Objectives

• Provide an overview of the *Florida Medicaid Optometric Services Coverage and Limitations Handbook*.
• Describe provider qualifications.
• Highlight covered services, limitations and exclusions.
• Improve compliance with Florida Medicaid policy.
Handbook Purpose

• 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.
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, cont’d

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.
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 the *Florida Medicaid Optometric Services and Limitations Handbook*. 
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 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.
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 Contracted with Medicaid Health Plan

• 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.
COVERED, LIMITED & EXCLUDED SERVICES
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 Services?

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.
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.
Medicaid will reimburse only **2** 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
Visual Examinations, cont’d

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.
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.
Eyeglasses & 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.
<table>
<thead>
<tr>
<th>Eyeglasses and Refractions in Recipient’s Home, Custodial Care Facility, Nursing Facility, or Intermediate Care Facility for Individuals with Intellectual Disabilities</th>
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<tr>
<td>▪ 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.</td>
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<td>▪ 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.</td>
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- 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.
Eyeglasses & Refractions

In a Recipient’s Home, Custodial Care Facility, Nursing Facility, or Intermediate Care Facility for Individuals with Intellectual Disabilities:

• When optometric services are provided in the recipient’s home or residential facility, documentation of medical necessity, 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.
Eyeglasses & Refractions

In a Recipient’s Home, Custodial Care Facility, Nursing Facility, or Intermediate Care Facility for Individuals with Intellectual Disabilities:

• 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 & 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
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.
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.
Inpatient Hospital Visits, cont’d

• 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.
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.
Consultation & 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.
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.
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 & Laboratory Services
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 & 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.
Lacrimal Punctum Plugs
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
Service Requirements

- 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 breakup time, tear assay, zone-quick and slit lamp exam.
Required Documentation

- 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 required 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

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.
REIMBURSEMENT & FEE SCHEDULE
Prior Authorization (PA)

How to read the Fee Schedule:

• **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 the Medicaid’s Quality Improvement Organization. For more information about the prior authorization process, see the Florida Medicaid Provider Reimbursement Handbook, CMS-1500.*
Bilateral Procedure Modifier 50

- 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.
Updates about the SMMC program and upcoming events and news can be found on the SMMC website at:
http://ahca.myflorida.com/SMMC

Statewide Medicaid Managed Care Program

In 2011, the Florida Legislature created Part IV of Chapter 409, Florida Statutes, directing the Agency to create the Statewide Medicaid Managed Care (SMMC) program. The SMMC program has two key components: the Managed Medical Assistance program and the Long-term Care program.

Program Overview and Summary

There will be two different components that make up the SMMC program:

- The Florida Long-term Care program and
- The Florida Managed Medical Assistance program.

If you are interested in learning more about these two programs, overviews and summaries may be accessed through the links below.

Long-term Care program Snapshot [214KB PDF]
Managed Medical Assistance program Snapshot [318KB PDF]
Sign up to receive SMMC program updates at:
http://ahca.myflorida.com/SMMC

Florida Medicaid

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Questions?

• Questions that arise during the training may be emailed to Shameria Davis at: shameria.davis@ahca.myflorida.com

For questions about the Statewide Medicaid Managed Care Program, please send your email to: FLMedicaidManagedCare@ahca.myflorida.com