



Florida Medicaid

Optometric Services Coverage and Limitations Handbook

Agency for Health Care Administration





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SECRETARY

March 20, 2007

Dear Optometric Services Provider:

The Florida Medicaid Optometric Services Coverage and Limitations Handbook was updated effective January 2007. The handbook revisions include Medicaid coverage for eyeglasses and for visual exams for the purpose of prescribing eyeglasses for recipients age 21 and older, which the Legislature reinstated effective July 2006. The handbook update also contains coverage of lacrimal punctum plugs; revised criteria for visual exams related to providing eyeglasses in a nursing facility, ICF/DD, custodial care facility, or recipient's home; and revisions in provider enrollment policies due to the National Provider Identifier (NPI).

The following pages were replaced in the enclosed handbook:

Updated Pages
Update Log
Table of Contents
Chapter 1
Chapter 2, pages 2-1 through 2-13, 2-17 and 2-18

Please contact your area Medicaid office if you have any questions. The area Medicaid offices' phone numbers and addresses are available on the Agency's website at <http://ahca.myflorida.com>. Click on Medicaid, and then on Area Offices. They are also listed in Appendix C of the Florida Medicaid Provider General Handbook. All the Medicaid handbooks are available on the Medicaid fiscal agent's website at <http://floridamedicaid.acs-inc.com>. Click on Provider Support, and then on Handbooks.

We appreciate the services that you provide to Florida's Medicaid recipients.

Sincerely,

Beth Kidder
Chief, Bureau of Medicaid Services

UPDATE LOG

OPTOMETRIC SERVICES

COVERAGE AND LIMITATIONS HANDBOOK

How to Use the Update Log

Introduction

Changes to the handbook will be sent out as handbook updates. An update can be a change, addition, or correction to policy. It may be either a pen and ink change to the existing handbook pages or replacement pages.

It is very important that the provider read the updated material and file it in the handbook as it is the provider's responsibility to follow correct policy to obtain Medicaid reimbursement.

Explanation of the Update Log

The provider can use the update log to determine if all the updates to the handbook have been received.

Update No. is the month and year that the update was issued.

Effective Date is the date that the update is effective.

Instructions

1. Make the pen and ink changes and file new or replacement pages.
2. File the cover page and pen and ink instructions from the update in numerical order after the log.

If an update is missed, write or call the Medicaid fiscal agent at the address given in Appendix C of the Florida Medicaid Provider General Handbook.

UPDATE NO.	EFFECTIVE DATE
Jan2000—Revised Handbook	January 2000
Jan2001—Revised Handbook	January 2001
July2001—Errata Replacement Page	January 2001
Update 02-1—Replacement Pages	January 2002
Update 02-02—Replacement Pages	April 2002
Update 02-02—Errata Replacement Pages	April 2002
Mar2003—Replacement Pages	March 2003
Jan2005—Revised Handbook	January 2005
Jan2006— Revised Handbook	January 2006
Jan2007—Replacement Pages	January 2007

OPTOMETRIC SERVICES COVERAGE AND LIMITATIONS HANDBOOK

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INTRODUCTION TO THE HANDBOOK

Overview

Introduction

This chapter introduces the format used for the Florida Medicaid handbooks and tells the reader how to use the handbooks.

Background

There are three types of Florida Medicaid handbooks:

- Provider General Handbook describes the Florida Medicaid Program.
- Coverage and Limitations Handbooks explain covered services, their limits, who is eligible to receive them, and the fee schedules.
- Reimbursement Handbooks describe how to complete and file claims for reimbursement from Medicaid.

Exceptions: For Prescribed Drugs, the coverage and limitations handbook and the reimbursement handbook are combined into one.

Legal Authority

The following federal and state laws govern Florida Medicaid:

- Title XIX of the Social Security Act,
 - Title 42 of the Code of Federal Regulations,
 - Chapter 409, Florida Statutes, and
 - Chapter 59G, Florida Administrative Code.
-

In This Chapter

This chapter contains:

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Handbook Use and Format

Purpose	<p>The purpose of the Medicaid handbooks is to furnish the Medicaid provider with the policies and procedures needed to receive reimbursement for covered services provided to eligible Florida Medicaid recipients.</p> <p>The handbooks provide descriptions and instructions on how and when to complete forms, letters or other documentation.</p>
Provider	<p>The term “provider” is used to describe any entity, facility, person or group who is enrolled in the Medicaid program and renders services to Medicaid recipients and bills Medicaid for services.</p>
Recipient	<p>The term “recipient” is used to describe an individual who is eligible for Medicaid.</p>
General Handbook	<p>General information for providers regarding the Florida Medicaid Program, recipient eligibility, provider enrollment, fraud and abuse policy, and important resources are included in the Florida Medicaid Provider General Handbook. This general handbook is distributed to all enrolled Medicaid providers and is updated as needed.</p>
Coverage and Limitations Handbook	<p>Each coverage and limitations handbook is named for the service it describes. A provider who furnishes more than one type of service will have more than one coverage and limitations handbook.</p>
Reimbursement Handbook	<p>Each reimbursement handbook is named for the claim form that it describes.</p>
Chapter Numbers	<p>The chapter number appears as the first digit before the page number at the bottom of each page.</p>
Page Numbers	<p>Pages are numbered consecutively throughout the handbook. Page numbers follow the chapter number at the bottom of each page.</p>
White Space	<p>The "white space" found throughout a handbook enhances readability and allows space for writing notes.</p>

Characteristics of the Handbook

Format

The format styles used in the handbooks represent a concise and consistent way of displaying complex, technical material.

Information Block

Information blocks replace the traditional paragraph and may consist of one or more paragraphs about a portion of the subject. Blocks are separated by horizontal lines.

Each block is identified or named with a label.

Label

Labels or names are located in the left margin of each information block. They identify the content of the block in order to facilitate scanning and locating information quickly.

Note

Note is used most frequently to refer the user to pertinent material located elsewhere in the handbook.

Note also refers the user to other documents or policies contained in other handbooks.

Topic Roster

Each chapter contains a topic roster on the first page, which serves as a table of contents for the chapter, listing the subjects and the page number where the subject can be found.

Handbook Updates

Update Log

The first page of each handbook will contain the update log.

Every update will contain a new updated log page with the most recent update information added to the log. The provider can use the update log to determine if all updates to the current handbook have been received.

Each update will be designated by an "Update No." and the "Effective Date."

Handbook Updates, continued

How Changes Are Updated

The Medicaid handbooks will be updated as needed. Changes may consist of any one of the following:

1. Pen and ink updates—Brief changes will be sent as pen and ink updates. The changes will be incorporated on replacement pages the next time replacement pages are produced.
 2. Replacement pages—Lengthy changes or multiple changes that occur at the same time will be sent on replacement pages. Replacement pages will contain an effective date that corresponds to the effective date of the update.
 3. Revised handbook—Major changes will result in the entire handbook being replaced with a new effective date throughout.
-

Numbering Update Pages

Replacement pages will have the same number as the page they are replacing. If additional pages are required, the new pages will carry the same number as the preceding replacement page with a numeric character in ascending order. (For example: page 1-3 may be followed by page 1-3.1 to avoid reprinting the entire chapter.)

Effective Date of New Material

The month and year that the new material is effective will appear at the bottom of each page. The provider can check this date to ensure that the material being used is the most current and up to date.

If an information block has an effective date that is different from the effective date on the bottom of the page, the effective date will be included in the label.

Identifying New Information

New material will be indicated by vertical lines. The following information blocks give examples of how new labels, new information blocks, and new or changed material within an information block will be indicated.

New Label

A new label for an existing information block will be indicated by a vertical line to the left and right of the label only.

