Medicaid Services Manual
Transmittal Letter

February 25, 2025

To: Custodians of Medicaid Services Manual

From: Casey Angres Casey Angres (Mar 4, 2025 08:23 PST)
Chief of Division Compliance

Subject: Medicaid Services Manual Changes
Chapter 1100 – Ocular Services

Background And Explanation

Revisions to Medicaid Services Manual (MSM) Chapter 1100 – Ocular Services are being revised to add language to clarify routine and medical eye examinations.

Throughout the chapter, grammar, punctuation and capitalization changes were made, duplications removed, acronyms used and standardized, and language reworded for clarity. Renumbering and re-arranging of sections was necessary.

Entities Financially Affected: None.

Financial Impact on Local Government: None.

These changes are effective February 26, 2025.

Material Transmitted	Material Superseded
MTL 04/25 MSM Chapter 1100 – Ocular Services	MTL 24/15, 26/23 MSM Chapter 1100 – Ocular Services

Manual Section	Section Title	Background and Explanation of Policy Changes, Clarifications and Updates
1103.1A	**Coverage and Limitations**	Grammar and language changes made for clarity.
1103.1A(1)(a-b)		Grammar and language changes made for clarity.
1103.1A(2)(a)	**Examinations**	Definition of routine eye examinations added.
1103.1A(2)(1)		Limitations and prior authorization requirements defined for routine eye examinations.
1103.1A(2)(b)		Definition of medical eye examinations added.
1103.1A(2)(b)(1)		Limitation language added based on medical necessity.

DIVISION OF HEALTH CARE FINANCING AND POLICY

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OCULAR SERVICES

1100 INTRODUCTION

The Nevada Medicaid Ocular program reimburses for medically necessary ocular services to eligible Medicaid recipients under the care of the prescribing practitioner. Such services shall maintain a high standard of quality and shall be provided within the limitations and exclusions described in this chapter.

All providers participating in the Medicaid program must offer services in accordance with the rules and regulations of the Medicaid program. Conditions of participation are available from Provider Support Services at Nevada Medicaid.

Ocular services are an optional benefit within the Nevada Medicaid Program.

All Medicaid policies and requirements (such as prior authorizations, etc.) are the same for Nevada Check Up (NCU), with the exception of areas where Medicaid and NCU policies differ. For further clarification, please refer to the NCU Manual, Chapter 1000.

1101 AUTHORITY

The citation denoting the amount, duration and scope of services are found in 42 Code of Federal Regulation (CFR) Part 440.200, and Sections 1902(a), 1902(e), 1905(a), 1905(p), 1915, 1920 and 1925 of the Social Security Act (SSA). CFR 440.225 and 441.30. Nevada State Plan Section 3.1, Pages 19, 216 and 27.

The State Legislature sets forth standards of practice for licensed professionals in the Nevada Revised Statutes (NRS) for the following Specialists:

- Physicians: NRS Chapter 630.375
- Optometry: NRS Chapter 636
- Dispensing Opticians: NRS Chapter 637

1102 RESERVED

1103 POLICY

1103.1 OCULAR SERVICES

1103.1A COVERAGE AND LIMITATIONS

Medicaid will reimburse for routine comprehensive ophthalmological examinations, refractive examinations of the eyes, and frames with a prescription for corrective lenses to eligible Medicaid recipients of all ages.

1. HEALTHY KIDS (Early and Periodic Screening, Diagnostic and Treatment) (EPSDT)

   a. Nevada Medicaid provides for vision screenings as referred by any appropriate health, developmental, or educational professional after a Healthy Kids Screening Exam. Optometrists and ophthalmologists may perform such exams without referral or prior authorization upon request or identification of medical need. "Medical Need" may be identified as any ophthalmological examination performed to diagnose, treat, or monitor any ophthalmological condition that has been identified during the Healthy Kids examination.

   b. Glasses may be provided at any time without prior authorization for Healthy Kids recipients, when there is a change in refractive status from the last documented exam, or when eyeglasses are broken or lost. Physician documentation must reflect a change and must be available for review in the time mandated by the federal government. Recipients enrolled in a Managed Care plan must access Healthy Kids ocular services through their Managed Care provider.

2. EXAMINATIONS

   a. Routine ocular examinations include the evaluation of vision and eye health to detect early signs of eye diseases and screening for refractive errors. Routine exams include diagnosis and treatment of non-medical complaints such as nearsightedness, farsightedness, and astigmatism, as well as prescriptions for corrective lenses when applicable.

