Kentucky Specific Information

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

Table of Contents

1.1 Notice of Updates

Notice of updates published January 1, 2025.

- UnitedHealthcare Dual Complete® H1889-030-000 and H6595-005-000 added effective 01/01/2025.
- UnitedHealthcare Dual Complete® H1889-008-000, H6595-003-000, and d H6595-004-000 updated effective 01/01/2025.

1.2 Covered Benefits – UnitedHealthcare Dual Complete® KY-S001 (Medicare) H1889-008

Benefit Plan(s): UDKYS-DCP

Benefit	Benefit Limitations/Criteria
Exam	▪ 1 service date every calendar year.
Necessary Medical Services	▪ Covered as needed when services are performed by an optometrist and are within the scope of licensure.
Eyewear	▪ $250 allowance every calendar year. ▪ Allowance may be used toward frames, lenses, lens extras and contact lenses.
Eyewear After Cataract Surgery	▪ One pair of eyeglasses (standard frame and lenses) OR one pair of contact lenses following cataract surgery with an intraocular lens. Allowance does not apply. ▪ **To identify eyewear after cataract surgery, please bill with the appropriate diagnosis code for cataract surgery.**
Glaucoma Screening	▪ 1 service date every calendar year when member is considered "at-risk" according to the following Medicare definitions of "at-risk": ▪ Individuals with a family history of glaucoma ▪ Individuals with diabetes mellitus ▪ African-Americans ages 50 and older ▪ Hispanic-Americans ages 65 and older
Non-Covered Services	▪ Surgical eye care

1.3 Covered Benefits – UnitedHealthcare Dual Complete® KY-S002 (Medicare) H6595-004

Benefit Plan(s): UDKYS-DC3

Benefit	Benefit Limitations/Criteria
Exam	▪ 1 service date every calendar year.
Necessary Medical Services	▪ Covered as needed when services are performed by an optometrist and are within the scope of licensure.
Eyewear	▪ $250 allowance every calendar year. ▪ Allowance may be used toward frames, lenses, lens extras and contact lenses.
Eyewear After Cataract Surgery	▪ One pair of eyeglasses (standard frame and lenses) OR one pair of contact lenses following cataract surgery with an intraocular lens. Allowance does not apply. ▪ **To identify eyewear after cataract surgery, please bill with the appropriate diagnosis code for cataract surgery.**
Glaucoma Screening	▪ 1 service date every calendar year when member is considered "at-risk" according to the following Medicare definitions of "at-risk": ▪ Individuals with a family history of glaucoma ▪ Individuals with diabetes mellitus ▪ African-Americans ages 50 and older ▪ Hispanic-Americans ages 65 and older
Non-Covered Services	▪ Surgical eye care

1.4 Covered Benefits – UnitedHealthcare Dual Complete® KY-V001 (Medicare) H6595-003

Benefit Plan(s): UDKYS-DC4

Benefit	Benefit Limitations/Criteria
Exam	▪ 1 service date every calendar year.
Necessary Medical Services	▪ Covered as needed 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.
Eyewear After Cataract Surgery	▪ One pair of eyeglasses (standard frame and lenses) OR one pair of contact lenses following cataract surgery with an intraocular lens. Allowance does not apply. ▪ **To identify eyewear after cataract surgery, please bill with the appropriate diagnosis code for cataract surgery.**
Glaucoma Screening	▪ 1 service date every calendar year when member is considered "at-risk" according to the following Medicare definitions of "at-risk": ▪ Individuals with a family history of glaucoma ▪ Individuals with diabetes mellitus ▪ African-Americans ages 50 and older ▪ Hispanic-Americans ages 65 and older
Non-Covered Services	▪ Surgical eye care

1.5 Covered Benefits – UnitedHealthcare Dual Complete® KY-S3 (Medicare) H1189-030

Benefit Plan(s): UDKYS-DC5

Benefit	Benefit Limitations/Criteria
Exam	▪ 1 service date every calendar year.
Necessary Medical Services	▪ Covered as needed when services are performed by an optometrist and are within the scope of licensure.
Eyewear	▪ $250 allowance every calendar year. ▪ Allowance may be used toward frames, lenses, lens extras and contact lenses.
Eyewear After Cataract Surgery	▪ One pair of eyeglasses (standard frame and lenses) OR one pair of contact lenses following cataract surgery with an intraocular lens. Allowance does not apply. ▪ **To identify eyewear after cataract surgery, please bill with the appropriate diagnosis code for cataract surgery.**
Glaucoma Screening	▪ 1 service date every calendar year when member is considered "at-risk" according to the following Medicare definitions of "at-risk": ▪ Individuals with a family history of glaucoma ▪ Individuals with diabetes mellitus ▪ African-Americans ages 50 and older ▪ Hispanic-Americans ages 65 and older
Non-Covered Services	▪ Surgical eye care