New Label and New Information Block

A new label and a new information block will be identified by a vertical line to the left of the label and to the right of the information block.

New Material in an Existing Information Block

New or changed material within an existing information block will be indicated by a vertical line to the left and right of the information block.

New or Changed Paragraph

A paragraph within an information block that has new or changed material will be indicated by a vertical line to the left and right of the paragraph.

| Paragraph with new material. |

CHAPTER 1

OPTOMETRIC SERVICES

PROVIDER QUALIFICATIONS AND REQUIREMENTS

Overview

Introduction

This chapter describes the general program requirements, the provider enrollment criteria, provider qualifications, and provider requirements.

Legal Authority

The Florida Medicaid Optometric Services Program is authorized by Chapter 409 F.S., and Chapter 59G, Florida Administrative Code (F.A.C.).

In This Chapter

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Purpose and Definitions

Purpose

This handbook is intended for use by optometrists and ophthalmologists who provide visual examinations, refractions, evaluation and management services, consultation and referral services, custodial care, pathology and laboratory services, and surgical services to Medicaid recipients.

Optometrists and ophthalmologists who provide eyeglasses, eyeglasses repair services, contact lenses, and prosthetic eyes should refer to the Florida Medicaid Visual Services Coverage and Limitations Handbook as these services are covered under the Visual Services Program.

This handbook must be used in conjunction with the Florida Medicaid Provider General Handbook, which contains information about the Medicaid program in general, and the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, which contains the specific procedures for submitting claims for payment.

Purpose and Definitions, continued

Purpose, continued

Note: The Medicaid handbooks are available on the Medicaid Handbook and Resource Library CD-ROM and the Medicaid fiscal agent's website at <http://floridamedicaid.acs-inc.com>. Click on Provider Support, and then click on Handbooks. The Florida Medicaid Provider General Handbook is incorporated by reference in 59G-5.020, F.A.C. and the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, is incorporated by reference in 59G-4.001, F.A.C.

Optometric Services

Optometric services are medically-necessary services that provide for examination, diagnosis, treatment and management of ocular and adnexal pathology. Visual examinations to determine the need for eyeglasses are also covered. Optometric services must be furnished by or under the direct supervision of a Medicaid-enrolled optometrist or ophthalmologist.

Optometrist Definition

Doctors of optometric medicine are eligible to enroll and participate as optometrists in the Medicaid program.

Ophthalmologist Definition

Doctors of ophthalmologic medicine are eligible to enroll and participate as ophthalmologists in the Medicaid Optometric Program.

Screening Definition

A screening is the testing of individuals who do not have complaints. It is designed to detect physical and mental conditions to determine the presence of a disease or of certain risk factors known to be associated with a disease or an anomaly. A screening also includes group testing of usually asymptomatic individuals to detect the manifestation of a disease or problem.

Provider Qualifications

Licensure

To enroll and provide services under the Medicaid Optometric Services Program, the provider must be currently licensed as an:

- Ophthalmologist as defined in Chapter 458, F.S.; or
- Optometrist as defined in Chapter 463, F.S. If enrolling using an optometric faculty certificate, an optometrist must meet all the requirements as defined in Section 463.0057, F.S.

Note: See Chapter 2 in the Florida Medicaid Provider General Handbook for information on out-of-state providers and services. The Medicaid handbooks are available on the Medicaid Handbook and Resource Library CD-ROM and the Medicaid fiscal agent's website at <http://floridamedicaid.acs-inc.com>. Click on Provider Support, and then click on Handbooks.

Provider Qualifications, continued

Laboratory Certification

The Centers for Medicare and Medicaid Services require all clinical laboratory testing sites to adhere to regulations implementing the Clinical Laboratory Improvement Amendments (CLIA) of 1988.

In order to perform the laboratory tests listed on the Optometry Procedure Codes and Fee Schedule, an optometrist's office laboratory must be licensed and CLIA-certified in the related laboratory specialties.

Operational at Time of Enrollment

Optometrists and ophthalmologists must meet all the provider requirements and qualifications and their practices must be fully operational before they can be enrolled as Medicaid providers.

Provider Enrollment

General Enrollment Requirements

Optometrists and ophthalmologists must meet the general Medicaid provider enrollment requirements that are contained in Chapter 2 of the Florida Medicaid Provider General Handbook. In addition, optometrists and ophthalmologists must follow the specific enrollment requirements that are listed in this section.

Group Providers

Two or more enrolled Medicaid providers whose practice is incorporated under the same tax identification number must enroll as a Medicaid provider group. In order to receive payment from Medicaid, each member of the group must also enroll as an individual treating provider within the group.

Any group consisting of ophthalmologists and optometrists must be credentialed as a physician group to ensure proper reimbursement for services submitted by the group.

Provider Enrollment, continued

Multiple Locations

Both individual and group providers who have practices at more than one location, i.e., satellite offices, must notify the Medicaid fiscal agent of additional practice locations. See Chapter 2 in the Florida Medicaid Provider General Handbook for instructions on notifying the fiscal agent of additional practice locations.

Any closure of a practice location must also be reported to the Medicaid fiscal agent, in writing on office letterhead stationery, along with the effective date of the closure.

Other Licensed Health Care Practitioners

If an optometric services provider employs or contracts with a non-optometric physician health care practitioner who can enroll as a Medicaid provider, and that health care provider is treating Medicaid recipients, the practitioner must enroll as a Medicaid provider.

Examples of non-optometric physician health care practitioners who can enroll as Medicaid providers are: physician assistants, advanced registered nurse practitioners, registered nurse first assistants, physical therapists, etc.

If the services rendered by a non-optometric physician health care practitioner are billed with that practitioner as the treating provider, the services must be provided in accordance with the policies and limitations contained in that practitioner's service-specific Coverage and Limitations Handbook.

Individual Provider Responsibilities With a Group Practice

An individual treating provider must be enrolled as a member of group practices for which he performs services. It is the responsibility of the individual treating provider to notify the Medicaid fiscal agent of all group practices with which he is affiliated.

Any treating provider who is terminating his relationship with a group practice must notify the Medicaid fiscal agent in writing of this termination in order to alter the provider file.

Provider Requirements

General Requirements

In addition to the general requirements and responsibilities that are contained in Chapter 2 of the Florida Medicaid Provider General Handbook, optometric providers are also responsible for complying with the provisions contained in this section.

Provider Responsibility

Florida Medicaid has implemented all of the requirements contained in the federal legislation known as the Health Insurance Portability and Accountability Act (HIPAA). As trading partners with Florida Medicaid, all Medicaid providers, including their staff, contracted staff and volunteers, must comply with HIPAA privacy requirements effective April 14, 2003. Providers who meet the definition of a covered entity according to HIPAA must comply with HIPAA Electronic Data Interchange (EDI) requirements effective October 16, 2003. This coverage and limitations handbook contains information regarding changes in procedure codes mandated by HIPAA. The Florida Medicaid Provider Reimbursement Handbooks contain the claims processing requirements for Florida Medicaid, including the changes necessary to comply with HIPAA.

Note: For more information regarding HIPAA privacy in Florida Medicaid see chapter 2 in the Medicaid Provider General Handbook. The Medicaid handbooks are available on the Medicaid Handbook and Resource Library CD-ROM and the Medicaid fiscal agent's website at <http://floridamedicaid.acs-inc.com>. Click on Provider Support, and then click on Handbooks.

Note: For more information regarding claims processing changes in Florida Medicaid because of HIPAA, see the Florida Medicaid Provider Reimbursement Handbook, CMS-1500.

Note: For information regarding changes in EDI requirements for Florida Medicaid because of HIPAA, contact the Medicaid fiscal agent EDI help desk at 800-829-0218.

