Mississippi Provider Reference Guide

UnitedHealthcare Community Vision Network
March Vision Network

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United Healthcare® | MARCH® Vision Care

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Provider Reference Guide Notice of Updates, effective Sept. 1, 2025

This document in its entirety is new as of Sept. 1, 2025. Any future updates made herein after this date will be summarized in this section.

About the Provider Reference Guide

We are committed to working with you and your staff to achieve the best possible health outcomes for our members. This guide provides helpful information about eligibility, benefits, claim submission, claim payments and much more. For easy navigation through this guide, click on the table of contents to go to the section of your choice.

This version of the Provider Reference Guide ("PRG") was created in August 2025, with an effective date of Sept. 1, 2025. 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 on **marchvisioncare.com**.

Terms used in this manual include the following:

- "You", "your" or "provider" refer to any provider subject to this PRG (with the exception the verbiage in Section 7: Members Rights and Responsibilities – "you" and "your" refer to the member)
- "Us", "we" or "our", refer to UnitedHealthcare | March Vision Care for those products and services subject to this PRG

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

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Mississippi information

In this section, you'll find information specific to Mississippi only. For additional details that pertain to all states, please see the applicable sections linked below.

1.1 Mississippi definitions

Terms used in this Mississippi Provider Reference Guide include the following:

- **Government-sponsored program** and **government-sponsored health plan** refer to Medicaid and Medicare
- Medicaid refers to MSCAN and MS CHIP

1.2 Mississippi contact information

General website	**marchvisioncare.com**
Provider website	**providers.eyesynergy.com**
Lab and contact lens orders	**providers.eyesynergy.com**
Provider resources	**marchvisioncare.com/providerresources.aspx**
Provider change notification email address	**visionnominations@uhc.com**
Customer Service phone number	**844-606-2724,** 7:30 a.m.–5:30 p.m. local time

Notice of call center closures will be posted on **providers.eyesynergy.com** prior to the date of closure. Our primary method of communication is email. At least 1 network provider email address is required for each office location. It is your responsibility to maintain an updated email address to ensure you receive important updates and information from us.

1.3 Mississippi claim filing limits

– **See 4.11 Claim filing limits for additional details**

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

State	Medicaid	Medicare	Medicare-Medicaid Plan (MMP)
Mississippi	180	365	-

1.4 Mississippi prompt claim processing

Claim payments are issued in accordance with the applicable provider services agreement and governing entity regulations. Following are prompt payment processing times 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. 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)
Mississippi	EDI 25 days Paper 30 days	60	-

1.5 Mississippi corrected claims

– **See 4.12 Corrected claims for additional details**

The following are corrected claim filing limits provided as days and begin on the date services are rendered, unless otherwise noted.

State	Medicaid	Medicare	Medicare-Medicaid Plan (MMP)
Mississippi	90*	365	-

* Filing limits begin on the original denial/paid date.

1.6 Mississippi provider appeal and dispute process

– **See 4.13 Provider appeals and Disputes for additional details**

1. Submit our Provider Dispute Resolution Request Form (Exhibit B) or a written summary of your appeal including supporting documentation; this is your only level of appeal
2. MSCAN Provider Appeal Resolution Requests are to be submitted within 30 calendar days following claim payment or recent adverse benefit determination
3. MS CHIP Provider Appeal Resolution Requests are to be submitted within 30 calendar days following claim payment or recent adverse benefit determination
4. We will acknowledge receipt of all participating provider appeals within 10 calendar days of the date we receive it
5. We will issue a written determination explaining the reasons for its determination within 30 calendar days from the date of receipt of the appeal

Please submit your request by mail to:

UnitedHealthcare | March Vision Care
Attn: Medicaid Vision Appeals
P.O. Box 30988
Salt Lake City, UT 84130

Submit your request electronically using the **Provider Dispute Form.**

Information for all states

2.1 Provider contracting

Contracting with us can help grow your patient base and make your practice thrive.
Benefits of being part of our vision networks:

- Connect with millions of Medicaid and Medicare members
- A member-focused approach that makes a difference with quality care and choice
- Ability to administer both routine and medical vision care within the scope of optometry to address overall member health
- Easy, efficient and profitable plans and timely, accurate electronic payments help your practice thrive
- Use of **providers.eyesynergy.com**, our online portal, is available 24/7 for verifying eligibility and benefits, and submitting and tracking lab orders and/or claims
- Dedicated Provider Relations Advocate (PRA) delivers the support you need when you need it

Out-of-state and/or non-contracted providers who are interested in joining our network can find additional information on our website at **marchvisioncare.com > Join Our Network**.

2.2 Providers.eyesynergy.com

We're proud to offer **providers.eyesynergy.com**, our web-based solution for electronic transactions.
On **providers.eyesynergy.com**, you can:

- Verify member eligibility and benefit status
- Obtain copayment and remaining allowance information
- Submit and track claims and lab orders electronically to reduce paperwork and eliminate costs
- 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 3.1**)
- Obtain detailed claim status, including check number and paid date
- Access online resources such as current PRGs, benefits and the **providers.eyesynergy.com portal training**

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

You will need to register for a One Healthcare ID account or use an existing One Healthcare ID before accessing your **providers.eyesynergy.com** account. Once you've registered for a One Healthcare ID, you'll need to complete the **providers.eyesynergy.com** registration process by entering your tax identification number, office phone number and registration number* or by using an activation code provided by your account administrator. Please refer to our **user guide** for more information on how to register for a One Healthcare ID and link your account to **providers.eyesynergy.com**. The first person registering for the **providers.eyesynergy.com** account will be assigned the account administrator role.

*Contact the Provider Relations department to access your unique registration number.

2.2 Providers.eyesynergy.com (cont.)

After registering for a One Healthcare ID and linking your accounts, you will sign in to your **providers.eyesynergy.com** account with your One Healthcare ID login information. If you have any questions or issues signing in to your account, please contact One Healthcare ID directly.

