Health Systems Division
Medicaid Programs

Visual Services Administrative Rulebook

Chapter 410, Division 140

Effective September 22, 2020

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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).

Stat. Auth.: ORS 413.042 & 414.065

Stats. Implemented: ORS 414.025, 414.065, 414.631 & 414.651

410-140-0040 – Prior Authorization

(1) Prior Authorization (PA) is defined in OAR 410-120-0000. 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/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.)

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 343.146, 414.065, 683.010 & 743A.250

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;

(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).

(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.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.065

410-140-0080 – Medicare/Medicaid Assistance Program Claims

(1) When a client has both Medicare and coverage through the Division, optometrists and ophthalmologists shall bill Medicare first for Medicare covered services.

(2) When an OHP client receives services on a fee-for-service basis under the Division's rules and has Medicare coverage:

(a) A provider may use any visual materials supplier to order visual materials; and

(b) The Division does not require PA for Medicare-covered services.

Stat. Auth.: ORS 413.042, 414.065

Stats. Implemented: ORS 414.025, 414.065, 414.075

410-140-0120 – ICD-10-CM Diagnosis, CPT/HCPCs Procedure Codes, and Modifiers

(1) Providers shall use an International Classification of Diseases, 10th revision, Clinical Modification (ICD-10-CM) diagnosis code on all claims.

(2) Providers shall provide the client's diagnosis to ancillary service providers (e.g., SWEEP Optical Laboratories) when prescribing services, equipment, and supplies.

(3) Providers shall use the standardized code sets required by the Health Insurance Portability and Accountability Act (HIPAA) and adopted by the Centers for Medicare and Medicaid Services (CMS). Providers shall accurately code claims using the combination of Health Care Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes in effect for the date the service was provided:

(a) Providers may not bill CPT or HCPCS procedure codes for separate procedures when a single CPT or HCPCS code includes all services provided. Providers shall comply with published coding guidelines;

(b) Intermediate and comprehensive ophthalmological services as described under the ophthalmology section of the CPT codebook shall be billed using codes included under this section and not those included under the Evaluation and Management section;

(c) When there is no appropriate descriptive procedure code to bill the Division, the provider shall use the code for “unlisted services.”

(4) The Division recognizes HIPAA compliant modifiers in coding.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.065

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);

(c) Health Evidence Review Commission's (HERC) Prioritized List of Health Services (List) (OAR 410-141-0520); 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) Diagnostic evaluations and medical examinations are not limited if documentation in the physician's or optometrist's clinical record justifies the medical need;

(b) Ophthalmological intermediate and comprehensive exam services are not limited for medical diagnosis;

(c) Vision therapy is not covered; and

(d) Visual services for the purpose of prescribing glasses or contact lenses, 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;

(B) Non-pregnant adults are not covered, except when the client:

(i) Has a medical diagnoses of aphakia, pseudoaphakia, 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) Orthoptic and pleoptic training or “vision therapy” is:

(A) Covered when therapy treatment pairs with a covered diagnosis on the HERC List;

(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);

(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).

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.065

410-140-0160 – Contact Lens Services and Supplies

(1) The following is general information regarding the Division's contact lens services and supplies coverage for clients who receive services on a fee-for-services basis:

(a) The prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation, is only covered when provided by an optometrist or other qualified physician. Contact lens fitting by an independent technician in an optometry office is not a covered service; and

(b) Contact lenses shall 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 postage for the item. Payment for contact lenses is the lesser of the Division fee schedule or acquisition cost.

(2) Coverage for eligible adults (age 21 or older) as defined in OAR 410-140-0050:

(a) PA is required for contact lenses for adults, except for a primary keratoconus diagnosis;

(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;

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

(D) Irregular astigmatism;

(E) Aphakia; or

(F) Post keratoplasty (e.g., corneal transplant), when medically necessary and within one year of procedure.

(c) Prescription and fitting of contact lenses is limited to once every 24 months. 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.

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

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

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

(B) Keratoconus;

(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.

