CSI - Ohio

The Common Sense Initiative

Business Impact Analysis

Agency Name: Ohio Department of Medicaid (ODM)

Regulation/Package Title: Eye care services

Rule Number(s):

SUBJECT TO BUSINESS IMPACT ANALYSIS:

5160-6-01 (New), 5160-6-01 (To be rescinded), 5160-6-04 (To be rescinded),

NOT SUBJECT TO BUSINESS IMPACT ANALYSIS, INCLUDED FOR INFORMATION ONLY:

5160-6-02 (To be rescinded), 5160-6-07 (To be rescinded),

5160-6-11 (To be rescinded), 5160-6-12 (To be rescinded)

Date: November 30, 2015

Rule Type:

- ☑ New
- ☐ Amended
- ☑ 5-Year Review
- ☑ Rescinded

The Common Sense Initiative was established by Executive Order 2011-01K and placed within the Office of the Lieutenant Governor. Under the CSI Initiative, agencies should balance the critical objectives of all regulations with the costs of compliance by the regulated parties. Agencies should promote transparency, consistency, predictability, and flexibility in regulatory activities. Agencies should prioritize compliance over punishment, and to that end, should utilize plain language in the development of regulations.

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Regulatory Intent

1. **Please briefly describe the draft regulation in plain language.**
   Please include the key provisions of the regulation as well as any proposed amendments.

   Rules concerning the coverage of and payment for eye care services are currently set forth in six rules located in Chapter 5160-6 of the Ohio Administrative Code.

   Existing rule 5160-6-01, "Eligible vision care providers and vision co-payment provisions," lists eligible providers of vision services and establishes copayment amounts for certain procedures.

   Existing rule 5160-6-02, "Scope of coverage," outlines the general coverage policy for examinations, fittings, and the dispensing of materials such as spectacle frames and lenses, contact lenses, and low vision aids, and it addresses vision services provided in an inpatient or outpatient hospital setting.

   Existing rule 5160-6-04, "Vision care limitations," establishes frequency limits for comprehensive vision examinations, requires that a provider obtain a signed request for vision care services provided in a long-term care facility, sets certain limits on lens prescriptions, and lists items for which prior authorization of payment is required.

   Existing rule 5160-6-07, "Covered vision services," defines certain diagnostic and treatment services and specifies certain claim-submission constraints.

   Existing rule 5160-6-11, "Covered services and materials not purchased under the vision volume purchase contract," lists covered low-vision aids, ocular prostheses, prosthesis services, contact lenses, and contact lens services.

   Existing rule 5160-6-12, "Spectacle fitting services," lists covered services related to the fitting of spectacles.

   These rules are being rescinded, and their provisions are being combined into a single new rule.

   New rule 5160-6-01, "Eye care services," sets forth coverage and payment policies for eye care services. The text is reorganized and streamlined, but no substantive policy changes are being made. The phrase "eye care services" is introduced as a collective term encompassing the various services and materials addressed in the rule: vision care services, vision care materials (spectacle lenses and frames, contact lenses), low-vision aids, and ocular prostheses and prosthesis services. Claim-submission instructions are removed because such information is available in more appropriate formats than administrative rule. An appendix to the rule lists maximum payment amounts for covered contact lenses, low-vision aids, ocular prostheses and prosthesis services; this information has been moved here from appendix DD to rule 5160-1-60 of the Administrative Code.

2. **Please list the Ohio statute authorizing the Agency to adopt this regulation.**

   Section 5164.02 of the Ohio Revised Code.

3. **Does the regulation implement a federal requirement? Is the proposed regulation being adopted or amended to enable the state to obtain or maintain approval to administer and enforce a federal law or to participate in a federal program?**
   If yes, please briefly explain the source and substance of the federal requirement.

   Vision care is an optional Medicaid service. These rules comport with but do not implement federal requirements.

4. **If the regulation includes provisions not specifically required by the federal government, please explain the rationale for exceeding the federal requirement.**

   These rules do not exceed federal requirements.

5. **What is the public purpose for this regulation (i.e., why does the Agency feel that there needs to be any regulation in this area at all)?**

   Medicaid rules perform several core business functions: They establish and update coverage and payment policies for medical goods and services. They set limits on the types of entities that can receive Medicaid payment for these goods and services. They establish payment formulas or publish payment schedules for the use of providers and the general public.

6. **How will the Agency measure the success of this regulation in terms of outputs and/or outcomes?**

   The success of the change in this rule will be measured by the extent to which providers continue to receive payment for rendering covered services and supplying covered items.

Development of the Regulation

7. **Please list the stakeholders included by the Agency in the development or initial review of the draft regulation.**
   If applicable, please include the date and medium by which the stakeholders were initially contacted.

   ODM staff members meet with representatives of the Ohio Optometric Association on a regular basis, nearly quarterly, and as needed. These meetings cover a variety of topics of interest to optometrists, either related directly to the Medicaid program or

of broader impact such as health care reform or the meaningful use of electronic health records.

In 2012 and 2013, meetings were held with the Coalition for Universal Vision Screening of Young Children, a grant-funded initiative led by Prevent Blindness Ohio and the Ohio Department of Health comprising 30 member organizations representing vision stakeholders, public agencies, providers, educators, and workforce development advocates. Formal and informal discussion focused on Ohio Medicaid's vision care benefit and how to coordinate Medicaid coverage with the efforts of this collaborative and other public and private resources. Members were apprised of program coverage and limitations and the changes that were being proposed to the program rules at the time.

Ongoing communication is also maintained with individual optometrists, eyeglass laboratories, and other providers through ODM news releases and through e-mail and telephone conversations regarding program coverage, prior authorization, and claim payment.

8. **What input was provided by the stakeholders, and how did that input affect the draft regulation being proposed by the Agency?**

   Most of the policy discussion took place in 2011 and 2012, when these rules (in Electronic Rule Filing packet 90477) went through the review process known as Clearance. Stakeholder response was limited and supportive of maintaining current program coverage. Likewise, most recent comments and questions from stakeholders have concerned maximum payment amounts for services rather than underlying administrative policy.

