feel that there is something wrong with the system.

I would like to speak to someone who knows how this system works. Apparently, someone knows the answers to these questions, as someone has programmed your computer to either accept or reject a claim. That person surely knows what codes are to be used, how they are to be used and what the proper procedure is for filing these glasses. How can I speak to that person or someone who knows the answers to my questions?

I would appreciate your looking into this problem and contacting me with answers to my questions as soon as possible. This program is already in effect, but I do not know how to participate effectively in it.

Sincerely,

A handwritten signature in cursive script, appearing to read "A. Douglas Marion".

A. Douglas Marion, M.D.

proofpoint? Reply  Reply All  Forward Help  Logout**From:** MEDICAID.RESPONSE@bcbssc.com**Sent:** Friday, January 24, 2014 12:42:53 PM**To:** dmarion@truvista.net**Cc:****Subject:** [SECURE] PSC RESPONSE Digital Signature is VALID

Thank you for your e-mail inquiry. The following response should address your question:

Name: DR. Marion

Email: dmarion@truvista.net

Phone Number: 803-581-2020

Provider Question/Inquiry: I need further clarification on the new Medicaid glasses program.

1. The U8 and U9 modifiers are required when filing for broken or destroyed glasses. The fee schedule lists a separate fee for the V2020 (frame), but no fees for U8 and U9 for lenses. Do we use the modifiers for the lenses or leave it blank? Is the fee reduced?
2. Why is the fee so low for the V2020 U8 and U9 replacement frames? The original fee V2020 is \$50.00. The U8 allowance (broken frame) is \$15.00. The U9 (lost or destroyed frame) is only \$5.00. I cannot provide a replacement frame for \$5.00. Surely, this is a mistake.
3. Polycarbonate lenses are "required" for all recipients under 21. There is a V code, (V2784) for polycarbonate lenses, which are more expensive than plastic. But, this is a "non-covered charge". How can it be on non-covered when it is required?
4. When we file the Vcodes for the glasses, the set Medicare fees are in our computer. If we file these higher charges, will Medicaid adjust them down to the approved amounts as you do for all other services, or will be penalized for filing charges over the allowed amounts.

Please respond ASAP, We need answer to these questions before a situation arises.

A. Douglas Marion, M.D.

Resolution: We have received and researched your issue, the following should address your questions above.

1. Please view our website at SCDHHS.GOV/PROVIDER and view the Vision Policy Manual, section # 2, as we are unable to advise if the use of a modifier is needed to be bill. Please consult with your biller. In addition, please view Medicaid Bulletin on same website, from home page, scroll down to blue section of page, select Media Room, link to bulletins is right below (Click), you find a list of bulletins, scroll down first page of bulletins, select

page 2, and then you will see and view Bulletin for Vision care Service Policy Update. As to the fee being reduced, we are unable to discuss reimbursement rates.

2. We have reviewed the procedures, and the reimbursement rate is correct as stated on the SC Medicaid fee schedule.

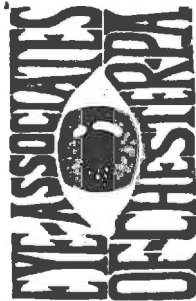
3. Please review Section 2 of Vision Services Provider Manual

4. Medicaid pay claims up to the Medicaid allowed amount per South Carolina Medicaid Fee Schedule on procedure codes, we do not adjust provider amounts on claims.

Thank you Dr. Marion for your Inquiry, if any additional questions/concerns, feel free to email us back with your concerns or call the South Carolina Healthy Connections Provider Service Center @ 1-888-289-0709 between the hours of 7:30 to 5:00pm Eastern Standard Time, again thank you for your inquiry.

Communication ID: 617232

Please do not reply to this email. Any replies to this email will go to an unmonitored INBOX. If you have any further question, please send us an email with your request through the Contact a Provider Representative at <http://www.SCDHHS.gov>. You can also call the Provider Service Center at 1-888-289-0709.



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Physician's Office Building
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Chester, S.C. 29706



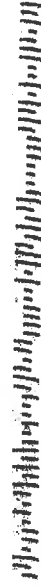
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FEB 20 2014

Anthony Keck
Director
SCDHHS
P.O. Box # 100101
Columbia, S.C. 29202

Department of Health & Human Services
OFFICE OF THE DIRECTOR

29202-3101 BOSS



March 19, 2014 Response 1 attached To Note Feb. 26/14

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

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FEB 24 2013

Department of Health & Human Services
Office of Health Programs

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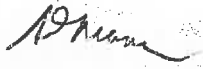
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proofpoint?

Reply

Reply All

Forward

Help

Logout

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3. Please review Section 2 of Vision Services Provider Manual

4. Medicaid pay claims up to the Medicaid allowed amount per South Carolina Medicaid Fee Schedule on procedure codes, we do not adjust provider amounts on claims.

