ARCHIVAL USE ONLY
Refer to the Online Handbook for current policy

PART R

VISION CARE SERVICES PROVIDER HANDBOOK

PART R
VISION CARE SERVICES PROVIDER HANDBOOK
TRANSMITTAL LOG

This log is designed as a convenient record sheet for recording receipt of handbook updates. Providers must delete old pages and insert new pages as instructed. Use of this log will eliminate errors and ensure an up-to-date handbook.

Each update to Part R of the handbook is numbered sequentially. This sequential numbering system alerts the provider to any updates not received. For example, if the last transmittal number on your log is R-3 and you receive R-5, you are missing R-4. If a provider is missing a transmittal, copies of complete provider handbooks may be purchased by completing the form in Appendix 36 of Part A of the WMAP Provider Handbook.

Transmittal Number	Initials	Issue Date
R-1		03/92
R-2		12/92
R-3		06/94
R-4		10/94
R-5		03/95

Transmittal Number	Initials	Issue Date

INTRODUCTION

The Wisconsin Medical Assistance Program (WMAP) is governed by a set of regulations known as the Wisconsin Administrative Code, Rules of Health and Social Services, Chapters HSS 101-108, and by state and federal law. These regulations are interpreted for provider use in two parts of the WMAP provider handbook. The two parts of the handbook are designed to be used in conjunction with each other and with the Wisconsin Administrative Code.

Part A of the WMAP handbook includes general policy guidelines, regulations, and billing information applicable to all types of providers certified in the WMAP. The service specific part of the handbook includes information on provider eligibility criteria, covered services, reimbursement methodology, and billing instructions. Each provider is sent a copy of the Part A and appropriate service specific part of the handbook at the time of certification.

Additional copies of provider handbooks may be purchased from EDS. Refer to Appendix 3 of Part A of the WMAP Provider Handbook for the address and telephone number.

When requesting a handbook, be sure to indicate the type(s) of service provided (e.g., physician, chiropractic, dental).

It is important that both the provider of service and the provider's billing personnel read all materials prior to initiating services to ensure a thorough understanding of WMAP policy and billing procedures.

NOTE: For a complete source of WMAP regulations and policies, the provider is referred to the Wisconsin Administrative Code, Chapters HSS 101-108. In the event of any conflict in meaning between HSS 101-108 and the handbook, the meaning of the Wisconsin Administrative Code will hold. Providers may purchase HSS 101-108 from Document Sales at the address indicated in Appendix 3 of Part A of the WMAP Provider Handbook.

Providers should also be aware of other documents, including state and federal laws and regulations, relating to the WMAP:

- Chapter 49.43 - 49.497, Wisconsin Statutes.
- Title XIX of the Social Security Act and its enabling regulations, Title 42 - Public Health, Parts 430-456.

A list of common terms and their abbreviations appears in Appendix 30 of Part A of the handbook and also in the Wisconsin Administrative Code, Chapter HSS 101.

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A. TYPE OF HANDBOOK

Part R, Vision Care Services, is the service-specific portion of the Wisconsin Medical Assistance Provider Handbook. Part R includes information for providers regarding provider eligibility criteria, recipient eligibility criteria, covered services, reimbursement rates, and billing instructions. Part R is to be used in conjunction with Part A of the Wisconsin Medical Assistance Provider Handbook which includes general policy guidelines, regulations, and billing information applicable to all types of providers certified in the Wisconsin Medical Assistance Program (WMAP).

B. PROVIDER INFORMATION

Provider Eligibility and Certification

For certification as a provider in the WMAP under HSS 105.32, Wis. Admin. Code, optometrists must be licensed and registered pursuant to ss. 449.04 and 449.06, Wis. Stats. Opticians wishing to be certified as WMAP providers under HSS 105.33, Wis. Admin. Code must practice as described in s. 449.01(2), Wis. Stats. Physicians (ophthalmologists) who want to participate under HSS 105.05, Wis. Admin. Code, must be licensed to practice medicine and surgery pursuant to ss. 448.05 and 448.07, Wis. Stats., and chs. Med 1, 2, 3, 4, 5, and 14. Optometrists, opticians, and ophthalmologists practicing outside Wisconsin, but who provide services to WMAP recipients, must meet the licensing and registration requirements of their own states.

Scope of Service

The policies in Part R govern services within the scope of the practice of the profession as defined in s. 449.01, Wis. Stats., and HSS 107.20, Wis. Admin. Code. Covered services and related limitations are listed in Section II of this handbook.

Optometrists and ophthalmologists may be reimbursed by the WMAP for services related to dispensing and repair of vision materials, as well as for covered diagnostic services. Optometrists with a Therapeutic Pharmaceutical Agents (TPA) certificate and ophthalmologists may be reimbursed for certain surgical procedures. Opticians may be reimbursed by the WMAP only for services pertaining to the supply, dispensing, and repair of eyeglasses. Refer to Appendix 1 of this handbook for a list of allowable procedure codes for vision providers. Ophthalmologists may be reimbursed for additional procedure codes not listed in this handbook, and are referred to the Physician Handbook, Part K, for additional information on covered services.

The State Purchase Eyeglass Contract (SPEC) contractor may be reimbursed by the WMAP for materials covered by the SPEC which are dispensed by WMAP-certified vision providers. Ophthalmologists, optometrists, and opticians may be reimbursed only for materials which are not covered under the SPEC and have been prior authorized by the WMAP.

Refer to Section II of this handbook for information on the SPEC and to Section III of this handbook for information on prior authorization.

Reimbursement

Optometrists, opticians, and ophthalmologists are reimbursed at the lesser of the provider's usual and customary charges or the maximum allowable fee established by the Department of Health and Social Services (DHSS) for these services.

Items/materials which are not available through the SPEC (including emergency vision items purchased out-of-state) are reimbursed at no more than the average wholesale cost of the materials. Refer to Section II of this handbook for more information on the SPEC.

B. PROVIDER INFORMATION (continued)

Provider Responsibilities

Specific responsibilities as a WMAP provider are stated in Section IV of Part A of the WMAP Provider Handbook. This section should be referenced for detailed information regarding fair treatment of the recipient, maintenance of records, recipient requests for noncovered services, services rendered to a recipient during periods of retroactive eligibility, grounds for provider sanctions, and additional state and federal requirements.

C. RECIPIENT INFORMATION

Eligibility for Medical Assistance

Recipients meeting eligibility criteria for Medical Assistance are issued Medical Assistance identification cards. The Medical Assistance identification cards include the recipient's name, date of birth, 10-digit Medical Assistance identification number, medical status code, and, when applicable, an indicator of private health insurance coverage, managed care program coverage, and Medicare coverage. The recipient must be eligible on the date that any services are rendered, including the ordering of replacement parts or eyeglasses.

Medical Assistance identification cards are sent to recipients on a monthly basis. All Medical Assistance identification cards are valid only through the end of the month for which they are issued. It is important that the provider or the designated agent check a recipient's Medical Assistance identification card prior to providing service to determine if the recipient is currently eligible and if there are any limitations to the recipient's coverage.

Section V of Part A of the WMAP Provider Handbook provides detailed information regarding eligibility for Medical Assistance, Medical Assistance identification cards, temporary cards, restricted cards, and eligibility verification. Section V of Part A of the WMAP Provider Handbook must be reviewed carefully by the provider before services are rendered. A sample Medical Assistance identification card can be found in Appendix 7 of Part A of the WMAP Provider Handbook.

Medical Status

Medical Assistance recipients are classified into one of several eligibility categories. These categories allow for a differentiation of benefit coverage. Refer to Section V of Part A of the WMAP Provider Handbook for additional information regarding medical status.

Copayment

Except as noted below, all recipients are responsible for paying part of the costs involved in obtaining vision care services. The procedure codes and their applicable copayment amounts are listed in Appendix 1 of this handbook.

Copayment must be collected from the recipient by the provider of service. Applicable copayment amounts are automatically deducted by EDS from payment allowed by the WMAP. Providers should not reduce the billed amount of the claim by the amount of recipient copayment.

Providers must not collect copayment for the following:

- Services provided in an emergency circumstance;
- Services provided to nursing home residents;
- Services provided to recipients under 18 years of age;
- Services provided to a pregnant woman if the services are related to the pregnancy;
- Services covered by a WMAP-contracted managed care program to enrollees of the managed care program.

C. **RECIPIENT INFORMATION** (continued)

Managed Care Program Coverage

WMAP recipients enrolled in WMAP-contracted managed care programs receive a yellow Medical Assistance identification card. This card has a six-character code in the "Other Coverage" column designating the recipient's managed care program. These codes are defined in Appendices 20, 21, 22, and 22a of Part A of the WMAP Provider Handbook.

Providers must always check the recipient's current Medical Assistance identification card for managed care program coverage before providing services. Claims submitted to EDS for services covered by WMAP-contracted managed care programs are denied.

The managed care program is responsible for providing all vision care services to recipients enrolled in WMAP-contracted managed care programs, including materials. For recipients enrolled in a WMAP-contracted managed care program, all conditions of reimbursement, provision of vision items/materials, and prior authorization for vision services are established by the contract between the managed care programs and certified providers.

Additional information regarding managed care program noncovered services, emergency services, and hospitalizations is included in Section IX-E of Part A of the WMAP Provider Handbook.

A. INTRODUCTION

Section II of this handbook describes basic coverage and limitations on vision procedures in the Wisconsin Medical Assistance Program (WMAP). Providers must familiarize themselves with this section in order to ensure that only covered services are rendered in compliance with all appropriate guidelines. Appendix 1 of this handbook contains a complete listing of all covered services.

Optometrists may be reimbursed for all procedures listed except that only TPA-certified optometrists may be reimbursed for procedures requiring TPA certification. Opticians may be reimbursed only for procedures pertaining to the dispensing and repair of eyeglasses.

Ophthalmologists may be reimbursed by the WMAP for all procedures listed in Appendix 1 of this handbook as well as WMAP-covered services identified in the Physician's Current Procedural Terminology (CPT). Ophthalmologists are referred to the Physician Handbook, Part K, for additional information on covered services.

B. STATE PURCHASE EYEGLASS CONTRACT (SPEC)

Under the State Purchase Eyeglass Contract (SPEC), all vision care providers certified in the WMAP must order all WMAP-covered eyeglasses and component parts directly from the provider contracted with the Department of Health and Social Services (DHSS) to supply those services.

Effective with orders placed on and after April 1, 1995, Precision Optics is the SPEC contractor. The address for the SPEC contractor is:

The Omega Group
Precision Optics, Incorporated
Box 1228, 6925 Saukview Drive
St. Cloud, MN 56302

Procedures for Ordering Materials

Vision care providers must order materials from the SPEC contractor on an order form supplied by the SPEC contractor. For SPEC billing information, refer to Section IV-E of this handbook.

Properly ordered materials, except in unforeseen or unusual circumstances, are expected to be shipped to providers by the SPEC contractor within six working days of receipt of the order. Providers should allow for mailing time for orders and materials when calculating an expected delivery date. If an order is not received within 14 days, providers should telephone the SPEC contractor. To expedite processing of orders, please type or clearly print all orders accurately and completely. Illegible orders will require additional processing time to clarify or return.

If within 30 days of delivery any material is found by the dispensing provider to be unsatisfactory due to the SPEC contractor's error, defective workmanship, or materials, the provider should return the materials and order form to the contractor. The SPEC contractor is required to adjust, correct, or replace the materials at the SPEC contractor's expense. The SPEC contractor is not liable for the cost of replacement orders required due to errors made by the prescribing or dispensing provider, nor for defective materials not reported within 30 days of delivery.

SPEC Lenses

The SPEC includes glass, plastic, and polycarbonate lenses for single vision, multifocal, and cataract lenses. Contracted lenses must conform to the American National Standards Institute (ANSI) recommendation for prescription of ophthalmic lenses, ANSI Z80.1 - 1979, and the Food and Drug Administration (FDA) requirements for impact resistant lenses. Providers should refer to Appendix 2 of this handbook for a list of lenses covered under the SPEC.

B. STATE PURCHASE EYEGLASS CONTRACT (SPEC) (continued)

SPEC Frames

The SPEC includes frames which meet ANSI Z80.5 - 1979 Standards. (Refer to Appendix 3 of this handbook for a list of SPEC-covered frames).

WMAP vision care providers must purchase a sample kit of SPEC frames. Sample kits are available from the contractor. Providers will not be reimbursed for materials included in sample kits. A sample kit can be ordered by writing to the SPEC contractor.

Ordering Partial Appliances

If a recipient requires new lenses only, the dispensing provider must, whenever possible, send the recipient's existing frames to the SPEC contractor with the lens order. Orders received by the contractor as "frame enclosed" must include:

- the actual frame or a machine-made pattern (not a hand tracing) with the order, if the frame enclosed is a new frame; or
- the actual frame, if the frame enclosed is a used frame. Hand tracings or drawings are not acceptable.

Orders without the frame enclosed, or without a pattern for a new frame, may be returned to the ordering provider within three working days of receipt of the order with a written explanation as to why the order was not processed.

The lenses are then mounted in the recipient's frame. If, in the opinion of the SPEC contractor, the lenses cannot be mounted without damage to the frames, the SPEC contractor may either return the frames with the unmounted lenses to the provider with a written explanation why the lenses were not mounted; or contact the provider by telephone so the provider may order a complete appliance from the SPEC contractor.

If a recipient has a metal frame, the frame must accompany the order for lenses.

If the recipient requires a new frame only, and the recipient's lenses do not fit a SPEC frame, a complete appliance must be ordered from the SPEC contractor.

Non-Contracted Materials/Out-of-State Providers/Out-of-State Foster Children

Prior authorization is required for all non-contracted vision items and for eyeglasses, frames, lenses, and components billed for out-of-state foster children and out-of-state providers. Please refer to Section III of this handbook for prior authorization requirements and to Section IV for billing instructions.

C. EVALUATION AND DIAGNOSTIC SERVICES

Evaluation and Management Services

Evaluation and Management, New Patient

The WMAP defines "new patient" as a patient who is new to the provider and whose medical and administrative records need to be established. The WMAP interprets this to be a new patient to either the physician or clinic. The WMAP allows one new patient procedure per recipient, per performing or billing provider, per lifetime.

