

# MARCH<sup>®</sup> Vision Care Tennessee Provider Reference Guide



keeping an eye on your health<sup>®</sup>

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**Provider Reference Guide Notice of Updates Effective June 2020:**

**Throughout the PRG:**

- Updated mailing address
- Use “us”, “we”, “our” to refer to MARCH®
- Use “you”, “your” to refer to providers
- Providers.eyesynergy.com to refer to eyeSynergy®

**Section 1: General Information:**

- Moved “About the Provider Reference Guide” from 1.1 to page 3
- 1.5 – Updated fax and email address

**Section 2: Eligibility and Benefits:**

- 2.2 – Updated 2<sup>nd</sup> paragraph to ensure it identifies the member knowingly signed a waiver

**Section 3: Billing and Claim Procedures:**

- 3.2 – Simplified verbiage in second to last paragraph

**Section 4: Standards of Accessibility:**

- 4.2 – Updated verbiage regarding who coordinates access monitoring

**Section 7: Health Care Services:**

- 7.1 – Updated “Quality Improvement Program” to “Quality Management Program”
- 7.2 – Updated verbiage
- 7.3 – Updated verbiage

**Section 9: Credentialing:**

- Section verbiage updated

**Section 11: Cultural Competency:**

- Included link to Cultural & Linguistics page on marchvisioncare.com

If you, the provider, require verbal communication regarding matters in a language other than English, please call us at (844) 966-2724 and we will provide you with the language assistance so that we can best serve you. You can also dial 711 for TTY assistance. Additionally, if you require MARCH® Vision Care materials in alternate formats, please call us at (844) 966-2724 to make such a request (e.g. provider manual, forms and newsletters in languages other than English or Spanish, braille, large font, etc.).

### **About the Provider Reference Guide**

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

This version of the Provider Reference Guide (“PRG”) was revised in June 2020. Reviews and updates to this guide are conducted as necessary and appropriate. Update notifications are distributed as they occur through provider newsletters. Recent newsletters and a current version of this guide are always available on [marchvisioncare.com](http://marchvisioncare.com). To request a current copy of the Provider Reference Guide on CD, please contact our Provider Relations Department at (844) 966-2724.

Terms used in this manual include the following:

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

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

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

**1.1 About the TennCare Program**

TennCare is the State of Tennessee’s Medicaid program. It has been operated under a waiver from CMS since 1994, including Medicaid categories, the Uninsured (Standard) and the medically eligible Uninsurable (“Standard”). The TennCare program operates under a Section 1115 waiver from the Centers for Medicare and Medicaid Services (CMS). Medicaid waiver programs are time-limited. The waiver under which TennCare is currently operating is called “TennCare II” which began on July 1, 2002 and was extended through June 30, 2016.

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

**1.2 Contact Information**

Provider Services and Customer Service	(844) 966-2724 or (844) 96-MARCH Monday through Friday, 8:00 am to 5:00 pm local time
Fax Number	(877) MARCH-88 or (877) 627-2488
General Website	<a href="http://www.marchvisioncare.com">www.marchvisioncare.com</a>
Provider Website	<a href="http://providers.eyesynergy.com">providers.eyesynergy.com</a>
Mailing Address	MARCH® Vision Care 6601 Center Drive West, Suite 200 Los Angeles, CA 90045
Lab and Contact Lens Orders	<a href="http://providers.eyesynergy.com">providers.eyesynergy.com</a>

**1.3 eyeSynergy®**

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

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

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

- log onto [marchvisioncare.com](http://marchvisioncare.com) and click on the orange and blue eyeSynergy® link located at the top of the page; or
- go directly to [providers.eyesynergy.com](http://providers.eyesynergy.com).

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

**Registration**

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

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

**Logging In**

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

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

#### **1.4 Interactive Voice Recognition System (IVR)**

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

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

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

#### **Registration**

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

#### **Logging In**

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

#### **1.5 Electronic Funds Transfer (EFT)**

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

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

We offer you the option to receive payments according to preference: electronically deposited into a bank account, or by traditional paper check.

We eliminated paper EOPs which are now available in electronic format (ERA) online via the PaySpan website.

#### **Provider Benefits**

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

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

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

### **1.6 Provider Change Notification**

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

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

Please report all changes via mail or fax to:

MARCH® Vision Care  
Attention: Provider Relations Department  
6601 Center Drive West, Suite 200  
Los Angeles, CA 90045  
Fax: (844) 558-8451  
Email: [visionnominations@uhc.com](mailto:visionnominations@uhc.com)

### **1.7 Licensure and Background Checks**

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

### **1.8 Monitoring Sanction and Exclusion Lists**

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

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

- LEIE at <http://www.oig.hhs.gov/fraud/exclusions.asp>;
- Health Integrity and Protection Data Bank (HIPDB) <http://www.npdb-hipdb.hrsa.gov>; and
- System for Award Management (SAM) <https://www.sam.gov/sam/>

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

## 2.1 Eligibility and Benefit Verification



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

### Confirmation Numbers

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

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

The following are examples of instances in which a confirmation number does not guarantee payment of a claim:

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

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

*\*If you generate a confirmation number through the IVR system, but finds that it is not found when entering the information in [providers.eyesynergy.com](http://providers.eyesynergy.com), please contact a Customer Service Representative for additional assistance.*

### Covered Benefits

A listing of covered benefits may be accessed by:

- Logging into [providers.eyesynergy.com](http://providers.eyesynergy.com):
  - Resources > Provider Reference Guide > select applicable state from the drop-down menu;
  - Benefits and Eligibility menu in [providers.eyesynergy.com](http://providers.eyesynergy.com);
- Going to [marchvisioncare.com](http://marchvisioncare.com) > Doctors and Office Staff > Provider Resources. Benefits may be accessed by selecting the desired state from the drop-down menu.

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

### Methods of Verification

You may utilize [providers.eyesynergy.com](http://providers.eyesynergy.com), the Interactive Voice Recognition System, or contact a Customer Service Representative to verify member eligibility and benefits.

## 2.2 Non-Covered Services

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

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

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

**REMINDER FOR ALL MEMBERS:**

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

Such agreement by the member must be made prior to the actual delivery of services. Documentation of the agreement must be placed in the member’s chart as part of his/her medical record. Additionally, a copy of the written agreement must be given to the member to ensure their understanding of their financial responsibility for non-covered frames and/or lenses

**2.3 TennCare Kids (EPSDT)**

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

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

**B. TennCare Kids (EPSDT) Screening Guidelines**

**1. Periodicity Schedule for Check-ups and Screenings**

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

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

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

Periodicity Schedule for TennCare Kids Screenings:

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

### 3.1 Claim Submission

#### Preferred Method

We prefer to receive claims electronically via [providers.eyesynergy.com](http://providers.eyesynergy.com), our web-based solution for electronic transactions. [Providers.eyesynergy.com](http://Providers.eyesynergy.com) helps reduce claim errors resulting in faster processing times.

