

Chapter Four

Select Vision Care Services

Overview

Introduction This chapter gives provides guidelines for providing select vision care services for Medicaid eligible recipients. For information regarding general ophthalmological services, refer to Clinical Coverage Policy # 1T-1, General Ophthalmological Services on the DMA Website at <http://www.ncdhhs.gov/dma/mp/mpindex.htm>. For information regarding routine eye exams and visual aids services, refer to Clinical Coverage Policy # 6A, Routine Eye Exams and Visual Aids for Recipients Under Age 21 on the Division of Medical Assistance (DMA) Website at <http://www.ncdhhs.gov/dma/mp/mpindex.htm>.

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Vision Care Services

What are Select Vision Care Services? Select vision care services are provided by ophthalmologists and optometrists within the scope of their practice as defined by North Carolina State Laws (NCGS 90-127.3 and NCAC 42E).

Recipient Eligibility

Who is Eligible for Vision Care Services? Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service.

Refer to **Appendix F** of the Basic Medicaid Billing guide on the Division of Medical Assistance’s (DMA) website at <http://www.dhhs.state.nc.us/dma/medbillcaguide.htm> for information on methods that can be used to verify eligibility.

Visual Field Examinations

Visual Fields Visual field exams are only covered by Medicaid with specific medical justification. Visual fields are deemed medically necessary in the following circumstances:

- glaucoma
- glaucoma suspect
- visual loss (not including refractive error)
- suspect tumor that may affect vision (such as tumors of the brain or spinal cord)
- large cup/disc ration
- patients on planquenil therapy (used for treatment of malaria, lupus erythematosus, and rheumatoid arthritis)
- any diagnosis that is medically justified regarding visual impairment (i.e., retinopathies, optic nerve disorders)

Punctum Plugs

Punctum Plugs When billing for punctum plugs, the provider should bill the appropriate CPT code, 68761. This code includes the reimbursement for the plugs. Specify in block 24G on the HCFA-1500 these units: 1 unit = 1 plug, 2 units = 2 plugs.

Cataract Surgery Billing Guidelines

Use of Modifiers to Bill for Cataract Surgeries Modifiers 54 and 55 allow a provider other than the surgeon to receive reimbursement for the follow-up care related to a major or minor surgery. Modifier 54 denotes “surgical care only” and is appended to a surgical procedure code if the surgeon agrees to relinquish the postoperative management to another provider. Modifier 55 denotes “postoperative management” only and is appended to a surgical procedure code if a provider other than the surgeon renders postoperative care.

Ophthalmologists who perform only the surgical component of cataract surgery shall bill one of the following CPT codes with modifier 54 appended:

CPT 66982
 CPT 66983
 CPT 66984
 CPT 66985

Ophthalmologists or optometrists who render postoperative care following cataract surgery shall bill one of the following codes with modifier 55 appended:

CPT 66982
 CPT 66983
 CPT 66984
 CPT 66985

Note: Providers shall bill the ICD-9-CM diagnosis code(s) to the highest level of specificity that supports medical necessity.

Examples of Billing with Modifiers **Example I: Surgery and Preoperative Care Only**

- The ophthalmologist performs surgical procedure 66984
- All postoperative care is transferred to another provider
- The ophthalmologist who performs the surgery will enter 66984-54 on the claim.

Example II: Provider (Other than Surgeon) Renders ALL Postoperative Care Following Surgery

- The optometrist provides all follow-up care to the patient who has had cataract surgery (CPT 66984).
- The optometrist submits a claim entering the surgical procedure codes 66984-55 with the same date of service (date of surgery) and place of service as surgeon.
- Dates the provider is responsible for postoperative care shall be entered in the FROM and TO dates on the claim.

Example III: Ophthalmologist Provides Initial Postoperative Care and Then Transfers Remainder of Care to Another Provider

- The ophthalmologist performs cataract surgery and enters surgical procedure code 66985-54 on the first detail line of the claim.
- On the second detail, the provider enters 66985-55 with the same date of surgery and place of service as on the first detail.
- Dates the provider is responsible for postoperative care shall be entered in the FROM and TO dates on the claim.

Note: The provider who has accepted responsibility for the remainder of postoperative days (ophthalmologist or optometrist) will also bill the surgical procedure code with modifier 55. Dates this provider is responsible for postoperative care shall be entered in the FROM and TO dates on the claim.

Example IV: Ophthalmologist Performs Surgery and All Postoperative Care

- The ophthalmologist performs cataract surgery, CPT procedure code 66983.
- Procedure code 66983 is entered on the claim without either modifier 54 or 55.

Note: When cataract surgery is performed on both eyes at the same time, modifier 50, which denotes a bilateral procedure, shall be added to the surgical procedure code along with either modifier 54 or 55.

Billing Restrictions

Reimbursements for codes billed with modifier 54 and 55 are based on Resource-based Relative Value Units. This table shows the percentage of the total global reimbursement amount that is allocated to the preoperative care, the surgical care, and the postoperative care. Reimbursement for global surgical care rendered by more than one physician, regardless of the number of physicians, cannot exceed the amount allowable if all services were rendered by one physician.

When a recipient is covered by both Medicare and Medicaid, the provider shall continue to follow Medicare billing guidelines. Medicaid will continue to pay coinsurance and deductible.

Optometrists and Services

Procedures Covered by Medicaid for Optometrists In compliance with a mutual agreement between the N.C. Board of Medical Examiners and the N.C. Board of Optometry, the following procedures are covered for payment by DMA for optometrists:

16000	68761	87210	92082	92950	99060	99213	99239	99255	99318
16020	76511	92002	92083	95060	99070	99214	99241	99281	99324
65205	76512	92004	92270	95933	99082	99215	99242	99282	99325
65210	76513	92012	92275	97010	99201	99221	99243	99283	99326
65220	76516	92014	92283	97110	99202	99222	99244	99284	99327
65222	76519	92015	92284	97112	99203	99223	99245	99285	99328
65430	76529	92020	92531	99050	99204	99231	99251	99307	99334
67820	82948	92060	92532	99051	99205	99232	99252	99308	99335
67938	87205	92070	92534	99053	99211	99233	99253	99309	99336
68040	87206	92081	92542	99058	99212	99238	99254	99310	99337

The following codes are billable by the optometrist only with modifier 55:

66982 66983 66984 66985

Procedures The following procedures are not covered in the practice optometry:

Not

Covered by 10160 17250 67825 76536 92543

Medicaid for 11900 36415 67840 92235 92544

Optometrists 11901 65435 67850 92265 95056

17000 65436 68020 92533 95857

17110 67700 68200 92541 97024