TITLE 317: OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 1. PHYSICIANS

317:30-5-10. Ophthalmology services

(a) **Covered services for adults.**

(1) Payment can be made for medical services that are reasonable and necessary for the diagnosis and treatment of illness or injury up to the patient's maximum number of allowed office visits per month.

(2) ~~Payment is made for treatment of eye disease not related to refractive errors.~~ There is no provision for routine eye exams, examinations for the purpose of prescribing glasses or for prescribing visual aids ~~treatment of refractive errors~~, for the determination of refractive state or treatment of refractive errors, or for the purchase of lenses, frames, ~~eye examinations for the purpose of prescribing glasses or for the purchase of~~ or visual aids. Payment is made for treatment of medical or surgical conditions which affect the eyes. Providers must notify members in writing of services not covered by SoonerCare prior to providing those services. Determination of refractive state or other non-covered service may be billed to the patient if properly notified.

(3) The global surgery fee ~~schedule~~ allowance includes preoperative evaluation and management services rendered the day before or the day of surgery, the surgical procedure, and routine postoperative period. ~~Postoperative care~~ Co-management for cataract surgery should be filed using appropriate CPT codes, modifiers and guidelines. If an optometrist has agreed to provide postoperative care, the optometrist's information must be in the referring provider's section of the claim.

(b) **Covered services for children.**

(1) ~~Payment can be made for medical services that are reasonable and necessary for the diagnosis and treatment of illness, injury, amblyopia, and significant refractive errors or strabismus.~~ Eye examinations are covered when medically necessary. Determination of the refractive state is covered when medically necessary.

(2) Within the scope of the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT), payment ~~will be~~ is made to health department clinics and schools for periodic ~~visual~~ vision screenings as set forth in the periodicity schedule adopted by the Oklahoma Health Care Authority (OHCA) ~~in accordance with the American Academy of Pediatrics~~. ~~Payment will be made for lenses and frames required to correct~~

~~visual defects or to protect children with monocular vision.~~ An EPSDT vision screening is considered a comprehensive examination. A provider billing the SoonerCare program for an EPSDT screen may not bill any other Evaluation and Management Current Procedure Terminology (CPT) code for that patient on that same day. It is expected that the screening provider will perform necessary treatment as part of the screening charge.

(3) In addition to ~~periodic visual~~ EPSDT vision screenings, payment ~~will be~~ is made for individual interperiodic ~~visual~~ vision screenings when ~~medically necessary.~~ medical necessity has been properly documented. OHCA does not pay for group screenings.

(4) Payment is made for lenses, frames, visual aids and certain tints when medically necessary. Refer to OAC 317:30-5-432.1. for specific guidelines.

(c) **Procedure codes.**

(1) ~~Routine checkups and eye examinations for the purpose of prescribing, fitting or changing eyeglasses and eye refractions are billed using the General Ophthalmological Services CPT codes for the Intermediate exam. CPT manual guidelines are the basis for this policy and coverage of services is dependent on the purpose of the examination rather than on the ultimate diagnosis. A routine examination is still routine even if a pathologic condition is identified.~~ The appropriate procedure codes used for billing eye care services are found in the Current Procedural Terminology (CPT) and HCPCS Level II Coding Manuals.

~~(2) Evaluation and Management codes should be used when the primary purpose of the examination is examination and treatment of a medical or surgical condition.~~

~~(3) Frames are billed using the appropriate HCPC code. Payment includes the dispensing fee.~~

~~(4)~~ (2) ~~Visual~~ Vision screening~~,~~ is a component of all eye ~~the EPSDT~~ exams performed by eye care providers ~~of an asymptomatic child, is included in a routine exam~~ and is not billed separately. ~~Use the appropriate visual acuity screening test CPT code (see CPT section A Other Services and Procedures) when billing visual screening separately from a routine eye exam.~~

~~(d) **Payment.** The Medicaid payment for frames and/or lenses represents payment in full. No difference can be collected from the patient or family.~~

~~(e) **Non-covered items.** Non-covered items, for example, progressive lenses, aspheric lenses, tints, coatings and photochromic lenses are non-compensable and may be billed to the patient.~~

~~(f) **Prior authorization.** Contact lenses for aphakia and keratoconus are a covered benefit. Other contact lenses require prior authorization and medical necessity. The appropriate HCPC~~

~~code should be used. Bifocal lenses for the treatment of accommodative esotropia are a covered benefit. Other multifocal lenses for children require prior authorization and medical necessity. Polycarbonate lenses are covered for children when medically necessary.~~

PART 45. OPTOMETRISTS

317:30-5-431. Coverage by category

Payment is made to optometrists as set forth in this Section.

(1) **Adults.** Payment can be made for medical services that are reasonable and necessary for the diagnosis and treatment of illness or injury up to the patient's maximum number of allowed office visits per month.

(A) ~~Payment is made for treatment of eye disease not related to refractive errors.~~ There is no provision for routine eye exams, examinations for the purpose of prescribing glasses or for prescribing visual aids, for the determination of refractive state or treatment of refractive errors, or for the purchase of lenses, frames, or visual aids. ~~eye examinations for the purpose of prescribing glasses or for the purchase of visual aids.~~ Providers must notify members in writing of services not covered by SoonerCare prior to providing those services. Determination of refractive state or other non-covered services may be billed to the patient if properly notified.

(B) The global surgery fee ~~schedule~~ allowance includes preoperative evaluation and management services rendered the day before or the day of surgery, the surgical procedure, and routine postoperative period. ~~Postoperative care~~ Co-management for cataract surgery should be filed using appropriate CPT codes, modifiers and guidelines. If an optometrist has agreed to provide postoperative care, the ~~optometrist's~~ surgeon's information must be in the referring provider's section of the claim.

