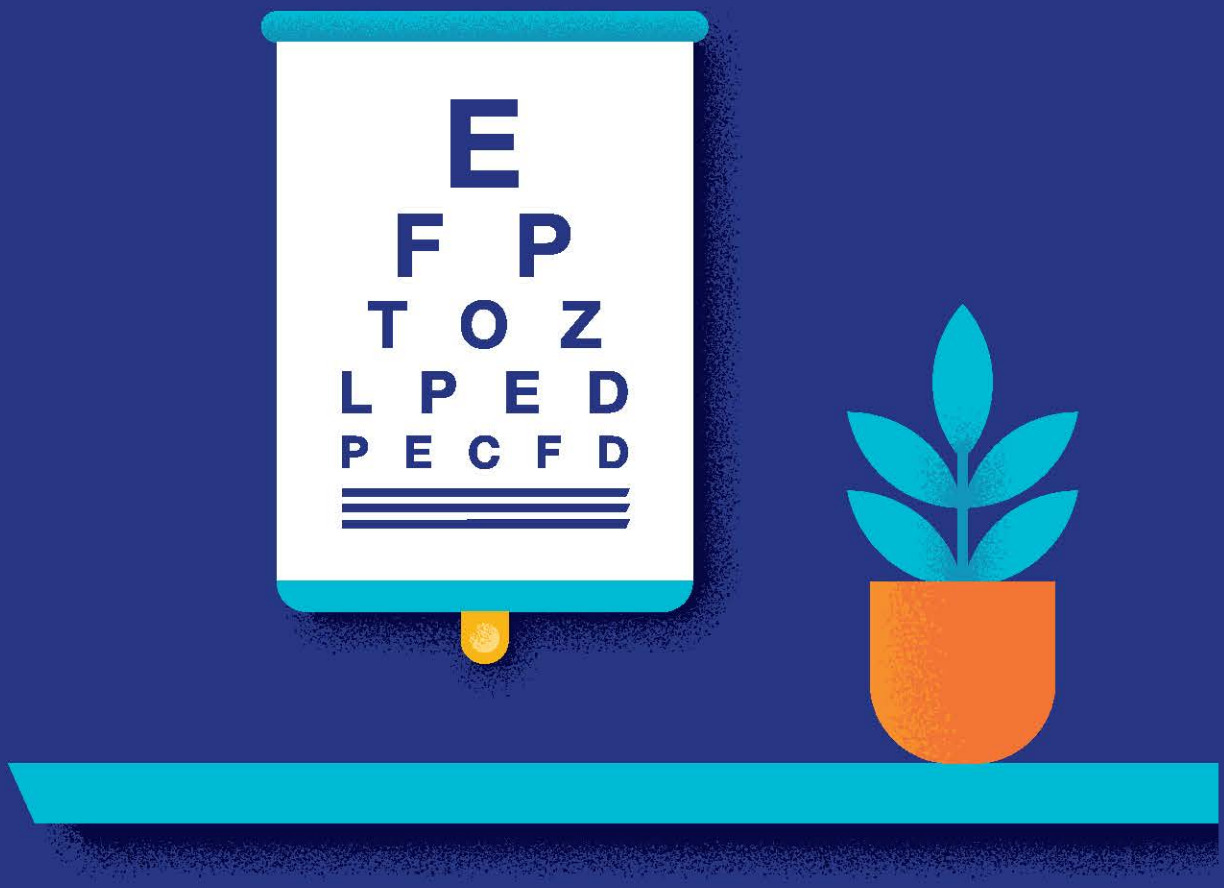


Texas Provider Reference Guide

UnitedHealthcare Community Vision Network
March Vision Network

United Healthcare | MARCH Vision Care

Disclaimer:

Provider Reference Guide Notice of Updates effective July 2022:

Section 3: Billing and claim procedures

- 3.5 – Updated telemedicine language

Section 7: Health care services

- 7.4 – Added optional equipment list guidelines

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 Texas Provider Reference Guide ("PRG") was revised in May 2022. 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 PRG on CD, please reach out to our Provider Relations Department at **844- 976-2724**.

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

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

Exhibits

1.1 Contact Information

Phone Number	844-97-MARCH or 844-976-2724
General website	www.marchvisioncare.com
Provider website	providers.eyesynergy.com
Lab and Contact Lens orders	providers.eyesynergy.com

1.2 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 such as a current copy of the PRG, state-specific benefits, and the providers.eyesynergy.com User Guide.

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

- Sign in to marchvisioncare.com UH 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

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

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

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 5 failed sign-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.

1.3 Interactive Voice Recognition System

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

- Eligibility and benefits
- Confirmation numbers
- Claim status

You may access the IVR System by calling **844-976-2724**. Select the provider option and follow the prompts to verify eligibility and benefits, request a confirmation number, or check claim status.

Registration

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

Sign in

Once registered, you may log sign in to the IVR System using your 10-digit ID and 4-digit PIN. The 10-digit ID is the office phone number provided during registration. The 4-digit PIN is the number designated by your office during registration.

1.4 Electonic funds transfer (EFT)

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

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

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

Provider benefits

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

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

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

1.5 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, when possible. All changes should be reported to us in writing. You may experience a delay in claim payments if you fail to report changes related to your billing address and/or tax identification number. Examples of changes that need to be reported to us in writing, include, but are not limited to:

- Practice phone
- Fax number
- Practice address
- Billing address.
- Tax Identification number (requires W9)
- Office hours
- Practice status regarding the acceptance of new members, children, etc.
- Providers added to practice/providers leaving practice
- Provider termination

Please report all changes by mail or email to:

UnitedHealthcare I March Vision Care
Attention: Provider Relations Department
5701 Katella Avenue
Cypress, CA 90630

Email: visionnominations@uhc.com

Please note: Member data or questions should not be sent to this email address.

The Centers for Medicare & Medicaid Services (CMS) requires you to verify the accuracy of their information included in the health plan's provider directory on a quarterly basis. You are encouraged to verify their 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.

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 you or your office verifies member benefits and services through us. 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 before rendering services.

