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

Table of Contents

1.1 Covered Benefits - Molina Healthcare of Ohio (Medicaid)

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 criterion is met: ▪ The member is unable to return to or obtain the prescription from the previous provider AND criteria for replacement frame and lenses are met. ▪ A replacement exam is necessary to determine a vision change AND criteria for replacement frame and lenses are met.
Frame	▪ 1 unit every year. ▪ **Frame must be selected from the MARCH frame kit.**
Frame Replacement	▪ 1 unit every year. ▪ Replacements must be due to normal wear and tear only and is subject to the same minimum lens criteria as initial lenses. Documentation of replacement must be attached to the claim. ▪ One complete frame and pair of lens per 12 month period. ▪ Additional replacements are available when medically necessary, which by definition means that without the service the member can expect to experience impairment of function. ▪ **To identify replacement frames, please bill using modifier code RA in conjunction with the current and appropriate HCPCS code(s) for frames.**
Deluxe Frame	▪ 10% discount, 1 unit $10 allowance every year. ▪ Members may waive the standard frame selection and opt for any frame shown at the provider's location. Members then receive the "Ten plus Ten" frame benefit. The member receives a courtesy 10% discount on the retail price and MARCH provides a ten dollar ($10.00) frame allowance. The member pays the reduced fee directly to the provider. The provider bills MARCH for the deluxe frame using the code V2025. ▪ **Provider is responsible for the cost of traceable shipping of a non-MARCH frame to the MARCH lab for lens fabrication.**
Deluxe Frame Replacement	▪ 10% discount, 1 unit $10 allowance every year. ▪ Replacements must be due to normal wear and tear only and is subject to the same minimum lens criteria as initial lenses. Documentation of replacement must be attached to the claim. ▪ One complete frame and pair of lens per 12 month period. ▪ Additional replacements are available when medically necessary, which by definition means that without the service the member can expect to experience impairment of function. ▪ **To identify replacement frames, please bill using modifier code RA in conjunction with the current and appropriate HCPCS code(s) for frames.**
Lens (Single, Bifocal, Trifocal, Polycarbonate)	▪ 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.** ▪ Glass lenses, UV lenses, and photochromatic lenses are a covered benefit if medically necessary. ▪ Lens prescriptions must be at least: +0.75 sphere or -0.50 sphere, 0.50 cylinder, 0.50 diopter imbalance, 0.50 prism diopter vertical, or 3.00 prism diopter lateral. These prescription minimums apply to new, duplications and changes in prescription. ▪ Lens prescription changes must still meet the lens prescription minimum requirements as stated in the above paragraph and must be at least: +/- 0.50 sphere, +/- 0.50 cylinder, 10 degrees for a 1.00 cylinder or less, or 5 degrees for a 1.12 cylinder or more.

Benefit	Benefit Limitations/Criteria
Lens Replacement	▪ 2 units every year. ▪ Replacements must be due to normal wear and tear only and is subject to the same minimum lens criteria as initial lenses. Documentation of replacement must be attached to the claim. ▪ One complete frame and pair of lenses per 12 month period. ▪ Additional replacements are available when medically necessary, which by definition means that without the service the member can expect to experience impairment of function. ▪ **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 as needed if medically necessary for the following conditions:
	  ▪ Aphakia
	  ▪ High refractive errors greater than 10.00 diopters, when the visual acuity cannot be corrected to 20/70 in the better eye with spectacle lenses and there is a significant improvement in the visual acuity with contact lenses.
	  ▪ High degree of anisometropia where binocularity can be substantiated.
	  ▪ Keratoconus
	▪ Contact lenses must be supplied by the provider.

Non-Covered Services	▪ Medical or surgical eye care.

1.2 Covered Benefits - Molina Healthcare of Ohio MMP – MyCare Ohio – (Medicare-Medicaid)(Medicaid Only) Plan 001

Benefit	Benefit Limitations/Criteria
Routine Eye Exam	▪ 1 service date every year for individuals 20 and under and 60 and over. ▪ 1 service date every two years for individuals age 21-59.

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

Frames	▪ 1 unit every year for individuals 20 and under and 60 and over. ▪ 1 unit every two years for individuals age 21-59. ▪ **Frame must be selected from the MARCH frame kit.**
Frame Replacement	▪ Covered as needed when medically necessary, which by definition means that without the service the member can expect to experience impairment of function.

