CHAPTER 24-000 VISUAL CARE SERVICES

24-001 Definitions

Eyeglasses: A set of both lenses and a frame, used to correct deficiencies in vision.

Simple Photophobia: A photophobia condition which is not caused by a disease or other significant health issue. Also referred to as a sensitivity.

24-002 Provider Requirements

24-002.01 General Provider Requirements: To participate in the Nebraska Medical Assistance Program (Medicaid), providers of visual care services shall comply with all applicable participation requirements codified in 471 NAC Chapters 2 and 3. In the event that participation requirements in 471 NAC Chapters 2 or 3 conflict with requirements outlined in this 471 NAC Chapter 24, the participation requirements in 471 NAC Chapter 24 shall govern.

24-002.02 Service Specific Provider Requirements: To participate in Medicaid, providers of visual care services shall:

i. Be enrolled in Nebraska Medicaid by complying with the provider agreement requirements included in 471 NAC 24-002.02A;
ii. Be licensed to practice by the Nebraska Department of Health and Human Services, or if the service is provided in another state, by the other state;
iii. Practice within their scope of practice as defined in Neb. Rev. Stat. Sections 38-2601 to 38-2623, or if the service is provided in another state, within the scope of practice as defined by the licensing laws of the other state;
iv. Comply with all applicable state and federal laws and regulations governing the provision of their services.

24-002.02A Provider Agreement: Providers of visual care services shall complete and sign Form MC-19, "Medical Assistance Provider Agreement," (see 471-000-90) and submit the completed form to the Department for approval to participate in Medicaid.

24-002.02B Contact Lens Services: Only providers whose licensure allows prescription, fitting, and supervision of adaptation, will be approved for payment of contact lenses.

24-003 Service Requirements

24-003.01 General Requirements

24-003.01A Medical Necessity: Vision services must be provided in accordance with the medical necessity guidelines outlined in 471 NAC 1-002.02A.

24-003.01B Services Provided for Clients Enrolled in the Nebraska Medicaid Managed Care Program: See 471 NAC 1-002.01.

24-003.01C HEALTH CHECK (EPSDT) Treatment Services: See 471 NAC Chapter 33.

24-003.02 Covered Services: Medicaid covers medically necessary and appropriate visual care services within program guidelines.

24-003.02A Examination, Diagnostic, and Treatment Services: Medicaid covers eye examinations, diagnostic services, and other treatment services within program guidelines when medically necessary and appropriate to diagnose or treat a specific eye illness, symptom, complaint or injury.

24-003.02A1 Eye Examinations

24-003.02A1a Clients Age 20 and Younger: Medicaid covers eye examinations for clients age 20 and younger once every 12 months, to the day. More frequent exams will be covered if medically necessary and appropriate to diagnose or treat a specific eye illness, symptom, complaint or injury.

24-003.02A1b Clients Age 21 and Older: Medicaid covers eye examinations for clients age 21 and older once every 24 months, to the day. More frequent eye examinations will be covered when medically necessary and appropriate to diagnose or treat a specific eye illness, symptom, complaint or injury.

24-003.02A2 Vision Therapy: Medicaid covers vision therapy (orthoptics) when medically necessary and reasonable. Vision therapy is limited to a maximum of 22 sessions.

24-003.02B Frames: Medicaid covers one pair of eyeglass frames every 24 months, to the day, when either of the two following conditions is met:

i. Required for one of the following medical reasons –
   a. The client's first pair of prescription eyeglasses;
   b. Size change needed due to growth; or
   c. A prescribed lens change, only if new lenses cannot be accommodated by the current frame.
ii. The client's current frame is no longer useable due to irreparable wear/damage, breakage, or loss.

24-003.02B1 Clients Age 20 and Younger: For clients age 20 and younger, Medicaid covers frames more frequently if medically necessary and appropriate.

24-003.02B2 Frame Specifications: The following specifications apply to all eyeglass frames:

a. Plastic and metal frames are covered; rimless frames are not covered;
b. Discontinued frames with new prescription lenses are not covered; and
c. Frame cases are covered with new eyeglasses.

24-003.02B3 Billing Clients for Frames: Clients may choose to purchase their own frames on a private pay basis. Charges to clients for a frames purchased privately must include the associated fitting charge.

24-003.02B4 Frame Repair: Medicaid covers frame repair if less costly than providing a new frame and if the repair would provide a serviceable frame for the client. Applicable manufacturer warranties are considered to be a third party resource, and must be utilized in accordance with 471 NAC 3-004.

24-003.02B5 Frame Replacement: Replacement of frames which are irreparable due to wear/damage, breakage or loss, is limited to once per 12-month period, for clients age 21 years and older.

