MSC PREAMBLE AND PAYMENT SCHEDULE: OPTOMETRY SERVICES

A. GENERAL PROVISIONS

1. Eye Examination Benefits

Optometric benefits are services defined in Section 23 of the *Medical and Health Care Services Regulations,* B.C. Reg. 426/97, and for which payment is provided pursuant to the Optometry Payment Schedule.

Routine eye examinations are not a MSP benefit for individuals aged 19 to 64 years. MSP provides as an insured benefit routine eye examinations for children under the age of 19 years and over the age of 65.

Medically required eye examinations are a benefit for all MSP beneficiaries. The diagnoses that meet the MSP definition of medically required are listed below by ICD9 code, and are payable at the frequency indicated. To support exceptions to these frequencies or for other special circumstances, practitioners should ensure this information is included with billing claims.

In general, the criteria for medically required include:

- ocular disease, trauma or injury
- systemic diseases associated with significant ocular risk (e.g. diabetes)
- medications associated with significant ocular risk

Refractive change (needing glasses or contact lenses) with no other pathology does not meet the MSP medically required criterion for payment. Patients presenting with refractive change only should not be formally referred for an eye exam. These patients should contact their optometrist or ophthalmologist directly to request an eye exam and they should also be advised that payment for the eye examination will be their responsibility.

Formal referrals to ophthalmologists or direct requests to optometrists by a medical practitioner for an eye examination on behalf of patients are appropriate only if, in the practitioner's judgment and based on clinical evidence, there is medical necessity for the examination.

MSP will accept claims and make payment for services provided by optometrists and ophthalmologists upon direct requests or referral from medical practitioners.

It is the responsibility of medical practitioners to exercise their judgment in referring those patients for whom an eye examination is medically required. This does not include visits for patients with refractive change (needing glasses or contact lenses) but with no other pathology. MSP will monitor referral patterns to ensure adherence to this policy.

For patients insured under the First Nations Health Authority (FNHA), prior approval is required for health benefits.

2. Medically Required Eye Examinations

The diagnoses which meet the MSP definition of medically required are listed below by ICD9 code, and are payable at the frequency indicated.

Practitioners must ensure that information necessary to support exceptions to these frequencies or for other special circumstances is included with referrals or billing claims.

Payment for services for conditions not listed below is the responsibility of the patient unless a referral is medically indicated and provided to the ophthalmologist or optometrist directly by the referring physician.

Please note, under each three digit diagnostic code – the four and five digit codes in the same category would be limited to the same frequency guidelines. The exceptions are listed below (3620, 36201 and 36202).

SCHEDULE A – DIAGNOSTIC CODES FOR MEDICALLY-REQUIRED EYE EXAMINATIONS

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Eye examinations billed with the following diagnostic codes are payable once every 24 months:

360	Disorders of the globe
363	Chorioretinal inflammations, scars and other disorders of choroid
368	Visual disturbances
369	Blindness and low vision
375	Disorders of lacrimal system
379	Other disorders of eye
4019	Hypertensive disease not specified as malignant or benign
05440	Herpes simplex – ophthalmic (acute onset)
05320	Herpes zoster – ophthalmic (acute onset)
94010	Burns of eyelids and periocular area
92190	Unspecified contusion of eye
9182	Superficial injury – conjunctiva
9301	Foreign body in conjunctival sac
9181	Superficial injury – cornea
9300	Corneal foreign body
8026	Fracture – orbital floor (blow out), closed
9502	Injury to optic pathways
9503	Injury to visual cortex
99520	Unspecified adverse effect of drug, medicament and biological (allergic reaction to medication)

Eye examinations billed with the following diagnostic codes are payable once every 12 months:

361	Retinal detachments and defects
364	Disorders of iris and ciliary body
366	Cataract
371	Corneal opacity and other disorders of cornea
372	Disorders of conjunctiva
373	Inflammation of eyelids
374	Other disorders of eyelids
376	Disorders of the orbit
377	Disorders of optic nerve and visual pathways
378	Strabismus and other disorders of binocular eye movements
27910	Deficiency of cell mediated immunity (AIDS (HIV))
7200	Ankylosing Spondylitis
43600	Cerebrovascular disease – acute but ill defined
17400	Malignant neoplasm of breast
16200	Malignant neoplasm of trachea, bronchus and lung
34000	Multiple sclerosis
35800	Myasthenia Gravis
23700	Neoplasm – pituitary gland and craniopharyngeal duct
13500	Sarcoidosis
24000	Goitre, specified as simple
71020	Sicca Syndrome (Sjogren's Syndrome)
71000	Systemic Lupus Erythematosus
44650	Giant Cell Arteritis (Temporal Arteritis)
224	Benign neoplasm of eye
8717	Unspecified ocular penetration
E07	Intraocular surgery or injury with penetrating wound
9404	Burn – Cornea / Conjunctiva
V6751	Following high risk medications ***
	***Claims with this code must be accompanied by a note stating type of medication.

