Wisconsin Specific Information

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

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1.1 Notice of Updates

Notice of updates published January 24, 2024.

- UnitedHealthcare Community Plan Standard Plan and Supplemental Security Income (SSI) benefits updated.

1.2 Covered Benefits - Anthem Blue Cross and Blue Shield – BadgerCare Plus Standard Plan (Medicaid)

Benefit Plan(s): BCP7

Benefit	Benefit Limitations/Criteria
Exam	▪ 1 service date every year. ▪ Exams exceeding the benefit limit require prior confirmation.
Frame	▪ 1 unit every year. ▪ **Frame must be selected from the March frame kit.**
Frame Replacement	▪ 1 unit every year. ▪ Additional materials exceeding the benefit limit require prior confirmation. ▪ **To identify replacement frames, please bill with modifier RA.**
Lens (Single, Bifocal, Trifocal)	▪ 2 units (1 pair) every year. ▪ **Lenses must be provided by the March contracted lab. Please refer to Exhibit D in the Provider Reference Guide for lab information.** ▪ Regular single vision, bifocal and trifocal lenses are covered.
Lens Replacement	▪ 2 units (1 pair) every year. ▪ Additional materials exceeding the benefit limit require prior confirmation. ▪ **To identify replacement lenses, please bill with modifier RA.**

Polycarbonate Lens	▪ 2 units (1 pair) every year ages 20 and under.
	▪ 2 units (1 pair) every year ages 21 and older when the need is substantiated in the medical record by clinical data and the following criteria is met:
	  ▪ The member has a +/- 8.00
	  ▪ Permanently reduced vision in one eye less than 20/200
	  ▪ A facial deformity or disease that interferes with eyeglass fit
	  ▪ A documented occupational hazard

Necessary Contact Lenses	▪ 2 units (1 pair) in lieu of frame and lenses every year for the following diagnoses:
	  ▪ Aphakia
	  ▪ Keratoconus
	▪ Contact lenses **MUST** be supplied by the provider.

Necessary Contact Lens Replacement	▪ 2 units (1 pair) every year. ▪ Additional materials exceeding the benefit limit require prior confirmation. ▪ **To identify replacement contact lenses, please bill with modifier RA.**
Non-Covered Services	▪ Low vision exams/aids. ▪ Glaucoma screenings. ▪ Medical eye care. ▪ Surgical eye care.

1.3 Covered Benefits - Anthem Blue Cross and Blue Shield – Supplemental Security Income (SSI) (Medicaid)

Benefit Plan(s): WP-WI-SSI

Benefit	Benefit Limitations/Criteria
Exam	▪ 1 service date every year. ▪ Exams exceeding the benefit limit require prior confirmation.
Frame	▪ 1 unit every year. ▪ **Frame must be selected from the March frame kit.**
Frame Replacement	▪ 1 unit every year. ▪ Additional materials exceeding the benefit limit require prior confirmation. ▪ **To identify replacement frames, please bill with modifier RA.**
Lens (Single, Bifocal, Trifocal)	▪ 2 units (1 pair) every year. ▪ **Lenses must be provided by the March contracted lab. Please refer to Exhibit D in the Provider Reference Guide for lab information.** ▪ Regular single vision, bifocal and trifocal lenses are covered.
Lens Replacement	▪ 2 units (1 pair) every year. ▪ Additional materials exceeding the benefit limit require prior confirmation. ▪ **To identify replacement lenses, please bill with modifier RA.**

Polycarbonate Lens	▪ 2 units (1 pair) every year ages 20 and under.
	▪ 2 units (1 pair) every year ages 21 and older when the need is substantiated in the medical record by clinical data and the following criteria is met:
	  ▪ The member has a +/- 8.00
	  ▪ Permanently reduced vision in one eye less than 20/200
	  ▪ A facial deformity or disease that interferes with eyeglass fit
	  ▪ A documented occupational hazard

Necessary Contact Lenses	▪ 2 units (1 pair) in lieu of frame and lenses every year for the following diagnoses:
	  ▪ Aphakia
	  ▪ Keratoconus
	▪ Contact lenses **MUST** be supplied by the provider.

