Clinical Policy: Routine Eye Examination and Visual Aids for Beneficiaries Under 21 years of Age

Reference Number: WNC.CP.107
Last Review Date:

Coding Implications
Revision Log

See Important Reminder **at the end of this policy for important regulatory and legal information.**

Note: When state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Description[1]
This policy describes the medical necessity of routine eye examination and visual aids for beneficiaries **under the age of 21**.

NOTE:
Information regarding coverage of both vision services and visual aids in this policy is provided for informational purposes to WellCare of NC providers and members. Not all information from the NC DHHS policy is provided here. For additional information regarding eyeglasses clinical coverage policy, NCTracks prior approvals, and frames, lenses, and eyeglasses fabrication through the NC DHHS Optical Laboratory Contractor please see NC Medicaid Clinical Coverage Policy 6A located at https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies/vision-services-clinical-coverage-policies.

WellCare of NC or Envolve Vision, as applicable based on provider contract, will be reimbursing providers for routine vision examinations and dispensing fees for eyeglasses and visual aids for NC Medicaid beneficiaries.

For eyeglasses: All clinical coverage guidance for eyeglasses in NC Medicaid Clinical Coverage Policy 6A will be applicable. Prior approval will be performed through NCTracks and frames, lenses, and fabrication will be supplied by the NC DHHS Optical Laboratory Contractor.

Policy/Criteria[1]

I. WellCare of North Carolina® shall cover the **medically necessary** routine vision services stated below:

- **A.** Medicaid shall cover the following optical services when provided by:
  - **1. Ophthalmologists and Optometrists**
    - **a. Routine Eye Exams, With The Determination Of Refractive Errors**
      - i. Limited to once every year, **unless** medical necessity is met based on the following criteria:

a) Documentation of medical necessity (significant decrease in acuity, medication, failed Department of Motor Vehicles (DMV) vision screening, etc.). The optical provider must obtain confirmatory documentation from a physician or DMV.
b) If requested to confirm medical necessity for the additional exam, the documentation must include:
    1. Corrected visual acuities **or**
    2. Documentation as to why corrected visual acuities data is missing (lost eyeglasses, never before corrected, etc.)
    3. Visual acuity data must include the right eye (OD), the left eye (OS), and both eyes (OU).

***Neither WellCare of NC or Envolve vision require prior approval for the initial or second or greater eye exam during a calendar year.**

ii. Refraction, Tonometry, Bio Microscopy, Depth Perception, Color Vision, and Ophthalmoscope study are considered part of the routine eye exam and must not be billed separately

b. Prescribing Corrective Lenses

i. Medically Necessary conventional daily wear contact lenses, supplied by the provider, may be approved with submission of medically necessary diagnosis for claim payment.
ii. The initial care kit (with medically necessary contact lenses) is a covered benefit

2. Ophthalmologists, Optometrists, and Opticians

a. Fitting and dispensing approved visual aids is:
    i. Limited to once every year
    ii. For clinical coverage guidance, please see NC Medicaid Clinical Coverage Policy 6A, located at: Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov).

Background[1]

A routine eye examination (exam), reimbursed by Envolve Vision, 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 allow for the correction of refractive error by way of ophthalmic eyeglass frames and lenses and/or medically necessary contact lenses (reimbursed by Envolve Vision) provided by ophthalmologists, optometrists, and opticians within their scope of practice as defined by North Carolina state laws.

Optical services reimbursed by Envolve Vision include routine eye exam with the determination of refractive errors; refraction only; prescribing corrective lenses; and fitting and dispensing fees for approved visual aids.
This policy does **not** address adult routine eye exam and visual aids services coverage or general or special ophthalmological services.

A. Provider Qualifications and Occupational Licensing Entity Regulations

1. 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.

