MARCH® Vision Care
Louisiana Provider Reference Guide

Disclaimer:

Provider Reference Guide Notice of Updates Effective June 2020:

Throughout the PRG:
- Updated mailing address
- Use "us", "we", "our" to refer to MARCH®
- Use "you", "your" to refer to providers
- Providers.eyesynergy.com to refer to eyeSynergy®
- Removed references to other states

Section 1: General Information:
- Moved "About the Provider Reference Guide" from 1.1 to page 3
- 1.5 – Updated fax and email address

Section 2: Eligibility and Benefits:
- 2.2 – Updated 2nd paragraph to ensure it identifies the member knowingly signed a waiver

Section 3: Billing and Claim Procedures:
- 3.2 – Simplified verbiage in second to last paragraph

Section 4: Standards of Accessibility:
- 4.2 – Updated verbiage regarding who coordinates access monitoring

Section 7: Health Care Services:
- 7.1 – Updated "Quality Improvement Program" to "Quality Management Program"
- 7.2 – Updated verbiage
- 7.3 – Updated verbiage

Section 10: Language Assistance Program:
- Removed Exhibit

Section 11: Cultural Competency:
- Included link to Cultural & Linguistics page on marchvisioncare.com

Exhibits:
- Removed all Exhibits that are not used in Louisiana
- All Exhibits after Exhibit B have been renumbered

Exhibit F:
- Updated "Quality Improvement Committee" to "Health Care Services"

About the Provider Reference Guide

MARCH® is committed to working with our contracted providers and their 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 ("PRG") was revised in June 2020. Reviews and updates to this guide are conducted as necessary and appropriate. Update notifications are distributed as they occur through provider newsletters. Recent newsletters and a current version of this guide are always available on marchvisioncare.com. To request a current copy of the Provider Reference Guide on CD, please contact our Provider Relations Department at (844) 526-2724.

Terms used in this manual include the following:

- "You", "your", or "provider" refers to any provider subject to this PRG (with the exception the verbiage in Section 6: Members Rights and Responsibilities – "you" and "your" refer to the member);
- "Us", "we", "our", "MARCH®" refers to MARCH® Vision Care for those products and services subject to this PRG.

We would like to thank you for your participation in the delivery of quality vision care services to our members.

Exhibits

1.1 Contact Information

Phone Number	(844) 526-2724
Fax Number	(877) 627-2488
General Website	www.marchvisioncare.com
Provider Website	providers.eyesynergy.com
Mailing Address	MARCH Vision Care 6601 Center Drive West, Suite 200 Los Angeles, CA 90045
Lab and Contact Lens Orders	providers.eyesynergy.com

1.2 eyeSynergy®

We are proud to offer eyeSynergy® (providers.eyesynergy.com), our web-based solution for electronic transactions. On providers.eyesynergy.com, you can:

- Verify member eligibility and benefit status.
- Obtain co-payment and remaining allowance information.
- Submit and track claims and lab orders electronically to reduce paperwork and eliminate costs associated with paperwork.
- Create new accounts and grant access to multiple users with user administration capabilities.
- Generate confirmation numbers for services (for the definition of "confirmation number", refer to section 2.1).
- Obtain detailed claim status including check number and paid date.
- Access online resources such as a current copy of the Provider Reference Guide, state-specific benefits, and the eyeSynergy® User Guide.

Providers.eyesynergy.com is provided free of charge to all participating providers. To access providers.eyesynergy.com, you can either:

- log onto marchvisioncare.com and click on the orange and blue eyeSynergy® link located at the top of the page; or
- go directly to providers.eyesynergy.com.

IMPORTANT: If you choose not to submit lab orders through providers.eyesynergy.com, you **must** fax your order to our Customer Service Center at (855) 640-6737.

Registration

First time users must register before accessing providers.eyesynergy.com. Please be prepared to enter the tax identification number, office phone number, and Registration number*. Once verified, you will complete the registration process, which includes creating a unique user name and password. The first person registering for the providers.eyesynergy.com account will be assigned the Account Administrator role for that account.

**Providers can contact the Provider Relations Department, to access their unique Registration number.*

Logging In

Once registered, you may log into providers.eyesynergy.com with their user name and password. Please note that passwords are case-sensitive. As a security feature, you will be asked to renew your password every 60 days. You can reset your own expiring password by selecting the "change your password" link in the message banner on the providers.eyesynergy.com home page. If the password has already expired, providers.eyesynergy.com will automatically redirect you to the password reset page upon login. You can also retrieve a forgotten password, by selecting the "Forgot your Password?" link on the sign-in page. As an additional safety feature, you are required to either call us or contact your Account Administrator to have your password reset after 5 failed log-in attempts.

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 providers.eyesynergy.com.

1.4 Interactive Voice Recognition (IVR) System

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

- Eligibility and benefits.
- Confirmation numbers.
- Claim status.

The IVR System may be accessed by calling us at (844) 526-2724 . Select the provider option and follow the prompts to verify eligibility and benefits, request a confirmation number, or check claim status.

Registration

First-time users must register before accessing the IVR 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.

Logging In

Once registered, you may log into the IVR 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.

1.3 Electronic Funds Transfer (EFT)

We are pleased to offer electronic funds transfer (EFT) and electronic remittance advices (ERAs) as the preferred methods of payments and explanations. EFT is the electronic transfer, or direct deposit, of money from us directly into your bank account. ERAs are electronic explanations of payment (EOPs). We partner with PaySpan Health, Inc. ® (PaySpan) – a solution that delivers EFTs, ERAs/Vouchers, and much more.

There is no fee for enrolling in or using PaySpan. PaySpan delivers ERAs via their website allowing straightforward reconciliation of payments to empower you to reduce costs, speed secondary billings, improve cash flow, and help the environment by reducing paper usage.

We offer you the option to receive payments electronically deposited into your bank account or by traditional paper check.

Provider Benefits

As a provider, you gain immediate benefits by signing up for electronic payments from us through PaySpan:

- 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 the registration process, please visit the PaySpan website at payspanhealth.com or contact them directly at (877) 331-7154

1.4 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 us 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 us in writing, include, but are not limited to:

- Practice phone and fax number.
- Practice address.
- Billing address (requires W9).
- Tax identification number (requires W9).
- Office hours.
- Practice status regarding the acceptance of new members, children, 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
6601 Center Drive West, Suite 200
Los Angeles, CA 90045
Fax: (877) MARCH-88 or (877) 627-2488

Email: visionnominations@uhc.com

2.1 Eligibility and Benefit Verification

We 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 an 11-digit identification number generated when you or your office verifies member eligibility for requested benefits and services through us. Verification is obtained by speaking with a Call Center Representative, or by accessing the IVR or providers.eyesynergy.com. Confirmation numbers affirm member eligibility for requested benefits and services. However, confirmation numbers are not required for all services. You are strongly encouraged to verify benefits and eligibility on the date services will be rendered.

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

- Replacement frames and lenses.
- Medically necessary contact lenses for Medicaid members.
- Two pairs of glasses in lieu of bifocals.
- Prescription sunglasses.

The confirmation request process requires the provider to attest that a member meets the defined benefit criteria, as outlined in the state specific Provider Reference Guide, when applicable. Upon attestation, a confirmation number is generated.

Example: A member is diagnosed with keratoconus and requires contact lenses. You are 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.

The following are examples of instances in which a confirmation number does not guarantee payment of a claim:
- The member is not eligible on the date of service.
- The member's benefit exhausted prior to claim submission.

IMPORTANT: We perform retrospective random chart audits on claims submitted for services requiring attestation.

Covered Benefits

A listing of covered benefits may be accessed by:

- Logging into providers.eyesynergy.com:
  - Resources > Provider Reference Guide > select applicable state from the drop-down menu;
  - Benefits and Eligibility menu in providers.eyesynergy.com;
- Going to marchvisioncare.com >Doctors and Office Staff > Provider Resources. Benefits may be accessed by selecting the desired state 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 providers.eyesynergy.com 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) prohibits you 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 these circumstances, prior to rendering non-covered service the provider must inform the member and is required to have the member knowingly sign a waiver or statement acknowledging that the service is not covered and that the member is

financially responsible. **Failure to do so may result in the provider being financially responsible for those services even if the member verbally agreed to the non-covered service or paid for the non-covered service up-front.**

Acceptable Waivers

A general waiver stating "the member is responsible for all services not covered by insurance" is not a valid waiver, as it does not specifically define which services are not covered and the amount the member is expected to pay.

The provider is required to have the member sign a waiver form that clearly explains that the specific service/procedure is not covered and that the member acknowledges that he/she will be responsible for the cost of the service(s).

We recommend using the Non-Covered Service Fee Acceptance Form (available in both Spanish and English) in Exhibit A, but it is not required. If the provider chooses to use another form in place of our Non-Covered Service Fee Acceptance Form, it must contain the following elements:

- Documentation of the specific services provided (including dates of service, description of procedure/service, amount charged).
- The member's signed acknowledgement that he/she understands the service is not covered and he/she is financially liable for the services provided.

Once the waiver is signed, the member must receive a copy of the signed waiver. A copy of the signed waiver must also be placed in the member's medical chart.

3.1 Claim Submission

Preferred Method

We prefer to receive claims electronically via providers.eyesynergy.com, our web-based solution for electronic transactions. providers.eyesynergy.com helps reduce claim errors resulting in faster processing times.

Clearinghouse Submissions

We have a direct agreement with Optum to accept electronic claims. Our payor ID for Optum is 52461.

Paper Claims

Paper claims will be accepted if submitted on an original red CMS-1500 form that is typed or computer generated with clear and legible black ink. Paper claims that are handwritten, contain light ink, or submitted on a copied CMS-1500 form are not acceptable and will be returned. Paper claims in the approved format can be mailed to:

MARCH® Vision Care
6601 Center Drive West, Suite 200
Los Angeles, CA 90045

Clean Claim Definition

We define a clean claim as a bill from a health care provider that can be processed without obtaining additional information from the provider of service or from a third party. An unclean claim is defined as any claim that does not meet the definition of a clean claim. State specific exceptions to our clean claim definition are provided below.

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.
- The rendering and billing National Provider Identifier (NPI).
- Date of service.
- Current and appropriate ICD-10 codes.
- Service units.
- Current and appropriate CPT/HCPCS codes.
- Current and applicable modifier codes.
- Place of service.
- Usual and customary charges.

We have the right to obtain further information from a you or your office upon request when a submitted claim has errors or when the health plan or we have 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

We reaffirm our adoption of CPT coding rules established by the American Medical Association, Medicaid, and Medicare Regulations, and applicable law:

- For an initial examination of a new patient, providers can use a new eye examination billing code. A provider may also bill for a new member examination if a member has not been examined for 3 consecutive years by that provider/group.
- A routine examination for an established patient in subsequent years can be billed as a follow up examination.
- Providers can continue to bill this way unless the member has not been examined for 3 consecutive years at that office, at which time the service may be billed with a new member examination code as indicated above.

- A medical examination may be billed if the member has the benefit as indicated in MARCH's State Specific Provider Reference Guide.
- Follow up examinations for the same medical condition noted above may be billed based on the acuteness of the condition and the documented services provided.
- According to **Medicare Carriers Manual Section 15501.1 H,** if more than one evaluation and management (face-to-face) service is provided on the same day to the same patient, whether by the same provider or more than one provider in the same specialty in the same group, only one evaluation and management service may be billed. Optometrists and Ophthalmologists from the same group are considered the same specialty, for covered services provided within the scope of optometry, in each applicable state. Therefore, a comprehensive eye examination and a medical examination, such as a diabetic eye evaluation, may not be billed on the same date of service. Instead of billing two examinations separately, providers should select a level of service representative of the combined visits and submit the appropriate code for that level. The less extensive procedure is bundled into the more extensive procedure. The services furnished and associated medical record documentation must meet the definition of the CPT code billed.
  This is especially important when providers bill the highest levels of visit and consultation codes. For example, to bill a comprehensive eye exam **-** new patient, the patient may not have been examined by a provider in the practice within the past three years, the history must meet the CPT code's definition of a comprehensive history, and all components of an examination need to be recorded, including dilation or equivalent. The provider may use professional discretion whether to dilate at subsequent visits for existing patients, but dilation is expected at the initial visit and at least every 3 years.
- Medical necessity of a service is the overarching criterion for payment, in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted or performed. In a similar vein, it would not be warranted to bill for services if medical necessity is not established by standards of medical or optometric practice.
- The date of service on the claim should always match the date of service on the medical record and the medical record should include complete documentation related to all billed services.
- The comprehensive nature of the examination codes includes a number of tests and evaluations. Some of these procedures have their own CPT code. When these procedures are broken out and billed in conjunction with a comprehensive examination is referred to as "unbundling" and is an inappropriate billing practice. This type of billing practice will be subject to action from a health plan or insurance carrier.

