

The Department of Vermont Health Access Medical Policy

Subject: Eyeglasses and Vision Care Services

Last Review: 1/10/2011

Revision 3:

Revision 2:

Revision 1: 7/14/09

Original Effective: 2004

Description of Service or Procedure

Eyewear and vision care services are those services requiring the application of theories, principles and procedures related to vision and vision disorders for the purpose of diagnosis and treatment, including lenses, frames, other aids to vision, and therapeutic drugs. The definition is consistent with the federal definition of services found at CFR 440.60(a), 440.120(d), and 441.30.

- Eyewear includes eyeglass frames, lenses, contact lenses and other aids to vision.
- Vision care services include routine eye exams, diagnostic tests and fitting fees.

Disclaimer

Coverage is limited to that outlined in Medicaid Rule that pertains to the Beneficiary's Aid Category. Prior Authorization is only valid if the beneficiary is eligible for the applicable item or service on the date of service.

- Coverage of eyewear is limited to eligible beneficiaries under the age of 21.
- Vision care services are provided to eligible beneficiaries of any age.

Medicaid Rule

[7102.2](#) Prior Authorization Determination

[7103](#) Medical Necessity

[7316](#) Eyeglasses and Vision Care Services

Medicaid Rules can be found at <http://humanservices.vermont.gov/on-line-rules>



Coverage Position

Vision care services and devices may be covered for those individuals of any age who:

- When this service is provided by a licensed medical provider enrolled in the Vermont Medicaid program who is knowledgeable in vision care services and devices and who provides vision care services to the beneficiary, AND
- Who meet the clinical guidelines below.

Coverage Guidelines

Eyeglasses (frames and lenses), are provided by the State of Vermont's sole source contractor, and are covered for beneficiaries under the age of 21.

Lenses may be placed in the beneficiary's own frames if the lenses can be incorporated safely and reasonably into those frames, as determined by the sole source contractor. If there is a medical reason for purchasing frames outside of the contract, the lenses will also need to be authorized for beneficiaries under the age of 21.

A prior authorization is required for the following:

- Contact lenses for optimum management of ocular conditions such as aphakia, keratinous, or corneal transplant. A single lens and not a pair are considered one unit.
- Special lenses
- Photosensitive lenses
- A repeat comprehensive visual analysis within the 24 month limit
- Replacement of frames or lenses, other than those that are broken or lost, within a 24 month period.

Clinical guidelines for repeat service or procedure

Earlier replacement is limited to the following circumstances.

- When eyeglasses (frames or lenses) have been lost, broken beyond repair, or scratched to the extent that visual acuity is compromised. Dispensing providers will make the clinical determination, and document reason, in regards to eyeglasses (frames or lenses) being broken beyond repair or visual acuity being compromised.
- When a change of at least one-half diopter in lens strength is documented by the dispensing provider on the Medicaid order form (OVHA 60).

Type of service or procedure not covered (this list may not be all inclusive)

- Eyeglasses (frames and/or lenses) purchased outside of the department's sole-source contract are not covered.
- Fitting fees for beneficiaries age 21 and older.
- Transition lenses ©

References

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Code of Federal Regulations,

- Medical or other remedial care provider by licensed practitioners - 440.60 (a)
- Prescribed drugs, dentures, prosthetic devices, and eyeglasses – 440.120 (d)
- Optometric services – 441.30

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