Kansas Specific Information

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

Table of Contents

1.1 Covered Benefits - UnitedHealthcare Community Plan – Medicaid

Benefit Plan(s): UDKSM-20, UDKSM-21

Benefit	Benefit Limitations/Criteria
Routine Exam	▪ 1 complete exam every 365 days. ▪ Additional exams covered as necessary ages 20 and under.
Routine Exam Replacement	▪ Covered as twice per calendar year ages 20 and under if there is a prescription change or if glasses are lost or stolen and it is not possible to return to or obtain the prescription from the previous provider.
Necessary Medical Services	▪ Covered as needed when services are performed by an optometrist and are within the scope of licensure.
Frame	▪ 1 unit every calendar year beginning January 1st. ▪ Frame can be selected from the March frame kit, OR ▪ Frame can be selected from the provider's Medicaid frame selection at no cost to the member, OR ▪ $100 allowance can be used for an enhanced frame every calendar year ages 21 and older. Enhanced frame must be sent to the March contracted lab for lens fabrication. To identify when the $100 enhanced frame benefit is used, please bill using modifier code 75 in conjunction with the current and appropriate HCPCS code for frames.
Frame Replacement	▪ 2 units (2 pair) per calendar year ages 20 and under. ▪ **To identify replacement frames, please bill using modifier code RA in conjunction with the current and appropriate HCPCS code(s) for frames.**
Frame Repair	▪ Covered as needed.

Lens (Single, Bifocal, Trifocal, Polycarbonate)	▪ 2 units (1 pair) every calendar year beginning January 1st.
	  ▪ Glass or plastic single, bifocal, or trifocal lenses are covered.
	  ▪ Polycarbonate lenses are covered
	  ▪ Scratch resistant coating is covered.
	  ▪ High index lenses are covered.
	  ▪ Plano lenses when there is a refractive error in only one eye.
	▪ **Lenses must be provided by the March lab if using the March frame kit. Please refer to Exhibit B in the Provider Reference Guide for lab information.**

Lens Replacement	▪ 4 units (2 pairs) per calendar year ages 20 and under. ▪ **To identify replacement lenses, please bill using modifier code RA in conjunction with the current and appropriate HCPCS code(s) for lenses.**

Benefit	Benefit Limitations/Criteria
Necessary Contact Lenses	▪ Covered, with prior confirmation, when ordered by a qualified health plan provider, and when such lenses provide better management of some visual or ocular conditions than can be achieved with eyeglass lenses. Covered for the following medical necessity reasons only: ▪ Monocular aphakia ▪ Bullous keratopathy ▪ Keratoconus ▪ Corneal transplant ▪ Anismetropia of more than 3 diopters of difference that is causing vision distortion and cannot be corrected with glasses. ▪ Anisekonia of more than 3 diopters of difference that is causing vision distortion and cannot be corrected with glasses. ▪ For ocular pathology in cases where the visual acuity is not correctable to 20/70 or better without contact lenses. ▪ Contact lens adaptation includes six months of care. Contact lens fitting is allowed once per lifetime when contacts are first prescribed. Subsequent fittings will be considered if a new type of contact lens is being prescribed and fitted. ▪ **Contact lenses must be supplied by the provider.**
Necessary Contact Lens Replacement	▪ Covered if lost or damaged or for a prescription change ages 20 and under. ▪ Covered if lost or damaged ages 21 and older. ▪ One of the following medical necessity reasons must also be met. ▪ Monocular aphakia ▪ Bullous keratopathy ▪ Keratoconus ▪ Corneal transplant ▪ Anismetropia of more than 3 diopters of difference that is causing vision distortion and cannot be corrected with glasses. ▪ Anisekonia of more than 3 diopters of difference that is causing vision distortion and cannot be corrected with glasses. ▪ For ocular pathology in cases where the visual acuity is not correctable to 20/70 or better without contact lenses. ▪ Contact lens adaptation includes six months of care. Contact lens fitting is allowed once per lifetime when contacts are first prescribed. Subsequent fittings will be considered if a new type of contact lens is being prescribed and fitted.