Required training

After registration, you must complete the **required online training**. Training must be completed before you begin using your **providers.eyesynergy.com** account.

2.3 Provider trainings

We are committed to supporting you and your practice by developing resource materials and providing easy, convenient access to educational information through various mediums. We make every effort to ensure our providers are informed with valid and reliable information and comply with state and federal legislative requirements.

Explore our library of interactive courses, educational resources and tools – and free COPE Accredited CE courses designed to inform and support you and your practice – by visiting our **Provider Training Academy**. Training courses include claims and payment, compliance, digital experience and more. Our courses are grouped into categories to help you get to the topics you're looking for more efficiently.

2.4 Clinical Care and Coordination Program

Our Clinical Care and Coordination Program is a comprehensive provider and member engagement program to influence the best outcomes for members with diabetes. You can become certified in our program, which includes a directory designation with a badge displayed by your name. The program also includes exam reminders for members, notifications to PCPs with exam outcomes and ongoing education opportunities. You will be eligible for certification once you meet the following clinical and quality program criteria.

Program certification criteria

- Must be an active provider with UnitedHealthcare Community Vision Network/March Vision Network for exams and materials
- Complete the required training courses
- Perform dilation/retinal imaging on members with diabetes during their comprehensive eye exam
- Send notifications with exam outcomes for every member with diabetes to their PCP
- Submit CPT® II codes on vision claims to UnitedHealthcare Community Vision Network/March Vision Network

Learn more about becoming certified by accessing our Clinical Care and Coordination Program dashboard in the Resources section of **providers.eyesynergy.com**.

2.5 Interactive Voice Recognition System

Our Interactive Voice Recognition (IVR) system provides responses to the following inquiries 24 hours per day, 7 days a week:

- Eligibility and benefits
- Confirmation numbers
- Claim status

You may access the IVR system by calling **Customer Service**. 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.

Sign in

Once registered, you may sign in to 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.

2.6 Electronic funds transfer

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 its 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.

You have the option to receive payments electronically deposited into your bank account or by traditional paper check.

Provider benefits

You gain immediate benefits by signing up for electronic payments from us through PaySpan, including:

- **Improved cash flow** – Electronic payments can mean faster payments
- **Maintaining control over bank accounts** – You keep total control over the destination of claim payment funds. Multiple practices and accounts are supported.
- **Matching payments to advice/vouchers** – You can associate electronic payments quickly and easily to an advice/voucher

2.6 Electronic funds transfer (cont.)

- **Managing 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 the registration process, please visit the **PaySpan website** or call 877-331-7154.

2.7 Provider change notification

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

- Practice phone
- Fax number
- Practice address
- Billing address
- Tax ID (requires W-9)
- 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 by mail to:

UnitedHealthcare | March Vision Care
Attention: Provider Relations Department – Mail Stop CA120-0307
5701 Katella Ave.
Cypress, CA 90630

To report changes by email, please use the **provider change notification email address.**

The Centers for Medicare & Medicaid Services (CMS) requires you to verify the accuracy of information it has on file for the health plan's provider directory on a quarterly basis. You are encouraged to verify your demographic information through our provider web portal, **providers.eyesynergy.com**.

Verifying your information

- Sign in to your **providers.eyesynergy.com** account and locate the banner on the top of your screen regarding your demographic information
- Click on the banner to be redirected to the demographic verification page
- Verify your information and submit the form electronically

The online verification option is only available to registered, active **providers.eyesynergy.com** users.

3.1 Eligibility and benefit verification

We strongly recommend verification of member eligibility and benefits before rendering services. Please do not assume the member is eligible if they present a current member 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 received when your office verifies member benefits and eligibility. Verification is obtained by:

- Speaking with a Call Center representative
- Accessing the IVR system
- Utilizing **providers.eyesynergy.com**

Confirmation numbers affirm member eligibility for requested benefits and services. Confirmation numbers are not required for all services. You are strongly encouraged to verify benefits and eligibility before rendering services.

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

- Replacement frames and lenses
- Medically necessary contact lenses
- 2 pairs of glasses in lieu of bifocals
- Prescription sunglasses

The confirmation request process requires you to attest that a member meets the defined benefit criteria, as outlined in the state specific benefit summary, 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. Payment is issued provided the member is eligible on the date services were rendered.

Instances in which a confirmation number does not guarantee payment of a claim include:

- The member is not eligible on the date of service
- The member's benefit has been exhausted prior to claim submission

Important: Retrospective random chart audits are performed on claims submitted for services requiring attestation.

Covered benefits

You can access a list of covered benefits by:

- Signing in to **providers.eyesynergy.com**
  - Resources > Provider Reference Guide > select the applicable state from the dropdown menu
  - Benefits and Eligibility menu in **providers.eyesynergy.com**
- Visiting **marchvisioncare.com > Provider Resources > Provider Reference Guide**
  - Benefits may be accessed by selecting the desired state from the dropdown menu

3.1 Eligibility and benefit verification (cont.)

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

For children receiving Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, any limits on services may be exceeded when medically necessary.

Methods of verification

You may access **providers.eyesynergy.com** or the IVR system to verify member eligibility, benefits and to request a confirmation number.

3.2 Non-covered services

The Centers for Medicare and Medicaid Services (CMS) prohibits providers from billing or seeking compensation from government-sponsored program beneficiaries for the provision of services that are covered benefits under their plan. There are certain circumstances in which a member requests services that are not covered or fully covered under their government-sponsored health plan.

In these circumstances, you must inform the member, and it's required that they knowingly sign a waiver or statement acknowledging that the service is not covered and that the member is financially responsible prior to rendering non-covered service. **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 upfront.**

Acceptable waivers

A general waiver stating "the member is responsible for all services not covered by insurance" is not a valid waiver.

It does not specifically define which services are not covered and the amount the member is expected to pay.