The most common errors include:

- Billing for a dilated fundus examination with the indirect ophthalmoscope and using the codes 92225, 92226, or separately billing visual fields using 92081.
- Billing color vision testing using 92283.
- Billing sensory motor testing using 92060
- Billing gonioscopy using 92020.

The appropriate and correct use of the CPT (procedure) and diagnosis code is the responsibility of every health care provider.

In all instances, the medical record should reflect the intensity of examination that is being billed. We will audit claim submissions to ensure compliance. Audits will include the review of medical records, including the records documenting all test results billed (i.e. photos, OCTs, etc.).

In an effort to improve HEDIS and Star Ratings performance, we require you to submit CPT II and ICD-10 codes, on claims, to demonstrate performance and diagnosis for diabetic members. Please see Exhibit K: HEDIS/Stars Performance Reporting for more information.

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 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.

CMS mandates 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.

3.5 Telemedicine

If telemedicine is acceptable in your state, you must be approved in advance in order to submit claims for telemedicine exams. Please contact us for instructions. Additional credentialing may be required, including verification of licensure in states where members are located. Once approved to submit claims, you may use Place of Service Code 02 with exam codes 92002, 92004, 92012, or 92014 on your electronic (EDI) or paper claim or online. Claims for materials must be filed separately with the appropriate Place of Service Code. Members must be informed in advance when exams are performed via telemedicine technology.

3.6 Frame Warranty

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

If you determine that the defective frame is covered under the warranty, please contact us at (844) 526-2724. Please do not send broken glasses to us or the contracted lab.

3.7 Order Cancellations

Orders placed with our 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 us at (844) 526-2724.

3.8 Non-Covered Lens Options

In most states, a member may opt to add a non-covered lens option such as tinting, anti-reflective coating, etc. to their eyeglass order. The process to do so is as follows:

Medicaid:

1. If a member chooses non-covered lens options such as AR, UV, tinting, etc., the provider should charge the member up to, but not to exceed, the retail amount listed on our Wholesale/Retail Fee Schedule (Exhibit G).

2. When the order for the non-covered lens options is complete, the contracted lab will submit an invoice to us for the non-covered lens options ordered. We reimburse the contracted lab directly for any materials ordered.

3. We will deduct the wholesale amount listed in Exhibit G from your claim payment with the Explanation of Payment (EOP) code of ”LABDED.” You may retain the difference between the retail amount charged and the wholesale amount.

Medicare:

The Medicare benefit is an allowance based benefit. Any non-covered lens options are counted towards the member’s benefit allowance amount. Please see Section 3.8 *Billing of Medicare Allowance* for further clarification.

As a reminder, the Medicaid or Medicare member must agree in writing and in advance to any non-covered service/procedure. Please refer to Section 2.2 for further clarification.

3.9 Billing 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". You 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. Member is responsible for charges exceeding their benefit allowance.

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.

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.

3.10 Claim Filing Limits

We impose claim filing limits in accordance with the applicable provider services agreement and governing entity regulations. Claim filing limits are provided below as days and begin on the date services are rendered.

State	Medicaid	Medicare	Medicare-Medicaid Plan (MMP)
Louisiana	365	365	-

Proof of Timely Filing

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

The following are examples of acceptable forms of documentation to show "good cause" for delayed filing:

- Explanation of payment/denial from the primary payor dated within the timely filing period.
- Explanation of payment/denial from the believed payor dated within the timely filing period.

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.

3.11 Prompt Claim Processing

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 us. However, in some cases such as with Medicare plans, the time limit begins on the date the claim is received by an associated entity.

State	Medicaid	Medicare	Medicare-Medicaid Plan (MMP)
Louisiana	30[1]	60	-

[1]At least 90% of all clean claims will be processed or paid within fifteen (15) business days of the receipt date.

3.12 Corrected Claims

A corrected claim may be submitted through providers.eyesynergy.com, under the Claims Details page. Providers will only have the option to submit a corrected claim after the claim has been paid. When using the "correct claim" function in providers.eyesynergy.com, providers are to indicate the reason for the correction in the note section field. If attachments are required to process the claim, please do not submit the corrected claim through providers.eyesynergy.com. Instead, please submit your corrected claim on a red CMS-1500 form along with the proof of timely filing or coordination of benefits attachment(s).

All other corrected claims, not submitted via providers.eyesynergy.com during the initial claim submission, must also be submitted on a red CMS-1500 form. 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
6601 Center Drive West, Suite 200
Los Angeles, CA 90045

Corrected claim filing limits are provided below as days and begin on the date services are rendered, unless otherwise noted.

State	Medicaid	Medicare	Medicare-Medicaid Plan (MMP)
Louisiana	365	365	-

3.13 Provider Disputes

We are committed to ensuring provider satisfaction. Our Customer Service department can be reached at (844) 526-2724. In addition to contacting our customer service department, our Provider Dispute Resolution Process provides a mechanism for you to communicate disputes in writing. We prefer to receive Provider Appeals electronically via the providers.eyesynergy.com Provider Appeal Resolution online form.

Provider Dispute Types

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

Provider Dispute Resolution Process

1. The provider submits our 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.
2. We will acknowledge receipt of all participating provider disputes as follows:
   a) Electronic disputes received from participating providers will be acknowledged by us within two (2) working days of the date we received it.
   b) Paper disputes received from participating providers will be acknowledged by us within fifteen (15) working days of the date we received it.
3. Provider disputes that do not include all required information will be returned to the submitter for completion within forty-five (45) working days from the date of receipt.
4. An amended dispute which includes the missing information may be submitted to us within thirty (30) working days of receipt of the request for additional information.
5. Amended disputes not received within thirty (30) working days will be closed and acknowledged within forty-five (45) working days from the date the request for additional information was due.
6. We will issue a written determination explaining the reasons for its determination within forty-five (45) working days from the date of receipt of the dispute or receipt of the requested information (amended dispute).
7. You may appeal a second level decision of the Provider Dispute Resolution Process directly to the health plan.

Please submit your request by mail to:

MARCH® Vision Care
Attention: Claims Appeals
6601 Center Drive West, Suite 200
Los Angeles, CA 90045

Submit your request electronically by using the link: https://forms.marchvisioncare.com/Forms/PDR.

3.14 Overpayment of Claims

If we determine a claim was overpaid or was paid incorrectly, we will notify the provider in writing. Overpayment refund requests are issued in accordance with the applicable provider services agreement and governing entity regulations. We do not issue overpayment refund requests more than three hundred and sixty five (365) days following the payment date, even when permitted by governing entity regulations.

Once an overpayment refund request is issued, if we do not receive an overpayment dispute request or refund of the overpaid amount within thirty (30) days*, we may offset the overpayment against future claim payments if not prohibited by governing entity regulations.

3.15 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.

You are prohibited from balance billing our members. The explanation codes we provide in the explanation of payment remittance advice clearly indicate when balance billing for a service is not permissible.

3.16 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. 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. If the secondary plan is billed without an attached primary insurance EOP, the claim will be contested and the primary insurance EOP will be requested. Medicaid/Medicare will not make an additional payment if the amount received from the primary insurance company is equal to or greater than the Medicaid/Medicare reimbursement amount.

We processes COB claims in accordance with the applicable provider services agreement and governing entity regulations. When we are the secondary payor, we are 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.

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

Please mail COB claims to:

MARCH® Vision Care
6601 Center Drive West, Suite 200
Los Angeles, CA 90045

4.1 Access Standards

Our 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, we have established the following accessibility standards, when otherwise not specified by regulation or by client performance standards:

- Appointments for routine, non-urgent eye examinations and eyeglass or contact lens fittings and dispensing are available within thirty (30) 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.
- When we are contractually responsible for more than routine eye examinations, appointments for urgent/emergent eye care services, within the optometrist's or ophthalmologist's scope of practice, are available within twenty-four (24) hours.
- You are required to employ an answering service or a voice mail system during non-business hours, which provide instructions to members on how they may obtain urgent or emergency care. The message may include:
  - An emergency contact number (i.e. cell number, auto forwarding call system, pager);
  - Information on how to contact another provider who has agreed to be on-call to triage or screen by phone, or if needed, deliver urgent or emergency care; and/or
  - Instructions to call 911 or go to the local emergency room.
- Members with scheduled appointments will wait no more than thirty (30) minutes from their appointment time 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.

Note: Centers for Medicare & Medicaid Services, HHS - Timely access - Each MCO, PIHP, and PAHP must do the following: (i) Meet and require its providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services. (ii) Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees. (iii) Make services included in the contract available 24 hours a day, 7 days a week, when medically necessary. (iv) Establish mechanisms to ensure compliance by providers. (v) Monitor providers regularly to determine compliance. (vi) Take corrective action if there is a failure to comply.

4.2 Access Monitoring

We are responsible for monitoring compliance with accessibility standards. We 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 our employees or otherwise noted.

The following are some of the mechanisms that will be employed by us 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 us 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.
- Our 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 Member Satisfaction Survey to comment on the service and products received from us and our providers.
- 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.

5.1 Protocol for Member Grievances and Appeals

Definitions

Grievance	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. A grievance would reflect a situation where a denial has not been issued and there is dissatisfaction.
Appeal	A request for reconsideration of an action/initial determination/request for service or claim that was denied, deferred, and/or modified where a notice of action (denial letter) was issued. The denial may occur before services are rendered or as a claim or partial claim denial.

It is our policy to address and resolve member grievances 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 grievance and/or submit an appeal through the Grievance and Appeal process. Members shall be directed to call the phone number, on the back of their health plan identification card, to obtain a grievance form or to file a grievance. We 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 grievance/appeal investigation. According to your contract with us, you are required to furnish medical records of our members for whom claims have been submitted. Member authorization is not required to release medical records per state and federal regulations. We will ensure that grievances and appeals will be investigated, and resolved in a regulatory compliant time frame, following related policies and procedures.

Discrimination against members who have filed a grievance is not permitted. All members are afforded the opportunity to effectively communicate with us regardless of cultural differences, linguistic limitations or other communicative impairments. When delegated to do so, we ensure that all members have access to, and can fully participate in the grievance system by providing assistance to those with limited English proficiency or with a visual or other communicative impairment.

Our providers and staff are proficient in many of the languages commonly spoken by non-English speaking members. When necessary, interpretation and translation services may be used to enable effective communication with members regarding grievances. Members who are hearing or speech impaired and use a telecommunication device with a keyboard and visual display can communicate with us regarding grievances by using the California Relay Service (TTY). You may contact us for assistance with this process. We provide grievance process assistance to visually impaired members and ensures verbal communications are conducted in a prompt manner.

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/Optometrist reviewer for evaluation and recommendations. 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 Severity Level that demonstrates the severity of breach in quality, along with the outcome and required intervention, if appropriate. Please refer to Exhibit D for Severity Levels of various issues and possible actions.

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

6.1 Member Rights

Each member has rights and responsibilities:

You have the right to be treated equally.
MARCH® and our providers cannot discriminate against you based on:

- Age, sex, race, skin color, religion or sexual orientation.
- The country you or your ancestors came from.
- Marital status (married, divorced, single or in a domestic partnership).
- Health care needs and how often you use services.
- History as a victim of domestic violence.

You have a right to file a complaint if you think you have been treated differently because of your race, color, birthplace, language, sex, age, religion, disability, or any status protected by federal or state civil rights laws. If you complain or appeal, you have the right to keep getting care without fear of bad treatment from your Provider, MARCH® or your Plan.

