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.

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.

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
- Vision therapy (Current Procedural Terminology (CPT) code 92065)
- Contact lens fitting (CPT code 92310)

Optometrist, Optician and Optical Business

- Prior authorization is required for the following codes for age 21 and older when the limitation of once every 12 months is exceeded:

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

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

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 Electronic Verification System (EVS) 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 submitting a claim for lenses, bill 1 unit for 1 lens, and 2 units for 2 lenses.

Optometrist, Optician and Optical Business

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.