

**Division of Medical Assistance
Routine Eye Exam and Visual Aids
for Recipients Under Age 21**

**Clinical Policy No. 6A
Effective Date: February 1, 1976
Revised Date: November 1, 2011**

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1.0 Description of the Procedure, Product, or Service

A routine eye examination 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).

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* (<http://www.ncdhhs.gov/dma/mp/mpindex.htm>).

2.0 Eligible Recipients

2.1 General Provisions

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service.

Refer to **Appendix F** of the *Basic Medicaid Billing Guide* on the Division of Medical Assistance's (DMA) website at <http://www.ncdhhs.gov/dma/basicmed/> for information on methods that can be used to verify eligibility.

2.2 Limitations

Routine eye exams and visual aids are only covered for Medicaid recipients under the age of 21.

2.3 EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age

[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 recipients 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 clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/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 recipient'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 recipient's right to a free choice of providers.

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

- a. that is unsafe, ineffective, or experimental/investigational.
- b. 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/or 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 will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

****EPSDT and Prior Approval Requirements**

- a. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does **NOT** eliminate the requirement for prior approval.
- b. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *Basic Medicaid Billing Guide*, sections 2 and 6, and on the EPSDT provider page. The Web addresses are specified below.

Basic Medicaid Billing Guide: <http://www.ncdhhs.gov/dma/basicmed/>

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

2.4 Eligible Categories

2.4.1 Regular Medicaid

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

2.4.2 Medicaid for Pregnant Women (MPW)

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

Refer to **Subsections 5.2.4** and **5.3.3** for service requirements.

2.4.3 Family Planning Waiver Program (MAFD)

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

3.0 When the Procedure, Product, or Service Is Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health

in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, refer to **Subsection 2.3** of this policy.

3.1 General Criteria

Medicaid covers procedures, products, and services related to this policy when they are 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 recipient'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 recipient, the recipient's caretaker, or the provider.

3.2 Specific Criteria

The following optical services are covered 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.

4.0 When Procedure, Product, or Service Is Not Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, refer to **Subsection 2.3** of this policy.

4.1 General Criteria

Procedures, products, and services related to this policy are not covered when:

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

4.2 Non-Covered Products and Services

Medicaid does not cover:

- 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

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

4.3 Non-Covered Products Related to Low Vision or Blindness

Medicaid does not cover low vision hand-held magnifiers or any visual aid that can be purchased without prescription.

4.4 Recipient Purchase of Non-Covered Services

With any non-covered service (tint, UV filter, etc.) that can be purchased by the recipient from the provider, the provider must inform the recipient prior to the transaction that Medicaid will not pay for the service and that the cost of the service is the responsibility of the recipient. The provider must make payment arrangements with the recipient for non-covered services. However, the provider cannot withhold approved Medicaid visual aids pending payment for an unpaid Medicaid, NCHC, or private bill.

5.0 Requirements for and Limitations on Coverage

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, refer to **Subsection 2.3** of this policy.

5.1 Prior Approval

Prior approval is required for any **early** routine eye examination or refraction only within the one year time limitation period.

Refer to **Attachment B, Section C** for additional information on completing a request for prior approval for an early routine eye exam or refraction only.

Prior approval is required for **all visual aids** except frame warranty replacements.

Refer to **Attachment B, Section D** for additional information on completing a request for prior approval for visual aids.

5.2 Eye Examinations and Refractions

Routine eye examinations with refractions that meet the criteria and requirements listed in this policy do not require prior approval. However, providers are advised to obtain a confirmation number through the Automated Voice Response (AVR) system.

Refer to **Attachment B, Section A** for additional information regarding use of the AVR system.

5.2.1 Service Limitations

Routine eye examination 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.

5.2.2 Routine Eye Examination 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 recipient records.

5.2.3 Carolina ACCESS (Community Care of North Carolina) Referral Authorization

Medicaid recipients 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.

5.2.4 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 recipients referred by a medical doctor due to complications of pregnancy.

Requests must be submitted in writing using the general Request for Prior Approval form (372-118). The request must include the following information:

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

5.2.5 Early Eye Exam or Refraction Only

Prior approval is required for any early routine eye examination or refraction only within the one year time limitation period.

Prior approval requests must be submitted in writing using the general Request for Prior Approval form (372-118) and include documentation of medical necessity (significant decrease in acuity, medication, failed Department of Motor Vehicles eye exam, etc.) as well as additional documentation obtained from physicians, school nurses, Department of Motor Vehicles, 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 recipient has an urgent need for an early eye exam or refraction, the provider may contact the Medicaid's Optical Services Program at 919-855-4310.

Refer to **Attachment B, Section C** for additional information on completing a request for prior approval for an early eye exam or refraction only.

5.3 Visual Aids

Providers must not order or dispense visual aids until prior approval is obtained. If a recipient has an urgent need for visual aids, the provider may contact the Medicaid Optical Services Program at 919-855-4310.

Refer to **Attachment B, Section D** for additional information on completing a request for prior approval for visual aids.

