# Rules of
# Department of Social Services
## Division 70—Division of Medical Services
## Chapter 40—Optical Program

## Title 13—DEPARTMENT OF SOCIAL SERVICES
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### Chapter 40—Optical Program

**13 CSR 70-40.010 Optical Care Benefits and Limitations—Medicaid Program**

*PURPOSE: This rule establishes the basis for administering the Optical Care program under the Missouri Medicaid program, including the designation of professional persons who may perform optical care services; services which are covered, noncovered and limitations within the program and the method of reimbursement.*

*PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.*

(1) Administration. The Optical Care program shall be administered by the Department of Social Services, Division of Medical Services. The optical care services covered and not covered, the program limitations and the maximum allowable fees for all covered services shall be determined by the Department of Social Services, Division of Medical Services and shall be included in the Optical provider manual and provider bulletins, which are incorporated by reference and made a part of this rule as published by the Department of Social Services, Division of Medical Services, 615 Howerton Court, Jefferson City, MO 65109, at its website at www.dss.mo.gov/dms, June 15, 2006. This rule does not incorporate any subsequent amendment or additions. Services covered shall include only those which are clearly shown to be medically necessary.

(2) Persons Eligible. Any person who is eligible for Title XIX benefits from the Family Support Division and who is found to be in need of optical care services as described in this regulation subject to the limitations set forth in subsections (7)(A)–(Y).

(3) Provider Participation. To be eligible for participation in the Missouri Medicaid Optical Care Program, a provider must meet the criteria specified for his/her profession as follows:

(A) An optometrist must be a duly licensed Doctor of Optometry (OD) to participate in Medicaid, must be licensed in accordance with the licensing provisions of the state in which s/he practices and must have a current Missouri Medicaid participation agreement and provider number;

(B) A physician must be a duly licensed Doctor of Medicine (MD) or Doctor of Osteopathy (DO) to participate in Medicaid must be licensed in accordance with the licensing provisions of the state in which s/he practices and must have a current Missouri Medicaid participation agreement and provider number;

(C) An optometric clinic can participate in the Optical Care program if it has a current Medicaid optometric clinic number. In addition to the clinic number, each of the performing optometrists must have an effective participation agreement and Medicaid provider number. Reimbursement can be made to the clinic for all covered services provided at the clinic; and

(D) An optician, optical dispenser or manufacturer of artificial eyes must have a current Missouri Medicaid participation agreement and provider number.

(4) Types of Service Reimbursed by Medicaid for Each Profession.

(A) Optometrist or Optometric Clinic.
1. Eye examinations.
2. Eyeglasses.
3. Artificial eyes.
4. Special ophthalmological services.

(B) Opticians or Optical Dispensers.
1. Eyeglasses.
2. Artificial eyes.

(C) Manufacturers of Artificial Eyes—Artificial Eyes.

(D) Physicians (MD or DO).
1. Eye examinations.
2. Eyeglasses.
3. Artificial eyes.
4. Special ophthalmological services.

(5) Reimbursement. Medicaid reimbursement will be the lower of the provider's usual and customary charge to the general public or the Medicaid allowable amount.

(6) Covered Services.

(A) Complete or limited eye examination with refraction.

(B) Eye refraction (Medicare-Medicaid recipient only).

(C) Glasses (frames and lenses, under 4.00 diopters).

(D) Frames.

(E) Temple.

(F) Lenses, single vision.

(G) Lenses, bifocal, Kryptok.

(H) Lenses, bifocal, Flat top.

(I) Lenses, bifocal, Executive.

(J) Lenses, trifocal.

(K) Lenses, cataract.

(L) Special frames (prior authorization required).

(M) Special lens (medical necessity required).

(N) Miscellaneous repairs (medical necessity required).

(O) Scleral shell, stock or custom.

(P) Artificial eye, stock or custom.

(Q) Artificial eye, refitting.

(R) Artificial eye prosthesis check/polishing/cleaning.

