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.

CHAPTER 24-000 VISUAL CARE SERVICES

24-001 Standards for Participation: To participate in the Nebraska Medical Assistance Program (NMAP), providers of visual care services shall meet any applicable state and federal laws and regulations governing the provision of their services. Optometrists must be licensed by the Nebraska Department of Health and Human Services Regulation and Licensure. If optometric services are provided outside Nebraska, the optometrist must be licensed in that state.

24-001.01 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 NMAP.

24-002 Covered Services: NMAP covers medically necessary and appropriate visual care services within program guidelines.

24-002.01 Services Provided for Clients Enrolled in the Nebraska Health Connection (NHC): Certain NMAP clients are required to participate in the Nebraska Medicaid Managed Care Program known as the Nebraska Health Connection (NHC). See 471-000-122 for a listing of the NHC plans.

24-002.01A Health Maintenance Organizations (HMO) Plans: The NHC HMO plans are required to provide, at a minimum, coverage of services as described in this Chapter. The prior authorization requirements, payment limitations, and billing instructions outlined in this Chapter do not apply to services provided to clients enrolled in an NHC HMO plan. Services provided to clients enrolled in an NHC HMO plan are not billed to NMAP. The provider shall provide services only under arrangement with the HMO.

24-002.01B Primary Care Case Management (PCCM) Plans: All NMAP policies apply to services provided to NHC clients enrolled in a PCCM plan. All services provided to clients enrolled in NHC PCCM plans are billed to NMAP.

All surgical procedures provided by an optometrist or ophthalmologist require approval from the PCCM plan. Providers shall contact the client's PCCM primary care physician (PCP) before providing surgical procedures. Non-surgical procedures provided by an optometrist or ophthalmologist do not require referral/approval by the PCP, however, when an optometrist or ophthalmologist diagnoses, monitors or treats a condition, except routine refractive conditions, the practitioner shall send the client's PCP a written summary of the client's condition and treatment/follow-up provided, planned or required.

24-003 Requirements and Limitations for Certain Services

24-003.01 Examination, Diagnostic, and Treatment Services: NMAP 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.

24-003.01A Eye Examinations

24-003.01A1 Clients Age 20 and Younger: NMAP covers annual eye examinations for clients age 20 and younger. More frequent exams will also be covered if needed to determine the existence of suspected conditions. Eye examinations are recommended beginning approximately age 3.

24-003.01A2 Clients Age 21 and Older: NMAP covers eye examinations for clients age 21 and older once every 24 months. More frequent eye examinations will also be covered when reasonable and appropriate. When billing for more frequent eye exams, the circumstances must be documented by the provider in the client's records.

24-003.01A3 Payment for Eye Exams: Eye examinations provided primarily for the purpose of prescribing, fitting, or changing eyeglasses for refractive errors are reimbursed at the NMAP 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.

24-003.01B Vision Therapy Training: NMAP covers vision therapy training (orthoptics) when medically necessary and reasonable. Vision therapy is limited to a maximum of 22 sessions. Providers shall bill per session using the appropriate CPT procedure code. Payment for vision therapy training includes all equipment and supplies necessary for home use.

24-003.02 Frames: NMAP covers a pair of eyeglass frames within a 24-month period when:

1. Required for 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.
2. The client's current frame is no longer useable due to irreparable wear/damage, breakage, or loss.

A pair of eyeglasses is covered for adults (21 and older) when one of the above conditions is met within a 24 month period.

When billing NMAP for frames, the provider must document the reason for the frame or use the appropriate indicator as outlined in claim submission instructions. Frames must be billed at the actual cost (including discounts) from the provider's frame supplier (see 471 NAC 24-005.02 for invoice requirements). The provider may also bill a separate charge for "eyeglass fitting" (see 471 NAC 24-003.05).

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

1. Plastic and metal frames are covered; rimless frames are not covered;
2. Discontinued frames with new prescription lenses are not covered; and
3. Frame cases are covered with new eyeglasses.

24-003.02B Billing the Client for Frames: Providers shall not make arrangements to furnish non-covered frames and bill NMAP with the difference or balance in cost being paid by the client or others. The client may choose to purchase his/her own frame. This arrangement must be on a private pay basis. The charge for a frame furnished on a private pay basis must include the associated fitting charge. NMAP may only be billed for the fitting charge associated with services billed to NMAP.

24-003.02C Frame Repair: NMAP 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 must be pursued for broken eyeglasses.

When billing NMAP for frame repair, the provider must bill at the provider's actual cost (including discounts) from the frame parts supplier (see 471 NAC 24-005.02 for invoice requirements). The provider may also bill a separate charge for "repair and refitting".

24-003.03 Lenses: NMAP covers a pair of eyeglass lenses within a 24-month period under the conditions listed below. When one lens meets the criteria for coverage, both lenses may be provided, unless the prescribing practitioner specifies replacement of one lens only.