5.3.1 Service Limitations

Visual aids are limited to once a year for recipients under 21 years of age. Early visual aids may be approved subject to the criteria and limitations listed in this policy.

5.3.2 Carolina ACCESS (Community Care of North Carolina) Referral Authorization

Medicaid recipients 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.

5.3.3 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 recipients 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 in writing using the Prior Approval Request for Visual Aids form (372-017/A).

5.3.4 State Optical Laboratory Contractor

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

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

Refer to **Subsection 5.4.3** for additional information regarding the use of a recipient's own frame.

Refer to **Attachment A, Section C, bullet 5** for additional information on billing for provider supplied visual aids.

Refer to **Attachment B, Section D** for additional information on completing a request for prior approval for visual aids.

5.4 Frames

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

5.4.1 Medicaid Fitting Kit

Medicaid enrolled optical providers agree to provide Medicaid services according to Medicaid Routine Eye Examinations and Visual Aids Policy. This includes allowing recipients to choose a frame from the complete Medicaid frame selection. Therefore, providers must have a Medicaid fitting kit consisting of frames in available sizes and colors sufficient for proper selection and fitting. Providers must not fit frames from a catalog or Medicaid Frame Selection Guide picture. For a list of Medicaid frames and instructions for obtaining a fitting frame 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 C** for the state optical laboratory contractor contact information.

5.4.2 Non-Medicaid Frames

Requests for Medicaid 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 frame information (manufacturer, style name or number, sizes, and wholesale cost of the frame) must be recorded on the Request for Prior Approval for Visual Aids form (372-017/A).

5.4.3 Recipient's Own Frame

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

Providers must not mail the recipient'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 recipient's own frame. The recipient's own frame must be identified on the Request for Prior Approval for Visual Aids form (372-017/A) by manufacturer, style name or number, and size.

Refer to **Subsection 5.7.7** for additional information regarding requests for early lens update using a recipient's own frame.

5.4.4 Recipient Purchase of Non-Covered Frame

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

5.5 Lenses

The state optical laboratory contractor supplies lenses according to Routine Eye Exam and Visual Aid Policy guidelines.

5.5.1 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 recipients who require a wider field of vision (mobility limitations, etc.)

5.5.2 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.

5.5.3 Exceptional Spectacle Lenses

Medicaid may approve the following lenses 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); - Recipient is blind or legally blind in one eye, with correction in accordance with guidelines found in Section 5.5 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 Prior Approval Request for Visual Aids form (372-017/A).</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) or visual distortion with polycarbonate.</p> <p>When submitting a request for hi-index lenses, document medical necessity on the Prior Approval Request for Visual Aids form (372-017/A).</p>
Other Lenses and Special Services	Myodisc, Press-on Prism, Special Base Curves, Slab-off, etc.

5.5.4 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 must 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 on the Prior Approval Request for Visual Aids form (372-017/A) by manufacturer, style name or number, size, and color.

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

Refer to **Subsection 5.4.3** for additional information regarding the use of a recipient's own frame.

Refer to **Attachment B, Section D** for additional information on completing a request for prior approval for visual aids.

5.6 Tints

Requests for tinted lenses are considered only when the Prior Approval Request for Visual Aids form (372-017/A) is accompanied by 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 by Medicaid for a documented diagnosis that induces photophobia (aphakia, albinism, etc.).
UV Filter	May be approved for aphakic recipients requiring cataract lenses and other requests supported by documentation of medical necessity.
Other	Requests for other tints must be medically justified for consideration.

5.7 Replacement Visual Aids

Replacement visual aids that are not covered under a manufacturer warranty require prior approval. Providers must include appropriate documentation with the Request for Prior Approval for Visual Aids form (372-017/A).

5.7.1 Replacement of Lost, Stolen or Damaged Visual Aids

Replacement of lost, stolen or damaged visual aids is considered when the Request for Prior Approval for Visual Aids form (372-017/A) is 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 stationary. 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 must 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 must note the reason on the Request for Prior Approval for Visual Aids form (372-017/A).

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

Refer to **Subsections 5.7.2** and **5.7.3** for information regarding exceptions to the requirement for a DSS caseworker letter.

5.7.2 Replacement of Lost, Stolen, or Damaged Visual Aids for Social Security Income (SSI) Recipients

A DSS caseworker's written recommendation is not required when the recipient receives SSI. The provider must note on the Request for Prior Approval for Visual Aids form (372-017/A) that the recipient receives SSI.

5.7.3 Replacement of Lost, Stolen or Damaged Visual Aids for Legally Adopted Recipients

A DSS caseworker's written recommendation is not required when the recipient is legally adopted. The provider must note on the Request for Prior Approval for Visual Aids form (372-017/A) that the recipient is adopted.

Refer to **Attachment B, Section D** for additional information on completing a request for prior approval for visual aids.

5.7.4 Warranty Frame Replacements

Medicaid frames carry a one-year warranty from the original approval date noted on the Request for Prior Approval for Visual Aids form (372-017/A). 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 must, 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.

Note: Prior approval is not required for warranty replacements.

