To: all optometrists and billing staff

Schedule of Optometric Benefits amendments
Amendments are being made to the Schedule of Optometric Benefits effective October 1, 2011, as the result of a new three-year agreement between Alberta Health and Wellness (AHW) and the Alberta Association of Optometrists (AAO).

Under the revised Schedule, coverage for medically necessary optometry services is expanded to all Albertans. Attachment A of this Bulletin provides details of the amendments, with new and amended text shown in bold print.

Attachment B of this Bulletin, which was developed jointly by AHW and the AAO, includes important information about eligibility requirements for coverage of medically necessary optometric services, changes to diagnostic code requirements, and common billing scenarios to assist optometrists with their claim submissions to the Alberta Health Care Insurance Plan.

A copy of the October 1, 2011 Schedule of Optometric Benefits will be posted for viewing/downloading on our website at: www.health.alberta.ca/professionals/allied-services-schedule.html. A link to the Optometric Benefits Regulation, as amended to include the terms of the new three-year agreement, will be available at: www.health.alberta.ca/about/health-legislation.html.

New explanatory code list available December 1, 2011
The Alberta Health Care Insurance Plan Explanatory Code List will be updated and available on our website at: www.health.alberta.ca/professionals/allied-services-schedule.html as of December 1, 2011.

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Approval: original signed by Yolanda Lackie
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Attachment A

Schedule of Optometric Benefits amendments effective October 1, 2011

New and amended general rules (GRs)

- Add the following new rule after GR 3.2:
  
  3.3 For the purpose of Section 12(1)(a)(ii) of the *Optometric Benefits Regulation* the prescription drugs are as follows:
  
  - chloroquine (Aralen)
  - ethambutol (Myambutol and Servambutol)
  - hydroxychloroquine (Plaquenil)
  - tamoxifen (Nolvadex)

- Add the following new rule after GR 3.3:

  3.4 For the purpose of the Benefit Limits contained in Section 12 of the *Optometric Benefits Regulation*, claims for services for a new episode of a condition, illness or trauma that was previously treated in the same patient in the current benefit year must include modifier NEWEP.

- Add the following new rule after GR 3.4:

  3.5 For the purpose of the Benefit Limits contained in Section 12 of the *Optometric Benefits Regulation* and the entry of four-digit ICD-9 codes as outlined in GR 4.4, claims for services for a new condition, illness or trauma that shares the same three-digit root ICD-9 code as a condition previously claimed for the same patient in the current benefit year, must include modifier NEWCON.

- GR 4.1 – Amend to read as follows:

  4.1 For the purpose of Section 12(1)(b) of the *Optometric Benefits Regulation* the ICD-9 Codes are as follows:

  250 Diabetes Mellitus
  250.0 - 250.3
  250.5 - 250.7
  360 Disorders of the Globe
  360.0 – 360.6, 360.8
  361 Retinal Detachments & Defects
  361.0 – 361.3, 361.8
  362 Other Retinal Disorders
  362.0 – 362.8
  363 Chorioretinal Inflammations and Scars and Other Disorders of Choroid
  363.0 – 363.8
  364 Disorders of the Iris and Giliary Body
  364.4 - 364.8
  365 Glaucoma
  365.0 – 365.6, 365.8
  366 Cataract
  366.0 – 366.5, 366.8
  368 Visual Disturbances
  368.2 - 368.4, 368.8
  371 Corneal Opacity and Other Disorders of the Cornea
  371.0 – 371.8
  372 Disorders of the Conjunctiva
  372.4 - 372.8
  373 Inflammation of the Eyelids
  373.3 - 373.6, 373.8
  374 Other Disorders of the Eyelids
  374.0 – 374.5, 374.8

(Continued on next page)
375 Disorders of the Lacrimal System
   375.5 - 375.6, 375.8
376 Disorders of the Orbit
   376.0
   376.2 - 376.6, 376.8
377 Disorders of Optic Nerve & Visual Pathways
   377.0 – 377.7
379 Other Disorders of the Eye
   379.1 - 379.4
   379.8 - 379.9
870 Open Wound of Ocular Adnexa
   870.0 – 870.4, 870.8
871 Open Wound of the Eyeball
   871.0 – 871.7

GR 4.2 – Amend to read as follows:

