

2012 **MARCH** Vision Care Tennessee Provider Reference Guide



keeping an eye on your health[®]

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1.1 About the Provider Reference Guide

MARCH is committed to working with you and your staff to achieve the best possible health outcomes for our members. This guide provides helpful information about MARCH eligibility, benefits, claim submission, claim payments, and much more. For easy navigation through this guide, click on the Table of Contents to be taken to the section of your choice.

This version of the Provider Reference Guide was revised on November 29, 2011. Reviews and updates to this guide are conducted as necessary and appropriate. Update notifications are distributed as they occur through provider newsletters/bulletins. A current version of this guide is always available on our website at www.marchvisioncare.com. To request a current copy of the Provider Reference Guide on CD, please contact our Provider Relations Department at (888) 493-4070, extension 7576 Monday through Friday, 8:00 am to 5:00 pm local time.

Thank you for your participation in the delivery of quality vision care services to our members.

1.2 About the TennCare Program

TennCare is the State of Tennessee’s Medicaid program. It has been operated under a waiver from CMS since 1994, including Medicaid categories, the Uninsured (Standard) and the medically eligible Uninsurable (“Standard”). The TennCare program operates under a Section 1115 waiver from the Centers for Medicare and Medicaid Services (CMS). Medicaid waiver programs are time-limited. The waiver under which TennCare is currently operating is called “TennCare II” which began on July 1, 2002 and has been extended through June 30, 2012.

TennCare services are offered through Managed Care Organizations or MCOs. Enrollees have their choice of MCO serving the region in which they live. TennCare enrollees are primarily low income children, pregnant women, parents of minor children, and people who are elderly or have a disability. March Vision Care provides vision services to TennCare members under the age of 21 who are enrolled with UnitedHealthcare Community Plan.

1.3 Contact Information

Provider Customer Service	(888) 493-4070 Monday through Friday, 8:00 am to 5:00 pm local time
Provider Relations Department	(888) 493-4070, extension 7576
Fax Number	(877) MARCH-88 or (877) 627-2488
General Website	www.marchvisioncare.com
Provider Website	https://www.eyesynergy.com
Mailing Address	March Vision Care 6701 Center Drive West, Suite 790 Los Angeles, CA 90045
Lab and Contact Lens Orders	https://www.eyesynergy.com

1.4 eyeSynergy®

MARCH is proud to offer eyeSynergy®, our web-based solution for electronic transactions. With eyeSynergy®, providers can:

- Verify member eligibility and benefits;
- Generate confirmation numbers for services (for the definition of a confirmation number refer to section 2.1);
- Submit claims;
- Retrieve and complete unfinished claims;
- Obtain detailed claim status including check number and paid date;
- Access online resources such as lab order forms and a current copy of the Provider Reference Guide.

eyeSynergy® is provided free of charge to all MARCH participating providers. To access eyeSynergy®, log onto our website at www.marchvisioncare.com and click on the orange and blue eyeSynergy® link located at the top of the page.

IMPORTANT: If you choose not to submit lab orders through eyeSynergy®, you **must** fax your order to our Customer Service Center at (800) 624-8101.

Registration

First time users must register before accessing eyeSynergy®. Please be prepared to enter the provider's name or group name, office phone number, and tax identification number during registration. Once verified, you will immediately be provided with a temporary password to log in.

Logging In

Once registered, you may log into eyeSynergy® with your user name and password. The user name is the 10-digit office phone number provided during registration. Do not include dashes, parenthesis or spaces when entering the user name. If it is your first time logging in, enter the temporary password provided during registration. You will then be prompted to create a new password for your account. Please note that passwords are case sensitive. As a security feature, you will be asked to renew your password every 60 days. After 3 failed log-in attempts, you will be required to call in to reset your password.

Once logged in, you may access the eyeSynergy® User Guide located on the Resources menu. This guide includes step-by-step instructions for completing various transactions within eyeSynergy®.

1.5 Interactive Voice Recognition System (IVR)

Our Interactive Voice Recognition System (IVR) provides responses to the following inquiries twenty-four (24) hours per day, seven (7) days per week:

- Eligibility and benefits;
- Confirmation numbers;
- Locate a provider;
- Claim status.

The Interactive Voice Recognition System may be accessed by calling (888) 493-4070. Select the provider option and follow the prompts to verify eligibility and benefits, request a confirmation number, locate a provider or check claim status.

Registration

First time users must register before accessing the Interactive Voice Recognition System. Please be prepared to enter your office phone number, office fax number and tax identification number during registration. Once verified, you will be prompted to select a 4-digit PIN for your account. Please note you will be required to enter a fax number when registering for the IVR.

Logging In

Once registered, you may log into the Interactive Voice Recognition System using your 10-digit ID and 4-digit PIN. The 10-digit ID is the office phone number provided during registration. The 4-digit PIN is the number designated by your office during registration.

1.6 Electronic Payments

MARCH partners with PaySpan Health – a solution that delivers Electronic Funds Transfers (EFTs), Electronic Remittance Advice (ERAs)/Vouchers, and much more.

This service is **free** to MARCH providers. The solution enables online presentment of remittance/vouchers and straightforward reconciliation of payments to empower our providers to reduce costs, speed secondary billings, improve cash flow, and help the environment by reducing paper usage.

March Vision Care offers you the option to receive payments according to preference: electronically direct to a bank account, or by traditional paper check.

Provider Benefits

As a provider, you gain immediate benefits by signing up for electronic payments from March Vision Care through PaySpan Health:

- Improve cash flow – Electronic payments can mean faster payments, leading to improvements in cash flow.
- Maintain control over bank accounts – You keep TOTAL control over the destination of claim payment funds. Multiple practices and accounts are supported.
- Match payments to advice/vouchers – You can associate electronic payments quickly and easily to an advice/voucher.
- Manage multiple payers – Reuse enrollment information to connect with multiple payers. Assign different payers to different banks.

Signing up for electronic payments is simple, secure, and will only take 5-10 minutes to complete. To complete your registration, please visit their website at www.payspanhealth.com.

1.7 Provider Change Notification

Please help us to ensure your current information is accurately displayed in our provider directory. When possible, please report changes concerning your provider information to us in advance. All changes should be reported to MARCH in writing. Failure to report changes related to your billing address and/or tax identification number, may delay claim payments. Examples of changes that need to be reported to MARCH in writing, include, but are not limited to:

- Practice phone and/or fax number;
- Practice address;
- Billing address (requires W9);
- Tax identification number (requires W9);
- Office hours;
- Practice status regarding the acceptance of new members, children, min/max age limitations, etc. ;
- Providers added to practice/providers leaving practice;
- Provider termination.

Please report all changes via mail or fax to:

March Vision Care
Attention: Provider Relations Department
6701 Center Drive West, Suite 790
Los Angeles, CA 90045
Fax: (877) MARCH-88 or (877) 627-2488

1.8 Licensure and Background Checks

Provider is responsible for conducting background checks in accordance with state law and TennCare policy and ensuring that all employees, agents, subcontractors, providers or anyone acting for or on behalf of the provider conducts background checks in accordance with state law and TennCare policy.

2.1 Eligibility and Benefit Verification



MARCH strongly recommends verification of member eligibility and benefits prior to rendering services. Please do not assume the member is eligible if they present a current ID card. Eligibility and benefits should be verified on the date services are rendered.

Confirmation Numbers

A confirmation number is a 11-digit identification number with the first 6-digits being the date the confirmation number was generated. Confirmation numbers are generated when the provider office verifies member eligibility for requested benefits and services through MARCH. Verification is obtained by speaking with a Call Center Representative or by accessing the IVR or eyeSynergy® webportal. Confirmation numbers are not required for all services; however providers are strongly encouraged to verify benefits and eligibility on the date services will be rendered.

Please refer to the State Specific Benefit Summary for Tennessee for services that require a confirmation (please see the section below “Covered Benefits” for instructions on how to access the benefit summary for Tennessee).

Benefits that generally require confirmation numbers include, but are not limited to:

- Replacement frames and lenses;
- Medically necessary contact lenses for Medicaid members;
- Replacements for medically necessary contact lenses;

For those services that require a confirmation, the confirmation request process requires the provider to attest that a member meets the defined benefit criteria when applicable. Upon attestation, a confirmation number is generated. The confirmation guarantees payment only if the member proves to be eligible at the time services are rendered.

Example: Member is diagnosed with keratoconus and requires contact lenses. Provider is required to request a confirmation and attest to the documented exam findings and/or diagnosis. The submitted claim must include the diagnosis of keratoconus. Provided the member is eligible on the date services were rendered, payment is issued.

IMPORTANT: MARCH performs retrospective random chart audits on claims submitted for services requiring attestation.

Covered Benefits

Covered benefits may be accessed by:

- Logging into eyeSynergy® at <https://www.eyesynergy.com>. Click on the Resources menu and Select Provider Reference Guide. Benefits may be accessed by selecting Tennessee from the drop-down menu. You may also access current benefits by plan or patient including the patient’s current benefit availability from the Benefits and Eligibility menu in eyeSynergy®;
- Accessing our website at www.marchvisioncare.com. Click on Doctors and Office Staff and then Provider Resources. Benefits may be accessed by Tennessee from the drop-down menu.

Covered benefits include details such as benefit frequency, copayment amount, allowance amount, benefit limitations and benefit criteria.

Methods of Verification

You may access eyeSynergy® or the Interactive Voice Recognition System to verify member eligibility, benefits, and to request a confirmation number.

2.2 Non-Covered Services

The Centers for Medicare and Medicaid Services (CMS) prohibit providers from billing or seeking compensation from Medicare and Medicaid beneficiaries for the provision of services that are covered benefits under their Medicare and/or Medicaid plans. However, there are certain circumstances in which a member requests services that are not covered or fully covered under their Medicare and/or Medicaid plans. In those circumstances, you may bill the member, provided the member agrees in writing that he or she is willing to accept payment responsibility.

Non-covered lens options for Medicaid members only:

MARCH reimburses the contracted lab directly for any materials ordered.

If a member chooses non-covered lens options such as AR, UV, tinting, etc., the provider may charge the member up to but not to exceed the retail amount listed on the MARCH Wholesale/Retail Fee Schedule (Exhibit N). When the order for the non-covered lens options is complete, the contracted lab will submit an invoice to MARCH for the non-covered lens options ordered. MARCH will then deduct the wholesale amount listed in Exhibit R from the provider's claim payment with the Explanation of Payment (EOP) code of LABDED.

REMINDER FOR ALL MEMBERS:

For all non-covered services, a member must sign a Non-Covered Service Fee Acceptance Form (Exhibit A).

Such agreement by the member must be made prior to the actual delivery of services. Documentation of the agreement must be placed in the member's chart as part of his/her medical record. Additionally, a copy of the written agreement must be given to the member.

2.3 TENNderCare (EPSDT)

A. TENNderCare Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

EPSDT of Children Screening, diagnostic and follow-up treatment services are covered when medically necessary in agreement with TennCare and federal regulations, including TennCare rules and regulations, TennCare policies and procedures, and federal requirements as described in 42 CFR Part 441, Subpart B, and the Omnibus Budget Reconciliation Act of 1989 for enrollees under 21. All children and teens under 21 who have TennCare should receive regular checkups. These regular checkups help find health, speech, hearing, vision, dental, mental health, and drug or alcohol problems. TennCare pays for medicine and treatments needed. Members under the age of 21 may be referred for behavioral health services as a result of the EPSDT screening by a healthcare professional. Behavioral health providers will provide diagnostic and treatment services in accord with the EPSDT screening or diagnosis findings.

B. TENNderCare (EPSDT) Screening Guidelines

1. Periodicity Schedule for Check-ups and Screenings

Any time a TennCare member is in your office, you should ask if they have had their age appropriate TENNderCare physical for that year. There are many opportunities to provide or schedule services when the member is in your office for other purposes, or on the telephone with office staff. If the child is in your office for a problem or illness, also perform an EPSDT exam if time allows. If they have not, this EPSDT examination should be performed, including any necessary immunizations. A WIC (Women, Infants, Children) visit is not considered a TENNderCare visit. It is also very important that delivery of these services is documented in the patient's medical record. Outreach activities are critical to successful health screening services. The outreach process assures that eligible families are contacted, informed, and assisted in securing health-screening services. **No prior authorization is required for TENNderCare Screenings, however referral to a specialist is required if necessary for completion of the exam or for treatment of problems discovered during the exam.**

TennCare requires that TENNderCare screening be performed according to the standards in the periodicity schedule of the Tennessee Chapter of the American Academy of Pediatrics. Interperiodic screens are available whenever a person like a teacher or parent notices a change that might require a screening.

The health plan sends each TENNderCare eligible member reminders to schedule an EPSDT exam. Please help us assist our members in obtaining their TENNderCare well-visit exams.

Periodicity Schedule for TENNderCare Screenings:

Infancy	Early Childhood	Middle Childhood	Adolescence
At birth	15 months old	5 years old	11 years old
2-4 days	18 months old	6 years old	12 years old
1 month old	24 months old	7 years old	13 years old
2 months old	30 months old	8 years old	14 years old

Infancy	Early Childhood	Middle Childhood	Adolescence
4 months old	3 years old	9 years old	15 years old
6 months old	4 years old	10 years old	16 years old
9 months old			17 years old
12 months old			18 years old
			19 years old
			20 years old

3.1 Claim Submission

Preferred Method

MARCH prefers to receive claims electronically via eyeSynergy®, our web-based solution for electronic transactions. eyeSynergy® helps reduce claim errors resulting in faster processing times.

Clearinghouse Submissions

MARCH has a direct agreement with RelayHealth to accept electronic claims. MARCH can also accept claims through RelayHealth from the clearinghouses listed below:

- Netwerkes/Ingenix
- Gateway
- All Scripts/PayorPath

MARCH also has a direct agreement with Office Ally and Emdeon. Claims submitted through these two clearinghouses can come directly to MARCH. They do not need to come through RelayHealth.

Our payor ID in all instances is 5246 and our receiver ID is 146383562 with a qualifier of 01 (DUNS number). If your clearinghouse is not listed, please contact our Provider Relations Department at (888) 493-4070.

Paper Claims

Paper claims should be submitted on a red CMS-1500 form and mailed to:

March Vision Care
6701 Center Drive West, Suite 790
Los Angeles, CA 90045

Clean Claim Definition

MARCH defines a clean claim as a claim received by MARCH for adjudication that requires no further information, adjustment, or alteration by the provider of the services in order to be processed and paid by MARCH. . An unclean claim is defined as any claim that does not meet the definition of a clean claim.

Claims submitted for payment should include the following:

- Member name, ID number, date of birth and gender;
- Provider and/or facility name, address and signature;
- Billing name, address and tax identification number;
- National Provider Identifier (NPI);
- Date of service;
- Current and appropriate ICD9 codes;
- Service units;
- Current and appropriate CPT/HCPCS codes;
- Current and applicable modifier codes;
- Place of service;
- Usual and customary charges.

MARCH has the right to obtain further information from a provider's office upon request when a submitted claim has errors or when MARCH or the health plan has reasonable grounds for suspecting possible fraud, misrepresentation or unfair billing practices.

Unclean claims are processed in accordance with applicable laws and regulations.

IMPORTANT: Please submit corrected claims on a red CMS-1500 form and clearly indicate on the claim that the submission is a **corrected claim**. This ensures the corrected information will be considered during claims processing and will help prevent payment delays.

3.2 American Medical Association CPT Coding Rules

MARCH reaffirms its adoption of CPT coding rules established by the American Medical Association:

- For an initial examination of a new patient, providers can use a new eye examination billing code of 92002 or 92004. A provider may also bill for a new member examination if a member has not been examined for 3 consecutive years.
- A routine annual examination for an established patient in subsequent years can be billed as a follow up examination using codes 92012 and 92014. Providers can continue to bill this way unless the member has not been examined for 3 consecutive years, at which time the service may be billed with a new member examination code as indicated above.