Evaluation and Management, Visits

Only one office visit is allowed per date of service for a new or established patient, per performing provider.

C. EVALUATION AND DIAGNOSTIC SERVICES (continued)

Ophthalmological Examinations
A refraction is not separately reimbursable with an ophthalmological examination as this procedure is included in the reimbursement for the examination. Refer to Section IV-B of this handbook for instructions on billing for refractions for dual entitlees.

A comprehensive ophthalmological examination for an established patient may be reimbursed once per recipient, per performing provider, per 12-month period without prior authorization. Additional comprehensive exams, if medically necessary, may be reimbursed if they have been prior authorized. (Refer to Section III of this handbook for prior authorization requirements.)

Low Vision Eye Examination
The WMAP covers one low vision examination per recipient per year. Prior authorization is required for low vision examinations.

Supplemental Tests
Supplemental tests are included in the reimbursement rate set for comprehensive or low vision examinations and are not reimbursed separately on the same date of service as a comprehensive examination or low vision examination. Refer to Appendix 1 of this handbook for information on which tests are not separately reimbursable.

D. DISPENSING AND REPAIR SERVICES

Dispensing Fees
The WMAP covers dispensing fees for furnishing contracted materials to recipients. The dispensing fee includes selecting, ordering, and dispensing contracted materials. Dispensing fees associated with non-SPEC materials are not covered by the WMAP unless the non-SPEC materials and dispensing fee have been prior authorized by the WMAP. All dispensing fees include routine follow-up and post-prescription visits for minor adjustments. The date of service used for billing purposes is the date of order of the eyeglasses. Only one dispensing fee is allowed per date of service.

Dispensing Complete SPEC Appliances
This procedure is covered when both a SPEC frame and SPEC lenses have been ordered (unifocal, bifocal, or trifocal). Only one pair and one replacement from the same prescription per 12-month period are covered unless prior authorization is obtained for additional services. (Refer to Section III of this handbook for prior authorization requirements.)

Dispensing SPEC Frames
This procedure is not covered when billed on the same date of service as dispensing a complete appliance, temple replacement, or lens replacement.

Dispensing SPEC Temple or Temples
This procedure is not covered when billed on the same date of service as dispensing a complete appliance or frame replacement.

Dispensing SPEC Lens or Lenses
This procedure is not covered when a SPEC lens(es) has been ordered (either unifocal or multifocal), on the same date of service as dispensing a complete appliance or frame replacement.

Dispensing a Complete Appliance or Lens(es) with a Changed Prescription
Providers may be reimbursed by the WMAP for dispensing one additional complete appliance or lens(es) without prior authorization when there is a documented change in the lens prescription of more than +/-.50 diopter in the spherical or cylinder power and a cylinder axis shift of greater than 10 degrees.

D. DISPENSING AND REPAIR SERVICES (continued)

Repair Service

This procedure is covered for minor repairs (e.g., new hinge, rivet, solder). Repair services beyond the 30-day warranty period are not a part of the SPEC and are not required to be ordered from the SPEC contractor. Repair services may be ordered through the lab of the ordering provider's choice, if not performed in the provider's office. Routine follow-up and post-prescription visits (for minor adjustments) are considered part of the initial dispensing fee and are not covered as repair services. However, an order that is unacceptable due to defects in materials, workmanship, or due to a processing error, must be returned to the SPEC contractor within 30 days of delivery for repair.

Date of Service

The date of service for billing the dispensing of eyeglass frames or lenses is the date the vision provider orders the materials, not the date the order was received by the SPEC contractor, nor the date the service obtained prior authorization, if required, nor the date the recipient obtains the materials. When ordering replacement materials from an existing prescription, the date of service is the date the replacement is ordered. Orders may not be backdated prior to the date the recipient is seen by the dispensing provider. Vision providers are responsible for verifying that the recipient is eligible on the date of service.

E. COVERED VERSUS NONCOVERED VISION MATERIALS

The WMAP reimburses vision providers only for covered materials listed in this handbook, when prior authorization and other requirements are met. A provider may provide a service which includes a noncovered portion. The provider may bill the recipient directly for the noncovered portion of the service only if the covered and noncovered portions of the service are distinctly separate and the recipient has been notified in advance and has agreed to pay separately for the noncovered portion. For example, a provider may order covered eyeglasses through the SPEC for a recipient, and may charge the recipient for the noncovered anti-glare coating or fashion tint that the recipient requests. This is allowable since the anti-glare coating or fashion tint may be added later as a separate procedure.

A provider may not, however, seek reimbursement from the WMAP for a noncovered service by charging the WMAP for a covered service which was not provided, and applying the reimbursement toward a noncovered service. For example, if a recipient chooses to receive photogrey lenses which have not been prior authorized, the provider may not bill the WMAP for lenses of any type and bill the recipient for the difference between the WMAP reimbursed amount and the actual cost of the service. In this instance, the entire lens is considered noncovered by the WMAP, because photogrey is an integral part of the lens and cannot be provided as a separate service.

Refer to Section IV of Part A of the WMAP Provider Handbook for information on recipient requests for noncovered services and provider acceptance of payment.

F. PRESCRIPTIONS

Requirements of Prescriptions for Drugs

Ophthalmologists practicing within their scope of practice may prescribe drugs for Medical Assistance recipients. Optometrists practicing within their scope of practice may prescribe drugs for Medical Assistance recipients if they hold a Therapeutic Pharmaceutical Agents (TPA) certificate. Before using or prescribing any Schedule II, III, IV, or V pharmaceutical agents, the provider must also obtain a Drug Enforcement Administration (DEA) certification of registration. The WMAP does not reimburse providers separately for any charges associated with writing prescriptions.

F. PRESCRIPTIONS
(continued)

Prescription Requirements

Except as otherwise noted in federal or state law, a prescription must be in writing or given orally and later reduced to writing and must include the following information:

- name of drug or service prescribed
- directions for use of the prescribed drug or item
- prescriber's name and address
- recipient's name and address
- date of the order
- prescriber's signature

E. PRESCRIPTIONS (continued)

Prescriptions for any Schedule II, III, IV, or V pharmaceutical agents must also contain the Drug Enforcement Agency (DEA) number of the prescriber.

For hospital and nursing home recipients, orders must be entered into the medical and nursing charts and must include the information listed above. Services ordered by prescription must be provided within one year of the date of the prescription.

"Brand Medically Necessary" Requirements

In order for a pharmacy to be reimbursed for a drug at a rate higher than that allowed for a generic equivalent, the prescribing provider must certify that a brand name drug is medically necessary by using the phrase "BRAND MEDICALLY NECESSARY" or "MEDICALLY NECESSARY."

This certification must be in the prescribing practitioner's own handwriting directly on the prescription order or on a separate authorization which is attached to the original prescription. Pharmacy orders must have this documentation prior to submitting claims to the WMAP. Prescriptions which indicate "No Substitutes" or "N.S." are not covered by the WMAP, and claims for these services are denied. The prescriber must also document in the recipient's medical record the reason why the brand drug is medically necessary.

Typed certification, signature stamps, or certification handwritten by someone other than the prescriber does not satisfy this requirement. "Blanket" authorization for an individual recipient, drug, or prescriber is not acceptable documentation. A letter of certification is acceptable as long as the notation is handwritten and is for specified drugs for an individual patient. While it is the pharmacy's responsibility to have this written documentation, it is the prescriber's responsibility to provide the pharmacy with the required documentation.

Nursing Home Orders

Prescriber certification that the brand is medically necessary must be made on each prescription order written for nursing home residents. This certification is good only for the length of time that the order is valid. Updated written certification is required for each new prescription order written.

Drug Rebate System

The drug rebate system is the result of the federal Omnibus Budget Reconciliation Act of 1990. Under the drug rebate system, drug manufacturers that choose to participate in state Medical Assistance programs are required to sign rebate agreements with the federal Health Care Financing Administration (HCFA). Participation in the Medical Assistance program is voluntary on the part of the drug manufacturers. Rebate agreements are valid for one year. At the end of one year, manufacturers may choose whether or not to continue participation in the rebate program. Non-participating manufacturers have the option each quarter of signing a rebate agreement which will be effective the following quarter.

Manufacturers that have signed rebate agreements have their prescription drugs covered by the WMAP if the drugs meet WMAP guidelines. For manufacturers that did not sign a rebate agreement, the WMAP does not cover drugs produced by the manufacturer, except as noted in Appendix 12 in this handbook. The prescriber may wish to contact a local WMAP-certified pharmacy to confirm the WMAP coverage status of a particular drug or product.

F. PRESCRIPTIONS (continued)

Appendix 12 of this handbook is a list of the types of drugs that are covered by the WMAP, including those which require prior authorization. Appendix 13 of this handbook lists noncovered drugs, including drugs sold by manufacturers that did not sign rebate agreements.

Documentation for Drugs Manufactured by Companies That Have Not Signed a Rebate Agreement

The WMAP recognizes that there are a few cases where it is medically necessary to provide a drug that is produced by a manufacturer that did not sign a rebate agreement. These drugs may be provided to the recipient when the pharmacy completes a prior authorization request.

The prescriber must provide the following documentation to the pharmacy in the above instance:

- A statement indicating that no other drug produced by a manufacturer that signed a rebate agreement is medically appropriate for the recipient.
- A statement indicating that WMAP coverage of the drug is cost effective for the WMAP.

A recipient request for a particular drug is not considered adequate justification for granting approval without the prescriber demonstrating medical necessity.

G. NONCOVERED SERVICES

The following services and items are not covered under the WMAP:

1. Services and items requiring prior authorization for which authorization has been either denied or not requested. If a provider fails to request prior authorization for a service which requires prior authorization, the recipient may not be billed.
2. Dispensing services related to noncovered items.
3. Eyeglass cases.
4. Spare eyeglasses.
5. Tinted lenses for non-medical reasons.
6. Anti-reflection coating.
7. Services or items provided principally for cosmetic reasons, including gradient focus or progressive bifocals, fashion or cosmetic tints, engraved lenses, and anti-scratch coating.
8. Charges for telephone calls.
9. Charges for missed appointments.
10. Consultations between or among providers.

A. GENERAL REQUIREMENTS

Prior authorization procedures are designed to safeguard against unnecessary utilization of care, to promote the most effective and appropriate use of available services, and to assist in cost containment. Providers are required to seek prior authorization for certain specified services before delivery of that service, unless the service is provided on an emergency basis. Reimbursement is not made for services provided either prior to the grant date or after the expiration date indicated on the approved prior authorization request form. If the provider renders a service which requires prior authorization without first obtaining authorization, the provider is responsible for the cost of the service and may not bill the recipient.

Providers are advised that prior authorization does not guarantee reimbursement. Provider eligibility, recipient eligibility, and medical status on the date of service, as well as all other Wisconsin Medical Assistance Program (WMAP) requirements, must be met prior to reimbursement of the claim.

B. SERVICES REQUIRING PRIOR AUTHORIZATION

The services listed below require authorization from the WMAP prior to delivery:

1. Vision training and therapy, including orthoptics and pleoptics.
2. Contact lenses and contact lens therapy except when the diagnosis is aphakia or keratoconus or when therapeutic or bandage contact lenses are required.
3. Low vision services and aids for all diagnostic conditions.
4. Aniseikonic services.
5. Eyeglass frames and lenses beyond the original and one unchanged prescription replacement pair (either a complete appliance or a lens replacement or a frame replacement dispensed on different dates of service) from the same provider in a 12-month period.
6. Ptosis crutch services and materials.
7. Contracted occupational safety frames and lenses.
8. Tinted eyeglass lenses (contracted tints and coatings including rose #1 and rose #2, ultraviolet coating, and photochromic lenses).
9. Special lens designs and components (contracted high index glass and plastic, polycarbonate lenses for recipients age 21 and over, large eye size 59mm or over).
10. Comprehensive vision examinations beyond the initial comprehensive vision examination within a 12-month period.
11. Frames and lens materials which are not obtained through the WMAP State Purchase Eyeglass Contract (SPEC).

C. PRIOR AUTHORIZATION FOR NON-CONTRACTED MATERIALS

Contact Lenses

Contact lenses are not part of the SPEC. A prior authorization request for contact lens approval must identify the lens material and specifications as well as materials costs. If the recipient has a diagnosis of keratoconus (diagnosis code 371.6) or aphakia (diagnosis code 379.3) or if the contacts are being used as a therapeutic or bandage lens (procedure code 92070), then prior authorization is not required.

C. PRIOR AUTHORIZATION FOR NON-CONTRACTED MATERIALS (continued)

Low Vision Aids

Low vision aids are not part of the SPEC. When submitting prior authorization requests for low vision aids, specify the type of aid and power as well as the material costs.

Special Lenses and Frames

The dispensing provider must submit a prior authorization request to EDS which documents the medical necessity of special lenses or tints or for occupational frames. A copy of the approved prior authorization form must be sent with the order to the SPEC contractor. A diagnosis of photophobia is not sufficient for approval of tints without additional justification of medical need by the prescribing provider.

Prior authorization for dispensing of non-contracted frames may be approved if medically necessary (e.g., for recipients allergic to plastic or requiring exceptional frame adjustments for cataract lenses). However, the lenses must still be ordered from the SPEC contractor. Refer to Appendix 1 of this handbook for the appropriate procedure codes.

D. PROCEDURES FOR OBTAINING PRIOR AUTHORIZATION

Section VIII of Part A of the WMAP Provider Handbook identifies procedures for obtaining prior authorization including emergency situations, appeal procedures, supporting materials, retroactive authorization, recipient loss of eligibility midway in treatment, and prior authorization for out-of-state providers.

Optometrists and ophthalmologists who determine that a recipient needs services requiring prior authorization should submit a Prior Authorization Request Form (PA/RF) and Prior Authorization Vision Services Attachment (PA/VA) to the EDS Prior Authorization Unit.

Refer to Appendices 6, 7, 8, and 9 of this handbook for sample prior authorization forms and completion instructions.

E. PROCEDURES AND SERVICES PRICED AT PRIOR AUTHORIZATION

The WMAP establishes the maximum reimbursement amount for certain procedures and services when the PA/RF and PA/VA are processed. Refer to Appendix 1 of this handbook for a list of procedures and services which are priced at prior authorization.

