DHS Oregon Department of Human Services

Health Services
Office of Medical Assistance Programs

Visual Services Program

Rulebook

Includes:

1) Current Update Information (changes since last update)

2) Table of Contents

3) Complete set of Visual Services Program Administrative Rules

Visual Services Program Rulebook

Update Information

for

October 1, 2005

OMAP updated the Visual Services Program Rulebook with the following:

- ✓ New cover page
- ✓ New Update information page (in place of a provider letter)
- ✓ New Table of Contents
- ✓ Rule and page numbers at the bottom of each rule

OMAP also amended the Rulebook by repealing 410-140-0000 to remove inaccurate text.

As administrative rules are revised in this program, you will receive a new update information page, a history page indicating how you can know you have a complete set of administrative rules for this program, and the revised administrative rules.

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

DEPARTMENT OF HUMAN SERVICES

MEDICAL ASSISTANCE PROGRAMS

DIVISION 140

VISUAL SERVICES

410-140-0020 Managed Health Care Organizations

410-140-0040 Prior Authorization

410-140-0050 Eligibility

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

410-140-0080 Medicare/Medicaid Assistance Program Claims

410-140-0110 Client Copayments

410-140-0115 Copayment for Standard Benefit Package

410-140-0120 Procedure Codes

410-140-0140 Ophthalmological Diagnostic and Treatment Services Coverage

Table 0140-1 Special Ophthalmological Services

410-140-0160 Contact Lens Services

410-140-0180 Ocular Prosthetics, Artificial Eye

410-140-0200 Fitting and Repair

Table 140-0200

410-140-0210 Buy-Ups

410-140-0220 Other Procedures

410-140-0240 Prescription Required

410-140-0260 Purchase of Ophthalmic Materials

410-140-0280 Vision Therapy Services

410-140-0300 Postsurgical Care

410-140-0320 Radiological Services

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

410-140-0400 Contractor Services

410-140-0020 Managed Health Care Organizations

(1) OMAP 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 OMAP, the FCHP, nor the client are responsible for payment.

(3) Services covered by an FCHP will not be reimbursed by OMAP; reimbursement is a matter between the FCHP and the provider. If the FCHP utilizes the OMAP 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 OMAP 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
Stats. Implemented: ORS 414.065 4-1-99

410-140-0040 Prior Authorization

(1) Prior Authorization (PA) requirements for services or supplies listed in the Visual Services guide are intended for clients that are not enrolled in a Fully Capitated Health Plan (FCHP). Contact the client's FCHP for their policy governing PA requirements.

(2) PA is approved by the Office of Medical Assistance Programs (OMAP) prior to the provision of services to make payment for medically appropriate services for clients that are not enrolled in an FCHP. To obtain a PA for vision services for clients that are enrolled in an FCHP, call the FCHP.

(3) If a claim has been denied because PA was not obtained prior to the service, or the rules as established by OMAP or the FCHP were not followed, neither OMAP, the FCHP, nor the client are responsible for payment.

(4) A PA number must be present on the billing claim for any visual service with a "PA" indicator in this guide, 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. Always check for eligibility on the date of service. After eligibility has been verified, (see General Rule #410-120-1140, that covers eligibility), it is the responsibility of the provider to determine if the service requires PA If a PA is required and the client is:

(a) Fee-for-service (not enrolled in an FCHP) -- Obtain PA from OMAP as outlined below;

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

(8) OMAP will review documentation submitted to determine if a PA will be made. PA requests which do not meet the rule criteria will be denied. If a PA is requested after the service has been rendered, it will be denied.

(9) OMAP will not accept phone calls for PA.

(10) To determine client eligibility, check the client's Medical Care ID for eligibility information or call AIS.

(11) The request for PA must be submitted and signed by the provider with the following information:

(a) The client's name and recipient number from the Medical Care ID;

(b) The provider's name and OMAP provider number;

(c) A description of the needed item or service. Use the appropriate procedure code from this guide and acquisition cost of the item, if applicable;

(d) A Statement of medical appropriateness showing the need for the item or service and why other options are inappropriate. Include diopter information and appropriate ICD-9-CM diagnosis codes;

(e) Any clinical data or evidence, including medical history, which provides additional information or may simplify the review process.

(12) Once OMAP receives the PA request from the provider SWEEP Optical will receive a Notice of Prior Authorization (OMAP 1072). The OMAP 1072 will specify the services authorized and show the nine-digit PA number. This number must be entered in Field 23 of the HCFA-1500, or in Field 23 of the OMAP 505, when appropriate. SWEEP Optical will then contact the provider. The provider will then fax or mail the prescription to SWEEP Optical.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065 10-1-00

410-140-0050 Eligibility

(1) The Vision Program requires the following types of eligibility conditions to be verified:

(a) The provider must verify if the client is eligible for Medical Assistance Program coverage (Title XIX or Title XXI) and if the client is enrolled in an MCO or assigned to a PCCM;

(b) The provider must verify if the client is eligible to receive vision services. For example, some vision services such as an intermediate or comprehensive eye exam for the purpose of prescribing glasses or contacts are limited to once every 24 months for adults. The provider must verify if the client has received these services within the limitation period from OMAP and/or the client's FCHP.

