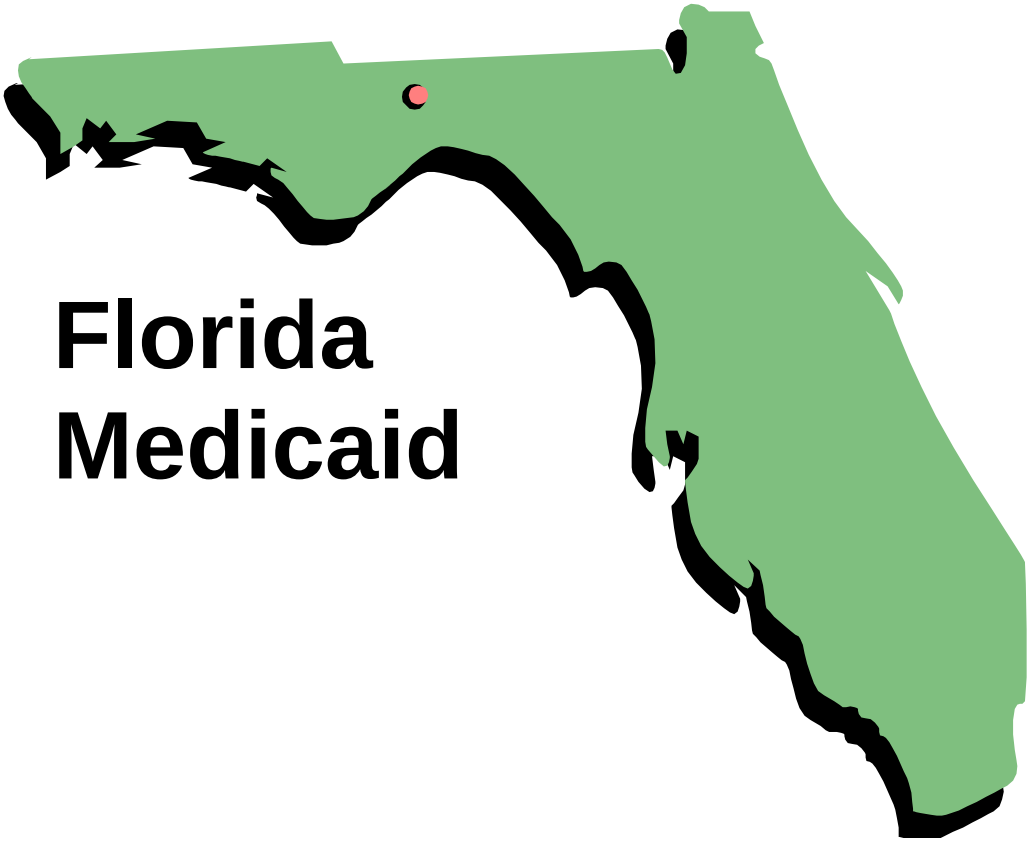

OPTOMETRIC SERVICES
COVERAGE AND LIMITATIONS HANDBOOK

Agency for Health Care Administration
May 2014

AHCA
FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

OPTOMETRIC SERVICES
COVERAGE AND LIMITATIONS HANDBOOK
UPDATE LOG

How to Use the Update Log

Introduction

The update log provides a history of the handbook updates. Each Florida Medicaid handbook contains an update log.

Obtaining the Handbook Update

When a handbook is updated, the Medicaid provider will be notified. The notification instructs the provider to obtain the updated handbook from the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks.

Medicaid providers who are unable to obtain an updated handbook from the Web site may request a paper copy from the Medicaid fiscal agent's Provider Services Contact Center at 1-800-289-7799.

Explanation of the Update Log

Providers can use the update log to determine if updates to the handbook have been received.

Update describes the change that was made.

Effective Date is the date that the update is effective.

UPDATE	EFFECTIVE DATE
Revised Handbook	January 2000
Revised Handbook	January 2001
Errata Replacement Page	January 2001
Replacement Pages	January 2002
Replacement Pages	April 2002
Errata Replacement Pages	April 2002
Replacement Pages	March 2003
Revised Handbook	January 2005
Revised Handbook	January 2006
Replacement Pages	January 2007
Revised Handbook	May 2014

OPTOMETRIC SERVICES
COVERAGE AND LIMITATIONS HANDBOOK
TABLE OF CONTENTS

Chapter and Topics **Page**

INTRODUCTION TO THE HANDBOOK

Overview

Introduction

This chapter outlines the three types of Florida Medicaid policy handbooks that all enrolled providers must comply with in order to obtain reimbursement. This chapter also describes the format used for the handbooks and instructs 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 any corresponding fee schedules. Fee schedules can be incorporated within the handbook or separately.
- Reimbursement handbooks describe how to complete and file claims for reimbursement from Medicaid.