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

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

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

Example: A member is diagnosed with keratoconus and requires contact lenses. You are required to request a confirmation and attest to the documented exam findings and/or diagnosis. The submitted claim must include the diagnosis of keratoconus. Payment is issue provided the member is eligible on the date services were rendered.

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

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

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

Covered benefits

You can access a list of covered benefits by:

- Signing 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 these circumstances, the provider must inform the member and is required to have the member knowingly sign a waiver or statement acknowledging that the service is not covered and that the member is financially responsible prior to rendering non-covered service. **Failure to do so may result in the provider being financially responsible for those services -- even if the member verbally agreed to the non-covered service or paid for the non-covered service up-front.**

Acceptable waivers

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

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

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

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

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

3.1 Claim submission

Preferred method

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 are accepted if submitted on an original red CMS-1500 form that is typed or computer generated with clear, 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 bill from a health care provider that can be processed without obtaining additional information from the provider of service or from a third party. An unclean claim is defined as any claim that does not meet the definition of a clean claim. State-specific exceptions to our clean claim definition are provided below.

Claims submitted for payment should include:

- 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
- Billing and rendering provider taxonomy code*
- Ordering, referring, or prescribing provider NPI*

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

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 reasonable grounds for suspecting possible fraud, misrepresentation or unfair billing practices.

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

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

3.2 American Medical Association CPT coding rules

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

- Providers can use a new eye examination billing code for an initial examination of a new patient. A provider may also bill for a new member examination if a member has not been examined for 3 consecutive years by that provider/group.
- A routine examination for an established patient in subsequent years can be billed as a follow up examination
- Providers can continue to bill this way unless the member has not been examined for 3 consecutive years at that office, at which time the service may be billed with a new member examination code as indicated above
- A medical examination may be billed if the member has the benefit as indicated in March's State-Specific PRG
- Follow-examinations for the same medical condition noted above may be billed based on the acuteness of the condition and the documented services provided
- According to **Medicare Carriers Manual Section 15501.1 H,** if more than one evaluation and management (face-to-face) service is provided on the same day to the same patient, whether by the same provider or more than one provider in the same specialty in the same group, only one evaluation and management service may be billed. Optometrists and Ophthalmologists from the same group are considered the same specialty, for covered services provided within the scope of optometry, in each applicable state. Therefore, a comprehensive eye examination and a medical examination, such as a diabetic eye evaluation, may not be billed on the same date of service. Instead of billing two examinations separately, providers should select a level of service representative of the combined visits and submit the appropriate code for that level. The less extensive procedure is bundled into the more extensive procedure.
- The services furnished and associated medical record documentation must meet the definition of the CPT code billed
- This is important when providers bill the highest levels of visit and consultation codes.

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

- The patient may not have been examined by a provider in the practice within the past three years
- The history must meet the CPT code's definition of a comprehensive history
- All components of an examination need to be recorded, including dilation or equivalent

The provider may use professional discretion whether to dilate at subsequent visits for existing patients, but dilation is expected at the initial visit and at least every three years.

- Medical necessity of a service is the overarching criterion for payment, in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted or performed. Similarly, it would not be warranted to bill for services if medical necessity is not established by standards of medical or optometric practice.
- The date of service on the claim should always match the date of service on the medical record, and the medical record should include complete documentation related to all billed services.
- The comprehensive nature of the examination codes includes a number of tests and evaluations. Some of these procedures have their own CPT code. When these procedures are broken out and billed in conjunction with a comprehensive examination it is referred to as "unbundling" and is an inappropriate billing practice. This type of billing practice will be subject to action from a health plan or insurance carrier.

The most common billing errors include:

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

- Billing sensory motor testing using 92060
- Billing gonioscopy using 92020

The appropriate and correct use of the CPT (procedure) and diagnosis code is the responsibility of every health care provider. Use the following set of links to national correct coding resources on www.cms.gov to assist you:

- 2019 ICD-10-CM – (cms.gov/Medicare/Coding/ICD10/2019-ICD-10-CM.html)
- National Correct Coding Initiative Edits – (cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html)
- Medicare Claims Process Manual: Chapter 23 - Fee Schedule Administration and Coding Requirements

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

In an effort to improve the Healthcare Effectiveness Data and Information Set (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:

- Retinal of dilated eye exams;
- Negative retinal or dilated eye exams;
- Diabetes;
- Diabetic retinopathy

Please see Exhibit J: HEDIS/Stars Performance Reporting.

3.3 Billing for replacements and repairs

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

- RA (Replacements)
- RB (Repairs)

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

3.4 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

CMS mandates payment for a glaucoma screening examination that is performed on an eligible beneficiary after at least 11 months have passed following the month in which the last glaucoma screening examination was performed.

3.5 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

3.6 Frame warranty

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

If you determine that the defective frame is covered under the warranty, please reach out to us at **844-976-2724**. Please do not send broken glasses to either us or the contracted lab.

3.7 Order cancellations

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

- Members are responsible for the cost of frames and/or lenses if the order is cancelled by the member after the order has been completed by the lab
- 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 reach out to us at **844-976-2724**.

3.8 Non-covered lens options

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

Medicaid:

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

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

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

Medicare:

The Medicare benefit is an allowance-based benefit. Any non-covered lens options are counted towards the member’s benefit allowance amount. Please see Section 3.9 *Billing of Medicare Allowance* for further clarification.

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

3.9 Billing and calculation of Medicare allowance

A set dollar amount is typically allowed to cover frames, lenses and/or contact lenses provided to Medicare members. This is known as an “allowance” or an “allowance-based benefit”. You should bill the current and appropriate HCPCS codes for frames, lenses, and/or contact lenses along with the usual and customary charges for those codes. You will be paid up to 90% of the Medicare allowance amount for billed charges, unless otherwise noted in the benefit plan summary. The allowance does not apply to routine eye exams. Routine eye exams are paid separately.

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.

