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Molina Healthcare of Illinois
Dual Options (MMP) Plan Sheet

SERVICE	BENEFIT / SERVICE CODE		AVĒSIS PAYS	MEMBER PAYS
ANNUAL ROUTINE EYE EXAMINATION	92002, 92012, 92004, 92014		Contracted Rate	$0.00
Materials				
AVĒSIS CONTRACTED LAB MATERIALS	Frame Kit Dispensing Fees	92340 / 92341 / 92342	$30.09	$0.00
PROVIDER FABRICATED MATERIALS	**Within Selection:**			
	Frames	V2020	$9.00	$0.00
	Lenses	V2100-V2114 / V2115 / V2121 V2200-V2214 / V2215 / V2221 V2784	$6.50 per lens $8.00 per lens $6.26 per pair	$0.00
	Out of Selection:			
	Frames	V2025 up to $40 retail value	$10.00	Amount exceeding $40 retail value
	Lenses	V2100-V2114 / V2115 / V2121 V2200-V2214 / V2215 / V2221 V2784	$6.50 per lens $8.00 per lens $6.26 per pair	$0.00
	Dispensing Fees	92340 / 92341 / 92342	$30.09	$0.00
Medically Necessary Contact Lenses (in lieu of eyeglasses)				
MEDICALLY NECESSARY CONTACT LENSES (MNCL) & FITTING** Prior Authorization Required	MNCL Fitting	92071 – Ocular surface disease 92072 – Keratoconus	$50.00 $100.00	$0.00
	Contact Lenses	V2500 / V2510 / V2520 V2531 / V2599	$18.97 Invoice Cost	
****Diagnosis codes appropriate for Medically Necessary Contact Lenses** H18.601-H18.609, H18.611-H18.619, H18.621-H18.629, H27.00-H27.03, H44.20-H44.23, H52.211-H52.219, H52.31, H52.32				
Post Cataract Benefit – 1 pair per lifetime after cataract surgery (1 frame, 2 lenses) **Diagnosis: *H27.00-H27.03, Z96.1 or Q12.3***				
POST CATARACT DISPENSING FEES	92352 / 92353		$30.09	$0.00
POST CATARACT PROVIDER FABRICATED MATERIALS	Frame	V2020	$9.00	$0.00
	Lenses	V2100-V2114 / V2115 / V2121 V2200-V2214 / V2215 / V2221 V2784	$6.50 per lens $8.00 per lens $6.26 per pair	$0.00
Post Cataract Benefit *must* be utilized within six (6) months after cataract extraction				

Diabetic Members

CPT® Category II Codes (2022F, 2023F, 2024F, 2025F, 2026F, 3051F, 3052F, 3072F) MUST be submitted for all diabetic member eye examinations. Diabetic members require dilation every year at a minimum, more often if there is retinopathy.

Benefit Frequency

- **Exam:** 1 every 12 months from date of service. Covered as needed when the practitioner documents the need for the additional examination, an explanation of special circumstances, and the services rendered.
- **Frame/Lenses:** 1 frame/2 lenses every 24 months from date of service; or medically necessary contact lenses with fitting every 24 months from date of service.

Replacement Frames and Lenses
Members are limited to 1 replacement pair of eyeglasses due to irreparable wear or damage, breakage, or loss in a two-year (730 day) period.

Avēsis Contracted Lab Providers
A participating network provider will be given a covered frame kit on consignment at no cost to the provider if the provider does not currently have one from the Avēsis-contracted laboratory. The provider will place all eyeglass orders directly with the Avēsis contracted lab.

Frame Requirement
- Each frame dispensed must carry a minimum of a one (1) year manufacturer's warranty.
- Minor adjustments are to be provided for a period of one (1) year at no additional charge.

Eyeglass Lens Requirement
- CR39 or glass lenses are a covered benefit for all Members
- Lenses must meet the requirements of inspection, tolerance, and testing procedures as outlined in the American Standard Prescription Requirements and the current Food and Drug Administration (FDA) standards of impact resistance
- Single vision lenses are covered only if the power is at least ± 0.75 diopters, in either the sphere **or** cylinder component; a change of lenses is a covered service only when there is a change of at least ± 0.75 diopters, in either the sphere **or** cylinder component
- Bifocal lenses are covered only if the power of the bifocal addition is ± 1.00 diopter or more; a change in lenses is covered if the distance power meets the minimum change requirements (± 0.75 diopters), or if the power of the bifocal addition is changed by at least ± 0.50 diopters
- When changing from a single vision to bifocal, the distance component must meet the minimum prescription requirement (± 0.75 diopters), or the resultant total power of the new prescription must meet the requirement for a change in prescription (± 0.75 diopters)
- When changing from bifocal to single vision, the new prescription must meet the requirement for a change in prescription (± 0.75 diopters) figured from the resultant total power of the bifocal prescription, **and** the new prescription must meet the minimum prescription power requirement (± 0.75 diopters)
- Prisms meeting the minimum power requirements do not require prior approval; the requirements are met only when the combined vertical prism power is at least ± 2 prism diopters, or the combined horizontal prism power is at least ± 5 prism diopters; V2715 $2.71 per eye
- Polycarbonate eyeglass lenses require a prescription of ± 2.50; no prior authorization required

Assignment
The Provider must accept an Assignment of Benefits for all eligible members. The member's signature is required on the Assignment clause. The claim form authorizing payment can be submitted online at: www.avesis.com or a CMS-1500 form can be mailed to: Avēsis Third Party Administrators, LLC, P.O. Box 38300, Phoenix, AZ 85069-8300. Please direct questions regarding eligibility to 855-704-0433.

Medically Necessary Contact Lenses
Medically necessary contact lenses are covered for all members, in lieu of eyeglasses, and require prior authorization. Member must be provided:
- Contact lens and required care kits
- Instructions on insertion, removal, and proper care of the lenses
- A 90-day follow-up visit period that includes acuities, assessment of corneal physiology, biomicroscopy examination, and other procedures required (as necessary)

Exclusions

Some provisions, benefits, exclusions, or limitations listed herein may vary depending on your state of residence. 1) Subnormal vision aids and any supplemental testing; 2) Plano (non-prescription) lenses, sunglasses (unless diagnosed with Albinism); 3) Two pairs of glasses in lieu of bifocal lenses; 4) Replacement of lost or broken lenses, contact lenses or frames, except when the member is normally eligible for services; 5) Any eye examination or corrective eyewear required by an employer as a condition of employment; 6) Services or materials provided as a result of Workers' Compensation Law, or similar legislation, required by any governmental agency whether Federal, State of subdivision thereof.

Avēsis Billing Tips
Providers should report ALL applicable diagnosis to Avēsis in section 21 of the CMS-1500 claims form and online. The diagnostic pointer in section 24E of the CMS-1500 claim form and online must be limited to those diagnoses specific to the procedure code billed per line in Section 24 of the CMS-1500 claim form or online.

Additional information regarding this program can be found in the Avēsis Illinois Medicare Provider Manual or online at www.avesis.com