      1. Routine examinations performed by an optometrist or ophthalmologist are covered for Medicaid recipients of all ages once every 12 months. Any exceptions require prior authorization.

   b. Medical ocular examinations include the evaluation and medically necessary testing to diagnose and treat medical conditions of the eyes, such as, but not limited to, glaucoma, conjunctivitis, and cataracts.

1. Ocular examinations performed by an optometrist for medical conditions within the scope of their license do not require a prior authorization. Current limitations are based on medical necessity.

2. Ocular examinations performed by an ophthalmologist for medical conditions do not require prior authorization and are considered a regular physician visit. Current limitations are based on medical necessity.

3. Following cataract surgery, if the recipient is Medicare eligible and requires eyeglasses, the provider must bill Medicare first and attach the Medicare Explanation of Benefits (EOB) to the claim for co-insurance and deductible.

3. LENSES

Lenses are covered for recipients of all ages. No prior authorization is needed for recipients under 21. For recipients 21 years of age or older, a prior authorization is required if the 12-month limitation is exceeded.

a. COVERED

The following are covered for Nevada Medicaid recipients of all ages as noted:

1. A change in refractive error must exceed plus or minus 0.5 diopter or 10 degrees in axis deviation in order to qualify within the 12-month limitation;

2. Lens material may be tempered glass tillyer grade or equivalent or standard plastic, at recipient's option;

3. Polycarbonate lenses;

4. Safety lenses when the recipient has vision in only one eye;

5. A single plano or balance lens is handled as if it were a corrective lens and so called "half glasses" are handled as if they were standard size corrective lenses;

6. Slab-off lenses, Prisms, Aspheric, Lenticular lenses;

7. "Executive" bifocals may be covered for children with: esotropia, and esophoria, accommodation, oculomotor dysfunction such as tracking and saccadic problems. Prior authorization is not required when using one of the above medical diagnoses;

8. Filters: PLS 40 filters when prescribed for patients with the following diagnoses: macular degeneration, retinitis pigmentosa, rod/cone dystrophy or

achromatopsia. In all these cases, the best uncorrected vision must test better than 20/200;

9. UV filters when prescribed following cataract surgery;

10. Bifocals and trifocals are reimbursable for a combination of any of the conditions at near or far point, including but not limited to esotropia, esophoria, cataracts, glaucoma, accommodative dysfunctions, nystagmus, stigmatism, myopia, presbyopia;

11. Double segment lenses required for employment which must be prior authorized;

12. Therapeutic contact lenses when prescribed for treatment of a medical condition;

13. Tints are covered when medically necessary;

14. Low vision aides such as telescopic lenses, magnifying glasses, bioptic systems and special inserts in regular lenses which must be prior authorized;

15. Scratch-proof coatings for plastic lenses are covered for EPSDT recipients.

b. NON-COVERED

The following are not covered:

1. Sunglasses and cosmetic lenses.

2. Contact lenses are disallowed unless their use is:

   a. The only means to bring vision to the minimum criteria required to avoid legal blindness; or

   b. Medically indicated following cataract surgery; or

   c. The necessary means for avoiding very heavy glasses which would hurt the bridge of the nose (e.g., where the correction is 9+ diopters in each eye). The necessary means for avoiding severe imbalance of the weight of glasses is where one eye is corrected to 9+ diopters and the other eye is 3+; or

   d. Required when the recipient has a diagnosis of Keratoconus.

3. Replacement of lenses, unless the patient has a significant change in refractive status.

4. Blended and progressive multi-focal lenses, “transitional lenses.”

5. Faceted lenses.

6. “Additional” Cost of an Extended Repair Replacement (ERR) warranty.

4. FRAMES

a. COVERED

1. Existing frames must be used whenever possible. If new frames are necessary, they may be metal or plastic, at the patient's option, up to Medicaid’s allowable cost.

