

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

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1.1 Covered Benefits - Aetna Better Health (Medicaid) – Effective 10/01/2020

Benefit	Benefit Limitations/Criteria
Routine Exam	<ul style="list-style-type: none"> ▪ 1 service date every year.
Frame	<ul style="list-style-type: none"> ▪ 1 unit every 2 years. ▪ Frame is provided from the MARCH frame kit at no cost to the member <u>or</u> a \$100 allowance will be applied toward the cost of the frame if the member chooses a non-MARCH frame. To identify frames within the provider’s selection, please bill using modifier code 75 in conjunction with the current and appropriate HCPCS code for frames.
Lens	<ul style="list-style-type: none"> ▪ 2 units every 2 years. ▪ Regular single vision lenses are covered when the power is at least +/- 0.75 diopters in either sphere or cylinder component. ▪ Regular bifocal lenses are covered when the power of the bifocal addition is +/- 1.00 diopter or more. ▪ Lenses must be provided by the MARCH lab. Please refer to Exhibit D in the Provider Reference Guide for lab information.
Contact Lens	<ul style="list-style-type: none"> ▪ \$80 allowance every 2 years. ▪ Contact lenses are in lieu of frame and lenses. ▪ Contact lenses must be supplied by the provider.
Non-Covered Services	<ul style="list-style-type: none"> ▪ Medical and surgical eye care.

1.2 Covered Benefits - Aetna Better Health – MMAI (Medicare-Medicaid)

Benefit	Benefit Limitations/Criteria
Routine Exam	<ul style="list-style-type: none"> ▪ 1 service date every year.
Exam Replacement	<ul style="list-style-type: none"> ▪ 2 service dates every year when it is not possible to return to or obtain the prescription from the previous provider and criteria for replacement lenses have been met. ▪ To identify a replacement exam, please bill with modifier RA.
Frame	<ul style="list-style-type: none"> ▪ 1 unit every 2 years. ▪ Frame must be selected from the MARCH frame kit.
Frame Replacement	<ul style="list-style-type: none"> ▪ 1 unit every year if initial pair is lost or broken beyond repair. ▪ Frame must be selected from the MARCH frame kit. ▪ To identify replacement frames, please bill with modifier RA.
Deluxe Frame	<ul style="list-style-type: none"> ▪ 10% discount, \$10 allowance 1 unit every 2 years. ▪ Members may waive the standard frame selection and opt for any frame shown at the provider's location. Members then receive the "Ten plus Ten" frame benefit. The member receives a courtesy 10% discount on the retail price and MARCH provides a ten dollar (\$10.00) frame allowance. The member pays the reduced fee directly to the provider. ▪ To identify deluxe frames, please bill using HCPCS code V2025.
Deluxe Frame Replacement	<ul style="list-style-type: none"> ▪ 10% discount, \$10 allowance every year if initial pair is lost or broken beyond repair. ▪ Members may waive the standard frame selection and opt for any frame shown at the provider's location. Members then receive the "Ten plus Ten" frame benefit. The member receives a courtesy 10% discount on the retail price and MARCH provides a ten dollar (\$10.00) frame allowance. The member pays the reduced fee directly to the provider. ▪ To identify deluxe replacement frames, please bill using HCPCS code V2025 and modifier RA.
Lens	<ul style="list-style-type: none"> ▪ 2 units every 2 years. ▪ Regular single vision lenses are covered when the power is at least +/- 0.75 diopters in either sphere or cylinder component. ▪ Regular bifocal lenses are covered when the power of the bifocal addition is +/- 1.00 diopter or more. ▪ Polycarbonate lenses are covered for the following: <ul style="list-style-type: none"> ▪ A prescription of +/- 2.50 diopters. ▪ Hi index lenses are covered when the criterion for regular single vision or regular bifocal lenses is met and the weight of a standard prescription could cause facial development issues (primarily for children). The need must be substantiated in the member's medical record by clinical data. ▪ Polarized lenses are covered if the prescription criterion for regular single vision or regular bifocal lenses is met in addition to one of the following: <ul style="list-style-type: none"> ▪ Chronic iritis ▪ Uveitis or other active inflammatory eye disease with fixed and dilated pupils or ▪ Aniridia ▪ Lenses must be provided by the MARCH lab. Please refer to Exhibit D in the Provider Reference Guide for lab information.