(2) To Verify Service Eligibility:

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

(b) It is the responsibility of the provider to maintain accurate and complete client records. If a client is an established client, incomplete information on AIS does not dissolve 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;

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

(d) AIS contains the last date of service for glasses/contacts. OMAP and several FCHPs contract with SWEEP Optical to provide vision materials. Regardless of the message on AIS, SWEEP Optical will

not fill orders for clients that have received services in the past 24 months. When this happens:

(A) If the client is currently a fee-for-service client (not enrolled in an FCHP), OMAP 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, OMAP will reimburse the provider for the exam only;

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

(e) It is the responsibility of the provider to verify eligibility for vision 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.

(f) AIS can verify client eligibility for Oregon's Medical Assistance Programs for past and present dates. AIS can only verify vision service history for a client for the day the provider accesses AIS (see the AIS User's guide). AIS does not verify future dates.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

4-1-02

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 OMAP 505 form for those clients who have Medicare/Medical Assistance Program coverage, if Medicare transmits incorrect information to OMAP. Opticians cannot bill Medicare.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

10-1-04

410-140-0080 Medicare/Medicaid Assistance Program Claims

(1) When a client has both Medicare and Medical Assistance Program coverage, optometrists and ophthalmologists must bill Medicare first. This must be done for all vision services.

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

(3) Medicare will automatically forward your claim to OMAP.

(4) In all of the following situations, bill OMAP on the OMAP 505:

(a) If Medicare sends incorrect claim information to OMAP 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. Enter any Medicare payment received in the "Amount Paid" field (box 28) or use the appropriate TPR explanation code in the "Other Health Insurance Coverage" (box 9) portion on the OMAP 505. Be sure to enter the Medicare Maximum Allowable in Box 24H. If any billing corrections are needed and payment is made by OMAP, an Adjustment Request (OMAP 1036) must be submitted to correct payment;

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

(5) Send all completed OMAP 505 forms to: Office of Medical Assistance Programs, PO Box 14015, Salem, OR 97309.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

10-1-04

410-140-0110 Client Copayments

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

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

1-1-03

410-140-0115 Standard Benefit Package

(1) 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.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

10-1-04

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 guide 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. OMAP will recognize modifiers from CPT, HCPCS and Oregon Medicare.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

4-1-02

410-140-0140 Ophthalmological Diagnostic and Treatment Services Coverage

(1) Ophthalmological diagnostic and treatment services are not limited except as directed by the rules contained in the Visual Services guide, General Rules -- 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) 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 adults age 21 and over are limited to once every 24 months. 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) If the client is assigned to a PCCM the provider must get a referral for a medical eye exam prior to the service being rendered.

(8) 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 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.

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

(10) 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.

(11) 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.
Table 0140-1.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
10-1-00

Table 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, includes the supply of lenses. Use for medical bandage for acute injury or disease including Keratoconus only. 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 speciular 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 Adults (age 21 or older):

(a) Prior Authorization 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. 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 does not require PA;

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

(D) Nystagmus;

(E) Irregular astigmatism;

(F) Aphakia.

(b) Prescription and fitting of either contact lenses or glasses is limited to once every 24 months. Replacement of contact lenses is limited to a total of two contacts every 12 months, and does not require PA;

(c) 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 does not require PA;

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

(D) Nystagmus;

(E) Irregular astigmatism;

(F) 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 may be obtained through SWEEP Optical. Include brand names with prescription information when ordering contact lenses. Contact lenses not obtained through SWEEP Optical must be billed to OMAP 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 not obtained through SWEEP Optical will be the lesser of OMAP 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.

(4) 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 required for adults only; for Keratoconus use 92070;

(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;

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

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

10-1-04

410-140-0180 Ocular Prosthetics, Artificial Eye

(1) 823390-- Prescription, fitting and supply of ocular prosthesis (artificial eye), with medical supervision of adaptation. Limited to one prosthesis every five years after age 20.

(2) 92335-- Prescription of ocular prosthesis (artificial eye) and direction of fitting and supply by independent technician, with medical supervision of adaptation. Limited to one prosthesis every five years after age 20.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

1-15-96

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, other), 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 below. 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. Presence of 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 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 billed when replacing parts and can only be billed 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 OMAP. 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 serous 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.

Table 140-0200

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
10-1-03

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
Stats. Implemented: ORS 414.065

4-1-99

410-140-0220 Other Procedures

CPT Code 92499 By Report -- Requires prior authorization.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

7-1-96

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
Stats. Implemented: ORS 414.065

6-1-92

410-140-0260 Purchase of Ophthalmic Materials

(1) The Office of Medical Assistance Programs (OMAP) buys materials (i.e., frames, lenses, specialty frames, contact lenses and miscellaneous items) through SWEEP Optical. Rates for materials are negotiated by the Oregon Department of Administrative Services. All frames listed in the OMAP Visual Services guide and the lenses and miscellaneous items filled into these frames are to be provided only by SWEEP Optical. It is the responsibility of the provider to verify eligibility of the client before ordering materials from the Contractor.

