Florida Blue/Health Options Provider Manual

EYE MANAGEMENT

Table of Contents

Appointment Scheduling

1. Appointments for Florida Blue members will be scheduled by the member's Primary Care Physician (PCP), or the member may also schedule an appointment himself. A control number may be issued to the member's PCP or the member (or member representative) when they contact EMI to obtain a referral for a Florida Blue member to be seen by a participating ophthalmologist.
2. Following an initial visit, PCPs should receive a written statement of your findings and recommendations on the EMI Report of Ophthalmic Consultation (See Section 1, Provider Policies). Contact with the member's PCP should continue throughout their course of treatment.
3. A member should be given an appointment within three weeks from the date that they contacted your office for a routine well-care appointment, two weeks for a routine symptomatic diagnosis, 24 hours for an urgent diagnosis and immediately for emergency care.

Co-Payments

Your office will be responsible for collecting co-payments. Each office visit by a member, including initial and follow-up visits, must be charged a co- payment at the time service is provided.

Surgery and Outpatient Diagnostics

1. Authorization must be obtained prior to any surgical procedures. This includes a pre-certification number from Florida Blue for the facility usage and an EMI Referral Authorization for the professional or physician component of the services to be performed.
2. To request authorization for the professional or physician component you must contact the referring general ophthalmologist or EMI, if the member was referred to you by EMI directly. If you are requesting the authorization from EMI directly, you may do so via facsimile on the **Surgical Control Number Request Form** (refer to Appendix A) to 305-868-7640 Miami-Dade County or 800-922-4132 all other counties. You may be required to submit a copy of the patients chart, a dictation and photos or test results if applicable.
3. To obtain authorization for the facility you must fax the approved EMI control number along with the facility request- **Pre-Service Medical Review Form** (refer to Appendix A) to Florida Blue's Pre Cert Department:
    - Medicare Pre-Cert fax number: 904-301-1614
    - Commercial Pre-Cert fax number: 877-219-9448
4. Any pre-operative testing must be coordinated with the PCP's office.
5. Any diagnostic tests that are to be performed outside the Specialist's office (e.g., MRI, CT scan, X-Ray, etc.) must be performed at a participating facility. This requires pre-certification by Florida Blue, but does not require an authorization from EMI.

Completion of Insurance Claim Forms

1. Receipt of properly completed claims in a timely manner will assist us in data collection. It is imperative that EMI receive a report of each patient encounter. Each form must include the following:

a. Patient's name, address, and phone number
b. Patient's birth date
c. Patient's membership identification number
d. Date of Service
e. Diagnosis code (ICD-10)
f. Procedure code (CPT)
g. Authorization number from EMI in field [23]
h. If applicable, valid facility Certification Number from health plan
i. Primary Care Physician's Name
j. Name of Ophthalmological Provider
k. Physician's Tax ID Number
l. Provider's NPI Number
m. Charged Amount
n. All CPT/HCPCS codes

2. Electronic Claims should be submitted via Payer ID 65062-Health Network One.
3. Paper claims should be mailed to:
   EMI - Health Network One
   P.O. Box 240247
   Apple Valley, MN 55124

Do not send the claims directly to the patient's health plan as they will be denied, and your reimbursement will be delayed. The health plan will not forward these claims to EMI.

Consultative Services (Sub-Specialty Services)

1. In the event that you wish to refer a patient for Sub-Specialty ophthalmology services, or wish to refer a patient for specific treatment (retina, cornea, pediatric, etc.), please complete the **EMI Subspecialty Service Request Form** (refer to Appendix A).
2. Fax the form to EMI at 305-868-7640 or 800-922-4132.
3. EMI will fax a copy of the authorization to the subspecialist and to your office for your records.
4. An EMI Referral Authorization is always necessary for Sub-Specialty ophthalmology services.

Non-Covered Services

Covered benefits are defined by Florida Blue as those services which are deemed medically necessary pursuant to the member's health plan benefit design and definition, and not for cosmetic purposes. Please note that **contact lenses, non-traditional IOLs (e.g. multi-focal, accommodating IOLs) and refractive services are NOT COVERED** under this Agreement.

1. In the event that a member requests that your office perform a refraction and/or contact lens fitting, EMI has provided you with the Vision Services Fee Information form (refer to the Provider Policy section of this

manual).This form explains to the member that refractive services are not covered under their medical eye care benefits and they are responsible in full for the cost of any refractive services provided by you.

2. The member must be adequately informed prior to receiving non-covered benefits that he/she will be responsible for payment of such services.
3. The form may never be used to collect monies in advance of, or for services which may be covered by the member's health plan benefits.
4. Please contact our office if you need further clarification about covered and non- covered services.

Ordering Injectable Medication

Florida Blue is contracted with Caremark for home infusion and drug replacement services.

When ordering Oculinum (Botulinum Toxin Type A) or any injectable drug with the exception of Avastin (Bevacizumab injection), follow the steps outlined below:

1. Complete the Injectable Drug Order form; a sample form is included in Appendix A of the manual. Please keep the original in the manual and copy the form when a request is needed.
2. Fax the form to: **800-323-2445**

Caremark will obtain the authorization for the drug from Florida Blue. If there is a denial of the requested drug by Florida Blue, CareMark will contact you.

Caremark's telephone number for your reference is: **866-278-5108**

Avastin (Bevacizumab injection), does not require any pre-authorization. Please submit your claims for the drug Avastin—HCPCS Code J9035 to EMI for reimbursement.

