Nebraska Specific Information

This document contains information specific to the State of Nebraska. 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 June 4, 2025.

- Added Interpreter Services for Medicaid plans.

1.2 Covered Benefits – UnitedHealthcare Dual Complete® NE-S002 (Medicare) H2001-054

Plan ID(s): UDNE-DSNP5

Benefit	Benefit Limitations/Criteria
Exam	▪ 1 service date every calendar year.
Eyewear	▪ $250 allowance for 1 pair of frames/lenses/lens extras and/or contacts every calendar year. ▪ 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

1.3 Covered Benefits – UnitedHealthcare Dual Complete® NE-S001 (Medicare) H0169-003

Plan ID(s): UDNE-DSNP

Benefit	Benefit Limitations/Criteria
Exam	▪ 1 service date every calendar year.
Eyewear	▪ $300 allowance for 1 pair of frames/lenses/lens extras and/or contacts every calendar year. ▪ 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 per lifetime, per eye after cataract surgery. ▪ Allowance does not apply and may not be used towards extras. Any add on items will be denied.
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 – UnitedHealthcare Dual Complete® NE-S003 (Medicare) H2802-053

Plan ID(s): UDNE-DSNP2

Benefit	Benefit Limitations/Criteria
Exam	▪ 1 service date every calendar year.
Eyewear	▪ $300 allowance for 1 pair of frames/lenses/lens extras and/or contacts every calendar year. ▪ 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 per lifetime, per eye after cataract surgery. ▪ Allowance does not apply and may not be used towards extras. Any add on items will be denied.
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® NE-V001 (Medicare) H0169-006

Plan ID(s): UDNE-DSNP3

Benefit	Benefit Limitations/Criteria
Exam	▪ 1 service date every calendar year.
Eyewear	▪ $250 allowance for 1 pair of frames/lenses/lens extras and/or contacts every calendar year. ▪ 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 per lifetime, per eye after cataract surgery. ▪ Allowance does not apply and may not be used towards extras. Any add on items will be denied.
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

1.6 Covered Benefits – UnitedHealthcare Community Plan Ages 20 and Under (Medicaid)

Plan ID(s): UDNEM-20

Benefit	Benefit Limitations/Criteria
Exam	▪ 1 exam every 12 months. ▪ More frequent exams will be covered if medically necessary.
Exam Replacement	▪ Covered as needed if glasses are lost, damaged or size change due to growth and it is not possible to return to or obtain the prescription from the previous provider.

Frame	▪ 1 unit every 12 months, to the day, when either of the two following conditions is met:
	  ▪ Required for one of the following medical reasons:
	  ▪ The member's first pair of prescription eyeglasses;
	  ▪ Size change needed due to growth; or
	  ▪ A prescribed lens change, only if new lenses cannot be accommodated by the member frame.
	  ▪ The member's current frame is no longer useable due to irreparable wear/damage, breakage or loss.
	▪ The following specifications apply to all frames:
	  ▪ Plastic and metal frames are covered; rimless frames are not covered.
	  ▪ Discontinued frames with new prescription lenses are not covered; and
	  ▪ Frame cases are covered with new eyeglasses.
	▪ Frames are covered more frequently if necessary and appropriate.
	▪ **Frame must be selected from the March frame kit.**
	▪ Member is financially responsible for full cost of non-March frame. Member must be notified in advance and in writing that they are responsible for the full cost of the frames including the fitting cost.

Frame Replacement	▪ Covered as needed if medically necessary and appropriate. ▪ **To identify replacement frames, please bill using modifier code RA in conjunction with the current and appropriate HCPCS code(s) for frames.**

Lenses	▪ 2 units (1 pair) every 12 months, to the day, when either of the two following conditions is met:
	  ▪ Required for one of the following medical reasons:
	  ▪ The member's first pair of prescription eyeglasses;
	  ▪ Size change needed due to growth; or
	  ▪ New lenses are required due to a new prescription when the refraction correction meets one of the following criteria (A copy of the former and current prescriptions must be maintained in the provider's records.):
	  ▪ A change of 0.50 diopters in the meridian of greatest change when placed on an optical cross;
	  ▪ A change in axis in excess of 10 degrees for 0.50 cylinder, 5 degrees for 0.75 cylinder; or
	  ▪ A change of prism correction of ½ prism diopter vertically or 2 prism diopters horizontally or more.
	  ▪ The member's current lenses are no longer useable due to damage, breakage or loss.
	▪ When one lens meets the criteria for coverage, both lenses may be provided, unless the prescribing practitioner specifies replacement of one lens only.
	▪ Lenses are covered more frequently when medically necessary and appropriate.
	▪ **Lenses must be provided by the March lab. Please refer to Exhibit D in the Provider Reference Guide for lab information.**
	Lens Specifications:
	▪ The following specifications apply to all eyeglass lenses:
	▪ Lenses are covered only if the refraction correction is at least 0.50 diopters in any meridian.

