2017 MARCH® Vision Care
Mississippi Provider Reference Guide

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This Provider Reference Guide is specific to the MississippiCAN ("MSCAN") and Mississippi Children's Health Insurance Program ("MS CHIP") programs only. For policies and administrative requirements related to a Medicare program, please refer to the general MARCH® Vision Care Provider Reference Guide.

Exhibits

1.1 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 was revised on November 16, 2017. Reviews and updates to this guide are conducted as necessary and appropriate. Update notifications are distributed as they occur through provider newsletters. A current version of this guide is always available on our website at www.marchvisioncare.com. To request a current copy of the Provider Reference Guide on CD, please contact our Provider Relations Department at (844) 606-2724.

MARCH® would like to thank our providers for their participation in the delivery of quality vision care services to our members.

1.2 Contact Information

Phone Number	(844) 60-MARCH or (844) 606-2724
Fax Number	(877) MARCH-88 or (877) 627-2488
General Website	www.marchvisioncare.com
Provider Website	providers.eyesynergy.com
Mailing Address	MARCH® Vision Care 6701 Center Drive West, Suite 790 Los Angeles, CA 90045
Lab and Contact Lens Orders	providers.eyesynergy.com

1.3 eyeSynergy®

MARCH® is proud to offer eyeSynergy®, our web-based solution for electronic transactions. With eyeSynergy®, providers can:

- Verify member eligibility and benefits.
- Generate confirmation numbers for services (for the definition of “confirmation number”, refer to section 2.1).
- Submit claims.
- Obtain detailed claim status including check number and paid date.
- Access online resources such as a current copy of the Provider Reference Guide.
- Submit lab orders for eyeglasses and contact lenses.

eyeSynergy® is provided free of charge to all MARCH® participating providers. To access eyeSynergy®, log onto our website at www.marchvisioncare.com and click on the orange and blue eyeSynergy® link located at the top of the page.

Registration

First time users must register before accessing eyeSynergy®. Please be prepared to enter the provider’s name or group name, office phone number, and tax identification number during registration. Once verified, you will immediately be provided with a temporary password to log in.

Logging In

Once registered, providers may log into eyeSynergy® with their user name and password. Please note that passwords are case-sensitive. As a security feature, the provider will be asked to renew their password every 60 days. After 5 failed log-in attempts, the provider is required to call MARCH® Vision Care to reset their password.

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

1.4 Interactive Voice Recognition (IVR) System

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

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

The IVR System may be accessed by calling (844) 606-2724. Select the provider option and follow the prompts to verify eligibility and benefits, request a confirmation number, or check claim status.

Registration

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

Logging In

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

1.5 Electronic Funds Transfer (EFT)

MARCH® Vision Care offers 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 MARCH® Vision Care directly into your bank account. ERAs are electronic explanations of payment (EOPs). MARCH partners with PaySpan Health, Inc. ® (PaySpan) – a solution that delivers EFTs, ERAs/Vouchers, and much more.

The service is free to MARCH® providers. The solution delivers ERAs via their website allowing straightforward reconciliation of payments to empower our providers to reduce costs, speed secondary billings, improve cash flow, and help the environment by reducing paper usage.

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

Provider Benefits

Providers gain the following immediate benefits by signing up for electronic payments from MARCH® through PaySpan:

- Improve cash flow – Electronic payments can mean faster payments, leading to improvements in cash flow.
- Maintain control over bank accounts – Providers have TOTAL control over the destination of claim payment funds. Multiple practices and accounts are supported.
- Match payments to advice/vouchers – Providers 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 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 MARCH® 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 MARCH® in writing, include, but are not limited to:

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

Please report all changes via mail, fax or email to:

MARCH® Vision Care
Attention: Provider Relations Department
6701 Center Drive West, Suite 790
Los Angeles, CA 90045

Fax: (877) MARCH-88 or (877) 627-2488

Email: providerdemographics@marchvisioncare.com

2.1 Eligibility and Benefit Verification

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

Confirmation Numbers

A confirmation number is an 11-digit identification number generated when the provider office verifies member eligibility for requested benefits and services through MARCH®. Verification is obtained by speaking with a Call Center Representative, or by accessing the IVR or eyeSynergy® web portal. Confirmation numbers affirm member eligibility for requested benefits and services. However, confirmation numbers may not be required for all services. Providers are strongly encouraged to verify benefits and eligibility on the date services will be rendered.