#### Clearinghouse Submissions

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

#### Paper Claims

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

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

#### Clean Claim Definition

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

Claims submitted for payment should include the following:

- Member name, ID number, date of birth and gender;
- Provider and/or facility name, address and signature;
- Billing name, address and tax identification number;
- National Provider Identifier (NPI) for both the rendering provider and the billing entity;
- Date of service;
- Current and appropriate ICD-10 codes;
- Service units;
- Current and appropriate CPT/HCPCS codes;
- Current and applicable modifier codes;
- Place of service;
- Usual and customary charges.

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

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

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

### 3.2 American Medical Association CPT Coding Rules

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

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

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

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

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

### **3.3 Billing for Replacements and Repairs**

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

- RA (Replacements)
- RB (Repairs)

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

### **3.4 Telemedicine**

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

### **3.5 Frame Warranty**

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

If you determine that the defective frame is covered under the warranty, please contact us at (844) 966-2724. Please do not send any broken glasses to us or the contracted lab.

### **3.6 Order Cancellations**

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

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

### **3.7 Billing for Glaucoma Screenings**

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

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

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

### **3.8 Billing of Medicare Allowance**

A set dollar amount is typically allowed to cover frames, lenses and/or contact lenses provided to Medicare members, also known as an "allowance" or an "allowance-based benefit". You should bill the current and appropriate HCPCS codes for frames, lenses and/or contact lenses along with the usual and customary charges for those codes. The allowance does not

apply to routine eye exams. Routine eye exams are paid separately. Member is responsible for charges exceeding their benefit allowance.

**Frames and Lenses**

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

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

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

**Contact Lenses**

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

**3.9 Claim Filing Limits**

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

Medicaid	Medicare
120	365

We will not deny your claims on the basis of untimely filing in the following situations:

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

**Proof of Timely Filing**

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

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

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

**3.10 Payment Policies**

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

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

### 3.11 Corrected Claims

A corrected claim will only be considered if the original claim was submitted within the claim filing limits. The corrected claim timely filing limit for the state of Tennessee is 120 days from the original paid date for Medicaid and 365 days from the date services are rendered for Medicare. The corrected claim filing limit is in accordance with the applicable provider service agreement and/or governing entity regulations.

A corrected claim may be submitted through providers.eyesynergy.com, under the Claims Details page. 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 are to indicate the reason for the correction in the note section field. If attachments are required to process the claim, please do not submit the corrected claim through providers.eyesynergy.com. Please submit your corrected claim on a red CMS-1500 form along with the proof of timely filing or coordination of benefits attachment(s).

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

Please mail corrected claims to:

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

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

### 3.12 Provider Disputes

We are committed to ensuring your satisfaction. Our Customer Service department can be reached at (844) 966-2724 Monday through Friday, 8:00am to 5:00pm local time. In addition to contacting our Customer Service Department, our Provider Dispute Resolution Process provides a mechanism for you to communicate disputes in writing.

#### Provider Dispute Types

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

#### Provider Dispute Resolution Process

1. You submit our Provider Dispute Resolution Request Form (Exhibit B) or a written summary of their dispute including supporting documentation. This serves as your first level of appeal. Please submit the form to:  
MARCH® Vision Care  
Attention: PDR Unit  
6601 Center Drive West, Suite 200  
Los Angeles, CA 90045
2. We will acknowledge receipt of all participating provider disputes within thirty (30) calendar days after receipt of request.
3. We will issue a written determination explaining the reasons for its determination within sixty (60) calendar days from the date of receipt of the dispute, unless a longer time to completely respond was agreed upon in writing by both you and us within the first thirty (30) calendar days of receipt of the dispute.
4. You may appeal a second level decision of the Provider Dispute Resolution Process by requesting an Independent Review of the partial or complete denial of a claim in accordance with T.C.A 56-32-126 (b).
5. You must file a request for independent review within three hundred sixty-five (365) calendar days after we have partially or totally denied the claim for the first time or has recouped payment on a previously allowed claim for the first time. The request for an independent reviewer should be directed to the following address:

Compliance Officer, TennCare Division  
Tennessee Dept. of Commerce & Insurance

500 James Robertson Parkway, 11<sup>th</sup> Floor  
Nashville, TN 37243-1169  
Telephone: (615) 741-2677

### **3.13 Overpayment of Claims**

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

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

### **3.14 Balance Billing**

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

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

### **3.15 Coordination of Benefits**

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

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

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

Please mail COB claims to:

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

### **3.16 Disclosure of Criminal Conviction, Ownership and Control Interest**

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

### **3.17 Medicaid ID**

All providers (both the rendering provider and the billing provider) must receive a Tennessee Medicaid ID prior to claims payment for TennCare members. This ID is assigned by the Bureau of TennCare, and is available on the web. To apply for a Tennessee Medicaid ID, you may call TennCare at 1-800-852-2683. The website address for applications is <http://www.tn.gov/tenncare/topic/provider-registration>.

### **3.18 Encounter Data**

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

## 4.1 Access Standards

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

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

- Appointments for routine, non-urgent eye examinations and eyeglass or contact lens fittings and dispensing are not to exceed three (3) weeks or twenty-one (21) calendar days.
- Appointments for urgent/emergent eye care services, within the optometrist's or ophthalmologist's scope of practice, are not to exceed forty-eight (48) hours.
- Rescheduling an appointment in a manner that is appropriate for the enrollee's health care needs and ensures continuity of care consistent with good professional practice.
- For members requiring urgent/emergent eye care services during non-business hours, each provider office is required to employ an answering service or a telephone answering machine which provides instructions regarding how members may obtain urgent/emergent care including, when applicable, how to contact another provider who has agreed to be on-call to triage by phone, or if needed, deliver urgent/emergent care. Alternatively, the answering service may instruct members to call 911 or go to the local emergency room.
- Members with scheduled appointments will wait no more than forty-five (45) minutes before being seen by a provider. Wait time is defined as the time spent in the lobby and in the examination room prior to being seen by a provider.
- Members are entitled to a second opinion from a qualified health care professional within the network, or arrangement may be made for the member to obtain one outside the network, at no cost to the member.
- Emergency services will be provided without regard to prior authorization requirements.

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

## 4.2 Emergency and Urgently Needed Services/After-Hours Calls

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

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

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

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

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

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

## 4.3 Access Monitoring

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

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

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

**5.1 Protocol for Member Complaints and Appeals**

**Definitions**

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

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

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

Members should be referred to their health plan for assistance. We will work with the member’s contracted health plan to resolve issues. You may be asked for medical records or a response as part of the complaint/appeal investigation. Per 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 complaints and appeals will be investigated, and resolved in a regulatory compliant time frame, following its policies and procedures.