You are 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 they will be responsible for the cost of the service(s).

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

3.2 Non-covered services (cont.)

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

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.

4.1 Claim submission

Preferred method

You are encouraged to submit claims electronically at **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 payer ID for Optum is 52461.

Paper claims

We impose a $2.00 processing fee* for all paper claim submissions, excluding COB claims. We accept paper claims if you submit them on an original red CMS-1500 form that is typed or computer-generated with clear, legible black ink. We'll reject and return paper claims that are handwritten, contain light ink or are submitted on a copied CMS-1500 form. Paper claims in the approved format can be mailed to:

UnitedHealthcare | March Vision Care
Attn: Medicaid Vision Claims
P.O. Box 30989
Salt Lake City, UT 84130

* $2 fee does not apply to Mississippi, Kansas, Louisiana, Missouri, Tennessee and Texas.

Clean claim definition

A clean claim is defined 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.

Claims submitted for payment should include:

- 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

4.1 Claim submission (cont.)

- Current and applicable modifier codes
- Place of service
- Usual and customary charges
- Billing and rendering provider taxonomy code*
- Ordering referring, or prescribing provider NPI*

* Data elements may be required by your State Medicaid agency to process claims in accordance with the 21st Century Cures Act, Federal Rule 42.CRF 438.602. Please ensure claim data submitted reflects the requirements of and your enrollment with applicable State Medicaid Agency.

We have the right to obtain further information from your office upon request when a submitted claim has errors or when we or the health plan has reasonable grounds for suspecting possible fraud, misrepresentation or unfair billing practices.

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

Important: Corrected claims can be submitted through **providers.eyesynergy.com** and EDI. Please contact the clearinghouse on guidance on how to submit. If submitting corrected claims 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 comply with the enrollment requirements of your state Medicaid agency to ensure you are eligible for Medicaid claims payment. The Affordable Care Act mandates that state Medicaid agencies require all furnishing ordering, referring and prescribing providers enroll as participating providers.

Please refer to our **Claim Denial Quick Reference Guide** for a list of commonly used denial codes to help you better understand why your claim may have been denied and to ensure timely payments.

4.2 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:

- You can use a new eye examination billing code for an initial examination of a new patient. 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
- You 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 the plan benefits
- 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

4.2 American Medical Association CPT coding rules (cont.)

- According to Medicare Carriers Manual Section 15501.1 H, if more than 1 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 1 provider in the same specialty in the same group, only 1 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 2 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 important when providers bill the highest levels of visit and consultation codes

Example: For a provider to bill a comprehensive eye exam for a new patient:

- The patient may not have been examined by a provider in the practice within the past 3 years
- The history must meet the CPT code's definition of a comprehensive history
- 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. Similarly, 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, it is referred to as "unbundling," which is an inappropriate billing practice. This type of billing practice will be subject to action from a health plan or insurance carrier.

The most billing 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

4.2 American Medical Association CPT coding rules (cont.)

The appropriate and correct use of the CPT (procedure) and diagnosis code is the responsibility of every health care provider. Providers are required to use the accurate diagnosis coding for the services provided, with appropriate diagnosis pointers for each line on a claim.

Use the following set of links to national correct coding resources on **www.cms.gov** to assist you:

- **ICD-10-CM**
- **National Correct Coding Initiative Edits**
- **Medicare Claims Process Manual: Chapter 23 – Fee Schedule Administration and Coding Requirements**

The medical record should reflect the intensity of examination that is being billed in all instances. Claim submissions will be audited to ensure compliance. Audits include the review of medical records, including the records documenting all test results billed (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 members with diabetes: Please see **Exhibit J: HEDIS/Stars Performance Reporting** for more information.

4.3 Billing for replacements and repairs

Replacements and repairs are generally covered only 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 following are valid modifiers:

- RA (Replacements)
- RB (Repairs)

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

4.4 Billing for glaucoma screenings

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

- Dilated exam with intraocular pressure (IOP) measurement
- 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 11 months have passed following the month in which the last glaucoma screening examination was performed.

4.5 Telemedicine[1]

We cover telemedicine routine vision exams consistent with an in-person exam when those telemedicine exams meet our expectations and requirements, as listed in the **critical elements of an eye exam section, Section 8.4**.

You must use your professional judgment to determine whether telemedicine is appropriate for a member. In order to submit telemedicine claims, telemedicine exams must be allowed in your state, and you must complete a Telemedicine Attestation and have it approved by us. Please reach out to your Provider Relations Advocate for instructions.

Additional credentialing may be required, including verification of licensure in states where members are located. Once approved to submit claims, use Place of Service Code 02 with the codes below on your electronic (EDI) claim paper claim, or claims submitted via the portal. 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.

Acceptable codes for telemedicine claims are: 92002, 92004, 92012, 92014, 92015, or S6020, S6021 when applicable. Our HEDIS requirements apply to all telemedicine exam claims.

Dilated fundus exam (DFE): If a telemedicine exam indicates the possibility of active ocular pathology, you must refer the member for local, in-person care. Additionally, if a DFE is warranted after a telemedicine exam, the DFE must be offered within 7 days and within a reasonable distance of the telemedicine site.

[1] Does not apply to North Carolina Medicaid

4.6 Frame warranty

When using our contracted lab, frames from our frame kit are fully guaranteed against manufacturing defects for a period of 1 year from the date the frame was dispensed.

If you determine that the defective frame is covered under the warranty, please contact **Customer Service**.

Please do not send broken glasses to us or the contracted lab.

4.7 Guidelines for patient-supplied frames

If the plan allows and the member wishes to purchase a frame from your office selection in lieu of using our frame kit, the frame must be shipped at your expense to the applicable contracted lab for fabrication. The shipping method must be a traceable shipping method (requiring signature for delivery). We and/or the contracted lab are not responsible for frames that are not sent by a traceable method, requiring signature, and not received by the lab.

