New York Specific Information

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

Table of Contents

1.1 Notice of Updates 2
1.2 Covered Benefits - UnitedHealthcare Community Plan Essential Plan 1 & 2 Plus (Medicaid) 3
1.3 Covered Benefits - UnitedHealthcare Community Plan Essential Plan 1 & 2 Standard (Medicaid) 5
1.4 Covered Benefits - UnitedHealthcare Community Plan Essential Plan 3 & 4 (Medicaid) 7
1.5 Covered Benefits - UnitedHealthcare Community Plan for Families (Medicaid) 9
1.6 Covered Benefits - UnitedHealthcare Community Plan for Kids (CHPlus) 11
1.7 Covered Benefits - UnitedHealthcare Community Plan Foster Children (Medicaid) 12
1.8 Covered Benefits - UnitedHealthcare Community Plan Medicaid Advantage Plus (MAP) (Medicaid) 13
1.9 Covered Benefits - UnitedHealthcare Community Plan Wellness4Me (Medicaid) 14
1.10 Covered Benefits - UnitedHealthcare Dual Advantage (Medicaid) 16
1.11 Covered Benefits - UnitedHealthcare Dual Complete® (Medicare) H0271-060-001 16
1.12 Covered Benefits - UnitedHealthcare Dual Complete® (Medicare) H0271-060-002 17
1.13 Covered Benefits - UnitedHealthcare Dual Complete® (Medicare) H3387-014-001 18
1.14 Covered Benefits - UnitedHealthcare Dual Complete® (Medicare) H3387-014-002 19
1.15 Covered Benefits - UnitedHealthcare Dual Complete® (Medicare) H3387-015-001 20
1.16 Covered Benefits - UnitedHealthcare Dual Complete® (Medicare) H3387-015-002 21
1.17 Medicaid Reimbursement Procedures 22
1.18 Liability 22

1.1 Notice of Updates

Notice of updates published April 11, 2024.

- Formatting updates.

1.2 UnitedHealthcare Community Plan Essential Plan 1 & 2 Plus (Medicaid)

Benefit Plan(s): UD-NYE-PLU, UD-NYE-PL2

Benefit	Benefit Limitations/Criteria
Exam	▪ 1 service date every year.
Exam Replacement	▪ Covered as needed when one of the following criteria is met: ▪ Glasses are lost, stolen or damaged and it is not possible to return to or obtain the prescription from the previous provider. ▪ A diopter change of 0.50 or more.
Necessary Medical Services	▪ Covered as needed when supported by medical necessity when services are performed by an optometrist and are within the scope of licensure.
Frame	▪ 1 unit every year. ▪ Frame may be selected from the March frame kit OR members may buy-up to any frame from the provider's selection. The member is responsible for the difference between the cost of the March frame ($21.00) and the provider's frame. 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.
Frame Replacement	▪ Covered as needed due to a diopter change of 0.50 or more, loss, theft or damage. ▪ To identify replacement frames, please bill with modifier RA. ▪ **Replacement frame must be selected from the March frame kit. If existing lenses cannot be inserted into the March frame, new lenses may be obtained from the March contracted lab.**
Lens	▪ 2 units every year. ▪ **Lenses must be provided by the March lab. 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 fabrication.** ▪ Regular single vision, lined bifocal and trifocal lenses are covered. ▪ Hi-index lenses are covered for 10 diopters (10DS) or greater.
Lens Replacement	▪ Covered as needed due to a diopter change of 0.50 or more, loss, theft or damage. ▪ Replacements should duplicate the original pair when possible. ▪ To identify replacement lenses, please bill with modifier RA.
Necessary Polycarbonate Lens	▪ 2 units every year when the following criteria is met: ▪ For children and adolescents up to 21 years of age, coverage criteria and documentation of ocular pathology which supports the medical necessity for polycarbonate lenses must be maintained in the ordering practitioner's clinical file. ▪ For adult enrollees age 21 and older, the enrollee must be essentially monocular with functional vision in only one eye or have a history of auto aggressive behavior with a history of breaking glasses. This documentation including a diagnosis must be submitted with claims for beneficiaries 21 and older. The statement qualifying the beneficiary's vision should be from an ophthalmologist or optometrist.
Two Pairs in Lieu of Bifocals	▪ 2 pairs (distance and reading) every year age 69 and under if it can be substantiated that the enrollee has one of the following conditions: ▪ A proven inability to tolerate bifocals ▪ An unusual correction ▪ A physical ailment or other condition which makes bifocals inadvisable. ▪ 2 pairs (distance and reading) every year age 70 and older.
Elective Contact Lenses	▪ 1 pair (2 units) in lieu of frame and lenses every year. ▪ Contact lenses must be supplied by the provider.

