To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP.

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Related Clinical Coverage Policies

Refer to https://medicaid.ncdhhs.gov/ for the related coverage policies listed below:
6B, *Adult Routine Eye Examination and Visual Aids.*
1T-1, *General Ophthalmological Services.*
1T-2 *Special 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 lenses and medically necessary contact lenses) provided by ophthalmologists, optometrists, and opticians within their scope of practice as defined by North Carolina state laws (NCGS § 90-127.3 and 21 NCAC 42E).

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

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

Note: This policy does not address adult routine eye exam and visual aids services coverage or general or special ophthalmological services. For coverage criteria for these services, refer to clinical coverage policy 6B, *Adult Routine Eye Examination and Visual Aids,* 1T-1, *General Ophthalmological Services,* and *1T-2 Special Ophthalmological Services*, found on NC Medicaid's website https://medicaid.ncdhhs.gov/.

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 policies*)

a. An eligible beneficiary shall be enrolled in the NC Medicaid Program *(Medicaid is NC Medicaid program, unless context clearly indicates otherwise*).

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b. Provider(s) shall verify each Medicaid 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.

2.1.2 Specific

(***The term "Specific" found throughout this policy only applies to this policy***)

a. Medicaid

Medicaid Eligible Categories

1. **Traditional Medicaid**
   None Apply.

2. **Family Planning Waiver Program (MAFD)**
   Beneficiaries with Family Planning Waiver benefits are not eligible for routine eye exams and visual aids.

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: https://medicaid.ncdhhs.gov/

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 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 Medicaid

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

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

Opticians only fit and dispense approved visual aids.

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

3.2.2 Medicaid 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 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 Medicaid

Medicaid shall not cover the following services:

a. affixing initials or engraving initials or name (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 or chains;
n. photochromatic lenses; and
o. hand-held low-vision magnifiers;

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.

4.3 Beneficiary Purchase of Non-Covered Services from the Provider

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 Medicaid 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, 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

Medicaid shall require prior approval for any **early** routine eye exam or refraction only within the one-year time limitation period.

Medicaid shall require 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

Medicaid shall not require prior approval for routine eye exams with refraction that meet the criteria and requirements listed in this policy. However, providers are advised to obtain a confirmation number at http://www.nctracks.com.gov.

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

5.3.1 Service Limitations

Routine eye exam with refraction is limited to once every 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's health record.

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. (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 Early Eye Exam or Refraction Only

Medicaid shall require prior approval for any early routine eye exam or refraction only within the one-year time limitation period.

Provider(s) shall submit an electronic Prior Authorization (PA) request via the Web at http://www.nctracks.nc.gov with documentation of medical necessity (significant decrease in acuity, medication, failed Department of Motor Vehicles (DMV) vision screening, etc.), as well as any additional documentation obtained from a physician or DMV. Each request for an early routine eye exam 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 NC Medicaid Optical Services Program at 919-527-7669.

5.4 Visual Aids

Medicaid shall require prior approval before provider(s) order or dispense visual aids. If a beneficiary has an urgent need for visual aids, the provider may contact NC Medicaid's Optical Services Program at 919-527-7669

5.4.1 Service Limitations

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

Note: Eyeglasses are made up of two components; frame and lenses. The one-year eligibility period is applicable to each component and starts with the last approval date for the individual component.

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. 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 DHHS Optical Laboratory Contractor

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

5.4.4 Eyeglasses, Lenses, or Frames Supplied by the Provider

Medicaid may grant prior approval for an exception for the provider to supply complete eyeglasses, lenses only, or a frame when medically necessary.

Refer to **Subsections 5.5.2** and **5.5.3** for additional information regarding frame exceptions.

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

5.5 Frames

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

5.5.1 Frame Fitting Kit

Beneficiaries must choose a frame from the complete Medicaid frame selection. Therefore, providers shall have a Medicaid 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 DHHS optical laboratory contractor.

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

Refer to **Attachment D, Section B** for the DHHS optical laboratory contractor contact information.

5.5.2 Non-Medicaid Frames

Requests for Medicaid reimbursement for frames other than those available from the DHHS optical laboratory contractor are considered on a case-by-case basis. Requests must be accompanied by documentation of medical necessity (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 electronic PA request for prior approval and submitted via the Web at http://www.nctracks.nc.gov.

5.5.3 Beneficiary's Own Medicaid Frame

Use of the beneficiary's existing Medicaid frame (not new) may be approved when medical necessity is documented on the electronic PA request.
Medical necessity may include:

a. Replacement of one lens due to a significant prescription change.
b. Replacement of both lenses due to a significant prescription change and the beneficiary cannot function without eyeglasses; or
c. An immediate post-surgical prescription change is required.