The contracted lab's liability is limited to replacing that frame or reimbursing you for the cost of the patient-supplied frame, not to exceed $50, if the contracted lab breaks a patient-supplied frame. If a patient-supplied frame breaks in the fabrication process and they are eligible for a covered frame, they may choose a frame from our frame kit to replace the broken patient-supplied frame. If you give the contracted lab permission to process the patient-supplied frame, after the contracted lab has advised you that the frame is likely to break in processing, we and/or the contracted lab do not bear any responsibility if the frame breaks.

4.7 Guidelines for patient-supplied frames (cont.)

Please refer to your state-specific benefits information to determine if the member can supply or purchase frames instead of using our frame kit. To access this information, please go to **marchvisioncare.com > Provider Resources > Provider Reference Guide** and select applicable state from the dropdown menu.

Note: Contracted labs cannot process a patient-supplied non-ophthalmic frame.

4.8 Order cancellations

When using our contracted lab, orders placed for frames and lenses are final.

- **Members** are responsible for the cost of frames and/or lenses if the order is canceled 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 reach out to us by contacting **Customer Service**.

4.9 Non-covered lens options

A member may opt to add a non-covered lens option, such as tinting, anti-reflective coating, etc., to their eyeglass order in most states. If allowed in your state, the process to do so includes:

Medicaid

1. If a member chooses non-covered lens options, such as AR, UV, tinting, etc., you should charge the member up to, but not to exceed, the retail amount listed on the **Wholesale/ Retail Fee Schedule (Exhibit H)**
2. When using our contracted lab, the lab will submit an invoice to us for the non-covered lens options when the order for the non-covered lens options is complete. We reimburse the contracted lab directly for any materials ordered.
3. We will deduct the wholesale amount listed in **Exhibit H** 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 toward the member's benefit allowance amount. Please see Section **3.2 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 3.2 for further clarification.

4.10 Billing and calculation of Medicare allowance

A set dollar amount is typically allowed to cover frames, lenses and/or contact lenses provided to Medicare members. This is 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. The member is responsible for charges exceeding their benefit allowance.

Frames and lenses

The allowance for frames and lenses is 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.

We do not pay dispensing/fitting fees for frames and lenses as part of the Medicare benefit.

Contact lenses

The allowance for contact lenses is applied to the purchase of contact lenses first and any remaining allowance will then be applied to the dispensing/fitting fee.

4.11 Claim filing limits

Proof of timely filing

We will consider issuing payment following a review of the "good cause" documentation in cases where:

- There is documentation proving "good cause" for a filing delay and a claim has not been submitted to us
- A claim has been denied by us for exceeding the filing limit

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

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

4.12 Corrected claims

You may submit a corrected claim through the Claims Details page in **providers.eyesynergy.com**. You 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**, you must indicate the reason for the correction in the note section field. Please do not submit the corrected claim through **providers.eyesynergy.com** if attachments are required to process the claim.

Please mail corrected claims to:

UnitedHealthcare | March Vision Care
Attn: Medicaid Vision Claims
P.O. Box 30989
Salt Lake City, UT 84130

4.13 Provider appeals and disputes[1]

We're here to help and are committed to supporting you and your practice. You can reach us by contacting **Customer Service**. In addition to our **Customer Service** option, our provider appeal and dispute resolution process provides a mechanism for you to communicate appeals and disputes in writing. You may submit electronically by using the appropriate Provider Appeal and Dispute Resolution form on **marchvisioncare.com**.

Provider appeal and dispute and types

- Claim
- Appeal of medical necessity/utilization management decision
- Request for reimbursement of overpayment
- Seeking resolution of a billing determination
- Contract

Provider appeal and dispute resolution process[2]

1. Submit the **Provider Appeal and Dispute Resolution Request Form (Exhibit B)** or a written summary of your appeal or dispute including supporting documentation. This serves as your first level of appeal/reconsideration.
2. We will acknowledge receipt of all participating provider appeals and disputes in different ways:
   2a) Electronic appeals and disputes received from participating providers will be acknowledged by us within 2 working days of the date we receive it
   2b) Paper appeals and disputes received from participating providers will be acknowledged by us within 15 working days of the date we receive it
3. Provider appeals and disputes that do not include all required information will be returned to the submitter for completion within 45 working days from the date of receipt
4. An amended appeal or dispute that includes the missing information may be submitted to us within 30 working days of receipt of the request for additional information
5. Amended appeals and disputes not received within 30 working days will be closed and acknowledged within 45 working days from the date the request for additional information was due

4.13 Provider appeals and disputes[1] (cont.)

6. A written determination explaining the reasons for its determination will be issued within 45 working days from the date of receipt of the appeal or dispute or receipt of the requested information (amended appeal or dispute)
7. Providers may appeal a second-level decision of the Provider Appeal and Dispute Resolution Process directly to the health plan. Providers have 60 calendar days to file for a claim appeal from the date of the provider remittance advice/reconsideration decision.[3]

Please submit your request by mail to:

UnitedHealthcare | March Vision Care
Attn: Medicaid Vision Appeals
P.O. Box 30988
Salt Lake City, UT 84130

Submit your request electronically using the appropriate **Provider Appeal and Dispute Form**.

[1] Does not apply to Kansas.
[2] Does not apply to Florida, Mississippi, Mississippi, New Jersey and Tennessee
[3] Does not apply to Kentucky and Wisconsin

4.14 Overpayment of claims[1]

We'll notify you in writing if we determine a claim was overpaid or was paid incorrectly. Overpayment refund requests are issued in accordance with the applicable provider services agreement and governing entity regulations. We don't issue overpayment refund requests more than 365[2] 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 appeals and dispute request or refund of the overpaid amount within 30 days[3] we may offset the overpayment against future claim payments if not prohibited by governing entity regulations.