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

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

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

Example: A member is diagnosed with keratoconus and requires contact lenses. The provider is required to request a confirmation and attest to the documented exam findings and/or diagnosis. The submitted claim must include the diagnosis of keratoconus. Provided the member is eligible on the date services were rendered, payment is issued.

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

IMPORTANT: MARCH® performs retrospective random chart audits on claims submitted for services requiring attestation.

Covered Benefits

A listing of covered benefits may be accessed by:

- Logging into eyeSynergy® at https://providers.eyesynergy.com. Click on the Resources menu and select Provider Reference Guide. Benefits may be accessed by selecting the desired state from the drop-down menu. Providers may also access current benefits by plan or patient including the patient's current benefit availability from the Benefits and Eligibility menu in eyeSynergy®;
- Accessing our website at www.marchvisioncare.com. Click on Doctors and Office Staff and then Provider Resources. Benefits may be accessed by selecting the desired state from the drop-down menu.

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

Methods of Verification

You may access eyeSynergy® or the Interactive Voice Recognition System to verify member eligibility, benefits, and to request a confirmation number.

2.2 Non-Covered Services

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

In these circumstances, the provider must inform the member PRIOR to rendering the non-covered service that the service is not covered and that member will be financially responsible. **Failure to do so may result in the provider being financially responsible for those services even if the member verbally agreed to those services or paid for them up-front.**

Acceptable Waivers

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

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

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

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

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

3.1 Claim Submission

Preferred Method

MARCH® prefers to receive claims electronically via eyeSynergy®, our web-based solution for electronic transactions. eyeSynergy® helps reduce claim errors resulting in faster processing times.

Clearinghouse Submissions

MARCH® has a direct agreement with RelayHealth, Office Ally, and Emdeon to accept electronic claims.

Through RelayHealth, MARCH® can also accept claims from the following clearinghouses:

- Netwerkes/Ingenix
- Gateway
- All Scripts/PayorPath

Our payor ID for RelayHealth and Office Ally is 5246.
Our payor ID for Emdeon is 52461.

For all clearinghouses, our receiver ID is 146383562 with a qualifier of 01 (DUNS number). If your clearinghouse is not listed above, please contact our Provider Relations Department at (844) 606-2724.

Paper Claims

Paper claims should be submitted on a red CMS-1500 form and mailed to:

MARCH® Vision Care
6701 Center Drive West, Suite 790
Los Angeles, CA 90045

Handwritten and/or faxed claims may delay claim payment.

Clean Claim Definition

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

Claims submitted for payment should include the following:

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

MARCH® has the right to obtain further information from a provider's office upon request when a submitted claim has errors or when MARCH® or the health plan has reasonable grounds for suspecting possible fraud, misrepresentation or unfair billing practices.

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

IMPORTANT: 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

MARCH® reaffirms its adoption of CPT coding rules established by the American Medical Association, Medicaid, and Medicare Regulations, and applicable law:

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

The most common errors include:

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

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

In all instances, the medical record should reflect the intensity of examination that is being billed. MARCH® will audit claim submissions to ensure compliance. Audits will include the review of medical records. These are some of the criteria that are used when MARCH® performs retrospective random chart audits based on claims submitted. Claims submitted that deviate from this standard may trigger a medical record audit. Audits that reveal chronic billing problems, or trends, or quality of care issues will require a Corrective Action Plan ("CAP"). Failure to execute the CAP may lead to termination as a MARCH® provider.

In an effort to improve HEDIS and Star Ratings performance, MARCH® Vision Care requires providers to submit CPT II and ICD-10 codes, on claims, to demonstrate performance and diagnosis of the following for diabetic members:

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

Please see Exhibit K: Performance Measurement & Reporting for more information.