In all instances, the medical record should reflect the intensity of examination that is being billed. MARCH will audit claim submissions to ensure compliance. Audits will include the review of medical records.

3.3 Billing for Replacements and Repairs

Replacements and repairs are generally only covered under certain circumstances. For this reason, confirmation numbers are required for replacements and repairs. Replacement and repair services must be billed with the applicable modifier. The valid modifiers are provided below:

- RA (Replacements)
- RB (Repairs)

Reimbursement for materials billed with the RB (Repairs) modifier will be reimbursed at 50% of the contracted rate.

3.4 Frame Warranty

Frames from the MARCH frame kit are fully guaranteed against manufacturing defects for a period of one (1) year from the date the frame was dispensed.

If the provider determines that the defective frame is covered under the warranty, please contact MARCH at (888) 493-4070. Please do not send any broken glasses to MARCH or the contracted lab.

3.5 Order Cancellations

Orders placed with the MARCH contracted lab for frames and lenses are final.

- Members are responsible for the cost of frames and/or lenses if the order is cancelled by the member after the order has been completed by the lab.
- Providers are responsible for the cost of frames and/or lenses if the order is incorrect due to provider error.
- In the event of an error, do not resubmit a corrected order. Please contact MARCH Vision Care at (888) 493-4070.

3.6 Billing for Glaucoma Screenings

The screening examination for glaucoma must include the following two (2) components:

1. Dilated exam with intraocular pressure (IOP) measurement;
2. Either direct ophthalmoscopy or slit lamp biomicroscopy.

The Centers for Medicare and Medicaid Services mandate payment for a glaucoma screening examination that is performed on an eligible beneficiary after at least eleven (11) months have passed following the month in which the last glaucoma screening examination was performed.

3.7 Billing and Calculation of Medicare Allowance

A set dollar amount is typically allowed to cover frames, lenses and/or contact lenses provided to Medicare members, also known as an “allowance” or an “allowance-based benefit”. Providers should bill the current and appropriate HCPCS codes for

frames, lenses and/or contact lenses along with the usual and customary charges for those codes. The allowance does not apply to routine eye exams. Routine eye exams are paid separately.

Frames and Lenses

The allowance for frames and lenses will be applied in the following order:

1. Basic lens codes (V2100-V2399)
2. Frame codes (V2020, V2025)
3. Any remaining allowance will be applied to lens upgrades such as tinting, scratch coating, polycarbonate lenses, etc.

Following are examples of how the allowance is applied to frames and lenses. The billed charges and paid amounts listed are for illustrative purposes only. MARCH does not pay dispensing/fitting fees for frames and lenses as part of the Medicare benefit.

The example provided below assumes a \$150.00 allowance for frames and lenses and a billed amount less than the allowance.

HCPCS	Description	Billed Charges	Paid Amount
V2020	Frame	\$ 95.00	\$ 95.00
V2100	Lens	\$ 30.00	\$ 30.00
V2745	Tint	\$ 10.00	\$ 10.00
Total		\$ 135.00	\$ 135.00

The example provided below assumes a \$150.00 allowance for frames and lenses and a billed amount greater than the allowance.

HCPCS	Description	Billed Charges	Paid Amount
V2020	Frame	\$ 200.00	\$ 120.00*
V2100	Lens	\$ 30.00	\$ 30.00
V2745	Tint	\$ 10.00	\$ 0.00*
Total		\$ 240.00	\$ 150.00

* Member is responsible for charges exceeding their benefit allowance.

Contact Lenses

The allowance for contact lenses will be applied to the purchase of contact lenses first and any remaining allowance will then be applied to the dispensing/fitting fee. Following is an example of how the allowance is applied to contact lenses. The billed charges and paid amounts listed are for illustrative purposes only.

The example provided below assumes a \$150.00 allowance for contact lenses and a billed amount equal to the allowance.

HCPCS	Description	Billed Charges	Paid Amount
V2500	Contact Lenses	\$ 100.00	\$ 100.00
92310		\$ 50.00	\$ 50.00
Total		\$ 150.00	\$ 150.00

The example provider below assumes a \$100 allowance for contact lenses and a billed amount that exceeds the allowance.

HCPCS	Description	Billed Charges	Paid Amount
V2500	Contact Lenses	\$ 100.00	\$ 100.00
92310	Fitting	\$ 50.00	\$ 0.00*
Total		\$ 150.00	\$ 100.00

* Member is responsible for charges exceeding their benefit allowance.

3.8 Claim Filing Limits

MARCH imposes claim filing limits in accordance with the applicable provider services agreement and governing entity regulations. Claim filing limits for contracted providers are provided below as days and begin on the date services are rendered.

Medicaid	Medicare	Commercial
120	180	90

MARCH will not deny provider claims on the basis of untimely filing in the following situations

- Coordination of Benefits (COB)
- Subrogation
- Retroactive Eligibility Date

Proof of Timely Filing

- Timeframe for filing a claim in situations involving third party benefits (COB and subrogation) shall begin on the date that the third party documented resolution of the claim.
- Timeframe for retroactive eligibility dates shall begin on the date that MARCH receives notification from the health plan of the enrollee’s eligibility/enrollment.

In all cases where there is documentation proving “good cause” for a filing delay and a claim has not been submitted to MARCH or a claim has been denied by MARCH for exceeding the filing limit, MARCH will consider issuing payment following a review of the “good cause” documentation.

IMPORTANT: Please attach delayed filing “good cause” documentation to late filed claims. Submit late filed claims on a red CMS-1500 form and clearly indicate on the claim that the submission is a **late file claim with good cause documentation attached**. This ensures the information will be considered during claims processing and will help prevent payment delays.

3.9 Payment Policies

Claim payments are issued in accordance with the applicable provider services agreement and governing entity regulations. Prompt payment processing times are provided below for paper and electronic data interchange (EDI) claims as calendar days unless otherwise specified. The processing time limit generally begins on the date the claim is received by MARCH. However, in some cases such as with Medicare plans, the time limit begins on the date the claim is received by an associated entity. MARCH has weekly check runs to comply with prompt payment policies.

Medicaid	Medicare	Commercial
Clean claims 30 days All other claims 60 days	60 days	30 days

3.10 Corrected Claims

Submit corrected claims on a red CMS-1500 form and clearly indicate on the claim that the submission is a **corrected claim**. This ensures the corrected information will be considered during claims processing and will help prevent payment delays.

Please mail corrected claims to:

March Vision Care
6701 Center Drive West, Suite 790
Los Angeles, CA 90045

3.11 Provider Disputes

March is committed to ensuring provider satisfaction. Our Customer Service department can be reached at (888) 493-4070 Monday through Friday, 8:00am to 5:00pm local time. In addition to contacting our Customer Service Department, the MARCH Provider Dispute Resolution Process provides a mechanism for you to communicate disputes in writing.

Provider Dispute Types

- Claim
- Appeal of Medical Necessity / Utilization Management Decision
- Request for Reimbursement of Overpayment
- Seeking Resolution of a Billing Determination

Provider Dispute Resolution Process

1. The provider submits the MARCH Provider Dispute Resolution Request Form (Exhibit B) or a written summary of their dispute including supporting documentation. This serves as the first level of appeal by the provider. Please submit the form to:

March Vision Care
Attention: PDR Unit
6701 Center Drive West, Suite 790
Los Angeles, CA 90045

2. MARCH will acknowledge receipt of all participating provider disputes within thirty (30) calendar days after receipt of request.
3. MARCH will issue a written determination explaining the reasons for its determination within sixty (60) calendar days from the date of receipt of the dispute, unless a longer time to completely respond was agreed upon in writing by the provider and MARCH within the first thirty (30) calendar days of receipt of the dispute.
4. Providers may appeal a second level decision of the Provider Dispute Resolution Process by requesting an Independent Review of the partial or complete denial of a claim in accordance with T.C.A 56-32-126 (b).
5. The provider must file a request for independent review within three hundred sixty-five (365) calendar days after MARCH has partially or totally denied the claim for the first time or has recouped payment on a previously allowed claim for the first time. The request for an independent reviewer should be directed to the following address:

Compliance Officer, TennCare Division
Tennessee Dept. of Commerce & Insurance
500 James Robertson Parkway, 11th Floor
Nashville, TN 37243-1169
Telephone: (615) 741-2677

3.12 Overpayment of Claims

Providers must report and return any overpayment to MARCH within sixty (60) days of the date on which the overpayment was identified and provide the reason for the overpayment. If MARCH or TennCare determines a claim was overpaid or was paid incorrectly, MARCH will notify the provider in writing. Overpayment refund requests are issued in accordance with the applicable provider services agreement and governing entity regulations.

Once an overpayment refund request is issued, if MARCH does not receive an overpayment dispute request or refund of the overpaid amount within such timeframe, MARCH may offset the overpayment against future claim payments, if not prohibited by governing entity regulations, in addition to any other remedies available.

3.13 Balance Billing

“Balance Billing” means charging or collecting an amount in excess of the Medicaid, Medicare, or contracted reimbursement rate for services covered under a Medicaid, Medicare or employer sponsored beneficiary’s plan. “Balance Billing” does not include charging or collecting deductibles or copayments and coinsurance required by the beneficiary’s plan.

Providers are prohibited from balance billing MARCH members. The explanation codes MARCH provides in the explanation of payment remittance advice clearly indicate when balance billing for a service is not permissible.

3.14 Coordination of Benefits

Coordination of Benefits (COB) is a method of integrating health benefits payable under more than one health insurance plan, allowing patients to receive up to 100% coverage for services rendered. Patients that have health benefits under more than one health insurance plan are said to have “dual coverage”. In some cases patients may have primary, secondary, and tertiary coverage. When a patient has multiple plans or “dual coverage”, it is necessary to know what plan is primary and what plan is secondary or tertiary. As the Tennessee state Medicaid plan, TennCare is always the payor of last resort. The primary plan must be billed first and the claim is billed just like any other claim would be billed. The secondary plan is billed once an explanation of payment (EOP) and possibly a payment is received from the primary plan. The claims submitted to a secondary or tertiary plan are considered “COB claims”. When billing a secondary plan, the bill must have the primary insurance plans’ EOP attached. The payments received from the primary plan should be indicated in field twenty-nine (29) of the CMS 1500 form.

MARCH processes COB claims in accordance with the applicable provider services agreement and governing entity regulations. When MARCH is the secondary payor, MARCH is responsible for the difference between the provider’s usual and customary charges and the amount payable by the primary insurance plan, not to exceed the applicable reimbursement rates and benefit allowance.

COB claims must be submitted as paper claims on a red CMS 1500 form.

Please mail COB claims to:

March Vision Care
6701 Center Drive West, Suite 790
Los Angeles, CA 90045

3.15 Disclosure of Criminal Conviction, Ownership and Control Interest

All potential providers must complete and sign the Disclosure of Ownership and Control Interest Statement and Criminal Information Form. Prior to participation and to any payment for services rendered to TennCare members (whether contracted with March Vision Care or not), the provider must have completed and filed with March Vision Care the disclosure information in accordance with requirements in 42 CFR, Part 455, Subpart B. This disclosure of criminal convictions related to the Medicare and Medicaid programs is required by CMS, as TennCare is the Tennessee Medicaid Program. These requirements hold that individual physicians and other healthcare professionals must disclose criminal convictions, while facilities and businesses must additionally disclose ownership and control interest.

3.16 Medicaid ID

All providers must receive a Tennessee Medicaid ID prior to claims payment for TennCare members. Your office can file for a group or business number, but individual health care professionals also need an assignment. This ID is assigned by the Bureau of TennCare, and is available on the web. To apply for a Tennessee Medicaid ID, you may call TennCare at 1-800-852-2683. The website address for applications is <http://www.tn.gov/tenncare/pro-forms.html>.

3.17 Encounter Data

An encounter is defined as a claim. This means data required for encounter collection and reporting is gathered from claims submitted by the provider’s office. All TennCare providers must bill services using the CMS approved standard billing formats.

4.1 Access Standards

MARCH optometrists and ophthalmologists are required to meet minimum standards of accessibility for members at all times as a condition of maintaining participating provider status.

In connection with the foregoing, MARCH has established the following accessibility standards, when otherwise not specified by regulation or by client performance standards:

- In urban areas, at least one provider within twenty (20) miles or twenty (20) minutes driving time from the member's home address, whichever is less.
- In rural areas, at least one provider within thirty (30) miles or thirty (30) minutes driving time from the member's home address, whichever is less.
- Appointments for routine, non-urgent eye examinations and eyeglass or contact lens fittings and dispensing are not to exceed three (3) weeks or twenty-one (21) calendar days.
- Rescheduling an appointment in a manner that is appropriate for the enrollee's health care needs and ensures continuity of care consistent with good professional practice.
- For members requiring urgent/emergent eye care services during non-business hours, each provider office is required to employ an answering service or a telephone answering machine which provides instructions regarding how members may obtain urgent/emergent care including, when applicable, how to contact another provider who has agreed to be on-call to triage by phone, or if needed, deliver urgent/emergent care. Alternatively, the answering service may instruct members to call 911 or go to the local emergency room.
- Members with scheduled appointments will wait no more than forty-five (45) minutes before being seen by a provider. Wait time is defined as the time spent in the lobby and in the examination room prior to being seen by a provider.
- Members are entitled to a second opinion from a qualified health care professional within the network, or arrangement may be made for the member to obtain one outside the network, at no cost to the member.
- Emergency services will be provided without regard to prior authorization requirements.

4.2 Emergency and Urgently Needed Services/After-Hours Calls

An **Emergency Medical Condition** is defined as "a physical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the health of the individual (or, with respect to pregnant women, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment of bodily functions; or
- Serious dysfunction of any bodily organ or part."

As a participant in a managed care health plan, the PCP is responsible for the emergency medical direction of members 24 hours a day, seven days a week. Members are encouraged to receive Emergency Services from their PCP or a Participating Hospital or Facility. Crisis services are available for members with behavioral health emergencies.

The health plan covers Emergency, Post Stabilization, and Urgently Needed Services without prior approval whether the member is in or out of the service area.

Members who present at an emergency room should be screened to determine whether a medical emergency exists. Prior authorization is not required for the medical screening.

A member is encouraged to contact their PCP as soon as possible, preferably within twenty four (24) hours after an Emergent/Urgent Service Procedure. The member's PCP is expected to work with the member to coordinate any follow-up care.

4.3 Access Monitoring

MARCH is responsible for monitoring organizational compliance with accessibility standards. MARCH will bear responsibility for reviewing and exercising oversight regarding matters such as member wait times, both for appointments and in the office, as well as other barriers to accessibility that may be reflected in member grievances, informal comments received by MARCH employees or otherwise noted.

The following are some of the mechanisms that will be employed by MARCH to verify access and compliance with its accessibility standards:

- Blast Fax requests may be used to gather information from providers to determine demographic, access and language information.
- Telephone access surveys will be conducted by MARCH through random calls to optometrist and ophthalmologist offices to verify capacity to ensure that appointments are scheduled on a timely basis, with appropriate office wait time, and that appropriate after hours answering systems are being utilized.
- MARCH's grievance system also serves to identify access-related concerns. The tracking of grievances and an investigation of grievance patterns may result in the implementation of new policies and procedures and/or the education of participating optometrists, ophthalmologists, and staff members.
- Members may be provided with a Customer Satisfaction Survey to comment on the service and products received from MARCH and its providers.
- Geo-access or other access monitoring reports are run to determine network adequacy.
- Customer Service Reports assess MARCH's Call Center responsiveness.
- The appointment books of participating optometrists and ophthalmologists may be periodically reviewed during on-site inspections to validate the availability of appointments for services within reasonable time frames. Waiting rooms may also be periodically monitored to determine how long members wait for scheduled appointments.

