Division of Medical Assistance Programs
Policy and Planning Section

Visual Services Administrative Rulebook

Chapter 410, Division 140

Effective October 1, 2015

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410-140-0020 – Service Delivery

(1) The Division of Medical Assistance Programs (Division) enrolls the following as providers of vision services:

(a) A person licensed by the relevant state licensing authority to practice optometry (e.g., doctors of optometry – optometrists, optometric physicians);

(b) A licensed ophthalmologist (e.g., physician). See also Oregon Administrative Rule (OAR) 410 Division 130 governing medical-surgical services, including radiology;

(c) Optician as defined in ORS 683.510-683.530. The Division contracts with SWEEP Optical Laboratories for eyeglass materials (i.e., frames, lenses, specialty frames, and miscellaneous items), excluding contact lenses. See OAR 410-140-0260 Purchase of Ophthalmic Materials for restrictions.

(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). See OAR 410-120-0250 Prepaid Health Plan or Coordinated Care Organization:

(A) Most Oregon Health Plan (OHP) clients have prepaid health services contracted for by the Oregon Health Authority (Authority) through enrollment in a PHP or a CCO;

(B) Payment for all vision services (including routine vision exams, fittings, repairs, therapies and materials) provided to PHP and CCO members by ophthalmologists, optometrists and opticians is a matter between the provider and the PHP or CCO:

(i) Providers shall comply with PHP and CCO policies, including prior authorization 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

(ii) 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

(iii) If the PHP or CCO utilizes 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 can 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. Refer to Oregon Administrative Rule (OAR) 410-120-1140 Verification of Eligibility.

(4) If a client receives services under sections (2)(b) of this rule:

(a) The Division may require a prior authorization for certain covered services or items before the service can be provided and before payment is made. See OAR 410-140-0040 Prior Authorization for more information; and

(b) Providers needing materials and supplies shall order those directly from SWEEP Optical, except when the Oregon Health Plan client has primary Medicare coverage. See OARs 410-140-0080, 410-140-0260 and 410-140-0400.

(5) Most Oregon Health Plan (OHP) clients are responsible for paying a co-payment for some services. See OAR 410-120-1230, Client Co-payment, and Table 120-1230-1 for specific details including client and service exemptions.

Stat. Auth.: ORS 413.042 and 414.065

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

410-140-0040 – Prior Authorization

(1) Prior Authorization (PA) is defined in Oregon Administrative Rule (OAR) 410-120-0000 Acronyms and Definitions. Providers must obtain a PA from the:

(a) Enrolled member's Prepaid Health Plan (PHP) or Coordinated Care Organization (CCO) (See OAR 410-140-0020 and refer to 410-120-0250, PHP or CCOs.); and

(b) Division of Medical Assistance Programs (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. It is the responsibility of the provider to verify the client's eligibility on the date of service and whether a PHP, CCO or the Division is responsible for reimbursement. Refer to OAR 410-120-1140 Verification of Eligibility.

(3) A PA is not required for clients with both Medicare and Division coverage when the service or item is covered by Medicare.

(4) It is the provider's responsibility to determine if a PA is required and to comply with all PA requirements outlined in these Visual Services administrative rules. See also OAR 410-120-1320 Authorization of Payment.

(5) It is the provider's responsibility to ensure:

(a) PA requests are completed and submitted correctly. The Division does not accept PA requests via the phone. Refer to the Visual Services Supplemental Information Guide found on this Division website at www.oregon.gov/OHA/healthplan/pages/vision.aspx;

(b) PA requests 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 in the provider's files 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 those services provided; and

(f) The services are provided within the timeframe specified on the authorization of payment document.

(6) It is the providers' responsibility to 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, prior authorization not obtained, etc.), cannot be billed to the client. (See OAR 410-120-1280.)

(7) Vision services requiring PA include:

(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 also 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;

(B) Deluxe frames; and

(C) 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 sends Notice of all approved PA requests for vision materials to DMAP'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.)

