DHS Oregon Department of Human Services

Division of Medical Assistance Programs

Visual Services Program

Rulebook

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DEPARTMENT OF HUMAN SERVICES

MEDICAL ASSISTANCE PROGRAMS

DIVISION 140

VISUAL SERVICES

Update Information (most current Rulebook changes)

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Visual Services Program Rulebook

Update Information

July 1, 2010

All program rules are updated to correct statutory information and change the acronyms for the Department of Human Services from (DHS) to (Department) and the Division of Medical Assistance Programs from (DMAP) to (Division).

There may be other minor “housekeeping” corrections to take care of misspelled words, punctuation or grammar and rule text consistency

If you have questions, contact a Provider Services Representative toll-free at 1-800-336-6016 or direct at 503-378-3697.

Other Provider Resources

DMAP has developed the following additional materials to help you bill accurately and receive timely payment for your services.

Supplemental Information

The Visual Services Supplemental Information booklet contains important information not found in the rulebook, including:

- ✓ Billing instructions
- ✓ Visual Materials Contractor information and order form
- ✓ Prior authorization information
- ✓ Specific billing requirements for certain services
- ✓ Other helpful information not found in the rulebook

Be sure to download a copy of the Visual Services Supplemental Information booklet at:

http://www.dhs.state.or.us/policy/healthplan/guides/vision/main.html

Note: DMAP revises the supplement booklet throughout the year, without notice. Check the Web page regularly for changes to this document.

Provider Contact Booklet

This booklet lists general information phone numbers, frequent contacts, phone numbers to use to request prior authorization, and mailing addresses.

Download the Provider Contact Booklet at:

http://www.oregon.gov/DHS/healthplan/data_pubs/add_ph_conts.pdf

Other Resources

We have posted other helpful information, including provider announcements, at:

http://www.oregon.gov/DHS/healthplan/tools_prov/main.shtml

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http://www.oregon.gov/DHS/govdelivery.shtml

410-140-0020 Managed Health Care Organizations

(1) Division of Medical Assistance Programs (Division) has contracted with Managed Care Organizations (MCO) and Primary Care Case Managers (PCCM) for medical services provided for Oregon's Medical Assistance Programs clients (Title XIX and Title XXI). MCOs include Fully Capitated Health Plans (FCHP), Mental Health Organizations (MHO), Dental Care Organizations (DCO) and Chemical Dependency Care Organizations (CDO).

(2) FCHPs are responsible for all vision services. When a client is enrolled with an FCHP, the FCHP covers all vision services (including routine vision exams, fittings, repairs, therapies and materials) provided by ophthalmologists, optometrists and opticians. These services must be obtained through the FCHP. When providing visual services for a client enrolled with an FCHP you must contact that FCHP for program limitations, criteria and prior authorization (PA). Failure to follow the rules established by the FCHP for visual services may result in the denial of payment. If the provider has been denied payment for failure to follow the rules established by the FCHP neither the Division, the FCHP, nor the client are responsible for payment.

(3) Services covered by an FCHP will not be reimbursed by the Division; reimbursement is a matter between the FCHP and the provider. If the FCHP utilizes the Division’s visual materials contractor or another visual materials contractor for visual materials and supplies, all issues must be resolved between the FCHP and the contractor.

(4) When a client is assigned to a PCCM all services by an ophthalmologist and optometrist require referrals from the PCCM except for routine vision exams, fittings, repairs, and materials. Bill the Division for all services referred by the PCCM and for routine vision exams, fittings, repair, and materials.

(5) Vision therapy is not a routine vision service and does require PA from the client's PCCM, and may require PA from the FCHP.

Stat. Auth.: ORS 409.010, 409.040 & 409.050
Stats. Implemented: ORS 414.025, 414.065, 414.725 & 414.737

2-1-10 (Stats)

7-1-10 (Hk)

410-140-0040 Prior Authorization

(1) Prior Authorization (PA) is when the Division of Medical Assistance Programs (Division) authorizes payment for medically appropriate services/supplies for clients prior to the provision of the services/supplies.

(2) PA requirements for services or supplies listed in the Visual Services administrative rules are intended for clients that are not enrolled in a Fully Capitated Health Plan (FCHP). If the client is enrolled in a FCHP, the provider must contact the client's FCHP for their policy governing PA requirements and to obtain any necessary PAs.

(3) If a claim has been denied because PA was not obtained appropriately, or the provider does not follow the rules established by the Division or the FCHP, the Division, the FCHP, and the client are not responsible for payment.

(4) A PA number must be present on the billing claim for any visual service listed in the Division's administrative rules as requiring a PA, or the claim will be denied.

(5) All dispensing of ophthalmic materials by a provider other than a physician or optometrist require a written prescription signed by a physician or optometrist.

(6) PA does not guarantee payment.

(7) PA does not guarantee eligibility. Providers must verify eligibility on the date of service. (Refer to General Rules 410-120-1140 (Verification of Eligibility) for specific details. After eligibility has been verified, it is the provider's responsibility to determine if the service requires PA.