Provider Requirements, continued

**Optometric or
Ophthalmologic
Supervision**

Delivery of all services must be done by or under the direct supervision of the optometrist or ophthalmologist.

Direct supervision means the optometrist or ophthalmologist:

- Is on the premises when the services are rendered; and
 - Reviews, signs and dates the medical record.
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CHAPTER 2 OPTOMETRIC SERVICES COVERED SERVICES, LIMITATIONS AND EXCLUSIONS

Overview

Introduction

This chapter describes the services covered under the Florida Medicaid Optometric Services Program. It also describes limited or excluded services.

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Covered and Excluded Services

Covered Services

Only those services designated in this chapter and listed in the Optometric Services Fee Schedule can be reimbursed by Medicaid to an optometrist and ophthalmologist.

Note: The Optometric Services Fee Schedule is available on the Medicaid Handbook and Resource Library CD-ROM and the Medicaid fiscal agent website at <http://floridamedicaid.acs-inc.com>. Click on Provider Support, and then click on Fees.

Limitations

Certain services are designated with limitations by diagnosis or other limitations listed on the Optometric Services Fee Schedule. Other limitations specified in this handbook also apply.

Covered and Excluded Services, continued

**Medically
Necessary**

Medicaid reimburses services that are determined medically necessary and do not duplicate another provider's service. In addition, the services must meet the following criteria:

- Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
- Be individualized, specific, consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;
- Be consistent with generally accepted professional standards as determined by the Medicaid program, and not be experimental or investigational;
- Reflect the level of services that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
- Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a covered service.

Note: See the Glossary in the Florida Medicaid Provider General Handbook for the definition of medically necessary. The handbook is available on the Medicaid Handbook and Resource Library CD-ROM and the Medicaid fiscal agent's website at <http://floridamedicaid.acs-inc.com>. Click on Provider Support and then click on Handbooks.

**Covered Services
Effective
July 1, 2006**

The Medicaid Optometric Services Program reimburses the following medically-necessary services for all recipients:

- Visual examinations;
- Evaluation and management services;
- Consultation and referral services;
- Custodial care facility services;
- Nursing facility services;
- Pathology and laboratory services; and
- Surgical services within the optometrist's and ophthalmologist's scope of practice.

These services may also be reimbursed to physicians through the Florida Medicaid Physician Services Program.

Covered and Excluded Services, continued

Duplicate Services

Medicaid will not reimburse an optometrist or ophthalmologist and the following provider types for the same procedure, same recipient, and same date of service:

- Advanced registered nurse practitioner;
- Chiropractor;
- County health department;
- Federally qualified health center;
- Licensed midwife;
- Physician;
- Physician assistant;
- Registered nurse first assistant;
- Rural health clinic; and
- Schools.

Service Limitations

Medicaid does not reimburse both an evaluation and management visit and a general ophthalmological visit on the same day for the same recipient.

Medicaid will reimburse only one visit per optometrist or optometrist group, per recipient, per day, except for emergency services.

Certain procedure codes have service frequency and diagnosis limitations based on utilization control measures.

Only evaluation and management procedure codes are reimbursable in a nursing facility, an ICF/DD, a recipient's home, or a custodial care facility. See the criteria in the section for visual exams using evaluation and management procedure codes in these places of service.

Professional Component Fee

For professional services rendered to a recipient in the inpatient or outpatient hospital or other facility, the provider may bill only a professional component (PC) fee.

Maximum Fee

The maximum fee is intended to pay the optometrist for performing the complete procedure including both the technical and professional components. It can be billed only when the same provider performs all components.

Excluded Services

Medicaid does not reimburse the following services:

- Services performed exclusively for screening of visual acuity in any place of service. (Screening of visual acuity is a required component of both a Child Health Check Up and an Adult Health Screening.)
- Visits for second opinions.
- Services furnished to Florida Medicaid recipients when they are out of the country.

Covered and Excluded Services, continued

Solicitation

Providers are not permitted to knowingly solicit, offer, pay, or receive any remuneration, including any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in kind, in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made, in whole or in part, under the Medicaid program, or in return for obtaining, purchasing, leasing, ordering, or arranging for or recommending, obtaining, purchasing, leasing, or ordering any goods, facility, item, or service, for which payment may be made, in whole or in part, under the Medicaid program.

Visual Examinations

Introduction

Medicaid reimburses medically-necessary visual exams through the Medicaid Optometric Services Program as well as through the Medicaid Physician Services Program.

Eyeglasses and contact lenses must be prescribed by an optometrist or an ophthalmologist. The visual service provider must keep a copy of the prescription in the recipient's medical record.

Eyeglasses and contact lenses are reimbursed through the Medicaid Visual Services Program. Coverage is limited. Please refer to the Florida Medicaid Visual Services Coverage and Limitations Handbook for service limitations. The handbook is available on the Medicaid Handbook and Resource Library CD-ROM and the Medicaid fiscal agent's website at <http://floridamedicaid.acs-inc.com>. Click on Provider Support and then click on Handbooks.

Visual Exams

A visual examination must be billed using the appropriate evaluation and management or general ophthalmological visit code and be conducted in accordance with the minimum procedures for vision analysis found in Chapter 64B-13.3, Standard of Practice for Licensed Optometrists, Florida Administrative Code.

The provider must initial and date lined-through data or strike throughs of an entire set of data in medical reports or patient records. A clearly written and acceptable assessment, plan, and treatment must be included in the chart.

Medicaid will reimburse eye examinations when there is a reported vision problem, illness, disease, or injury.

Visual Exam in Conjunction With a Child Health Check-Up

Medicaid does not reimburse procedure codes 92081 (visual field exam), 92082 (intermediate visual field exam), or 92083 (threshold visual field) when these services are performed in conjunction with or on the same date of service as any of the Child Health Check-Up (CHCUP) procedure codes 99381, 99382, 99383, 99384, 99385 EP, 99391, 99392, 99393, 99394, or 99395 EP. Codes 92555 and 92557 cannot be billed separately.

Visual Examinations, continued

Visual Exams Related to Providing Eyeglasses in a Nursing Facility, ICF/DD, Recipient's Home, or Custodial Care Facility

Medicaid may reimburse for visual exams (using evaluation and management procedure codes only) when the need for the exam is related to a reported vision problem, illness, disease, or injury. The exam and dispensing of the eyeglasses may be conducted in a nursing facility, an intermediate care facility for developmentally disabled (ICF/DD), a recipient's home, or a custodial care facility only when the following criteria are met:

- Transportation to the provider's office would require an ambulance or stretcher van or would pose an unacceptable health risk to the recipient, due to the recipient's medical condition. This may be documented by a copy of the facility's plan of care for the recipient that addresses this need as long as the physician's order requesting the services is filed in recipient's medical record at both the facility and the optometric provider's office.
- The medical need for the exception is ordered by the recipient's primary-care physician and is documented in the recipient's medical record at both the facility and the optometric provider's office. The physician's order is valid up to 90 days after the order is given. If additional care is needed by the provider, then another order must be written by the recipient's primary care physician. Pursuant to Chapter 59A-4.107, F.A.C., the order may be given verbally by the licensed nurse or attending physician at the facility. The verbal order, including telephone orders, shall be immediately recorded, dated, and signed by the person receiving the order. All verbal treatment orders shall be countersigned by the primary care physician on the next visit to the facility and must be filed in the recipient's medical record at both the facility and the optometric provider's office.
- The recipient, the recipient's guardian, or the primary-care physician requested the services.
- The services provided in the facility or home are qualitatively comparable to services provided in the provider's office.
- The recipient is given the right to choose his provider.
- If the exam reveals a need for eyeglasses, or a significant change in the recipient's previous prescription, the eyeglasses must significantly benefit the recipient. Recipients who are comatose, semi-comatose, or who are not cognizant of their surroundings would not normally be expected to benefit from the provision of eyeglasses.
- When services are provided, documentation of the above criteria must be maintained in the recipient's medical record in the optometric provider's office and at the facility.