   These rules were put through Clearance again from 08/20/2015 through 08/27/2015. No comments were received.

9. **What scientific data was used to develop the rule or the measurable outcomes of the rule? How does this data support the regulation being proposed?**

   The updating of this rule involves no substantive change in policy. Utilization and expenditure data for eye care services could be drawn from ODM's Quality Decision Support System.

10. **What alternative regulations (or specific provisions within the regulation) did the Agency consider, and why did it determine that these alternatives were not appropriate? If none, why didn't the Agency consider regulatory alternatives?**

    Requiring providers to be licensed and to document the medical necessity of services are standard measures taken to ensure program integrity. No comparable alternatives are readily apparent.

11. Did the Agency specifically consider a performance-based regulation? Please explain. Performance-based regulations define the required outcome, but don't dictate the process the regulated stakeholders must use to achieve compliance.

The concept of performance-based regulation does not apply to these services.

12. What measures did the Agency take to ensure that this regulation does not duplicate an existing Ohio regulation?

Rules involving Medicaid providers are housed exclusively within agency 5160 of the Ohio Administrative Code. Within this division, rules are generally separated out by topic. It is clear which rules apply to which type of provider and item or service; in this instance, there was no duplication.

13. Please describe the Agency's plan for implementation of the regulation, including any measures to ensure that the regulation is applied consistently and predictably for the regulated community.

The updating of this rule involves no substantive change in policy. Notification of the update will be published and made available to all affected providers.

Adverse Impact to Business

14. Provide a summary of the estimated cost of compliance with the rule. Specifically, please do the following:

a. Identify the scope of the impacted business community;

b. Identify the nature of the adverse impact (e.g., license fees, fines, employer time for compliance); and

c. Quantify the expected adverse impact from the regulation.
The adverse impact can be quantified in terms of dollars, hours to comply, or other factors; and may be estimated for the entire regulated population or for a "representative business." Please include the source for your information/estimated impact.

a. Changes in this policy affect providers of eye care services.

b. These rules impose no license fees or fines. The existing rules indicate that no eligible provider may receive payment without a valid Medicaid provider agreement. Both the existing rules and the new rule specify that participating practitioners must hold a current license, and, when appropriate, medical

necessity must be documented for certain items (such as specialty lenses) and services.

c. The requirements for holding a Medicaid provider agreement and licensure are means of identifying providers by credentials they already possess; these provisions impose no additional requirements.

Documentation of medical necessity consists of spending a few minutes making or transferring notations in a medical file. The time involved in documentation is less than 15 minutes, an estimate based on ODM's knowledge of the type and quantity of information needed and an understanding of provider office operations and staffing. The median statewide hourly wage for an optometrist, according to Labor Market Information (LMI) data published by the Ohio Department of Job and Family Services, is $53.88; adding 30% for fringe benefits brings this figure to $70.04. So the cost associated with documenting medical necessity can be up to $17.51.

15. Why did the Agency determine that the regulatory intent justifies the adverse impact to the regulated business community?

Licensure and documentation of medical necessity are standard, effective tools for preventing fraud, waste, and abuse and for promoting quality and cost-effectiveness.

Regulatory Flexibility

16. Does the regulation provide any exemptions or alternative means of compliance for small businesses? Please explain.

Requirements set forth in these rules are not predicated on the size of the provider, and no alternate means of compliance is available.

17. How will the agency apply Ohio Revised Code section 119.14 (waiver of fines and penalties for paperwork violations and first-time offenders) into implementation of the regulation?

These rules impose no sanctions on providers.

18. What resources are available to assist small businesses with compliance of the regulation?

Providers that submit claims through an electronic clearinghouse (a "trading partner") can generally rely on the clearinghouse to know current Medicaid claim-submission procedures.

Information sheets and instruction manuals on various claim-related topics are readily available on the Medicaid website.

The Bureau of Provider Services renders technical assistance to providers through its hotline, (800) 686-1516.

Policy questions may be directed via e-mail to the Non-Institutional Benefit Management section of ODM's policy bureau, at *noninstitutional_policy@medicaid.ohio.gov*.

TO BE RESCINDED

5160-6-01 **Eligible vision care providers and vision co-payment provisions.**

(A) Eligible providers of vision services.

(1) Ophthalmologists, optometrists, and opticians currently licensed under Chapters 4725. and 4731. of the Revised Code are eligible to participate in the medicaid program and may provide services within the scope of practice as established by Chapters 4725. and 4731. of the Revised Code. These services are identified in Chapter 5101:3-6 of the Administrative Code.

(2) A professional organization (group practice or partnership) of optometrists, ophthalmologists, and/or opticians is also considered an eligible provider if organized under Chapter 1785. of the Revised Code for the sole purpose of providing vision care services.

(3) Optical laboratories with whom the department has a current vision volume purchasing contract are eligible providers of frames and lenses.

(4) Medicaid reimbursement is contingent upon a valid provider agreement being in effect while services were provided in accordance with rule 5101:3-1-60 of the Administrative Code.

(5) Other eligible providers of vision services include, but are not limited to, the following medicaid providers if the providers employ or have under contractual arrangement individuals licensed to practice optometry:

(a) Fee-for-service ambulatory health care clinics as defined in Chapter 5101:3-13 of the Administrative Code.

(b) Outpatient health facilities as defined in Chapter 5101:3-29 of the Administrative Code.

(c) Rural health clinics as defined in Chapter 5101:3-16 of the Administrative Code.

(d) Federally qualified health centers as defined in Chapter 5101:3-28 of the Administrative Code.

(B) Co-payment (except for medicaid consumers enrolled in the medicaid managed health care program).

(1) For dates of service beginning on or after January 1, 2006, vision services are subject to medicaid co-payments in accordance with this rule and are subject to the provisions in accordance with rules 5101:3-1-09 and 5101:3-1-60 of the Administrative Code.