Eye examinations billed with the following diagnostic codes are payable once every 6 months:

250	Diabetes Mellitus
3620	Diabetic Retinopathy
36201	Background diabetic retinopathy
36202	Proliferative diabetic retinopathy
365	Glaucoma

370	Keratitis
362	Other Retinal Disorders

3. "Referral"

Notifying MSP of a referral is usually done by including the practitioner number of the physician to whom the patient is being referred on your claim. If no FFS (Fee for Service) claim is being submitted, a "no charge referral" is a claim submitted to MSP under fee item 03333 with a zero dollar amount.

On occasion, a practitioner's number is not available. For these rare cases, the following generic number has been established for optometry:

99992 – Referral by an optometrist to an ophthalmologist and referral by an optometrist to a neurologist

4. Treatment and Management of Glaucoma

Glaucoma patients and suspects are as defined by the Standards, Limits and Conditions for Practice – Anti-Glaucoma Medication Prescribing (SLCs) set by the College of Optometrists of British Columbia. The SLCs set out the criteria including any and all testing required. The fee item 02891 – Extended Diagnostic Testing, is to be used for this purpose.

Patients who present with Glaucoma or with risk factors that classify them as glaucoma suspects as per the ICD9 code 365 criteria are eligible for this semi-annual benefit billed in conjunction with 02898, 02899, 02889 fee items only.

5. Treatment and Management of Keratitis

Patients who present with Keratitis, ICD9 code 370XX, as defined by the Screening, Diagnosis and Management of Dry Eye Disease: Practical Guidelines for Canadian Optometrists, Canadian Journal of Optometry, Vol. 76 Suppl. 1, 2014. Inflammation must be confirmed by vital dye staining, including fluorescein, or tear osmolarity to be eligible for this semi-annual benefit billed in conjunction with 02898, 02899, 02889 fee items only.

Fee item 02891 – Extended Diagnostic Testing, is to be used for this purpose.

Patients who present with Diabetic Retinopathy, ICD9 code 3620X, defined as limited to pathologies causing potential vision loss and where Fundus Photography is clinically indicated to document the nature of the condition are eligible for this semi-annual benefit billed in conjunction with 02898, 02899, 02889 and 02891 fee items only.

Fee item 02881 - Extended Diagnostic Testing – Fundus Photography, which comes into effect April 1, 2020 for this condition, is to be used for this purpose.

B. ADMINISTRATION

1. Fees Payable by the Medical Services Plan (MSP)

A Payment Schedule for optometrists is established under Section 26 of the *Medicare Protection Act* and is referred to in the Agreement between the Government of the Province of British Columbia and the Medical Services Commission (MSC) and the British Columbia Association of Optometrists. The fees listed are the amounts payable by the Medical Services Plan (MSP) for listed benefits.

2. MSP Billing Number

A billing number consists of two numbers - a practitioner number and a payment number. The practitioner number identifies the practitioner performing and taking responsibility for the service. The payment number identifies the person or party to whom payment will be directed by the MSP. Each claim submitted must include both a practitioner number and payment number.

3. Group Practice, Partnerships, and Locum Tenens

The *Medicare Protection Act* requires that the practitioner will charge for his/her own services. For MSP and WorkSafeBC (WSBC) billings this requires the use of the individual's personal practitioner number. This includes members of Group Practices, Partnerships and Locum Tenens.

4. Assignment of Payment

An "Assignment of Payment" is a legal agreement by which an attending practitioner designates payment for his/her services to another party. In this circumstance, the designated party may use the attending practitioner's practitioner number in combination with its own payment number when submitting claims to MSP. To authorize MSP to make payment to a designated party, the attending practitioner must complete and file an "Assignment of Payment" form. However, even though the payment has been assigned, the responsibility for the clinical service and its appropriate billing remains with the practitioner whose practitioner number is used.