General and special ophthalmological services procedure codes are not reimbursable when performed in a facility or home setting.

Visual Examinations, continued

Provision of Eyeglasses in ICF/DDs	<p>Eyeglasses are included in the ICF/DD per diem. Visual service providers cannot bill Medicaid for eyeglasses when the recipient is a resident of an ICF/DD. Providers should arrange with the ICF/DD for payment of eyeglasses.</p>
	<p><u>Note:</u> See the Florida Medicaid Intermediate Care Facility for the Developmentally Disabled Coverage and Limitations Handbook for more information on this type of facility. The handbook is available on the Medicaid Handbook and Resource Library CD-ROM and the Medicaid fiscal agent's website at http://floridamedicaid.acs-inc.com. Click on Provider Support and then click on Handbooks.</p>
Refractions	<p>Medicaid will reimburse only two medically-necessary refractions per recipient, per 365 days. The date of the first refraction begins the 365-day period.</p>
	<p>For dually-eligible Medicare and Medicaid recipients, providers must enter keyed claim type 63 in item 19 on the CMS-1500 claim form when submitting paper claims for refractions and visual examinations using a refractive error diagnosis (367.0-367.9). If the claim is submitted electronically, this requirement is not required, since HIPAA standards do not allow for keyed claim types.</p>
	<p>Optometrists and ophthalmologists must be enrolled in the Medicaid Visual Services Program in order to use keyed claim type 63.</p>
	<p>Medicaid reimburses refractions performed in a provider's office, an ICF/DD, a recipient's home, a nursing facility, and a custodial care facility.</p>
	<p><u>Note:</u> Refer to the Florida Medicaid Visual Services Coverage and Limitations Handbook for policy regarding enrollment, eyeglasses and contact lenses. The handbook is available on the Medicaid Handbook and Resource Library CD-ROM and the Medicaid fiscal agent's website at http://floridamedicaid.acs-inc.com. Click on Provider Support and then click on Handbooks.</p>
Computerized Corneal Topography	<p>Medicaid reimburses computerized corneal topography (procedure code S0820 or 92025) up to a maximum of four times per year, per recipient.</p>
Service Exclusions	<p>A routine eye exam in the absence of a reported vision problem, illness, disease, or injury is not reimbursable.</p>

Visual Examinations, continued

General and Special Ophthalmological Services

Medicaid covers general and special ophthalmological services as described in this handbook. Please refer to the Optometric Services Fee Schedule for descriptions of the services included in intermediate and comprehensive general ophthalmological visits.

Medicaid may reimburse special ophthalmological services in addition to a general ophthalmological visit or an evaluation and management visit if a special evaluation of part of the visual system is made, or if special treatment is given.

General and special ophthalmological services are not reimbursed when performed in a nursing facility, an ICF/DD, a recipient's home, or a custodial care facility.

Medicaid does not reimburse both an evaluation and management visit and a general ophthalmological visit on the same day for the same recipient.

Note: The Optometric Services Fee Schedule is available on the Medicaid Handbook and Resource Library CD-ROM and the Medicaid fiscal agent's website at <http://floridamedicaid.acs-inc.com>. Click on Provider Support, and then click on Fees.

Evaluation and Management Services

Description

Evaluation and management services are face-to-face optometrist and recipient encounters provided in the inpatient or outpatient hospital, recipient's home, or optometrist's office.

Note: See Consultations, Custodial Care Facility Services and Nursing Facility Services in this chapter for information on those types of visits.

New Patient Visit

One new patient visit may be reimbursed once per recipient, per optometrist or ophthalmologist, or optometric or ophthalmologist group. If the group is comprised of optometrists and ophthalmologist, then the group must be credentialed as physician group.

A new patient is one who has not received any professional services from the provider or provider group within the past three years.

Established Patient Visit

An established patient is one who has received professional services from the provider or provider group within the past three years.

Office Visits

Office visits can be reimbursed for services provided in an optometrist's office or an outpatient facility.

Evaluation and Management Services, continued

Home Visits

Home visits can be reimbursed when the optometrist completes a medically necessary visit in the private residence of the recipient. Please refer Visual Exams Related to Providing Eyeglasses in a Nursing Facility, ICF/DD, Recipient's Home, or Custodial Care Facility in this section for the criteria that must be met for Medicaid to reimburse home visits.

Documentation demonstrating that the visit is medically necessary must be maintained in the recipient's medical record in the optometrist's office.

Services must be requested by the recipient, the recipient's guardian, or the primary care physician and documented in the recipient's medical record in the optometrist's office.

Medicaid does not reimburse optometrists for other services provided in a recipient's home except for refractions and the home visit evaluation and management codes listed on the Optometric Services Fee Schedule.

Custodial care facility and nursing facility visits are not considered home visits and must be billed in accordance with the policies stated in the Custodial Care Facility and Nursing Facility sections in this chapter.

Note: See the Visual Examination Section in this chapter for visual exam criteria related to providing eyeglasses in a recipient's home.

Hospital Visits

Hospital visits for an inpatient recipient are reimbursable for the following services:

- Evaluation and management visit;
- Non-surgical service; or
- Surgical procedure.

Hospital visits to a recipient are not reimbursed if the visits relate to a procedure not covered by Medicaid or are not within the pre-op or follow-up period.

Billing for an Additional Hospital Visit

Medicaid will reimburse a visit that is for a significant, separately identifiable service above and beyond the usual pre- and postoperative care associated with the surgical procedure that was performed. To be reimbursed for this visit, the provider must bill with a modifier 25 and submit a copy of the optometrist's notes documenting the medical necessity of the visit.

To be reimbursed for an evaluation and management visit that is performed during the postoperative period for a reason unrelated to the original procedure, the provider must bill with a modifier 24. A report explaining the medical necessity of the visit must be submitted with the claim.

Note: See Chapter 3 for additional information on procedure code modifiers.

Evaluation and Management Services, continued

Visit Reimbursement Limitations

Office, home, and hospital visits are limited to one visit per recipient, per day.

Procedure Codes and Fees

See the Optometric Services Fee Schedule for a list and description of procedure codes and fees.

Note: The Optometric Services Fee Schedule is available on the Medicaid Handbook and Resource Library CD-ROM and the Medicaid fiscal agent's website at <http://floridamedicaid.acs-inc.com>. Click on Provider Support, and then click on Fees.

Consultation and Referral Services

Description

A consultation is a face-to-face evaluation provided by an optometrist or ophthalmologist whose opinion or advice regarding evaluation or management of a recipient's specific problem is requested by another practitioner.

A consultation initiated by a recipient or the recipient's family and not requested by another practitioner is neither reimbursable as a consultation, nor can it be interpreted or billed as a second opinion for reimbursement. It is reimbursed using the procedure codes for office visits, as appropriate.

Consultation services may be rendered in an inpatient, outpatient, or office setting.

Consultation that Becomes a Referral

If subsequent to the completion of a consultation, the provider assumes responsibility for management of a portion or all of the recipient's care, the provider may not bill for the follow-up consultation codes as defined by the Current Procedural Terminology (CPT).

In the hospital setting, the optometrist receiving the recipient for partial or complete transfer of care must use the appropriate inpatient hospital consultation code for the initial encounter and then subsequent hospital care codes.

In the office setting, the appropriate established patient evaluation and management code must be used.