Laboratory Specimens

Quest Diagnostics, Inc. is the participating lab covered under Florida Blue. When you require specimen analysis for a Florida Blue member complete the appropriate lab requisition form and include the following information:

1. The specific test code for each test ordered.
2. Any and all applicable diagnosis code(s).
3. Specify that you are a Florida Blue provider.
4. Give your name and address and they will send a courier to your office.
5. All billing is handled between Quest Diagnostics, Inc. and Florida Blue.
6. Your office or the member will not be financially responsible for these costs.
7. Do not send specimens to any other laboratory, or to the member's PCP.
8. Broward, Martin, Miami-Dade, Monroe and Palm Beach counties call: (800) 800-1749. All other counties call: (800) 282-6613.

There is no out-of-network lab benefit for HMO members. Use Quest Diagnostics for your members' lab needs. If Quest Diagnostics does not offer the service requested, call (800) 955-5692 to locate another lab in the Florida Blue network. Authorization must be obtained for non-emergency out-of-network lab services.

Visit **www.questdiagnostics.com** for patient service center locations, and to order lab tests and view results through the Quest Diagnostics Care360 Physician Portal. Ordering physicians may also schedule appointments on behalf of the member by calling Quest Diagnostics or accessing the website at **www.questdiagnostics.com/appointment**. While appointments are not required, they may ease patient wait times associated with testing and improve compliance.

Florida Blue Drug Formulary

For an up-to-date copy of the Florida Blue Drug Formulary please refer to **www.floridablue.com**

Florida Blue Hospital Listing

For an up-to-date listing of the Florida Blue participating facilities please refer to **www.floridablue.com**

Appendix A

Eye Management

SURGICAL CONTROL NUMBER REQUEST FORM

The form must be faxed to EMI at **1 (800) 922-4132. All fields must be completed** in order for a surgical control number to be issued.

Date of Request (mm/dd/yyyy)	Patient Last Name	Patient First Name
Patient Date of Birth (mm/dd/yyyy)	Health Plan	Patient ID

Contact Person Last Name	Contact Person First Name
Name of Surgeon Last Name	Name of Surgeon First Name
Phone	Fax (We MUST have your Fax Number)

Surgical Procedure(s)

CPT Code(s)	CPT Code(s)	CPT Code(s)	CPT Code(s)
ICD-10 Code(s)	ICD-10 Code(s)	ICD-10 Code(s)	ICD-10 Code(s)

Facility/Hospital Name

Date of Surgery	Place of Service: ☐ Office ☐ Outpatient Facility ☐ Inpatient Hospital	Facility Authorization Obtained from Health Plan

A surgical control number will be faxed to your office within 72 hours of the receipt of your request. If you have not received the request within this time frame, or for any Urgent/STAT requests, or if you require further clarification of this information, please contact EMI at 1 (800) 329-1152.

Eye Management

SUBSPECIALTY SERVICE REQUEST FORM

Fax this form to 1 (800) 922-4132. An authorization will be faxed to the office of the general ophthalmologist and the subspecialist within 72 hours of the receipt of the request. If you have not received the authorization within this time frame, or for any Urgent/STAT requests, or if you have any questions,please contact EMI at (305) 861-1152 or 1 (800) 329-1152.

Date of Request (mm/dd/yyyy)	Patient Last Name	Patient First Name
Patient Date of Birth (mm/dd/yyyy)	Health Plan	Patient ID

Contact Person Last Name	Contact Person First Name
Name of Surgeon Last Name	Name of Surgeon First Name
Phone	Fax (We MUST have your Fax Number)

PHYSICIAN REFERRED TO

Subspecialist Last Name	Subspecialist First Name

Address

City	State	Zip

Phone	Fax	Appointment Date & Time

Tentative Diagnosis

Brief Case History/Reason for Referral

Authorized Service(s) by Referring Ophthalmologist (MUST BE COMPLETED in order for authorization to be issued):

☐ Evaluation ONLY ☐ Evaluation and Treatment

Diagnostic Testing Approved:

☐ External Photos ☐ Fundus Photos ☐ Visual Field ☐ Fluorescein Angiography ☐ ICG

☐ OCT for the tx of Retinal Disease ☐ OCT for the tx of Glaucoma

☐ Other:

Signature of Referring Physician

Last Name, First Name (Please Print)

Florida Blue

An independent Licensee of the Blue Cross and Blue Shield Association

Specialty Pharmacy Services Enrollment Form

Date: _____ Needs by Date: _____

CVS CAREMARK

Fax Referral To: 800-323-2445

Phone: 866-278-5108

Ship to: ☐ **Patient** ☐ **Office** ☐ **Other:** _____

PATIENT INFORMATION

(Complete the following ***or send patient demographic sheet****)*

Patient Name: _____

Address: _____

City, State, Zip: _____

Home Phone: _____

Alternate Phone: _____

Last Four of SS #: _____ Primary Language: _____

Date of Birth _____ Gender: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____

State License #: _____ UPIN: _____

DEA #: _____ NPI #: _____

Group or Hospital: _____

Address: _____

City, State Zip: _____

Phone: _____ Fax: _____

Contact Person: _____ Phone: _____

INSURANCE INFORMATION *(Please copy and attach the front and back of insurance and prescription drug card)*

Prescription Card: Name of Insurer: _____ ID#: _____ ID#: _____ PCN: _____ Group: _____