You have the right to informed consent.
Informed consent means that before you agree to a treatment or procedure, you understand:

- What the treatment or procedure is.
- The possible risks and benefits of the treatment or procedure.
- Other treatments or procedures that exist and what their risks and benefits are.
- What you can expect if you choose not to have the treatment or procedure.

You have the right to help to make decisions about your health care and to refuse or accept a treatment or procedure. The only exception to this right is when it is an emergency and there is no time to get your informed consent without risking your health.

You have the right to have a copy of your medical records.
You may ask for and get information about your medical records according to federal and state laws. You can see your medical records, get copies of your medical records, and ask to correct your medical records if they are wrong.

You have the right to keep your medical records private.
You may ask MARCH® to send you a statement that describes our privacy and confidentiality policies and procedures. Please call MARCH® at (844) 526-2724.

You have the right to file appeals or complaints about your Provider or your care, MARCH, your Health Plan. Contact your Health Plan at the number on the back of your Identification Card and they will assist you.

6.2 Member Responsibilities

It is your responsibility to:

- Understand your benefits.
- Pay your co-pays, amounts for non-covered items or amounts above your allowance (when applicable).
- Give your doctors and other providers all the information you can to help them decide on your care.
- Keep your appointments. If you need to cancel an appointment, let the office know ahead of time and schedule a new appointment.
- Show respect to your providers, to the MARCH® staff and to other members.
- Notify your Health Plan of a change of address or telephone number (when applicable).

7.1 Quality Management Program

Our Quality Management Program is our quality assurance program that provides a planned, systematic, and comprehensive approach to monitor and evaluate quality improvement initiatives that both directly or indirectly influence our ability to meet our goal to deliver high quality of services to all of our customers that includes members, providers and clients. The scope of the program's focus is evaluated on an annual basis and includes, but is not limited to monitoring activities in the following areas: delivery of quality of care, complaints and grievances, member access and availability to care, health education, satisfaction surveys, and others.

7.2 Coordination with Primary Care Providers

Providers are asked to contact a member's Primary Care Provider (PCP) should they notice any additional medical needs while providing vision services. In an example, if a significant change is observed in an eye exam of a diabetic member, please call the PCP. The assigned PCP is noted on the front of the member's ID card. Additionally, you may contact the member's Health Plan directly for assistance in coordinating additional medical needs for the member.

7.3 Clinical Decision Making

Our clinical decisions are based only on appropriateness of care and service, and existence of coverage. We do 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.

7.4 Medical Charting for Eye Care Services

In an effort to ensure quality of services and to combat fraud, waste and abuse, our Health Care Services Department perform audits of medical records used as supporting documentation to substantiate post-payment claims submissions. Our PEER Review Sub-Committee has identified over seventeen (17) elements necessary in a comprehensive eye examination and, using a proprietary scoring system; records are evaluated and assigned a point value for each element based on their hierarchy of significance. The cumulative total point value is then used to determine the adequacy of the supporting documentation. When a comprehensive examination is billed, if any of the critical elements are skipped 10 out 10 times, the audit score automatically defaults to the failing Severity Level score 4. These critical elements include: biomicroscopy/slit lamp exam, intraocular pressure, optic nerve head evaluation, and dilated fundus exam.

If any of these elements are missing or inadequately documented in the medical chart, we may send a request for a corrective action plan ("CAP"), asking you to address the documentation issue(s) identified during the audit.

Below are items to keep in mind for ensuring your medical chart supporting documentation is sufficient to pass an audit:

Paper Charts

- The encounter must record critical general health care information as well as the traditional refractive data. Details of a patient's medicine list and a formal review of systems are critical elements of the eye exam.
- Notes on pulse, blood pressure and body mass index.
- You must query about tobacco use and alcohol use, assess patient orientation to time and place, and rate the patient's emotional state during the exam.

Traditional paper charts may need to be updated to meet these standards. In addition to the requirements noted above, the form must include adequate space for a detailed slit lamp exam, notations for drugs that are administered during the exam, and a detailed posterior pole exam. A sample form that meets these requirements can be found in Exhibit I.

Electronic Medical Records

If you are using Electronic Medical Records ("EMR"), the following issues may be problematic. It is important to take them into consideration to ensure supporting documentation is sufficient:

- The templates for each encounter type, including the eye exam are customizable. Many providers have customized their office system in a way that has deleted key elements of the eye exam. Deleting some elements may make your charts non-compliant.

- EMR's have "defaults" for normal findings that often fill in descriptive, detailed language for normal structures/findings. Caution should be used with defaults so that the clinical data and test results correlate with the diagnosis, assessment and management plan.
- When documentation is worded exactly like or similar to previous entries, the documentation is referred to as "cloned". Cloning of documentation from a previous visit lacks the encounter-specific information necessary to support services rendered to patients.
- A review of the EMR for consistency, logical assessment, and treatment plans should be completed before signing the chart. The chart should not be manipulated n or corrected once it is signed by the provider.

Critical Elements of an Eye Exam

The goal in medical chart review is to assist you in the improvement of the eye care encounter to meet today's standards. For both paper charts and EMRs, the following elements are required for all comprehensive eye examinations:

Element 1
Reason for Visit

- **Why important:** This element should trigger the encounter type and then direct the examination to meet the needs of the encounter. The "reason for visit" should be addressed in the diagnosis/impression section at the end of the exam as well as in the treatment/management plan. The reason may be related to the time since the last examination and the patient may not have symptoms or abnormal signs.
- **What is expected:** The patient should be directly questioned as to why they presented for the encounter. The patient should also be asked about issues with their eyes and vision or other problems that may be related to the visual system. The answers to these queries should be documented in the medical record.
- **Who can collect data:** Doctor or Technician but findings must be attested to by doctor stating data has been reviewed.
- **How to document findings:** The information should be entered in free text or with bullet points.
- **When should optional testing be performed?** The responses to the reason for visit may redirect the exam to a problem focused visit rather than a routine eye examination. Testing and examination should follow the reason for the visit.
- **Quality point value:** 3 points
- **Critical element if box checked**: ☐

Element 2
Review of Systems

- **Why important:** In addition to this review being a requirement for billing comprehensive eye examination codes and the Medical Vision evaluation and management codes, a review of systems documents all reported health issues and allows the doctor to discuss compliance with recommendations and follow-up with any necessary medical treatment with providers of the health care team. Historical information can assist in providing guidance as to required testing during the eye examination.
- **What is expected:** Each of the following systems should be queried and the patients' response recorded. For all positive responses, additional questioning may be indicated.
    - Cardiovascular
    - Constitutional
    - Endocrine
    - Gastrointestinal
    - Head
    - Hematologic/Lymphatic
    - Immunologic
    - Integumentary
    - Musculoskeletal
    - Neurological
    - Psychiatric
    - Respiratory
- **Who can collect data:** Doctor or Technician but findings must be attested to by doctor stating data has been reviewed.
- **How to document findings:** Findings are recorded as positive or negative. All positive findings should be questioned further and responses recorded in the patient's record.

- **When should optional testing be performed?** If history reveals a condition that may have manifestations in the eye, adnexa or visual pathways, additional testing may be warranted.
- **Quality point value:** 3 points
- **Critical element if box checked**: ☐

Element 3
Medications and Allergies

- **Why important:** A patient's current medication list is an indicator of the overall health of the patient. Patients taking a number of medications have chronic health issues that can affect ocular health and the ultimate visual outcome. A patient's current list of medications also directs the eye examination so that the provider focuses more closely on certain components of the exam. For example, patients on several medicines for heart and circulation may develop optic nerve damage at a lower IOP and are at risk to develop macular degeneration. Some patient will report "no medical problems" because they assume that the use of medicines eliminates the problems. For example, in some cases, only a review of the medication list will reveal that the patient is a diabetic. The list of the patient's allergies is also critical as a patient may be allergic to some of the medications used in the eye examination. The patient may also call at some point after the exam and need a prescription for conjunctivitis or other medical eye conditions. Most providers review the last examination notes to assess the clinical situation and prescribe medications.
- **What is expected:**
    - Medications: Medication name and dosage for all drugs or supplements the patient is taking. If taking no medication, this should be indicated on the chart as none and not left blank.
    - Allergies: For allergies related to medications, the name should be listed as well as the adverse effect the member experienced. If the patient experiences environmental or food allergies, these should be noted as well. If no allergies are reported, the chart should indicate this result.
- **Who can collect data:** Data is collected from the patient intake form and verified by the doctor / technician during the history. It may also be collected during the history. It is required for each exam or patient encounter.
- **How to document findings:** Document as a list in the history section of the chart.
- **When should optional testing be performed?** If history reveals a condition that may have manifestations in the eye, adnexa or visual pathways, additional testing may be warranted
- **Quality point value:** 3 points
- **Critical element if box checked**: ☐

Element 4
Ocular, Family History

- **Why important:**
    - **Ocular:** A patient's ocular history is one of the most important elements of the eye examination. It is impossible to provide a meaningful eye examination without the knowledge of previous problems, procedures and conditions
    - **Family History:** The modern understanding of genetics has opened new considerations for the treatment and management of ocular disease. From the routine problems of cataracts and glaucoma to the full spectrum of macular degeneration, the family history is critical in the treatment and management plan for each patient.

- **What is expected:** A detailed list of the patient's previous eye problems and procedures should be listed. The family history should query medical problems including diabetes, hypertension, thyroid problems and cancer in addition to eye problems such as cataracts, glaucoma, and macular degeneration.
- **Who can collect data:** This is collected from the patient intake form and verified by the doctor / technician during the history but findings must be attested to by doctor stating data has been reviewed.
- **How to document findings:** Document as a list or in free text in the history section of the chart.
- **When should optional testing be performed?** If history reveals a condition that may have manifestations in the eye, adnexa or visual pathways, additional testing may be warranted
- **Quality point value:** 3 points
- **Critical element if box checked**: ☐

Element 5
Entering Visual Acuity at Distance and Near

- **Why important:** For medico-legal reasons entering visual acuity must be measured. In addition, the patient's acuity level establishes both a baseline for and a guide to further testing. All additional refractive findings should relate back to and be consistent with the entering visual acuity.

- **What is expected:** A measurement of visual acuity both uncorrected and with the patient's habitual correction should be performed at both distance and near.
- **Who can collect data:** Doctor or Technician
- **How to document findings:** Distance Visual Acuity is recorded as a Snellen fraction with the numerator the testing distance and the denominator the level of visual acuity the patient read. The most appropriate measure of near visual acuity is a fraction with the target size seen in meters as the numerator and the testing distance in meters as the denominator. Alternatively, near vision may be recorded using reduced Snellen acuity followed by the testing distance.
- **When should optional testing be performed:** If vision is abnormal or inadequate, the examination should be geared to finding the cause. If this is related to a stable pathology that is not resolvable, a low vision evaluation may be indicated.
- **Quality point value:** 10 points
- **Critical element if box checked:** ☐

Element 6
Entering Tests
Vital Signs and
External Examination (Pupil testing/Extra Ocular Muscle testing
The Cover test/Screening Visual Field)

- **Why important:**
  - **Vital signs** are mandated by the Stage 2 Meaningful Standards for the appropriate use of an electronic health record. MARCH® requires vital signs to be recorded in both electronic and hand written medical records.
  - **External Examination** includes a battery of entering tests to assess a significant portion of the physical examination of the patient. Each test not only reveals clues to visual function, but also provides important screening of the neurological system.
- **What is expected: Measurement of-**
  - Height
  - Weight
  - Body Mass Index
  - Blood Pressure – for patients age 13 and older
  - Pulse
  - Testing of pupil response
    - Direct
    - Consensual
    - Swinging flashlight
  - Extra Ocular Muscle testing
  - Cover test
  - Visual filed
    - Confrontation or
    - Automated test
- **Who can collect data:** Doctor or technician but findings must be attested to by doctor stating data has been reviewed.
- **How to document findings:** The information should be documented as each test is completed with the appropriate results listed for each test.
- **When should optional testing be performed?** If testing reveals a condition that is abnormal, additional testing may be warranted.
- **Quality point value:** 10 points
- **Critical element if box checked**: ☐

Element 7
Refraction

- **Why important:** The subjective refraction is used to establish the final prescription.
- **What is expected:** The refraction required by the MARCH® standards is the subjective test that allows for the patients visual perception of the physical refractive error. Auto-refraction, by itself, is not an acceptable measurement
- **Who can collect data:** Doctor
- **How to document findings:** Sphere power, Cylinder power and axis for each eye as well as prism and bifocal power as indicated.