Consultation and Referral Services, continued

Documentation Requirements

The following components, at a minimum, must be recorded in the recipient's medical record:

- Request and need for consultation from the attending or requesting practitioner;
 - Consultant's opinion and any services ordered or performed; and
 - Written report provided to the attending or requesting practitioner.
-

Hospital Inpatient Consultation Visits

Medicaid reimburses one initial consultation, per hospitalization, per recipient, per optometrist.

If a partial or complete transfer of care ensues following the initial hospital consultation, all follow-up visits are considered subsequent hospital visits.

Medicaid reimburses a follow-up inpatient consultation only if it is requested by the attending physician to obtain a management modification or advice on a new plan of care in response to changes in the recipient's status. This request must be documented in the recipient's medical record.

Office or Hospital Outpatient Consultation Visits

Medicaid reimbursement is limited to one initial consultation visit, per practitioner of any specialty, per 365 days, for a non-hospitalized recipient.

If a partial or complete transfer of care ensues following the initial office or outpatient consultation visit, all follow-up visits are considered subsequent evaluation and management services.

If an additional request for an opinion or advice regarding the same or a new problem is received from the attending practitioner, an evaluation and management code should be used.

Non-reimbursable Consultation Visits

Medicaid does not reimburse a consultation visit in addition to an office, home, nursing facility, custodial care facility or hospital visit on the same day of service, by the same provider.

Medicaid does not reimburse consultations rendered in nursing or custodial care facilities.

Medicaid does not reimburse the following:

- Consultations for a second opinion;
 - Consultation on a decision for surgery; or
 - Consultations and surgical procedures on the same day.
-

Custodial Care Facility Services

Description

Custodial care facility services are evaluation and management services that are provided to a recipient in a facility that provides room, board, and other personal assistance services generally on a long term basis. It includes domiciliary, rest home, or custodial care facilities such as:

- Assisted Living Facilities (ALF);
- Adult Family Care Homes (AFCH);
- Extended Congregate Care Facilities (ECC); and
- Continuing Care Retirement Communities (CCRC).

Service Requirements

The provider must bill the custodial care facility evaluation and management procedure codes when providing services to a recipient at a custodial care facility.

Documentation demonstrating that the visit is medically necessary must be maintained in the recipient's medical record in the optometrist's office and at the facility.

Services must be requested by the recipient, the recipient's guardian, or the primary-care physician and documented in the recipient's medical record in the optometrist's office and at the facility.

Note: See Visual Examinations in this chapter for visual exam criteria related to providing eyeglasses in a custodial care facility.

Service Frequency

Visits are limited to one per month, per provider or provider group, per recipient.

Additional visits may be reimbursed by submitting the claim with modifier 22 and a report documenting the care provided. Claims will be reviewed by the Medicaid medical consultant for medical necessity.

Note: See Chapter 3 for additional information on modifiers.

Facility visit

A custodial care facility visit is not reimbursed in addition to another evaluation and management visit on the same day, same provider, same recipient.

Excluded services

Consultation services rendered in a custodial care facility cannot be reimbursed. Services provided in an office or room located in a custodial care facility cannot be reimbursed as an office evaluation and management visit.

Medicaid does not reimburse optometrists for services provided in a custodial care facility except for refractions and the evaluation and management services as outlined in the evaluation and management section of the CPT.

Custodial Care Facility Services, continued

Procedure Codes and Fees	<p>See the Optometric Services Fee Schedule for a list and description of procedure codes and fees.</p> <p><u>Note:</u> The Optometric Services Fee Schedule is available on the Medicaid Handbook and Resource Library CD-ROM and the Medicaid fiscal agent's website at http://floridamedicaid.acs-inc.com. Click on Provider Support, and then click on Fees.</p>
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Nursing Facility and ICF/DD Services

Description	<p>Nursing facility evaluation and management services are reimbursable when provided to a recipient in a nursing facility or an intermediate care facility for developmentally disabled (ICF/DD).</p>
Service Requirements	<p>The provider must bill the nursing facility evaluation and management procedure codes when providing services to a recipient at a nursing facility or an ICF/DD.</p> <p>Documentation demonstrating that the visit is medically necessary must be maintained in the recipient's medical record in the optometrist's office and at the facility.</p> <p>Services must be requested by the recipient, the recipient's guardian, or the primary care physician and documented in the recipient's medical record in the optometrist's office and at the facility.</p> <p><u>Note:</u> See Visual Examinations in this chapter for visual exam criteria related to providing eyeglasses in a nursing facility or ICF/DD.</p>
Service Frequency	<p>Evaluation and management visits are limited to one per month, per provider or provider group, per recipient.</p> <p>Additional visits may be reimbursed by submitting the claim with modifier 22 and a report documenting the care provided. Claims will be reviewed by the Medicaid medical consultant for medical necessity.</p> <p><u>Note:</u> See Chapter 3 for additional information on modifiers.</p>

Nursing Facility and ICF/DD Services, continued

Facility Visit

A nursing facility evaluation and management visit cannot be reimbursed in addition to any other evaluation and management visit on the same date, for the same provider or provider group, for the same recipient.

Excluded Services

Consultation services rendered in a nursing facility or ICF/DD cannot be reimbursed. Services provided in an office or room located in a nursing facility or ICF/DD cannot be reimbursed as an office evaluation and management visit.

Medicaid does not reimburse optometrists for additional services provided in a nursing care facility or ICF/DD except for refractions and the nursing facility evaluation and management procedures as outlined in the evaluation and management section of the CPT.

Procedure Codes and Fees

See the Optometric Services Fee Schedule for a list and description of procedure codes and fees.

Note: The Optometric Services Fee Schedule is available on the Medicaid Handbook and Resource Library CD-ROM and the Medicaid fiscal agent's website at <http://floridamedicaid.acs-inc.com>. Click on Provider Support, and then click on Fees.

Pathology and Laboratory Services

CLIA Certification and Licensure

Optometrists and ophthalmologists who perform laboratory tests in their offices must be certified under the Clinical Laboratory Improvement Amendments of 1988 (CLIA) and have a current state of Florida clinical laboratory license.

Separate laboratory facilities require separate CLIA certifications and state licenses even if they are operated under the same management.

Covered Services

Medicaid may reimburse pathology and laboratory services that include the performance of the tests, interpretation of the tests, and the reporting of results.

Note: The Optometric Services Fee Schedule is available on the Medicaid Handbook and Resource Library CD-ROM and the Medicaid fiscal agent's website at <http://floridamedicaid.acs-inc.com>. Click on Provider Support, and then click on Fees.

Specimen Collection

Medicaid does not reimburse providers for venipuncture, collection, handling or transportation of specimens. This is considered part of the maximum fee for the service.

Place of Service

Pathology services can be provided in a hospital setting or in an optometrist's office when the service is adjunctive to the examination and treatment.

Independent Lab

Pathology services for specimens sent to an independent laboratory are reimbursed to the independent laboratory. The optometrist must order the tests individually, not by panels; provide diagnoses in support of the medical necessity; and sign and date the order.

Maximum Fee

Pathology services in an optometrist's office must include both the technical and professional components if the optometrist is to receive the maximum reimbursement. These components are:

- Performing the services; and
- Interpreting the results.

The optometrist must have the appropriate CLIA certification and state licensure to perform the service.

Urinalysis, Hemoglobin and Hematocrit

Manual or automated dipstick urine, hemoglobin and hematocrit tests performed as part of a visit are not reimbursed in addition to the visit. The provider cannot bill for them as separate procedures.

Surgical Services

Covered Services

Surgical services, within the optometrist's or ophthalmologist's scope of practice, covered under the Medicaid Optometric Services Program are identified in the optometric fee schedule.