B. Contact Lenses

1. **Medically Necessary Contact Lenses:**
   a. Medically necessary conventional daily wear contact lenses, supplied by the provider, may be approved with submission of medically necessary diagnosis for claim payment.
   b. Medical necessity is evaluated based on documentation of medical diagnosis (anisometropia, aphakia, keratoconus, progressive myopia, etc.). One care kit is covered for approved contact lenses.
2. **Requests for Extended Wear Lenses, Frequent Replacement Lenses or Disposable Lenses:**
   a. Medical necessity for exceptional cases requiring extended wear, frequent replacement, or disposable contact lenses is demonstrated by documentation in the clinical record (aphakic lens not available in a daily wear, Schirmer Test indicates severe dry eyes, etc.). Submit medically necessary diagnosis with the claim for the service.
   b. 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.
3. **Back-Up Eyeglasses for Contact Lens Wearers:**
   a. When medically necessary contact lenses are approved, back-up eyeglasses may be obtained through Medicaid.

C. Provision of Service

1. **Optical providers** shall extend the services of routine eye exams and visual aid fitting and dispensing for a Medicaid Member 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 Member prior to services being offered or scheduled. The Member shall be given the option to select a provider who will provide both services.
   b. If the Member elects to have the exam, a written prescription for the lenses must be given or offered to the Member at the time of the exam.
   c. The prescribing provider shall not withhold the prescription pending payment for the routine eye exam or previously unpaid Medicaid, or private bills.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2024, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT®* Codes	Description
92015	Determination of refractive state (refraction only)
92310	Dispense contact lens (two contact lenses) Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens, both eyes, except for aphakia
92326	Replacement of contact lens s (dispense replacement contact lens)
92340	Fitting of spectacles, except for aphakia; monofocal
92341	Fitting of spectacles, except for aphakia; bifocal
92342	Fitting of spectacles, except for aphakia; multifocal other than bifocal
92353	Fitting of spectacle prosthesis for aphakia; multifocal
92370	Repair and refitting spectacles, except for aphakia

HCPCS ®* Codes	Description
S0620	Routine ophthalmological examination including refraction; new patient
S0621	Routine ophthalmological examination including refraction; established patient
V2510	Contact lens, gas permeable, sph, per lens
V2520	Contact lens, hydrophilic, sph, per lens
V2599	Contact lens, other type
V2600	Handheld, low vision aids and other nonspectacle mounted aids
V2615	Telescopic and other compound lens systems
V2610	Single lens spectacle mounted low vision aids
V2797	Supply of low vision aids (dispense low vision aid)
V2799	Vision services, miscellaneous (frames, lenses, special services)

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

+ Indicates a code(s) requiring an additional character

ICD-10-CM Code
Refer to https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies/vision-services-clinical-coverage-policies for a current list of applicable ICD-10-CM codes.

Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
Original approval date	01/21	06/21
Reviewed CPT and HCPCS codes.	03/22	05/22
Annual Review. Reviewed CPT and HCPCS codes.	02/23	02/23
NCHC verbiage removed from NC Guidance Verbiage	04/23	04/23
Annual Review. Reviewed CPT and HCPCS codes.	02/24	02/24
Health Choice and Medicaid for Pregnant Women verbiage removed from policy.		

References

1. State of North Carolina Medicaid Clinical Coverage Policy No: 6A Routine Eye Examination and Visual Aids for Beneficiaries Under 21 years of Age. Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov). Published May 1, 2024. Accessed May 30, 2024.

North Carolina Guidance

Eligibility Requirements

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

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.

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/

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.

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).

Claims-Related Information
Provider(s) shall comply with the NC Tracks 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 - as applicable to the service provided:
   Professional (CMS-1500/837P transaction)
   Institutional (UB-04/837I transaction)
   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.
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.
   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 - Providers shall follow applicable modifier guidelines.
e. Billing Units - Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).
f. Co-payments -
   For Medicaid refer to Medicaid State Plan:
   https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

g. Reimbursement - Provider(s) shall bill their usual and customary charges. For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.