The current Florida Medicaid provider handbooks are posted on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks.

Federal and State 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
- Rule Division 59G, Florida Administrative Code

In This Chapter

This chapter contains:

Handbook Use

Purpose	The purpose of the Medicaid handbooks is to educate the Medicaid provider about the policies and procedures needed to receive reimbursement for covered services provided to eligible Florida Medicaid recipients. The handbooks provide descriptions and instructions on how and when to complete forms, letters, or other documentation.
Provider	Term used to describe any entity, facility, person, or group who is enrolled in the Medicaid program and provides services to Medicaid recipients and bills Medicaid for services.
Recipient	Term used to describe an individual enrolled in Florida Medicaid.
Provider General Handbook	Information that applies to all 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.
Coverage and Limitations Handbook	Each coverage and limitations handbook is named for the service it describes. A provider who renders more than one type of service will have more than one coverage and limitations handbook with which they must comply.
Reimbursement Handbook	Most reimbursement handbook are named for the claim form submitted.

Characteristics of the Handbook

Format	The format of the handbook represents a reader-friendly way of displaying material.
Label	Labels are located in the left margin of each information block. They identify the content of the block in order to help scanning and locating information quickly.
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.
Chapter Topics	Each chapter contains a list of topics 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.
Note	Note is used to refer the reader to other important documents or policies contained outside of this handbook.
Page Numbers	Pages are numbered consecutively within each chapter throughout the handbook. The chapter number appears as the first digit before the page number at the bottom of each page.
White Space	The "white space" found throughout a handbook enhances readability and allows space for writing notes.

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" and "Effective Date."
Handbook Update Classifications	The Medicaid handbooks will be updated as needed. Updates are classified as either a: • Replacement handbook – Major revisions resulting in a rewrite of the existing handbook, without any underlines and strikethroughs throughout the rulemaking process. • Revised handbook – Minor revisions resulting in modification of the existing handbook identified during the rulemaking process by underlines and strikethroughs.
Handbook Effective Date	The effective date of a handbook is the month and year that will appear on the final published handbook. The provider can check this date to ensure that the material being used is the most current and up to date.
Identifying New Information	New information or information moved from one place to another within the handbook will be identified by an underline on draft versions of the handbook during the development and proposed stages of the rulemaking process (e.g., <u>new information</u>).
Identifying Deleted Information	Deleted information will be identified by a line through the middle of the selected text on draft versions of the handbook during the development and proposed stage of the rulemaking process (e.g., ~~deleted information~~).
Final Published Handbook	The adopted and published version of the handbook will not have underlines (indicating insertions) and text with strikethroughs (indicating deletions).

CHAPTER 1
QUALIFICATIONS, ENROLLMENT, AND REQUIREMENTS

Overview

Introduction

This chapter describes Florida Medicaid's optometric services, the specific authority regulating these services, and provider qualifications, enrollment, and requirements.

Legal Authority

Optometric services are authorized by Chapter 409.906, Florida Statutes (F.S.) and in Rule 59G-4.210, Florida Administrative Code (F.A.C.).

In This Chapter

This chapter contains:

Purpose and Definitions

Medicaid Provider Handbooks

This handbook is intended for use by optometric and ophthalmologic providers that render services to eligible Medicaid recipients. It must be used in conjunction with the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, which contains information about specific procedures for submitting claims for payment, and the Florida Medicaid Provider General Handbook, which describes the Florida Medicaid program.

Note: The Florida Medicaid provider handbooks are available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks. All of the Florida Medicaid provider handbooks are incorporated by reference in Rule Division 59G, F.A.C.

Consultation

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.

