STATE OF OKLAHOMA

2nd Session of the 59th Legislature (2024)

HOUSE BILL 3882 By: Ford

AS INTRODUCED

An Act relating to Medicaid; providing for Medicaid coverage for eye exams and eyeglasses for adults; providing for codification; and providing an effective date.

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4005 of Title 56, unless there is created a duplication in numbering, reads as follows:

Payment for adult members is made to optometrists through SoonerCare as set forth in this section.

A. Eye examinations are covered when medically necessary. Determination of the refractive state is covered when medically necessary.

B. 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.

1. Payment is made for treatment of medical or surgical conditions which affect the eyes;

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

3. Payment for laser surgery to optometrist is limited to those optometrists certified by the Board of Optometry as eligible to perform laser surgery; and

C. When medically necessary, payment will be made for lenses, frames, low vision aids, and certain tints for adults. Coverage includes lenses and frames to protect adults with monocular vision. Coverage includes two sets of non-high-index polycarbonate lenses and frames per year. Any lenses and frames beyond this limit must be prior authorized and determined to be medically necessary. All non-high-index lenses must be polycarbonate.

D. Corrective lenses must be based on medical need. Medical need includes a significant change in prescription or replacement due to normal lens wear.

E. 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.

F. Providers must accept SoonerCare reimbursement as payment in full for services rendered, except when authorized by SoonerCare, including but not limited to, copayments or other cost sharing arrangements authorized by the state:

1. Providers must be able to dispense standard lenses and frames which SoonerCare would fully reimburse with no cost to the eligible member; and

2. If the member wishes to select lenses and frames with special features which exceed the SoonerCare allowable fee, and are not medically necessary, the member may be billed the excess cost. The provider must obtain signed consent from the member acknowledging that they are selecting lenses and/or frames that will not be covered in full by SoonerCare and that they will be responsible to pay the excess cost. The signed consent must be included in the member's medical record;

G. Replacement of or additional lenses and frames are allowed when medically necessary. The Oklahoma Health Care Authority does not cover lenses or frames meant as a backup for the initial lenses/frames. Prior authorization is not required unless the number of glasses exceeds two per year. The provider must always document in the member's record the reason for the replacement or

additional lenses and frames. The OHCA or its designated agent will conduct ongoing monitoring of replacement frequencies to ensure OHCA policy is followed. Payment adjustments will be made on claims not meeting these requirements;

H. A fitting fee will be paid if there is documentation in the record that the provider or technician took measurements of the member's anatomical facial characteristics, recorded lab specifications and made final adjustment of the spectacles to the visual axes and anatomical topography. A fitting fee can only be paid in conjunction with a pair of covered lenses and frames.

I. Bifocal lenses for the treatment of accommodative esotropia are a covered benefit. Progressive lenses, trifocals, photochromic lenses, and tints for adults require prior authorization and must satisfy the medical necessity standard. Payment is limited to two glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.

J. Replacement of lenses and frames due to abuse and neglect by the member is not covered.

K. Bandage contact lenses are a covered benefit for adults. Contact lenses for medically necessary treatment of conditions such as aphakia, keratoconus, following keratoplasty, aniseikonia/anisometropia or albinism are a covered benefit for adults. Other contact lenses for children require prior authorization and must satisfy the medical necessity standard.

SECTION 2. This act shall become effective November 1, 2024.

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