Submitting the Prior Authorization Request Form (PA/RF)

PA/RFs for procedures priced at prior authorization must be submitted using the following procedures and services:

- Prior authorization for procedures requiring more than one item should list each item, with a procedure code description, on a separate line on the PA/RF. The items must be individually identified on the PA/RF with complete and specific descriptions and prices from the manufacturer.
- Do not include a modifier in element 15.
- Indicate a quantity of "1" in element 19 of the PA/RF. If dispensing a pair of items, indicate "pair" in the description and include the cost of the pair in element 20 of the PA/RF.

Receiving an Approved PA/RF

When an approved PA/RF is returned to the provider, the maximum amount that will be reimbursed when the claim is submitted is indicated on the PA/RF. If several items are approved under one procedure code, a procedure code modifier (numbers 11-22) is assigned by the WMAP consultant in element 15 for each approved item. Refer to Section IV of this handbook for information on billing for procedures priced at prior authorization.

E. PROCEDURES AND SERVICES PRICED AT PRIOR AUTHORIZATION (continued)

Submitting Amendments to An Approved PA/RF

If the average wholesale cost increases for an item priced at prior authorization, a provider may obtain a higher level of reimbursement than is identified on the PA/RF only by submitting a prior authorization amendment request. The amendment must document that the wholesale cost has increased.

If an amended PA/RF is approved after the claim is paid, a claim adjustment request for additional reimbursement may be submitted which indicates that the amount approved at prior authorization has been changed. Refer to Section IX of Part A of the WMAP Provider Handbook for information about adjustment requests.

F. OBTAINING AND SUBMITTING PRIOR AUTHORIZATION REQUEST FORMS

Completed prior authorization request forms must be submitted to:

EDS
Attn: Prior Authorization Unit
6406 Bridge Road
Madison, WI 53784-0088

Prior authorization request forms can be obtained by submitting a written request to:

EDS
Attn: Claim Reorder Department
6406 Bridge Road
Madison, WI 53784-0003

Please specify the form requested and the number of forms desired. Reorder forms are included in the mailing of each request for forms. Do not request forms by telephone.

G. BACKDATING PRIOR AUTHORIZATION

Under normal circumstances, prior authorization must be obtained before services are performed to receive WMAP reimbursement for vision services. However, in the case of provider or recipient retroactive eligibility, or the provision of a service requiring prior authorization which was performed on an emergency basis, retroactive prior authorization may be obtained. Refer to Section VIII of Part A of the WMAP Provider Handbook for additional information on retroactive prior authorization.

Approved prior authorization requests for lenses or frames will be backdated to the date the requesting provider signs and dates the PA/RF.

The grant date for all other prior authorization requests will be no earlier than the date the request is received by EDS.

A. COORDINATION OF BENEFITS

The Wisconsin Medical Assistance Program (WMAP) is the payer of last resort for any service covered by the WMAP. If the recipient is covered under health insurance, the WMAP reimburses that portion of the allowable cost remaining after all other health insurance sources have been exhausted. Refer to Section IX of Part A of the WMAP Provider Handbook for more detailed information on services requiring health insurance billing, exceptions, and the "Other Coverage Discrepancy Report." Refer to the claim form completion instructions in Appendix 4 of this handbook for health insurance indicator codes.

B. MEDICARE/ MEDICAL ASSISTANCE DUAL ENTITLEMENT

Dual Entitlees

Recipients covered under both Medicare and Medical Assistance are referred to as dual-entitlees. Claims for Medicare-covered services provided to dual-entitlees must be billed to Medicare prior to billing Medical Assistance.

If the recipient has Medicare and Medicare has denied the service, a Medicare disclaimer code must be indicated on the claim. Refer to the claim form completion instructions in Appendix 4 of this handbook.

Billing for Medicare Noncovered Refractions

The refraction portion of a comprehensive vision exam is not paid by Medicare, nor can Medicare forward it to the WMAP for payment. However, refractive services for dual-entitlees which are not covered by Medicare are reimbursable by the WMAP.

In order to obtain Medical Assistance reimbursement for refractions for dual entitlees, providers must do the following:

- Complete and submit a claim to Medicare (using standard Medicare billing procedures) for the comprehensive exam; including the information necessary for all crossover claims. Medicare will cross over the claim to EDS for coinsurance and deductible;
- Complete and submit a HCFA 1500 claim form directly to EDS for Medicare noncovered refractive services;
- Indicate "M-8" ("Not a Medicare Benefit") in element 11 of the HCFA 1500 claim form; and
- Indicate procedure code 92015 in element 24D.

C. QMB-ONLY RECIPIENTS

Qualified Medicare Beneficiary-only (QMB-only) recipients are only eligible for WMAP payment of the coinsurance and deductible for Medicare-covered services. (Since Medicare covers some vision services, claims submitted for QMB-only recipients are reimbursed for Medicare-covered services.) Refer to Section V of Part A of the WMAP Provider Handbook for instructions on how to identify QMB-only recipients.

D. BILLED AMOUNTS

Providers must bill the WMAP their usual and customary charge for services provided, that charge being the amount charged by the provider for the same service when provided to private pay patients. For providers using a sliding fee scale for specific services, usual and customary means the median of the individual provider's charge for the service when provided to non-Medical Assistance patients. Providers may not discriminate against Medical Assistance recipients by charging a higher fee for the service than is charged to a private pay patient. Providers must bill for materials not covered under the State Purchase Eyeglass Contract (SPEC) at actual wholesale cost.

D. BILLED AMOUNTS (continued)

The billed amount should not be reduced by the amount of recipient copayment. The applicable copayment amount is automatically deducted from the payment allowed by the WMAP.

Providers should refer to Appendix 4 of this handbook for complete claim form completion instructions.

E. ORDERING THROUGH STATE PURCHASE EYEGLASS CONTRACT (SPEC)

Order Form Requirements
Order forms submitted to the SPEC contractor by mail or FAX must include:

- The date of order.
- The name, address, and eight-digit Medical Assistance provider number of the dispensing provider.
- The name, address, birthdate, sex, and complete 10-digit Medical Assistance identification number of the recipient.
- A copy of the approved prior authorization request form for all services requiring prior authorization.
- All other pertinent prescription detail.

Please make certain that all information is accurate and legible to ensure that orders are processed correctly and in a timely manner.

Ordering SPEC Frames or Temples
The name of the contracted frame or temple(s) must be specified on the order form submitted to the SPEC contractor.

Ordering SPEC Lenses
The complete lens formula of the contracted lenses must be specified on the order form submitted to the SPEC contractor.

Recipients must have a current Medical Assistance identification card for all orders submitted, including orders for replacement parts. The recipient must be eligible on the date of order. Orders may not be backdated prior to the date the recipient is seen by the dispensing provider.

All orders must be submitted to the SPEC contractor in writing or by FAX. No telephone orders are accepted. Order forms must be signed by the dispensing provider or an authorized representative.

Orders for managed care program enrollees should be handled according to the terms of the managed care program contract.

F. NON-CONTRACTED MATERIALS

Ordering Non-Contracted Lenses and Frames
All non-contracted materials require prior authorization. Orders for prior authorized non-contracted materials may be placed with any vendor of the provider's choice, and do not have to be obtained through the SPEC contractor. Refer to Appendices 2 and 3 of this handbook for a list of lenses and frames provided by the SPEC contractor.

Billing for Non-Contracted Lenses and Frames
Claims for non-contracted materials must indicate procedure codes V2799 ("non-contracted materials") or W8190 ("dispensing non-contracted materials, and other miscellaneous services") in element 24C of the HCFA 1500 claim form.

G. BILLING FOR EVALUATION AND MANAGEMENT PROCEDURE CODES AND CONSULTATIONS

Evaluation and Management Procedure Codes

Claims submitted by optometrists for the highest level evaluation and management procedure codes and unlisted medical procedures (92499) require documentation describing the procedure performed. All claims for these procedure codes must be submitted on paper claims. The provider must write "See Attached" in element 19 (Reserved for Local Use) of the HCFA 1500 claim form and attach additional documentation justifying the level of service billed. This documentation may be in the form of a history and physical exam report or medical progress notes. The documentation must be sufficient to allow the WMAP medical consultant to determine the procedure performed as well as the medical necessity of the procedure. Claims for these medical procedures which do not have sufficient documentation attached to the claim, or for which the documentation does not substantiate the complex level of medical practice being billed, are denied. Refer to Appendix 1 of this handbook for procedure codes requiring documentation.

Other Evaluation and Management Services

Evaluation and Management CPT procedure codes in the ranges 99201-99285 and 99301-99353 may be billed only when the patient encounter does not include a surgical procedure code. If a surgical procedure is performed, the provider is reimbursed on the basis of the procedure performed, not on the basis of an evaluation and management visit.

Consultations

Claims for consultations must indicate the referring physician's name in element 17, and the referring physician's UPIN number, WMAP provider number, or license number in element 17a of the HCFA 1500 claim form.

H. BILLING FOR PROCEDURES PRICED AT PRIOR AUTHORIZATION

Claims for procedures which are priced at prior authorization must be submitted on the HCFA 1500 claim form with:

- a quantity of "1" for each item; and
- the specific modifier from element 15 on the approved PA/RF on the claim form when billing for procedures which are assigned a modifier.

Refer to Section III of this handbook for information on procedures priced at prior authorization.

I. BILLING FOR UNLISTED PROCEDURE CODES

Claims for unlisted procedures (92499) require documentation describing the procedure performed. The provider may use element 19 (Reserved for Local Use) of the HCFA 1500 claim form, if the procedure can be clearly described in a few words. If this space is not sufficient, providers should write "See Attached" in element 19 and attach additional documentation. This documentation may be in the form of a history and physical exam report or medical progress notes. The documentation must be sufficient to allow the medical consultant to determine the procedure performed as well as the medical necessity of the procedure. Claims for unlisted medical procedures which do not have documentation either on the claim or attached to the claim are denied.

J. LABORATORY TESTS

Laboratory Tests

Optometrists and ophthalmologists may be reimbursed for laboratory tests billed as a "complete" procedure or for the professional component only. A complete lab test includes both the professional and technical components. A vision provider may not be reimbursed for the technical component of a laboratory test only.

J. LABORATORY TESTS (continued)

Laboratory Test Preparation and Handling Fees

If an optometrist or ophthalmologist performs both the professional and technical components of a laboratory test, the vision provider is reimbursed for the complete procedure. In this instance, a handling fee is not paid.

If a vision provider obtains a specimen and refers it to an outside laboratory for analysis or interpretation, the outside laboratory is reimbursed for the complete procedure. The vision provider may bill only for a handling fee using the handling fee procedure code.

Additional limitations on billing handling fees are:

1. One lab handling fee is paid per provider, per recipient, per outside laboratory, per date of service, regardless of the number of specimens sent to the laboratory. One handling fee is paid only when "yes" is indicated for outside laboratory in element 20 of the HCFA 1500 claim form.
2. When billing handling fees for specimens sent to two or more laboratories for one recipient on the same date of service, indicate the number of laboratories in the units field in element 24G and the total charges in element 24F of the HCFA 1500 claim form.
3. Claims for a lab handling fee which do not have "yes" checked for outside lab in element 20 of the HCFA 1500 claim form are denied.

Clinical interpretations of lab tests are not separately billable, since interpretations are reimbursed within the payment for the recipient's visit.

K. CLAIM SUBMISSION

Paperless Claim Submission

EDS encourages submission of claims on magnetic tape (tape-to-tape) or through telephone transmission via modem. Claims submitted electronically have the same legal requirements as claims submitted on paper and are subjected to the same processing requirements as paper claims. Claim processing statistics demonstrate that providers submitting electronically reduce their claim submission errors. Additional information on paperless claim submission is available by contacting the Electronic Media Claims (EMC) Department at:

EDS
Attn: EMC Department
6406 Bridge Road
Madison, WI 53784-0009
(608) 221-4746

Paper Claim Submission

Paper claims for vision care services must be submitted using the National HCFA 1500 claim form. A sample claim form and completion instructions can be found in Appendices 4 and 5 of this handbook.

Paper claims for vision care services submitted on any form other than the National HCFA 1500 claim form are denied.

The National HCFA 1500 claim form is not provided by the WMAP or EDS. It may be obtained from a number of forms suppliers. One such source is:

State Medical Society Services, Inc.
Post Office Box 1109
Madison, WI 53701

(608) 257-6781 (Madison area)
1-800-362-9080 (toll-free)

K. CLAIM SUBMISSION (continued)

Completed paper claims submitted for reimbursement must be mailed to the following address:

EDS
6406 Bridge Road
Madison, WI 53784-0002

Submission of Claims

All claims for services rendered to eligible WMAP recipients must be received by EDS within 365 days from the date the service was rendered. This policy applies to all initial claim submissions, resubmissions, and adjustment requests.

Exceptions to the claim submission deadline and requirements for submission to Late Billing appeals can be found in Section IX of Part A of the WMAP Provider Handbook.

L. DIAGNOSIS CODES

All diagnoses must be from the ICD-9-CM (International Classification of Diseases, 9th Edition, Clinical Modifications) coding structure.

Claims received without the appropriate ICD-9-CM code are denied.

The complete ICD-9-CM code book can be ordered by writing to the address listed in Appendix 3 of Part A of the WMAP Provider Handbook.

Providers should note the following diagnosis code restrictions:

- Codes with an "E" prefix must not be used as the primary or sole diagnosis on a claim submitted to the WMAP.
- Codes with an "M" prefix are not acceptable on a claim submitted to the WMAP.

Refer to Appendix 10 of this handbook for a listing of frequently used diagnosis codes for vision care services.

M. PROCEDURE CODES

HCFA Common Procedure Coding System (HCPCS) codes are required on all HCFA 1500 claims. Claims or adjustments received without HCPCS codes are denied. Allowable HCPCS codes, their descriptions and allowable modifiers for vision services are included in Appendix 1 of this handbook.

N. MODIFIERS

Procedure code modifiers may be used to indicate that a service or procedure has been modified by a specific circumstance relative to a procedure performed. A maximum of two valid modifiers may be used for each procedure code. Refer to Appendix 1 of this handbook for a list of allowable procedure codes and modifiers. Only those modifiers listed in this handbook are recognized by the WMAP for vision services. Refer to the Current Procedural Terminology, Fourth Edition (CPT-4) for a complete description of allowable modifiers.