(2) The vision co-payments set forth in this rule apply to consumers who are eligible under the disability medical assistance (DMA) program in accordance with rule 5101:3-23-01 of the Administrative Code, when the vision services provided are covered under the DMA program in accordance with Chapter 5101:3-23 of the Administrative Code.

(3) The following exam codes are subject to a two dollar co-payment per date of service per claim:

(a) 92002 medical exam and evaluation: intermediate, new patient

(b) 92012 medical exam and evaluation; intermediate, established patient

(c) 92004 comprehensive, new patient, one or more visits

(d) 92014 comprehensive, established patient, one or more visits

(4) The following dispensing codes are subject to a one dollar co-payment per date of service per claim:

(a) 92340 fitting of spectacles, except for aphakia; monofocal

(b) 92341 fitting of bifocals, except for aphakia; monofocal

(c) 92342 fitting of multifocal, other than bifocal for aphakia; monofocal

Effective:

Five Year Review (FYR) Dates:

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Certification

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Date

Promulgated Under:	119.03
Statutory Authority:	5162.20, 5164.02
Rule Amplifies:	5162.03, 5162.20, 5164.02, Section 206.66.45 of Am. Sub. HB 66 (126th GA)
Prior Effective Dates:	04/07/1977, 12/21/1977, 04/0l/1984, 05/09/1986, 08/22/1988 (Emer), 11/18/1988, 07/01/2002, 01/01/2006

TO BE RESCINDED

5160-6-02 **Scope of coverage.**

(A) Ohio medicaid reimburses for covered vision services and ophthalmic materials included in appendix DD to rule 5101:3-1-60 of the Administrative Code and delivered by eligible providers to eligible consumers. The range of covered vision care professional services includes examinations, fittings, and dispensing of ophthalmic materials (including contact lenses, low vision aids, etc.).

(B) If a volume purchase contract(s) is not in effect, the cost of frames and lenses will be reimbursed to the provider.

(1) The standard frame for the vision care program is a moderately priced ZYL or metal frame. Discountined frames will not be reimbursed at original wholesale price.

(2) The following lenses are covered under the vision care program:

(a) Single-vision scratch resistant coated plastic and polycarbonate lenses.

(b) Bifocal scratch resistant coated plastic and polycarbonate.

(c) Aphakic single vision and multifocal lenses.

(d) Trifocals scratch resistant coated plastic and polycarbonate lenses.

(e) Additions for single and bifocal vision include: prism, industrial thickness, myodisc, cylinder> 6.25, special base curve, ultra-violet tint, slab-off lens, fresnel prism, frosted lens, tints, photochromatic , and high index plastic lenses, and engraved name on temple.

(f) Glass lenses will be covered with prior authorization (PA) when medically necessary.

(C) If the Ohio department of job and family services (ODJFS) has entered into a volume purchase contract(s) for the purchase of frames and lenses for Ohio medicaid patients:

(1) The covered frames and lenses shall be specified in the contract(s).

(2) Only those lenses specified in the contract(s) and supplied by the contractor(s) shall be covered unless the purchase of materials is prior-authorized by ODJFS.

(3) Only those frames specified in the contract(s) and supplied by the contractor(s) or frames covered under a previous contract(s) shall be covered unless the purchase of materials is prior authorized by ODJFS.

(4) The prices for materials under the contract shall be determined by competitive bid, or request for proposal.

(5) ODJFS will directly reimburse the optical laboratory for the contracted lenses and frames.

(6) All lenses and frames must be of acceptable quality and workmanship as determined by ODJFS.

(D) For covered materials not part of the vision volume purchase contract see rule 5101:3-6-11 of the Administrative Code.

(E) The following applies to vision services provided in an inpatient or outpatient hospital setting:

(1) Vision care exam and fitting services are covered and reimbursed in accordance with paragraph (D) of rule 5101:3-2-04 of the Administrative Code.

(2) Vision care materials are covered and reimbursed in accordance with paragraphs (B), (C), and (D) of this rule.

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TO BE RESCINDED

5160-6-04 **Vision care limitations.**

(A) The following are limitations to comprehensive vision examinations:

(1) Each consumer age twenty-one and older but younger than age sixty is limited to one comprehensive vision examination and to one complete frame and pair of lenses per twenty-four-month period.

(2) Each consumer age twenty and younger or age sixty and older is limited to one comprehensive vision examination and to one complete frame and pair of lenses per twelve-month period.

(B) The following limitation applies to vision care services in long-term care facilities (LTCF):

Vision care services provided in an LTCF must have a written request for examination or treatment signed by the consumer or responsible guardian that is retained by the billing provider. The attending physician may sign the request if the consumer is mentally unable to sign and the guardian is not available to sign the request for services.

(C) The following limitations apply to lens prescriptions:

(1) Lens prescriptions must be at least: +0.75 sphere or -0.50 sphere, 0.50 cylinder, 0.50 diopter imbalance, 1/2 prism diopter vertical, or 3 prism diopter lateral. These prescription minimums apply to new, duplications, and changes in a prescription.

(2) Lens prescription changes must still meet the lens prescription minimum requirements as stated in paragraph (C)(1) of this rule and must be at least: ± 0.50 sphere, ± 0.50 cylinder, 10 degrees for a 1.00 cylinder or less, or 5 degrees for a 1.12 cylinder or more.

(3) Lens coatings of any type are not separately reimbursable by the department.

(4) Lens edge polishing or any other cosmetic lens embellishment is not separately reimbursable by the department.

(5) Lenses prescribed to be used primarily as sunglasses that are prescribed in addition to regular prosthetic lenses are not reimbursable by the department unless a prior authorization is obtained for medical necessity.