Primary Insruance: Subscriber: _____ ID#: _____ Name of Insurer: _____ Phone: _____

Secondary Insurance: Subscriber: _____ ID#: _____ Name of Insurer: _____ Phone: _____

STATEMENT OF MEDICAL NECESSITY

Diagnosis:

Please include diagnosis name and ICD-9:

_____

_____

_____

_____

Date of Diagnosis: _____

Additional Clinical Information: Therapy: ☐ New ☐ Reauthorization ☐ Restart

- Weight: _____ • Height: _____ in/cm
- Allergies: _____
- Lab Data: _____
- Concomitant Medications: _____
- Additional Comments: _____

Injection Training/Home Health Coordination:

- Injection training/home health will be/has been conducted/coordinated by the Physician's office. ☐ Yes ☐ No • If Yes, Date: _____
- Specialty Pharmacy to coordinate injection training/home health nursing. ☐ Yes ☐ No *Agency of Choice: _____

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐				
☐				
☐				
☐				
☐				
☐				
☐				

X _____

PRODUCT SUBSTITUTION PERMITTED

X _____

DISPENSE AS WRITTEN (Date)

CVS Caremark is an independent specialty pharmacy management company and does not provide Florida Blue products or services. CVS Caremark is solely responsible for the administration of specialty pharmacy benefits. Florida Blue is a trade name of the Blue Cross and Blue Shield of Florida Inc., an Independent Licensee of the Blue Cross and Blue Shield Association.

Payment Policies

- Payment of General Ophthalmological Services
- Documentation Requirements
- Other Payment Policies
- Diagnostic Tests

Payment of General Ophthalmological Services

An ophthalmological eye examination includes many components. The following section was written to furnish the provider with a clear understanding of what documentation Eye Management, Inc. (EMI) requires from the provider to substantiate the level of coding used. Ophthalmological examinations can be divided into intermediate and comprehensive services.

An intermediate eye examination **(CPT codes 92002 and 92012)** pertains to the evaluation of a new or existing condition, respectively, complicated by a new diagnostic or management problem not necessarily relating to the primary diagnosis.

The intermediate eye exam includes the following components:

- a medical history with focus on ophthalmologic history
- general medical history including medicines
- external ocular and adnexal examination
- other diagnostic procedures as indicated
- use of mydriasis

These codes should be used when the examination reveals:

- no ocular pathology, or;
- pathology which does not require high level decision making, or;
- pathology which does not require treatment, or;
- refractive errors when no other complex ocular pathology is present.

These codes should also be used when:

- the exam is problem focused, not comprehensive (as described on the following pages), and is being billed in conjunction with other testing (such as a refraction, 92015, an extended ophthalmoscopy, 92225, a visual field, 92083, etc.)

The 92012 code should also be used when:

- the examination is for follow-up during a course of treatment and requires only a problem focused exam, or;
- a complex follow-up examination (92014) has been performed within the last six months for the same condition.

A comprehensive eye examination **(CPT codes 92004 and 92014)** requires a general evaluation of the complete visual system, and **must include all of the following** to be considered comprehensive:

- a complete medical and ocular history
- general medical observation
- external and ophthalmoscopic examination
- examination with cyclopegia or mydriasis and tonometry
- ALWAYS includes initiation of diagnostic and treatment program as indicated

An ophthalmoscopic exam is considered appropriate in patients with the following conditions:

- previously diagnosed ocular pathology
- ocular or periocular symptoms such as ocular pain, tearing, discharge, swelling, decreased vision not related to refractive disorders, etc. (decreased vision or ocular discomfort related to refractive errors are considered non-complex and should be billed as a 92002 or 92012, with a 92015 if a refraction is performed)
- neurologic abnormalities which could affect the eye, periocular regions or visual system (i.e. blepharospasm, stroke) and/or local or systemic disorders affecting the eye, periocular regions, or visual system (i.e. Sarcoid, Systemic Lupus, Diabetes, intracranial tumor).
- traumatic injury to the ocular region, periocular region or skull

Documentation Requirements

The documentation for an intermediate exam will **include a minimum** of two sections of the comprehensive examination depending on the symptoms which drove the exam.

The documentation for a comprehensive exam **must include all of the following** in order to be considered comprehensive, (if the exam is deficient in any area, it will be considered intermediate):

- Visual Acuity (does not include determination of refractive error). This will typically include a description noted by a large capital "V" in two or three designations without correction (SC-meaning without any visual aids), with correction (CC- meaning with visual aids in use at the time of exam), or best corrected (BC- meaning the best obtainable eyeglass prescription in place). A designation of "N" is a visual acuity test performed at near, while the traditional visual acuity test is performed at the equivalent of a distance of 20'.
- Gross visual field testing by confrontation using the standard confrontation approach described by the term "full to finger counting" or FTFC.
- Ocular motility test including primary gaze alignment. This is a sensory motor exam which should be documented with comments such as: straight (ortho); esophoria or esotropia (E', ET) in a latent or manifest form, exodeviation, exophoria, or exotropia (X, XT); or full ductions and versions (full D&V).
- Examination of ocular adnexae including lids, lacrimal glands, lacrimal drainage, orbits and preauricular lymph nodes. Documentation should include comments regarding the ocular adnexae and lids such as the absence or presence of ptosis, lagophthalmos, blepharitis, lid margin scaling, aberrant lashes, stagnation of tear flow, etc.
- Examination of pupils and irises including shape, direct and consensual reaction (afferent pupil), size, and morphology. Documentation of this component usually may be made in the form of PERLA (pupils equally reactive to light and accommodation).
- Anterior segment performed through a slit lamp examination (biomicroscopy) and involves: inspection of the corneas including epithelium, stroma, endothelium, tear film; inspection of the anterior chambers including depth, cells, flare; and inspection of the lenses including clarity, anterior and posterior capsule, cortex, and nucleus;