Benefit	Benefit Limitations/Criteria
Elective Contact Lens Replacement	▪ Covered as needed due to a diopter change of 0.50 or more, loss, theft or damage. ▪ Replacements should duplicate the original pair when possible. ▪ To identify replacement lenses, please bill with modifier RA.
Necessary Contact Lenses	▪ Covered as needed for the treatment of ocular pathology. ▪ Contact lenses are considered medically necessary when the doctor shows that optimal correction cannot be achieved with eyeglasses. ▪ Contact lenses must be supplied by the provider.
Necessary Contact Lens Replacements	▪ Covered as needed when initial criteria for medically necessary contact lenses is met.
Non-Covered Services	▪ Surgical eye care

1.3 UnitedHealthcare Community Plan Essential Plan 1 & 2 Standard (Medicaid)

Benefit Plan(s): UD-NYE-STD

Benefit	Benefit Limitations/Criteria
Exam	▪ 1 service date every year.
Exam Replacement	▪ Covered as needed when one of the following criteria is met: ▪ Glasses are lost, stolen or damaged and it is not possible to return to or obtain the prescription from the previous provider. ▪ A diopter change of 0.50 or more.
Necessary Medical Services	▪ Covered as needed when supported by medical necessity when services are performed by an optometrist and are within the scope of licensure.
Frame	▪ 1 unit every year. ▪ Frame may be selected from the March frame kit OR members may buy-up to any frame from the provider's selection. The member is responsible for the difference between the cost of the March frame ($21.00) and the provider's frame. 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.
Frame Replacement	▪ Covered as needed due to a diopter change of 0.50 or more, loss, theft or damage. ▪ To identify replacement frames, please bill with modifier RA. ▪ **Replacement frame must be selected from the March frame kit. If existing lenses cannot be inserted into the March frame, new lenses may be obtained from the March contracted lab.**
Lens	▪ 2 units every year. ▪ **Lenses must be provided by the March lab. 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 fabrication.** ▪ Regular single vision, lined bifocal and trifocal lenses are covered. ▪ Hi-index lenses are covered for 10 diopters (10DS) or greater.
Lens Replacement	▪ Covered as needed due to a diopter change of 0.50 or more, loss, theft or damage. ▪ Replacements should duplicate the original pair when possible. ▪ To identify replacement lenses, please bill with modifier RA.
Necessary Polycarbonate Lens	▪ 2 units every year when the following criteria is met: ▪ For children and adolescents up to 21 years of age, coverage criteria and documentation of ocular pathology which supports the medical necessity for polycarbonate lenses must be maintained in the ordering practitioner's clinical file. ▪ For adult enrollees age 21 and older, the enrollee must be essentially monocular with functional vision in only one eye or have a history of auto aggressive behavior with a history of breaking glasses. This documentation including a diagnosis must be submitted with claims for beneficiaries 21 and older. The statement qualifying the beneficiary's vision should be from an ophthalmologist or optometrist.
Two Pairs in Lieu of Bifocals	▪ 2 pairs (distance and reading) every year age 69 and under if it can be substantiated that the enrollee has one of the following conditions: ▪ A proven inability to tolerate bifocals ▪ An unusual correction ▪ A physical ailment or other condition which makes bifocals inadvisable. ▪ 2 pairs (distance and reading) every year age 70 and older.
Elective Contact Lenses	▪ 1 pair (2 units) in lieu of frame and lenses every year. ▪ Contact lenses must be supplied by the provider.

Benefit	Benefit Limitations/Criteria
Elective Contact Lens Replacement	▪ Covered as needed due to a diopter change of 0.50 or more, loss, theft or damage. ▪ Replacements should duplicate the original pair when possible. ▪ To identify replacement lenses, please bill with modifier RA.
Necessary Contact Lenses	▪ Covered as needed for the treatment of ocular pathology. ▪ Contact lenses are considered medically necessary when the doctor shows that optimal correction cannot be achieved with eyeglasses. ▪ Contact lenses must be supplied by the provider.
Necessary Contact Lens Replacements	▪ Covered as needed when initial criteria for medically necessary contact lenses is met.
Non-Covered Services	▪ Surgical eye care

1.4 UnitedHealthcare Community Plan Essential Plan 3 & 4 (Medicaid)

Benefit Plan(s): UD-NYE-3-4

Benefit	Benefit Limitations/Criteria
Exam	▪ 1 service date every 2 years. ▪ Diabetic members may receive 1 dilated retinal exam every year.