Note: The Optometric Services Fee Schedule is available on the Medicaid Handbook and Resource Library CD-ROM and the Medicaid fiscal agent's website at <http://floridamedicaid.acs-inc.com>. Click on Provider Support, and then click on Fees. Surgical procedure codes that are used for only post-operative care are identified in Appendix A.

Note: See Chapter 3 in this handbook for a description of surgery procedure codes and other modifiers.

Global Surgical Package

The payment for a surgical procedure includes a standard package of preoperative, intraoperative, and postoperative services. The preoperative period included in the global fee for surgery is the day of surgery (day one). The postoperative period included in the global fee for major surgery is 90 days and for minor surgery is 0 - 10 days depending on the procedure.

Separate billing for related post-surgical follow-up care that falls within the designated postoperative days for the performed procedure is not allowed.

Global Surgical Package Components

The following services are included in the payment amount for a global surgery:

- The preoperative visit on day one (the day of surgery).
- Intraoperative Services - Intraoperative services that are a usual and necessary part of a surgical procedure. Examples are local anesthetic, digital block, or topical anesthesia.
- Complications Following Surgery - All additional medical or surgical services required of the surgeon during the postoperative period of the surgery, because of complications that do not require additional trips to the operating room.
- Post-surgical Pain Management - By the optometrist.
- Miscellaneous Services and Supplies - Items such as dressing changes; local incisional care; removal of operative pack, removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; and changes and removal of tracheostomy tubes.
- Postoperative Visits - Follow-up visits within the postoperative period of the surgery that are related to recovery from the surgery.

Note: See the Optometric Services Fee Schedule for the number of follow-up days that are included in the surgical fee.

Surgical Services, continued

Global Surgical Package Exclusions	<p>The following services are not included in the payment amount for a global surgery:</p> <ul style="list-style-type: none">• The initial consultation or evaluation for the problem, performed on the service date of the procedure, by the optometrist to determine the need for surgery.• Diagnostic tests and procedures, including diagnostic radiological procedures.• Treatment for postoperative complications, which requires a return trip to the operating room (OR). An OR for this purpose is defined as a place of service specifically equipped and staffed for the sole purpose of performing procedures. It does not include a patient's room, a minor treatment room, a post-anesthesia care unit, or an intensive care unit (unless the patient's condition was so critical there would be insufficient time for transportation to an OR).
Surgical Care Only	<p>If performing surgical care only, the provider must bill using modifier 54 with the appropriate surgery code.</p> <p><u>Note:</u> See Chapter 3 for additional information on modifiers.</p>
Post-operative Management	<p>Medicaid can pay an optometrist for post-operative care of a Medicaid recipient only when the recipient is referred by the surgeon for follow-up care. The referral must be written and signed by the surgeon and kept in the recipient's medical record.</p> <p>The provider must bill using modifier 55 with the appropriate surgery code to indicate post-operative care.</p> <p><u>Note:</u> See Chapter 3 in this handbook for a description of modifier 55.</p> <p><u>Note:</u> See Appendix A in Chapter 3 for the surgical procedure codes that are used for post-operative care only.</p>
Unlisted Procedures	<p>Unlisted procedures or procedure codes ending in 99 may be billed only when there is no available procedure code. If the provider bills an unlisted procedure code when there is an appropriate procedure code, the claim will be denied.</p> <p>An unlisted procedure code requires that an operative report documenting the service provided be submitted with the claim for Medicaid medical consultant pricing.</p>

Lacrimal Punctum Plugs

Introduction

Medicaid reimburses for medically-necessary lacrimal punctum plugs.

Service Requirements

Medicaid reimburses for lacrimal punctum plugs for recipients who meet the following criteria:

- Are diagnosed with either:
 - ⇒ 375.15—Tear film insufficiency, unspecified; dry eye syndrome; or
 - ⇒ 370.33—Keratoconjunctivitis sicca, not specified as Sjögren's.
- Have complaints that are normally associated with dry eye syndrome;
- Have a positive Schirmer's test or some other measurement of lacrimal gland deficiency or evidence of corneal decomposition by slit lamp exam;
- Have undergone two to four weeks of conventional treatment using eye drops, gels, or ointments; and
- Show no evidence of any improvements after conventional treatments.

Required Documentation

The provider must maintain the following documentation for each claim in the recipient's medical record.

- Recipient's ICD-9-CM code supporting the medical necessity for the procedure;
- Results of Schirmer test or equivalent tear break-up time, tear assay, zone-quick and slit lamp exam;
- Operative report that contains:
 - ⇒ Patient's signature consenting to the procedure;
 - ⇒ Which puncta were involved;
 - ⇒ What plugs were used, described by type (collagen, silicone acrylic), brand and size;
 - ⇒ Whether the patient received topical anesthesia;
 - ⇒ What were pre-op and post-op diagnoses; and
 - ⇒ Discharge instructions.

If the above listed documentation is not in the recipient's medical record, the claim is subject to recoupment.

Lacrimal Punctum Plugs, continued

Contraindications

Use of lacrimal punctum plugs is contraindicated in recipients with:

- Signs and symptoms of an infection;
- Inflammation of eyelids;
- Dacryocystitis; or
- Allergies to bovine collagen or silicone.

**Reimbursement
Limitations**

Temporary lacrimal punctum plugs are limited to 12 per year (maximum of four plugs every four months), under procedure code 68761, closure of lacrimal punctum by plug, each, for treatment of dry eye syndrome when a more permanent conservative treatment will cause discomfort to the recipient. Documentation of this must be maintained in the recipient's medical record.

Procedure code 68761, closure of lacrimal punctum by plug, each, includes reimbursement for plugs; therefore, the plug may not be billed separately.

CHAPTER 3 OPTOMETRIC SERVICES PROCEDURE CODES AND FEE SCHEDULE

Overview

Introduction

This chapter describes the procedure codes for services reimbursable by Medicaid that must be used by the optometric providers rendering services to eligible recipients.

In This Chapter

This chapter contains:

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Appendix A: Procedures Codes that Are Used for Post-Operative Care	A-1

Note: The Optometric Services Fee Schedule is available on the Medicaid Handbook and Resource Library CD-ROM and the Medicaid fiscal agent's website at <http://floridamedicaid.acs-inc.com>. Click on Provider Support, and then on Fees.

Reimbursement Information

Procedure Codes

The procedure codes listed in this chapter are Healthcare Common Procedure Coding system (HCPCS) Level 1 and Level 2. The codes are part of the standard code set described in the Physician's Current Procedure Terminology (CPT) book. Please refer to the CPT book for complete descriptions of the standard codes. The CPT includes HCPCS descriptive terms and parameters and numeric identifying codes for reporting service and procedures. CPT codes and descriptions are copyright 2006 by the American Medical Association. All rights reserved.

Level 1 procedure codes (CPT) are a systematic listing and coding of procedures and services performed by providers. Each procedure or service is identified by a five-digit numeric code. Level 2 procedure codes are national codes usually used to describe medical services and supplies. They are distinguished from Level 1 codes by beginning with a single letter (A through V) followed by four numeric digits.

Reimbursement Information, continued

Procedure Codes, continued Effective October 16, 2003, in compliance with the federal requirements found in the Health Insurance Portability and Accountability Act (HIPAA), Florida Medicaid will process claims for only the standard code sets allowed in the federal legislation.

Diagnosis Code A diagnosis code is required for the CMS-1500 claim form for all medical procedures. Use the most specific code available. Fourth and fifth digits are required when available.

Copayment Medicaid recipients, unless they are exempt, are responsible for paying a copayment of \$2.00, per provider or group provider, per day, for optometric services.

Note: See Chapter 1 in Florida Medicaid Provider General Handbook for categories of recipients and services that are exempt from the copayment.

