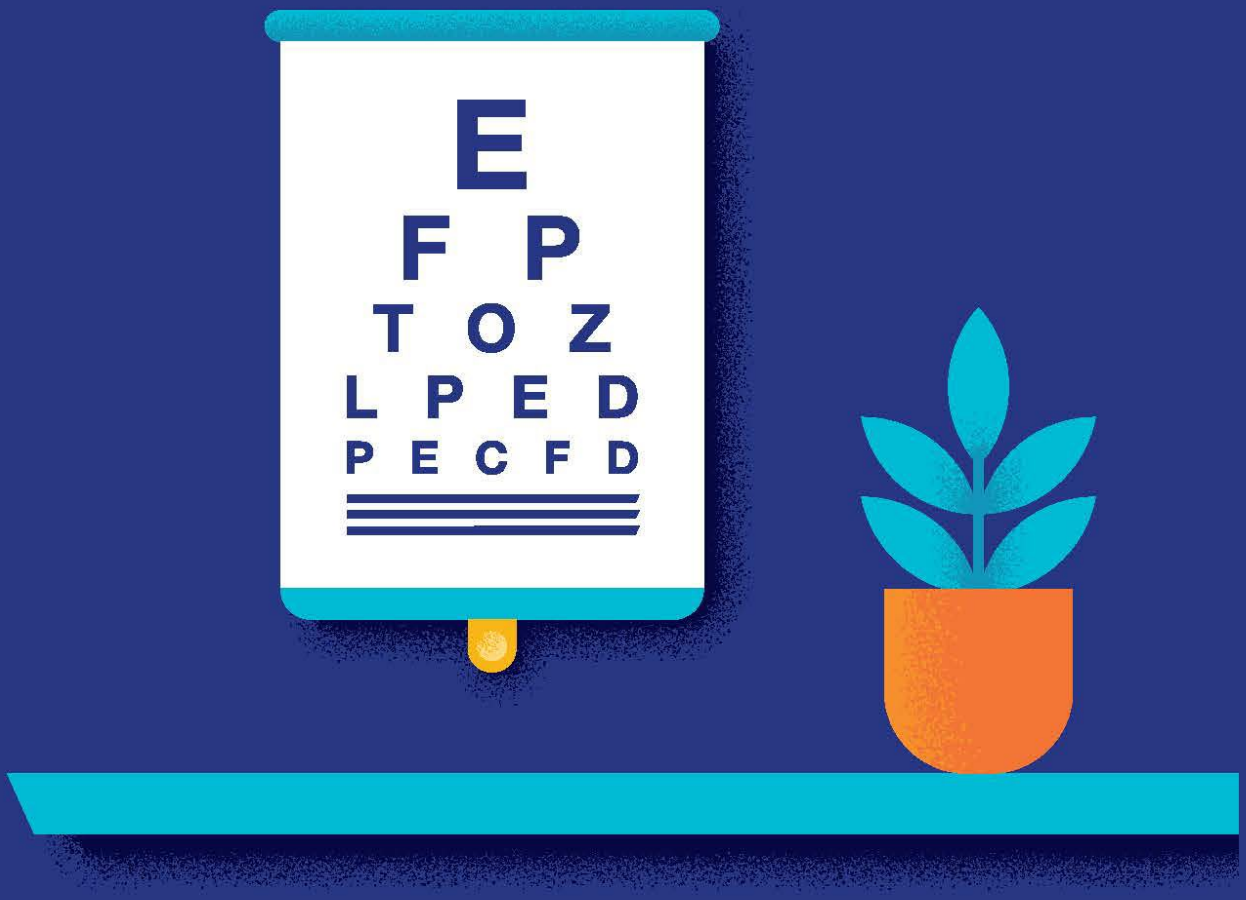


Tennessee Provider Reference Guide

UnitedHealthcare Community Vision Network

March Vision Network

United Healthcare | MARCH Vision Care

Disclaimer:

Provider Reference Guide Notice of Updates effective January 2024:

Section 1: General information
- 1.3 – Updated the Registration section with new One Healthcare ID requirement
- 1.10 – Added registry and exclusion check requirements

Section 3: Billing and claims procedures
- 3.1 – Linked our Claim Denial Quick Reference Guide in the Clean claim definition section
- 3.2 – Added language regarding the use of accurate and detailed ICD-10 codes for all diagnosis codes

If you require language and communication assistance services, like interpretation in a language other than English or an auxiliary aid or service, please reach out to us at **844-966-2724** and we will provide you with effective communication assistance to best serve you. You can also dial 711 for TRS assistance. Additionally, if you require March Vision Care materials in alternate formats, please call **844-966-2724** to make a request (e.g. provider manual, forms and newsletters in languages other than English or Spanish, braille, large font, etc.).

About the Provider Reference Guide

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

This version of the Tennessee Provider Reference Guide ("PRG") was revised in October 2023. 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 available on marchvisioncare.com. To request a current copy of the Provider Reference Guide on CD, please reach out to our Provider Relations department at **844-966-2724**.

Terms used in this manual include the following:

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

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

Exhibits

1.1 About the TennCare Program

TennCare is the State of Tennessee's Medicaid program. It has been operated under a waiver from CMS since 1994, including Medicaid categories, the Uninsured (Standard) and the medically eligible Uninsurable ("Standard"). The TennCare program operates under a Section 1115 waiver from the Centers for Medicare and Medicaid Services (CMS). Medicaid waiver programs are time-limited. The waiver under which TennCare is currently operating is called "TennCare III" which began on January 8, 2021, and extends through December 31, 2030.

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

1.2 Contact information

Provider Services and Customer Service	(844) 966-2724 or (844) 96-MARCH Monday through Friday, 8:00 am to 5:00 pm local time
General Website	www.marchvisioncare.com
Provider Website	providers.eyesynergy.com
Lab and Contact Lens Orders	providers.eyesynergy.com
Provider Resources	marchvisioncare.com/providerresources.aspx

Our primary method of communication is email. At least one network provider's 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 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 patients
- A patient-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 patient 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, benefits and submitting and tracking lab orders and/or claims
- Dedicated Provider Relations Advocate (PRA) delivers the support you need when you need it

Non-contracted providers who are interested in joining our network can find additional information on our website at marchvisioncare.com > Join Our Network.

1.4 Providers.eysynergy.com

We are 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 co-payment 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 2.1)
- Obtain detailed claim status including check number and paid date
- Access online resources including a current copy of the PRG, state-specific benefits, and the providers.eyesynergy.com User Guide.

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

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

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

Registration

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 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 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.

**You can contact the Provider Relations department, to access their unique Registration number.*

Required Training

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

Sign in

Once registered, you may sign in at providers.eyesynergy.com with your username and password. Remember that passwords are case-sensitive. As a security feature, you will be asked to renew your password every 60 days.

- You can reset your own expiring password by selecting the "change your password" link in the message banner on the providers.eyesynergy.com home page
- If the password has already expired, providers.eyesynergy.com will automatically redirect you to the password reset page upon login
- You can also retrieve a forgotten password, by selecting the "Forgot your Password?" link on the sign-in page

As an additional safety feature, you are required to either call or contact your Account Administrator to have your password reset after five failed log-in attempts.

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

1.5 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.

Watch training videos on navigating our website, verifying members benefits and submitting claims and orders on our Provider Training Portal. You can also access additional trainings, including our free COPE Accredited CE courses at marchvisioncare.com >Training & Education.

1.6 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 diabetic members. You have the opportunity to 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 diabetic patients during comprehensive exam
- Send notifications with exam outcomes for every diabetic member to their PCP
- Submit CPTII 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.

1.7 Interactive Voice Recognition System (IVR)

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

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

You may access the Interactive Voice Recognition System by calling **844-966-2724**. Select the provider option and follow the prompts to verify eligibility and benefits, request a confirmation number, locate a provider or check claim status.

Registration

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

Sign in

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

1.8 Electronic Funds Transfer (EFT)

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

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

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

Paper EOPs have been eliminated. They are now available in electronic format (ERA) online via the PaySpan website.

Provider benefits

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

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

Signing up for electronic payments is simple, secure, and will only take 5-10 minutes to complete. To complete the registration process, please visit the PaySpan website (payspanhealth.com) or contact them directly at 877-331-7154.

1.9 Provider change notification

Please help us to ensure your current information is accurately displayed in our provider directory. Report changes concerning your provider information to us in advance. All changes should be reported to us in writing. You may experience a delay in claims 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 identification number (requires W9)
- Office hours
- Practice status regarding the acceptance of new members, children, min/max age limitations, etc.
- Providers added to practice/providers leaving practice
- Provider termination

Please report all changes via mail or email to:

UnitedHealthcare I March Vision Care
Attention: Provider Relations Department Mail Stop CA120-0307
5701 Katella Avenue
Cypress, CA 90630

Email: visionnominations@uhc.com

The Centers for Medicare & Medicaid Services (CMS) requires you to verify the accuracy of your information included in 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.

1.10 Licensure and background, registry and exclusion checks

You are responsible for conducting background checks in accordance with state law and TennCare policy and ensuring that all employees, agents, subcontractors, providers or anyone acting for or on behalf of you conducts background, registry and exclusion checks in accordance with state law and TennCare policy.

1.11 Monitoring sanction and exclusion lists

You are obligated to screen your employees and contractors ("Screened Persons") initially and on an ongoing monthly basis to determine whether any of them have been excluded from participation in Medicare, Medicaid, SCHIP, or any Federal Health Care Programs (as defined in Section 1128B(f) of the Social Security Act).

You are required to search the following lists of excluded individuals (the "Exclusions Lists") on the HHS-OIG website, at no cost, by the names of any individuals or entities through the following databases:

- LEIE
- Health Integrity and Protection Data Bank (HIPDB)
- System for Award Management (SAM)

You shall not employ or contract with an individual or entity that has been excluded, debarred, suspended or otherwise ineligible to participate in Federal Health Care Programs or convicted of a criminal offense that falls within the realm of 42 U.S.C. § 1320a-7(a) ("Ineligible Persons"). You acknowledge and agrees that civil monetary penalties may be imposed against you if you employ or enter into contracts with excluded individuals or entities to provide items or Covered Services to Covered Persons. You are to immediately notify us regarding any exclusion information that is discovered at (844) 966-2724.

2.1 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 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
- 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 on the date services will be rendered.

If you generate a confirmation number in providers.eyesynergy.com, you must first verify the member's available services in the system. You have the option of choosing a confirmation number for exam services only, material services only, or for all services (exam and materials) after the member's available services are verified. The confirmation number is valid from the date of service selected until the end of that month.

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 is exhausted prior to claim submission

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

**Please contact a Customer Service Representative for additional assistance if you generate a confirmation number through the IVR system, but it is not found when entering the information in providers.eyesynergy.com.*

Covered benefits

You can access a list of covered benefits by:

- Signing into providers.eyesynergy.com
  - Resources > Provider Reference Guide > select the applicable state from the drop-down 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 drop-down menu

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

Methods of verification

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

2.2 Non-covered services

The Centers for Medicare and Medicaid Services (CMS) prohibits you from billing or seeking compensation from Medicare and Medicaid beneficiaries for the provision of services that are covered benefits under their Medicare and/or Medicaid plans. There are certain circumstances in which a member requests services that are not covered or fully covered under their Medicare and/or Medicaid plans.

In those circumstances, you may bill the member, provided the member agrees in writing that he or she is willing to accept payment responsibility.