Purpose and Definitions, continued

Evaluation and Management	Face-to-face optometrist or ophthalmologist and recipient encounters.
Fully Operational	For the purpose of optometric services, a licensed optometrist, ophthalmologist, or their group practice operating in an established practice location, providing services to the public, and receiving reimbursements for optometric services rendered.
Operating Room (OR)	A place of service specifically equipped and staffed for the sole purpose of performing procedures. An OR does not include a recipient's room, a minor treatment room, a postanesthesia 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).
Personal Supervision	Personal supervision means that the services are furnished while the supervising practitioner is in the building and that the supervising practitioner signs and dates the medical records (chart) within 24 hours of the provision of the service.
Screening	A screening is the testing of individuals who do not have complaints. It is designed to detect physical and vision 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.

Qualifications

Licensure	To receive reimbursement for optometric services, the enrolled provider must be currently licensed as one of the following: • Ophthalmologist licensed in accordance with Chapter 458 or 459, F.S. • 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.

Qualifications, continued

Clinical Laboratory Improvement Amendments (CLIA) of 1988 Certification and Licensure	The Centers for Medicare and Medicaid Services require all clinical laboratory testing sites to adhere to regulations implementing the CLIA of 1988. To receive reimbursement for laboratory tests listed on the Optometric Services Fee Schedule, the enrolled provider's office laboratory must be licensed and CLIA-certified, in the related laboratory specialties.

Enrollment

General Enrollment Requirements	Optometrists and ophthalmologists must meet the general Medicaid provider enrollment requirements that are contained in the Florida Medicaid Provider General Handbook. In addition, optometrists and ophthalmologists must follow the specific enrollment requirements that are listed in this section.
Other Licensed Health Care Practitioners	If an optometric 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 nonoptometric physician health care practitioners who can enroll as Medicaid providers are: physician assistants, advanced registered nurse practitioners, registered nurse first assistants, physical therapists, etc.
Operational at Time of Enrollment	Providers of Medicaid optometric services must meet all the provider requirements and qualifications specified in this handbook and their practices must be fully operational prior to enrollment as Medicaid providers.

Requirements

Providers Contracted with Medicaid Health Plan	The service-specific Medicaid coverage and limitations handbooks provide the minimum requirements for all providers. This includes providers who contract with Florida Medicaid health plans (e.g., provider service networks and health maintenance organizations). Providers shall comply with all of the requirements outlined in this handbook, unless otherwise specified in their contract with the health plan. The provision of services to recipients enrolled in a Medicaid health plan shall not be subject to more stringent criteria or limits than specified in this handbook.

CHAPTER 2
COVERED, LIMITED, AND EXCLUDED SERVICES

Overview

Introduction

This chapter provides service coverage, limitations, and exclusions information. It also describes who can provide and receive services and any applicable service requirements.

In This Chapter

This chapter contains:

General Coverage Information

Medical Necessity

Medicaid reimburses services that are determined medically necessary and do not duplicate another provider's service.

Rule 59G-1.010(166), Florida Administrative Code (F.A.C.) defines "medically necessary" or "medical necessity" as follows:

"[T]he medical or allied care, goods, or services furnished or ordered must:

(a) Meet the following conditions:

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

General Coverage Information, continued

Medical Necessity, continued	"(c) 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."
Exceptions to Limits (Special Services) Process	As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the Social Security Act, Title 42 of the United States Code 1396d(a). Services requested for recipients under the age of 21 years in excess of limitations described within this handbook or the associated fee schedule may be approved, if medically necessary, through the prior authorization process described in this handbook.
Description	Optometric services are medically necessary services that provide examination, diagnosis, treatment, and management of ocular and adnexal pathology. Visual examinations to determine the need for eyeglasses are also covered. Note: Eyewear is covered through Medicaid's visual services. Optometrists and ophthalmologists providing eyeglasses, eyeglass repair services, contact lenses, and prosthetic eyes must also enroll with visual services as a category of service to be eligible for Medicaid reimbursement for these services.
Who Can Provide	Delivery of all Medicaid optometric services must be furnished by or under the personal supervision of a Medicaid-enrolled optometrist or ophthalmologist.
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. Note: For more information on the procedure codes for this service, see the Optometric Services Fee Schedule on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Click on Public Information for Providers, then Provider Support, and then Fee Schedules.

