Frequently Asked Questions

Children

V404: Major Oculo-Visual Exam for Patients 19 years or less

What is the eligibility period for children 0-19? The eligibility period for V404s is unchanged. Children 0-19 are eligible for a V404 every 12 months.

V402: Oculo-Visual Minor Assessment for Patients age 19 years or less

Are there restrictions on how many V402s I can bill for children? No. There are no frequency limits for V402s for children, subject to the limit of one service per day.

Are Rx checks a valid use of a V402? If the patient is requesting a recheck only to ensure currency of the optical prescription before purchasing glasses, the visit is **uninsured**. However, if refraction is required as part of a workup to determine the cause of vision change/chief complaint, the refraction is **insured** with a V402.

Paediatric Cycloplegic Refraction Complexity Premium for Assessment of Strabismus or Amblyopia

How often can I tandem bill this code? It can be billed once every 12 months for children aged 15 years or younger.

Can I bill this code with a V402? Yes, it can be billed with either V402 or V404 as long as it hasn't been billed within the past 12 months and the child is aged 15 years or younger requiring a workup for strabismus or amblyopia..

Can I bill this code for a dilated fundus exam? No, a dilated fundus exam for the purposes of examining the retina does not qualify for the use of this code. It is intended for the evaluation and management of strabismus and amblyopia.

Can I bill this code if I perform a cycloplegic refraction to rule out latent hyperopia when the patient does not have strabismus or amblyopia? No, the evaluation of latent hyperopia does not qualify for the use of this code. It is intended for the evaluation and management of strabismus and amblyopia.

Can I bill this code if I perform a cycloplegic refraction on an infant where I cannot measure visual acuities and I am trying to rule out uncorrected refractive error that could lead to the development of amblyopia? Yes.

Can I bill this code if I perform cycloplegic refraction as part of myopia management? No, cycloplegia for the purposes of myopia management is not an appropriate use of the cycloplegic refraction code. It is intended for the evaluation and management of strabismus and amblyopia.

If the patient needs cycloplegic refraction more than once a year, or if the patient needs cycloplegia for reasons other than working up strabismus or amblyopia, can I charge the patient privately for the service? No, the patient cannot be charged privately for cycloplegic evaluation, as it would be included as part of an insured service.

Adults

V409: Major Oculo-Visual Exam for Patients 20-64 with One or more Eligible Medical Conditions

What qualifies a patient for a V409 with the new eligibility criteria?

Eligible conditions include:

- Ocular drug toxicity screening for patients using hydroxychloroquine, chloroquine, ethambutol, or tamoxifen
- Acquired cranial nerve palsy resulting in a strabismus during the acute phase or until the condition resolves or stabilizes
- Diabetes
- Glaucoma requiring treatment using medication, laser (excluding prophylactic laser peripheral iridotomy) or surgical means
- Cataracts/Posterior capsular opacification with a visual acuity of 20/40 or worse in the best corrected eye, or when a surgical referral is made
- Uveitis (acute or chronic), during episodes of inflammation only
- Retinal disease that is acute or chronically progressive
- Corneal disease that is acute or chronically progressive
- Optic pathway disease that is acute or chronically progressive

Does a patient taking hydroxychloroquine, chloroquine, ethambutol or tamoxifen have to have retinal toxicity to be a V409? No, a patient on any of these medications does not have to have retinal toxicity to be eligible for a V409.

A patient has 20/25 cataracts in the worse eye but requires referral for surgery due to debilitating glare from a posterior capsular cataract. Is this patient a V409? Yes, if a surgical referral is made, the patient is eligible for a V409 even if the visual acuity (VA) criteria is not met.

A patient with 20/25 acuity needs a referral for YAG capsulotomy due to posterior capsular opacification. Is this a V409? Yes, if a surgical referral is made, the patient is eligible for a V409, even if the VA criteria is not met.

If someone has an old major eye exam (MEE) form that is still good for, say 3 years, do I still need to honour it, or is it no longer valid after September 1, 2023? Once the appropriateness changes take effect on September 1, 2023, old MEE forms will no longer be valid, and the patient will only be eligible for a V409 under the new criteria.