Non-covered frame and lens options for Medicaid members only:

The member is fully responsible for the entire materials charge if a member chooses non-covered materials (either a frame and/or non-covered lens options such as AR, UV, tinting, etc.).

REMINDER FOR ALL MEMBERS:
A member must sign a Non-Covered Service Fee Acceptance Form (Exhibit A) for all non-covered services. Such agreement by the member must be made prior to the actual delivery of services. Documentation of the agreement must be placed in the member's chart as part of his/her medical record. A copy of the written agreement must be given to the member to ensure their understanding of their financial responsibility for non-covered frames and/or lenses

2.3 TennCare Kids (EPSDT)

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

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

B. TennCare Kids (EPSDT) Screening Guidelines

1. Periodicity schedule for check-ups and screenings

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

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

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

Periodicity schedule for TennCare Kids screenings:

Infancy	Early childhood	Middle childhood	Adolescence
At birth	15 months old	5 years old	11 years old
3-5 days	18 months old	6 years old	12 years old
1 month old	24 months old	7 years old	13 years old
2 months old	30 months old	8 years old	14 years old
4 months old	3 years old	9 years old	15 years old
6 months old	4 years old	10 years old	16 years old
9 months old			17 years old
12 months old			18 years old
			19 years old
			20 years old

3.1 Claim submission

Preferred method

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 payor ID for Optum is 52461.

Paper claims

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

UnitedHealthcare I March Vision Care
Attn: Medicaid Vision Claims
PO Box 30989
Salt Lake City, UT 84130

Clean claim definition

A clean claim is defined as a claim we receive for adjudication that requires no further information, adjustment, or alteration by the provider of the services in order to be processed and paid. 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
- Current and applicable modifier codes
- Place of service
- Usual and customary charges

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

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

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

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.

3.2 American Medical Association CPT coding rules

We reaffirm our adoption of CPT coding rules established by the American Medical Association:

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

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.

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

In an effort to improve HEDIS and Star Ratings performance, we require you to submit CPT II and ICD-10 codes, on claims, to demonstrate performance and diagnosis for diabetic members.

Please see Exhibit O: HEDIS/Stars Performance Reporting for more information.

3.3 Billing for replacements and repairs

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

3.4 Telemedicine

March Vision Care covers telemedicine routine vision exams consistent with an in-person exam when those telemedicine exams meet UnitedHealthcare's expectations and requirements. You must be approved in advance in order to submit claims for telemedicine exams if telemedicine is acceptable in your state. 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, you may use Place of Service Code 02 with the codes below on your electronic (EDI) or paper claim or 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 technology.

Exam codes: 92002, 92004, 92012, or 92014

3.5 Frame warranty

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

If you determine that the defective frame is covered under the warranty, please reach out to us at **844-966-2724**. Do not send any broken glasses to us or the contracted lab.

3.6 Order cancellations

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

- **Members** are responsible for the cost of frames and/or lenses if the order is cancelled by the member after the order has been completed by the lab
- **You** are responsible for the cost of frames and/or lenses if the order is incorrect due to provider error
- In the event of an error, do not resubmit a corrected order. Please contact us at **844-966-2724**.

3.7 Billing for glaucoma screenings

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

- Dilated exam with intraocular pressure (IOP) measurement
- Either direct ophthalmoscopy or slit lamp biomicroscopy

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

3.8 Billing of Medicare allowance

A set dollar amount, also known as an "allowance" or an "allowance-based benefit", is typically allowed to cover frames, lenses and/or contact lenses provided to Medicare members. 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.

3.9 Claim filing limits

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

Medicaid	Medicare
120	365

We will not deny your claims on the basis of untimely filing in the following situations:
- Coordination of Benefits (COB)
- Subrogation
- Retroactive Eligibility Date

Proof of timely filing

- Timeframe for filing a claim in situations involving third party benefits (COB and subrogation) shall begin on the date that the third party documented resolution of the claim.

- Timeframe for retroactive eligibility dates shall begin on the date that we receive notification from the health plan of the enrollee's eligibility/enrollment

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

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.

3.10 Payment policies

Claim payments are issued in accordance with the applicable provider services agreement and governing entity regulations. The 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. We have weekly check runs to comply with prompt payment policies.

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

3.11 Corrected claims

A corrected claim will only be considered if the original claim was submitted within the claim filing limits. The corrected claim timely filing limit for the state of Tennessee is:

- 120 days from the original paid date for Medicaid
- 365 days from the date services are rendered for Medicare

The corrected claim filing limit is in accordance with the applicable provider service agreement and/or governing entity regulations.

A corrected claim may be submitted 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. Instead, please submit your corrected claim on a red CMS-1500 form along with the proof of timely filing or coordination of benefits attachment(s).

All other corrected claims, not submitted using providers.eyesynergy.com during the initial claim submission, must also be submitted on a red CMS-1500 form. Clearly indicate on the claim that the submission is a "**corrected claim**." This ensures the corrected information will be considered during claims processing and helps prevent payment delays. Corrected claims are not subject to the $2.00 paper claim processing fee.

Please mail corrected claims to:

UnitedHealthcare I March Vision Care
Attn: Medicaid Vision Claims
PO Box 30989
Salt Lake City, UT 84130

The corrected claim filing limit in Tennessee is 120 days for Medicaid and begins on the original denial/paid date. For Medicare, the corrected claim filing limit is 365 days and begins on the date services are rendered.

3.12 Provider disputes

We're here to help and are committed to supporting you and your practice. You can reach our Customer Service department at **844-966-2724** Mon-Fri., 8:00 a.m. to 5:00 p.m. local time. In addition to contacting our Customer Service Department, our Provider Dispute Resolution Process provides a mechanism for you to communicate disputes in writing.

Provider dispute types

- Claim

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

Provider dispute resolution process

1. Submit the Provider Dispute Resolution Request Form (Exhibit B) or a written summary of your dispute including supporting documentation. This serves as your first level of appeal/reconsideration.

   Please submit your request by mail to:

   UnitedHealthcare I March Vision Care
   Attn: Medicaid Vision Appeals
   PO Box 30988
   Salt Lake City, UT 84130

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

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

3.13 Overpayment of claims

You must report and return any overpayment to us within 60 days of the date on which the overpayment was identified and provide the reason for the overpayment. You will notify you in writing by us if we or TennCare determines 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.

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

3.14 Balance billing

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

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

3.15 Coordination of benefits

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

As the Tennessee state Medicaid plan:

- TennCare is always the payor of last resort

- The primary plan must be billed first, and the claim is billed just like any other claim would be billed
- The secondary plan is billed once an explanation of payment (EOP) and possibly a payment is received from the primary plan.
- The claims submitted to a secondary or tertiary plan are considered "COB claims"
- When billing a secondary plan, the bill must have the primary insurance plans' EOP attached
- The payments received from the primary plan should be indicated in field 29 of the CMS 1500 form

We process COB claims in accordance with the applicable provider services agreement and governing entity regulations. When we are the secondary payor, we are responsible for the difference between your usual and customary charges and the amount payable by the primary insurance plan, not to exceed the applicable reimbursement rates and benefit allowance.

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

Please mail COB claims to:

UnitedHealthcare I March Vision Care
Attn: Medicaid Vision Claims
PO Box 30989
Salt Lake City, UT 84130

3.16 Disclosure of Criminal Conviction, Ownership and Control Interest

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

3.17 Medicaid ID

All providers (both the rendering provider and the billing provider) must receive a Tennessee Medicaid ID prior to claims payment for TennCare members. This ID is assigned by the Bureau of TennCare and is available on the web. To apply for a Tennessee Medicaid ID, you may call TennCare at 800-852-2683. The website address for applications is http://www.tn.gov/tenncare/topic/provider-registration.

3.18 Encounter data

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

4.1 Access standards

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

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

- Appointments for routine, non-urgent eye examinations and eyeglass or contact lens fittings and dispensing are not to exceed three (3) weeks or 21 calendar days
- Appointments for urgent/emergent eye care services, within the optometrist's or ophthalmologist's scope of practice, are not to exceed 48 hours
- 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
- You are required to employ an answering service or a voice mail system during non-business hours, which provide instructions to members on how they may obtain urgent or emergency care. The message may include:
    - An emergency contact number (i.e. cell number, auto forwarding call system, pager)
    - Information on how to contact another provider who has agreed to be on-call to triage or screen by phone, or if needed, deliver urgent or emergency care
    - Instructions to call 911 or go to the local emergency room
- Members with scheduled appointments will wait no more than 45 minutes before being seen by a provider
    - Wait time is defined as the time spent in the lobby and in the examination room prior to being seen by a provider
- Members are entitled to a second opinion from a qualified health care professional within the network, or arrangement may be made for the member to obtain one outside the network, at no cost to the member.
- Emergency services will be provided without regard to prior authorization requirements

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

4.2 Emergency and urgently needed services/After-hours calls

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

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

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

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

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

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

4.3 Access monitoring

We are responsible for monitoring compliance with accessibility standards. This includes monitoring member's 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:

- Blast Fax requests may be used to gather information from providers to determine demographic, access and language information
- Telephone access surveys will be conducted by us through random calls to optometrist and ophthalmologist offices to verify capacity to ensure that appointments are scheduled on a timely basis, with appropriate office wait time, and that appropriate after-hours answering systems are being utilized
- Our grievance system serves to identify access-related concerns
    - The tracking of grievances and an investigation of grievance patterns may result in the implementation of new policies and procedures and/or the education of participating optometrists, ophthalmologists, and staff members
- Members may be provided with a Member Satisfaction Survey to comment on the service and products received from us and its providers if delegated to do so
- 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 also be periodically monitored to determine how long members wait for scheduled appointments

5.1 Protocol for member complaints and appeals

Definitions

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

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 Complaint and Appeal process. Please refer to the TennCare Medical Appeal Form which is to be provided upon member's request. A complaint can be filed in person or by telephone at 800-878-3192.

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

Members should be referred to their health plan for assistance. 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 complaint/appeal investigation. You are required to furnish medical records of members for whom claims have been submitted per your contract with us. Member authorization is not required to release medical records per state and federal regulations. We will ensure that complaints and appeals will be investigated, and resolved in a regulatory compliant time frame, following its policies and procedures.

Discrimination against members who have filed a complaint is not permitted. By providing assistance to those with limited English proficiency or with a visual or other communicative impairment, all members have access to and can fully participate in the complaint system. Such assistance may include, but is not limited to, translations of complaint procedures, forms, and plan responses to complaints, as well as access to interpreters and devices that aid impaired individuals in communication. You may direct individuals wanting to file a discrimination complaint about TennCare services to TennCare's Office of Civil Rights Compliance's webpage at: https://www.tn.gov/tenncare/members-applicants/civil-rights-compliance.html or to call TennCare Connect at 855-259-0701 if they need assistance with filing a complaint. Providers may also file a discrimination complaint at: https://www.tn.gov/tenncare/members-applicants/civil-rights-compliance.html.

5.2 Potential quality issue

A potential quality issue is an individual occurrence of a suspected deviation from expected provider performance, clinical care or outcome of care that cannot be determined to be justified without additional review.