Benefit	Benefit Limitations/Criteria

	▪ Lenses may be plastic or glass.
	▪ All plastic lenses must include front surface scratch resistant coating (factory applied or "in-house" dipped). The cost for the scratch resistant coating must be included in the lens cost and is not billed under a separate procedure code. The laboratory invoice must indicate that the scratch resistant coating was provided. Medicaid does not require that lenses with scratch resistant coating be warranted.
	▪ Lenses must be of a quality at least equal to Z-80 standards of the American National Standard Institute; and
	▪ All lenses dispensed must be prescribed by a licensed practitioner. A copy of the prescribing practitioner's original prescription must be maintained in the provider's records and must be readily available for review by the Department upon request.
	Special Lens Features:
	▪ Bifocal and trifocal segments exceeding 28mm - covered only if necessary for specific employment or educational purposes, or due to a specific disability which limits head and neck movement.
	▪ High index lenses are covered when there is +/- 10.00 diopter in the meridian of greatest power when placed on an optical cross.
	▪ Myodisc lenses are covered only if prescribed.
	▪ Nylon cord, metal cord, or rimless mount - covered only if the member purchases own frame or uses previously purchased frame.
	▪ Oversize lenses covered if:
	  ▪ Medically necessary - examples include:
	  ▪ Narrow interpupillary distance
	  ▪ Unusual facial configuration
	  ▪ The member purchases his/her own frame or uses previously purchased frame.
	▪ Polycarbonate (standard and thin) lenses are covered.
	▪ Slab-off prism covered when there is at least 3.00 diopter of anisometropia in the vertical meridian.
	▪ Special base curve is covered for aniseikonia.
	▪ Tint is covered when there is significant photophobia under indoor lighting conditions. Simple “photophobia” is not an acceptable diagnosis for coverage.
	▪ UV is covered when there is a chronic disorder that is complicated or accelerated by ultraviolet light.
	▪ Balance lenses are covered.
	▪ Press on fresnel prism lenses are covered.
	▪ Occluder lenses are covered.

Lens Replacement	▪ Covered as needed if lost, damaged, size change due to growth or prescription change. If lenses are needed due to prescription change one of the following criteria must be met:
	  ▪ Change of 0.50 diopters in the meridian of greatest change when placed on an optical cross.
	  ▪ Change in axis in excess of 10 degrees for 0.50 cylinder, 5 degrees for 0.75 cylinder.
	  ▪ Change of prism correction of ½ prism diopter vertically or 2 prism diopters horizontally or more.
	▪ **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 when medically necessary for the treatment of the following diseases or injury to the eye:
	  ▪ Keratoconus
	  ▪ Aphakia (excluding pseudophakia)
	  ▪ High plus corrections of +12.00 diopters (spherical equivalent) or greater due to the visual field defect caused by a high plus correction.
	  ▪ High minus corrections of -12.00 diopters (spherical equivalent) or greater, but only with an increase in binocular best visual acuity of at least 2 Snellen lines when comparing the contact lenses to the spectacle lens correction.

