Texas Specific Information

This document contains information specific to the State of Texas. 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 August 22, 2024.

- Removed references to 20 and under for UnitedHealthcare Community Plan– STAR+PLUS (Medicaid).

1.2 Covered Benefits – UnitedHealthcare Community Plan – STAR (Medicaid)

Benefit Plan(s): UDTXM-S20, UDTXM-S21

Benefit	Benefit Limitations/Criteria

Exam	▪ 1 service date every year ages 20 and under.
	▪ 1 service date every 2 years ages 21 and older.
	▪ Additional exams are covered as necessary when one of the following is met:
	  ▪ The parent, teacher, or school nurse requests the refraction testing and it is medically necessary. Ages 20 and under only.
	  ▪ There is a significant change in vision, and documentation supports a diopter change of 0.50 or greater in the sphere, cylinder, prism measurements, or axis changes.

Exam Replacement	▪ Covered in accordance with frame and lens replacement benefit frequencies when one of the following is met:
	  ▪ The member is unable to return to or obtain the prescription from the previous provider AND criteria for replacements have been met.
	  ▪ A replacement exam is necessary to determine a vision change AND replacement criteria are met. Ages 20 and under only.

Frame	▪ 1 unit every 2 years ages 20 and under from the March frame kit. ▪ 1 unit every 2 years ages 21 and older from the March frame kit OR $105 allowance toward frame and lenses from the provider's selection. ▪ Member is responsible for paying the provider the difference between $105 and the retail amount of the frame and/or lenses. ▪ **If frames are selected from the March frame kit, lenses must be provided by the March lab. If frames are selected from the provider's selection using the retail allowance, lenses must be supplied by the provider. Please refer to Exhibit C in the Provider Reference Guide for March lab information. To identify frames and lenses from the provider's selection, please bill using modifier code 75 in conjunction with the current and appropriate HCPCS codes(s) for frames and lenses.**
Frame Replacement	▪ Covered as needed when lost, stolen or damaged ages 20 and under. ▪ Any remaining allowance may be used toward replacements for ages 21 and older. ▪ **To identify replacement frames, please bill with modifier RA.**

Lens (Single, Bifocal, Trifocal, Lenticular, Polycarbonate)	▪ 2 units (1 pair) every 2 years ages 20 and under from the March contracted lab.
	▪ 2 units (1 pair) ever 2 years ages 21 and older from the March contracted lab OR $105 allowance toward frame and lenses from the provider's selection.
	  ▪ Member is responsible for paying the provider the difference between $105 and the retail amount of the frame and/or lenses.
	▪ **If frames are selected from the March frame kit, lenses must be provided by the March lab. If frames are selected from the provider's selection using the retail allowance, lenses must be supplied by the provider. Please refer to Exhibit C in the Provider Reference Guide for March lab information. To identify frames and lenses from the provider's selection, please bill using modifier code 75 in conjunction with the current and appropriate HCPCS codes(s) for frames and lenses.**
	▪ Single vision; bifocal (FT-25, FT-28 and round); trifocal and aspheric lenticular (single vision and bifocal round seg)
	▪ Polycarbonate lenses are covered when one of the following is met:
	  ▪ There is a medical or physical condition such as, but not limited to:
	  ▪ Cerebral palsy
	  ▪ Multiple sclerosis
	  ▪ Muscular dystrophy
	  ▪ Epilepsy
	  ▪ Autism
	  ▪ Down's Syndrome
	  ▪ Brain trauma
	  ▪ Balance disorders