- The investigation of the potential quality issue is conducted by the Quality Management Department and documented in the case file
- The potential quality issue is presented to the Chief Medical Officer/Optometrist reviewer for evaluation and recommendations
- If it is determined that a potential breach in quality exists, the case may be referred for further levels of review, which include outside specialists, peer review, credentialing or the Legal Department
- Upon completion of the medical review, the case is assigned a level that demonstrates the severity of breach in quality, along with the outcome and required intervention, if appropriate. Please refer to Exhibit I for severity levels for various issues and possible actions.

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

6.1 TennCare[SM] member rights and responsibilities:

Rights and responsibilities as a TennCare[SM] and UnitedHealthcare Community Plan member

Members have the right to:

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

Rights to stay with UnitedHealthcare Community Plan

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

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

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

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

- Upon your death

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

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

Cultural competency and non-discrimination

TennCare members should receive culturally competent care that is free from discrimination due to a person's race, color, national origin, language, sex, age, religion, disability, or any status protected by federal or state civil rights laws, in TennCare or UnitedHealthcare Community Plan. Discrimination can take the following forms:

- Not letting a person take part in the same things as other people
- A patient not getting the help they needed to make a healthcare appointment
- A patient not getting the care they needed during a health care encounter

Under the disability nondiscrimination laws, qualified individuals with disabilities must be provided with an equal opportunity to participate in a program, service, or activity. This means a patient may need a mitigating measure like a reasonable accommodation or auxiliary aids and services during a service encounter. You can learn more about Titles II and III of the ADA, Section 1557 of the Patient Protection and Affordable Care Act, and Section 504 of the Rehabilitation Act of 1973 at:

- www.ada.gov
- Civil Rights for Providers of Health Care and Human Services | HHS.gov

Members are to be provided with proper accommodations for any disabilities. In determining what types of auxiliary aids and services are necessary, you shall give primary consideration to the requests of individuals with disabilities in accordance with 28 C.F.R. § 35.160 and 28 C.F.R. § 36.303. In order to be effective, auxiliary aids and services must be provided in accessible formats, in a timely manner, and in such a way as to protect the privacy and independence of the individual with a disability. If an individual requests an auxiliary aid or service that you can demonstrate would result in a fundamental alteration in the nature of its services or result in an undue financial and administrative burden, you do not have to provide the requested auxiliary aid or service to the individual. However, if available, you shall provide the individual with another form of an auxiliary aid or service that would achieve effective communication with the individual and not result in a fundamental alteration in the nature of your services or result in an undue financial and administrative burden.
The nondiscrimination laws require effective communication with individuals. This means that a provider must provide translation or interpretation services needed to effectively communicate with a Limited English Proficiency (LEP) individual or

an auxiliary aid or service to effectively communicate with an individual with a disability. The National Institute of Minority Health and Health Disparities created a *Language Access Portal* (LAP). The LAP contains information, in multiple languages, for six disease areas (cancer, diabetes, cardiovascular disease, and more) where major health disparities have been identified in non-English speaking populations. To learn more: https://www.nimhd.nih.gov/programs/edu-training/language-access/index.html

You are responsible for ensuring that patients have a full understanding of their diagnosis and treatment guidelines, regardless of their preferred language. To ensure that all limited English proficient members receive appropriate access to vision care, you are expected to comply with federal and state requirements regarding cultural and linguistic services.

It is not permissible to:

- Turn a member away
- Limit the member's participation or access to services because of language barriers
- Subject a member to unreasonable delays due to language barriers
- Provide services to Limited English Proficiency (LEP) members that are lower in quality than those offered in English

You must have written procedures for the provision of language interpretation and translation services for any member who needs such services, including but not limited to, members with LEP. Limited English Proficiency services ensure that members receive free translation and interpretation services. The health plan provides translation services to any of its members during direct contacts with health plan staff. The health plan does not reimburse for translation services offered to TennCare members in your office setting. You are responsible for offering these services without charge to the member. This is a requirement under Title VI of federal regulations, which applies to any provider that accepts TennCare funds.

Health literacy also plays an important role in effective communication and culturally competent care. The U.S. Department of Health and Human Services has health literacy and communication tools and resources at:

- Health Literacy | health.gov

  and

- Consumer Health Content on MyHealthfinder | health.gov

You can learn more about civil rights compliance and cultural competency and find resources like trainings, toolkits, forms, policies, and notices at:

- https://www.tn.gov/tenncare/providers/programs-and-facilities/civil-rights-information.html

  and

- https://www.tn.gov/tenncare/members-applicants/civil-rights-compliance.html

When a program or entity receives federal funding, beneficiaries, like TennCare members, and participants, like providers, in that program have the right to receive services or participate in that program free from discrimination because of their race, color, national origin, disability, age, sex, conscience and religious freedom, or other statuses protected by federal and/or state law. By law, no one can retaliate against a person for making a complaint.

Information on how to file a complaint and the TennCare real-time and PDF discrimination complaint forms can be found at: https://www.tn.gov/tenncare/members-applicants/civil-rights-compliance.html. Complaints can also be filed by calling TennCare Connect at 855-259-0701 or by mailing completed complaint forms to:

TennCare, Office of Civil Rights Compliance
310 Great Circle Rd, Floor 3W
Nashville, TN 37243

Providers are required to assist members with obtaining discrimination complaint forms and assistance from the UnitedHealthcare Community Plan Nondiscrimination Compliance Officer for TennCare:

Jay Taylor
Compliance Officer, Tennessee
UnitedHealthcare Community Plan
10 Cadillac Drive, Suite 200

Brentwood, TN 37027
Office: 615-493-9530
email: jay_taylor@uhc.com

If your complaint is not about TennCare services and is about either physical health care and/or mental health care, please call UnitedHealthcare Community Plan at **800-690-1606**, or write to us at:

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

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

A copy of TennCare's Discrimination Complaint form is available as Exhibit N of this PRG.

7.1 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 or indirectly influence our ability to meet our goal to deliver high quality of services to all of our customers that includes members, providers and clients.

The scope of the program's focus is evaluated on an annual basis and includes, but is not limited to monitoring activities in the following areas:

- Delivery of quality of care
- Complaints and grievances
- Member access and availability to care, health education, satisfaction surveys, and others

7.2 Clinical decision making

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

7.3 Coordination with Primary Care Providers

You are asked to contact a member's Primary Care Provider (PCP) should you notice any additional medical needs while providing vision services.

Example: If you observe a significant change in an eye exam of a diabetic member, please call the PCP. The assigned PCP is noted on the front of the member's ID card. You may contact the member's Health Plan directly for assistance in coordinating additional medical needs for the member.

7.4 Medical records standards

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

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

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

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. Our Chief Eye Care Officer and our Peer Committee 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.

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

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.

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
- 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)

8.1 Fraud, Waste, and Abuse (FWA)

Training of providers concerning the prevention, detection and reporting of health care fraud

We recognize the importance of properly educating and training you to prevent, detect and report 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 requirements of our participating providers

Fraud, Waste, and Abuse (FWA) and general compliance training is required. You must complete and provide this training to your employees (including temporary or volunteers) and contractors that support the delivery and administration program benefits or services within 90 days of hire and annually thereafter. You may provide your own training materials, or utilize FWA and general compliance training materials provided by the Centers for Medicare & Medicaid Services (CMS) available on their website (https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/webbasedtraining). For additional information, please refer to our website (https://www.marchvisioncare.com/complianceinformation.aspx).

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 or lists such as Tennessee Department of Health's Health Professional Boards Disciplinary Action and TennCare's Terminated Provider Lists

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. If a state agency asks for file and/or records, they will be supplied at no cost to the requesting agency.

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 health care system. We expressly prohibit retaliation if a suspected issue is reported in good faith.

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

8.2 Member abuse and neglect

Abuse and neglect – Elderly

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

1. Types of abuse and neglect

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

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

- Dehydration (extreme thirst)
- Pressure sores (bed sores)

b) Physical abuse definition and examples:

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

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

c) Material/financial abuse definition and examples:

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

- Unusual banking activity (e.g. large withdrawals during a brief period of time, switching of accounts from one bank to another, ATM activity by a homebound elder)
- Bank statements (credit card statements, etc.) no longer come to the older adult
- Documents are being drawn up for the elder to sign but the elder cannot explain or understand the purpose of the papers
- The elders' living situation is not commensurate with the size of the elder's estate (e.g. lack of new clothing or amenities, unpaid bills)
- The caregiver only expresses concern regarding the financial status of the older person and does not ask questions or express concern regarding the physical and/or mental health status of the elder
- Personal belongings such as jewelry, art, furs are missing
- Signatures on checks and other documents do not match the signature of the older person
- Recent acquaintances, housekeepers, "care" providers, etc. declare undying affection for the older person and isolate the elder from long-term friends or family
- Recent acquaintances, housekeeper, caregiver, etc. make promises of lifelong care in exchange for deeding all property and/or assigning all assets over to the acquaintance, caregiver, etc.

d) Psychological abuse definition and examples:

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

e) Psychological signs:

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

f) Behavioral signs:

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

g) Sexual abuse definition and examples:

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

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

h) Violations of basic rights definitions and examples:

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

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

i) Self-neglect definition and examples:

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

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

j) Other examples of abuse and neglect:

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

k) Risk factors for abuse

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

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

Abuse and neglect – children

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

- **Physical abuse** is non-accidental physical trauma or injury inflicted by a parent or caretaker on a child. It also includes a parent's or a caretaker's failure to protect a child from another person who perpetrated physical abuse on a child. In its most severe form, physical abuse is likely to cause great bodily harm or death.

- **Physical neglect** is the failure to provide for a child's physical survival needs to the extent that there is harm or risk of harm to the child's health or safety. This may include, but is not limited to abandonment, lack of supervision, life endangering physical hygiene, lack of adequate nutrition that places the child below the normal growth curve, lack of shelter, lack of medical or dental that results in health threatening conditions, and the inability to meet basic clothing needs of a child. In its most severe form, physical neglect may result in great bodily harm or death.

- **Sexual abuse** includes penetration or external touching of a child's intimate parts, oral sex with a child, indecent exposure or any other sexual act performed in a child's presence for sexual gratification, sexual use of a child for prostitution, and the manufacturing of child pornography.
  - Child sexual abuse is also the willful failure of the parent or the child's caretaker to make a reasonable effort to stop child sexual abuse by another person.

- **Emotional Abuse** includes verbal assaults, ignoring and indifference or constant family conflict. If a child is degraded enough, the child will begin to live up to the image communicated by the abusing parent or caretaker. Possible Indicators of Abuse and Neglect include:

- The child has repeated injuries that are not properly treated or adequately explained.
- The child begins acting in unusual ways ranging from disruptive & aggressive to passive & withdrawn.
- The child acts in the role of parent toward their brothers and sisters or even toward their own parents.
- The child may have disturbed sleep (nightmares, bed wetting, fear of sleeping alone, and needing nightlight).
- The child loses his/her appetite, overeats, or may report being hungry.
- There is a sudden drop in school grades or participation in activities.
- The child may act in stylized ways, such as sexual behavior that is not normal for his/her age group.
- The child may report abusive or neglectful acts.

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

- **Parents who abuse or neglect their children may show some common characteristics:**
  - Possible drug/alcohol history
  - Disorganized home life
  - May seem to be isolated from the community and have no close friends
  - When asked about a child's injury, may offer conflicting reasons or no explanation at all
  - May seem unwilling or unable to provide for a child's basic needs
  - May not have age-appropriate expectations of their children
  - May use harsh discipline that is not appropriate for child's age or behavior
  - Were abused or neglected as a child

Action required by Tennessee state law

For Abuse or Neglect Reports call:

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

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

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

When you call, please be prepared to give:

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

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

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

9.1 Credentialing and recredentialing

You are required to submit your CAQH number for credentialing.

