Kentucky Specific Information

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

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1.1 Covered Benefits – Passport Health Plan by Molina Healthcare Ages 20 and Under (Medicaid)

Benefit	Benefit Limitations/Criteria
Exam	▪ 1 service date every calendar year.
Necessary Medical and Surgical Services	▪ Covered as needed when services are performed by an optometrist and are within the scope of licensure.

Eyeglasses (Single, Bifocal and Multi-focal)	▪ 1 unit every calendar year when the recipient has a diagnosed visual condition that:
	  ▪ Requires the use of eyeglasses;
	  ▪ Is within one of the following categories:
	  ▪ Amblyopia;
	  ▪ Post surgical eye condition;
	  ▪ Diminished or subnormal vision; or
	  ▪ Other diagnosis which indicates the need for eyeglasses; and
	  ▪ Requires a prescription correction in the stronger lens no weaker than:
	  ▪ +0.50, 0.50 sphere +0.50, or 0.50 cylinder;
	  ▪ 0.50 diopter of vertical prism; or
	  ▪ A total of two (2) diopter of lateral prism.
	▪ Polycarbonate and scratch coating are covered.
	▪ Tinted lenses are covered when the prescription specifically indicates a diagnosis of photophobia.
	▪ Plano safety glasses are covered when medically indicated for the recipient.
	▪ The following is covered when medically necessary:
	  ▪ Photochromics
	  ▪ Anti-reflective coating
	  ▪ Other lens options
	  ▪ Press-on prism
	▪ In-house frame and lenses **MUST** be used.

Eyeglass Replacements	▪ 1 pair every calendar year when:
	  ▪ The recipient's eyeglasses are broken or lost during the calendar year; or
	  ▪ The eyeglass prescription for the recipient is changed during the calendar year.
	▪ **To identify replacement materials, please bill using modifier code RA in conjunction with the current and appropriate HCPCS code(s) for materials.**

Medically Necessary Contacts	▪ 1 pair every calendar year when:
	  ▪ The corrected acuity in a recipient's stronger eye is 20/50 and shall be improved with the use of contact lenses;
	  ▪ The visual prescription is of + 8.00 diopter or greater; or
	  ▪ The recipient's diagnosis is 4.00 diopter anisometropia.

1.2 Covered Benefits – Passport Health Plan by Molina Healthcare Ages 21 and Older (Medicaid)

Benefit	Benefit Limitations/Criteria
Exam	▪ 1 service date every calendar year.
Necessary Medical and Surgical Services	▪ Covered as needed when services are performed by an optometrist and are within the scope of licensure.
Eyeglasses	▪ $100 allowance every 2 calendar years. ▪ Allowance may be used toward one pair of eyeglasses or contact lenses. ▪ In-house frame and lenses **MUST** be used.

1.3 Covered Benefits – Passport Health Plan by Molina Healthcare Passport Advantage HMO D-SNP (Medicare) H1799-001
Effective 01/01/2022

Benefit	Benefit Limitations/Criteria
Eyewear	▪ $300 allowance every calendar year. ▪ Allowance may be used toward frames, lenses, lens extras and contact lenses. ▪ In-house frame and lenses **MUST** be used.
Eyewear After Cataract Surgery	▪ 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.**

Glaucoma Screening	▪ 1 service date every calendar year when member is considered "at-risk" according to the following Medicare definitions of "at-risk":
	  ▪ Individuals with a family history of glaucoma
	  ▪ Individuals with diabetes mellitus
	  ▪ African-Americans ages 50 and older
	  ▪ Hispanic-Americans ages 65 and older

Non-Covered Services	▪ Medical eye care ▪ Surgical eye care

1.4 Covered Benefits – Passport Health Plan by Molina Healthcare Passport Medicare Choice Care HMO (Medicare) H1799-002 Effective 01/01/2022

Benefit	Benefit Limitations/Criteria
Routine Eye Exam	▪ 1 service date every calendar year.
Eyewear	▪ $200 allowance every calendar year. ▪ Allowance may be used toward frames, lenses, lens extras and contact lenses. ▪ In-house frame and lenses **MUST** be used.
Eyewear After Cataract Surgery	▪ 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.**
Glaucoma Screening	▪ 1 service date every calendar year when member is considered "at-risk" according to the following Medicare definitions of "at-risk": ▪ Individuals with a family history of glaucoma ▪ Individuals with diabetes mellitus ▪ African-Americans ages 50 and older ▪ Hispanic-Americans ages 65 and older
Non-Covered Services	▪ Medical eye care ▪ Surgical eye care

1.5 Covered Benefits – UnitedHealthcare Dual Complete® HMO D-SNP (Medicare) H6595-002

Benefit	Benefit Limitations/Criteria
Exam	▪ 1 service date every calendar year.
Necessary Medical Services	▪ Covered as needed when services are performed by an optometrist and are within the scope of licensure.
Eyewear	▪ $300 allowance every calendar year. ▪ Allowance may be used toward frames, lenses, lens extras and contact lenses. ▪ In-house frame and lenses **MUST** be used.
Eyewear After Cataract Surgery	▪ 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.**

Glaucoma Screening	▪ 1 service date every calendar year when member is considered "at-risk" according to the following Medicare definitions of "at-risk":
	  ▪ Individuals with a family history of glaucoma
	  ▪ Individuals with diabetes mellitus
	  ▪ African-Americans ages 50 and older
	  ▪ Hispanic-Americans ages 65 and older

Non-Covered Services	▪ Surgical eye care

1.6 Covered Benefits – UnitedHealthcare Community Plan (Medicaid)

Benefit	Benefit Limitations/Criteria
Exam	▪ 1 service date every calendar year.
Necessary Medical and Surgical Services	▪ Covered as needed when services are performed by an optometrist and are within the scope of licensure.