O. FOLLOW-UP TO CLAIM SUBMISSION

It is the responsibility of the provider to initiate follow-up procedures on claims submitted to EDS. Processed claims appear on the Remittance and Status Report either as paid, pending, or denied. Providers are advised that EDS will take no further action on a denied claim until the information is corrected and the claim is resubmitted for processing. If a claim was paid incorrectly, the provider is responsible for submitting an Adjustment Request Form to EDS. Section X of Part A of the WMAP Provider Handbook includes detailed information regarding:

- the Remittance and Status Report
- adjustments to paid claims
- return of overpayments
- duplicate payments
- denied claims
- Good Faith claims filing procedures

VISION CARE PROVIDER HANDBOOK
APPENDICES

APPENDIX 1
VISION CARE SERVICES
PROCEDURE CODES AND COPAYMENT TABLE
(For Dates of Service On or After January 1, 1994)

Additional explanations of these codes and modifiers are contained in the CPT Procedure Code Book, which is available from the American Medical Association.

NOTE: Ophthalmologists may be reimbursed by the WMAP for all procedures with a single asterisk (*) indicated in this Appendix. Optometrists may be reimbursed for all procedures listed with a double asterisk (**) indicated. Only TPA-certified optometrists may be reimbursed for procedures requiring TPA certification. Opticians may be reimbursed only for procedures listed with a triple asterisk (***) pertaining to the dispensing and repair of eyeglasses.

Code	Description	Limitations	Copayment[1]
OFFICE OR OTHER OUTPATIENT SERVICES New Patient			
99201 TOS 1* TOS J**	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a problem focused history; a problem focused examination; and straightforward medical decision making	Once per recipient, per provider, per lifetime.	$1.00
99202 TOS 1* TOS J**	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and straightforward medical decision making	Once per recipient, per provider, per lifetime.	$1.00
99203 TOS 1* TOS J**	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of low complexity	Once per recipient, per provider, per lifetime.	$1.00
99204 TOS 1* TOS J**	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity	Once per recipient, per provider, per lifetime.	$2.00

Key: * Ophthalmologists are reimbursed for this procedure.
** Optometrists are reimbursed for this procedure (only TPA-certified optometrists are reimbursed for procedures requiring TPA certification).
*** Opticians are reimbursed for this procedure as it pertains to dispensing and repair of eyeglasses.

[1] Refer to Section I-C of this handbook for standard copayment exemptions.

Code	Description	Limitations	Copayment[1]
99205 TOS 1* TOS J**	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity	Once per recipient, per provider, per lifetime. Optometrists must submit documentation justifying the level of service when submitting a claim for this procedure code. Refer to Section IV-G of this handbook for instructions on claims submission.	$2.00
W8004 TOS J** *	Office visit, new patient; low vision	Once per recipient, per provider, per lifetime; prior authorization required.	$1.00
Established Patient			
99211 TOS 1* TOS J**	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician		$1.00
99212 TOS 1* TOS J**	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused history; a problem focused examination; straightforward medical decision making		$1.00
99213 TOS 1* TOS J**	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; and medical decision making of low complexity		$1.00
99214 TOS 1* TOS J**	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed history; a detailed examination; and medical decision making of moderate complexity		$1.00

Key: * Ophthalmologists are reimbursed for this procedure.
** Optometrists are reimbursed for this procedure (only TPA-certified optometrists are reimbursed for procedures requiring TPA certification).
*** Opticians are reimbursed for this procedure as it pertains to dispensing and repair of eyeglasses.

[1] Refer to Section I-C of this handbook for standard copayment exemptions.

Code	Description	Limitations	Copayment[1]
99215 TOS 1* TOS J**	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a comprehensive history; a comprehensive examination; and medical decision making of high complexity	Optometrists must submit documentation justifying the level of service when submitting a claim for this procedure code. Refer to Section IV-G of this handbook for instructions on claims submission.	$2.00
W8009 TOS J* TOS J**	Office visit, established patient; low vision	Prior authorization required.	$1.00
CONSULTATIONS			
99241 TOS J**	Office consultation for a new or established patient, which requires these three key components: a problem focused history; a problem focused examination; and straightforward medical decision making.	Referring physician information required on claim form.	$3.00
99242 TOS J**	Office consultation for a new or established patient, which requires these three key components: a problem focused history; a problem focused examiniation; and straightforward medical decision making.	Referring physician information required on claim form.	$3.00
99243 TOS J**	Office consultation for a new or established patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of low complexity.	Referring physician information required on claim form.	$3.00
99244 TOS J**	Office consultation for a new of established patient which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity.	Referring physician information required on claim form.	$3.00

Key: * Ophthalmologists are reimbursed for this procedure.
** Optometrists are reimbursed for this procedure (only TPA-certified optometrists are reimbursed for procedures requiring TPA certification).
*** Opticians are reimbursed for this procedure as it pertains to dispensing and repair of eyeglasses.

[1] Refer to Section I-C of this handbook for standard copayment exemptions.

Code	Description	Limitations	Copayment[1]
99245 TOS 3* TOS J**	Office consultation for a new or establihsed patient, which requires these three key components; a comprehensive history; a comprehensive examination; and medical decision making of high complexity.	Referring physician information required on claim form. Optometrists must submit documentation justifying the level of service when submitting a claim for this procedure code. Refer to Section IV-G of this handbook for instructions on claims submission.	$3.00
99251 TOS J**	Initial inpatient consultation for a new or establsihed patient, which requires these three key components: a problem focused history; a problem focused examination; and straightforward medical decision making.	Referring physician information required on claim form.	$3.00
99252 TOS J**	Initial inpatient consultation for a new or established patient, which requires these three components: a problem focused history; a problem focused examination; and straightforward medical decision making.	Referring physician information required on claim form.	$3.00
99253 TOS J**	Initial inpatient consultation for a new or established patient, which requires these three components: a detailed history; a detailed examination; and medical decision making of low capacity.	Referring physician information required on claim form.	$3.00
99254 TOS J**	Initial inpatient consultation for a new or established patient, which requires three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate complexity.	Referring physician information required on claim form.	$3.00
99255 TOS 3* TOS J**	Initial inpatient consultation for a new or established patient, which requires these three components; a comprehensive history; a comprehensive examination; and medical decision making of high complexity.	Referring physician information required on claim form. Optometrists must submit documentation justifying the level of service when submitting a claim for this procedure code. Refer to Section IV-G of this handbook for instructions on claims submission.	$3.00

Key:
* Ophthalmologists are reimbursed for this procedure.
** Optometrists are reimbursed for this procedure (only TPA-certified optometrists are reimbursed for procedures requiring TPA certification).
*** Opticians are reimbursed for this procedure as it pertains to dispensing and repair of eyeglasses.

[1] Refer to Section I-C of this handbook for standard copayment exemptions.

Code	Description	Limitations	Copayment[1]
99263 TOS 3* TOS J**	Follow-up inpatient consultation for an established patient which requires at least two of these three key components; a detailed interval history, a detailed examination; medical decision making of high complexity.	Referring physician information required on claim form. Optometrists must submit documentation justifying the level of service when submitting a claim for this procedure code. Refer to Section IV-G of this handbook for instructions on claims submission.	$3.00
99275 TOS 3* TOS J**	Confirmatory consultation for a patient, which requires these three key components; a comprehensive history; a comprehensive examination; and medical decision making of high complexity.	Referring physician information required on claim form. Optometrists must submit documentation justifying the level of service when submitting a claim for this procedure code. Refer to Section IV-G of this handbook for instructions on claims submission.	$3.00
HOME SERVICES New Patient			
99341 TOS 1* TOS J**	Home visit for the evaluation and management of a new patient, which requires these three key components: a problem focused history; a problem focused examination; and medical decision making that is straightforward or of low complexity	Once per recipient, per provider, per lifetime.	$1.00
99342 TOS 1* TOS J**	Home visit for the evaluation and management of a new patient, which requies these three key components: an expanded problem focused history; an expanded problem focused examination; and medical decision making of moderate complexity	Once per recipient, per provider, per lifetime.	$1.00
99343 TOS 1* TOS J**	Home visit for the evaluation and management of a new patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of high complexity	Optometrists must submit documentation justifying the level of service when submitting a claim for this procedure code. Refer to Section IV-G of this handbook for instructions on claims submission. Once per recipient, per provider, per lifetime.	$1.00

Key: * Ophthalmologists are reimbursed for this procedure.
** Optometrists are reimbursed for this procedure (only TPA-certified optometrists are reimbursed for procedures requiring TPA certification).
*** Opticians are reimbursed for this procedure as it pertains to dispensing and repair of eyeglasses.

[1] Refer to Section I-C of this handbook for standard copayment exemptions.

Code	Description	Limitations	Copayment[1]
Established Patient			
99351 TOS 1* TOS J**	Home visit for the evaluation and management of an established patient, which requires at least two of these three components: a problem focused interval history; a problem focused examination; and medical decision making that is straightforward or of low complexity		$1.00
99352 TOS 1* TOS J**	Home visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem focused interval history; an expanded problem focused examination; and medical decision making of moderate complexity		$1.00
99353 TOS 1* TOS J**	Home visit for the evaluation and management of an established patient, which requies at least two of these three key components: a detailed interval history; a detailed examination; and medical decision making of high complexity	Optometrists must submit documentation justifying the level of service when submitting a claim for this procedure code. Refer to Section IV-G of this handbook for instructions on claims submission.	$1.00
HOSPITAL INPATIENT SERVICES Initial Hospital Care (New and Established Patient)			
99221 TOS 1* TOS J*	Initial hospital care, per day, for the evaluation and management of a patient which requires these three key components: a comprehensive history, a comprehensive examination; and medical decision making that is straightforward or of low complexity		$3.00
99222 TOS 1* TOS J*	Initial hospital care, per day, for the evaluation and management of a patient which requires these three key components: a comprehensive history, a comprehensive examination; and medical decision making of moderate complexity		$3.00

Key: * Ophthalmologists are reimbursed for this procedure.
** Optometrists are reimbursed for this procedure (only TPA-certified optometrists are reimbursed for procedures requiring TPA certification).
*** Opticians are reimbursed for this procedure as it pertains to dispensing and repair of eyeglasses.

[1] Refer to Section I-C of this handbook for standard copayment exemptions.

Code	Description	Limitations	Copayment[1]
99223 TOS 1* TOS J*	Initial hospital care, per day, for the evaluation and management of a patient, which requires these three key compoennts: a comprehensive history; a comprehensive examination; and medical decision making of high complexity	Optometrists must submit documentation justifying the level of service when submitting a claim for this procedure code. Refer to Section IV-G of this handbook for instructions on claims submission.	$3.00
Subsequent Hospital Care			
99231 TOS 1* TOS J**	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: a problem focused interval history; a problem focused examination; and medical decision making that is straightforward or of low complexity		n/a
99232 TOS 1* TOS J**	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: an expanded problem focused interval history; an expanded problem focused examination; and medical decision making of moderate complexity		n/a
99233 TOS 1* TOS J**	Subsequent hosptial care, per day, for the evaluation and management of a patient, which requires at least two of these three key components: a detailed interval history; a detailed examination; medical decision making of high complexity	Optometrists must submit documentation justifying the level of service when submitting a claim for this procedure code. Refer to Section IV-G of this handbook for instructions on claims submission.	n/a
NURSING FACILITY SERVICES Comprehensive Nursing Facility Assessments (New or Established Patient)			
99301 TOS 1* TOS J**	Evaluation and management of a new or established patient involving an annual nursing facility assessment which requires these three components: a detailed interval history; a comprehensive evaluation; and medical decision making that is straightforward or of low complexity		n/a

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Key: * Ophthalmologists are reimbursed for this procedure.
** Optometrists are reimbursed for this procedure (only TPA-certified optometrists are reimbursed for procedures requiring TPA certification).
*** Opticians are reimbursed for this procedure as it pertains to dispensing and repair of eyeglasses.

[1] Refer to Section I-C of this handbook for standard copayment exemptions.

Code	Description	Limitations	Copayment[1]
99302 TOS 1* TOS J**	Evaluation and management of a new or established patient involving a nursing facility assessment which requires these three key components: a detailed interval history; a comprehensive evaluation; and medical decision making of moderate to high complexity		n/a
99303 TOS 1* TOS J**	Evaluation and management of a new or established patient involving a nursing facility assessment at the time of initial admission to the facility, which requires these three key components: a comprehensive history; a comprehensive examination; and medical decision making of moderate to high complexity	Optometrists must submit documentation justifying the level of service when submitting a claim for this procedure code. Refer to Section IV-G of this handbook for instructions on claims submission.	n/a
Subsequent Nursing Facility Care (New or Established Patient)			
99311 TOS 1* TOS J**	Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three components: a problem focused interval history; a problem focused examination; and medical decision making that is straightforward or of low complexity		n/a
99312 TOS 1* TOS J**	Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three components: an expanded problem focused interval history; an expanded problem focused examination; and medical decision making of moderate complexity		n/a
99313 TOS 1* TOS J**	Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three key components: a detailed interval history; a detailed examination; and medical decision making of moderate to high complexity	Optometrists must submit documentation justifying the level of service when submitting a claim for this procedure code. Refer to Section IV-G of this handbook for instructions on claims submission.	n/a

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Key: * Ophthalmologists are reimbursed for this procedure.
** Optometrists are reimbursed for this procedure (only TPA-certified optometrists are reimbursed for procedures requiring TPA certification).
*** Opticians are reimbursed for this procedure as it pertains to dispensing and repair of eyeglasses.

[1] Refer to Section I-C of this handbook for standard copayment exemptions.