Does the removal of the MEE form mean that physician referrals sent on letterhead (and not using the MEE form) also don't automatically become a 409? Once the appropriateness changes take effect on September 1, 2023, all physician referrals (whether sent via MEE forms

or on physician letterhead) will no longer be valid. Only those patients who meet the new eligibility criteria for medical conditions will be V409-insured.

Does the V409 cover all cranial nerve palsies? For example, is Bell's Palsy and Trigeminal Nerve Palsy covered? No. Only those cranial nerve palsies that cause strabismus (eg. third, fourth and sixth nerve palsies) are eligible medical conditions, but only during the acute phase. Once the condition has resolved or stabilized, the patient will no longer be covered, even if the strabismus remains.

If a patient has mild cataracts (BCVA 20/25) but is interested in cataract surgery at a private surgical center, does the visit become V409 eligible? Yes, if a surgical referral is made, the patient is eligible for a V409 regardless of whether their surgery is performed in a publicly or privately funded center.

Will initial presentations of uveitis now be covered as a V409? Is recurrent uveitis still covered? Yes. Both initial presentation and recurrent forms of uveitis (whether acute or chronic) will be covered, but only during episodes of active inflammation. Once the uveitis resolves, the patient will no longer be covered.

Does a corneal foreign body qualify as a V409-eligible condition? Yes. The assessment is insured as a V409. However, the procedure of foreign body removal is **not an insured service,** so you may bill the patient privately for the removal procedure.

Are glaucoma suspects eligible for a V409? No. Only those diagnosed with glaucoma who require or have had treatment using medication, laser (excluding prophylactic peripheral iridotomies), or surgical means are eligible for a V409.

A patient had a transient intraocular pressure spike from chronic steroid use 10 years ago. The patient does not have glaucoma currently. Is this patient eligible for a V409? No. Only patients currently diagnosed with glaucoma are V409-eligible.

A patient develops a transient intraocular pressure spike from recent ocular surgery. The patient does not have glaucoma currently. Is this patient eligible for a V409? No. Only patients currently diagnosed with glaucoma are V409-eligible. Ocular hypertension is not a medical condition eligible for a V409.

Are patients with narrow angles requiring prophylatic peripheral iritodotomy covered as a V409? No. As long as the patient does not have a diagnosis of glaucoma and has only narrow angles, the patient is not covered as a V409 (both before or after prophylactic laser iridotomies).

Is keratoconus treated with cross-linking and stable considered a V409? No. Corneal conditions that are stable and not progressive are not V409-eligible. If cross-linking does not result in corneal stability, the patient would continue to be insured as a V409.

Are patients with diabetes whose blood glucose is controlled by lifestyle measures covered as a V409? Yes. As long as the physician has made a diagnosis of diabetes mellitus, the patient is V409-eligible. OAO recommends that members clarify with the patient's physician in situations where a diagnosis of diabetes is unclear. Patients with prediabetes (as defined by Diabetes Canada) are not covered.

V408

Since there is a limit of two V408s, may I choose which minor assessments are covered? No. The first two eligible V408s after the V409 would be insured. Subsequent V408s within the 12 month period after the V409 are uninsured.

If a patient has diabetes and their V409 was claimed with diagnostic code 250, then presents 2 months later with a new keratitis (not present at the V409), is the follow-up assessment insured as a V408? No. Only eligible medical conditions present at the time of the V409 are insured.

What happens when a patient runs out of eligible V408s? The patient is then no longer insured for a partial exam and can be billed privately for those services.

How will I know how many V408s were rendered in the eligibility period and if the patient is still eligible for another V408? The health card validation/IVR system will be updated to allow optometrists to determine eligibility for all minor assessments. This is one of the reasons it will require until September 1, 2023 to implement these changes.

Are Rx checks a valid use of a V408? No. Since the V408 code specifically excludes refraction, Rx checks are not insured.

Should I be billing a V408 for a patient that is returning for a post-op refraction after being billed as a V409 for cataracts? If it has been less than 1 year, the ocular health component is insured as a V408; however the service of refraction is uninsured.

