



## Maryland Specific Information

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

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1.1 Covered Benefits - UnitedHealthcare Community Plan Maryland HealthChoice Ages 20 and Under (Medicaid) (UDMDM-20)

Benefit	Benefit Limitations/Criteria
Routine Exam	<ul style="list-style-type: none"> <li>1 service date every year.</li> </ul>
Exam Replacement	<ul style="list-style-type: none"> <li>Covered as needed when eyewear is lost, broken, stolen, or otherwise when necessary if it is not possible to return to or obtain the prescription from the previous provider.</li> </ul>
Necessary Medical Services	<ul style="list-style-type: none"> <li>Covered as needed when services are performed by an optometrist and are within the scope of licensure.</li> </ul>
Frame	<ul style="list-style-type: none"> <li>1 unit every year.</li> <li>Frame may be selected from the March frame kit <u>OR</u> a \$50 retail allowance may be used toward any frame in the provider's selection. <b>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.</b></li> </ul>
Frame Replacement	<ul style="list-style-type: none"> <li>Covered as needed when eyewear is lost, broken, stolen, or otherwise when necessary.</li> <li><b>Replacement frame must be selected from the March frame kit. If existing lenses can not be inserted into the March frame, new lenses may be obtained from the March lab.</b></li> <li><b>To identify replacement frames, please bill with modifier RA.</b></li> </ul>
Lens	<ul style="list-style-type: none"> <li>2 units (1 pair) every year.</li> <li><b>Lenses must be provided by the March lab for lenses. Please refer to Exhibit D in the Provider Reference Guide for lab information. Provider is responsible for the cost of traceable shipping of a non-March frame to the March lab for lens insertion.</b></li> <li>Regular single vision, bifocal and trifocal lenses are covered.</li> </ul>
Lens Replacement	<ul style="list-style-type: none"> <li>Covered as needed when eyewear is lost, broken, stolen, or otherwise when necessary.</li> <li>Regular single vision, bifocal, trifocal and polycarbonate lenses are covered.</li> <li><b>Replacement lenses must be obtained from the March lab and inserted into the member's existing frame. The provider is responsible for any costs associated with shipping the frame to the March lab for lens insertion.</b></li> <li><b>To identify replacement lenses, please bill with modifier RA.</b></li> </ul>
Polycarbonate Lens	<ul style="list-style-type: none"> <li>2 units (1 pair) every year.</li> </ul>
Contact Lenses	<ul style="list-style-type: none"> <li>\$200 allowance in lieu of eyeglasses every year.</li> <li><b>To identify contact lenses provided using the allowance, 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.</b></li> <li><b>Contact lenses must be supplied by the provider.</b></li> <li>Contact lens fitting is separately reimbursable and may not be deducted from the allowance.</li> </ul>
Necessary Contact Lenses	<ul style="list-style-type: none"> <li>2 units (1 pair) every year.</li> <li>Necessary contact lenses are covered when contact lenses provide better management of a visual or ocular condition than can be achieved with spectacle lenses, including, but not limited to the diagnosis of: <ul style="list-style-type: none"> <li>Unilateral aphakia</li> <li>Keratoconus when vision with eyeglasses is less than 20/40</li> <li>Corneal transplant when vision with eyeglasses is less than 20/40</li> <li>Anisometropia that is greater than or equal to 4.00 diopter</li> </ul> </li> <li><b>Contact lenses must be supplied by the provider.</b></li> <li>Allowance is not applicable.</li> </ul>
Necessary Contact Lens Replacements	<ul style="list-style-type: none"> <li>Covered as needed when initial criteria for medically necessary contact lenses is met.</li> <li><b>To identify replacement contact lenses, please bill with modifier RA.</b></li> </ul>
Non-Covered Services	<ul style="list-style-type: none"> <li>Surgical eye care.</li> </ul>

Benefit	Benefit Limitations/Criteria
	<ul style="list-style-type: none"><li data-bbox="480 267 951 292">▪ Lens extras except as described above.</li><li data-bbox="480 293 821 318">▪ Contact lens replacements.</li></ul>