Code	Description	Limitations	Copayment[1]
DOMICILIARY, REST HOME (e.g., BOARDING HOME), OR CUSTODIAL CARE SERVICES New Patient			
99321 TOS 1* TOS J**	Domiciliary or rest home visit for the evaluation and management of a new patient which requires these three key components: a problem focused history; a problem focused examination; and medical decision making that is straightforward or of low complexity	Once per recipient, per provider, per lifetime.	n/a
99322 TOS 1* TOS J**	Domiciliary or rest home visit for the evaluation and management of a new patient which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and medical decision making that is straightforward or of low complexity	Once per recipient, per provider, per lifetime.	n/a
99323 TOS 1* TOS J**	Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of high complexity	Optometrists must submit documentation justifying the level of service when submitting a claim for this procedure code. Refer to Section IV-G of this handbook for instructions on claims submission. Once per recipient, per provider, per lifetime.	n/a
Established Patient			
99331 TOS 1* TOS J**	Domiciliary of rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components: a problem focused interval history; a problem focused examination; and medical decision making that is straightforward or of low complexity		n/a

Key: * Ophthalmologists are reimbursed for this procedure.
** Optometrists are reimbursed for this procedure (only TPA-certified optometrists are reimbursed for procedures requiring TPA certification).
*** Opticians are reimbursed for this procedure as it pertains to dispensing and repair of eyeglasses.

[1] Refer to Section I-C of this handbook for standard copayment exemptions.

Code	Description	Limitations	Copayment[1]
99332 TOS 1* TOS J*	Domiciliary of rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem focused interval history; a expanded problem focused examination; and medical decision making that is straightforward of moderate complexity		
99333 TOS 1* TOS J**	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed interval history; a detailed examination; and medical decision making of high complexity	Optometrists must submit documentation justifying the level of service when submitting a claim for this procedure code. Refer to Section IV-G of this handbook for instructions on claims submission.	n/a
EMERGENCY DEPARTMENT SERVICES New or Established Patient			
99281 TOS 1* TOS J*	Emergency department visit for the evaluation and management of a patient, which requires these three key components: a problem focused history; a problem focused examination; and medical decision making that is straightforward		$1.00
99282 TOS 1* TOS J**	Emergency department visit for the evaluation and management of a patient, which requires these three key components: a problem focused history; a problem focused examination; and medical decision making that is straightforward		$1.00
99283 TOS 1* TOS J**	Emergency department visit for the evaluation and management of a patient, which requires these three key components: an expanded problem focused history; an expanded problem focused examination; and medical decision making of low to moderate complexity		$1.00

Key: * Ophthalmologists are reimbursed for this procedure.
** Optometrists are reimbursed for this procedure (only TPA-certified optometrists are reimbursed for procedures requiring TPA certification).
*** Opticians are reimbursed for this procedure as it pertains to dispensing and repair of eyeglasses.

[1] Refer to Section I-C of this handbook for standard copayment exemptions.

Code	Description	Limitations	Copayment[1]
99284 TOS 1* TOS J**	Emergency department visit for the evaluation and mangement of a patient, which requires these three key components: a detailed history; a detailed examination; and medical decision making of moderate complexity		$1.00
99285 TOS 1* TOS J**	Emergency department visit for the evaluation and management of a patient, which requires these three key components within the constraints imposed by the urgency of the patient';s clinical condition and mental status: a comprehensive history; a comprehensive examination; and medical decision making of high complexity	Optometrists must submit documentation justifying the level of service when submitting a claim for this procedure code. Refer to Section IV-G of this handbook for instructions on claims submission.	$1.00
GENERAL OPHTHALMOLOGICAL SERVICES New Patient			
92002 TOS 1* TOS J**	Ophthalmological services; medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient	Once per recipient, per provider, per lifetime.	$1.00
92004 TOS 1* TOS J**	Comprehensive, new patient, one or more visits	Once per recipient, per provider, per lifetime.	$2.00 (TOS J) $1.00 (TOS 1)
Established Patient			
92012 TOS 1* TOS J**	Ophthalmological services; medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient		$1.00
92014 TOS 1* TOS J**	Comprehensive, established patient, one or more visits	Prior authorization required for more than one per recipient, per provider, per 12-month period.	$1.00
SPECIAL OPHTHALMOLOGICAL SERVICES			
92020 TOS B* TOS J**	Gonioscopy with medical diagnostic evaluation (separate procedure)	Not separately reimbursable in conjunction with comprehensive or low vision office visits.	$1.00

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[1] Refer to Section I-C of this handbook for standard copayment exemptions.

Code	Description	Limitations	Copayment[1]
92060 TOS B* TOS J**	Sensorimotor examination with multiple measurements of ocular deviation and medical diagnostic evaluation (e.g., restrictive or paretic muscle with diplopia) (separate procedure)		n/a
92065 TOS B* TOS J**	Orthoptic and/or pleoptic training, with continuing medical direction and evaluation	Prior authorization required.	$1.00
92065-52 TOS B* TOS J**	Orthoptic and/or pleoptic training, with continuing medical direction and evaluation, reduced service	Prior authorization required.	$1.00
VISUAL FIELDS			
92081 TOS B* TOS J**	Visual field examination, unilateral or bilateral, with medical diagnostic evaluation; limited examination (e.g., tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)	Not separately reimbursable in conjunction with comprehensive or low vision office visits.	$1.00
92082 TOS B* TOS J**	Intermediate examination (e.g., at least two isopters on Goldmann perimeter, or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test; Octopus program 33)	Not separately reimbursable in conjunction with comprehensive or low vision office visits.	$.50
92083 TOS B* TOS J**	Extended examination (e.g., Goldmann visual fields with at least three isopters pltted and static determination within the central 30°, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)	Not separately reimbursable in conjunction with comprehensive or low vision office visits.	$.50
TONOMETRY/TONOGRAPHY			
92100 TOS 1* TOS J**	Serial tonometry (separate procedure) with multiple measurements of intraocular pressure over an extended time period with medical diagnostic evaluation, same day (e.g., diurnal curve or medical treatment of acute elevation of intraocular pressure)	Not separately reimbursable in conjunction with comprehensive or low vision office visits.	$.50

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Code	Description	Limitations	Copayment[1]
92120 TOS 1* TOS J**	Tonography with medical diagnostic evaluation, recording indentation tonometer method or perilimbal suction method	Not separately reimbursable in conjunction with comprehensive or low vision office visits.	$1.00
92130 TOS 1* TOS J**	Tonography with water provocation	Not separately reimbursable in conjunction with comprehensive or low vision office visits.	$1.00
92140 TOS 1* TOS J**	Provocative tests for glaucoma, with medical diagnostic evaluation, without tonography	Not separately reimbursable in conjunction with comprehensive or low vision office visits.	$1.00
OPHTHALMOSCOPY			
92225 TOS 1* TOS J**	Ophthalmoscopy, extended as for retinal detachment (may include use of contact lens, drawing or sketch, and/or fundus biomicroscopy), with medical diagnostic evaluation; initial	Not separately reimbursable in conjunction with comprehensive or low vision office visits.	$1.00
92226 TOS 1* TOS J**	Ophthalmoscopy, extended as for retinal detachment (may include use of contact lens, drawing or sketch, and/or fundus biomicroscopy), with medical diagnostic evaluation; subsequent	Not separately reimbursable in conjunction with comprehensive or low vision office visits.	$1.00
92250 92250-26 TOS 1* TOS J**	Ophthalmoscopy, with medical diagnostic evaluation; with fundus photography	Not separately reimbursable in conjunction with comprehensive or low vision office visits.	$1.00
92260 92260-26 TOS 1* TOS J**	Ophthalmoscopy, with medical diagnostic evaluation; with ophthalmodynamometry	Not separately reimbursable in conjunction with comprehensive or low vision office visits.	$1.00
92265 TOS B* TOS J**	Oculoelectromyography, one or more extraocular muscles, one or both eyes, with medical diagnostic evaluation.	Not separately reimbursable in conjunction with comprehensive or low vision office visits.	$1.00

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Code	Description	Limitations	Copayment[1]
ELECTRO-DIAGNOSTIC			
92270 TOS B* TOS J**	Electro-oculography, with medical diagnostic evaluation	Not separately reimbursable in conjunction with comprehensive or low vision office visits.	n/a
92280 92280-26 TOS B* TOS J**	Visually evoked potential (response) study, with medical diagnostic evaluation	Not separately reimbursable in conjunction with comprehensive or low vision office visits.	$1.00
OTHER SPECIALIZED SERVICES			
92283 92283-26 TOS B* TOS J**	Color vision examination, extended (e.g., anomaloscope or equivalent)	Not separately reimbursable in conjunction with comprehensive or low vision office visits.	$.50
92284 92284-26 TOS B* TOS J**	Dark adaptation examination, with medical diagnostic evaluation	Not separately reimbursable in conjunction with comprehensive or low vision office visits.	$1.00
92285 92285-26 TOS B* TOS J**	External ocular photography with medical diagnostic evaluation for documentation of medical progress (e.g., close-up photography, slit lamp photography, goniophotography, stereo-photography)	Not separately reimbursable in conjunction with comprehensive or low vision office visits.	$1.00
92286 92286-26 TOS B* TOS J**	Special anterior segment photography with medical diagnostic evaluation; with specular endothelial microscopy and cell count	Not separately reimbursable in conjunction with comprehensive or low vision office visits.	$1.00
W8000 TOS J* TOS J** TOS J***	Ptosis Crutch (fitting and supply)	Prior authorization is required. Priced at prior authorization.	$1.00
W8001 TOS 1* TOS J** TOS J***	Therapeutic "Bandage" Lens (fitting and supply)	Not separately reimbursable in conjunction with 99201-99215	$1.00

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[1] Refer to Section I-C of this handbook for standard copayment exemptions.

Code	Description	Limitations	Copayment[1]
CONTACT LENS AND THERAPY			
92310 TOS J* TOS J**	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens both eyes, except for aphakia	Prior authorization required.	$3.00
92310-52 TOS J* TOS J**	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens one eye, except for aphakia reduced service	Prior authorization required.	$3.00
92310-76 TOS J* TOS J**	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens both eyes, except for aphakia, repeat procedure by same physician	Prior authorization required.	$3.00
92311 TOS J* TOS J**	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, one eye		$3.00
92311-22 TOS J* TOS J**	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, one eye, unusual service		$3.00
92312 TOS J* TOS J**	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, both eyes		n/a
92312-22 TOS J* TOS J**	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, both eyes, unusual service		n/a
92312-52 TOS J* TOS J**	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, both eyes, reduced service		n/a

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Code	Description	Limitations	Copayment[1]
92312-76 TOS J* TOS J**	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, both eyes, repeat procedure by same physician		n/a
92326 TOS J* TOS J** TOS J***	Replacement of contact lens.	Prior authorization required unless provided for aphakia or keratoconus.	$3.00
92391 TOS J* TOS J** TOS J***	Supply of contact lenses, except prosthesis for aphakia (materials).	Prior authorization required unless provided for aphakia or keratoconus. Description required in the PA request indicating type of contact lenses being dispensed.	$3.00
OCULAR PROSTHESIS			
92330 TOS J* TOS J**	Prescription, fitting, and supply of ocular prosthesis (artificial eye), with medical supervision of adaptation		n/a
92393 TOS J* TOS J** TOS J***	Supply of ocular prosthesis (artificial eye)		n/a
V2624 TOS J* TOS J** TOS J***	Polishing/resurfacing of ocular prosthesis		$1.00
DISPENSING/REPAIR/MATERIALS			
92340 TOS J* TOS J** TOS J***	Fitting of spectacles, except for aphakia; monofocal		$3.00

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[1] Refer to Section I-C of this handbook for standard copayment exemptions.

Code	Description	Limitations	Copayment[1]
92341 TOS J* TOS J** TOS J***	Fitting of spectacles, except for aphakia; bifocal		$3.00
92342 TOS J* TOS J** TOS J***	Fitting of spectacles, except for aphakia; multifocal, other than bifocal		$3.00
92352 TOS J* TOS J** TOS J***	Fitting of spectacle prosthesis for aphakia; monofocal		$3.00
92353 TOS J* TOS J** TOS J***	Fitting of spectacle prosthesis for aphakia; multifocal		$3.00
W8191 TOS J* TOS J** TOS J***	Minor repair		$.50
W8525 TOS J* TOS J** TOS J***	Lens replacement, unifocal, dispensing fee		$2.00
V2118 TOS J* TOS J** TOS J***	Aniseikonic lens, single vision (materials)	Prior authorization required, priced at prior authorization	$1.00
V2799 TOS J* TOS J** TOS J***	Non-contracted materials	Prior authorization required, priced at prior authorization. A copy of the catalog page is required indicating materials dispensed and cost of item(s).	n/a

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[1] Refer to Section I-C of this handbook for standard copayment exemptions.

Code	Description	Limitations	Copayment[1]
W8520 TOS J* TOS J** TOS J***	Frame replacement, dispensing fee		$2.00
W8522 TOS J* TOS J** TOS J***	Temple replacement, dispensing fee		$2.00
W8190 TOS J* TOS J** TOS J***	Dispensing of non-contracted materials and other miscellaneous services	Prior authorization required, priced at prior authorization	n/a
W8112 TOS J* TOS J** TOS J***	Fitting of spectacles, changed prescription, complete appliance, single vision	A change in the lens prescription of more than +/-.50 diopter in the spherical or cylinder power must be documented in the recipient's medical record. The WMAP only reimburses one of these procedures, per provider, per recipient, per 12-month period.	$3.00
W8113 TOS J* TOS J** TOS J***	Fitting of spectacles, changed prescription, complete appliance, bifocal or multifocal		$3.00
W8523 TOS J* TOS J** TOS J***	Lens replacement, changed prescription, single vision, dispensing fee		$2.00
W8524 TOS J* TOS J** TOS J***	Lens replacement, changed prescription, bifocal or multifocal, dispensing fee		$2.00
LOW VISION SERVICES			
92354 TOS J* TOS J** TOS J***	Fitting of spectacle mounted low vision aid; single element system (dispensing fee)	Prior authorization required	$1.00

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[1] Refer to Section I-C of this handbook for standard copayment exemptions.