1.6 Covered Benefits – UnitedHealthcare Dual Complete® KY-S4 (Medicare) H6595-005

Benefit Plan(s): UDKYS-DC6

Benefit	Benefit Limitations/Criteria
Exam	▪ 1 service date every calendar year.
Necessary Medical Services	▪ Covered as needed when services are performed by an optometrist and are within the scope of licensure.
Eyewear	▪ $250 allowance every calendar year. ▪ Allowance may be used toward frames, lenses, lens extras and contact lenses.
Eyewear After Cataract Surgery	▪ One pair of eyeglasses (standard frame and lenses) OR one pair of contact lenses following cataract surgery with an intraocular lens. Allowance does not apply. ▪ **To identify eyewear after cataract surgery, please bill with the appropriate diagnosis code for cataract surgery.**
Glaucoma Screening	▪ 1 service date every calendar year when member is considered "at-risk" according to the following Medicare definitions of "at-risk": ▪ Individuals with a family history of glaucoma ▪ Individuals with diabetes mellitus ▪ African-Americans ages 50 and older ▪ Hispanic-Americans ages 65 and older
Non-Covered Services	▪ Surgical eye care

1.7 Covered Benefits – UnitedHealthcare Community Plan (Medicaid)

Benefit Plan(s): UDKYM-20, UDKYM-21, UDKYM-PG20, UDKYM-PG21

Benefit	Benefit Limitations/Criteria
Exam	▪ 1 service date every year.
Necessary Medical and Surgical Services	▪ Covered as needed when services are performed by an optometrist and are within the scope of licensure.

Eyeglasses (Single, Bifocal and Multi-focal)	▪ 1 unit every calendar year when the recipient has a diagnosed visual condition that:
	  ▪ Requires the use of eyeglasses;
	  ▪ Is within one of the following categories:
	  ▪ Amblyopia;
	  ▪ Post surgical eye condition;
	  ▪ Diminished or subnormal vision; or
	  ▪ Other diagnosis which indicates the need for eyeglasses; and
	  ▪ Requires a prescription correction in the stronger lens no weaker than:
	  ▪ +0.50, 0.50 sphere +0.50, or 0.50 cylinder;
	  ▪ 0.50 diopter of vertical prism; or
	  ▪ A total of two (2) diopter of lateral prism.
	▪ Polycarbonate and scratch coating are covered.
	▪ Tinted lenses are covered when the prescription specifically indicates a diagnosis of photophobia.
	▪ Plano safety glasses are covered when medically indicated for the recipient.
	▪ The following is covered when medically necessary for:
	  ▪ Photochromics
	  ▪ Anti-reflective coating
	  ▪ Other lens options
	  ▪ Press-on prism

Eyeglass Replacements	▪ 1 pair every calendar year when:
	  ▪ The recipient's eyeglasses are broken or lost during the calendar year; or
	  ▪ The eyeglass prescription for the recipient is changed during the calendar year.
	▪ **To identify replacement materials, please bill using modifier code RA in conjunction with the current and appropriate HCPCS code(s) for materials.**

Medically Necessary Contacts	▪ Contact lenses are covered in lieu of eyeglasses when a medical condition prevents the use of eyeglasses. ▪ **Annual Contact Lenses:** 1 contact lens per eye, per year. Please bill using modifier code(s) RT/LT to designate eye. ▪ **Monthly Contact Lenses:** Year supply of monthly contact lenses is two boxes of contacts per year, per eye. Please bill using modifier code U1, and RT/LT to designate eye. ▪ **Daily Contact Lenses:** Year supply of daily contacts is four boxes per eye, per year. Please bill using modifier code U2, and RT/LT to designate eye. ▪ **Bi-Weekly Contact Lenses:** Year supply of bi-weekly contacts is four boxes of contacts per eye, per year. Please bill using modifier code U3, and RT/LT to designate eye.
Medically Necessary Replacement Contacts	▪ **Annual Contact Lenses:** One replacement lens per eye, per year. Please bill using modifier code(s) RT/LT to designate eye. ▪ **Monthly Contact Lenses:** One replacement box per eye, per year. Please bill using modifier code U1, RA, and RT/LT to designate eye. ▪ **Daily Contact Lenses:** One replacement box per eye, per year. Please bill using modifier code U2, RA, RT/LT to designate eye.

	▪ **Bi-Weekly Contact Lenses:** One replacement box per eye, per year. Please bill using modifier code U3, RA and RT/LT to designate eye.