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

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

HCPCS	Description	Billed Charges	Paid Amount
V2020	Frame	$ 95.00	$ 85.50
V2100	Lens	$ 30.00	$ 27.00
V2745	Tint	$ 10.00	$ 9.00
Total		**$ 135.00**	**$ 121.50**

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

HCPCS	Description	Billed Charges	Paid Amount
V2020	Frame	$ 200.00	$ 108.00*
V2100	Lens	$ 30.00	$ 27.00
V2745	Tint	$ 10.00	$ 0.00*
Total		**$ 240.00**	**$ 135.00**

* Member is responsible for charges exceeding their benefit allowance.

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.

The following example shows the allowance is applied to contact lenses. The billed charges and paid amounts listed are for illustrative purposes only.

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

HCPCS	Description	Billed Charges	Paid Amount
V2500	Contact Lenses	$ 100.00	$ 90.00
92310	Fitting	$ 50.00	$ 45.00
Total		**$ 150.00**	**$ 135.00**

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

HCPCS	Description	Billed Charges	Paid Amount
V2500	Contact Lenses	$ 100.00	$ 90.00
92310	Fitting	$ 50.00	$ 0.00*
Total		**$ 150.00**	**$ 90.00**

* Member is responsible for charges exceeding their benefit allowance.

3.10 Claim filing limits

Claim filing limits are imposed in accordance with the applicable provider services agreement and governing entity regulations. Claim filing limits in Texas are 180* calendar days for Medicaid and 365 calendar days for Medicare, and begin on the date services are rendered.

*The normal Medicaid claim filing limit of 95 calendar days has temporarily been extended to 180 calendar days to accommodate delays due to COVID-19.

Proof of timely filing

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

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

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

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

IMPORTANT: Please attach delayed filing "good cause" documentation to late filed claims.

- Submit late filed claims on a red CMS-1500 form
- Clearly indicate on the claim that the submission is a **late file claim with good cause documentation attached**

This ensures the information will be considered during claims processing and will help prevent payment delays.

3.11 Prompt claim processing

Claim payments are issued in accordance with the applicable provider services agreement and governing entity regulations. The prompt payment processing time in Texas is 30 calendar days for Medicaid and 60 calendar days for Medicare, 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.

3.12 Corrected claims

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.

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 Texas is 90 days for Medicaid and begins on the original denial/paid date. For both Medicare and Medicare-Medicaid Plan (MMP), the corrected claim filing limits in Texas are 365 days and begin on the date services are rendered.

3.13 Provider disputes

We're here to help and are committed to supporting you and your practice. You can reach to our Customer Service department at **844-976-2724.** In addition to contacting Customer Service, our Provider Dispute Resolution Process provides a mechanism for you to communicate disputes in writing. You may submit your Provider Appeals electronically by using Provider Appeal Resolution online form on providers.eyesynergy.com.

Provider Dispute Types

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

Provider dispute resolution process

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

Please submit your request by mail to:

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

Submit your request electronically using the Provider Dispute Form.

3.14 Overpayment of claims

You will be notified in writing if we determine a claim was overpaid or was paid incorrectly. Overpayment refund requests are issued in accordance with the applicable provider services agreement and governing entity regulations. We do not issue overpayment refund requests more than 365 days following the payment date, even when permitted by governing entity regulations.

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

3.15 Balance billing

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

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

3.16 Coordination of Benefits

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

- The primary plan must be billed first and the claim is billed just like any other claim would be billed
- The secondary plan is billed once an explanation of payment (EOP) and possibly a payment is received from the primary plan
- The claims submitted to a secondary or tertiary plan are considered "COB claims"
- When billing a secondary plan, the bill must have the primary insurance plans' EOP attached
- The payments received from the primary plan should be indicated in field 29 of the CMS 1500 form. The claim will be contested and the primary insurance EOP will be requested if the secondary plan is billed without an attached primary insurance EOP.
- .Medicaid/Medicare will not make an additional payment if the amount received from the primary insurance company is equal to or greater than the Medicaid/Medicare reimbursement amount

We 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.

The timeframe for filing a claim in situations involving third party benefits (COB and subrogation) shall begin on the date that the third party documented resolution of the claim. COB claims must be submitted as paper claims on a red CMS 1500 form.

Please mail COB claims to:

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

4.1 Access standards

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

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

- Appointments for routine, non-urgent eye examinations and eyeglass or contact lens fittings and dispensing are available within 21 calendar days
- Rescheduling an appointment in a manner that is appropriate for the enrollee's health care needs and ensures continuity of care consistent with good professional practice
- When we are contractually responsible for more than routine eye examinations, appointments for urgent/emergent eye care services, within the optometrist's or ophthalmologist's scope of practice, are available within 24 hours
- 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 30 minutes from their appointment time before being seen by a provider
    - Wait time is defined as the time spent in the lobby and in the examination room prior to being seen by a provider

4.2 Access monitoring

We are responsible for monitoring compliance with accessibility standards. This that 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 our 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 be periodically monitored to determine how long members wait for scheduled appointments

5.1 Protocol for member grievances and appeals

Definitions

Grievance	A written or oral expression of dissatisfaction regarding UnitedHealthcare I March Vision Care and/or its provider(s) including access to care, quality of care and quality of service. A grievance would reflect a situation where a denial has not been issued and there is dissatisfaction.
Appeal	A request for reconsideration of an action/initial determination/request for service or claim that was denied, deferred, and/or modified where a notice of action (denial letter) was issued. The denial may occur before services are rendered or as a claim or partial claim denial.

Our policy is to address and resolve member grievances and/or appeals in an orderly and timely manner according to all regulations and client contractual requirements. All members or the member's personal representative have the right to file a grievance and/or submit an appeal through the Grievance and Appeal process. Members shall be directed to call the phone number, on the back of their health plan identification card, to obtain a grievance form or to file a grievance. We will work with the member's contracted health plan to resolve issues. You may be asked for medical records or a response as part of the grievance/appeal investigation. According to your contract with us, you are required to furnish medical records of members for whom claims have been submitted. Member authorization is not required to release medical records per state and federal regulations. We will ensure that grievances and appeals will be investigated, and resolved in a regulatory compliant time frame, following related policies and procedures.

