

Table of Contents

1.0	Description of the Procedure, Product, or Service.....	1
1.1	Definitions	1
2.0	Eligibility Requirements	1
2.1	Provisions.....	1
2.1.1	General.....	1
2.1.2	Specific	2
2.2	Special Provisions.....	2
2.2.1	EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age	2
2.2.2	EPSDT does not apply to NCHC beneficiaries	3
2.2.3	Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age	3
2.3	Medicaid Eligible Categories.....	3
2.3.1	Regular Medicaid.....	3
2.3.2	Medicaid for Pregnant Women (MPW).....	3
2.3.3	Family Planning Waiver Program (MAFD)	3
3.0	When the Procedure, Product, or Service Is Covered.....	3
3.1	General Criteria Covered	3
3.2	Specific Criteria Covered.....	4
3.2.1	Specific criteria covered by both Medicaid and NCHC	4
3.2.2	Medicaid Additional Criteria Covered.....	4
3.2.3	NCHC Additional Criteria Covered	4
4.0	When the Procedure, Product, or Service Is Not Covered.....	4
4.1	General Criteria Not Covered	4
4.2	Specific Criteria Not Covered.....	5
4.2.1	Specific Criteria Not Covered by both Medicaid and NCHC.....	5
4.2.2	Medicaid Additional Criteria Not Covered.....	5
4.2.3	NCHC Additional Criteria Not Covered.....	5
4.3	Beneficiary Purchase of Non-Covered Services	5
5.0	Requirements for and Limitations on Coverage	6
5.1	Prior Approval	6
5.2	Prior Approval Requirements	6
5.2.1	General.....	6
5.2.2	Specific	6
5.3	Routine Eye Exams and Refractions.....	6
5.3.1	Service Limitations	6
5.3.2	Routine Eye Exam Components	6
5.3.3	Medicaid Carolina ACCESS (Community Care of North Carolina) Referral Authorization	6
5.3.4	Medicaid for Pregnant Women (MPW).....	7
5.3.5	Early Eye Exam or Refraction Only	7
5.4	Visual Aids	7

5.4.1	Service Limitations	7
5.4.2	Medicaid Carolina ACCESS (Community Care of North Carolina) Referral Authorization	8
5.4.3	Medicaid for Pregnant Women (MPW).....	8
5.4.4	State Optical Laboratory Contractor.....	8
5.4.5	Eyeglasses, Lenses, or Frames Supplied by the Provider	8
5.5	Frames.....	8
5.5.1	Frame Fitting Kit	8
5.5.2	Non-Medicaid and Non-NCHC Frames	9
5.5.3	Beneficiary’s Own Medicaid or NCHC Frame	9
5.5.4	Beneficiary Purchase of Non-Covered Frame	9
5.6	Lenses	10
5.6.1	Spectacle Lenses	10
5.6.2	Cataract Spectacle Lenses.....	10
5.6.3	Exceptional Spectacle Lenses.....	11
5.6.4	Uncut Lenses Only.....	11
5.7	Tints	12
5.8	Replacement Visual Aids.....	12
5.8.1	Medicaid and NCHC Replacement of Lost, Stolen or Damaged Visual Aids.....	12
5.8.2	Medicaid Replacement of Lost, Stolen, or Damaged Visual Aids for Social Security Income (SSI) Beneficiaries.....	13
5.8.3	Medicaid Replacement of Lost, Stolen or Damaged Visual Aids for Legally Adopted Beneficiaries.....	13
5.8.4	Warranty Frame Replacements.....	13
5.8.5	Non-Warranty Frame Replacements.....	13
5.8.6	Allergy Related Frame Replacements	14
5.8.7	Early Lens Replacement	14
5.9	Medically Necessary Contact Lenses	14
5.9.1	Requests for Extended Wear Lenses, Frequent Replacement Lenses or Disposable Lenses.....	15
5.9.2	Back-Up Eyeglasses for Contact Lens Wearers	15
6.0	Provider(s) Eligible to Bill for the Procedure, Product, or Service	15
6.1	Provider Qualifications and Occupational Licensing Entity Regulations.....	15
6.2	Provider Certifications	15
7.0	Additional Requirements	16
7.1	Compliance	16
7.2	Provision of Service.....	16
7.3	Checking the Status of Eyeglass Orders	16
7.4	State Optical Laboratory Contractor.....	16
7.4.1	Requesting Non-Covered Services	16
7.5	State Optical Laboratory Contractor Errors.....	17
7.5.1	Inspection by Provider	17
7.5.2	Returning Visual Aid Errors to the State Optical Laboratory Contractor.....	17
7.5.3	Damaged or Incorrect Orders.....	17
7.5.4	Misdirected Orders	18
7.5.5	Duplicate Orders	18
7.6	Provider Errors.....	18

7.6.1	Documentation and Fitting Errors	18
7.6.2	Prescription Errors	18
7.6.3	Provider Remakes	18
8.0	Policy Implementation/Revision Information.....	19
Attachment A:	Claims Related Information	20
A.	Claim Type	20
B.	International Classification of Diseases, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS).....	20
C.	Code(s).....	20
D.	Modifiers.....	23
E.	Billing Units.....	23
F.	Place of Service	23
G.	Co-payments	23
H.	Reimbursement Rate.....	24
Attachment B:	Billing Information Specific to the Routine Eye Examination and Visual Aids Policy	25
A.	Electronic Claim vs. Paper Claim.....	25
B.	Billing Guidelines for Routine Eye Exams, Eyeglasses, and Contact Lenses	25
C.	Billing Dispensing Fees for Eyeglasses that Cannot be Dispensed	26
D.	Billing for Eyeglasses Repair or Replacements.....	27
E.	Denied Visual Aid Claims Due to Beneficiary Ineligibility on Date of Service	27
Attachment C:	Web tool for Refraction and Eyeglass History	28
A.	Confirmation for Eye Exams and Refractions that do not Require Prior Approval	28
B.	Confirmation for Eyeglasses.....	28
Attachment D:	Contractor Contact Information	29
A.	State’s Fiscal Agent Contractor	29
B.	State Optical Laboratory Contractor.....	29
C.	Provider Enrollment and Support Contractor	29
Attachment E:	Warranty Frame Replacement	30

Related Clinical Coverage Policies

Refer to <http://www.ncdhhs.gov/dma/mp/> for the related coverage policies listed below:
1T-1, *General Ophthalmological Services*

1.0 Description of the Procedure, Product, or Service

A routine eye examination (exam) is an examination of the eyes in the absence of disease or symptoms to determine the health of the organs and visual acuity. Visual aids are the manual correction of diminished eyesight, by way of lenses (ophthalmic eyeglass frames and/or lenses and medically necessary contact lenses) provided by ophthalmologists, optometrists, and opticians within the scope of practice as defined by N.C. state laws (NCGS 90-127.3 and NCAC 42E).

Optical services include: routine eye exam, including the determination of refractive errors; refraction only; prescribing corrective lenses; and dispensing approved visual aids.

Refer to **Subsection 3.2** for specific criteria regarding ophthalmologists, optometrists, and opticians.