Benefit	Benefit Limitations/Criteria
Eyewear After Cataract Surgery	▪ Covered for one year following cataract surgery ages 21 and older. ▪ Once per eye, per lifetime. Additional pairs of glasses are covered within one year following cataract surgery, with documentation of medical necessity. ▪ Eyewear must meet dispensing requirements and lens specifications ▪ The expectation is that the annual benefit will be utilized, if available. If the annual benefit has been utilized and the post cataract glasses represent an additional pair of glasses within the benefit period, pre-authorization is required. ▪ The following lens options are covered following cataract extraction when visually necessary and documented by the treating physician: ▪ Tints (V2745) ▪ Anti-reflective coating (V2750) ▪ UV lenses (V2755) ▪ Oversize lenses (V2780) ▪ Aphakic without IOL: In addition to the post-surgical exam, aphakic patients who do not have an IOL are covered for the following lenses or combination of lenses when visually necessary: ▪ Bifocal lenses in frames; or ▪ Lenses in frames for distance vision and lenses in frames for near vision (two pairs of glasses); or ▪ Conventional contact lenses for distance vision, eyeglasses for near vision to wear with contact lenses and eyeglasses to wear when the contact lenses have been removed.
Non-Covered Services	▪ Surgical eye care.

1.2 Covered Benefits - UnitedHealthcare Community Plan – Medicaid - Spenddown

Benefit Plan(s): UDKSM-SD21

Benefit	Benefit Limitations/Criteria
Routine Exam	▪ 1 exam every 365 days. ▪ **Exams in years 2, 3 and 4 are not subject to the spenddown.**
Necessary Medical Services	▪ Covered as needed when services are performed by an optometrist and are within the scope of licensure.
Frame	▪ 1 unit every calendar year beginning January 1st. ▪ **Frames in years 2, 3 and 4 are not subject to the spenddown.** ▪ Frame can be selected from the March frame kit, OR ▪ Frame can be selected from the provider's Medicaid frame selection at no cost to the member, OR ▪ $100 allowance can be used for an enhanced frame every calendar year. Enhanced frame must be sent to the March contracted lab for lens fabrication. To identify when the $100 enhanced frame benefit is used, please bill using modifier code 75 in conjunction with the current and appropriate HCPCS code for frames.
Frame Repair	▪ Covered as needed.

Lens (Single, Bifocal, Trifocal, Polycarbonate)	▪ 2 units (1 pair) every calendar year beginning January 1st.
	  ▪ Glass or plastic single, bifocal, or trifocal lenses are covered.
	  ▪ Polycarbonate lenses are covered.
	  ▪ Scratch resistant coating is covered.
	  ▪ High index lenses are covered.
	  ▪ Plano lenses when there is a refractive error in only one eye.
	▪ **Lenses in years 2, 3 and 4 are not subject to the spenddown.**
	▪ **Lenses must be provided by the March lab if using the March frame kit. Please refer to Exhibit D in the Provider Reference Guide for lab information.**

Necessary Contact Lenses	▪ Covered, with prior confirmation, when ordered by a qualified health plan provider, and when such lenses provide better management of some visual or ocular conditions than can be achieved with eyeglass lenses. Covered for the following medical necessity reasons only:
	  ▪ Monocular aphakia
	  ▪ Bullous keratopathy
	  ▪ Keratoconus
	  ▪ Corneal transplant
	  ▪ Anismetropia of more than 3 diopters of difference that is causing vision distortion and cannot be corrected with glasses.
	  ▪ Anisekonia of more than 3 diopters of difference that is causing vision distortion and cannot be corrected with glasses.
	  ▪ For ocular pathology in cases where the visual acuity is not correctable to 20/70 or better without contact lenses.
	  ▪ Contact lens adaptation includes six months of care. Contact lens fitting is allowed once per lifetime when contacts are first prescribed. Subsequent fittings will be considered if a new type of contact lens is being prescribed and fitted.
	▪ **Contact lenses must be supplied by the provider.**

Benefit	Benefit Limitations/Criteria

Necessary Contact Lens Replacement	▪ Covered if lost or damaged.
	▪ One of the following medical necessity reasons must also be met.
	  ▪ Monocular aphakia
	  ▪ Bullous keratopathy
	  ▪ Keratoconus
	  ▪ Corneal transplant
	  ▪ Anismetropia of more than 3 diopters of difference that is causing vision distortion and cannot be corrected with glasses.
	  ▪ Anisekonia of more than 3 diopters of difference that is causing vision distortion and cannot be corrected with glasses.
	  ▪ For ocular pathology in cases where the visual acuity is not correctable to 20/70 or better without contact lenses.
	  ▪ Contact lens adaptation includes six months of care. Contact lens fitting is allowed once per lifetime when contacts are first prescribed. Subsequent fittings will be considered if a new type of contact lens is being prescribed and fitted.