(C) Payment for laser surgery to optometrist is limited to those optometrists certified by the Board of Optometry as eligible to perform laser surgery.

(2) **Children.**

(A) ~~Payment can be made for medical services that are reasonable and necessary for the diagnosis and treatment of illness, injury, amblyopia and significant refractive errors or strabismus.~~ Eye examinations are covered when medically necessary. Determination of the refractive state is covered when medically necessary.

(B) Within the scope of the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT), payment will be made to health department clinics and schools for periodic

~~visual~~ vision screenings as set forth in the periodicity schedule found at OAC 317:30-3-65.7. ~~Payment will be made for lenses and frames required to correct visual defects or to protect children with monocular vision.~~ In addition to ~~periodic visual~~ EPSDT vision screenings, payment ~~will be~~ is made for individual interperiodic ~~visual~~ vision screenings when medical necessity has been properly documented. OHCA does not pay for group screenings.~~medically necessary.~~

(3) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services.

317:30-5-432. Procedure Codes

(a) ~~Routine checkups and eye examinations for the purpose of prescribing, fitting or changing eyeglasses and eye refractions are billed using the General Ophthalmological Services CPT codes for the Intermediate exam. CPT manual guidelines are the basis for this policy and coverage of services is dependent on the purpose of the examination rather than on the ultimate diagnosis. A routine examination is still routine even if a pathologic condition is identified.~~ The appropriate procedure codes used for billing Optometry services are found in the Current Procedural Terminology (CPT) and HCPCS Coding Manuals.

~~(b) Evaluation and Management codes should be used when the primary purpose of the examination is examination and treatment of a medical or surgery condition.~~

~~(c) Payment for frames includes the dispensing fee.~~

~~(d)~~(b) ~~Visual~~ Vision screening~~,~~ is a component of ~~the EPSDT~~ all eye exams performed by ophthalmologists or optometrists ~~of an asymptomatic child, is included in a routine exam~~ and is not billed separately. ~~Use the appropriate visual acuity screening test CPT code when billing visual screening separately from a routine eye exam.~~

~~(e) Medicaid payment for frames and/or lenses represents payment in full. No difference can be collected from the patient or family.~~

~~(f) Non covered items, for example, progressive lenses, aspheric lenses, tints, coatings and photochromic lenses are non-compensable and may be billed to the patient.~~

~~(g) Contact lenses for aphakia and keratoconus are a covered benefit. Other contact lenses require prior authorization and medical necessity. Bifocal lenses for the treatment of accommodative esotropia are a covered benefit. Other multifocal lenses for children require prior authorization and medical necessity. Polycarbonate lenses are covered for children when medically necessary.~~

317:30-5-432.1 Corrective Lenses

(a) Payment will be made for children for lenses, frames, low vision aids and certain tints when medically necessary. Coverage includes one set of lenses and frames per year.

(b) Corrective lenses must be based on medical need. Medical need includes a change in prescription or replacement due to normal lens wear.
(c) SoonerCare provides frames when medically necessary. Frames are expected to last at least one year and must be reusable. If a lens prescription changes, the same frame must be used if possible. Payment for frames includes the dispensing fee.
(d) SoonerCare reimbursement for frames or lenses represents payment in full. No difference can be collected from the patient or family.
(e) Replacement of or additional lenses and frames are allowed when medically necessary. Prior authorization is not required; however, the provider must document in the patient record the reason for the replacement or additional eyeglasses. The OHCA or its designated agent will conduct ongoing monitoring of replacement frequencies to ensure guidelines are followed. Payment adjustments will be made on claims not meeting these requirements.
(f) Bifocal lenses for the treatment of accommodative esotropia are a covered benefit. Progressive lenses, trifocals, photochromic lenses and tints for children require prior authorization and medical necessity. Polycarbonate lenses are covered for children when medically necessary.
(g) Progressive lenses, aspheric lenses, tints, coatings and photochromic lenses for adults are non-compensable and may be billed to the patient.
(h) Replacement of lenses and frames due to abuse and neglect by the member is not covered.
(i) Bandage contact lenses are a covered benefit. Contact lenses for medically necessary treatment of conditions such as: aphakia, keratoconus (post keratoplasty), aniseikonia/anisometropia or albinism are a covered benefit. Other contact lenses require prior authorization and medical necessity.

PART 47. OPTICAL COMPANIES

317:30-5-450. Eligible providers
Payment can be made to optical suppliers who have a current Memorandum of Agreement with this Authority.

317:30-5-451. Coverage by category
Payment is made to optical suppliers as set forth in this Section.

(1) **Adults.** There is no provision for the coverage of glasses for adults, or for the purchase of visual aids.

(2) **Children.** Payment ~~will be~~ is made for medically necessary lenses and frames ~~required to correct visual defects or to~~

~~protect children with monocular vision~~. Refer to OAC 317:30-5-432.1. for specific guidelines.

(3) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services.

~~317:30-5-452. Procedure codes~~ [REVOKED]

~~(a) **Claims.** Payment for frames includes the dispensing fee.~~

~~(b) **Payment.** Medicaid payment for frames and/or lenses represents payment in full. No difference can be collected from the patient or family.~~

~~(c) **Non-covered items.** Non covered items, for example, progressive lenses, aspheric lenses, tints, coatings and photochromic lenses are non compensable and may be billed to the patient.~~

~~(d) **Prior authorization.** Contact lenses for aphakia and keratoconus are a covered benefit. Other contact lenses require prior authorization and medical necessity. Bifocal lenses for the treatment of accommodative esotropia are a covered benefit. Other multifocal lenses for children require prior authorization and medical necessity. Polycarbonate lenses are covered for children when medically necessary.~~