Exam Replacement	▪ Covered as needed when one of the following criteria is met:
	  ▪ Glasses are lost, stolen or damaged and it is not possible to return to or obtain the prescription from the previous provider.
	  ▪ A diopter change of 0.50 or more.

Necessary Medical Services	▪ Covered as needed when supported by medical necessity when services are performed by an optometrist and are within the scope of licensure.
Frame	▪ 1 unit every year. ▪ **Frame must be selected from the March frame kit.**
Frame Replacement	▪ Covered as needed due to a diopter change of 0.50 or more, loss, theft or damage. ▪ Replacements should duplicate the original pair when possible. ▪ To identify replacement frames, please bill with modifier RA.
Lens	▪ 2 units every year. ▪ **Lenses must be provided by the March lab. Please refer to Exhibit D in the Provider Reference Guide for lab information.** ▪ Regular single vision, lined bifocal and trifocal lenses are covered. ▪ Members may elect to pay for the entire cost of unlined bifocals if desired. Please refer to Exhibit R, the Wholesale/Retail Fee Schedule, in the Provider Reference Guide. Providers may charge the member up to the retail amount listed in the fee schedule. March will then deduct the wholesale amount from the provider's claim payment with Explanation Code LABDED. Members must sign the Non-Covered Fee Acceptance Form. Please refer to Exhibit A in the Provider Reference Guide. ▪ Hi-index lenses are covered for 10 diopters (10DS) or greater.
Lens Replacement	▪ Covered as needed due to a diopter change of 0.50 or more, loss, theft or damage. ▪ Replacements should duplicate the original pair when possible. ▪ To identify replacement lenses, please bill with modifier RA.

Necessary Polycarbonate Lens	▪ 2 units every year when the following criteria is met:
	  ▪ For children and adolescents up to 21 years of age, coverage criteria and documentation of ocular pathology which supports the medical necessity for polycarbonate lenses must be maintained in the ordering practitioner's clinical file.
	  ▪ For adult enrollees age 21 and older, the enrollee must be essentially monocular with functional vision in only one eye or have a history of auto aggressive behavior with a history of breaking glasses. This documentation including a diagnosis must be submitted with claims for beneficiaries 21 and older. The statement qualifying the beneficiary's vision should be from an ophthalmologist or optometrist.

Two Pairs in Lieu of Bifocals	▪ 2 pairs (distance and reading) every year age 69 and under if it can be substantiated that the enrollee has one of the following conditions:
	  ▪ A proven inability to tolerate bifocals
	  ▪ An unusual correction
	  ▪ A physical ailment or other condition which makes bifocals inadvisable.
	▪ 2 pairs (distance and reading) every year age 70 and older.

Necessary Contact Lenses	▪ Covered as needed for the treatment of ocular pathology.

Benefit	Benefit Limitations/Criteria
	▪ Contact lenses are considered medically necessary when the doctor shows that optimal correction cannot be achieved with eyeglasses. ▪ Contact lenses must be supplied by the provider.
Necessary Contact Lens Replacements	▪ Covered as needed when initial criteria for medically necessary contact lenses is met.
Non-Covered Services	▪ Surgical eye care ▪ Lenses for non-covered frames and/or lens options including unlined bifocals

1.5 UnitedHealthcare Community Plan for Families (Medicaid)

Benefit Plan(s): UDNYM-FAM, UDNYMIDMMO, UDNYMIDMMU

Benefit	Benefit Limitations/Criteria
Exam	▪ 1 service date every 2 years. ▪ Diabetic members may receive 1 dilated retinal exam every year.

Exam Replacement	▪ Covered as needed when one of the following criteria is met:
	  ▪ Glasses are lost, stolen or damaged and it is not possible to return to or obtain the prescription from the previous provider.
	  ▪ A diopter change of 0.50 or more.