Dually-Eligible Medicare and Medicaid Recipients Providers must follow special claim procedures when submitting claims for optometric services furnished to dually-eligible Medicare and Medicaid recipients.

- Services that are reimbursable by Medicare must be billed to Medicare.
- For services not covered by Medicare (refractions, visual examinations using a refractive error diagnosis [367.0-367.9], enter keyed claim type 63 in block 19 on the CMS-1500 claim form and submit it directly to Medicaid.
- Optometrists must have category of service 62 (visual services) on their provider file in order to use keyed claim type 63. See Chapter 1 for more information on visual services enrollment.

Note: See Chapter 4 in the Florida Medicaid Provider General Handbook for additional information on Medicare crossovers.

MediPass Authorization Exemption Optometrists are not required to obtain MediPass authorization, except for prosthetic eye services.

How to Read the Optometric Fee Schedule

Introduction

Specific CPT codes are reimbursed by Medicaid to optometrists. These CPT codes are listed on the Optometric Services Fee Schedule.

Note: The Optometric Services Fee Schedule is available on the Medicaid Handbook and Resource Library CD-ROM and the Medicaid fiscal agent's website at <http://floridamedicaid.acs-inc.com>. Click on Provider Support, and then on Fees.

Description

The Optometry Procedure Codes and Fee Schedule is a table of columns listing CPT codes, their descriptors and other information pertinent to each code.

The information that follows identifies and explains the fee schedule columns, reading from left to right.

Code

The number in this column identifies the procedure being billed.

Code Description

The information in this column describes the service or procedure associated with the procedure code. Medicaid providers are instructed to refer to the current CPT or HCPCS Level II books for a complete description for billing purposes. The CPT and HCPCS Level II books include identifying numeric codes and descriptions for reporting medical services and procedures.

**Age 00-20
Max Fee**

The fee in this column is the maximum allowable amount Medicaid will pay for that procedure for Medicaid recipients age 20 and younger.

**21+
Max Fee**

The fee in this column is the maximum allowable amount Medicaid will pay for that procedure for Medicaid recipients age 21 and older.

**Age 0-20
PC Fee**

The fee in this column designates the amount payable for the professional component of the service only for Medicaid recipients under the age of 21.

**Age 21+
PC Fee**

The fee in this column designates the amount payable for the professional component of the service only for Medicaid recipients age 21 and older.

**FUD
(Surgery Follow-Up
Days)**

The number in this column designates the number of days following the date of surgery during which provider's services are included in the surgical fee and cannot be billed separately.

Units

The number in this column indicates the number of units of service that may be billed on one claim line.

Spec

An alphabetic code in this column indicates special requirements for submission of a claim for that procedure. Any of the alphabetic codes described below may appear in this column.

AS

Identifies a procedure code that requires billing with a modifier 80 when an assistant at surgery is requesting reimbursement.

PA

Identifies a procedure code for which written prior authorization from the Medicaid office for services performed in a setting outside of the inpatient hospital is required before performing the service.

Prior authorization forms are available from the Medicaid fiscal agent by calling (800) 289-7799 (in state) or (800) 955-7799 (out of state), or from the fiscal agent's website at <http://floridamedicaid.acs-inc.com>.

Note: See Prior Authorization in Chapter 2 of the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for additional information on the prior authorization process. The Reimbursement Handbook, CMS 1500, is available on the Medicaid Handbook and Resource Library CD-ROM and the Medicaid fiscal agent's website at <http://floridamedicaid.acs-inc.com>. Click on Provider Support, and then on Handbooks.

R

Identifies a procedure code for which either documentation of medical necessity for the procedure performed is required, or information is needed in order to review and price the procedure correctly. This requires that a report be submitted with the claim.

L/R

When an "L/R" appears in Spec column it indicates that when the code is billed, the provider must enter a modifier LT or RT on the claim to indicate whether the service or surgical procedure is for the left or right eye.

B

Identifies a procedure code that allows billing as a bilateral procedure by using a modifier 50.

Modifiers and Their Descriptions

Definition of Modifier

A modifier is a two-digit code that is used with a procedure code to more fully describe the procedure performed so that accurate payment may be determined.

There are two different types of modifiers that optometrists use: pricing modifiers and local-code modifiers. The two types of modifiers are described below.

Pricing Modifiers

A pricing modifier is a two-digit code that is used with a procedure code listed in the fee schedule to affect the procedure code's fee or cause a claim to pend for review. The provider is required to use pricing modifiers under certain circumstances described in Chapter 2 of this handbook or in the pricing modifiers' definitions in this section.

The pricing modifiers are 22, 24, 25, 26, 50, 54, 55, 56, 57, 99, LT, RT, and TC.

Local-Code Modifiers

Optometrists use "local-code modifiers" with certain visual services procedure codes listed on the Optometric Services Fee Schedule. Local-code modifiers can only be used with the procedure codes listed. Use of local-code modifiers with any other procedure codes will cause the claim to deny or pay incorrectly.

Entering Modifiers on the Claim Form

The modifier is entered in the field next to the procedure code field in item 24D, Modifier, on the CMS-1500 claim form.

Entering pricing modifiers: Enter the pricing modifier in the first modifier field on the claim form. If more than one pricing modifier is applicable, enter the multiple pricing modifier 99. See modifier 99 in this chapter for the full requirements.

Entering a pricing modifier and local-code modifier: If a situation requires both a pricing modifier and local-code modifier, enter the pricing modifier in the first modifier field on the claim form, and enter the local-code modifier in the second modifier field.

Modifiers and Their Descriptions, continued

Reports

Some modifiers require that a report be submitted with the claim. The claim and report are reviewed by a Medicaid medical consultant for appropriate pricing. All claims that require a report must be signed or fully attested to as appropriate to the media.

**22
Unusual Services**

Use this modifier only when a provided service(s) exceeds the usual service as described in the CPT.

- Modifier 22 requires the claim to be reviewed by a Medicaid medical consultant for appropriate pricing.
 - Documentation must clearly indicate why modifier 22 is being used. Documentation will need to be submitted along with routine documentation to indicate:
 - ⇒ Medical necessity for the units of service exceeded, and
 - ⇒ Why additional reimbursement is being requested. Examples include explanation of increased complexity of the service, or unexpected complications during a service.
 - Failure to submit the requested documentation can result in denial of the service, request for more information, or no increase in reimbursement.
 - If a claim denial is received for units of service exceeded, use of modifier 22 would be appropriate. Inappropriate use of this modifier can result in claim denial or delayed reimbursement time.
-

**24
Separate
Evaluation and
Management
Services**

Use this modifier when an evaluation and management service is performed by the same provider or provider group during the postoperative period for a reason unrelated to the original procedure.

A report must be submitted with the claim. This modifier requires the claim to be reviewed by a Medicaid medical consultant for appropriate pricing.

Modifiers and Their Descriptions, continued

**25
Separate
Evaluation and
Management
Services**

Use modifier 25 for a significant, separately identifiable evaluation and management service by the same provider or provider group on the same day of the procedure or other service. A provider may need to indicate that on the same day a procedure or service identified by a procedure code was performed, the patient's condition required a significant, separately identifiable evaluation and management service above and beyond the usual preoperative and postoperative care associated with the procedure that was performed.

The evaluation and management service may be prompted by the symptom or condition for which the procedure or the service was provided. As such, different diagnoses are not required for reporting of the evaluation and management services on the same date. This circumstance is reported by adding the modifier 25 to the appropriate level of evaluation and management service.

This modifier is not used to report an evaluation and management service that resulted in a decision to perform surgery.

**26
Professional
Component**

Certain procedures are a combination of a professional component and a technical component.

Use this modifier when the professional component is reported separately. This modifier can only be used for the hospital inpatient or outpatient setting.