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

**5.2 Potential Quality Issue**

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

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

### 6.1 **TennCare<sup>SM</sup> Member Rights and Responsibilities:**

#### **Your rights and responsibilities as a TennCare<sup>SM</sup> and UnitedHealthcare Community Plan member**

##### **You have the right to:**

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

##### **Your rights to stay with UnitedHealthcare Community Plan**

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

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

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

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

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

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

**Your right to not be treated differently due to your protected status**

We do not allow different treatment due to a person's race, color, birthplace, language, sex, age, religion, disability, or any status protected by federal or state civil rights laws, in TennCare or UnitedHealthcare Community Plan.

In TennCare, different treatment due to a person's race, color, birthplace, language, sex, age, religion, disability, or any status protected by federal or state civil rights laws, can mean things like:

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

**You have the right to make a complaint if you think you are being treated differently due to a person's race, color, birthplace, language, sex, age, religion, disability, or any status protected by federal or state civil rights laws.** By law, no one can get back at you for making a complaint.

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

Jay Taylor  
Compliance Officer, Tennessee  
UnitedHealthcare Community Plan  
8 Cadillac Drive, Suite 100  
Brentwood, TN 37027  
Office: 615-493-9530  
email: [jay\\_taylor@uhc.com](mailto:jay_taylor@uhc.com)

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

## Tennessee Provider Reference Guide | Section 6: Member Rights and Responsibilities

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

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

A copy of the Discrimination Complaint form is available as Exhibit J of this Provider Reference Guide. You can also access this form on the state website at:

- <http://www.tn.gov/assets/entities/tenncare/attachments/complaintform.pdf> (English)
- <https://www.tn.gov/content/dam/tn/tenncare/documents/complaintformSP.pdf> (Spanish)
- <https://www.tn.gov/content/dam/tn/tenncare/documents/complaintformAB.pdf> (Arabic)

You may also write to the following agencies if you think you have been treated differently due to your race, color, birthplace, language, sex, age, religion, disability, or any status protected by federal or state civil rights laws:

Agency	Phone Number	Address
TennCare	1-615-507-6474 1-855-857-1673 toll-free For Free TRS dial/lamar al 711 and ask for 855-857-1673	310 Great Circle Road 3W Floor Nashville, TN 37243
State of Tennessee	1-800-251-3589 toll-free (615) 741-5825 Spanish Toll Free Line: 1-866-856-1252 1-615-253-1886 fax www.tn.gov/humanrights	Tennessee Human Rights Commission Central Office, Tennessee Tower 312 Rosa Parks Ave., 23rd Floor Nashville, TN 37243
U.S. Dept. of Health and Human Services, Region IV Office	(800) 368-1019 TTY/TDD: Toll Free 1-800-537-7697 1-404-562-7881 fax Use Complaint Portal: <a href="https://ocrportal.hhs.gov/ocr/cp/complaint_frontpage.jsf">https://ocrportal.hhs.gov/ocr/cp/complaint_frontpage.jsf</a>	U.S. DHHS / Region IV Office of Civil Rights Sam Nunn Atlanta Federal Center, Suite 16T70 61 Forsyth Street, SW Atlanta, GA 30303-8909
U.S. Dept. of Health and Human Services, Washington Office	1-800-368-1019 toll-free 1-800-537-7697 TDD	U.S. DHHS / Office of Civil Rights 200 Independence Ave. SW, Room 506F Washington, D.C. 20201
U.S. Department of Justice	1-800-514-0301 (Voice) 1-800-514-0383 (TTY) <a href="http://www.ada.gov/filing_complaint.htm">http://www.ada.gov/filing_complaint.htm</a>	US Department of Justice 950 Pennsylvania Avenue, NW Civil Rights Division Disability Rights Section – 1425 NYAV Washington, D.C. 20530

### **7.1 Quality Management Program**

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

### **7.2 Clinical Decision Making**

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

### **7.3 Coordination with Other TennCare Contractors/Providers**

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

### **7.4 Medical Records Standards**

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

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

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

## 8.1 Anti-Fraud Plan

### Training of Providers Concerning the Detection of Health Care Fraud

We recognize the importance of properly educating and training you 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 its website. We require you to provide your own standards of conduct of another compliant code of conduct to employees. We require Participating you 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.

### Sanction List Monitoring

We require you to screen employees against the Federal and State exclusion lists prior to hiring and monthly thereafter. At a minimum, 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 (FWA)

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

You can report suspected FWA concerns to UnitedHealthcare online [uhc.com/fraud](https://uhc.com/fraud) or by calling 1-844-359-7736.

## 8.2 Member Abuse and Neglect

### Abuse and Neglect – Elderly

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

#### 1. Types of Abuse and Neglect

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

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

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

- Pressure sores (bed sores)

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

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

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

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

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

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

**d) Psychological Abuse definition and examples:**

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

**e) Psychological Signs:**

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

**f) Behavioral Signs:**

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

**g) Sexual Abuse definition and examples:**

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

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

**h) Violations of Basic Rights definitions and examples:**

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

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

**i) Self Neglect definition and examples:**

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

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

**j) Other examples of Abuse and Neglect:**

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

**k) Risk Factors for Abuse**

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

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

**Abuse and Neglect – Children**

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

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

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

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

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

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

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

### Action Required by Tennessee State Law

For Abuse or Neglect Reports call:

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

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

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

When you call, please be prepared to give:

- Name of individual
- Address

- Age
- Phone #
- Specifics of abuse

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

**Penalties for failure to report:**

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

## 9.1 Credentialing and Re-Credentialing

You are required to submit your CAQH number for credentialing.

### Disclosure of Criminal Conviction, Ownership and Control Interest

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

### CAQH ProView

Unless use of another credentialing source is required by your state, CAQH ProView will be used to obtain the necessary information to complete your credentialing. The use of CAQH ProView will expedite the credentialing process as well as decrease the amount of paperwork for you and your staff. To expedite credentialing, please provide us with your CAQH number as soon as possible. CAQH ProView does not accept paper applications. To further avoid delays in processing please be sure to give Spectera Eyecare Networks permission on the CAQH ProView site to access your record. You will be notified when the review has been completed.