Benefit	Benefit Limitations/Criteria
	▪ Anisometropia (difference in correction) of at least 6.00 diopters (spherical equivalent) in order to avoid double vision. ▪ Other pathological conditions of the eye when useful vision cannot be obtained with eyeglasses.
Necessary Contact Lens Replacements	▪ Covered as needed due to loss, damage or prescription change. For prescription change one of the following criteria must be met: ▪ Change of 0.50 diopters in the meridian of greatest change when placed on an optical cross. ▪ Change in axis in excess of 10 degrees for 0.50 cylinder, 5 degrees for 0.75 cylinder. ▪ Change of prism correction of ½ prism diopter vertically or 2 prism diopters horizontally or more.
Repairs	▪ Repair of damaged lenses and/or frames is covered. ▪ If damage cannot be repaired or repair costs exceed the Medicaid allowable amount for new frames and lenses, the provider must dispense new eyeglasses. ▪ Applicable manufacturer warranties are considered to be a third party resource, and must be utilized in accordance with 471 NAC 3-004.
Interpreter Services	▪ Oral or sign language interpretation services will be covered only when an additional cost is incurred from the servicing provider and will not be reimbursed when the provider does not incur an added cost to provide the service. Examples include but are not limited to: ▪ Interpretation service is provided by bilingual/ASL trained provider staff who are providing the covered Medicaid services, ▪ Interpretation service is provided by the patient's family member or a friend, ▪ When a free software program such as Google translate is used ▪ And when the following criteria is met: ▪ Providers may only bill for these services if offered in conjunction with a Medicaid covered service, ▪ The rule of 8's will be followed for billing. This means that a minimum of 8 minutes of service must be provided to bill for a quarter hour (15-minute period) ▪ The billing provider must document the member's record with the following information: ▪ Interpreter's name or company name with which the interpreter is associated with ▪ Type of service provided, ▪ Method or interpretation (e.g. in person or via phone) ▪ Date and time of the interpretation ▪ Service duration (time in and time out), ▪ A general description of the medical service that patient received ▪ **To identify interpreter services please use code T1013 for Sign Language, Oral interpretive, and Translator services. The service can be billed in increments of 15 minutes up to a maximum of 2 hours (or 8 units).**
Services Not Covered by March	▪ Medical eye care. ▪ Surgical eye care. Contact UntiedHealthcare Community Plan for more information.

1.7 Covered Benefits – UnitedHealthcare Community Plan Ages 21 and Older (Medicaid)

Plan ID(s): UDNEM-21

Benefit	Benefit Limitations/Criteria
Exam	▪ 1 exam every 24 months. ▪ More frequent exams will be covered if medically necessary.
Exam Replacement	▪ Covered as needed if glasses are lost, damaged and it is not possible to return to or obtain the prescription from the previous provider.

Frame	▪ 1 unit every 24 months, to the day, when either of the two following conditions is met:
	  ▪ Required for one of the following medical reasons:
	  ▪ The member's first pair of prescription eyeglasses;
	  ▪ Size change needed due to growth; or
	  ▪ A prescribed lens change, only if new lenses cannot be accommodated by the member frame.
	  ▪ The member's current frame is no longer useable due to irreparable wear/damage, breakage or loss.
	▪ The following specifications apply to all frames:
	  ▪ Plastic and metal frames are covered.
	  ▪ Discontinued frames with new prescription lenses are not covered.
	  ▪ Frame cases are covered with new eyeglasses.
	▪ **Frame must be selected from the March frame kit.**
	▪ Member is financially responsible for full cost of non-March frame. Member must be notified in advance and in writing that they are responsible for the full cost of the frames including the fitting cost.

Frame Replacement	▪ 1 unit every 12 months when frame is irreparable due to wear/damage, breakage or loss. ▪ **To identify replacement frames, please bill using modifier code RA in conjunction with the current and appropriate HCPCS code(s) for frames.**

Lenses	▪ 2 units (1 pair) every 24 months, to the day, when the following is present:
	  ▪ Required for one of the following medical reasons:
	  ▪ The member's first pair of prescription eyeglasses;
	  ▪ Size change needed due to growth; or
	  ▪ New lenses are required due to a new prescription when the refraction correction meets one of the following criteria (A copy of the former and current prescriptions must be maintained in the provider's records.):
	  ▪ A change of 0.50 diopters in the meridian of greatest change when placed on an optical cross;
	  ▪ A change in axis in excess of 10 degrees for 0.50 cylinder, 5 degrees for 0.75 cylinder; or
	  ▪ A change of prism correction of ½ prism diopter vertically or 2 prism diopters horizontally or more.
	  ▪ The members current lenses are no longer useable due to damage, breakage or loss.
	▪ When one lens meets the criteria for coverage, both lenses may be provided, unless the prescribing practitioner specifies replacement of one lens only.
	▪ **Lenses must be provided by the March lab. Please refer to Exhibit D in the Provider Reference Guide for lab information.**
	Lens Specifications:
	▪ The following specifications apply to all eyeglass lenses:
	▪ Lenses are covered only if the refraction correction is at least 0.50 diopters in any meridian.
	▪ Lenses may be plastic or glass.
	▪ All plastic lenses must include front surface scratch resistant coating (factory applied or "in-house" dipped). The cost for the scratch resistant coating must be included in the lens cost and is not billed under a separate procedure code. The laboratory invoice must

