Ohio Administrative Code

Rule 5160-6-01 Eye care services.

Effective: January 1, 2024

(A) Scope. This rule sets forth general coverage and payment policy for eye care services. Additional provisions for eye care services provided through a medicaid managed care organization are described in Chapter 5160-26 of the Administrative Code.

(B) 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) "Participating optical laboratory" is an optical laboratory that is a party to the volume purchasing contract.

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

(5) "Volume purchase contract," for purposes of this rule, is the current contract designated "medicaid vision volume purchase program: ophthalmic laboratory services and delivery" that is maintained by the Ohio department of administrative services. The contract can be accessed at https://ohiobuys.ohio.gov/page.aspx/en/ctr/contract_browse_public.

(C) Providers.

(1) Rendering providers. The following eligible providers may receive medicaid payment for rendering 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 furnishing services in accordance with professional standards; and

(b) For the provision of spectacle lenses and frames, a participating optical laboratory.

(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.

(D) Coverage.

(1) Vision care services.

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

(i) General ophthalmological services; and

(ii) 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 (PA) for items and services listed in the volume purchase contract that are provided by a participating optical laboratory.

(ii) Payment may be made with PA for items and services that are categorized in the healthcare common procedure coding system (HCPCS) with spectacle lenses and frames but are not listed in the volume purchase contract.

(b) Contact lenses.

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

(ii) A PA request may be denied if contact lenses have no advantage over eyeglasses for the individual. This provision does not apply to replacement contact lenses.

(iii) Contact lenses are deemed to have an advantage over eyeglasses in the treatment of any of the conditions specified in the following non-exhaustive list of examples:

(A) Aphakia;

(B) Keratoconus;

(C) Irregular corneal astigmatism;

(D) Corneal ectasia;

(E) Post-operative corneal irregularity;

(F) Anisometropia with a difference of three or more diopters; or

(G) High ametropia in either eye of ten diopters or more (either plus or minus).

(c) Low-vision aids. Payment is subject to PA, 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 PA.

(3) 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 for more than one comprehensive vision examination and one complete frame and pair of lenses per

twenty-four-month period is subject to PA.

(b) For an individual younger than twenty-one years of age or sixty years of age or older, payment for more than one comprehensive vision examination and one complete frame and pair of lenses per twelve-month period is subject to PA.

(4) A vision care provider may render service to an individual living in a long-term care facility (LTCF) only after having received a request signed by the individual, the individual's authorized representative, or (if the authorized representative is not available) the individual's attending physician.

(5) Payment for the following items and services is subject to PA:

(a) Orthoptic or pleoptic training;

(b) Frames or lenses provided by a source other than a participating optical laboratory, even if they are identical to items listed in the volume purchase contract; and

(c) Lenses prescribed as supplementary sunglasses in addition to regular eyeglasses.

(6) No separate payment is made for both an evaluation and management service and a general ophthalmological service performed during the same visit.

(7) The medicaid payment amount for a covered item is compensation for the dispensing of that item. It cannot be used as a "credit" toward payment for a substitute item. In particular, medicaid payment for a covered frame listed in the volume purchase contract cannot be applied toward a frame not listed in the contract. If no volume purchasing contract is currently in effect, however, or if no frame suited to an individual's particular needs is listed on the volume purchase contract, payment for spectacle lenses and frames may be made to an eligible medicaid provider of vision care services.

(8) Nothing in this rule is to be construed as preventing a medicaid-eligible individual from voluntarily paying out of pocket for a non-covered additional service in accordance with rule 5160-1-13.1 of the Administrative Code.

(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 the 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 the volume purchase contract is the lesser of the provider's submitted charge or the provider's cost.

(4) 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.

(5) For a covered vision care service furnished at a federally qualified health center (FQHC), payment is made in accordance with Chapter 5160-28 of the Administrative Code.