24-003.02C Lenses: Medicaid covers one pair of eyeglass lenses every 24 months, to the day, when either of the two following conditions is met:

i. Required for the following medical reasons –
   a. The client's first pair of prescription eyeglasses;
   b. Size change needed due to growth; or
   c. New lenses are required due to a new prescription when the refraction correction meets one of the following criteria (A copy of the former and current prescriptions must be maintained in the provider's records.):
      1. A change of 0.50 diopters in the meridian of greatest change when placed on an optical cross;
      2. A change in axis in excess of 10 degrees for 0.50 cylinder, 5 degrees for 0.75 cylinder; or
      3. A change of prism correction of ½ prism diopter vertically or 2 prism diopters horizontally or more.
ii. The client's current lenses are no longer useable due to damage, breakage, or loss.

When one lens meets the criteria for coverage, both lenses may be provided, unless the prescribing practitioner specifies replacement of one lens only.

24-003.02C1 Clients Age 20 and Younger: For clients age 20 and younger, Medicaid covers lenses more frequently if medically necessary and appropriate.

24-003.02C2 Specifications for Lenses: The following specifications apply to all eyeglass lenses -

a. Lenses are covered only if the refraction correction is at least 0.50 diopters in any meridian;
b. Lenses may be plastic or glass. For special lens material, see 471 NAC 24-003.02C3;
c. All plastic lenses must include front surface scratch resistant coating (factory applied or "in-house" dipped). The cost for the scratch resistant coating must be included in the lens cost and is not billed under a separate procedure code. The laboratory invoice must indicate that the scratch resistant coating was provided Medicaid does not require that lenses with scratch resistant coating be warranted;

d. Lenses must be of a quality at least equal to Z-80 standards of the American National Standard Institute; and
e. All lenses dispensed must be prescribed by a licensed practitioner. A copy of the prescribing practitioner's original prescription must be maintained in the provider's records and must be readily available for review by the Department upon request.

24-003.02C3 Special Lens Features and Lab Procedures: Medicaid coverage limitations are as follows;

a. Anti-reflective and mirror lens coating - not covered.
b. Bifocal and trifocal segments exceeding 28mm - covered only if necessary for specific employment or educational purposes, or due to a specific disability which limits head and neck movement.
c. Blended and progressive multifocal lenses - not covered.
d. Drilling, notching, grooving, faceting of lenses - not covered.
e. Edging or beveling of lenses for cosmetic reasons - not covered.
f. Engraving - not covered.
g. High index lenses - covered only if the refraction correction is at least +/- 10.00 diopters in meridian of greatest power when placed on an optical cross.
h. Myodisc lenses - covered only if prescribed.
i. Nylon cord, metal cord, or rimless mount - covered only if the client purchases own frame or uses previously purchased frame.
j. Oversize lens charges - covered only if:
    i. Medically necessary (e.g., narrow interpupillary distance or unusual facial configuration); or
    ii. The client purchases his/her own frame or uses previously purchased frame.
k. Photochromatic and transition tints - not covered.
l. Polycarbonate (standard) lenses - covered for children. For adults, covered only if prescribed for clients with significantly monocular vision (e.g., due to amblyopia, eye injury, eye disease, or other disorder).
m. Polycarbonate (thin) lenses - covered for clients age 20 and younger. For clients age 21 and older, covered only if the refraction correction is at least +/- 8.00 diopters in the meridian of greatest power when placed on an optical cross.
n. Roll and polish edges - not covered.
o. Scratch resistant coating - see 471 NAC 24-003.02C2c for lens coating requirements. Additional scratch resistant coating is not covered.
p. Slab-off prism - covered only if there is at least 3.00 diopters of anisometropia in the vertical meridian.
q. Special base curve - covered only if prescribed for aniseikonia.
r. Tint - covered only for chronic disorders which cause significant photophobia under indoor lighting conditions. Simple "photophobia" is not an accepted diagnosis for coverage. Photochromatic tints and sunglasses are not covered.
s. Ultraviolet (UV) lens coating - covered only for chronic disorders that are complicated or accelerated by ultraviolet light.

24-003.02C4 Billing the Client for Lenses: The provider may bill the client for non-covered lens tints under the following conditions:

a. The client has been notified by the provider in writing that Medicaid will not cover the lens tint; and
b. The client voluntarily agrees to reimburse the provider for the lens tint on a private pay basis.

Providers are expressly prohibited from billing Medicaid for lenses that are not provided to the client. If non-covered lens features or lab procedures other than non-covered tints are desired by clients, they must purchase their own lenses on a private pay basis. The charge for lenses furnished on a private pay basis must include the associated portion of the fitting charge.