Lenses	▪ 2 units every year for individuals 20 and under and 60 and over.
	▪ 2 units every two years for individuals age 21-59.
	▪ Standard, plastic single vision, bifocal, trifocal and polycarbonate lenses are covered.
	  ▪ Lens prescriptions must be at least: +0.75 sphere or -0.50 sphere, 0.50 cylinder, 0.50 diopter imbalance, 0.50 prism diopter vertical, or 3.00 prism diopter lateral. These prescription minimums apply to new, duplications and changes in prescription.
	  ▪ Lens prescription changes must still meet the lens prescription minimum requirements as stated in the above paragraph and must be at least: +/- 0.50 sphere, +/- 0.50 cylinder, 10 degrees for a 1.00 cylinder or less, or 5 degrees for a 1.12 cylinder or more.
	▪ Lenses must be provided by the MARCH lab.

Lens Replacement	▪ Covered as needed when medically necessary, which by definition means that without the service the member can expect to experience impairment of function.
Contact Lenses	▪ 2 units every year in lieu of lenses and frames for individuals 20 and under and 60 and over. ▪ 2 units every two years in lieu of lenses and frames for individuals age 21-59.

Necessary Contact Lenses	▪ Covered as needed if medically necessary for the following conditions:
	  ▪ Aphakia
	  ▪ High refractive errors greater than 10.00 diopters, when the visual acuity cannot be corrected to 20/70 in the better eye with spectacle lenses and there is a significant improvement in the visual acuity with contact lenses.
	  ▪ High degree of anisometropia where binocularity can be substantiated.
	  ▪ Keratoconus
	▪ Contact lenses must be supplied by the provider.

Non-Covered Services	▪ Medical or surgical eye care. ▪ Vision therapy. ▪ Low vision. ▪ Eyewear after cataract surgery.

1.3 Covered Benefits - Molina Healthcare of Ohio MMP – Dual Options MyCare Ohio (Medicare-Medicaid) Plan 001

Benefit	Benefit Limitations/Criteria
Routine Eye Exam	▪ 1 service date every year for individuals 20 and under and 60 and over. ▪ 1 service date every two years for individuals age 21-59.
Routine Eye Exam Replacement	▪ Covered in accordance with frame and lens replacement benefit frequencies when one of the following criterion is met: ▪ The member is unable to return to or obtain the prescription from the previous provider AND criteria for replacement frame and lenses are met. ▪ A replacement exam is necessary to determine a vision change AND criteria for replacement frame and lenses are met.
Frames	▪ 1 unit every year for individuals 20 and under and 60 and over. ▪ 1 unit every two years for individuals age 21-59. ▪ **Frame must be selected from the MARCH frame kit.**
Frame Replacement	▪ Covered as needed when medically necessary, which by definition means that without the service the member can expect to experience impairment of function.
Lenses	▪ 2 units every year for individuals 20 and under and 60 and over. ▪ 2 units every two years for individuals age 21-59. ▪ Standard, plastic single vision, bifocal, trifocal and polycarbonate lenses are covered. ▪ Lens prescriptions must be at least: +0.75 sphere or -0.50 sphere, 0.50 cylinder, 0.50 diopter imbalance, 0.50 prism diopter vertical, or 3.00 prism diopter lateral. These prescription minimums apply to new, duplications and changes in prescription. ▪ Lens prescription changes must still meet the lens prescription minimum requirements as stated in the above paragraph and must be at least: +/- 0.50 sphere, +/- 0.50 cylinder, 10 degrees for a 1.00 cylinder or less, or 5 degrees for a 1.12 cylinder or more. ▪ **Lenses must be provided by the MARCH lab. Please refer to Exhibit D in the Provider Reference Guide for lab information.**
Lens Replacement	▪ Covered as needed when medically necessary, which by definition means that without the service the member can expect to experience impairment of function.
Contact Lenses	▪ 2 units every year in lieu of lenses and frames for individuals 20 and under and 60 and over. ▪ 2 units every two years in lieu of lenses and frames for individuals age 21-59.
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. ▪ **To identify eyewear after cataract surgery, please bill with the appropriate diagnosis code for cataract surgery.**
Non-Covered Services	▪ Medical or surgical eye care. ▪ Vision therapy. ▪ Low vision.

1.4 Covered Benefits - Molina Healthcare of Ohio – Complete Care (Medicare) H8176-002

Benefit	Benefit Limitations/Criteria
Exam	▪ 1 service date every calendar year.
Eyewear	▪ $300 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.
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. ▪ 20% coinsurance applies to select members. Please refer to the Patient Benefit Summary in eyeSynergy® or contact Customer Service at (844) 756-2724 to determine if the member has a coinsurance. ▪ **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 age 50 and older.
	  ▪ Hispanic-Americans age 65 and older.