Benefit	Benefit Limitations/Criteria
Lens Replacement	<ul style="list-style-type: none"> ▪ 2 units every year when one of the following criteria are met: <ul style="list-style-type: none"> ▪ Single vision replacement lenses are covered when there is a +/- 0.75 diopter change, in either sphere or cylinder component. ▪ Bifocal replacement lenses are covered when one of the following criterion is met: <ul style="list-style-type: none"> ▪ The distance power meets the minimum change requirements (+/- 0.75 diopters) ▪ The power of the bifocal addition is changed by at least +/- 0.50 diopters. ▪ Single vision lenses may be replaced with bifocal lenses when the distance component meets the minimum prescription requirement (+/- 0.75 diopters), OR the resultant total power of the new prescription meets the requirement for a change in prescription (+/- 0.75 diopters). ▪ Bifocal lenses may be replaced by single vision lenses when the new prescription meets the requirement for a change in prescription (+/- 0.75 diopters) figured from the resultant total power of the bifocal prescription, AND the new prescription meets the minimum prescription power requirement (+/- 0.75 diopters). ▪ The new lenses must be placed in the existing frames. ▪ 2 units every year if the initial pair is lost or broken beyond repair. This is in addition to the replacement pair for vision change. ▪ To identify replacement lenses, please bill with modifier code RA. ▪ Lenses must be provided by the MARCH lab. Please refer to Exhibit D in the Provider Reference Guide for lab information.
Necessary Contact Lens	<ul style="list-style-type: none"> ▪ 2 units (1 unit per eye) every 2 years. ▪ Contact lenses are in lieu of frame and lenses when one or more of the following criterion is met: <ul style="list-style-type: none"> ▪ A diagnosis of aphakia ▪ A diagnosis of monocular aphakia ▪ A pathological condition of the cornea ▪ When useful vision cannot be obtained with glasses ▪ Contact lenses must be supplied by the provider.
Eyewear After Cataract Surgery	<ul style="list-style-type: none"> ▪ One pair of eyeglasses (standard frame and lenses) OR one pair of contact lenses following cataract surgery with an intraocular lens. ▪ To identify eyewear after cataract surgery, please bill with the appropriate diagnosis code for cataract surgery.
Glaucoma Screening	<ul style="list-style-type: none"> ▪ One service date every 12 months for members who are at high risk of glaucoma, such as people with family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older.
Non-Covered Services	<ul style="list-style-type: none"> ▪ Medical and surgical eye care. ▪ Low vision aids. ▪ Trifocal lenses. ▪ Necessary contact lens replacement.

1.3 Covered Benefits - Molina Healthcare of Illinois (Medicaid)

Benefit	Benefit Limitations/Criteria
Routine Exam	<ul style="list-style-type: none"> ▪ 1 service date every year. ▪ Covered as needed when the practitioner documents the need for the additional examination, an explanation of special circumstances, and the services rendered.
Necessary Medical Services	<ul style="list-style-type: none"> ▪ Covered as needed when services are performed by an optometrist and are within the scope of licensure.
Exam Replacement	<ul style="list-style-type: none"> ▪ Covered as needed when it is not possible to return to or obtain the prescription from the previous provider and criteria for replacement lenses have been met. ▪ To identify a replacement exam, please bill with modifier RA.
Frame	<ul style="list-style-type: none"> ▪ 1 unit every year ages 20 and under. ▪ 1 unit every 2 years ages 21 and older. ▪ Frame is provided from the MARCH frame kit at no cost to the member or a \$40 allowance will be applied toward the cost of eyeglasses if the member chooses a non-MARCH frame. To identify frames within the provider's selection, please bill using modifier code 75 in conjunction with the current and appropriate HCPCS code for frames.
Frame Replacement	<ul style="list-style-type: none"> ▪ Covered as needed if one of the following criterion is met: <ul style="list-style-type: none"> ▪ The most recent pair of eyeglasses was lost or destroyed for reasons beyond the control of the recipient. ▪ The additional pair is determined medically necessary by the practitioner. ▪ For three or more frames, one of the following criterion must be met in addition to one of the above. <ul style="list-style-type: none"> ▪ +/-2.00 in the base power or +/-1.50 in the cylinder ▪ Eyeglasses are needed for the management of amblyopia. ▪ Frame must be selected from the MARCH frame kit. ▪ To identify replacement frames, please bill with modifier RA.
Frame Repair	<ul style="list-style-type: none"> ▪ Frame repairs are covered as needed in instances where it is evident that the repair of an existing frame is less costly than providing a new frame, and when such repairs provide a serviceable frame for the patient, consideration is to be given to repairing the existing frame. New frame parts, including fronts, temples, etc. are covered when used to repair an existing frame. ▪ To identify frame repairs which <u>can</u> be done in the provider's office, please bill with HCPCS code 92370. ▪ To identify frame repairs which <u>cannot</u> be done in the provider's office, please send the broken materials to the MARCH lab and bill with modifier code RB. Provider is responsible for the cost of traceable shipping of broken materials to the MARCH lab.
Deluxe Frame	<ul style="list-style-type: none"> ▪ 10% discount, \$10 allowance 1 unit every year ages 20 and under. ▪ 10% discount, \$10 allowance 1 unit every 2 years ages 21 and older. ▪ Members may waive the standard frame selection and opt for any frame shown at the provider's location. Members then receive the "Ten plus Ten" frame benefit. The member receives a courtesy 10% discount on the retail price and MARCH provides a ten dollar (\$10.00) frame allowance. The member pays the reduced fee directly to the provider. ▪ To identify deluxe frames, please bill using HCPCS code V2025.

