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SUBJECT Medical Assistance Program Outpatient Fee Schedule Procedure Code Changes for Vision Services		BY  Michael Nardone, Deputy Secretary Office of Medical Assistance Programs

PURPOSE:

The purpose of this Medical Assistance (MA) Bulletin is to notify providers of vision services, of the national procedure codes and modifiers, as applicable, which will be used in place of local procedure codes that are being end-dated with dates of service on and after March 1, 2010. These procedure codes were previously end-dated for other types of providers.

SCOPE:

This bulletin applies to optometrists and physicians who render vision services to MA recipients in the Fee-for-Service (FFS) delivery system, including ACCESS Plus. Optometrists and physicians rendering vision services under the managed care delivery system should address any coding or rate-related questions to the appropriate managed care organization (MCO).

BACKGROUND/DISCUSSION:

The Office of Medical Assistance Programs (OMAP) issued MA Bulletin 05-05-04, et al., titled "Medical Assistance Program Fee Schedule Procedure Code Changes for Durable Medical Equipment, Medical Supplies, Vision Supplies and Hearing Supplies" and MA Bulletin 01-07-12, et al., titled, "Issuance of an Updated MA Program Outpatient Fee Schedule for Durable Medical Equipment, Medical Supplies, Orthotics, Prosthetics, Vision and Hearing Supplies included in MA Bulletin 05-05-04, et al., titled Medical Assistance Program Fee Schedule Procedure Code Changes for Durable Medical Equipment, Medical Supplies, Vision Supplies and Hearing Supplies" to notify providers that certain national procedure codes were replacing local codes for durable medical equipment (DME), medical supplies, orthotics, prosthetics, and vision and hearing supplies. At that time, the local to national code cross walks attached to the aforementioned MA Bulletins, did not specifically address vision services rendered by optometrists and physicians.

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

The appropriate toll-free number for your provider type.

Visit the Office of Medical Assistance Programs Web site at www.dpw.state.pa.us/PartnersProviders

There are national procedure codes already on the MA Program Outpatient Fee Schedule that may be used by optometrists and physicians for vision services in place of local procedure codes Y0012, Y0017, Y0034, Y2021 and Y2411. Therefore, effective with dates of service on and after March 1, 2010, the Department of Public Welfare (Department) is end-dating local procedure codes Y0012, Y0017, Y0034, Y2021 and Y2411.

Local procedure code Y0090, defined as “contact lens used as a corneal bandage”, will not be replaced with a national procedure code since there were only 6 claims paid from January 1, 2007 through July 30, 2009. Therefore, effective with dates of service on and after March 1, 2010, the Department is end-dating local procedure code Y0090 and is not replacing it with a national procedure code.

National procedure code V2770 defined as “occluder lens, per lens” is being added to the MA Program Outpatient Fee Schedule, effective with dates of service on and after March 1, 2010. This will replace local procedure code Y2411, defined as “eye occluder, Jamieson type or its equivalent.” The MA Program Outpatient Fee Schedule rate for national procedure code V2770 will remain the same as the MA Program fee for local procedure code Y2411.

MA Program requirements at 55 Pa.Code, § 1147.21, relating to scope of benefits for the categorically needy, and § 1123.60(d) and § 1147.53(e), relating to limitations on payment, set forth that lenses, frames and contact lenses are only compensable for adults 21 years of age and older, when used as a prosthesis, such as, to replace the lens of the eye. Therefore, claims for eyeglass lenses, contact lenses and frames for recipients 21 years of age and older require a VP modifier, which indicates a diagnosis of aphakia, in order to be paid by the MA Program.

The Department reviewed the optometrist’s scope of practice under the Pennsylvania State Board of Optometry. Based upon that review, the Department determined that physical therapy services are not within an optometrist’s scope of practice and are not an appropriate optometric service. Therefore, physical therapy procedure codes 97112, 97116 and 97530 are being end-dated for optometrists on the MA Program Outpatient Fee Schedule, effective with dates of service on and after March 1, 2010.

PROCEDURE:

Providers who render vision services to MA recipients in the FFS delivery system are directed to refer to the attached Vision Services Local to National Code Cross Walk which identifies the appropriate national procedure codes and modifiers, if applicable, that are to be used in place of the local procedure codes that are being end-dated for dates of service on and after March 1, 2010. Columns one through four provide information related to the end-dated Local Code, former MAMIS Provider Type, former MAMIS Type of Service, and Local Code Definition. Columns five through sixteen provide information on the National Code, *PROMISE™* Provider Type and *PROMISE™* Specialty eligible to bill the procedure code, required Pricing Modifier, Informational Modifier, Prior Authorization Required, National Code Definition, MA Unit of Service, Limits, MA Fee and Comments.

As indicated in the attached Vision Services Local to National Code Cross Walk, the MA Program has established limits for these procedure codes for individuals 21 years of age and older. For children under 21 years of age, however, if the prescriber believes that the established limits cannot meet the recipient's needs, the prescriber may, on behalf of the recipient, request a waiver of the limits through the 1150 Administrative Waiver (Program Exception) process. See footnote (*) related to the Limits Column on the attached cross walk.

Managed Care Delivery System: MCOs are not required to impose the service limits that apply in the FFS delivery system, although they are permitted to do so. MCOs may not impose service limits that are more restrictive than the service limits established in the FFS delivery system. An MCO that chooses to establish service limits must notify network providers of the limits before implementing the limits.

Failure to use the appropriate national procedure code and modifier(s) combination or correct place of service will result in inappropriate claim payment or claim denial. Services rendered on and after March 1, 2010, must be billed using the national procedure code.

ATTACHMENT: Vision Services Local to National Procedure Code Cross Walk