Acceptable procedure codes billable for professional component are identified in the "PC" column in the fee schedule.

**TC
Technical
Component**

Certain procedures are a combination of a professional component and a technical component.

Use this modifier when the radiological technical component is reported separately. Acceptable procedure codes billable for technical component are identified in the "TC" column in the fee schedule.

**LT/RT
Left and Right
Modifiers**

Use these modifiers to indicate left (LT) or right (RT) radiology or surgical procedures. "L/R" in the "Spec" column of the fee schedule identifies applicable procedure codes for use of these modifiers. When doing a bilateral procedure, please use modifier 50 as described on the next page when billing.

Modifiers and Their Descriptions, continued

**50
Bilateral
Procedure**

Modifier 50 is used to identify bilateral procedures that are performed during the same operative session.

- If the claim requires medical review, a report must be submitted documenting the service.
 - This modifier reimburses at 150 percent of the maximum allowable for the procedure code fee or suspends for multiple surgery pricing, if applicable.
 - Do not use modifier 50 if the CPT definition identifies the service solely as a bilateral procedure or identifies the service as “unilateral or bilateral” in the descriptor.
 - The procedure code along with modifier 50 should be identified on one claim line. Do not bill the procedure code on one claim line and then identify the same procedure code on the next claim line with the modifier 50.
-

**54
Surgical Care
Only**

Modifier 54 is used to identify the surgical component when only one physician performs a surgical procedure.

- Reimbursement rate is 50 percent of the maximum allowable fee of the procedure code.
 - Preoperative or postoperative management is performed by another physician.
 - For claims requiring medical review, a report must be submitting documenting that the service was for the surgery only.
-

**55
Postoperative
Management
Only**

Modifier 55 is used to identify the postoperative component of patient management.

- Reimbursement rate is 30 percent of the maximum allowable fee of the procedure code.
 - Surgery and postoperative management have been performed by other physicians.
 - If the claim requires medical review, a report must be submitted documenting the service was for postoperative management only.
-

**56
Preoperative
Management
Only**

Modifier 56 is used to identify the preoperative component including preoperative care and evaluation of patient management.

- Reimbursement rate is 20 percent of the maximum allowable fee of the procedure code.
 - Surgery and postoperative management have been performed by other physicians.
 - If the claim requires medical review, a report must be submitted documenting the service was for preoperative management only.
-

Modifiers and Their Descriptions, continued

57 Decision for Surgery	Modifier 57 is used to indicate that an evaluation and management service that results in the initial decision to perform a surgical procedure.
99 Multiple Modifiers	Modifier 99 is used when two or more modifiers are applicable to one procedure code line. <ul style="list-style-type: none">• When modifier 99 is used, there must be an indication made on either the claim form or documentation indicating the individual modifiers that 99 represents (Example: 99=80, 51). Absence of this indication can result in a claim line denial.• Use of this modifier requires the claim to be reviewed by a Medicaid medical consultant for appropriate pricing. Pricing will be based on the use of valid modifiers applicable to the procedure code.

APPENDIX A

PROCEDURE CODES THAT ARE USED FOR POST-OPERATIVE CARE (Modifier 55)

CODE	DESCRIPTION	Age 00-20	Age 00-20	Age 21 +	Age 21 +	Units	Spec
		Max Fee	PC Fee	Max Fee	PC Fee		
15820	BLEPHAROPLASTY, LOWER EYELID;	259.54	0.00	249.56	0.00	1	PAB
15822	BLEPHAROPLASTY, UPPER EYELID;	220.82	0.00	212.33	0.00	1	PAB
65420	EXCISION OR TRANSPOSITION OF PTERYGIUM; WITHOUT GRAFT	250.13	0.00	240.51	0.00	1	B
65426	EXCISION OR TRANSPOSITION OF PTERYGIUM; WITH GRAFT	272.52	0.00	262.04	0.00	1	B
65772	CORNEAL RELAXING INCISION FOR CORRECTION OF SURGICALLY INDUCED ASTIGMATISM	244.90	0.00	235.48	0.00	1	B
65775	CORNEAL WEDGE RESECTION FOR CORRECTION OF SURGICALLY INDUCED ASTIGMATISM	281.53	0.00	270.70	0.00	1	B
65855	TRABECULOPLASTY BY LASER SURGERY, ONE OR MORE SESSIONS (DEFINED TREATMENT S	194.45	0.00	186.97	0.00	1	B
66761	IRIDOTOMY/IRIDECTOMY BY LASER SURGERY (EG, FOR GLAUCOMA) (ONE OR MORE SESSI	206.17	0.00	198.24	0.00	1	B
66821	DISCISSION OF SECONDARY MEMBRANEOUS CATARACT (OPACIFIED POSTERIOR LENS CAPS	135.43	0.00	130.22	0.00	1	B
66830	REMOVAL OF SECONDARY MEMBRANOUS CATARACT (OPACIFIED POSTERIOR LENS CAPSULE	328.20	0.00	315.58	0.00	1	B
66840	REMOVAL OF LENS MATERIAL; ASPIRATION TECHNIQUE, ONE OR MORE STAGES	320.25	0.00	307.93	0.00	1	B
66850	REMOVAL OF LENS MATERIAL; PHACOFRAGMENTATION TECHNIQUE (MECHANICAL OR ULTRA	362.52	0.00	348.58	0.00	1	B
66852	REMOVAL OF LENS MATERIAL; PARS PLANA APPROACH, WITH OR WITHOUT VITRECTOMY	390.78	0.00	375.75	0.00	1	B
66920	REMOVAL OF LENS MATERIAL; INTRACAPSULAR	350.39	0.00	336.91	0.00	1	B
66930	REMOVAL OF LENS MATERIAL; INTRACAPSULAR, FOR DISLOCATED LENS	402.93	0.00	387.43	0.00	1	B
66940	REMOVAL OF LENS MATERIAL; EXTRACAPSULAR (OTHER THAN 66840, 66850, 66852)	364.20	0.00	350.19	0.00	1	B
66982	EXTRACAPSULAR CATARACT REMOVAL WITH INSERTION OF INTRAOCULAR LENS PROSTHESI	504.65	0.00	485.24	0.00	1	B

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CODE	DESCRIPTION	Age 00-20 Max Fee	Age 00-20 PC Fee	Age 21 + Max Fee	Age 21 + PC Fee	Units	Spec
66983	INTRACAPSULAR CATARACT EXTRACTION WITH INSERTION OF INTRAOCULAR LENS PROSTH	327.57	0.00	314.97	0.00	1	B
66984	EXTRACAPSULAR CATARACT REMOVAL WITH INSERTION OF INTRAOCULAR LENS PROSTHESI	384.30	0.00	369.52	0.00	1	B
66985	INSERTION OF INTRAOCULAR LENS PROSTHESIS (SECONDARY IMPLANT), NOT ASSOCIATE	340.76	0.00	327.65	0.00	1	B
66986	EXCHANGE OF INTRAOCULAR LENS	462.79	0.00	444.99	0.00	1	
92018*	OPHTHALMOLOGICAL EXAMINATION AND EVALUATION, UNDER GENERAL ANESTHESIA, WITH	75.77	0.00	72.86	0.00	1	
92019*	OPHTHALMOLOGICAL EXAMINATION AND EVALUATION, UNDER GENERAL ANESTHESIA, WITH	39.98	0.00	38.44	0.00	1	
92235*	FLUORESCEIN ANGIOGRAPHY (INCLUDES MULTIFRAME IMAGING) WITH INTERPRETATION A	80.37	25.12	77.28	24.15	2	

* These procedures must be performed in conjunction with an ophthalmologist (M.D. or D.O.)



Charlie Crist
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