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 as well as decrease the amount of paperwork for you and your staff.

Please provide us with your CAQH number as soon as possible to expedite credentialing. 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 in processing. 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 last 3 months
- Certificate of Insurance showing Professional Liability Coverage (malpractice insurance)
- State License including Diagnostic Pharmaceutical Agent (DPA) License or Therapeutic Pharmaceutical Agent (TPA) License
- Copy of DEA and CDS (if applicable)
- Board Certification (if applicable)
- Vitae/Resume, including work history (only needed for initial credentialing)
- If participating with Medicaid, you must enroll with your state agency

You must be credentialed through CAQH in order to be paid for TennCare Program services.

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. 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.

Recredentialing process

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

9.2 National Provider Identifier

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

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

10.1 Cultural competency

We shall ensure that all health plan members receive equitable and effective treatment in a culturally and linguistically appropriate manner. 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 beliefs, practices and unique needs for each and every 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:

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

It also defines health care expectations such as:

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

And why is it important?

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

Cultural competence emphasizes the idea of effectively operating in different cultural contexts and altering practices to reach different cultural groups. Cultural competence is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services; thereby producing better outcomes.

A cultural competency program can help you respectfully and sensitively address the needs of your patients who have been marginalized because of their race, gender, sex, age, and other protected statuses. There are many cultural influences that impact the office visit. Some cultural preferences to remember include:

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

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

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

11.1 Confidentiality

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

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

11.2 Protected Health Information

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

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

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

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

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

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

11.3 Secure transmission of Protected Health Information (PHI)

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

- Please 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 setup with our email systems. For more details, follow steps described in Exhibit L: “Sending a Secure Email to us for PHI related data” to ensure that HIPAA guidelines are being met and PHI is secured. 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. In addition, if such an event occurs, you agree to cooperate with any remediation efforts undertaken by us.

Exhibits

Exhibit A Non-Covered Service Fee Acceptance form

Exhibit B Provider Dispute Resolution Request form (online)
Provider Dispute Resolution Request form (paper)

Exhibit C Lab Order form

Exhibit D Tips for Working with Limited English Proficient Members

Exhibit E Tips for Working with Interpreters

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

Exhibit G Language ID Poster

Exhibit H TennCare Member Appeal Form

Exhibit I Potential Quality Issue - Severity Levels

Exhibit J Potential Quality Issue Referral form

Exhibit K Clinical Practice Guidelines

Exhibit L Instructions on Sending a Secure Email Containing PHI

Exhibit M TennCare Member Appeal Rights Poster

Exhibit N UnitedHealthcare Community Plan Discrimination Complaint Form

Exhibit O HEDIS and Stars performance reporting

Exhibit P TennCare Discrimination Complaint Form (Arabic)

— Exhibit D —

Tips for Working with Limited English Proficient Members

- Who is a Limited English Proficient (LEP) member?
  Individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English, may be considered LEP.

- How to identify a LEP member over the phone:
  - Member is quiet or does not respond to questions
  - Member simply says yes or no, or gives inappropriate or inconsistent answers to your questions
  - Member may have trouble communicating in English or you may have a very difficult time understanding what they are trying to communicate
  - Member self identifies as LEP by requesting language assistance

- Tips for working with LEP members and how to offer interpreter services:
  - Member does not speak English and you are unable to discern the language
  - Connect with contracted telephonic interpretation vendor to identify language needed
  - Member speaks some English
  - Speak slowly and clearly. Do not speak loudly or shout. Use simple words and short sentences.

- How to offer interpreter services:
  - "I think I am having trouble with explaining this to you, and I really want to make sure you understand. Would you mind if we connected with an interpreter to help us? Which language do you speak? OR
  - "May I put you on hold? I am going to connect us with an interpreter." (In the event you are having difficulty communicating with a member, using this statement is a good transition to initiating interpreter assistance.)

- Best practice to capture language preference:
  - For LEP members it is best practice to capture the members preferred language and record it in the plans' member data system.
    - "In order for me (or Health Plan) to be able to communicate most effectively with you, may I ask what your preferred spoken and written language is?"

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

— Exhibit E —

Tips for Working with Interpreters

Telephonic interpreters

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

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

- When the interpreter comes onto the line let the interpreter know: **
  - Who you are
  - Who else is in the room
  - What sort of office practice this is
  - What sort of appointment this is

  Example: “Hello interpreter, this is Dr. Jameson. I have Mrs. Dominguez and her adult daughter here for Mrs. Dominguez’ annual exam.” **

- Give the interpreter the opportunity to introduce himself or herself quickly to the member **
- If you point to a chart, a drawing, a body part or a piece of equipment, describe what you are pointing to as you do it **

Onsite interpreters

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

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

Footnotes:

* “Limited English Proficiency Plan,” Minnesota Department of Human Services: Helpful hints for using telephone interpreters (page 6).
** “Addressing Language Access Issues in Your Practice - A Toolkit for Physicians and Their Staff Members,” California Endowment website

— Exhibit F —

Tips for documenting interpretive services for limited English proficient members -- Notating the Provision or the Refusal of Interpretive Services

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

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

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

— Exhibit G —

Language ID Poster

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

Amharic አማርኛ
ወደቋንቋዎ ያመልክቱ
አስተረጓሚ ሊመጣሎ

Arabic اللغة العربية
اشر إلى لغتك الأصلية وسوف نستدعي المترجم اللازم

Armenian Հայերէն
Ցույց տուէք ո՞ր մէկ լեզուն կը խօսիք՝
որպէսզի թարգմանիչ մը կանչել տանք.

Cambodian ភាសាខ្មែរ
សូមចង្អុលភាសាអ្នក
យើងនឹងហៅអ្នកបកប្រែមកជូន

Cantonese 廣東話
唔該點出您講嘅語言.
等我哋幫您搵翻譯.

Farsi فارسی
زبان مادری خود را مشخص کنید.
مترجم بطور رایگان در اختیار شما گذاشته خواهد شد.

French Français
Montrez-nous quelle langue vous parlez.
Nous vous fournirons un/e interprète.

Hindi हिन्दी
अपनी भाषा इशारे से दिखाइये ।
आपके लिए दुभाषिया बुलाया जाऐगा ।

Italian Italiano
Faccia vedere qual è la sua lingua.
Un interprete sarà chiamato.

Japanese 日本語
あなたの話す言葉を指さしてください。
通訳を呼びます。

Korean 한국말
당신이 쓰는 말을 지적하세요.
통역관을 불러 드리겠어요.

Lao ພາສາລາວ
ຊີ້ບອກພາສາທີ່ເຈົ້າເວົ້າໄດ້
ພວກເຮົາຈະຕິດຕໍ່ນາຍພາສາໃຫ້

Mandarin 國語
請指認您的語言.
以便爲您請翻譯.

Russian Русский Язык
Укажите, на каком языке Вы говорите.
Сейчас Вам вызовут переводчика.

Samoan Gagana Samoa
Tusi lou a ao i lau gagana. O le a vala ´auina se tasi e fa´amatala´upu mo´oe.

Somali Soomaali
Tilmaan afka aad ku hadasho.
Tarjumaan ayaa la wacayaaye.

Spanish Español
Señale su idioma.
Se llamará a un intérprete.

Swahili Kiswahili
Onyesha lugha yako.
Tutamwita mtu atakayekufasiria.

Tagalog Tagalog
Pakituro po ninyo ang inyong wika.
Magpapatawag kami ng interpreter.

Thai ภาษาไทย
ช่วยชี้ให้เราดูหน่อยว่าภาษาไหนคือภาษาที่ท่านพูด
แล้วเราจะจัดหาล่ามให้ท่าน

Tongan Tonga
Tuhu kihe lea oku ke lea aki.
´E fetu´utaki kihe fakatonulea.

Urdu أردو
آپ کون سی زبان میں بات کرنا پسند کرینگی؟
آپ کی مدد کیئے ایھی کی ترجمان کو بلایا جائے گا.

Vietnamese Tiếng Việt
Chỉ rõ tiếng bạn nói.
Sẽ có một thông dịch viên nói chuyện với bạn ngay.

— Exhibit H —

TennCare Member Appeal Form

Having problems getting health care or medicine in TennCare?

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

Need help filing a medical appeal?
- Call **1-800-878-3192** for free.

Versión en español atrás

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

1. Who is the person that wants to appeal?

Full name _____ Date of birth___/___/____

Social Security Number_____-_____-_____ Or number on their TennCare card _____

Current mailing address_____

City_____ State _____ Zip Code_____

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

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

2. Who filled out this form?

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

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

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

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

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

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

4. Do you think you <u>have an emergency</u>?

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

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

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

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

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

Physician Signature:_____ Date:_____

Tennessee License Number:_____

Rev: 08Feb10

Keep reading. There is **1 more page** for you to fill out.

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

_____

_____

_____

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

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

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

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

Did your doctor prescribe the care or medicine? ___Yes ___No If yes, doctor's name_____

Have you asked your health plan for this care or medicine? ___Yes ___No If yes, when? _____

What did they say? _____

Did you get a letter about this problem? ___Yes ___No If yes, the date of the letter_____

Who was the letter from? _____

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

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

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

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

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

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

Their address _____

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

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

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

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

Then, **mail** these pages and other facts to:

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

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

To appeal by **phone**, call 1-800-878-3192 for free.
Have speech or hearing problems? Call our TTY/TDD line for free at 1-866-771-7043.

Rev:08Feb10

We do not allow unfair treatment in TennCare.

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

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

Use esta página **únicamente** para presentar una Apelación Médica de TennCare.

¿Necesita ayuda para presentar una apelación médica?
- Llame gratis al **1-800-878-3192.**

Version in English on other side

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

1. ¿Quién es la persona que quiere apelar?

Nombre completo_____ Fecha de nacimiento___/___/_____

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

Dirección postal vigente_____

Ciudad_____ Estado _____ Código postal_____

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

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

2. ¿ Quién completó este formulario?

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

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

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

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

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

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

4. ¿Piensa que tiene una emergencia?

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

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

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

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

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

Physician Signature:_____ Date:_____

Tennessee License Number:_____

Rev: 08Feb10

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

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

_____

_____

_____

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

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

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

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

¿Le recetó el médico la atención médica o la medicina? ___Sí ___No
Si respondió Sí, el nombre del médico _____
¿Le ha pedido a su plan de salud esta atención médica o medicina? ___Sí ___No
Si respondió Sí, ¿cuándo? _____
¿Qué dijeron? _____
¿Le llegó una carta sobre este problema? ___Sí ___No Si respondió Sí, la fecha de la carta _____
¿Quién le envió la carta? _____
¿Está recibiendo ahora esta atención médica o medicina por medio de TennCare? ___ Sí ___ No
¿Quiere ver si puede continuar recibiéndola durante su apelación? ___ Sí ___ No
¿Su médico dice que sigue necesitándola? ___ Sí ___ No Si respondió Sí, nombre del médico _____
Si sigue recibiendo la atención médica o la medicina durante su apelación y pierde es posible que le tenga que rembolsar los gastos a TennCare.