Visual Examinations

Visual Exams	Visual examination services are performed when there is a reported vision problem, illness, disease, or injury. Visual examinations must be billed using the appropriate evaluation and management or general ophthalmological visit.
Refractions	Medicaid will reimburse only two refractions performed in the provider's office per recipient, per 365 days. The 365-day period begins with the date of the first refraction.
Computerized Corneal Topography	Computerized corneal topography is reimbursed up to a maximum of four times per year, per recipient.
Special Ophthalmological Services	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. In a nursing facility, an intermediate care facility for individuals with intellectual disabilities (ICF/IID), a recipient's home, or a custodial care facility, general and special ophthalmological services are not reimbursed, except for determination of refractive state, fitting of contact lens for treatment of ocular surface disease, and extended ophthalmoscopy with retinal drawing, interpretation, and report.
Documentation Requirements	All of the following documents must be recorded in the recipient's medical record: • Clearly written patient assessment • Plan of care • Description of treatment provided • Retinal drawing, if applicable
In Conjunction with a Child Health Check-Up	Medicaid does not reimburse visual field exam procedure codes when these services are performed in conjunction with or on the same date of service as any of the Child Health Check-Up evaluation and management procedure codes.

Visual Examinations, continued

Eyeglasses and Contact Lenses

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

Eyeglasses and contact lenses are reimbursed through Florida Medicaid's visual services.

Note: For service limitations regarding eyeglasses and contact lenses, see the Florida Medicaid Visual Services Coverage and Limitations Handbook.

Eyeglasses and Refractions in a Recipient's Home, Custodial Care Facility, Nursing Facility, or Intermediate Care Facility for Individuals with Intellectual Disabilities

Dispensing of eyeglasses and performing refractions may be claimed for services rendered in a recipient's home, custodial care facility, or nursing facility.

Performing refractions may also be claimed for services rendered in an ICF/IID.

Dispensing of eyeglasses or performing refractions may be claimed when all the following criteria are met:

- The recipient is given the right to choose an optometric service provider.
- The optometric services provided in the facility or recipient's home are qualitatively comparable to optometric services provided in the provider's office.
- Transportation to the optometric services provider's office would require an ambulance or stretcher van or if moving the recipient out of the recipient's home or residential facility would pose an unacceptable health risk to the recipient due to the recipient's current and documented medical condition.
- The recipient's primary care physician or facility physician must order a referral for medically necessary optometric services to be performed in a recipient's home, custodial care facility, nursing facility, or ICF/IID.
- The physician's order (documentation of medical necessity) is valid up to 90 days after the order is signed and dated by the referring physician. If additional optometric services are required, the medical necessity for the service must be redetermined by the recipient's primary care physician.

Verbal orders, 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 physician or health care professional on the next visit to the facility.

Visual Examinations, continued

Eyeglasses and Refractions in a Recipient's Home, Custodial Care Facility, Nursing Facility or ICF/IID, continued

When optometric services are provided in the recipient's home or residential facility, documentation of medical necessity, as described above, and documentation of services received must be maintained in the recipient's medical record at both the facility and provider's office, respectively.

The appropriate place of service code must be entered on the provider's claim form. Optometric services performed in a recipient's home, nursing home, ICF/IID, or custodial care facility must not be billed with a place of service code designated for an office, inpatient, clinic, or outpatient setting.

All claims for optometric services conducted in a nursing facility, an ICF/IID, a recipient's home, or custodial care facility must include the referring physician's name and Medicaid identification number or National Provider Identifier (NPI).

Note: Eyeglasses are included in the ICF/IID per diem. Providers cannot bill Medicaid for eyeglasses when the recipient is a resident of an ICF/IID. Providers must make payment arrangements with the ICF/IID for eyeglasses (frames and lenses) furnished to its residents. For more information about covered eyewear services, see the Florida Medicaid Intermediate Care Facility for the Developmentally Disabled Coverage and Limitations Handbook and the Visual Services Coverage and Limitations Handbook.

Evaluation and Management Services

Covered Services

One new patient visit may be reimbursed once per recipient, per optometrist, ophthalmologist, optometric group, or ophthalmologist group.

Place of Service

Evaluation and management services can take place in the following:

- Recipient's home
- Office or outpatient hospital
- Inpatient hospital
- Custodial care facility
  - Domiciliary
  - Rest home
  - Assisted living facilities
  - Adult family care homes
  - Extended congregate care facilities
  - Continuing care retirement communities
- Nursing facility
- ICF/IID

Note: For a listing of place of service codes and their descriptions, see the Provider Reimbursement Handbook, CMS-1500.