(S) Rose I and Rose II tints (medical necessity required).

(T) Photochromatic (prior authorization required).

(U) Orthoptic and/or pleoptic training, with continuing optometric direction and evaluation (visual therapy/training) (prior authorization required).

(V) Fitting of contact lens for treatment of disease, including supply of lens (therapeutic bandage lens) (medical necessity required).

(W) Visual field examination with optometric diagnostic evaluation; tangent screen, Autoplot or equivalent (prior authorization required).

(X) Electro-oculography, with medical diagnostic evaluation (prior authorization required).

(Y) Visually evoked potential (response) study, with medical diagnostic evaluation (prior authorization required).

(Z) Quantitative perimetry, for example, several isopters on Goldmann perimeter or equivalent (prior authorization required).

(AA) Static and kinetic perimetry or equivalent.

(BB) Serial tonometry with optometric diagnostic evaluation (separate procedure), one (1) or more sessions, same day.

(CC) Tonography with optometric diagnostic evaluation, recording indentation tonometer method or perilimbal suction method.

(DD) Color vision examination, extended, for example, anomaloscope or equivalent.

(EE) Dark adaptation examination, with optometric diagnostic evaluation.

(7) Program Limitations.

(A) One (1) comprehensive or one (1) limited eye examination is allowed per two (2) years (within a twenty-four (24)-month period of time) under the Medicaid program. Eligible needy children, pregnant women, and

blind persons are allowed one (1) comprehensive or one (1) limited eye examination per year (within a twelve (12)-month period of time) under the Medicaid program. Payment for a comprehensive eye examination will be made only if six (6) or more of the following procedures have been performed:

1. Refraction far point and near point;
2. Case history;
3. Visual acuity testing;
4. External eye examination;
5. Pupillary reflexes;
6. Ophthalmoscopy;
7. Ocular motility testing;
8. Binocular coordination;
9. Vision fields;
10. Biomicroscopy (slit lamp);
11. Tonometry;
12. Color vision; and
13. Depth perception.

(B) If fewer than six (6) of these procedures are performed, a limited examination must be billed.

(C) Eligible needy children, pregnant women, and blind persons may be allowed additional eye examinations during the year (within a twelve (12)-month period of time) if medically necessary (that is, cataract examination, prescription change of 0.50 diopters or greater). A Medical Necessity Form must be completed for eye examinations in excess of one (1) per year.

(D) Eyeglasses are covered by Medicaid for Medicaid eligible individuals when the prescription is at least 0.75 diopters for one (1) eye or 0.75 diopters for each eye.

(E) Only one (1) pair of eyeglasses is allowed every two (2) years (within any twenty-four (24)-month period of time) for Medicaid eligible individuals.

(F) All claims for eyeglasses or lenses must contain the prescription and the name of the prescribing physician (MD or DO) or optometrist (OD).

(G) The original eyeglass prescription and laboratory invoices listing costs for optical materials, lenses and/or frames provided; and the charge for grinding, edging or assembling of glasses must be kept on file by the provider for five (5) years and furnished to the Department of Social Services (DOSS) upon request.

(H) Special frames are covered under the Missouri Medicaid program if they are required for medical reasons and are prior authorized by DOSS. Special frames may be authorized if the patient requires special lenses (over 4.00 diopters for one (1) eye or over 4.00 diopters for each eye and are extra thick or heavy), the structure of the patient's face requires special frames (a very large face, wide-set eyes) or the patient needs glasses with pads because of nose surgery. The Prior Authorization Request Form must be completed and signed by the prescribing physician or optometrist.

(I) Special lenses are covered under the Missouri Medicaid program if they are medically justified and the prescription is plus or minus 4.00 diopters for one (1) eye or 4.00 diopters for each eye, cataract lenses or special bifocal lenses (for example, plastic Executive lenses). A Medical Necessity Form stating the reason special lenses are required must be completed and signed by the prescribing physician or optometrist and attached to the claim form.