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

La fecha en que recibió la atención o medicina _____El nombre del médico, farmacia u otro lugar que lo atendió o le dio la medicina _____Su número de teléfono (___)_____-_____
Su dirección _____
¿Pagó usted la atención o medicina y quiere que le reembolsen? ___ Sí ___ No
Si respondió Sí, debe enviar una copia de un **recibo** que compruebe que usted pagó la atención médica o la medicina.
Si no pagó, **¿le va a llegar una cuenta?** ___ Sí ___ No Si respondió Sí y piensa que TennCare debería pagar usted deberá enviar una copia de una **cuenta.**
Díganos la fecha en que recibió la primera cuenta (si la sabe). _____

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

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

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

O, envíelas por **FAX** (gratis) al 1-888-345-5575. **Conserve una copia** de la página que demuestra que su fax pasó.
Para apelar por **TELÉFONO,** llame gratis al 1-800-878-3192.
¿Tiene problemas del habla o del oído? Llame gratis a nuestra línea TTY/TDD al 1-866-771-7043.

Rev: 08Feb10

TennCare no permite el trato injusto.

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

— Exhibit I —

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

— Exhibit K —

Clinical practice guidelines

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

We are committed to providing high quality services to its members. 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 its providers:

Standard of Care for eyeglass dispensing/fitting and contact lens fitting

Eyeglass dispensing/fitting

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

Contact lenses fitting

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

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.

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 HA1c 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 diabetes provider. 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 CPTII (2022F, 2023F, 2024F, 2025F, 2026F, 2033F or 3072F).

Management of glaucoma

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

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

Moderate glaucoma
- Testing protocol:
    - Threshold VF testing
        - Every 6 months
    - OCT testing NH cube and Ganglion cell
        - Every 6 months
    - Pachymetry
        - One time only
        - Keratoconus
            - Every 18 months
        - Post corneal surgery
            - Yearly

- NH photo
  - Every 6 months

Advanced glaucoma

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

Clinical criteria*

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

Benefit	Available when	Clinical criteria
Eyewear after eye surgery	Determined to be medically necessary	The stable refractive prescription changes are more than +/-0.75 diopters in any meridian or more than 20 degrees of axis shift or a change in add power greater than 0.50 diopters
Oversize lens	Needed for physiological reasons	The pupillary distance is 70mm or greater or other facial or ocular anomalies requiring a large lens
Trifocal lens	Member has a special need due to a job training program or extenuating circumstances	The base prescription is greater than +/- 1.00 and a bifocal greater than or equal to 2.00
Necessary contact lens	Such lenses provide better management of a visual or ocular condition than can be achieved with spectacle lenses, including, but not limited to the diagnosis of	Irregular astigmatism; unilateral aphakia; keratoconus when vision with glasses is less than 20/40; corneal transplant when vision with glasses is less than 20/40 or anisometropia that is greater than or equal to 4.00 diopter
Color tinting	Light sensitivity which will hinder driving or seriously handicap the outdoor activity of such member is evident	The member has photophobia, aniridia, uveitis, corneal dystrophy, cataracts, albinism, or use a medication that has a side effect of photophobia
Single vision eyeglasses in lieu of bifocals	Need is substantiated in member's medical record by clinical data	The need for distance correction > +/- 1.50 diopter AND Net combination of distance RX and bifocal > +1.00 or -2.00 AND you are unable to tolerate a multifocal len
Progressive lenses	Need is substantiated in member's medical record by clinical data	Epilepsy, childhood disorders with multiple impairments
Transitions lenses	Need is substantiated in member's medical record by clinical data	Chronic iritis or uveitis, albinism
Polycarbonate lenses	Need is substantiated in member's medical record by clinical data	▪ The member has a prescription of +/-8.00 ▪ Permanently reduced vision in one eye to less than 20/60 ▪ A facial deformity or disease that interferes with eye glass fit ▪ A documented occupational hazard
Ultra-violet coating	Need is substantiated in member's medical record by clinical data	▪ Provided to members with aphakia, albinism, members that have clinical evidence of macular degeneration, or are taking medicine that makes them more sensitive to ultra-violet light
Replacement due to outgrown glasses	Need is substantiated in member's medical record by clinical data	▪ Available for children under 18 when the member's pupil distance is wider than the frame's mechanical optical center by greater than 5mm ▪ Available when the new frame size is at least 3mm larger than the existing frames

Second opinion examination	Need is substantiated in member's medical record by clinical data	▪ Available when medical chart review of the first examination shows inadequate examination, documentation, or when clinical issues are not adequately addressed
High index lenses (Higher than polycarbonate)	Need is substantiated in member's medical record by clinical data	▪ Available when weight of a standard prescription could cause facial development issues (primarily for children) ▪ Available when lab cannot practically produce lenses with a lower index lens
Allergy to certain frames	Need is substantiated in member's medical record by clinical data	Alternative frame to be provided when a provider documents a rash or other adverse reaction to all March frame kit materials
SLAB Off/Prism	Need is substantiated in member's medical record by clinical data	▪ Available for bifocal or trifocal prescriptions that generate greater than 2 prism diopters of imbalance at the reading plane
Safety frames	Need is substantiated in member's medical record by clinical data	▪ Used with polycarbonate lenses based on polycarbonate criteria noted above; and ▪ Member is in and around a hazardous environment where, in the discretion of the patient, (parent) and the provider, extra ocular safety measures are required ▪ These would be considered "deluxe frames" and covered by March Vision Network ▪ These must meet ANSI standards
Non-standard frames	Need is substantiated in member's medical record by clinical data	▪ Used when member has facial parameters where standard frames do not fit correctly ▪ Used when optical correction will not fit practically in a standard frame

Low vision rehabilitation	Need is substantiated in member's medical record by clinical data	▪ Visual loss with best corrected visual acuity of 20/50 or worse in the better eye ▪ Constriction of visual fields to be less than 20 degrees or hemianopia ▪ Limited contrast sensitivity due to underlying pathology ▪ Initial consult codes of 97241 – 97245 or 99244 ▪ Maximized medical treatment of conditions such as, but not limited to, diabetic retinopathy, macular degeneration, optic atrophy, and glaucoma ▪ Diagnosis codes consistent with low vision pathology. Under certain circumstances, medical records may be requested. If requested, they need to demonstrate that medical, surgical, and other treatments that have been tried and failed. They must have a diagnosis as noted below AND reduced vision. The appropriate diagnosis codes are necessary, including, but not limited to: ▪ D49.81 ▪ G.35 ▪ H47.099 ▪ H33.08-H33-303 ▪ E11.319, E10,319 ; H35.00-H35.443 ▪ H40.001-H40-2234 ▪ H53.40-H53-483 ▪ H54.2-H54.60 ▪ H46.00-H47.333 ▪ H55.00-H55.01 ▪ Or others by pre-approval ▪ A low vision rehabilitation request form must be completed and submitted ▪ Before proceeding, prior approval is required
Dilation of eyes	Initial examination required. Subsequent examinations as follows:	▪ All new members require a dilated fundus exam, a wide-angle photograph, or equivalent image (if acceptable per state/federal regulation). Diabetics require dilation every year at a minimum, more often if they have retinopathy. Members with other certain pathology such as lattice degeneration, choroidal nevi, or retinoschisis for example, may also need a dilated exam every year or as medically indicated. Dilation of members with no risk factors thereafter should be based on the professional judgment of the provider or every 3 years, whichever occurs first.
Polarized lenses	Need is substantiated in member's medical record by clinical data	▪ Chronic iritis, uveitis, or other active inflammatory eye disease with fixed and dilated pupils or aniridia
Necessary contact lens replacement	Such lenses provide better management of a visual or ocular condition than can be achieved with spectacle lenses (see criteria above)	▪ The member meets criteria as noted above for necessary contact lens and there is: -Change of +/- 1.00 diopter in power -Change of 0.50 mm in base curve -Change of 0.30 mm in optic zone -Change of 0.75 mm in peripheral curve radius -Change of 0.30 mm in peripheral curve width

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

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

— Exhibit L —

Sending a secure email to March Vision Care for PHI related data

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

The following details are from the Microsoft TechNet article "Secure Your E-mail Traffic."

Secure Your E-Mail Traffic

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

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

- Identify the Exchange Server on which to install the certificate
- Generate a certificate request
- Acquire the certificate
- Install the certificate
- Create a Simple Mail Transfer Protocol (SMTP) connector
- Enable TLS

Step 1: Identify the Exchange Server on which to install the certificate

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

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

Note:

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

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

Step 2: Generate a certificate request

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

Step 3: Acquire the certificate

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

Step 4: Install the certificate

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

Step 5: Create an SMTP connector

Based on your current email environment, use one of the following procedures to create an SMTP connector or send connector.

Create an SMTP connector in Exchange 2000 or Exchange 2003

- In Exchange System Manager, right-click **Connectors**, and then click **New SMTP Connector**
- Type a name for the connector (for example, MicrosoftOnline)
- On the **General** tab, select **Forward all e-mail through this connector to the following smart host**, and then type **mail.global.frontbridge.com**

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

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

For more information about creating SMTP connectors, see How to configure the SMTP connector in Exchange 200x.

To create a Send connector in Exchange 2007

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

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

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

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

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

Step 6: Enable TLS

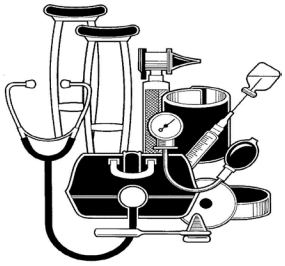
After you install the certificate, your server will be able to receive TLS email. However, it cannot send TLS email until you enable TLS.

To enable TLS

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

– Exhibit M –

TennCare Member Appeal Rights Poster



Having problems getting health care from TennCare?

Call your health plan <u>first</u>. Their free phone number is on your TennCare card.

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

You have the right to appeal if:

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

You **only** have **30 days** to appeal after you find out that there is a problem.
You can **ask someone to help you file an appeal.**

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

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

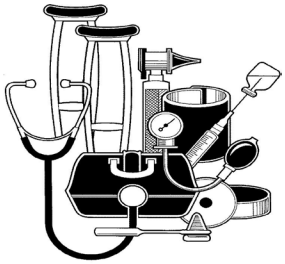
- You will be at risk of serious health problems OR you may die.
- OR, it will cause serious problems with your heart, lungs, or other parts of your body.
- OR, you will need to go into the hospital.

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

Have questions? Need help? Want to appeal?

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

We do not allow unfair treatment in TennCare. No one is treated differently because of race, color, birthplace, religion, language, sex, age, or disability. If you think you have been treated unfairly, call the Tennessee Health Connection for free at **1-855-259-0701.**



¿Tiene problemas para obtener atención médica en TennCare?

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

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

Usted tiene el derecho de apelar si:

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

Usted **solamente** tiene **30 días** para apelar después de enterarse de que hay un problema.
Usted puede **pedirle a alguien que le ayude a presentar una apelación.**

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

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

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

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

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

TennCare no permite el trato injusto. Nadie recibe un trato diferente debido a su raza, color, lugar de nacimiento, religión, idioma, sexo, edad o incapacidad. ¿Cree que lo han tratado injustamente? Entonces, llame gratis al Centro de Servicio para Asistencia Familiar al **1-855-259-0701.**

– Exhibit N –

UnitedHealthcare Community Plan Discrimination Complaint Form

TENNCARE DISCRIMINATION COMPLAINT

Federal and State laws do not allow the TennCare Program to treat you differently because of your race, color, birthplace, disability, age, sex, religion, or any other group protected by law. Do you think you have been treated differently for these reasons? Use these pages to report a complaint to TennCare.