3.3 Billing for Replacements and Repairs

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

- RA (Replacements)
- RB (Repairs)

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

3.4 Billing for Glaucoma Screenings

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

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

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

3.5 Frame Warranty

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

If the provider determines that the defective frame is covered under the warranty, please contact MARCH® at (844) 606-2724. Please do not send broken glasses to MARCH® or the contracted lab.

3.6 Order Cancellations

Orders placed with the MARCH® contracted lab for frames and lenses are final.

- Members are responsible for the cost of frames and/or lenses if the order is cancelled by the member after the order has been completed by the lab.
- Providers are responsible for the cost of frames and/or lenses if the order is incorrect due to provider error.
- In the event of an error, do not resubmit a corrected order. Please contact MARCH® at (844) 606-2724.

3.7 Non-Covered Lens Options

MSCAN / MS CHIP

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

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

3. MARCH® will deduct the wholesale amount listed in Exhibit R from the provider's claim payment with the Explanation of Payment (EOP) code of "LABDED." The provider may retain the difference between the retail amount charged and the wholesale amount.

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

3.8 Claim Filing Limits

MARCH® imposes claim filing limits in accordance with the applicable provider services agreement and governing entity regulations. The claim filing limit for MSCAN and MS CHIP is 180 days and begin on the date services are rendered.

Proof of Timely Filing

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

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

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

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

3.9 Prompt Claim Processing

Claim payments are issued in accordance with the applicable provider services agreement and governing entity regulations. The prompt payment processing time for MSCAN and MS CHIP is 30 calendar days for paper claims and 25 calendar days for electronic data interchange (EDI) claims, unless otherwise specified. The processing time limit generally begins on the date the claim is received by MARCH®. However, in some cases, the time limit begins on the date the claim is received by an associated entity.

3.10 Corrected Claims

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

All other corrected claims, not submitted via eyeSynergy® during the initial claim submission, must also be submitted on a red CMS-1500 form. Clearly indicate on the claim that the submission is a "**corrected claim**." This ensures the corrected information will be considered during claims processing and will help prevent payment delays.

Please mail corrected claims to:

MARCH® Vision Care
6701 Center Drive West, Suite 790
Los Angeles, CA 90045

3.11 Provider Disputes

MARCH® is committed to ensuring provider satisfaction. Our Customer Service department can be reached at (844) 606-2724. In addition to contacting our customer service department, the MARCH® 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
- Contract

Provider Dispute Resolution Process

1. The provider submits the MARCH® Provider Dispute Resolution Request Form (Exhibit B) or a written summary of their dispute including supporting documentation. This is the only level of appeal by the provider.
2. MARCH® will acknowledge receipt of all participating provider disputes within 5 calendar days of the date of receipt by MARCH®
3. MARCH® will issue a written determination explaining the reasons for its determination within thirty (30) calendar days from the date of receipt of the dispute

Please submit your request to:

MARCH® Vision Care
Attention: PDR Unit
6701 Center Drive West, Suite 790
Los Angeles, CA 90045

3.12 Overpayment of Claims

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

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

3.13 Balance Billing

"Balance Billing" means charging or collecting an amount in excess of the MSCAN, MS CHIP, or the contracted reimbursement rate for services covered under MSCAN or MS CHIP. "Balance Billing" does not include charging or collecting deductibles or copayments and coinsurance required by the beneficiary's plan.

Providers are prohibited from balance billing MARCH® members. The explanation codes MARCH® provides in the explanation of payment remittance advice clearly indicate when balance billing for a service is not permissible.

3.14 Coordination of Benefits

Coordination of Benefits (COB) is a method of integrating health benefits payable under more than one health insurance plan, allowing patients to receive up to 100% coverage for services rendered. Patients that have health benefits under more than one health insurance plan are said to have "dual coverage". In some cases patients may have primary, secondary, and tertiary coverage. When a patient has multiple plans or "dual coverage", it is necessary to know what plan is primary and what plan is secondary or tertiary. The primary plan must be billed first and the claim is billed just like any other claim would be billed. The secondary plan is billed once an explanation of payment (EOP) and possibly a payment is received from the primary plan. The claims submitted to a secondary or tertiary plan are considered "COB claims". When billing a secondary plan, the bill must have the primary insurance plans' EOP attached. The payments received from the primary plan should be indicated in field twenty-nine (29) of the CMS 1500 form. If the secondary plan is billed without an attached primary insurance EOP, the claim will be contested and the primary insurance EOP will be requested. MSCAN and/or MS CHIP will not make an additional payment if the amount received from the primary insurance company is equal to or greater than the MSCAN and/or MS CHIP reimbursement amount.