- **When should optional testing be performed?** If history reveals a condition that may have manifestations in the eye, adnexa or visual pathways, additional testing may be warranted
- **Quality point value:** 10 pts.
- **Critical element if box checked**: ☐

Element 8
Near Point Testing

- **Why important:** If the patient is presbyopic or demonstrates signs or symptoms of near point problems, testing is indicated.
- **What is expected:** Testing may include measurements of accommodation and/ or convergence as well as additional testing as determined by the provider (e.g. evaluation of saccadic eye movements)
- **Who can collect data:** Doctor
- **How to document findings:** Responses to testing documented in medical record
- **When should optional testing be performed:** If reading issues are elicited during case history or if additional testing is indicated based upon clinical examination
- **Quality point value:** 3 points
- **Critical element if box checked:** ☐

Element 9
Current Optical Prescriptions

- **Why important:** To prescribe eyeglasses, the provider must compare the patient's perception of their current vision with and without their current glasses, the entering visual acuity, the refractive testing and the patient's vision demands. The measurement and recording of the current prescription is a very necessary part of this decision making.
- **What is expected:** The current glasses prescription should be recorded in the refractive testing area.
- **Who can collect data:** This may be recorded by a technician or the doctor.
- **How to document findings:** Readings documented in medical record
- **When should optional testing ibe performed:** N/A
- **Quality point value:** 3 points
- **Critical element if box checked:** ☐

Element 10
Corneal Curvature

- **Why important:** This test can be an important part of the refractive evaluation. It is a required element for contact lens fittings but it is an optional test for the eye examination. The clarity, regularity and quality of the mires can point to the cornea or the tear film as a cause of reduced vision or other symptoms. In cases where the final acuity is less than expected, a Keratometry reading would be expected as part of the refractive work up. In lieu of keratometry, corneal topography is an acceptable procedure.
- **What is expected:** The measurement should be recorded in the refractive testing area when indicated.
- **Who can collect data:** This may be recorded by a technician or the doctor.
- **How to document findings:** Readings documented in medical record
- **When should optional testing be performed:** N/A
- **Quality point value:** 3 points
- **Critical element if box checked:** ☐

Element 11
Biomicroscopy

- **Why important:** Biomicroscopy is useful in diagnosing infections, allergies, inflammations and other disease entities affecting structures in the anterior segment of the eye.
- **What is expected:** Use of the biomicroscope to inspect all anterior segment eye structures including the lids and lashes, tear film, cornea, anterior chamber, angle grade, iris and lens. The documentation must be individualized based on the findings of the examination. Cloned language in Electronic Health Records should be carefully reviewed and revised to be consistent with the rest of the documentation in the record.
- **Who can collect data:** Doctor

- **How to document findings:** Positive and negative findings are recorded by structure (e.g. cornea, lids, etc.). Using "WNL" or a line through a list of anatomical parts is not adequate documentation.
- **When should optional testing be performed:** Findings may indicate the need to perform gonioscopy if narrow anterior chamber angles are suspected as well as retinal examination with a hand-held fundus lens or 4 mirror lens.
- **Quality point value:** 10 points
- **Critical element if box checked:** ☒

Element 12
Intraocular Pressure

- **Why important:** Intraocular pressure must be measured at each comprehensive eye examination. This is a critical evaluation of eye health. The pressure result in each eye is important as well as its relationship to the fellow eye. The trend over time is significant for each patient.
- **What is expected:** The type of instrument used as well as the time of measurement should be included with the numerical finding.
- **Who can collect data:** Doctor /Technician (subject to applicable laws)
- **How to document findings:** The test may be performed by any of the accepted methods such as Goldman Applanation, non-contact, or Tonopen, including digital or finger tension depending on the clinical situation. The numerical value should be charted along with the time of measurement.
- **When should optional testing be performed:** Appropriate treatment or addition al testing should be done depending on the results and correlation with other clinical findings.
- **Quality point value:** 10 points
- **Critical element if box checked**: ☒

Element 13
Optic Nerve Head Evaluation

- **Why important:** The health and status of the optic nerve head is critical to vision and ocular health. The relationship to the fellow eye and any change over time is clinically significant.
- **What is expected:** The optic nerve must be visualized and details recorded at each visit. The details of the evaluation of the Optic nerve should include all aspects of the nerve itself including: -Cup to disc ratio, - disc margin, - disc size, - color, - thickness, - vessel caliber. The exam may be performed with a fundus lens, the direct ophthalmoscope, indirect ophthalmoscope, or photographically. At a minimum a fundus lens should be utilized.
- **Who can collect data:** Doctor
- **When should optional testing be performed:** Appropriate treatment or addition al testing should be done depending on the results and correlation with other clinical findings.
- **Quality point value:** 10 points
- **Critical element if box checked**: ☒

For additional information, you may refer to the following link:
http://eyewiki.aao.org/Examination_of_the_optic_nerve_at_the_slit-lamp_biomicroscope_with_a_handheld_lens.

Element 14
Dilated Fundus Examination

- **Why important:** A dilated retinal examination is performed to detect any abnormal findings for baseline documentation. Retinal abnormalities may indicate the presence of local and/or systemic disease and indicate the need for further diagnosis and/or treatment. MARCH® has approved criteria which requires the entire ocular fundus be examined on the initial visit and periodically thereafter depending on each patient's risk factors, but at least every three (3) years. Patients with diabetes must be dilated every year.
- **What is expected:** A thorough inspection of the optic nerve, macula, vascular tree and retinal surface with a fundus lens and biomicroscope, a binocular indirect ophthalmoscope and/or a wide angle retinal camera. Document the method of examination. Although the photographic method is acceptable in some cases, it is not a substitute for a binocular physical retina examination. All providers must be licensed and capable to dilate the pupil and perform the physical retina examination.
- **Who can collect data:** Doctor
- **How to document findings:** Positive and negative findings are recorded by structure (e.g. optic nerve, macula etc.). Using "WNL", a line through a list of anatomical parts, or noting clear is not adequate documentation. The name of the dilating drops as well as the time of instillation should be documented. Confirm drops have not expired prior to instilling them.

- **When should optional testing be performed:** Suspected lesions, macular abnormalities, retinal holes or tears, etc. may require photographic imaging, ocular coherence tomography, ultra-sound, etc. to determine a diagnosis and treatment plan.
- **Quality point value:** 10 points
- **Critical element if box checked:** ☒

Element 15
Diagnosis

- **Why important:** Following each clinical encounter, the provider must list each relevant diagnosis.
- **What is expected:** These can be a refractive diagnosis such as Myopia, Astigmatism, Emmetropia, Hyperopia, or Presbyopia or medical eye diagnoses such as Cataract, Corneal Dystrophy, Choroidal Nevus or Glaucoma. Pertinent medical diagnoses such as diabetes should also be listed.
- **Who can collect data:** Doctor
- **How to document findings:** The provider should list these at the end of the exam chart. The diagnosis of each eye examination is often forwarded to the Primary Care Provider as part of the MARCH® quality initiative to coordinate care.
- **Quality point value:** 3 points
- **Critical element if box checked:** ☐

Element 16
Assessment/Management/Treatment Plan

- **Why important:** The review, summation and recommended treatment plan requires the critical thinking by the doctor to summarize the eye examination.
- **What is expected:** In this section, the provider should summarize the overall examination, and clarify the points that need to be managed. The treatment/management plan should spell out the steps to be taken to address the chief concerns identified in the clinical findings. In healthy patients, this can be as simple as, "Normal Exam, return in 1 year for re-examination." For a patient with refractive error, the verbiage can include the diagnosis and be stated as "Myopia, order glasses to be used for distance only, return in 1 year. For patients with pathology, this section should be more specific and address patient education, glasses, contact lenses, low-vision aids, medications prescribed with directions for use, referrals, recommended testing, time frames and follow-up schedules. Other clinicians, reviewers, and any party evaluating this clinical encounter will look to this section to determine the important clinical points of the case and identify the plan of action/recommended follow-up.
- **Who can collect data:** Doctor
- **How to document findings:** The provider should list these at the end of the exam chart.
- **Quality point value:** 3 points
- **Critical element if box checked:** ☐

Element 17
Legible Records

- **Why important:** Charts must be readable and legible so they may be interpreted by anyone authorized to review them, including MARCH®. This is important for review of historical patient data, continuity of patient care, auditing purposes, quality measures and for medico-legal reasons.
- **What is expected:** Records that are easily deciphered, following a consistent examination sequence, that are complete and document all findings, clinical decisions and any continuity of care recommendations. If using electronic medical records, it is important to review any "pre-populated" and/or "cloned" default data for accuracy, attest to the doctor personally reviewing history and medications and review all recorded data to ensure it reflects the examination findings and recommendations. A signature is required on all charts.
- **Who can collect data:** Doctor or staff
- **How to document findings:** Examination results are recorded on a "paper" chart or entered into an electronic medical record.
- **When optional testing is performed:** Any additional testing that generates data (e.g. retinal photography, visual fields, etc.) should be printed and included in the patient's medical record, scanned and attached to the electronic medical record or the location of the information documented within the patient's chart. For testing that requires it, an "Interpretation and Report" analysis must also be included in the record.
- **Quality point value:** 3 points
- **Critical element if box checked:** ☐

8.1 Anti-Fraud Plan

Training of Providers Concerning the Detection of Health Care Fraud

We recognize the importance of properly educating and training our providers to detect fraud. As part of its anti-fraud efforts, we require our personnel and contractors to receive the following training in the detection of health care fraud:

Training of Our Participating Providers

We post specific Compliance and Fraud, Waste, and Abuse (FWA) requirements on our website. We require you to provide your own standards of conduct of another compliant code of conduct to employees. We require you to provide either their own training materials or the CMS Parts C and D FWA and General Compliance Training module for employees.

Training must be completed within 90 days of hire and annually thereafter.

Sanction List Monitoring

We require you to screen employees against the Federal and State exclusion lists prior to hiring and monthly thereafter. At a minimum, providers must screen employees through the following

- HHS-OIG List of Excluded individuals/Entities (LEIE),
- General Services Administration (GSA) Excluded Parties List (EPLS)
- The Medicare Exclusion Database (the MED) databases
- Any applicable State specific databases

Document Retention

Documentation must be retained for 10 years to demonstrate compliance with regulatory requirements, including standards of conduct education, Fraud, Waste & Abuse (FWA) and general compliance training, Office of the Inspector General (OIG)/U.S. General Services Administration (GSA) exclusion checks, and supporting policies and procedures. Documentation must be available upon request from our organization, or a regulatory agency.

Reporting Suspected Fraud, Waste, or Abuse (FWA)

If you identify suspected FWA it is your right and responsibility to report it to us immediately so that we can detect, correct and prevent FWA in the health care system. We expressly prohibit retaliation if a suspected issue is reported in good faith.

You can report suspected FWA concerns to UnitedHealthcare online uhc.com/fraud or by calling 1-844-359-7736.

9.1 Credentialing and Re-Credentialing

CAQH ProView

Unless use of another credentialing source is required by your state, CAQH ProView will be used to obtain the necessary information to complete your credentialing. The use of CAQH ProView 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. CAQH ProView does not accept paper applications. To further avoid delays in processing please be sure to give Spectera Eyecare Networks permission on the CAQH ProView site to access your record. You will be notified when the review has been completed.

Up-to-date versions of the following items are needed on CAQH ProView:

- CAQH Application Release to Spectera Eyecare Networks;
- CAQH Attestation within the last 3 months;
- Certificate of Insurance showing Professional Liability Coverage (malpractice insurance);
- State License including Diagnostic Pharmaceutical Agent (DPA) License or Therapeutic Pharmaceutical Agent (TPA) License;
- Copy of DEA and CDS (if applicable);
- Board Certification (if applicable);
- Vitae/Resume, including work history (only needed for initial credentialing);
- If participating with Medicaid, you must enroll with your state agency.