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

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

5.2 Potential quality issue

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

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

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

6.1 Member rights

Each member has rights and responsibilities:

Members have the right to:

- Be treated with respect and dignity by personnel, network doctors and other health care professionals
- Privacy and confidentiality for treatments, tests and procedures you receive. See Notice of Privacy Practices in your benefit plan documents for a description of how your personal health information is protected.
- Voice concerns about the service and care they receive
- Register complaints and appeals concerning their health plan and the care provided to them
- Get timely responses to their concerns
- Candidly discuss with their doctor the appropriate and medically necessary treatment options for their conditions, regardless of cost or benefit coverage
- Access doctors, health care professionals and other health care facilities
- Participate in decisions about their care with their doctor and other health care professionals
- Get and make recommendations regarding the organization's rights and responsibilities policies
- Get information about us, our services, network doctors and health care professionals
- Be informed about, and refuse to participate in, any experimental treatment
- Have coverage decisions and claims processed according to regulatory standards, when applicable
- Choose an Advance Directive to designate the kind of care they wish to receive should they become unable to express your wishes

6.2 Member responsibilities

Member have the responsibility to:

- Know and confirm their benefits before receiving treatment
- Contact an appropriate health care professional when they have a medical need or concern
- Show your ID card before receiving health care services
- Pay any necessary copayment at the time they receive treatment
- Use emergency room services only for injuries and illnesses that, in the judgment of a reasonable person, require immediate treatment to avoid jeopardy to life or health
- Keep scheduled appointments
- Provide information needed for their care
- Follow the agreed-upon instructions and guidelines of doctors and health care professional.
- Participate in understanding their health problems and developing mutually agreed-upon treatment goals
- Notify their Health Plan of any changes in their address or family status

Please refer to Exhibit L: Member Rights and Responsibilities for information on member rights and responsibilities for MCOs serving MMC Members, MCOs serving chip members, and for CHIP Perinate Members.

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

7.3 Clinical decision making

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

7.4 Medical charting for eye care services

Our Health Care Services Department perform audits of medical records used as supporting documentation to substantiate post-payment claims submissions to ensure quality of services and to combat fraud, waste and abuse. Led by our Chief Eye Care Officer, we have identified over 17 elements necessary in a comprehensive eye examination. Records are evaluated and assigned a point value for each element based on their hierarchy of significance using a proprietary scoring system. The cumulative total point value is used to determine the adequacy of the supporting documentation.

When a comprehensive examination is billed, if any of the critical elements are skipped 10 out 10 times, the audit score automatically defaults to the failing Severity Level score 4. These critical elements include:

- Biomicroscopy/slit lamp exam
- Intraocular pressure
- Optic nerve head evaluation
- Dilated fundus exam.

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

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

Paper charts

- The encounter must record critical general health care information and the traditional refractive data
    - Details of a patient's medicine list and a formal review of systems are critical elements of the eye exam
- Notes on pulse, blood pressure and body mass index

- You must query about tobacco use and alcohol use
- Assess patient orientation to time and place
- Rate the patient's emotional state during the exam

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

Electronic Medical Records

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

- The templates for each encounter type, including the eye exam are customizable. Many providers have customized their office system in a way that has deleted key elements of the eye exam. Deleting some elements may make your charts non-compliant.
- EMR's have "defaults" for normal findings that often fill in descriptive, detailed language for normal structures/findings. Caution should be used with defaults so that the clinical data and test results correlate with the diagnosis, assessment and management plan.
- When documentation is worded exactly like or similar to previous entries, the documentation is referred to as "cloned". Cloning of documentation from a previous visit lacks the encounter-specific information necessary to support services rendered to patients.
- A review of the EMR for consistency, logical assessment, and treatment plans should be completed before signing the chart. The chart should not be manipulated or corrected once it is signed by you.

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 detection of health care fraud

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

Training of our participating providers

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

Training must be completed within 90 days of hire and annually thereafter. The Centers for Medicare & Medicaid Services (CMS) has FWA training resources available on their website (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/WebBasedTraining).

Sanction list monitoring

You are required to screen employees against the Federal and State exclusion lists prior to hiring and monthly thereafter. At a minimum, you must screen employees through the following:

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

Document retention

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

Reporting Suspected Fraud, Waste, or Abuse

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 it 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**
- Texas Health and Human Services Office of Inspector Genreal (OIG) by hotline at 800-436-6184, or online https://oig.hhsc.state.tx.us/ and select available report fraud, waste or abuse link to access and complete the online form.

9.1 Credentialing and re-credentialing

CAQH ProView

CAQH ProView will be used to obtain the necessary information to complete your credentialing and check various state systems unless use of another credentialing source is required by your state regulations. You will be notified when the review has been completed.

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

- CAQH application release to UHC Vision Networks: Spectera and March
- CAQH attestation within the past 3 months
- Certificate of insurance showing Professional Liability Coverage (malpractice insurance);
- State license including Diagnostic Pharmaceutical Agent (DPA) License or Therapeutic Pharmaceutical Agent (TPA) License
- Copy of DEA and CDS (if applicable)
- Board certification (if applicable)
- Vitae/resume, including work history (only needed for initial credentialing)
- If participating with Medicaid, you must enroll with your state agency

Credentialing process

Credentialing information is reviewed by the Credentialing Coordinator for completeness upon receipt of the CAQH number. All data, licenses and certificates are electronically confirmed by the applicable regulatory agencies, and any provider not in good standing with his/her respective regulatory agency is pended. The confirmed CAQH number is forwarded to the Professional Review Committee Chairperson 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.

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.

Re-credentialing process

You are re-credentialed at least every three (3) years. The Provider Services Agreement stipulates automatic yearly renewal. You must forward to us, on an annual basis, a current photocopy of your yearly state license renewal and malpractice insurance. Failure to provide updated information may affect claims payments. Membership in good standing is re-confirmed.