Code	Description	Limitations	Copayment[1]
92355 TOS J* TOS J** TOS J***	Fitting of spectacle mounted low vision aid; telescopic or other compound lens system (dispensing fee)	Prior authorization required	$1.00
V2600 TOS J* TOS J** TOS J***	Hand held low vision aids and other non-spectacle mounted aids (materials)	Prior authorization required, priced at prior authorization	$1.00
V2610 TOS J* TOS J** TOS J***	Single lens spectacle mounted low vision aids (materials)	Prior authorization required, priced at prior authorization	$1.00
V2615 TOS J* TOS J** TOS J***	Telescopic and other compound lens system, including distance vision telescopic, near vision telescopes and compound microscopic lens sytem (materials)	Prior authorization required, priced at prior authorization	$1.00
REFRACTION SERVICES (for crossover claims only)			
92015 TOS 1* TOS J**	Determination of refractive state		n/a
VESTIBULAR FUNCTION TESTS			
92531 TOS B* TOS J**	Spontaneous nystagmus, including gaze	Not separately reimbursable in conjunction with comprehensive or low vision office visits	$1.00
92532 TOS B* TOS J**	Postitional nystagmus	Not separately reimbursable in conjunction with comprehensive or low vision office visits	$1.00
92533 TOS B* TOS J**	Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes four tests)	Not separately reimbursable in conjunction with comprehensive or low vision office visits	$1.00

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[1] Refer to Section I-C of this handbook for standard copayment exemptions.

Code	Description	Limitations	Copayment[1]
92534 TOS B* TOS J**	Optokinetic nystagmus	Not separately reimbursable in conjunction with comprehensive or low vision office visits	$1.00
EYEBALL			
65205 TOS 2* TOS J**	Removal of foreign body, external eye; conjunctival superficial	Only allowable for ophthalmologists and TPA-certified optometrists	$3.00
65210 TOS 2* TOS J**	Conunctival embedded (includes concretions), subconunctival, or scleral nonperforating	Only allowable for ophthalmologists and TPA-certified optometrists	$3.00
65220 TOS 2* TOS J**	Corneal, without slit lamp	Only allowable for ophthalmologists and TPA-certified optometrists	$3.00
65222 TOS 2* TOS J**	Corneal, with slit lamp	Only allowable for ophthalmologists and TPA-certified optometrists	$3.00
ANTERIOR SEGMENT CORNEA			
65430 TOS 2* TOS J**	Scraping of cornea; diagnostic, for smear and/or culture	Only allowable for ophthalmologists and TPA-certified optometrists	$3.00
65435 TOS 2* TOS J**	Removal of corneal epithelium; with or without chemocauterization (abrasion, curettage)	Only allowable for ophthalmologists and TPA-certified optometrists	$3.00
65436 TOS 2* TOS J**	With application of chelating agent (e.g., EDTA)	Only allowable for ophthalmologists and TPA-certified optometrists	$3.00
OCULAR ADNEXA-EYELIDS			
67820 TOS 2* TOS J**	Correction of trichiasis; epilation, by forceps only		$3.00

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[1] Refer to Section I-C of this handbook for standard copayment exemptions.

Code	Description	Limitations	Copayment[1]
67825 TOS 2* TOS J**	Epilation (e.g., by electrosurgery or cryotherapy)		$3.00
67938 TOS 2* TOS J**	Removal of embedded foreign body, eyelid	Only allowable for ophthalmologists and TPA-certified optometrists	$3.00
OCULAR ADNEXA-LACRIMAL SYSTEM			
68800 TOS 2* TOS J**	Dilation of lacrimal punctum, with or without irrigation, unilateral or bilateral	Only allowable for ophthalmologists and TPA-certified optometrists	$3.00
68820 TOS 2* TOS J**	Probing of nasolacrimal duct, with or without irrigation, unilateral or bilateral	Only allowable for ophthalmologists and TPA-certified optometrists	$3.00
68840 TOS 2* TOS J**	Probing of lacrimal canaliculi, with or without irrigation	Only allowable for ophthalmologists and TPA-certified optometrists	$3.00
OPHTHALMIC ULTRASOUND			
76511 76511-26 TOS 4* TOS Q* TOS J**	Ophthalmic ultrasound, echography diagnostic; A-scan only, with amplitude quantification	Not separately reimbursable in conjunction with comprehensive or low vision office visits	$1.00
76512 76512-26 TOS 4* TOS Q* TOS J**	Contact B-scan (with or without simultaneous A-scan)	Not separately reimbursable in conjunction with comprehensive or low vision office visits	$1.00
76516 76516-26 TOS 4* TOS Q* TOS J**	Ophthalmic biometry by ultrasound echography, A-scan	Not separately reimbursable in conjunction with comprehensive or low vision office visits	$1.00

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Code	Description	Limitations	Copayment[1]
76519 76519-26 TOS 4* TOS Q* TOS J**	With intraocular lens power calculation	Not separately reimbursable in conjunction with comprehensive or low vision office visits	$1.00
76529 76529-26 TOS 4* TOS Q* TOS J**	Ophthalmic ultrasonic foreign body localization	Not separately reimbursable in conjunction with comprehensive or low vision office visits	$1.00
92499 TOS J* TOS J**	Unlisted ophthalmological service or procedure	Description required of the service(s) or procedure(s) provided.	n/a
MISCELLANEOUS SERVICES			
99000 TOS 1* TOS J**	Laboratory handling fee	Only allowable for ophthalmologists and TPA-certified optometrists	n/a

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APPENDIX 2
LENSES AVAILABLE THROUGH THE WISCONSIN MEDICAL ASSISTANCE STATE PURCHASE EYEGLASS CONTRACT

Single Vision

Minus Cylinder Corrected Curve

Bifocals

Flattop
Round Top
One Piece Flattop (Executive Style)

Trifocals

Flattop
One Piece Flattop (Executive Style)

Cataract Lenses

Full Field Aspheric
- Single Vision
- Bifocal
  - Round Segment
  - Straight Top

Lenticular Aspheric
- Single Vision
- Bifocal
  - Round Segment
  - Straight Top

Non-Aspheric Lenticular
- Single Vision
- Bifocal
  - Round Segment
  - Straight Top

Lens Components in Addition to Lens Formula

Extra Thick Blanks
High Index Glass or Plastic*
Large Blanks (59 mm eye size & over)*
Myodisc
Photochromic (Photograys, etc.*)
Special Base Curve
Cylinders 3.25 to 6.00D
Cylinders 6.25 and above
Prism
Tinted Eyeglass lenses (rose tints 1 and 2)*
Polycarbonate Lenses**
Slab Off Prism
Ultraviolet Protective Coating*
Minus over 20.00D (add to 12.25 to 20.00D)

* These items require prior authorization before ordering from the SPEC contractor.
** This item requires prior authorization for recipients age 21 and over.

APPENDIX 3
FRAMES AVAILABLE THROUGH STATE PURCHASE EYEGLASS CONTRACT

Womens' Frames
RO 204 (Rochester)
RO 604 (Rochester)
RO 151 (Rochester)
Mainstreet 220 (Hart Spec.)
Jenny (Hart Spec.)
RO 275 (Rochester)
Justafit 3 (Pathway)
Boulevard 3112 (Hart Spec.)
Mainstreet 962 (Hart Spec.)

Girl's Frames
Mainstreet 401 (Hart Spec.)
Mainstreet 403 (Hart Spec.)
Jenny (Hart Spec.)
Justa-Fit 4 (Pathway)
Mainstreet 229 (Hart Spec.)
Mainstreet 885 (Hart Spec.)
Boulevard 3115 (Hart Spec.)

Infant's Frames
Teddy Bear (Tart)

Unisex Half-Eye
Mainstreet Looker

Men's Frames
Passport 14 (Artcraft)
RO 401 (Rochester)
RO 524 (Rochester)
Mainstreet 106 (Hart Spec.)
Boulevard 1003 (Hart Spec.)
Mainstreet 302 (Hart Spec.)
Mainstreet 859 (Hart Spec.)
Boulevard 1015 (Hart Spec.)

Boy's Frames
Boulevard 3013 (Hart Spec.)
Skipper (Tart)
Mainstreet 304 (Hart Spec.)
Baby (Hart Spec.)
RO 200 (Rochester)
Starwalker Combination (Martin-Copeland)
Mainstreet 302 (spring hinge) (Hart Spec.)

Occupational Frames
SP 83

APPENDIX 4

NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS FOR VISION SERVICES
(For Claims Received on or after January 4, 1993)

To avoid denial or inaccurate claim payment, providers must use the following claim form completion instructions. Enter all required data on the claim form in the appropriate element. Do not include attachments unless instructed to do so. All elements are required unless "not required" is specified.

Wisconsin Medical Assistance recipients receive a Medical Assistance identification card upon initial enrollment into the Wisconsin Medical Assistance Program (WMAP) and at the beginning of each month thereafter. Providers should always see this card before rendering services. Please use the information exactly as it appears on the Medical Assistance identification card to complete the patient and insured information.

ELEMENT 1 - Program Block/Claim Sort Indicator
Enter the claim sort indicator in the Medicaid check box. Enter claim sort indicator "P" for ophthalmologist for diagnostic services. Enter "V" for an ophthalmologist when billing for services related to materials, dispensing and repair, or for any service by an optometrist or optician. Claims submitted without this indicator are denied.

ELEMENT 1a - INSURED'S I.D. NUMBER
Enter the recipient's 10-digit Medical Assistance identification number as found on the current Medical Assistance identification card. This element must contain no other numbers, unless the claim is a Medicare crossover claim, in which case the recipient's Medicare number may also be indicated.

ELEMENT 2 - PATIENT'S NAME
Enter the recipient's last name, first name, and middle initial as it appears on the current Medical Assistance identification card.

NOTE: A provider may submit claims for an infant if the infant is 10 days old or less on the date of service and the mother of the infant is a Medical Assistance recipient. To bill for an infant using the mother's Medical Assistance identification number, enter the mother's last name followed by "Newborn" in element 2. Enter the infant's date of birth in element 3. In element 4, enter the mother's name followed by "Mom" in parentheses. Finally, in element 1A enter the mother's 10-digit Medical Assistance identification number.

ELEMENT 3 - PATIENT'S BIRTH DATE, PATIENT'S SEX
Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) as it appears on the Medical Assistance identification card. Specify if male or female with an "X."

ELEMENT 4 - INSURED'S NAME (not required)

ELEMENT 5 - PATIENT'S ADDRESS
Enter the complete address of the recipient's place of residence.

ELEMENT 6 - PATIENT RELATIONSHIP TO INSURED (not required)

ELEMENT 7 - INSURED'S ADDRESS (not required)

ELEMENT 8 - PATIENT STATUS (not required)

ELEMENT 9 - OTHER INSURED'S NAME

Third-party insurance (commercial insurance coverage) must be billed prior to billing the WMAP, unless the service does not require third-party billing according to Appendix 18a of Part A of the WMAP Provider Handbook.

- When the provider has not billed other insurance because the "Other Coverage" of the recipient's Medical Assistance identification card is blank, or the service does not require third party billing according to Appendix 18a of Part A of the WMAP Provider Handbook, the recipient's Medical Assistance identification card indicates "DEN" only, this element must be left blank.

- When "Other Coverage" of the recipient's Medical Assistance identification card indicates HPP, BLU, WPS, CHA, or OTH, and the service requires third party billing according to Appendix 18a of Part A of the WMAP Provider Handbook, one of the following codes MUST be indicated in the first box of element 9. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.)

Code	Description
OI-P	PAID in part by other insurance. The amount paid by private insurance to the provider or the insured is indicated on the claim.
OI-D	DENIED by private insurance following submission of a correct and complete claim or payment was applied towards the coinsurance and deductible. DO NOT use this code unless the claim in question was actually billed to and denied by the private insurer.
OI-Y	YES, card indicates other coverage but it was not billed because for reasons including, but not limited to: - Recipient denies coverage or will not cooperate; - The provider knows the service in question is noncovered by the carrier; - Insurance failed to respond to initial and follow-up claim; or - Benefits not assignable or cannot get an assignment.

- When "Other Coverage" of the recipient's Medical Assistance identification card indicates "HMO" or "HMP", one of the following disclaimer codes must be indicated, if applicable:

Code	Description
OI-P	PAID by HMO or HMP. The amount paid is indicated on the claim.
OI-H	HMO or HMP does not cover this service or the billed amount does not exceed the coinsurance or deductible amount.

Important Note: The provider may not use OI-H if the HMO or HMP denied payment because an otherwise covered service was not rendered by a designated provider. Services provided by an HMO or HMP are not reimbursable by the WMAP except for the copayment and deductible amounts. Providers who receive a capitation payment from the HMO may not bill the WMAP for services which are included in the capitation payment.

ELEMENT 10 - IS PATIENT'S CONDITION RELATED TO (not required)

ELEMENT 11 - INSURED'S POLICY, GROUP OR FECA NUMBER
The first box of this element is used by the WMAP for Medicare information. (Elements 11a, 11b, 11c, and 11d are not required.) Medicare must be billed prior to billing to the WMAP. When the recipient's Medical Assistance identification card indicates Medicare coverage, but Medicare does not allow any charges, one of the following Medicare disclaimer codes MUST be indicated. The description is not required.

Code	Description
M-1	Medicare benefits exhausted. This disclaimer code may be used by hospitals, nursing homes, and home health agencies when Medicare has made payment up to the lifetime limits of its coverage.
M-5	Provider not Medicare certified for the benefits provided.
M-6	Recipient not Medicare eligible.
M-7	Medicare disallowed (denied) payment. Medicare claim cannot be corrected and resubmitted.
M-8	Medicare was not billed because Medicare never covers this service.

If Medicare is not billed because the recipient's Medical Assistance identification card indicated no Medicare coverage, this element must be left blank.

If Medicare allows an amount on the recipient's claim, the Explanation of Medicare Benefits (EOMB) must be attached to the claim and this element must be left blank. Do not enter Medicare paid amounts on the claim form. Refer to Appendix 17 of Part A of the WMAP Provider Handbook for further information regarding the submission of claims for dual entitlees.

ELEMENTS 12 AND 13 - AUTHORIZED PERSON'S SIGNATURE
(Not required since the provider automatically accepts assignment through Medical Assistance certification.)

ELEMENT 14 - DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (not required)

ELEMENT 15 - IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS (not required)

ELEMENT 16 - DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (not required)

ELEMENT 17 - NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
When required, enter the referring or prescribing physician's name.

ELEMENT 17a - I.D. NUMBER OF REFERRING PHYSICIAN
When required, enter the referring provider's six-character UPIN number. If the UPIN number is not available, enter the WMAP provider number or license number of the referring provider.