The information marked with a star (*) must be answered. If you need more room to tell us what happened, use other sheets of paper and mail them with your complaint.

1. * Write your name and address.

Name:

_____

Address: _____Zip _____

Telephone: Home: (_____)_____ Work or Cell: (_____)_____

Email Address: _____

Name of MCO/Health Plan:

_____

2. * Are you reporting this complaint for someone else? Yes: _____ No: _____

If Yes, who do you think was treated differently because of their **race, color, birthplace, disability/handicap, age, sex, religion, or any other group protected by law?**

Name:

_____

Address: _____Zip _____

Telephone: Home: (_____) _____ Work or Cell: (_____)_____

How are you connected to this person (wife, brother, friend)?

_____

Name of this person's MCO/Health Plan:

_____

3. * Which part of the TennCare Program do you think treated you in a different way:

Medical Services _____ Dental Services_____ Pharmacy Services____ Behavioral Health _____

Long-Term Services & Supports_____ Eligibility Services_____ Appeals_____

4. *** How do you think you were you treated in a different way?** Was it your

Race___ Birthplace____ Color____ Sex____ Age____ Disability____ Religion____

Other_____

5. **What is the best time to talk to you about this complaint?**

_____

6. *** When did this happen to you? Do you know the date?**

Date it started: _____ Date of the last time it happened: _____

7. **Complaints must be reported by 6 months from the date you think you were treated in a different way.** You may have more than 6 months to report your complaint if there is a good reason (like a death in your family or an illness) why you waited.

_____

_____

_____

8. *** What happened?** How and why do you think it happened? Who did it? Do you think anyone else was treated in a different way? You can write on more paper and send it in with these pages if you need more room.

_____

_____

_____

9. **Did anyone see you being treated differently?** If so, please tell us their:

Name **Address** **Telephone**

_____

_____

_____

10. **Do you have more information you want to tell us about?**

_____

_____

11. *** We cannot take a complaint that is not signed**. **Please write your name and the date on the line below.** Are you the Authorized Representative of the person who thinks they were treated differently? Please sign your name below. As the Authorized Representative, you must have proof that you can act for this person. If the patient is less than 18 years old, a parent or guardian should sign for the minor. Declaration: *I agree that the information in this complaint is true and correct and give my OK for TennCare to investigate my complaint.*

_____

(**Sign your name here if you are the person this complaint is for**) (Date)

_____

(Sign here if you are the Authorized Representative) (Date)

Are you reporting this complaint for someone else but you are not the person's Authorized Representative? Please sign your name below. The person you are reporting this complaint for must sign above or must tell his/her health plan or TennCare that it is okay for them to sign for him/her. Declaration: *I agree that the information in this complaint is true and correct and give my OK for TennCare to contact me about this complaint.*

_____

(Sign here if you reporting this for someone else) (Date)

Are you a helper from TennCare or the MCO/Health Plan assisting the member in good faith with the completion of the complaint? If so, please sign below:

_____

(Sign here if you are either a helper from TennCare or the MCO/Health Plan) (Date)

It is okay to report a complaint to your MCO/Health Plan or TennCare. Information in this complaint is treated privately. Names or other information about people used in this complaint are shared only when needed. Please mail a signed Agreement to Release Information page with your complaint. If you are filing this complaint on behalf of someone else, have that person sign the Agreement to Release Information page and mail it with this complaint. Keep a copy of everything you send. Please mail or email the completed, signed Complaint and the signed Agreement to Release Information pages to us at:

TennCare, Office of Civil Rights Compliance
310 Great Circle Road; Floor 3W • Nashville, TN 37243
615-507-6474 or for free at 855-857-1673 (TRS 711)
HCFA.fairtreatment@tn.gov

You can also call us if you need help with this information.

Division of TennCare

TennCare Agreement to Release Information

To investigate your complaint, TennCare may need to tell other persons or organizations important to this complaint your name or other information about you.

To speed up the investigation of your complaint, read, sign, and mail one copy of this Agreement to Release Information with your complaint. Please keep one copy for yourself.

- I understand that during the investigation of my complaint TennCare may need to share my name, date of birth, claims information, health information, or other information about me to other persons or organizations. And TennCare may need to gather this information about you from persons or organizations. For example, if I report that my doctor treated me in a different way because of my color, TennCare may need to talk to my doctor and gather my medical records.
- You do not have to agree to release your name or other information. It is not always needed to investigate your complaint. If you do not sign the release, we will still try to investigate your complaint. If you don't agree to let us use your name or other details, it may limit or stop the investigation of your complaint. We may have to close your case. Before we close your case because you did not sign the release, we may contact you to find out if you want to sign a release so the investigation can continue.

If you are filing this complaint for someone else, we need that person to sign the Agreement to Release Information. Are you signing this as an Authorized Representative? Then you must also give us a copy of the documents appointing you as the Authorized Representative.

By signing this Agreement to Release Information, I agree that I have read and understand my rights written above. I agree to TennCare sharing my name or other information about me to other persons or organizations important to this complaint during the investigation and outcome.

This Agreement to Release Information is in place until the final outcome of your complaint. You may cancel your agreement at any time by calling or writing to TennCare without canceling your complaint. If you cancel your agreement, information already shared cannot be made unknown.

Signature: _____ Date: _____

Name (Please print): _____

Address: _____

Telephone: _____

Need help? Want to report a complaint? Please contact or mail a completed, signed Complaint and a signed Agreement to Release Information form:

TennCare OCRC
310 Great Circle Road, 3W
Nashville, TN 37243

Phone: 1-615-507-6474 or for free at 1-855-857-1673 (TRS 711)
Email: HCFA.fairtreatment@tn.gov

Do you need free help with this letter?

If you speak a language other than English, help in your language is available for free. This page tells you how to get help in a language other than English. It also tells you about other help that's available.

Spanish: **Español**

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-259-0701 (TTY: 1-800-848-0298).

Kurdish: **کوردی**

ئاگاداری: ئەگەر بە زمانی کوردی قسە دەکەیت، خزمەتگوزاریەکانی یارمەتی زمان، بەخۆڕایی، بۆ تۆ بەردەستە. پەیوەندی بە
1- 855-259-0701 (1-800-848-0298) TTY بکە.

Arabic: **العربية**

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 855-259-0701-1
(رقم هاتف الصم والبكم:1-800-848-0298).

Chinese: **繁體中文**

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-259-0701（TTY 1-800-848-0298）。

Vietnamese: **Tiếng Việt**

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855- 259-0701 (TTY: 1-800-848-0298).

Korean: **한국어**

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-
259-0701 (TTY: 1-800-848-0298)번으로 전화해 주십시오.

French: **Français**

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-259-0701 (ATS : 1-800-848-0298).

Amharic: **አማርኛ**

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው
ቁጥር ይደውሉ 1-855-259-0701 (መስማት ለተሳናቸው: 1-800-848-0298).

Gujarati: **ગુજરાતી**

ધ્યાન: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-855-259-0701 (TTY: 1-800-848-0298).

Laotian:	**ພາສາລາວ**
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-855-259-0701 (TTY: 1-800-848-0298).	
German:	**Deutsch**
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-259-0701 (TTY: 1-800-848-0298).	
Tagalog:	**Tagalog**
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-259-0701 (TTY: 1-800-848-0298).	
Hindi:	**हिंदी**
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-855-259-0701 (TTY: 1-800-848-0298) पर कॉल करें।	
Serbo-Croatian:	**Srpsko-hrvatski**
OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-855-259-0701 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1- 800-848-0298).	
Russian:	**Русский**
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-259-0701 (телетайп: 1-800-848-0298).	
Nepali:	**नेपाली**
ध्यान दिनुहोस्: तपाइँले नेपाली बोल्नुहुन्छ भने तपाइँको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ। फोन गनुर्होस् 1-855-259-0701 (टेटिवाइ: 1-800-848-0298)।	
Persian:	
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم میباشد.با تماس بگیرید. 1-855-259-0701 (TTY: 1-800-848-0298)	

- **Do you need help talking with us or reading what we send you?**
- **Do you have a disability and need help getting care or taking part in one of our programs or services?**
- **Or do you have more questions about your health care?**

Call us for free at 1-855-259-0701. We can connect you with the free help or service you need.

(For TTY call: 1-800-848-0298)

TENNCARE QUEJA DE DISCRIMINACIÓN

Las leyes federales y estatales no permiten que el Programa TennCare lo trate de manera diferente debido a su **raza, color de la piel, lugar de nacimiento, discapacidad, edad, sexo, religión o cualquier otro grupo protegido por la ley**. ¿Piensa que ha sido tratado de manera diferente por estas razones? Use estas hojas para presentar una queja a TennCare.

Es obligatorio proporcionar la información marcada con un asterisco (*). Si necesita más espacio para decirnos lo que pasó, use otras hojas de papel y envíelas con su queja.

1. Escriba su nombre y dirección.

Nombre:__

_____

Dirección:

_____Código postal _____

Teléfono: Hogar: (_____)_____Trabajo o Celular: (_____)_____

Dirección de correo electrónico: _____

Nombre del MCO/plan de seguro médico:

_____

2. *¿Está usted presentando esta queja en nombre de otra persona? Si: _____ No: _____

Si respondió Sí, ¿quién piensa usted que fue tratado de manera diferente debido a su **raza, color de la piel, lugar de nacimiento, discapacidad, edad, sexo, religión o cualquier otro grupo protegido por la ley?**

Nombre: _____

Dirección: _____

_____ Código postal _____

Teléfono: Hogar: (_____) _____ Trabajo o Celular: (_____)_____

¿Qué relación tiene usted con esta persona (cónyuge, hermano, amigo)?

_____

Nombre del MCO/plan de seguro médico de esa persona:

_____

3. ***¿Cuál parte del Programa TennCare cree que lo trató de una manera diferente?**

Servicios médicos ____ Servicios dentales ____ Servicios de farmacia _____

Servicios y apoyos de largo plazo _____ Servicios de elegibilidad _____ Apelaciones _____

4. ***¿Por qué cree que lo trataron de una manera diferente?** Fue a causa de su

Raza ___ Lugar de nacimiento ____ Color de la piel ____ Sexo____ Edad ____

Discapacidad ____ Religión ____ Otra cosa _____

5. **¿Cuál es la mejor hora para llamarlo acerca de esta queja?**

_____

6. *** ¿Cuándo sucedió esto? ¿Sabe la fecha?**

Fecha en que comenzó: _____ Última fecha en que sucedió: _____

7. **Las quejas deben reportarse no más de 6 meses de la fecha en que piensa que fue tratado de una manera diferente.** Si tiene una causa justificada (como enfermedad o fallecimiento en la familia), puede reportar su queja más de 6 meses después.

_____

_____

_____

8. *** ¿Qué sucedió?** ¿Cómo y por qué piensa que pasó? ¿Quién lo hizo? ¿Piensa que alguna otra persona también fue tratada de una manera diferente? Si necesita más lugar, puede escribir en otra(s) hoja(s) y enviarlas con estas hojas.