Benefit	Benefit Limitations/Criteria
	▪ Parkinson's disease ▪ Seizure disorder ▪ Motor ataxia ▪ Marfan's syndrome ▪ Ocular prostheses ▪ Amblyopia ▪ Lens power in at least one meridian of -5.25/+4.00 diopters or more and the eyeglasses are not functional in regular standard glass or plastic lens materials due to weight, thickness or aberration ▪ Monocular vision with functional vision in one eye ▪ Retinal detachment or risk for retinal detachment (e.g., lattice degeneration, history of retinal detachment in the family, posterior vitreous detachment ▪ UV lenses are covered for the following diagnoses: ▪ Aphakia ▪ Subluxation of lens ▪ Anterior dislocation of lens ▪ Posterior dislocation of lens. ▪ Congenital aphakia ▪ Presence of intraocular lens. ▪ The following lens options are covered: ▪ Balance lenses ▪ Slab off prism ▪ Prism lenses ▪ Fresnell prism press on lenses ▪ Special base curve ▪ Occluder lenses ▪ Oversize lenses
Lens Replacement	▪ Covered as needed ages 20 and under when lost, stolen, damaged, or if there is a diopter change of 0.50 or greater. ▪ Any remaining allowance may be used toward replacements for ages 21 and older. ▪ **To identify replacement lenses, please bill with modifier RA.**
Elective Contact Lenses	▪ $105 allowance in lieu of frame and lenses every 2 years ages 21 and older. ▪ Contact lenses must have a prescription of at least +/- 0.50 diopters in at least one eye in order to qualify for coverage. ▪ Member is responsible for paying the provider the difference between $105 and the retail amount of the contact lenses. ▪ Contact lenses **must** be supplied by the provider. ▪ **To identify elective contact lenses, please bill using modifier code 75 in conjunction with the current and appropriate HCPCS codes(s) for contact lenses.**
Elective Contact Lens Replacement	▪ Any remaining allowance may be used toward replacements for ages 21 and older. ▪ **To identify replacement lenses, please bill with modifier RA.** ▪ **To identify elective contact lenses, please bill using modifier code 75 in conjunction with the current and appropriate HCPCS codes(s) for contact lenses.**
Necessary Contact Lenses	▪ 2 units (1 pair) every 24 months when medically necessary. ▪ Additional contact lenses are covered when there is a diopter change of 0.50 or more in the sphere, cylinder, prism measurements, or axis changes. ▪ Contact lenses **must** be supplied by the provider.

Benefit	Benefit Limitations/Criteria
Necessary Contact Lens Replacement	▪ Covered as needed ages 20 and under when lost or destroyed. ▪ **To identify replacement contact lenses, please bill with modifier RA.**

Repairs	▪ Covered as needed ages 20 and under when damaged.
	  ▪ Repairs that cost $2 or more may be billed using HCPCS code V2799 when the following criteria are met.
	  ▪ The cost of repair supplies cannot exceed the cost of replacement eyeglasses.
	  ▪ All repair supplies must be new and at least equivalent to the original item.
	  ▪ The provider must maintain in the client's medical record an itemized list of repairs and the replacement cost to determine whether criteria are met for repair.
	▪ Covered as needed ages 21 and older when the cost of the repair does not exceed $2.

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

1.3 Covered Benefits – UnitedHealthcare Community Plan– STAR+PLUS Ages 21 and Older (Medicaid)

Benefit Plan(s): UDTXM-SP21

Benefit	Benefit Limitations/Criteria
Exam	▪ 1 service date every 2 years. ▪ Additional exams are covered as necessary when one of the following is met: ▪ Due to aphakia and disease or injury to the eye.
Exam Replacement	▪ Covered in accordance with frame and lens replacement benefit frequencies when one of the following is met: ▪ The member is unable to return to or obtain the prescription from the previous provider AND criteria for replacements have been met.
Frame	▪ 1 unit every 2 years from the March frame kit OR $105 allowance toward frame and lenses from the provider's selection. ▪ Member is responsible for paying the provider the difference between $105 and the retail amount of the frame and/or lenses. ▪ **If frames are selected from the March frame kit, lenses must be provided by the March lab. If frames are selected from the provider's selection using the retail allowance, lenses must be supplied by the provider. Please refer to Exhibit C in the Provider Reference Guide for March lab information. To identify frames and lenses from the provider's selection, please bill using modifier code 75 in conjunction with the current and appropriate HCPCS codes(s) for frames and lenses.**
Frame Replacement	▪ Any remaining allowance may be used toward replacements. ▪ **To identify replacement frames, please bill with modifier RA.**