Note: This policy does not address general ophthalmological services coverage. For coverage criteria for these services, refer to clinical coverage policy 1T-1, *General Ophthalmological Services*.

1.1 Definitions

None Apply.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

(The term “General” found throughout this policy applies to all Medicaid and NCHC policies)

- a. An eligible beneficiary shall be enrolled in either:
 1. the NC Medicaid Program (*Medicaid is NC Medicaid program, unless context clearly indicates otherwise*); or
 2. the NC Health Choice (*NCHC is NC Health Choice program, unless context clearly indicates otherwise*) Program on the date of service and shall meet the criteria in **Section 3.0 of this policy**.
- b. Provider(s) shall verify each Medicaid or NCHC beneficiary’s eligibility each time a service is rendered.
- c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.
- d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

2.1.2 Specific

(The term “Specific” found throughout this policy only applies to this policy)

- a. **Medicaid**
None Apply.
- b. **NCHC**
None Apply.

2.2 Special Provisions

2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary’s physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary’s right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider’s documentation shows that the requested service is medically necessary “to correct or ameliorate a defect, physical or mental illness, or a condition” [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary’s health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

b. EPSDT and Prior Approval Requirements

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below.

NCTracks Provider Claims and Billing Assistance Guide:

<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>

EPSDT provider page: <http://www.ncdhhs.gov/dma/epsdt/>

2.2.2 EPSDT does not apply to NCHC beneficiaries

2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age

The Division of Medical Assistance (DMA) shall deny the claim for coverage for an NCHC beneficiary who does not meet the criteria within **Section 3.0** of this policy. Only services included under the NCHC State Plan and the DMA clinical coverage policies, service definitions, or billing codes are covered for an NCHC beneficiary.

2.3 Medicaid Eligible Categories

2.3.1 Regular Medicaid

Beneficiaries under 21 years of age with regular Medicaid are eligible for routine eye exams and visual aids.

2.3.2 Medicaid for Pregnant Women (MPW)

Routine eye exams and visual aids are not covered for beneficiaries with Medicaid for Pregnant Women except when the service is related to medical conditions associated with pregnancy or complications of pregnancy and the beneficiary is under 21 years old.

Refer to **Subsections 5.3.4** and **5.4.3** for service requirements.

2.3.3 Family Planning Waiver Program (MAFD)

Routine eye exams and visual aids are not covered for beneficiaries with Family Planning Waiver benefits.

3.0 When the Procedure, Product, or Service Is Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

3.1 General Criteria Covered

Medicaid and NCHC shall cover the procedure, product, or service related to this policy when medically necessary, and:

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by both Medicaid and NCHC

Medicaid and NCHC shall cover the following optical services when provided by ophthalmologists and optometrists:

- a. routine eye exams, including the determination of refractive errors;
- b. prescribing corrective lenses; and
- c. dispensing approved visual aids.

Opticians may dispense approved visual aids.

Refer to **Section 5.0** for service requirements and limitations.

3.2.2 Medicaid Additional Criteria Covered

None Apply.

3.2.3 NCHC Additional Criteria Covered

None Apply.

4.0 When the Procedure, Product, or Service Is Not Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

4.1 General Criteria Not Covered

Medicaid and NCHC shall not cover the procedure, product, or service related to this policy when:

- a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0**;
- b. the beneficiary does not meet the criteria listed in **Section 3.0**;
- c. the procedure, product, or service duplicates another provider's procedure, product, or service; or
- d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC

Medicaid and NCHC shall not cover the following services:

- a. affixing initials or engraving initials, name, etc. (frame or lenses);
- b. anti-reflective coatings;
- c. tinted, cosmetic contact lenses;
- d. contact lens supplies (except for the initial care kit with approved contact lenses);
- e. gradient tints; sunglasses; and any tint not medically justified by diagnosis;
- f. over the counter, hand-held magnifiers or any visual aid that can be purchased without a prescription;
- g. nonophthalmic frames (sunglasses, wrap-around, cosmetic, etc.);
- h. progressive or blended multifocals;
- i. repairs costing less than \$5.00;
- j. rimless frames requiring grooving, drilling, faceting, or beveling;
- k. safety glasses;
- l. scratch resistant coating;
- m. sport straps, chains, etc.;
- n. photochromatic lenses;
- o. hand-held low-vision magnifiers; or
- p. visual aid that can be purchased without a prescription

Note: This list is not all-inclusive. Requests for special products or services are considered on an individual basis.

4.2.2 Medicaid Additional Criteria Not Covered

None Apply.

4.2.3 NCHC Additional Criteria Not Covered

- a. NCGS § 108A-70.21(b) “Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:
 1. No services for long-term care.
 2. No nonemergency medical transportation.
 3. No EPSDT.
 4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection.”

4.3 Beneficiary Purchase of Non-Covered Services

For any non-covered service (tint, UV filter, etc.) that can be purchased by the beneficiary from the provider, the provider shall inform the beneficiary prior to the transaction that neither Medicaid nor NCHC will pay for the service and that the cost of the service is the responsibility of the beneficiary. The provider shall make payment arrangements with the beneficiary for non-covered services. However, the provider shall not withhold approved visual aids pending payment for an unpaid Medicaid, NCHC, or private bill.

5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for Medicaid Beneficiaries under 21 Years of Age.

5.1 Prior Approval

The provider shall obtain prior approval for any **early** routine eye exam or refraction only within the one year time limitation period for Medicaid or NCHC beneficiary(s).

The provider shall obtain prior approval for **all visual aids** except frame warranty replacements.

5.2 Prior Approval Requirements

5.2.1 General

The provider(s) shall submit to the Department of Health and Human Services (DHHS) Utilization Review Contractor the following:

- a. the prior approval request; and
- b. all health records and any other records that support the beneficiary has met the specific criteria in **Subsection 3.2** of this policy.

5.2.2 Specific

None Apply.

5.3 Routine Eye Exams and Refractions

Routine eye exams with refractions that meet the criteria and requirements listed in this policy do not require prior approval for Medicaid or NCHC beneficiary(s). However, providers are advised to obtain a confirmation number at <http://www.nctracks.com.gov>.

Refer to **Attachment C, A** for additional information regarding confirmation numbers.

5.3.1 Service Limitations

Routine eye exam with refraction is limited to once per year. An early routine eye exam may be approved subject to the criteria and limitations listed in this policy.

5.3.2 Routine Eye Exam Components

Refraction, tonometry, biomicroscopy, depth perception, color vision, and ophthalmoscope study are considered part of the routine eye exam and must not be billed separately.

Note: Providers are not required to document visual acuities and tonometry findings on the claim; however, this documentation must be kept in the beneficiary records.

5.3.3 Medicaid Carolina ACCESS (Community Care of North Carolina) Referral Authorization

Medicaid beneficiaries enrolled in Carolina ACCESS (Community Care of North Carolina) are eligible to receive optical services subject to all Medicaid guidelines, limitations, and prior approval criteria according to the eligibility

categories (Regular, MPW, Family Planning Waiver, etc.). Authorization by an enrollee's Carolina ACCESS primary care provider (PCP) is not required for routine eye exams. However, some vision services require PCP authorization.