Necessary Contact Lens Replacement	▪ 2 units (1 pair) every year. ▪ Additional materials exceeding the benefit limit require prior confirmation. ▪ **To identify replacement contact lenses, please bill with modifier RA.**
Non-Covered Services	▪ Low vision exams/aids. ▪ Glaucoma screenings. ▪ Medical eye care. ▪ Surgical eye care.

1.4 Covered Benefits - UnitedHealthcare Community Plan - Standard Plan (Medicaid)

Benefit Plan(s): UD-WI-M

Benefit	Benefit Limitations/Criteria
Exam	▪ 1 service date every year. ▪ Exams exceeding the benefit limit require prior confirmation.
Frame	▪ 1 unit every year. ▪ **Frame must be selected from the March frame kit.**
Frame Replacement	▪ 1 unit every year. ▪ Additional materials exceeding the benefit limit require prior confirmation. ▪ **To identify replacement frames, please bill with modifier RA.**
Lens (Single, Bifocal, Trifocal)	▪ 2 units (1 pair) every year. ▪ **Lenses must be provided by the March contracted lab. Please refer to Exhibit D in the Provider Reference Guide for lab information.** ▪ Regular single vision, bifocal and trifocal lenses are covered.
Lens Replacement	▪ 2 units (1 pair) every year. ▪ Additional materials exceeding the benefit limit require prior confirmation. ▪ **To identify replacement lenses, please bill with modifier RA.**

Polycarbonate Lens	▪ 2 units (1 pair) every year ages 20 and under.
	▪ 2 units (1 pair) every year ages 21 and older when the need is substantiated in the medical record by clinical data and the following criteria is met:
	  ▪ The member has a +/- 8.00
	  ▪ Permanently reduced vision in one eye less than 20/200
	  ▪ A facial deformity or disease that interferes with eyeglass fit
	  ▪ A documented occupational hazard

Necessary Contact Lenses	▪ 2 units (1 pair) in lieu of frame and lenses every year for the following diagnoses:
	  ▪ Aphakia
	  ▪ Keratoconus
	▪ Contact lenses **MUST** be supplied by the provider.

Necessary Contact Lens Replacement	▪ 2 units (1 pair) every year. ▪ Additional materials exceeding the benefit limit require prior confirmation. ▪ **To identify replacement contact lenses, please bill with modifier RA.**
Interpreter Services	▪ Services provided by interpreters of the spoken word or sign language will be covered with code T1013 (sign language or oral interpretive services, per 15 minutes) ▪ Interpreters may provide services in person or via telehealth.
Non-Covered Services	▪ Low vision exams/aids. ▪ Glaucoma screenings. ▪ Medical eye care. ▪ Surgical eye care.

1.5 Covered Benefits - UnitedHealthcare Community Plan - Supplemental Security Income (SSI) (Medicaid)

Benefit Plan(s): UD-WI-SSI

Benefit	Benefit Limitations/Criteria
Exam	▪ 1 service date every year. ▪ Exams exceeding the benefit limit require prior confirmation.
Frame	▪ 1 unit every year. ▪ **Frame must be selected from the March frame kit.**
Frame Replacement	▪ 1 unit every year. ▪ Additional materials exceeding the benefit limit require prior confirmation. ▪ **To identify replacement frames, please bill with modifier RA.**
Lens (Single, Bifocal, Trifocal)	▪ 2 units (1 pair) every year. ▪ **Lenses must be provided by the March contracted lab. Please refer to Exhibit D in the Provider Reference Guide for lab information.** ▪ Regular single vision, bifocal and trifocal lenses are covered.
Lens Replacement	▪ 2 units (1 pair) every year. ▪ Additional materials exceeding the benefit limit require prior confirmation. ▪ **To identify replacement lenses, please bill with modifier RA.**