Non-Covered Services	▪ Medical or surgical eye care

1.5 Covered Benefits - UnitedHealthcare Community Plan (Medicaid)

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 criterion is met: ▪ The member is unable to return to or obtain the prescription from the previous provider AND criteria for replacement frame and lenses are met. ▪ A replacement exam is necessary to determine a vision change AND criteria for replacement frame and lenses are met.
Necessary Medical Services	▪ Covered as needed 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 at no cost to the member **OR** frame with a retail amount greater than $25 may be selected from the provider's selection. If the member selects a frame with a retail amount greater than $25, the member is responsible for the difference between the retail cost of the frame selected and $25. ▪ **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 with prior confirmation when medically necessary. ▪ **Frame MUST be selected from the MARCH Frame Kit.** ▪ **To identify replacement frames, please bill using modifier code RA in conjunction with the current and appropriate HCPCS code(s) for frames.**
Lens (Single, Bifocal, Trifocal, Polycarbonate)	▪ 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.** ▪ Single, bifocal, or trifocal scratch resistant plastic or polycarbonate lenses are covered. ▪ Aphakic single vision and multifocal lenses are covered. ▪ Additions for single and bifocal vision include: ▪ Prism ▪ Industrial thickness ▪ Myodisc ▪ Cylinder > 6.25 ▪ Special base curve ▪ Ultra-violet tint (requires prior confirmation) ▪ Slab off lens ▪ Fresnel prism ▪ Frosted lens ▪ Tints (requires prior confirmation) ▪ Photochromic (requires prior confirmation) ▪ High index plastic lenses ▪ Glass lenses will be covered with prior confirmation when medically necessary. ▪ Lens prescriptions must be at least: +0.75 sphere or -0.50 sphere, 0.50 cylinder, 0.50 diopter imbalance, 0.50 prism diopter vertical, or 3.00 prism diopter lateral. These prescription minimums apply to new, duplications and changes in prescription. ▪ Lens prescription changes must still meet the lens prescription minimum requirements as stated in the above paragraph and must be at least: +/- 0.50 sphere, +/- 0.50 cylinder, 10 degrees for a 1.00 cylinder or less, or 5 degrees for a 1.12 cylinder or more.

Benefit	Benefit Limitations/Criteria
Lens Replacement	▪ Covered as needed when medically necessary. ▪ Replacements are subject to the same minimum lens critiera as initial lenses. ▪ **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 as needed if medically necessary for the following conditions:
	  ▪ Aphakia
	  ▪ High refractive errors greater than 10.00 diopters, when the visual acuity cannot be corrected to 20/70 in the better eye with spectacle lenses and there is a significant improvement in the visual acuity with contact lenses.
	  ▪ High degree of anisometropia where binocularity can be substantiated.
	  ▪ Keratoconus where there is a high corneal astigmatism or corneal irregularities when visual acuity cannot be corrected to 20/70 in the better eye with spectacles and there is a significant improvement with contact lenses.
	▪ Contact lenses must be supplied by the provider.

Elective Contact Lenses	▪ $150 allowance every year in lieu of frame and 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 code(s) for contact lenses and CPT code for contact lens fitting.** ▪ Contact lens fitting/examination/evaluation is deducted from the allowance.
Non-Covered Services	▪ 15% discount on the usual and customary fee for eyewear purchases which exceed the benefit coverage (excludes disposable contact lenses.) Certain provider limitations and exclusions may apply. ▪ Surgical eye care.

1.6 Covered Benefits - UnitedHealthcare Connected® for MyCare Ohio (MMP)

Benefit	Benefit Limitations/Criteria
Exam	▪ 1 service date every year ages 20 and under or 60 and older. ▪ 1 service date every 2 years ages 21-59.

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

Necessary Medical Services	▪ Covered as needed when services are performed by an optometrist and are within the scope of licensure.
Frame	▪ 1 unit every year ages 20 and under or 60 and older. ▪ 1 unit every 2 years ages 21-59. ▪ Frame may be selected from the MARCH Frame Kit at no cost to the member **OR** frame with a retail amount greater than $25 may be selected from the provider's selection. If the member selects a frame with a retail amount greater than $25, the member is responsible for the difference between the retail cost of the frame selected and $25. ▪ **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 with prior confirmation when medically necessary. ▪ **Frame MUST be selected from the MARCH Frame Kit.** ▪ **To identify replacement frames, please bill using modifier code RA in conjunction with the current and appropriate HCPCS code(s) for frames.**