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

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

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

### Medicaid ID Requirement

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

### Credentialing Process

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

### Recredentialing Process

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

## **9.2 National Provider Identifier**

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

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

### 10.1 Access to Interpreters



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

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

## 11.1 Cultural Competency

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

### What is Cultural Competency?

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

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

It also defines health care expectations such as:

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

### And why is it important?

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

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

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

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

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

## 12.1 Confidentiality

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

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

## 12.2 Protected Health Information

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

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

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

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

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

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

### **12.3 Secure Transmission of Protected Health Information (PHI)**

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

- First, please determine if it is business necessary to exchange PHI with us, the recipient of PHI is appropriate, and include only the "minimum necessary" information.
- If you have a business need to exchange PHI with our personnel via email, please check with your IT personnel to make sure they have a secure transmission setup with our email systems. For more details, follow steps described in Exhibit L: "Sending a Secure Email to us for PHI related data" to ensure that HIPAA guidelines are being met and PHI is secured. This will prevent us from receiving unencrypted or unsecured emails with PHI.
- While sending PHI securely via encrypted emails, please be aware that the HIPAA Privacy Rule still requires that PHI only be shared with those who are permitted to have the information and share only the minimum amount of PHI necessary to accomplish the business purpose.
- Please be aware that when contacting us by phone, email, or fax that we are required to confirm your name, associated Provider/Physician Organization, and contact information before exchanging or confirming PHI.
- If you receive PHI or Personally Identifiable Information ("PII") directed to, or meant for, another provider or someone other than you, you agree to promptly destroy all such PHI or PII and not further use or disclose it. In addition, if such an event occurs, you agree to cooperate with any remediation efforts undertaken by us.

### **13.1 Notice of Non-Discrimination**

No person, on the grounds of handicap and/or disability, age, race, color, religion, sex, national origin, or any other classifications protected under federal or state laws shall be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or service provided in the TennCare Program.

As a contracted provider, your office has agreed to receive Federal funding through the TennCare program. All organizations that participate in Federal and state programs must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that receive Federal funding, and any other laws and rules that apply for any other reason. You are required to cooperate with TennCare, MARCH®, and/or UnitedHealthcare Community Plan during discrimination complaint investigations.

You shall, upon request, show proof of such nondiscrimination compliance and shall post notices of nondiscrimination in conspicuous places available to all employees, TennCare applicants, and enrollees.

Any member who feels he/she has been discriminated against, or anyone that witnesses a discriminatory practice, should be encouraged to file a complaint. You are required to assist TennCare members in obtaining discrimination complaint forms and contact information. Complaints can be filed by calling UnitedHealthcare Community Plan's Customer Service Department at 800-690-1606, or by mailing a completed complaint form to UHCCP at the following address:

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

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

In addition, a copy of the Discrimination Complaint form is available on the state website at <http://tn.gov/tenncare/topic/non-discrimination-compliance>.

### **13.2 Assistance with Disabilities**

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

**Exhibits A through N**

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

## Non-Covered Service Fee Acceptance

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

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

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

\_\_\_\_\_  
Member's Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

## Formulario de aceptación del cargo por servicios no cubiertos

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

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

Confirmando que recibí una copia de este acuerdo.

\_\_\_\_\_  
Firma del miembro

\_\_\_\_\_  
Nombre en letra de imprenta

\_\_\_\_\_  
Fecha

## Provider Dispute Resolution Request Form

**Instructions:**

- Please complete the form below. Fields with an asterisk (\*) are required.
- Be specific when completing DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed.
- Mail the completed form to: MARCH<sup>®</sup> Vision Care, 6601 Center Drive West, Suite 200, Los Angeles, CA 90045

<b>Provider Name*:</b>	<b>Provider Tax ID #/Medicare ID #*:</b>
<b>Provider Address:</b>	

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

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

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

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

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

<b>For MARCH<sup>®</sup> use only.</b>	
Tracking Number:	Provider ID:
Contracted:	Non-Contracted:

## Provider Dispute Resolution Request Form

(For use with multiple “like” claims)

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

Page \_\_\_ of \_\_\_

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

## Lab Order Form Instructions

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

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

Lab orders can be submitted online through eyeSynergy<sup>®</sup>. If you choose not to submit lab orders through eyeSynergy<sup>®</sup>, you **must** fax your order to our Customer Service Center at (855) 640-6737.

State(s)	Contact Information	Contact Information
Tennessee	Hoya Knoxville	1529 Western Avenue Knoxville, TN 37921 Phone (800) 227-5697 MARCH <sup>®</sup> Vision Care fax: (855) 640-6737

# Lab Order Form

Please fax completed form to (855) 640-6737

## MEMBER INFORMATION

Member's name: \_\_\_\_\_ Today's date: \_\_\_\_\_  
 Member's ID number: \_\_\_\_\_ Date of eye exam (if known): \_\_\_\_\_

## PROVIDER INFORMATION

TIN: \_\_\_\_\_ Confirmation Number: \_\_\_\_\_  
 Provider name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

### Material to Order Check all that apply.

- Frame  Right Lens  Left Lens  Uncut Lenses

Is this a replacement?  Yes  No

	Sphere	Cylinder	Axis	Prism In / Out	Prism Up/ Down	Add Power	Seg Height
Right							
Left							

	Distant PD	Near PD	Requested Base Curve	Ocular Center
Right				
Left				

### Materials:

- Plastic  Hi-Index 1.60  
 Glass  Hi-Index 1.67  
 Polycarbonate  Photochromic: Grey or Brown  
 Trivex  Edge Polish

### Segment Style

- SV  PAL Standard  Trifocal 7x28  
 FT28  PAL Standard Short  Round 22 or 24  
 FT35  PAL Premium  Slab Off  
 FT45  PAL Premium Short

### Coating Options:

- Solid  Mirror Coating Mirror Type: \_\_\_\_\_  
 Gradient  Scratch Coating  AR Standard  
 Double Gradient  UV  AR Premium  
 Color: \_\_\_\_\_ % or Density #1 #2 #3

### Frame Selection:

- Patient Supplied Frame/Non-Formulary Frame  Rimless Drill 2 Hole  Rimless Drill 4 Hole  
 (Please include copy of order form with shipment of PSF/NFF. Please ship frame to lab within 48 hours of submitting order to MARCH<sup>®</sup>).

Frame Manufacturer: \_\_\_\_\_ Lens Size: \_\_\_\_\_ Bridge Size: \_\_\_\_\_

Frame Model: \_\_\_\_\_ B Measurement \_\_\_\_\_ ED Measurement: \_\_\_\_\_

Frame Color: \_\_\_\_\_ Temple Size \_\_\_\_\_ Edge Type \_\_\_\_\_

### Other Instructions/Special Notes

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

Provider Signature: \_\_\_\_\_

## Tips for Working with Limited English Proficient (LEP) Members

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



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

## Tips for Working with Interpreters

### Telephonic Interpreters

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

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

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

### Onsite Interpreters

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

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

Footnotes:

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

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

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

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



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

Language ID Poster

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

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

## TennCare Member Appeal Form

### Having problems getting health care or medicine in TennCare?

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

**Need help filing a medical appeal?**

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

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

#### 1. Who is the person that wants to appeal?

Full name \_\_\_\_\_ Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Social Security Number \_\_\_\_-\_\_\_\_-\_\_\_\_ Or number on their TennCare card \_\_\_\_\_

Current mailing address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

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

A daytime phone number for that person (\_\_\_\_) \_\_\_\_-\_\_\_\_

#### 2. Who filled out this form?

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

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

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

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

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

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

#### 4. Do you think you have an emergency?

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

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

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

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

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

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

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Tennessee License Number: \_\_\_\_\_

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

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

**Part A. Want to change health plans.** Name of health plan you want \_\_\_\_\_

**Part B. Need care or medicine.** What kind - be specific \_\_\_\_\_

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

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

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

What did they say? \_\_\_\_\_

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

Who was the letter from? \_\_\_\_\_

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

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

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

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

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

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

Their address \_\_\_\_\_

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

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

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

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

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

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

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

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

Rev:08Feb10

**We do not allow unfair treatment in TennCare.**

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

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

Use esta página **únicamente** para

presentar una **Apelación Médica de TennCare.**

¿Necesita ayuda para presentar una apelación médica?