_____

_____

_____

9. **¿Alguien vio cómo lo trataban de una manera diferente?** Si es así, por favor, proporcione la siguiente información sobre esa persona:

Nombre	**Dirección**	**Teléfono**

_____

_____

_____

10. **¿Tiene usted más información que nos desee dar?**

_____

_____

_____

11. *** No podemos aceptar ninguna queja que no esté firmada**. Por favor, escriba su nombre y la fecha en la línea de abajo. ¿Es usted el Representante Autorizado de la persona que piensa que fue tratada de manera

diferente? Firme abajo. Como el Representante Autorizado, usted debe tener un comprobante de que puede actuar en nombre de esta persona. Si el paciente es menor de 18 años de edad, uno de los padres o tutor debe firmar en su nombre. **Declaración:** *Declaro que la información presentada en esta queja es verídica y correcta y doy mi autorización para que TennCare investigue mi queja.*

_____

(**Firme aquí si usted es la persona de quien trata esta queja**) (Fecha)

_____

(Firme aquí si usted es el Representante Autorizado) (Fecha)

¿Está usted reportando esta queja en nombre de otra persona pero usted **no** es el Representante Autorizado de la persona? Firme abajo. **La persona para quien usted está reportando esta queja debe firmar arriba o debe decirle a su plan de seguro médico o a TennCare que está bien que él/ella firme en su lugar. Declaración:** *Afirmo que la información contenida en esta queja es verdadera y correcta y doy mi permiso para que TennCare se comunique conmigo acerca de esta queja.*

_____

(Firme aquí si está reportando en nombre de otra persona) (Fecha)

¿Es usted ayudante de TennCare o del MCO/plan de seguro médico y está ayudando al miembro de buena fe a presentar la queja? Si es así, por favor firme abajo:

_____

(Firme aquí si usted es ayudante de TennCare o del MCO/plan de seguro médico) (Fecha)

Está bien que reporte una queja a su MCO/plan de seguro médico o a TennCare. La información contenida en esta queja se trata de manera privada. Los nombres y otros datos sobre las personas que aparecen en esta queja sólo se divulgan cuando es necesario. Por favor, envíe una hoja de Autorización para Divulgar Información con su queja. Si está presentando esta queja en nombre de otra persona, pídale a la persona que firme la hoja de Autorización para Divulgar Información y envíela por correo con esta queja. Conserve una copia de todo lo que envíe. Envíe las hojas firmadas de la Queja **y la** Autorización para Divulgar Información a:

TennCare OCRC
310 Great Circle Road, 3rd Floor
Nashville, TN 37243
Teléfono: 1-615-507-6474 o gratis en el 1-855-857-1673
Para TRS gratis, marque el 711
Correo electrónico: HCFA.fairtreatment@tn.gov

También puede llamarnos si necesita ayuda con esta información.

TENNCARE QUEJA DE DISCRIMINACIÓN

Para investigar su queja, es posible que TennCare y su MCO/plan de seguro médico tengan que divulgar su nombre u otra información sobre usted a otras personas o agencias importantes en esta queja.

Para acelerar la investigación de su queja, lea, firme y envíe por correo una copia de esta Autorización para Divulgar Información con su queja. Por favor, conserve una copia para usted.

• Entiendo que durante la investigación de mi queja TennCare y _____ (escriba en la línea el nombre de su MCO/plan de seguro médico) posiblemente tengan que dar mi nombre u otra información sobre mí a otras personas o agencias. Por ejemplo, si reporto que mi doctor me trató de manera diferente debido al color de mi piel, es posible que mi MCO/plan de seguro médico tenga que hablar con mi doctor.

• Usted no tiene que estar de acuerdo en divulgar su nombre u otra información. No siempre se necesita para investigar una queja. Aunque no firme la autorización trataremos de investigar su queja. Pero, si usted no está de acuerdo en permitirnos usar su nombre u otros detalles, eso podría limitar o detener la investigación de su queja. Y, tal vez tengamos que cerrar su caso. Sin embargo, antes de cerrar su caso, si no podemos seguir investigando su queja porque usted no firmó la autorización, podríamos comunicarnos con usted para preguntarle si quiere firmar una autorización para que la investigación pueda continuar.

Si usted está presentando esta queja para otra persona, necesitamos que esa persona firme la Autorización para Divulgar Información. ¿Está firmando esto en la capacidad de Representante Autorizado? Si es así, también debe darnos una copia de los documentos que lo nombran como Representante Autorizado.

Al firmar esta Autorización para Divulgar Información, acepto que he leído y entiendo mis derechos dispuestos anteriormente. Yo autorizo a TennCare para que dé mi nombre u otra información sobre mí a otras personas o agencias importantes en esta queja durante la investigación y el resultado.

Al firmar esta Autorización para Divulgar Información, acepto que he leído y entiendo mis derechos dispuestos anteriormente. Yo autorizo a mi MCO/plan de seguro médico que dé mi nombre u otra información sobre mí a otras personas o agencias importantes en esta queja durante la investigación y el resultado.

Esta Autorización para Divulgar Información tiene vigencia hasta el resultado final de su queja. Usted puede cancelar su autorización en cualquier momento llamando o escribiendo a TennCare o a su MCO/plan de seguro médico sin cancelar su queja. Si cancela su autorización, la información ya divulgada no se puede hacer desconocer.

Firma: _____ Fecha: _____

Nombre (en letra de imprenta):_____

Dirección: _____

Teléfono: _____

¿Necesita ayuda? ¿Quiere reportar una queja? Por favor llame o envíe una queja y una Autorización para Divulgar Información completadas y firmadas a:

TennCare OCRC
310 Great Circle Road, 3rd Floor
Nashville, TN 37243

Teléfono: 1-615-507-6474 o gratis en el 1-855-857-1673
Para TRS gratis, marque el 711 y pida el 855-857-1673
Correo electrónico: HCFA.fairtreatment@tn.gov

¿Necesita ayuda gratuita con esta carta?

Si usted habla un idioma diferente al inglés, existe ayuda gratuita disponible en su idioma. Esta página le indica cómo obtener ayuda en otro idioma. Le indica también sobre otras ayudas disponibles.

Spanish: **Español**

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-259-0701 (TTY: 1-800-848-0298).

Kurdish: **یدروک**

ئاگاداری: ئەگەر هبزمانی کوردی

بکە. TTY (1-800-848-0298) 1- 855-259-0701

Arabic: **ةيبرعلا**

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 0701-259-855-1

(رقم هاتف الصم والبكم:1-800-848-0298).

Chinese: **繁體中文**

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-259-0701

（TTY 1-800-848-0298）。

Vietnamese: **Tiếng Việt**

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855- 259-0701 (TTY: 1-800-848-0298).

Korean: **한국어**

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-259- 0701 (TTY: 1-800-848-0298)번으로 전화해 주십시오.

French: **Français**

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-259-0701 (ATS : 1-800-848-0298).

Amharic: **አማርኛ**

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-855-259-0701 (መስማት ለተሳናቸው: 1-800-848-0298).
Gujarati: **ગુજરાતી** ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો, તો નિઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-855- 259-0701 (TTY: 1-800-848-0298).
Laotian: **ພາສາລາວ** ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-855-259-0701 (TTY: 1-800-848-0298).
German: **Deutsch** ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-259-0701 (TTY: 1-800-848-0298).
Tagalog: **Tagalog** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-259-0701 (TTY: 1-800-848-0298).
Hindi: **हिंदी** ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं 1-855-259-0701 (TTY: 1-800-848-0298) पर कॉल करें।
Serbo-Croatian: **Srpsko-hrvatski** OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-855-259-0701 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1- 800-848-0298).
Russian: **Русский** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-259-0701 (телетайп: 1-800-848-0298).
Nepali: **नेपाल** ध्यान दिनुहोस्: तपाइले नेपाली बोल्नुहुन्छ भने तपाइको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गनुर्होस् 1-855-259-0701 (टटवाइ: 1-800-848-0298) ।
Persian: توجه :اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم میباشد.با .بگیرید تماس 1-855-259-0701 (TTY: 1-800-848-0298)

- ¿Necesita ayuda para hablar con nosotros o para leer lo que le enviamos?
- ¿Tiene alguna discapacidad y necesita ayuda para su cuidado o para tomar parte en uno de nuestros programas o servicios?
- ¿O tiene más preguntas sobre su atención médica?

Llámenos gratis al 1-855-259-0701. Podemos conectarlo con la ayuda o servicio gratuito que necesite.

(Para el sistemaTTY (Para los sordos) llame al: 1-800-848-0298)

— Exhibit O —

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 CPTII 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 Stars ratings. Appropriate coding limits requests for HEDIS and Stars chart reviews, allowing your practice to spend more time on patient care.

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

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

CPTII Code*	Description
2022F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; 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	Seven standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy.
2026F	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; with evidence of retinopathy.
2033F	Eye imaging validated to match diagnosis from seven standard field stereoscopic retinal photos results documented and reviewed; without evidence of retinopathy.
3072F	Low risk for retinopathy (no evidence of retinopathy in the prior year).

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

Important:

- Always bill the appropriate ICD-10 code, including any medical diagnosis codes, at the highest level of specificity.
- A patient's medical record should always support the CPT, CPTII and ICD-10 codes billed. Normal billing rules apply. The requirements listed here should be included in your billing process.

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

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

— Exhibit P —

TN Division of TennCare

TENNCARE DISCRIMINATION COMPLAINT

لا تسمح القوانين الاتحادية وقوانين الولايات لبرنامج TennCare أن يقوم بالتمييز ضدك بسبب **عرقك أو لونك أو مكان ميلادك، أو عجزك، أو عمرك، أو جنسك، أو دينك، أو أي فئة أخرى يحميها القانون.** هل تعتقد أنك قد تعرضت للتمييز لهذه الأسباب؟ استخدم تلك الصفحات للإبلاغ عن أي شكوى إلى برنامج TennCare.
يتعين عليك الإجابة على المعلومات التي تحمل علامة نجمة (*). وإن احتجت إلى المزيد من المساحة لتخبرنا بما حدث، فاستخدم أوراق أخرى وارسلها مع شكوتك.

1. * اكتب اسمك وعنوانك.