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

5.7.5 Non-Warranty Frame Replacements

When the damaged frame is not covered by the manufacturer warranty, providers must state on the Request for Prior Approval for Visual Aids form (372-017/A) that the frame is not covered under warranty, and document the cause and the

extent of the damage. 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 must note the reason on the Request for Prior Approval for Visual Aids form (372-017/A).

Refer to **Section 5.7.1** for information regarding required documentation for non-warranty frame replacement prior approval requests.

5.7.6 Allergy Related Frame Replacements

When a recipient presents with an allergic reaction to the Medicaid frame material, the provider must 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 Prior Approval for Visual Aids form (372-017/A) 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 Prior Approval for Visual Aids form (372-017/A).

5.7.7 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 recipient's current Medicaid frame must be accompanied by medical justification for the prescription change (progressive myopia, cataract development, medication, etc.).

Additional documentation obtained from physicians, school nurses, Department of Motor Vehicles, etc., justifying the prescription change must also be included with the prior approval request.

Refer to **Subsection 5.4.3** for additional information regarding the use of a recipient's own frame.

5.8 Medically Necessary Contact Lenses

Medicaid covers medically necessary conventional daily wear contact lenses supplied by the provider. Prior approval requests are evaluated based on documentation of medical necessity and medical diagnosis (anisometropia, aphakia, keratoconus, progressive myopia, etc.).

One care kit is covered for approved contact lenses.

5.8.1 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 Prior Approval Request for Visual Aids form (372-017/A) and must be on the contact lens manufacturer price sheet or manufacturer letterhead stationary.

5.8.2 Back-Up Eyeglasses for Contact Lens Wearers

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

- a. Requests for contact lenses and back-up eyeglasses must be submitted on separate Prior Approval Request for Visual Aids forms (372-017/A).
- b. The provider must indicate on the Prior Approval Request for Visual Aids forms (372-017/A) that the request is for “back-up glasses.”

6.0 Providers Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for procedures, products, and services related to this policy, providers shall

- a. meet N.C. Medicaid’s qualifications for participation;
- b. be currently enrolled with N.C. Medicaid; 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.

North Carolina licensed ophthalmologists, optometrists, and opticians who are enrolled with N.C. Medicaid are eligible to provide optical services.

7.0 Additional Requirements

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient’s health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, refer to **Subsection 2.3** of this policy.

7.1 Compliance

Providers shall comply with all applicable federal, state, and local laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements.

7.2 Provision of Service

Optical providers must extend the services of eye examinations and visual aid fitting and dispensing for Medicaid recipients 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 must inform the recipient prior to services being offered or scheduled. The recipient must be given the option to select a provider who will provide both services.
- b. If the recipient elects to have the examination, a written prescription for the lenses must be given or offered to the recipient at the time of the examination. The prescribing provider cannot withhold the prescription pending Medicaid payment for the refraction, 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 eyeglass orders for any recipient experiencing delivery delays.

Note: If an order is not received **within 10 working days of the prior approval date**, the optical provider must contact the state optical laboratory contractor to verify that they have a record of the order. If no record is found, the provider must contact the state's fiscal agent for assistance. The state optical laboratory contractor cannot 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 is required to duplicate the order at no charge to Medicaid or the provider.

7.4 State Optical Laboratory Contractor

The Division of Medical Assistance (DMA) contracts with a state optical laboratory to provide authorized services.

7.4.1 Requesting Non-Covered Services

Providers must 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

State optical laboratory contractor errors are not billed to Medicaid or to the provider and require "priority" expediting.

7.5.1 Inspection by Provider

All eyeglasses received from the state optical laboratory contractor must 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 must document the inspection date and inspector's initials. This information must be stored with the recipient 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 must 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.

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 must contact the state optical laboratory contractor, and then return the eyeglasses to the state optical laboratory contractor for a remake at no charge to the provider or to Medicaid.

b. Frames

If the frame is damaged, wrong style, color, or size, wrong temple length, etc., the provider must 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 on state optical laboratory contractor errors.

7.5.4 Misdirected Orders

If a provider receives an order for a Medicaid recipient who is not the provider's patient, the provider must 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 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 must return the second pair to the state optical laboratory contractor.

Refer to **Subsection 7.5.2** for shipping information on 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 form, the provider is responsible for absorbing 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 for Visual Aids form (372-017/A), the provider must 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 must 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.

8.0 Policy Implementation/Update Information

Original Effective Date: February 1, 1976

Update Information:

Date	Section Updated	Change
10/1/2011	Throughout	Initial promulgation of policy for recipients under 21 years of age, as pursuant to HB 200, DMA must eliminate current optical services for adults.

Attachment A: Claims Related Information

Reimbursement requires compliance with all Medicaid guidelines.

A. General Billing Guidelines

- Providers must bill claims that do not require an invoice electronically.
- Providers enrolled in the Medicaid program bill for services using the CMS-1500 claim form.
- Providers must bill services requiring an invoice on a paper CMS-1500 claim form and attach the invoice to the claim.
- Providers must bill the ICD-9-CM diagnosis codes(s) to the highest level of specificity that supports medical necessity.
- Providers must bill usual and customary charges.