Health plan credentialing process

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

9.2 National Provider Identifier

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

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

10.1 Language Assistance Program (LAP)

Access to interpreters

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

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

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

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

You shall not:

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

Non-compliance may expose you to the risk of violating a consumer's civil rights. This may result in civil rights lawsuits and subject you to lawsuits filed by the Office of Civil Rights.Enforcement and lawsuits may occur up to 1 year after the Date of Service.

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

To assist in this area, you are encouraged to:

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

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

Telephonic interpreting services

Access to free language assistance services for members with Limited English Proficiency is required by various regulations. Interpreters must be professionally trained and versed in medical terminology and health care benefits.

Contact the member's Health Plan Customer Service phone number for member translation services. The Health Plan has interpreter services to help ensure effective communication for our members regarding treatment, medical history or health condition. This is at no cost to you or our members and includes written, spoken, and sign language interpretation, when the member is receiving services from you in an office or other location or accessing emergency services. Over-the-phone (OPI) interpretation, including three-way calls facilitated between Health Plan, you as the care provider and a telephone interpreter, does not require advance notification by the you or the member.

Face-to-face and American Sign Language interpreting services

Face-to-face and American Sign Language services are recommended to explain complex medical consultation or education (i.e. medical diagnosis, treatment options, etc.) to a LEP or hearing-impaired member. Face-to-face interpreters to assist LEP members should be offered at no cost to the member. These services will need to be scheduled at least 10 business days in advance of the appointment date to ensure coordination between all involved parties. We will do our best to accommodate more urgent requests.

Reach out to our Customer Service Department at **844-976-2724** to schedule these services. A Customer Service representative will request the information outlined above for telephonic requests, in addition to the following:

Provider information:

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

Help getting a ride

Medicaid members or their representative can arrange a ride for medical appointments, including dental, and for picking up prescriptions by calling the Texas Health and Human Services (HHS)'s Medical Transportation Program at 877-633-8747.

Schedule rides at least two days in advance. A parent or guardian must accompany members younger than 15. The parent or guardian can sign a consent form for another adult to accompany the member. Members ages 15 to 17 can get a ride with a signed consent form from their parents or guardian. For details, go to TXHealthsteps.com > Tutorials > HHSC's Medical Transportation.

We also offer rides to members through our transportation program when Medicaid transportation isn't available. If you are 75 miles or more from where the member lives, transportation assistance requires prior approval. An adult must accompany members younger than 18. STAR, STAR+PLUS and dual eligible members are limited to eight one-way trips each year.

Medical Record Documentation for LAP

For all LEP members, it is best practice to document the member's preferred language in paper and/or electronic medical records in the manner that best fits your practice flow. You should attempt to collect and document member's race, ethnicity, and preferred written language in member's medical record, when possible.

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

Documentation of provider/staff language capabilities

Interpretive services pursuant to the Language Assistance Program have not been delegated to its providers in some states. The provider directory lists fluent languages spoken by you and your office. This information is received by self-reported Provider Demographic Forms updated on a quarterly basis, or whenever there is a demographic

change. The information you provide will be used to update our provider database, which is used to generate our provider directories and to provide members with online and automated information to assist them in identifying provider offices that may meet their language needs.

Translation of written material

Translations of written informational material such as applications, consent forms, denial notices and explanation of payments are available through the member's Health Plan (the number on the back of their Identification Card) at **844-976-2724**.

11.1 Cultural competency

We shall ensure that all health plan members receive equitable and effective treatment in a culturally and linguistically appropriate manner. As a health care provider, 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.

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

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

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

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

12.1 Secure transmission of Protected Health Information (PHI)

We are asking you to follow the recommended guiding principles when exchanging Protected Health Information (PHI) with us to ensure that all communications (email, phone, or fax) containing PHI (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 H: "Sending a Secure Email to March Vision Care for PHI related data" to ensure that HIPAA guidelines are being met and PHI is secured. This will prevent us from receiving unencrypted or unsecured emails with PHI.
- While sending PHI securely via encrypted emails, please be aware that the HIPAA Privacy Rule still requires that PHI only be shared with those who are permitted to have the information and share only the minimum amount of PHI necessary to accomplish the business purpose
- Please be aware that when contacting us by phone, email, or fax that we are required to confirm your name, associated provider/physician organization, and contact information before exchanging or confirming PHI
- If you receive PHI or Personally Identifiable Information (PII) directed to, or meant for, another provider or someone other than you, you agree to promptly destroy all such PHI or PII and not further use or disclose it. If such an event occurs, you agree to cooperate with any remediation efforts undertaken by us.

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

Exhibits

Exhibit A	Non-Covered Service Fee Acceptance form
Exhibit B	Provider Dispute Resolution Request form (online) Provider Dispute Resolution Request form (paper)
Exhibit C	Lab Order form
Exhibit D	Potential Quality Issue Severity Levels
Exhibit E	Potential Quality Issue Referral Form
Exhibit F	Clinical Practice Guidelines
Exhibit G	Wholesale/Retail fee schedule
Exhibit H	Sending a secure email to March Vision Care for PHI related data
Exhibit I	Examination Record template
Exhibit J	HEDIS/Stars Performance Reporting
Exhibit K	Identifying and Reporting Abuse, Neglect, and Exploitation
Exhibit L	Member Rights and Responsibilities

— Exhibit D —

Potential quality issue — Severity levels

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

— Exhibit F —

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 u.
- 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	▪ MARCH adopted the American Optometric Association (“AOA”) “Evidence-Based Clinical Practice Guidelines - Diabetes Mellitus” http://aoa.uberflip.com/i/374890-evidence-based-clinical-practice-guideline-diabetes-mellitus https://www.aoa.org/optometrists/tools-and-resources/clinical-care-publications/clinical-practice-guidelines
Extended ophthalmoscopy	When benefit includes medical within the scope of an OD	▪ Extended ophthalmoscopy codes are reserved for the meticulous evaluation of the eye in detailed documentation of a severe ophthalmologic problem needing continued follow-up, which cannot be sufficiently evaluated by photography. ▪ In all instances extended ophthalmoscopy must be medically necessary. It must add information not available from the standard evaluation services and/or information that will demonstrably affect the treatment plan. It is not necessary, for example, to confirm information already available by other means. ▪ A detailed sketch must be included in the medical record and available upon request. The sketch should be a minimum size of 3-4" in diameter. All items noted must be identified (i.e., any findings must be drawn and labeled). Drawings in 4-6 standard colors are preferred. However, non-colored drawings are also acceptable. https://downloads.cms.gov/medicare-coverage-database/lcd_attachments/33567_6/APPENDIX A.pdf ▪ This is not payable on the same day as a fundus photo, Ophthalmic Ultrasound (B scan), Optical Coherence Tomography (OCT) or Fluorescein Angiography (FA)

* QIC approval 6/5/2019

– Exhibit H –

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 United Healthcare I 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 e-mail traffic on Microsoft Exchange 2000 Server and Exchange Server 2003 and Exchange Server 2007.