inspection of bulbar and palpebral conjunctivae. Documentation may include "2+ injection", "white and quiet". Documentation about the cornea might include "clear" or demonstrate an inflammatory process of any of the epithelial, stromal, or endothelial layers. Documentation about the anterior chamber should have a comment with regard to its depth and the status of its inflammatory state. Documentation about the iris should be included and might include transillumination defects or rubeosis, and the lens will have comments regarding clarity with respect to cataract changes, be they cortical, nuclear, or posterior subcapsular.

- Measurement of intraocular pressures (for glaucoma). Documentation is typically noted with a capital letter "T" and numbers listed to the side in a vertical arrangement. The right eye is always listed above the left eye. This recording is in millimeters of mercury and, typically, the instrument chosen for the exam is noted. A small "a" reflects Goldman applanation, an "s" which is rarely seen is the Schiotz indentation tonometer, and an "NCT" is one of the air driven noncontact tonometers. "TP" reflects use of a Tonopen.
- Ophthalmoscopic fundus examination with or without dilation to examine the optic discs including size, C/D ratio, appearance and nerve fiber layer; and the posterior segments including retina and vessels. This component of the exam may be performed using the direct method which assesses the optic nerve head, macula, vessels and retina or the indirect method which includes all of the previous plus the peripheral retina.

In review, documentation is the key to the level of reimbursement which will be made. If an exam is essentially normal, but documentation is not made to indicate that each anatomical structure of the eye (as described above) was assessed, the reviewer will assume that the assessment was therefore not made, and the exam will most likely be considered intermediate.

Furthermore, if a comprehensive exam is billed and then individual components are additionally billed (unbundled), the exam will be considered intermediate (problem focused) and the separate components billed will be reimbursed based on documentation (see sections on individual procedures billed as a separate component).

Other Payment Policies

E/M Coding-New Patient Visit

While it may be the practice of a physician to code a new patient visit using the E/M codes

99204 or 99205 it is our policy to adjudicate these codes as a comprehensive ophthalmologic exam for the purpose of reimbursement for the following reason:

These codes carry specific time criteria and a problem focus. For example, a 99204 involves a comprehensive history, a comprehensive exam, and medical decision making of moderate complexity which requires the physician to typically spend forty-five minutes face-to-face with the patient. Whereas a 92004 is a comprehensive ophthalmologic exam with the initiation of a diagnostic and treatment program. This code more often reflects the ophthalmologist's actual exam.

If you bill a 99204 or 99205 it will be reimbursed to reflect the more appropriate ophthalmologic examination which corresponds to the diagnostic findings. Understandably, there may be times when the higher E/M code is indicated. In these circumstances, if a claim has been adjusted and you feel it was inappropriate, you may dispute the determination following the dispute process outlined in your Provider Manual.

Vision Exams (92015)

Vision exams are not a covered benefit by a medical eye care provider under the Florida Blue member's medical eye care benefits. Please refer to page 8 of the Provider manual for more information.

Billing For Follow-Up Exams (92012 & 92014)

A comprehensive follow-up exam will not be paid more than once every six months. If a 92014 is billed within a six-month period it will be reimbursed as a 92012, intermediate services.

Payment of Procedures as Separate Components of an Exam

Payment of Sensorimotor Exams (92060)

A 92060 will be considered included in a comprehensive or intermediate exam. It may be billed as a separate procedure only if a comprehensive or intermediate exam is not billed on the same day as the 92060.

Payment of Extended Ophthalmoscopies (92201 & 92202)

These codes have been identified by many insurance carriers as being frequently overused. EMI has therefore; set forth the following policy regarding payment of these procedures. An ophthalmoscopy is considered part of a general exam and is not considered to be separately payable. If a comprehensive exam code is used, a separate billing for a 92201 or 92202 on the same day will not be paid. However, if the ophthalmologist performs an extended ophthalmoscopy in conjunction with an intermediate level exam (92002, 92012), it may be billed as a separate procedure. **The following documentation should be noted in the patient record and may be requested by EMI upon retrospective review.**

A detailed drawing, with detailed notes describing the optic nerve, macula, vessels, retina, vitreous, and all pathology and the medical necessity of performing the extended ophthalmoscopy. If no pathology is present, or the medical necessity is not documented, and/or the drawing is not detailed (only a few lines with no explanation), payment will not be made for a 92201 or a 92202 as a separate procedure. All of the criteria must be met for the extended ophthalmoscopy to be considered a separate billable service.

See *Payment of Fundus Photography (92250) for additional guidelines.*

Payment of Flourescein Angiographies (92235)

A fluorescein angiogram will be paid unilaterally (paid for both the left and right eye) whether the test was performed on one or both eyes. Fluorescein angiography performed within 30 days of indocyanine green angiography will be denied as not medically necessary, unless there is documentation in the patient's medical record of co-existing diseases.

Payment of Indocyanine Green Angiography (92240, 92242)

This test has been proven to be useful in the diagnosis and treatment of a certain number of choroidal neovascular membrane disorders. It will be paid on a limited basis when certain criteria are met. There must be documentation in the patient's record that there is evidence of retinal disease on previous fluorescein angiography (FA). Medical documentation must be included with the claims submission.