B. Routine Eye Exam and Refraction Only Diagnostic Codes and Billing Guidelines

- Medical necessity for procedures billed must be documented in the recipient record. Procedures billed without justification/documentation of medical necessity are subject to recoupment.
 Refer to the *Basic Medicaid Billing Guide* on DMA's website at <http://www.ncdhhs.gov/dma/basicmed/> for additional information on medical record documentation.
- New patient routine eye exams (S0620) are limited to once every three years for the same recipient and same provider.
- Office visits and consultations are included in the routine eye examination and must not be billed separately. Exceptions are allowed with documentation of medical necessity.
- Medical 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).
- When billing a refraction code (S0620, S0621 or 92015), providers use a refractive diagnosis as the primary diagnosis code. If a medical diagnosis is used, the claim will be denied. One of the following diagnosis codes must be the primary diagnosis for payment of the refraction:

Code	Diagnosis
367.0	Hyperopia
367.1	Myopia
367.2	Astigmatism
367.3	Anisometropia/Aniseikonia
367.4	Presbyopia
367.5	Disorders of accommodation
367.8	Other disorders of refraction and accommodation
367.9	Unspecified disorders of refraction and accommodation
V72.0	Routine eye examination, emmetropia (no correction required)

C. Visual Aid Procedure Codes and Billing Guidelines

All Visual Aids

- Physician services and visual aids cannot be processed on the same claim.
- Providers must use the same provider name and number on the prior approval request form and the claim.
- 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 recipient. If the eyeglasses are dispensed to someone other than the recipient, the provider must document in Blocks 68-71 on the Provider Copy of the Prior Approval Request for Visual Aids form (372-017/A) that the recipient was absent, the name and relation of the person receiving the eyeglasses (father, aunt, etc.), and the method of delivery (mail, in person, etc.). The individual picking up the eyeglasses must sign the Prior Approval Request for Visual Aids form (372-017/A).
- The dispensing fee for visual aids must only be billed **after** the visual aids have been dispensed to the recipient.
Refer to **Attachment A, Section D** for billing information for visual aids that cannot be dispensed.
- When billing for visual aids 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 CMS-1500 claim form. The provider bills V2799 for “vision services, miscellaneous”, one unit, at invoice cost, and attaches a copy of the supplier’s invoice to the CMS-1500 claim form. The invoice must identify 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 and must be deducted from the invoice total.
- Do not bill Medicaid for provider errors.

Contact Lenses Only

Dispensing fees for contact lenses include K-readings, measurements, fitting, trial lens (if required), recipient education, training, dispensing and follow-up care for six-months.

- Dispensing fees are billed only by the dispensing provider after the contact lenses are dispensed to the recipient.
- The CMS-1500 claim form must be accompanied by a contact lens manufacturer’s invoice.
- The contact lens code and the contact lens dispensing code must be billed on the same CMS-1500 claim form. 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 recipient, provider, and date of service will deny for payment. The reverse is also true.
- Use V2599 when billing for the initial contact lens care kit.

**Visual Aids and Dispensing Code Descriptions Table
 (Type of Service 9)**

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

Note: Bill V2799 as one unit only.

Spectacle Lenses Dispensing Fee	
CPT Codes	Units
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 recipient at dispensing. The codes listed above must not be billed until the final dispensing is complete.

Frames and Repairs Dispensing Fee (To Include Adjustments)	
CPT Code	Units
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. 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 recipient. The contact lenses (invoice cost) and the dispensing fee must be billed on the same CMS-1500 form. The above code must not be billed until the final dispensing is complete.

- **Diagnosis Codes for Visual Aids**

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

Code	Diagnosis
367.0	Hyperopia
367.1	Myopia
367.2	Astigmatism
367.3	Anisometropia/Aniseikonia
367.4	Presbyopia
367.5	Disorders of accommodation
367.8	Other disorders of refraction and accommodation
367.9	Unspecified disorders of refraction and accommodation
V72.0	Routine eye examination, emmetropia (no correction required)

D. 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.

Provider Responsible for Eyeglasses Retention

When a recipient 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:

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

Providers must submit claims within one year of the state's fiscal agent approval date and retain the undelivered eyeglasses for the remainder of the recipient's eligibility period (one year from the original approval date) in the provider's office. If a recipient 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 recipient 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 fitting kit, etc.

The fitting and dispensing service is not complete until the eyeglasses are dispensed to the recipient. Therefore, providers must not bill for the dispensing fee until the eyeglasses have been dispensed to the recipient. Only when the provider has documented the attempts to contact the recipient, 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 recipient must be maintained with the recipient record.

