

**Table of Contents**

1.0 Description of the Procedure, Product, or Service ..... 1

2.0 Eligible Recipients ..... 1

    2.1 General Provisions ..... 1

3.0 When the Procedure, Product, or Service Is Covered ..... 1

    3.1 General Criteria ..... 1

    3.2 Specific Criteria ..... 1

4.0 When the Procedure, Product, or Service Is Not Covered ..... 2

    4.1 General Criteria ..... 2

    4.2 Specific Criteria ..... 2

5.0 Requirements for and Limitations on Coverage ..... 3

    5.1 Prior Approval ..... 3

6.0 Providers Eligible to Bill for the Procedure, Product, or Service ..... 3

7.0 Additional Requirements ..... 4

    7.1 Compliance ..... 4

8.0 Policy Implementation/Revision Information ..... 4

Attachment A: Claims-Related Information ..... 5

    A. Claim Type ..... 5

    B. Diagnosis Codes ..... 5

    C. Procedure Code(s) ..... 5

    D. Modifiers ..... 5

    E. Billing Units ..... 6

    F. Place of Service ..... 6

    G. Co-payments ..... 6

    H. Reimbursement ..... 6

## **1.0 Description of the Procedure, Product, or Service**

Routine vision care is the examination of the eyes in the absence of disease or symptoms to determine the health of the organs and visual acuity. It also includes manual correction of diminished eyesight, as needed, by way of lenses (glasses or contacts).

## **2.0 Eligible Recipients**

### **2.1 General Provisions**

To be eligible, NCHC recipients must be enrolled on the date of service.

## **3.0 When the Procedure, Product, or Service Is Covered**

### **3.1 General Criteria**

NCHC 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; **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**

- a. Routine visual examinations in the absence of disease or symptoms are covered once every twelve months. Medically necessary refractions may be covered more than once every twelve months but are subject to prior approval. Examinations must be performed by a licensed or certified ophthalmologist, optometrist, or optical dispensing laboratory employing a licensed or certified ophthalmologist or optometrist.
- b. Prescription lenses (eyeglass or non-disposable contacts) are covered once every twelve months when obtained from a licensed or certified ophthalmologist, optometrist or optical dispensing laboratory. Coverage for lenses more than once in a 12 month period is subject to review for medical necessity and requires prior approval. Purchase of disposable contact lenses is covered twice per 12 month period.

- c. Replacement of eyeglass frames is covered once every 24 months. Replacement of eyeglass frames more than once in a 24 month period is subject to review for medical necessity and requires prior approval. Frames may be replaced when broken only if the licensed or certified ophthalmologist, optometrist or optical dispensing laboratory certifies that the frames cannot be repaired.
- d. Routine optical supplies and solutions are covered only when obtained from a licensed or certified ophthalmologist, optometrist or optical dispensing laboratory..

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

### 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 unnecessarily duplicates another provider's procedure, product, or service; or
- d. the procedure, product, or service is experimental or investigational.

### 4.2 Specific Criteria

Routine vision care is not covered for:

- a. routine visual examinations in excess of one per twelve month period;
- b. visual examinations, optical supplies, and solutions are not covered when obtained from an ineligible provider.
- c. lenses other than single vision, bifocal, trifocal, or other medically necessary complex lenses;
- d. eyeglass frames other than non-deluxe frames made of zylonite, metal, or a combination of zylonite and metal;
- e. sunglasses, prescription or otherwise;
- f. non-prescription glasses and other visual aids that are available without a doctor's prescription (e.g., reading glasses, safety glasses, hand-held magnifiers);
- g. purchase of disposable contact lenses more than twice in a 12 month period;
- h. eyeglass cases, neck strings and chains, sports straps, and other similar items;
- i. Additional costs for oversized lenses and frames, designer frames, photosensitive lenses, tinted contact lenses, blended lenses, progressive multifocal lenses, coated lenses and laminated lenses beyond existing benefits for single vision, bifocal, trifocal, or other medically necessary complex lenses.