**1.2 Covered Benefits - UnitedHealthcare Community Plan Maryland HealthChoice Ages 21 and Older (Medicaid) (UDMDM-21)**

<b>Benefit</b>	<b>Benefit Limitations/Criteria</b>
Routine Exam	<ul style="list-style-type: none"> <li>▪ 1 service date every 2 years.</li> </ul>
Diabetic Exam	<ul style="list-style-type: none"> <li>▪ Covered as needed with a diagnosis of diabetes.</li> </ul>
Necessary Medical Services	<ul style="list-style-type: none"> <li>▪ Covered as needed when services are performed by an optometrist and are within the scope of licensure.</li> </ul>
Frame and Lenses	<ul style="list-style-type: none"> <li>▪ \$150 allowance every 2 years.</li> <li>▪ Allowance may be used toward frames, lenses or lens extras.</li> <li>▪ In-house frame and lenses <b>MUST</b> be used.</li> </ul>
Contact Lenses	<ul style="list-style-type: none"> <li>▪ \$200 allowance in lieu of eyeglasses every 2 years.</li> <li>▪ <b>To identify contact lenses provided using the allowance, 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.</b></li> <li>▪ <b>Contact lenses must be supplied by the provider.</b></li> <li>▪ Contact lens fitting is separately reimbursable and may not be deducted from the allowance.</li> </ul>
Necessary Contact Lenses	<ul style="list-style-type: none"> <li>▪ 2 units (1 pair) every 2 years.</li> <li>▪ Necessary contact lenses are covered when contact lenses provide better management of a visual or ocular condition than can be achieved with spectacle lenses, including, but not limited to the diagnosis of: <ul style="list-style-type: none"> <li>▪ Unilateral aphakia</li> <li>▪ Keratoconus when vision with eyeglasses is less than 20/40</li> <li>▪ Corneal transplant when vision with eyeglasses is less than 20/40</li> <li>▪ Anisometropia that is greater than or equal to 4.00 diopter</li> </ul> </li> <li>▪ <b>Contact lenses must be supplied by the provider.</b></li> <li>▪ Allowance is not applicable.</li> </ul>
Non-Covered Services	<ul style="list-style-type: none"> <li>▪ Surgical eye care.</li> <li>▪ Lens extras except as described above.</li> </ul>

### 1.3 Medicaid Ages 20 and Under Reimbursement Procedures

The benefit affords members the opportunity to:

- Select a frame from the March frame kit, OR
- Use a set retail allowance toward the cost of any frame in the provider's selection, OR
- Use a set retail allowance toward the cost of contact lenses in lieu of frame and lenses.

The following examples illustrate reimbursement when the March frame kit is used and when the retail allowance is used for frames or contact lenses in lieu of frame and lenses. These examples are for illustrative purposes only and may not reflect actual amounts.

#### March Frame Kit

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 contracted rate. Frame and lens codes are not reimbursable and should not be billed as materials are provided by the March lab.

The following example assumes a contracted rate of \$27.88 for the fitting of spectacles.

Service Code	Description	Modifier	Billed Charges	Paid Amount
92340	Fitting of Spectacles		\$ 50.00	\$ 27.88
<b>Total</b>			<b>\$ 50.00</b>	<b>\$ 27.88</b>

#### Retail Allowance - Frames

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 allowance amount. Lens codes are not reimbursable and should not be billed as materials are provided by the March lab.

The following example assumes a \$50 retail allowance for frames and a billed amount less than the allowance.

Service Code	Description	Modifier	Billed Charges	Paid Amount
V2020	Frame	75	\$ 45.00	\$ 45.00
92340	Fitting of Spectacles*		\$ 40.00	\$ 0.00
<b>Total</b>			<b>\$ 85.00</b>	<b>\$ 45.00</b>

\* Fitting of Spectacles is not reimbursable when frames are dispensed from the provider's selection. This fee is not billable to the member.

