Optometrist, Optician and Optical Business

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:
- Exams (annual exams or exams for medical reasons)
- Ocular medical services (e.g., eye infection, foreign body in eye, glaucoma, cataract services)
- Ocular prosthesis
- Vision therapy
- Qualifying eyeglass lenses and frames

See Medicaid Services Manual (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.

If a Medicaid recipient selects non-covered frames/lenses, or frames/lenses over the Medicaid allowable cost, the recipient is responsible for the additional cost. The provider must retain a copy of the agreement for recipient payment in the recipient’s medical record.

Prior authorization (PA)
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
- Contact lens fitting (CPT code 92310)
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- Prior authorization is required for the following codes for age 21 and older when the limitation of once every 12 months is exceeded:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>92002</td>
<td>Eye exam new patient</td>
</tr>
<tr>
<td>92004</td>
<td>Eye exam new patient, comprehensive</td>
</tr>
<tr>
<td>92012</td>
<td>Eye exam established patient</td>
</tr>
<tr>
<td>92014</td>
<td>Eye exam and treatment for established patient, comprehensive, one or more visits</td>
</tr>
<tr>
<td>92015</td>
<td>Determine refractive state</td>
</tr>
<tr>
<td>92018</td>
<td>New eye exam and treatment, under general anesthesia</td>
</tr>
<tr>
<td>92019</td>
<td>Eye exam and treatment, limited</td>
</tr>
<tr>
<td>92020</td>
<td>Special eye evaluation</td>
</tr>
<tr>
<td>92060</td>
<td>Special eye evaluation</td>
</tr>
<tr>
<td>92081</td>
<td>Visual field examination(s)</td>
</tr>
<tr>
<td>92082</td>
<td>Visual field examination(s), intermediate</td>
</tr>
<tr>
<td>92083</td>
<td>Visual field examination(s), extended</td>
</tr>
<tr>
<td>V2020</td>
<td>Vision services, frames</td>
</tr>
</tbody>
</table>

To request PA for a service, complete and submit the Ocular Services or Medical Nutrition Therapy Services Prior Authorization Request (form FA-9). If you have questions regarding coverage, PA requirements or a recipient’s eligibility for a service, contact Nevada Medicaid at (800) 525-2395.

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 CMS-1500 Claim Form Instructions on the Nevada Medicaid website www.medicaid.nv.gov for complete, field-by-field claim form requirements.

**Field 17** (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 in Field 17 on the CMS-1500 claim form.

**Field 24D** (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 V2756, V2761, V2788 and V2702).
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Field 24G (DAYS OR UNITS): When submitting a claim for lenses, bill 1 unit for 1 lens, and 2 units for 2 lenses.

Field 33 (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).

Service Groups: The following service groups may not be billed within a 12-month period, i.e., code 92002 and code 92004 cannot be billed in the same 12-month period. Please see the groups of procedure codes below that cannot be billed together in the same 12-month period:

- Procedure codes 92002, 92004, 92012 and 92014.
- Procedure codes 92015, 92018, 92019, 92020, 92060, 92081, 92082 and 92083.