24-003.02C5 Lens Replacement: Replacement of lenses which are irreparable due to wear/damage, breakage or loss, is limited to once per lens in 12 month period, for clients age 21 years and older.

24-003.02D Eyeglass Fitting: Medicaid covers fitting of eyeglasses associated with provision Medicaid covered lenses and/or frames to a Medicaid client. Fitting includes:

1. Measurement of anatomical facial characteristics;
2. Writing of laboratory specifications;
3. Ordering eyeglasses;
4. Verifying order once received;
5. Final adjustment of the eyeglasses to the visual axes and anatomical topography;
6. Dispensing; and,
7. Any associated overhead (including shipping and postage charges).

24-003.02E Contact Lens Services: Contact lens services include prescription, fitting, supervision of adaptation, and supply of contact lenses. Medicaid covers contact lens services only when prescribed for clients with:

i. Keratoconus;
ii. Aphakia (excluding pseudophakia);
iii. High plus corrections of +12.00 diopters (spherical equivalent) or greater due to the visual field defect caused by a high plus correction;
iv. High minus corrections of -12.00 diopters (spherical equivalent) or greater, but only with an increase in binocular best visual acuity of at least 2 Snellen lines when comparing the contact lenses to the spectacle lens correction;
v. Anisometropia (difference in correction) of at least 6.00 diopters (spherical equivalent) in order to avoid double vision; or
vi. Other pathological conditions of the eye when useful vision cannot be obtained with eyeglasses.

24-003.02E1 Replacement of Contact Lenses: Covered when required due to loss, damage or for prescription changes when the client's condition meets the criteria for Medicaid coverage as outlined in 471 NAC 24-003.02E(i)-(vi) directly above.

24-003.03 Non-Covered Services: The following services are not covered by Medicaid:

24-003.03A Eyeglasses:

1. Sunglasses;
2. Multiple pairs of eyeglasses for the same individual;
3. Non-spectacle mounted aids, hand-held or single lens spectacle mounted low vision aids, and telescopic and other compound lens systems (including distance vision telescopic, near vision telescopes and compound microscopic lens systems); and
4. Replacement insurance.

24-003.03B Contact Lenses:

1. Medicaid does not cover contact lenses when prescribed for routine correction of vision.
2. Medicaid does not cover disposable contact lenses.

24-004 Billing and Payment for Visual Care Services

24-004.01 Billing

24-004.01A General Billing Requirements: Providers shall comply with all applicable billing requirements codified in 471 NAC Chapter 3. In the event that billing requirements in 471 NAC Chapter 3 conflict with billing requirements outlined in this 471 NAC Chapter 24, the billing requirements in 471 NAC Chapter 24 shall govern.

24-004.01B Specific Billing Requirements

24-004.01B1 Billing Requirements: Providers shall bill Medicaid for visual care services on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49), and in accordance with the Billing Instructions included in Appendix 471-000-65.

24-004.01B2 Usual and Customary Charge: The provider or the provider's authorized agent shall submit the provider's usual and customary charge for services rendered. The provider's total charge for services may not exceed the provider's usual and customary charge.

24-004.01B3 Non-Covered Items or Services: If the provider furnishes items (frames, lenses, etc.) or services not covered by Medicaid, on a private basis, the client must pay the full charge of the items or services. The provider is prohibited from billing Medicaid for any portion of the non-covered items or services.

24-004.02 Payment

24-004.02A General Payment Requirements: Medicaid will reimburse the provider for services rendered in accordance with the applicable payment regulations codified in 471 NAC Chapter 3. In the event that payment regulations in 471 NAC Chapter 3 conflict with

payment regulations outlined in this 471 NAC Chapter 24, the payment regulations in 471 NAC Chapter 24 shall govern.

24-004.02B Specific Payment Requirements

24-004.02B1 Reimbursement: Medicaid pays for covered visual care services in an amount equal to the lesser of:

a. The provider's submitted charge; and
b. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule (see 471-000-524) in effect on the date the service was rendered by the provider.

24-004.02B2 Medicare/Medicaid Crossover Claims: For payment of Medicare/Medicaid crossover claims, see 471-000-70.

24-004.02B3 Copayment: For Medicaid copayment requirements, see 471 NAC 3-008.

24-004.02B4 Payment for Eye Exams: Eye examinations provided primarily for the purpose of prescribing, fitting, or changing eyeglasses for refractive errors are reimbursed at the Medicaid fee schedule allowable for intermediate level general ophthalmological services, as defined in the American Medical Association's Physicians' Current Procedural Terminology (CPT). Determination of the refractive state is reimbursed separately from examination services.

24-004.02B5 Vision Therapy Training: Payment for vision therapy training includes all equipment and supplies necessary for home use.