(D) The following vision care items are covered if prior-authorized as set forth in rule 5101:3-1-31 of the Administrative Code:

(1) Contact lenses;

(2) Tinted lenses;

(3) Glass lenses;

(4) U-V lenses;

(5) Orthoptic or pleoptic training;

(6) Prosthetic eye;

(7) Any replacement of a complete set of eyeglasses prior to the expiration of the time limitations found in paragraph (A) of this rule;

(8) Photochromatic lenses;

(9) Low or subnormal vision aids; or

(10) Frames and lenses provided from a source other than the current vision volume purchase contract optical laboratory.

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Prior Effective Dates:	04/07/1977, 09/19/1977, 12/30/1977, 04/01/1984, 05/09/1986, 05/01/1987, 08/22/1988 (Emer), 11/18/1988, 07/01/2002, 01/01/2006, 03/05/2009

TO BE RESCINDED

5160-6-07 **Covered vision services.**

(A) General ophthalmological services.

(1) A "comprehensive ophthalmological service" is a general evaluation of the complete visual system The service includes history, general medical observation, external and ophthalmoscopic examination, gross visual fields and basic sensorimotor examination. It can includes: biomicroscopy, examination with cycloplegia or mydriasis, tonometry and determination of refractive state. Comprehensive ophthalmological services always include initiation of diagnostic and treatment programs (e.g. prescription of lenses). In order to be reimbursed, providers must use the following procedure codes when rendering comprehensive ophthalmological services:

For dates of service beginning on and after April 1, 2004, to be reimbursed for comprehensive ophthalmologic services, bill the following codes:

(a) Code 92004 for a new consumer or code 92014 for an established consumer.

(b) If the individual receiving special ophthalmologic services is either twenty years of age or under or sixty years of age or older, codes 92004 and 92014 must be billed in conjunction with modifier UB, i.e., 92004UB.

(c) The UB modifier allows for a comprehensive ophthalmologic service once per year.

(2) An "intermediate ophthalmological service" is an evaluation of a new or existing condition complicated with a new diagnostic or management problem not necessarily relating to the primary diagnosis. An intermediate ophthalmological service includes history, general medical observation, external ocular and adnexal examination and other diagnostic procedures. The following procedure codes must be used in order to be reimbursed for rendering intermediate ophthalmological services.

(a) 92002 - New patient intermediate service; or

(b) 92012 - Established patient intermediate service.

(B) Other vision care services including covered ophthalmological/optometric diagnostic and treatment services:

(1) For the detection and/or treatment of ocular abnormalities that may be evidence of disease, pathology or injury, vision care providers may bill for services using the appropriate evaluation and management service level code (99XXX series) in accordance with the physicians' "Current Procedural Terminology (CPT)," code definitions and instructions as referenced in rule 5101:3-1-60 of the Administrative Code. These services may be subject to review by the department to determine whether they are necessary to detect or treat, within the scope of the provider's license, ocular abnormalities that may be evidence of disease, pathology, or injury. These evaluation and management services codes may not be billed with the general ophthalmological service codes listed in paragraphs (A)(1) and (A)(2) of this rule.

(2) A "refractive service" is the medicaid-covered component of a comprehensive eye exam provided to a medicaid and medicare-covered consumer in conjunction with other medicare covered eye exam procedures. It is only reimbursed as a separate and distinct service by medicaid when medicare payment for an eye exam does not include payment for the refraction services component of the exam. Use code 92015 to bill for the refraction component of a medicare-covered exam. Code 92015 cannot be billed in conjunction with the general ophthalmological service codes listed in paragraphs (A)(1) and (A)(2) of this rule.

(3) "Special ophthalmological/optometric services", non-routine ophthalmoscopy and other specialized ophthalmological services are medicaid-covered and are reimbursable by billing the appropriate physicians' "Current Procedural Terminology (CPT)" code as referenced in rule 5101:3-1-60 of the Administrative Code. These services are subject to review by the department to determine whether the service is necessary to detect or treat ocular abnormalities that may be evidence of disease, pathology

(4) Certain vision procedures listed under the "Special Ophthalmological Services," the "Ophthalmoscopy," and the "Other Specialized Services" section of the CPT have been identified as diagnostic and therapeutic procedures which are composed of professional and technical components. These services are specifically identified, must be billed, and shall be reimbursed in accordance with rule 5101:3-4-11 of the Administrative Code.

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TO BE RESCINDED

5160-6-11 **Covered services and materials not purchased under the vision volume purchase contract.**

(A) Low or subnormal vision aids: low vision aids are not purchased under the volume purchase contract. All low or subnormal vision aids require prior authorization and must be ordered from an optical laboratory of the provider's choice. To be reimbursed for low vision aids, the provider must use the appropriate healthcare common procedure coding system (HCPCS) level codes as follows:

(1) V2600 - Hand-held low vision aid and any other non-spectacle mounted aid;

(2) V2610 - Single-lens spectacle mounted low vision aid; or

(3) V2615 - Telescopic and other compound lens systems including: distance vision telescope, near vision telescopes, or compound lens systems.

(B) Ocular prostheses and prostheses services: Ocular prostheses and prostheses services require prior authorization and are not purchased under the volume purchase contract. To be reimbursed for ocular prostheses, the provider must use the appropriate HCPCS level codes as follows:

(1) V2623 - Prosthetic eye, plastic, custom;

(2) V2624 - Polishing/resurfacing of ocular prosthesis;

(3) V2625 - Enlargement of ocular prosthesis;

(4) V2626 - Reduction of ocular prosthesis;

(5) V2627 - Scleral cover shell;

(6) V2628 - Fabrication and fitting of ocular conformer; or

(7) V2629 - Prosthetic eye, other type.

(C) Contact lenses and contact lens services.

(1) Contact lenses and contact lens services are covered when prior-authorized by the Ohio department of job and family services (ODJFS). The department will authorize contact lenses under the following conditions:

(a) To correct aphakia.

(b) To correct high refractive errors, greater than ten diopters, when the visual acuity cannot be corrected to 20/70 in the better eye with spectacle lenses and there is a significant improvement in visual acuity with contact lenses.