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

Version in English on other side

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

### 1. ¿Quién es la persona que quiere apelar?

Nombre completo \_\_\_\_\_ Fecha de nacimiento \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Número de Seguro Social \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ O número de su tarjeta TennCare \_\_\_\_\_

Dirección postal vigente \_\_\_\_\_

Ciudad \_\_\_\_\_ Estado \_\_\_\_\_ Código postal \_\_\_\_\_

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

Número telefónico de esa persona durante el día (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

### 2. ¿Quién completó este formulario?

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

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

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

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

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

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

### 4. ¿Piensa que tiene una emergencia?

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

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

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

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

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

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Tennessee License Number: \_\_\_\_\_

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

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

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

**Parte A. Quiero cambiar de plan de salud.** Nombre del plan de salud que quiere \_\_\_\_\_

**Parte B. Necesita atención o medicina.** ¿De qué clase? Sea específico \_\_\_\_\_

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

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

Si respondió Sí, el nombre del médico \_\_\_\_\_

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

Si respondió Sí, ¿cuándo? \_\_\_\_\_

¿Qué dijeron? \_\_\_\_\_

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

¿Quién le envió la carta? \_\_\_\_\_

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

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

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

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

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

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

Su dirección \_\_\_\_\_

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

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

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

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

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

Luego, ENVÍE POR CORREO estas hojas y otros datos a: TennCare Solutions  
 P.O. Box 593  
 Nashville, TN 37202-0593

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

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

Rev: 08Feb10 **TennCare no permite el trato injusto.**

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

Potential Quality Issue – Severity Levels

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

## Potential Quality Issue Referral Form

### Identifying Data

Member name: \_\_\_\_\_ DOB: \_\_\_\_\_ Member ID number: \_\_\_\_\_

Provider name: \_\_\_\_\_ NPI : \_\_\_\_\_

Provider address: \_\_\_\_\_ Phone number: \_\_\_\_\_

Group/plan: \_\_\_\_\_ Phone number: \_\_\_\_\_ PR number: \_\_\_\_\_

Referred by: \_\_\_\_\_ ICD-10\* code: \_\_\_\_\_ Client case: Y or N

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

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

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

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

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\_\_\_\_\_  
Referring Staff Signature

\_\_\_\_\_  
Department

\_\_\_\_\_  
Date

\_\_\_\_\_  
Phone Number

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

## Clinical Practice Guidelines

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

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

### Standards for the Comprehensive Eye Examination

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

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

The comprehensive eye examination will include additional testing when:

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

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

#### EYEGLOSS DISPENSING/FITTING

- Assist with frame 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 eyeSynergy<sup>®</sup> or fax order to us.
- Monitor laboratory for appropriate turnaround time and follow up as necessary with us and the member.
- 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 quality and volume of tar 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.
- Train patient on safe and effective lens care, and insertion and removal of lenses.
- Dispense final lenses or provide final prescription.

- Follow-up with visits for one month as indicated.

**Clinical Criteria**

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

Benefit	Available When	Clinical Criteria
Eyewear After Eye Surgery	Determined to be medically necessary.	The stable refractive prescription changes are more than +/-0.75 diopters in any meridian or more than 20 degrees of axis shift or a change in add power greater than 0.50 diopters.
Oversize Lens	Needed for physiological reasons.	The pupillary distance is 70mm or greater or other facial or ocular anomalies requiring a large lens.
Trifocal Lens	Member has a special need due to a job training program or extenuating circumstances.	The base prescription is greater than +/- 1.00 and a bifocal greater than or equal to 2.00
Necessary Contact Lens	Such lenses provide better management of a visual or ocular condition than can be achieved with spectacle lenses, including, but not limited to the diagnosis of:	Irregular astigmatism; unilateral aphakia; keratoconus when vision with glasses is less than 20/40; corneal transplant when vision with glasses is less than 20/40 or anisometropia that is greater than or equal to 4.00 diopter
Color Tinting	Light sensitivity which will hinder driving or seriously handicap the outdoor activity of such member is evident.	The member has photophobia, aniridia, uveitis, corneal dystrophy, cataracts, albinism, or use a medication that has a side effect of photophobia.
Single Vision Eyeglasses In Lieu Of Bifocals	Need is substantiated in member’s medical record by clinical data.	The need for distance correction > +/- 1.50 diopter AND Net combination of distance RX and bifocal > +1.00 or -2.00 AND you are unable to tolerate a multifocal lens.
Progressive Lenses	Need is substantiated in member’s medical record by clinical data.	Epilepsy, childhood disorders with multiple impairments.
Transitions Lenses	Need is substantiated in member’s medical record by clinical data.	Chronic iritis or uveitis, albinism.
Polycarbonate Lenses	Need is substantiated in member’s medical record by clinical data.	<ul style="list-style-type: none"> <li>▪ The member has a prescription of +/-8.00; or</li> <li>▪ Permanently reduced vision in one eye to less than 20/60; or</li> <li>▪ A facial deformity or disease that interferes with eye glass fit; or</li> <li>▪ A documented occupational hazard.</li> </ul>
Ultra Violet Coating	Need is substantiated in member’s medical record by clinical data	<ul style="list-style-type: none"> <li>▪ 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.</li> </ul>
Replacement Due To Outgrown Glasses	Need is substantiated in member’s medical record by clinical data	<ul style="list-style-type: none"> <li>▪ Available for children under 18 when the member’s pupil distance is wider than the frame’s mechanical optical center by greater than 5mm.</li> <li>▪ Available when the new frame size is at least 3mm larger than the existing frames.</li> </ul>
Second Opinion Examination	Need is substantiated in member’s medical record by clinical data	<ul style="list-style-type: none"> <li>▪ Available when medical chart review of the first examination shows inadequate examination, documentation, or when clinical issues are not adequately addressed.</li> </ul>

