

## Nebraska Specific Information

This document contains information specific to the State of Nebraska. Please refer to the Provider Reference Guide for general information regarding plan administration.

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## 1.1 Notice of Updates

Notice of updates published January 2024.

- Molina Healthcare of Nebraska Ages 20 and Under (Medicaid) added effective 01/01/2024.
- Molina Healthcare of Nebraska Ages 21 and Older (Medicaid) added effective 01/01/2024.

1.2 Covered Benefits – Molina Healthcare of Nebraska Ages 20 and Under (Medicaid)

Plan ID(s): M-NE-M20

Benefit	Benefit Limitations/Criteria
Exam	<ul style="list-style-type: none"> <li>▪ 1 exam every 12 months.</li> <li>▪ More frequent exams will be covered if medically necessary.</li> </ul>
Exam Replacement	<ul style="list-style-type: none"> <li>▪ Covered as needed if glasses are lost, damaged or size change due to growth and it is not possible to return to or obtain the prescription from the previous provider.</li> </ul>
Necessary Medical Services	<ul style="list-style-type: none"> <li>▪ Covered as needed when services are performed by an optometrist and are within the scope of licensure.</li> <li>▪ Vision therapy and orthoptics is limited to 22 sessions.               <ul style="list-style-type: none"> <li>▪ Payment for vision therapy includes all equipment and supplies necessary for home use.</li> </ul> </li> </ul>
Frame	<ul style="list-style-type: none"> <li>▪ 1 unit every 12 months, to the day, when either of the two following conditions is met:               <ul style="list-style-type: none"> <li>▪ Required for one of the following medical reasons:                   <ul style="list-style-type: none"> <li>▪ The member's first pair of prescription eyeglasses;</li> <li>▪ Size change needed due to growth; or</li> <li>▪ A prescribed lens change, only if new lenses cannot be accommodated by the member frame.</li> </ul> </li> <li>▪ The member's current frame is no longer useable due to irreparable wear/damage, breakage or loss.</li> </ul> </li> <li>▪ The following specifications apply to all frames:               <ul style="list-style-type: none"> <li>▪ Plastic and metal frames are covered; rimless frames are not covered.</li> <li>▪ Discontinued frames with new prescription lenses are not covered; and</li> <li>▪ Frame cases are covered with new eyeglasses.</li> </ul> </li> <li>▪ Frames are covered more frequently if necessary and appropriate.</li> <li>▪ <b>Frame must be selected from the March frame kit.</b></li> <li>▪ Member is financially responsible for full cost of non-March frame. Member must be notified in advance and in writing that they are responsible for the full cost of the frames including the fitting cost.</li> </ul>
Frame Replacement	<ul style="list-style-type: none"> <li>▪ Covered as needed if medically necessary.</li> <li>▪ <b>To identify replacement frames, please bill using modifier code RA in conjunction with the current and appropriate HCPCS code(s) for frames.</b></li> </ul>
Lenses	<ul style="list-style-type: none"> <li>▪ 2 units (1 pair) every 12 months, to the day, when either of the two following conditions is met:</li> <li>▪ Required for one of the following medical reasons:               <ul style="list-style-type: none"> <li>▪ The member's first pair of prescription eyeglasses;</li> <li>▪ Size change needed due to growth; or</li> <li>▪ 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.):                   <ul style="list-style-type: none"> <li>▪ A change of 0.50 diopters in the meridian of greatest change when placed on an optical cross;</li> <li>▪ A change in axis in excess of 10 degrees for 0.50 cylinder, 5 degrees for 0.75 cylinder; or</li> <li>▪ A change of prism correction of ½ prism diopter vertically or 2 prism diopters horizontally or more.</li> </ul> </li> <li>▪ The member's current lenses are no longer useable due to damage, breakage or loss.</li> </ul> </li> <li>▪ When one lens meets the criteria for coverage, both lenses may be provided, unless the prescribing practitioner specifies replacement of one lens only.</li> <li>▪ Lenses are covered more frequently when medically necessary and appropriate.</li> <li>▪ <b>Lenses must be provided by the March lab. Please refer to Exhibit D in the Provider Reference Guide for lab information.</b></li> <li>▪ <b>Lens Specifications:</b> <ul style="list-style-type: none"> <li>▪ The following specifications apply to all eyeglass lenses:</li> <li>▪ Lenses are covered only if the refraction correction is at least 0.50 diopters in any meridian.</li> </ul> </li> </ul>