(8) If a PA is required and the client is:

(a) Fee-for-service (not enrolled in an FCHP) -- Obtain PA from the Division as outlined in the Visual Services administrative rules and in the Visual Services Supplemental Information;

(b) Enrolled with an FCHP -- Contact the FCHP for their policy governing PAs.

(9) The Division will review documentation submitted to determine if a request for PA will be approved. PA requests that do not meet the rule criteria will be denied. If the Division receives a request for PA after the service has been rendered, PA will be denied.

(10) The Division does not accept requests for PA via the phone.

(11) The provider must submit a signed request for PA. Refer to the Visual Services Supplemental Guide for information required on the PA form and processing of the PA.

Stat. Auth.: ORS 409.010 & 409.050
Stats. Implemented: ORS 343.146, 414.065, 414.705, 683.010 & 743.842

2-1-10 (Stats only)
7-1-10 (Hk)

410-140-0050 Eligibility

(1) It is the responsibility of the provider to verify that the individual is eligible for Medical Assistance Program coverage (Title XIX or Title XXI) on the date of service and whether a managed care plan or the Division of Medical Assistance Programs (Division) is responsible for reimbursement. The provider assumes full financial risk in serving a person not confirmed as eligible for the service provided on the date(s) of service. Refer to General Rules 410-120-1140 (Verification of Eligibility) for specific details.

(2) Service eligibility verification:

(a) The provider must also verify if the client is eligible to receive vision services. The vision benefit is as follows:

(A) OHP Plus non-pregnant adults, 21 years and older: Visual services for the purpose of prescribing glasses/contact lenses, fitting fees, or glasses or contact lenses are not covered, except for those with the following diagnoses; aphakia, pseudoaphakia, congenital aphakia, keratoconus, cataracts, and congenital cataracts. Non-pregnant adults with the above diagnoses are subject to service limitations described in rule;

(B) OHP Plus pregnant women: Visual services for the purpose of prescribing glasses/contact lenses, fitting fees, glasses and contact lenses are limited to once every 24 months and as further described in rule;

(C) Children (birth through age 20): Visual services for the purpose of prescribing glasses/contact lenses, fitting fees, glasses and contact lenses are covered as described in rule and when documentation in the clinical record justifies the medical need;

(D) Standard Benefit Package: Visual services for the purpose of vision correction, including routine eye examinations, frames, lenses, contacts, vision aids, and orthoptic and/or pleoptic training (vision therapy) are not covered under the OHP Standard Benefit Package;

(E) The provider must verify from the Division, the client's Fully Capitated Health Plan (FCHP) or Primary Care Organization (PCO), if the client has received these services within the limitation period;

(b) The provider must check the service being provided for any limitations;

(c) It is the provider's responsibility to maintain accurate and complete client records so that they are able to verify service eligibility. If a client is an established client, incomplete information through phone or electronic verification systems detailed in General Rules 410-120-1140 (Verification of Eligibility) does not absolve the provider's responsibilities of informing the client that their benefit of an eye exam for the purpose of prescribing glasses/contacts and the supply of glasses/contacts, has been exhausted; or that they are not eligible for vision services;

(d) FCHPs and PCO: If the client is enrolled in an FCHP or PCO, the provider must contact the FCHP/PCO to find out what their policy is and if the client is eligible for services. Some FCHP's/PCOs may decide to allow more frequent exams for the purpose of prescribing glasses/contacts and the supply of glasses/contacts. When calling the FCHP or PCO, the provider must inform the FCHP/PCO of the last date of service;

(e) Phone or electronic verification: Verify eligibility and the last date of service for glasses/contacts as detailed in General Rules 410-120-1140 (Verification of Eligibility);

(f) SWEEP Optical: The Division and several FCHPs contract with SWEEP Optical to provide vision materials. Regardless of verification received via phone or electronic sources, SWEEP Optical will not fill orders for clients who do not have coverage or the vision benefit and/or have received services within the past 24 months. When this happens:

(A) If the client is currently a fee-for-service client with vision benefits (not enrolled in an FCHP or PCO), The Division will not pay for another pair of glasses/contacts (except when client has had cataract

surgery within the last 120 days). If the client is not an established client of the provider and the client is currently a fee-for-service client with vision benefits, the Division will reimburse the provider for the exam only;

(B) If the client with vision benefits is currently enrolled in an FCHP/PCO that has a contract with SWEEP Optical and the client received glasses/contacts through the Division's fee-for-service or through a previous FCHP/PCO who had a contract with SWEEP Optical, SWEEP Optical will refuse to fill the order. It is the provider's responsibility to contact the client's FCHP/PCO and give them the last date of service. The current FCHP/PCO will then determine if they want to allow for an additional supply of glasses/contacts. If the client is an established client, regardless of incomplete information through phone or electronic verification systems or SWEEP Optical, it is the provider's responsibility to inform the FCHP/PCO of the last date of service;

(g) It is the provider's responsibility to verify eligibility for vision benefits and services prior to the initiation of the service. If any services are provided by SWEEP Optical and the client is not eligible, the provider is responsible for payment to SWEEP Optical (see the "Contracted Services" section of this guide). SWEEP Optical is prohibited by contract to sell materials and supplies for non-eligible clients at the State Contracted Price.