(c) There is a high degree of anisometriopta where binocularity can be substantiated.

(d) To treat keratoconus, where there is a high corneal astigmatism or corneal irregularities when the visual acuity cannot be corrected to 20/70 in the better eye with spectacles and there is a significant improvement with contact lenses.

(2) Contact lenses are not purchased under the vision volume purchase contract. All contact lenses must be prior-authorized and then ordered from an optical laboratory of the provider's choice. The following codes are per lens and must be reported twice when the code is appropriate for both eyes. To be reimbursed for contact lenses, use the appropriate HCPCS level codes as follows:

(a) V2500 - Contact lens, PMMA, spherical, per lens;

(b) V2501 - Contact lens, PMMA, toric or prism ballast, per lens;

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

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

(e) V2513 - Contact lens, gas permeable, extended wear, per lens;

(f) V2520 - Contact lens, hydrophilic, spherical, per lens;

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

(h) V2523 - Contact lens, hydrophilic, extended wear, per lens;

(i) V2530 - Contact lens, scleral, gas impermeable, per lens; or

(j) V2599 - Contact lens, other type.

(3) Contact lens services are reimbursable by billing the appropriate physicians' "Current Procedural Terminology (CPT)" code as referenced in rule 5101:3-1-60 of the Administrative Code. Contact lens services must be prior-authorized by ODJFS.

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TO BE RESCINDED

5160-6-12 **Spectacle fitting services.**

(A) Spectacle fitting services are covered by medicaid. The consumer must be eligible at the time the fitting was initiated. If the exam and the fitting are performed by the same provider, the date of the exam may be considered the date the fitting was initiated. To be reimbursed for spectacle services, the provider must use the appropriate physicians' "Current Procedural Terminology (CPT)" code as referenced in rule 5101:3-1-60 of the Administrative Code as listed in paragraphs (A)(1) to (A)(8) of this rule.

(1) 92340 - Monofocal, except for aphakia.

(2) 92341 - Bifocal, except for aphakia.

(3) 92342 - Multifocal, other than bifocal, except for aphakia.

(4) 92352 - Fitting of spectacle prosthesis for aphakia; monofocal.

(5) 92353- Fitting of spectacle prosthesis for aphakia; multifocal.

(6) 92354 - Fitting of spectacle-mounted low-vision aid; monofocal.

(7) 92355 - Fitting of spectacle-mounted low-vision aid; telescopic or other compound lens system.

(8) 92358 - Prosthesis service for aphakia, temporary.

(B) Spectacle fitting services for less than a complete pair of spectacles must be reported as a reduced service by using the modifier 52 following the procedure code. These services will be reimbursed at one-half the full service rate.

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5160-6-01 **Eye care services.**

(A) Definition. "Eye care services" is a collective term for the following services and materials involving the health of the eyes:

(1) Vision care services, which include the following procedures:

(a) Diagnostic examination;

(b) Testing;

(c) Therapeutic treatment; and

(d) Lens fitting;

(2) Vision care materials, which include the following items:

(a) Spectacle lenses and frames; and

(b) Contact lenses;

(3) Low-vision aids; and

(4) Ocular prostheses and prosthesis services.

(B) Providers.

(1) Rendering providers. The following eligible providers may render an eye care service:

(a) Professional practitioners (e.g., ophthalmologists, optometrists, opticians, ocularists) currently licensed and acting within their scope of practice;

(b) Eligible medicaid providers employing or contracting with individuals licensed to practice optometry, such as fee-for-service clinics (rules for which are set forth in Chapter 5160-13 of the Administrative Code) and cost-based clinics (rules for which are set forth in Chapter 5160-28 of the Administrative Code); or

(c) For the provision of spectacle frames and spectacle lenses, an optical laboratory with which the department has a current volume purchasing contract.

(2) Billing providers. The following entities may receive medicaid payment for submitting a claim for an eye care service on behalf of a rendering provider:

(a) A rendering provider; or

(b) A professional organization (group practice or partnership) of optometrists, ophthalmologists, opticians, or a combination of these practitioners organized under Chapter 1785. of the Revised Code for the sole purpose of providing vision care services.

(C) Coverage.

(1) Vision care services.

(a) Payment may be made for the following classes of service:

(i) General ophthalmological services;

(ii) Refraction as a separate service only when medicare payment for an examination does not include refraction; and

(iii) Spectacle fitting.

(b) Certain specialized ophthalmological services are identified as diagnostic or therapeutic procedures comprising both professional and technical components. Payment for these services is made in accordance with Chapter 5160-4 of the Administrative Code.

(c) Coverage of other individual procedures is indicated in appendix DD to rule 5160-1-60 of the Administrative Code.

(d) If an examination and a fitting are performed by the same provider, then the date of the examination may be used as the initial date of fitting.

(e) Vision care services are subject to the following copayments per date of service per claim unless the individual is excluded from the copayment requirement pursuant to rule 5160-1-09 of the Administrative Code:

(i) Two dollars for the following examinations:

(a) Medical examination and evaluation; intermediate, new patient;

(b) Medical examination and evaluation; intermediate, established patient;

(c) Medical examination and evaluation; comprehensive, new patient, one or more visits; and

(d) Medical examination and evaluation; comprehensive, established patient, one or more visits; and

(ii) One dollar for the following dispensing services:

(a) Fitting of spectacles, except for aphakia; monofocal;

(b) Fitting of spectacles, except for aphakia; bifocal; and

(c) Fitting of spectacles, except for aphakia; multifocal, other than bifocal.

(2) Vision care materials.

(a) Spectacle lenses and frames.

(i) Payment may be made without prior authorization for the following items provided by an optical laboratory holding a current volume purchase contract:.

(a) Scratch-resistant coated plastic and polycarbonate lenses – monofocal, bifocal, or trifocal;

(b) Aphakic monofocal and multifocal lenses; and

(c) A moderately-priced standard acetate or metal frame.