Evaluation and Management Services, continued

Home Visits

Home visits are encounters in the private residence of the recipient. Custodial care facility and nursing facility visits are not considered home visits.

A referral for optometric services must be ordered in writing by the recipient's primary care physician. The services must be fully documented and maintained in the recipient's medical record at the optometrist's office location and made available upon request.

Office or Hospital Outpatient Visits

Office or hospital outpatient visits are encounters in the optometric services provider's office or an outpatient facility.

Inpatient Hospital Visits

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

- Evaluation and management visit
- Nonsurgical
- Surgical procedure

Hospital visits for an inpatient recipient are not reimbursed if the visit relates to a procedure not covered by Medicaid or is within the preoperative or follow-up global period for procedures covered by Medicaid.

Medicaid will reimburse an additional hospital visit for a significant, separately identifiable service above and beyond the usual preoperative and postoperative care associated with the surgical procedure that was performed. To be reimbursed for this visit, the provider must bill using the appropriate modifier 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 using the appropriate modifier. A report explaining the medical necessity of the visit must be submitted with the claim.

Evaluation and Management Services, continued

Custodial Care Facility, Nursing Facility, and Intermediate Care Facility for Individuals with Intellectual Disabilities Visits	Custodial care facilities provide a recipient with room, board, and other personal assistance services, generally on a long-term basis. A nursing facility or ICF/IID is a facility where the recipient resides. Services rendered must be requested in writing by the recipient's primary care physician. Documentation must be maintained in the recipient's medical record at the optometrist's office and a copy provided to the facility to be maintained in the recipient's record. The provider must bill with the evaluation and management code pertaining to the facility where services were rendered.
Visit Limitations	Office, home, and hospital visits are limited to one visit per recipient, per day, unless otherwise specified. Custodial care facility, nursing facility, and ICF/IID visits 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. Custodial care facility, nursing facility, and ICF/IID 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.

Consultation and Referral Services

Covered Services	A consultation must be requested by another practitioner. A consultation initiated by a recipient or the recipient's family is not reimbursable as a consultation or as a second opinion.
Place of Service	Consultation services may be rendered in an inpatient hospital, outpatient hospital, or office setting. The service is to be billed with procedure codes used for an office visit, as appropriate.

Consultation and Referral Services, continued

Consultation that Becomes a Referral

Upon completion of a consultation, if the consulting provider assumes responsibility for the management of all, or a portion of, the recipient's care, then follow-up consultation codes, as defined by the Current Procedural Terminology (CPT), billed by the provider are not reimbursable.

In a hospital setting, the optometrist or ophthalmologist 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 an office setting, the appropriate established recipient evaluation and management code must be used.

Documentation Requirements

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

- Referral with statement of medical need for consultation from the attending or requesting practitioner.
- Consultant's opinion and any services ordered or performed.
- Written report provided to the attending or requesting practitioner.

Hospital Inpatient Visits

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

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 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.

The consultation request must be documented and maintained in the recipient's medical record.

Office or Hospital Outpatient Visits

Medicaid reimburses one initial consultation visit, per practitioner specialty, per 365 days, for a nonhospitalized 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.

Consultation and Referral Services, continued

Nonreimbursable 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, for the same recipient.

Consultations rendered in nursing or custodial care facilities are not reimbursed.

Medicaid does not reimburse consultations for the following:

- A second opinion.
- As a decision for surgery.
- In combination with surgical procedures on the same day.

Pathology and Laboratory Services

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. The procedure codes for the laboratory services can be found in the Optometric Services Fee Schedule.

Place of Service

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

Laboratory Tests

To receive reimbursement for laboratory tests listed on the Optometric Services Fee Schedule, the enrolled provider's office laboratory must be licensed and certified under the Clinical Laboratory Improvement Amendments of 1988 (CLIA) in the related laboratory specialties.

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

Pathology and Laboratory Services, continued

Optometrist's or Ophthalmologist's Office	Pathology services in an optometrist's or ophthalmologist's office must include both the technical and professional components for the optometrist or ophthalmologist to receive the maximum reimbursement. These components are: • Performing the services • Interpreting the results The maximum reimbursement pays the optometrist or ophthalmologist for performing the complete procedure including both the technical and professional components. It can be billed only when the same provider performs all components.
Hospital or Other Facility	For professional pathology or laboratory services rendered to a recipient in the inpatient or outpatient hospital or other facility, the provider may bill only a professional component (PC) fee.
Independent Lab	Pathology services for specimens sent to an independent laboratory are reimbursed directly to the independent laboratory. Providers must: • Order the tests individually, not by panels. • Provide diagnoses in support of the medical necessity. • Sign and date the order.
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.
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.