4.2 For the purpose of Section 12(3) of the Optometric Benefits Regulation the ICD-9 Codes are as follows:

250 Diabetes Mellitus
   250.4
364 Disorders of the Iris and Ciliary Body
   364.0 - 364.3 (grade 1 or 2)
370 Keratitis
   370.2 - 370.5, 370.8
372 Disorders of the Conjunctiva
   372.0 - 372.3
373 Inflammation of the Eyelids
   373.0 - 373.2
375 Disorders of the Lacrimal System
   375.3 - 375.4
376 Disorders of the Orbit
   376.1
378 Strabismus and other disorders of binocular eye movements
   378.0 – 378.8
379 Other Disorders of the Eye
   379.0
918 Superficial Injury of the Eye & Adnexa
   918.0 – 918.2
930 Foreign Body on External Eye
   930.0 – 930.2, 930.8

Add the following new rule after GR 4.3:

4.4 For the purpose of section 12 of the Optometric Benefits Regulation, claims for services requiring an eligible ICD-9 code listed in GRs 4.1 through 4.3 must include the minimum four-digit ICD-9 code.

Add the following new rule after GR 4.4:

4.5 For the purpose of section 12 of the Optometric Benefits Regulation, each eligible four-digit ICD-9 code listed in GRs 4.1 through 4.3 represents a mutually exclusive condition for the purpose of claims, except for the following groups of diagnostic codes which represent conditions that are equivalent for the purpose of claims:

a) 250.0 – 250.3, 250.5 – 250.7 (GR 4.1)
b) 364.1, 364.2 (GR 4.2 and GR 4.3)
c) 365.0, 365.1, 365.3 - 365.6 (GR 4.1)
d) 366.0 – 366.4, 366.8 (GR 4.1)
New and amended modifier definitions

- In the “LMTS LIMITS” modifier definitions section, add the following new modifier code after L44ANE:
  NEWCON   NEW CONDITION FOR OPTOMETRY – (EXPLICIT) – Indicates an optometrist is providing optometric services to an eligible resident for a new condition whose diagnostic code contains the same first three-digit root as a condition previously billed in the same benefit year.

<table>
<thead>
<tr>
<th>Billing note: Effective October 1, 2011, the following NEWCON modifier details are added to all health service codes listed in the Schedule of Optometric Benefits:</th>
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<td>TYPE</td>
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<td>LMTS</td>
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- In the “LMTS LIMITS” modifier definitions section, add the following new modifier code after NEWCON:
  NEWEP   NEW EPISODE FOR OPTOMETRY - (EXPLICIT) - Indicates an Optometrist is providing optometric services to an eligible resident for a condition that was previously billed, but the resident incurred a new occurrence of the condition in the same benefit year.

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- SPCDRG – Amend this “LMTS LIMITS” modifier code to read as follows:
  SPCDRG   SPECIFIED DRUGS FOR OPTOMETRY - (EXPLICIT) - Indicates an Optometrist is providing optometric services as the patient is receiving treatment with the drug Chloroquine (Aralen), Ethambutol (Myambutol and Servambutol), Hydroxychloroquine Sulfate (Plaquenil), or Tamoxifen (Novaldex).

Other amendments

- In the Procedure List, the heading “Other Eligible Residents” is amended to “Eligible Residents of All Ages” in the Table of Contents and above health service code B900 on Page 1 Basic Optometry.

- In the Price List, the heading “Other Eligible Residents” is amended to “Eligible Residents of All Ages” in the Table of Contents and above health service code B900 on Page 1 Basic Optometry.
Information for optometrists

Submitting claims to the Alberta Health Care Insurance Plan
for services provided on or after October 1, 2011

Effective October 1, 2011, optometric services required to treat specific medical conditions are now covered for Alberta residents of all ages who are eligible for coverage under the Alberta Health Care Insurance Plan. These optometric services are defined in Part 3 “Eligible Residents of All Ages” of the Optometric Benefits Regulation and are identified by Health Service Codes B900 through B905 in the Procedure and Price Lists of the Schedule of Optometric Benefits.

To qualify for coverage of these medically necessary optometric services, patients must meet at least one of the four eligibility requirements listed in Part 3 of the Optometric Benefits Regulation:

- patient has been diagnosed with diabetes mellitus by physician or nurse practitioner;
- patient has been prescribed a drug with known ocular side effects and regular monitoring of the patient is standard of care;
- patient has been referred to the optometrist by a physician or nurse practitioner; and/or
- patient has been diagnosed with a specific ocular or systemic disease or condition, trauma or injury and confirmed by an eligible ICD-9 diagnostic code.

Patients less than 19 or over 64 years of age continue to be eligible for coverage of basic optometric services which are identified by Health Service Codes B650 through B661.