Eyewear After Cataract Surgery	▪ Covered for one year following cataract surgery.
	  ▪ Once per eye, per lifetime. Additional pairs of glasses are covered within one year following cataract surgery, with documentation of medical necessity.
	  ▪ Eyewear must meet dispensing requirements and lens specifications
	  ▪ The expectation is that the annual benefit will be utilized, if available. If the annual benefit has been utilized and the post cataract glasses represent an additional pair of glasses within the benefit period, pre-authorization is required.
	  ▪ The following lens options are covered following cataract extraction when visually necessary and documented by the treating physician:
	  ▪ Tints (V2745)
	  ▪ Anti-reflective coating (V2750)
	  ▪ UV lenses (V2755)
	  ▪ Oversize lenses (V2780)
	  ▪ Aphakic without IOL: In addition to the post-surgical exam, aphakic patients who do not have an IOL are covered for the following lenses or combination of lenses when visually necessary:
	  ▪ Bifocal lenses in frames; or
	  ▪ Lenses in frames for distance vision and lenses in frames for near vision (two pairs of glasses); or
	  ▪ Conventional contact lenses for distance vision, eyeglasses for near vision to wear with contact lenses and eyeglasses to wear when the contact lenses have been removed.

Non-Covered Services	▪ Surgical eye care.

1.3 Covered Benefits - UnitedHealthcare Community Plan – Foster Care

Benefit Plan(s): UDKSM-FC

Benefit	Benefit Limitations/Criteria
Routine Exam	▪ 1 complete exam every 365 days. ▪ Additional exams covered as necessary.
Routine Exam Replacement	▪ Covered twice per calendar year if there is a prescription change or if glasses are lost or stolen and it is not possible to return to or obtain the prescription from the previous provider.
Necessary Medical Services	▪ Covered as needed when services are performed by an optometrist and are within the scope of licensure.
Frame	▪ 1 unit every calendar year beginning January 1st. ▪ Frame can be selected from the March frame kit or provider's frame selection at no cost to the member.
Frame Replacement	▪ 2 units (2 pair) per calendar year. ▪ **To identify replacement frames, please bill using modifier code RA in conjunction with the current and appropriate HCPCS code(s) for frames.**
Frame Repair	▪ Covered as needed.

Lens (Single, Bifocal, Trifocal, Polycarbonate)	▪ 2 units (1 pair) every calendar year beginning January 1st.
	  ▪ Glass or plastic single, bifocal, or trifocal lenses are covered.
	  ▪ Polycarbonate lenses are covered.
	  ▪ Scratch resistant coating is covered.
	  ▪ High index lenses are covered.
	  ▪ Plano lenses when there is a refractive error in only one eye.
	▪ **Lenses must be provided by the March lab if using the March frame kit. Please refer to Exhibit D in the Provider Reference Guide for lab information.**

Lens Replacement	▪ 4 units (2 pairs) per calendar year. ▪ **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, with prior confirmation, when ordered by a qualified health plan provider, and when such lenses provide better management of some visual or ocular conditions than can be achieved with eyeglass lenses. Covered for the following medical necessity reasons only:
	  ▪ Monocular aphakia
	  ▪ Bullous keratopathy
	  ▪ Keratoconus
	  ▪ Corneal transplant
	  ▪ Anismetropia of more than 3 diopters of difference that is causing vision distortion and cannot be corrected with glasses.
	  ▪ Anisekonia of more than 3 diopters of difference that is causing vision distortion and cannot be corrected with glasses.
	  ▪ For ocular pathology in cases where the visual acuity is not correctable to 20/70 or better without contact lenses.
	  ▪ Contact lens adaptation includes six months of care. Contact lens fitting is allowed once per lifetime when contacts are first prescribed. Subsequent fittings will be considered if a new type of contact lens is being prescribed and fitted.
	▪ **Contact lenses must be supplied by the provider.**