Benefit	Benefit Limitations/Criteria

	indicate that the scratch resistant coating was provided. Medicaid does not require that lenses with scratch resistant coating be warranted.
	▪ Lenses must be of a quality at least equal to Z-80 standards of the American National Standard Institute; and
	▪ All lenses dispensed must be prescribed by a licensed practitioner. A copy of the prescribing practitioner's original prescription must be maintained in the provider's records and must be readily available for review by the Department upon request.
	Special Lens Features:
	▪ Glass or plastic single lenses are covered.
	▪ Bifocal and trifocal segments exceeding 28mm - covered only if necessary for specific employment or educational purposes, or due to a specific disability which limits head and neck movement.
	▪ High index lenses are covered where there is +/- 10.00 diopter in the meridian of greatest power when placed on an optical cross.
	▪ Myodisc lenses are covered only if prescribed.
	▪ Nylon cord, metal cord, or rimless mount - covered only if the member purchases own frame or uses previously purchased frame.
	▪ Oversize lenses covered if:
	  ▪ Medically necessary - examples include:
	  ▪ Narrow interpupillary distance
	  ▪ Unusual facial configuration
	  ▪ The member purchases his/her own frame or uses previously purchased frame.
	▪ Polycarbonate (standard) lenses are covered only if prescribed for members with significantly monocular vision (e.g. due to amblyopia, eye injury, eye disease, or other disorder).
	▪ Polycarbonate (thin) lenses are covered only if the refraction correction is at least +/- 8.00 diopters in the meridian of greatest power when placed on an optical cross.
	▪ Slab-off prism covered when there is at least 3.00 diopters of anisometropia in the vertical meridian.
	▪ Special base curve is covered for aniseikonia.
	▪ Tint is covered when there is significant photophobia under indoor lighting conditions. Simple “photophobia” is not an acceptable diagnosis for coverage. Photochromatic tints and sunglasses are not covered.
	▪ UV is covered when there is a chronic disorder that is complicated or accelerated by ultraviolet light.
	▪ Balance lenses are covered.
	▪ Press on fresnel prism lenses are covered.
	▪ Occluder lenses are covered.

Lens Replacement	▪ 2 units (1 pair) every 12 months if lost, damaged, or prescription change. If lenses are needed due to prescription change one of the following criteria must be met:
	  ▪ Change of 0.50 diopters in the meridian of greatest change when placed on an optical cross.
	  ▪ Change in axis in excess of 10 degrees for 0.50 cylinder, 5 degrees for 0.75 cylinder.
	  ▪ Change of prism correction of ½ prism diopter vertically or 2 prism diopters horizontally or more.
	▪ **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 when medically necessary for the treatment of the following diseases or injury to the eye:
	  ▪ Keratoconus
	  ▪ Aphakia (excluding pseudophakia)
	  ▪ High plus corrections of +12.00 diopters (spherical equivalent) or greater due to the visual field defect caused by a high plus correction.

Benefit	Benefit Limitations/Criteria
	▪ High minus corrections of -12.00 diopters (spherical equivalent) or greater, but only with an increase in binocular best visual acuity of at least 2 Snellen lines when comparing the contact lenses to the spectacle lens correction. ▪ Anisometropia (difference in correction) of at least 6.00 diopters (spherical equivalent) in order to avoid double vision. ▪ Other pathological conditions of the eye when useful vision cannot be obtained with eyeglasses.
Necessary Contact Lens Replacements	▪ Covered as needed due to loss, damage or prescription change. For prescription change one of the following criteria must be met: ▪ Change of 0.50 diopters in the meridian of greatest change when placed on an optical cross. ▪ Change in axis in excess of 10 degrees for 0.50 cylinder, 5 degrees for 0.75 cylinder. ▪ Change of prism correction of ½ prism diopter vertically or 2 prism diopters horizontally or more.
Repairs	▪ Repair of damaged lenses and/or frames is covered. ▪ If damage cannot be repaired or repair costs exceed the Medicaid allowable amount for new frames and lenses, the provider must dispense new eyeglasses. ▪ Applicable manufacturer warranties are considered to be a third party resource, and must be utilized in accordance with 471 NAC 3-004.
Interpreter Services	▪ Oral or sign language interpretation services will be covered only when an additional cost is incurred from the servicing provider and will not be reimbursed when the provider does not incur an added cost to provide the service. Examples include but are not limited to: ▪ Interpretation service is provided by bilingual/ASL trained provider staff who are providing the covered Medicaid services, ▪ Interpretation service is provided by the patient's family member or a friend, ▪ When a free software program such as Google translate is used ▪ And when the following criteria is met: ▪ Providers may only bill for these services if offered in conjunction with a Medicaid covered service, ▪ The rule of 8's will be followed for billing. This means that a minimum of 8 minutes of service must be provided to bill for a quarter hour (15-minute period) ▪ The billing provider must document the member's record with the following information: ▪ Interpreter's name or company name with which the interpreter is associated with ▪ Type of service provided, ▪ Method or interpretation (e.g. in person or via phone) ▪ Date and time of the interpretation ▪ Service duration (time in and time out), ▪ A general description of the medical service that patient received ▪ **To identify interpreter services please use code T1013 for Sign Language, Oral interpretive, and Translator services. The service can be billed in increments of 15 minutes up to a maximum of 2 hours (or 8 units).**
Services Not Covered by March	▪ Medical eye care. ▪ Surgical eye care. Contact UnitedHealthcare Community Plan for more information.