Stat. Auth.: ORS 409.010, 409.040 & 409.050
Stats. Implemented: ORS 411.060, 414.065, 414.532, 414.536, 414.538, 414.540 & 743.847

2-1-10 (Stats only)

7-1-10 (Hk)

410-140-0060 Health Insurance Claim Form (CMS-1500)

(1) Opticians, optometrists and ophthalmologists bill using the CMS-1500.

(2) Optometrists and ophthalmologists use the DMAP 505 form for those clients who have Medicare/Medical Assistance Program coverage, if Medicare transmits incorrect information to Division of Medical Assistance Programs (Division). Opticians cannot bill Medicare.

[ED. NOTE: Forms referenced are available from the agency.]

Stat. Auth.: ORS 409.010, 409.040 & 409.050
Stats. Implemented: ORS 411.146, 411.300, 414.025, 414.065, 414.075, 414.725, 414.737 & 743.028

2-1-10 (Stats only)

7-1-10 (Hk)

410-140-0080 Medicare/Medicaid Assistance Program Claims

(1(1) When a client has both Medicare and coverage through the Division of Medical Assistance Programs (Division), optometrists and ophthalmologists must bill Medicare first for Medicare covered services.

(2) Refer to OAR 410-120-1210 (General Rules) for information on the Division reimbursement.

(3) Medicare will automatically forward your claim to the Division.

(4) In all of the following situations, bill the Division on the DMAP 505 or 837P:

(a) If Medicare sends incorrect claim information to the Division and no payment is made on the entire claim;

(b) If an out-of-state Medicare carrier or intermediary was billed;

(c) If Medicare does not cover the service:

(A) If submitting a paper claim, enter any Medicare payment received in the "Amount Paid" field (Field 28) or use the appropriate TPR explanation code in the "Other Health Insurance Coverage" (Field 9) portion on the DMAP 505. Be sure to enter the Medicare Maximum Allowable in Field 24H.

(B) If any billing corrections are needed and the Division made payment, the provider must submit an Adjustment Request (DMAP 1036) to correct payment;

(d) If Medicare crosses the claim over incorrectly or it does not cross-over.

Stat. Auth.: ORS 409.010, 409.040 & 409.050
Stats. Implemented: ORS 411.790, 414.025, 414.065, 414.075, 414.725 & 414.737

410-140-0110 Client Copayments

Copayments may be required for certain services. See OAR 410-120-1230 for specific details.

Stat. Auth.: ORS 409.010, 409.025, 409.040, 409.050, 409.110

Stats. Implemented: ORS 414.025, 414.065

2-1-10 (Stats)

410-140-0120 Procedure Codes

(1) Providers billing CPT/HCPCS codes must use the CPT or HCPCS codes that are effective for the current Calendar Year. The CPT/HCPCS codes most commonly used by optometrists and opticians are listed in the Visual Services guide. Ophthalmologists should refer to the Medical-Surgical Services administrative rules for additional coverage information:

(a) Always use the most applicable CPT/HCPCS code. Do not "unbundle" coding when services can be included in a single code;

(b) Always read the definition at the beginning of each section of CPT/HCPCS to verify the level of service.

(2) Evaluation and Management codes from CPT cannot be used in lieu of the intermediate, comprehensive exam codes listed in the Ophthalmology section of CPT.

(3) All ophthalmological services and materials must be medically necessary, and documented in the client's clinical record. Specific coverage and restrictions can be found in the Procedure Codes Section of the Visual Services guide.

(4) Modifiers can be used with any code. The Division of Medical Assistance Programs (Division) will recognize modifiers from CPT, HCPCS and Oregon Medicare.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 409.010, 409.025, 409.040 & 409.050
Stats. Implemented: ORS 414.025, 414.065 & 414.085

2-1-10 (Stats only)

7-1-10 (Hk)

410-140-0140 Ophthalmological Diagnostic and Treatment Services Coverage

(1) Ophthalmological diagnostic and treatment services are not limited for eligible adults (see 410-140-0050) except as directed by the administrative rules contained in the Division of Medical Assistance Programs' (Division) Visual Services program (chapter 410, division 140), the Division's General Rules (chapter 410, division 120) -- Medical Assistance Benefits: Excluded Services and Limitations, and the Health Services Commission's (HSC) Prioritized List of Health Services (List) as follows:

(a) Coverage for diagnostic services and treatment for those services funded on the HSC List; and

(b) Coverage for diagnostic services only, for those conditions that fall below the funded portion of the HSC List; (The date of service determines the appropriate version of the General Rules and HSC List to determine coverage).

(2) Eligible adults (age 21 and over): Reimbursement for ophthalmological examinations for the purpose of prescribing glasses/contacts is limited to one complete examination which includes the refractive state every 24 months for adults. Diagnostic evaluations and examinations may be reimbursed more frequently if documentation in the physician's or optometrist's clinical record justifies the medical need.

(3) Ophthalmological intermediate and comprehensive exam services are not limited for medical diagnosis.

(4) If the client is assigned to a Primary Care Case Manager (PCCM) the provider must get a referral for a medical eye exam prior to the service being rendered.