(9) Table 140-0040-1. [Table not included. See ED. NOTE.]

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

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.025, 414.065, 683.010 & 743.842

Table 140-0040-1 – Services That Require Payment Authorization

92065	For seven or greater therapy sessions in a calendar year (six or fewer therapy sessions do not require a PA)
92310	PA requirement is for adults (age 21 and older) only, and a primary keratoconus diagnosis is excluded from PA requirement. Contact lenses are reimbursed separately.
92499	By Report

410-140-0050 – Eligibility and Benefit Coverage

(1) It is the provider's responsibility to verify that a person is an Oregon Health Plan (OHP) client with appropriate benefits prior to providing services in order to ensure reimbursement of services rendered. The provider assumes full financial risk in serving a person not confirmed by the Division as eligible on the date of service. Refer to OAR 410-120-1140 Verification of Eligibility. It is the responsibility of the provider to verify a client's eligibility and:

(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 (open card) basis or is enrolled with a Prepaid Health Plan (PHP) or Coordinated Care Organization (CCO). (See OAR 410-140-0020 Service Delivery.);

(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), (See OAR 410-120-1280 Billing.)

(2) Division OHP vision benefit packages include:

(a) Non-pregnant adults (age 21 and older):

(A) Visual services and materials to diagnose and correct disorders of refraction and accommodation are not covered, except 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/or pleoptic training (vision therapy) is not covered; and

(C) Other visual services are covered with limitations as described in this rule.

(b) Pregnant adult women (age 21 and older):

(A) Orthoptic and/or pleoptic training (vision therapy) is not covered; and

(B) Other visual services are covered with limitations as described in these rules;

(c) 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) It is the provider's responsibility to maintain accurate and complete client records, and includes documenting the quantity of services provided, as outlined in OAR 410-120-1360 Requirements for Financial, Clinical and Other Records:

(4) The provider has a responsibility to inform an OHP client when a:

(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; and

(c) Service limitation has been met and is no longer covered for an established client, even if the provider receives incomplete information through verification systems included in OAR 410-120-1140. Incorrect information does not absolve the provider's responsibility, as client records maintained by the Provider in section (3) should be complete and correct.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 and 414.065

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

(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. Refer to the Division's General Rules, Oregon Administrative Rules (OAR) 410-120-1210, Medical Assistance Benefit Packages and Delivery.

(2) When an Oregon Health Plan (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 (i.e., frames, lenses, specialty frames, and miscellaneous items); and

(b) The Division does not require payment authorization for Medicare-covered services. Refer to OAR 410-120-1320, Authorization of Payment.

(3) Effective only for dates of service between 6/1/2010 and 12/1/2011, a provider may resubmit a claim for visual materials from a visual materials supplier other than SWEEP Optical (as noted above), and receive appropriate reimbursement from the Division in accordance with OARs 410-120-1210, Medical Assistance Benefit Packages and Delivery, OAR 410-120-1300, Timely Submission of Claims, and 410-120-1340, Payment.

Stat. Auth.: ORS 413.042 and 414.065

Stats. Implemented: ORS 414.025, 414.065 and 414.075

410-140-0120 – ICD-9-CM Diagnosis, CPT/HCPCs Procedure Codes, and Modifiers

(1) The Division of Medical Assistance Program (Division) requires an International Classification of Diseases, 10th revision, Clinical Modification (ICD-10-CM) diagnosis code on all claims. Refer to OAR 410-120-1280 Billing for diagnosis code requirements.

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

(3) The Division requires providers to 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 are required to 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(s) was provided:

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

(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.” See OAR 410-140-0040 Prior Authorization.

(4) The Division recognizes HIPAA compliant modifiers.