Surgical Services

Covered Services

Surgical services, within the optometrist's or ophthalmologist's scope of practice, are covered by Florida Medicaid and are identified in the Optometric Services Fee Schedule.

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 postsurgical follow-up care provided within the designated postoperative days for the performed procedure is not reimbursed.

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—Services that are a usual and necessary part of a surgical procedure, for example, local anesthetic, digital block, and 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.
- Postsurgical 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.

Surgical Services, continued

Global Surgical Package Exclusions

The following services are not included in the payment amount for a global surgery:

- 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.

Surgical Care Only

If performing surgical care only, the provider must bill the appropriate modifier with the appropriate surgery code.

Postoperative Management

Medicaid reimburses an optometrist for postoperative care only when the Medicaid recipient is referred by the surgeon for follow-up care. The referral must be written, signed, and dated by the surgeon and kept in the recipient's medical record.

The provider must bill for postoperative management services using the appropriate modifier with the appropriate surgery code.

Lacrimal Punctum Plugs

Covered Services

Medicaid reimburses for medically necessary lacrimal punctum plugs.

Service Requirements

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

- Are diagnosed with one of the following conditions:
  - Dry eye syndrome of the lacrimal glands (right, left, bilateral, or unspecified)
  - Keratoconjunctivitis sicca, not specified as Sjögren's (right, left, bilateral, or unspecified)
  - Lagophthalmos
  - Chemical burns
  - Ocular pemphigus
  - Severe punctate keratitis
  - Other similar serious anterior segment conditions

Lacrimal Punctum Plugs, continued

Service Requirements, continued

- 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.
- Show no evidence of any improvements after conventional treatments.

Required Documentation

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

- Diagnosis code supporting the medical necessity for the procedure.
- Results of Schirmer's test or equivalent tear break-up time, tear assay, zone-quick and slit lamp exam.
- Operative report that contains at a minimum:
  - Patient's dated signature, consenting to the procedure.
  - Which puncta were involved.
  - Which plugs were used, described by type (collagen, silicone acrylic), brand, and size.
  - Whether or not the patient received topical anesthesia.
  - Preoperative and postoperative diagnoses.
  - Discharge instructions.

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

Contraindications

Use of lacrimal punctum plugs is contraindicated in recipients with:

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

Limitations

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

The procedure for closure of lacrimal punctum by plug includes reimbursement for plugs. The plug(s) may not be billed separately.

Excluded Services

Optometric

Medicaid does not reimburse the following optometric 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.

CHAPTER 3
REIMBURSEMENT AND FEE SCHEDULE

Overview

Introduction

This chapter describes the reimbursement and fee schedule information for optometric services.

In This Chapter

This chapter contains:

Note: Fee schedules are available on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Fee Schedules.

Reimbursement Information

Procedure Codes

The procedure codes listed in this handbook are Healthcare Common Procedure Coding System (HCPCS) Levels I and II. Both levels are part of the nationally standardized code sets.

Level I of the HCPCS is comprised of Current Procedural Terminology (CPT), a numeric coding system maintained by the American Medical Association. All rights reserved. The CPT is a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. CPT codes are identified using five numeric digits.

Level II of the HCPCS is a standardized coding system used primarily to identify products, supplies, and services not included in the CPT codes. HCPCS Level II codes are also referred to as alpha-numeric codes because they consist of a single alphabetical letter (A – V) followed by four numeric digits.

Reimbursement Information, continued

Unlisted Procedures	Unlisted procedures or procedure codes ending in 99 may be billed only when there is no available procedure code. Billing Medicaid with an unlisted procedure code for a service with an available and appropriate procedure code will result in denial of the claim. An unlisted procedure code requires an operative report, documenting the service provided, to be included with the submitted claim. The claim and attachments will be reviewed for medical necessity and priced.
Diagnosis Code	A standard diagnosis code is required on the CMS-1500 claim form for all medical procedures. Providers, or their billing agents, must use the most current and specific International Classification of Diseases diagnosis code(s) available.
Copayment	Medicaid recipients, unless exempt, are responsible for a copayment of $2.00, per provider or group provider, per day, for optometric services. Note: For more information regarding categories of recipients and services that are exempt from a copayment, see the Florida Medicaid Provider General Handbook.
MediPass Authorization Exemption	Optometrists are not required to obtain MediPass authorization, except for prosthetic eye services.