Provider(s) shall not mail the beneficiary's existing frame to NC Medicaid, the DHHS fiscal contractor, or the DHHS optical laboratory contractor. NC Medicaid, the DHHS fiscal contractor, nor the DHHS optical laboratory contractor are 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

NC Medicaid shall not allow payment for non-covered frames that a beneficiary elects to purchase instead of a Medicaid frame. If the beneficiary elects to purchase a non-Medicaid 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 eyeglasses. Providers shall not bill NC Medicaid for eyeglasses purchased by the beneficiary.

5.6 Lenses

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

5.6.1 Spectacle Lenses

Lenses are available in CR-39 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 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)	- 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; or - Children birth through 6 years of age; - Medical/physical conditions that result in frequent trauma or falls. 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.
Hi-Index (plastic)	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. Document medical necessity on the electronic prior approval request and submit via the Web at http://www.nctracks.nc.gov. Single vision or bifocal + or – 8.00 or higher in one meridian (sphere, cylinder, combination of sphere and cylinder, or prism). No medical necessity documentation is required.
Other Lenses and Special Services	Myodisc, Press-on Prism, Special Base Curves, Slab-off, etc.

5.6.4 Uncut Lenses Only

In special circumstances, prior approval may be granted for uncut lenses from the DHHS 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 DHHS 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 Medicaid approved 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 DHHS 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 contains 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).
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 submit appropriate documentation with the electronic prior approval request submitted via the Web at http://www.nctracks.nc.gov.

Refer to **Subsection 5.8.4** for additional information regarding frame warranty.

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

5.8.1 Replacement of Lost, Stolen or Damaged Visual Aids

Replacement of lost, stolen or damaged Medicaid 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 (school principal, school nurse, etc.) may be submitted.

Providers shall evaluate the damaged visual aid and document the cause and the extent of the damage. Prior approval requests for replacement visual aids that do not contain the evaluation information are returned to the provider for completion.

If the visual aid 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 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 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 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 legally adopted and submit via the Web to http://www.nctracks.nc.gov.

5.8.4 Warranty Frame Replacements

Medicaid frames carry a one-year warranty from the original approval date assigned by the DHHS fiscal contractor. 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 DHHS 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 DHHS optical laboratory contractor. Subsequently, the DHHS 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. The request for replacement lenses must include 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). The lens circumference must also be included in the request for replacement spectacle lenses, when available.

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

Additional documentation from a physician, school nurse, 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 (aphakic lens 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.

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.nctracks.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 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, a provider 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 NC Medicaid'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 routine eye exams and visual aid fitting and dispensing for a Medicaid beneficiary if these same services are extended to a private patient in the same practice or business.

a. If both routine 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, 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 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 DHHS optical laboratory contractor to verify that they have a record of the order. If no record is found, the provider shall contact the DHHS fiscal contractor for assistance. The DHHS 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 DHHS optical laboratory contractor, the DHHS optical laboratory contractor shall duplicate the order at no charge to NC Medicaid or the provider.

7.4 DHHS Optical Laboratory Contractor

NC Medicaid contracts with a state optical laboratory to provide authorized services.

7.4.1 Requesting Non-Covered Services

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

7.5 DHHS Optical Laboratory Contractor Errors

Correction of DHHS optical laboratory contractor errors are not billed to NC Medicaid or the provider. The replacement eyeglasses lenses, frame, or complete eyeglasses require "priority" expediting.

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

Refer to **Attachment D** for the DHHS fiscal contractor and DHHS optical laboratory contractor contact information.

7.5.1 Inspection by Provider

All eyeglasses received from the DHHS optical laboratory contractor must be inspected by the provider prior to dispensing. Inspection consists of 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 (single vision, 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's health record.

7.5.2 Returning Visual Aid Errors to DHHS Optical Laboratory Contractor

All DHHS optical laboratory contractor errors must be returned to the contractor, as follows:

a. Shipping for DHHS optical laboratory contractor errors is at no cost to the provider.
b. The provider shall contact the DHHS optical laboratory contractor to request delivery arrangements for the return of the error to the contractor. The DHHS optical laboratory contractor provides a prepaid mailing label and scheduled pick-up by a shipping service (RPS, UPS, FedEx, etc.), which will be charged to the DHHS optical laboratory contractor's shipping service account.
c. DHHS optical laboratory contractor errors must be received by the DHHS 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 workmanship (poor edging, lens size, flaws, scratches, incorrect power, misaligned axis, incorrect tinting, etc.), the provider shall contact the DHHS optical laboratory contractor, and then return the lenses to the DHHS optical laboratory contractor for a remake at no charge to NC Medicaid or the provider.

b. **Frames**
If the frame is in unacceptable condition (damaged, wrong style, color, or size, wrong temple length, etc.), the provider shall contact the DHHS optical laboratory contractor and request a new frame and return the frame at no charge to NC Medicaid or the provider. If necessary, the DHHS optical laboratory contractor shall furnish new lenses.