Refer to NCTracks Provider Claims and Billing Assistance Guide:
<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html> for information regarding PCP referral requirements for vision services.

5.3.4 Medicaid for Pregnant Women (MPW)

Pregnant women eligible for Medicaid for Pregnant Women (MPW) benefits are not covered for routine eye exams. Special consideration can be given to MPW beneficiaries referred by a medical doctor due to complications of pregnancy. Providers shall submit an electronic prior approval request via the Web at <http://www.nctracks.nc.gov>. The request must include the following information:

- a. blood sugar
- b. blood pressure
- c. hemoglobin
- d. protein in urine (if any)
- e. weeks gestation

5.3.5 Early Eye Exam or Refraction Only

The provider shall obtain prior approval for any early routine eye exam or refraction only within the one year time limitation period for Medicaid or NCHC beneficiaries.

Providers shall submit an electronic PA requests via the Web at <http://www.nctracks.nc.gov> and include documentation of medical necessity (significant decrease in acuity, medication, failed Department of Motor Vehicles (DMV) eye exam, etc.) as well as additional documentation obtained from physicians, school nurses, DMV, etc. Each request for an early routine eye exam and/or refraction only is reviewed on a case-by-case basis.

The request must include corrected visual acuities or documentation as to why corrected visual acuities data is missing (lost eyeglasses, never before corrected, etc.). Visual acuity data must include the right eye (OD), the left eye (OS), and both eyes (OU).

If a beneficiary has an urgent need for an early eye exam or refraction, the provider may contact DMA's Optical Services Program at 919-855-4310.

5.4 Visual Aids

Providers shall not order or dispense visual aids until prior approval is obtained. If a beneficiary has an urgent need for visual aids, the provider may contact DMA's Medicaid Optical Services Program at 919-855-4190.

5.4.1 Service Limitations

Visual aids are limited to once a year. Early visual aids may be approved subject to the criteria and limitations listed in this policy.

5.4.2 Medicaid Carolina ACCESS (Community Care of North Carolina) Referral Authorization

Medicaid beneficiaries enrolled in Carolina ACCESS (Community Care of North Carolina) are eligible to receive optical services subject to all Medicaid guidelines, limitations, and prior approval criteria according to the eligibility categories (Regular, MPW, Family Planning Waiver, etc.). Authorization by an enrollee's Carolina ACCESS primary care provider (PCP) is not required for visual aids. However, some vision services require PCP authorization.

5.4.3 Medicaid for Pregnant Women (MPW)

Pregnant women eligible for Medicaid for Pregnant Women (MPW) benefits are not covered for visual aids. Special consideration can be given to MPW beneficiaries under 21 years of age who are referred by a medical doctor due to complications of pregnancy. The request for visual aids must be submitted electronically via the Web at <http://www.nctracks.nc.gov>.

5.4.4 State Optical Laboratory Contractor

Medicaid and NCHC eyeglasses are supplied by the state optical laboratory contractor unless prior approval is granted for the provider to supply the eyeglasses.

5.4.5 Eyeglasses, Lenses, or Frames Supplied by the Provider

When circumstances justify an exception, prior approval may be granted for the provider to supply complete eyeglasses, lenses only, or a frame. Exceptions include, but are not limited to, the following:

- a. A beneficiary using his/her existing Medicaid or NCHC frame (not new), who cannot function without eyeglasses; or
- b. An immediate post-surgical correction is necessary.

Refer to **Subsection 5.5.3** for additional information regarding the use of a beneficiary's own frame.

Refer to **Attachment B, Section B, 3, b** for additional information on billing for provider-supplied visual aids.

5.5 Frames

The state optical laboratory contractor supplies zylonite, combination, and metal frames for eligible Medicaid and NCHC beneficiaries.

5.5.1 Frame Fitting Kit

Medicaid enrolled optical providers agree to provide Medicaid and NCHC services according to the Medicaid and Health Choice Routine Eye Examination and Visual Aids policy. This includes allowing beneficiaries to choose a frame from the complete Medicaid and NCHC frame selection. Therefore, providers shall have a Medicaid and NCHC fitting kit consisting of frames in available sizes and colors sufficient for proper selection and fitting. Providers shall not fit frames from a catalog or Medicaid Frame Selection Guide picture. For a list of approved frames and instructions for obtaining a frame fitting kit, contact the state optical laboratory contractor.

Refer to **Subsection 7.6.1** for information regarding provider error resulting in an ill-fitting frame.

Refer to **Attachment D** for the state optical laboratory contractor contact information.

5.5.2 Non-Medicaid and Non-NCHC Frames

Requests for Medicaid or NCHC reimbursement for frames other than those available from the state optical laboratory contractor are considered on a case-by-case basis. Requests must be accompanied by documentation of medical necessity (i.e., facial anomaly, cranial deformity, etc.). The non-Medicaid or non-NCHC frame information (manufacturer, style name or number, sizes, and wholesale cost of the frame) must be recorded on the electronic PA request for prior approval and submitted via the Web at <http://www.nctracks.nc.gov>.

5.5.3 Beneficiary's Own Medicaid or NCHC Frame

The beneficiary's own Medicaid or NCHC frame may be approved when medical necessity is documented, such as replacement of one lens only due to a significant prescription change.

Providers shall not mail the beneficiary's frame to DMA, the state's fiscal agent, or the state optical laboratory contractor. DMA, the state's fiscal agent, nor the state optical laboratory contractor will be responsible for the beneficiary's own frame. The beneficiary's own frame must be identified on the electronic PA request by manufacturer, style name or number, and size and submitted via the Web at <http://www.nctracks.nc.gov>.

Refer to **Subsection 5.8.7** for additional information regarding requests for early lens replacement using a beneficiary's own frame.

5.5.4 Beneficiary Purchase of Non-Covered Frame

Medicaid and NCHC do not provide payment for non-covered frames that a beneficiary elects to purchase in lieu of a Medicaid or NCHC frame. If the beneficiary elects to purchase a frame, the beneficiary is also responsible for the lens purchase. This private transaction between the provider and the beneficiary does not negate the beneficiary's eligibility for Medicaid or NCHC eyeglasses. Providers shall not bill Medicaid or NCHC for eyeglasses purchased by the beneficiary.

5.6 Lenses

The state optical laboratory contractor supplies lenses according to Routine Eye Examination and Visual Aids policy guidelines.

5.6.1 Spectacle Lenses

Lenses are available in plastic.

Single Vision	Lenses must be + or -.50 diopters or greater in one meridian (sphere, cylinder, combination of sphere and cylinder, or prism) for either eye. Requests for prescriptions requiring less than + or -.50 diopters or greater in one meridian, which are accompanied by documentation of medical necessity, are evaluated on a case-by-case basis. Approval or denial of these requests is based on supporting documentation and medical necessity (accommodative insufficiency, accommodative spasms, etc.).
Bifocal	Lenses must have an add power of +1.00 diopter or greater and are available in CFR and ST-28.
Trifocal	Lenses are available in ST-7x28 and require documentation of medical necessity (Rx warrants intermediate correction, previous wearer, etc.).
Exceptions	ST-35 and executive lenses require documentation of medical necessity for approval for young children, students, and beneficiaries who require a wider field of vision (mobility limitations, etc.)