The coordination of access monitoring is facilitated by MARCH's Department of Health Care Services. Reports of the results of these initiatives are prepared and presented to the Quality Improvement Committee and the Board of Directors which is responsible to ensure compliance with such standards.

5.1 Protocol for Member Complaints and Appeals

Definitions

Complaint	A written or oral expression of dissatisfaction regarding MARCH and/or its provider(s) including access to care, quality of care and quality of service.
Appeal	A member’s right to contest verbally or in writing, any adverse action taken by the plan to deny, reduce, terminate, delay or suspend a covered service as well as any other acts or omissions of the plan which impair the quality, timeliness, or availability of such benefits.

It is MARCH’s policy to address and resolve member complaints and/or appeals in an orderly and timely manner according to all regulations and client contractual requirements. All members or the member’s personal representative have the right to file a complaint and/or submit an appeal through the Complaint and Appeal process. Please refer to Exhibit H for the TennCare Medical Appeal Form which is to be provided upon member’s request. A complaint can be filed in person or by telephone at (800) 878-3192.

You must provide reasonable assistance to Members during their appeal process. You must also display notices of TennCare Members adverse appeal rights as required by the applicable state and federal law. This includes a poster describing TennCare Member Appeal rights displayed in public areas of your office. This poster is included in Exhibit M. Please copy and post both English and Spanish versions of the poster.

Members should be referred to their health plan for assistance. MARCH will work with the member’s contracted health plan to resolve issues. You may be asked for medical records or a response as part of the complaint/appeal investigation. Per your contract with MARCH, you are required to furnish medical records of members for whom claims have been submitted. Member authorization is not required to release medical records per state and federal regulations. MARCH will ensure that complaints and appeals will be investigated, and resolved in a regulatory compliant time frame, following its policies and procedures.

Discrimination against members who have filed a complaint is not permitted. By providing assistance to those with limited English proficiency or with a visual or other communicative impairment, all members have access to and can fully participate in the complaint system. Such assistance may include, but is not limited to, translations of complaint procedures, forms, and plan responses to complaints, as well as access to interpreters and devices that aid impaired individuals in communication.

5.2 Potential Quality Issue

A potential quality issue is an individual occurrence of a suspected deviation from expected provider performance, clinical care or outcome of care that cannot be determined to be justified without additional review. The investigation of the potential quality issue is conducted by the Quality Management Department and documented in the case file. The potential quality issue is presented to the Chief Medical Officer/Optometrlist reviewer for evaluation, recommendations and signature. If it is determined that a potential breach in quality exists, the case may be referred for further levels of review, which include outside specialists, peer review, credentialing or the Legal Department. Upon completion of the medical review, the case is assigned a level that demonstrates the severity of breach in quality, along with the outcome and required intervention, if appropriate. Please refer to Exhibit I for severity levels for various issues and possible actions.

Potential quality issues may be sent to the Quality Management Department for investigation from anyone and any place in the MARCH organization. Please refer to Exhibit J for the Potential Quality Issue Referral Form.

6.1 **TennCareSM Member Rights and Responsibilities:**

Your rights and responsibilities as a TennCareSM and UnitedHealthcare Community Plan member

You have the right to:

- Be treated with respect and in a dignified way. You have a right to privacy and to have your medical and financial information treated with privacy.
- Ask for and get information about UnitedHealthcare Community Plan, its policies, its services, its caregivers, and members' rights and duties.
- Ask for and get information about how UnitedHealthcare Community Plan pays its providers, including any kind of bonus for care based on cost or quality.
- Ask for and get information about your medical records as the federal and state laws say. You can see your medical records, get copies of your medical records, and ask to correct your medical records if they are wrong.
- Get services without being treated in a different way because of race, color, birthplace, language, sex, age, religion, or disability. You have a right to file a complaint if you think you have been treated unfairly. If you complain or appeal, you have the right to keep getting care without fear of bad treatment from UnitedHealthcare Community Plan, providers, or TennCare.
- Get care without fear of physical restraint or seclusion used for bullying, discipline, convenience or revenge.
- Make appeals or complaints about UnitedHealthcare Community Plan or your care.
- Make suggestions about your rights and responsibilities or how UnitedHealthcare Community Plan works.
- Choose a PCP in the UnitedHealthcare Community Plan network. You can turn down care from certain providers.
- Get medically necessary care that is right for you, when you need it. This includes getting emergency services, 24 hours a day, 7 days a week.
- Be told in an easy-to-understand way about your care and all of the different kinds of treatment that could work for you, no matter what they cost or even if they aren't covered.
- Help to make decisions about your health care.
- Make a living will or advance care plan and be told about Advance Medical Directives.
- Change health plans. If you are new to TennCare, you can change health plans once during the 45 days after you get TennCare. After that, you can ask to change health plans through an appeal process. There are certain reasons why you can change health plans.
- Ask TennCare and UnitedHealthcare Community Plan to look again at any mistake you think they make about getting on TennCare or keeping your TennCare or about getting your health care.
- End your TennCare at any time.
- Exercise any of these rights without changing the way UnitedHealthcare Community Plan or its providers treat you.

Your rights to stay with UnitedHealthcare Community Plan

As a UnitedHealthcare Community Plan member, you **cannot** be moved from UnitedHealthcare Community Plan just because:

- Your health gets worse.
- You already have a medical problem. This is called a pre-existing condition.
- Your medical treatment is expensive.
- Of how you use your services.
- You have a mental health condition.
- Your special needs make you act in an uncooperative or disruptive way.

Here are the only reasons you **can** be moved from UnitedHealthcare Community Plan:

- If you change health plans.
- If you move out of the UnitedHealthcare Community Plan area.
- If you let someone else use your ID cards, or if you use your TennCare to get medicines to sell.
- If you end your TennCare or your TennCare ends for other reasons.
- If you don't renew your TennCare when it is time or if you don't give TennCare information they ask for when it is time to renew.
- If you don't let TennCare, DHS, and UnitedHealthcare Community Plan know that you moved, and they can't find you.
- If you lie to get or keep your TennCare.
- Upon your death.

As a TennCare and UnitedHealthcare Community Plan member, you also have the responsibility to:

- Understand the information in your member handbook and other papers that we send you.
- Show your UnitedHealthcare Community Plan ID card whenever you get health care. If you have other insurance, you must show that card too.
- Go to your PCP for all your medical care unless:
 - Your PCP sends you to a specialist for care. You must get a referral from your PCP to go to a specialist.
 - You are pregnant or getting well-woman check ups.
 - It is an emergency.
- Use providers who are in the UnitedHealthcare Community Plan provider network. But, you can see anyone if it is an emergency. And, you can see anyone who has been approved with a referral.
- Let your PCP know when you have had to go to the Emergency Room. You (or someone for you) need to let your PCP know by 24 hours of when you got care at the ER.
- Give information to the UnitedHealthcare Community Plan and to your health care providers so that they can care for you.
- Follow instructions and rules that are in the handbook about your coverage and benefits. You must also follow instructions and rules from the people who are giving you health care.
- Help to make the decisions about your health care.
- Work with your PCP so that you understand your health problems. You must also work with your PCP to come up with a treatment plan that you both say will help you.
- Treat your health care giver with respect and dignity.
- Keep health care appointments and call the office to cancel if you can't keep your appointment.
- Be the only one who uses your UnitedHealthcare Community Plan ID card and let us know if it is lost or stolen.
- Tell DHS of any changes like:
 - If you or a family member change your name, address, or phone number.
 - If you have a change in family size.
 - If you or a family member get a job, lose your job, or change jobs.
 - If you or a family member has other health insurance or can get other health insurance.
- Pay any copays you need to pay.
- Let UnitedHealthcare Community Plan know if you have another insurance company that should pay your medical care. The other insurance company could be insurance like auto, home, or worker's compensation.

Your right to fair treatment

We do not allow unfair treatment in TennCare or UnitedHealthcare Community Plan. No one is treated in a different way because of race, language, birthplace, disability, religion, sex, color, or age.

In TennCare, unfair treatment can mean things like:

- They didn't let you take part in the same things as other people.
- You didn't get the help you needed to get your care.
- You didn't get the care that you needed.

You have the right to make a complaint if you think you are not getting fair treatment. By law, no one can get back at you for making a complaint.

If your complaint is about either physical health care and/or mental health care, please call UnitedHealthcare Community Plan at 1-800-690-1606, or write to United as directed below:

UnitedHealthcare Community Plan
 P.O. Box 5220
 Kingston, NY 12402-5220

If you write to United, be sure to include your name, address, daytime phone number, and your Social Security number. Please include as much information as you can about the problem.

You may also write to the following agencies if you think you have been treated unfairly:

Agency	Phone Number	Address
TennCare	1-800-342-3145 toll-free 1-615-253-2917 fax	Office of Non-Discrimination Bureau of TennCare 310 Great Circle Road Nashville, TN 37243
State of Tennessee	1-800-251-3589 toll-free	Director

	1-615-253-1886 fax	Title VI Compliance Program Tennessee Human Rights Commission 710 James Robertson Parkway, Suite 100 Nashville, TN 37243
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Agency	Phone Number	Address
U.S. Dept. of Health and Human Services, Region IV Office	1-404-562-7886 (this is not a free call) 1-404-562-7881 fax	U.S. DHHS / Region IV Office of Civil Rights 61 Forsyth St., SW, 3 rd floor, Suite 3B70 Atlanta, GA 30303
U.S. Dept. of Health and Human Services, Washington Office	1-800-368-1019 toll-free 1-800-537-7697 TDD	U.S. DHHS / Office of Civil Rights 200 Independence Ave. SW, Room 506F Washington, D.C. 20201

7.1 Quality Improvement Program

Provider participation is of key importance to a successful Quality Improvement Program.

Provider participation in QM activities includes:

- Participate in MARCH Quality Committees including the Quality Improvement Committee, Peer Review Sub-Committee, Utilization Management Sub-Committee, and the Professional Review Committee;
- Participate in Disease Management Programs;
- Adhere to adopted clinical care guidelines;
- Appropriately respond to member appeals and grievances;
- Meet member access requirements;
- Participate in clinical reviews;
- Maintain medical record standards;
- Maintain the confidentiality of member information and records.

Please refer to the link below for additional information regarding the 2011 Quality Improvement Program.

[2011 Quality Improvement Program](#)

7.2 Clinical Decision Making

MARCH Vision Care clinical decisions are based only on appropriateness of care and service, and existence of coverage. MARCH Vision Care does not reward health care providers for denying, limiting, or delaying coverage of health care services. We also do not give monetary incentives to our staff making medical necessity decisions to provide less health care coverage or services.

7.3 Coordination with Other TennCare Contractors/Providers

Providers are encouraged to contact a member's Primary Care Provider (PCP) should they notice any additional medical needs while providing vision services. The assigned PCP is noted on the front of the member's ID card. Additionally, you may contact UnitedHealthcare directly for assistance in coordinating any other needs for the member, including transportation to appointments. UnitedHealthcare may be contacted at 1-800-690-1606.

7.4 Medical Records Standards

Providers shall maintain medical records in a manner that is current, detailed and organized and which permits effective and confidential patient care and quality review, administrative, civil and/or criminal investigations and/or prosecutions. Vision records are to be maintained at the site where vision services are provided for each member. Records are to be stored securely, with access given to authorized personnel only.

In order to perform its utilization management and quality improvement activities, MARCH and/or the health plan may request access to such records, including claims records. The federal, state and local government or accrediting agencies may also request such information necessary to comply with accreditation standards, statutes or regulations applicable to the health plan or clinicians. As a condition of participation with the TennCare program, all members give access permission to their medical records to the health plan, TennCare, and applicable oversight institutions. No further permissions are needed.

The provider is not allowed to charge MARCH, the health plan or the member for copies of medical records provided for claims payment or medical management. The provider may charge the member for records provided at the member's request, in accordance with Tennessee Code Annotated 63-2-101 & 63-2-102. Providers are not allowed to charge MARCH, the health plan or the member for records provided when a member moves from one primary care provider to another.

8.1 Anti-Fraud Plan

Pursuant to Health and Safety Code Section 1348, MARCH's anti-fraud plan includes, but is not limited to, the following requirements:

1. The designation of an organization with specific investigative expertise in the management of fraud investigations.
2. Training of personnel and contractors concerning the detection of health care fraud.
3. Procedures for managing incidents of suspected fraud.
4. Procedures for referring suspected fraud to the appropriate government agency.

Designation of an Organization with Specific Investigative Expertise in the Management of Fraud Investigations

MARCH has designated the law firm of Katten Muchin & Rosenman, LLP ("KMR") as its fraud investigator. KMR has substantial experience in the management of fraud investigations.

Training of Personnel and Contractors Concerning the Detection of Health Care Fraud

MARCH recognizes the importance of properly educating and training its personnel and contractors to detect fraud by MARCH, MARCH's providers and MARCH's members. As part of its anti-fraud plan, MARCH requires its personnel and contractors to receive the following training in the detection of health care fraud:

Training of MARCH Personnel

All MARCH personnel will be annually trained in the detection of fraud and all new personnel will be trained in the detection of fraud upon hire.

The training of MARCH personnel will include a general training session for all MARCH personnel regarding the most common types of health care fraud that impact managed care organizations and may include specialized training for MARCH personnel who work in the enrollment, credentialing, claims and marketing areas regarding the identification and detection of fraud that is likely to specifically impact their jobs. In addition, the Chief Executive Officer shall establish such other training and dissemination of information to all employees concerning the necessity of complying with all applicable laws and regulations and shall keep MARCH personnel abreast of current trends and issues relating to fraud and on an ongoing basis through informational bulletins and discussions.

MARCH personnel shall sign an Employee Statement of Understanding regarding the anti-fraud plan both at the time of their initial anti-fraud training, and thereafter on a yearly basis. All such signed Statements of Understanding shall be kept in each employee's personnel file.

Training of MARCH's Participating Providers

All of MARCH's participating providers will receive a copy of MARCH's anti-fraud plan. They will be required to either adopt and comply with MARCH's anti-fraud plan, or to have their own anti-fraud plan/compliance program in place that meets or exceeds the standards of MARCH's anti-fraud plan. MARCH will also issue provider communications from time to time concerning fraud detection and related issues.

Areas of Training

Training includes an overview of health care fraud, a summary of the applicable fraud and abuse laws, training on how to identify potentially fraudulent claims (including indicators of fraud), examples of fraudulent activity that has been uncovered and the procedure for referring suspected fraudulent activity to the Chief Executive Officer.

Training topics will include, but not be limited to, methods of detecting the following types of fraud:

1. Detection of Fraud by the Plan
 - a) Marketing - Using marketing techniques that coerce, mislead or confuse potential members and engaging in marketing that discriminates among potential members based on their health status.
 - b) Underutilized/Quality of Care - Failing to employ or contract with sufficient providers to accommodate all members; failing to provide geographically reachable services to members; and categorically denying payment of claims.

- c) Enrollment Fraud - Using unnecessarily complex disenrollment procedures and materials.
- d) Licensure/Credentialing - Not adequately credentialing providers; contracting with unlicensed providers.
- e) Kickbacks - Accepting kickbacks in order to refer certain members to a particular provider.

2. Detection of Fraud by Providers

- a) Marketing - Failing to comply with the applicable licensing board's advertising guidelines.
- b) Kickbacks - Providers paying kickbacks to MARCH employees in order to be referred members.
- c) False Claims - Billing for services that were never performed or were not medically necessary; and waivers of copayments or deductibles.
- d) Licensure/Credentialing - Misrepresenting licensure status to MARCH.

3. Detection of Fraud by Members

- a) Enrollment Fraud - Members claiming to be eligible for MARCH health coverage when they are, in fact, ineligible.