How to Read the Fee Schedule

Introduction

Specific CPT codes are reimbursed by Medicaid to optometric service providers and are listed on the Optometric Services Fee Schedule.

The Optometric Services Fee Schedule includes the following information:

- Covered procedure code
- Code description
- Maximum limit per code
- Fees
- Codes requiring prior authorization or medical review by report

Information provided at the top of the first page of the Optometric Services Fee Schedule provides instruction to eligible licensed practitioners about calculating fee increases for services provided to recipients under the age of 21.

Code

The number in this column identifies the Florida Medicaid reimbursable procedure code.

Description

The information in this column describes the service or procedure associated with the procedure code listed in the first column. Medicaid providers are instructed to refer to the current CPT or HCPCS Level II guidebooks for complete code descriptions.

Units

The number of service limits per code, per day.

Base Fee

The amount reimbursed for services provided to adult recipients, age 21 years and older.

Base PC Fee

The amount reimbursed for only the professional component of a service provided to adult recipients, age 21 years and older.

Base TC Fee

The amount reimbursed for only the technical component of a service provided to adult recipients, age 21 years and older.

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.

How to Read the Fee Schedule, continued

PA	Indicates the procedure code requires written prior authorization from Medicaid when the services are performed outside of the inpatient hospital setting. Note: Prior authorization request forms are available through Medicaid's Quality Improvement Organization. For more information about the prior authorization process, see the Florida Medicaid Provider Reimbursement Handbook, CMS-1500.
R	Identifies the procedure code for which documentation of medical necessity is required to be submitted with the claim for reimbursement. Procedures listed on the fee schedule without a set fee require manual pricing by the Medicaid reviewer. Therefore, the provider's usual and customary fee for the procedure or proof of the provider's attainment cost for the supply item claimed must be included with the claim.
L/R	Indicates when a procedure code requires a modifier LT or RT on the claim. This information will indicate whether the service or surgical procedure was performed on the left or right eye.
B	Indicates when a procedure code is allowed as a bilateral procedure.

Modifiers and their Descriptions

Modifier	A two-digit code used with a procedure code to more fully describe the procedure performed so that accurate payment may be determined.
Reports	Some modifiers require that a report be submitted with the claim. All claims that require a report must be signed or fully attested to as appropriate to the media.

Modifiers and their Descriptions, continued

22 **Unusual Services**	Use modifier 22 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 reviewer, for appropriate claim processing. Documentation will need to be submitted along with routine documentation to indicate medical necessity for the units of service being exceeded. The documentation submitted must clearly indicate why modifier 22 is being used. Failure to submit the requested documentation can result in denial of the service. If a previous submission of a claim resulted in denial for exceeding units of service, 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 modifier 24 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.
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.

Modifiers and their Descriptions, continued

26 **Professional Component**	Certain procedures are a combination of a professional component and a technical component. Use modifier 26 when the professional component is reported separately. This modifier can only be used for the hospital inpatient or outpatient setting. Acceptable procedure codes reimbursable 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 modifier TC when the radiological technical component is reported separately. Acceptable procedure codes reimbursable 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.
50 **Bilateral Procedure**	Use modifier 50 to identify bilateral procedures that are performed during the same operative session. • This modifier reimburses at 150 percent of the maximum allowable for the procedure code fee. • Do not use modifier 50 if the CPT code's description specifically indicates the procedure is a "bilateral procedure." • Do not use modifier 50 if the CPT code's description specifically indicates the procedure is "unilateral or bilateral." • The procedure code along with modifier 50 should be identified on one claim line. When modifier 50 is used with a covered procedure code, indicating a bilateral procedure, the appropriate maximum number of units allowed on the claim line is "1." 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**	Use modifier 54 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.

Modifiers and their Descriptions, continued

55 **Postoperative Management Only**	Use modifier 55 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.
56 **Preoperative Management Only**	Use modifier 56 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.
57 **Decision for Surgery**	Use modifier 57 to indicate that an evaluation and management service resulted in the initial decision to perform a surgical procedure.