Benefit	Available When	Clinical Criteria
High Index lenses (Higher than Polycarbonate)	Need is substantiated in member's medical record by clinical data	<ul style="list-style-type: none"> <li>▪ Available when weight of a standard prescription could cause facial development issues (primarily for children).</li> <li>▪ Available when lab cannot practically produce lenses with a lower index lens.</li> </ul>
Allergy To Certain Frames	Need is substantiated in member's medical record by clinical data	<ul style="list-style-type: none"> <li>▪ Alternative frame to be provided when a provider documents a rash or other adverse reaction to all MARCH frame kit materials.</li> </ul>
SLAB Off/Prism	Need is substantiated in member's medical record by clinical data	<ul style="list-style-type: none"> <li>▪ Available for bifocal or trifocal prescriptions that generate greater than 2 prism diopters of imbalance at the reading plane.</li> </ul>
Safety Frames	Need is substantiated in member's medical record by clinical data	<ul style="list-style-type: none"> <li>▪ Used with polycarbonate lenses based on polycarbonate criteria noted above; and</li> <li>▪ 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</li> <li>▪ These would be considered "deluxe frames" and covered by MARCH.</li> <li>▪ These must meet ANSI standards.</li> </ul>
Non-Standard Frames	Need is substantiated in member's medical record by clinical data	<ul style="list-style-type: none"> <li>▪ Used when member has facial parameters where standard frames do not fit correctly.</li> <li>▪ Used when optical correction will not fit practically in a standard frame.</li> </ul>
Low Vision Rehabilitation	Need is substantiated in member's medical record by clinical data.	<ul style="list-style-type: none"> <li>▪ Visual loss with best corrected visual acuity of 20/50 or worse in the better eye.</li> <li>▪ Constriction of visual fields to be less than 20 degrees or hemianopia.</li> <li>▪ Limited contrast sensitivity due to underlying pathology.</li> <li>▪ Initial consult codes of 97241 – 97245 or 99244.</li> <li>▪ Maximized medical treatment of conditions such as, but not limited to, diabetic retinopathy, macular degeneration, optic atrophy, and glaucoma.</li> <li>▪ 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:               <ul style="list-style-type: none"> <li>▪ D49.81</li> <li>▪ G.35</li> <li>▪ H47.099</li> <li>▪ H33.08-H33-303</li> <li>▪ E11.319, E10,319 ; H35.00-H35.443</li> <li>▪ H40.001-H40-2234</li> <li>▪ H53.40-H53-483</li> <li>▪ H54.2-H54.60</li> <li>▪ H46.00-H47.333</li> <li>▪ H55.00-H55.01</li> <li>▪ Or others by pre-approval</li> </ul> </li> <li>▪ A Low Vision Rehabilitation request form must be completed and submitted.</li> <li>▪ Before proceeding, prior approval is required.</li> </ul>

Benefit	Available When	Clinical Criteria
Dilation of Eyes	Initial examination required. Subsequent examinations as follows:	<p>All new members require a dilated fundus exam, a wide angle photograph, or equivalent image (if acceptable per state/federal regulation). Diabetics require dilation every year at a minimum, more often if they have retinopathy. Members with other certain pathology such as lattice degeneration, choroidal nevi, or retinoschisis for example, may also need a dilated exam every year or as medically indicated. Members with no risk factors should be dilated thereafter based on the professional judgment of the provider or every three (3) years, whichever occurs first. Although the photographic method is acceptable in some cases, it is not a substitute for a binocular physical retina examination. All providers must be licensed and capable to dilate the pupil and perform the physical retina examination.</p>
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).	<ul style="list-style-type: none"> <li>▪ The member meets criteria as noted above for necessary contact lens and there is:               <ul style="list-style-type: none"> <li>-Change of +/- 1.00 diopter in power</li> <li>-Change of 0.50 mm in base curve</li> <li>-Change of 0.30 mm in optic zone</li> <li>-Change of 0.75 mm in peripheral curve radius</li> <li>-Change of 0.30 mm in peripheral curve width</li> </ul> </li> </ul>
Replacement Glasses When A Member Can Not Adapt To Bifocals	Member has presbyopia and unable to adapt to bifocals.	<ul style="list-style-type: none"> <li>▪ Members should attempt to make the adjustment to bifocal lenses for a minimum of two (2) weeks.</li> <li>▪ When lens manufacturers and/or the laboratory provides a warranty for "non-adapts", this should be used.</li> <li>▪ 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.</li> <li>▪ The frame that was used for the bifocals will be reused for one of the new single vision glasses.</li> </ul>
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.	<p>Coverage for either medically necessary contact lenses <b>or</b> glasses in a given benefit period, but not both except for the following circumstances:</p> <ul style="list-style-type: none"> <li>▪ 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.</li> </ul> <p>The patient has vision less than 20/200 in the poorer eye, or pathology where 20/200 or less is expected but can not be measured (ie. PHPV, RD, macula scarring, coloboma involving the posterior pole) and a spectacle lens is needed for protection of the good eye.</p>

Benefit	Available When	Clinical Criteria
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	<ul style="list-style-type: none"> <li>▪ MARCH adopted the American Optometric Association (“AOA”) “Evidence-Based Clinical Practice Guidelines - Diabetes Mellitus.”</li> </ul> <p><a href="http://aoa.uberflip.com/i/374890-evidence-based-clinical-practice-guideline-diabetes-mellitus">http://aoa.uberflip.com/i/374890-evidence-based-clinical-practice-guideline-diabetes-mellitus</a></p> <p><a href="https://www.aoa.org/optometrists/tools-and-resources/clinical-care-publications/clinical-practice-guidelines">https://www.aoa.org/optometrists/tools-and-resources/clinical-care-publications/clinical-practice-guidelines</a></p>
Extended Ophthalmoscopy	When benefit includes medical within the scope of an OD	<ul style="list-style-type: none"> <li>▪ 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.</li> <li>▪ 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.</li> <li>▪ 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.</li> </ul> <p><a href="https://downloads.cms.gov/medicare-coverage-database/lcd_attachments/33567_6/APPENDIX A.pdf">https://downloads.cms.gov/medicare-coverage-database/lcd_attachments/33567_6/APPENDIX A.pdf</a></p> <p>This is not payable on the same day as a fundus photo, Ophthalmic Ultrasound (B scan), Optical Coherence Tomography (OCT) or Fluorescein Angiography (FA).</p>

<p>Extended Ophthalmoscopy</p>	<p>When benefit includes medical within the scope of an OD</p>	<ul style="list-style-type: none"> <li>▪ 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.</li> <li>▪ 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.</li> <li>▪ 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.</li> </ul> <p><a href="https://downloads.cms.gov/medicare-coverage-database/lcd_attachments/33567_6/APPENDIX_A.pdf">https://downloads.cms.gov/medicare-coverage-database/lcd_attachments/33567_6/APPENDIX A.pdf</a></p> <ul style="list-style-type: none"> <li>▪ This is not payable on the same day as a fundus photo, Ophthalmic Ultrasound (B scan), Optical Coherence Tomography (OCT) or Fluorescein Angiography (FA).</li> </ul>
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\* QIC approval 6/5/2019

