

**PROVIDER BULLETIN****No. 05-15**

July 11, 2005

TO: Vision Care Providers in the Nebraska Medicaid Program

FROM: Mary Steiner, Medicaid Administrator

BY: Janeen Berg, RN, Program Specialist, Vision

RE: Eyeglass Replacement, Eye Examination, Vision Condition Codes, and Lens Tints

Nebraska Medicaid providers are responsible for providing visual care services within Medicaid criteria, and are accountable for submitting accurate information on the claim. Post-payment review of vision claims is performed for review of activities related to the kind, amount and frequency of services billed to the Department of Health and Human Services-Finance and Support to ensure that funds are spent only for medically necessary and appropriate services covered by Nebraska Medicaid rules and regulations. All Nebraska Medicaid providers are encouraged to review coverage criteria and billing instructions in their Nebraska Medicaid Vision Provider Handbooks.

EYEGLASS FRAMES

Eyeglass frames are covered under the following criteria. There is not an automatic annual or other time-framed replacement for eyeglasses for Medicaid clients.

471 NAC 24-003.02 Frames: NMAP(Nebraska Medical Assistance Program/Medicaid) covers eyeglass frames 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. Replacement of frames is limited to one per year for clients 21 years and older.

When billing NMAP for frames, the provider must document the reason for the frame with a vision condition code as outlined in claim submission instructions.

EYEGLASS LENSES

Eyeglass lenses are covered under the following criteria. There is not an automatic annual or other time-framed replacement for lenses for Medicaid clients.

471 NAC 24-003.03 Lenses: NMAP covers eyeglass lenses 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. If the client received his prior lens prescription from another provider, validate the previous lenses prescription strength in your office and document):
 - 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. Replacement of lenses is limited to once per year for clients 21 years or older.

When billing NMAP for lenses, the provider must document the reason for the lenses by using the appropriate vision condition code as outlined in claim submission instruction.

VISION CONDITION CODES (For frames and lenses)

471 NAC 471-000-65 Nebraska Medicaid Billing Instructions for Visual Care Services:

Field 24K. Reserved for Local Use: When billing for lenses and frames, enter the appropriate **vision condition code** to document the reason.

L1—General standard of 20 degree or 0.5 diopter sphere or cylinder change met

- (Note: The L1 code cannot be used if the client does not have an eye exam at the time of the lenses replacement; but in order to perform the eye exam the client needs to be eligible for their 24 month exam for clients age 21 and older; or 12 month exam for children ages 20 and younger .)

L2—Replacement due to loss or theft

L3—Replacement due to breakage or damage

L5—Replacement due to medical reason

- (The L5 code should seldom be needed, some examples are: Client has had facial surgery due to

cancer and needs a new size of frame; client had change in facial size and needs new frame due to growth.)

EYE EXAMINATIONS

An additional area of concern is the frequency of **eye examinations** provided to Nebraska Medicaid eligible clients. NMAP coverage criteria for eye exams is as follows: 471 NAC 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.

LENS TINTS

Another policy requiring clarification is Nebraska Medicaid's coverage of **lens tints**. Nebraska Medicaid covers tint only for chronic disorders under indoor lighting conditions. Simple "photophobia" is not an accepted diagnosis for coverage. Photochromatic tints and transition tints are not covered (471-NAC 24-003.03B). Medicaid policy allows for one exception for clients to pay for tints that are stationary, constant tints only (not transitional tints). The client cannot pay for the difference between non-tinted lenses and transitional lenses. If the client prefers transitional lenses, they must pay for the total cost of the lenses and the fitting fee (471 NAC 24-003.03C).

For additional questions or clarification of this Provider Bulletin, please contact Janeen Berg, RN Program Specialist at (402) 471-9342.