4. Identification of Possible Indicators of Fraud

The training will emphasize that certain circumstances may be indicative of fraudulent activity, and should be reviewed further. Such circumstances include, but are not limited to, the following:

- a) Inconsistency between the services billed and the services rendered.
- b) A provider's advertisement of "free" services.
- c) An unusually high number of members/member visits in a given time frame.
- d) A provider's lack of supporting documentation for a claim selected for audit.
- e) A high-dollar claim for services dated soon after the effective date of coverage or just before the termination of coverage.

Procedures for Managing Incidents of Suspected Fraud

Upon reports or reasonable indications of fraud, the Chief Executive Officer will promptly initiate steps to investigate the conduct in question to determine whether fraudulent activity has occurred. As needed, the fraud investigator will be requested to conduct the investigation. If the Chief Executive Officer and/or fraud investigator determines that fraudulent activity has occurred, the Chief Executive Officer will develop an appropriate response, as described below.

Discovery of Fraudulent Activities

1. Reporting Incidents of Suspected Fraud

All MARCH personnel are responsible for preventing, detecting and reporting suspected fraud. If an employee detects any suspicious activity, he/she is required to notify the Chief Executive Officer. The person reporting fraud may make himself/herself known by reporting the suspected fraud in person, or may report the suspected fraud anonymously via inter-office mail or U.S. Mail.

The manager of each department will be responsible for the early detection of fraud within his/her department. If fraud is suspected within a department, that department's manager is required to immediately notify the Chief Executive Officer. Each manager's performance evaluation will be based in part on his/her efforts to detect fraud.

2. Implementation of a Monitoring and Audit Program

The Chief Executive Officer will implement a monitoring and audit program, as necessary. Through the use of ongoing auditing and monitoring, the Chief Executive Officer will investigate any changes from the baseline audit that may be indicative of fraud. Ongoing auditing and monitoring will enable MARCH to gather some of the information MARCH will need to make annual reports to the Department of Managed Health Care as required by Health and Safety Code Section 1348(c).

3. As determined to be necessary by the Chief Executive Officer, the implementation of the monitoring and audit program may involve the following steps:

- a) Interviewing personnel involved in enrollment, credentialing, claims, marketing and related areas to detect potential improper conduct.

- b) Reviewing medical and financial records and other source documents that support claims for reimbursement.
- c) Reviewing written materials and documentation prepared by the different departments within MARCH.

Investigate the Incident to Determine Whether there is a Violation of Law/Regulations/MARCH Policy

The Chief Executive Officer or his/her designee will investigate all credible incidents of suspected fraud that are reported and all credible incidents that are uncovered pursuant to the auditing and monitoring program. The investigation will involve interviews and document review. In the case where employee fraud is suspected, the Chief Executive Officer will determine whether the employee should be removed from his/her duties until the investigation is completed and whether or not immediate steps should be taken to prevent the destruction of documents or other evidence relevant to the investigation. The Chief Executive Officer shall record the progress of the investigation, including the results of interview and document reviews.

Take Appropriate Remedial Measures

If fraudulent activity has occurred, the Chief Executive Officer will consult with the manager of the department in which the fraudulent activity has occurred to determine the appropriate action necessary to correct the matter. The following remedial measures will be taken, as applicable:

1. Deny/Recoup Payment - If the fraudulent activity involves payment to a provider or to a member, the payment will be denied if not yet made, and will be recouped if already made.
2. Terminate Contract/Discipline Employee Appropriately - If appropriate, contracts with providers will be terminated, and employees will be disciplined. Corrective action will be based upon the individual circumstances and the severity of the incident. All personnel will be disciplined similarly, regardless of their position within MARCH.
3. File Appropriate Reports - If fraudulent behavior constitutes a reportable offense, a report will be made to the appropriate entity. Examples include reports required by California Business & Professions Code Section 805, and reports required by the National Practitioner Data Bank.
4. Notify Appropriate Government Agencies - See below.
5. Take Further Remedial Measures - In order to decrease the possibility that fraud will reoccur, the Chief Executive Officer will educate MARCH personnel and participating providers regarding how to avoid the recurrence of any fraudulent activities that are discovered. In addition, the Chief Executive Officer will undertake additional investigations or other actions if it appears there may be a continuing pattern of fraud.

Procedures for Referring Suspected Fraud to the Appropriate Government Agency

MARCH is committed to aggressively investigate suspected fraud and is committed to referring fraud for prosecution as appropriate. At least annually, MARCH shall submit a report to the Department of Managed Health Care regarding MARCH's adherence to its anti-fraud plan generally and the results of investigations conducted by MARCH regarding suspected fraud.

The Chief Executive Officer will discuss the findings of fraud investigations with legal counsel to determine whether or not a violation of federal or state law or health care program requirements has occurred, whether or not the conduct should be disclosed to a governmental agency, and, if so, to which agency. Such disclosure will observe the following guidelines:

1. Providers that are found to be in violation of state licensing requirements will be reported to the appropriate state licensing board.
2. Plan employees, providers or members who are found to be in violation of other state laws will be reported to the District Attorney's Office.
3. Providers that are found to be in violation of a federal, criminal, civil or administrative law related to a federal health care program will be reported to the Office of Inspector General, Department of Justice or the Centers for Medicare and Medicaid Services, as appropriate.
4. Plan employees, providers or members who are found to be in violation of other federal laws will be reported to the Department of Justice/U.S. Attorney's Office.

Anti Fraud Plan Oversight

MARCH's Board of Directors is responsible for overseeing MARCH's anti-fraud plan. The Chief Executive Officer is responsible for implementing MARCH's anti-fraud plan and will make quarterly reports to Board of Directors regarding anti-fraud activities to enable the Board of Directors to monitor the anti-fraud plan and recommend any necessary changes.

8.2 Member Abuse and Neglect

Abuse and Neglect – Elderly

Frail Elderly and Disabled population are vulnerable to abuse, neglect and exploitation. Health care providers are responsible for identifying and reporting suspected cases of abuse, neglect or exploitation. This section outlines the protocols for preventing, identifying, and reporting suspected abuse, neglect, and exploitation of members who are adults (see TCA 71-6-101 et seq.) and suspected brutality, abuse, or neglect of members who are children (see TCA 37-1-401 et seq. and TCA 37-1-601 et seq.).

1. Types of Abuse and Neglect

a) **Passive and active neglect definition and examples:**

With passive and active neglect the caregiver fails to meet the physical, social, and/or emotional needs of the older person. The difference between active and passive neglect lies in the intent of the caregiver. With active neglect, the caregiver intentionally fails to meet his/her obligations towards the older person. With passive neglect, the failure is unintentional; often the result of caregiver overload or lack of information concerning appropriate caregiving strategies.

- Evidence that personal care is lacking or neglected
- Signs of malnourishment (e.g. sunken eyes, loss of weight)
- Chronic health problems both physical and/or psychiatric
- Dehydration (extreme thirst)
- Pressure sores (bed sores)

b) **Physical Abuse definition and examples:**

Physical abuse consists of an intentional infliction of physical harm of an older person. The abuse can range from slapping an older adult to beatings to excessive forms of physical restraint (e.g. chaining).

- Overt signs of physical trauma (e.g. scratches, bruises, cuts, burns, punctures, choke marks)
- Signs of restraint trauma (e.g. rope burns, gag marks, welts)
- Injury - particularly if repeated (e.g. sprains, fractures, detached retina, dislocation, paralysis)
- Additional physical indicators - hypothermia, abnormal chemistry values, pain upon being touched
- Repeated "unexplained" injuries
- Inconsistent explanations of the injuries
- A physical examination reveals that the older person has injuries which the caregiver has failed to disclose
- A history of doctor or emergency room "shopping"
- Repeated time lags between the time of any "injury or fall" and medical treatment

c) **Material/Financial Abuse definition and examples:**

Material and financial abuse consists of the misuse, misappropriation, and/or exploitation of an older adult's material (e.g. possessions, property) and/or monetary assets.

- Unusual banking activity (e.g. large withdrawals during a brief period of time, switching of accounts from one bank to another, ATM activity by a homebound elder)
- Bank statements (credit card statements, etc.) no longer come to the older adult
- Documents are being drawn up for the elder to sign but the elder can not explain or understand the purpose of the papers
- The elders living situation is not commensurate with the size of the elder's estate (e.g. lack of new clothing or amenities, unpaid bills)
- The caregiver only expresses concern regarding the financial status of the older person and does not ask questions or express concern regarding the physical and/or mental health status of the elder
- Personal belongings such as jewelry, art, furs are missing

- Signatures on checks and other documents do not match the signature of the older person
- Recent acquaintances, housekeepers, "care" providers, etc. declare undying affection for the older person and isolate the elder from long-term friends or family
- Recent acquaintances, housekeeper, caregiver, etc. make promises of lifelong care in exchange for deeding all property and/or assigning all assets over to the acquaintance, caregiver, etc.

d) Psychological Abuse definition and examples:

Psychological or emotional abuse consists of the intentional infliction of mental harm and/or psychological distress upon the older adult. The abuse can range from insults and verbal assaults to threats of physical harm or isolation.

e) Psychological Signs:

- Ambivalence, deference, passivity, shame
- Anxiety (mild to severe)
- Depression, hopelessness, helplessness, thoughts of suicide
- Confusion, disorientation

f) Behavioral Signs:

- Trembling, clinging, cowering, lack of eye contact
- Evasiveness
- Agitation
- Hypervigilance

g) Sexual Abuse definition and examples:

Sexual abuse consists of any sexual activity for which the older person does not consent or is incapable of giving consent. The sexual activity can range from exhibitionism to fondling to oral, anal, or vaginal penetration.

- Trauma to the genital area (e.g. bruises)
- Venereal disease
- Infections/unusual discharge or smell
- Indicators common to psychological abuse may be concomitant with sexual abuse.

h) Violations of Basic Rights definitions and examples:

Violations of basic rights is often concomitant with psychological abuse and consists of depriving the older person of the basic rights that are protected under state and federal law ranging from the right of privacy to freedom of religion.

- Caregiver withholds or reads the elder's mail
- Caregiver intentionally obstructs the older person's religious observances (e.g. dietary restrictions, holiday participation, visits by minister/priest/rabbi etc.)
- Caregiver has removed all doors from the older adult's rooms.
- As violation of basic rights is often concomitant with psychological abuse the indicators of basic rights violations are similar indicators as those for psychological abuse.

i) Self Neglect definition and examples:

The older person fails to meet their own physical, psychological, and/or social needs.

- Person is unable to complete the processes/steps needed of daily living, i.e., obtain and prepare food, care for personal hygiene, obtain and retain running water, obtain and retain electricity/gas/heat, etc.
- Person is unable to keep personal dwelling free from hazards, i.e., pests or rodents, unable to walk through home or allow an escape route due to extreme clutter, structural damage to include holes in floors, outside walls, and/or roofing.

j) Other examples of Abuse and Neglect:

- Elder is not given the opportunity to speak without the caregiver being present.
- Caregiver exhibits high levels of indifference or anger towards the older adult
- Overmedication or over sedation

k) Risk Factors for Abuse

There are certainly various risk factors that increase the likelihood that an individual will be victim of abuse or neglect.

- Spouses make up a large percentage of elder abusers. Partnerships where one member of a couple has tried to exert power over the other can be vulnerable.
- Abusers are often dependent on their victims for financial assistance, housing and other forms of support. The risk of elder abuse is particularly high when these adult children live with the elder.
- Living with others and isolation. Abusers who live with the elder have more opportunity to abuse and may at the same time be isolated from the community and may seek to isolate the elder from others.
- Caregiver stress. Well intentioned caregivers are so overwhelmed by the burden of caring for dependent elders that they end up striking out, neglecting, or harming the elder.
- Personality characteristics of the elder such as dementia, disruptive behaviors and significant needs for assistance may place the elder at increased risk

Abuse and Neglect – Children

According to Tennessee law, all persons (including doctors, mental health professionals, child care providers, dentists, family members and friends) must report suspected cases of child abuse or neglect. Failure to report child abuse or neglect is a violation of the law. Child abuse and neglect occurs when a child is mistreated, resulting in injury or risk of harm. Abuse can be physical, verbal, emotional or sexual.

1. **Physical Abuse** is non-accidental physical trauma or injury inflicted by a parent or caretaker on a child. It also includes a parent's or a caretaker's failure to protect a child from another person who perpetrated physical abuse on a child. In its most severe form, physical abuse is likely to cause great bodily harm or death.
2. **Physical Neglect** is the failure to provide for a child's physical survival needs to the extent that there is harm or risk of harm to the child's health or safety. This may include, but is not limited to abandonment, lack of supervision, life endangering physical hygiene, lack of adequate nutrition that places the child below the normal growth curve, lack of shelter, lack of medical or dental that results in health threatening conditions, and the inability to meet basic clothing needs of a child. In its most severe form, physical neglect may result in great bodily harm or death.
3. **Sexual Abuse** includes penetration or external touching of a child's intimate parts, oral sex with a child, indecent exposure or any other sexual act performed in a child's presence for sexual gratification, sexual use of a child for prostitution, and the manufacturing of child pornography.

Child sexual abuse is also the willful failure of the parent or the child's caretaker to make a reasonable effort to stop child sexual abuse by another person.

4. **Emotional Abuse** includes verbal assaults, ignoring and indifference or constant family conflict. If a child is degraded enough, the child will begin to live up to the image communicated by the abusing parent or caretaker.
Possible Indicators of Abuse and Neglect:
 - The child has repeated injuries that are not properly treated or adequately explained.
 - The child begins acting in unusual ways ranging from disruptive & aggressive to passive & withdrawn.
 - The child acts in the role of parent toward their brothers and sisters or even toward their own parents.
 - The child may have disturbed sleep (nightmares, bed wetting, fear of sleeping alone, and needing nightlight).
 - The child loses his/her appetite, overeats, or may report being hungry.
 - There is a sudden drop in school grades or participation in activities.
 - The child may act in stylized ways, such as sexual behavior that is not normal for his/her age group.
 - The child may report abusive or neglectful acts.

The above signs indicate that something is wrong but do not necessarily point to abuse. However, if you notice these signs early, you may be able to prevent abuse or neglect.

5. **Parents who abuse or neglect their children may show some common characteristics:**
 - Possible drug/alcohol history
 - Disorganized home life
 - May seem to be isolated from the community and have no close friends
 - When asked about a child's injury, may offer conflicting reasons or no explanation at all

- May seem unwilling or unable to provide for a child's basic needs
- May not have age appropriate expectations of their children
- May use harsh discipline that is not appropriate for child's age or behavior
- Were abused or neglected as a child

Action Required by Tennessee State Law

For Abuse or Neglect Reports call:

- Adult Protective Services: (888) APS-TENN (1-888-277-8366)
- Child Protective Services: (877) 237-0004 or (877) 54ABUSE (1-877-542-2873)
- Local Numbers for Adult Protective Services:
 - Knoxville: (865) 594-5685
 - Chattanooga: (423) 634-6624
 - Nashville: (615) 532-3492
 - Memphis: (901) 320-7220

*****CALLS ARE CONFIDENTIAL*****

A secure website (<https://reportabuse.state.tn.us>) is available for you to report suspicions of abuse/neglect of children when the suspected abuse/neglect took place in Tennessee. This reporting system is provided for your convenience to report instances of abuse or neglect that do not require an emergency response.

When you call, please be prepared to give:

- Name of individual
- Address
- Age
- Phone #
- Specifics of abuse

If the individual is at immediate risk, please contact 911 immediately.

Penalties for failure to report:

Any person or institution required by law to report a case of suspected elder or child abuse/neglect who willfully fails to do so may be held criminally liable or civilly liable.

9.1 Credentialing and Re-Credentialing

All potential providers are required to complete a Provider Credentialing Application or submit their CAQH number for credentialing.