Benefit	Benefit Limitations/Criteria
	<ul style="list-style-type: none"> <li>▪ Lenses may be plastic or glass.</li> <li>▪ 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.</li> <li>▪ Lenses must be of a quality at least equal to Z-80 standards of the American National Standard Institute; and</li> <li>▪ 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.</li> </ul> <p><b>Special Lens Features:</b></p> <ul style="list-style-type: none"> <li>▪ 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.</li> <li>▪ High index lenses are covered when there is +/- 10.00 diopter in the meridian of greatest power when placed on an optical cross.</li> <li>▪ Myodisc lenses are covered only if prescribed.</li> <li>▪ Nylon cord, metal cord, or rimless mount - covered only if the member purchases own frame or uses previously purchased frame.</li> <li>▪ Oversize lens charges if medically necessary or if the recipient purchases their own frame or uses previously purchased frame.</li> <li>▪ Polycarbonate (standard and thin) lenses are covered.</li> <li>▪ Scratch resistant coating is required for plastic lenses. Additional scratch resistant coating is not covered.</li> <li>▪ Slab-off prism covered when there is at least 3.00 diopter of anisometropia in the vertical meridian.</li> <li>▪ Special base curve is covered for aniseikonia.</li> <li>▪ Tint only for chronic disorders which cause significant photophobia under indoor lighting conditions. Simple photophobia is not an accepted diagnosis for coverage.</li> <li>▪ Ultraviolet lens coating only for chronic disorders that are complicated or accelerated by ultraviolet light.</li> </ul>
Lens Replacement	<ul style="list-style-type: none"> <li>▪ Covered as needed if medically necessary.</li> <li>▪ <b>To identify replacement lenses, please bill using modifier code RA in conjunction with the current and appropriate HCPCS code(s) for lenses.</b></li> </ul>
Necessary Contact Lenses	<ul style="list-style-type: none"> <li>▪ Covered as needed when prescribed for members with: <ul style="list-style-type: none"> <li>▪ Keratoconus</li> <li>▪ Aphakia (excluding pseudophakia)</li> <li>▪ High plus corrections of +12.00 diopters (spherical equivalent) or greater due to the visual field defect caused by a high plus correction.</li> <li>▪ 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.</li> <li>▪ Anisometropia (difference in correction) of at least 6.00 diopters (spherical equivalent) in order to avoid double vision.</li> <li>▪ Other pathological conditions of the eye when useful vision cannot be obtained with eyeglasses.</li> </ul> </li> </ul>
Necessary Contact Lens Replacements	<ul style="list-style-type: none"> <li>▪ Covered as needed due to loss, damage, or for prescription changes when the member's condition meets criteria for coverage of contact lenses.</li> </ul>
Repairs	<ul style="list-style-type: none"> <li>▪ Frame repair is covered if less costly than providing a new frame and if the repair would provide a serviceable frame for the member.</li> <li>▪ Applicable manufacturer warranties are considered to be a third party resource, and must be utilized in accordance with 471 NAC 3.</li> </ul>
Services Not Covered by March	<ul style="list-style-type: none"> <li>▪ Surgical eye care.</li> </ul>

1.3 Covered Benefits – Molina Healthcare of Nebraska Ages 21 and Older (Medicaid)

Plan ID(s): M-NE-M21

Benefit	Benefit Limitations/Criteria
Exam	<ul style="list-style-type: none"> <li>▪ 1 exam every 24 months.</li> <li>▪ More frequent exams will be covered if medically necessary.</li> </ul>
Exam Replacement	<ul style="list-style-type: none"> <li>▪ Covered as needed if glasses are lost, damaged and it is not possible to return to or obtain the prescription from the previous provider.</li> </ul>
Necessary Medical Services	<ul style="list-style-type: none"> <li>▪ Covered as needed when services are performed by an optometrist and are within the scope of licensure.</li> <li>▪ Vision therapy and orthoptics is limited to 22 sessions.               <ul style="list-style-type: none"> <li>▪ Payment for vision therapy includes all equipment and supplies necessary for home use.</li> </ul> </li> </ul>
Frame	<ul style="list-style-type: none"> <li>▪ 1 unit every 24 months, to the day, when either of the two following conditions is met:               <ul style="list-style-type: none"> <li>▪ Required for one of the following medical reasons:                   <ul style="list-style-type: none"> <li>▪ The member's first pair of prescription eyeglasses;</li> <li>▪ Size change needed due to growth; or</li> <li>▪ A prescribed lens change, only if new lenses cannot be accommodated by the member frame.</li> </ul> </li> <li>▪ The member's current frame is no longer useable due to irreparable wear/damage, breakage or loss.</li> </ul> </li> <li>▪ The following specifications apply to all frames:               <ul style="list-style-type: none"> <li>▪ Plastic and metal frames are covered.</li> <li>▪ Discontinued frames with new prescription lenses are not covered.</li> <li>▪ Frame cases are covered with new eyeglasses.</li> </ul> </li> <li>▪ <b>Frame must be selected from the March frame kit.</b></li> <li>▪ Member is financially responsible for full cost of non-March frame. Member must be notified in advance and in writing that they are responsible for the full cost of the frames including the fitting cost.</li> </ul>
Frame Replacement	<ul style="list-style-type: none"> <li>▪ 1 unit every 24 months when frame is irreparable due to breakage or loss.</li> <li>▪ <b>To identify replacement frames, please bill using modifier code RA in conjunction with the current and appropriate HCPCS code(s) for frames.</b></li> </ul>
Lenses	<ul style="list-style-type: none"> <li>▪ 2 units (1 pair) every 24 months, to the day, when the following is present:               <ul style="list-style-type: none"> <li>▪ Required for one of the following medical reasons:                   <ul style="list-style-type: none"> <li>▪ The member's first pair of prescription eyeglasses;</li> <li>▪ Size change needed due to growth; or</li> <li>▪ 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.):                       <ul style="list-style-type: none"> <li>▪ A change of 0.50 diopters in the meridian of greatest change when placed on an optical cross;</li> <li>▪ A change in axis in excess of 10 degrees for 0.50 cylinder, 5 degrees for 0.75 cylinder; or</li> <li>▪ A change of prism correction of ½ prism diopter vertically or 2 prism diopters horizontally or more.</li> </ul> </li> <li>▪ The members current lenses are no longer useable due to damage, breakage or loss.</li> </ul> </li> <li>▪ When one lens meets the criteria for coverage, both lenses may be provided, unless the prescribing practitioner specifies replacement of one lens only.</li> <li>▪ <b>Lenses must be provided by the March lab. Please refer to Exhibit D in the Provider Reference Guide for lab information.</b></li> </ul> </li> <li>▪ <b>Lens Specifications:</b> <ul style="list-style-type: none"> <li>▪ The following specifications apply to all eyeglass lenses:</li> <li>▪ Lenses are covered only if the refraction correction is at least 0.50 diopters in any meridian.</li> <li>▪ Lenses may be plastic or glass.</li> <li>▪ 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</li> </ul> </li> </ul>