Medicaid ID Requirement

Per Federal Rule 42.CRF 438.602 the 21st Century Cures Act requires billing, rendering and prescribing providers be enrolled with their State Medicaid agency in order to receive payments from managed care plans. This applies to Medicaid, CHIP and for some clients Medicare-Medicaid (MMP) lines of business.

Credentialing Process

Upon receipt of the CAQH number, credentialing information is reviewed by the Credentialing Coordinator for completeness. All NCQA, federal and state requirements, including data, licenses and certificates are electronically confirmed by the applicable regulatory agencies. Your complete credentialing documentation is forwarded to the Professional Review Committee for review and consideration. If consideration is favorable, you are approved. If the consideration is not favorable, the information is sent back to the Credentialing Coordinator with recommendations for further review.

Re-Credentialing Process

All providers are re-credentialed every three (3) years. All NCQA, federal and state requirements are re-verified. Documentation received is presented to the Professional Review Committee for review and consideration. The Provider Services Agreement stipulates automatic yearly renewal. You must forward to us, on an annual basis, a current photocopy of your yearly state license renewal and malpractice insurance. Failure to provide updated information may affect claims payments. Membership in good standing is re-confirmed.

Health Plan Credentialing Process

Health plans may perform Primary Source Verification on their own or in parallel. In order to comply with any state and/or health plan specific policies, you may be required to provide all pertinent credentialing documents on more than one occasion.

9.2 National Provider Identifier

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

In accordance with 45 CFR § 162.410, we shall require each provider rendering services to members to have a National Provider Identifier.

9.3 Disclosure of Criminal Conviction, Ownership and Control Interest

In accordance with 42 CFR, Part 455, Subpart B and as required by CMS, individual physicians and other healthcare professionals must disclose criminal convictions, while facilities and businesses must additionally disclose ownership and control interest, **prior to payment for any services rendered to Medicare or Medicaid enrollees.**

Prior to participation, you must accurately complete and sign the Disclosure of Ownership and Control Interest Statement Form. Our Disclosure form is available as Exhibit J of this Provider Reference Guide. This form can be used for all states except New Mexico, North Carolina, and South Carolina. Please visit marchvisioncare.com > Provider Resources > Forms for the appropriate form to use for these states (excluding North Carolina – the Disclosure of Ownership for North Carolina providers is collected in NCTracks).

The Disclosure of Ownership and Control Interest Statement is to be submitted with your initial credentialing and recredentialing application (every three (3) years), with the exception of South Carolina which requires annual renewal or at initial and renewal of a contract or agreement and any time there is a revision to the information. This form must also be provided within thirty-five (35) days of a request for this information. If you are a member of a group practice, **both** the individual member and group practice must submit a signed Statement attesting to the requirements under these regulations.

In order to comply with these Federal Regulations we have suspended payments to providers who have failed to comply and have not submitted a valid and completed disclosure form to us. If you do not return a completed disclosure form you will receive a claim denial with an explanation code "REJDSAN - DISCLOSURE FORM ON FILE IS INCOMPLETE OR EXPIRED. COMPLETE DISCLOSURE FORM REQUIRED FOR PAYMENT. DO NOT BILL MEMBER."

The Centers for Medicare & Medicaid Services (CMS) requires all providers to verify the accuracy of their information included in the health plan's provider directory on a quarterly basis. We encourage our providers to verify their demographic information through providers.eyesynergy.com. When logging into your account, you will see a banner on the top of your screen regarding your demographic information. You will click on that banner to be redirected to the demographic verification page where you can quickly verify your information and submit the form electronically. The online verification option is only available to registered and active providers.eyesynergy.com users.

10.1 Language Assistance Program (LAP)

Access to Interpreters

If you or your office identifies a member as being Limited English Proficient (LEP) and the member is present in the office, telephone interpretation should be used immediately to avoid any delay in services. There are new federal requirements for language services. The federal guidance, published as Section 1557 of the Affordable Care Act (ACA), provides specific limitations on the use of Bilingual Staff and minors as interpreters. These requirements are not limited to federal programs.

You are at risk if you use in house bilingual staff if they are not qualified interpreters. Qualified interpreters:

- Adhere to generally accepted interpreter ethics principles, including client confidentiality;
- Have demonstrated proficiency in speaking and understanding both spoken English and at least one other spoken language;
- Is able to interpret effectively, accurately, and impartially, both receptively and expressly, to and from such language(s) and English, using any necessary specialized vocabulary, terminology and phraseology.

Minors may not be used as interpreters except in emergency situations involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter for the individual with limited English proficiency immediately available; **No one** can give permission to use a minor in a non-emergency.

You shall not:

(1) Require an individual with limited English proficiency to provide his or her own interpreter;
(2) Rely on an adult accompanying an individual with limited English proficiency to interpret or facilitate communication, except:
   a. In an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter for the individual with limited English proficiency immediately available;
   b. Where the individual with limited English proficiency specifically requests that the accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide such assistance, and reliance on that adult for such assistance is appropriate under the circumstances;

Non-compliance may expose you to the risk of violating a consumer's civil rights resulting in civil rights law suits and also be subject to law suits filed by the Office of Civil Rights. Enforcement and law suits may occur up to a year after the Date of Service.

You should document all actions taken to comply with this law – this documentation must be accessible and complete. Suggestions:

- Appoint an employee to oversee compliance;
- Make sure aids and services comply with the law;
- Draft the required nondiscrimination notice and, if the entity has 15 or more employees, grievance policy;
- Review covered services to identify if any changes are needed
- Conduct training.

You 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, you 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 Proficient (LEP) members that are lower in quality than those offered in English.

Telephonic Interpreting Services

Access to free language assistance services for members with Limited English Proficiency is required by various regulations. Interpreters must be professionally trained and versed in medical terminology and health care benefits. In some states the Health Plan is responsible to provide Language Assistance Services, while in other states, you are required to arrange and pay for these services.

A Customer Service Representative will require the following information:

Member Information:

- Member name and identification number.
- Language requested.

Provider information:

- Provider name and telephone number.
- Office address.

Face-to-Face and American Sign Language Interpreting Services

Face-to-face and American Sign Language services are recommended to explain complex medical consultation or education (i.e. medical diagnosis, treatment options, etc.) to a LEP or hearing-impaired member. Face-to-face interpreters to assist LEP members should be offered at no cost to the member. These services will need to be scheduled at least ten (10) business days in advance of the appointment date to ensure coordination between all involved parties, although we will do our best to accommodate more urgent requests. If an appointment is cancelled or rescheduled please, immediately contact our Customer Service Department. To schedule these services, please contact our Customer Service Department at (844) 336-2724. A Customer Service Representative will request the information outlined above for telephonic requests, in addition to the following:

Provider information:

- Location of appointment.
- Appointment date and time.
- Special instructions (member's disabilities, facility access, etc.).

New Mexico

- Oral interpreter services are available in all languages, not just top languages we have identified.
- We shall inform Members of the availability of free interpreter services, sign language and TDD/TTY services, and inform Members on how to access services.

Medical Record Documentation for LAP

For all LEP 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. In addition, when possible, you should attempt to collect and document member's race, ethnicity, and preferred written language in member's medical record.

If a member refuses or declines interpretive services, you should document the refusal/declination of services in the medical record. This documentation not only protects you and your practice, it also ensures consistency if your medical records are monitored through site reviews or audits.

Documentation of Provider/Staff Language Capabilities

In some states, interpretive services pursuant to the Language Assistance Program have not been delegated to its providers. The provider directory lists fluent languages spoken by providers. This information is received via self-reported Provider Demographic Forms updated on a quarterly basis, or whenever there is a demographic change. The information you provide will be used to update our provider database, which is used to generate our provider directories and to provide members with online and automated information to assist them in identifying provider offices that may meet their language needs.

Translation of Written Material

Translations of written informational material such as applications, consent forms, denial notices and explanation of payments are available through the member's Health Plan (the number on the back of their Identification Card) at (844) 336-2724.

Additional Language Assistance Program Information for Providers can be found on the MARCH website by Clicking Here.

Exhibit C	Tips for Documenting Interpretive Services for Limited English Proficient (LEP) Members: Notating the Provision or The Refusal of Interpretive Services

11.1 Cultural Competency

We shall ensure that all health plan members receive equitable and effective treatment in a culturally and linguistically appropriate manner. As a health care provider, we expect you to be culturally sensitive to the diverse population you serve by effectively and appropriately providing services to people of all races, cultures, religions, ethnic backgrounds, education, and medical status in a manner that recognizes values, affirms and respects the worth of each individual member, and protects and preserves the dignity of each.

What is cultural competency?

Culture refers to integrated patterns of human behavior that include the language, thoughts, actions, customs, beliefs, values, and institutions that unite a group of people. It impacts the care given to members because it describes:

- Concepts of health, healing
- How illness, disease, and their causes are perceived
- The behaviors of patients who are seeking health care
- Attitudes toward health care providers

It also defines health care expectations such as:

- Who provides treatment
- What is considered a health problem
- What type of treatment
- Where care is sought
- How symptoms are expressed
- How rights and protections are understood

And why is it important?

Cultural competency is one the main ingredients in closing the disparities gap in health care. It's the way patients and doctors can come together and talk about health concerns without cultural differences hindering the conversation, but enhancing it. Quite simply, health care services that are respectful of and responsive to the health beliefs, practices and cultural and linguistic needs of diverse patients can help bring about positive health outcomes.

There are many cultural influences that impact the office visit. Some cultural preferences to remember include:

- Do members feel their privacy is respected?
- Are they the health care decision maker?
- Does their belief in botanical treatments and healers contradict standard medical practices and does it impact their decisions?
- What type of language skills and preferences do they use in their interactions?

Because health care is a cultural construct based in beliefs about the nature of disease and the human body, cultural issues are actually central in the delivery of health services.

Culture impacts every health care encounter**.** By understanding these influences and by communicating clearly at each visit you fulfill the opportunity to build rapport, help improve adherence and safety. Additional information and/or resource(s) are available on marchvisioncare.com > Doctors & Office Staff > Provider Resources > Cultural & Linguistics.

12.1 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, we are asking providers to 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®, the MARCH® recipient of PHI is appropriate, and include only the "minimum necessary" information.
- If you have a business need to exchange PHI with MARCH® personnel via email, please check with your IT personnel to make sure they have a secure transmission setup with MARCH® email systems. For more details, follow steps described in Exhibit H: “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® 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® 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.
- If you receive PHI or Personally Identifiable Information (“PII”) directed to, or meant for, another provider or someone other than you, you agree to promptly destroy all such PHI or PII and not further use or disclose it. In addition, if such an event occurs, you agree to cooperate with any remediation efforts undertaken by MARCH®.

Thank you in advance for following these recommended steps as we improve our business processes.

Exhibits

Exhibit A Non-Covered Service Fee Acceptance Form

Exhibit B Provider Dispute Resolution Request Form

Exhibit C Tips for Documenting Interpretive Services for Limited English Proficient Members

Exhibit D Potential Quality Issue Severity Levels

Exhibit E Potential Quality Issue Referral Form

Exhibit F Clinical Practice Guidelines

Exhibit G MARCH® Wholesale / Retail Fee Schedule

Exhibit H Sending a Secure E-mail to MARCH® Vision Care for PHI Related Data

Exhibit I Examination Record Template

Exhibit J Disclosure of Ownership and Control Interest Statement

Exhibit K Performance Measurement & Reporting

Non-Covered Service Fee Acceptance Form

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

Formulario de aceptación del cargo por servicios no cubiertos

Yo _____, miembro de _____deseo obtener y pagar el costo de _____, un servicio que no tiene cobertura como beneficio cubierto en el programa de Medicaid/Medicare bajo el cual tengo cobertura.

El/la Dr(a). _____ me explicó que yo seré el único responsable del costo total de _____, que es $ _____.Acepto responsabilizarme del pago de $_____. Entiendo que no tengo la obligación de pagar por el servicio indicado arriba si posteriormente se determina que cuando se me brindó el servicio sí tenía cobertura en el programa de Medicaid/Medicare bajo el cual tengo cobertura, aunque Medicaid/Medicare no le haya pagado al/a la Dr(a). _____ _____ el servicio porque él o ella no cumplió con los requisitos de facturación de Medicaid/Medicare.

Confirmo que recibí una copia de este acuerdo.