[1] Does not apply to Tennessee
[2] Does not apply to Kentucky
[3] Does not apply to Illinois, Kansas, Minnesota and New Jersey

4.15 Balance billing

"Balance billing" means charging or collecting an amount in excess of the reimbursement rates for services covered under a government-sponsored program 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 members. The explanation codes provided in the explanation of payment remittance advice clearly indicate when balance billing for a service is not permissible.

4.16 Coordination of benefits

Coordination of benefits (COB) is a method of integrating health benefits payable under more than 1 health insurance plan, allowing patients to receive up to 100% coverage for services rendered. Patients who have health benefits under more than 1 health insurance plan are said to have “dual coverage.” In some cases, patients may have primary, secondary and tertiary coverage. It is necessary to know what plan is primary and what plan is secondary or tertiary when a patient has multiple plans or “dual coverage.”

- 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 plan’s EOP attached with correlating Date of Service (DOS) and services performed
- The payments received from the primary plan should be indicated in field 29 of the **CMS 1500 form**
- The claim will be contested and the primary insurance EOP will be requested if the secondary plan is billed without an attached primary insurance EOP
- Medicaid is the payer of last resort
- The government-sponsored program will not make an additional payment if the amount received from the primary insurance company is equal to or greater than the reimbursement amount

We process COB claims in accordance with the applicable provider services agreement and governing entity regulations. When we are the secondary payer, 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 time frame 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 with other insurance payer information can be submitted through your clearinghouse, on **providers.eyesynergy.com,** and can also be submitted as paper claims on a **CMS 1500 form**. COB paper claims are not subject to the $2.00 paper claim processing fee.

Please mail COB claims to:

UnitedHealthcare | March Vision Care
Attn: Medicaid Vision Claims
P.O. Box 30989
Salt Lake City, UT 84130

5.1 Access standards[1]

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 30 calendar days[2,3]
- 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 24 hours[3]
- We require you to employ an answering service or a voicemail system during non-business hours, which provides instructions to members on how they may obtain urgent or emergency care. The message may include:
  - An emergency contact number (e.g., 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
  - Instructions to call 911 or go to the local emergency room
- Members with scheduled appointments will wait no more than 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.

[1] Does not apply to Tennessee
[2] Does not apply to Texas
[3] Does not apply to Iowa

5.2 Access monitoring

We are responsible for monitoring compliance with accessibility standards. This includes monitoring members' accessibility to providers within their demographic region to oversight regarding a member's wait times for scheduling or while at a provider's office waiting to be seen by the provider. The following are mechanisms we may employ to verify accessibility standards are met:

- Requests your office to gather demographic, access and language information
- Telephone access surveys may 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 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
- Geo-access or other access monitoring reports are run to determine network adequacy
- Customer service reports assess our Call Center responsiveness
- The appointment books of participating optometrists and ophthalmologists may be periodically reviewed during on-site inspections to validate the availability of appointments for services within reasonable time frames
- Waiting rooms may be periodically monitored to determine how long members wait for scheduled appointments

6.1 Protocol for member grievances and appeals[1]

Definitions

Grievance[2]	A written or oral expression of dissatisfaction regarding UnitedHealthcare | March Vision Care 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.

Our policy is 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 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. Interpretation and translation services may be used to enable effective communication with members regarding grievances when necessary. 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 teletypewriter (TTY) services when calling the the phone number on the back of their health plan ID card. You may contact us for assistance with this process. We provide grievance process assistance to visually impaired members and ensure verbal communications are conducted in a prompt manner.

[1] Does not apply to Tennessee

[2] Does not apply to Nebraska

7.1 Member rights[1]

Each member has rights and responsibilities:

Members have the right to be treated equally.

Our vision networks cannot discriminate against members based on:
- Age, sex, race, skin color, religion or sexual orientation
- The country where a member's ancestors came from
- Marital status (married, divorced, single or in a domestic partnership)
- Health care needs and how often the member uses services
- History as a victim of domestic violence

Members have a right to file a complaint if they think they have been treated differently because of their race, color, birthplace, language, sex, age, religion, disability or any status protected by federal or state civil rights laws. If they complain or appeal, they have the right to keep getting care without fear of bad treatment from their provider, UnitedHealthcare | March Vision Care or their plan.

Members have the right to informed consent
Informed consent means that before they agree to a treatment or procedure, they 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 they can expect if they choose not to have the treatment or procedure

Members have the right to help to make decisions about their 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 their informed consent without risking their health.

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

Members have the right to keep their medical records private
They may ask us to send them a statement that describes our privacy and confidentiality policies and procedures. To request a statement, contact **Customer Service**.

Members have the right to file appeals or complaints about their provider, the care they received, UnitedHealthcare | March Vision Care or their health plan
They may contact their health plan at the number on the back of their identification card for assistance.

[1] Does not apply to Tennessee and Texas

7.2 Member responsibilities[1]

It is a members' responsibility to:
- Understand their benefits
- Pay their copays, amounts for non-covered items or amounts above their allowance (when applicable)
- Give their doctors and other providers all the information they can to help them decide on their care
- Keep their appointments. If they need to cancel an appointment, let the office know ahead of time and schedule a new appointment.
- Show respect to their providers, to our staff and to other members
- Notify their health plan of a change of address or telephone number (when applicable)

[1] Does not apply to Tennessee and Texas

8.1 Quality Management Program

Our Quality Management Program is our quality assurance program. It provides a planned, systematic and comprehensive approach to monitor and evaluate quality improvement initiatives that both directly and indirectly influence our ability to meet our goal to deliver high-quality services to all of our customers, including 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 more

8.2 Potential quality issue

A potential quality issue is an individual occurrence of a suspected deviation from expected provider performance, clinical care, outcome of care or provider-preventable conditions that cannot be determined to be justified without additional review.
- The investigation of the potential quality issue is conducted by the Clinical Programs Team and documented in the case file
- The potential quality issue is presented to our Clinical team 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 E for severity levels** of various issues and possible actions.