(4) Contact lenses for treatment of disease or trauma (e.g., corneal bandage lens) are inclusive of the fitting. Follow up visits to determine eye health status may be separately reimbursed when the trauma or disease is clearly documented in the client record.

(5) An extra or spare pair of contacts is not covered.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.065

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.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.065

410-140-0260 – Contractor Services for Provider Ordering Vision Materials and Supplies

(1) The Division contracts with SWEEP Optical Laboratories (also referred to herein as contractor) to buy vision materials and supplies, excluding contact lenses. All frames, lenses, and miscellaneous items must be provided:

(a) Only by the contractor, unless the client has primary Medicare coverage; or

(b) By any visual materials supplier when the client has primary Medicare coverage for a Medicare covered item.

(2) Provider's shall:

(a) Verify the client's eligibility prior to submitting vision materials order to contractor;

(b) Obtain PA from the Division for items requiring PA prior to placing a vision materials order;

(c) Comply with the contractor's order submission requirements, as outlined in the Visual Services Supplemental Information Guide found at Division website: http://www.oregon.gov/OHA/healthplan/pages/vision.aspx;

(d) Submit prescription or order to the contractor upon notification of PA approval from the contractor; and

(e) Pay SWEEP Optical for any services provided by SWEEP Optical to a client who is not eligible for items. SWEEP Optical may not sell materials and supplies for non-eligible clients at the State Contracted Price.

(3) The Division covers glasses for:

(a) Eligible adults (age 21 and older) once every 24 months;

(b) Clients once within 120 days following cataract surgery. When ordering glasses from contractor, the date of surgery must be listed on the order form;

(c) Eligible children (birth through age 20) without limitation when it is documented in the physician's or optometrist's clinical record as medically appropriate.

(4) The contractor shall:

(a) Forward Division PA approval to the provider;

(b) Order specifications:

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

(B) The contractor shall pay for all shipping and handling charges for shipments to the provider via United States mail or United Parcel Service for all returned orders that do not meet the order specifications or that are damaged in shipping;

(C) The contractor may not accept initial orders via telephone. The contractor shall accept telephone calls or faxed messages regarding orders that do not meet specifications;

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

(c) Original order delivery:

(A) The contractor shall deliver the original order of materials and supplies to the provider within ten business days of the date the order is received;

(B) In the event of a delay in manufacturing or delivery, the contractor shall:

(i) Notify the ordering provider within two business days of receipt of the order;

(ii) Include a description of the order, the reason for delay, and the revised time of completion and delivery.

(C) Delivery of special order frames and lenses may exceed the required delivery time. In this event, the contractor shall provide the ordering provider with notice of the anticipated delay, provide a projected delivery date, and document the actual delivery time.

(5) The contractor:

(a) 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;

(b) Shall bill the Division using Health Care Common Procedure Coding System (HCPC) Codes listed in the contract agreement. Payment will be at contracted rates;

(c) Shall include eyeglass cases with every frame. Cases may not be included in orders for only lenses, temples, or frame fronts;

(d) Shall have unisex frame styles available and shall allow clients to choose any frame regardless of category listed;

(e) Is not responsible if the Division determines the documentation in the client's record does not allow for the service pursuant to limitations indicated set forth in the administrative rules.

(6) The contractor and the Division may not pay for costs, expenses, or any required rework due to errors by the provider.

(7) Frames for display purposes may be purchased from the contractor for the same price as frames for glasses negotiated by the Oregon Department of Administrative Services:

(a) A case may not be provided with display frames; and

(b) Quantity, style, size, and color of frames should be specified in the order for display frames.

(8) Buying-up, as defined in OAR 410-120-0000 is prohibited.