(5) Frames and lenses for eligible adults age 21 and over are limited to once every 24 months. There is no coverage for glasses with a prescription that is equal to or less than +/-.25 diopters in both eyes.

(6) Children (birth through age 20): All ophthalmological examinations are covered when documentation in the clinical record justifies the medical need.

(7) Refractions: Determination of the refractive state is included in an ophthalmological examination and may not be billed as a separate service. The determination of the refractive state is limited to once every 24 months for eligible adults age 21 and over for the purpose of prescribing glasses/contacts. The refraction can be billed as a separate sole service, if the refraction is done as a stand-alone service to follow a medical condition (such as, but not limited to, multiple sclerosis) and is not limited for medical diagnosis.

(8) General Ophthalmological Services: See Definitions under Ophthalmology section in the current CPT/HCPCS code book for definitions and examples of levels of service.

(9) New Client: A new client is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice within the past three years:

(a) 92002 Ophthalmological services: Medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new client;

(b) 92004 Comprehensive, new client, one or more visits.

(10) Established Client: An established client is one who has received professional services from the physician or another physician of the same specialty who belongs to the same group practice within the past three years:

(a) 92012 Ophthalmological services: Medical examination and evaluation with initiation or continuation of diagnostic and treatment program; intermediate, established client;

(b) 92014 Comprehensive, established client, one or more visits.

(11) Table 140-0140-1.

[Publications: Publications referenced are available from the agency.]
[ED. NOTE: Tables referenced are not included in rule text. Click here for PDF copy of table(s).]

Stat. Auth.: ORS 409.010, 409.040, 409.050 & 409.110
Stats. Implemented: ORS 414.010, 414.025, 414.065 & 743.842

2-1-10 (Stats)

7-1-10 (Hk)

Table 140-0140-1 Special Ophthalmological Services

92015	Determination of refractive state
92018	Ophthalmological examination and evaluation, under general anesthesia, with or without manipulation of globe for passive range of motion or other manipulation to facilitate diagnostic examination; complete. Note: payable to ophthalmologists only.
92019	limited (Note: payable to ophthalmologists only).
92020	Gonioscopy with medical diagnostic evaluation (separate procedure)
92060	Sensorimotor examination with multiple measurements of ocular deviation and medical diagnostic evaluation procedure
92070	Fitting of contact lens for treatment of disease, including the supply of lenses. Use for medical bandage for acute injury or disease. See “Contact Lens” section (in the CPT code book) for rules governing *contacts for routine visual correction*.
92081	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).
92082	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).
92083	extended examination, (e.g., Goldmann visual fields with at least 3 isopters plotted and static determination

within the central 30º 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)

(Gross visual field testing [e.g., confrontation testing] is a part of general ophthalmological services and is not reported separately)

92100 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)

92120 Tonography with medical diagnostic evaluation, recording indentation tonometer method or perilimbal suction method

92130 Tonography with water provocation

92135 Scanning computerized ophthalmic diagnostic imaging

92140 Provocative tests for glaucoma, with medical diagnostic evaluation, without tonography

Ophthalmoscopy

Routine ophthalmoscopy is part of general and special ophthalmologic services whenever indicated. It is a non-itemized service and is not reported separately.

92225 Ophthalmoscopy, extended, with retinal drawing (may include use of contact lens, drawing or sketch and/or fundus biomicroscopy), with interpretation and report

92226 subsequent

92230 Fluorescein angioscopy with interpretation and report

92235 Fluorescein angiography (includes multiframe photography)

92240 Indocyainine-green angiography (includes multiframe imaging) with interpretation and report

92250 Fundus photography with interpretation and report

92260 Ophthalmodynamometry

Other Specialized Services

92265 Needle oculoelectromyography, one or more extraocular muscles, one or both eyes, with medical diagnostic evaluation

92270 Electro-oculography, with medical diagnostic evaluation

92275 Electroretinography, with medical diagnostic evaluation

92283 Color vision examination, extended (e.g., anomaloscope or equivalent)

(Color vision testing with pseudoisochromatic plates [such as HRR or Ishihara] is not reported separately. It is included in the appropriate general or ophthalmological service.)

92284 Dark adaptation examination, with medical diagnostic evaluation

92285	External ocular photography with medical diagnostic evaluation for documentation of medical progress (e.g., close-up photography, slit lamp photography, goniophotography, stereo-photography)
92286	Special anterior segment photography with medical diagnostic evaluation; with specular endothelial microscopy and cell count
92287	with fluorescein angiography
95930	Visual evoked potential (VEP) testing central nervous system, checkerboard or flash

410-140-0160 Contact Lens Services

(1) Coverage for eligible adults (age 21 or older) as defined in Division of Medical Assistance Programs (Division) Visual Services Program administrative rules 410-140-0050, 410-120-1140, and 410-120-1210:

(a) Prior Authorization (PA) is required for contact lenses for adults, except for the medical condition of Keratoconus. See OAR 410-140-0040, Prior Authorization, for information on requesting prior authorization;

(b) Contact lenses for adults are covered only when one of the following conditions exists:

(A) Refractive error which is 9 diopters or greater in any meridian;

(B) Keratoconus-contacts for Keratoconus do not require PA;

(C) Anisometropia when the difference in power between two eyes is 3 diopters or greater;

(D) Irregular astigmatism; or

(E) Aphakia;

(c) Prescription and fitting of either contact lenses or glasses is limited to once every 24 months for eligible adults. Replacement of contact lenses is limited to a total of two contacts every 12 months (or the equivalent in disposable lenses), and does not require PA;

(d) Corneoscleral lenses are not covered.