Lens (Single, Bifocal, Trifocal, Polycarbonate)	▪ 2 units every year ages 20 and under or 60 and older.
	▪ 2 units ever 2 years ages 21-59.
	▪ **Lenses must be provided by the MARCH lab. Please refer to Exhibit D in the Provider Reference Guide for lab information.**
	▪ Single, bifocal, or trifocal scratch resistant plastic or polycarbonate lenses are covered.
	▪ Aphakic single vision and multifocal lenses are covered.
	▪ Additions for single and bifocal vision include:
	  ▪ Prism
	  ▪ Industrial thickness
	  ▪ Myodisc
	  ▪ Cylinder > 6.25
	  ▪ Special base curve
	  ▪ Ultra-violet tint (requires prior confirmation)
	  ▪ Slab off lens
	  ▪ Fresnel prism
	  ▪ Frosted lens
	  ▪ Tints (requires prior confirmation)
	  ▪ Photochromic (requires prior confirmation)
	  ▪ High index plastic lenses
	▪ Glass lenses will be covered with prior confirmation when medically necessary.
	▪ Lens prescriptions must be at least: +0.75 sphere or -0.50 sphere, 0.50 cylinder, 0.50 diopter imbalance, 0.50 prism diopter vertical, or 3.00 prism diopter lateral. These prescription minimums apply to new, duplications and changes in prescription.
	▪ Lens prescription changes must still meet the lens prescription minimum requirements as stated in the above paragraph and must be at least: +/- 0.50 sphere, +/- 0.50 cylinder, 10 degrees for a 1.00 cylinder or less, or 5 degrees for a 1.12 cylinder or more.

Benefit	Benefit Limitations/Criteria
Lens Replacement	▪ Covered as needed when medically necessary. ▪ Replacements are subject to the same minimum lens critiera as initial lenses. ▪ **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 as needed if medically necessary for the following conditions:
	  ▪ Aphakia
	  ▪ High refractive errors greater than 10.00 diopters, when the visual acuity cannot be corrected to 20/70 in the better eye with spectacle lenses and there is a significant improvement in the visual acuity with contact lenses.
	  ▪ High degree of anisometropia where binocularity can be substantiated.
	  ▪ Keratoconus where there is a high corneal astigmatism or corneal irregularities when visual acuity cannot be corrected to 20/70 in the better eye with spectacles and there is a significant improvement with contact lenses.
	▪ Contact lenses must be supplied by the provider.

Eyewear After Cataract Surgery	▪ One pair of eyeglasses (standard frame and lenses) **OR** contact lenses after each cataract surgery. ▪ Frame must be selected from the MARCH Frame Kit and lenses must be supplied by the MARCH lab. Contact lenses must be supplied by the provider. ▪ **To identify eyewear after cataract surgery, please bill with the appropriate diagnosis code for cataract surgery.**
Non-Covered Services	▪ 15% discount on the usual and customary fee for eyewear purchases which exceed the benefit coverage (excludes disposable contact lenses.) Certain provider limitations and exclusions may apply. ▪ Surgical eye care.

1.7 State Mandated Guidelines

Per Ohio Administrative Code 5101:3-6-07, CPT 92015 (refraction) cannot be billed in conjunction with general ophthalmological service codes. In accordance with this Code, MARCH will not provide reimbursement for CPT 92015 (refraction) when billed in conjunction with CPT codes 92004, 92014, 92002 and 92012.

The following provisions are required for Providers in the state of Ohio:

1. Use of the Council for Affordable Quality Healthcare (CAQH) application for all Providers completing credentialing and recredentialing;
2. Credentialing and recredentialing applications are processed within ninety (90) days of receipt date;
3. In the event missing information is discovered on the credentialing application, Providers must be notified in writing within twenty-one (21) days of discovery;
4. Documentation of written practice protocol for all nurse practitioners, with a Practitioner Provider;
5. Recredentialing process includes review of Quality of Care and Quality of Service complaints;
6. PHI is not transferred by Provider outside of the United States or its Territories;
7. There is no sub-delegation of Credentialing functions to offshore organizations;
8. Provider and/or Participating Providers may not be debarred, suspended, proposed for debarment, declared ineligible or otherwise excluded from participation in transactions by any federal agency;
    a. Report civil or criminal convictions of any individual(s) with an ownership or controlling interest of five percent (5%) or more or who is a managing employee, within five (5) business days of discovery; and
    b. Report for cause termination of any individual(s) with an ownership or controlling interest of five percent (5%) or more or who is a managing employee, within five (5) business days of discovery.
9. Credentialing policies state that practitioners will not be discriminated against based on race, color, religion, gender, sexual orientation, age, disability, national origin, military status, health status, or ancestry, or need for health care services; and
10. Pursuant to OAC rule 5160-26-05(D)(24), third party administrators must include the elements in paragraph D in its subcontracts;
11. Provider will maintain a list of Practitioner Providers and other employed individuals, including administrative staff, with five percent (5%) or more ownership or controlling interest in Provider group. List should be produced as requested, and within five (5) business days of request; and
12. In the event an excluded individual is discovered through ongoing monitoring processes, Provider will:
    a. Report civil or criminal convictions of any individual(s) with an ownership or controlling interest of five percent (5%) or more or who is a managing employee, within five (5) business days of discovery; and
    b. Report for cause termination of any individual(s) with an ownership or controlling interest of five percent (5%) or more or who is a managing employee, within five (5) business days of discovery.