(J) Plastic lenses may be dispensed under the Missouri Medicaid program. Reimbursement will be at the same rate as comparable glass lenses. Additional payment will be allowed for plastic lenses that meet the definition of special lenses and are medically justified.

(K) Photochromatic lenses are covered only if medically necessary and prior authorized by the DOSS medical consultant. The Prior Authorization Request Form must be completed and signed by the prescribing physician or optometrist.

(L) Tinted lenses (Rose I and Rose II) are covered if medically necessary. A Medical Necessity Form completed and signed by the prescribing physician or optometrist must be attached to the claim form for the glasses.

(M) Replacement of optical materials and repairs in excess of program limitations may be covered if medically necessary or required for employment training, or educational purposes as follows:

1. Replacement of complete eyeglasses (frames and lenses)—Prior authorization required.

A. Lenses and frames broken (recipient must show provider the broken glasses or Medicaid will not pay for the glasses).

B. Lost.

C. Destroyed.

D. Stolen.

E. Repair of existing glasses would exceed the Medicaid allowable amount for new frames and lenses;

2. Lenses—Medical Necessity Form required.

A. Scratched.

B. Broken.

C. Prescription change of at least 0.50 diopters or greater (old and new prescription must appear on the Medical Necessity and claim forms); or

3. Frames—Prior authorization required. Temples, fronts or both broken and repair would exceed the Medicaid allowable amount for new frames.

(N) Repair of frames or replacement of parts of frames (temples) are covered as follows (Medical Necessity Form required):

1. The cost of the repairs do not exceed the Medicaid allowable amount for new frames; and

2. Repair would provide a serviceable frame for the recipient.

(O) Temples may never be billed in addition to complete new eyeglasses and new frames.

(P) Prior authorization is required for all optical services for Missouri Medicaid recipients residing in a nursing home, boarding home or domiciliary home when the service is provided in the nursing home. The provider must submit a Prior Authorization Request Form to DOSS before the service is provided in order for Medicaid payment to be made.

(Q) An eye refraction is included in the reimbursement for a comprehensive or limited eye examination. Because the eye refraction is not covered by Medicare but is covered by Medicaid, providers may bill Medicaid for an eye refraction when the patient has Medicare and Medicaid coverage.

(R) Eyeglasses may be covered by Medicaid for a prescription of less than 0.75 diopters if medically necessary. A Medical Necessity Form must be completed by the prescribing physician or optometrist and attached to the claim form. Eyeglasses less than 0.75 diopters will be approved for the following reasons:

1. Child under age eighteen (18) who requires glasses for school performances;

2. Visual acuity 20/40 or less; or

3. Protective eyewear for persons with sight in only one (1) eye.

(S) Any warranties extended by optical companies for optical materials to private-pay patients must also apply to those same materials dispensed to Medicaid recipients.

(T) Medicaid allows one (1) artificial eye per eye (one (1) left and one (1) right) within a five (5)-year period. If the artificial eye is lost, destroyed, cracked or deteriorated, payment will be allowed for replacement if a Medical Necessity Form is completed and attached to the claim.

(U) Optometrist may be reimbursed for visual therapy training when there is a prognosis for substantial improvement or correction of an ocular or vision condition. These conditions include amblyopia, eccentric (nonfoveal) monocular fixation, suppression, inadequate motor or sensory fusion and strabismus (squint). Orthoptic and pleoptic training must be prior authorized by the DOSS Optometric Consultant. The number of training sessions are limited to one (1) per day, two (2) per week and a maximum of twenty

(20) sessions may be requested on the Prior Authorization Request Form. If the patient shows significant improvement after the initial twenty (20) sessions and the optometrist feels that further progress could be made, DOSS may grant prior authorization for additional training sessions not to exceed a total of forty (40) sessions.