MARCH® processes COB claims in accordance with the applicable provider services agreement and governing entity regulations. When MARCH® is the secondary payor, MARCH® is responsible for the difference between the provider's usual and customary charges and the amount payable by the primary insurance plan, not to exceed the applicable reimbursement rates and benefit allowance.

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

Please mail COB claims to:

MARCH® Vision Care
6701 Center Drive West, Suite 790
Los Angeles, CA 90045

4.1 Access Standards

MARCH® 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, MARCH® has established the following accessibility standards, when otherwise not specified by regulation or by client performance standards:

- Appointments for routine, non-urgent eye examinations and eyeglass or contact lens fittings and dispensing are available within thirty (30) calendar days.
- Rescheduling an appointment in a manner that is appropriate for the enrollee's health care needs and ensures continuity of care consistent with good professional practice.
- When MARCH® is contractually responsible for more than routine eye examinations, appointments for urgent/emergent eye care services, within the optometrist's or ophthalmologist's scope of practice, are available within twenty-four (24) hours.
- Providers are required to employ an answering service or a voice mail system during non-business hours, which provide instructions to members on how they may obtain urgent or emergency care. The message may include:
  - An emergency contact number (i.e. cell number, auto forwarding call system, pager);
  - Information on how to contact another provider who has agreed to be on-call to triage or screen by phone, or if needed, deliver urgent or emergency care; and/or
  - Instructions to call 911 or go to the local emergency room.
- Members with scheduled appointments will wait no more than thirty (30) minutes from their appointment time before being seen by a provider. Wait time is defined as the time spent in the lobby and in the examination room prior to being seen by a provider.

4.2 Access Monitoring

MARCH® is responsible for monitoring compliance with accessibility standards. MARCH® 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 MARCH® employees or otherwise noted.

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

- Blast Fax requests may be used to gather information from providers to determine demographic, access and language information.
- Telephone access surveys will be conducted by MARCH® 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.
- MARCH®'s 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.
- 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.

The coordination of access monitoring is facilitated by MARCH®'s Department of Health Care Services. Reports of the results of these initiatives are prepared and presented to the Quality Improvement Committee and the Board of Directors which is responsible to ensure compliance with such standards.

5.1 Protocol for Member Grievances and Appeals

Definitions

Grievance	A written or oral expression of dissatisfaction regarding MARCH® and/or its provider(s) including access to care, quality of care and quality of service. A grievance would reflect a situation where a denial has not been issued and there is an expression of dissatisfaction about any matter or aspect of MARCH® or its operation, other than an Adverse Benefit Determination.
Appeal	A request for reconsideration of an action/initial determination/request for service or claim that was denied, deferred, and/or modified where a notice of action (denial letter) was issued. The denial may occur before services are rendered or as a claim or partial claim denial.

It is MARCH®'s policy to address and resolve member grievances and/or appeals in an orderly and timely manner according to all regulations and client contractual requirements. All MARCH® members or the member's authorized representative have the right to file a grievance and/or submit an appeal through the Grievance and Appeal process. A grievance can be filed directly with UnitedHealthcare either by telephone at (877) 743-8731, TTY 711, or write to:

Grievance and Appeals
P.O. Box 5032
Kingston, NY 12402-5032

Members should be referred to their health plan for assistance. MARCH® will work with the member's contracted health plan to resolve issues. You may be asked for medical records or a response as part of the grievance/appeal investigation. According to your contract with MARCH®, you are required to furnish medical records of MARCH® members for whom claims have been submitted. Member authorization is not required to release medical records per state and federal regulations. MARCH® will ensure that grievances 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 grievance is not permitted. All MARCH® members are afforded the opportunity to effectively communicate with MARCH® regardless of cultural differences, linguistic limitations or other communicative impairments. MARCH® ensures that all members have access to, and can fully participate in the grievance system by providing assistance to those with limited English proficiency or with a visual or other communicative impairment. Such assistance may include, but is not limited to, translations of grievance procedures, forms, and plan responses to grievances, as well as access to interpreters and devices that aid impaired individuals in communication.