Lens (Single, Bifocal, Trifocal, Lenticular, Polycarbonate)	▪ 2 units (1 pair) every 2 years from the March contracted lab OR $105 allowance toward frame and lenses from the provider's selection.
	  ▪ Member is responsible for paying the provider the difference between $105 and the retail amount of the frame and/or lenses.
	▪ **If frames are selected from the March frame kit, lenses must be provided by the March lab. If frames are selected from the provider's selection using the retail allowance, lenses must be supplied by the provider. Please refer to Exhibit C in the Provider Reference Guide for March lab information. To identify frames and lenses from the provider's selection, please bill using modifier code 75 in conjunction with the current and appropriate HCPCS codes(s) for frames and lenses.**
	▪ Lenses must have a prescription of at least +/-0.50 diopter in at least one eye in order to qualify for coverage.
	▪ Single vision; bifocal (FT-25, FT-28 and round); trifocal and aspheric lenticular (single vision and bifocal round seg)
	▪ Polycarbonate lenses are covered when one of the following is met:
	  ▪ There is a medical or physical condition such as, but not limited to:
	  ▪ Cerebral palsy
	  ▪ Multiple sclerosis
	  ▪ Muscular dystrophy
	  ▪ Epilepsy
	  ▪ Autism
	  ▪ Down's Syndrome
	  ▪ Brain trauma
	  ▪ Balance disorders
	  ▪ Parkinson's disease
	  ▪ Seizure disorder
	  ▪ Motor ataxia
	  ▪ Marfan's syndrome
	  ▪ Ocular prostheses
	  ▪ Amblyopia
	  ▪ Lens power in at least one meridian of -5.25/+4.00 diopters or more and the eyeglasses are not functional in regular standard glass or plastic lens materials due to weight, thickness or aberration

Benefit	Benefit Limitations/Criteria
	▪ Monocular vision with functional vision in one eye ▪ Retinal detachment or risk for retinal detachment (e.g., lattice degeneration, history of retinal detachment in the family, posterior vitreous detachment ▪ UV lenses are covered for the following diagnoses: ▪ Aphakia ▪ Subluxation of lens ▪ Anterior dislocation of lens ▪ Posterior dislocation of lens. ▪ Congenital aphakia ▪ Presence of intraocular lens. ▪ The following lens options are covered: ▪ Balance lenses ▪ Slab off prism ▪ Prism lenses ▪ Fresnell prism press on lenses ▪ Special base curve ▪ Occluder lenses ▪ Oversize lenses
Lens Replacement	▪ Any remaining allowance may be used toward replacements. ▪ **To identify replacement lenses, please bill with modifier RA.**
Elective Contact Lenses	▪ $105 allowance in lieu of frame and lenses every 2 years. ▪ Contact lenses must have a prescription of at least +/- 0.50 diopters in at least one eye in order to qualify for coverage. ▪ Member is responsible for paying the provider the difference between $105 and the retail amount of the contact lenses. ▪ Contact lenses **must** be supplied by the provider. ▪ **To identify elective contact lenses, please bill using modifier code 75 in conjunction with the current and appropriate HCPCS codes(s) for contact lenses.**
Elective Contact Lens Replacement	▪ Any remaining allowance may be used toward replacements. ▪ **To identify replacement lenses, please bill with modifier RA.** ▪ **To identify elective contact lenses, please bill using modifier code 75 in conjunction with the current and appropriate HCPCS codes(s) for contact lenses.**
Necessary Contact Lenses	▪ 2 units (1 pair) every 24 months when medically necessary. ▪ Additional contact lenses are covered when there is a diopter change of 0.50 or more in the sphere, cylinder, prism measurements, or axis changes. ▪ Contact lenses **must** be supplied by the provider.
Repairs	▪ Covered as needed when the cost of the repair does not exceed $2.
Non-Covered Services	▪ Medical eye care. ▪ Surgical eye care.

1.4 Covered Benefits – UnitedHealthcare Community Plan – STAR Kids (Medicaid)

Benefit Plan(s): UDTXM-SKID

Benefit	Benefit Limitations/Criteria

Exam	▪ 1 service date every year.
	▪ Additional exams are covered as necessary when one of the following is met:
	  ▪ The parent, teacher, or school nurse requests the refraction testing and it is medically necessary.
	  ▪ There is a significant change in vision, and documentation supports a diopter change of 0.50 or greater in the sphere, cylinder, prism measurements, or axis changes.

Exam Replacement	▪ Covered in accordance with frame and lens replacement benefit frequencies when one of the following is met:
	  ▪ The member is unable to return to or obtain the prescription from the previous provider AND criteria for replacements have been met.
	  ▪ A replacement exam is necessary to determine a vision change AND replacement criteria are met.

