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

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
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.

(1) Administration. The Optical Care program shall be administered by the Division of Medical Services, Department of Social 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 Division of Medical Services and shall be made available through the Department of Social Services, Division of Medical Services website at www.dss.state.mo.us/dms, provider bulletins, and updates to the provider manual. 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 Division of Family Services and who is found to be in need of optical care services as described in this regulation.

(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 for adults, only following cataract surgery.
3. Artificial eyes.
4. Special ophthalmological services.

(B) Opticians or Optical Dispensers.
1. Eyeglasses for adults, only following cataract surgery.
2. Artificial eyes.

(C) Manufacturers of Artificial Eyes—Artificial Eyes.

(D) Physicians (MD or DO).
1. Eye examinations.
2. Eyeglasses for adults, only following cataract surgery.
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 for adults, only following cataract surgery).

(D) Lenses, cataract.

(E) Special frames (prior authorization required).

(F) Special lens (medical necessity required).

(G) Miscellaneous repairs (medical necessity required).

(H) Scleral shell, stock or custom.

(I) Artificial eye, stock or custom.

(J) Artificial eye, refitting.

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

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

(M) Photochromatic (prior authorization required).

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

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

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

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

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

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

(T) Static and kinetic perimetry or equivalent.

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

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

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

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

(7) Program Limitations.

(A) One (1) comprehensive or one (1) limited eye examination is allowed 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) Additional eye examinations may be allowed 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 attached to the claim form for eye examinations in excess of one (1) per year.

(D) 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.

(E) 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.

(F) Eyeglasses may be covered by Medicaid for adults following cataract surgery.

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

(H) 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.

(I) 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.

(J) 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.

(K) 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.

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

(M) 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.

(W) Eyeglasses for adults, except one (1) pair following cataract surgery.

(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, 208.153 and 208.201, RSMo 2000. 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, expired Feb. 27, 2003. Amended: Filed July 15, 2002, effective Feb. 28, 2003.*

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