Disclosure of Criminal Conviction, Ownership and Control Interest

All potential providers must complete and sign the Disclosure of Ownership and Control Interest Statement and Criminal Information Form. Prior to participation and to any payment for services rendered to TennCare members (whether contracted with March Vision Care or not), the provider must have completed and filed with March Vision Care the disclosure information in accordance with requirements in 42 CFR, Part 455, Subpart B. This disclosure of criminal convictions related to the Medicare and Medicaid programs is required by CMS, as TennCare is the Tennessee Medicaid Program. These requirements hold that individual physicians and other healthcare professionals must disclose criminal convictions, while facilities and businesses must additionally disclose ownership and control interest.

CAQH

MARCH accepts CAQH numbers for the purpose of credentialing which will expedite the credentialing process as well as decrease the amount of paperwork for you and your staff. To expedite credentialing, please provide us with your CAQH number as soon as possible. To further avoid delays in processing; please be sure to give MARCH permission on the CAQH site to access the provider's record. The CAQH application must have been attested to no earlier than 180 days.

Non-CAQH

MARCH will provide you with a credentialing application to use for any provider that is not currently enrolled in the CAQH program. Please contact our Provider Relations Department at (888) 493-4070 Monday through Friday, 8:00 am to 5:00 pm local time to obtain an application.

If you are utilizing the credentialing application, please be sure to include copies of the following documents with our completed application:

- Completed W-9 form.
- State license.
- Current malpractice face sheet showing expiration dates, limits and provider's name.
- Curriculum Vitae/resume to include work history if application does not cover last ten years.
- Board certificate (if applicable).
- Current DPA or DEA certificate (if applicable) with provider's name, address and expiration date.
- Current CDS/CSR Certificate, if applicable, with providers name, address and expiration date.
- Disclosure of Ownership and Control Interest Statement and Criminal Information Form.
- Attestation signed no earlier than 180 days.

Credentialing Process

Upon receipt of the credentialing application or CAQH number, credentialing information is reviewed by the Credentialing Coordinator for completeness. All data, licenses and certificates are electronically confirmed by the applicable regulatory agencies, and any provider not in good standing with his/her respective regulatory agency is pended. The completed and confirmed application or CAQH number is forwarded to the Professional Review Committee Chairperson for review and consideration. If consideration is favorable, the provider is approved. If the consideration is not favorable, the information is sent back to the Credentialing Coordinator with recommendations for further review. Once a completed application or valid CAQH number has been received, the credentialing process will be complete within thirty (30) days. The thirty (30) day timeframe will be initiated upon receipt of a completed application and all valid documents including the Disclosure of Ownership and Control of Interest Statement and criminal information form for each provider.

Recredentialing Process

All providers participating on the MARCH panel are re-credentialed not more than thirty-six (36) months from the last credentialing approval date. The Provider Services Agreement stipulates automatic yearly renewal. The provider must forward to MARCH on an annual basis a current photocopy of his or her yearly state license renewal and malpractice insurance. Membership in good standing is re-confirmed.

9.2 National Provider Identifier

The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The National Provider Identifier is a unique identification number for covered health care providers. Covered health care providers, all health plans and health care clearinghouses must use National Provider Identifiers in the administrative and financial transactions adopted under the Health Insurance Portability and Accountability Act.

In accordance with 45 CFR § 162.410, MARCH shall require each physician providing services to members to have a National Provider Identifier.

10.1 Access to Interpreters



Health care providers are responsible for ensuring that patients have a full understanding of their diagnosis and treatment guidelines, regardless of their preferred language. To ensure that all limited English proficient members receive appropriate access to vision care, all providers are expected to comply with federal and state requirements regarding cultural and linguistic services. It is not permissible to turn a member away; to limit the member's participation or access to services because of language barriers; to subject a member to unreasonable delays due to language barriers; or to provide services to Limited English Proficiency (LEP) members that are lower in quality than those offered in English.

Limited English Proficiency services ensure that members receive free translation and interpretation services. The health plan provides translation services to any of its members during direct contacts with health plan staff. The health plan does not reimburse for translation services offered to TennCareSM members in the provider's office setting. Providers are responsible for offering these services without charge to the member. This is a requirement under Title VI of federal regulations, which applies to any provider that accepts TennCareSM funds. Tips for working with interpreters can be found in Exhibit E.

11.1 Cultural Competency

MARCH shall ensure that all health plan members receive equitable and effective treatment in a culturally and linguistically appropriate manner. MARCH shall exhibit congruent behaviors, attitudes and policies that come together in a system that enables effective work in cross-cultural situations.

12.1 Confidentiality

Personal and medical information regarding members of UnitedHealthCare are highly confidential. It is the responsibility of each employee of the health plan, MARCH and of independent contactors providing services to the health plan to protect all confidential information by adhering to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the Gramm-Leach-Bliley Act of 1999 (GLBA) when appropriate as well as established health plan policies and guidelines.

Employees of the health plan and independent contractors providing services to the health plan shall have access to confidential information only as minimally necessary to perform their functional responsibilities. Wrongful disclosure of confidential information will result in appropriate discipline and correction action.

12.2 Protected Health Information

Regulations under The Health Insurance Portability and Accountability Act of 1996 (HIPAA) govern individually identifiable health information. A portion of these regulations, known as the Privacy and Security Rules (“Privacy Rule”), define protected health information (PHI), when it can (or cannot) be disclosed, and security of such information. These regulations can be found at 45 CFR Part 164.

The Privacy Rule protects all individually identifiable health information held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The Privacy Rule calls this information protected health information (PHI).

Individually identifiable health information is information, including demographic data, which relates to:

- the individual’s past, present or future physical or mental health or condition,
- the provision of health care to the individual, or
- the past, present, or future payment for the provision of health care to the individual, and
- that identifies the individual or for which there is a reasonable basis to believe it can be used to identify the individual. Individually identifiable health information includes many common identifiers, as outlined below.

The following list of 18 identifiers must be treated with special care according to HIPAA:

1. Names
2. All geographical subdivisions smaller than a State, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of a zip code, if according to the current publicly available data from the Bureau of the Census: (1) The geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people; and (2) The initial three digits of a zip code for all such geographic units containing 20,000 or fewer people is changed to 000
3. Dates (other than year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older
4. Phone numbers
5. Fax numbers
6. Electronic mail addresses
7. [Social Security numbers](#)
8. Medical record numbers
9. Health plan beneficiary numbers
10. Account numbers
11. Certificate/license numbers
12. Vehicle identifiers and serial numbers, including license plate numbers;
13. Device identifiers and serial numbers;
14. Web [Universal Resource Locators](#) (URLs)
15. Internet Protocol (IP) address numbers
16. [Biometric](#) identifiers, including finger, retinal and voice prints
17. Full face photographic images and any comparable images
18. Any other unique identifying number, characteristic, or code (note this does not mean the unique code assigned by the investigator to code the data)

12.3 Secure Transmission of Protected Health Information (PHI)

To ensure that all communications (email, phone, or fax) containing Protected Health Information (PHI) (i.e. Member number, name, address, etc.) from provider organizations meet HIPAA privacy guidelines, please follow the recommended guiding principles when exchanging PHI with March Vision Care:

- First, please determine if it is business necessary to exchange PHI with March Vision Care, the March Vision Care recipient of PHI is appropriate, and include only the "minimum necessary" information.
- If you have a business need to exchange PHI with March Vision Care personnel via email, please check with your IT personnel to make sure they have a secure transmission setup with March Vision Care email systems. For more details, follow steps described in Exhibit L: "Sending a Secure Email to March Vision Care for PHI related data" to ensure that HIPAA guidelines are being met and PHI is secured. This will prevent March Vision Care from receiving unencrypted or unsecured emails with PHI.
- While sending PHI securely via encrypted emails, please be aware that the HIPAA Privacy Rule still requires that PHI only be shared with those who are permitted to have the information and share only the minimum amount of PHI necessary to accomplish the business purpose.
- Please be aware that when contacting March Vision Care by phone, email, or fax that we are required to confirm your name, associated Provider/Physician Organization, and contact information before exchanging or confirming PHI.

Exhibits A through N

- Exhibit A Non-Covered Service Fee Acceptance Form
- Exhibit B Provider Dispute Resolution Request Form
- Exhibit C MARCH Lab Order Form
- Exhibit D Tips for Working with Limited English Proficient Members
- Exhibit E Tips for Working with Interpreters
- Exhibit F Tips for Documenting Interpretive Services for Limited English Proficient Members - Notating the Provision or the Refusal of Interpretive Services
- Exhibit G Language ID Poster
- Exhibit H Member Grievance Form
(English and Spanish)
- Exhibit I Potential Quality Issue - Severity Levels
- Exhibit J Potential Quality Issue Referral Form
- Exhibit K Clinical Practice Guidelines
- Exhibit L Instructions on Sending a Secure Email Containing PHI
- Exhibit M TennCare Member Appeal Rights Poster
- Exhibit N MARCH Wholesale / Retail Fee Schedule

Non-Covered Service Fee Acceptance

I _____, a member of _____ wish to obtain and pay for _____, a service which is not covered as a covered benefit under the Medicaid/Medicare Program under which I have coverage.

Dr. _____ has explained to me that I will be solely responsible for the cost of _____, which is \$_____. I agree to accept responsibility for payment of \$_____. I understand that I am not obligated to pay for the above service if it is later found that the service was covered under the Medicaid/Medicare Program under which I have coverage at the time it was provided, even if Medicaid/Medicare did not pay Dr. _____ for the service because he or she did not satisfy Medicaid/Medicare billing requirements.

I acknowledge that I have been given a copy of this agreement.

Member's Signature

Printed Name

Date

Provider Dispute Resolution Request Form

Instructions:

- Please complete the form below. Fields with an asterisk (*) are required.
- Be specific when completing DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed.
- For routine follow-up, please contact MARCH at (888) 493-4070 Monday through Friday, 8:00 am to 5:00 pm local time.
- Mail the completed form to: March Vision Care, 6701 Center Drive West, Suite 790, Los Angeles, CA 90045

Provider Name*:	Provider Tax ID #/Medicare ID #*:
Provider Address:	

Provider Type: MD Mental Health Professional Mental Health Institutional Hospital ASC
SNF DME Rehab Home Health Ambulance Other (please specify):

Claim Information Single Multiple "Like" Claims (Complete attached spreadsheet) **Number of claims:**

Patient Name*:		Date of Birth:	
Health Plan ID Number*:	Patient Account Number:	Original Claim ID Number: (If multiple claims, use attached spreadsheet)	
Service "From/To" Date*: (Required for Claim, Billing, and Reimbursement Of Overpayment Disputes)	Original Claim Amount Billed:	Original Claim Amount Paid:	
Dispute Type: <input type="checkbox"/> Claim <input type="checkbox"/> Appeal of Medical Necessity / Utilization Management Decision <input type="checkbox"/> Disputing Request for Reimbursement of Overpayment		<input type="checkbox"/> Seeking Resolution of a Billing Determination <input type="checkbox"/> Contract Dispute <input type="checkbox"/> Other:	
Description of Dispute:			
Expected Outcome:			

Contact Name (Please Print)	Title	() Phone Number
Signature	Date	() Fax Number

[] Check here if additional information is attached. Please do not staple.

For MARCH use only.	
Tracking Number:	Provider ID:
Contracted:	Non-Contracted:

Provider Dispute Resolution Request Form

(For use with multiple “like” claims)

Number	Patient Name		Date of Birth	Health Plan ID Number	Original Claim ID Number	Service From/To Date	Original Claim Amount Billed	Original Claim Amount Paid	Expected Outcome
	Last	First							
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									

Page ___ of ___

Check here if additional information is attached. Please do not staple.

MARCH Lab Order Form Instructions

- Complete the Lab Order Form on the following page. Please print clearly.
- Use of this Lab Order Form for non-plan members is prohibited.

If you need to contact our contracted lab for technical lens option questions, please refer to the table below.

Lab orders can be submitted online through eyeSynergy®. If you choose not to submit lab orders through eyeSynergy®, you **must** fax your order to our Customer Service Center at (800) 624-8101.

State(s)	Contact Information	Contact Information
Tennessee	Hoya Knoxville	1529 Western Avenue Knoxville, TN 37921 Phone (800) 227-5697 March Vision Care fax: (800) 624-8101

MARCH Lab Order Form

Member Information

Patient's name: _____ Today's date: _____
 Patient's ID number: _____ Date of eye exam: _____
 Confirmation number (if available): _____

Provider Information

Provider name: _____
 Address: _____
 Phone number: _____

	Sphere	Cylinder	Axis	Prism (H) with Indicator	Prism (V) with Indicator
Right					
Left					

ADD	Power	Seg Ht	Dist PD	Near PD	Fresnel Prism	Special Base Curve	Occluder Lens
Right							<input type="checkbox"/>
Left							<input type="checkbox"/>

Lens Options (Covered and Non-Covered) Check all that apply.

- | | | | | |
|--|----------------------------------|-----------------------------------|---------------------------------------|---|
| <input type="checkbox"/> Polycarbonate | <input type="checkbox"/> FT 25 | <input type="checkbox"/> FT 35 | <input type="checkbox"/> AR Standard | <input type="checkbox"/> Scratch Coating |
| <input type="checkbox"/> Plastic | <input type="checkbox"/> FT 28 | <input type="checkbox"/> FT 45 | <input type="checkbox"/> PAL Standard | <input type="checkbox"/> Trivex (Phoenix) |
| <input type="checkbox"/> Glass | <input type="checkbox"/> FT 7x25 | <input type="checkbox"/> Hi-Index | <input type="checkbox"/> AR Premium | <input type="checkbox"/> Oversized Lenses |
| <input type="checkbox"/> SV | <input type="checkbox"/> FT 7x28 | <input type="checkbox"/> UV | <input type="checkbox"/> PAL Premium | <input type="checkbox"/> Photochromatic |

- | | | | |
|---|------------------------|--------------------|---|
| Tints | Coating Options | | |
| <input type="checkbox"/> Gradient | UV: _____ | AR: _____ | <input type="checkbox"/> Edge Polish |
| <input type="checkbox"/> Multi-gradient | Scratch: _____ | Mirror Type: _____ | <input type="checkbox"/> Slab Off Prism |
| <input type="checkbox"/> Solid | | | |

Color: _____

Frame Information

Frame name: _____ Edge Type: _____
 Color: _____ Lens size: _____
 Bridge size: _____ Temple size: _____

- Rimless Drill 2 Hole Rimless Drill 4 Hole

Other Instructions/Special Notes

I certify that the prescription information supplied above is medically indicated and necessary to the health of this patient and was personally furnished by me or my employee under my personal direction. This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this order will be from Federal and State funds, and that any false claims, statements, or documents or concealment of a material fact may be prosecuted under applicable Federal and State laws.

Provider Signature: _____

Tips for Working with Limited English Proficient (LEP) Members

- Who is a LEP member?
Individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English, may be considered LEP.
- How to identify a LEP member over the phone.
 - Member is quiet or does not respond to questions
 - Member simply says yes or no, or gives inappropriate or inconsistent answers to your questions
 - Member may have trouble communicating in English or you may have a very difficult time understanding what they are trying to communicate
 - Member self identifies as LEP by requesting language assistance.
- Tips for working with LEP members and how to offer interpreter services.
 - Member does not speak English and you are unable to discern the language.
 - Connect with contracted telephonic interpretation vendor to identify language needed.
 - Member speaks some English.
 - Speak slowly and clearly. Do not speak loudly or shout. Use simple words and short sentences.
 - How to offer interpreter services.
"I think I am having trouble with explaining this to you, and I really want to make sure you understand. Would you mind if we connected with an interpreter to help us? Which language do you speak? OR
"May I put you on hold? I am going to connect us with an interpreter." (In the event you are having difficulty communicating with a member, using this statement is a good transition to initiating interpreter assistance.)
- Best practice to capture language preference.
 - For LEP members it is best practice to capture the members preferred language and record it in the plans' member data system.
"In order for me (or Health Plan) to be able to communicate most effectively with you, may I ask what your preferred spoken and written language is?"