Frame	▪ 1 unit every year from the March frame kit OR $105 allowance toward frame and lenses from the provider's selection. ▪ Member is responsible for paying the provider the difference between $105 and the retail amount of the frame and/or lenses. ▪ **If frames are selected from the March frame kit, lenses must be provided by the March lab. If frames are selected from the provider's selection using the retail allowance, lenses must be supplied by the provider. Please refer to Exhibit C in the Provider Reference Guide for March lab information. To identify frames and lenses from the provider's selection, please bill using modifier code 75 in conjunction with the current and appropriate HCPCS codes(s) for frames and lenses.**
Frame Replacement	▪ Covered as needed when lost, stolen or damaged. ▪ **Frame must be selected from the March frame kit** ▪ **To identify replacement frames, please bill with modifier RA.**

Lens (Single, Bifocal, Trifocal, Lenticular, Polycarbonate)	▪ 2 units (1 pair) every year from the March contracted lab OR $105 allowance toward frame and lenses from the provider's selection.
	  ▪ Member is responsible for paying the provider the difference between $105 and the retail amount of the frame and/or lenses.
	▪ **If frames are selected from the March frame kit, lenses must be provided by the March lab. If frames are selected from the provider's selection using the retail allowance, lenses must be supplied by the provider. Please refer to Exhibit C in the Provider Reference Guide for March lab information. To identify frames and lenses from the provider's selection, please bill using modifier code 75 in conjunction with the current and appropriate HCPCS codes(s) for frames and lenses.**
	▪ Single vision; bifocal (FT-25, FT-28 and round); trifocal and aspheric lenticular (single vision and bifocal round seg)
	▪ Polycarbonate lenses are covered when one of the following is met:
	  ▪ There is a medical or physical condition such as, but not limited to:
	  ▪ Cerebral palsy
	  ▪ Multiple sclerosis
	  ▪ Muscular dystrophy
	  ▪ Epilepsy
	  ▪ Autism
	  ▪ Down's Syndrome
	  ▪ Brain trauma
	  ▪ Balance disorders
	  ▪ Parkinson's disease
	  ▪ Seizure disorder
	  ▪ Motor ataxia
	  ▪ Marfan's syndrome
	  ▪ Ocular prostheses

Benefit	Benefit Limitations/Criteria
	▪ Amblyopia ▪ Lens power in at least one meridian of -5.25/+4.00 diopters or more and the eyeglasses are not functional in regular standard glass or plastic lens materials due to weight, thickness or aberration ▪ Monocular vision with functional vision in one eye ▪ Retinal detachment or risk for retinal detachment (e.g., lattice degeneration, history of retinal detachment in the family, posterior vitreous detachment ▪ UV lenses are covered for the following diagnoses: ▪ Aphakia ▪ Subluxation of lens ▪ Anterior dislocation of lens ▪ Posterior dislocation of lens. ▪ Congenital aphakia ▪ Presence of intraocular lens. ▪ The following lens options are covered: ▪ Balance lenses ▪ Slab off prism ▪ Prism lenses ▪ Fresnell prism press on lenses ▪ Special base curve ▪ Occluder lenses ▪ Oversize lenses
Lens Replacement	▪ Covered as needed when lost, stolen, damaged, or if there is a diopter change of 0.50 or greater. ▪ **Lenses must be provided by the March contracted lab.** ▪ **To identify replacement lenses, please bill with modifier RA.**
Elective Contact Lenses	▪ $105 allowance in lieu of frame and lenses every year. ▪ Contact lenses must have a prescription of at least +/- 0.50 diopters in at least one eye in order to qualify for coverage. ▪ Member is responsible for paying the provider the difference between $105 and the retail amount of the contact lenses. ▪ Contact lenses **must** be supplied by the provider. ▪ **To identify elective contact lenses, please bill using modifier code 75 in conjunction with the current and appropriate HCPCS codes(s) for contact lenses.**
Necessary Contact Lenses	▪ 2 units (1 pair) every 24 months when medically necessary. ▪ Additional contact lenses are covered when there is a diopter change of 0.50 or more in the sphere, cylinder, prism measurements, or axis changes. ▪ Contact lenses **must** be supplied by the provider.
Necessary Contact Lens Replacement	▪ Covered as needed when lost or destroyed. ▪ **To identify replacement contact lenses, please bill with modifier RA.**
Repairs	▪ Covered as needed when lost, stolen, damaged, or if there is a diopter change of 0.50 or greater. ▪ Covered as needed when damaged. ▪ Repairs that cost $2 or more may be billed using HCPCS code V2799 when the following criteria are met. ▪ The cost of repair supplies cannot exceed the cost of replacement eyeglasses. ▪ All repair supplies must be new and at least equivalent to the original item. ▪ The provider must maintain in the client's medical record an itemized list of repairs and the replacement cost to determine whether criteria are met for repair.
Non-Covered Services	▪ Medical eye care.