Eyeglasses (Single, Bifocal and Multi-focal)	▪ 1 unit every calendar year for ages 20 and under and 1 unit every 2 calendar years ages 21 and older when the recipient has a diagnosed visual condition that:
	  ▪ Requires the use of eyeglasses;
	  ▪ Is within one of the following categories:
	  ▪ Amblyopia;
	  ▪ Post surgical eye condition;
	  ▪ Diminished or subnormal vision; or
	  ▪ Other diagnosis which indicates the need for eyeglasses; and
	  ▪ Requires a prescription correction in the stronger lens no weaker than:
	  ▪ +0.50, 0.50 sphere +0.50, or 0.50 cylinder;
	  ▪ 0.50 diopter of vertical prism; or
	  ▪ A total of two (2) diopter of lateral prism.
	▪ Polycarbonate and scratch coating are covered for ages 20 and under.
	▪ Tinted lenses are covered when the prescription specifically indicates a diagnosis of photophobia for ages 20 and under.
	▪ Plano safety glasses are covered when medically indicated for the recipient for ages 20 and under.
	▪ The following is covered when medically necessary for ages 20 and under:
	  ▪ Photochromics
	  ▪ Anti-reflective coating
	  ▪ Other lens options
	  ▪ Press-on prism
	▪ In-house frame and lenses **MUST** be used.

Eyeglass Replacements	▪ 1 pair every calendar year for ages 20 and under when:
	  ▪ The recipient's eyeglasses are broken or lost during the calendar year; or
	  ▪ The eyeglass prescription for the recipient is changed during the calendar year.
	▪ **To identify replacement materials, please bill using modifier code RA in conjunction with the current and appropriate HCPCS code(s) for materials.**

Medically Necessary Contacts	▪ 1 pair every calendar year for ages 20 and under when:
	  ▪ The corrected acuity in a recipient's stronger eye is 20/50 and shall be improved with the use of contact lenses;
	  ▪ The visual prescription is of +8.00 diopter or greater; or
	  ▪ The recipient's diagnosis is 4.00 diopter anisometropia.

1.7 Passport Health Plan by Molina Healthcare Medicaid Reimbursement Procedures

Passport Health Plan by Molina Healthcare Medicaid members ages 21 and older have a $100 allowance for eyeglasses or contact lenses. Providers must bill the current and appropriate HCPCS codes for materials along with the usual and customary charges for those codes. Reimbursement will be the lesser of billed charges or billed charges up to 90% of the allowance amount.

Frame and Lenses

When the allowance is used for frames and lenses, it will be applied in the following order:

1. Basic lens codes (V2100-V2399)
2. Frame codes (V2020, V2025)
3. Any remaining allowance will be applied to lens upgrades such as tinting, scratch coating, polycarbonate lenses, etc.
4. Dispensing/fitting fees are not reimbursable

The following example assumes a $100 allowance and billed charges exceeding the allowance amount.

Service Code	Description	Billed Charges	Paid Amount
V2020	Frame	$ 50.00	$ 40.00
V2100	Lens	$ 50.00	$ 50.00
V2745	Tint	$ 35.00	$ 0.00
92340	Fitting*	$ 25.00	$ 0.00
Total		**$ 160.00****	**$ 90.00**

* Fitting is not reimbursable. This fee is not billable to the member.
**Member is responsible for charges exceeding their $100 benefit allowance. In this example, the member is responsible for $35.

The following example assumes a $100 allowance and billed charges less than the allowance amount

Service Code	Description	Billed Charges	Paid Amount
V2020	Frame	$ 35.00	$ 35.00
V2100	Lens	$ 25.00	$ 25.00
Total		**$ 60.00**	**$ 60.00**

Contact Lenses

When the allowance is use for contact lenses, it will be applied to the purchase of contact lenses. Dispensing/fitting fees are not reimbursable. Following is an example of how the allowance is applied to contact lenses.

The following example assumes a $100 allowance and a billed charges exceeding the allowance amount.

Service Code	Description	Billed Charges	Paid Amount
V2500	Contact Lenses	$ 110.00	$ 90.00
92310	Fitting*	$ 50.00	$ 0.00
Total		**$ 150.00****	**$ 90.00**

* Fitting is not reimbursable. This fee is not billable to the member.
**Member is responsible for charges exceeding their $100 benefit allowance. In this example, the member is responsible for $10.

The following example assumes a $100 allowance and billed charges less than the allowance amount.

Service Code	Description	Billed Charges	Paid Amount
V2500	Contact Lenses	$ 50.00	$ 50.00
92310	Fitting	$ 20.00	$ 0.00
Total		**$ 70.00**	**$ 50.00**