Necessary Medical Services	▪ Covered as needed when supported by medical necessity when services are performed by an optometrist and are within the scope of licensure.
Frame	▪ 1 unit every 2 years. ▪ **Frame must be selected from the March frame kit.**
Frame Replacement	▪ Covered as needed due to a diopter change of 0.50 or more, loss, theft or damage. ▪ Replacements should duplicate the original pair when possible. ▪ To identify replacement frames, please bill with modifier RA.
Lens	▪ 2 units every 2 years. ▪ **Lenses must be provided by the March lab. Please refer to Exhibit D in the Provider Reference Guide for lab information.** ▪ Regular single vision, lined bifocal and trifocal lenses are covered. ▪ Members may elect to pay for the entire cost of unlined bifocals if desired. Please refer to Exhibit R, the Wholesale/Retail Fee Schedule, in the Provider Reference Guide. Providers may charge the member up to the retail amount listed in the fee schedule. March will then deduct the wholesale amount from the provider's claim payment with Explanation Code LABDED. Members must sign the Non-Covered Fee Acceptance Form. Please refer to Exhibit A in the Provider Reference Guide. ▪ Hi-index lenses are covered for 10 diopters (10DS) or greater.
Lens Replacement	▪ Covered as needed due to a diopter change of 0.50 or more, loss, theft or damage. ▪ Replacements should duplicate the original pair when possible. ▪ To identify replacement lenses, please bill with modifier RA.

Necessary Polycarbonate Lens	▪ 2 units every 2 years when the following criteria is met:
	  ▪ For children and adolescents up to 21 years of age, coverage criteria and documentation of ocular pathology which supports the medical necessity for polycarbonate lenses must be maintained in the ordering practitioner's clinical file.
	  ▪ For adult enrollees age 21 and older, the enrollee must be essentially monocular with functional vision in only one eye or have a history of auto aggressive behavior with a history of breaking glasses. This documentation including a diagnosis must be submitted with claims for beneficiaries 21 and older. The statement qualifying the beneficiary's vision should be from an ophthalmologist or optometrist.

Two Pairs in Lieu of Bifocals	▪ 2 pairs (distance and reading) every 2 years age 69 and under if it can be substantiated that the enrollee has one of the following conditions:
	  ▪ A proven inability to tolerate bifocals
	  ▪ An unusual correction
	  ▪ A physical ailment or other condition which makes bifocals inadvisable.
	▪ 2 pairs (distance and reading) every 2 years age 70 and older.

Necessary Contact Lenses	▪ Covered as needed for the treatment of ocular pathology.

Benefit	Benefit Limitations/Criteria
	▪ Contact lenses are considered medically necessary when the doctor shows that optimal correction cannot be achieved with eyeglasses. ▪ Contact lenses must be supplied by the provider.
Necessary Contact Lens Replacements	▪ Covered as needed when initial criteria for medically necessary contact lenses is met.
Non-Covered Services	▪ Surgical eye care ▪ Lenses for non-covered frames and/or lens options including unlined bifocals

1.6 UnitedHealthcare Community Plan for Kids (CHPlus)

Benefit Plan(s): UDNYM-20

Benefit	Benefit Limitations/Criteria
Exam	▪ 1 service date every year.
Exam Replacement	▪ 1 unit every year when glasses are lost or stolen and it is not possible to return to or obtain the prescription from the previous provider. ▪ Covered as needed due to a diopter change of 0.50 or more.
Necessary Medical Services	▪ Covered as needed when supported by medical necessity when services are performed by an optometrist and are within the scope of licensure.
Frame	▪ 1 unit every year. ▪ Frame may be selected from the March frame kit OR members may buy-up to any frame from the provider's selection. The member is responsible for the difference between the cost of the March frame ($21.00) and the provider's frame. 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.
Frame Replacement	▪ 1 unit every year when eyeglasses are lost or stolen. ▪ Covered as needed due to diopter change of 0.50 or more or if damaged. ▪ Covered as needed when supported by medical necessity. ▪ To identify replacement frames, please bill with modifier RA. ▪ **Replacement frame must be selected from the March frame kit. If existing lenses cannot be inserted into the March frame, new lenses may be obtained from the March contracted lab.**
Lens	▪ 2 units every year. ▪ **Lenses must be provided by the March lab. 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 fabrication.** ▪ Regular single vision, bifocal and trifocal lenses are covered. ▪ Hi-index lenses are covered for 10 diopters (10DS) or greater.
Lens Replacement	▪ 2 units every year when eyeglasses are lost or stolen. ▪ Covered as needed due to diopter change of 0.50 or more or if damaged. ▪ Covered as needed when supported by medical necessity. ▪ To identify replacement lenses, please bill with modifier RA.
Necessary Polycarbonate Lens	▪ 2 units every year when the following criteria is met: ▪ For children and adolescents up to 21 years of age, coverage criteria and documentation of ocular pathology which supports the medical necessity for polycarbonate lenses must be maintained in the ordering practitioner's clinical file.