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

5.2 Potential Quality Issue

A potential quality issue is an individual occurrence of a suspected deviation from expected provider performance, clinical care or outcome of care that cannot be determined to be justified without additional review. The investigation of the potential quality issue is conducted by the Quality Management Department and documented in the case file. The potential quality issue is presented to the Chief Medical Officer/Optometrist reviewer for evaluation, 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 Severity Level that demonstrates the severity of breach in quality, along with the outcome and required intervention, if appropriate. Please refer to Exhibit N for Severity Levels of various issues and possible actions.

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

6.1 Member Rights

Each member has rights and responsibilities.

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

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

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

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

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

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

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

You have the right to keep your medical records private.
You may ask MARCH® to send you a statement that describes our privacy and confidentiality policies and procedures. Please call MARCH® at (844) 606-2724.

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

6.2 Member Responsibilities

It is your responsibility to:

- Pay your premium, co-pays, and yearly deductible (when applicable).
- Give your doctors and other providers all the information you can to help them decide on your care.
- Keep your appointments. If you need to cancel an appointment, let the office know ahead of time and schedule a new appointment.
- Show respect to your providers, to the MARCH® staff and to other members.
- Notify MARCH® of a change of address or telephone number (when applicable).

For additional information on Member Rights and Responsibilities, please refer to: www.uhccommunityplan.com.

7.1 Quality Improvement Program

Provider participation is of key importance to a successful Quality Improvement Program.

Provider participation in Quality Management ("QM") activities includes:

- Participate in MARCH® Quality Committees including the Quality Improvement Committee, Peer Review Sub-Committee, Utilization Management Sub-Committee, Professional Review Committee and/or the Public Policy Committee (commercial business only).
- Participate in disease management programs.
- Adhere to adopted clinical care guidelines.
- Timely and appropriate response to member appeals and grievances.
- Meet member access requirements.
- Participate in clinical reviews.
- Maintain medical record standards.
- Maintain the confidentiality of member information and records.

If you are interested in an active role in one of the committees noted above, please contact MARCH®'s Director, Health Care Services, Reva Sober at (310) 216-2300.

Please refer to the links below for additional information regarding the 2017 Quality Improvement Programs.

2017 Quality Improvement Program Non-Commercial Group

7.2 Medical Charting for Eye Care Services

In an effort to ensure quality of services and to combat fraud, waste and abuse, MARCH®'s Health Care Services Department perform audits of medical records used as supporting documentation to substantiate post-payment claims submissions. MARCH®'s PEER Review Sub-Committee has identified over fifteen (15) elements necessary in a comprehensive eye examination and, using a proprietary scoring system, records are evaluated and assigned a point value for each element based on their hierarchy of significance. The cumulative total point value is then used to determine the adequacy of the supporting documentation. When a comprehensive examination is billed, if any of the following critical elements are skipped 10 out 10 times, the audit score automatically defaults to the failing Severity Level score 4. These critical elements include: slit lamp exam, intraocular pressure, optic nerve head evaluation, external testing and dilated fundus exam.

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

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

Paper Charts

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

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

Electronic Medical Records

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

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

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

Critical Elements of an Eye Exam

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

Element 1
Reason for Visit

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

Element 2
Review of Systems

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

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

Element 3
Medications and Allergies

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

Element 4
Ocular, Family History

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

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

Element 5
Entering Visual Acuity at Distance and Near

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

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

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

Element 7
Refraction

- **Why important:** The subjective refraction is used to establish the final prescription.
- **What is expected:** The refraction required by the MARCH® standards is the subjective test that allows for the patients visual perception of the physical refractive error. Auto-refraction, by itself, is not an acceptable measurement
- **Who can collect data:** Doctor