الاسم:_____
العنوان:_____
_____الرمز البريدي _____
الهاتف: المنزل (_____)_____ العمل أو المحمول (_____)_____
البريد الإلكتروني: _____
اسم منظمة الرعاية المدارة \خطة الصحة:
_____

2. * هل تبلغ عن هذه الشكوى من أجل شخص آخر؟ نعم: _____ لا:_____
إن كانت الإجابة نعم، فمن هو الشخص تعرض للتمييز بسبب **العرق، أو اللون، أو مكان الميلاد، أو العجز\الإعاقة، أو العمر، أو الجنس، أو الدين، أي فئة أخرى يحميها القانون؟**
الاسم:_____
العنوان: _____
_____الرمز البريدي _____
الهاتف: المنزل (_____)_____ العمل أم المحمول (_____)_____
ما هي صلتك بذلك الشخص (زوجة، أخ، صديق)؟

اسم منظمة الرعاية المدارة \خطة الصحة الخاصة بذلك الشخص:
_____

3. * أي جزء من برنامج TennCare تعتقد أنه قام بالتمييز ضدك:
الخدمات الطبية _____ خدمات طب الأسنان _____ الخدمات الصيدلية _____ الصحة السلوكية _____
الدعم والخدمات طويلة المدى _____ خدمات الأهلية _____ الالتماسات _____

4. *كيف تعرضت للتمييز؟ هل كان بسبب
عرقك____ مكان ميلادك ____ لونك ____ عمرك ____
عجزك____ دينك ____ سبب آخر _____

5. ما هو أنسب وقت للتحدث إليك بشأن هذه الشكوى؟
_____

6. * متى حدث ذلك لك؟ هل تعلم التاريخ؟
تاريخ بداية الحدث: _____ تاريخ آخر مرة حدث ذلك: _____

7. يتعين عليك الإبلاغ عن الشكوى قبل 6 أشهر من تاريخ اليوم الذي تعرضت فيه للتمييز.
يجوز لك الحصول على أكثر من 6 أشهر للإبلاغ عن الشكوى إذا كانت هناك أسباب قوية لانتظارك كل هذه الفترة (مثل حالة وفاة في عائلتك أو مرض ما).
_____
_____
_____

8. *** ما الذي حدث؟** كيف ولماذا تعتقد أن ذلك حدث؟ من قام بذلك؟ هل تعتقد أن أي هناك شخص آخر تعرض للتمييز؟ يمكنك الكتابة على المزيد من الورق وإرساله مع هذه الصفحات إذا احتجت لمزيد من المساحة.
_____
_____
_____

9. **هل هناك شاهد على ذلك التمييز؟** إن كان الأمر كذلك، يرجى إخبارنا بـ:

الاسم	العنوان	الهاتف

10. هل لديك مزيد من المعلومات تريد أن تطلعنا عليها؟

_____

_____

11.* لا يمكننا استلام شكوى غير موقعة. يرجى كتابة اسمك والتاريخ على السطر أدناه. هل تعد ممثلاً مخولاً للشخص الذي تظن أنه تعرض للتمييز؟ يرجى توقيع اسمك أدناه. وبصفتك الممثل المخول، فلابد أن يكون لديك دليل على أنه يمكنك التصرف نيابة عن ذلك الشخص. إذا كان المريض أصغر من 18 عام، فيتعين على الوالد و الوصي التوقيع للقاصر. ***بيان:*** *أوافق على أن المعلومات المتضمنة في تلك الشكوى حقيقية وصحيحة وأعطي برنامج* ***TennCare*** *موافقتي للتحقيق في شكوتي؟*

_____

(وقع اسمك هنا إن كنت أنت الشخص الذي تتعلق به هذه الشكوى) (التاريخ)

_____ (وقع هنا إن كنت الممثل المخول) (التاريخ)

هل تبلغ عن هذه الشكوى لشخص آخر ولكنك **لست** الممثل المخول للشخص؟ يرجى توقيع اسمك بالأسفل. **يتعين على الشخص الذي تبلغ عن هذه الشكوى له التوقيع أعلاه أو إخبار خطة الصحة الخاصة به\ابها أوبرنامج TennCare بأنه لا يوجد مانع من قيامك بالتوقيع له\الها. بيان:** أوافق على أن المعلومات المتضمنة في تلك الشكوى حقيقية وصحيحة وأعطي برنامج **TennCare** موافقتي للاتصال بي بشأن تلك الشكوى.

_____

(وقع هنا إن كنت تبلغ عن هذه الشكوى من أجل شخص آخر) (التاريخ)

هل أنت مساعد من برنامج TennCare أو خطة الصحة\ منظمة الرعاية المدارة التي تساعد العضو بنية طيبة لملء تلك الشكوى؟ إن كان الأمر كذلك، يرجى التوقيع بالأسفل:

_____ (وقع هنا إن كنت مساعد من TennCare أو من خطة الصحة\ منظمة الرعاية المدارة) (التاريخ)

لا يوجد مانع من الإبلاغ عن أي شكوى لخطة الصحة\ منظمة الرعاية المدارة الخاصة بك أو برنامج TennCare. ويتم التعامل مع المعلومات المتضمنة في تلك الشكوى بسرية. ولا يتم مشاركة الأسماء وأي معلومات أخرى بشأن الأشخاص المستخدمين في تلك الشكوى إلا عند الحاجة. يرجى إرسال اتفاق الكشف عن المعلومات موقعًا مع شكوتك. وفي حال تقديمك لتلك الشكوى نيابة عن شخص آخر، فيتعين على هذا الشخص توقيع اتفاق الكشف عن المعلومات وارساله مع تلك الشكوى. احتفظ بنسخة من كل شيء ترسله. يرجى ارسال بريد أو بريد إلكتروني بالشكوى الموقعة والكاملة وصفحات اتفاق الكشف عن المعلومات الموقع لنا على:

TennCare, Office of Civil Rights Compliance
310 Great Circle Road; Floor 3W • Nashville, TN 37243
615-507-6474 or for free at 855-857-1673 (TRS 711)
HCFA.fairtreatment@tn.gov

كما يمكنك الاتصال بنا إن احتجت للمساعدة بخصوص تلك المعلومات.

TN Division of TennCare

اتفاقية برنامج TennCare للإفصاح عن المعلومات

قد يحتاج برنامج TennCare من أجل التحقيق في شكواك إلى إطلاع أشخاص آخرين أو مؤسسات أخرى ذات أهمية بالنسبة لهذه الشكوى على اسمك أو معلومات أخرى عنك.

لتعجيل التحقيق في شكواك، احرص على قراءة نسخة من اتفاقية الإفصاح عن المعلومات هذه وتوقيعها وإرسالها بالبريد مع شكواك. ويُرجى الاحتفاظ بنسخة لنفسك.

- أفهم أنه أثناء التحقيق في شكواي، يجوز لبرنامج TennCare مشاركة اسمي أو تاريخ ميلادي أو معلومات المطالبات أو المعلومات الصحية أو غيرها من المعلومات المتعلقة بي مع أشخاص آخرين أو مؤسسات أخرى. وقد يحتاج برنامج TennCare إلى جمع هذه المعلومات عنك من بعض الأشخاص أو المؤسسات. فعلى سبيل المثال، إذا اشتكيت من أن طبيبي قد عاملني بطريقة مختلفة بسبب لوني، فقد يحتاج برنامج TennCare إلى التحدث إلى طبيبي والحصول على سجلاتي الطبية.
- لست مُلزمًا بالموافقة على الإفصاح عن اسمك أو أي معلومات أخرى. فقد لا تكون هذه المعلومات ضرورية في جميع الأوقات من أجل التحقيق في شكواك. وإذا لم توقع على اتفاقية الإفصاح، فسنستمر في محاولة التحقيق في شكواك. لكن يُرجى العلم أنه إذا لم توافق على السماح لنا باستخدام اسمك أو تفاصيل أخرى، فقد يؤدي ذلك إلى تقييد أو إيقاف التحقيق في شكواك. وقد نضطر إلى إغلاق حالتك. قبل إغلاق حالتك بسبب عدم توقيعك على اتفاقية الإفصاح، قد نتصل بك لمعرفة ما إذا كنت تريد توقيع اتفاقية إفصاح حتى يتسنى مواصلة التحقيق.

إذا كنت تقدم هذه الشكوى نيابة عن شخص آخر، فإننا بحاجة إلى توقيع هذا الشخص على اتفاقية الإفصاح عن المعلومات. هل توقع على هذه الاتفاقية بصفتك ممثلًا مفوضًا؟ في هذه الحالة، يجب عليك أيضًا أن تقدم لنا نسخة من وثائق تعيينك كممثل مفوض.

بالتوقيع على اتفاقية الإفصاح عن المعلومات هذه، أوافق على أنني قد قرأت وفهمت حقوقي المكتوبة أعلاه. كما أوافق على السماح لبرنامج TennCare بمشاركة اسمي أو معلومات أخرى عني مع أشخاص آخرين أو مؤسسات أخرى مهمة بالنسبة لهذه الشكوى أثناء التحقيق وحتى الوصول إلى النتيجة.

تسري اتفاقية الإفصاح عن المعلومات هذه حتى الوصول إلى النتيجة النهائية لشكواك. ويمكنك إلغاء الاتفاقية في أي وقت عن طريق الاتصال ببرنامج TennCare أو مراسلته كتابيًا ولن يؤدي ذلك إلى إلغاء شكواك. في حالة إلغاء الاتفاقية، لا يمكن منع المعرفة بالمعلومات التي تمت مشاركتها بالفعل.

التوقيع: _____ التاريخ: _____

الاسم (يُرجى الكتابة بحروف واضحة):

_____

العنوان: _____

الهاتف: _____

United Healthcare | MARCH Vision Care

هل تريد تقديم شكوى؟ يُرجى إرسال نموذج شكوى مُستوفى وموقع واتفاقية إفصاح عن المعلومات موقعة بالبريد إلى:

TennCare OCRC
الاتصالات (711)
310 Great Circle Road, 3W
Nashville, TN 37243

هاتف: 1-615-507-6474 أو مجانًا عبر 1-855-857-1673 (خدمة ترحيل)

بريد إلكتروني: HCFA.fairtreatment@tn.gov

Do you need free help with this letter?

If you speak a language other than English, help in your language is available for free. This page tells you how to get help in a language other than English. It also tells you about other help that's available.

Spanish: **Español**

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-259-0701 (TTY: 1-800-848-0298).

Kurdish: **کوردی**

ئاگاداری: ئەگەر بە زمانی کوردی قسە دەکەیت، خزمەتگوزاریەکانی یارمەتی زمان، بەخۆڕایی، بۆ تۆ بەردەستە. پەیوەندی بە 1- 855-259-0701 TTY (1-800-848-0298) بکە.

Arabic: **العربية**

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-259-0701
(رقم هاتف الصم والبكم:1-800-848-0298).

Chinese: **繁體中文**

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-259-0701（TTY 1-800-848-0298）。

Vietnamese: **Tiếng Việt**

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-259-0701 (TTY: 1-800-848-0298).

Korean: **한국어**

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-259-0701 (TTY: 1-800-848-0298)번으로 전화해 주십시오.

French: **Français**

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-259-0701 (ATS : 1-800-848-0298).

Amharic: **አማርኛ**

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-855-259-0701 (መስማት ለተሳናቸው: 1-800-848-0298).

Gujarati: **ગુજરાતી**

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-855-259-0701 (TTY: 1-800-848-0298).

Laotian: **ພາສາລາວ**

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-855-259-0701 (TTY: 1-800-848-0298).

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German:	**Deutsch**
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-259-0701 (TTY: 1-800-848-0298).	
Tagalog:	**Tagalog**
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-259-0701 (TTY: 1-800-848-0298).	
Hindi:	**हिंदी**
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-855-259-0701 (TTY: 1-800-848-0298) पर कॉल करें।	
Serbo-Croatian:	**Srpsko-hrvatski**
OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-855-259-0701 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1- 800-848-0298).	
Russian:	**Русский**
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-259-0701 (телетайп: 1-800-848-0298).	
Nepali:	**नेपाली**
ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-855-259-0701 (टिटिवाइ: 1-800-848-0298) ।	
Persian:	
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم میباشد.با 1-855-259-0701 (TTY: 1-800-848-0298) تماس بگیرید.	

- **هل تحتاج إلى مساعدة في التحدث إلينا أو قراءة ما نرسله إليك؟**
- **هل تعاني من إعاقة وتحتاج إلى المساعدة في الحصول على الرعاية أو المشاركة في أحد برامجنا أو خدماتنا؟**
- **أو هل لديك أسئلة أخرى بشأن رعايتك الصحية؟**

اتصل بنا مجانًا على 1-855-259-0701. يمكننا توصيلك بالمساعدة المجانية أو الخدمة التي تحتاجها.
(للاتصال عبر الهاتف النصي (TTY): 1-800-848-0298