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CHAPTER 410
OREGON HEALTH AUTHORITY
HEALTH SYSTEMS DIVISION: MEDICAL ASSISTANCE PROGRAMS

FILING CAPTION: Vision And Dental Benefits Update, Removal Of Outdated Language, And Benefit Clarification

EFFECTIVE DATE: 09/25/2022

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RULES:
410-123-1510, 410-140-0020, 410-140-0040, 410-140-0050, 410-140-0140, 410-140-0200

AMEND: 410-123-1510

REPEAL: Temporary 410-123-1510 from DMAP 44-2022

NOTICE FILED DATE: 08/10/2022

RULE SUMMARY: Detailed dental care benefits for pregnant individuals

CHANGES TO RULE:

410-123-1510
Additional Dental Care Benefits for Pregnant Individuals ¶

(1) This rule sets forth the access standards for dental care for pregnant individuals who receive Oregon Health Plan (OHP) benefits through the fee-for-service (FFS) delivery system.¶
(2) Pregnant clients shall be seen, treated in person or via teledentistry for an OHP-covered service within the following time frames:¶
(a) For emergency dental care: within 24 hours;¶
(b) For urgent dental care: within one week.¶
(c) For routine dental care: within four weeks, unless there is a documented special clinical reason that would make access longer than four weeks appropriate;¶
(d) For initial dental screening or examination: four weeks.¶
(3) Additional Dental Services are available to pregnant individuals if authorized as medically/Dentally Necessary due to the pregnancy. Additional services include:¶
(a) Additional prophylaxis, fluoride and periodontal services;¶
(b) Permanent crowns and resin-based composite crowns for anterior teeth;¶
(c) Prefabricated post and core;¶
(d) Root canals on first molars;¶
(e) Apexification/recalcification, pulpal regeneration;¶
(f) Alveoplasty not in conjunction with extractions.¶
(4) Nothing in this rule obligates a pregnant individual who receives dental care through the FFS delivery system to accept an offered appointment.¶

(5) Dental care benefits for pregnant individuals will continue 12 months following the end of the pregnancy.
Statutory/Other Authority: ORS 413.042, ORS 414.065
Statutes/Other Implemented: ORS 414.065

AMEND: 410-140-0020

NOTICE FILED DATE: 08/10/2022

RULE SUMMARY: Service delivery requirements.

CHANGES TO RULE:

410-140-0020
Service Delivery ¶

(1) The Division enrolls the following as providers of vision services:¶
(a) An individual licensed by the relevant state licensing authority to practice optometry; and¶
(b) A licensed ophthalmologist; and¶
(c) An optician as defined in ORS 683.510-683.530;¶
(2) Division clients are enrolled for covered health services to be delivered through one of the following means:¶
(a) Prepaid Health Plan (PHP) or Coordinated Care Organization (CCO):¶
(A) Payment for all vision services provided to PHP and CCO members by ophthalmologists, optometrists, and opticians is a matter between the provider and the PHP or CCO;¶
(B) Providers shall comply with PHP and CCO policies, including PA requirements, for reimbursement. Providers shall inform PHPs and CCOs of the last date of service when inquiring on service limitations. Failure to follow PHP and CCO rules may result in the denial of payment; and¶
(C) If the provider has been denied payment for failure to follow the rules established by the PHP or CCO, neither the Division, the PHP or CCO, nor the PHP or CCO member are responsible for payment; and¶
(D) If the PHP or CCO uses the Division's visual materials contractor or another visual materials contractor for visual materials and supplies, all issues shall be resolved between the PHP or CCO and the contractor;¶
(b) Fee-for-service (FFS):¶
(A) FFS clients are not enrolled in a PHP or CCO and may receive vision services from any Division-enrolled provider that accepts FFS clients subject to limitations and restrictions in the visual services program rules; and¶
(B) All claims shall be billed directly to the Division.¶
(3) The provider shall verify whether a PHP, CCO, or the Division is responsible for reimbursement.¶
(4) If a client receives services under section (2)(b) of this rule:¶
(a) The Division may require a PA for certain covered services or items before the service may be provided and before payment is made; and¶
(b) Providers needing materials and supplies shall order those directly from SWEEP Optical, except when the OHP client has primary Medicare coverage.¶
~~(5) Most OHP clients must pay a co-payment for some services. (See OAR 410-120-1230, Client Co-payment, and Table 120-1230-1 outlining details including client and service exemptions).~~
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025, 414.065, 414.631, 414.651

AMEND: 410-140-0040

NOTICE FILED DATE: 08/10/2022

RULE SUMMARY: Prior authorization requirements.