1. 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.):
      i. A change of 0.50 diopters in the meridian of greatest change when placed on an optical cross;
      ii. A change in axis in excess of 10 degrees for 0.50 cylinder, 5 degrees for 0.75 cylinder;
      iii. A change of prism correction of ½ prism diopter vertically or 2 prism diopters horizontally or more; or
2. The client's current lenses are no longer useable due to damage, breakage, or loss.

For persons 21 and older, NMAP covers a pair of lenses within a 24 month period when anyone of the above medical reasons exist.

When billing NMAP for lenses, the provider must document the reason for the lenses or use the appropriate indicator as outlined in claim submission instruction. Lenses and all lens charges must be billed at the actual cost (including discounts) from the optical laboratory that fabricated the lenses (see 471 NAC 24-005.02 for invoice requirements.) The provider may also bill a separate charge for "eyeglass fitting" (see 471 NAC 24-003.05).

24-003.03A Specifications for Lenses: The following specifications apply to all eyeglass lenses –

1. Lenses are covered only if the refraction correction is at least 0.50 diopters in any meridian;
2. Lenses may be plastic or glass. For special lens material, see 471 NAC 24-003.03B;
3. 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. NMAP does not require that lenses with scratch resistant coating be warranted;
4. Lenses must be of a quality at least equal to Z-80 standards of the American National Standard Institute; and
5. 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.

24-003.03B Special Lens Features and Lab Procedures: NMAP coverage criteria for special lens features and lab procedures is outlined below. When billing NMAP for covered services, the diagnosis and/or circumstances which substantiate the need must be documented on or with the claim.

1. Anti-reflective and mirror lens coating - not covered.
2. 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.
3. Blended and progressive multifocal lenses - not covered.
4. Drilling, notching, grooving, faceting of lenses - not covered.
5. Edging or beveling of lenses for cosmetic reasons - not covered.
6. Engraving - not covered.
7. 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. (When billing for high index lenses, use procedure code modifier "22" with the lens procedure code.)
8. Myodisc lenses - covered if prescribed.
9. Nylon cord, metal cord, or rimless mount - covered only if the client purchases own frame or uses previously purchased frame.
10. Oversize lens charges - covered only if medically necessary (e.g., narrow interpupillary distance or unusual facial configuration) or if the client purchases his/her own frame or uses previously purchased frame.
11. Photochromatic and transition tints - not covered.
12. Polycarbonate (standard) lenses - covered only if prescribed for clients with significantly monocular vision (e.g., due to amblyopia, eye injury, eye disease, or other disorder). (When billing for polycarbonate lenses, use procedure code modifier "22" with the lens procedure code.)
13. Polycarbonate (thin) lenses - covered only if the refraction correction is at least +/- 8.00 diopters in the meridian of greatest power when placed on an optical cross. (When billing for polycarbonate lenses, use procedure code modifier "22" with the lens procedure code.)
14. Roll and polish edges - not covered.
15. Scratch resistant coating - see 471 NAC 24-003.04A3 for lens coating requirements. Additional scratch resistant coating is not covered.
16. Slab-off prism - covered only if there is at least 3.00 diopters of anisometropia in the vertical meridian.
17. Special base curve - covered only if prescribed for aniseikonia.
18. 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.
19. Ultraviolet (UV) lens coating - covered only for chronic disorders that are complicated or accelerated by ultraviolet light.

24-003.03C Billing the Client for Lenses: The items listed in 471 NAC 24-003.03B are considered to be an integral part of eyeglass lenses. When billing NMAP for lenses, providers shall not make arrangements to furnish more costly lenses or lenses with non-covered lens features or lab procedures with the difference or balance in cost being paid by the client or others. EXCEPTION: The provider may bill the client or others for non-covered lens tints under the following conditions:

1. The client has been notified by the provider in writing that NMAP will not cover the lens tint for his/her condition; and
2. The client voluntarily agrees to reimburse the provider for the lens tint on a private-pay basis.

If non-covered lens features or lab procedures other than non-covered tints are desired by the client, the client must purchase his/her 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. NMAP may only be billed for the fitting charge associated with services billed to NMAP.

24-003.04 Non-Covered Eyeglass Services: The following services are not covered by NMAP -

1. Sunglasses;
2. Multiple pairs of eyeglasses for the same individual (e.g., two pairs of eyeglasses in lieu of bifocals or trifocals in single frame); and
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.

24-003.05 Eyeglass Fitting: NMAP covers fitting of eyeglasses associated with provision of lenses and/or frames. Fitting includes: measurement of anatomical facial characteristics; writing of laboratory specifications; ordering eyeglasses; verifying order once received; final adjustment of the eyeglasses to the visual axes and anatomical topography; dispensing; and any associated overhead (including shipping and postage charges).

When billing NMAP for eyeglasses (lenses and frame), the provider may bill one charge for eyeglass fitting using the appropriate CPT procedure code. When billing for only lenses or frame, procedure code modifier "52" must be used with the appropriate eyeglass fitting procedure code.

