

Texas Medicaid Benefit Criteria to Change for Some Vision Surgical Services

Effective for dates of services on or after April 1, 2010, benefit criteria for some vision surgical services will change for Texas Medicaid.

New Benefits

Procedure code 66990 will be a surgical benefit when it is performed in the office, inpatient hospital, and outpatient hospital settings by a physician.

Procedure code V2790 will be a benefit for ambulatory surgical centers (ASC) when it is performed in the outpatient hospital setting.

Procedure code 65780 will be a surgical benefit when it is performed in the inpatient hospital or outpatient hospital setting by a physician. Procedure code 65780 will be a benefit for ambulatory surgical centers when it is performed in the outpatient hospital setting.

The following procedure codes will be denied when submitted for reimbursement on the same date of service by the same provider as procedure code 65780:

• Procedure Codes				
00140	00142	00144	00145	65220
65222	65270	65272	65273	65275
65280	65285	65286	65290	65400
65430	65435	65436	65450	65800
65805	66999	67500	67515	68200
68320	68325	68326	68328	68330
68335	68340	68360	68362	69990

Reimbursement

New procedure codes 65780, 66990, and V2790 will be reimbursed as follows:

Procedure Code	Age Range	Reimbursement Rate
Surgical Services		
65780	20 years of age or younger	\$629.51 (21.98 relative value units [RVUs], \$28.640 conversion factor)
65780	21 years of age or older	\$599.53 (21.98 RVUs, \$27.276 conversion factor)
66990	20 years of age or younger	\$65.59 (2.29 RVUs, \$28.640 conversion factor)
66990	21 years of age or older	\$62.46 (2.29 RVUs, \$27.276 conversion factor)
ASC Service		

65780	All	Group 9
V2790	All	\$745.00

Age Limitations

The age limitation for procedure code 67229 will change from birth through 12 months of age to birth through 11 months of age.

Modifier Requirements

The following procedure codes will require modifier LT or RT to identify the eye for which the surgery is being performed:

Procedure Codes				
65205	67311	67312	67314	67316
67318	67320	67331	67332	67334
67345	67414	67800	67801	67805
67808	V2790			

Benefit Limitations

In the following table, the procedure codes in Column A may be reimbursed only when at least one corresponding procedure code from Column B has been paid to the same provider for the same date of service:

Column A Procedure Code Must Be Billed With	Column B Procedure Code
66990	65820, 65875, 65920, 66985, 66986, 67036, 67039, 67040, 67041, 67042, 67043, or 67112
67225	67221
67320, 67331, 67332, 67334	67311, 67312, 67314, 67316, or 67318
67335, 67340	67311, 67312, 67314, 67316, or 67318
V2790	65780

Procedure codes 67335 and 67340 will be denied as part of another service when they are submitted for reimbursement on the same date of service by the same provider as procedure code 67320, 67331, 67332, or 67334.

For Primary Care Case Management (PCCM) clients, when procedure codes 65270 and 65275 are performed by an ophthalmologist, they will not require a referral from a primary care provider or any other type of prior authorization.

Diagnosis Restrictions

The following procedure codes will no longer have diagnosis restrictions:

Procedure Codes

65450	65855	65860	66600	66605
66710	66711	66761	66762	66770
66821	66983	66984	66985	66986
67027	67031	67036	67039	67040
67041	67042	67043	67105	67107
67108	67110	67112	67113	67145
67210	67220	67221	67225	67228
67229	G0186			

For more information, call the TMHP Contact Center at 1-800-925-9126.