Ohio Administrative Code

Rule 5160-6-01 Eye care services.

Effective: June 1, 2021

(A) Definitions.

(1) "Eligible provider" has the same meaning as in rule 5160-1-17 of the Administrative Code.

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

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

(i) Diagnostic and comprehensive examination;

(ii) Testing;

(iii) Therapeutic treatment;

(iv) Lens fitting; and

(v) Vision therapy;

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

(i) Spectacle lenses and frames; and

(ii) Contact lenses;

(c) Low-vision aids; and

(d) Ocular prostheses and prosthesis services.

(3) "Prior authorization" has the same meaning as in rule 5160-1-31 of the Administrative Code.

(B) Providers.

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

(a) Eye care professionals (such as ophthalmologists, optometrists, opticians, and ocularists) acting within their scope of practice in accordance with Chapter 4725. or Chapter 4731. of the Revised Code; and

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

(2) Billing ("pay to") 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;

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

(c) An ambulatory health care clinic described in Chapter 5160-13 of the Administrative Code; or

(d) A federally qualified health center (FQHC) described in Chapter 5160-28 of the Administrative Code.

(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 provision pursuant to rule 5160-1-09 of the Administrative Code:

(i) Two dollars for the following general ophthalmological services:

(A) Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program, intermediate, new patient;

(B) Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program, comprehensive, new patient, one or more visits;

(C) Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program, intermediate, established patient; and

(D) Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program, 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;

(C) A moderately-priced standard acetate or metal frame; and

(D) The following items or services:

(i) Frosted lenses;

(ii) High-index plastic lenses;

(iii) Lenses of industrial thickness;

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

(v) Lenses with a special base curve;

(vi) Slab-off lenses;

(vii) Myodisc lenses;

(viii) Prisms; and

(ix) Engraved name on temple.

(ii) Payment for the following items and services is subject to prior authorization:

(A) Glass lenses;

(B) Tinted lenses;

(C) Ultraviolet-protective lenses;

(D) Photochromatic lenses;

(E) Orthoptic or pleoptic training;

(F) Frames or lenses provided by a source other than an optical laboratory holding a current volume purchase contract; and

(G) Replacement of a complete set of eyeglasses before the end of the time period specified in this rule.

(b) Contact lenses.

(i) Payment is subject to prior authorization, and each item may 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 is subject to prior authorization, and each item may be ordered from an optical laboratory of the provider's choice.

(d) Ocular prostheses and prosthesis services. Payment is subject to prior authorization.

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

(D) 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 is 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) If no volume purchasing contract is currently in effect, payment for spectacle lenses and frames may be made to an eligible medicaid provider.

(7) 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.

(7) For a covered vision care service furnished at an FQHC, payment is made in accordance with Chapter 5160-28 of the Administrative Code.