Tennessee Specific Information

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

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1.1 Notice of Updates

Notice of updates published 07/21/2023.

- UnitedHealthcare Community Plan CoverKids benefit updated.

1.2 Covered Benefits - UnitedHealthcare Community Plan (TennCare) – Middle, West and East Ages 20 and Under

Benefit Plan(s): UDTNM-20

Benefit	Benefit Limitations/Criteria
Routine Exam	Covered as required for individual needs.
Frame	▪ 1 unit every year. ▪ Frame must be selected from the March frame kit. ▪ There is no coverage for eyeglasses when non-covered frame and/or lens options are selected. If there is a frame type that is necessary, but not included in the March frame kit, the specialized frame must be provided. **To identify specialized frames, please bill using modifier code 75 in conjunction with the current and appropriate HCPCS code for frames.**
Frame Replacement	▪ Covered as required for individual needs. ▪ **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 (1 pair) every year. ▪ Lens options are covered when medically necessary and as documented in the member's medical record. There is no coverage for eyeglasses when non-covered frame and/or lens options are selected. ▪ **Lenses must be provided by the March lab. Please refer to Exhibit C in the Provider Reference Guide for lab information. Provider is responsible for the cost of traceable shipping of a specialized frame to the March lab for lens fabrication.**
Lens Replacement	▪ Covered as required for individual needs. ▪ **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	▪ 2 units (1 pair) every year 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 Replacement	▪ Covered as needed when initial criteria for medically necessary contact lenses is met. ▪ **To identify replacement contact lenses, please bill using modifier code RA in conjunction with the current and appropriate HCPCS code(s) for contact lenses.** ▪ **Contact lenses must be supplied by the provider.**
Non-Covered Services	▪ Medical and surgical eye care.

1.3 Covered Benefits - UnitedHealthcare Community Plan CoverKids

Benefit Plan(s): UDTNP-C0, UDTNP-CH, UDTNP-CL

Benefit	Benefit Limitations/Criteria
Routine Exam	▪ 1 unit every calendar year.
Glaucoma Screening	▪ 1 unit every calendar year.
Frame	▪ 1 unit every 2 calendar years. ▪ $100 max benefit toward any frame in the provider's selection. ▪ A $5 or $15 copay may apply. Please refer to the Patient Benefit Summary in eyeSynergy® or contact Customer Service at (844) 966-2724 to determine if the member has a copay. ▪ When both frame and lenses are ordered at the same time, only one copay is charged.
Frame Replacement	▪ 1 unit every 2 calendar years. ▪ $100 max benefit toward any frame in the provider's selection. ▪ **To identify replacement frames, please bill using modifier code RA in conjunction with the current and appropriate HCPCS code(s) for frames.**
Lenses	▪ 2 units (1 pair) every calendar year. ▪ $85 max benefit toward lenses or lens extras. ▪ A $5 or $15 copay may apply. Please refer to the Patient Benefit Summary in eyeSynergy® or contact Customer Service at (844) 966-2724 to determine if the member has a copay. ▪ When both frame and lenses are ordered at the same time, only one copay is charged.
Necessary Contact Lenses	▪ 2 units (1 pair) every calendar year in lieu of eyeglasses. ▪ $150 max benefit. ▪ A $5 or $15 copay may apply. Please refer to the Patient Benefit Summary in eyeSynergy® or contact Customer Service at (844) 966-2724 to determine if the member has a copay.
Non-Covered Services	▪ Medical and surgical eye care.

1.4 Covered Benefits - UnitedHealthcare Dual Complete® HMO D-SNP (Medicare) H0251-002

Benefit Plan(s): UDTNS

Benefit	Benefit Limitations/Criteria
Routine Exam	▪ 1 service date every calendar year.
Eyewear	▪ $600 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 contact lenses after each cataract surgery that includes insertion of an intraocular lens. ▪ Allowance is not applicable. ▪ **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	▪ Medical and surgical eye care.

1.5 Covered Benefits - UnitedHealthcare Dual Complete® ONE HMO D-SNP (Medicare) H0251-004

Benefit Plan(s): UDTNS1

Benefit	Benefit Limitations/Criteria
Routine Exam	▪ 1 service date every calendar year.
Eyewear	▪ $600 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 contact lenses after each cataract surgery that includes insertion of an intraocular lens. ▪ Allowance is not applicable. ▪ **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	▪ Medical and surgical eye care.

1.6 UnitedHealthcare Community Plan CoverKids Reimbursement Procedures

The UnitedHealthcare Community Plan CoverKids benefit affords members the opportunity to use up to a $100 retail allowance towards frames, a $85 retail allowance towards lenses or a $150 retail allowance towards contact lenses. The following examples illustrate reimbursement for frames, lenses and contact lenses. These examples are for illustrative purposes only and may not reflect actual amounts unless stated otherwise.

Frames and Lenses

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 $80 for frames and $68 for lenses.

Service Code	Description	Billed Charges	Paid Amount
V2020	Frame	$ 100.00	$ 80.00
V2100	Lenses	$ 40.00	$ 40.00
V2755	UV Lenses	$ 100.00	$ 28.00
92340	Fitting of Spectacles**	$ 40.00	$ 0.00
Total		**$ 280.00***	**$ 148.00**

*Member is responsible for charges exceeding their benefit allowance ($100 for frames and $85 for lenses). In this example, the member is responsible for $55.
**Fitting of Spectacles is not reimbursable when the allowance is used. This fee is not billable to the member.

Contact Lenses

Providers should bill the current and appropriate HCPCS codes for contact lenses along with the usual and customary charges for those codes. Reimbursement will be the lesser of billed charges or the contracted rate of $120.

Service Code	Description	Billed Charges	Paid Amount
V2500	Contact Lenses	$ 200.00	$ 120.00
92310	Contact Lens Fitting**	$ 25.00	$ 0.00
Total		**$ 225.00***	**$ 120.00**

*Member is responsible for charges exceeding their benefit allowance ($150). In this example, the member is responsible for $50.
**Contact lens fitting is not reimbursable when the allowance is used. This fee is not billable to the member.