Ohio Specific Information

This Medical Policy only applies to the state of Ohio. Any requests for services that are stated as unproven or services for which there is a coverage or quantity limit will be evaluated for medical necessity by the provider using Ohio Administrative Code 5160-1-01.

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

Table of Contents

1.1 Notice of Updates

Notice of updates published March 2024.

- Added the following language to the beginning of the document: This Medical Policy only applies to the state of Ohio. Any requests for services that are stated as unproven or services for which there is a coverage or quantity limit will be evaluated for medical necessity by the provider using Ohio Administrative Code 5160-1-01.

1.2 Covered Benefits - UnitedHealthcare Community Plan (Medicaid)

Benefit Plan(s): UD-OH-M

Benefit	Benefit Limitations/Criteria
Exam	▪ 1 service date every year.
Exam Replacement	▪ Covered in accordance with frame and lens replacement benefit frequencies when one of the following criterion is met: ▪ The member is unable to return to or obtain the prescription from the previous provider AND criteria for replacement frame and lenses are met. ▪ A replacement exam is necessary to determine a vision change AND criteria for replacement frame and lenses are met.
Necessary Medical Services	▪ Covered as needed when services are performed by an optometrist and are within the scope of licensure.
Frame	▪ 1 unit every year. ▪ Frame may be selected from the March Frame Kit at no cost to the member **OR** frame with a retail amount greater than $25 may be selected from the provider's selection. If the member selects a frame with a retail amount greater than $25, the member is responsible for the difference between the retail cost of the frame selected and $25. ▪ **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	▪ Covered as needed with prior confirmation when medically necessary. ▪ **Frame MUST be selected from the March Frame Kit.** ▪ **To identify replacement frames, please bill using modifier code RA in conjunction with the current and appropriate HCPCS code(s) for frames.**
Lens (Single, Bifocal, Trifocal, Polycarbonate)	▪ 2 units every year. ▪ **Lenses must be provided by the March lab. Please refer to Exhibit D in the Provider Reference Guide for lab information.** ▪ Single, bifocal, or trifocal scratch resistant plastic or polycarbonate lenses are covered. ▪ Aphakic single vision and multifocal lenses are covered. ▪ Additions for single and bifocal vision include: ▪ Prism ▪ Industrial thickness ▪ Myodisc ▪ Cylinder > 6.25 ▪ Special base curve ▪ Ultra-violet tint (requires prior confirmation) ▪ Slab off lens ▪ Fresnel prism ▪ Frosted lens ▪ Tints (requires prior confirmation) ▪ Photochromic (requires prior confirmation) ▪ High index plastic lenses ▪ Glass lenses will be covered with prior confirmation when medically necessary. ▪ Lens prescriptions must be at least: +0.75 sphere or -0.50 sphere, 0.50 cylinder, 0.50 diopter imbalance, 0.50 prism diopter vertical, or 3.00 prism diopter lateral. These prescription minimums apply to new, duplications and changes in prescription. ▪ Lens prescription changes must still meet the lens prescription minimum requirements as stated in the above paragraph and must be at least: +/- 0.50 sphere, +/- 0.50 cylinder, 10 degrees for a 1.00 cylinder or less, or 5 degrees for a 1.12 cylinder or more.

Benefit	Benefit Limitations/Criteria
Lens Replacement	▪ Covered as needed when medically necessary. ▪ Replacements are subject to the same minimum lens critiera as initial lenses. ▪ **To identify replacement lenses, please bill using modifier code RA in conjunction with the current and appropriate HCPCS code(s) for lenses.**

Necessary Contact Lenses	▪ Covered as needed if medically necessary for the following conditions:
	  ▪ Aphakia
	  ▪ High refractive errors greater than 10.00 diopters, when the visual acuity cannot be corrected to 20/40 in the better eye with spectacle lenses and there is a significant improvement in the visual acuity with contact lenses.
	  ▪ High degree of anisometropia, with a difference of three or more diopters, where binocularity can be substantiated.
	  ▪ High ametropia in either eye of ten diopters or more (either plus or minus).
	  ▪ Keratoconus where there is a high corneal astigmatism or corneal irregularities when visual acuity cannot be corrected to 20/40 in the better eye with spectacles and there is a significant improvement with contact lenses.
	  ▪ Corneal ectasia.
	  ▪ Post-operative corneal irregularity.
	▪ Contact lenses must be supplied by the provider.