5.6.2 Cataract Spectacle Lenses

Lenticular and lenticular aspheric lenses are covered and are subject to eligibility and time limitations.

Single Vision	Lenticular-Aspheric Aspheric, Full Field, Super Modular*, Hyper-Aspheric
Bifocal	Round Seg Lenticular-Aspheric, Aspheric Round, Hyper-Aspheric Round, Super Modular Round*
Bifocal	Straight Top Lenticular-Aspheric ST, Hyper-Aspheric ST, Full Field

Note: *Super-Modular lenses are available in Single Vision and Round Seg only. Straight top is not available.

5.6.3 Exceptional Spectacle Lenses

The following lenses may be approved with documentation of medical necessity:

Polycarbonate (plastic)	<ul style="list-style-type: none"> - Single vision or bifocal + or - 5.00 or higher in one meridian (sphere, cylinder, combination of sphere and cylinder, or prism); - Beneficiary is blind or legally blind in one eye, with correction in accordance with guidelines found in Subsection 5.6 for the sighted eye; - Children birth through 6 years of age; - Medical/physical conditions that result in frequent trauma or falls. <p>When submitting a request for polycarbonate lenses, document medical necessity on the electronic prior approval request and submit via the Web at http://www.nctracks.nc.gov.</p>
Hi-Index (plastic)	<p>Single vision or bifocal + or - 5.00 or higher in one meridian (sphere, cylinder, combination of sphere and cylinder, or prism) AND visual distortion with polycarbonate.</p> <p>When submitting a request for hi-index lenses, document medical necessity on the electronic prior approval request and submit via the Web at http://www.nctracks.nc.gov.</p>
Other Lenses and Special Services	<p>Myodisc, Press-on Prism, Special Base Curves, Slab-off, etc.</p>

5.6.4 Uncut Lenses Only

In special circumstances, prior approval may be granted for uncut lenses from the state optical laboratory contractor for edging in the provider’s office. The provider shall inspect the lens prescription and check the lens for scratches or defects before beginning the edging process. If a flaw is found in a lens, the lens must be returned to the state optical laboratory contractor prior to edging at no charge to the provider. In the event of an error during edging, the provider assumes responsibility for the lens remake.

The frame must be identified by manufacturer, style name or number, size, and color on the electronic prior approval request and submitted via the Web at <http://www.nctracks.nc.gov>.

Refer to **Subsection 7.5.2** for shipping information for state optical laboratory contractor errors.

Refer to **Subsection 5.5.3** for additional information regarding the use of a beneficiary’s own frame.

5.7 Tints

Requests for tinted lenses are considered only when the electronic prior approval request includes documentation of medical necessity.

The following table provides guidelines for coverage of tints:

Tints	Pink #1, Pink #2, Gray #1, Gray #2, and Gray #3 may be covered for a documented diagnosis that induces photophobia (aphakia, albinism, etc.).
UV Filter	May be approved for aphakic beneficiaries requiring cataract lenses and other requests supported by documentation of medical necessity.
Other	Requests for other tints must be medically justified for consideration.

5.8 Replacement Visual Aids

Providers shall obtain prior approval for replacement visual aids that are not covered under a manufacturer warranty. Providers shall include appropriate documentation with the electronic prior approval request submitted via the Web at <http://www.nctracks.nc.gov>.

Refer to **Subsections 5.8.2** and **5.8.3** for documentation exceptions for **Medicaid** beneficiaries.

5.8.1 Medicaid and NCHC Replacement of Lost, Stolen or Damaged Visual Aids

Replacement of lost, stolen or damaged Medicaid and NCHC visual aids is considered when the electronic prior approval request is submitted via the Web at <http://www.nctracks.nc.gov> and accompanied by the following documentation:

- a. Visual aid is **stolen**: requires a copy of the police report with date preceding prior approval request date;
- b. Visual aid is damaged or lost due to an **automobile accident**: requires a copy of the accident/police report with date preceding prior approval request date;
- c. Visual aid is **damaged by fire**: requires a copy of the fire report with date preceding prior approval request date;
- d. Visual aid is lost in a **hurricane, flood, or other natural disaster**: requires a copy of documentation from FEMA or the American Red Cross indicating loss of possessions with date preceding prior approval request date;
- e. Visual aid is lost or damaged beyond repair due to **medical condition**: requires documentation from the medical professional treating the condition;
or
- f. Visual aid is lost or damaged beyond repair for reasons other than theft, automobile accident, fire, or natural disaster: requires a letter from a local department of social services (DSS) caseworker or social worker on agency letterhead stationery. Additional letters written on professional letterhead, from an appropriate person with knowledge of the occurrence, such as the school principal or nurse, may be included.

Providers shall evaluate the damaged visual aid and document the cause and the extent of the damage. Prior approval requests for replacement frames that do not

contain the frame evaluation information are returned to the provider for completion.

If the frame is not available for evaluation, the provider shall note the reason on the electronic prior approval request.

All requests for replacement of lost, stolen or damaged Medicaid or NCHC visual aids are reviewed on a case-by-case basis. Approval is granted or denied based on lens power, extenuating circumstances, medical necessity, beneficiary's responsibility in the loss or damage, frequency of replacements, etc. Improper care or negligence does not constitute extenuating circumstances.

5.8.2 Medicaid Replacement of Lost, Stolen, or Damaged Visual Aids for Social Security Income (SSI) Beneficiaries

A DSS caseworker's written recommendation is not required when the Medicaid beneficiary receives SSI. The provider shall note on the electronic prior approval request that the beneficiary receives SSI and submit via the Web to <http://www.nctracks.nc.gov>.

5.8.3 Medicaid Replacement of Lost, Stolen or Damaged Visual Aids for Legally Adopted Beneficiaries

A DSS caseworker's written recommendation is not required when the Medicaid beneficiary is legally adopted. The provider shall note on the electronic prior approval request that the beneficiary is adopted and submit via the Web to <http://www.nctracks.nc.gov>.

5.8.4 Warranty Frame Replacements

Medicaid and NCHC frames carry a one-year warranty from the original approval date assigned by the State's fiscal agent. The warranty covers manufacturing defects. All defective frames less than one year old must be visually evaluated by the provider for warranty coverage.

When the state optical laboratory contractor agrees to immediately ship a warranty replacement frame, the provider shall, upon receipt of the replacement frame, mail the defective frame to the state optical laboratory contractor. Subsequently, the state optical laboratory contractor can return the defective frame to the manufacturer for credit.

Refer to **Attachment E** for information on the replacement process for frames under warranty.

Note: Prior approval is not required for warranty replacements.

5.8.5 Non-Warranty Frame Replacements

When the damaged frame is not covered by the manufacturer warranty, providers shall state on the electronic prior approval request that the frame is not covered under warranty, and document the cause and the extent of the damage and submit via the Web to <http://www.nctracks.nc.gov>. Prior approval requests for replacement frames that do not contain the frame warranty status and evaluation information are returned to the provider for completion.