(2) Adults (age 21 and older) are limited to either one complete pair of glasses (frame and lenses) or contact lenses every 24 months. 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) Children (birth through age 20) are covered for glasses 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 pairs 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 must be provided by SWEEP Optical including any frames purchased "off" contract.

(7) Frames not "on" 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 larger frame than provided on the contract or a custom frame. This does not imply that a client can select an "off" contract frame because your office does not carry the full selection of contract frames or that the client does not approve of the selection.

(8) Frames purchased "off" 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 OMAP.

(9) If you need assistance with locating a frame to meet the client's need, you may also contact Sweep Optical's optician. Once the approval is granted, Sweep Optical will order and process the glasses. Frames "off" 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. Scratch coating cannot be charged to OMAP, the Fully Capitated Health Plan or the client as a separate service.

(11) Prior Authorization (PA):

(a) Materials provided by SWEEP Optical which require PA must be medically necessary and will be subject to the following limitations:

(A) Frames not listed in the Visual Services provider guide;

(B) Contact lenses -- adults only (except for the treatment of injury or disease including Keratoconus);

(C) Polycarb lenses.

(b) PA will be sent to SWEEP Optical who then must forward a copy of the PA approval and number to the requesting provider.

(12) Limitations: The following services no longer require PA but are subject to strict limitations. The provider is responsible for providing SWEEP Optical with the specific documentation in writing as indicated under each service. It is the responsibility of the provider to maintain proper documentation of services provided to a client. Sweep Optical will not be responsible if OMAP determines the documentation in the client's record does not allow for the service as directed by the limitations indicated in the rules in this guide:

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

(b) Replacement frame fronts and temples for frames not listed in the Visual Services provider guide. Limited to frames purchased "off" contract 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. Documentation can only

be provided by a physician or an optometrist. The physician or optometrist must select the most appropriate ICD-9-CM code and supply the 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. Documentation can only be provided by a physician or an optometrist. Provide appropriate documentation for the add-on to SWEEP Optical;

(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. Documentation can only be provided by a physician or an optometrist. Provide appropriate documentation to Sweep Optical;

(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.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

10-1-02

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 OMAP 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 Office of Medical Assistance Programs (OMAP) 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
Stats. Implemented: ORS 414.065

10-1-02

410-140-0300 Postsurgical Care

The office of Medical Assistance Programs (OMAP) 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 184.750 & ORS 184.770
Stats. Implemented: ORS 414.065

6-1-92

410-140-0320 Radiological Services

Radiological Services are covered within scope of practice of an optometrist or an ophthalmologist. Bill the most appropriate CPT code, using Type of Service "K" for a complete service; "T" for technical service only and "P" for professional service only.

Stat. Auth.: ORS 184.750 & ORS 184.770
Stats. Implemented: ORS 414.065

6-1-92

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 & ORS 409.110
Stats. Implemented: ORS 414.065

10-104

410-140-0400 Contractor Services

(1) The Office of Medical Assistance Programs (OMAP) contracts with SWEEP Optical Laboratories to provide vision materials and supplies. Order forms can be obtained from SWEEP Optical. A copy of the order form is included, for your information in the Visual Services provider guide. It is the responsibility of the requesting provider to check client eligibility prior to mailing or faxing an order to the Contractor. Written orders should be mailed or faxed to SWEEP Optical using the address and fax number shown in the provider guide. Orders may not be given over the phone. A phone number is listed in the provide guide for order inquiries or general information.

(2) Clients may choose any frame regardless of category listed (i.e. women may choose "Girls" frames).

(3) Contractor responsibilities:

(a) Turn-around time shall be seven calendar days from receipt of the order by the contractor until delivery to the ordering provider;

(b) Ordering provider must be notified within two days of receipt of order whenever there is a delay. Delayed orders must be delivered within a reasonable time;

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

(d) Provide the order as specified by the ordering provider;

(e) 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;

(f) Contractor will not accept phone orders for the initial orders. Contractor must accept phone calls or faxed messages if orders are not to specifications and must begin remaking the product before receiving the materials not to specifications. The ordering provider must return the product to the contractor with a note stating the

problem and date contact was made with the contractor to remake the order.

(4) Neither the Contractor nor OMAP are responsible for expenses incurred due to "doctor's error" or "re-do's".

(5) Eyeglass cases are to be included with every frame. Cases will not be included in orders for only lenses, temples or frame fronts.

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

(7) Contractor must bill OMAP using HCPCS or OMAP Unique Codes listed in the contract agreement. Payment will be at contracted rates.

(8) Contractor must use Type of Service (TOS) Code "S" when billing for plastic lenses, frames and miscellaneous items, and TOS "F" when billing for glass lenses.

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

(10) All brands of contacts will be available through the Contractor. When requesting contacts, include the brand in addition to the prescription. The Contractor cannot mail contacts directly to the client. All contacts, including replacement lenses, must be dispensed to the client by the Ophthalmologist or Optometrist.

(11) Unisex frame styles for men, women, girls or boys are available through the Contractor.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

10-1-01