Benefit	Benefit Limitations/Criteria
	▪ Surgical eye care.

1.5 Covered Benefits – UnitedHealthcare Community Plan – CHIP (Medicaid)

Benefit Plan(s): UDTXM-CHIP

Benefit	Benefit Limitations/Criteria
Exam	▪ 1 service date every year.
Exam Replacement	▪ Covered in accordance with frame and lens replacement benefit frequencies when one of the following is met: ▪ The member is unable to return to or obtain the prescription from the previous provider AND criteria for replacements have been met. ▪ A replacement exam is necessary to determine a vision change AND replacement criteria are met.
Frame	▪ 1 unit every year from the March frame kit OR $105 allowance toward frame and lenses from the provider's selection. ▪ Member is responsible for paying the provider the difference between $105 and the retail amount of the frame and/or lenses. ▪ **If frames are selected from the March frame kit, lenses must be provided by the March lab. If frames are selected from the provider's selection using the retail allowance, lenses must be supplied by the provider. Please refer to Exhibit C in the Provider Reference Guide for March lab information. To identify frames and lenses from the provider's selection, please bill using modifier code 75 in conjunction with the current and appropriate HCPCS codes(s) for frames and lenses.**
Frame Replacement	▪ Covered as needed when lost, stolen or damaged. ▪ **Frame must be selected from the March frame kit.** ▪ **To identify replacement frames, please bill with modifier RA.**
Lens (Single, Bifocal, Trifocal, Lenticular, Polycarbonate)	▪ 2 units (1 pair) every year from the March contracted lab OR $105 allowance toward frame and lenses from the provider's selection. ▪ Member is responsible for paying the provider the difference between $105 and the retail amount of the frame and/or lenses. ▪ **If frames are selected from the March frame kit, lenses must be provided by the March lab. If frames are selected from the provider's selection using the retail allowance, lenses must be supplied by the provider. Please refer to Exhibit C in the Provider Reference Guide for March lab information. To identify frames and lenses from the provider's selection, please bill using modifier code 75 in conjunction with the current and appropriate HCPCS codes(s) for frames and lenses.** ▪ Lenses must have a prescription of at least +/- 0.50 diopter in at least one eye in order to qualify for coverage. ▪ Single vision; bifocal (FT-25, FT-28 and round); trifocal and aspheric lenticular (single vision and bifocal round seg) ▪ Polycarbonate lenses are covered when one of the following is met: ▪ There is a medical or physical condition such as, but not limited to: ▪ Cerebral palsy ▪ Multiple sclerosis ▪ Muscular dystrophy ▪ Epilepsy ▪ Autism ▪ Down's Syndrome ▪ Brain trauma ▪ Balance disorders ▪ Parkinson's disease ▪ Seizure disorder ▪ Motor ataxia ▪ Marfan's syndrome ▪ Ocular prostheses ▪ Amblyopia ▪ Lens power in at least one meridian of -5.25/+4.00 diopters or more and the eyeglasses are not functional in regular standard glass or plastic lens materials due to weight, thickness or aberration