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 recipient fails to respond to verbal and written communication, the provider may send the eyeglasses, with a copy of the original Prior Approval Request for Visual Aids form (372-017/A) or a copy of the state optical laboratory contractor invoice, to the fiscal agent's Optical Prior Approval unit. The provider must 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:

1. Dates of attempts to contact the recipient by telephone are documented and maintained with the recipient record;
2. A copy of the final written (letter/postcard) attempt to contact the recipient, requesting that the recipient return to the provider's office to pick up the eyeglasses must be maintained with the recipient record;
3. If the recipient 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 recipient returns to the provider requesting the eyeglasses, the provider must 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 must submit a new Prior Approval Request for Visual Aids form (HC-017) for replacement eyeglasses. The provider must document on the request form the original approval date, the date the eyeglasses were returned to the state's fiscal agent, and that the recipient did not return to pick up the original eyeglasses.

E. 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 must verify eligibility prior to requesting the repair or replacement. If the recipient'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.

Note: The provider must retain a copy of the recipient's Medicaid eligibility record, that corresponds to the date of service, with the recipient record.

Refer to **Appendix F** of the *Basic Medicaid Billing Guide* on DMA's website at <http://www.dhhs.state.nc.us/dma/medbillcaguide.htm> for information on methods that can be used to verify eligibility.

F. Denied Visual Aid Claims Due to Recipient Ineligibility on Date of Service

Visual aid claims for recipients 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:

- The recipient was eligible for Medicaid 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.
- Providers enter the refraction date as the date of service on the CMS-1500 claim.

G. Co-payments

Co-payments are not required for services covered under the Routine Eye Exam and Visual Aids for Recipients Under Age 21 Policy.

H. Modifiers

Modifiers are not billed for services covered under the Routine Eye Exam and Visual Aids for Recipients Under Age 21 Policy.

I. Reimbursement Rate

Providers must bill their usual and customary charges. Fee schedules for covered services are available on DMA's website at <http://www.ncdhhs.gov/dma/fee/index.htm>

Attachment B: Prior Approval and AVR System Confirmations

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

The Automated Voice Response (AVR) system allows providers to access automated routine eye exam and refraction only history for each Medicaid recipient. The AVR confirmation number is verification of the provider inquiry, not prior approval for the service.

If there is no history of a routine eye exam or refraction within the previous twelve months, the recipient 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 an AVR confirmation number on the day of service, prior to rendering the service. If a confirmation number is obtained through the AVR system 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 AVR system reveals that a recipient 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 by telephone through the Automated Voice Response (AVR) system at 1-800-723-4337.

Note: A confirmation number **cannot** be obtained through the AVR system if:

- The state eligibility file does not reflect current eligibility information;
- The recipient has a history of a paid routine eye exam or refraction within the last year;
- The AVR system is down and eligibility cannot be verified (providers are instructed to call back);
- The recipient 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
- The recipient is eligible only for limited Medicaid coverage: pregnant women (MPW) or Family Planning Waiver.

The 14-digit confirmation number is for the provider's records. Providers do not enter this number on the CMS-1500 claim.

Note: A confirmation number does not guarantee payment.

B. Confirmation for Eyeglasses

The AVR system does not contain eyeglass history information. Therefore, providers must submit a Request for Prior Approval for Visual Aids form (372-017/A) for all visual aids.

Refer to the July 2001 Special Bulletin II, *Automated Voice Response System Provider Inquiry Instructions*, on DMA's website at <http://www.dhhs.state.nc.us/dma/bulletin.htm> for detailed instructions on using the AVR system.

C. Prior Approval Request for Early Eye Exams and Refractions

Submit a general Request for Prior Approval form (372-118) following the instructions below.

Block	Field Name	Description
1	Prior Authorization Number	Do not enter anything in this box.
2	Patient Name	Enter the patient's name as it appears on the MID card.
3	Medicaid ID Number	Enter the patient's 10-character MID number, which is found on the MID card. (The MID number is a 9-digit number followed by an alpha character.)
4	Date of Birth	Enter the patient's date of birth in MMDDYY format.
5	Diagnosis	If known, enter the patient's diagnosis.
6	ICD-9-CM	Enter the ICD-9-CM code from the most current ICD-9-CM manual. Check the appropriate box for the type of request.
7	Brief Summary of Clinical Finding	If applicable, enter the clinical findings that substantiate request for service.
8/9	Retroactive Date(s) Requested (From/To)	If applicable, enter retroactive dates for service.
10	Procedure to be Performed	Enter description of requested procedure.
11	Procedure Code	Enter the procedure code, if applicable.
12	Reason Procedure is Necessary to the Patient's Health	Enter information substantiating medical necessity for requested service.
13	Has Patient Been Previously Provided with this Service	Indicate Yes or No.
13a	If Yes, Give Date Previous Service Rendered	Enter date(s) service rendered.
13b	Give Dates of Previous Prior Approval(s) Granted	Enter previous prior approval date(s) for this service.
14	Signature	Provider's signature required.
15	Provider's Number	Enter the provider's 7-digit Medicaid provider number, which is printed on the top left-hand corner of the Remittance and Status Advice.
16	Date	Enter the date the form was completed in MMDDYY format.
17	Place of Service	Enter the appropriate place of service code from the listing on the back of the form.
18	Provider's Name and Address	Enter the provider's name, street address, city, state, and zip code.