- **How findings documented:** Sphere power, Cylinder power and axis for each eye as well as prism and bifocal power as indicated.
- **When should optional testing be performed?** If history reveals a condition that may have manifestations in the eye, adnexa or visual pathways, additional testing may be warranted
- **Quality point value:** 10 pts.
- **Critical element if box checked**: ☐

Element 8
Near Point Testing

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

Element 9
Current Optical Prescriptions

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

Element 10
Corneal Curvature

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

Element 11
Biomicroscopy

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

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

Element 12
Intraocular Pressure

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

Element 13
Optic Nerve Head Evaluation

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

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

Element 14
Dilated Fundus Examination

- **Why important:** A dilated retinal examination is performed to detect any abnormal findings for baseline documentation. Retinal abnormalities may indicate the presence of local and/or systemic disease and indicate the need for further diagnosis and/or treatment. MARCH® has approved criteria which requires the entire ocular fundus be examined on the initial visit and periodically thereafter depending on each patient's risk factors, but at least every three (3) years.
- **What is expected:** A thorough inspection of the optic nerve, macula, vascular tree and retinal surface with a fundus lens and biomicroscope, a binocular indirect ophthalmoscope and/or a wide angle retinal camera.
- **Who can collect data:** Doctor
- **How findings documented:** Positive and negative findings are recorded by structure (e.g. optic nerve, macula etc.). Using "WNL", a line through a list of anatomical parts, or noting clear is not adequate documentation. The name of the dilating drops as well as the time of instillation should be documented. Confirm drops have not expired prior to instilling them.
- **When optional testing is performed:** Suspected lesions, macular abnormalities, retinal holes or tears, etc. may require photographic imaging, ocular coherence tomography, ultra-sound, etc. to determine a diagnosis and treatment plan.

- **Quality point value:** 10 points
- **Critical element if box checked:** ☒

Element 15
Diagnosis

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

Element 16
Assessment/Management/Treatment Plan

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

Element 17
Legible Records

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

8.1 Anti-Fraud Plan

Pursuant to Health and Safety Code Section 1348, MARCH®'s anti-fraud plan includes, but is not limited to, the following requirements:

1. The designation of an organization with specific investigative expertise in the management of fraud investigations.
2. Training of personnel and contractors concerning the detection of health care fraud.
3. Procedures for managing incidents of suspected fraud.
4. Procedures for referring suspected fraud to the appropriate government agency.

Designation of an Organization with Specific Investigative Expertise in the Management of Fraud Investigations

MARCH® has designated the law firm of Katten Muchin & Rosenman, LLP ("KMR") as its fraud investigator. KMR has substantial experience in the management of fraud investigations.

Training of Personnel and Contractors Concerning the Detection of Health Care Fraud

MARCH® recognizes the importance of properly educating and training its personnel and contractors to detect fraud by MARCH®, MARCH®'s providers, and MARCH®'s members. As part of its anti-fraud plan, MARCH® requires its personnel and contractors to receive the following training in the detection of health care fraud:

Training of MARCH® Personnel

All MARCH® personnel will be annually trained in the detection of fraud and all new personnel will be trained in the detection of fraud upon hire.

The training of MARCH® personnel will include a general training session for all MARCH® personnel regarding the most common types of health care fraud that impact managed care organizations and may include specialized training for MARCH® personnel who work in the enrollment, credentialing, claims, and marketing areas regarding the identification and detection of fraud that is likely to specifically impact their jobs. In addition, the Chief Executive Officer shall establish such other training and dissemination of information to all employees concerning the necessity of complying with all applicable laws and regulations and shall keep MARCH® personnel abreast of current trends and issues relating to fraud on an ongoing basis through informational bulletins and discussions.

MARCH® personnel shall sign an Employee Statement of Understanding regarding the anti-fraud plan both at the time of their initial anti-fraud training, and thereafter on a yearly basis. The initial signed Statements of Understanding shall be kept in each employee's personnel file. The annual attestation is collected through an electronic form and signature once the Compliance Department completes the annual training.

Training of MARCH®'s Participating Providers

All of MARCH®'s participating providers will receive a copy of MARCH®'s anti-fraud plan. They will be required to either adopt and comply with MARCH®'s anti-fraud plan, or to have their own anti-fraud plan/compliance program in place that meets or exceeds the standards of MARCH®'s anti-fraud plan. MARCH® will also issue provider communications from time to time concerning fraud detection and related issues.