In addition, Indocyanine Green Angiography will be paid bilaterally. EMI will reimburse for one eye only, whether the test was performed on one or both eyes. There is no supporting evidence to substantiate the frequency of repeat exams, but discretion should be used since this is an invasive procedure, and follow-up diagnostics can often be obtained with an FA alone.

Payment of Fundus Photography (92250)

Reimbursement shall be made for fundus photography when it is indicated to document the baseline of a fundal abnormality. CPT 92250 is defined as bilateral so reimbursement is for both eyes. It will not be reimbursed on subsequent exams unless the pathology has caused a change to occur, and documentation of such change is medically necessary. Both interpretation and a report in addition to the photo must be documented in the patient record and included with the claim submission. In addition, fundus photography will not be reimbursed when performed on the same day as extended ophthalmoscopies (92201, 92202).

Payment for ERG (92273/92274) and VEP/VER (95930) Testing

EMI will pay for eletroretinogram (ERG) when one of the following conditions is present: unexplained visual loss, hereditary retinal degeneration/dystrophies, retinal vascular occlusion when the diagnosis is in doubt (not diabetic retinopathy or senile macular degeneration), drug toxicity (e.g. plaquenil) or occult macular degeneration when the diagnosis cannot be confirmed with prior fluorescein or ICG angiography.

EMI will pay for visual evoked potential (VEP) or visual evoked response (VER) when one of the following conditions are met: unexplained visual loss, multiple sclerosis, optic nerve or pathway disease, suspected functional visual loss.

Documentation supporting the medical necessity should be legible, maintained in the patient's medical record, and must be included with the claim submission.

Payment of Color Vision Examinations (92283)

Color vision testing with pseudoisochromatic plates is not considered a separately reimbursable procedure and is included in a comprehensive and limited exam.

Payment of External Ocular Photography (92285)

The use of this code is frequently overused. While the physician may elect to perform this procedure for the documentation of any external pathology, there is generally no medical indication for this. Therefore, this code will be reimbursed on a limited basis for pathology which requires the documentation by photography of the condition prior to a surgical procedure, i.e. pre-authorization for procedures such as blepharoptosis, removal of basal cell carcinoma, severe ectropion or entropion. External photography of pterygiums, benign lesions or cysts of the lids, or pingueculi are expected to be used to document and/or monitor the progression of ocular surface pathology, interpretation and a report should be included in the patient's medical record and may be subject to retrospective review.

Bi-Lateral Reimbursement of Certain Diagnostic Tests

These procedures are paid on a bilateral basis by EMI. While it may be performed on both eyes, it is considered one service when performed on both eyes on the same day and includes the following: 76519, 92136, and 92285.

Payment During the Post-Operative Period

All testing and exams performed following a surgical procedure shall be considered included in the global surgical fee following the procedure, unless the patient returns during the post-operative period with an unrelated chief complaint.

Payment of A Repeat Surgery During the Post-Operative Period

Any pathology requiring repeat surgery or laser which is identified within the 90 day post-operative period will be reimbursed at 50% of the payable amount unless it is performed for a problem with a new diagnosis. Laser surgery is described as one or more sessions.

Payment of Multiple Surgical Procedures on the Same Eye, Same Day

Multiple procedures on the same eye performed on the same day will be reimbursed in the following manner: the primary procedure will be reimbursed at the full fee schedule rate; subsequent procedures will be paid at 50/50/50/50/and by report % of the payable amount. Procedures that have been unbundled (are a component of another billed procedure) will be re-bundled and will not be considered for further reimbursement. In certain retinal and oculoplastic procedures, there are no accurate CPT codes to describe all of the components of a particular series of procedures. In this case, if a component is included as part of each billed procedure; the cost of the component will be deducted from each subsequent procedure before the 50/50/50/50/and by report adjustment is made.

Payment of ECCE with Insertion of IOL, Complex (66982, 66987- with endoscopic cyclophotocoagulation, 66989 – with insertion of intraocular anterior segment aqueous drainage device, without extraocular reservoir, internal approach)

The code for complex cataract surgery is intended to differentiate the extraordinary work performed during the intraoperative or postoperative periods in this subset of cataract operations versus that performed in routine cataract surgery. The indications for use of this code are as follows:

1. A miotic pupil which will not dilate sufficiently to allow adequate visualization of the lens in the posterior chamber of the eye and which requires complex devices or techniques not generally used in routine cataract surgery. These must be implantable devices, not simply stretching devices.

2. The presence of a disease state that produces lens support structures that are abnormally weak or absent and which requires complex devices or techniques not generally used in routine cataract surgery.

3. Mature cataract requiring blue to complete the capsulorhexis.

4. Pediatric cataract surgery or surgery performed if the patient is in an amblyogenic developmental stage (decreased vision in one or both eyes without detectable anatomic damage to eye).

The preoperative clinical notes and the operative report must accompany all claims submitted for payment and provide documentation of the medical necessity of the procedure. Claims received without the proper documentation will be paid at zero. The provider must resubmit the claim with the required documentation for review. The medical necessity of this complex procedure must be evident in the documentation submitted for payment approval. Those claims submitted with the code of 66982 that do not meet the above criteria will be paid at the lesser rate paid for the code of 66984, routine cataract surgery. Those claims submitted with the code of 66987 that do not meet the above criteria will be paid at the lesser rate paid for the code of 66988, routine cataract surgery with endoscopic cyclophotocoagulation. Those claims submitted with the code of 66989 that do not meet the above criteria will be paid at the lesser rate paid for the code of 66991 routine cataract with insertion of intraocular anterior segment aqueous drainage device, without extraocular reservoir, internal approach.