_____
Firma del miembro

_____
Nombre en letra de imprenta

_____
Fecha

MARCH® Vision Care

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.
- Mail the completed form to: MARCH® Vision Care, 6601 Center Drive West, Suite 200, Los Angeles, CA 90045
- This form does not apply to the State of New Jersey

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: ☐ Claim ☐ Appeal of Medical Necessity / Utilization Management Decision ☐ Disputing Request for Reimbursement of Overpayment	☐ Seeking Resolution of a Billing Determination ☐ Contract Dispute ☐ 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 Last	First	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
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									

Page ___ of ___

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

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

California law requires that health plans and insurers offer free interpreter services to both limited English proficient members and health care providers and also ensure that the interpreters are professionally trained and are versed in medical terminology and health care benefits.

- **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 (EMR) 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.

Potential Quality Issue - Severity Levels

Severity Level	Description	Example of Issues	Required Corrective Action
Level 0	▪ No quality issue ▪ Meets expectations of quality ▪ No adverse outcome	▪ Unfounded complaint ▪ Unavoidable complication ▪ Member issue	▪ None ▪ Track and trend
Level I	▪ No quality of care issue ▪ Possible quality of service issue ▪ He says, she says issues ▪ No adverse outcome	▪ Unavoidable complication ▪ He say/she say – can not determine fault	▪ None ▪ Track and trend
Level II	▪ Borderline quality – no potential for serious adverse effects but could become a problem if repeated or not corrected ▪ Unavoidable adverse outcome	▪ Illegibility of record ▪ Inadequate documentation ▪ Documented poor communication ▪ Delay in follow up/referral	▪ None ▪ Informal/verbal/written counseling by Medical Director
Level III	▪ Questionable quality of care with opportunity for improvement exists ▪ Moderate potential for adverse effects ▪ Could become a problem if repeated or not corrected	▪ Unnecessary delay in treatment ▪ Inadequate examination ▪ Failure to diagnose/examine/properly treat findings	▪ Verbal counseling by Medical Director and one or more of the following: ▪ Written counseling ▪ Focused review of medical record ▪ Mandatory skill retraining or CME ▪ Proctoring
Level IV	▪ Qualities of Care unacceptable – serious ▪ Significant potential for serious adverse affects ▪ Serious adverse affect occurred	▪ Clinical significant outcome ▪ Preventable death ▪ Preventable disability ▪ Preventable impairment ▪ Other preventable serious complication	• Level IV, written counseling and one or more of the following: ▪ 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: _____ ICD-10* code: _____ Client case: Y or N

*ICD-9 codes must be used if dates of service are prior to October 1, 2015. If dates of service are on or after October 1, 2015, please use ICD-10 codes.

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) to the Quality Management Department by fax (855) 640-6735. 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.

We are committed to providing high quality services to its members. We do not pressure health care providers or institutions to render care beyond the scope of their training or experience. Health Care Services has adopted the following guidelines for its providers:

Standard of Care for Eyeglass Dispensing/Fitting and Contact Lens Fitting

EYEGLASS DISPENSING/FITTING

- Assist with frame fashion selection.
- Evaluate frame for appropriate eye size, bridge, and A, B, and ED for required lenses.
- Take physical measurements including PD, Seg Height.
- Order materials via providers.eyesynergy.com or fax order to us.
- Monitor laboratory for appropriate turnaround time and follow up with us and the member as necessary.
- When materials have been received, measure lens power, PD, and Seg Height and physically inspect frame and lenses for manufacturer defects.
- Promptly contact the member when the eyewear has passed inspection.
- Adjust frame as needed to assure proper fit and alignment of lenses.
- Discuss proper use.

CONTACT LENSES FITTING

- Assess the health of the eyes in relationship to wearing contact lenses (age/anatomy etc.).
- Assess the anatomical appropriateness of the eyelids.
- Assess the quality and volume of tear film.
- Perform refractive tests and calculations related to contact lenses.
- Examine for issues and physical findings related to contact lenses.
- Measure cornea by keratometry and/or topography.
- Conduct diagnostic contact lens evaluation.
- Order materials via providers.eyesynergy.com or fax order to us.
- Train patient on safe and effective lens care, and insertion and removal of lenses.
- Dispense final lenses or provide final prescription.
- Follow up visits for one month as indicated.

Standards for Dilation

All new members require a dilated fundus exam, a wide angle photograph, or equivalent image (if acceptable per state/federal regulation). 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 or as medically indicated. Members with no risk factors should be dilated thereafter based on the professional judgment of the provider or every three (3) years, whichever occurs first.

Although the photographic method is acceptable in some cases, it is not a substitute for a binocular physical retina examination. All providers must be licensed and capable to dilate the pupil and perform the physical retina examination.

Health Care Services has developed the following standards regarding the examination of members with diabetes:

- The history should include the name and, if available, contact information of the Primary Care Physician (“PCP”), or the provider managing the diabetes.
- List of all diabetes medications.
- The HA1c should be documented in the chart - this may come from the patient, a lab report, or the PCP.
- Dilation is required. All common eye changes that result from diabetes should be documented in the medical record. These include, but are not limited to: retinopathy, dry eye, blepharitis, cataract, and low tension glaucoma.
- The retina examination must be detailed and subtle background changes should be noted.

- Education and counseling about blood sugar control and the required numbers to prevent vision loss should be emphasized.
- **It is highly recommended to communicate and coordinate with the PCP -** Send a full report of the dilated eye examination results for all patients with diabetes to the PCP and/or diabetes provider. The assigned PCP is noted on the front of the member's ID card. Additionally, you may contact the Health Plan directly or the PCP for assistance in coordinating additional medical needs for the member, as identified while providing vision services.
- Include the correct coding for retinopathy on your claim; the appropriate ICD-10 code if positive or CPT II code 3072F if negative.

Medical record documentation will be evaluated based on these standards, when they are reviewed as part of a quality audit.

Management of Glaucoma

Pre-Glaucoma

- Family History
- Abnormal Nerve Head
    - C/D greater than 0.5
    - Difference of > 0.2 between NH
    - NH pallor
- Abnormal IOP
- Other signs
- Testing protocol:
    - Threshold VF testing
        - Yearly
    - OCT testing NH cube and Ganglion cell
        - Yearly
    - Pachymetry
        - One time only
        - Keratoconus
            - Every 18 months
        - Post corneal surgery
            - Yearly
        - NH photo
            - Yearly
        - Gonioscopy

Mild Glaucoma

- Testing protocol:
    - Threshold VF testing
        - Yearly
    - OCT testing NH cube and Ganglion cell
        - Yearly
    - Pachymetry
        - One time only
        - Keratoconus
            - Every 18 months
        - Post corneal surgery
            - Yearly
    - NH photo
        - Yearly

Moderate Glaucoma

- Testing protocol:
    - Threshold VF testing
        - Every 6 months
    - OCT testing NH cube and Ganglion cell
        - Every 6 months
    - Pachymetry
        - One time only
        - Keratoconus

        - Every 18 months
    - Post corneal surgery
        - Yearly
- NH photo
    - Every 6 months

Advanced Glaucoma

- Testing protocol:
    - Threshold VF testing
        - As per a glaucoma specialist
    - OCT testing NH cube and Ganglion cell
        - As per a glaucoma specialist
    - Pachymetry
        - As per a glaucoma specialist
    - NH photo
        - As per a glaucoma specialist

Clinical Criteria*

The state specific criteria in the Provider Reference Guide (PRG) outline 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 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 is 70mm or greater or other facial or ocular anomalies 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
Necessary 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:	Irregular astigmatism; 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.	The member has photophobia, aniridia, uveitis, corneal dystrophy, cataracts, albinism, or use a medication that has a side effect of photophobia.
Single Vision Eyeglasses In Lieu Of Bifocals	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	Need is substantiated in member's medical record by clinical data.	Epilepsy, childhood disorders with multiple impairments.
Transitions Lenses	Need is substantiated in member's medical record by clinical data.	Chronic iritis or uveitis, albinism.
Polycarbonate Lenses	Need is substantiated in member's medical record by clinical data.	▪ The member has a prescription of +/-8.00; or ▪ Permanently reduced vision in one eye to less than 20/60; or ▪ A facial deformity or disease that interferes with eye glass fit; or ▪ A documented occupational hazard.

Ultra Violet Coating	Need is substantiated in member's medical record by clinical data	▪ 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	Need is substantiated in member's medical record by clinical data	▪ Available for children under 18 when the member's pupil distance is wider than the frame's mechanical optical center by greater than 5mm. ▪ Available when the new frame size is at least 3mm larger than the existing frames.
Second Opinion Examination	Need is substantiated in member's medical record by clinical data	▪ Available when medical chart review of the first examination shows inadequate examination, documentation, or when clinical issues are not adequately addressed.
High Index lenses (Higher than Polycarbonate)	Need is substantiated in member's medical record by clinical data	▪ Available when weight of a standard prescription could cause facial development issues (primarily for children). ▪ Available when lab cannot practically produce lenses with a lower index lens.
Allergy To Certain Frames	Need is substantiated in member's medical record by clinical data	▪ Alternative frame to be provided when a provider documents a rash or other adverse reaction to all MARCH frame kit materials.
SLAB Off/Prism	Need is substantiated in member's medical record by clinical data	▪ Available for bifocal or trifocal prescriptions that generate greater than 2 prism diopters of imbalance at the reading plane.
Safety Frames	Need is substantiated in member's medical record by clinical data	▪ 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. ▪ These must meet ANSI standards.
Non-Standard Frames	Need is substantiated in member's medical record by clinical data	▪ Used when member has facial parameters where standard frames do not fit correctly. ▪ Used when optical correction will not fit practically in a standard frame.

Low Vision Rehabilitation	Need is substantiated in member's medical record by clinical data.	▪ Visual loss with best corrected visual acuity of 20/50 or worse in the better eye. ▪ Constriction 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 99244. ▪ 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: ▪ D49.81 ▪ G.35 ▪ H47.099 ▪ H33.08-H33-303 ▪ E11.319, E10,319 ; H35.00-H35.443 ▪ H40.001-H40-2234 ▪ H53.40-H53-483 ▪ H54.2-H54.60 ▪ H46.00-H47.333 ▪ H55.00-H55.01 ▪ Or others by pre-approval ▪ A Low Vision Rehabilitation request form must be completed and submitted. ▪ Before proceeding, prior approval is required.
Dilation of Eyes	Initial examination required. Subsequent examinations as follows:	▪ All new members require a dilated fundus exam, a wide angle photograph, or equivalent image (if acceptable per state/federal regulation). 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 or as medically indicated. Members with no risk factors should be dilated thereafter based on the professional judgment of the provider or every three (3) years, whichever occurs first.
Polarized Lenses	Need is substantiated in member's medical record by clinical data.	▪ Chronic iritis, uveitis, or other active inflammatory eye disease with fixed and dilated pupils or aniridia.
Necessary Contact Lens Replacement	Such lenses provide better management of a visual or ocular condition than can be achieved with spectacle lenses (see criteria above).	▪ The member meets criteria as noted above for necessary contact lens and there is: -Change of +/- 1.00 diopter in power -Change of 0.50 mm in base curve -Change of 0.30 mm in optic zone -Change of 0.75 mm in peripheral curve radius -Change of 0.30 mm in peripheral curve width