Seniors

Major Oculo-Visual Exam for Patients 65 and older with One or more Eligible Medical Conditions

What qualifies a patient for a V406 with an eligible medical condition (allowing them to have their visits covered every 12 months)?
Eligible conditions are the same as the new eligibility criteria for V409s:

- Ocular drug toxicity screening for patients using hydroxychloroquine, chloroquine, ethambutol, or tamoxifen
- Acquired cranial nerve palsy resulting in a strabismus during the acute phase or until the condition resolves or stabilizes
- Diabetes
- Glaucoma requiring treatment using medication, laser (excluding prophylactic laser peripheral iridotomy) or surgical means
- Cataracts/Posterior capsular opacification with a visual acuity of 20/40 or worse in the best corrected eye, or when a surgical referral is made
- Uveitis (acute or chronic), during episodes of inflammation only
- Retinal disease that is acute or chronically progressive
- Corneal disease that is acute or chronically progressive
- Optic pathway disease that is acute or is chronically progressive

Patients that do not meet the criteria of these listed conditions are eligible for a V406 covered once every 18 months.

Are seniors with mild cataracts (BCVA 20/30) covered for visits every 12 months? No, a senior must have a VA of 20/40 or worse in the best-corrected eye or require a surgical referral to be eligible for a V406 every 12 months. If the VA and referral criteria are not met, the senior would not be eligible.

If a senior without an eligible condition still wants to come in for a V406 at 12 months, can we private bill for this service? Yes, if the patient would like to continue having an annual major oculo-visual exam within the eligibility period, the service is uninsured, and you may charge your customary fee.

How often will AMD patients be eligible for exams? AMD (regardless of stage) is considered a chronically progressive retinal disease, and therefore, a senior would be eligible for a V406 every 12 months.

Can a senior's eligibility change from 18 to 12 months if they develop an eligible medical condition 14 months after their V406? Yes. The eligibility period is based on the results of the exam they are having (not on the results of their previous exam). If a patient develops an eligible medical condition, then they would be able to have an insured V406 every 12 months.

Oculo-Visual Minor Assessment for Patients age 65 years or older

If an optometrist provides the 1-day and 1-week post op care at an ophthalmologist's office for a senior, does that mean they will not be covered for their 6-week post op visit in our office? Yes. Patients are only eligible for two minor assessments within the eligibility period.

Since there is a limit of 2 minor assessments for seniors within the eligibility period, may I choose which minor assessments are covered? No. The first two minor assessments after the V406 would be insured. Subsequent minor assessments are uninsured.

Is the limit of 2 minor assessments per eligibility period based per optometrist or per eligibility period (regardless of who performed the service?) The limit is based on the number of minor assessments during the eligibility period only, regardless of whether it is provided by one or by two optometrists.

How will I know how many minor assessments were rendered in the eligibility period and if the patient is still eligible for another minor assessment? The health card validation/IVR system will be updated to allow optometrists to determine eligibility for the minor assessment. This is one of the reasons it will require until September 1, 2023 to implement these changes.

Why didn't the fee code for the minor assessments and V410 change? There were too many V402 and V410 services rendered to make the reinvestment into these codes worthwhile. The dollars were better spent on other areas (example, complexity codes) to give members a better return on investment dollars. Frequency limits on minor assessments and restrictions on V410s will mitigate abuse of the system.

What happens when a patient runs out of eligible minor assessments? The patient is then no longer insured for a partial exam and can be billed privately for those services.

Are Rx checks a valid use of a minor assessment? If the patient is requesting a recheck only to ensure accuracy of the optical prescription before purchasing glasses, the visit is uninsured. However, if refraction is required as part of a workup to determine the cause of vision change/chief complaint, then the refraction is insured.

V410: Automated Visual Field Assessment

Will I need to include a diagnostic code for V410? Yes. With the new eligibility criteria, you must include an eligible diagnostic code for the V410.

Are patients with cataracts worse than 20/40 in the better eye eligible for V410s? No. A diagnosis of cataracts (regardless of VA level) is not one of the eligible medical conditions for a V410.

Is there a limit on how many V410s can be billed in a year? No. There is no frequency limit, subject to one service per day, as clinically required.