Benefit	Benefit Limitations/Criteria
	▪ Monocular vision with functional vision in one eye ▪ Retinal detachment or risk for retinal detachment (e.g., lattice degeneration, history of retinal detachment in the family, posterior vitreous detachment ▪ UV lenses are covered for the following diagnoses: ▪ Aphakia ▪ Subluxation of lens ▪ Anterior dislocation of lens ▪ Posterior dislocation of lens. ▪ Congenital aphakia ▪ Presence of intraocular lens. ▪ The following lens options are covered: ▪ Balance lenses ▪ Slab off prism ▪ Prism lenses ▪ Fresnell prism press on lenses ▪ Special base curve ▪ Occluder lenses ▪ Oversize lenses
Lens Replacement	▪ Covered as needed when lost, stolen, damaged, or if there is a diopter change of 0.50 or greater. ▪ **Lenses must be provided by the March contracted lab.** ▪ **To identify replacement lenses, please bill with modifier RA.**
Elective Contact Lenses	▪ $105 allowance in lieu of frame and lenses every year. ▪ Contact lenses must have a prescription of at least +/- 0.50 diopters in at least one eye in order to qualify for coverage. ▪ Member is responsible for paying the provider the difference between $105 and the retail amount of the contact lenses. ▪ Contact lenses **must** be supplied by the provider. ▪ **To identify elective contact lenses, please bill using modifier code 75 in conjunction with the current and appropriate HCPCS codes(s) for contact lenses.**
Necessary Contact Lenses	▪ 2 units (1 pair) every 24 months when medically necessary. ▪ Additional contact lenses are covered when there is a diopter change of 0.50 or more in the sphere, cylinder, prism measurements, or axis changes. ▪ Contact lenses **must** be supplied by the provider.
Necessary Contact Lens Replacement	▪ Covered as needed when lost or destroyed. ▪ **To identify replacement contact lenses, please bill with modifier RA.**
Repairs	▪ Covered as needed when damaged. ▪ Repairs that cost $2 or more may be billed using HCPCS code V2799 when the following criteria are met. ▪ The cost of repair supplies cannot exceed the cost of replacement eyeglasses. ▪ All repair supplies must be new and at least equivalent to the original item. ▪ The provider must maintain in the client's medical record an itemized list of repairs and the replacement cost to determine whether criteria are met for repair.
Non-Covered Services	▪ Medical eye care. ▪ Surgical eye care.

1.6 Covered Benefits – UnitedHealthcare Connected® (MMP)

Benefit Plan(s): UD-TX-E

Benefit	Benefit Limitations/Criteria
Exam	▪ 1 service date every 2 years.
Frame	▪ 1 unit, $105 allowance every 2 years toward frame and lenses from the provider's selection. ($70 max toward frame.) ▪ Member is responsible for paying the provider the difference between $105 and the retail amount of the frame and/or lenses.
Lens (Single, Bifocal, Trifocal, Lenticular, Polycarbonate)	▪ $105 allowance every 2 years toward frame and lenses from the provider's selection. ▪ Member is responsible for paying the provider the difference between $105 and the retail amount of the frame and/or lenses. ▪ Single vision; bifocal (FT-25, FT-28 and round); trifocal and aspheric lenticular (single vision and bifocal round seg) ▪ Polycarbonate lenses are covered when one of the following is met: ▪ There is a medical or physical condition such as, but not limited to: ▪ Cerebral palsy ▪ Multiple sclerosis ▪ Muscular dystrophy ▪ Epilepsy ▪ Autism ▪ Down's Syndrome ▪ Brain trauma ▪ Balance disorders ▪ Parkinson's disease ▪ Seizure disorder ▪ Motor ataxia ▪ Marfan's syndrome ▪ Ocular prostheses ▪ Amblyopia ▪ Lens power in at least one meridian of -5.25/+4.00 diopters or more and the eyeglasses are not functional in regular standard glass or plastic lens materials due to weight, thickness or aberration ▪ Monocular vision with functional vision in one eye ▪ Retinal detachment or risk for retinal detachment (e.g., lattice degeneration, history of retinal detachment in the family, posterior vitreous detachment ▪ UV lenses are covered for the following diagnoses: ▪ Aphakia ▪ Subluxation of lens ▪ Anterior dislocation of lens ▪ Posterior dislocation of lens. ▪ Congenital aphakia ▪ Presence of intraocular lens. ▪ The following lens options are covered: ▪ Balance lenses ▪ Slab off prism ▪ Prism lenses ▪ Fresnell prism press on lenses ▪ Special base curve

Benefit	Benefit Limitations/Criteria
	▪ Occluder lenses ▪ Oversize lenses
Elective Contact Lenses	▪ $105 allowance in lieu of frame and lenses every 2 years. ▪ Contact lenses must have a prescription of at least +/- 0.50 diopters in at least one eye in order to qualify for coverage. ▪ Member is responsible for paying the provider the difference between $105 and the retail amount of the contact lenses. ▪ Contact lenses **must** be supplied by the provider. ▪ **To identify elective contact lenses, please bill using modifier code 75 in conjunction with the current and appropriate HCPCS codes(s) for contact lenses.**
Necessary Contact Lenses	▪ 2 units (1 pair) every 24 months when medically necessary. ▪ Additional contact lenses are covered when there is a diopter change of 0.50 or more in the sphere, cylinder, prism measurements, or axis changes. ▪ Contact lenses **must** be supplied by the provider.
Repairs	▪ Covered as needed when the cost of the repair does not exceed $2.
Non-Covered Services	▪ Medical eye care. ▪ Surgical eye care.