Necessary Contact Lenses	▪ Covered as needed 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:
	  ▪ Unilateral aphakia
	  ▪ Keratoconus when vision with eyeglasses is less than 20/40
	  ▪ Corneal transplant when vision with eyeglasses is less than 20/40
	  ▪ Anisometropia that is greater than or equal to 4.00 diopter
	▪ Contact lenses must be supplied by the provider.

Necessary Contact Lens Replacements	▪ Covered as needed when initial criteria for medically necessary contact lenses is met.
Non-Covered Services	▪ Surgical eye care

1.7 UnitedHealthcare Community Plan Foster Children (Medicaid)

Benefit Plan(s): UDNYM-FC

Benefit	Benefit Limitations/Criteria
Exam	▪ Covered as needed.
Exam Replacement	▪ Covered as needed.
Necessary Medical Services	▪ Covered as needed when supported by medical necessity when services are performed by an optometrist and are within the scope of licensure.
Frame	▪ Covered as needed. ▪ **Frame must be selected from the March frame kit.**
Frame Replacement	▪ Covered as needed. ▪ To identify replacement frames, please bill with modifier RA.
Lens	▪ Covered as needed. ▪ **Lenses must be provided by the March lab. Please refer to Exhibit D in the Provider Reference Guide for lab information.** ▪ Regular single vision, lined bifocal and trifocal lenses are covered. ▪ Members may elect to pay for the entire cost of unlined bifocals if desired. Please refer to Exhibit R, the Wholesale/Retail Fee Schedule, in the Provider Reference Guide. Providers may charge the member up to the retail amount listed in the fee schedule. March will then deduct the wholesale amount from the provider's claim payment with Explanation Code LABDED. Members must sign the Non-Covered Fee Acceptance Form. Please refer to Exhibit A in the Provider Reference Guide. ▪ Hi-index lenses are covered for 10 diopters (10DS) or greater.
Lens Replacement	▪ Covered as needed. ▪ To identify replacement lenses, please bill with modifier RA.
Necessary Polycarbonate Lens	▪ Covered as needed when the following criteria is met: ▪ For children and adolescents up to 21 years of age, coverage criteria and documentation of ocular pathology which supports the medical necessity for polycarbonate lenses must be maintained in the ordering practitioner's clinical file.
Necessary Contact Lenses	▪ Covered as needed for the treatment of ocular pathology. ▪ Contact lenses are considered medically necessary when the doctor shows that optimal correction cannot be achieved with eyeglasses. ▪ Contact lenses must be supplied by the provider.
Necessary Contact Lens Replacements	▪ Covered as needed when initial criteria for medically necessary contact lenses is met.
Non-Covered Services	▪ Surgical eye care ▪ Lenses for non-covered frames and/or lens options including unlined bifocals

1.8 UnitedHealthcare Community Plan Medicaid Advantage Plus (MAP) (Medicaid)

Benefit Plan(s): UDNYM-MAP

Benefit	Benefit Limitations/Criteria
Exam	▪ 1 service date every 2 years.
Exam Replacement	▪ Covered as needed when medically necessary, due to loss, damage, or destruction, and it is not possible to return to or obtain the prescription from the previous provider.
Necessary Medical Services	▪ Covered as needed when supported by medical necessity when services are performed by an optometrist and are within the scope of licensure.
Frame	▪ 1 unit every 2 years. ▪ **Frame must be selected from the March frame kit.**
Frame Replacement	▪ Covered as needed when medically necessary, due to loss, damage, or destruction. ▪ To identify replacement frames, please bill with modifier RA.
Lens	▪ 2 units every 2 years. ▪ **Lenses must be provided by the March lab. Please refer to Exhibit D in the Provider Reference Guide for lab information.** ▪ Regular single vision, lined bifocal and trifocal lenses are covered.
Lens Replacement	▪ Covered as needed when medically necessary, due to loss, damage, or destruction. ▪ To identify replacement lenses, please bill with modifier RA.
Necessary Polycarbonate Lens	▪ 2 units every 2 years when medically necessary.
Necessary Contact Lenses	▪ Covered as needed when medically necessary. ▪ Contact lenses must be supplied by the provider.
Non-Covered Services	▪ Surgical eye care ▪ Lenses for non-covered frames and/or lens options including unlined bifocals

1.9 UnitedHealthcare Community Plan Wellness4Me (Medicaid)

Benefit Plan(s): UDNYM-HID, UDNYM-W4ME

Benefit	Benefit Limitations/Criteria
Exam	▪ 1 service date every 2 years. ▪ Diabetic members may receive 1 dilated retinal exam every year.