(ii) Payment for the following items and services requires prior authorization and, when appropriate, documentation of medical necessity:

(a) Glass lenses;

(b) Tinted lenses;

(c) Frosted lenses;

(d) Ultraviolet-protective lenses;

(e) Photochromatic lenses;

(f) High-index plastic lenses;

(g) Lenses of industrial thickness;

(h) Lenses with cylindrical power greater than ±6.25;

(i) Lenses with a special base curve;

(j) Slab-off lenses;

(k) Myodisc lenses;

(l) Prisms;

(m) Engraved name on temple;

(n) Orthoptic or pleoptic training; and

(o) Frames or lenses provided by a source other than an optical laboratory holding a current volume purchase contract.

(iii) Replacement of a complete set of eyeglasses before the end of the time period specified in this rule requires prior authorization.

(b) Contact lenses.

(i) Payment requires prior authorization, and each item must be ordered from an optical laboratory of the provider's choice.

(ii) Prior authorization can be given only if at least one of the following criteria is met:

(a) The lens or lenses will be used to correct aphakia;

(b) The lens or lenses will be used to correct high refractive errors, greater than ten diopters, the visual acuity cannot be corrected to 20/70 in the better eye with spectacles, and there is significant improvement in visual acuity with contact lenses;

(c) There is a high degree of anisometropia, and binocularity can be substantiated; or

(d) The lens or lenses will be used to treat keratoconus, there is a high degree of corneal astigmatism or corneal irregularity, the visual acuity cannot be corrected to 20/70 in the better eye with spectacles, and there is a significant improvement with contact lenses.

(c) Low-vision aids. Payment requires prior authorization, and each item must be ordered from an optical laboratory of the provider's choice.

(d) Ocular prostheses and prosthesis services. Payment requires prior authorization.

(3) Coverage of vision care materials is indicated in appendix A to this rule.

(D) Requirements, constraints, and limitations.

(1) Subject to age-based exceptions set forth in rule 5160-1-14 of the Administrative Code, the following limits are established:

(a) For an individual twenty-one years of age or older but younger than sixty years of age, payment will not be made for more than one comprehensive vision examination and one complete frame and pair of lenses per twenty-four-month period.

(b) For an individual younger than twenty-one years of age or sixty years of age or older, payment will not be made for more than one comprehensive vision examination and one complete frame and pair of lenses per twelve-month period.

(2) When vision care is provided in an inpatient or outpatient hospital setting, payment for the service is made in accordance with Chapter 5160-2 of the Administrative Code, and payment for materials is made in accordance with this rule.

(3) Before a vision care service is rendered to an individual living in a long-term care facility (LTCF), a request for examination or treatment must be submitted, signed by the individual, the individual's authorized representative, or (if the authorized representative is not available) the individual's attending physician.

(4) Payment may be made for a lens only if the following two criteria are met:

(a) The prescription specifies at least one parameter value meeting or exceeding the following minima:

(i) +0.75 or –0.50 sphere;

(ii) ±0.50 cylinder;

(iii) ±0.50 diopter imbalance;

(iv) 0.50 prism diopter vertically; or

(v) 3.00 prism diopters laterally; and

(b) If applicable, the prescription differs from the previous prescription in at least one of the following measures:

(i) ±0.50 sphere;

(ii) ±0.50 cylinder; or

(iii) Ten degrees of axis shift for a cylinder up to ±1.00 or five degrees of axis shift for a cylinder at least ±1.12.

(5) Evaluation and management services, non-routine ophthalmoscopy, and other specialized ophthalmological services performed for the purpose of detecting or treating ocular abnormalities may be subject to review by the department.

(6) No separate payment is made for the following items or services:

(a) Both an evaluation and management service and a general ophthalmological service performed during the same visit;

(b) Refraction as a separate service, unless medicare payment for an examination does not include refraction;

(c) Additional coatings of any type that are not included with a lens;

(d) Lens edge polishing or other cosmetic lens embellishment; and

(e) Lenses prescribed as supplementary sunglasses in addition to regular eyeglasses, unless medical necessity is demonstrated and prior authorization is obtained.

(E) Claim payment.

(1) The payment amount for a covered vision care service is the lesser of the submitted charge or the amount listed in appendix DD to rule 5160-1-60 of the Administrative Code.

(2) The payment amount for a covered spectacle lens or frame listed in a volume purchase contract is determined by the terms of the contract.

(3) The payment amount for a covered spectacle lens or frame not listed in a volume purchase contract is the lesser of the provider's submitted charge or the provider's cost.

(4) Payment for a discontinued frame will not be made at the original wholesale price.

(5) The payment amount for a covered contact lens, low-vision aid, ocular prosthesis or prosthesis service, or spectacle fitting is the lesser of the submitted charge or the amount listed in appendix A to this rule. (Appendix A supersedes any corresponding entries in appendix DD to rule 5160-1-60 of the Administrative Code.)

(6) The payment amount for the fitting of less than a complete pair of spectacles is one half of the amount for the fitting of a complete pair.

Replaces: 5160-6-01, 5160-6-02, 5160-6-04, 5160-6-07, 5160-6-11, 5160-6-12

Effective:

Five Year Review (FYR) Dates:

_____

Certification

_____

Date

Promulgated Under:	119.03
Statutory Authority:	5164.02
Rule Amplifies:	5162.20, 5164.02
Prior Effective Dates:	04/07/1977, 09/19/1977, 12/21/1977, 12/30/1977, 04/0l/1984, 05/09/1986, 07/22/1986, 08/01/1986, 05/01/1987, 05/09/1988, 08/22/1988 (Emer), 11/18/1988, 07/01/1993, 07/01/1994, 12/31/1996 (Emer), 03/22/1997, 07/01/2002, 04/01/2004, 12/30/2005 (Emer), 01/01/2006, 03/27/2006, 03/05/2009

Appendix to rule 5160-6-01

STATUS CODE:
1 = Initial maximum payment amount
2 = Change in maximum payment amount as of the Effective Date
3 = Discontinued coverage