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FEB 20 2014

Anthony Keck

Director

SCDHHS

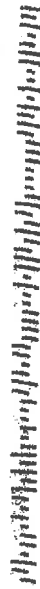
P.O. Box # 100101

Columbia, S.C. 29202

Department of Health & Human Services

OFFICE OF THE DIRECTOR

2920233101 BOSS



March 13, 2014

A. Douglas Marion, M.D.
Eye Associates of Chester, PA
Physician's Office Building
1 Medical Park Drive
Chester, South Carolina 29706

Dear Dr. Marion,

This letter is a response to your February 11, 2014 request for assistance with the collection of additional information about the Department's Vision Care Services Policy.

Responses to your questions are provided below.

Question #1: When should provider bill a U8/U9 modifier?

Response: The U8 modifier should be appended to the Current Procedural Terminology (CPT) code when a component or part of the eyeglasses such as screws, arms or face pads have been broken and the provider is replacing these items.

A U9 modifier should be appended to the CPT code when a complete pair of eyeglasses is replaced. Please note that the beneficiary can receive a maximum of two pairs of glasses in a twelve consecutive month period (the original and a replacement).

Providers should bill the original glasses with HCPCS code V2020 without a modifier. The replacement pair of glasses should be billed with HCPCS code V2020 appending modifier U9. If the provider is only replacing a part of the glasses the provider would bill a HCPCS code of V2020 (regular frames) or a HCPCS code of V2025 (deluxe frames) with a U8 modifier.

Question #2: Please clarify the reimbursements for the frames.

Response: The reimbursement for new or replacement regular frames is \$50.00 and the reimbursement for new or replacement deluxe frames is \$65.00. Billing for these two codes must follow the guidelines described in the above paragraph.

During our review of your question, the Department identified an error within the fee schedule for the replacement frames (V2020 or V2025 with a U9 modifier). This error in pricing has been fixed to appropriately register \$50.00 for regular frames and \$65.00 for deluxe frames—to reflect the same reimbursement amount as the original frames. Thank you for bringing this error to our attention.

SCDHHS will be reviewing previously paid claims for potential correction of the fee schedule amount. Any claims incorrectly paid at the lower rate will be adjusted with no action required on the part of the provider. The corrected payments will be made on a separate remittance prior to April 1, 2014.

Question #3: Billing for polycarbonate lenses.

Response: Since January 1, 2014, the Department's policy is to bill for the appropriate HCPCS code for the lenses, with no additional coding to reflect the polycarbonate lenses. The fee schedule will include the V2784 code. This change will ensure proper coding for polycarbonate lenses.

Providers should bill for the appropriate lens code as well as the V2784 polycarbonate code. Reimbursement for the polycarbonate lenses will be made at a rate of \$10 per lens (a total of \$20 per pair of glasses).

SCDHHS will be updating our policy for billing of polycarbonate lenses on April 1, 2014, retroactive to January 1, 2014. Providers wishing to receive the updated reimbursement for the polycarbonate lenses will need to submit a new stand-alone claim for the V2784 code.

SCDHHS will provide our Provider Service Center (PSC) staff with updated training on the vision benefit. This training will allow for a more effective and efficient response experience for our stakeholders and providers. Additionally, the Department will conduct expanded reviews of other policies associated with these benefits and services to ensure consistency throughout the Department's resources (i.e., the Physician Laboratories and Other Medical Professional Manual, located at www.scdhhs.gov).

Thank you for bringing your concerns to our attention and for the continued participation in the South Carolina Healthy Connections Medicaid program. If you have additional

Page 3 of 3
Marion

questions or comments regarding Medicaid Managed Care policies, please contact me by phone at (803) 898-2018 or by email at pattnat@scdhhs.gov.

Sincerely,

A handwritten signature in black ink, appearing to read "Nat Patterson", written over a horizontal line.

Nathaniel J. Patterson
Program Director, Health Services

cc: Deirdra T. Singleton, Deputy Director
Bryan Amick, Program Director
Evan Gessner, Assistant General Counsel

Log #289



Nikki Haley GOVERNOR
Anthony Mack DIRECTOR
P.O. Box 8206 Columbia, SC 29202
www.scdhhs.gov

March 13, 2014

A. Douglas Marion, M.D.
Eye Associates of Chester, PA
Physician's Office Building
1 Medical Park Drive
Chester, South Carolina 29706

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Marion

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Sincerely,

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Nathaniel J. Patterson
Program Director, Health Services

cc: Deirdra T. Singleton, Deputy Director
Bryan Amick, Program Director
Evan Gessner, Assistant General Counsel

Brenda James

Log # 289

From: Stephanie Cox
Sent: Thursday, March 13, 2014 1:55 PM
To: Brenda James; Cynthia Gore; Deirdra Singleton; Stephen Boucher; Nathaniel Patterson
Subject: Response to log letter 000289
Attachments: 000289 Response.pdf

Good Afternoon,

If no one has any objections to this log letter response, we will mail this out today.

Thanks!

wait to heard from
Cynthia before closing