5. Balance Billing

Optometrists who are opted-out of MSP are permitted to charge patients more for a service than is set out in the Optometry Payment Schedule.

Before providing services, practitioners must inform the patient:

- that the practitioner has opted out;
- how much, if any, the patient will be reimbursed by MSP; and
- how much, if any, the patient will be paying in addition to the MSP fee.

Opted out practitioners who intend to bill MSP for an insured service rendered to a patient must: (a) have a signed written consent from the patient to directly receive the patient's MSP reimbursement for rendered insured services; and (b) retain the signed patient consent in the patient's file, prior to submitting a MSP claim."

6. Personal Services

Section 29 of the Medical and Health Care Services Regulation specifies the nature of personal services which are not benefits.

> ***29*** *(1) Services are not benefits if they are provided by a health care practitioner to the following members of the health care practitioner's family*
>
> *(a) a spouse,*
> *(b) a son or daughter,*
> *(c) a step-son or step-daughter,*
> *(d) a parent or step-parent,*
> *(e) a parent of a spouse,*
> *(f) a grandparent,*
> *(g) a grandchild,*
> *(h) a brother or sister, or*
> *(i) a spouse of a person referred to in paragraphs (b) to (h).*
>
> *(2) Services are not benefits if they are provided by a health care practitioner to a member of the same household as the health care practitioner.*

7. Adequate Clinical Record

Section 16 of the Medical and Health Care Services Regulation lists requirements for an "adequate clinical record" – See Appendix A. For the purposes of Section 16, clinical records must be created and maintained in English.

Appendix A - Medical and Health Care Services Regulation (Part 4)
Services of Health Care Practitioners

Definition

16 *In this Part,* ***"adequate clinical record"*** *means a record of a health care practitioner, prepared in accordance with the applicable payment schedule, that contains sufficient information to allow another practitioner of the same profession, who is unfamiliar with both the beneficiary and the attending practitioner, to determine from that record, together with the beneficiary's clinical records from previous encounters, information about the service provided to the beneficiary including:*

(a) the date, time and location of the service;

(b) the identity of the beneficiary and the attending practitioner;

(c) if the service resulted from a referral, the identity of the referring practitioner and the instructions and requests of the referring practitioner;

(d) the presenting complaints, symptoms and signs, including their history;

(e) the pertinent previous history including family history;

(f) the positive and negative results of a systematic inquiry relevant to the beneficiary's problems;

(g) the identification of the extent of the physical examination and all relevant findings from that examination;

(h) the results of any investigations carried out during the encounter;

(i) the differential diagnosis, if appropriate;

(j) the provisional diagnosis;

(k) the summation of the beneficiary's problems and the plan for their management.

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OPTOMETRY PAYMENT SCHEDULE

Fee Item	Fee Item Description	$
02899	Full optometric diagnostic examination of the eyes ***Notes:*** *1) Includes the determination of the refractive error of the eye, the presence of any abnormality in the visual system, and the provision of a written prescription, if lenses are required.* *2) Routine eye exams for children 18 years of age or younger are billable once every 11 months.*	$47.08
02889	Optometric diagnostic examination of the eyes, where final determination of the refractive index is not applicable ***Notes:*** *1) Includes the determination of the visual acuity, the presence of any abnormality in the visual system, with TPA if required.* *2) Includes the provision of a written report to the physician where applicable.*	$47.08
02898	Re-examination or minor examination ***Note:*** *Cannot be billed on same calendar day as 02899, 02889 or another 02898.* .	$32.96
02897	Repeat Tonometry (maximum 3x per 24 hour period) ***Note:*** *Cannot be billed on the same day as 2899, 2889, 2898, 2888.*	$10.61
02881*	Extended Diagnostic Testing – Fundus Photography ***Notes***: *1) Only payable in conjunction with 02889, 02899, 02898.* *2) Limited to one exam every six months for the same diagnosis.* *3) Payable only when submitted with ICD-9 code and sub-codes of 363.XX (Choroid) and 362.XX (Other Retinal Disorders).* *4) Only billable when clinically indicated for diagnosis, treatment, or monitoring of an eligible condition.*	$12.50
02891	Extended Diagnostic Testing ***Notes:*** *1) Only payable in conjunction with 02889, 02899, 02898.* *2) Limited to one exam every six months for the same diagnosis.* *3) Payable only when submitted with ICD-9 codes or sub-codes of 370 (keratitis) or with ICD-9 codes or sub codes 365 (Glaucoma). Refer to the Optometry Preamble for guidelines.* *4) OCT, HRT, and GDx excluded. Fee item 02882 is to be used for that purpose.*	$24.25