1.7 Medicaid and MMP Reimbursement Procedures

The UnitedHealthcare Community Plan STAR, STAR+PLUS, CHIP and MMP benefits afford members the opportunity to:

- Select eyeglasses from the March frame kit and lab, OR
- Select eyeglasses from the provider's selection using a $105 allowance, OR
- Select contact lenses in lieu of frame and lenses using a $105 allowance.

The following examples illustrate reimbursement for each scenario. These examples are for illustrative purposes only and may not reflect actual amounts unless stated otherwise.

March Frame Kit and March Lab

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 $20.00 for the fitting of monofocal spectacles.

Service Code	Description	Modifier	Billed Charges	Paid Amount
92340	Fitting of Spectacles		$ 50.00	$ 20.00
Total			**$ 50.00**	**$ 20.00**

Retail Allowance - Eyeglasses

Providers should bill the current and appropriate HCPCS codes for frames and lenses along with the usual and customary charges for those codes. Reimbursement will be the lesser of billed charges or the contracted rate of $75 for Medicaid and $85 for MMP.

Example 1 – Medicaid

The following example assumes a $105 retail allowance for eyeglasses from the provider's selection/in-house lab.

The allowance for frames and lenses 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.

Service Code	Description	Modifier	Billed Charges	Paid Amount
V2100	Lenses	75	$ 40.00	$ 40.00
V2020	Frame	75	$ 50.00	$ 25.00
V2755	UV Lenses	75	$ 100.00	$ 10.00
92340	Fitting of Spectacles**		$ 40.00	$ 0.00
Total			**$ 230.00***	**$ 75.00**

*Member is responsible for charges exceeding their benefit allowance ($105). In this example, the member is responsible for $85.
**Fitting of Spectacles is not reimbursable when the allowance is used. This fee is not billable to the member.

Example 2 – MMP

The following example assumes a $105 retail allowance for eyeglasses from the provider's selection/in-house lab.

The allowance for frames and lenses will be applied in the following order:

1. Frame codes (V2020, V2025)
2. Basic lens codes (V2100-V2399)
3. Any remaining allowance will be applied to lens upgrades such as tinting, scratch coating, polycarbonate lenses, etc.

Service Code	Description	Modifier	Billed Charges	Paid Amount
V2020	Frame	75	$ 80.00*	$ 70.00
V2100	Lenses	75	$ 50.00	$ 15.00
92340	Fitting of Spectacles***		$ 40.00	$ 0.00
Total			**$ 170.00****	**$ 85.00**

*$70 max toward frame.
**Member is responsible for charges exceeding their benefit allowance ($105). In this example, the member is responsible for $25.
***Fitting of Spectacles is not reimbursable when the allowance is used. This fee is not billable to the member.

Retail Allowance – Contact Lenses

Providers must bill the current and appropriate HCPCS code(s) for contact lenses and CPT code for contact lens fitting. Reimbursement will be the lesser of billed charges or the contracted rate of $75 for Medicaid and $85 for MMP.

Example 1 – Medicaid

Service Code	Description	Modifier	Billed Charges	Paid Amount
V2500	Contact Lenses	75	$ 75.00	$ 75.00
92310	Contact Lens Fitting	75	$ 25.00	$ 0.00
Total			**$ 100.00***	**$ 75.00**

*Member is responsible for charges exceeding their benefit allowance ($105). In this example, there is no member responsibility.

Example 2 – MMP

Service Code	Description	Modifier	Billed Charges	Paid Amount
V2500	Contact Lenses	75	$ 150.00	$ 85.00
92310	Contact Lens Fitting	75	$ 25.00	$ 0.00
Total			**$ 175.00***	**$ 85.00**

*Member is responsible for charges exceeding their benefit allowance ($105). In this example, the member is responsible for $70.

March may modify the Provider Services Agreement, the Provider Policies or any other contract, policy or procedure affecting Providers or the provision or payment of health care services to Members, only upon at least 30 days prior written notice unless the change is required by law or regulation.