CURRENT/PREVIOUS MAXIMUM PAYMENT AMOUNT:
D = DISCONTINUED PROCEDURE CODE
NC = NON-COVERED SERVICE
PA = PRIOR AUTHORIZATION (DETERMINED DURING PRIOR AUTHORIZATION)
PC = PROVIDER CHARGE (DETERMINED INDIVIDUALLY BY PROVIDER)

HCPCS CODE	DESCRIPTION	EFFECTIVE DATE	STATUS CODE	CURRENT MAXIMUM PAYMENT AMOUNT	PREVIOUS MAXIMUM PAYMENT AMOUNT
S0580	SV polycarbonate lens each	10/01/2003	1	PC	
S0581	Industrial thickness SV or bif	10/01/2003	1	PC	
V2020	Frames, purchases	01/01/2004	1	PC	
V2025	Deluxe frame	01/01/2004	1	NC	
V2100	Lens spher single plano 4.00	01/01/2004	1	PC	
V2101	Single visn sphere 4.12-7.00	01/01/2004	1	PC	
V2102	Singl visn sphere 7.12-20.00	01/01/2004	1	PC	
V2103	Spherocylindr 4.00d/12-2.00d	01/01/2004	1	PC	
V2104	Spherocylindr 4.00d/2.12-4d	01/01/2004	1	PC	
V2105	Spherocylinder 4.00d/4.25-6d	01/01/2004	1	PC	
V2106	Spherocylinder 4.00d/>6.00d	01/01/2004	1	PC	
V2107	Spherocylinder 4.25d/12-2d	01/01/2004	1	PC	
V2108	Spherocylinder 4.25d/2.12-4d	01/01/2004	1	PC	
V2109	Spherocylinder 4.25d/4.25-6d	01/01/2004	1	PC	
V2110	Spherocylinder 4.25d/over 6d	01/01/2004	1	PC	
V2111	Spherocylindr 7.25d/.25-2.25	01/01/2004	1	PC	
V2112	Spherocylindr 7.25d/2.25-4d	01/01/2004	1	PC	
V2113	Spherocylindr 7.25d/4.25-6d	01/01/2004	1	PC	
V2114	Spherocylinder over 12.00d	01/01/2004	1	PC	
V2115	Lens lenticular bifocal	01/01/2004	1	PC	
V2116	Nonaspheric lens bifocal	01/01/2005	3	D	
V2117	Aspheric lens bifocal	01/01/2005	3	D	
V2118	Lens aniseikonic single	01/01/2004	1	PC	
V2121	Lenticular lens, single	01/01/2005	2	PC	
V2199	Lens single vision not oth c	01/01/2004	1	PC	
V2200	Lens spher bifoc plano 4.00d	01/01/2004	1	PC	
V2201	Lens sphere bifocal 4.12-7.0	01/01/2004	1	PC	
V2202	Lens sphere bifocal 7.12-20.	01/01/2004	1	PC	
V2203	Lens sphcyl bifocal 4.00d/.1	01/01/2004	1	PC	
V2204	Lens sphcy bifocal 4.00d/2.1	01/01/2004	1	PC	
V2205	Lens sphcy bifocal 4.00d/4.2	01/01/2004	1	PC	
V2206	Lens sphcy bifocal 4.00d/ove	01/01/2004	1	PC	
V2207	Lens sphcy bifocal 4.25-7d/.	01/01/2004	1	PC	
V2208	Lens sphcy bifocal 4.25-7/2.	01/01/2004	1	PC	
V2209	Lens sphcy bifocal 4.25-7/4.	01/01/2004	1	PC	
V2210	Lens sphcy bifocal 4.25-7/ov	01/01/2004	1	PC	
V2211	Lens sphcy bifo 7.25-12/.25-	01/01/2004	1	PC	
V2212	Lens sphcyl bifo 7.25-12/2.2	01/01/2004	1	PC	
V2213	Lens sphcyl bifo 7.25-12/4.2	01/01/2004	1	PC	
V2214	Lens sphcyl bifocal over 12.	01/01/2004	1	PC	
V2215	Lens lenticular bifocal	01/01/2004	1	PC	
V2216	Lens lenticular nonaspheric	01/01/2005	3	D	
V2217	Lens lenticular aspheric bif	01/01/2005	3	D	
V2218	Lens aniseikonic bifocal	01/01/2004	1	PC	
V2219	Lens bifocal seg width over	01/01/2004	1	PC	
V2220	Lens bifocal add over 3.25d	01/01/2004	1	PC	
V2221	Lenticular lens, bifocal	01/01/2005	2	PC	
V2299	Lens bifocal speciality	01/01/2004	1	PC	
V2300	Lens sphere trifocal 4.00d	01/01/2004	1	PC	
V2301	Lens sphere trifocal 4.12-7.	01/01/2004	1	PC	
V2302	Lens sphere trifocal 7.12-20	01/01/2004	1	PC	
V2303	Lens sphcy trifocal 4.0/.12-	01/01/2004	1	PC	
V2304	Lens sphcy trifocal 4.0/2.25	01/01/2004	1	PC	
V2305	Lens sphcy trifocal 4.0/4.25	01/01/2004	1	PC	
V2306	Lens sphcyl trifocal 4.00/>6	01/01/2004	1	PC	
V2307	Lens sphcy trifocal 4.25-7/.	01/01/2004	1	PC	
V2308	Lens sphc trifocal 4.25-7/2.	01/01/2004	1	PC	
V2309	Lens sphc trifocal 4.25-7/4.	01/01/2004	1	PC	
V2310	Lens sphc trifocal 4.25-7/>6	01/01/2004	1	PC	
V2311	Lens sphc trifo 7.25-12/.25-	01/01/2004	1	PC	
V2312	Lens sphc trifo 7.25-12/2.25	01/01/2004	1	PC	
V2313	Lens sphc trifo 7.25-12/4.25	01/01/2004	1	PC	
V2314	Lens sphcyl trifocal over 12	01/01/2004	1	PC	
V2315	Lens lenticular trifocal	01/01/2004	1	PC	
V2316	Lens lenticular nonaspheric	01/01/2005	3	D	
V2317	Lens lenticular aspheric tri	01/01/2005	3	D	
V2318	Lens aniseikonic trifocal	01/01/2004	1	PC	