7.5.4 Misdirected Orders

If a provider receives an order for a Medicaid beneficiary who is not the provider's patient, the provider shall contact the DHHS optical laboratory contractor immediately and return the eyeglasses to the contractor as soon as possible, at no charge to NC Medicaid or the provider.

7.5.5 Duplicate Orders

If a provider receives a duplicate pair of eyeglasses from the DHHS optical laboratory contractor, the provider shall return the second pair to the DHHS optical laboratory contractor, at no charge to NC Medicaid or the provider.

7.6 Provider Errors

If a provider error occurs, and the DHHS 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 provider's change in the prescription, the prescribing provider 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 DHHS optical laboratory contractor and must not be billed to NC Medicaid.

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 Las 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 attachment(s)	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/01/2015 implementation where applicable.
03/15/2019	All sections and attachment(s)	Updated 10/01/2015 policy version to the revised Policy Development language and template used for new adult optical policy (6B). No impact to amount, duration, or scope and no substantive change in the meaning, interpretation, or application of a clinical coverage policy.
03/15/2019	All sections and attachment(s)	Changed "state" optical laboratory contractor to "DHHS" optical laboratory contractor to mirror new adult optical policy language (6B) recommended by Policy Development. No impact to amount, duration, or scope and no substantive change in the meaning, interpretation, or application of a clinical coverage policy.

Date	Section Revised	Change
03/15/2019	Subsection 2.1.2	Based on Policy Development feedback and Template revision, moved list to 2.3.1 and combined with existing references in 2.1.2. There is no longer a separate Subsection 2.3.1. No impact to amount, duration, or scope and no substantive change in the meaning, interpretation, or application of a clinical coverage policy.
03/15/2019	Subsection 3.2.1	Changed "may" to "only" in 'Opticians may fit and dispense approved visual aids.' Simply to clarify that eye exams and prescribing lenses are not within the optician's scope of practice. No impact to amount, duration, or scope and no substantive change in the meaning, interpretation, or application of a clinical coverage policy.
03/15/2019	Subsection 4.2.1	Removed "p. visual aids that can be purchased without a prescription" because this is already stated in "f. over the counter, hand-held magnifiers or any visual aid that can be purchased without a prescription". No impact to amount, duration, or scope and no substantive change in the meaning, interpretation, or application of a clinical coverage policy.
03/15/2019	Subsection 4.2.1	Added "p. dispensing fee for any non-covered or non-Medicaid approved service or product." This was added so that the child policy (6A) mirrors the new adult optical policy (6B). GS 148-134 requires the State to use DPS/Nash Optical Plant for eyeglasses for Medicaid and NCHC. SL 2017-186 carved fabrication of eyeglasses by Nash Optical Plant out of capitation. NC Medicaid has never paid a dispensing fee for non-covered or non-Medicaid approved optical services. This language simply clarifies that Medicaid/NCHC dollars do not cover non-Medicaid services under this policy. No impact to amount, duration, and scope and no substantive change in the meaning, interpretation, or application of a clinical coverage policy.

Date	Section Revised	Change
03/15/2019	Subsections 5.3.3 and 5.4.2	Deleted "Family Planning Waiver" to eliminate contradiction to correct information in Subsection 2.1.2.a.3. No impact to amount, duration, and scope and no substantive change in the meaning, interpretation, or application of a clinical coverage policy.
03/15/2019	Subsection 5.3.5	Corrected DMV "eye exam" to DMV "vision screening". DMV never has and does not currently perform eye exams. One only receives a vision screening at DMV. No impact to amount, duration, or scope and no substantive change in the meaning, interpretation, or application of a clinical coverage policy.
03/15/2019	5.4.1	Added "Eyeglasses are made up of two components; frame and lenses. The one-year eligibility period is applicable to each component and starts with the last approval date for the individual component." This has always been true for the history of the program. Added language to eliminate calls from new providers or new staff in current provider offices. No impact to amount, duration, or scope.
03/15/2019	Subsection 5.4.5	Moved list to applicable Subsection 5.5.3 and combined with this subsection criteria. No impact to amount, duration, or scope and no substantive change in the meaning, interpretation, or application of a clinical coverage policy.
03/15/2019	Subsection 5.5.3	See note, above, regarding Subsection 5.4.5
03/15/2019	Subsection 5.8.7	Added criteria for providers to include lens circumference for lens only orders, when available. This helps the optical lab fabricate the lens only order with greater specificity. No impact to amount, duration, or scope and no substantive change in the meaning, interpretation, or application of a clinical coverage policy.