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

- 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 HUExchange Server 2003 Message Routing TopologyUH.

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

Note:

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

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

Step 2: Generate a certificate request
Use the Exchange System Manager in Exchange Server to generate a certificate request on your bridgehead server. You must provide the fully qualified domain name (FQDN) of the bridgehead server. For more information, see Creating a Certificate or Certificate Request for TLS.

Step 3: Acquire the certificate
Locate a recognized certification authority (CA), such as VeriSign, Comodo, or GoDaddy. Submit the certificate request file that you generated in the previous section. The CA will provide you with a certificate (CER) file that contains the certificate for your server.

Step 4: Install the certificate
Use the Exchange System Manager to install the certificate file. You must provide the path to the certificate file that you received from the CA.

Step 5: Create an SMTP connector
Based on your current e-mail environment, use one of the following procedures to create an SMTP connector or send connector.

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

- 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 e-mail routing domain (for example, contoso1.microsoftonline.com).

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

To create a Send connector in Exchange 2007
- 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 e-mail 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**, e-mail messages are routed through servers to follow a path that balances the network load efficiently. If you want e-mail messages to be routed through servers in the United States instead of being routed through servers that might be located in other countries, type the following URL: **mail.us.messaging.microsoft.com.**

- 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 e-mail. However, it cannot send TLS e-mail 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.

Texas Medicaid Confidentiality

A provider or agency contracted with the Texas Health and Human Services Commission may receive or create sensitive personal information (defined by Section 521.002 of the Business and Commerce Code). The provider or agency must protect this sensitive personal information from unauthorized acquisition. Safeguards must include maintaining this information such that it is unusable, unreadable or indecipherable to unauthorized persons. To determine ways to meet this standard, consult http://www.hhs.gov/ocr/privacy/hipaa/administrative/breachnotificationrule/brguidance.html "Guidance to Render Protected Health Information Unusable, Unreadable or Indecipherable to Unauthorized Individuals," issued by the U.S. Department of Health and Human Services.

Reporting Breach of Confidentiality Incidents

The provider or agency must notify HHSC of any unauthorized acquisition of sensitive personal information related to its contract with HHSC, including any breach of system security (defined by Section 521.053 of the Business and Commerce Code). The provider or agency should report potential incidents to HYPERLINK "mailto:privacy@hhsc.state.tx.us" privacy@hhsc.state.tx.us using Form 0402, Potential Privacy/Security Incident https://hhs.texas.gov/laws-regulations/forms/0-999/form-0402-potential-privacysecurity-incident.

The provider or agency must:
Submit Potential Privacy/Security Incident Form to HHSC as soon as possible and no later than 48 consecutive clock hours after discovery of an event or breach of confidential information or a time within which discovery reasonably should have been made. Continue to provide the HHSC Privacy Office with updates regarding the investigation and mitigation of the breach until the matter is resolved and closed.

Please complete the entire form. If any fields are left blank, Privacy Office staff will return the form for completion. If you have questions regarding this alert, please contact the HHSC Privacy Office at 877-378-9869.

— Exhibit I —

Sample eye examination record

Patient Name: **DOS:**

Last name **First Name** **Middle Initial**

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

Review of Systems

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

Vision:

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

Current RX:	OD	OS

External Exam:

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

Refractions:

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

Patient Name: **DOS:**

Last name **First Name** **Middle Initial**

Near Testing:	Add:

Slit Lamp Examination:

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

Intra Ocular Pressure

OD	OS	Time:	
Method: AP	Puff	Tono	FT

Gonioscopy:	OD	OS

Medicines: Prop	Tetra	Fluress	NaF	Myd	Paradryn	Cyclo	Other:	

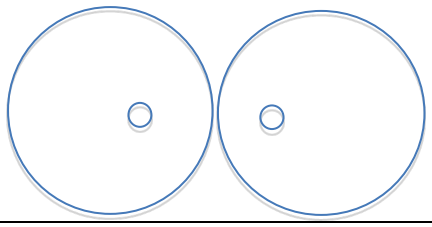
Fundus:

Direct	Indirect	Slit Lamp Lens	Photo

Nerve:

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

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



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

— Exhibit J —

HEDIS and Stars performance reporting

Because we administer benefits for medical plans, we are invested in improving members overall health care quality and cost. Including appropriate 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.
2023F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy.
2024F	Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist.
2025F	Seven standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy.
2026F	Eye imaging validated to match diagnosis from seven standard field stereoscopic photos results documented and reviewed.
2033F	Eye imaging validated to match diagnosis from seven standard field stereoscopic retinal photos results documented and reviewed; without evidence of retinopathy.
3072F	Low risk for retinopathy (no evidence of retinopathy in the prior year)

Important:

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

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

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

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

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

Identifying and reporting abuse, neglect, and exploitation

This section addresses the identification and reporting abuse, neglect and exploitation which you need to know as a mandatory reporter.

Abuse

The negligent or willful infliction of injury, unreasonable confinement, intimidation, or cruel punishment with resulting physical, sexual, emotional harm or pain to a person by the person's caretaker, family member, or other individual who has an ongoing relationship with the person.