(2) Coverage for Children (birth through age 20):

(a) Contact lenses for children are covered when it is documented in the clinical record that glasses cannot be worn for medical reasons, including, but not limited to:

(A) Refractive error which is 9 diopters or greater in any meridian;

(B) Keratoconus-contacts for Keratoconus do not require PA;

(C) Anisometropia when the difference in power between two eyes is 3 diopters or greater;

(D) Irregular astigmatism; or

(E) Aphakia;

(b) Replacement of contact lenses is covered when documented as medically appropriate in the clinical record, and does not require PA;

(c) Corneoscleral lenses are not covered.

(3) General Information regarding contact lens coverage:

(a) Contact lenses for clients not enrolled in a Fully Capitated Health Plan/Primary Care Organization must be billed to the Division at the provider's acquisition cost. Acquisition cost is defined as the actual dollar amount paid by the provider to purchase the item directly from the manufacturer (or supplier) plus any shipping and/or postage for the item. Payment for contact lenses will be the lesser of the Division fee schedule or acquisition cost;

(b) The prescription for contact lenses includes specifying the optical and physical characteristics (such as power, size, curvature, flexibility, gas permeability);

(c) Fitting contact lenses includes instruction and training of the wearer and incidental revision of the lens during the training period;

(d) Follow-up of successfully fitted extended wear lenses is part of the general opthalmological service (such as office visits). Adaptation of contacts due to trauma or disease is not included as part of the general service. The client's record must show clear documentation of the trauma or disease to support additional reimbursement for follow-up visits;

(e) Contact lenses are not billed separately when used for treatment of disease (sometimes referred to as a corneal bandage lens rather

than for vision correction). Use CPT code 92070 for fitting of contact lens for treatment of disease which includes the supply of lenses. See OAR 410-140-0140 (Table 140-0140-1).

(4) CPT Codes to use for contact lens services:

(a) 92310, Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, both eyes; except for aphakia. Does not include the cost of the contact lenses. Prior authorization is required for adults only; when using this code for Keratoconus, no PA is required for adults or children.

(b) 92311, corneal lens for aphakia, one eye. Does not include the cost of the contact lenses;

(c) 92312, corneal lens for aphakia, both eyes. Does not include the cost of the contact lenses;

(d) 92325, Modification of contact lens (separate procedure), with medical supervision of adaptation;

(e) V2510-Contact lens, gas permeable, spherical, per lens;

(f) V2511-Contact lens, gas permeable, toric or prism ballast, per lens;

(g) V2520-Contact lens, hydrophilic, spherical, per lens; and

(h) V2521-Contact lens, hydrophilic, toric or prism ballast, per lens.

Stat. Auth.: ORS 409.010, 409.040, 409.050 & 414.110
Stats. Implemented: ORS 414.025, 414.065, 683.180, 683.525 & 683.570

2-1-10 (Stats) 7-1-10 (Hk)

410-140-0180 Ocular Prosthetics, Artificial Eye

(1) Ocular prosthesis and related services are covered for clients 20 years or younger with documentation of medical necessity in the client's medical record.

(2) The following CPT codes apply:

(a) V2623 Prosthetic Eye, Plastic custom after removal. Limited to one prosthesis every five years after age 20. Supplier must keep on file an order for the prosthesis that is signed and dated by the ordering physician;

(b) V2624 Polishing /resurfacing of ocular prosthesis. Limited to once a year after age 20;

(c) V2625 Enlargement of ocular prosthesis. One enlargement or reduction of the prosthesis is covered every five years after age 20;

(d) V2626 Reduction of ocular prosthesis. One enlargement or reduction of the prosthesis is covered every five years after age 20.

Stat. Auth.: ORS 409.010, 409.040, 409.050

Stats. Implemented: ORS 414.025, 414.065

2-1-10 (Stats)

410-140-0200 Fitting and Repair

(1) Prescription of glasses, when required, is a part of general ophthalmological services (eye exams) and is not reported separately. It includes specification of lens type (monofocal, bifocal, trifocal), lens power, axis, prism, absorptive factor, impact resistance, and other factors.

(2) The fitting of glasses is a separate service. The fitting can be billed using only the codes listed in the attached table (410-0200). Fitting of glasses is covered only when glasses are provided by the contractor. Fitting includes measurement of anatomical facial characteristics, the writing of laboratory specifications, and the final adjustment of the spectacles to the visual axes and anatomical topography. The presence of a physician or optometrist is not required.

(3) Supply of frames and lenses is a separate service component; it is not part of the service of fitting spectacles.

