

North Carolina Health Choice (NCHC) Frequently Asked Questions for Vision Care Specialists

GENERAL INFORMATION

1. *What is NC Health Choice for Children?*

It is a fee-for-service health insurance program that provides free or low-cost coverage to uninsured children under the age of nineteen whose families cannot afford private health insurance and who do not qualify for Health Check (Medicaid). The program was established in October 1998 by the federal government and the State of North Carolina. It is modeled after the State Teachers' and Employees' Comprehensive Major Medical Plan and is administered by BlueCross BlueShield of North Carolina (BCBSNC) with the exception of pharmacy benefits, which are managed by AdvancePCS; and mental health, which is managed by ValueOptions, Inc. Children are enrolled on a first-come, first-serve basis.

2. *What services does NC Health Choice for Children cover?*

NC Health Choice for Children is a comprehensive health insurance program covering a range of services for children. These include acute care, preventative care services, hospitalization, and special hearing and vision benefits. Prescription drugs are covered. Dental benefits include prophylactic, evaluative and therapeutic services. Almost all services for children with special needs are covered. No special application for these services is necessary. Vision care benefits are summarized in [Question 5](#). Details on NC Health Choice covered services can be found in the member handbook online.

3. *How will I know that an individual is a member of the NC Health Choice for Children plan?*

Children will have a card identifying them as members of the NC Health Choice for Children plan. There is one-year of continuous eligibility; the expiration date is on the card.

4. *What does a vision care specialist have to do to enroll in NC Health Choice for Children?*

No enrollment is necessary. To participate a health care provider must be licensed to practice in North Carolina.

VISION CARE SERVICES

5. *What vision care services does NC Health Choice for Children cover?*

The plan covers one eye exam every 12 months. With prior approval, it also covers one set of lenses (glasses or contacts) once every 12 months and one set of frames once every 24 months. If the lenses or frames are broken, the doctor must state that the frames and/or lenses cannot be fixed before approval is given for another pair. Medical care related to treatment of eye diseases is also covered. NC Health Choice for Children does not cover orthoptics or visual training or refractive surgery (radial keratotomy, LASIK, or other procedures to correct vision in place of glasses or contacts).

6. *Are there restrictions on the type of frame that a child may select?*

The benefit allows for reimbursement to providers for frames costing up to \$50. If a member selects a more expensive frame, the vision care specialist should explain that the member will be responsible for the cost that exceeds this limit. The difference should be billed to NC Health Choice for Children under the "deluxe frame" code (V2025). This code will be denied as non-covered and will be the responsibility of the member.

REIMBURSEMENT

7. *How is a vision care specialist reimbursed for services?*

Claims are filed with BCBSNC using CPT codes and standard HCFA 1500 forms. Reimbursement is made directly to providers. Approximately 90% of the claims are paid within 30 days. If you are a Blue Cross provider, use your BlueCross Provider Number along with your federal tax identification number. If you are not a BlueCross provider, use your federal tax identification number. Having a BlueCross Provider Number will facilitate the claim and assure that you are paid on a timely basis. However, it is not required for participation in the program.

8. *How much is a vision care specialist reimbursed for services?*

Reimbursements are equivalent to the payments received when services are provided under the State Teachers' and Employees' Comprehensive Major Medical Plan. Currently, reimbursement rates are 100% of the Usual, Customary and Reasonable rate (UCR) established by the BCBSNC. Although fee schedules are not available, BCBSNC will work with individual vision care specialists and other providers to help them ascertain their individual rates. Vision care specialists are encouraged to file a claim to see the rates for themselves. Filing one claim does not commit a vision care specialist to file a second claim. See [Question 20](#) for telephone numbers to call with questions.

9. Can I bill the NC Health Choice for Children member for the difference between my charges and the BCBSNC reimbursement?

No. You cannot bill a NC Health Choice for Children member any amount other than the copayment. With regard to frames see [Question 6](#).

10. Can I bill members for services that are not covered by NC Health Choice for Children?

Yes. You can bill for services not covered by NC Health Choice. See [Question 6](#) for an example of how to bill for a deluxe frame.

11. Is enrollment retroactive?

Yes. Enrollment is retroactive to the first of the month in which the application is received by the County Department of Social Services.

12. How will I know what copayment to collect?

Some families are subject to copayments of \$5 for office visits and certain services, and others are not. Check the member's insurance card. If the member's card shows \$0.00 beside "office/outpatient copay," no copayment is required for any covered services. If "\$5.00" appears, a \$5.00 copayment is required for the following services/codes:

- 92002 - Eye exam, new patient
- 92012 - Eye exam, established patient
- 92004 - Eye exam, new patient
- 92014 - Eye exam, established patient

No copayments are required for other covered services for these children.