(9) The following ophthalmic materials are not covered and include, but are not limited to:

(a) Glasses with a prescription that is equal to or less than +/-.25 diopters in both eyes;

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

(c) Hand-held, low vision aids;

(d) Non-spectacle mounted aids;

(e) Single lens spectacle mounted low vision aids;

(f) Telescopic and other compound lens systems, including distance vision telescopic, near vision telescopes, and compound microscopic lens systems;

(g) Extra or spare pairs of glasses;

(h) Anti-reflective lens coating;

(i) U-V lens;

(j) Progressive and blended lenses;

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

(L) Aniseikonic lenses;

(m) Sunglasses; and

(n) Frame styles outside of the contract between the Division and contractor based on client preference and are not medically necessary.

(10) Costs for the following are included in reimbursement for the lens and are not separately reimbursed by the Division:

(a) Scratch coating;

(b) Prism;

(c) Special base curve; and

(d) Tracings.

(11) Materials that require PA are set forth in OAR 410-140-0040.

(12) If a frame cannot be located in the contractor's catalog at www.sweepoptical.com that meets the medical needs of the client:

(a) Providers shall contact contractor for assistance with locating a frame to meet the client's need; and

(b) Frames not included in the contract between the Division and contractor may be purchased through contractor with PA.

(13) The following services do not require PA, are subject to strict limitations, and require the physician or optometrist to submit appropriate documentation to contractor:

(a) Replacement parts for non-contracted frame styles are limited to frames purchased with PA approval;

(b) Tints and photochromic lenses are limited to clients with documented albinism and pupillary defects. Documentation provided to contractor shall include the most appropriate International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) code selected by a physician or optometrist;

(c) Other medically necessary items for a contract frame, when a client has a medical condition that requires the use of a specialty temple, nose pieces, head strap frame;

(d) Nonprescription glasses are 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;

(e) 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;

(f) Polycarbonate lenses are limited to the following populations:

(A) Eligible 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.

(14) Regardless of verification received via phone or electronic sources, the contractor may not fill orders for clients who do not have coverage or have met their vision benefit. When glasses are ordered and the client has met their vision benefit for the time period:

(a) The Division shall reimburse the provider for the exam only if the client is not an established client of the provider and the client is currently a fee-for-service (FFS) client with vision benefits;

(b) The provider shall contact the client's PHP or CCO if the client is enrolled with a PHP or CCO that contracts with SWEEP Optical. The contractor shall apply vision limitations pursuant to Division rules, regardless of changes to a client's enrollment status. The provider shall contact the client's PHP or CCO with the last date of service. The PHP or CCO shall determine if they will allow for an additional supply of glasses. If the client is an established client, regardless of incomplete information through phone or electronic verification systems or SWEEP Optical, the provider shall inform the PHP or CCO of the last date of service

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 279A.140, 414.025 & 414.065

410-140-0280 – Vision Therapy Services

(1) The Division covers orthoptic and pleoptic training or “vision therapy” as outlined in OAR 410-140-0140 Vision Services Coverage and Limitations.

(2) Providers shall develop a therapy treatment plan and regimen that shall be taught to the client, family, foster parents, and caregiver during the therapy treatments. No extra treatments shall be authorized for teaching.

(3) Therapy that can be provided by the client, family, foster parents, and caregiver is not a reimbursable service.

(4) All vision therapy services including the initial evaluation shall be billed to the Division with the Current Procedural Terminology (CPT) code for orthoptic and pleoptic training.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.06565

410-140-0300 – Post-operative Care

(1) The Division reimburses all covered surgical procedures as global packages, except when the surgeon codes the surgical procedure with a modifier indicating surgical procedure only, excluding post-operative care.

(2) Post-operative care provided outside the global package is:

(a) Reimbursable to optometrists when furnished within their scope of practice;

(b) Billed with:

(A) The surgical CPT code billed by the surgeon;

(B) The appropriate modifier noting post-operative care only; and

(C) The first post-operative date of service; and

(c) Reimbursed a percentage of the global reimbursement.

(3) Post-operative care includes all related follow-up visits and examinations provided within:

(a) Ninety days following the date of major surgery; or

(b) Ten days following the date of minor surgery; and

(c) Claims for evaluation and management services and ophthalmological examinations billed within the follow-up period shall be denied.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 & 414.065