(4) Fitting of either glasses or contact lenses is limited to once every 24 months for eligible adults (age 21 years and older), except when dispensing glasses within one year following corneal transplantation or within 120 days of cataract surgery. When billing for fitting within 120 days following cataract surgery, use an appropriate cataract diagnosis code, and document on the claim the date of the cataract surgery. When billing for fitting within one year of corneal transplantation, document the date of surgery on the claim. (See OAR 410-140-0160 for information on coverage of contact lenses.) Fitting of glasses is not limited for children (birth through age 20) when documented in the patient's record as medically necessary.

(5) Use fitting codes 92340-92353 only when a complete pair of glasses is dispensed. Repair codes 92370 and 92371 must be used for billing when replacing parts and can only be used when the parts have been ordered through the contractor. A delivery invoice will be included with the parts order. Keep a copy of the delivery invoice in the client's records or document the delivery invoice number in the client's records.

(6) Fitting of spectacle mounted low vision aids, single element systems, telescopic or other compound lens systems is not covered.

(7) Periodic adjustment of frames (including tightening of screws) is included in the dispensing fee and is not covered.

(8) Either the date of order or date of dispensing may be used in the "Date of Service" field; however, glasses must be dispensed prior to billing the Division of Medical Assistance Programs (Division). Note: Providers may bill for a fitting or repair on undispensed glasses under the following conditions:

(a) Death of the client prior to dispensing;

(b) Client failure to pick up ordered glasses. Documentation in the client's record must show that serious efforts were made by the provider to contact the client.

(9) All frames have a limited warranty. Check specific frame styles for time limits. All defective frames must be returned to the contractor.

(10) Table 140-0200

[ED. NOTE: Tables referenced are not included in rule text. Click here for PDF copy of table(s).]

Stat. Auth.: ORS 409.010, 409.040 & 409.050
Stats. Implemented: ORS 414.025, 414.065, 683.010 & 683.060

2-1-10 (Stats.)

7-1-10 (Hk)

Table 140-0200

CPT Code – Description

92340-- Fitting of spectacles, (except for aphakia); monofocal;

92341-- Bifocal;

92342-- Multifocal;

92352-- Fitting of spectacle prosthesis, (for aphakia;) monofocal;

92353-- Multifocal;

92358-- Prosthesis service for aphakia, temporary (disposable or loan, including materials);

92370-- Repair and refitting spectacles; (except for aphakia)

92371-- Spectacle prosthesis for aphakia.

410-140-0210 Buy-Ups

(1) When a client wants to pay the difference for a frame, lens type, or supply that is not on contract.

(2) Buy-ups are prohibited. Please refer to OAR 410-120-1350 for specific language on buy-ups.

Stat. Auth.: ORS 409.010, 409.040, 409.050

Stats. Implemented: ORS 414.025, 414.065

2-1-10 (Stats)

410-140-0220 Other Procedures

CPT Code 92499 By Report -- Requires prior authorization.

Stat. Auth.: ORS 409.010, 409.040, 409.050

Stats. Implemented: ORS 414.025, 414.065, 414.705, 683.010, 743.842

2-1-10 (Stats)

410-140-0240 Prescription Required

Dispensing of glasses by opticians must be supported by proper written order of a physician or optometrist. The order must specify the correction required.

Stat. Auth.: ORS 409.010, 409.040, 409.050

Stats. Implemented: ORS 414.025, 414.065, 683.010, 683.130, 683.160, 683.190, 683.510

2-1-10 (Stats)

410-140-0260 Purchase of Ophthalmic Materials

(1) The Division of Medical Assistance Programs (Division) contracts with SWEEP Optical to buy materials (i.e., frames, lenses, specialty frames, and miscellaneous items). Rates for materials are negotiated by the Oregon Department of Administrative Services. All frames, lenses and miscellaneous items filled into these frames are to be provided only by SWEEP Optical. It is the provider's responsibility to verify the client's eligibility for vision materials before ordering from SWEEP Optical. See OAR 410-140-0050.

(2) Contact lenses or glasses are limited to once every 24 months for eligible adults (see 410-140-0050). Replacement of contact lenses is limited to a total of two contacts every 12 months (or the equivalent in disposable lenses), and does not require PA; See OAR 410-140-0160 for information on coverage of contact lenses.

(3) One pair of additional glasses is covered within 120 days following cataract surgery. When ordering glasses from SWEEP Optical for post-cataract surgery, mark the appropriate box indicating surgery was performed within 120 days.

(4) The purchase of glasses for children (birth through age 20) is covered when it is documented in the physician/optometrist's clinical record as medically appropriate.

(5) Ophthalmic materials that are not covered include, but are not limited to the following:

(a) Two pair of glasses in lieu of bifocals or trifocals in a single frame;

(b) Hand-held, low vision aids;

(c) Nonspectacle mounted aids;

(d) Single lens spectacle mounted low vision aids;

(e) Telescopic and other compound lens system, including distance vision telescopic, nearvision telescopes, and compound microscopic lens systems;

(f) Extra or spare pairs of glasses or contacts;

(g) Anti-reflective lens coating;

(h) U-V lens;

(i) Progressive and blended lenses;

(j) Bifocals and trifocals segments over 28mm including executive;

(k) Aniseikonia lenses;

(l) Sunglasses.