Payment of Chalazion Incision and Intralesional Injection (67800 and 11900)

The usual and customary treatment for chalazion can be medical or surgical. Warm compresses and topical antibiotics are often used for medical treatment. Surgical incision and drainage is also appropriate initial treatment for a chalazion. Some doctors may use steroid injections for small chalazia as an initial treatment, although this is unusual.

EMI will reimburse for a chalazion incision and drainage (67800) when performed alone. EMI will reimburse for the intralesional injection of steroids when performed alone. However, EMI will not pay for both procedures when performed on the same day.

Payment of Sutureless Placement of Amniotic Membrane on the Ocular Surface; Without Sutures (65778)

Amniotic tissue has been used in a variety of surgical procedures to cover a defect on the surface of the eye and facilitate wound healing as well as decreasing inflammation. There must be documentation in the patient's record to support the use of amniotic membrane as a biological corneal bandage and may be subject to retrospective review*. Use of amniotic membrane within the postoperative period of a prior surgery, not requiring a return to the operating room and not pre-planned is subject to the principles for global surgery and will not be reimbursed separately. Do not report CPT codes 65778 or 65779 in conjunction with CPT codes 65430, 65435, and 65780.

*Please reference First Coast Service Options, Inc. Local Coverage Determination (LCD): Amniotic Membrane-Sutureless Placement on the Ocular Surface (L36237)

Payment of Aqueous Shunts and Stents for Glaucoma (66183, 0449T &, 66988, 66991)

EMI recognizes that first-line treatment of glaucoma typically involves pharmacologic therapy. Surgical intervention may be indicated in individuals with glaucoma when the target IOP cannot be reached pharmacologically. Minimally invasive glaucoma surgeries (MIGS) may be an alternative to trabeculectomy, the most established surgical procedure for glaucoma.

Ab externo (outside the eye) MIGS meet the definition of medical necessity as a method to reduce intraocular pressure in individuals with glaucoma where medications have failed to adequately control intraocular pressure. Use of ab externo aqueous shunt for all other conditions, including in individuals with glaucoma when intraocular pressure is adequately controlled by medications, is considered experimental or investigational and is not payable by EMI.

Ab interno (inside the eye) MIGS meet the definition of medical necessity as a method to reduce intraocular pressure in individuals with glaucoma where medical therapy has failed to adequately control intraocular pressure.

Implantation of 1 or 2 ab interno aqueous stents approved by the FDA in conjunction with cataract surgery also meets the definition of medical necessity in individuals with moderate open-angle glaucoma treated with ocular hypotensive medication.

Use of ab interno stents for all other conditions, or when medical therapy has adequately controlled intraocular pressure, is considered experimental or investigational and is not payable by EMI.

Medical documentation must be submitted to EMI for pre-authorization approval prior to performing services. Services billed without prior authorization will be denied.

Billing/Coding Information:

66183 Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach

0449T Insertion of aqueous drainage device, without extraocular reservoir, internal approach, into the subconjunctival space: initial device.

66988 Extracapsular cataract removal with insertion of intraocular lens prosthesis; with endoscopic cyclophotocoagulation

66991 Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); with insertion of intraocular (eg, trabecular meshwork, supraciliary, suprachoroidal) anterior segment aqueous drainage device, without extraocular reservoir, internal approach, one or more

*Reference: First Coast Service Options, Inc. Local Coverage Determination (LCD): Micro-Invasive Glaucoma Surgery (MIGS) (L38233)

These payment policies are a composite of several sources. They were developed using the guidelines as set forth by Medicare, descriptions of billing using Current Procedural Terminology (CPT) written by the American Medical Association, and proposed and reviewed by the Eye Management, Inc. Quality and Utilization Review Committees.

EMI Provider Policies

- Provider Trainings
- Provider Code of Conduct
- Vacation Emergency Coverage
- Vacation/Emergency Notification Form
- Grievance Policy
- Provider Action Request Form
- Report of Ophthalmic Consultation
- Report of Ophthalmic Consultation Form
- Non-Covered Services
- Vision Services Fee Information Form
- Claims Dispute
- Claims Review/Dispute Form
- Claims Inquiries

Provider Trainings

All providers with EMI, are required to complete the Provider Trainings, within thirty days of their contract effective date and annually thereafter. The trainings can be located via the web at https://myemifl.com/trainings . You may complete the trainings on any desk top or mobile device for ease of access and completion. Your attestation will confirm that your office has received all mandatory trainings for the year. Should you want a copy of the trainings for your office, they can be downloaded from the attestation page. NOTE: For providers who function under more than one Tax ID; please be sure to complete an attestation for each Tax ID that is contracted with EMI.

Provider Code of Conduct

Eye Management, Inc. (EMI) vision is to "develop and market products, through our family of companies that facilitates access for consumers and payers to quality and cost effective healthcare". Our extensive network of providers help to support this vision by providing quality service to our clients. To ensure that we meet this goal, the Organization has established a set of business conduct guidelines based on the Organization's code of ethics.