## Sending a Secure Email to MARCH<sup>®</sup> Vision Care for PHI Related Data

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

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

### **Secure Your E-Mail Traffic**

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

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

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

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

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

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

#### **NOTE:**

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

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

#### **Step 2: Generate a Certificate Request**

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

#### **Step 3: Acquire the Certificate**

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

#### **Step 4: Install the Certificate**

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

#### **Step 5: Create an SMTP Connector**

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

**To create an SMTP connector in Exchange 2000 or Exchange 2003**

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

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

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

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

**To create a Send connector in Exchange 2007**

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

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

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

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

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

**Step 6: Enable TLS**

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

**To enable TLS**

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



## Having problems getting health care from TennCare?

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

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

**You have the right to appeal if:**

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

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

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

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

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

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

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

### **Have questions? Need help? Want to appeal?**

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

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



## ¿Tiene problemas para obtener atención médica en TennCare?

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

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

### Usted tiene el derecho de apelar si:

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

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

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

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

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

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

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

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

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

**TENNCARE DISCRIMINATION COMPLAINT**

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

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

**1. \* Write your name and address.**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ Zip \_\_\_\_\_

Telephone: Home: (\_\_\_\_) \_\_\_\_\_ Work or Cell: (\_\_\_\_) \_\_\_\_\_

Email Address: \_\_\_\_\_

Name of MCO/Health Plan:

\_\_\_\_\_

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

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

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ Zip \_\_\_\_\_

Telephone: Home: (\_\_\_\_) \_\_\_\_\_ Work or Cell: (\_\_\_\_) \_\_\_\_\_

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

\_\_\_\_\_

Name of this person's MCO/Health Plan:

\_\_\_\_\_

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

Medical Services \_\_\_\_\_ Dental Services \_\_\_\_\_ Pharmacy Services \_\_\_\_\_

Long-Term Services & Supports \_\_\_\_\_ Eligibility Services \_\_\_\_\_ Appeals \_\_\_\_\_

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

Race \_\_\_ Birthplace \_\_\_ Color \_\_\_ Sex \_\_\_ Age \_\_\_

Disability/Handicap\_\_\_\_\_ Religion\_\_\_\_\_ Other\_\_\_\_\_

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

\_\_\_\_\_

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

Date it started: \_\_\_\_\_ Date of the last time it happened: \_\_\_\_\_

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

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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

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

\_\_\_\_\_  
 \_\_\_\_\_

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

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

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

Are you reporting this complaint for someone else but you are **not** the person's Authorized Representative? Please sign your name below. **The person you are reporting this complaint for must sign above or must tell his/her**

**health plan or TennCare that it is okay for them to sign for him/her. Declaration:** *I agree that the information in this complaint is true and correct and give my OK for TennCare to contact me about this complaint.*

---

(Sign here if you reporting this for someone else)

(Date)

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

---

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

(Date)

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

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

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



**TennCare Agreement to Release Information**

To investigate your complaint, TennCare and UnitedHealthcare Community Plan may need to tell other persons or agencies important to this complaint your name or other information about you.

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

- I understand that during of the investigation of my complaint TennCare and \_\_\_\_\_ (write name of your MCO/Health Plan on the line) may need to tell people my name or other information about me to other persons or agencies. For example, if I report that my doctor treated me in a different way because of my color, my MCO/Health Plan may need to talk to my doctor.
- You do not have to agree to release your name or other information. It is not always needed to investigate your complaint. If you do not sign the release, we will still try to investigate your complaint. But, if you don't agree to let us use your name or other details, it may limit or stop the investigation of your complaint. And, we may have to close your case. However, before we close your case if your complaint can no longer be investigated because you did not sign the release, we may contact you to find out if you want to sign a release so the investigation can continue.

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

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

**By signing this Agreement to Release Information, I agree that I have read and understand my rights written above. I agree to my MCO/Health Plan telling people my name or other information about me to other persons or agencies important to this complaint during the investigation and outcome.**

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

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name (Please print): \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

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

TennCare OCRC Phone: 1-615-507-6474 or for free at 1-855-857-1673  
 310 Great Circle Road, 3W For free TRS dial/llamar al 711 and ask for 855-857-1673  
 Nashville, TN 37243  
 Email: HCFA.fairtreatment@tn.gov

<b>Do you need free help with this letter?</b>	
<p>If you speak a language other than English, help in your language is available for free. This page tells you how to get help in a language other than English. It also tells you about other help that's available.</p>	
<b>Spanish:</b>	<b>Español</b>
<p>ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-259-0701 (TTY: 1-800-848-0298).</p>	
<b>Kurdish:</b>	<b>یەكۆك</b>
<p>ئاگاداری: ئەگەر بە زمانی کوردی</p>	
<p>TTY (1-800-848-0298) 1- 855-259-0701 بەکە.</p>	
<b>Arabic:</b>	<b>آبیرعلا</b>
<p>ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 0701-259-855-1 (رقم هاتف الصم والبكم: 1-800-848-0298).</p>	
<b>Chinese:</b>	<b>繁體中文</b>
<p>注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-259-0701 (TTY 1-800-848-0298)。</p>	
<b>Vietnamese:</b>	<b>Tiếng Việt</b>
<p>CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855- 259-0701 (TTY: 1-800-848-0298).</p>	
<b>Korean:</b>	<b>한국어</b>
<p>주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-259- 0701 (TTY: 1-800-848-0298)번으로 전화해 주십시오.</p>	
<b>French:</b>	<b>Français</b>
<p>ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-259-0701 (ATS : 1-800-848-0298).</p>	
<b>Amharic:</b>	<b>አማርኛ</b>
<p>ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገዝዎት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 1-855-259-0701 (መስማት ለተሳናቸው፡ 1-800-848-0298)።</p>	
<b>Gujarati:</b>	<b>જરાતી</b>
<p>જ્યુ ના: જો તમે જુ રાતી બોલતા હો, તો િન: જુ ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-855- 259-0701 (TTY: 1-800-848-0298).</p>	
<b>Laotian:</b>	<b>ພາສາລາວ</b>
<p>ໂບດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-855-259-0701 (TTY: 1-800-848-0298).</p>	
<b>German:</b>	<b>Deutsch</b>
<p>ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-259-0701 (TTY: 1-800-848-0298).</p>	
<b>Tagalog:</b>	<b>Tagalog</b>
<p>PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-259-0701 (TTY: 1-800-848-0298).</p>	
<b>Hindi:</b>	<b>हंद</b>
<p>ध्यानद: यद आप हंद बोलते ह तो आपके िलए मुफ्त म भाषा सहायता सेवाएं</p>	