Requirements for a Proper Prior Approval Request

A proper prior approval request must include the following information:

- Service being requested
- Recipient name
- Recipient Medicaid identification number (MID)
- Recipient date of birth
- Provider number
- Provider address
- Provider phone number
- Provider signature
- Date of prior approval request
- Any additional information required by program coverage and/or prior approval policies

When any part of the above information is missing, the state's fiscal agent will return the general Request for Prior Approval form (372-118) to the provider for completion.

Refer to the January 2006 Medicaid Special Bulletin, *Prior Approval Process and Request for Non-Covered Services* at <http://www.dhhs.state.nc.us/dma/bulletin.htm> for additional information.

1. PRIOR AUTHORIZATION NUMBER		3. MEDICAID IDENTIFICATION NUMBER	
2. PATIENT NAME (LAST) Recipient (FIRST) Jill (M.I.) A		9 9 9 9 9 9 9 9 9 9 A	
4. DATE OF BIRTH (MO.) 04 (DAY) 01 (YEAR) 01		5. DIAGNOSIS: Myopia w/ regular astigmatism	
7. BRIEF SUMMARY OF CLINICAL FINDINGS: Myopia/astig + lost glasses		6. ICD 9TH EDITION 367.21	
10. PROCEDURE TO BE PERFORMED: Early Routine Eye Exam		11. PROCEDURE CODE	
12. REASON PROCEDURE IS NECESSARY TO PATIENT'S HEALTH: Last exam was on 7-15-10 and last glasses were approved on 7-20-10. Jill has lost her glasses. A new exam is necessary to obtain a current Rx for her replacement glasses. She is 20/200 in the right eye and 20/300 in the left - without correction.			
13. HAS PATIENT BEEN PREVIOUSLY PROVIDED WITH THIS SERVICE? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
(a) IF YES, GIVE DATE PREVIOUS SERVICE RENDERED AND 7-15-2010			
(b) GIVE DATES OF ANY PREVIOUS PRIOR APPROVAL(S) GRANTED			
14. PHYSICIAN OR DENTIST HEARING AID DEALER OPTOMETRIST: Dr. Z.F. White		16. DATE: 5-27-11	
15. PROVIDER'S NUMBER: 99999999		17. PLACE OF SERVICE (SEE OTHER SIDE FOR CODE)	
EDS USE ONLY			
<input checked="" type="checkbox"/> 01 APPROVAL			
<input checked="" type="checkbox"/> 02 DENIED			
REVIEWED BY _____ DATE _____			
COMMENTS			
APPROVAL CONSTITUTES MEDICAL APPROVAL FOR SERVICES ONLY. ELIGIBILITY FOR CARE ON THE DATE(S) THE SERVICES ARE PROVIDED SHOULD BE VERIFIED FROM THE PATIENT'S MEDICAID CARD.			
18. TYPE, PRINT OR STAMP		INDICATE:	
NAME A Great Provider		PROVIDER'S NAME AND MAILING ADDRESS TO ENSURE RETURN OF THIS FORM.	
STREET 123 Any Street		(999) 555-5555	
CITY Anytown (STATE) NC (ZIP CODE) 12345			

D. Prior Approval Requests for Visual Aids

Prior approval must be obtained for all visual aids. Providers must submit a Request for Prior Approval for Visual Aids form (372-017/A) following the instructions below.

Block	Field Name	Description
1	Recipient Name - Last	Enter the patient's last name as it appears on the MID card.
2	First	Enter the patient's first name as it appears on the MID card.
3	MI	Enter the patient's middle initial as it appears on the MID card.
4	Sex	Enter the patient's gender (M for male or F for female).
5	Recipient ID Number	Enter the patient's 10-character MID number, which is found on the MID card. (The MID number is a 9-digit number followed by an alpha character.)
6	Date of Birth	Enter the patient's date of birth in MMDDYY format.
7	Date of Refraction	Enter the date of the most recent refraction
8	Name of Prescriber	Enter the name of the prescriber
9	Diagnosis & ICD-9 Codes	Enter the patient's diagnosis.
10	Department Use Only	For the state's fiscal agent prior authorization action only. Required information for contractors to process provider's requests or orders.
11	Frame: Standard Medicaid Selection	Check one
12	* Frame Exception	Enter the invoice cost to be billed to Medicaid (requires medical justification).
13	* Exceptional Services	Check medically necessary exceptional service (requires medical justification).
14	Please provide documentation/medical justification. . .	Enter medical justification for exceptional services.
15	Complete Eyeglasses	Circle when complete eyeglasses are requested
16	Lenses Only	Circle when lenses only are requested
17	Frame Only	Circle when frame only is requested
18	* Frame to Follow	Do NOT circle. Frames are no longer sent to the state optical laboratory contractor.
19	R Lens Only	Circle when right lens only is requested
20	L Lens Only	Circle when left lens only is requested
21	Lens Circumference	Enter lens circumference with all 'lens only' requests.
22	Manufacturer/Frame Name or Number	Enter the frame manufacturer and name or model number of frame.
23	Eye Size	Enter the frame eye size.
24	Bridge Size	Enter the frame bridge size.
25	Temple Length	Enter the appropriate temple length for the patient. If different from the standard length available with eye size listed in Block 23, circle or highlight the requested temple length.
26	Color	Enter the frame color.
27	Single Vision	Circle if single vision lenses are requested.
28	ST 28 (Bifocals)	Circle if ST 28 bifocals are requested.
29	*ST 35 (Bifocals)	Circle if ST 35 bifocals are requested (requires medical justification).
30	Round (Bifocals)	Circle if round bifocals are requested.