Providers Conduct

EMI has built an all-encompassing specialty delivery system of quality physicians, providing the full service of benefits that meet our client's population. Our providers shall not abuse, neglect, exploit or maltreat members in anyway, whether by omission or through acts or by failing to deter others from acting. If the provider becomes aware that a member has been subjected to any abuse, neglect, exploitation or maltreatment, the Provider's first duty is to protect the member's health and safety.

Provider Education and Support

The provider network representatives, in addition to the provider manual, conducts ongoing training which may include webinars, and web based tutorials as deemed necessary by the Client or state agency to ensure compliance with client or state agency program standards. These standards include annual distribution of general compliance, HIPAA, Cultural Competency, FWA and any health plan specific trainings as applicable. EMI maintains evidence of annual training and all providers within our network are required to complete the training.

Provider Cultural Competency

EMI's participating providers, and their staff, will ensure that services are provided in a culturally competent manner to provide to all contracted health plan's members and practitioners specific to local cultures, demographics, and ethnicity. EMI has created the cultural competency policy to ensure that effective medical services are provided. EMI's participating providers, and their staff shall not discriminate on the basis of religion, gender, race, color, age or national origin, health status, pre-existing condition or need for health care services, and shall not use any policy practice that has the effect of such discrimination. This policy recognizes Section 1557 of the Affordable Care Act (ACA) and all other applicable national, state and/or local laws that prohibit the practice of discrimination.

Policies and Procedures

Should you as a provider like to receive a copy of the specific Policy and Procedure that governs any of the processes discussed in this Provider Manual, you can request it through your Provider Service Representative via email to augustem@healthnetworkone.com , or by calling our Provider Service Call Center at 305-614-0100 and selecting Option 2, or via the Contact Us link on our website https://www.myemifl.com/.

Vacation/Emergency Coverage

Your office is responsible for providing covered services on a 24 hour, 7-day per week basis (including emergencies). EMI must be notified in advance whenever your office will not be available to provide this coverage. The following Vacation/Emergency Notification Form has been created in order to provide EMI with this information. This form must be faxed to EMI at (305) 868-7640, Attention: Authorization Coordinator, prior to the time when you will be unavailable to provide covered services.

If your office is temporarily unavailable to provide coverage, you must arrange for a substitute physician. The substitute physician must be aware of his/her rights and obligations in providing covered services to a member. The substitute physician may not charge the patient any amount greater than their co-payment.

When a substitute physician will be providing covered services in your absence, EMI must be provided with the name of the substitute physician and the dates of coverage, prior to the start of the coverage. The Vacation/Emergency Notification Form should be used to provide EMI with this information.

Eye Management

VACATION/EMERGENCY NOTIFICATION FORM

Fax to EMI at (305) 868-7640 at least one week prior to physician's leave.

Date (mm/dd/yyyy)	Provider Last Name	Provider First Name

DATES HE/SHE WILL BE UNAVAILABLE TO SEE PATIENTS:

From [month/day/year and time (am/pm)]	To [month/day/year and time (am/pm)]

NAME AND TELEPHONE NUMBER OF COVERING PHYSICIAN(S) IF APPLICABLE:

Covering Provider Last Name	Covering Provider First Name	Phone Number
Covering Provider Last Name	Covering Provider First Name	Phone Number
Covering Provider Last Name	Covering Provider First Name	Phone Number
Covering Provider Last Name	Covering Provider First Name	Phone Number
Covering Provider Last Name	Covering Provider First Name	Phone Number

Policy for Provider Inquires

When a provider has a specific inquiry or concern (e.g. question regarding an EMI policy or procedure; request for resolution to a claim inquiry; problem or question regarding a health plan policy or procedure), the provider may contact EMI at 800-329-1152, Option 2, or the provider may complete the following “Provider Action Request” and fax to EMI for resolution.

Our fax number is **(305) 868-7640**

This form should NOT be used to inquire about the status of claims or to appeal claim denials. Separate forms have been developed for this purpose. See Section “Claims Appeal” and “Claims Inquiries”. This form can be used in the event that the provider does not receive a satisfactory response to a claim’s status or a claim dispute in addition to the other reasons previously stated.

EMI will address all provider concerns upon receipt. All provider inquires will be logged and the provider may receive a reference number upon request.

Eye Management

PROVIDER ACTION REQUEST FORM

Date (mm/dd/yyyy)	Provider Last Name	Provider First Name

Contact Person in Providers Office Last Name	Contact Person in Providers Office First Name
Phone Number	Fax Number

EXPLAIN THE NATURE OF YOUR PROBLEM OR INQUIRY:

THE FOLLOWING TO BE COMPLETED BY EYE MANAGEMENT

Date Received	Started By	Department

Action Taken

Report of Ophthalmic Consultation

As part of our Quality Improvement (QI) activities, EMI has created the EMI Report of Ophthalmic Consultation to be used by our providers as a tool for communication between themselves and the PCP. This form was created in collaboration with fellow ophthalmologists in the network. This form or a similar comprehensive exam report should be sent to the member's PCP following each exam.

A copy of the form follows for your reference.