If the frame is not available for evaluation, the provider shall note the reason on the electronic prior approval request.

Refer to **Subsection 5.8.1** for information regarding required documentation for non-warranty frame replacement prior approval requests.

5.8.6 Allergy Related Frame Replacements

When a beneficiary presents with an allergic reaction to the frame material, the provider shall include documentation of medical necessity for the replacement frame.

- a. If the allergic reaction, such as dermatitis, is visible to the provider, documentation of visual assessment on the electronic prior approval request serves as medical justification.
- b. If the allergic reaction is not visible to the provider, documentation from a primary care physician, dermatologist or allergist regarding the allergy must accompany the electronic prior approval request.

5.8.7 Early Lens Replacement

When justified by medical necessity, the provider may request prior approval for additional lenses during the time limitation. A change in lens power generally equal to or greater than one half diopter (+/- .50D) in one meridian, in either eye may justify approval for a new lens or lenses. This request must include current lens circumference, visual acuities with current lenses, and visual acuities with the new prescription. Visual acuity data must include the right eye (OD), the left eye (OS), and both eyes (OU).

Prior approval requests for early lenses in the beneficiary's current Medicaid or NCHC frame must be accompanied by medical justification for the prescription change (progressive myopia, cataract development, medication, etc.).

Additional documentation obtained from physicians, school nurses, DMV, etc., justifying the prescription change must also be included with the electronic prior approval request.

Refer to **Subsection 5.5.3** for additional information regarding the use of a beneficiary's own frame.

Refer to **Subsection 5.4.5** for additional information regarding provider supplied visual aids.

5.9 Medically Necessary Contact Lenses

Medically necessary conventional daily wear contact lenses, supplied by the provider, may be approved when the prior approval request is accompanied by documentation of medical justification. Prior approval requests are evaluated based on documentation of medical necessity and medical diagnosis (anisometropia, aphakia, keratoconus, progressive myopia, etc.).

Note: One care kit is covered for approved contact lenses.

5.9.1 Requests for Extended Wear Lenses, Frequent Replacement Lenses or Disposable Lenses

Prior approval requests for exceptional cases requiring extended wear, frequent replacement, or disposable contact lenses must be accompanied by documentation of medical necessity (i.e., pediatric aphakic lens that is not available in a daily wear, Schirmer Test indicates severe dry eyes, etc.).

If the invoice cost of the extended wear, frequent replacement, or disposable contact lens is equal to or less than the invoice cost of a comparable conventional daily wear lens, approval may be granted without documentation of medical necessity. Pricing documentation must accompany the electronic prior approval request and must be on the contact lens manufacturer price sheet or manufacturer letterhead stationery.

5.9.2 Back-Up Eyeglasses for Contact Lens Wearers

When medically necessary contact lenses are approved, back-up eyeglasses may be obtained through Medicaid or NCHC.

- a. Requests for contact lenses and back-up eyeglasses must be submitted on separate electronic prior approval request submitted via the Web at <http://www.netracks.nc.gov>.
- b. The provider shall indicate on the electronic prior approval request that the request is for “back-up glasses.”

6.0 Provider(s) Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

- a. meet Medicaid or NCHC qualifications for participation;
- b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

To be eligible to bill for procedures, products, and services related to this policy, provider(s) shall be licensed as an ophthalmologist, optometrist, or optician.

6.2 Provider Certifications

None Apply.

7.0 Additional Requirements

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

7.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

- a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
- b. All DMA's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

7.2 Provision of Service

Optical providers shall extend the services of eye exams and visual aid fitting and dispensing for Medicaid and NCHC beneficiaries if these same services are extended to private patients in the same practice or business.

- a. If both eye exams and visual aids are not available in the provider's office for all patients, the provider shall inform the beneficiary prior to services being offered or scheduled. The beneficiary shall be given the option to select a provider who will provide both services.
- b. If the beneficiary elects to have the exam, a written prescription for the lenses must be given or offered to the beneficiary at the time of the exam. The prescribing provider shall not withhold the prescription pending payment for the routine eye exam or previously unpaid Medicaid, NCHC, or private bills.

7.3 Checking the Status of Eyeglass Orders

The optical provider is responsible for checking the status of Medicaid and NCHC eyeglass orders for any beneficiary experiencing delivery delays.

Note: If an order is not received **within 10 working days of the prior approval date**, the optical provider shall contact the state optical laboratory contractor to verify that they have a record of the order. If no record is found, the provider shall contact the state's fiscal agent for assistance. The state optical laboratory contractor shall not accept a provider copy of a prior approval request directly from the provider.

If an order is not received **within 20 days after shipment** from the state optical laboratory contractor, the state optical laboratory contractor shall duplicate the order at no charge to Medicaid, NCHC, or the provider.

7.4 State Optical Laboratory Contractor

DMA contracts with a state optical laboratory to provide authorized services.

7.4.1 Requesting Non-Covered Services

Providers shall not ask the state optical laboratory contractor to supply materials or services prohibited by the contractual agreement with DMA. The state optical laboratory contractor is not authorized to bill providers for non-covered services.

7.5 State Optical Laboratory Contractor Errors

Correction of state optical laboratory contractor errors shall not be billed to Medicaid, NCHC, or the provider. The replacement eyeglasses lenses, frame, or complete eyeglasses require “priority” expediting.

7.5.1 Inspection by Provider

All eyeglasses received from the state optical laboratory contractor shall be inspected by the provider prior to dispensing. Inspection includes, but is not limited to, the following:

- a. Verify the frame manufacturer, model, size, and color.
- b. Verify quality of frame and lenses (scratches, chips, damaged parts, etc.)
- c. Verify lens material (CR-39, poly, etc.), and style (SV, bifocal, trifocal, etc.).
- d. Verify lens prescription and fitting parameters (PD, OC, seg. height, base curve, center/edge thickness, etc.)
- e. Verify additions (prism, slab off, tint, UV filter, etc.)

The provider shall document the inspection date and inspector’s initials. This information must be stored with the beneficiary record.

7.5.2 Returning Visual Aid Errors to the State Optical Laboratory Contractor

All state optical laboratory contractor errors must be returned to the contractor.

- a. Shipping for state optical laboratory contractor errors is at no cost to the provider.
- b. The provider shall call the state optical laboratory contractor to request delivery arrangements for the return of the error to the contractor. The state optical laboratory contractor will provide either a prepaid mailing label and schedule a pick-up by a shipping service (i.e., RPS, UPS, FedEx, etc.), which will be charged to the state optical laboratory contractor’s shipping service account.
- c. State optical laboratory contractor errors must be received by the state optical laboratory contractor within 45 days of the contractor’s original shipping date. If incorrect lenses are not returned to the contractor within this time frame, the provider assumes responsibility for any necessary remake.

Refer to **Attachment D** for state optical laboratory contractor and the state’s fiscal agent contact information.