Billings for basic and medically necessary optometric services continue to be defined by their respective benefit limits as outlined in section 8 and section 12 of the Optometric Benefits Regulation.

Beginning October 1, 2011:

1. Optometrists are required to record the four-digit diagnostic code instead of the three-digit code on any billings requiring a diagnostic code (Governing Rule 4.4 of Schedule of Optometric Benefits).

2. The lists of eligible diagnostic codes in Governing Rules 4.1 through 4.3 are updated as follows:
   (i) Strabismus and other disorders of the binocular eye (ICD-9 378.0 – 378.8) is added to the list of eligible diagnostic codes listed in Governing Rule 4.2 of the Schedule of Optometric Benefits;
   (ii) Diagnostic codes with number “9” in the fourth digit are no longer eligible, except for ICD-9 379.9 in Governing Rule 4.1 (explanatory text on claims indicating this diagnostic code is still required); and
   (iii) Diagnostic code 368.8 in Governing Rule 4.1 no longer requires explanatory text on claims indicating this code but all other eligible diagnostic codes with number “8” appearing in the fourth digit continue to require text.

3. Optometrists can enter the “New Episode” modifier (NEWEP) on claims for patients who have been treated for a particular condition, illness or trauma in a benefit year but incur a new episode of the same condition, illness or trauma in the same benefit year (Governing Rule 3.4 of Schedule of Optometric Benefits);

4. The list of eligible prescription drugs with known ocular side effects increases from one to four - joining hydroxychloroquine are chloroquine, ethambutol and tamoxifen (Governing Rule 3.3 of Schedule of Optometric Benefits);

5. Nurse practitioners join physicians as eligible referring practitioners for the purpose of permitting patients less than 19 and over 64 years of age with additional coverage of basic optometric services (Section 8(2) of Optometric Benefits Regulation).
The expansion of coverage of Part 3 medically necessary optometric services to include patients of all ages should improve the flexibility of optometrists to treat medical ocular conditions in patients less than 19 and over 64 years of age. For example, if a patient of this age group meets the criteria for Part 3 medically necessary optometric services, the optometrist may provide and bill for a medically necessary service as well as a basic service on the same day or on different days, depending on the patient’s condition and/or the patient’s ability to return for a separate visit.

To help guide optometrists on how to properly bill for optometric services beginning October 1, 2011, here are some common scenarios with the recommended billing procedures:

A. Patient less than 19 years of age presents for routine eye examination

1. Patient expresses discomfort from getting sand in eye. Optometrist to bill B900 (ICD-9 918.1) to assess sand issue and delay the routine exam (B650) until the corneal situation from the sand is resolved. This delay in the routine examination ensures proper refraction and health examination.

2. Examination shows normal stereopsis and far acuity. If dry refraction results in +3.00 OU and patient shows intermittent hyperopia and eye is turning inwards, optometrist shall bill the basic examination as a B650 and the cycloplegic follow-up exam as a B900 (ICD-9 387.2 or ICD-9 378.7), regardless of whether or not the follow-up exam occurs on the same day or at a later date.

3. Patient’s cooperation is limited during the retinoscopy. If optometrist cannot confirm a medical condition, a cycloplegic exam scheduled for a different day shall be billed as a follow-up exam B651.

4. Patient has a family history of migraines. If the examination shows the patient to require a change in prescription glasses and the patient returns on a later date with onset of headaches, the optometrist repeats refraction and performs a binocular vision workup. Optometrist to bill second exam as a B651 as there is no medical condition.

5. Patient is a juvenile diabetic. If optometrist recommends a dilated examination (DFE) and the DFE is performed on the same day or another day, bill DFE as B900 (ICD-9 250.0).

6. Patient has -8.00 in each eye. During the health exam, patient mentions that he gets occasional flashes of light in right eye. If DFE is prescribed by optometrist on same day, optometrist to bill the dilation examination as a B900. If examination finds only floaters, bill as B900 (ICD-9 379.2).

7. Optometrist notices an acute chalazion on upper eye lid during observation in case history. Optometrist to bill for the chalazion as a B900 (ICD-9 373.2). Follow-up visit to be billed as a B901 (ICD-9 373.2) and so on, until chalazion is cleared up. A further follow-visit can then be billed as B650.

8. Six months after previous routine examination, patient complains of difficulty reading the chalkboard at school. Optometrist confirms a -1.00 change in myopia and the health assessment is normal. Optometrist to bill examination as B650 with myopia (ICD-9 367.1).