Benefit	Benefit Limitations/Criteria
Deluxe Frame Replacement	<ul style="list-style-type: none"> ▪ 10% discount, \$10 allowance as needed if one of the following criterion is met: <ul style="list-style-type: none"> ▪ The most recent pair of eyeglasses was lost or destroyed for reasons beyond the control of the recipient. ▪ The additional pair is determined medically necessary by the practitioner. ▪ For three or more frames, one of the following criterion must be met in addition to one of the above: <ul style="list-style-type: none"> ▪ +/-2.00 in the base power or +/-1.50 in the cylinder. ▪ Members may waive the standard frame selection and opt for any frame shown at the provider's location. Members then receive the "Ten plus Ten" frame benefit. The member receives a courtesy 10% discount on the retail price and MARCH provides a ten dollar (\$10.00) frame allowance. The member pays the reduced fee directly to the provider. ▪ To identify deluxe replacement frames, please bill using HCPCS code V2025 and modifier RA.
Lens	<ul style="list-style-type: none"> ▪ 2 units every year ages 20 and under. ▪ 2 units every 2 years ages 21 and older. ▪ Lenses must be provided by the MARCH lab <u>or</u> a \$40 retail allowance may be used toward the total cost of eyeglasses from the provider's selection. To identify lenses within the provider's selection, please bill using modifier code 75 in conjunction with the current and appropriate HCPCS codes(s) for lenses. ▪ Regular single vision lenses are covered when the power is at least +/- 0.75 diopters in either sphere or cylinder component. ▪ Regular bifocal lenses are covered when the power of the bifocal addition is +/- 1.00 diopter or more. ▪ Polycarbonate lenses are covered for the following: <ul style="list-style-type: none"> ▪ Ages 20 and under if the prescription criterion for regular single vision or regular bifocal lenses is met. ▪ Ages 21 and older when the prescription is +/- 2.50 diopters. ▪ Hi index lenses are covered when the power is at least +/-12 diopters. ▪ Polarized lenses are covered if the prescription criterion for regular single vision or regular bifocal lenses is met in addition to one of the following: <ul style="list-style-type: none"> ▪ Chronic iritis ▪ Uveitis or other active inflammatory eye disease with fixed and dilated pupils or ▪ Aniridia