Neglect

The failure to provide for the goods or services, including food, clothing, shelter and/or medical services, which are necessary to avoid physical, emotional harm or pain. This includes leaving someone who cannot care for themselves in a situation where they are at risk of harm due to situations such as starvation, dehydration, over or under medication, unsanitary living conditions, lack of heat, running water, electricity or personal hygiene.

Exploitation

The illegal or improper act or process of a caretaker, family member, or other individual who has an ongoing relationship with a person that involves using, or attempting to use, the resources of the person, including the person's Social Security number or other identifying information, for monetary or personal benefit, profit, or gain without the informed consent of the person.

Reporting Abuse and Neglect

If you suspect that someone is being abused, neglected or exploited, you are obligated to report.

Department of Family and Protective Services (DFPS) if the victim is one of the following:
- Living in the community
- Receiving services from home and community support services agencies
- Residing in an unlicensed adult foster care provider with three or fewer beds
- Local authority, LBHAs, community center, or mental health facility operated by the Department of State Health Services
- An adult with a disability receiving services through the consumer-directed services option

Call **800-252-5400** or report online in non-emergency situations at **txabusehotline.org**

Local Law Enforcement if it is an emergency, call 911 or report to the Department of Family and Protective Services by calling **800-252-5400**.

Failure to Report or False Reporting
- Not reporting suspected abuse, neglect and/or exploitation of a person is a criminal offense.
- Knowingly or intentionally reporting false information to DFPS or a law enforcement agency regarding abuse, neglect and/or exploitation is a criminal offense.
- Everyone has an obligation to report suspected abuse, neglect and/or exploitation. This includes reporting even when abuse, neglect or exploitation is committed by a family member, licensed foster parent or DFPS licensed general residential operation.

For life-threatening or emergency situations, call your local law enforcement agency or 911 immediately. Then make a report to DFPS.

Provider must coordinate with DFPS and foster parents for the care of a child who is receiving services from or has been placed in the conservatorship of DFPS and must respond to requests from DFPS, including providing medical records.

— Exhibit L —

Member rights and responsibilities

This section addresses member rights and responsibilities for MCOs serving MMC Members, MCOs serving CHIP members, and for CHIP Perinate Members.

Member Rights and Responsibilities for MCOs Serving MMC Members

MEMBER RIGHTS:

1. You have the right to respect, dignity, privacy, confidentiality, and nondiscrimination. That includes the right to:

    a. Be treated fairly and with respect.
    b. Know that your medical records and discussions with your providers will be kept private and confidential.

2. You have the right to a reasonable opportunity to choose a health care plan and primary care provider. This is the doctor or health care provider you will see most of the time and who will coordinate your care. You have the right to change to another plan or provider in a reasonably easy manner. That includes the right to:

    a. Be told how to choose and change your health plan and your primary care provider.
    b. Choose any health plan you want that is available in your area and choose your primary care provider from that plan.
    c. Change your primary care provider.
    d. Change your health plan without penalty.
    e. Be told how to change your health plan or your primary care provider.

3. You have the right to ask questions and get answers about anything you do not understand. That includes the right to:

    a. Have your provider explain your health care needs to you and talk to you about the different ways your health care problems can be treated.
    b. Be told why care or services were denied and not given.

4. You have the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:

    a. Work as part of a team with your provider in deciding what health care is best for you.
    b. Say yes or no to the care recommended by your provider.

5. You have the right to use each available complaint and appeal process through the managed care organization and through Medicaid, and get a timely response to complaints, appeals, and fair hearings. That includes the right to:

    a. Make a complaint to your health plan or to the state Medicaid program about your health care, your provider, or your health plan.
    b. Get a timely answer to your complaint.
    c. Use the plan's appeal process and be told how to use it.
    d. Ask for a fair hearing from the state Medicaid program and get information about how that process works.

6. You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:

a. Have telephone access to a medical professional 24 hours a day, 7 days a week to get any emergency or urgent care you need.
b. Get medical care in a timely manner.
c. Be able to get in and out of a health care provider's office. This includes barrier free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act.
d. Have interpreters, if needed, during appointments with your providers and when talking to your health plan. Interpreters include people who can speak in your native language, help someone with a disability, or help you understand the information.
e. Be given information you can understand about your health plan rules, including the health care services you can get and how to get them.

7. You have the right to not be restrained or secluded when it is for someone else's convenience or is meant to force you to do something you do not want to do or is to punish you.

8. You have a right to know that doctors, hospitals, and others who care for you can advise you about your health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.

9. You have a right to know that you are not responsible for paying for covered services. Doctors, hospitals, and others cannot require you to pay copayments or any other amounts for covered services.

MEMBER RESPONSIBILITIES:

1. You must learn and understand each right you have under the Medicaid program. That includes the responsibility to:

    a. Learn and understand your rights under the Medicaid program.
    b. Ask questions if you do not understand your rights.
    c. Learn what choices of health plans are available in your area.

2. You must abide by the health plan's and Medicaid's policies and procedures. That includes the responsibility to:

    a. Learn and follow your health plan's rules and Medicaid rules.
    b. Choose your health plan and a primary care provider quickly.
    c. Make any changes in your health plan and primary care provider in the ways established by Medicaid and by the health plan.
    d. Keep your scheduled appointments.
    e. Cancel appointments in advance when you cannot keep them.
    f. Always contact your primary care provider first for your non-emergency medical needs.
    g. Be sure you have approval from your primary care provider before going to a specialist.
    h. Understand when you should and should not go to the emergency room.

3. You must share information about your health with your primary care provider and learn about service and treatment options. That includes the responsibility to:

    a. Tell your primary care provider about your health.
    b. Talk to your providers about your health care needs and ask questions about the different ways your health care problems can be treated.
    c. Help your providers get your medical records.

4. You must be involved in decisions relating to service and treatment options, make personal choices, and take action to maintain your health. That includes the responsibility to:

a. Work as a team with your provider in deciding what health care is best for you.
b. Understand how the things you do can affect your health.
c. Do the best you can to stay healthy.
d. Treat providers and staff with respect.
e. Talk to your provider about all of your medications.