7.5.3 Damaged or Incorrect Orders

a. Lenses

If the lenses are unacceptable due to poor edging, lens size, flaws, scratches, incorrect power, misaligned axis, incorrect tinting, etc., the provider shall contact the state optical laboratory contractor, and then return the eyeglasses to the state optical laboratory contractor for a remake at no charge to Medicaid, NCHC, or the provider.

b. Frames

If the frame is damaged, wrong style, color, or size, wrong temple length, etc., the provider shall contact the state optical laboratory contractor and request a new frame and return the order for a frame replacement at no

charge. If necessary, the state optical laboratory contractor will then be obligated to furnish new lenses.

Refer to **Subsection 7.5.2** for shipping information for returning state optical laboratory contractor errors.

7.5.4 Misdirected Orders

If a provider receives an order for a Medicaid or NCHC beneficiary who is not the provider's patient, the provider shall telephone the state optical laboratory contractor immediately and return the eyeglasses to the contractor as soon as possible.

Refer to **Subsection 7.5.2** for shipping information for returning state optical laboratory contractor errors.

7.5.5 Duplicate Orders

If a provider receives a duplicate pair of eyeglasses from the state optical laboratory contractor, the provider shall return the second pair to the state optical laboratory contractor.

Refer to **Subsection 7.5.2** for shipping information for returning state optical laboratory contractor errors.

7.6 Provider Errors

If a provider error occurs, and the state optical laboratory contractor supplies the eyeglasses as ordered by the provider on the prior approval request, the provider shall absorb the cost of the remake.

7.6.1 Documentation and Fitting Errors

If the provider lists incorrect specifications (transcribing or transposing the lens prescription, incorrect fitting measurements, improper frame fit, etc.) on the prior approval request, the provider shall absorb the cost of the remake.

7.6.2 Prescription Errors

If there is a professional error regarding the lens prescription that necessitates a doctor's change in the prescription, the prescribing doctor shall absorb the cost of the remake.

7.6.3 Provider Remakes

Remakes fabricated at the provider's expense must not be ordered from the state optical laboratory contractor and must not be billed to Medicaid or NCHC.

8.0 Policy Implementation/Revision Information

Original Effective Date: February 1, 1976

Revision Information:

Date	Section Revised	Change
10/01/2011	All sections and attachment(s)	Initial promulgation of policy for recipients under 21 years of age, as pursuant to HB 200, DMA must eliminate current optical services for adults.
07/15/2012	All sections and attachment(s)	To be equivalent where applicable to NC DMA's Clinical Coverage Policy # 6A under Session Law 2011-145, § 10.41.(b)
07/15/2012	All sections and attachment(s)	Technical changes to merge Medicaid and NCHC current coverage into one policy.
07/01/2013	All sections and attachment(s)	Changed "HP" to "CSC." Updated websites and contact information. Updated Prior Approval instructions to match CSC technology.
07/01/2013	Attachment A, F	Updated place of service numerical values.
07/01/2013	All sections and attachment(s)	Replaced "recipient" with "beneficiary."
10/01/2015	All Sections and Attachments	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.

Attachment A: Claims Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, DMA’s clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid and NCHC:

A. Claim Type

Professional (CMS-1500/837P transaction)

Refer to **Attachment B, A** for additional information regarding electronic and paper claims.

B. International Classification of Diseases, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

When billing for routine eye exams and visual aids, the provider is required to enter one of the following refractive diagnosis codes on the claim form.

ICD-10-CM Code(s)		
H44.21	H52.212	H52.513
H44.22	H52.213	H52.521
H44.23	H52.221	H52.522
H52.01	H52.222	H52.523
H52.02	H52.223	H52.531
H52.03	H52.31	H52.532
H52.11	H52.32	H52.533
H52.12	H52.4	H52.6
H52.13	H52.511	H52.7
H52.211	H52.512	Z01.00

C. Code(s)

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy.

If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

The relevant CPT and HCPCS codes are as follows:

Routine Eye Exam and Refraction Only Code Description Table

Routine Eye Exam and Refraction Only		Maximum Reimbursement Rate
HCPCS or CPT Code		
S0620	Routine ophthalmological examination including refraction; new patient	Refer to fee schedule
S0621	Routine ophthalmological examination including refraction; established patient	Refer to fee schedule
92015	Determination of refractive state (refraction only)	Refer to fee schedule

Refer to **Attachment A, H** for fee schedule information.

Visual Aids and Dispensing Code Description Table

Provider's Supply of Medicaid and NCHC Frames/Lenses (Requires Justification and Prior Approval)		Maximum Reimbursement Rate
HCPCS Code		
V2799	Vision services, miscellaneous (frames, lenses, special services)	Attach invoice(s)

Note: Bill V2799 as one unit only.

Spectacle Lenses Dispensing Fee		Units
CPT Codes		
92340	Fitting of spectacles, except for aphakia; monofocal (single vision lens – 1)	1 lens = 1 unit 2 lenses = 2 units
92341	Fitting of spectacles, except for aphakia; bifocal (bifocal lens – 1)	1 lens = 1 unit 2 lenses = 2 units
92342	Fitting of spectacles, except for aphakia; multifocal other than bifocal (trifocal lens – 1)	1 lens = 1 unit 2 lenses = 2 units
92353	Fitting of spectacle prosthesis for aphakia; multifocal (Cataract lens – 1)	1 lens = 1 unit 2 lenses = 2 units

Note: Bill one lens as one unit. Bill a pair of lenses as two units. Spectacle Lens Dispensing Fee codes include the initial selection, measurements and fitting, final inspection, and final fitting verification and adjustment to the beneficiary at dispensing. The codes listed above must not be billed until the final dispensing is complete.

Frames and Repairs Dispensing Fee (To Include Adjustments)		Units
CPT Code		
92370	Repair and refitting spectacles, except for aphakia (dispense frame)	1 unit

Note: Bill one unit for dispensing any frame that has been prior approved by Medicaid or NCHC. This includes frames for complete eyeglasses and frame replacements. The Frame Dispensing Fee

code includes the initial selection, measurements and fitting, final inspection, and final fitting verification and adjustment at dispensing. The code listed above must not be billed until the final dispensing is complete.

Subnormal Visual Aids	
HCPCS Code	Maximum Reimbursement Rate
V2600 Handheld, low vision aids	Attach invoice
V2615 Telescopic and other compound lens systems	Attach invoice
V2610 Single lens spectacle mounted low vision aids	Attach invoice

Telescopic and Microscopic Aids Dispensing Fee	
HCPCS Code	Units
V2797 Supply of low vision aids (dispense low vision aid)	1 unit

Contact Lenses	
HCPCS Codes	Maximum Reimbursement Rate
V2510 Contact lens, gas permeable, sph, per lens	Attach invoice
V2520 Contact lens, hydrophilic, sph, per lens	Attach invoice
V2599 Contact lens, other type (use for care kit)	Attach invoice

Contact Lenses Dispensing Fee	
CPT Code	Units
92310 Dispense contact lens (two contact lenses)	1 unit

Note: Bill one unit for a pair of contact lenses and **.5 unit** for **one contact lens**.