Elective Contact Lenses	▪ $150 allowance every year in lieu of frame and lenses. ▪ Contact lenses must be supplied by the provider. ▪ **To identify elective contact lenses, please bill using modifier code 75 in conjunction with the current and appropriate HCPCS code(s) for contact lenses and CPT code for contact lens fitting.** ▪ Contact lens fitting/examination/evaluation is deducted from the allowance.
Non-Covered Services	▪ 15% discount on the usual and customary fee for eyewear purchases which exceed the benefit coverage (excludes disposable contact lenses.) Certain provider limitations and exclusions may apply. ▪ Surgical eye care.

1.3 Covered Benefits - UnitedHealthcare Connected® for MyCare Ohio (MMP)

Benefit Plan(s): UD-OH-E

Benefit	Benefit Limitations/Criteria
Exam	▪ 1 service date every year ages 20 and under or 60 and older. ▪ 1 service date every 2 years ages 21-59.
Exam Replacement	▪ Covered in accordance with frame and lens replacement benefit frequencies when one of the following criterion is met: ▪ The member is unable to return to or obtain the prescription from the previous provider AND criteria for replacement frame and lenses are met. ▪ A replacement exam is necessary to determine a vision change AND criteria for replacement frame and lenses are met.
Necessary Medical Services	▪ Covered as needed when services are performed by an optometrist and are within the scope of licensure.
Frame	▪ 1 unit every year ages 20 and under or 60 and older. ▪ 1 unit every 2 years ages 21-59. ▪ Frame may be selected from the March Frame Kit at no cost to the member **OR** frame with a retail amount greater than $25 may be selected from the provider's selection. If the member selects a frame with a retail amount greater than $25, the member is responsible for the difference between the retail cost of the frame selected and $25. ▪ **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	▪ Covered as needed with prior confirmation when medically necessary. ▪ **Frame MUST be selected from the March Frame Kit.** ▪ **To identify replacement frames, please bill using modifier code RA in conjunction with the current and appropriate HCPCS code(s) for frames.**

Benefit	Benefit Limitations/Criteria

Lens (Single, Bifocal, Trifocal, Polycarbonate)	▪ 2 units every year ages 20 and under or 60 and older.
	▪ 2 units ever 2 years ages 21-59.
	▪ **Lenses must be provided by the March lab. Please refer to Exhibit D in the Provider Reference Guide for lab information.**
	▪ Single, bifocal, or trifocal scratch resistant plastic or polycarbonate lenses are covered.
	▪ Aphakic single vision and multifocal lenses are covered.
	▪ Additions for single and bifocal vision include:
	  ▪ Prism
	  ▪ Industrial thickness
	  ▪ Myodisc
	  ▪ Cylinder > 6.25
	  ▪ Special base curve
	  ▪ Ultra-violet tint (requires prior confirmation)
	  ▪ Slab off lens
	  ▪ Fresnel prism
	  ▪ Frosted lens
	  ▪ Tints (requires prior confirmation)
	  ▪ Photochromic (requires prior confirmation)
	  ▪ High index plastic lenses
	▪ Glass lenses will be covered with prior confirmation when medically necessary.
	▪ Lens prescriptions must be at least: +0.75 sphere or -0.50 sphere, 0.50 cylinder, 0.50 diopter imbalance, 0.50 prism diopter vertical, or 3.00 prism diopter lateral. These prescription minimums apply to new, duplications and changes in prescription.
	▪ Lens prescription changes must still meet the lens prescription minimum requirements as stated in the above paragraph and must be at least: +/- 0.50 sphere, +/- 0.50 cylinder, 10 degrees for a 1.00 cylinder or less, or 5 degrees for a 1.12 cylinder or more.