Exam Replacement	▪ Covered as needed when one of the following criteria is met:
	  ▪ Glasses are lost, stolen or damaged and it is not possible to return to or obtain the prescription from the previous provider.
	  ▪ A diopter change of 0.50 or more.

Necessary Medical Services	▪ Covered as needed when supported by medical necessity when services are performed by an optometrist and are within the scope of licensure.
Frame	▪ 1 unit every 2 years. ▪ **Frame must be selected from the March frame kit.**
Frame Replacement	▪ Covered as needed due to a diopter change of 0.50 or more, loss, theft or damage. ▪ Replacements should duplicate the original pair when possible. ▪ To identify replacement frames, please bill with modifier RA.
Lens	▪ 2 units every 2 years. ▪ **Lenses must be provided by the March lab. Please refer to Exhibit D in the Provider Reference Guide for lab information.** ▪ Regular single vision, lined bifocal and trifocal lenses are covered. ▪ Members may elect to pay for the entire cost of unlined bifocals if desired. Please refer to Exhibit R, the Wholesale/Retail Fee Schedule, in the Provider Reference Guide. Providers may charge the member up to the retail amount listed in the fee schedule. March will then deduct the wholesale amount from the provider's claim payment with Explanation Code LABDED. Members must sign the Non-Covered Fee Acceptance Form. Please refer to Exhibit A in the Provider Reference Guide. ▪ Hi-index lenses are covered for 10 diopters (10DS) or greater.
Lens Replacement	▪ Covered as needed due to a diopter change of 0.50 or more, loss, theft or damage. ▪ Replacements should duplicate the original pair when possible. ▪ To identify replacement lenses, please bill with modifier RA.

Necessary Polycarbonate Lens	▪ 2 units every 2 years when the following criteria is met:
	  ▪ For children and adolescents up to 21 years of age, coverage criteria and documentation of ocular pathology which supports the medical necessity for polycarbonate lenses must be maintained in the ordering practitioner's clinical file.
	  ▪ For adult enrollees age 21 and older, the enrollee must be essentially monocular with functional vision in only one eye or have a history of auto aggressive behavior with a history of breaking glasses. This documentation including a diagnosis must be submitted with claims for beneficiaries 21 and older. The statement qualifying the beneficiary's vision should be from an ophthalmologist or optometrist.

Two Pairs in Lieu of Bifocals	▪ 2 pairs (distance and reading) every 2 years age 69 and under if it can be substantiated that the enrollee has one of the following conditions:
	  ▪ A proven inability to tolerate bifocals
	  ▪ An unusual correction
	  ▪ A physical ailment or other condition which makes bifocals inadvisable.
	▪ 2 pairs (distance and reading) every 2 years age 70 and older.

Necessary Contact Lenses	▪ Covered as needed for the treatment of ocular pathology.

Benefit	Benefit Limitations/Criteria
	▪ Contact lenses are considered medically necessary when the doctor shows that optimal correction cannot be achieved with eyeglasses. ▪ Contact lenses must be supplied by the provider.
Necessary Contact Lens Replacements	▪ Covered as needed when initial criteria for medically necessary contact lenses is met.
Non-Covered Services	▪ Surgical eye care ▪ Lenses for non-covered frames and/or lens options including unlined bifocals

1.10 UnitedHealthcare Dual Advantage (Medicaid)

Benefit Plan(s): UDNYM-DA

Benefit	Benefit Limitations/Criteria
Eyewear Repair/Part Replacement	▪ Covered as needed.
Non-Covered Services	▪ Routine, medical and surgical eye care ▪ Eyewear, except replacement parts or repair

1.11 UnitedHealthcare Dual Complete® (Medicare) H0271-060-001

Benefit Plan(s): UDNYS-DC5

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

UnitedHealthcare Dual Complete® (Medicare) members have additional coverage under the UnitedHealthcare Community Plan for Families (Medicaid) and UnitedHealthcare Wellness4Me (Medicaid) plans. Please refer to sections 1.5 and 1.9.