(6) Contractor Services: All materials and supplies (except for contact lenses) must be provided by SWEEP Optical including any frames purchased that are not in the contract.

(7) Frames not included in the contract with SWEEP Optical may be purchased through SWEEP Optical if there is an unusual circumstance or medical need that prevents the client from using any of the existing frames or lenses. For example: A client has an unusually large head size that requires a custom frame or a larger frame than provided in the contract. This does not imply that a client can select a frame that is not included in the contract because the providers's office does not carry the full selection of contract frames or that the client does not approve of the selection.

(8) Frames purchased that are not included in the contract require prior authorization. The provider working with the client should make every attempt to determine what frame will work and provide that information in writing to the Division.

(9) If providers need assistance with locating a frame to meet the client's need, you may contact SWEEP Optical's optician. Once the approval is granted, SWEEP Optical will order and process the glasses. Frames not included in the contract may exceed the limit of the required 7-10 calendar-day turn-around time frame.

(10) Scratch Coating is included in the lens service. Providers cannot charge scratch coating to the Division, the Fully Capitated Health Plan or the client as a separate service.

(11) Prior Authorization (PA) for materials provided by SWEEP Optical:

(a) Materials that require PA must be medically necessary and include:

(A) Frames not in contract with SWEEP Optical (See Visual Services Supplemental Information for accessing frames catalog);

(B) Deluxe frames;

(C) Specialty lenses or lenses considered as “not otherwise classified” by HCPCS;

(b) If the Division approves PA, the Division will send Notice of PA to SWEEP Optical, who then must submit a copy of the PA approval and confirmation number to the requesting provider;

(c) After receiving PA approval, the provider will submit the prescription to SWEEP Optical to be filled.

(12) PA for contact lenses -- PA is required for adults (except for the treatment of injury or disease, including Keratoconus).

(13) Limitations: The provider is responsible to submit to SWEEP Optical specific, appropriate written documentation required for each service. It is the provider’s responsibility to maintain proper documentation of services provided to each client. SWEEP Optical is not responsible if the Division determines the documentation in the

client's record does not allow for the service as directed by the limitations indicated in the administrative rules. The following services no longer require PA but are subject to strict limitations:

(a) Frames and lenses for adults age 21 and over are limited to once every 24 months. Glasses with a prescription that is equal to or less than +/-.25 diopters in both eyes are not covered;

(b) Replacement of frame fronts and temples for frames not in the SWEEP Optical contract (See Visual Services Supplemental Information for accessing frames catalog): Limited to frames that were not included in contract that were purchased with proper prior approval or when a client has a medical condition that requires the use of a specialty temple;

(c) Tints and Photochromic lenses: Limited to clients with documented albinism and pupillary defects. Appropriate documentation must be submitted to SWEEP Optical by a physician or an optometrist. The physician or optometrist must select and submit the most appropriate ICD-9-CM code to SWEEP Optical;

(d) Other medically necessary items for a contract frame (i.e., cable temples, head-strap frame), when a client has a medical condition that requires the use of a specialty temple, nose pieces, head strap frame. Appropriate documentation must be submitted to SWEEP Optical by a physician or an optometrist;

(e) Nonprescription glasses: Limited to clients that do not require any correction in one eye and where there is blindness in one eye. The purpose of this exception is to offer maximum protection for the remaining functional eye. Appropriate documentation must be submitted to SWEEP Optical by a physician or an optometrist;

(f) High Index Lenses:

(A) Power is +/- 10 or greater in any meridian in either eye; or

(B) Prism diopters are 10 or more diopters in either lens;

(g) Polycarb lenses are limited to the following populations:

(A) Children (birth through age 20);

(B) Clients with developmental disabilities; and

(C) Clients who are blind in one eye and need protection for the other eye, regardless of whether a vision correction is required.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 409.010, 409.040 & 409.050
Stats. Implemented: ORS 414.025, 414.065 & 683.52

2-1-10 (Stats)

7-1-10 (Hk)

410-140-0280 Vision Therapy Services

(1) Vision therapy is not covered for adults (age 21 and older).

(2) Vision therapy is only covered for children (birth through age 20) for treatment of strabismus and other disorders of binocular eye movements (See the Health Services Commission's Prioritized List of Health Services). It is limited to a total of six sessions per calendar year without prior authorization (additional therapy sessions require prior authorization):

(a) The therapy treatment plan and regimen will be taught to the client, family, foster parents and/or caregiver during the therapy treatments. No extra treatments will be authorized for teaching. Therapy that can be provided by the client, family, foster parents, and/or caregiver is not a reimbursable service;

(b) Include the following additional information on the DMAP 3071 (Request for Prior Authorization):

(A) Client's name;

(B) Medical Assistance Program recipient number;

(C) Date of birth;

(D) Provider number;

(E) Procedure code;

(F) Medical justification;

(G) Diagnosis and ICD-9-CM code (to the highest specificity);

(H) Development diagnostic exam result;

(I) Goals and objectives.