CHANGES TO RULE:

410-140-0040
Prior Authorization ¶

(1) Prior Authorization (PA) is defined in OAR 410-120-0000 and OAR 410-120-1320. Providers must obtain a PA from the:¶
(a) Enrolled member's Prepaid Health Plan (PHP) or Coordinated Care Organization (CCO); and¶
(b) The Division for clients who receive services on a fee-for-services basis and are not enrolled with a PHP or CCO.¶
(2) A PA does not guarantee eligibility or reimbursement. Providers shall verify the client's eligibility on the date of service and whether a PHP, CCO, or the Division is responsible for reimbursement.¶
(3) A PA is not required for clients with both Medicare and Division coverage when the service or item is covered by Medicare.¶
(4) Provider's shall determine if a PA is required and comply with all PA requirements outlined in these rules.¶
(5) Provider's shall ensure:¶
(a) That all PA requests are completed and submitted correctly. The Division does not accept PA requests via the phone. See Visual Services Supplemental Information Guide found at www.oregon.gov/OHA/~~healthplan/pages/v~~HSD/OHP/Pages/Policy-Vision.aspx;¶
(b) PA requests shall include:¶
(A) A statement of medical appropriateness showing the need for the item or service and why other options are inappropriate;¶
(B) Diopter information and appropriate International Classification of Diseases, 10th revision, Clinical Modification (ICD-10-CM) diagnosis codes;¶
(C) All relevant documentation that is needed for Division staff to make a determination for authorization of payment, including clinical data or evidence, medical history, any plan of treatment, or progress notes;¶
(c) The service is adequately documented. (See OAR 410-120-1360 Requirements for Financial, Clinical and Other Records.) Providers must maintain documentation to adequately determine the type, medical appropriateness, or quantity of services provided;¶
(d) The services or items provided are consistent with the information submitted when authorization was requested;¶
(e) The services billed are consistent with the services provided; and¶
(f) The services are provided within the timeframe specified on the PA document.¶
(6) Providers shall comply with the Division's PA requirements or other policies necessary for reimbursement before providing services to any OHP client who is not enrolled in a PHP. Services or items denied due to provider error (e.g., required documentation not submitted, PA not obtained, etc.) may not be billed to the client.¶
(7) The following vision services require PA:¶
(a) Contact lenses for adults (age 21 and older) and excludes a primary keratoconus diagnosis, which is exempt from the PA requirement. (See OAR 410-140-0160 Contact Lens Services for service and supply coverage and limitations);¶
(b) Vision therapy greater than six sessions. Six sessions are allowed per calendar year without PA. (See OAR 410-140-0280 Vision Therapy Services); and¶
(c) Specific vision materials (See OAR 410-140-0260 Purchase of Ophthalmic Materials for more information.):¶
(A) Frames not included in the Division's contract with contractor, SWEEP Optical; and¶
(B) Specialty lenses or lenses considered as "not otherwise classified" by Health Care Common Procedure Coding System (HCPCS);¶
(d) An unlisted ophthalmological service or procedure, or "By Report" (BR) procedures.¶
(8) The Division shall send notice of all approved PA requests for vision materials to the Division's contractor, SWEEP Optical; who forwards a copy of the PA approval and confirmation number to the requesting provider. (See OAR 410-140-0260 Purchase of Ophthalmic Materials.)
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 343.146, 414.065, 683.010, 743A.250

AMEND: 410-140-0050

NOTICE FILED DATE: 08/10/2022

RULE SUMMARY: Vision eligibility and benefit coverage.