Date	Section Revised	Change
03/15/2019	Attachment B.3.a	Added "The provider shall document the dispense date and the dispenser's initials in the beneficiary's health record." All other dispense scenarios captured in Attachment B.3.a except dispense to the beneficiary directly. Documenting the dispense date and dispenser in the beneficiary's health record is standard practice but was not outlined in policy 6A. No impact to amount, duration, or scope and no substantive change in the meaning, interpretation, or application of a clinical coverage policy.
03/15/2019	Attachment B.3.b	Changed "non-approved tint" to "non-approved service" to eliminate any contradiction to the requirement of PA for all visual aid services as outlined in Subsection 5.4. No impact to amount, duration, or scope and no substantive change in the meaning, interpretation, or application of a clinical coverage policy.
03/15/2019	Attachment B.C.2.c	Correction of requirement to document date of death on claim form. Date of death cannot be entered on an 837 claim. C.2.c now reads like Attachment C.1.c, which states 'on the beneficiary's health record'. No impact to amount, duration, or scope and no substantive change in the meaning, interpretation, or application of a clinical coverage policy.
03/15/2019	Table of Contents	Added, "To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after November 1, 2019, please contact your PHP."
01/13/2020	Table of Contents	Updated policy template language, "To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP."
01/13/2020	Attachment A	Added, "Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines".
03/15/2021	Subsection 5.4	Correct phone number providers call for urgent eyeglass needs from (919)855-4314 to (919)527-7669. Correction is necessary due to office relocation (from Kirby Building to McBryde Building).
03/15/2021		Policy posted 03/17/2021 with an amendment date of 03/15/2021

Date	Section Revised	Change
08/15/2023	All Sections and Attachments	Updated policy template language due to North Carolina Health Choice Program's move to Medicaid. Policy posted 08/15/2023 with an effective date of 4/1/2023.
05/01/2024	Subsections: 2.1.2a.2., 5.3.3, 5.3.4, 5.4.2, 5.4.3, and Attachment C: A.5.	In accordance with SL 2021-180, Section 9D.13.(a), deleted Medicaid for Pregnant Women coverage guidance. Effective date is 4/1/22
07/25/2024		Fixed error in section 8.0 for 5/1/24 amended date. Policy posted 7/25/24 amended date not changed

Attachment A: Claims Related Information

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

A. Claim Type

Professional (CMS-1500/837P transaction)

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

Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.

B. International Classification of Diseases and Related Health Problems, 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 shall enter one of the following refractive diagnosis codes on the claim.

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		
HCPCS or CPT Code		Maximum Reimbursement Rate
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, Section H** for fee schedule information.

Visual Aids and Dispensing Code Description Table

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 consists of 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. Dispending fees are paid only for approved Medicaid visual aids.

Frames and Repairs Dispensing Fee	
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 NC Medicaid. This consists of frames for complete eyeglasses and frame replacements. The Frame Dispensing Fee code consists of 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. Dispending fees are paid only for approved Medicaid visual aids.

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 consist of keratometry readings, measurements, fitting, and training, 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. Dispending fees are paid only for approved Medicaid visual aids.

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

Medical necessity for procedures billed must be documented in the beneficiary's health record. Procedures billed without justification and 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.

Provider(s) 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).

F. Place of Service

1. **Medicaid Routine Eye Exams**
   Inpatient Hospital, Outpatient Hospital, Office, Home, School, Intermediate Care Facility, Skilled Nursing Facility.

2. **Medicaid Visual Aids**
Inpatient Hospital, Outpatient Hospital, Office, School, Intermediate Care Facility, Skilled Nursing Facility.

G. Co-payments

For Medicaid refer to the NC Medicaid State Plan:
https://medicaid.ncdhhs.gov/meetings-notices/medicaid-state-plan-public-notices

1. **Medicaid Routine Eye Exam Co-payment**
There is no co-payment for Medicaid routine eye exams.