24-003.06 Contact Lens Services: Contact lens services include prescription, fitting, supervision of adaptation and supply of contact lenses. NMAP covers contact lens services only when prescribed for clients with -

1. Keratoconus;
2. Aphakia (excluding pseudophakia);
3. High plus corrections of +12.00 diopters (spherical equivalent) or greater due to the visual field defect caused by a high plus correction;
4. 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;
5. Anisometropia (difference in correction) of at least 6.00 diopters (spherical equivalent) in order to avoid double vision; or
6. Other pathological conditions of the eye when useful vision cannot be obtained with eyeglasses.

Replacement of contact lenses is covered when required due to loss, damage or for prescription changes when the client's condition meets the criteria for NMAP coverage.

NMAP does not cover contact lenses when prescribed for routine correction of vision. NMAP does not cover disposable contact lenses. Only practitioners whose licensure allows prescription, fitting, and supervision of adaptation will be approved for payment of contact lenses.

When billing for contact lens services for clients with keratoconus or monocular aphakia, the provider shall list the diagnosis on the claim. When billing for contact lens services for other covered conditions, the provider shall submit the following documentation on or with the claim -

1. A description of the client's eye condition;
2. The client's best spectacle lens prescription and the visual acuity achieved with this correction in both eyes; and
3. The type of contact lenses prescribed.

Contact lenses must be billed at the provider's actual cost (including discounts) from the provider's lens supplier. The provider may also bill a separate charge for "prescription, fitting, and supervision of contact lenses" or "replacement of contact lens dispensing fee."

24-003.07 HEALTH CHECK (EPSDT) Treatment Services: Services not covered under the Nebraska Medical Assistance Program (NMAP) but defined in Section 1905(a) of the Social Security Act must meet the conditions of items 1 through 8 listed in the definition of "Treatment Services" in 471 NAC 33-001.04. These services must be prior authorized by the Medicaid Division.

24-004 Payment for Visual Care Services: The Nebraska Medical Assistance Program (NMAP) pays for covered visual care services at the lower of -

1. The provider's submitted charge; or
2. The allowable amount for that procedure code in the Nebraska Medicaid Practitioner Fee Schedule in effect for that date of service. The allowable amount is indicated in the fee schedule as -
   a. The unit value multiplied by the conversion factor;
   b. The invoice cost (indicated as "IC" in the fee schedule) - the provider's actual cost (including discounts) from the provider's supplier. The maximum invoice cost payable is limited to reasonable available cost;
   c. The maximum allowable dollar amount;
   d. For clinical laboratory services including collection of laboratory specimens by venipuncture or catheterization, 97.5 percent of the amount allowed for each procedure code in the national fee schedule for clinical laboratory services as established by Medicare; or
   e. The reasonable charge for the procedure as determined by the Medicaid Division (indicated as "BR" - by report or "RNE" - rate not established - in the fee schedule).

24-004.01 Revisions of the Fee Schedule: The Department may adjust the fee schedule to -

1. Comply with changes in state or federal requirements;
2. Comply with changes in national standard code sets, such as HCPCS and CPT;
3. Establish an initial allowable amount for a new procedure or a procedure which was previously identified as "RNE" or "BR" based on information that was not available when the fee schedule was established for the current year; and
4. Adjust the allowable amount when the Medicaid Division determines that the current allowable amount is -
   a. Not appropriate for the service provided; or
   b. Based on errors in data or calculation.

Providers will be notified of changes and their effective dates.

24-004.02 Medicare/Medicaid Crossover Claims: For payment of Medicare/Medicaid crossover claims, see 471 NAC 3-004.

24-004.03 Copayment: For Medicaid copayment requirements, see 471 NAC 3-008.

24-005 Billing Requirements: Providers shall bill NMAP for visual care services on the appropriate claim form or electronic format (see Claim Submission Table at 471-000-49).

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.

24-005.01 Procedure Codes: Providers shall use the appropriate CPT or HCPCS procedure codes when billing NMAP. HCPCS/CPT procedure codes used by NMAP are listed in the Nebraska Medicaid Practitioner Fee Schedule (see 471-000-524).

24-005.02 Invoice Requirements: Providers shall bill for all visual care supplies at the provider's actual cost (including discounts) from the provider's supplier. A copy of the purchase invoice from the provider's supplier must be submitted with the claim when procedure code modifier '22' is used with lens and frame procedure codes.

24-005.02A Lens Invoices: Lens invoices must include -

1. The name and address of the optical laboratory;
2. The charge(s) for lenses and any additional lab procedures or services; and
3. For plastic lenses, verification that the lenses include scratch resistant coating (see 471 NAC 24-003.03A3); and
4. The lens prescription.

The lens purchase invoice must be completed by the optical laboratory that fabricated the lenses. Only providers using their own non-independent full-service or finish labs may prepare or complete their own invoices. Price lists from all independent and non-independent optical laboratories must be available to the Department upon request.

24-005.02B Frame Invoices: The frame purchase invoice must be from the provider's frame supplier and must show the actual cost (including discounts) of the frame or frame part. If frames are ordered from the laboratory supplying the lenses, the frame cost must be listed on the lens invoice by the laboratory.