31	* Executive (Bifocals)	Circle if executive bifocals are requested (requires medical justification).
32	* 7X28 (Trifocal)	Circle if 7X28 trifocals are requested (requires medical justification).
33	* 8X35 (Trifocals)	Circle if 8X35 trifocals are requested (requires medical justification).
34	Cataract Lens	Circle if cataract lenses are requested.
35	* Other	Circle if 'other' lens type is requested (requires medical justification).
36	CR39	Circle if CR39 plastic is requested.
37	* Polycarbonate	Circle if polycarbonate is requested (may require medical justification in some circumstances).
38	* Hi Index	Circle if hi index is requested (requires medical justification).
39	Glass	Glass lenses are not available.
40	* Other	Circle if 'other' lens material is requested (requires medical justification).
41	Sphere	Enter the sphere power.
42	Cylinder	Enter the cylinder power.
43	Axis	Enter the axis.
44	Prism	Enter the prism.
45	Base	Enter the prism base direction.
46	Add	Enter the bifocal power.
47	Seg. Ht.	Enter the bifocal segment height.
48	Distance PD	Enter the distance PD (monocular or binocular)
49	Near PD	Enter the near PD (same format as distance PD in Block 48)
50	Manufacturer/Lens Name	Enter the contact lens manufacturer and contact lens name.
51	Lens Type	Enter the type of contact lens (annual daily wear, gas permeable, etc.)
52	Invoice Cost	Enter the invoice cost of the lens that will be billed to Medicaid.
53	Please specify reason for contact lens request	Check one.
54	Special Instruction for Medicaid Contractor Laboratory	Enter special instruction for the state optical laboratory contractor (grind thin as possible, old FBC = 2.5D, etc.)
55	Initial Fitting Optician/Technician (print)	Enter PRINTED name of the individual assisting in the frame selection and fitting process.
56	Initial Fitting Optician/Technician (signature) and Fitting Date	Enter the signature of the individual recorded in Block 55 and the encounter date of fitting.
57	Provider Phone Number	Enter the provider's area code and phone number.
58	Submission Date	Enter the date prior approval request is sent to the state fiscal agent.
59	Provider Address	Enter the provider's address
60	Provider Number	Enter the provider's Medicaid Provider Number
61	Caller's Initials	Enter the initial of the staff person notifying the recipient that visual aids are ready to be picked up.
62	Date	Enter the date that the recipient is notified that visual aids are ready to be picked up.
63	Method	Check the method used to notify the recipient.

64	Inspected by	Enter the initials of the staff person performing the inspection after the eyeglasses are received from the state optical laboratory contractor.
65	Date Inspected	Enter the date the eyeglasses are inspected.
66	Dispensed by	Enter the initials of the staff person dispensing the eyeglasses.
67	Date Dispensed	Enter the date the eyeglasses are dispensed.
68	Printed name of Parent/Guardian (if recipient is under 18)	Enter PRINTED name of the parent or guardian.
69	Signature of Recipient or Parent/Guardian (if recipient is under 18)	Have the recipient (if 18 or older) or the parent or guardian (if recipient is under 18) sign at dispensing.
70	Relationship to recipient (if recipient is under 18)	Enter relationship to recipient (Father, Aunt, etc.)
71	Date	Recipient, parent or guardian enters date eyeglasses were received.

Requirements for a Proper Prior Approval Request for Visual Aids

A proper prior approval request must include the following information:

- Service being requested
- Recipient name
- Recipient Medicaid identification number (MID)
- Recipient date of birth
- Provider number
- Provider address
- Provider phone number
- Provider signature
- Date of prior approval request
- Any additional information required by program coverage and/or prior approval policies

When any part of the above information is missing, the state’s fiscal agent will return the Prior Approval for Visual Aids form (372-017/A) to the provider for completion.

Unlike the general prior approval form (372-118), a copy of the Prior Approval Request for Visual Aids form (372-017/A) is forwarded to the state optical laboratory contractor. Therefore, **to prevent the dissemination of personal recipient information**, do **NOT** record the recipient address or phone number on any page of the prior approval request form that leaves the provider’s office.

Contact Information

Enter the name of the fitting optician or technician and the office area code and telephone number on the form. This will help prevent delays when further clarification of the request is required.

When Visual Aid Prior Approval Can Not be Issued

A visual aid prior approval will not be issued if:

- The state eligibility file does not show current eligibility on the date of the review or the date of refraction.
- The recipient has MPW coverage, except in special circumstances due to complications of pregnancy.
- The recipient has Family Planning Waiver Program (MAFD) coverage.