Benefit	Benefit Limitations/Criteria
	<p>indicate that the scratch resistant coating was provided. Medicaid does not require that lenses with scratch resistant coating be warranted.</p> <ul style="list-style-type: none"> <li>▪ Lenses must be of a quality at least equal to Z-80 standards of the American National Standard Institute; and</li> <li>▪ 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.</li> </ul> <p><b>Special Lens Features:</b></p> <ul style="list-style-type: none"> <li>▪ 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.</li> <li>▪ High index lenses are covered when there is +/- 10.00 diopter in the meridian of greatest power when placed on an optical cross.</li> <li>▪ Myodisc lenses are covered only if prescribed.</li> <li>▪ Nylon cord, metal cord, or rimless mount - covered only if the member purchases own frame or uses previously purchased frame.</li> <li>▪ Oversize lens charges if medically necessary or if the recipient purchases their own frame or uses previously purchased frame.</li> <li>▪ Standard polycarbonate lenses are covered only if prescribed for significantly monocular vision.</li> <li>▪ Thin polycarbonate lenses are covered only if the refraction correction is at least +/- 8.00 diopters in the meridian of greatest power when placed on an optical cross</li> <li>▪ Scratch resistant coating is required for plastic lenses. Additional scratch resistant coating is not covered.</li> <li>▪ Slab-off prism covered when there is at least 3.00 diopter of anisometropia in the vertical meridian.</li> <li>▪ Special base curve is covered for aniseikonia.</li> <li>▪ Tint only for chronic disorders which cause significant photophobia under indoor lighting conditions. Simple photophobia is not an accepted diagnosis for coverage.</li> <li>▪ Ultraviolet lens coating only for chronic disorders that are complicated or accelerated by ultraviolet light.</li> </ul>
Lens Replacement	<ul style="list-style-type: none"> <li>▪ 2 units (1 pair) every 12 months due to wear, damage, breakage or loss.</li> <li>▪ <b>To identify replacement lenses, please bill using modifier code RA in conjunction with the current and appropriate HCPCS code(s) for lenses.</b></li> </ul>
Necessary Contact Lenses	<ul style="list-style-type: none"> <li>▪ Covered as needed when prescribed for members with: <ul style="list-style-type: none"> <li>▪ Keratoconus</li> <li>▪ Aphakia (excluding pseudophakia)</li> <li>▪ High plus corrections of +12.00 diopters (spherical equivalent) or greater due to the visual field defect caused by a high plus correction.</li> <li>▪ 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.</li> <li>▪ Anisometropia (difference in correction) of at least 6.00 diopters (spherical equivalent) in order to avoid double vision.</li> <li>▪ Other pathological conditions of the eye when useful vision cannot be obtained with eyeglasses.</li> </ul> </li> </ul>
Necessary Contact Lens Replacements	<ul style="list-style-type: none"> <li>▪ Covered as needed due to loss, damage, or for prescription changes when the member's condition meets criteria for coverage of contact lenses.</li> </ul>
Repairs	<ul style="list-style-type: none"> <li>▪ Frame repair is covered if less costly than providing a new frame and if the repair would provide a serviceable frame for the member.</li> <li>▪ Applicable manufacturer warranties are considered to be a third party resource, and must be utilized in accordance with 471 NAC 3.</li> </ul>
Services Not Covered by March	<ul style="list-style-type: none"> <li>▪ Surgical eye care.</li> </ul>