When the total copay amount for a covered family reaches five percent of the family's income, no further copayments are to be collected. When this occurs, BCBSNC will send the member a letter stating that the copayment maximum has been met for the year. The letter will specify the date when he or she must resume making copayments. It is the responsibility of the member to share this information with you. You may also contact the BCBSNC State Customer Service Department at 1-800-422-4658 to verify this information. You will continue to receive your full, allotted reimbursement.

13. What should I do if I do not agree with a decision to deny a claim, or if I disagree with the reimbursement provided?

The same reconsideration and appeals processes that are now established for the State Health Plan are also available for NC Health Choice for Children. There is an appeals line that can be called by members or providers. It is 1-800-422-4658.

OTHER

14. Does the patient need authorization from a primary care physician to see a vision care specialist?

No, the patient does not need authorization from a primary care physician to see a vision care specialist for an eye exam or for medical care related to the treatment of the eye. (The service must be covered in order for the provider to receive reimbursement.)

15. Are pre-admission certification and second surgical opinions required? If so, are there any penalties if these are not obtained prior to the delivery of service?

Pre-admission certification is required; however, there is no penalty if it is not obtained. Second surgical opinions are not required; however, benefits will be available in the event a NC Health Choice for Children member gets a second surgical opinion.

16. Does the NC Health Choice for Children plan have pre-existing condition waiting periods?

No.

17. Will prior plan approval be required for any services? If prior plan approval is not obtained, will the claims for services be denied? If so, can I bill the member for the services?

Prior plan approval will be required for certain services such as lenses (glasses, contacts), frames, and surgeries. If prior plan approval is not obtained when necessary, claims for the service will be denied. You can bill the member for services that are denied due to failure to obtain prior plan approval. However, the Health Plan asks that you try to help the member obtain the necessary approvals - even after the fact - before billing the member. If prior approval is not granted, the member will be responsible to pay you for services rendered. To verify which services require prior approval, contact State Medical Review at 800-422-1582.

To obtain "prior approval," call 1-800-422-1582 and have the patient's identification number, eye exam results and your provider number available. If you prefer, you may

fax information for prior approval to 919-765-4890, but the response time will not be as quick as with phone requests.

18. *What is the link between Medicaid and NC Health Choice for Children?*

The state's Medicaid agency, the Division of Medical Assistance, is responsible for setting eligibility standards, overseeing eligibility determination in county departments of social services and assessing program performance. Benefit structure and claims payments are not connected to the Division of Medicaid Assistance. Children who apply for NC Health Choice for Children are first screened for eligibility for Health Check (Medicaid) and are placed in the program that is appropriate for their income level.

19. *Will I have to double check whether or not the patient is eligible each visit the way I have had to double check on Medicaid?*

No, you will not. NC Health Choice for Children members are continuously eligible for one full year and the benefit close date is stamped on the membership card.

Very rarely, it is possible for benefits to end prior to the date stamped on the card. This could occur if a child reached the age of nineteen prior to the end date, became eligible for Medicaid or was found to have other insurance coverage. If the provider wishes to eliminate this small risk, coverage can be confirmed by calling the customer service line (800-422-4658).

NC Health Choice is not renewed automatically. Review the certification period at each visit and remind patients to start the re-enrollment process 2 months prior to the end of their certification period.

If the patient is found to be ineligible at re-determination, you will not be reimbursed by NC Health Choice for services that occur after the original termination date.

20. *Who do I contact if I have questions or concerns?*

For questions about reimbursement, benefits or to verify eligibility, contact the customer service line at 800-422-4658. To verify which services require prior approval and to obtain prior approval, call 800-422-1582.

If you have feedback that you would like to share with a vision care representative from the NC Health Choice for Children Provider Task Force, contact Charles Wiggins, OD at 919-851-4142.

Information contained in this document is the best information available as of November 2001 and is subject to change. Sources include:

1. *"The North Carolina Pediatrician,"* a publication of the North Carolina Pediatric Society, Spring, 1999.
2. Memo from the State of North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan and NC Health Choice, BlueCross BlueShield of North Carolina, September 1998.
3. Conversations with Connie Williams and Brenda Cash, State Education Consultants, BlueCross BlueShield of North Carolina.
4. Letter from State Customer Services to Vision Care Providers regarding NC Health Choice for Children, April 3, 2001.
5. Input from members of the NC Health Choice for Children Provider Task Force and the members of the vision care community in Cabarrus County, NC.

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For more information about NC Health Choice, please contact your local Department of Social Services. The number can be found in your phone book under "County Government." 12/2001

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