(V) Fitting of contact lens for treatment of disease, including supply of lens (therapeutic bandage lens) is covered if it is prescribed by a physician, (MD or DO), as a bandage to cover a diseased condition of the eye, such as a bandage over an abrasion of the skin. The lens must be plain with no corrective power. Diagnosis for which the lens should be reimbursed are Bullous Kerotopathy, Corneal Ulcers, Ocular Pemphigoid and other corneal exposure problems. A Medical Necessity Form completed and signed by the prescribing physician must be attached to the claim form.

(W) Visual field examination with optometric diagnosis evaluation, tangent screen, Autoplot or equivalent, are covered when performed by an optometrist and prior authorized by DOSS. The following criteria will be considered in granting prior authorization:

1. Elevated intraocular pressure;
2. Best corrected visual acuity of 20/40 or less in either eye;
3. Headaches not attributed to refractive error; and
4. Reduction of confrontation fields.

(X) Quantitative perimetry, for example, several isopters on Goldmann perimeter, or equivalent is covered.

(Y) Serial tonometry with optometric diagnostic evaluation (separate procedure), one (1) or more sessions on the same day is covered when performed by an optometrist. Routine tonometry is included in the reimbursement for a comprehensive examination and cannot be billed separately.

(8) Noncovered Services.

(A) Eyeglass frames with hearing aids attached.

(B) Optical services or materials provided to a recipient who was not eligible on the date the service was provided or the optical materials were delivered to the patient.

(C) Sales or use tax on optical materials (the recipient is not responsible for and may not be billed for such taxes).

(D) Contact lenses.

(E) Wire-rimmed frames.

(F) Ornamental, jeweled and trimmed frames.

(G) Sunglasses.

(H) Lenses exceeding 65 mm in diameter of frames for such lenses.

(I) Temporary lenses for cataract lenses.

(J) Eyeglass cases.

(K) Monicals.

(L) Magnifiers.

(M) Eye medications.

(N) Repair of old frames if the repair exceeds the cost of new frames.

(O) Replacement of optical materials resulting from patient abuse.

(P) Optical materials which are not medically necessary.

(Q) Nose pads.

(R) Eyeglass adjustments.

(S) Optical materials not meeting DOSS standards.

(T) Lenses or frames supplied incorrectly to the provider by the supplier or manufacturer.

(U) Replacement of lenses, complete eyeglasses, frames or artificial eyes supplied incorrectly to recipient by optical provider.

(V) Optical materials in excess of those authorized within the benefit period.

(9) General Regulations. This rule shall not encompass all of the general regulations of the Medicaid program. These regulations, however, shall be in effect for the optical care section of the overall program.

*AUTHORITY: sections 208.152, RSMo Supp. 2005 and 208.153 and 208.201, RSMo 2000 and Conference Committee Substitute for Senate Committee Substitute for House Committee Substitute for House Bill 1011, 93rd General Assembly.* This rule was previously filed as 13 CSR 40-81.170. Emergency rule filed April 10, 1981, effective April 20, 1981, expired July 10, 1981. Original rule filed April 10, 1981, effective July 11, 1981. Emergency amendment filed June 27, 2002, effective July 7, 2002, terminated Feb. 23, 2003. Amended: Filed July 15, 2002, effective Feb. 28, 2003. Amended: Filed March 3, 2003, effective Oct. 30, 2003. Emergency amendment filed Aug. 11, 2005, effective Sept. 1, 2005, expired Feb. 27, 2006. Amended: Filed June 1, 2005, effective Nov. 30, 2005. Emergency amendment filed June 15, 2006 effective July 1, 2006, expired Dec. 28, 2006. Amended: Filed May 15, 2006, effective Nov. 30, 2006.*

**Original authority: 208.152, RSMo 1967, amended 1969, 1971, 1972, 1973, 1975, 1977, 1978, 1978, 1981, 1986, 1988, 1990, 1992, 1993, 2004, 2005; 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991; and 208.201, RSMo 1987.*