1.8 Covered Benefits – UnitedHealthcare Community Plan Heritage Health Adult Expansion Prime Ages 19 and 20 (Medicaid)

Plan ID(s): UDNEM-P19

Benefit	Benefit Limitations/Criteria
Exam	▪ 1 exam every 12 months. ▪ More frequent exams will be covered if medically necessary.
Exam Replacement	▪ Covered as needed if glasses are lost, damaged or size change due to growth and it is not possible to return to or obtain the prescription from the previous provider.

Frame	▪ 1 unit every 24 months, to the day, when either of the two following conditions is met:
	  ▪ Required for one of the following medical reasons:
	  ▪ The member's first pair of prescription eyeglasses;
	  ▪ Size change needed due to growth; or
	  ▪ A prescribed lens change, only if new lenses cannot be accommodated by the member frame.
	  ▪ The member's current frame is no longer useable due to irreparable wear/damage, breakage or loss.
	▪ The following specifications apply to all frames:
	  ▪ Plastic and metal frames are covered; rimless frames are not covered.
	  ▪ Discontinued frames with new prescription lenses are not covered; and
	  ▪ Frame cases are covered with new eyeglasses.
	▪ Frames are covered more frequently if necessary and appropriate.
	▪ **Frame must be selected from the March frame kit.**
	▪ Member is financially responsible for full cost of non-March frame. Member must be notified in advance and in writing that they are responsible for the full cost of the frames including the fitting cost.

Frame Replacement	▪ Covered as needed if medically necessary and appropriate. ▪ **To identify replacement frames, please bill using modifier code RA in conjunction with the current and appropriate HCPCS code(s) for frames.**

Lenses	▪ 2 units (1 pair) every 24 months, to the day, when either of the two following conditions is met:
	  ▪ Required for one of the following medical reasons:
	  ▪ The member's first pair of prescription eyeglasses;
	  ▪ Size change needed due to growth; or
	  ▪ New lenses are required due to a new prescription when the refraction correction meets one of the following criteria (A copy of the former and current prescriptions must be maintained in the provider's records.):
	  ▪ A change of 0.50 diopters in the meridian of greatest change when placed on an optical cross;
	  ▪ A change in axis in excess of 10 degrees for 0.50 cylinder, 5 degrees for 0.75 cylinder; or
	  ▪ A change of prism correction of ½ prism diopter vertically or 2 prism diopters horizontally or more.
	  ▪ The member's current lenses are no longer useable due to damage, breakage or loss.
	▪ When one lens meets the criteria for coverage, both lenses may be provided, unless the prescribing practitioner specifies replacement of one lens only.
	▪ Lenses are covered more frequently when medically necessary and appropriate.
	▪ **Lenses must be provided by the March lab. Please refer to Exhibit D in the Provider Reference Guide for lab information.**
	Lens Specifications:
	▪ The following specifications apply to all eyeglass lenses:
	▪ Lenses are covered only if the refraction correction is at least 0.50 diopters in any meridian.