Benefit	Benefit Limitations/Criteria

Necessary Contact Lens Replacement	▪ Covered if lost or damaged or for a prescription change.
	▪ One of the following medical necessity reasons must also be met.
	  ▪ Monocular aphakia
	  ▪ Bullous keratopathy
	  ▪ Keratoconus
	  ▪ Corneal transplant
	  ▪ Anismetropia of more than 3 diopters of difference that is causing vision distortion and cannot be corrected with glasses.
	  ▪ Anisekonia of more than 3 diopters of difference that is causing vision distortion and cannot be corrected with glasses.
	  ▪ For ocular pathology in cases where the visual acuity is not correctable to 20/70 or better without contact lenses.
	  ▪ Contact lens adaptation includes six months of care. Contact lens fitting is allowed once per lifetime when contacts are first prescribed. Subsequent fittings will be considered if a new type of contact lens is being prescribed and fitted.

Non-Covered Services	▪ Surgical eye care.

1.4 Covered Benefits - UnitedHealthcare Community Plan – CHIP

Benefit Plan(s): UDKSM-CHIP

Benefit	Benefit Limitations/Criteria
Routine Exam	▪ 1 complete exam every 365 days. ▪ Additional exams covered as necessary.
Routine Exam Replacement	▪ Covered as needed if glasses are lost or stolen and it is not possible to return to or obtain the prescription from the previous provider.
Necessary Medical Services	▪ Covered as needed when services are performed by an optometrist and are within the scope of licensure.
Frame	▪ 1 unit every calendar year beginning January 1st. ▪ Frame can be selected from the March frame kit or provider's frame selection at no cost to the member.
Frame Replacement	▪ 2 units (2 pair) per calendar year. ▪ **To identify replacement frames, please bill using modifier code RA in conjunction with the current and appropriate HCPCS code(s) for frames.**
Frame Repair	▪ Covered as needed.

Lens (Single, Bifocal, Trifocal, Polycarbonate)	▪ 2 units (1 pair) every calendar year beginning January 1st.
	  ▪ Glass or plastic single, bifocal, or trifocal lenses are covered.
	  ▪ Polycarbonate lenses are covered.
	  ▪ Scratch resistant coating is covered.
	  ▪ High index lenses are covered.
	  ▪ Plano lenses when there is a refractive error in only one eye.
	▪ **Lenses must be provided by the March lab if using the March frame kit. Please refer to Exhibit D in the Provider Reference Guide for lab information.**

Lens Replacement	▪ 4 units (2 pairs) per calendar year. ▪ **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, with prior confirmation, when ordered by a qualified health plan provider, and when such lenses provide better management of some visual or ocular conditions than can be achieved with eyeglass lenses. Covered for the following medical necessity reasons only:
	  ▪ Monocular aphakia
	  ▪ Bullous keratopathy
	  ▪ Keratoconus
	  ▪ Corneal transplant
	  ▪ Anismetropia of more than 3 diopters of difference that is causing vision distortion and cannot be corrected with glasses.
	  ▪ Anisekonia of more than 3 diopters of difference that is causing vision distortion and cannot be corrected with glasses.
	  ▪ For ocular pathology in cases where the visual acuity is not correctable to 20/70 or better without contact lenses.
	  ▪ Contact lens adaptation includes six months of care. Contact lens fitting is allowed once per lifetime when contacts are first prescribed. Subsequent fittings will be considered if a new type of contact lens is being prescribed and fitted.
	▪ **Contact lenses must be supplied by the provider.**

Benefit	Benefit Limitations/Criteria

Necessary Contact Lens Replacement	▪ Covered if lost or damaged or for a prescription change.
	▪ One of the following medical necessity reasons must also be met.
	  ▪ Monocular aphakia
	  ▪ Bullous keratopathy
	  ▪ Keratoconus
	  ▪ Corneal transplant
	  ▪ Anismetropia of more than 3 diopters of difference that is causing vision distortion and cannot be corrected with glasses.
	  ▪ Anisekonia of more than 3 diopters of difference that is causing vision distortion and cannot be corrected with glasses.
	  ▪ For ocular pathology in cases where the visual acuity is not correctable to 20/70 or better without contact lenses.
	  ▪ Contact lens adaptation includes six months of care. Contact lens fitting is allowed once per lifetime when contacts are first prescribed. Subsequent fittings will be considered if a new type of contact lens is being prescribed and fitted.