This universal symbol for interpretive services is from Hablamos Juntos, a Robert Wood Johnson funded project found at: http://www.hablamosiuntos.org/signage/symbols/default.using_symbols.asp#bpw.

Tips for Working with Interpreters

Telephonic Interpreters

- Tell the interpreter the purpose of your call. Describe the type of information you are planning to convey. *
- Enunciate your words and try to avoid contractions, which can be easily misunderstood as the opposite of your meaning, i.e., “can’t - cannot.” *
- Speak in short sentences, expressing one idea at a time.*
- Speak slower than your normal speed of talking, pausing after each phrase.*
- Avoid the use of double negatives, i.e., “If you don’t appear in person, you won’t get your benefits.” * Instead, “You must come in person in order to get your benefits.”
- Speak in the first person. Avoid the “he said/she said.” *
- Avoid using colloquialisms and acronyms, i.e., “MFIP.” If you must do so, please explain their meaning.*
- Provide brief explanations of technical terms, or terms of art, i.e., “Spend-down” means the client must use up some of his/her monies or assets in order to be eligible for services.” *
- Pause occasionally to ask the interpreter if he/she understands the information that you are providing, or if you need to slow down or speed up in your speech patterns. If the interpreter is confused, so is the client. *
- Ask the interpreter if, in his/her opinion, the client seems to have grasped the information that you are conveying. You may have to repeat or clarify certain information by saying it in a different way. *
- ABOVE ALL, BE PATIENT with the interpreter, the client and yourself! Thank the interpreter for performing a difficult and valuable service. *
- The interpreter will wait for you to initiate the closing of the call and will be the last to disconnect from the call.

When working with an interpreter over a speakerphone or with dual head/handsets, many of the principles of on-site interpreting apply. The only additional thing to remember is that the interpreter is “blind” to the visual cues in the room. The following will help the interpreter do a better job. **

- When the interpreter comes onto the line let the interpreter know the following: **
 - Who you are.
 - Who else is in the room.
 - What sort of office practice this is.
 - What sort of appointment this is.
 For example, “Hello interpreter, this is Dr. Jameson. I have Mrs. Dominguez and her adult daughter here for Mrs. Dominguez’ annual exam.” **
- Give the interpreter the opportunity to introduce himself or herself quickly to the member. **
- If you point to a chart, a drawing, a body part or a piece of equipment, describe what you are pointing to as you do it. **

Onsite Interpreters

- Hold a brief meeting with the interpreter beforehand to clarify any items or issues that require special attention, such as translation of complex treatment scenarios, technical terms, acronyms, seating arrangements, lighting or other needs.
 - For face-to-face interpreting, position the interpreter off to the side and immediately behind the member so that direct communication and eye contact between the provider and member is maintained. For American Sign Language interpreting, it is best to position the interpreter beside the member so the member can capture the hand signals easily.
 - Be aware of possible gender conflicts that may arise between interpreters and members. In some cultures, males should not be requested to interpret for females.
 - Be attentive to cultural biases in the form of preferences or inclinations that may hinder clear communication. For example, in some cultures, especially Asian cultures, “yes” may not always mean “yes.” Instead, “yes” might be a polite way of acknowledging a statement or question, a way of politely reserving one’s judgment, or simply a polite way of declining to give a definite answer at that juncture.
 - Greet the member first, not the interpreter. **
 - During the medical interview, speak directly to the member, not to the interpreter: “Tell me why you came in today” instead of “Ask her why she came in today.” **
 - A professional interpreter will use the first person in interpreting, reflecting exactly what the member said: i.e. “My stomach hurts” instead of “She says her stomach hurts.” This allows you to hear the member’s “voice” most accurately and deal with the member directly. **
 - Speak at an even pace in relatively short segments; pause often to allow the interpreter to interpret. You do not need to speak especially slowly; this actually makes a competent interpreter’s job more difficult. **
 - Don’t say anything that you don’t want interpreted; it is the interpreter’s job to interpret everything. **
 - If you must address the interpreter about an issue of communication or culture, let the member know first what you are going to be discussing with the interpreter. **
- Speak in:

- Standard English (avoid slang) **
- Layman's terms (avoid medical terminology and jargon)
- Straightforward sentence structure.
- Complete sentences and ideas.
- Ask one question at a time. **
- Ask the interpreter to point out potential cultural misunderstandings that may arise. Respect an interpreter's judgment that a particular question is culturally inappropriate and either rephrase the question or ask the interpreter's help in eliciting the information in a more appropriate way. **
- Do not hold the interpreter responsible for what the member says or doesn't say. The interpreter is the medium, not the source, of the message. **
- Avoid interrupting the interpretation. Many concepts you express have no linguistic or conceptual equivalent in other languages. The interpreter may have to paint word pictures of many terms you use. This may take longer than your original speech. **
- Don't make assumptions about the member's education level. An inability to speak English does not necessarily indicate a lack of education. **
- Acknowledge the interpreter as a professional in communication. Respect his or her role. **

Footnotes:

* "Limited English Proficiency Plan," Minnesota Department of Human Services: Helpful hints for using telephone interpreters (page 6).

** "Addressing Language Access Issues in Your Practice - A Toolkit for Physicians and Their Staff Members," California Endowment website

Tips for Documenting Interpretive Services for Limited English Proficient Members - Notating the Provision or the Refusal of Interpretive Services

- **Documenting refusal of interpretive services** in the medical record not only protects you and your practice, it also ensures consistency when your medical records are monitored through site reviews/audits by contracted health plans to ensure adequacy of the plan's Language Assistance Program.
 - It is preferable to use professionally trained interpreters and to document the use of the interpreter in the member's medical record.
 - If the member was offered an interpreter and refused the service, it is important to note that refusal in the medical record for that visit.
 - Although using a family member or friend to interpret should be discouraged, if the member insists on using a family member or friend, it is extremely important to document this in the medical record, especially if the chosen interpreter is a minor.
 - Smart Practice Tip: Consider offering a telephonic interpreter *in addition* to the family member/friend to ensure accuracy of interpretation.
 - For all limited English proficient members, it is best practice to document the member's preferred language in paper and/or electronic medical records in the manner that best fits your practice flow.*
 - For a paper record, one way to do this is to post color stickers on member's chart to flag when an interpreter is needed. (For example: Orange = Spanish, Yellow = Vietnamese, Green = Russian)*
 - For EMR's, contact your IT department to determine the best method of advising all health care team members of a preferred spoken language.



This universal symbol for interpretive services is from Hablamos Juntos, a Robert Wood Johnson funded project found at: http://www.hablamosjuntos.org/signage/symbols/default.using_symbols.asp#bpw.

*Source: Industry Collaboration Effort (ICE) Tips for Communicating Across Language Barriers; www.iceforhealth.org.

Language ID Poster

English – Point to your language. An interpreter will be called.

Amharic ስዕግረና ወደቋንቋዎ የመልከቱ ስከተረንጫሲ መጣኑዎ	Mandarin 國語 請指認您的語言。 以便為您請翻譯。
Arabic اللغة العربية اشر إلى لغتك الأصلية وسوف نستدعي المترجم اللازم	Russian Русский Язык Укажите, на каком языке Вы говорите. Сейчас Вам вызовут переводчика.
Armenian Հայերէն Տոյց տուէք ո՞ր լեզու լեզուն կը խօսիք՝ որպէսզի թարգմանիչ մը կանչել տանք.	Samoan Gagana Samoa Tusi lou a ao i lau gagana. O le a vala ‘auina se fasi e fa’amatala ‘upu mo’ oe.
Cambodian ភាសាខ្មែរ សូមចង្អុលភាសាអ្នក ដើម្បីស្នើសុំអ្នកបកប្រែមកជូន	Somali Soomaali Tilmaan afka aad ku hadasho. Tarjumaan ayaa la wacayaaye.
Cantonese 廣東話 唔該點出您講嘅語言。 等我哋幫您搵翻譯。	Spanish Español Señale su idioma. Se llamará a un intérprete.
Farsi فارسی زبان مادری خود را مشخص کنید. مترجم بطور رایگان در اختیار شما گذاشته خواهد شد.	Swahili Kiswahili Onyesha lugha yako. Tutamwita mtu atakayekufasiria.
French Français Montrez-nous quelle langue vous parlez. Nous vous fournirons un/e interprète.	Tagalog Tagalog Pakituro po ninyo ang inyong wika. Magpapatawag kami ng interpreter.
Hindi हिन्दी अपनी भाषा इशारे से दिखाइये । आपके लिए दुभाषिया बुलाया जाएगा ।	Thai ภาษาไทย ช่วยชี้ให้เราดูหน่อยว่าภาษาไหนคือภาษาที่ท่านพูด แล้วเราจะจัดหาคนให้ท่าน
Italian Italiano Faccia vedere qual è la sua lingua. Un interprete sarà chiamato.	Tongan Tonga Tuhu kihe lea oku ke lea aki. ‘E fetu utaki kihe fakatonulea.
Japanese 日本語 あなたの話す言葉を指さしてください。 通訳を呼びます。	Urdu اُردو آپ کون سی زبان میں بات کرنا پسند کریں گی؟ آپ کی مدد کیے ابھی کی ترجمان کو بلا یا جائے گا.
Korean 한국말 당신이 쓰는 말을 지적하세요. 통역관을 불러 드리겠습니다.	Vietnamese Tiếng Việt Chỉ rõ tiếng bạn nói. Sẽ có một thông dịch viên nói chuyện với bạn ngay.
Lao ພາສາລາວ ຊື່ຍອກພາສາທີ່ເຈົ້າເວົ້າໄດ້ ພວກເຮົາຈະຕິດຕໍ່ນາຍພາສາໃຫ້	

TennCare Member Appeal Form

Having problems getting health care or medicine in TennCare?

Use this page **only** to file a
TennCare Medical Appeal.

Need help filing a medical appeal?

- Call 1-800-878-3192 for free.
- Versión en español atrás

Fill out **both** pages. These are facts we must have to work your appeal. If you don't tell us all the facts we need, we may not be able to decide your appeal. You may not get a fair hearing. Need help understanding what facts we need? Call us for free at 1-800-878-3192. If you call, we can also take your appeal by phone.

1. Who is the person that wants to appeal?

Full name _____ Date of birth ___/___/___

Social Security Number ___ - ___ - ___ Or number on their TennCare card _____

Current mailing address _____

City _____ State _____ Zip Code _____

The name of the person we should call if we have questions about this appeal: _____

A daytime phone number for that person (____) _____ - _____

2. Who filled out this form?

If **not** the person that wants to appeal, tell us your name. _____

Are you a: ___ Parent, relative, or friend ___ Advocate or attorney ___ Doctor or health care provider

3. What is the appeal for? (Place an X beside the right answer below.)

___ Want to change health plans. (Fill out Part A on page 2.)

___ Need care or medicine. (Fill out Part B on page 2.)

___ Have bills or paid for care or medicine you think TennCare should pay. (Fill out Part C on page 2.)

4. Do you think you have an emergency?

Usually, your appeal is decided within 90 days after you file it. But, if you have an emergency, you may not be able to wait 90 days. An emergency means if you don't get the care or medicine sooner than 90 days:

- You will be at risk of serious health problems or you may die.
- Or, it will cause serious problems with your heart, lungs, or other parts of your body.
- Or, you will need to go into the hospital.

Do you **STILL** think you have an emergency? If so, you can ask TennCare for an emergency appeal.

Your appeal may go faster if your doctor signs below saying that this appeal is an emergency. What if your doctor doesn't sign below, but you ask for an emergency appeal? TennCare will ask your doctor if your appeal is an emergency. If your doctor says it's not an emergency, TennCare will decide your appeal within 90 days. Some kinds of care are never treated as an emergency. To get a list of those kinds of care, ask TennCare.

If YOU want to ask TennCare for an EMERGENCY APPEAL, check this box.

Your DOCTOR can read and sign here to ask TennCare for an emergency appeal. I certify under penalty of perjury that I am the treating physician of the patient on behalf of whom this medical appeal is filed and that this appeal is an emergency. If this patient is required to wait 90 days for this care, s/he is at risk of serious health problems or death, severe impairment of bodily organs or parts, or hospitalization. I understand that any intentional act on my part to provide false information is considered an act of fraud under the State's TennCare Program & Title XIX of the Social Security Act.

Physician Signature: _____ Date: _____

Tennessee License Number: _____

5. Tell us why you want to appeal this problem. Include any mistake you think TennCare made. And, send copies of any papers that you think may help us understand your problem.

To see which Part(s) you should fill out below, look at number 3 on page 1.

Part A. Want to change health plans. Name of health plan you want _____

Part B. Need care or medicine. What kind - be specific _____

- What's the problem? Can't get the care or medicine at all.
 Can't get as much of the care or medicine as I need.
 The care or medicine is being cut or stopped.
 Waiting too long to get the care or medicine.

Did your doctor prescribe the care or medicine? Yes No If yes, doctor's name _____

Have you asked your health plan for this care or medicine? Yes No If yes, when? _____

What did they say? _____

Did you get a letter about this problem? Yes No If yes, the date of the letter _____

Who was the letter from? _____

Are you getting this care or medicine from TennCare now? Yes No

Do you want to see if you can keep getting it during your appeal? Yes No

Does your doctor say you still need it? Yes No If yes, doctor's name _____

If you keep getting care or medicine during your appeal and you lose, you may have to pay TennCare back.

Part C. Bills for care or medicine you think TennCare should pay for

The date you got the care or medicine _____ Name of doctor, drug store, or other place that gave you the care or medicine _____ Their phone number (____)____-_____
Their address _____

Did you pay for the care or medicine and want to be paid back? Yes No

If yes, you must send a copy of a receipt that proves you paid for the care or medicine.

If you didn't pay, are you getting a bill? Yes No If yes, and you think TennCare should pay, you must send a copy of a bill. Tell us the date you first got a bill (if you know). _____

How to file your medical appeal Make a copy of the completed pages to keep.

Then, mail these pages and other facts to: TennCare Solutions
P.O. Box 593
Nashville, TN 37202-0593

Or, fax it (toll-free) to 1-888-345-5575. Keep a copy of the page that shows your fax went through.

To appeal by phone, call 1-800-878-3192 for free.

Have speech or hearing problems? Call our TTY/TDD line for free at 1-866-771-7043.

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We do not allow unfair treatment in TennCare.

No one is treated in a different way because of race, color, birthplace, language, sex, age, religion, or disability. If you think you've been treated unfairly, call the Family Assistance Service Center for free at 1-866-311-4287.

¿Tiene problemas para obtener atención médica o medicina en TennCare?

Use esta página **únicamente** para

presentar una **Apelación Médica de TennCare.**

¿Necesita ayuda para presentar una apelación médica?

- Llame gratis al 1-800-878-3192.

Version in English on other side

Complete ambas páginas. Esta es información que debemos tener para tramitar su apelación. Si no nos dice todo lo que tenemos que saber, es posible que no podamos decidir sobre su apelación. Es posible que no le den una audiencia imparcial. ¿Necesita ayuda para entender qué información necesitamos? Llámenos gratis al 1-800-878-3192. Si llama, también podemos recibir su apelación por teléfono.

1. ¿Quién es la persona que quiere apelar?

Nombre completo _____ Fecha de nacimiento ____ / ____ / ____

Número de Seguro Social _____ - _____ - _____ O número de su tarjeta TennCare _____

Dirección postal vigente _____

Ciudad _____ Estado _____ Código postal _____

El nombre de la persona a quien debemos llamar si tenemos preguntas sobre esta apelación: _____

Número telefónico de esa persona durante el día (____) _____ - _____

2. ¿Quién completó este formulario?