The following example assumes a \$50 retail allowance for frames and a billed amount greater than the allowance.

Service Code	Description	Modifier	Billed Charges	Paid Amount
V2020	Frame	75	\$ 75.00*	\$ 50.00
92340	Fitting of Spectacles**		\$ 40.00	\$ 0.00
<b>Total</b>			<b>\$ 115.00</b>	<b>\$ 50.00</b>

\*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 frames are dispensed from the provider's selection. This fee is not billable to the member.

In all instances, providers are required to use the March lab for lenses. Providers will be responsible for the cost of shipping non-March frames to the contracted lab for fabrication. This cost is not billable to the member nor can it be deducted from the member's allowance.

### Retail Allowance - Contact Lenses

Providers must bill the current and appropriate service code for contact lenses. Reimbursement for contact lenses will be at the lesser amount of billed charges or the allowance amount.

The following example assumes a \$200 retail allowance for contact lenses and a billed amount less than the allowance and a contracted rate of \$75.28 for the contact lens fitting.

Service Code	Description	Modifier	Billed Charges	Paid Amount
V2500	Contact Lenses	75	\$ 175.00	\$ 175.00
92310	Contact Lens Fitting	75	\$ 80.00	\$ 75.28
<b>Total</b>			<b>\$ 255.00</b>	<b>\$ 250.28</b>

The following example assumes a \$200 retail allowance for contact lenses and a billed amount greater than the allowance and a contracted rate of \$75.28 for the contact lens fitting.

Service Code	Description	Modifier	Billed Charges	Paid Amount
V2500	Contact Lenses	75	\$ 225.00*	\$ 200.00
92310	Contact Lens Fitting	75	\$ 80.00	\$ 75.28
<b>Total</b>			<b>\$ 305.00</b>	<b>\$ 275.28</b>

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

Providers are required to use in-house contact lenses.

#### 1.4 Medicaid Ages 21 and Older Reimbursement Procedures

Members ages 21 and older have a \$150 allowance for eyeglasses or a \$200 allowance for 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 80% 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 \$150 allowance and billed charges exceeding the allowance amount.

Service Code	Description	Billed Charges	Paid Amount
V2020	Frame	\$ 50.00	\$ 40.00
V2100	Lens	\$ 80.00	\$ 80.00
V2745	Tint	\$ 35.00	\$ 0.00
92340	Fitting*	\$ 25.00	\$ 0.00
<b>Total</b>		<b>\$ 190.00**</b>	<b>\$ 120.00</b>

\* Fitting is not reimbursable. This fee is not billable to the member.

\*\*Member is responsible for charges exceeding their \$150 benefit allowance. In this example, the member is responsible for \$15.

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
<b>Total</b>		<b>\$ 60.00</b>	<b>\$ 60.00</b>

##### Contact Lenses

Providers must bill the current and appropriate service code for contact lenses. Reimbursement for contact lenses will be at the lesser amount of billed charges or the allowance amount.

The following example assumes a \$200 retail allowance for contact lenses and a billed amount less than the allowance and a contracted rate of \$75.28 for the contact lens fitting.

Service Code	Description	Modifier	Billed Charges	Paid Amount
V2500	Contact Lenses	75	\$ 175.00	\$ 175.00
92310	Contact Lens Fitting	75	\$ 80.00	\$ 75.28
<b>Total</b>			<b>\$ 255.00</b>	<b>\$ 250.28</b>

The following example assumes a \$200 retail allowance for contact lenses and a billed amount greater than the allowance and a contracted rate of \$75.28 for the contact lens fitting.

Service Code	Description	Modifier	Billed Charges	Paid Amount
V2500	Contact Lenses	75	\$ 225.00*	\$ 200.00
92310	Contact Lens Fitting	75	\$ 80.00	\$ 75.28
<b>Total</b>			<b>\$ 305.00</b>	<b>\$ 275.28</b>

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

Providers are required to use in-house contact lenses.