Replacement Contact Lenses Dispensing Fee	
CPT Code	Units
92326 Replacement of contact lens (dispense replacement contact lens)	1 unit

Note: Dispensing fees for contact lenses include K-readings, measurements, fitting, training, etc. and are billed only by the dispensing provider after the contact lenses have been dispensed to the beneficiary. The contact lenses (invoice cost) and the dispensing fee must be billed on the same electronic claim via the Web at <http://www.nctracks.nc.gov> or the same CMS-1500 form. The above code must not be billed until the final dispensing is complete.

Refer to **Attachment B, B** for additional guidelines when billing for routine eye exams, eyeglasses, and medically necessary contact lenses.

Medical necessity for procedures billed must be documented in the beneficiary record. Procedures billed without justification/documentation of medical necessity are subject to recoupment.

Refer to NCTracks Provider Claims and Billing Assistance Guide:
<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html> for additional information on medical record documentation.

Unlisted Procedure or Service

CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service.

D. Modifiers

Provider(s) shall follow applicable modifier guidelines.

Providers shall **not** bill modifiers for services covered under the Routine Eye Examination and Visual Aids policy.

E. Billing Units

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).

Refer to **Attachment A, C** for specific billing unit information.

F. Place of Service

1. Medicaid Routine Eye Exams

Inpatient Hospital (21), Outpatient Hospital (22), Office (11), Home (12), School (03), Intermediate Care Facility (54), Skilled Nursing Facility (31).

2. NCHC Routine Eye Exams

Inpatient Hospital (21), Outpatient Hospital (22), Office (11), Home (12), School (03).

3. Medicaid Visual Aids

Inpatient Hospital (21), Outpatient Hospital (12), Office (11), School (03), Intermediate Care Facility (54), Skilled Nursing Facility (31).

4. NCHC Visual Aids

Inpatient Hospital (21), Outpatient Hospital (22), Office (11), School (03).

G. Co-payments

For Medicaid refer to Medicaid State Plan, Attachment 4.18-A, page 1, located at
<http://www.ncdhhs.gov/dma/plan/sp.pdf>.

For NCHC refer to G.S. 108A-70.21(d), located at http://www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_108A/GS_108A-70.21.html

1. Medicaid Routine Eye Exam Co-payment

There is no co-payment for Medicaid routine eye exams.

2. NCHC Routine Eye Exams Co-payment

There is a co-payment of \$5 for NCHC routine eye exams unless otherwise specified on the beneficiary's card.

3. Medicaid and NCHC Visual Aids Co-payment

There is no co-payment for visual aids.

H. Reimbursement Rate

Providers shall bill their usual and customary charges.

For a schedule of rates, see: <http://www.ncdhhs.gov/dma/fee/>

Attachment B: Billing Information Specific to the Routine Eye Examination and Visual Aids Policy

Reimbursement requires compliance with all Medicaid and NCHC guidelines, including obtaining appropriate referrals for beneficiaries enrolled in the Medicaid and NCHC managed care programs.

A. Electronic Claim vs. Paper Claim

1. Providers shall bill claims that do not require an invoice electronically.
2. Providers shall bill claims requiring an invoice electronically or on a paper CMS-1500 claim form. Both electronic and paper claims must include required invoices.

B. Billing Guidelines for Routine Eye Exams, Eyeglasses, and Contact Lenses

1. Routine Eye Exams

- a. New patient routine eye exams (S0620) are limited to once every three years for the same beneficiary and same provider.
- b. Office visits and consultations are included in the routine eye exam and must not be billed separately. Exceptions are allowed with documentation of medical necessity.
- c. General ophthalmological exams and office visits must not be billed by the same provider on the same day as a routine eye exam (S0620 or S0621) or a refraction only (92015).

2. All Visual Aids

- a. Physician services and visual aids cannot be processed on the same claim.
- b. Providers shall use the same provider name and number on the prior approval request form and the claim.
- c. The dispensing fee for visual aids must only be billed after the visual aids have been dispensed to the beneficiary.
- d. Providers shall not bill Medicaid or NCHC for provider errors.

Refer to **Attachment B, Section C** for billing information for visual aids that cannot be dispensed.

3. Eyeglasses

- a. The dispensing fee for eyeglasses includes the initial fitting, prior approval documentation, final inspection once eyeglasses are received by the provider from the state optical laboratory contractor, and final fitting verification and adjustment of the eyeglasses on the beneficiary. If the eyeglasses are dispensed to someone other than the beneficiary, the provider shall document that the beneficiary was absent, the name and relation of the person receiving the eyeglasses (father, aunt, etc.), and the method of delivery (mail, in person, etc.).
- b. When billing for eyeglasses that have been approved for fabrication or supply by the provider rather than the state optical laboratory contractor, materials are billed at invoice cost and invoices must be submitted with the electronic claim or the CMS-1500 claim form. The provider bills V2799 for "vision services, miscellaneous," one unit, at invoice costs. The submitted invoices must identify the frame manufacturer and the outside lab's name, address, telephone number, and invoice number. Invoices are verified for appropriate billing values. Shipping (postage), insurance charges, non-approved tints, etc. are not reimbursed by Medicaid or NCHC and must be deducted from the invoice total.

4. Contact Lenses

- a. Dispensing fees for contact lenses include K-readings, measurements, fitting, trial lens (if required), beneficiary education, training, dispensing and follow-up care for six-months.
- b. Dispensing fees are billed only by the dispensing provider after the contact lenses are dispensed to the beneficiary.
- c. The claim must be accompanied by a contact lens manufacturer's invoice.
- d. The contact lens code and the contact lens dispensing code must be billed on the same claim. Claims that are billed with the contact lens dispensing code but without the contact lens code on the claim or in system history with the same beneficiary, provider, and date of service will deny for payment. The reverse is also true.
- e. Use V2599 when billing for the initial contact lens care kit.

C. Billing Dispensing Fees for Eyeglasses that Cannot be Dispensed

Providers may choose to retain the eyeglasses in the provider's office or return them to the state's fiscal agent.

1. Provider Responsible for Eyeglasses Retention

When a beneficiary fails to respond to verbal and written communications advising that eyeglasses are ready for dispensing, the dispensing claim may be entered for payment if the following conditions are met:

- a. Dates of attempts to contact the beneficiary by telephone are documented and maintained with the beneficiary record;
- b. A copy of the final written attempt (letter/postcard) to contact the beneficiary, requesting that the beneficiary return to the provider's office to pick up the eyeglasses must be maintained with the beneficiary record.
- c. If the beneficiary is deceased, document the date of death on the beneficiary record.

Providers shall submit claims within one year of the state's fiscal agent approval date and retain the undelivered eyeglasses for the remainder of the beneficiary's eligibility period (one year from the original approval date) in the provider's office. If a beneficiary returns to pick up the eyeglasses during this retention period and the provider is unable to produce the eyeglasses for dispensing, the provider will be responsible for making an identical pair of eyeglasses for the beneficiary at the provider's expense. At the end of the retention period, the provider is no longer responsible for retaining the eyeglasses. Therefore, the provider may utilize the eyeglasses as deemed appropriate. This may include using the frame for replacement parts, donating the eyeglasses to the Lion's Club, adding the frame to the provider's Medicaid and NCHC frame fitting kit, etc.