Polycarbonate Lens	▪ 2 units (1 pair) every year ages 20 and under.
	▪ 2 units (1 pair) every year ages 21 and older when the need is substantiated in the medical record by clinical data and the following criteria is met:
	  ▪ The member has a +/- 8.00
	  ▪ Permanently reduced vision in one eye less than 20/200
	  ▪ A facial deformity or disease that interferes with eyeglass fit
	  ▪ A documented occupational hazard

Necessary Contact Lenses	▪ 2 units (1 pair) in lieu of frame and lenses every year for the following diagnoses:
	  ▪ Aphakia
	  ▪ Keratoconus
	▪ Contact lenses **MUST** be supplied by the provider.

Necessary Contact Lens Replacement	▪ 2 units (1 pair) every year. ▪ Additional materials exceeding the benefit limit require prior confirmation. ▪ **To identify replacement contact lenses, please bill with modifier RA.**
Interpreter Services	▪ Services provided by interpreters of the spoken word or sign language will be covered with code T1013 (sign language or oral interpretive services, per 15 minutes) ▪ Interpreters may provide services in person or via telehealth.
Non-Covered Services	▪ Low vision exams/aids. ▪ Glaucoma screenings. ▪ Medical eye care. ▪ Surgical eye care.

1.6 Covered Benefits - UnitedHealthcare Dual Complete® (Medicare) H0294-027

Benefit Plan(s): UDWI-DCPPO

Benefit	Benefit Limitations/Criteria
Exam	▪ 1 service date every calendar year.
Eyewear	▪ $400 allowance every calendar year. ▪ Allowance may be used toward frames, lenses, lens extras and/or contact lenses. ▪ In-house frame and lenses **MUST** be used.
Non-Covered Services	▪ Medical or surgical eye care.

1.7 Covered Benefits - UnitedHealthcare Dual Complete® (Medicare) H5253-024

Benefit Plan(s): UDWI-DCLP

Benefit	Benefit Limitations/Criteria
Exam	▪ 1 service date every calendar year.
Eyewear	▪ $400 allowance every calendar year. ▪ Allowance may be used toward frames, lenses, lens extras and/or contact lenses. ▪ In-house frame and lenses **MUST** be used.
Non-Covered Services	▪ Medical or surgical eye care.

1.8 Covered Benefits - UnitedHealthcare Dual Complete® (Medicare) H3794-002

Benefit Plan(s): UDWI-DCLP1

Benefit	Benefit Limitations/Criteria
Exam	▪ 1 service date every calendar year.
Eyewear	▪ $400 allowance every calendar year. ▪ Allowance may be used toward frames, lenses, lens extras and/or contact lenses. ▪ In-house frame and lenses **MUST** be used.
Non-Covered Services	▪ Medical or surgical eye care.

1.9 Covered Benefits - UnitedHealthcare Dual Complete® (Medicare) H3794-004

Benefit Plan(s): UDWI-DCHMO

Benefit	Benefit Limitations/Criteria
Exam	▪ 1 service date every calendar year.
Eyewear	▪ $250 allowance every calendar year. ▪ Allowance may be used toward frames, lenses, lens extras and/or contact lenses. ▪ In-house frame and lenses **MUST** be used.
Non-Covered Services	▪ Medical or surgical eye care.

1.10 Accessibility

All providers participating in Wisconsin must provide accessible programs, facilities and reasonable accommodations to service participants/customers with disabilities in compliance with Section 504 of the Rehabilitation Act of 1973, Title II of the American With Disabilities Act of 1990 as amended (ADA) and as it applies to local governments and municipalities, Title III of the ADA or Wisconsin Civil Rights Statute Chapter 106.52 Public Places of Accommodations or Amusement, and DWD Chapter 221.1.

1.11 State Mandated Contract Provisions

Please click here to access state mandated contract provisions.