Non-Covered Services	▪ Surgical eye care.

1.5 Spenddown

In some cases, the income of a family or individual exceeds the income standard to receive public assistance; however, their income is not sufficient to meet all medical expenses. The family group/individual must then incur a specified amount of medical expense before they are eligible for benefits. This process is referred to as spenddown. Spenddown is like an insurance deductible. It is the amount of medical costs for which a family or individual is responsible.

How to identify spenddown members

To identify spenddown beneficiaries, please refer to the Member Benefit Summary in eyeSynery®. You may also contact us at 844-506-2724.

How to determine the spenddown amount

Please login to the KMAP website at https://www.kmap-state-ks.us/provider/security/logon.asp and navigate to Eligibility to determine the unmet spenddown amount in real time.

Billing

The provider is responsible for collecting the appropriate spenddown amount from the member at the time of service. When billing, submit a claim for all services rendered and do not reduce billed charges by the spenddown amount. For example, if the Usual and Customary Charge for an eye exam is $100 and the member has a $50 spenddown, March must be billed $100 for the eye exam.

Exceptions

The following value added benefits are **NOT** subject to the spenddown.

- Routine vision exams in years 2, 3 and 4.
- Frame and lenses in years 2, 3 and 4.

Example 1 – Member receives an eye exam, frame and lenses in years 1-4.

Service	Year 1 DOS 01/01/2017	Year 2 DOS 01/01/2018	Year 3 DOS 01/01/2019	Year 4 DOS 01/01/2020
Exam	✓	✗	✗	✗
Frame	✓	✗	✗	✗
Lenses	✓	✗	✗	✗

Example 2 – Member only receives an eye exam in year one, but receives an eye exam, frame and lenses in years 2, 3 and 4.

Service	Year 1 - Exam DOS 01/01/2017	Year 2 – Exam Year 1 – Frame/Lens DOS 01/01/2018	Year 3 – Exam Year 2 – Frame/Lens DOS 01/01/2019	Year 4 – Exam Year 3 – Frame/Lens DOS 01/01/2020
Exam	✓	✗	✗	✗
Frame	N/A	✓	✗	✗
Lenses	N/A	✓	✗	✗

Example 3 – Member receives an eye exam, frame and lenses in years 1, 2, 3 and 4 and replacement frame and lenses in year 1.

Service	Year 1 DOS 01/01/2017	Year 1 DOS 06/30/2017	Year 2 DOS 01/01/2018	Year 3 DOS 01/01/2019	Year 4 DOS 01/01/2020
Exam	✓	N/A	✗	✗	✗
Frame	✓	N/A	✗	✗	✗
Lenses	✓	N/A	✗	✗	✗
Replacements	N/A	✓	N/A	N/A	N/A

✓ = Spenddown **DOES** apply

✗ = Spenddown does **NOT** apply

1.6 Medicaid Reimbursement Procedures

Medicaid members ages 21 and older and members in the Spenddown plan have the option of choosing one of the following frame benefits:

- Frame from the March frame kit, OR
- Frame from the provider's Medicaid frame selection at no cost, OR
- $100 allowance for an enhanced frame.

When the $100 allowance for an enhanced frame is used, providers must bill the current and appropriate service code for frames with modifier code 75. Reimbursement for frames will be at the lesser amount of billed charges or the contracted rate of $80.

The following example assumes a $100 retail allowance for enhanced frames and a billed amount less than the allowance.

Service Code	Description	Modifier	Billed Charges	Paid Amount
V2020	Frame	75	$ 75.00	$ 75.00
Total			**$ 75.00**	**$ 75.00**

The following example assumes a $100 retail allowance for enhanced frames and a billed amount greater than the allowance.

Service Code	Description	Modifier	Billed Charges	Paid Amount
V2020	Frame	75	$ 125.00*	$ 80.00
Total			**$ 125.00**	**$ 80.00**

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