Eye Management

REPORT OF OPHTHALMIC CONSULTATION

Date of Service (mm/dd/yyyy)	Patient First Name	Patient Last Name
Provider Last Name	Provider First Name	Provider Phone Number
Consulting Ophthalmologist First Name	Consulting Ophthalmologist Last Name	Consulting Ophthalmologist Phone Number

DIAGNOSIS/FINDINGS:

CONJUNCTIVA
____ 1. Conjunctivitis
____ 2. Conjunctival Hemorrhage
____ 3. Dry Eye
____ 4. Pinguecula
____ 5. Pterygium

CORNEA
____ 6. Corneal Abrasion
____ 7. Corneal Foreign Body
____ 8. Corneal Ulcer
____ 9. Keratitis

EYELIDS
____ 10. Blepharitis
____ 11. Chalazion
____ 13. Ectropion
____ 14. Entropion
____ 15. Neoplasm, Benign Eyelid
____ 16. Neoplasm, Malignant Eyelid
____ 17. Ptosis, Eyelid
____ 18. Trichiasis, without entropion

GLAUCOMA
____ 19. Glaucoma, Open Angle Primary
____ 20. Glaucoma Suspect
____ 21. Glaucoma, Narrow Angle
____ 22. Normal Tension

LACRIMAL
____ 23. Nasolacrimal Duct Obstruction
____ 24. Dacryocystitis

LENS
____ 25. Cataract, Primary
____ 26. Cataract, Secondary

MUSCLES
____ 27. Esotropia
____ 28. Strabismus
____ 29. Amblyopia

NEURO
____ 30. Bell's Palsy
____ 31. Nystagmus
____ 32. Optic Atrophy
____ 33. Optic Neuropathy

VISUAL
____ 34. Photophobia
____ 35. Pseudophakia (IOL)

RETINA
____ 36. Retinopathy, Diabetic
____ 37. Retinopathy, Hypertensive
____ 38. Retinal Tear
____ 39. Macular Degeneration
____ 40. Macular Retinal Edema
____ 41. Retinal Detachment
____ 42. Retinal Vein Occlusion

VITREOUS
____ 43. Vitreous Floaters/Opacity
____ 44. Vitreous Hemorrhage
____ 45. Vitreous Detachment

Other:

VISUAL ACUITY: 20/_____ (OD) 20/_____ (OS)

☐ NSAID:	☐ Beta Blocker Selective:	☐ Beta Blocker Non Selective:
☐ Parasympathomimetic:	☐ Steroid:	☐ Antibiotic/Steroid:
☐ CAI(carbonic anhydrase inhibitor):	☐ Prostaglandin analogue:	☐ Antibiotic:

☐ Other:

Treatment/Recommendations:

☐ Referred to Optometrist for Vision/Refractive Care

☐ Follow up: ____ Day(s) ____ Week(s) ____ Month(s) ____ Year ____ PRN

Physician Signature

Non-Covered Vision Services

Covered benefits by EMI ophthalmologists vary according to the member's health plan. Refer to the applicable health plan section of the Procedure Manual in the Index under "Non-Covered Services".

In the event that a member requests that your office perform a non-covered vision service, EMI has provided you with the following Vision Fee Information form.

This form explains to the member that the services you are providing are not covered under their benefit package and they are responsible in full for the cost of any non- covered services provided by you.

The member must be adequately informed prior to receiving non-covered vision services that they will be responsible for the payment of such services.

In addition to written consent by the member, EMI must be notified in advance and give written approval to charge the member for these services.

This form must be signed each time a non-covered vision service is provided.

Eye Management

VISION SERVICES FEE INFORMATION

Vision Services are not a covered benefit under your insurance plan medical benefit package, this includes: routine eye examinations to check vision problems, vision services, refractive examinations, and prescriptions for glasses and contact lenses. If you have requested that any of these services be performed by a network ophthalmologist, you will be charged his/her usual and customary fee to provide these services, and you will be required to pay this fee to the ophthalmologist at the time the service is rendered.

This information is being provided to you so that you may make an informed decision before receiving these services. We recommend that you contact your insurance carrier to obtain complete information regarding vision services available to you. At the time the services are performed, you will be required to pay for the vision services provided in addition to your usual co-payment if medical services were rendered at the same time. Because these services are not a covered benefit, you may not seek reimbursement for these services from your health plan at a later date.

This information is being provided to you so that you may make an informed decision before receiving these services. We recommend that you contact your insurance carrier to obtain complete information regarding vision services available to you.

I have read the above information and understand my financial responsibility.

Member Name (Printed)

Name of Legal Guardian (if Minor)

Signature

Date (mm/dd/yyyy)

Claims Dispute

If a provider wishes to contest any claim payment, or reduction in reimbursement for specific procedures, the following actions must be taken within 60 days after receipt of the provider remittance or Explanation of Payment (EOP).

1. Complete the Claims Review/Dispute Form on the following page.
2. Attach all pertinent documentation.
3. Submit a copy of the original claim (marked "COPY") and a copy of the EOP, which accompanied the original claim.
4. **Mail** all information "Attention Claims Review" to:

   EMI - Health Network One
   P.O. Box 240247
   Apple Valley, MN 55124

   Do not call the office, fax information, or direct the information to any other department.
5. All attempts will be made to answer your response within thirty business days or sooner. However, at times, a claims dispute may be forwarded to the Peer Review Sub-Committee in which case you will be notified of this action, and the time expected before a response will be forthcoming.
6. Dispute **must** be submitted within 60 days of receipt of the EMI EOP. Receipt of dispute after 60 days will not be considered.

Claims Status Inquiries

All claims status inquires must be made via the HS1 Provider Web Portal. If you do not have a web portal account with EMI, please complete the form online.

If you do not have access to the internet, you may also make any claims status inquires telephonically at one of the numbers below:

- Miami-Dade County (305) 614-0133
- Broward County (954) 335-8130
- All other counties (877) 372-1273