Potential quality issues may be sent to the Clinical Programs Team for investigation from anyone and any place in our organization. Please refer to **Exhibit F for the Potential Quality Issue Referral Form**.

8.3 Coordination with primary care providers

You are asked to contact a member's primary care provider (PCP) should they notice any additional medical needs while providing vision services.

Example: If a significant change is observed in an eye exam of a member with diabetes, please call the PCP. The assigned PCP is noted on the front of the member's ID card. You may contact the member's health plan directly for assistance in coordinating additional medical needs for the member.

8.4 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 fewer services.

8.5 Medical charting for eye care services

We perform audits of medical records used as supporting documentation to substantiate post-payment claims submissions to ensure quality of services and to combat fraud, waste and abuse. We have identified over 17 elements necessary in a comprehensive eye examination. Records are evaluated and assigned a point value for each element based on their hierarchy of significance using a proprietary scoring system. The cumulative total point value is 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
- 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.

Keep in mind the following items to ensure your medical chart supporting documentation is sufficient to pass an audit:

Paper charts

- The encounter must record critical general health care information and 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 must include pulse, blood pressure and body mass index
- You must ask about tobacco use and alcohol use
- Assess patient orientation to time and place
- Rate the patient's emotional state during the exam

8.5 Medical charting for eye care services (cont.)

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

The following issues may be problematic if you are using electronic medical records (EMR). 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 noncompliant.
- EMRs 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 or corrected once it is signed by the provider.

Critical elements of an eye exam

Comprehensive eye exams are critical, not only to correct and preserve vision, but also for the early detection of systemic disease. We have developed Care Standards for eye health examinations to support our commitment to quality care for all patients. These guidelines reflect our focus on early detection and prevention.

The following elements are required for all comprehensive eye health examinations:

Element 1: Reason for visit

What is expected: The patient should be directly questioned as to why they presented for the encounter. The patient should be asked about issues with their eyes and vision or other problems that may be related to the visual system. The answers to these questions should be documented in the medical record.

Element 2: Review of systems

What is expected: Each of the following systems should be queried and the patient's response recorded. For all positive responses, additional questioning may be indicated.

8.5 Medical charting for eye care services (cont.)

- Cardiovascular
- Constitutional
- Endocrine
- Gastrointestinal
- Head
- Hematologic/lymphatic
- Immunologic
- Integumentary
- Musculoskeletal
- Neurological
- Psychiatric
- Respiratory

Element 3: Medications and allergies
What is expected: Medication name and dosage for all drugs or supplements the patient is taking should be recorded. If no medication is being taken, this should be indicated on the chart as "none" and not left blank. For allergies related to medications, the name and the adverse effect the member experienced should be listed. If the patient experiences environmental or food allergies, these should be noted as well. If no allergies are reported, the chart should indicate this.

Element 4: Ocular history; family history; orientation, mood and affect

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. The patients should be asked if they know the day, date and their current location. The clinician should note the validity and assess whether the patient's mood or affect is normal or abnormal.

Element 5: Entering visual acuity at distance and near
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.

Element 6: Entering tests, including vital signs and external examination
What is expected:
Measurements of the following:
- Height*
- Weight *
- Body mass index*
- Blood pressure for patients age 13 and older*
- Pulse*
- Testing of pupil response
- Direct
- Consensual
- Swinging flashlight

8.5 Medical charting for eye care services (cont.)

- Extra ocular muscle testing
- Cover test
- Visual field
- Confrontation
- Automated test

*Measurements for these items are highly recommended, but not required.

Element 7: Refraction
What is expected: The refraction is the subjective test that allows for the patient's visual perception of the physical refractive error. Auto-refraction, by itself, is not an acceptable measurement.

Element 8: Near point testing
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).

Element 9: Current optical prescriptions
What is expected: The current glasses prescription should be measured and recorded in the refractive testing area.

Element 10: Corneal curvature
What is expected: The measurement should be recorded in the refractive testing area when indicated.

Element 11: Biomicroscopy
What is expected: Use of the slit lampbiomicroscope 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.

Element 12: Intraocular pressure
What is expected: The type of instrument used and the time of measurement should be included with the numerical finding.

Element 13: Optic nerve head evaluation
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 and vessel caliber. The exam may be performed with a minimum of a fundus lens, or a direct ophthalmoscope, indirect ophthalmoscope or photographically.

8.5 Medical charting for eye care services (cont.)

Element 14: Dilated fundus examination
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 imaging system. Document the method of examination. Although retinal imaging 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.

Element 15: 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 systemic medical diagnoses, such as diabetes, should also be listed.

Element 16: Assessment, management and treatment plan
What is expected: The provider should summarize the overall examination and clarify the points that need to be managed in this section. 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 **patients 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 and recommended follow-up.

Element 17: Legible records
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. If electronic, it needs to be time and date stamped.

The following equipment list is optional and can be used as a guideline during a comprehensive eye examination:

- Visual acuity testing charts
  - Distance
  - Near
- Color vison plates

8.5 Medical charting for eye care services (cont.)

- Stereo plate
- Hand equipment (Occluders, Saccade/Pursuit targets, PD stick, Maddox rod, Prism bars, Flippers)
- Blood pressure measuring device
- Height and weight measuring device
- Keratometer
- Lensometer
- Refractor
  - Phoropter or Trial frame and Lens
- Biomicroscope (Slit lamp)
  - Slit lamp condensing lenses (78, 90)
  - Gonio lenses
- Tonometer
- Ophthalmoscope (Direct and Indirect)
  - Condensing lenses (20, 28)

9.1 Fraud, waste and abuse

We recognize the importance of properly educating and training our providers to detect fraud. As part of our 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 have **compliance and fraud, waste and abuse (FWA) training** available on our website. You are required to provide your own standards of conduct of another compliant code of conduct to employees. You are required to provide either your 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. The Centers for Medicare & Medicaid Services (CMS) has **FWA training resources** available on its website.