02882	Extended Diagnostic Testing, Optical Coherence Tomography ***Notes:*** *1) Includes computerized retinal nerve fibre layer imaging and neuro-retinal assessment (e.g.: Heidelberg, GDX, OCT) or cross-sectional imaging (e.g.: OCT).* *2) Only billable when clinically indicated for diagnosis, treatment, or monitoring of an eligible diagnosis.* *3) Limited to ICD-9 code V6751 and ICD-9 codes or sub-codes 362 (Other Retinal Disorders), 365 (Glaucoma), and 363 (Choroid).* *4) Only payable in conjunction with 02889, 02899, 02898.* 5) *Limited to one exam every six months for the same diagnosis.*	$45.00
02883	Corneal Topography for Irregular Cornea ***Notes:*** *1) Limited to ICD-9 code or sub-codes 371.6X (Keratoconus) or code 371.48 (Peripheral corneal degeneration).* *2) Only payable in conjunction with 02889, 02899, 02898.* *3) Limited to one exam every twelve months for the same diagnosis.* *4) Not payable for pre- or post-operative cataract patients except where there is documented evidence of irregular astigmatism resulting from cataract surgery.* *5) Not an insured benefit when used in association with laser refractive surgery or assessment for same.*	$45.00
02884	Axial Length Measurement ***Notes:*** *1) Limited to ICD-9 codes: 367.1 (Myopia) or 367.2 (Astigmatism).* *2) Only for patients aged 6-18 years of age with a spherical equivalent myopic refractive error of 3.00D or greater.* *3) Cannot be billed more than once per year*	$45.00
02892	Examination for low vision aid ***Notes:*** *1) Fee item 02892 billable only by optometrist having appropriate equipment.* *2) Fee item 02899 not billable in addition to 02892 when patient referred for low vision assessment.*	$41.12
02893	Computer assisted quantitative visual fields ***Notes:*** *1) Fee item 02893 billable only by optometrists having the appropriate computerized equipment for quantitative perimetry examinations.* *2) Claim must specify reason for visual fields examination.* **Rate effective April 1, 2021*	$39.20*

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02880	02880 - Ocular Foreign Body Removal* ***Notes:*** *3) Removal and treatment of damage resulting from foreign body in cornea or conjunctival sac; only billable with ICD9 codes 9300 or 9301.* *4) Billable for two services per patient per 12-month period with follow-up visits and services to be billed as minor examinations (02898), as required.* *5) A Note Record explaining the necessity is required for more than two services to be paid per patient per 12-month period.* **Effective April 1, 2021*	$40.00
02890	Contact Lens Bandage ***Notes:*** *1) Payable when the patient requires a therapeutic contact lens bandage after damage to the cornea.* *2) Includes all visits and services necessary for fitting and follow-up for three months.*	$50.99
02894	Contact Lenses Fitting – Unilateral ***Notes:*** *1) Applicable only to patients who are unable to achieve 20/40 visual acuity with conventional glasses or that report diplopia due to anisometropia or irregular astigmatism that cannot be eliminated with the use of conventional glasses but can be through the use of contact lenses.* 2) *Includes all visits and services necessary for fitting and follow-up for three months.*	$218.14
02895	Contact Lenses Fitting – Bilateral ***Notes:*** *1) Applicable only to patients who are unable to achieve 20/40 visual acuity with conventional glasses or that report diplopia due to anisometropia or irregular astigmatism that cannot be eliminated with the use of conventional glasses but can be through the use of contact lenses.* 2) *Includes all visits and services necessary for fitting and follow-up for three months.*	$329.05

02885	Blepharitis Treatment of anterior blepharitis including therapeutic debridement of the eyelid margin and/or posterior blepharitis including therapeutic expression of the meibomian gland **Notes:** 1) Limited to ICD-9 code or sub-codes 373.XX (Inflammation of eyelids) or code 375.15 (tear film insufficiency). 2) Includes thermal stimulation where appropriate. 3) Cannot be billed more than once per six months per eligible ICD-9 code.	$24.00