Si no es la persona que quiere apelar, díganos su nombre. _____

¿Es usted: ___ padre/madre, pariente o amigo ___ Representante o abogado ___ Médico o proveedor de servicios médicos

3. ¿Para qué es la apelación? (Escriba una X al lado de la respuesta correcta a continuación.)

___ Quiero cambiar de plan de salud. (Complete la Parte A en la página 2.)

___ Necesita atención o medicina. (Complete la Parte B en la página 2.)

___ Tiene cuentas o pagó atención médica o medicina que usted piensa que TennCare debería pagar. (Complete la Parte C en la página 2.)

4. ¿Piensa que tiene una emergencia?

Usualmente las apelaciones se deciden en un plazo de 90 días de haber sido presentadas. Pero, si tiene una emergencia, es posible que no pueda esperar 90 días. Una emergencia significa que si usted **no** obtiene la atención médica o la medicina antes de 90 días:

- Correrá riesgo de problemas graves de salud o podría morir.
- O, le causará graves problemas del corazón, los pulmones u otras partes del cuerpo.
- O, tendrán que hospitalizarlo.

¿SIGUE pensando que tiene una emergencia? Si es así, puede pedirle a TennCare una apelación de emergencia. Su apelación podría ser más rápida si su médico firma abajo diciendo que esta apelación es una emergencia. ¿Qué ocurrirá si su médico no firma abajo pero usted pide una apelación de emergencia? TennCare le preguntará a su médico si su apelación es una emergencia. Si su médico dice que no es una emergencia, TennCare decidirá su apelación en un término de 90 días. Algunas clases de atención médica nunca se consideran una emergencia. Para obtener una lista de esos tipos de atención médica, pídasela a TennCare.

Si USTED quiere pedirle a TennCare una APELACIÓN DE EMERGENCIA, marque esta casilla.

Su MÉDICO puede leer y firmar aquí para pedirle a TennCare una apelación de emergencia. Your DOCTOR can read and sign here to ask TennCare for an emergency appeal. I certify under penalty of perjury that I am the treating physician of the patient on behalf of whom this medical appeal is filed and that this appeal is an emergency. If this patient is required to wait 90 days for this care, s/he is at risk of serious health problems or death, severe impairment of bodily organs or parts, or hospitalization. I understand that any intentional act on my part to provide false information is considered an act of fraud under the State's TennCare program and Title XIX of the Social Security Act.

Physician Signature: _____ Date: _____

Tennessee License Number: _____

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Siga leyendo. Todavía queda 1 página más que debe completar.

5. Díganos por qué quiere apelar este problema. Incluya cualquier error que piensa que TennCare cometió. Y, envíe copias de todos los papeles que cree que nos podrían ayudar a entender su problema.

Para ver cuál(es) Parte(s) debe llenar a continuación, mire el número 3 en la página 1.

Parte A. Quiero cambiar de plan de salud. Nombre del plan de salud que quiere _____

Parte B. Necesita atención o medicina. ¿De qué clase? Sea específico _____

- ¿Cuál es el problema? No puedo obtener nada de atención médica ni medicina.
 No puedo obtener toda la atención médica o medicina que necesito.
 Me están reduciendo o suspendiendo la atención médica o medicina.
 Tengo que esperar demasiado tiempo para obtener la atención médica o medicina.

¿Le recetó el médico la atención médica o la medicina? Sí No

Si respondió Sí, el nombre del médico _____

¿Le ha pedido a su plan de salud esta atención médica o medicina? Sí No

Si respondió Sí, ¿cuándo? _____

¿Qué dijeron? _____

¿Le llegó una carta sobre este problema? Sí No Si respondió Sí, la fecha de la carta _____

¿Quién le envió la carta? _____

¿Está recibiendo ahora esta atención médica o medicina por medio de TennCare? Sí No

¿Quiere ver si puede continuar recibéndola durante su apelación? Sí No

¿Su médico dice que sigue necesiéndola? Sí No Si respondió Sí, nombre del médico _____

Si sigue recibiendo la atención médica o la medicina durante su apelación y pierde es posible que le tenga que rembolsar los gastos a TennCare.

Parte C. Cuentas de atención médica o medicina que usted piensa que TennCare debería pagar

La fecha en que recibió la atención o medicina _____ El nombre del médico, farmacia u otro lugar que lo atendió o le dio la medicina _____ Su número de teléfono (____) _____ - _____

Su dirección _____

¿Pagó usted la atención o medicina y quiere que le reembolsen? Sí No

Si respondió Sí, debe enviar una copia de un recibo que compruebe que usted pagó la atención médica o la medicina.

Si no pagó, ¿le va a llegar una cuenta? Sí No Si respondió Sí y piensa que TennCare debería pagar usted deberá enviar una copia de una cuenta.

Díganos la fecha en que recibió la primera cuenta (si la sabe). _____

CÓMO presentar su apelación médica Haga una copia de las página completadas y guárdela.

Luego, ENVÍE POR CORREO estas hojas y otros datos a:

TennCare Solutions
P.O. Box 593
Nashville, TN 37202-0593

O, envíelas por FAX (gratis) al 1-888-345-5575. Conserve una copia de la página que demuestra que su fax pasó. Para apelar por TELÉFONO, llame gratis al 1-800-878-3192.

¿Tiene problemas del habla o del oído? Llame gratis a nuestra línea TTY/TDD al 1-866-771-7043.

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TennCare no permite el trato injusto.

Nadie recibe un trato diferente debido a su raza, color de la piel, lugar de nacimiento, idioma, sexo, edad, religión, o discapacidad. Si piensa que lo han tratado injustamente, llame gratis al Centro de Servicio para Asistencia Familiar al 1-866-311-4290

Potential Quality Issue – Severity Levels

Severity Level	Description	Example of Issues	Required Corrective Action
Level 0	<ul style="list-style-type: none"> No quality issue. Meets expectations of quality. No adverse outcome. 	<ul style="list-style-type: none"> Unfounded complaint. Unavoidable complication. Member issue. 	<ul style="list-style-type: none"> None. Track and trend.
Level I	<ul style="list-style-type: none"> No quality of care issue. Possible quality of services issue. He says, she says issues. No adverse outcome. 	<ul style="list-style-type: none"> Unavoidable complication. He say/she say – can not determine fault. 	<ul style="list-style-type: none"> None. Track and trend.
Level II	<ul style="list-style-type: none"> Borderline quality – no potential for serious adverse effects but could become a problem if repeated or not corrected. Unavoidable adverse outcome. 	<ul style="list-style-type: none"> Illegibility of record. Inadequate documentation. Documented poor communication. Delay in follow up/referral. 	<ul style="list-style-type: none"> None Informal/verbal/written counseling by Medical Director.
Level III	<ul style="list-style-type: none"> Questionable quality of care with opportunity for improvement exists. Moderate potential for adverse effects. Could become a problem if repeated or not corrected. 	<ul style="list-style-type: none"> Unnecessary delay in treatment. Inadequate examination. Failure to diagnose/examine/properly treat findings. 	<ul style="list-style-type: none"> Verbal counseling by Medical Director and one or more of the following: <ul style="list-style-type: none"> Written counseling. Focused review of medical record. Mandatory skill retraining or CME. Proctoring.
Level IV	<ul style="list-style-type: none"> Qualities of Care unacceptable – serious. Significant potential for serious adverse affects. Serious adverse affect occurred. 	<ul style="list-style-type: none"> Clinical significant outcome. Preventable death. Preventable disability. Preventable impairment. Other preventable serious complication. 	<ul style="list-style-type: none"> Level IV, written counseling and one or more of the following: <ul style="list-style-type: none"> Focused review. Concurrent review. Mandatory skill retraining or CME. Proctoring. Reduction/Restriction of privileges. Probation. Termination. License revocation recommendation (Filing of report with appropriate authority).

Potential Quality Issue Referral Form

Identifying Data

Member name: _____ DOB: _____ Member ID number: _____

Provider name: _____ NPI : _____

Provider address: _____ Phone number: _____

Group/plan: _____ Phone number: _____ PR number: _____

Referred by: _____ ICD9 code: _____ Client case: Y or N

Reason for Quality Management Department Review (check ALL that apply)

- Was there a **delay in diagnosis or medical treatment**?
- Was there a **diagnosis error**?
- Was there a **treatment error**?
- Was there an **unexpected trauma or other safety issues during health care visit**?
- Was there a **lack of required medical record documentation**?
- Was there a **complaint about accessibility to care**?
- Was there a **complaint about a delay in obtaining an appointment or services**?
- Was there a **potential quality of care issue**?
- Was there a **quality of service issue**?
- Other - please specify:

Brief Summary of Events (Include date of service. Attach additional pages as needed.)

Referring Staff Signature

Department

Date

Phone Number

Forward this completed form and any additional documentation (i.e. copy of complaint/grievance) via facsimile to the Quality Management Department at (888) 453-4987. To maintain confidentiality of this referral, please do not copy completed form.

Clinical Practice Guidelines

Clinical practice guidelines describe the expected standard of practice for participating providers that is specific to the membership demographics and service needs and serves as the basis for a health management programs benefit interpretation and quality/performance measurements.

MARCH is committed to providing high quality services to its members. MARCH does not pressure health care providers or institutions to render care beyond the scope of their training or experience. The Quality Improvement Committee has adopted the following guidelines for its providers:

Standards for the Comprehensive Eye Examination

MARCH pays its providers a pre-established fee for each eye examination. Each participating provider has complete authority to authorize and provide ancillary testing, such as computerized visual field screenings. These ancillary tests are performed during the course of a routine eye examination, if determined to be warranted by MARCH's standards and the standards and norms of optometric and ophthalmologic care. MARCH's standards require that the comprehensive examination include at minimum the following:

1. General evaluation of the complete visual system;
2. Case history including, but not limited to chief complaint, general health, ocular history, current medications, any known allergies;
3. Ocular tensions, pupillary reflexes, cover test, gross visual fields and extra ocular muscle balance tests;
4. Refraction, biomicroscopy, and ophthalmoscopy;
5. Dilation of pupils or equivalent examination; and
6. Impressions or diagnosis, treatment plan, and indicated follow-up.

The comprehensive eye examination will include additional testing when:

- The doctor believes it is indicated;
- It is necessary to support additional benefits. For example, additional testing necessary to fit contact lenses;
- It is supported by an appropriate visual disorder diagnosis;
- A physical or mental condition exists which precludes the member from conventional testing;
- It is necessary to support a tentative, medical diagnosis for the purpose of proper medical referral and/or treatment (additional testing for an established medical condition is not covered); and/or
- Unless contractually indicated, treatment for a medical condition, whether involving the eye and its adnexa or when systemic, are to be referred through the member's medical insurance.

Clinical Criteria

The state specific criteria in the Provider Reference Guide (PRG) outlines the benefits according to the member's plan. This chart is not an indication that the member has a specific benefit. Rather this chart is used to define the medically necessary indications when the PRG indicates that the benefit is available to a member and when no regulatory/client criteria is available.

Benefit	Available When	Clinical Criteria
Eyewear after eye surgery	Determined to be medically necessary.	The stable refractive prescription changes are more than +/-0.75 diopters in any meridian or cylinder power or more than 20 degrees of axis shift or a change in add power greater than 0.50 diopters.
Oversize Lens	Needed for physiological reasons.	The pupillary distance 70mm or greater or other facial or ocular anomaly requiring a large lens.
Trifocal Lens	Member has a special need due to a job training program or extenuating circumstances.	The base prescription is greater than +/- 1.00 and a bifocal greater than or equal to 2.00
Contact Lens	Such 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:	You have one of the following diagnoses: unilateral Aphakia; Keratoconus when vision with glasses is less than 20/40; Corneal transplant when vision with glasses is less than 20/40 or Anisometropia that is greater than or equal to 4.00 diopter
Color Tinting	Light sensitivity which will hinder driving or seriously handicap the outdoor activity of such member is evident.	You have photophobia, Aniridia, Uveitis, Corneal Dystrophy, Cataracts, Albinism, or use a medication that have a side effect of photophobia.

MARCH Vision Care

Single vision eyeglasses in lieu of bifocals	If need is substantiated in member's medical record by clinical data.	The need for distance correction > +/- 1.50 diopter AND Net combination of distance RX and bifocal > +1.00 or -2.00 AND you are unable to tolerate a multifocal lens.
Progressive Lenses	If need is substantiated in member's medical record by clinical data.	Epilepsy, childhood multiple impairments.
Transitions Lenses	If need is substantiated in member's medical record by clinical data.	Chronic Iritis or Uveitis, Albinism.
Polycarbonate Lenses	If need is substantiated in member's medical record by clinical data.	<ul style="list-style-type: none"> ▪ The member has a +/-8.00; or ▪ Permanently reduced vision in one eye less than 20/60; or ▪ A facial deformity or disease that interferes with eye glass fit; or ▪ A documented occupational hazard.
Ultra Violet Coating	If need is substantiated in member's medical record by clinical data	<ul style="list-style-type: none"> ▪ Provided to members' with Aphakia, Albinism, members that have clinical evidence of Macular Degeneration, or are taking medicine that makes them more sensitive to Ultra Violet light.
Replacement due to Outgrown Glasses	If need is substantiated in member's medical record by clinical data	<ul style="list-style-type: none"> ▪ Available for children under 18 when the members' pupil distance is wider than the frame's mechanical optical center by greater than 10mm. ▪ Available when the new frame size is at least 4 mm larger than the existing frames.
Second Opinion Examination	If need is substantiated in member's medical record by clinical data	<ul style="list-style-type: none"> ▪ Available when medical chart review of the first examination shows inadequate examination, documentation, or when clinical issues are not adequately addressed.
High Index lenses	If need is substantiated in member's medical record by clinical data	<ul style="list-style-type: none"> ▪ Available when weight of a standard prescription could cause facial development issues (primarily for children).
Allergy to certain frames	If need is substantiated in member's medical record by clinical data	<ul style="list-style-type: none"> ▪ Available when a provider documents a rash or other adverse reaction to certain frame materials.
SLAB off/Prism	If need is substantiated in member's medical record by clinical data	<ul style="list-style-type: none"> ▪ Available for bifocal or trifocal prescriptions that generates greater than 2 prism diopters of imbalance at the reading plane.
Safety Frames	If need is substantiated in member's medical record by clinical data	<ul style="list-style-type: none"> ▪ Used with polycarbonate lenses based on polycarbonate criteria noted above; and ▪ Member is in and around a hazardous environment where, in the discretion of the patient, (parent) and the provider, extra ocular safety measures are required ▪ These would be considered "deluxe frames" and covered by MARCH.
Non-Standard Frames	If need is substantiated in member's medical record by clinical data	<ul style="list-style-type: none"> ▪ Used when member has facial parameters where standard frames do not fit correctly. ▪ Used when optical correction will not fit practically in a standard frames.

<p>Low Vision Rehabilitation</p>	<p>If need is substantiated in member's medical record by clinical data.</p>	<ul style="list-style-type: none"> ▪ Visual loss with best corrected visual acuity of 20/50 or worse ▪ Restriction of visual fields to be less than 20 degrees or hemianopia. ▪ Limited Contrast Sensitivity due to underlying pathology. ▪ Initial consult codes of 97241 – 97245 or 99214. ▪ Maximized medical treatment of conditions such as, but not limited to, diabetic retinopathy, macular degeneration, optic atrophy, and glaucoma. ▪ Diagnosis codes consistent with low vision pathology. Under certain circumstances, medical records may be requested. If requested, they need to demonstrate that medical, surgical, and other treatments that have been tried and failed. They must have a diagnosis as noted below AND reduced vision. The appropriate diagnosis codes are necessary, including, but not limited to: 190.00 – 190.80 340.00 352.00 (Optic) 361.00 – 361.07 362.00 – 368.90 365.00 – 365.90 368.40 – 368.47 369.00 – 369.90 377.00 – 377.90 379.50 – 379.59 Or others by pre-approval ▪ A Low Vision Rehabilitation request form must be completed and submitted. ▪ Before proceeding, prior approval is required.
<p>Dilation of Eyes</p>	<p>Initial examination required. Subsequent examinations as follows:</p>	<ul style="list-style-type: none"> ▪ All patients require a dilated fundus exam or equivalent. Once this is performed however, the provider can set the timing for the next dilated exam. Diabetics require dilation every year at a minimum, more often if they have retinopathy. Members with other certain pathology such as lattice degeneration, choroidal nevi, or retinoschisis for example, may also need a dilated exam every year. Patients with no risk factors should be dilated based on the professional judgment of the provider.