(3) Evaluation and Management CPT codes, or any unlisted CPT or HCPC procedure code, cannot be used to bill the Division of Medical Assistance Programs (Division) for vision therapy services. Vision Therapy Services are limited to code 92065, Orthoptic and/or pleoptic training with continuing medical direction and evaluation. Use this code for initial evaluation exam:

(A) Limited to six sessions per calendar year;

(B) More than six sessions require prior authorization.

Stat. Auth.: ORS 409.010, 409.040 & 409.050
Stats. Implemented: ORS 414.025 & 414.065

2-1-10 (Stats only)

7-1-10 (Hk)

410-140-0300 Post-surgical Care

The Division of Medical Assistance Programs (Division) will pay optometrists for post-operative care which is within their scope of practice. The ophthalmologist performing the surgery must indicate on the claim, by the use of an appropriate modifier, that only the surgical procedure is being billed, not the follow-up care:

(1) Ophthalmologists and optometrists will be paid a percentage of the maximum allowable for the surgical procedure.

(2) Optometrists must bill using the first post-operative date of service and the same CPT procedure code as the surgeon. Follow-up care includes all visits and examinations provided within 90 days following the date of surgery. Claims for evaluation and management services and ophthalmological examinations will be denied if billed within the 90 days follow-up period.

Stat. Auth.: ORS 409.010, 409.040 & 409.050
Stats. Implemented: ORS 414.025, 414.065, 683.010 & 683.030

2-1-10 (Stats)

7-1-10 (Hk)

410-140-0320 Radiological Services

The Division of Medical Assistance Programs reimburses radiological services that are within the scope of practice of an optometrist or an ophthalmologist. Providers must bill the most appropriate CPT and modifier codes.

Stat. Auth.: ORS 409.010, 409.040, 409.050

Stats. Implemented: ORS 414.025, 414.055, 414.065, 683.010, 683.030

2-1-10 (Stats)

410-140-0380 Administrative Exam Services Authorized by the Branch Office

Effective for Services Provided On or After December 15, 1992

Administrative Exam Services Authorized by the Branch Office

(1) Refer to the Administrative Examination and Billing Services rules for information on administrative examinations.

Stat. Auth.: ORS 409.010, 409.040, 409.050, 409.110

Stats. Implemented: ORS 414.025, 414.065, 414.725, 414.737

2-1-10 (Stats)

410-140-0400 Contractor Services/Provider Ordering

(1(1) The Division of Medical Assistance Programs (Division) contracts with SWEEP Optical Laboratories (also referred to herein as contractor) to provide vision materials and supplies. Providers needing materials and supplies must order those directly from the contractor.

(2) Requesting provider's responsibilities:

(a) Requesting providers must check client eligibility prior to mailing or faxing an order to the contractor;

(b) Providers must use the appropriate order forms that can be obtained from the contractor. A copy of the order form is included in the Visual Services Supplemental Information found on this Division website:
http://www.dhs.state.or.us/policy/healthplan/guides/vision/main.html;

(c) Providers must mail or fax written orders to the contractor using the address and fax number shown in the Visual Services Supplemental Information;

(d) Providers cannot request orders by telephone. The telephone number listed in the Visual Services Supplemental Information is for order inquiries or general information.

(3) Contractor's responsibilities:

(a) Order specifications:

(A) The contractor must provide the order as specified by the ordering provider;

(B) The contractor must pay for postage via US mail or UPS for all returned orders which are not to specifications of the order or that are damaged in shipping;

(C) While the contractor will not accept initial orders via telephone, the contractor must accept telephone calls or faxed messages regarding orders that are not made to specifications;

(D) When the contractor is notified of an item to be returned due to the item not being made to specifications in the original order, the contractor must begin remaking the product as soon as they are notified, whether or not they have received the item being returned. (The ordering provider must return the original product to the contractor with a written explanation of the problem and indicate the date the provider contacted the contractor to remake the order.);

(b) Original order delivery:

(A) The contractor must deliver the original order of materials and supplies to the ordering provider within 7 calendar days of the date the order is received;

(B) If there is an unavoidable delay causing the need for more turn-around time, the contractor must:

(i) Notify the ordering provider of the delay within 2 days of receipt of the order;

(ii) Document the reason for delay and the date the ordering provider was notified; and

(iii) Deliver delayed orders within a “reasonable” time.

(4) Neither the Contractor nor the Division is responsible for expenses incurred due to "doctor's error" or "re-do's" (remake of materials or supplies not due to client’s negligence).

(5) Contractor may use the date of order as the date of service (DOS) but may not bill the Division until the order has been completed and shipped.

(6) Contractor must bill the Division using HCPCS Codes listed in the contract agreement. Payment will be at contracted rates. Refer to

Supplemental Information, found on the Division website, for billing instructions.

(7) The contractor must include eyeglass cases with every frame. Cases need not be included in orders for only lenses, temples or frame fronts.

(8) Contractor will provide display frames to the ordering provider at a cost not to exceed the contract cost.

(9) Contractors will have unisex frame styles available, and will allow clients to choose any frame regardless of category listed (i.e. women may choose "Girls" frames).

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 409.010, 409.040 & 409.050
Stats. Implemented: ORS 414.025, 414.065, 414.085, 683.510 & 683.520

2-1-10 (Stats)

7-1-10 (Hk)