2. **Medicaid 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, refer to: https://medicaid.ncdhhs.gov/

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

Reimbursement requires compliance with all Medicaid policies, along with obtaining appropriate referrals for beneficiaries enrolled in the Medicaid 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 Policies 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 components of 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 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 NC Medicaid 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 consists of the initial fitting, prior approval documentation, final inspection once eyeglasses are received by the provider from the DHHS optical laboratory contractor, and final fitting verification and adjustment of the eyeglasses on the beneficiary. The provider shall document the dispense date and the dispenser's initials in the beneficiary's health record. 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 or in person).
b. When billing for eyeglasses that have been approved for fabrication or supply by the provider rather than the DHHS 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, and non-approved services are not reimbursed by NC Medicaid and must be deducted from the invoice total.

4. Contact Lenses

a. Dispensing fees for contact lenses consist of keratometry 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 shall allow at least three months to lapse after receiving the eyeglasses from the DHHS optical laboratory contractor before billing as undeliverable. Providers may choose to retain the eyeglasses in the provider's office or return them to the DHHS fiscal contractor.

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's health record;
b. A copy of the final written attempt (letter or postcard) to contact the beneficiary, requesting that the beneficiary return to the provider's office to pick up the eyeglasses, is maintained with the beneficiary's health record.
c. If the beneficiary is deceased, the date of death is documented on the beneficiary's health record.

Providers shall submit claims within one year of the DHHS fiscal contractor approval date and retain the undeliverable 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 shall 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 could mean using the frame for replacement parts, donating the eyeglasses to the Lion's Club, or adding the frame to the provider's Medicaid frame fitting kit.

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's health record.

2. DHHS Fiscal Contractor Responsible for Eyeglasses Retention

Providers may return the undeliverable eyeglasses to the DHHS fiscal contractor and file the claim electronically, rather than retaining the eyeglasses in the office for the duration of the eligibility period (one year from the DHHS fiscal contractor 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 DHHS optical laboratory contractor invoice, to the DHHS fiscal contractor Optical Prior Approval unit. 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 ALL the following conditions are met:

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

If, after the eyeglasses have been returned to the DHHS fiscal contractor agent, the beneficiary returns to the provider requesting the eyeglasses, the provider shall contact the DHHS fiscal contractor to determine if the returned eyeglasses can be retrieved. If they can be retrieved, the eyeglasses are 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, the original approval date, the date the eyeglasses were returned to the DHHS fiscal contractor, 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 report 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 shall 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

A visual aid claim for a beneficiary whose eligibility was terminated in the month following the date of the routine eye exam are allowed when resubmitted with the routine eye exam date as the date of service if the following criteria are met:

1. The beneficiary was eligible for services on the date of the routine eye exam and the date of the initial visual aid fitting, but is not eligible on the date the visual aids were dispensed; and
2. The provider enters the routine eye exam date as the date of service on the claim.

Attachment C: Web tool for Refraction and Eyeglass History

A. Confirmation for Routine 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 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 year, 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 DHHS fiscal contractor for assistance.

If the Web tool reveals that a beneficiary has already received a routine eye exam or refraction only within the previous year, the provider shall 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 the:

1. State eligibility file does not reflect current eligibility information;
2. beneficiary has a history of a paid routine eye exam or refraction within the previous one-year period;
3. Web tool is down and eligibility cannot be verified (providers are instructed to call back);
4. beneficiary has a notice of eligibility approval from the county DSS but eligibility is not yet showing on the state eligibility file; or
5. beneficiary is only eligible for limited Medicaid coverage-such as MAFD.

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 at http://www.nctracks.nc.gov allows the provider to view the history of approval for complete eyeglasses. Access is obtained via a dropdown box under the Prior Approval tab marked Eyeglass Service History. This tool does not report medically necessary contact lens, replacement spectacle lens, or replacement frame approval history.

Unlike the Web Tool for routine eye exam and refraction only history, no confirmation number is issued. It is in the provider's best interest to access the Web Tool on the day of service, before submitting the Prior Approval Request for Visual Aids.

Note: The Web Tool eyeglass history inquiry does not replace prior approval. Prior approval through NCTracks is required for all eyeglasses.

Attachment D: Contractor Contact Information

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

A. DHHS Fiscal Contractor

CSRA is the fiscal contractor contracted by NC Medicaid to process Medicaid prior approval requests and claims for Medicaid enrolled providers according to NC Medicaid policies.

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

B. DHHS Optical Laboratory Contractor

Nash Optical Plant is the optical laboratory contracted by NC Medicaid to fabricate eyeglasses for Medicaid enrolled providers according to NC Medicaid policies.

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

Attachment E: Warranty Frame Replacement

To replace a frame covered under warranty, contact the DHHS 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 DHHS optical laboratory contractor. Instead, seek prior approval for replacement. Lab staff will check replacement frame availability.

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

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

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