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NC = NON-COVERED SERVICE
PA = PRIOR AUTHORIZATION (DETERMINED DURING PRIOR AUTHORIZATION)
PC = PROVIDER CHARGE (DETERMINED INDIVIDUALLY BY PROVIDER)

HCPCS CODE	DESCRIPTION	EFFECTIVE DATE	STATUS CODE	CURRENT MAXIMUM PAYMENT AMOUNT	PREVIOUS MAXIMUM PAYMENT AMOUNT
V2319	Lens trifocal seg width > 28	01/01/2004	1	PC	
V2320	Lens trifocal add over 3.25d	01/01/2004	1	PC	
V2321	Lenticular lens, trifocal	01/01/2005	2	PC	
V2399	Lens trifocal speciality	01/01/2004	1	NC	
V2410	Lens variab asphericity sing	01/01/2004	1	PC	
V2430	Lens variable asphericity bi	01/01/2004	1	PC	
V2499	Variable asphericity lens	01/01/2004	1	NC	
V2500	Pmma,Spherical,Per Lens	04/13/1989	2	31.06	
V2501	Pmma,Toric Or Prism Ballast, Per Lens	04/13/1989	2	51.77	
V2502	Pmma,Bifocal,Per Lens	04/13/1989	2	51.77	
V2503	Pmma,Color Vision Deficiency,Per Lens	04/13/1989	2	51.77	
V2510	Gas Permeable, Spherical, Per Lens	01/01/2010	2	50.22	
V2511	Gas Permeable, Toric,Prism Ballast,Per	01/01/2010	2	75.32	
V2512	Gas Permeable, Bifocal, Per Lens	01/01/2010	2	100.42	
V2513	Gas Permeable ,Extended Wear, Per Lens	01/01/2010	2	100.42	
V2520	Hydrophylic, Spherical, Per Lens	01/01/2010	2	60.26	
V2521	Hydrophylic, Toric Or Prism Ballast, Per	01/01/2010	2	70.30	
V2522	Hydrophylic, Bifocal, Per Lens	04/13/1989	2	77.65	
V2523	Hydrophylic, Extenede Wear, Per Lens	01/01/2010	2	97.00	
V2530	Scleral, Per Lens	04/13/1989	2	62.12	
V2531	Contact lens gas permeable	01/01/2004	1	NC	
V2599	Contact Lens,Not Otherwise Classified	10/01/1999	2	PA	
V2600	Hand Held Low Vision Aids And Other Aids	04/13/1989	1	PA	
V2610	Single Lens Spectacle Mntd Low Vision Ad	08/01/1973	1	PA	
V2615	Telescope And Other Compound Lens System	08/01/1973	1	PA	
V2623	Prosthetic Eye,Plastic, Custom	01/01/2010	2	588.64	
V2624	Polish/resurface ocular prosthesis	01/01/2010	2	38.00	
V2625	Enlargement of ocular prosthesis	01/01/2010	2	300.96	
V2626	Reduction of ocular prosthesis	01/01/2010	2	124.54	
V2627	Scleral cover shell	01/01/2010	2	774.19	
V2628	Fabrication/Fitting of ocular conformer	01/01/2010	2	189.93	
V2629	Prosthetic Eye, Not Otherwise Classified	01/01/1997	2	PA	
V2630	Anterior Chamber Intraocular Lens	03/21/1996	3	NC	
V2631	Iris Supported Intraocular Lens	03/21/1996	3	NC	
V2632	Posterior Chamber Intraocular Lens	03/21/1996	3	NC	
V2700	Balance lens	01/01/2004	1	PC	
V2702	Deluxe lens feature	09/01/2005	1	NC	
V2710	Glass/plastic slab off prism	01/01/2004	1	PC	
V2715	Prism lens/es	01/01/2004	1	PC	
V2718	Fresnell prism press-on lens	01/01/2004	1	PC	
V2730	Special base curve	01/01/2004	1	PC	
V2740	Rose tint plastic	01/01/2005	3	D	
V2741	Non-rose tint plastic	01/01/2005	3	D	
V2742	Rose tint glass	01/01/2005	3	D	
V2743	Non-rose tint glass	01/01/2005	3	D	
V2744	Tint photochromatic lens/es	01/01/2004	1	PC	
V2745	Tint, any color/solid/grad	01/01/2005	2	PC	
V2750	Anti-reflective coating	01/01/2009	3	NC	
V2755	UV lens/es	01/01/2004	1	PC	
V2756	Eye glass case	01/01/2004	1	NC	
V2760	Scratch resistant coating	01/01/2004	1	PC	
V2761	Mirror coating	01/01/2004	1	NC	
V2762	Polarization, any lens	01/01/2004	1	NC	
V2770	Occluder lens/es	01/01/2004	1	PC	
V2780	Oversize lens/es	01/01/2004	1	PC	
V2781	Progressive lens per lens	01/01/2004	1	PC	
V2782	Lens, 1.54-1.65 p/1.60-1.79g	01/01/2004	1	NC	
V2783	Lens, >= 1.66 p/>=1.80 g	01/01/2004	1	NC	
V2784	Lens polycarb or equal	01/01/2004	1	NC	
V2785	Corneal Tissue Implanted in ASC	01/01/2004	1	1,049.00	
V2786	Occupational multifocal lens	01/01/2004	1	NC	
V2788	Presbyopia-correct function	01/01/2004	1	NC	
V2790	Amniotic membrane	01/01/2004	1	PC	
V2797	Vis item/svc in other code	01/01/2004	1	NC	
V2799	Miscellaneous vision service	03/22/2006	2	PA	