Replacement Glasses When A Member Can Not Adapt To Bifocals	Member has presbyopia and unable to adapt to bifocals.	▪ Members should attempt to make the adjustment to bifocal lenses for a minimum of two (2) weeks. ▪ When lens manufacturers and/or the laboratory provides a warranty for "non-adapts", this should be used. ▪ When two pairs of glasses is the solution, each pair must have a sphere power of at least +/- 1.00 or a cylinder power of greater than +/-0.75 in at least one eye. In cases where one of the final single vision Rx calculation yield lower powers, the member will just be entitled to distance only or near distance only glasses. ▪ The frame that was used for the bifocals will be reused for one of the new single vision glasses.
Medically Necessary Contact Lenses And Glasses For Aphakia In Children Aged 2 Weeks To 12 Years.	Post surgically, for children born with a visually significant Cataract(s), or other medical eye problems that result in pediatric aphakia.	Coverage for either medically necessary contact lenses **or** glasses in a given benefit period, but not both except for the following circumstances: ▪ The patient has greater than three (3) diopters of astigmatism in one or both eyes and requires this correction over the contact lens or lenses. ▪ The patient has vision less than 20/200 in the poorer eye, or pathology where 20/200 or less is expected but can not be measured (ie. PHPV, RD, macula scarring, coloboma involving the posterior pole) and a spectacle lens is needed for protection of the good eye.
Prescription/ Fitting check	Glasses are dispensed, including when a member has ongoing vision issues using new materials	▪ Included in the fitting fee/payment for materials for up to 45 days after member has received materials.
Eye Care of Patient with Diabetes Mellitus	Person has Diabetes Mellitus	▪ MARCH adopted the American Optometric Association ("AOA") "Evidence-Based Clinical Practice Guidelines - Diabetes Mellitus." http://aoa.uberflip.com/i/374890-evidence-based-clinical-practice-guideline-diabetes-mellitus https://www.aoa.org/optometrists/tools-and-resources/clinical-care-publications/clinical-practice-guidelines

Extended Ophthalmoscopy	When benefit includes medical within the scope of an OD	▪ Extended ophthalmoscopy codes are reserved for the meticulous evaluation of the eye in detailed documentation of a severe ophthalmologic problem needing continued follow-up, which cannot be sufficiently evaluated by photography. ▪ In all instances extended ophthalmoscopy must be medically necessary. It must add information not available from the standard evaluation services and/or information that will demonstrably affect the treatment plan. It is not necessary, for example, to confirm information already available by other means. ▪ A detailed sketch must be included in the medical record and available upon request. The sketch should be a minimum size of 3-4" in diameter. All items noted must be identified (i.e., any findings must be drawn and labeled). Drawings in 4-6 standard colors are preferred. However, non-colored drawings are also acceptable. https://downloads.cms.gov/medicare-coverage-database/lcd_attachments/33567_6/APPENDIX A.pdf ▪ This is not payable on the same day as a fundus photo, Ophthalmic Ultrasound (B scan), Optical Coherence Tomography (OCT) or Fluorescein Angiography (FA).

* QIC approval 6/5/2019

Wholesale / Retail Fee Schedule

CPT Code	Modifier	Description	Wholesale Per Pair Rate	Retail Max Per Pair Rate
V2744	0L	Photochromatic TF 7X28	$60.00	$110.00
V2744	1L	Photochromatic PAL Standard	$70.00	$110.00
V2744	2L	Photochromatic PAL Standard Mini	$80.00	$110.00
V2744	3L	Photochromatic PAL Premium	$70.00	$110.00
V2744	4L	Photochromatic PAL Premium Mini	$80.00	$110.00
V2744	5L	Photochromatic SV	$70.00	$90.00
V2744	6L	Photochromatic Round Bifocal (22 or 24)	$32.00	$50.00
V2744	L1	Photochromatic GLASS SV	$46.00	$70.00
V2744	L2	Photochromatic GLASS Multifocal	$46.00	$70.00
V2744	L3	Photochromatic HI-INDEX 1.60 SV	$50.00	$72.00
V2744	L4	Photochromatic HI-INDEX 1.60 Multifocal	$52.00	$72.00
V2744	L5	Photochromatic HI-INDEX 1.67 SV	$50.00	$80.00
V2744	L6	Photochromatic HI-INDEX 1.67 Multifocal	$52.00	$80.00
V2744	L8	Photochromatic FT28	$82.00	$110.00
V2744	L9	Photochromatic FT35	$88.00	$110.00
V2745		Tint - All Colors and Density	$12.00	$20.00
V2745	TG	Tint Type - Solid, Gradient, Multi Gradient	$12.00	$20.00
V2750		Anti-Reflective Coating Standard	$38.00	$50.00
V2750	TG	Anti-Reflective Coating Premium	$48.00	$58.00
V2755		UV Treatment	$12.00	$25.00
V2760	L1	Scratch Resistant Coating SV	$12.00	$24.00
V2760	L2	Scratch Resistant Coating BF	$14.00	$25.00
V2760	L3	Scratch Resistant Coating TF	$14.00	$25.00
V2760	L4	Scratch Resistant Coating PAL	$14.00	$25.00
V2761		Mirror Coat - Any Type, Solid, Gradient	$50.00	$100.00
V2762	L1	Polarized SV	$36.00	$60.00
V2762	L2	Polarized BF	$40.00	$65.00
V2762	L3	Polarized TF	$44.00	$75.00
V2762	L4	Polarized PAL**	$50.00	$75.00
V2770		Occluder Lens/Frosted	$20.00	$30.00
V2780		Oversize Lens	$10.00	$23.00
V2781	L1	PAL Standard	$46.00	$60.00
V2781	L2	PAL Standard MINI	$50.00	$65.00
V2781	L3	PAL Premium	$56.00	$75.00
V2781	L4	PAL Premium MINI	$60.00	$75.00
V2782	L1	HI-INDEX 1.60 SV Lens, 1.54-1.65 P/1.60-1.79G	$26.00	$45.00

CPT Code	Modifier	Description	Wholesale Per Pair Rate	Retail Max Per Pair Rate
V2782	L2	HI-INDEX 1.60 BF Lens, 1.54-1.65 P/1.60-1.79G	$30.00	$47.00
V2782	L3	HI-INDEX 1.60 TF Lens, 1.54-1.65 P/1.60-1.79G	$30.00	$47.00
V2782	L4	HI-INDEX 1.60 PAL Lens, 1.54-1.65 P/1.60-1.79G	$30.00	$47.00
V2783	L1	HI-INDEX 1.67 SV LENS, >= 1.66 P/>= 1.80 G	$48.00	$75.00
V2783	L2	HI-INDEX 1.67 BF LENS, >= 1.66 P/>= 1.80 G	$58.00	$100.00
V2783	L3	HI-INDEX 1.67 TF LENS, >= 1.66 P/>= 1.80 G	$58.00	$100.00
V2783	L4	HI-INDEX 1.67 PAL LENS, >= 1.66 P/>= 1.80 G	$60.00	$100.00
V2784	L1	Polycarbonate SV	$20.00	$28.00
V2784	L2	Polycarbonate BF	$24.00	$36.00
V2784	L3	Polycarbonate TF	$24.00	$36.00
V2784	L4	Polycarbonate PAL	$26.00	$40.00
V2784	L5	TRIVEX® SV	$20.00	$50.00
V2784	L6	TRIVEX® BF	$22.00	$55.00
V2784	L7	TRIVEX® TF	$24.00	$60.00
V2784	L8	TRIVEX® PAL**	$26.00	$65.00
V2797	L1	Rimless Drill 2 Hole or 4 Hole***	$22.00	$36.00
V2797	L2	Edge Polish**	$12.00	$26.00
V2799	L1	Executive	$30.00	$35.00
V2799	L2	FT35	$20.00	$35.00
V2799	L3	FT45	$22.00	$50.00
V2799	L4	Round Bi-Focal RD22	$12.00	$40.00
V2799	L5	Round Bi-Focal RD24	$12.00	$40.00

Rates listed are per pair.

* MARCH® recommends using the MARCH® Non-Covered Service Fee Acceptance Form (Exhibit A) prior to ordering non-covered materials. Please refer to Section 2.2 of the Provider Reference Guide for additional information.

** These lenses are not available through all labs. Please contact Customer Service for verification prior to ordering.

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

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.

Eye Examination Record MARCH® Vision Care

Patient Name: **DOS:**

Last name First Name Middle Initial

Date of Birth:		**Patient ID:**	
Reason for Visit (Chief Complaint/ Concern)			
Medical History			
Eye History			**Date of last DFE**
Family Medical and Eye History			
Allergies:			
Current Medicines:			
Social History:	Tobacco:		Alcohol:
Orientation /Mood	Oriented to time and place:	Normal	Abnormal
	Mood or Affect:	Normal	Abnormal
Comments:			
Physical Findings:	BP:	Pulse:	Height: Weight: BMI:

Review of Systems

Constitution	Neg	Problem:
Ear/Nose/Throat	Neg	Problem:
Neurological	Neg	Problem:
Psychological	Neg	Problem:
Cardiovascular	Neg	Problem:
Respiratory	Neg	Problem:
Gastrointestinal	Neg	Problem:
Genital urinary	Neg	Problem:
Muscular-Skeletal	Neg	Problem:
Integument	Neg	Problem:
Endocrine	Neg	Problem:
Hematology/Lymphatic	Neg	Problem:
Allergy/Immunology	Neg	Problem:

Vision:

Vcc: Distance R: 20/	L: 20/	Both: 20/
Vcc: Near R: 20/	L: 20/	Both: 20/
Vsc: Distance R: 20/	L: 20/	Both: 20/
Vsc: Near R: 20/	L: 20/	Both: 20/

Current RX:	OD	OS

External Exam:

Pupils:		
Cover:	Distance	Near
Motility:		
Confrontation Fields:	OD	OS
Keratometry/Topo:	OD	OS
Color Vision:	OD	OS
Depth Perception:		

Refractions:

Auto: OD	20/	OS	20/
Static: OD	20/	OS	20/
Dry: OD	20/	OS	20/

Wet: OD	20/	OS	20/

Patient Name: **DOS:**

Last name First Name Middle Initial

Near Testing:	Add:

Slit Lamp Examination:

Lids/ Lashes/Adnexa:	OD	OS
Cornea:	OD	OS
Conjunctiva:	OD	OS
AC:	OD	OS
Iris:	OD	OS
Lens:	OD	OS

Intra Ocular Pressure

OD	OS	Time:	
Method: AP	Puff	Tono	FT

Gonioscopy:	OD	OS

Medicines: Prop	Tetra	Fluress	NaF	Myd	Paradryn	Cyclo	Other:	

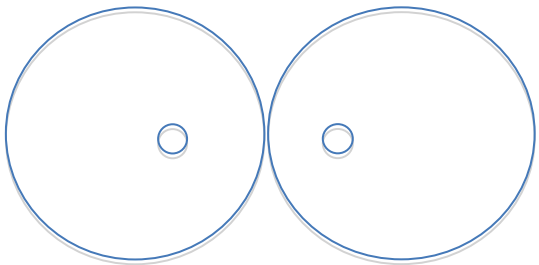
Fundus:

Direct	Indirect	Slit Lamp Lens	Photo

Nerve:

C/D:	OD	OS
Rim:	OD	OS
Color:	OD	OS
Comments:		

Macula:	OD	OS
Post Pole:	OD	OS
Vessels:	OD	OS
Vitreous:	OD	OS
Rim:	OD	OS
Periphery:	OD	OS



Diagnosis Impression:	
Assessment:	
Management Plan:	

I have personally reviewed this medical record including the patient's health history. **Signature:**	**Date:**	**Return**:

Disclosure of Ownership and Control Interest Statement

The federal regulations set forth in 42 CFR §455.100 - §455.106 require providers to disclose to the U.S. Department of Health and Human Services, the State Medicaid Agency, and to Managed Care Organizations that contract with a State Medicaid Agency: 1) the identity of all owners with a control interest of 5% or greater, 2) certain business transactions as described in 42 CFR §455.105 and 3) the identity of any excluded individual with an ownership or control interest in the provider entity or who is an agent or managing employee of the provider entity. Please attach a separate sheet if necessary.

Provider Entity Information

Type of disclosing entity: ____Individual Member of a Group or Sole Proprietor ____Partnership ____Corporation ____Limited Liability Co. ___Other (Specify): _____			
Legal Name of individual or entity ("**Provider Entity**"):	DBA Name:		
*Group Name:	*Provider/Health Care Professional Name/EIN:		
Practice Address 1:	City:	State:	Zip:
Practice Address 2: (If Applicable)	City:	State:	Zip:
Practice Address 3: (If Applicable)	City:	State:	Zip:
Federal Tax Identification #:	Medicaid ID #:	National Provider ID (NPI) #:	Provider CAQH #:

* If applicable, add the group, provider or health care professional name and EIN when the Provider Entity is part of a group practice

Section I

Are there any individuals or organizations with an Ownership or Control Interest of 5% or more in the Provider Entity? **___Yes___No**

List the name, title, address, date of birth (DOB) and Social Security Number (SSN) for each person having an Ownership or Control Interest in the Provider Entity of 5% or greater.