Lens Replacement	▪ Covered as needed when medically necessary. ▪ Replacements are subject to the same minimum lens critiera as initial lenses. ▪ **To identify replacement lenses, please bill using modifier code RA in conjunction with the current and appropriate HCPCS code(s) for lenses.**

Necessary Contact Lenses	▪ Covered as needed if medically necessary for the following conditions:
	  ▪ Aphakia
	  ▪ High refractive errors greater than 10.00 diopters, when the visual acuity cannot be corrected to 20/40 in the better eye with spectacle lenses and there is a significant improvement in the visual acuity with contact lenses.
	  ▪ High degree of anisometropia, with a difference of three or more diopters, where binocularity can be substantiated.
	  ▪ High ametropia in either eye of ten diopters or more (either plus or minus).
	  ▪ Keratoconus where there is a high corneal astigmatism or corneal irregularities when visual acuity cannot be corrected to 20/40 in the better eye with spectacles and there is a significant improvement with contact lenses.
	  ▪ Corneal ectasia.
	  ▪ Post-operative corneal irregularity.
	▪ Contact lenses must be supplied by the provider.

Eyewear After Cataract Surgery	▪ One pair of eyeglasses (standard frame and lenses) **OR** contact lenses after each cataract surgery. ▪ Frame must be selected from the March Frame Kit and lenses must be supplied by the March lab. Contact lenses must be supplied by the provider. ▪ **To identify eyewear after cataract surgery, please bill with the appropriate diagnosis code for cataract surgery.**

Benefit	Benefit Limitations/Criteria
Non-Covered Services	▪ 15% discount on the usual and customary fee for eyewear purchases which exceed the benefit coverage (excludes disposable contact lenses.) Certain provider limitations and exclusions may apply. ▪ Surgical eye care.

1.4 State Mandated Guidelines

Per Ohio Administrative Code 5101:3-6-07, CPT 92015 (refraction) cannot be billed in conjunction with general ophthalmological service codes. In accordance with this Code, March will not provide reimbursement for CPT 92015 (refraction) when billed in conjunction with CPT codes 92004, 92014, 92002 and 92012.

The following provisions are required for Providers in the state of Ohio:

1. Use of the Council for Affordable Quality Healthcare (CAQH) application for all Providers completing credentialing and recredentialing;
2. Credentialing and recredentialing applications are processed within ninety (90) days of receipt date;
3. In the event missing information is discovered on the credentialing application, Providers must be notified in writing within twenty-one (21) days of discovery;
4. Documentation of written practice protocol for all nurse practitioners, with a Practitioner Provider;
5. Recredentialing process includes review of Quality of Care and Quality of Service complaints;
6. PHI is not transferred by Provider outside of the United States or its Territories;
7. There is no sub-delegation of Credentialing functions to offshore organizations;
8. Provider and/or Participating Providers may not be debarred, suspended, proposed for debarment, declared ineligible or otherwise excluded from participation in transactions by any federal agency;
    a. Report civil or criminal convictions of any individual(s) with an ownership or controlling interest of five percent (5%) or more or who is a managing employee, within five (5) business days of discovery; and
    b. Report for cause termination of any individual(s) with an ownership or controlling interest of five percent (5%) or more or who is a managing employee, within five (5) business days of discovery.
9. Credentialing policies state that practitioners will not be discriminated against based on race, color, religion, gender, sexual orientation, age, disability, national origin, military status, health status, or ancestry, or need for health care services; and
10. Pursuant to OAC rule 5160-26-05(D)(24), third party administrators must include the elements in paragraph D in its subcontracts;
11. Provider will maintain a list of Practitioner Providers and other employed individuals, including administrative staff, with five percent (5%) or more ownership or controlling interest in Provider group. List should be produced as requested, and within five (5) business days of request; and
12. In the event an excluded individual is discovered through ongoing monitoring processes, Provider will:
    a. Report civil or criminal convictions of any individual(s) with an ownership or controlling interest of five percent (5%) or more or who is a managing employee, within five (5) business days of discovery; and
    b. Report for cause termination of any individual(s) with an ownership or controlling interest of five percent (5%) or more or who is a managing employee, within five (5) business days of discovery.