<p>उपलब्ध है 1-855-259-0701 (TTY: 1-800-848-0298) पर कॉल करे।</p>	
<p><b>Serbo-Croatian:</b></p>	<p><b>Srpsko-hrvatski</b>                  OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-855-259-0701 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1- 800-848-0298).</p>
<p><b>Russian:</b></p>	<p><b>Русский</b>                  ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-259-0701 (телетайп: 1-800-848-0298).</p>
<p><b>Nepali:</b></p>	<p><b>नेपाल</b>                  ध्यान दनुहोस्: तपाइलेनेपाल बोल्नुहुन्छ भनेतपाइको निम्त भाषा सहायता सेवाहरू नःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-855-259-0701 (टटवाइ: 1-800-848-0298) ।</p>
<p><b>Persian:</b></p>	<p>توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم میباشد. با بگیرد تماس 0701-259-855-1 (TTY: 1-800-848-0298)</p>

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

**Call us for free at 1-855-259-0701. We can connect you with the free help or service you need.  
 (For TTY call: 1-800-848-0298)**



**TENNCARE QUEJA DE DISCRIMINACIÓN**

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

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

**1. Escriba su nombre y dirección.**

Nombre: \_\_\_\_\_

Dirección: \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_ Código postal \_\_\_\_\_

Teléfono: Hogar: (\_\_\_\_) \_\_\_\_\_ Trabajo o Celular: (\_\_\_\_) \_\_\_\_\_

Dirección de correo electrónico: \_\_\_\_\_

Nombre del MCO/plan de seguro médico: \_\_\_\_\_  
 \_\_\_\_\_

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

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

Nombre: \_\_\_\_\_

Dirección: \_\_\_\_\_  
 \_\_\_\_\_ Código postal \_\_\_\_\_

Teléfono: Hogar: (\_\_\_\_) \_\_\_\_\_ Trabajo o Celular: (\_\_\_\_) \_\_\_\_\_

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

\_\_\_\_\_

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

\_\_\_\_\_

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

Servicios médicos \_\_\_\_\_ Servicios dentales \_\_\_\_\_ Servicios de farmacia \_\_\_\_\_

Servicios y apoyos de largo plazo \_\_\_\_\_ Servicios de elegibilidad \_\_\_\_\_ Apelaciones \_\_\_\_\_

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

Raza \_\_\_\_\_ Lugar de nacimiento \_\_\_\_\_ Color de la piel \_\_\_\_\_ Sexo \_\_\_\_\_ Edad \_\_\_\_\_

Discapacidad \_\_\_\_\_ Religión \_\_\_\_\_ Otra cosa \_\_\_\_\_

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

\_\_\_\_\_

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

Fecha en que comenzó: \_\_\_\_\_ Última fecha en que sucedió: \_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

**Nombre**

**Dirección**

**Teléfono**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

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

---

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

(Fecha)

---

(Firme aquí si usted es el Representante Autorizado)

(Fecha)

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

---

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

(Fecha)

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

---

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

(Fecha)

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

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

También puede llamarnos si necesita ayuda con esta información.



### **TENNCARE QUEJA DE DISCRIMINACIÓN**

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

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

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

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

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

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

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

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

Firma: \_\_\_\_\_ Fecha: \_\_\_\_\_

Nombre (en letra de imprenta): \_\_\_\_\_

Dirección: \_\_\_\_\_

Teléfono: \_\_\_\_\_

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

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

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

<b>¿Necesita ayuda gratuita con esta carta?</b>	
Si usted habla un idioma diferente al inglés, existe ayuda gratuita disponible en su idioma. Esta página le indica cómo obtener ayuda en otro idioma. Le indica también sobre otras ayudas disponibles.	
<b>Spanish:</b>	<b>Español</b>
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-259-0701 (TTY: 1-800-848-0298).	
<b>Kurdish:</b>	<b>یەدروک</b>
ئاگاداری: ئەگەر بە زمانی کوردی	
. 1-855-259-0701 (TTY 1-800-848-0298) بەکە.	
<b>Arabic:</b>	<b>قېير علا</b>
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 0701-259-855-1 (رقم هاتف الصم والبكم: 1-800-848-0298).	
<b>Chinese:</b>	<b>繁體中文</b>
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-259-0701 (TTY 1-800-848-0298)。	
<b>Vietnamese:</b>	<b>Tiếng Việt</b>
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855- 259-0701 (TTY: 1-800-848-0298).	
<b>Korean:</b>	<b>한국어</b>
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-259- 0701 (TTY: 1-800-848-0298)번으로 전화해 주십시오.	
<b>French:</b>	<b>Français</b>
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-259-0701 (ATS : 1-800-848-0298).	
<b>Amharic:</b>	<b>አማርኛ</b>
ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል፡ ወደ ሚክላው ቁጥር ይደውሉ 1-855-259-0701 (መስማት ለተሳናቸው፡ 1-800-848-0298)።	

<p><b>Gujarati:</b> જરાતી</p> <p>જુ ના: જો તમે જુ રાતી બોલતા હો, તો િન: ૧-૮૫૫-૨૫૯-૦૭૦૧ ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-855-259-0701 (TTY: 1-800-848-0298).</p>
<p><b>Laotian:</b> ພາສາລາວ</p> <p>ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-855-259-0701 (TTY: 1-800-848-0298).</p>
<p><b>German:</b> Deutsch</p> <p>ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-259-0701 (TTY: 1-800-848-0298).</p>
<p><b>Tagalog:</b> Tagalog</p> <p>PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-259-0701 (TTY: 1-800-848-0298).</p>
<p><b>Hindi:</b> हंद</p> <p>ध्यान द: यद आप हंद बोलते ह तो आपके िलए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह 1-855-259-0701 (TTY: 1-800-848-0298) पर कॉल कर।</p>
<p><b>Serbo-Croatian:</b> Srpsko-hrvatski</p> <p>OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-855-259-0701 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-848-0298).</p>
<p><b>Russian:</b> Русский</p> <p>ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-259-0701 (телетайп: 1-800-848-0298).</p>
<p><b>Nepali:</b> नेपाल</p> <p>ध्यान ढदनुहोस्: तपाइलेनेपाल बोलनुहुन्छ भनेतपाइको ढनिम्त भाषा सहायता सेवाहरू ढन: शुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-855-259-0701 (ढटढटवाइ: 1-800-848-0298) ।</p>
<p><b>Persian:</b></p> <p>توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم میباشد. یا. بیگیرید تماس 0701-259-855-1 (TTY: 1-800-848-0298)</p>

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

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

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

## HEDIS/Stars Performance Reporting

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

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

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

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

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

**Important:**

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

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

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

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