Optometrist, Optician and Optical Business

Policy

The Nevada Medicaid Ocular program reimburses for medically necessary ocular services to eligible Medicaid recipients under the care of the prescribing practitioner. Providers shall follow current national guidelines, recommendations and standards of care.

Please see the Medicaid Services Manual (MSM) Chapter 1100, Ocular Services for complete policy, coverage and limitations.

See MSM Chapter 1500, Healthy Kids Program (EPSDT).

For Nevada Check Up covered services, service limitations and prior authorization requirements, refer to the Nevada Check Up Manual on the Division of Health Care Financing and Policy (DHCFP) website.

Covered Services/Supplies

For recipients of all ages, Medicaid covers:

- Routine eye exams including prescription for corrective lenses (this includes non-medical complaints such as blurred vision, nearsightedness, farsightedness, and astigmatism)
- Eye exams due to medical conditions of the eye (such as infections, foreign body, glaucoma, cataract services)
- Ocular prosthesis
- Vision therapy
- Qualifying eyeglass lenses and frames with a prescription
- Polycarbonate lenses

See MSM Chapter 1100 on the DHCFP website for a complete list of Medicaid covered services, limitations and prior authorization requirements.

Non-Covered Services/Supplies

For recipients of all ages, Medicaid does not cover:

- Sunglasses
- Eyeglass case
- Cosmetic lenses
- Frames with ornamentation
- Frames that attach to or act as a holder for hearing aid(s)
- Contact lenses are not covered unless (1) required to bring vision to the minimum criteria to avoid legal blindness, (2) medically indicated after cataract surgery or (3) the necessary means for avoiding heavy eyeglasses.

Frames:

If the recipient selects a frame with a wholesale cost greater than the Medicaid allowable, he/she will be responsible for the additional amount. The recipient's agreement to make payment must be in writing and the provider must retain a copy of the agreement in the recipient's medical record.

Lenses:

If the recipient selects a lens option not covered by Medicaid, he/she is then responsible for payment only of the non-covered options. Medicaid pays the lens cost minus the cost of options. Non-covered options must be listed separately on the invoice.

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Prior Authorization (PA) Requirements

Prior authorization is required for:

- Ocular prosthesis (Procedure codes V2624 and V2628 require prior authorization when service limits are exceeded. The service limit for V2624 is once every 12 months per eye per recipient. The service limit for V2628 is once every 60 months per eye per recipient.
- For eyeglasses, recipients age 21 and older require PA if the 12-month limitation is exceeded. This includes procedure code V2784 for polycarbonate lenses. The service limit for V2784 is 2 units per 12 months.
- Vision therapy (Current Procedural Terminology (CPT) code 92065)
- Contact lens fitting (CPT code 92310)
- Ocular examinations performed for medical conditions are considered a regular physician visit. Use E/M CPT codes.
- For recipients age 21 and older, eye tests completed for the diagnosis/monitoring of medical conditions (CPT codes 92020, 92081, 92082, 92083) and sensorimotor exams for the testing of ocular deviations (CPT code 92060) require prior authorization after limitations have been met. Service limitations are 3 examinations every 12 months.
- Prior authorization is required for the following codes delivered to individuals age 21 and older when the service limit is exhausted. The service limitation is one (1) visit every 12 months:

92002	Eye exam new patient, intermediate
92004	Eye exam new patient, comprehensive
92012	Eye exam established patient, intermediate
92014	Eye exam established patient, comprehensive
92015	Determine refractive state
92018	Eye exam under general anesthesia, complete
92019	Eye exam under general anesthesia, limited
V2020	Frames, purchases

Service Groups: Multiple claims from a single service group may not be billed within a 12-month rolling period unless a PA is submitted and approved. Recipients under age 21 are exempt from this requirement.

- Procedure codes 92002, 92004, 92012, 92014, 92018 and 92019

Providers may use the Authorization Criteria search function in the Provider Web Portal at www.medicaid.nv.gov to verify which services require authorization, as well as the Treatment History function in the Electronic Verification System (EVS) portal to determine if service limitations have been met.

Submit prior authorization requests through the Nevada Medicaid Provider Web Portal as an Ocular/Retro Ocular (if applicable) Process Type. The Ocular Services or Medical Nutrition Therapy Services Prior Authorization Request (form FA-9) must be completed and submitted with your PA request.

When submitting a PA for lenses that are provided bilaterally and the same code is used for both lenses, submit each item on two separate PA lines using the right (RT) and left (LT) modifiers and 1 unit of service on each line.

If you have questions regarding coverage, PA requirements or a recipient's eligibility for a service, contact Nevada Medicaid at (800) 525-2395.

Authorization does not guarantee payment of a claim. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program.

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Rates

Rates information is on the DHCFP website at http://dhcfp.nv.gov (select "Rates" from the "Resources" menu). Rates are available on the Provider Web Portal at www.medicaid.nv.gov through the Search Fee Schedule function, which can be accessed on the Electronic Verification System Provider Login (EVS) webpage under Resources (you do not need to login). Any provider-specific rates will not be shown in the Search Fee Schedule function.

Billing Instructions

List each non-covered ocular service/supply on its own claim line. This allows Medicaid to track all services/supplies received by the recipient. See the EVS User Manual Chapter 3 Claims for billing instructions.

NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: If an eye exam was referred through a Healthy Kids Screening, enter the name of the referring physician on the claim.

PROCEDURES, SERVICES, OR SUPPLIES: When dispensing optical supplies, specify spectacle services using CPT codes 92340-92371 and supply of materials using HCPCS codes V2100-V2799 (non-covered codes in this range are V2744, V2756, V2761, V2788 and V2702).

DAYS OR UNITS: When lenses are provided bilaterally and the same code is used for both lenses, bill each item on two separate claim lines using the RT and LT modifiers and 1 unit of service on each claim line. If a prior authorization has been obtained, the claim must match the approved PA.

PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #: Claims for prosthetic eye supplies are paid under provider type 41. Enter your Optical Business NPI in this field when billing for prosthetic eye supplies (HCPCS codes V2623-V2629).