List the name, Tax Identification Number (TIN), business address of each organization, corporation, or entity having an Ownership or Control Interest of 5% or greater. (42 CFR §455.104)

Name/Title	DOB	Address	SSN or TIN	% Interest

Section II

Does the Provider Entity's owner have an Ownership or Control Interest in any other provider or entity? **___Yes ___No**

List the name of **any other** provider or entity in which a person with an Ownership or Controlling Interest in the Provider Entity **also has an Ownership or Controlling Interest in another provider or entity**. This requirement applies to the extent the information can be obtained by requesting it in writing from the person with the Ownership or Controlling Interest. (42 CFR §455.104)

Name of Owner from Section I	Name of Other Provider or Entity	SSN (if listing an individual) TIN (if listing an entity)

Section III

Does the Provider Entity have a Direct or Indirect Ownership Interest in any Subcontractor of 5% or more that another individual or organization also has an Ownership or Controlling Interest? **___Yes ___No**

List the following information for each person with an Ownership or Controlling Interest in any Subcontractor in which the Provider Entity has Direct or Indirect Ownership Interest of 5% or more. (42 CFR §455.104)

Name/Title	DOB	Address	SSN or TIN	% Interest

Disclosure of Ownership and Control Interest Statement

Section IV

Are any of the individuals identified in Sections I, II or III related to each other? ____**Yes** ____**No**

If yes, list the individuals identified and the relationship to each other (spouse, sibling, parent, child). (42 CFR §455.104)

Name of individual	Relationship

Section V

Has Provider Entity, or any person who has an Ownership or Control Interest in the Provider Entity, or is an agent or Managing Employee of the Provider Entity ever been convicted of a crime related to that person's involvement in any program under Medicaid, Medicare, or Title XX program?___**Yes** ___**No** (verify HHS-OIG List of Excluded individuals/Entities (LEIE), General Services Administration (GSA) Excluded Parties List (EPLS), the Medicare Exclusion Database (the MED) databases and any State specific databases.)

If yes, please list those persons below. (42 CFR §455.106)

Name/Title	DOB	Address	SSN

Section VI

Business Transactions: Has the Provider Entity had any business transactions with a Subcontractor or Wholly Owned Supplier totaling more than $25,000 or 5% of operating expenses in the previous twelve (12) month period? ___**Yes** ___**No**
If yes, list the ownership of Subcontractors with whom the Provider Entity has had business transactions totaling more than $25,000 during the previous 12 month period and any Wholly Owned Supplier or Subcontractor with whom the Provider Entity has had any Significant Business Transactions exceeding the lesser of $25,000 or 5% of operating expenses during the past 5-year period. This information must be provided within 35 days of a request. (42 CFR §455.105)

Name of Supplier/Subcontractor	Address	Owner	Transaction Amount

Section VII

Managing Employees: Does the Provider Entity have any Managing Employees? ___**Yes** ___**No**

List each member of the Board of Directors, Governing Board and Managing Employees (general manager, business manager, administrator or director), including the name, date of birth (DOB), Address, Social Security Number (SSN), and percent of interest.

Name/Title	DOB	Address	SSN	% Interest

I certify that the information provided herein, is true, accurate and complete. Additions or revisions to the information above will be submitted immediately upon revision. Additionally, I understand that misleading, inaccurate, or incomplete data may result in a denial of participation. Individuals and Sole Proprietors must sign their own form. An authorized representative may sign for Partnership, Corporation, LLC or Other disclosing entities.

_____ _____

Signature Title (indicate if authorized Agent)

_____ _____

Name (please print) Date

March Vision Care Disclosure Form

Instructions and Definitions for Disclosure of Ownership and Control Interest Statement

Completion and submission of this Statement is a condition of participation in the Medicaid program and is also/will be a contractual obligation with MARCH® Vision Care, IPA, Inc., for services to members under Medicaid benefit plans. Failure to submit the requested information may result in a refusal to enter into a provider agreement or contract, or in termination of existing provider agreements and contracts.

This Statement should be submitted with your initial credentialing and recredentialing application, or at initial and renewal of a contract or agreement and any time there is a revision to the information. A Statement must also be provided within 35 days of a request for this information. If a provider or health care professional is a member of a group practice, **both** the individual member and group practice must submit a signed Statement attesting to the requirements under these regulations.

INSTRUCTIONS

Section I: Ownership and Control Interest Information in Provider Entity:

List information about each individual or organization that has a direct or indirect Ownership of 5% or more or has a Controlling Interest in your entity.

** SSN/TIN required under Sect 4313 of Balanced Budget Act of 1997, amended Sect 1124 and Federal Register Vol. 76 No. 22

Section II: Ownership and Control Interest Information in Other Provider or Entity:

List information for other providers or Other Entities that are owned or controlled at least 5% by an individual or organization with an Ownership or Control Interest in your entity.

Section III: Ownership and Control Interest Information in Subcontractor:

List each individual or organization that has an Ownership or Control Interest in a Subcontractor that your entity has a direct or indirect Ownership of 5% or more.

Section IV: Relationship:

Report whether any of the persons listed are related to each other.

Section V: Criminal Convictions:

List your own criminal convictions, as well as any person who has an ownership or control interest, or is an agent or employee of your entity, who has ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Waivers, CHIP or the Title XX services since the inception of these programs. Review all of the databases necessary to verify this information.

Section VI: Business Transactions:

List any Subcontractors that your entity owns and that you have had business transactions totaling more than $25,000 within the last year.

List any Significant Business Transaction between your entity and any Wholly Owned Supplier during the past 5 years. Also list any Significant Business Transaction between your entity and any Subcontractor during the past 5 years.

This information must be available within 35 days of a request by the U.S. Department of Health and Human Services, the State Medicaid Agency, or a Managed Care Organization.

** Remember that a Significant Business Transaction is defined as any transaction or series of related transactions that exceeds the lesser of $25,000 or 5% of a provider's operating expenses during any one fiscal year.

Section VII: Managing Employees:

List any person who holds a position of Managing Employee within your entity.

DEFINITIONS

Provider Entity: an individual or entity who operates as a Medicaid provider and is engaged in the delivery of health care services and is legally authorized to do so by the state in which it delivers the services. For purposes of this Statement, the Provider Entity is the individual or entity identified on this form as the disclosing entity.

Ownership or Control Interest: an individual or corporation that—
(a) Has an ownership interest totaling 5 percent or more in a disclosing entity;
(b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;
(c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;
(d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;
(e) Is an officer or director of a disclosing entity that is organized as a corporation; or
(f) Is a partner in a disclosing entity that is organized as a partnership.

Direct Ownership Interest: the possession of equity in the capital, the stock, or the profits of the disclosing entity.
Indirect Ownership Interest: an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

Controlling Interest: defined as the operational direction or management of a disclosing entity which may be maintained by any or all of the following devices: the ability or authority, expressed or reserved, to amend or change the corporate identity; the ability or authority to nominate or name members of the Board of Directors or Trustees; the ability or authority, expressed or reserved to amend or change the by-laws, constitution, or other operating or management direction; the ability or authority, expressed or reserved, to control the sale of any or all of the assets, to encumber such assets by way of mortgage or other indebtedness, to dissolve the entity, or to arrange for the sale or transfer of the disclosing entity to new ownership control.

Determination of ownership or control percentages:
(a) Indirect ownership interest. The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if A owns 10 percent of the stock in a corporation which owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80 percent of the stock of a corporation which owns 5 percent of the stock of the disclosing entity, B's interest equates to a 4 percent indirect ownership interest in the disclosing entity and need not be reported.
(b) Person with an ownership or control interest. In order to determine percentage of ownership, mortgage, deed of trust, note, or
other obligation, the percentage of interest owned in the obligation is multiplied by the percentage of the disclosing entity's assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the provider's assets, A's interest in the provider's assets equates to 6 percent and must be reported. Conversely, if B owns 40 percent of a note secured by 10 percent of the provider's assets, B's interest in the provider's assets equates to 4 percent and need not be reported.

Other Entity: any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XV III, or XX of the Act. This includes:

(a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health
clinic, or health maintenance organization that participates in Medicare (title XV III);
(b) Any Medicare intermediary or carrier; and
(c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of,
health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.

Significant Business Transaction: any business transaction or series of related transactions that, during any one fiscal year, exceeds the lesser of twenty-five thousand ($25,000) or five percent (5 %) of a Provider Entity's total operating expenses.

Subcontractor:
(a) an individual, agency, or organization to which a Provider Entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or
(b) an individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

Supplier: an individual, agency, or organization from which a provider purchases goods or services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, manufacturer of hospital beds, or pharmaceutical firm).

Wholly Owned Supplier: a Supplier whose total ownership interest is held by the Provider Entity or by a person(s) or other entity with an ownership or control interest in the Provider Entity.

Managing Employee: a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.

HEDIS/Stars Performance Reporting

Because we administer benefits for medical plans, we are invested in improving members overall health care quality and cost. When you include appropriate CPTII and ICD-10 codes on your claims, it helps us support our health plan partners as they manage members' medical conditions and identify candidates for disease management programs. The inclusion of appropriate codes also helps to improve plan quality as measured by HEDIS and Stars ratings. Appropriate coding also limits requests for HEDIS and Stars chart reviews, which allows your practice to spend more time on patient care.

We only require CPTII coding for diabetic retinopathy screening at this time. However, you may include additional codes on your claims.

- Claims for members who have diabetes and present **without evidence of retinopathy** should include appropriate ICD-10 diagnosis codes and the applicable CPTII code: **2023F, 2025F or 2033F**
- Claims for members who have diabetes and present **with evidence of retinopathy** should include the appropriate ICD-10 diagnosis code and the applicable CPTII code: **2022F, 2024F or 2026F**
- Claims for members who have diabetes and present with **low** risk for retinopathy (no evidence of retinopathy in the prior year) should include the appropriate ICD-10 diagnosis code and the applicable CPT II code: **3072F**

CPTII Code*	Description
2022F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed.
2023F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy.
2024F	Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist.
2025F	Seven standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy.
2026F	Eye imaging validated to match diagnosis from seven standard field stereoscopic photos results documented and reviewed.
2033F	Eye imaging validated to match diagnosis from seven standard field stereoscopic retinal photos results documented and reviewed; without evidence of retinopathy.
3072F	Low risk for retinopathy (no evidence of retinopathy in the prior year)

ICD-10 Diagnosis Codes**	
Nonproliferative Diabetic Retinopathy (NPDR)	
Type 1	**Type 2**
E10.3211, E10.3212, E10.3213, E10.3291, E10.3292, E10.3293, E10.3311, E10.3312, E10.3313, E10.3391, E10.3392, E10.3393, E10.3411, E10.3412, E10.3413, E10.3491, E10.3492, E10.3493	E11.3211, E11.3212, E11.3213, E11.3291, E11.3292, E11.3293, E11.3311, E11.3312, E11.3313, E11.3391, E11.3392, E11.3393, E11.3411, E11.3412, E11.3413, E11.3491, E11.3492, E11.3493
Proliferative Diabetic Retinopathy (PDR)	
Type 1	**Type 2**
E10.3511, E10.3512, E10.3513, E10.3521, E10.3522, E10.3523, E10.3531, E10.3532, E10.3533, E10.3541, E10.3542, E10.3543, E10.3551, E10.3552, E10.3553, E10.3591, E10.3592, E10.3593	E11.3511, E11.3512, E11.3513, E11.3521, E11.3522, E11.3523, E11.3531, E11.3532, E11.3533, E11.3541, E11.3542, E11.3543, E11.3551, E11.3552, E11.3553, E11.3591, E11.3592, E11.3593

Important:

- Always bill the appropriate ICD-10 code, including any medical diagnosis codes, at the highest level of specificity.
- A patient's medical record should always support the CPTI, CPTII and ICD-10 codes billed.

Normal billing rules apply. The requirements listed here should be included in your billing process.

* CPTII codes are tracking codes used for performance measurement. They should be billed in the CPT/HCPCS field on your claim form and submitted on the same claim as the CPTI codes. CPTII codes do not have relative value and can be billed with a $0 charge amount.

** This list contains the most common ICD-10 codes.