REQUEST FOR PRIOR APPROVAL FOR VISUAL AIDS

Please Type or Print Please Type or Print

1. Recipient Name - Last Recipient		2. First Jack		3. MI O	4. Sex M <input checked="" type="checkbox"/> F <input type="checkbox"/>	5. Recipient I.D. Number 999-99-9999-C	
6. Date of Birth		7. Date of Refraction		8. Name of Prescriber		9. Diagnosis & ICD-9 Codes 367.20/360.21/367.31	
10. Department Use Only Decision:						Agent: _____ Date: _____	
11. Frame: Standard Medicaid Selection Metal <input type="checkbox"/> Zyl <input type="checkbox"/> Combination <input type="checkbox"/>		12. * Frame: Exception Invoice Cost _____ Also Fill In Blocks 22, 23, 24, 25 & 26 Include Manufacturer in Block 22		13. * Exceptional Services Gray Tint <input type="checkbox"/> <input checked="" type="checkbox"/> <input checked="" type="checkbox"/> Sun Photogray <input type="checkbox"/> Repair or Replacement <input type="checkbox"/> Pink Tint <input type="checkbox"/> <input checked="" type="checkbox"/> Ultraviolet Filter <input type="checkbox"/> Other: _____			
14. * Please provide documentation/medical justification for approval of requests for exceptional (*) services. Anisometropia; Progressive Myopia							
Order (circle one)	15. Complete Glasses	16. Lenses Only	17. Frame Only	18. * Frame to Follow	19. R Lens Only	20. L Lens Only	21. Lens circumference R _____ L _____
Frame	22. Manufacturer/Frame Name or Number		23. Eye Size	24. Bridge Size	25. Temple Length	26. Color	
Lenses (circle one)	27. Single Vision	28. ST 28 (Bifocals)	29. *ST 35 (Bifocals)	30. Round (Bifocals)	31. *Executive (Bifocals)	32. * 7X28 (Trifocals)	33. * 8X35 (Trifocals)
Material (circle one)	36. CR39	37. * Polycarbonate	38. * Hi-Index	39. Glass	40. * Other		
R	41. Sphere -13.00	42. Cylinder 8.4	43. Axis	44. Prism	45. Base	46. Add	47. Seg. Ht.
L	-17.00	8.4					48. Distance P.D.
49. Near							49. Near
* Contact Lenses Evaluation for approval based on documentation of medical diagnosis and necessity							Slab Off <input type="checkbox"/>
50. Manufacturer/Lens Name B&L Silsoft			53. Please specify reason for contact lens request				Fresnell Prism
51. Lens Type <input checked="" type="checkbox"/> RGP, etc.)			Keratoconus <input type="checkbox"/>	Significant Anisometropia <input checked="" type="checkbox"/>	Significant Progressive Myopia <input checked="" type="checkbox"/>	* Other (Attach documentation of medical necessity) <input type="checkbox"/>	Power
52. Invoice Cost \$150.00							Base
54. Special Instruction for Medicaid Contractor Laboratory							
55. Initial Fitting Optician/Technician (print) A.B. Fitter				Recipient notified to pick up visual aids			64. Inspected by
56. Initial Fitting Optician/Technician (signature) Fitting Date A.B. Fitter 5-8-11				61. Caller's Initials			65. Date Inspected
57. Provider Phone Number 999 555-5555				62. Date			66. Dispensed by
58. Submission Date 5-6-11				63. Method	Phone <input type="checkbox"/>	Phone <input type="checkbox"/>	Phone <input type="checkbox"/>
59. Provider Address A Great Provider 123 Any Street Anytown, NC 12345				60. Provider Number 999 9999	Mail <input type="checkbox"/>	Mail <input type="checkbox"/>	Mail <input type="checkbox"/>
Signature denotes receipt of visual aid outlined above							
68. Printed name of Parent/Guardian (if recipient is under 18)							
69. Signature of Recipient or Parent/Guardian (if recipient is under 18)							
70. Relationship to recipient (if recipient is under 18)							
71. Date							

Attachment C: Contractor Contact Information

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

A. State's Fiscal Agent Contractor

HP Enterprise Services is the fiscal agent contracted by DMA to process prior approval requests and claims for Medicaid enrolled providers according to DMA's policies and guidelines.

Prior Approval Request for Visual Aids forms (372-017/A)	Mail To: HP Enterprises P. O. Box 31188 Raleigh, North Carolina 27622
CMS-1500 optical claim forms which require an invoice	Mail To: HP Enterprises P. O. Box 30968 Raleigh, North Carolina 27622
HP Optical Prior Approval Unit	1-800-688-6696 or 919-851-8888 Press 2 for Prior Approval Press 2 for Optical
HP Provider Services Unit	1-800-688-6696 or 919-851-8888 Press 3 for Provider Services Listen to the various prompts

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 to this address)	Nash Optical Plant P. O Box 600 2869 US Highway Alternate 64 West Nashville, North Carolina 27856
Telephone Numbers	1-888-388-1353 or 1-252-459-6200
Fax Number	1-252-459-7400

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	1-866-844-1113
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Attachment D: 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.