Sending a Secure Email to March Vision Care for PHI Related Data

NOTE: This document is technical in nature and will require expertise in understanding the workings of the Microsoft Exchange Server Infrastructure. The information provided in this document can be used by your IT administrator to implement secure email transmission with March Vision Care. For any support questions please call Microsoft Support for more details.

The below details are from Microsoft TechNet Article on Secure Your E-mail Traffic

Secure Your E-Mail Traffic

As part of establishing e-mail coexistence between your local Microsoft Exchange Server environments, we recommend that you implement Transport Layer Security (TLS) send and receive capability in your local Exchange Server environment. This is necessary because, during coexistence with Exchange Online, e-mail that was previously sent and received within your organization will now be sent over the Internet. The instructions in this section describe how to secure e-mail traffic on Microsoft Exchange 2000 Server and Exchange Server 2003 and Exchange Server 2007.

To secure your e-mail traffic with TLS, you will require a certificate that is granted by a recognized certification authority (CA). To implement TLS in your local Exchange Server environment, you are required to:

1. Identify the Exchange Server on which to install the certificate.
2. Generate a certificate request.
3. Acquire the certificate.
4. Install the certificate.
5. Create a Simple Mail Transfer Protocol (SMTP) connector.
6. Enable TLS.

Step 1: Identify the Exchange Server on Which to Install the Certificate

TLS should be enabled on the bridgehead server of your local Exchange Server environment. That is the computer that directs your organization's e-mail to and from the Internet. For more information about bridgehead servers and Exchange Server message routing, see [Exchange Server 2003 Message Routing Topology](#).

If you have separate bridgehead servers for sending and receiving e-mail from the Internet, you will need to acquire and install a certificate on the SMTP server of each bridgehead server computer running Exchange Server; however, you will need to set up a connector and enable TLS only on the server that is used for sending e-mail to the Internet.

NOTE:

- If your Exchange Server environment relies on an external relay server to send and receive e-mail to and from the Internet, you will need to contact the administrator of the external service about their TLS support. When TLS has been enabled on the external service, secure e-mail will flow between their relay server and Microsoft Online Services.
- If you have third-party bridgehead software or service, refer to that documentation to see how you can configure TLS.

If you have a local Exchange Server bridgehead server running the standard SMTP virtual server, continue reading this topic.

Step 2: Generate a Certificate Request

Use the Exchange System Manager in Exchange Server to generate a certificate request on your bridgehead server. You must provide the fully qualified domain name (FQDN) of the bridgehead server. For more information, see [Creating a Certificate or Certificate Request for TLS](#).

Step 3: Acquire the Certificate

Locate a recognized certification authority (CA), such as VeriSign, Comodo, or GoDaddy. Submit the certificate request file that you generated in the previous section. The CA will provide you with a certificate (CER) file that contains the certificate for your server.

Step 4: Install the Certificate

Use the Exchange System Manager to install the certificate file. You must provide the path to the certificate file that you received from the CA.

Step 5: Create an SMTP Connector

Based on your current e-mail environment, use one of the following procedures to create an SMTP connector or Send connector.

To create an SMTP connector in Exchange 2000 or Exchange 2003

1. In Exchange System Manager, right-click **Connectors**, and then click **New SMTP Connector**.

2. Type a name for the connector (for example, MicrosoftOnline).
3. On the **General** tab, select **Forward all e-mail through this connector to the following smart host**, and then type **mail.global.frontbridge.com**.

IMPORTANT: When you use the URL **mail.global.frontbridge.com**, e-mail messages are routed through servers to follow a path that balances the network load efficiently. If you want e-mail messages to be routed through servers in the United States instead of being routed through servers that might be located in other countries, type the following URL: **mail.us.messaging.microsoft.com**.

4. Under **Local Bridgeheads**, click **Add**, and then select your bridgehead server computer running Exchange Server.
5. On the **Address Space** tab, click **Add**, and then type your organization's Microsoft Online Services e-mail routing domain (for example, contoso1.microsoftonline.com).

For more information about creating SMTP connectors, see [How to configure the SMTP connector in Exchange 200x](#).

To create a Send connector in Exchange 2007

1. Open the Exchange Management Console, and then do one of the following:
 - On the computer that has the Edge Transport server role installed, select **Edge Transport**, and then, in the work pane, click the **Send Connectors** tab.
 - On the computer with the Hub Transport server role installed, in the console tree, expand **Organization Configuration**, select **Hub Transport**, and then, in the work pane, click the **Send Connectors** tab.
2. In the action pane, click **New Send connector**. The new SMTP Send Connector wizard starts.
3. On the **Introduction** page, do the following:
 - In the **Name** field, type a meaningful name for the connector (for example, type MicrosoftOnlineServices)
 - In the **Select the intended use for this Send connector** field, select **Internet**, and then click **Next**.
4. On the **Address Space** page, click **Add**.
5. In the **Add Address Space** dialog box, in the **Address** field, type your organization's Microsoft Online Services e-mail routing domain (for example, contoso1.microsoftonline.com), and then click **OK**.
6. On the **Address Space** page, click **Next**.
7. On the **Network Settings** page, select **Route all mail through the following smart hosts**, and then click **Add**.
8. In the **Add Smart Host** dialog box, select **Fully qualified domain name (FQDN)**, type **mail.global.frontbridge.com**, and then click **OK**.

IMPORTANT: When you provide the URL **mail.global.frontbridge.com**, e-mail messages are routed through servers to follow a path that balances the network load efficiently. If you want e-mail messages to be routed through servers in the United States instead of being routed through servers that might be located in other countries, type the following URL: **mail.us.messaging.microsoft.com**.

9. On the **Network Settings** page, click **Next**.
10. On the **Configure Smart host authentication settings** page, select **None**, and then click **Next**.

The Source Server page appears only on a computer with the Hub Transport server role installed. By default, the Hub Transport server that you are currently working on is listed as a source server.

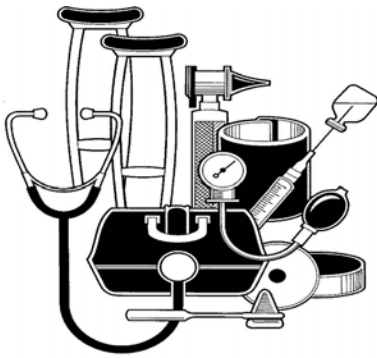
11. To add a source server, click **Add**.
12. In the **Select Hub Transport and subscribed Edge Transport servers** dialog box, select one or more Hub Transport servers in your organization, and then click **OK**.

Step 6: Enable TLS

After you install the certificate, your server will be able to receive TLS e-mail. However, it cannot send TLS e-mail until you enable TLS.

To enable TLS

1. In Exchange System Manager, expand **Connectors** and locate the MicrosoftOnline connector that you created in the previous procedure.
2. Right-click the connector and then click **Properties**.
3. On the **Advanced** tab, click **Outbound Security**, and then select **TLS Encryption**.



Having problems getting health care from TennCare?

Call your health plan first. Their free phone number is on your TennCare card.

Don't have your card? OR, still have problems AFTER you call your health plan? Then, call TennCare Solutions for free at **1-800-878-3192**. They can help you with your problem OR help you file an appeal. An appeal is one way to fix problems with TennCare.

You have the right to appeal if:

- TennCare says **NO** when you ask for health care.
- OR, TennCare stops or changes your health care.
- OR, you have to wait too long to get health care.
- OR, you have health care bills you think TennCare should have paid for, but didn't.
- OR, there's some other reason you can't get health care when you need it.

You **only** have **30 days** to appeal after you find out that there is a problem.

You can **ask someone to help you file an appeal**.

Usually, your appeal is decided within **90 days** after you file it. What if you can't wait 90 days for your health care or medicine? **If you have an emergency**, your appeal can be decided sooner—usually within 31 days (but sometimes up to 45 days).

An emergency means if you don't get the care sooner than 90 days:

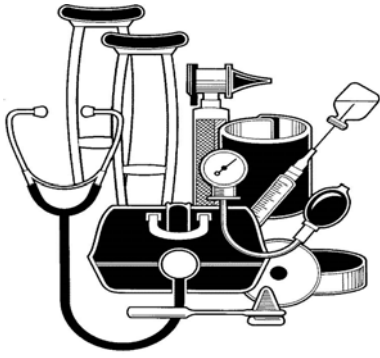
- You will be at risk of serious health problems OR you may die.
- OR, it will cause serious problems with your heart, lungs, or other parts of your body.
- OR, you will need to go into the hospital.

If you think you have an emergency, you can ask TennCare for an emergency appeal. Your appeal may go **faster** if your **doctor signs your appeal saying that it is an emergency**. What if your doctor **doesn't** sign your appeal, but **you ask** for an emergency appeal? **TennCare will ask your doctor** if your appeal is an emergency. If **your doctor** says it's **not** an emergency, TennCare will decide your appeal within 90 days.

Have questions? Need help? Want to appeal?

Call TennCare Solutions for free at **1-800-878-3192**. They can help solve many problems **before** you have to appeal. They can also take your appeal over the phone.

We do not allow unfair treatment in TennCare. No one is treated differently because of race, color, birthplace, religion, language, sex, age, or disability. Do you think you've been treated unfairly? Then call the Family Assistance Service Center for free at **1-866-311-4287**.



¿Tiene problemas para obtener atención médica en TennCare?

Llame a su plan de salud primero. El teléfono gratuito se indica en su tarjeta de TennCare.

¿No tiene su tarjeta? O, ¿sigue teniendo problemas DESPUÉS de haber llamado a su plan de salud? Entonces, llame a TennCare Solutions gratis al **1-800-878-3192**. Ellos le pueden ayudar con su problema O le pueden ayudar a presentar una apelación. Una apelación es una manera de corregir problemas con TennCare.

Usted tiene el derecho de apelar si:

- TennCare dice que **NO** cuando usted pide atención médica.
- O, TennCare suspende o cambia su atención médica.
- O, tiene que esperar demasiado tiempo para recibir atención médica.
- O, tiene cuentas de atención médica que usted piensa que TennCare debería haber pagado pero no lo hizo.
- O, hay alguna otra razón por la cual no puede obtener la atención médica cuando la necesita.

Usted **solamente** tiene **30 días** para apelar después de enterarse de que hay un problema.

Usted puede **pedirle a alguien que le ayude a presentar una apelación**.

Usualmente las apelaciones se deciden en un plazo de **90 días** de haber sido presentadas. ¿Qué debe hacer si no puede esperar 90 días para acudir al médico o tomar su medicina? **Si tiene una emergencia**, su apelación se puede decidir más pronto, usualmente en un plazo de 31 días (pero a veces hasta 45 días).

Una emergencia significa que si usted **no** obtiene la atención médica o la medicina antes de 90 días:

- Correrá riesgo de problemas graves de salud O podría morir.
- O, le causará graves problemas del corazón, los pulmones u otras partes del cuerpo.
- O, tendrán que hospitalizarlo.

Si usted piensa que tiene una emergencia, puede pedirle a TennCare una apelación de emergencia. Su apelación podría ser **más rápida** si su **médico firma su apelación diciendo que es una emergencia**. ¿Qué debe hacer si su médico **no** firma su apelación pero usted **pide** una apelación de emergencia? **TennCare le preguntará a su médico** si su apelación es una emergencia. Si **su médico** dice que **no** es una emergencia, TennCare decidirá su apelación en un término de 90 días.

¿Tiene preguntas? ¿Necesita ayuda? ¿Desea apelar?

Llame gratis a TennCare Solutions al **1-800-878-3192**. Ellos pueden ayudarle a resolver muchos problemas **antes** de que tenga que apelar. También pueden aceptar su apelación por teléfono.

TennCare no permite el trato injusto. Nadie recibe un trato diferente debido a su raza, color, lugar de nacimiento, religión, idioma, sexo, edad o incapacidad. ¿Cree que lo han tratado injustamente? Entonces, llame gratis al Centro de Servicio para Asistencia Familiar al **1-866-311-4290**.

Wholesale/Retail Fee Schedule

CPT Code	Mod	Description	Lens Style	Wholesale	Retail Max
V2744		TINT PHOTOCHROMATIC LENS/ES	BF, TF, PAL	\$55.50	\$75.50
V2744		TINT PHOTOCHROMATIC LENS/ES	SV	\$45.50	\$65.50
V2744		TINT PHOTOCHROMATIC LENS/ES (GLASS)	BF, TF, PAL	\$40.50	\$60.50
V2744		TINT PHOTOCHROMATIC LENS/ES (GLASS)	SV	\$25.50	\$45.50
V2745		TINT, ANY COLOR/SOLID/GRAD		\$3.50	\$23.50
V2750		ANTI-REFLECTIVE COATING		\$25.50	\$45.50
V2750	TG	ANTI-REFLECTIVE COATING PREMIUM		\$38.00	\$58.00
V2755		UV LENS/ES		\$3.50	\$23.50
V2760		SCRATCH RESISTANT COATING	SV	\$3.50	\$23.50
V2760		SCRATCH RESISTANT COATING	BF, TF, PAL	\$4.50	\$24.50
V2761		MIRROR COATING		\$50.00	\$100.00
V2762		POLARIZATION, ANY LENS	PAL	\$50.50	\$70.50
V2762		POLARIZATION, ANY LENS	TF	\$45.50	\$65.50
V2762		POLARIZATION, ANY LENS	BF	\$40.50	\$60.50
V2762		POLARIZATION, ANY LENS	SV	\$35.50	\$55.50
V2780		OVERSIZE LENS/ES		\$2.50	\$22.50
V2781		PROGRESSIVE LENS PER LENS	PAL Premium	\$50.50	\$70.50
V2781		PROGRESSIVE LENS PER LENS	PAL Premium Mini	\$50.50	\$70.50
V2781		PROGRESSIVE LENS PER LENS	PAL Standard	\$36.50	\$56.50
V2781		PROGRESSIVE LENS PER LENS	PAL Standard Mini	\$36.50	\$56.50
V2782		LENS, 1.54-1.65 P/1.60-1.79G (High Index 1.54-1.65)	BF, TF, PAL	\$25.50	\$45.50
V2782		LENS, 1.54-1.65 P/1.60-1.79G (High Index 1.54-1.65)	SV	\$23.50	\$43.50
V2783		LENS, >= 1.66 P/>=1.80 G (High Index >=1.66)	BF, TF, PAL	\$60.50	\$80.50
V2783		LENS, >= 1.66 P/>=1.80 G (High Index >=1.66)	SV	\$40.50	\$60.50
V2784		LENS POLYCARB OR EQUAL (Polycarbonate)	BF, TF, PAL	\$10.50	\$30.50
V2784		LENS POLYCARB OR EQUAL	SV	\$6.50	\$26.50
V2799		FT 35	FT 35	\$5.50	\$25.50
V2799		FT 45	FT 45	\$15.50	\$35.50
V2799		EXECUTIVE	Executive	\$12.50	\$32.50
V2799*	PS	EDGE POLISH SV*	SV	\$5.50	\$25.50
V2799*	PM	EDGE POLISH MF*	BF, TF, PAL	\$5.50	\$25.50
V2799*	RD	RIMLESS DRILL *		\$15.50	\$35.50

The rates listed are per pair.

* Use of this code requires that you check the appropriate box on the lab order form.