Sanction list monitoring

You are required to screen employees against the federal and state exclusion lists prior to hiring and monthly thereafter. At a minimum, you 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, 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.

9.1 Fraud, waste and abuse (cont.)

Reporting suspected fraud, waste or abuse
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 healthcare system. We expressly prohibit retaliation if a suspected issue is reported in good faith.

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

10.1 Credentialing and recredentialing[1]

CAQH ProView

CAQH ProView will be used to obtain the necessary information to complete your credentialing unless use of another credentialing source is required by your state.

The use of CAQH ProView will expedite the credentialing process and 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.

Be sure to give "UHC Vision Networks: Spectera and March" permission on the CAQH ProView site to access your record to avoid delays. 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 UHC Vision Networks: Spectera and March
- CAQH attestation within the past 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
Credentialing information is reviewed by the Credentialing Coordinator for completeness upon receipt of the CAQH number. All NCQA, federal and state requirements, including data, licenses and certificates, are electronically confirmed by the applicable regulatory agencies.

10.1 Credentialing and recredentialing[1] (cont.)

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. Please refer to your provider contract for specific information regarding requests for appeals or reconsideration.

Recredentialing process

All providers are recredentialed at least every 3 years. All NCQA, federal and state requirements are reverified. 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 reconfirmed.

Health plan credentialing process

Health plans may perform Primary Source Verification on their own or in parallel. To comply with any state and/or health plan specific policies, you may be required to provide all pertinent credentialing documents on more than 1 occasion.

[1] Does not apply to Kansas

10.2 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 HIPAA.

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

11.1 Language assistance program

Access to interpreters

If 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 who are not qualified interpreters.

11.1 Language assistance program (cont.)

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 1 other spoken language
- Are 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 LEP individual or the public where there is no qualified interpreter for the individual immediately available. No one can give permission to use a minor in a non-emergency.

You shall not:
- Require an LEP individual to provide their own interpreter
- Rely on an adult accompanying an LEP individual to interpret or facilitate communication, except:
  - 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 LEP individual immediately available
  - Where the LEP individual 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. This may result in civil rights lawsuits and subject you to lawsuits filed by the Office of Civil Rights (OCR). The OCR states that complaints can be filed within 180 days from when the complainant knew the act or omission occurred, and OCR may extend the 180-day period if the complainant can show "good cause."

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

To assist in this area, you are encouraged to:
- 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 LEP members receive appropriate access to vision care, you are expected to comply with federal and state requirements regarding cultural and linguistic services.

11.1 Language assistance program (cont.)

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 LEP members that are lower in quality than those offered in English.

Telephonic interpreting services

Access to free language assistance services for LEP members is required by various regulations. Interpreters must be professionally trained and versed in medical terminology and health care benefits. The health plan is responsible to provide Language Assistance Services in some states. In other states, you are required to arrange and pay for these services.

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 (medical diagnosis, treatment options, etc.) to an 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 10 business days in advance of the appointment date to ensure coordination between all involved parties. We will do our best to accommodate more urgent requests.

Please contact **Customer Service** to schedule these services. 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.)

If an appointment is cancelled or rescheduled, please contact our **Customer Service** team.

Medical record documentation for the language assistance program

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. You should attempt to collect and document member's race, ethnicity and preferred written language in member's medical record, when possible.

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.

11.1 Language assistance program (cont.)

Documentation of provider/staff language capabilities

Interpretive services pursuant to the language assistance program have not been delegated to its providers in some states. 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 member identification card). To request translation services, please contact **Customer Service**.

Additional language assistance program information for providers

Exhibit D	Tips for documenting interpretive services for Limited English Proficient (LEP) members: Notating the provision or the refusal of interpretive services

12.1 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, you are expected 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.

Everyone has the right to receive culturally and linguistically appropriate services (CLAS). The care delivered needs to be respectful of the person's believes, practices and unique needs for each member. For more information, including national standards and training, we encourage you to visit **thinkculturalhealth.hhs.gov**.

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:

12.1 Cultural competency (cont.)

- How illness, disease and their causes are perceived
- Concepts of health, healing
- 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 of 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. 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 types 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 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, and help improve adherence and safety.

13.1 Secure transmission of protected health information

All providers, office staff or those involved with creating, receiving, using or maintaining an individual's personal health information must comply with the HIPAA Security Rule that is located at 45 CFR Part 160 and Subparts A and C of Part 164 to ensure an individual's electronic personal health information is safeguarded to ensure confidentiality, integrity, and security of protected health information. For further information regarding the HIPAA Privacy and Security Rules, please refer to **HHS.gov**.

We are asking you to follow the recommended guiding principles when exchanging Protected Health Information (PHI) with us to ensure that all communications (email, phone or fax) containing PHI (member number, name, address, etc.) from provider organizations meet HIPAA privacy guidelines.

- Please determine if it is business-necessary to exchange PHI with us, that the recipient of PHI is appropriate, and include only the "minimum necessary" information
- If you have a business need to exchange PHI with our personnel via email, please check with your IT personnel to make sure they have a secure transmission set up with our email systems. This will prevent us 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 us 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. If such an event occurs, you agree to cooperate with any remediation efforts undertaken by us.

