



Louisiana Specific Information

This document contains information specific to the State of Louisiana. 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 1, 2024.

- UnitedHealthcare Dual Complete[®] (Medicare) H5008-010 updated effective 01/01/2024.

1.2 Covered Benefits – UnitedHealthcare Community Plan – ages 20 and under (Medicaid)

Benefit Plan(s): UD-LA-M-20

Benefit	Benefit Limitations/Criteria
Exam	1 service date every calendar year.
Replacement Exam	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.
Necessary Medical Services	Covered as needed when services are performed by an optometrist and are within the scope of licensure.
Standard Frame	<ul style="list-style-type: none"> ▪ 1 unit every calendar year. ▪ Metal or plastic frames. The frames must be sturdy and nonflammable. Both the metal and non-metal frames must carry at least a one year manufacturer's warranty.
Deluxe Frame	<ul style="list-style-type: none"> ▪ 1 unit every calendar year (in lieu of Standard Frame) when medically necessary and documented in Member's chart. Examples include: <ul style="list-style-type: none"> ▪ Has a wide nose bridge due to a medical syndrome. ▪ Has a small head and regular frames would not fit.
Frame Replacement	<ul style="list-style-type: none"> ▪ Covered as needed. ▪ Billing for the fourth and subsequent frame must have documentation attached justifying the need for more than three pair of eyewear per calendar year. Acceptable documentation includes, but is not limited to: <ul style="list-style-type: none"> ▪ Documentation which shows the necessity of changing the prescription for the eyewear more than three times in the calendar year. ▪ Copies of the different prescriptions for eyeglasses which were written within the calendar year. ▪ Providers may dispense a replacement frame to a complete eyeglass which a recipient already owns.
Lens (Single, Bifocal, Trifocal)	<ul style="list-style-type: none"> ▪ 2 units (1 pair) every calendar year. ▪ Regular single vision lenses are covered if the following criterion is met. <ul style="list-style-type: none"> ▪ At least one lens must exceed +1.00 sphere, -0.50 sphere, or +/-0.50 plano cylinder. ▪ Regular bifocal/trifocal lenses are covered when medically necessary and documented in the Member's chart.
Polycarbonate Lens	<ul style="list-style-type: none"> ▪ 2 units (1 pair) every calendar year. ▪ Polycarbonate lenses are covered when medically necessary and documented in the Member's chart. Examples include: <ul style="list-style-type: none"> ▪ Has seizures and may be prone to fall ▪ Blind in one eye
Lens Replacement (including contact lenses)	<ul style="list-style-type: none"> ▪ Covered as needed. ▪ Billing for more than 4 replacement lenses must have documentation attached justifying the need for more than four replacement lenses per calendar year. Acceptable documentation includes, but is not limited to: <ul style="list-style-type: none"> ▪ Documentation which shows the necessity of changing the prescription for the eyewear more than three times in the calendar year. ▪ Copies of the different prescriptions for eyeglasses which were written within the calendar year.

Benefit	Benefit Limitations/Criteria
Contact Lenses	<ul style="list-style-type: none"> ▪ 2 units (1 lens per eye) every calendar year in lieu of eyeglasses; requires prior confirmation. ▪ Medically necessary contact lenses are covered when the following criterion is met: <ul style="list-style-type: none"> ▪ An unusual eye disease or disorder exists which is not correctable with eyeglasses; ▪ Nystagmus, congenital or acquired but not latent monocular, where there is significant improvement of the visual acuity with contact lens wear; ▪ Irregular cornea or irregular astigmatism (does not apply if the recipient has had previous refractive surgery); ▪ Significant, symptomatic anisometropia; or ▪ Aphakia (post surgical).
Non-Covered Services	<ul style="list-style-type: none"> ▪ Services not mentioned above are not administered by March, including, but not limited to: <ul style="list-style-type: none"> ▪ Surgical eye care ▪ Low vision aids ▪ Tinted Lenses ▪ Hi Index Lenses ▪ Polarized Lenses ▪ “Spare” or “back-up” eyewear ▪ Eyewear upgrades for cosmetic purposes

1.3 Covered Benefits – UnitedHealthcare Community Plan – ages 21 and older (Medicaid)

Benefit Plan(s): UD-LA-M-21

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.
Frame and Lenses	<ul style="list-style-type: none"> ▪ \$100 allowance toward one pair of frames & lenses every calendar year.
Contact Lenses	<ul style="list-style-type: none"> ▪ Up to \$105 allowance in lieu of glasses for fitting/evaluation, contacts (disposable contacts up to four boxes, depending on prescription) and up to two follow-up visits every calendar year.
Non-Covered Services	<ul style="list-style-type: none"> ▪ Services not mentioned above are not administered by March, including, but not limited to: <ul style="list-style-type: none"> ▪ Surgical eye care ▪ Low vision aids ▪ “Spare” or “back-up” eyewear ▪ Eyewear upgrades for cosmetic purposes



1.4 Covered Benefits – UnitedHealthcare Dual Complete® (Medicare) H5008-010

Benefit Plan(s): UDLAS-DC

Benefit	Benefit Limitations/Criteria
Exam	<ul style="list-style-type: none">1 service date every calendar year.
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">\$400 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	<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.
Glaucoma Screening	<ul style="list-style-type: none">1 service date every calendar year when member is considered “at-risk” according to the following Medicare definitions of “at-risk”:<ul style="list-style-type: none">Individuals with a family history of glaucomaIndividuals with diabetes mellitusAfrican-Americans ages 50 and olderHispanic-Americans ages 65 and older
Non-Covered Services	<ul style="list-style-type: none">Surgical eye care