2. Providers must stock a variety of frames to enable the recipient to choose a frame at no cost to them, if they so choose.

b. NON-COVERED

The following are not covered:

1. Frames with ornamentation.

2. Eyeglass frames which attach to or act as a holder for hearing aid(s).

5. OCULAR PROSTHETIC SERVICES

a. Ocular prosthesis is covered when medically necessary, allowing one per eye, per 60 months (five years).

b. Ocular prosthesis requires prior authorization. Please reference Medicaid Services Manual (MSM) Chapter 1300, Durable Medical Equipment (DME), for prior authorization guidelines.

c. A physician or optometrist must submit a referral for an ocular prosthesis, and the referral must be maintained in the recipient’s medical record.

d. Necessity for the procedure must include:

1. explanation of medical necessity for the prosthetic eye;

2. prior prosthetic eye history, if applicable; and

3. description and justification other than a pre-cast prosthesis.

e. For replacement of a prosthetic eye or sclera cover shell, one of the following justifications must be included:

1. accommodation for changes resulting from orbital development;

2. as necessary to prevent a significant disability;

3. when prior prosthesis was lost or destroyed due to circumstances beyond the recipient's control; or

4. when the prior prosthesis can no longer be rehabilitated.

f. Polishing/resurfacing of an ocular prosthesis is covered once each 12 months, per eye without prior authorization. If medical necessity exceeds limitations, a prior authorization is required.

g. If there is one paid claim historically for the same eye, right or left, medical necessity for a second claim within the 60-month period must include one of the following conditions:

1. socket growth or contracture;

2. lagophthalmos;

3. ptosis;

4. lower lid laxity;

5. entropion;

6. ectropion;

7. implant exposure; or

8. other conditions that can be improved or minimized with appropriate prosthetic modification.

h. Fabrication and fitting of an ocular conformer must include:

1. a written prescription by a physician or optometrist, and the prescription must be retained in the recipient's medical record;

2. medical necessity for the recipient; and

3. documentation of post-surgical use to prevent closure and/or adhesions between the orbit and eyelid during the healing process.

i. The recipient is responsible for general care and maintenance of the eye socket and prosthesis, as directed by the provider.

6. VISION THERAPY

Vision therapy is a covered Medicaid benefit and must be prior authorized by the Quality Improvement Organization (QIO)-like vendor.

1103.1B PROVIDER RESPONSIBILITY

1. Providers must confirm the recipient's eligibility by reviewing the current Medicaid card before providing services, or access eligibility via the Electronic Verification of Eligibility (EVE) system.

2. It is the provider's responsibility to ask the recipient if there is additional visual coverage through third party payers.

1103.1C RECIPIENT RESPONSIBILITY

Services requested by the recipient but for which Medicaid makes no payment are the responsibility of, and may be billed to, the recipient. Nevada Medicaid recipients are only responsible for payment of services not covered by Medicaid, such as eyeglass extras. Prior to service, the recipient must be informed in writing and agree in writing he/she will be responsible for payment.

1. The recipient is responsible for presenting a valid Medicaid card to the examiner and/or optician.

2. The recipient is responsible for presenting any form or identification necessary to utilize other health insurance coverage.

3. If the recipient selects a frame with a wholesale cost greater than the Medicaid allowable, they will be responsible for the additional amount. The recipient's agreement to make payment must be in writing. A copy of the agreement must be retained in the recipient's chart. The Nevada Medicaid Surveillance and Utilization Review Unit (SUR) conducts a regular review of claims history to monitor this.

4. 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. Claims will be returned to providers for correction.

5. If the recipient chooses an ERR warranty which is not covered by Medicaid's payment, he/she is responsible for warranty payment.

6. The recipient is responsible for making and keeping appointments with the doctor.

7. The recipient is responsible for contacting the provider of the eyeglasses (if different from the examiner) for fitting and delivery.

8. The recipient is responsible for picking up the eyeglasses and returning for any necessary adjustments within the time allotted for such adjustments. (Medicaid will not pay for office visits for adjustments. The provider is expected to make reasonable adjustments and repair, without charge).

9. UNCLAIMED EYEGLASSES

   The recipient has 15 days to claim eyeglasses reimbursed by Nevada Medicaid. If after 15 days, the item is still held by the provider:

   a. The provider shall notify the appropriate district office.

   b. The caseworker attempts to contact the recipient and make arrangements to claim the eyeglasses.

      If the caseworker is unable to contact the recipient or the recipient refuses to claim the eyeglasses, the worker advises the Nevada Medicaid Office (NMO) and notifies the provider the item will not be picked up, NMO then notifies Utilization Control for a possible restriction of the recipient's medical services.

   c. Following notification, the item will remain unclaimed, provider may submit a bill in the normal fashion to the Nevada Medicaid fiscal agent.

1104 HEARINGS

Please reference MSM Chapter 3100, for the Medicaid Recipient Hearings process.