Benefit	Benefit Limitations/Criteria

	▪ Lenses may be plastic or glass.
	▪ All plastic lenses must include front surface scratch resistant coating (factory applied or "in-house" dipped). The cost for the scratch resistant coating must be included in the lens cost and is not billed under a separate procedure code. The laboratory invoice must indicate that the scratch resistant coating was provided. Medicaid does not require that lenses with scratch resistant coating be warranted.
	▪ Lenses must be of a quality at least equal to Z-80 standards of the American National Standard Institute; and
	▪ All lenses dispensed must be prescribed by a licensed practitioner. A copy of the prescribing practitioner's original prescription must be maintained in the provider's records and must be readily available for review by the Department upon request.
	Special Lens Features:
	▪ Bifocal and trifocal segments exceeding 28mm - covered only if necessary for specific employment or educational purposes, or due to a specific disability which limits head and neck movement.
	▪ High index lenses are covered when there is +/- 10.00 diopter in the meridian of greatest power when placed on an optical cross.
	▪ Myodisc lenses are covered only if prescribed.
	▪ Nylon cord, metal cord, or rimless mount - covered only if the member purchases own frame or uses previously purchased frame.
	▪ Oversize lenses covered if:
	  ▪ Medically necessary - examples include:
	  ▪ Narrow interpupillary distance
	  ▪ Unusual facial configuration
	  ▪ The member purchases his/her own frame or uses previously purchased frame.
	▪ Polycarbonate (standard and thin) lenses are covered.
	▪ Slab-off prism covered when there is at least 3.00 diopter of anisometropia in the vertical meridian.
	▪ Special base curve is covered for aniseikonia.
	▪ Tint is covered when there is significant photophobia under indoor lighting conditions. Simple “photophobia” is not an acceptable diagnosis for coverage.
	▪ UV is covered when there is a chronic disorder that is complicated or accelerated by ultraviolet light.
	▪ Balance lenses are covered.
	▪ Press on fresnel prism lenses are covered.
	▪ Occluder lenses are covered.

Lens Replacement	▪ Covered as needed if lost, damaged, size change due to growth or prescription change. If lenses are needed due to prescription change one of the following criteria must be met:
	  ▪ Change of 0.50 diopters in the meridian of greatest change when placed on an optical cross.
	  ▪ Change in axis in excess of 10 degrees for 0.50 cylinder, 5 degrees for 0.75 cylinder.
	  ▪ Change of prism correction of ½ prism diopter vertically or 2 prism diopters horizontally or more.
	▪ **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 when medically necessary for the treatment of the following diseases or injury to the eye:
	  ▪ Keratoconus
	  ▪ Aphakia (excluding pseudophakia)
	  ▪ High plus corrections of +12.00 diopters (spherical equivalent) or greater due to the visual field defect caused by a high plus correction.
	  ▪ High minus corrections of -12.00 diopters (spherical equivalent) or greater, but only with an increase in binocular best visual acuity of at least 2 Snellen lines when comparing the contact lenses to the spectacle lens correction.

Benefit	Benefit Limitations/Criteria
	▪ Anisometropia (difference in correction) of at least 6.00 diopters (spherical equivalent) in order to avoid double vision. ▪ Other pathological conditions of the eye when useful vision cannot be obtained with eyeglasses.
Necessary Contact Lens Replacements	▪ Covered as needed due to loss, damage or prescription change. For prescription change one of the following criteria must be met: ▪ Change of 0.50 diopters in the meridian of greatest change when placed on an optical cross. ▪ Change in axis in excess of 10 degrees for 0.50 cylinder, 5 degrees for 0.75 cylinder. ▪ Change of prism correction of ½ prism diopter vertically or 2 prism diopters horizontally or more.
Repairs	▪ Repair of damaged lenses and/or frames is covered. ▪ If damage cannot be repaired or repair costs exceed the Medicaid allowable amount for new frames and lenses, the provider must dispense new eyeglasses. ▪ Applicable manufacturer warranties are considered to be a third party resource, and must be utilized in accordance with 471 NAC 3-004.
Interpreter Services	▪ Oral or sign language interpretation services will be covered only when an additional cost is incurred from the servicing provider and will not be reimbursed when the provider does not incur an added cost to provide the service. Examples include but are not limited to: ▪ Interpretation service is provided by bilingual/ASL trained provider staff who are providing the covered Medicaid services, ▪ Interpretation service is provided by the patient's family member or a friend, ▪ When a free software program such as Google translate is used ▪ And when the following criteria is met: ▪ Providers may only bill for these services if offered in conjunction with a Medicaid covered service, ▪ The rule of 8's will be followed for billing. This means that a minimum of 8 minutes of service must be provided to bill for a quarter hour (15-minute period) ▪ The billing provider must document the member's record with the following information: ▪ Interpreter's name or company name with which the interpreter is associated with ▪ Type of service provided, ▪ Method or interpretation (e.g. in person or via phone) ▪ Date and time of the interpretation ▪ Service duration (time in and time out), ▪ A general description of the medical service that patient received ▪ **To identify interpreter services please use code T1013 for Sign Language, Oral interpretive, and Translator services. The service can be billed in increments of 15 minutes up to a maximum of 2 hours (or 8 units).**
Services Not Covered by March	▪ Medical eye care. ▪ Surgical eye care. Contact UnitedHealthcare Community Plan for more information.