The fitting and dispensing service is not complete until the eyeglasses are dispensed to the beneficiary. Therefore, providers shall not bill for the dispensing fee until the eyeglasses have been dispensed to the beneficiary. Only when the provider has documented the attempts to contact the beneficiary, with the last attempt being in writing, can the provider bill for eyeglasses that were not able to be dispensed. Documentation of attempts to contact the beneficiary must be maintained with the beneficiary record.

2. State's Fiscal Agent Responsible for Eyeglasses Retention

Providers may return the undelivered eyeglasses to the state's fiscal agent and file the claim electronically, rather than retaining the eyeglasses in the office for the duration of the eligibility period (one year from the state's fiscal agent approval date). If the beneficiary fails to respond to verbal and written communication, the provider may send the eyeglasses, with a printed copy of the original prior approval request or a copy of the state optical laboratory contractor invoice, to the fiscal agent's Optical Prior Approval unit. The provider shall allow at least three months to lapse after receiving the eyeglasses from the state optical laboratory contractor before billing as undeliverable. The provider may file the dispensing fee for up to one year from the date of approval. The dispensing claim may be entered for payment if the following conditions are met:

- a. Dates of attempts to contact the beneficiary by telephone are documented and maintained with the beneficiary record;
- b. A copy of the final written (letter/postcard) attempt to contact the beneficiary, requesting that the beneficiary return to the provider's office to pick up the eyeglasses must be maintained with the beneficiary record;
- c. If the beneficiary is deceased, document the date of death on the claim form.

If, after the eyeglasses have been returned to the state's fiscal agent, the beneficiary returns to the provider requesting the eyeglasses, the provider shall contact the state's fiscal agent to determine if the returned eyeglasses can be retrieved. If they can be retrieved, the eyeglasses will be returned to the provider for dispensing. If the eyeglasses are not retrievable, the provider shall submit a new electronic prior approval request for replacement eyeglasses. The provider shall document on the request form the original approval date, the date the eyeglasses were returned to the state's fiscal agent, and that the beneficiary did not return to pick up the original eyeglasses.

D. Billing for Eyeglasses Repair or Replacements

Claims for repairs or replacements must include the actual date of authorization or date of dispensing as the date of service. The provider shall verify eligibility prior to requesting the repair or replacement. If the beneficiary's eligibility has ended when the new or repaired eyeglasses are dispensed, providers can use the date that the repair or replacement request was initiated.

Refer to NCTracks Provider Claims and Billing Assistance Guide:

<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html> for information on methods that can be used to verify eligibility.

E. Denied Visual Aid Claims Due to Beneficiary Ineligibility on Date of Service

Visual aid claims for beneficiaries whose eligibility was terminated in the month following the date of the eye refraction are allowed when resubmitted with the refraction date as the date of service if the following criteria are met:

1. The beneficiary was eligible for services on the date of the refraction and the date of the initial visual aid fitting but is not eligible on the date the eyeglasses were dispensed.
2. Providers enter the refraction date as the date of service on the claim.

Attachment C: Web tool for Refraction and Eyeglass History

A. Confirmation for Eye Exams and Refractions that do not Require Prior Approval

The Web tool at <http://www.nctracks.nc.gov> allows providers to access routine eye exam and refraction only paid claim history for each Medicaid and NCHC beneficiary. This assigned confirmation number is verification of the provider inquiry, not prior approval for the service.

If there is no paid claim history of a routine eye exam or refraction within the previous twelve months, the beneficiary is eligible for a routine eye exam or refraction only and prior approval is not required. However, it is in the provider's best interest to obtain a Web tool confirmation number on the day of service, prior to rendering the service. If a confirmation number is obtained through the Web tool prior to the service being rendered, and the claim is denied for previous service by the same or different provider, contact the Optical Prior Approval unit of the state's fiscal agent for assistance.

If the Web tool reveals that a beneficiary has already received a routine eye exam or refraction only within the past twelve months, the provider must obtain prior approval or the claim will deny.

Confirmation can be obtained at <http://www.nctracks.nc.gov>.

Note: A confirmation number **cannot** be obtained through the Web tool if:

1. The state eligibility file does not reflect current eligibility information;
2. The beneficiary has a history of a paid routine eye exam or refraction within the last year;
3. The Web tool is down and eligibility cannot be verified (providers are instructed to call back);
4. The beneficiary has a notice of eligibility approval from the county Department of Social Services (DSS) but eligibility is not yet showing on the state eligibility file; or
5. The beneficiary is eligible only for limited Medicaid coverage: pregnant women (MPW) or Family Planning Waiver.

The 17-digit confirmation number is for the provider's records. Providers do not enter this number on the claim.

Note: A confirmation number does not guarantee payment.

B. Confirmation for Eyeglasses

The Web tool does not contain eyeglass history information.

Attachment D: Contractor Contact Information

This contact information is for providers only and should not be given to Medicaid or NCHC beneficiaries. Beneficiaries may call the phone number on the back of their Medicaid or NCHC card.

A. State’s Fiscal Agent Contractor

CSC is the fiscal agent contracted by DMA to process Medicaid and NCHC prior approval requests and claims for Medicaid enrolled providers according to DMA’s policies and guidelines.

Fiscal Agent Prior Approval Unit	Mail To: CSC P. O. Box 31188 Raleigh, North Carolina 27622
Fiscal Agent Claims Unit	Mail To: CSC Enterprises P. O. Box 30968 Raleigh, North Carolina 27622
CSC Optical Prior Approval Unit	Phone: 800-688-6696
CSC Provider Services Unit	Phone: 800-688-6696

B. State Optical Laboratory Contractor

Nash Optical Plant is the optical laboratory contracted by DMA to fabricate eyeglasses for Medicaid enrolled providers according to DMA’s policies and guidelines.

Address (do not mail prior approval requests or frames to this address)	Nash Optical Plant P. O Box 600 2869 US Highway Alternate 64 West Nashville, North Carolina 27856
Telephone Numbers	888-388-1353 or 252-459-6200
Fax Number	252-459-7400

C. Provider Enrollment and Support Contractor

CSC is the agent contracted by DMA to perform Medicaid provider enrollment, verification, credentialing provider file update and maintenance.

EVC Call Center	866-844-1113
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Attachment E: Warranty Frame Replacement

To replace a frame covered under warranty, contact the state optical laboratory contractor with the frame information and description of the problem. Although manufacturing defects are covered under the manufacturer warranty, abuse and neglect are not. Do not send abused frames to the state optical laboratory contractor. Instead, seek prior approval for replacement. Lab staff will check replacement frame availability.

Notify the state optical laboratory contractor if the defective frame is not wearable and the recipient cannot function without the eyeglasses and does not have backup eyeglasses.

If the state optical laboratory contractor receives a damaged frame in which abuse or neglect is evident, the frame will be returned to the provider or forwarded to DMA for evaluation and follow-up with the provider.

Refer to **Attachment D, B** for state optical laboratory contractor contact information.