Complexity Modifiers

Will the complexity codes get billed automatically when we code a 248 or 365, or will I have to bill them separately? A separate tandem code, the glaucoma complexity premium or the diabetes complexity premium, must be tandem billed with the V404, V409, or V406. They cannot be billed with a minor assessment.

I have a patient with both diabetic retinopathy and glaucoma. Can I bill both the glaucoma and diabetes complexity premiums together on the same V404, V409, or V406? No, only ONE of the two codes can be tandem billed with the V404, V409, or V406.

I have a child with congenital glaucoma who needs cycloplegic refraction as part of a workup for strabismus. Can I bill the paediatric cycloplegic refraction complexity premium with the V404 as well as the glaucoma complexity premium? No. Only one complexity premium may be billed with the V404 annually.

What if diabetic ocular complications or glaucoma are diagnosed on the minor assessment? Neither complexity code premium can be billed on the minor assessment, only the V404, V409, or V406.

Diabetes Complexity Premium

If a patient with diabetes has one microaneurysm, would this qualify for this code? Yes, any diabetic ocular complications present at the V404, V409, or V406 would qualify for billing the diabetes complexity premium.

If any ocular complications from diabetes resolves (e.g. dot heme is not present at the following full exam), can I still bill the complexity code? No. The complexity code is only

eligible if they have diabetic ocular complications at that V404, V409, or V406, not for all future full exams.

Glaucoma Complexity Premium

If I am co-managing a patient with an ophthalmologist for glaucoma management, can I still bill the glaucoma complexity code? Yes. Glaucoma patients generally require more chair time, even if primarily managed by an ophthalmologist.

Does the glaucoma complexity premium also apply to glaucoma suspects? No. Glaucoma suspect is not an eligible medical condition for adults and seniors. As such, they would not be eligible for the glaucoma complexity code.

How does it work if I co-manage my glaucoma patient with another optometrist? Whoever performs the V404, V409, or V406 would be eligible to bill the glaucoma complexity code.

Implementation

When will the fee increases take effect? The fee increases to existing codes only will take effect April 1, 2023. If there is a delay in updating the claims processing system, the fees will be retroactive to April 1, 2023. All other changes (removal of MEE, change in 409 definitions, new complexity codes) will not take effect until they become law on September 1, 2023.

When can I stop accepting Major Eye Exam forms? All physician referrals, whether sent via formal requisition or on physician letterhead, will no longer be eligible for a V409 once the appropriateness changes are implemented in the claims processing system on September 1, 2023.

When can we start communicating these changes to staff and patients? Once the OAO has a ratified deal with the Ministry of Health, you may start communicating the changes to staff. As no eligibility changes will take place until September 1, 2023, you can reassure your staff that your office will have 5 months to prepare for the changes and that the OAO will help provide scripts to communicate messaging to your patients.

What is best way to inform patients that they are no longer eligible for an insured service? OAO will provide staff scripts to assist in the transition to the new schedule. Again, no changes to eligibility will take place until September 1, 2023.

When can we start billing the new complexity premium codes? The target implementation date is September 1, 2023.

Why are all the new changes and fee increases not retroactive to April 2021, since that is the beginning of our new contract? The new codes and second round of fee increases in 2023 are appropriateness changes resulting from re-investment dollars. The government provided optometrists with a fee increase from new money in April 2022 that was retroactive to April 2021.

Other

If we vote "no" to the tentative agreement, does that mean the working group goes back to the negotiation table to get a better deal? No. The next step would be another job action or acceptance of the status quo. Any changes to the agreement would need to be negotiated when the next round commences in Fall 2024.

Is there an option to make minor amendments to the tentative agreement? (Is there an option to vote "yes" but with conditions?) No. All the elements are bundled as one package and must be either accepted or rejected as a whole.

Can I bill an insured and uninsured service at the same visit? Yes. OAO recommends that the receipt clearly indicate what service was privately billed, using language from the new schedule of benefits (which lists all uninsured services).

Are we allowed to decline an exam to an OHIP patient who does not want to pay for retinal imaging? No. The Commitment to the Future of Medicare Act still prohibits providers from making it a condition to pay for uninsured services in order to access an OHIP-insured service.