1.12 UnitedHealthcare Dual Complete® (Medicare) H0271-060-002

Benefit Plan(s): UDNYS-DC6

Benefit	Benefit Limitations/Criteria
Exam	▪ 1 service date every calendar year.
Necessary Medical Services	▪ Covered as needed when supported by medical necessity when services are performed by an optometrist and are within the scope of licensure.
Eyewear	▪ $350 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 after cataract surgery. 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.

UnitedHealthcare Dual Complete® (Medicare) members have additional coverage under the UnitedHealthcare Community Plan for Families (Medicaid) and UnitedHealthcare Wellness4Me (Medicaid) plans. Please refer to sections 1.5 and 1.9.

1.13 UnitedHealthcare Dual Complete® (Medicare) H3387-014-001

Benefit Plan(s): UDNYS-DC1,

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

UnitedHealthcare Dual Complete® (Medicare) members have additional coverage under the UnitedHealthcare Community Plan for Families (Medicaid) and UnitedHealthcare Wellness4Me (Medicaid) plans. Please refer to sections 1.5 and 1.9.

1.14 UnitedHealthcare Dual Complete® (Medicare) H3387-014-002

Benefit Plan(s): UDNYS-DC2

Benefit	Benefit Limitations/Criteria
Exam	▪ 1 service date every calendar year.
Necessary Medical Services	▪ Covered as needed when supported by medical necessity when services are performed by an optometrist and are within the scope of licensure.
Eyewear	▪ $350 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 after cataract surgery. 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.

UnitedHealthcare Dual Complete® (Medicare) members have additional coverage under the UnitedHealthcare Community Plan for Families (Medicaid) and UnitedHealthcare Wellness4Me (Medicaid) plans. Please refer to sections 1.5 and 1.9.

1.15 UnitedHealthcare Dual Complete® Plan (Medicare) H3387-015-001

Benefit Plan(s): UDNYS-DC3

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

UnitedHealthcare Dual Complete® (Medicare) members have additional coverage under the UnitedHealthcare Community Plan for Families (Medicaid) and UnitedHealthcare Wellness4Me (Medicaid) plans. Please refer to sections 1.5 and 1.9.

1.16 UnitedHealthcare Dual Complete® Plan (Medicare) H3387-015-002

Benefit Plan(s): UDNYS-DC4

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

UnitedHealthcare Dual Complete® (Medicare) members have additional coverage under the UnitedHealthcare Community Plan for Families (Medicaid) and UnitedHealthcare Wellness4Me (Medicaid) plans. Please refer to sections 1.5 and 1.9.

1.17 Medicaid Reimbursement Procedures

The UnitedHealthcare Community Plan for Kids and Essential Plan benefits afford members the opportunity to select a frame from the March frame kit OR buy-up to any frame from the provider's selection.

The following examples illustrate reimbursement when the March frame kit is used and when the buy-up option is used. 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 $15.00 for the fitting of spectacles.

Service Code	Description	Modifier	Billed Charges	Paid Amount
92340	Fitting of Spectacles		$ 35.00	$ 15.00
Total			**$ 35.00**	**$ 15.00**

Buy-Up

Providers must bill the current and appropriate service code for frames with modifier code 75. Reimbursement for the frame will be at the lesser amount of billed charges or $21.00. Lens codes are not reimbursable and should not be billed as materials are provided by the March lab.

The following example assumes the member selected a frame from the provider's selection with a retail value of $100.00.

Service Code	Description	Modifier	Billed Charges	Paid Amount
V2020	Frame	75	$ 100.00*	$ 21.00
92340	Fitting of Spectacles**		$ 40.00	$ 0.00
Total			**$ 140.00**	**$ 21.00**

* Member is responsible for the difference between the cost of the March frame ($21.00) and the cost of the provider's frame. In this example, the member is responsible for $79.00.
** Fitting of Spectacles is not reimbursable when frames are dispensed from the provider's selection. Providers will be responsible for the cost of traceable shipping of non-March frames to the March lab for lens fabrication. This fee is not billable to the member.

For billing and calculation of the **Medicare** allowance, please refer to Section 3 in the Provider Reference Guide.

1.18 Liability

No provider shall have any liability relating to the activities, actions or omissions of March Vision Care acting in its role as a utilization review agent.