Member Rights and Responsibilities for MCOs Serving CHIP Members

MEMBER RIGHTS:

5. You have a right to get accurate, easy-to-understand information to help you make good choices about your child's health plan, doctors, hospitals, and other providers.

6. Your health plan must tell you if they use a "limited provider network." This is a group of doctors and other providers who only refer patients to other doctors who are in the same group. "Limited provider network" means you cannot see all the doctors who are in your health plan. If your health plan uses "limited networks," you should check to see that your child's primary care provider and any specialist doctor you might like to see are part of the same "limited network."
7. You have a right to know how your doctors are paid. Some get a fixed payment no matter how often you visit. Others get paid based on the services they give to your child. You have a right to know about what those payments are and how they work.
8. You have a right to know how the health plan decides whether a service is covered or medically necessary. You have the right to know about the people in the health plan who decide those things.
9. You have a right to know the names of the hospitals and other providers in your health plan and their addresses.
10. You have a right to pick from a list of health care providers that is large enough so that your child can get the right kind of care when your child needs it.
11. If a doctor says your child has special health care needs or a disability, you may be able to use a specialist as your child's primary care provider. Ask your health plan about this.
12. Children who are diagnosed with special health care needs or a disability have the right to special care.
13. If your child has special medical problems, and the doctor your child is seeing leaves your health plan, your child may be able to continue seeing that doctor for three months, and the health plan must continue paying for those services. Ask your plan about how this works.
14. Your daughter has the right to see a participating obstetrician/gynecologist (OB/GYN) without a referral from her primary care provider and without first checking with your health plan. Ask your plan how this works. Some plans may make you pick an OB/GYN before seeing that doctor without a referral.
15. Your child has the right to emergency services if you reasonably believe your child's life is in danger, or that your child would be seriously hurt without getting treated right away. Coverage of emergencies is available without first checking with your health plan. You may have to pay a co-payment, depending on your income. Co-payments do not apply to CHIP Perinatal Members.
16. You have the right and responsibility to take part in all the choices about your child's health care.
17. You have the right to speak for your child in all treatment choices.
18. You have the right to get a second opinion from another doctor in your health plan about what kind of treatment your child needs.
19. You have the right to be treated fairly by your health plan, doctors, hospitals, and other providers.
20. You have the right to talk to your child's doctors and other providers in private, and to have your child's medical records kept private. You have the right to look over and copy your child's medical records and to ask for changes to those records.

21. You have the right to a fair and quick process for solving problems with your health plan and the plan's doctors, hospitals and others who provide services to your child. If your health plan says it will not pay for a covered service or benefit that your child's doctor thinks is medically necessary, you have a right to have another group, outside the health plan, tell you if they think your doctor or the health plan was right.
22. You have a right to know that doctors, hospitals, and others who care for your child can advise you about your child's health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
23. You have a right to know that you are only responsible for paying allowable co-payments for covered services. Doctors, hospitals, and others cannot require you to pay any other amounts for covered services.

MEMBER RESPONSIBILITIES

You and your health plan both have an interest in seeing your child's health improve. You can help by assuming these responsibilities.

24. You must try to follow healthy habits. Encourage your child to stay away from tobacco and to eat a healthy diet.
25. You must become involved in the doctor's decisions about your child's treatments.
26. You must work together with your health plan's doctors and other providers to pick treatments for your child that you have all agreed upon.
27. If you have a disagreement with your health plan, you must try first to resolve it using the health plan's complaint process.
28. You must learn about what your health plan does and does not cover. Read your Member Handbook to understand how the rules work.
29. If you make an appointment for your child, you must try to get to the doctor's office on time. If you cannot keep the appointment, be sure to call and cancel it.
30. If your child has CHIP, you are responsible for paying your doctor and other providers co-payments that you owe them. If your child is getting CHIP Perinatal services, you will not have any co-payments for that child.
31. You must report misuse of CHIP or CHIP Perinatal services by health care providers, other members, or health plans.
32. Talk to your child's provider about all of your child's medications.

Member Rights and Responsibilities for CHIP Perinate Members

MEMBER RIGHTS:

33. You have a right to get accurate, easy-to-understand information to help you make good choices about your unborn child's health plan, doctors, hospitals, and other providers.
34. You have a right to know how the Perinatal providers are paid. Some may get a fixed payment no matter how often you visit. Others get paid based on the services they provide for your unborn child. You have a right to know about what those payments are and how they work.
35. You have a right to know how the health plan decides whether a Perinatal service is covered or medically necessary. You have the right to know about the people in the health plan who decide those things.
36. You have a right to know the names of the hospitals and other Perinatal providers in the health plan and their addresses.
37. You have a right to pick from a list of health care providers that is large enough so that your unborn child can get the right kind of care when it is needed.

38. You have a right to emergency Perinatal services if you reasonably believe your unborn child's life is in danger, or that your unborn child would be seriously hurt without getting treated right away. Coverage of such emergencies is available without first checking with the health plan.
39. You have the right and responsibility to take part in all the choices about your unborn child's health care.
40. You have the right to speak for your unborn child in all treatment choices.
41. You have the right to be treated fairly by the health plan, doctors, hospitals, and other providers.
42. You have the right to talk to your Perinatal provider in private, and to have your medical records kept private. You have the right to look over and copy your medical records and to ask for changes to those records.
43. You have the right to a fair and quick process for solving problems with the health plan and the plan's doctors, hospitals, and others who provide Perinatal services for your unborn child. If the health plan says it will not pay for a covered Perinatal service or benefit that your unborn child's doctor thinks is medically necessary, you have a right to have another group, outside the health plan, tell you if they think your doctor or the health plan was right.
44. You have a right to know that doctors, hospitals, and other Perinatal providers can give you information about your or your unborn child's health status, medical care, or treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.

MEMBER RESPONSIBILITIES

You and your health plan both have an interest in having your baby born healthy. You can help by assuming these responsibilities.

45. You must try to follow healthy habits. Stay away from tobacco and eat a healthy diet.
46. You must become involved in the doctor's decisions about your unborn child's care.
47. If you have a disagreement with the health plan, you must try first to resolve it using the health plan's complaint process.