9. Patient is diabetic and is new to the optometrist clinic. Refraction exam shows minor difference from current prescription spectacles but the fundus exam reveals hemorrhages near the macula and mild edema:

   (i) optometrist bills routine exam as B650 and follow-up dilations as B900 (ICD-9 362.0 or ICD-9 250.4). Once edema is gone and fundus results are stable, optometrist to bill B651 for refraction on another day.

   (ii) If optometrist refers patient to retinal specialist, when patient’s symptoms are finally cured by the retinal specialist and the patient is referred back to the optometrist, optometrist to bill for examination as B650 (ICD-9 250.4) and indicate PRAC ID of retinal specialist on billing.

   (iii) If optometrist refers patient to retinal specialist, if patient’s symptoms are cured by the retinal specialist but the patient’s refractions were fluctuating and the retinal specialist refers the patient back to the optometrist for monitoring, optometrist to bill for monitoring examination as a B901 (ICD-9 250.4) and indicate PRAC ID of retinal specialist on billing.
10. Optometrist discovers marked nasal redness to LT eye and patient wears contacts and has noticed the redness and associated tenderness for last week. Optometrist performs the routine exam and concludes the patient has episcleritis LT. Optometrist sees the patient three days later to monitor redness condition. Optometrist to bill routine eye examination B650 and follow-up exam as B900 (ICD-9 379.0).

B. Patient over 64 years of age presents for routine eye examination

1. Patient is asymptomatic. During course of examination, optometrist discovers tiny ulcer at peripheral cornea. Optometrist to bill B650 as the chief reason for visit was a routine exam and no additional procedures were required.

2. During course of examination, the best corrected acuity is 20/200 OD and 20/30 OS and the existence of a cataract is revealed in both eyes but not enough for acuity in right eye. Fundus view is limited due to 2mm pupil size but unable to see if healthy enough to prescribe. The patient cannot come back another day so the optometrist performs additional testing beyond the routine eye exam on same day. Optometrist bills for the routine examination as B650 and the additional testing as B900 (ICD-9 366.1).

3. Optometrist discovers 20/40 vision and extreme dry eyes. Optometrist initiates aggressive dry eye therapy to treat eyelid condition before seeing patient again in two weeks for follow-up. Optometrist bills initial visit as B900 (ICD-9 370.3) and only when dry-eye condition is stable will optometrist start billing for routine examinations (B650).

4. Patient has Alzheimer’s Disease. Optometrist notices immediately the existence of very red eye OD. Optometrist to bill B900 with appropriate ICD-9 for cause of red eye. Only when red eye condition is stable will optometrist bill for a routine examination (B650).

5. Patient is pseudophakic and has not had a routine dilation in a decade. As there are no signs of AMD or Glaucoma and the patient's pupil size is normal, optometrist to bill as B650 and follow-up exam as B651.

6. Patient is in a nursing home, demonstrates mobility difficulty, has 20/60 vision and cataracts in both eyes. Optometrist recommends same day dilated eye exam because of patient’s limited mobility and the limited view of retina from the existence of cataracts. Optometrist to bill for routine examination B650 and the dilated eye exam as B900 (ICD-9 366.1).

7. Patient is diabetic and requests dilated exam on same day because of the lengthy distance the patient must travel to appointment. Optometrist to bill routine examination B650 and dilated exam as B900 (ICD-9 366.1).

8. Patient is diabetic with unknown sugars. Optometrist provides examination and refraction is 2.5 D different from current spectacles. The un-dilated exam from a few months ago showed no problems. Another refraction is done a few weeks later, and the results are in the opposite direction as the previous results. Optometrist to bill routine examination as B650 and the follow-up exam, including the refraction and the re-examination to rule out changes in retina, as B650 (ICD-9 250.4). The next visit to be billed as B900 (ICD-9 250.4).

C. New Episode (NEWEP) and New Condition (NEWCON) Modifiers - required on claims where a four-digit ICD-9 is entered to enable the Alberta Health and Wellness billing system to differentiate conditions within the same category ICD-9 (i.e. having the same first three digits).

1. A 34 year old patient the optometrist saw a few months ago with blepharitis has since developed a chalazion in the left eye. Optometrist to bill the new visit as a B900 (ICD-9 373.2) with the modifier NEWCON. The original visit would have been a B900 (ICD-9 373.0).

2. A 50 year old had a bacterial conjunctivitis in December for which a B900 (ICD-9 372.0) was charged. In June, the patient returns with a viral conjunctivitis. Optometrist to bill the June visit also as a B900 (ICD-9 372.0) with the modifier NEWEP.