ELEMENT 18 - HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (not required)

ELEMENT 19 - RESERVED FOR LOCAL USE
If an unlisted procedure code is billed, providers must describe the procedure. If there is not enough space for the description, or if multiple unlisted procedure codes are being billed, providers must attach documentation to the claim describing the procedure(s). In this instance, providers must indicate "See Attachment" in element 19.

ELEMENT 20 - OUTSIDE LAB
If laboratory services are billed, check either "yes" or "no" to indicate whether an outside lab was used.

ELEMENT 21 - DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
The International Classification of Disease, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis code must be entered for each symptom or condition related to the services provided. Manifestation ("M") codes are not acceptable. List the primary diagnosis first. Etiology ("E") codes may not be used as a primary diagnosis. The diagnosis description is not required.

ELEMENT 22 - MEDICAID RESUBMISSION (not required)

ELEMENT 23 - PRIOR AUTHORIZATION
Enter the seven-digit prior authorization number from the approved prior authorization request form. Services authorized under multiple prior authorizations must be billed on separate claim forms with their respective prior authorization numbers.

ELEMENT 24A - DATE(S) OF SERVICE
Enter the month, day, and year for each procedure using the following guidelines:

- When billing for one date of service, enter the date in MM/DD/YY format in the "From" field.
- When billing for two, three, or four dates of service on the same line, enter the first date of service in MM/DD/YY format in the "From" field, and subsequent dates of service in the "To" field by listing only the date(s) of the month (i.e., DD, DD/DD, or DD/DD/DD)

It is allowable to enter up to four dates of service per line if:

- All dates of service are in the same calendar month.
- All services are billed using the same procedure code and modifier, if applicable.
- All procedures have the same type of service code.
- All procedures have the same place of service code.
- All procedures were performed by the same provider.
- The same diagnosis is applicable for each procedure.
- The charge for all procedures is identical. (Enter the total charge per detail line in element 24F.)
- The number of services performed on each date of service is identical.
- All procedures have the same HealthCheck or family planning indicator.
- All procedures have the same emergency indicator.

ELEMENT 24B - PLACE OF SERVICE
Enter the appropriate WMAP single-digit place of service code for each service. Refer to Appendix 11 of this handbook for a list of allowable place of service codes for vision providers.

ELEMENT 24C - TYPE OF SERVICE CODE
Enter the appropriate single-digit type of service code. Refer to Appendix 11 of this handbook for a list of allowable type of service codes for vision providers.

ELEMENT 24D - PROCEDURES, SERVICES, OR SUPPLIES
Enter the appropriate five-character procedure code and, if applicable, a maximum of two, two-character modifiers under the "Modifier" column. Refer to Appendix 1 of this handbook for a list of allowable procedure codes for vision providers.

ELEMENT 24E - DIAGNOSIS CODE
When multiple procedures related to different diagnoses are submitted, column E must be used to relate the procedure performed (element 24D) to a specific diagnosis in element 21. Enter the number (1, 2, 3, or 4) which corresponds to the appropriate diagnosis in element 21.

ELEMENT 24F - CHARGES
Enter the total charge for each line.

ELEMENT 24G - DAYS OR UNITS
Enter the total number of services billed for each line. A decimal must be indicated when a fraction of a whole unit is billed.

ELEMENT 24H - EPSDT/FAMILY PLANNING
Enter an "H" for each procedure that was performed as a result of a HealthCheck (EPSDT) referral. Enter an "F" for each family planning procedure. Enter "B" if BOTH HealthCheck and family planning services were provided. If HealthCheck or family planning does not apply, leave this element blank.

ELEMENT 24I - EMG
Enter an "E" for each procedure performed as an emergency, regardless of the place of service. If the procedure is not an emergency, leave this element blank.

ELEMENT 24J - COB (not required)

ELEMENT 24K - RESERVED FOR LOCAL USE
Enter the eight-digit, Medical Assistance provider number of the performing provider for each procedure, if it is different than the billing provider number indicated in element 33.

When applicable, enter the word "spenddown" and under it, the spenddown amount on the last detail line of element 24K directly above element 30. Refer to Section IX of Part A of the WMAP Provider Handbook for information on recipient spenddown.

Any other information entered in this column may cause claim denial.

ELEMENT 25 - FEDERAL TAX ID NUMBER (not required)

ELEMENT 26 - PATIENT'S ACCOUNT NO.
Optional - provider may enter up to 12 characters of the patient's internal office account number. This number will appear on the EDS Remittance and Status Report.

ELEMENT 27 - ACCEPT ASSIGNMENT
(Not required, provider automatically accepts assignment through Medical Assistance certification.)

ELEMENT 28 - TOTAL CHARGE
Enter the total charges for this claim.

ELEMENT 29 - AMOUNT PAID
Enter the amount paid by other insurance. If the other insurance denied the claim, enter $0.00. (If a dollar amount is indicated in element 29, "OI-P" must be indicated in element 9.)

ELEMENT 30 - BALANCE DUE
Enter the balance due as determined by subtracting the recipient spenddown amount in element 24K and the amount paid in element 29 from the amount in element 28.

ELEMENT 31 - SIGNATURE OF PHYSICIAN OR SUPPLIER
The provider or the authorized representative must sign in element 31. The month, day, and year the form is signed must also be entered in MM/DD/YY format.

NOTE: This may be a computer-printed or typed name and date, or a signature stamp with the date.

ELEMENT 32 - NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED
If the services were provided to a recipient in a nursing home (place of service 7 or 8), indicate the nursing home's eight-digit Medical Assistance provider number.

ELEMENT 33 - PHYSICIAN'S, SUPPLIERS BILLING NAME, ADDRESS, ZIP CODE AND PHONE #
Enter the provider's name (exactly as indicated on the provider's notification of certification letter) and address of the billing provider. At the bottom of element 33, enter the billing provider's eight-digit Medical Assistance provider number.

APPENDIX 5
NATIONAL HCFA 1500 CLAIM FORM SAMPLE

PICA — **HEALTH INSURANCE CLAIM FORM** — PICA

CARRIER

PATIENT AND INSURED INFORMATION

1 MEDICARE (Medicare #) [ ] MEDICAID (Medicaid #) [ ] CHAMPUS (Sponsor's SSN) [ ] CHAMPVA (VA File #) [ ] GROUP HEALTH PLAN (SSN or ID) [ ] FECA BLK LUNG (SSN) [ ] OTHER (ID) [ ]			1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890
2 PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Ima A	3 PATIENT'S BIRTH DATE MM DD YY: MM DD YY — SEX: M [ ] F [X]		4 INSURED'S NAME (Last Name, First Name, Middle Initial):
5 PATIENT'S ADDRESS (No., Street): 609 Willow St.	6 PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]		7. INSURED'S ADDRESS (No., Street):
CITY: Anytown — STATE: WI	8 PATIENT STATUS: Single [ ] Married [ ] Other [ ]		CITY: — STATE:
ZIP CODE: 55555 — TELEPHONE (Include Area Code): (XXX) XXX-XXXX	Employed [ ] Full-Time Student [ ] Part-Time Student [ ]		ZIP CODE: — TELEPHONE (INCLUDE AREA CODE): ( )
9 OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): OI-P	10 IS PATIENT'S CONDITION RELATED TO:		11 INSURED'S POLICY GROUP OR FECA NUMBER: M-8
a. OTHER INSURED'S POLICY OR GROUP NUMBER:	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [ ]		a. INSURED'S DATE OF BIRTH MM DD YY — SEX: M [ ] F [ ]
b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX: M [ ] F [ ]	b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State):		b. EMPLOYER'S NAME OR SCHOOL NAME:
c. EMPLOYER'S NAME OR SCHOOL NAME:	c. OTHER ACCIDENT? YES [ ] NO [ ]		c. INSURANCE PLAN NAME OR PROGRAM NAME:
d. INSURANCE PLAN NAME OR PROGRAM NAME:	10d. RESERVED FOR LOCAL USE		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED _____

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM — TO
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: I.M. Referring	17a. I.D. NUMBER OF REFERRING PHYSICIAN: 76543210	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM — TO
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE): 1. 365.9 2. 3. 4.		22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO 23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24 A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 01 02 92		3	J	99213		1	XX XX	1				87654321
2 01 02 92		3	J	92083		1	XX XX	2				87654321
3 01 02 92		3	J	92100		1	XX XX	2				87654321
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER — SSN [ ] EIN [ ]	26. PATIENT'S ACCOUNT NO.: 1234JED	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]	28. TOTAL CHARGE: $ XX XX — 29. AMOUNT PAID: $ XX XX — 30. BALANCE DUE: $ XX XX
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.): I.M. Authorized — MM/DD/YY — SIGNED — DATE	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office):		33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #: I.M. Billing, 1 W. Williams, Anytown, WI 55555 — PIN# — GRP# 65432109

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) — ***PLEASE PRINT OR TYPE*** — FORM HCFA-1500 (U2) (12-90) FORM OWCP-1500 FORM RRB-1500

APPENDIX 6
INSTRUCTIONS FOR THE COMPLETION OF THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF) FOR VISION SERVICES

ELEMENT 1 - PROCESSING TYPE
Enter the three-digit processing type 122 (vision).

ELEMENT 2 - RECIPIENT'S MEDICAL ASSISTANCE IDENTIFICATION NUMBER
Enter the recipient's 10-digit Medical Assistance identification number as found on the recipient's Medical Assistance identification card.

ELEMENT 3 - RECIPIENT'S NAME
Enter the recipient's last name, followed by first name and middle initial, exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 4 - RECIPIENT'S ADDRESS
Enter the address of the recipient's place of residence; the street, city, state, and zip code must be included. If the recipient is a resident of a nursing home or other facility, also include the name of the nursing home or facility.

ELEMENT 5 - RECIPIENT'S DATE OF BIRTH
Enter the recipient's date of birth in MM/DD/YY format (e.g., June 8, 1941, would be 06/08/41), as it appears on the recipient's Medical Assistance identification card.

ELEMENT 6 - RECIPIENT'S SEX
Enter an "X" to specify male or female.

ELEMENT 7 - BILLING PROVIDER'S NAME, ADDRESS AND ZIP CODE
Enter the name and complete address (street, city, state, and zip code) of the billing provider. No other information should be entered in this element since it also serves as a return mailing label.

ELEMENT 8 - BILLING PROVIDER'S TELEPHONE NUMBER
Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the billing provider.

ELEMENT 9 - BILLING PROVIDER'S MEDICAL ASSISTANCE PROVIDER NUMBER
Enter the eight-digit Medical Assistance provider number of the billing provider.

ELEMENT 10 - RECIPIENT'S PRIMARY DIAGNOSIS
Enter the appropriate International Classification of Disease, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis code and description most relevant to the service/procedure requested. A diagnosis of V53.1 cannot be used as the primary or sole diagnosis.

ELEMENT 11 - RECIPIENT'S SECONDARY DIAGNOSIS
Enter the appropriate ICD-9-CM diagnosis code and description additionally descriptive of the recipient's clinical condition.

ELEMENT 12 - START DATE OF SPELL OF ILLNESS (not required)

ELEMENT 13 - FIRST DATE OF TREATMENT (not required)

ELEMENT 14 - PROCEDURE CODE(S)
Enter the appropriate HCPCS procedure code for each service/procedure/item requested, in this element.

ELEMENT 15 - MODIFIER
Enter the modifier corresponding to the procedure code (if a modifier is required by Wisconsin Medical Assistance Program [WMAP] policy and the coding structure used) for each service/procedure/item requested.

ELEMENT 16 - PLACE OF SERVICE
Enter the appropriate place of service code designating where the requested service/procedure/item would be provided/performed/dispensed. Refer to Appendix 11 for allowable place of service codes.

ELEMENT 17 - TYPE OF SERVICE
Enter the appropriate type of service code for each service/procedure/item requested. Refer to Appendix 11 for allowable type of service codes.

ELEMENT 18 - DESCRIPTION OF SERVICE
Enter a written description corresponding to the appropriate HCPCS procedure code for each service/procedure/item requested.

ELEMENT 19 - QUANTITY OF SERVICE REQUESTED
Enter the quantity (e.g., number of services, dollar amount) requested for each service/procedure/item requested.

ELEMENT 20 - CHARGES
Enter your usual and customary charge for each service/procedure/item requested. If the quantity is greater than "1", multiply the quantity by the charge for each service/procedure/item requested. Enter that total amount in this element.

> **NOTE:**
> The charges indicated on the request form should reflect the provider's usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to Terms of Provider Reimbursement issued by the Department of Health and Social Services.

ELEMENT 21 - TOTAL CHARGE
Enter the anticipated total charge for this request.

ELEMENT 22 - BILLING CLAIM PAYMENT CLARIFICATION STATEMENT
An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration. Reimbursement will be in accordance with WMAP payment methodology and policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

ELEMENT 23 - DATE
Enter the month, day, and year (in MM/DD/YY format) the prior authorization request form was completed and signed.

ELEMENT 24 - REQUESTING PROVIDER'S SIGNATURE
The signature of the provider requesting/performing/dispensing the service/procedure/item must appear in this element.

DO NOT ENTER ANY INFORMATION BELOW THE SIGNATURE OF THE REQUESTING PROVIDER - - THIS SPACE IS RESERVED FOR THE WISCONSIN MEDICAL ASSISTANCE PROGRAM CONSULTANT(S) AND ANALYST(S).

APPENDIX 7
PRIOR AUTHORIZATION REQUEST FORM

MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM
PA/RF (DO NOT WRITE IN THIS SPACE)
ICN #
A.T. #
P.A. # 1234567

1 PROCESSING TYPE: 122

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER: 1234567890

3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL): Recipient, Ima A.