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

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.025 & 414.065

410-140-0140 – Vision Services Coverage and Limitations

(1) Providers shall use the following rules in conjunction with the Visual Services program rules (OAR 410 Division 140) to determine service coverage and limitations for Oregon Health Plan (OHP) clients according to their benefit packages: General Rules (OAR chapter 410, division 120), OHP administrative rules (OARs 410-141-0480, 410-141-0500, and 410-141-0520), the Health Evidence Review Commission's (HERC) Prioritized List of Health Services (List) (See OAR 410-141-0520 Prioritized List of Health Services.), including referenced guideline notes (The date of service determines the appropriate version of the General Rules and HERC List to determine coverage.), and the Oregon Health Authority (Authority) general rules related to provider enrollment and claiming (OARs 943-120-0300 through 0380).

(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 does 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/contact lenses, fitting fees, or glasses or contact lenses for:

(A) Pregnant adult women are covered, and a complete examination and determination of refractive state is limited to once every 24 months;

(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/or 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 prior authorization (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 in compliance with Division provider guidance outlined in OAR 410-140-0280 Vision Therapy.

(6) Refraction determination is not limited following a diagnosed medical condition (e.g. multiple sclerosis).

(7) Refer to Table 140-0140-1 for provider restrictions and service limitations for specific ophthalmological services and items.

(8) 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 413.042

Stats. Implemented: ORS 414.025 and 414.065

Table 140-0140-1 – Special Ophthalmological Services

92018	Payable to ophthalmologists only
92019	Payable to ophthalmologists only
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*

410-140-0160 – Contact Lens Services and Supplies

(1) General information regarding the Division of Medical Assistance Programs' (Division) 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. Fittings by an independent technician in the optometrist's office are not covered; 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 Oregon Administrative Rule (OAR) 410-140-0050:

(a) Prior Authorization (PA) is required for contact lenses for adults, except for a primary Keratoconus diagnosis. 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;

(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 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;

(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. Refer to Table 140-0160-1 for Division guidance for provider billing. 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.

(6) Table 140-0160-1.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 and 414.065

Table 140-0160-1 – Contact Lens Services - Provider Guidance

92070	Use for medical bandage for acute injury or disease.

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

(1) The Division of Medical Assistance Programs (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, see Oregon Administrative Rule (OAR) 410-140-0260 Purchase of Ophthalmic Materials; or

(b) Any visual materials supplier only when the client has primary Medicare coverage and the glasses were a Medicare-covered benefit. See OAR 410-140-0080 Medicare/Medicaid Assistance Program Claims.

(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) is not limited when documented in the patient's record as medically necessary.

(3) Periodic adjustment of frames (including 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 two 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 serious efforts were made by the provider 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 and 414.065

410-140-0260 – Purchase of Glasses

(1) The Division of Medical Assistance Programs (Division) contracts with SWEEP Optical Laboratories (also referred to herein as contractor) to buy vision materials (e.g., frames, lenses and miscellaneous items), excluding contact lenses. (See OAR 410-140-0160 Contact Lens Services and Supplies.) Rates for materials are negotiated by the Oregon Department of Administrative Services. All frames, lenses and miscellaneous items are to be provided:

(a) Only by 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. See Oregon Administrative Rule (OAR) 410-140-0080 Medicare/Medicaid Assistance Program Claims; and

(c) It is the provider's responsibility to verify the client's eligibility prior to ordering vision materials. See OAR 410-140-0050 Eligibility and Benefit Coverage and refer to 410-120-1140 Verification of Eligibility.

(2) Buying-up, defined in OAR 410-120-0000 Acronyms and Definitions, is prohibited. See 410-120-1350 Buying Up.

(3) The Division covers glasses for:

(a) Eligible adults (age 21 and older) once every 24 months (see OAR 410-140-0050).

(b) Clients once within 120 days following cataract surgery. When ordering glasses from contractor, the date of surgery is required 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) Division non-covered ophthalmic materials include, but are not limited to, the following:

(a) Glasses with a prescription that is equal to or less than +/-.25 diopters in both eyes are not covered;

(b) Two pair of glasses in lieu 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.