CHANGES TO RULE:

410-140-0050
Eligibility and Benefit Coverage ¶

(1) Providers shall verify that an individual is an OHP client and eligible for benefits prior to providing services to ensure reimbursement for services provided. If the provider fails to confirm eligibility on the date of service, the provider may not be reimbursed. Providers must verify the client's eligibility including:¶
(a) That the individual receiving vision services is eligible on the date of service for the service provided;¶
(b) Whether an OHP client receives services on a fee-for-service basis or is enrolled with a PHP or CCO;¶
(c) That the service is covered under the client's OHP Benefit Package; and¶
(d) Whether the service is covered by a third party resource (TPR).¶
(2) The Division OHP vision benefit packages:¶
(a) For non-pregnant adults (age 21 and older):¶
(A) Visual services and materials to diagnose and correct disorders of refraction and accommodation are covered only when the client has a covered medical diagnosis ~~or,~~ following cataract surgery or a corneal lens transplant as described in OAR 410-140-0140, or when the client is in their protected post-partum 12-month period (see OAR 410-200-0135);¶
(B) Orthoptic and pleoptic training (vision therapy) is not covered; and¶
(C) Other visual services are covered with limitations as described in this rule.¶
(b) For pregnant adult women (age 21 and older):¶
(A) Orthoptic and pleoptic training (vision therapy) is not covered; and¶
(B) Other visual services are covered with limitations as described in these rules;¶
(c) For children (birth through age 20): Visual services are covered as described in this rule and without limitation when documentation in the clinical record justifies the medical need.¶
(3) Providers shall maintain accurate and complete client records, which includes documenting the quantity of services provided, as outlined in OAR 410-120-1360 (Requirements for Financial, Clinical and Other Records). For comprehensive eye exams, the standard of care and expectation is that the provider shall provide a dilated exam and document the type of dilating drops and time of dilation.¶
(4) The provider shall inform an OHP client when:¶
(a) Vision service or materials are not covered under the clients benefit package;¶
(b) Service limitation has been met and the benefit is no longer covered.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025, 414.065

AMEND: 410-140-0140

NOTICE FILED DATE: 08/10/2022

RULE SUMMARY: Vision Services Coverage and Limitations

CHANGES TO RULE:

410-140-0140
Vision Services Coverage and Limitations ¶

(1) Providers shall comply with the following rules in addition to the Visual Services program rules to determine service coverage and limitations for OHP clients according to their benefit packages:¶
(a) General Rules (OAR chapter 410, division 120);¶
(b) OHP administrative rules (~~410-141-0480, 410-141-0500, and 410-141-0520~~Chapter 410, Division 141);¶
(c) Health Evidence Review Commission's (HERC) Prioritized List of Health Services (List) (OAR 410-141-~~052~~3830); and¶
(d) Referenced guideline notes (The date of service determines the correct version of the administrative rules and HERC List to determine coverage.); and¶
(e) The Authority's general rules related to provider enrollment and claiming (OAR 943-120-0300 through 1505).¶
(2) The Division covers ocular prosthesis (e.g., artificial eye) and related services~~. See~~ (OAR 410-122-0640 ~~Eye Prostheses for service coverage and limitations~~).¶
(3) The Division covers reasonable services for diagnosing conditions, including the initial diagnosis of a condition that is below the funding line on the HERC List. Once a diagnosis is established for a service, treatment, or item that falls below the funding line, the Division may not cover any other service related to the diagnosis.~~¶~~
~~(4) Coverage for eligible adults (age 21 and older):¶~~
~~(a~~ unless the member meets the comorbidity rules (OAR 410-141-3820(10)).¶
(4) Coverage for eligible adults (age 21 and older):¶
(a) One complete examination and determination of refractive state is limited to once every 24 months for non-pregnant people;¶
(b) One complete examination and determination of refractive state is limited to once every 24 months for pregnant people and during the protected post-partum 12-month period (OAR 410-200-0135).¶
(c) Diagnostic evaluations and medical examinations are not limited if documentation in the physician's or optometrist's clinical record justifies the medical need for diagnosis;¶
(~~b~~d) Ophthalmological intermediate and comprehensive exam services are not limited for allowable medical diagnosis;¶
(~~c~~e) Vision therapy is not covered; and¶
(~~d~~f) Visual services for the purpose of prescribing glasses or contact lenses~~,~~ and fitting fees~~, or glasses or contact lenses:¶~~
~~(A) One complete examination and determination of refractive state is limited to once every 24 months for pregnant adult women;~~ are as follows:¶
(A) When determined necessary during a limited complete examination and determination of refractive state for pregnant people and during the protected post-partum 12-month period (OAR 410-200-0135).¶
(B) Non-pregnant adults are not covered, except when the client:¶
(i) Has a medical diagnose~~a~~is of aphakia, pseudo~~a~~phakia, congenital aphakia, keratoconus; or¶
(ii) Lacks the natural lenses of the eye due to surgical removal (e.g., cataract extraction) or congenital absence; or¶
(iii) Has had a keratoplasty surgical procedure (e.g., corneal transplant) with limitations described in OAR 410-140-0160 (Contact Lens Services and Supplies)~~; and¶~~
~~(iv) Is limited to one complete examination and determination of refractive state once every 24 months.~~¶
(5) OHP Plus Children (birth through age 20):¶
(a) All ophthalmological examinations and vision services, including routine vision exams, fittings, repairs, and materials are covered when documentation in the clinical record justifies the medical need;¶
(b) The standard of care and expectation is that all comprehensive eye exams for children be dilated.¶
(c) With the diagnosis of Amblyopia, band-aid patches treatment will be covered.¶
(d) Orthoptic and pleoptic training or "vision therapy" is:¶
(A) Covered when therapy treatment pairs with a covered diagnosis on the HERC List; and¶
(B) Limited to six sessions per calendar year without PA:¶
(i) The initial evaluation is included in the six therapy sessions;¶
(ii) Additional therapy sessions require PA (OAR 410-140-0040); and¶

(C) Shall be provided pursuant to OAR 410-140-0280 (Vision Therapy).¶
(6) Refraction determination is not limited following a diagnosed medical condition (e.g., multiple sclerosis).¶
~~[ED. NOTE: Tables referenced are available from the agency.]¶~~
~~[Publications: Publications referenced are available from the agency.]~~
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025, 414.065

AMEND: 410-140-0200

NOTICE FILED DATE: 08/10/2022

RULE SUMMARY: This section is regarding dispensing, fitting and repair of glasses.

CHANGES TO RULE:

410-140-0200
Dispensing, Fitting and Repair of Glasses ¶

(1) The Division covers the fitting of glasses and the refitting and repair of glasses only when glasses and replacement parts are purchased from:¶
(a) The Division's contractor;¶
(b) Any visual materials supplier when the client has primary Medicare coverage and the glasses were a Medicare-covered benefit.¶
(2) Fitting of glasses for:¶
(a) Eligible adults (age 21 years and older) is limited to once every 24 months, except when dispensing glasses within 120 days of cataract surgery;¶
(b) Eligible children (birth through age 20) only when documented in the patient's record as medically necessary.¶
¶
(3) Periodic adjustment of frames and tightening of screws is included in the dispensing fee and is not separately reimbursed.¶
(4) The Division accepts either the date of order or date of dispensing as the date of service on claims. Glasses must be dispensed prior to billing the Division, except under the following conditions:¶
(a) Death of the client prior to dispensing; or¶
(b) Client failure to pick up ordered glasses. Documentation in the client's record must show that the provider made serious efforts to contact the client.¶
(5) Providers must keep a copy of the delivery invoice included with all parts orders in the client's records or document the delivery invoice number in the client's records for all repair and refitting claims.¶
(6) Fitting of spectacle mounted low vision aids, single element systems, telescopic or other compound lens systems are not covered.¶
(7) All frames have a limited warranty. Check specific frame styles for time limits. All defective frames must be returned to the contractor.
Statutory/Other Authority: ORS 413.042
Statutes/Other Implemented: ORS 414.025, 414.065