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 (online)** **Provider Dispute Resolution Request Form (paper)** *Does not apply to New Jersey
Exhibit C*	**Lab Order Form** *Does not apply to Kentucky
Exhibit D	**Tips for documenting interpretive services for Limited English Proficient members: Notating the provision for the refusal of interpretive services**
Exhibit E	**Potential Quality Issue Severity Levels**
Exhibit F	**Potential Quality Issue Referral Form**
Exhibit G	**Clinical Practice guidelines**
Exhibit H*	**Wholesale/retail fee schedule** *Does not apply to California, Kentucky, North Carolina, Tennessee and Washington
Exhibit I	**Examination Record template**
Exhibit J	**HEDIS/Stars Performance Reporting**

Exhibit D

Tips for documenting interpretive services for Limited English Proficient members –

Notating the provision or the refusal of interpretive services

Health plans and insurers are required to offer free interpreter services to both Limited English Proficient (LEP) members and health care providers. It also ensures 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 (LAP).
  - 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 LEP 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 a member's chart to flag when an interpreter is needed (for example: orange = Spanish, yellow = Vietnamese, green = Russian)*
    - For EMRs, 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.

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

Exhibit E

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 • Conflicting story issues • No adverse outcome	• Unavoidable complication • Conflicting story – cannot 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 • 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 1 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 effects • Serious adverse effect occurred	• Clinical significant outcome • Preventable death • Preventable disability • Preventable impairment • Other preventable serious complication	• Level IV, written counseling and 1 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)

Exhibit G

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 program's benefit interpretation and quality/performance measurements.

We are committed to providing high-quality services to our members. You or institutions are not expected to render care beyond the scope of their training or experience. Health Care Services has adopted the following guidelines for our 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 at 855-640-6737
- 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 ensure 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 1 month, as indicated

Care standards: Diabetes

Dilation of the pupil for fundus examination is required for members with diabetes. All providers must be licensed and capable to dilate the pupil and perform the physical retina examination.

Exhibit G (cont.)

New patients

All new patients require a detailed examination of the fundus. This can be accomplished with the pharmacological dilation of the pupil and examination with a binocular indirect ophthalmoscope and a slit lamp fundus lens or the professional review of a wide-angle fundus image (Optos or equivalent).

Established patients

Patients who have been diagnosed with diabetes require dilation every year at a minimum, more often if they have retinopathy. Although the retinal imaging method is acceptable in some cases, it is not a substitute for a physical binocular retina examination.

Care for patients with diabetes

The following actions will assure the care required for patients 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
- The history should include a list of all diabetes medications
- The HbA1c should be documented in the chart. This may come from the patient, a lab report or the PCP.
- Dilation is required every year
- 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

Communication and coordination with the PCP are required. Send a full report of the dilated eye examination results to the PCP and/or the provider managing the diabetes. You may contact the health plan or PCP to coordinate additional medical needs as identified while providing vision services.

Correct coding and billing is required. Include the correct codes for retinopathy on your claim: the appropriate ICD-10 code related to the diagnosis of diabetes and CPT II (2022F, 2023F, 2024F, 2025F, 2026F, 2033F or 3072F).

Exhibit G (cont.)

Management of glaucoma

Pre-glaucoma	Mild glaucoma	Moderate glaucoma	Advanced 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 o Yearly – OCT testing NH cube and Ganglion cell o Yearly – Pachymetry o 1 time only o Keratoconus • Every 18 months o Post corneal surgery • Yearly – NH photo o Yearly – Gonioscopy	• Testing protocol: – Threshold VF testing o Yearly – OCT testing NH cube and Ganglion cell o Yearly – Pachymetry o 1 time only o Keratoconus • Every 18 months o Post corneal surgery • Yearly – NH photo o Yearly	• Testing protocol: – Threshold VF testing o Yearly – OCT testing NH cube and Ganglion cell o Yearly – Pachymetry o 1 time only o Keratoconus • Every 18 months o Post corneal surgery • Yearly – NH photo o Yearly	• 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

Post-cataract glasses

Post-cataract glasses are meant to be an interim pair and should not include extras such as anti-reflective coating, photochromic, tints, etc. Any add-on items will be denied within the claim and members will be responsible for those out-of-pocket costs.

The following diagnosis codes must be billed in order to satisfy the benefit requirements of post cataract glasses:

- H27.00 Aphakia, unspecified eye
- H27.01 Aphakia, right eye
- H27.02 Aphakia, left eye
- H27.03 Aphakia, bilateral
- Q12.3 Congenital aphakia
- Z96.1 Presence of intraocular lens

Where applicable, please refer to the **state-specific clinical policies** for your state. The clinical policies do not indicate that the member has a specific benefit. The clinical policies are used to define the medically necessary indications when a benefit is offered, but no regulatory/client criteria is available.

Exhibit I

Sample eye examination record

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:	
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/	

Exhibit I (cont.)

Sample eye examination record (cont.)

Vision:							
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/		
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		
Intraocular pressure:							
OD	OS		Time:				
Method: AP	Puff		Tono		FT		
Gonioscopy:	OD				OS		
Medicines: Prop	Tetra	Fluress	NaF	Myd	Paradryn	Cyclo	Other:

Exhibit I (cont.)

Sample eye examination record (cont.)

Fundus:			
Direct:	Indirect:	Slit lamp lens:	Photo:
Nerve:			
C/D:	OD		OS
Rim:	OD		OS
Color:	OD		OS
Comments:	OD		OS
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:

Exhibit J

HEDIS and Stars performance reporting

Because we administer benefits for medical plans, we are invested in improving members', overall health care quality and cost. Including appropriate CPT II and ICD-10 codes on your claims 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 improves plan quality as measured by HEDIS and Star Ratings. Appropriate coding limits requests for HEDIS and Stars chart reviews, allowing your practice to spend more time on patient care.

We only require CPT II* 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 CPT II 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 CPT II 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**

CPT® II code	Description
2022F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy.
2023F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy.
2024F	7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy.
2025F	7 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 7 standard field stereoscopic retinal photos results documented and reviewed; with evidence of retinopathy.
2033F	Eye imaging validated to match diagnosis from 7 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).

Exhibit J (cont.)

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

ICD-10 diagnosis codes**	
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 CPT, CPT II and ICD-10 codes billed

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

* CPT II 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 CPT codes. CPT II codes do not have relative value and can be billed with a $0 charge amount.

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