1.9 Covered Benefits – UnitedHealthcare Community Plan Heritage Health Adult Expansion Prime Ages 21 and Older (Medicaid)

Plan ID(s): UDNEM-P

Benefit	Benefit Limitations/Criteria
Exam	▪ 1 exam every 24 months. ▪ More frequent exams will be covered if medically necessary.
Exam Replacement	▪ Covered as needed if glasses are lost, damaged and it is not possible to return to or obtain the prescription from the previous provider.

Frame	▪ 1 unit every 24 months, to the day, when either of the two following conditions is met:
	  ▪ Required for one of the following medical reasons:
	  ▪ The member's first pair of prescription eyeglasses;
	  ▪ Size change needed due to growth; or
	  ▪ A prescribed lens change, only if new lenses cannot be accommodated by the member frame.
	  ▪ The member's current frame is no longer useable due to irreparable wear/damage, breakage or loss.
	▪ The following specifications apply to all frames:
	  ▪ Plastic and metal frames are covered.
	  ▪ Discontinued frames with new prescription lenses are not covered.
	  ▪ Frame cases are covered with new eyeglasses.
	▪ **Frame must be selected from the March frame kit.**
	▪ Member is financially responsible for full cost of non-March frame. Member must be notified in advance and in writing that they are responsible for the full cost of the frames including the fitting cost.

Frame Replacement	▪ 1 unit every 12 months when frame is irreparable due to wear/damage, breakage or loss. ▪ **To identify replacement frames, please bill using modifier code RA in conjunction with the current and appropriate HCPCS code(s) for frames.**

Lenses	▪ 2 units (1 pair) every 24 months, to the day, when the following is present:
	  ▪ Required for one of the following medical reasons:
	  ▪ The member's first pair of prescription eyeglasses;
	  ▪ Size change needed due to growth; or
	  ▪ New lenses are required due to a new prescription when the refraction correction meets one of the following criteria (A copy of the former and current prescriptions must be maintained in the provider's records.):
	  ▪ A change of 0.50 diopters in the meridian of greatest change when placed on an optical cross;
	  ▪ A change in axis in excess of 10 degrees for 0.50 cylinder, 5 degrees for 0.75 cylinder; or
	  ▪ A change of prism correction of ½ prism diopter vertically or 2 prism diopters horizontally or more.
	  ▪ The members current lenses are no longer useable due to damage, breakage or loss.
	▪ When one lens meets the criteria for coverage, both lenses may be provided, unless the prescribing practitioner specifies replacement of one lens only.
	▪ **Lenses must be provided by the March lab. Please refer to Exhibit D in the Provider Reference Guide for lab information.**
	Lens Specifications:
	▪ The following specifications apply to all eyeglass lenses:
	▪ Lenses are covered only if the refraction correction is at least 0.50 diopters in any meridian.
	▪ Lenses may be plastic or glass.
	▪ All plastic lenses must include front surface scratch resistant coating (factory applied or "in-house" dipped). The cost for the scratch resistant coating must be included in the lens cost and is not billed under a separate procedure code. The laboratory invoice must