## 5.0 Requirements for and Limitations on Coverage

### 5.1 Prior Approval

- a. Prior approval based on medical necessity is required under the following circumstances for lenses (eyeglass or nondisposable contacts) and eyeglass frames:
  1. any non-standard lenses (e.g., tinted or polycarbonate);
  2. replacement of lenses more than once in a 12 month period; OR
  3. replacement of eyeglass frames more than once in a 24 month period.
- b. Prior approval is required for refractions when performed more than once every twelve months based on medical necessity.
  1. To ensure both the provider and the recipient know whether the item or service will be covered, DMA's vendor will respond to the request by letter if coverage has not been approved. If coverage for the item or service is approved, the provider will be advised of the approval by phone.
- c. A letter of medical necessity signed and dated by a licensed or certified ophthalmologist, optometrist or optical dispensing laboratory employing a licensed or certified ophthalmologist or optometrist must be submitted to DMA's vendor when requesting prior approval for services, lenses and frames as listed above in **Subsection 5.1.a** and **b**.
- d. The following documentation must be included:
  - a. recipient demographics, including name, mailing address, NCHC ID number;
  - b. recipient's diagnosis;
  - c. recipient's visual acuity results;
  - d. type of lenses and frames (noting composition) to be prescribed;
  - e. condition requiring special lenses (polycarbonate or tinted), when applicable;
  - f. reason for replacement of lenses in excess of every twelve months and/or frames in excess of every twenty-four months, when applicable;
  - g. certification, when appropriate, that frames cannot be repaired and new frames are required;
  - h. reason for refraction examinations, when appropriate, in excess of one every twelve months.

## 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 NCHC qualifications for participation;
- b. be currently enrolled with NCHC; **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.

## 7.0 Additional Requirements

### 7.1 Compliance

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

## 8.0 Policy Implementation/Revision Information

**Original Effective Date:** July 1, 2010

**Revision Information:**

Date	Section Revised	Change
July 1, 2010		Policy Conversion: Implementation of Session Law 2009-451, Section 10.32 "NC HEALTH CHOICE/PROCEDURES FOR CHANGING MEDICAL POLICY."

## Attachment A: Claims-Related Information

Reimbursement requires compliance with all NCHC guidelines.

### A. Claim Type

Professional (CMS-1500/837P transaction)

### B. Diagnosis Codes

Providers must bill the ICD-9-CM diagnosis codes(s) to the highest level of specificity that supports medical necessity.

### C. Procedure Code(s)

CPT Codes		
92310	92325	92326

HCPCS Codes				
V2020	V2100	V2101	V2102	V2103
V2104	V2105	V2106	V2107	V2108
V2109	V2110	V2111	V2112	V2113
V2114	V2115	V2118	V2121	V2199
V2201	V2202	V2203	V2204	V2205
V2206	V2207	V2208	V2209	V2210
V2211	V2212	V2213	V2214	V2215
V2218	V2219	V2220	V2221	V2299
V2301	V2302	V2303	V2304	V2305
V2306	V2307	V2308	V2309	V2310
V2311	V2312	V2313	V2314	V2315
V2318	V2319	V2320	V2321	V2399
V2700	V2710	V2715	V2718	V2730
V2744	V2780	V2784	V2500	V2501
V2502	V2503	V2510	V2511	V2512
V2513	V2520	V2521	V2522	V2523
V2530	V2531	V2599		

The following codes deny as non-covered:

HCPCS Codes				
V2025	V2410	V2430	V2499	V2750
V2755	V2756	V2760	V2761	V2762
V2770	V2781	V2782	V2783	V2786
V2787				

### D. Modifiers

Providers are required to follow applicable modifier guidelines.

**E. Billing Units**

The appropriate procedure code(s) used determines the billing unit(s).

**F. Place of Service**

Office and Home

**G. Co-payments**

Co-payment(s) may apply to covered prescription drugs and services.

**H. Reimbursement**

Providers must bill their usual and customary charges.