4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE): 609 Willow, Anytown, WI 55555

5 DATE OF BIRTH: MM/DD/YY

6 SEX: M [ ] F [X]

8 BILLING PROVIDER TELEPHONE NUMBER: (XXX) XXX-XXXX

7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE:
I.M. Provider O.D.
1 W. Williams
Anytown, WI 55555

9 BILLING PROVIDER NO.: 87654321

10 DX: PRIMARY: 366.9 Cataract

11 DX: SECONDARY: 368.13 Photophobia

12 START DATE OF SOI:

13 FIRST DATE RX:

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 QR	20 CHARGES
W8110		3	J	Photochromic Lenses	1	LAB
					TOTAL CHARGE	21 LAB

22. An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

23 MM/DD/YY (DATE)

24 I. M. Provider, O. D. (REQUESTING PROVIDER SIGNATURE)

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

[ ] APPROVED — GRANT DATE — EXPIRATION DATE — PROCEDURE(S) AUTHORIZED — QUANTITY AUTHORIZED

[ ] MODIFIED – REASON:

[ ] DENIED – REASON:

[ ] RETURN – REASON:

DATE — CONSULTANT/ANALYST SIGNATURE

482-120

APPENDIX 8
INSTRUCTIONS FOR THE COMPLETION OF THE PRIOR AUTHORIZATION VISION ATTACHMENT (PA/VA)

The timely determination of authorization is significantly enhanced by the completeness and quality of the documentation submitted by providers when requesting prior authorization. Carefully complete the Prior Authorization Vision Attachment (PA/VA) form, attach it to the Prior Authorization Request Form (PA/RF), and submit to the following address:

EDS
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

Questions regarding completion of the PA/RF and/or the PA/VA may be addressed to the EDS Telephone/ Written Correspondence Unit.

RECIPIENT INFORMATION:

ELEMENT 1 - RECIPIENT'S LAST NAME
Enter the recipient's last name exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 2 - RECIPIENTS' FIRST NAME
Enter the recipient's first name exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 3 - RECIPIENT'S MIDDLE INITIAL
Enter the recipient's middle initial exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 4 - RECIPIENT'S MEDICAL ASSISTANCE IDENTIFICATION NUMBER
Enter the recipient's 10-digit Medical Assistance identification number exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 5 - RECIPIENT'S NUMERICAL AGE
Enter the age of the recipient in numerical form (e.g., 45, 60, 21).

PROVIDER INFORMATION:

ELEMENT 6 - REFERRING/PRESCRIBING PROVIDER'S NAME
Enter the name of the referring/prescribing provider, if available.

ELEMENT 7 - REFERRING/PRESCRIBING PROVIDER'S MEDICAL ASSISTANCE PROVIDER NUMBER
Enter the eight-digit Medical Assistance provider number of the referring/prescribing provider, if available.

ELEMENT 8 - PERFORMING/DISPENSING PROVIDER'S TELEPHONE NUMBER
Enter the telephone number, including area code of the provider providing/dispensing the service/item.

The remaining portions of this attachment are to be used to document the justification for the requested service/procedure.

1. Complete elements A through D, which are pertinent to the request.

2. Lens formula information is required for all requests for frames or lenses (Element A).

3. All requests for tints must include specific documentation of visual or medical necessity from the prescribing provider.

4. Specify the type of contacts prescribed.

5. Date and sign the attachment (Element E).

APPENDIX 9

PRIOR AUTHORIZATION VISION SERVICES ATTACHMENT (PA/VA)

Mail To:

E.D.S. FEDERAL CORPORATION
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

PA/VA

PRIOR AUTHORIZATION VISION SERVICES ATTACHMENT

1. Complete this form
2. Attach to PA/RF (Prior Authorization Request Form)
3. Mail to EDS

RECIPIENT INFORMATION

1	2	3	4	5
Recipient	Ima	A	1234567890	65
LAST NAME	FIRST NAME	MIDDLE INITIAL	MEDICAL ASSISTANCE ID NUMBER	AGE

PROVIDER INFORMATION

6	7	8
I.M. Provider, O.D.	88888888	(XXX) XXX . XXXX
REFERRING/PRESCRIBING PROVIDER'S NAME	REFERRING/PRESCRIBING PROVIDER'S MEDICAL ASSISTANCE PROVIDER NUMBER	PERFORMING/DISPENSING PROVIDER'S TELEPHONE NUMBER

A. **LENSES AND FRAMES**

NOTE: Lens formula information is required for all requests for frames or lenses

LENS FORMULA: (L) +1.50-- ADD+2.75
(R) +1.50--

☐ REPLACEMENT ONLY

FRAME NAME: Far Horizon 94
FRAME MANUFACTURER: Martin-Copleland
☐ REPLACEMENT ONLY

☒ COMPLETE APPLIANCE (Lenses and frames)

B. **SPECIAL LENS/FRAME REQUEST:**

☐ Oversize
☐ Add over +.4.00
☐ Patient supplied frame
☒ Contract lab supplied frame
☐ Non-contract frame (Not supplied by recipient)

Justification for Non-Contract Frame:

(Principle justification may not be cosmetic; principle justification must be medically/visually necessity)

☐ Other (provide pertinent history /findings and justification along with specifics of request)

If request is for a non-contract item, estimate wholesale cost:

C. **TINTS:**

(All requests for tints must include specific documentation of visual or medical necessity from the prescribing provider. A diagnosis of photophobia, without substantiation is insufficient justification.)

☐ Rose 1 ☐ Rose 2 ☒ Photochromic

☐ Other tint (explain)

Justification for tint (See above)

Recipient has cortical cataracts which are causing excessive glare and light sensitivity. Photochromic lenses will help eliminate this glare and allow the recipient's visual system to function more effectively.

D. **OTHER VISION SERVICE REQUESTED:**

Service Requested:

Pertinent history/findings and justification:

THE PROVISION OF SERVICES WHICH ARE GREATER THAN OR SIGNIFICANTLY DIFFERENT FROM THOSE AUTHORIZED MAY RESULT IN NON-PAYMENT OF THE BILLING CLAIM(S).

E. MM/DD/YY
Date

J. M. Provider, O.D.
Requesting/Performing Provider's Signature

APPENDIX 10
FREQUENTLY USED DIAGNOSIS CODES

Frequently used ICD-9-CM diagnosis codes and descriptions pertaining to vision care:

361	Detached Retina
362	Other Retinal Disorders
362.1	Other Background Retinopathy and Retinal Vascular Changes
365	Glaucoma
366.9	Cataract
367.0	Hypermetropia
367.1	Myopia
367.2	Astigmatism
367.4	Presbyopia
368.0	Amblyopia ex anopsia
368.1	Subjective Visual Disturbances
368.5	Color Blindness
368.6	Night Blindness
369.3	Unqualified Visual Loss (both eyes)
371	Corneal Opacity
371.6	Keratoconus
374.3	Ptosis of Eyelid
374.9	Unspecified Disorder of Eyelid
377.0	Papilledema
377.1	Optic Atrophy
378.0	Esotropia
378.1	Exotropia
378.31	Hypertropia
379.3	Aphakia and Other Disorders of Lens
V72.0	Annual Eye Exam (when done for a routine purpose, such as to check eyeglass prescription)
V53.1	Fitting, Adjustment or Replacement Glasses

Opticians should use V53.1 (Fitting, Adjustment or Replacement Glasses) when dispensing eyeglasses which have been prescribed by another provider.

NOTE: V53.1 cannot be used as either the primary or sole diagnosis on a prior authorization request form.

APPENDIX 11
ALLOWABLE VISION CARE PLACE OF SERVICE (POS) CODES AND TYPE OF SERVICE (TOS) CODES FOR VISION CARE PROCEDURE CODES

POS	Description
0	Other
1	Inpatient Hospital
2	Outpatient Hospital
3	Office
4	Home
7	Nursing Home
8	Skilled Nursing Facility
B	Ambulatory Surgery Center

TOS	
J	Vision Services (including all optometrist and optician services, as well as dispensing, materials and repair by an ophthalmologist)
1	Medical Care (ophthalmologist only)
2	Surgery (ophthalmologist only)
3	Consultations
4	Ultrasound Total or Complete Procedure (including professional and technical components)
Q	Ultrasound Professional Component (interpretation)

APPENDIX 12
WMAP COVERED DRUGS

A. *COVERED DRUGS - LEGEND DRUGS*

The WMAP uses an Open Formulary for legend drugs with few restrictions. Restrictions include:
Drugs Which Require Prior Authorization (See Sections C and D below), Noncovered Manufacturer Drugs (see Section A of Appendix 29 of this handbook), Less-Than-Effective Drugs (See Section B of Appendix 29 of this handbook) and Negative Formulary Drugs (See Section C of Appendix 29 of this handbook).

B. *COVERED DRUGS - OVER-THE-COUNTER DRUGS*

WMAP covered over-the-counter drugs are limited to ONLY the following categories:

ANALGESICS-ORAL/RECTAL[1]	COUGH SYRUPS[2]	INSULIN
ANTACIDS	FERROUS GLUCONATE/SULFATE FOR PREGNANT WOMEN	OPHTHALMIC LUBRICANTS
CONTRACEPTIVE SUPPLIES		

(***NOTE:*** Coverage is limited to generic drugs for all covered OTC drugs [excluding the OTC product categories of insulin, ophthalmic lubricants, and contraceptive supplies]. Some products in these categories are NOT covered because the manufacturer did not sign a rebate agreement. Examples of noncovered brand name products include Mylanta, Rolaids, Clear Tears, Lyteers, Neo Tears, Maalox, Titralac, Ecotrin, Robitussin, Tylenol, Ascriptin, Riopan and Advil.)

C. *COVERED NON REBATED DRUGS - PRIOR AUTHORIZATION REQUIRED*

These drugs require prior authorization because the manufacturer did not sign a rebate agreement. Prescribers are requested to provide a statement regarding the nature of the medical need for these specific brand drugs, as well as a statement which asserts that failure to cover the drug will result in costs to the WMAP which exceed the cost of the drug. This list may change if the manufacturer signs a rebate agreement.

Generic equivalents of these drugs are not included in this requirement and may be billed without prior authorization if the generic manufacturer has signed a rebate agreement.

DALMANE	LIBRIUM	QUARZAN	TRANS-PLANTAR
EIGHT MOP	MELANEX	RIMSO 50	VALIUM
LIBRITABS	MENRIUM	TRANS-VER-SAL	

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1 Limited to single entity aspirin, acetaminophen, ibuprofen products only.

2 Covered "cough syrups" are limited to products for treatment of coughs only. Covered products include those containing a single component (terpin hydrate or guaifenesin), a single cough suppressant (codeine or dextromethorphan), or a combination of an expectorant and cough suppressant. Multiple ingredient cough/cold combination products are noncovered.

D. COVERED REBATED DRUGS - PRIOR AUTHORIZATION REQUIRED

These drugs are produced by manufacturers which have signed rebate agreements but require prior authorization to determine medical necessity. Diagnosis and information regarding the medical requirements for these drugs must be provided on the prior authorization request.

CS III & IV STIMULANTS
(Excludes Mazindol)
Benzphetamine
Diethylpropion
Fenfluramine
Phendimetrazine
Phentermine

ENTERAL NUTRITIONALS
Ensure, Pediasure
Meritine, Enrich
Sustacal, etc.

EPOETIN ALFA
Epogen, Procrit

LACTULOSE
Cephulac, Chronulac
Enulose, etc.

HUMAN GROWTH HORMONE
Humatrope
Protropin

CLOZAPINE
Clozaril

HYPERALIMENTATION
Total Parenteral Nutrition
Peripheral Parenteral Nutrition

UNLISTED/ INVESTIGATIONAL DRUGS
Biopterin (tetrahydrobiopterin)
Somogard (deslorelin)

ALPHA-1-PROTEINASE INHIBITOR
Prolastin

MUROMONAB-CD3
Orthoclone OKT3

INTERFERON
Alferon N, Intron-A
Roferon-A

DIPYRIDAMOLE (07/01/92)
Persantine

ALGLUCERASE (11/1/92)
Ceredase

TICLOPIDINE (11/1/92)
Ticlid

APPENDIX 13
WMAP NONCOVERED DRUGS

A. *NONCOVERED DRUGS - NO MANUFACTURER REBATE AGREEMENT*

Manufacturers of the following drugs have chosen not to participate in the Medicaid program. This is not a complete list of noncovered drugs. This list may change if manufacturers sign rebate agreements. Prior Authorization will NOT be granted for these drugs. Generic alternatives for these drugs are covered if the manufacturer signed a rebate agreement.

AEROLATE	DUOLUBE	KARIDIUM	NAFRINSE	XERAC AC
ASTHMANEPHRINE	EPPY N OPTH SOLN	KARIGEL	NEO-TEARS	YODOXIN
BICHLORACETIC ACID	EPPY SOL OPH	LYTEERS	PIMA	
CLEAR TEARS	EXTENDRYL	MOISTURE DROPS	RUM-K	
DRYSOL	FLUORITAB	MONOJECT INSULIN JEL	TINVER LOTION	

B. *WMAP NONCOVERED DRUGS - FDA LESS-THAN-EFFECTIVE DRUGS.*

Prior Authorization will not be granted for these drugs nor for any generic alternatives identified by the Food and Drug Administration (FDA) as identical, related or similar to these drugs. This list represents only the most commonly prescribed LTE drugs.

AMESEC	DEPROL	KINESED	MUDRANE	QUIBRON PLUS
ARLIDIN	DONNATAL	LEVSIN W PHENOBARB	NALDECON	RAUTRAX
BELLABARB	DONNATAL EXTENTABS	LIBRAX	NYLIDRIN	THEOFED
BELLADENAL	ENTEX	LUFYLLIN EPG	PENTAERYTHRITOL TN	TIGAN ORAL/RECTAL
BELLADENAL S	ENTEX LIQ	MARAX	PERITRATE	TUSS ORNADE
BELLERGAL S	FEDRINAL	MEPERGAN FORTIS	PHENOBARB & BELLADONNA	VASODILAN
BUTIBEL	ISOLATE COMP	MIDRIN	PRISCOLINE	VIOFORM W HC
CYCLANDELATE	ISOXUPRINE	P.V. TUSSIN	QUADRINAL	VYTONE

C. *WMAP NONCOVERED DRUGS - WISCONSIN NEGATIVE FORMULARY*

Prior Authorization will not be granted for these drugs.

ALGINATE	MINOXIDIL TOPICAL	PROGESTERONE FOR PMS
GAVISCON	NON REBATED DRUGS INELIGIBLE FOR PA	LEGEND MULTI-VITAMINS (NON PRENATAL)