Benefit	Benefit Limitations/Criteria

	indicate that the scratch resistant coating was provided. Medicaid does not require that lenses with scratch resistant coating be warranted.
	▪ Lenses must be of a quality at least equal to Z-80 standards of the American National Standard Institute; and
	▪ All lenses dispensed must be prescribed by a licensed practitioner. A copy of the prescribing practitioner's original prescription must be maintained in the provider's records and must be readily available for review by the Department upon request.
	Special Lens Features:
	▪ Glass or plastic single lenses are covered.
	▪ Bifocal and trifocal segments exceeding 28mm - covered only if necessary for specific employment or educational purposes, or due to a specific disability which limits head and neck movement.
	▪ High index lenses are covered where there is +/- 10.00 diopter in the meridian of greatest power when placed on an optical cross.
	▪ Myodisc lenses are covered only if prescribed.
	▪ Nylon cord, metal cord, or rimless mount - covered only if the member purchases own frame or uses previously purchased frame.
	▪ Oversize lenses covered if:
	  ▪ Medically necessary - examples include:
	  ▪ Narrow interpupillary distance
	  ▪ Unusual facial configuration
	  ▪ The member purchases his/her own frame or uses previously purchased frame.
	▪ Polycarbonate (standard) lenses are covered only if prescribed for members with significantly monocular vision (e.g. due to amblyopia, eye injury, eye disease, or other disorder).
	▪ Polycarbonate (thin) lenses are covered only if the refraction correction is at least +/- 8.00 diopters in the meridian of greatest power when placed on an optical cross.
	▪ Slab-off prism covered when there is at least 3.00 diopters of anisometropia in the vertical meridian.
	▪ Special base curve is covered for aniseikonia.
	▪ Tint is covered when there is significant photophobia under indoor lighting conditions. Simple “photophobia” is not an acceptable diagnosis for coverage. Photochromatic tints and sunglasses are not covered.
	▪ UV is covered when there is a chronic disorder that is complicated or accelerated by ultraviolet light.
	▪ Balance lenses are covered.
	▪ Press on fresnel prism lenses are covered.
	▪ Occluder lenses are covered.

Lens Replacement	▪ 2 units (1 pair) every 12 months if lost, damaged, or prescription change. If lenses are needed due to prescription change one of the following criteria must be met:
	  ▪ Change of 0.50 diopters in the meridian of greatest change when placed on an optical cross.
	  ▪ Change in axis in excess of 10 degrees for 0.50 cylinder, 5 degrees for 0.75 cylinder.
	  ▪ Change of prism correction of ½ prism diopter vertically or 2 prism diopters horizontally or more.
	▪ **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 when medically necessary for the treatment of the following diseases or injury to the eye:
	  ▪ Keratoconus
	  ▪ Aphakia (excluding pseudophakia)
	  ▪ High plus corrections of +12.00 diopters (spherical equivalent) or greater due to the visual field defect caused by a high plus correction.

Benefit	Benefit Limitations/Criteria
	▪ High minus corrections of -12.00 diopters (spherical equivalent) or greater, but only with an increase in binocular best visual acuity of at least 2 Snellen lines when comparing the contact lenses to the spectacle lens correction. ▪ Anisometropia (difference in correction) of at least 6.00 diopters (spherical equivalent) in order to avoid double vision. ▪ Other pathological conditions of the eye when useful vision cannot be obtained with eyeglasses.
Necessary Contact Lens Replacements	▪ Covered as needed due to loss, damage or prescription change. For prescription change one of the following criteria must be met: ▪ Change of 0.50 diopters in the meridian of greatest change when placed on an optical cross. ▪ Change in axis in excess of 10 degrees for 0.50 cylinder, 5 degrees for 0.75 cylinder. ▪ Change of prism correction of ½ prism diopter vertically or 2 prism diopters horizontally or more.
Repairs	▪ Repair of damaged lenses and/or frames is covered. ▪ If damage cannot be repaired or repair costs exceed the Medicaid allowable amount for new frames and lenses, the provider must dispense new eyeglasses. ▪ Applicable manufacturer warranties are considered to be a third party resource, and must be utilized in accordance with 471 NAC 3-004.
Interpreter Services	▪ Oral or sign language interpretation services will be covered only when an additional cost is incurred from the servicing provider and will not be reimbursed when the provider does not incur an added cost to provide the service. Examples include but are not limited to: ▪ Interpretation service is provided by bilingual/ASL trained provider staff who are providing the covered Medicaid services, ▪ Interpretation service is provided by the patient's family member or a friend, ▪ When a free software program such as Google translate is used ▪ And when the following criteria is met: ▪ Providers may only bill for these services if offered in conjunction with a Medicaid covered service, ▪ The rule of 8's will be followed for billing. This means that a minimum of 8 minutes of service must be provided to bill for a quarter hour (15-minute period) ▪ The billing provider must document the member's record with the following information: ▪ Interpreter's name or company name with which the interpreter is associated with ▪ Type of service provided, ▪ Method or interpretation (e.g. in person or via phone) ▪ Date and time of the interpretation ▪ Service duration (time in and time out), ▪ A general description of the medical service that patient received ▪ **To identify interpreter services please use code T1013 for Sign Language, Oral interpretive, and Translator services. The service can be billed in increments of 15 minutes up to a maximum of 2 hours (or 8 units).**
Services Not Covered by March	▪ Medical eye care. ▪ Surgical eye care. Contact UnitedHealthcare Community Plan for more information.