(5) 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.

(6) Materials that require Prior Authorization (PA) are included in OAR 410-140-0040 Prior Authorization.

(7) 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 should 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 prior authorization.

(8) Contractor 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.

(9) 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 (e.g., frame fronts, cable temple arm) for non-contracted frame styles are limited to frames purchased with prior authorization approval. See section (7) of this rule;

(b) Tints and Photochromic lenses: 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 (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;

(d) 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;

(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.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 279A.140, 414.025 & 414.065

410-140-0280 – Vision Therapy Services

(1) The Division of Medical Assistance Programs (Division) covers orthoptic and/or pleoptic training or “vision therapy” as outlined in Oregon Administrative Rule 410-140-0140 Vision Services Coverage and Limitations.

(2) Providers shall develop a therapy treatment plan and regimen that will be taught to the client, family, foster parents and caregiver during the therapy treatments. No extra treatments will 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 solely with the Current Procedural Terminology (CPT) code for orthoptic and/or pleoptic training.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 and 414.065

410-140-0300 – Post-operative Care

(1) The Division of Medical Assistance Programs (Division) reimburses all covered surgical procedures as global packages (Refer to Oregon Administrative Rule (OAR) 410-130-0480 Surgical Guidelines.), 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 current procedural terminology (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) 90 days following the date of major surgery, or

(b) 10 days following the date of minor surgery; and

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

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 and 414.065

410-140-0400 – Contractor Services/Provider Ordering

(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, except when the Oregon Health Plan client has primary Medicare coverage. See OAR 410-140-0080.

(2) Providers are responsible for:

(a) Verifying client eligibility prior to submitting an order to the contractor. Refer to OAR 410-120-1140 Verification of Eligibility;

(b) Obtaining prior authorization (PA) from the Division for items requiring PA prior to placing a vision materials order. (See OAR 410-140-0040 Prior Authorization.);

(c) Complying with the contractor's order submission requirements, as outlined in the Visual Services Supplemental Information Guide found on this Division website: http://www.dhs.state.or.us/policy/healthplan/guides/vision/main.html;

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

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

(3) The contractor's responsibilities:

(a) Forward Division prior authorization approval to the provider;

(b) Order specifications:

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

(B) The contractor shall be responsible for all shipping and handling charges for shipments to the provider via United States mail or United Parcel Service for all returned orders that are not to the specifications of the order 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 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 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) Delivery Date: The contractor shall deliver the original order of materials and supplies to the ordering provider within seven business days of the date the order is received;

(B) Delay: 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; and

(C) Special Orders: 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, give the ordering provider a projected delivery date, and document the actual delivery time for future reference.

(4) Provider Error: Neither the contractor nor the Division shall be responsible for costs, expenses or for any required rework due to errors by any provider.

(5) The 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) The contractor shall bill the Division using Health Care Common Procedure Coding System (HCPC) Codes listed in the contract agreement. Payment will be at contracted rates.

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

(8) Frame Displays: 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.

(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).

(10) 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. See OAR 410-140-0140 Vision Services Coverage and Limitations. When glasses are ordered and the client has met their vision benefit for the time period:

(a) The Division will 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. See OAR 410-140-0050 Eligibility and Benefit Coverage;

(b) The provider needs to contact the client’s Prepaid Health Plan (PHP) or Coordinated Care Organization (CCO) if the client is enrolled with a PHP or CCO that contracts with SWEEP Optical. The contractor applies vision limitations included in rule, regardless of changes to a client’s enrollment status. It is the provider’s responsibility to contact the client’s PHP of CCO and give them the last date of service. The current PHP or CCO will then determine if they want to 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, it is the provider’s responsibility to inform the PHP/CCO of the last date of service.

Stat. Auth.: ORS 413.042

Stats. Implemented: ORS 414.025 and 414.065