Benefit	Benefit Limitations/Criteria
Lens Replacement	<ul style="list-style-type: none"> ▪ Covered as needed if one of the following criteria is met: <ul style="list-style-type: none"> ▪ The most recent pair of eyeglasses was lost or destroyed for reasons beyond the control of the recipient. ▪ There is a change in prescription that meets the requirements described below. ▪ The additional pair is determined medically necessary by the practitioner. ▪ For three or more pairs of lenses, one of the following criterion must be met in addition to one of the above: <ul style="list-style-type: none"> ▪ +/-2.00 in the base power or +/-1.50 in the cylinder ▪ Eyeglasses are needed for the management of amblyopia ▪ Single vision replacement lenses are covered when there is a +/- 0.75 diopter change, in either sphere or cylinder component. ▪ Bifocal replacement lenses are covered when one of the following criteria is met: <ul style="list-style-type: none"> ▪ The distance power meets the minimum change requirements (+/- 0.75 diopters) ▪ The power of the bifocal addition is changed by at least +/- 0.50 diopters. ▪ Single vision lenses may be replaced with bifocal lenses when the distance component meets the minimum prescription requirement (+/- 0.75 diopters), OR the resultant total power of the new prescription meets the requirement for a change in prescription (+/- 0.75 diopters). ▪ Bifocal lenses may be replaced by single vision lenses when the new prescription meets the requirement for a change in prescription (+/- 0.75 diopters) figured from the resultant total power of the bifocal prescription, AND the new prescription meets the minimum prescription power requirement (+/- 0.75 diopters). ▪ The new lenses must be placed in the existing frames. ▪ 2 units every year if the initial pair is lost or broken beyond repair. This is in addition to the replacement pair for vision change. ▪ To identify replacement lenses, please bill with modifier code RA. ▪ Lenses must be provided by the MARCH lab. Please refer to Exhibit D in the Provider Reference Guide for lab information.
Necessary Contact Lens	<ul style="list-style-type: none"> ▪ 2 units (1 unit per eye) every year ages 20 and under. ▪ 2 units (1 unit per eye) every 2 years ages 21 and older. ▪ Contact lenses are in lieu of frame and lenses when one or more of the following criterion is met: <ul style="list-style-type: none"> ▪ A diagnosis of aphakia ▪ A diagnosis of monocular aphakia ▪ A pathological condition of the cornea ▪ When useful vision cannot be obtained with glasses ▪ Contact lenses must be supplied by the provider.
Eyewear After Cataract Surgery	<ul style="list-style-type: none"> ▪ One pair of eyeglasses (standard frame and lenses) OR one pair of contact lenses following cataract surgery with an intraocular lens ages 21 and older. ▪ Allowance does not apply. ▪ To identify eyewear after cataract surgery, please bill with the appropriate diagnosis code for cataract surgery.
Non-Covered Services	<ul style="list-style-type: none"> ▪ Surgical eye care. ▪ Low vision aids. ▪ Trifocal lenses. ▪ Necessary contact lens replacement.

1.4 Covered Benefits - Molina Healthcare of Illinois – MMP (Medicare-Medicaid)

Benefit	Benefit Limitations/Criteria
Routine Exam	<ul style="list-style-type: none"> ▪ 1 service date every year. ▪ Covered as needed when the practitioner documents the need for the additional examination, an explanation of special circumstances, and the services rendered.
Necessary Medical Services	<ul style="list-style-type: none"> ▪ Covered as needed when services are performed by an optometrist and are within the scope of licensure.
Eyewear	<ul style="list-style-type: none"> • \$125 allowance every year. ▪ Allowance may be used toward frames, lenses, lens extras and/or contact lenses. ▪ In-house frame and lenses must be used.
Eyewear After Cataract Surgery	<ul style="list-style-type: none"> ▪ One pair of eyeglasses (standard frame and lenses) OR one pair of contact lenses following cataract surgery with an intraocular lens. ▪ Allowance does not apply ▪ To identify eyewear after cataract surgery, please bill with the appropriate diagnosis code for cataract surgery.
Non-Covered Services	<ul style="list-style-type: none"> ▪ Surgical eye care. ▪ Low vision aids. ▪ Necessary contact lens replacement.

1.5 Medicaid Reimbursement Procedures – Aetna Better Health (Medicaid)

The Medicaid frame benefit affords members the opportunity to select a frame from the MARCH frame kit **OR** members may choose to use a set retail allowance toward the cost of any frame in the provider’s selection. The retail allowance is \$100.

The following examples illustrate reimbursement for each scenario. These examples are for illustrative purposes only and may not reflect actual amounts.

MARCH Frame Kit and MARCH Lab

Providers must bill the current and appropriate service code for the fitting of spectacles. Reimbursement for the fitting of spectacles will be at the lesser amount of billed charges or the provider’s rate.

The following example assumes a contracted rate of \$29.28 for the fitting of spectacles

Service Code	Description	Modifier	Billed Charges	Paid Amount
V2020	Frame	75	\$ 40.00*	\$ 0.00
92340	Fitting of Spectacles**		\$ 30.00	\$ 29.28
Total			\$ 70.00	\$ 29.28

Retail Allowance - Frame

Providers must bill the current and appropriate service code(s) for frames with modifier code 75. Reimbursement for frames will be at the lesser amount of billed charges or the provider’s contracted rate. The contracted rate is \$75.00.

The following example assumes a \$100.00 retail allowance for frames from the provider’s selection.

Service Code	Description	Modifier	Billed Charges	Paid Amount
V2100	Lenses		\$ 80.00	\$ 0.00
V2020	Frame	75	\$ 125.00*	\$ 75.00
92340	Fitting of Spectacles**		\$ 40.00	\$ 0.00
Total			\$ 245.00	\$ 75.00

*Member is responsible for charges exceeding their benefit allowance. In this example, the member is responsible for \$25.

**Fitting of Spectacles is not reimbursable when the allowance is used. This fee is not billable to the member.

The following example assumes a \$100.00 retail allowance for eyeglasses from the provider’s selection.

Service Code	Description	Modifier	Billed Charges	Paid Amount
V2100	Lenses		\$ 15.00	\$ 0.00
V2020	Frame	75	\$ 105.00*	\$ 75.00
92340	Fitting of Spectacles**		\$ 40.00	\$ 0.00
Total			\$ 160.00	\$ 75.00

*Member is responsible for charges exceeding their benefit allowance. In this example, the member is responsible for \$5.

**Fitting of Spectacles is not reimbursable when the allowance is used. This fee is not billable to the member.

Retail Allowance – Contact Lenses

Providers must bill the current and appropriate service code(s) for contact lenses. Reimbursement for contact lenses will be at the lesser amount of billed charges or the provider’s contracted rate. The contracted rate is \$80.00.

The following example assumes a \$80.00 retail allowance for contact lenses from the provider’s selection.

Service Code	Description	Modifier	Billed Charges	Paid Amount
V2500	Contact Lenses		\$ 120.00*	\$ 80.00
92310	Contact Lens Fitting**		\$ 40.00	\$ 0.00
Total			\$ 160.00	\$ 80.00

*Member is responsible for charges exceeding their benefit allowance. In this example, the member is responsible for \$40.

**Contact lens fitting is not reimbursable. This fee is not billable to the member.

1.6 Medicaid Reimbursement Procedures – Molina Healthcare of Illinois Health (Medicaid)

The Medicaid frame benefit affords members the opportunity to select a frame from the MARCH frame kit **OR** members may choose to use a set retail allowance toward the cost of any frame and lenses in the provider's selection. The retail allowance is \$40.

The following examples illustrate reimbursement for each scenario. These examples are for illustrative purposes only and may not reflect actual amounts.

MARCH Frame Kit and MARCH Lab

Providers must bill the current and appropriate service code for the fitting of spectacles. Reimbursement for the fitting of spectacles will be at the lesser amount of billed charges or the provider's rate.

The following example assumes a contracted rate of \$29.28 for the fitting of spectacles

Service Code	Description	Modifier	Billed Charges	Paid Amount
V2020	Frame	75	\$ 40.00*	\$ 0.00
92340	Fitting of Spectacles**		\$ 30.00	\$ 29.28
Total			\$ 70.00	\$ 29.28

Retail Allowance - Eyeglasses

Providers must bill the current and appropriate service code(s) for frame and lenses with modifier code 75. Reimbursement for frames and lenses will be at the lesser amount of billed charges or the provider's contracted rate. The contracted rate is \$30.00.

The following example assumes a \$40.00 retail allowance for eyeglasses from the provider's selection/in-house lab.

Service Code	Description	Modifier	Billed Charges	Paid Amount
V2100	Lenses	75	\$ 50.00*	\$ 30.00
V2020	Frame	75	\$ 60.00*	\$ 0.00
92340	Fitting of Spectacles***		\$ 40.00	\$ 0.00
Total			\$ 150.00	\$ 30.00

*Member is responsible for charges exceeding their benefit allowance. In this example, the member is responsible for \$70.

**Allowance is not applicable to medically necessary lens options.

***Fitting of Spectacles is not reimbursable when the allowance is used. This fee is not billable to the member.

The following example assumes a \$40.00 retail allowance for eyeglasses from the provider's selection/in-house lab.

Service Code	Description	Modifier	Billed Charges	Paid Amount
V2100	Lenses	75	\$ 15.00*	\$ 15.00
V2020	Frame	75	\$ 50.00*	\$ 15.00
92340	Fitting of Spectacles***		\$ 40.00	\$ 0.00
Total			\$ 105.00	\$ 30.00

*Member is responsible for charges exceeding their benefit allowance. In this example, the member is responsible for \$25.

**Allowance is not applicable to medically necessary lens options.

***Fitting of Spectacles is not reimbursable when the allowance is used. This fee is not billable to the member.

1.7 State Mandated Contract Provisions

Please click [here](#) to access state mandated contract provisions.