Areas of Training

Training includes an overview of health care fraud, a summary of the applicable fraud and abuse laws, training on how to identify potentially fraudulent claims (including indicators of fraud), examples of fraudulent activity that has been uncovered and the procedure for referring suspected fraudulent activity to the Chief Executive Officer.

Training topics will include, but not be limited to, methods of detecting the following types of fraud:

1. Detection of Fraud by the Plan

    a) Marketing - Using marketing techniques that coerce, mislead or confuse potential members and engaging in marketing that discriminates among potential members based on their health status.

b) Underutilized/Quality of Care - Failing to employ or contract with sufficient providers to accommodate all members; failing to provide geographically reachable services to members; and categorically denying payment of claims.
c) Enrollment Fraud - Using unnecessarily complex disenrollment procedures and materials.
d) Licensure/Credentialing - Not adequately credentialing providers; contracting with unlicensed providers.
e) Kickbacks - Accepting kickbacks in order to refer certain members to a particular provider.

2. Detection of Fraud by Providers

a) Marketing - Failing to comply with the applicable licensing board's advertising guidelines.
b) Kickbacks - Providers paying kickbacks to MARCH® employees in order to be referred members.
c) False Claims - Billing for services that were never performed or were not medically necessary; and waivers of copayments or deductibles.
d) Licensure/Credentialing - Misrepresenting licensure status to MARCH®.

3. Detection of Fraud by Members

a) Enrollment Fraud - Members claiming to be eligible for MARCH® health coverage when they are, in fact, ineligible.

4. Identification of Possible Indicators of Fraud

The training will emphasize that certain circumstances may be indicative of fraudulent activity, and should be reviewed further. Such circumstances include, but are not limited to, the following:

a) Inconsistency between the services billed and the services rendered.
b) A provider's advertisement of "free" services.
c) An unusually high number of members/member visits in a given time frame.
d) A provider's lack of supporting documentation for a claim selected for audit.
e) A high-dollar claim for services dated soon after the effective date of coverage or just before the termination of coverage.

Procedures for Managing Incidents of Suspected Fraud

Upon reports or reasonable indications of fraud, the Chief Executive Officer will promptly initiate steps to investigate the conduct in question to determine whether fraudulent activity has occurred. As needed, the fraud investigator will be requested to conduct the investigation. If the Chief Executive Officer and/or fraud investigator determines that fraudulent activity has occurred, the Chief Executive Officer will develop an appropriate response, as described below.

Discovery of Fraudulent Activities

1. Reporting Incidents of Suspected Fraud

All MARCH® personnel are responsible for preventing, detecting and reporting suspected fraud. If an employee detects any suspicious activity, he/she is required to notify the Chief Executive Officer. The person reporting fraud may make himself/herself known by reporting the suspected fraud in person, or may report the suspected fraud anonymously via inter-office mail or U.S. Mail.

The manager of each department will be responsible for the early detection of fraud within his/her department. If fraud is suspected within a department, that department's manager is required to immediately notify the Chief Executive Officer. Each manager's performance evaluation will be based in part on his/her efforts to detect fraud.

2. Implementation of a Monitoring and Audit Program

The Chief Executive Officer will implement a monitoring and audit program, as necessary. Through the use of ongoing auditing and monitoring, the Chief Executive Officer will investigate any changes from the baseline audit that may be indicative of fraud. Ongoing auditing and monitoring will enable MARCH® to gather some of the information MARCH® will need to make annual reports to the Department of Managed Health Care as required by Health and Safety Code Section 1348(c).

3. As determined to be necessary by the Chief Executive Officer, the implementation of the monitoring and audit program may involve the following steps:

a) Interviewing personnel involved in enrollment, credentialing, claims, marketing, and related areas to detect potential improper conduct.
b) Reviewing medical and financial records and other source documents that support claims for reimbursement.
c) Reviewing written materials and documentation prepared by the different departments within MARCH®.

Investigate the Incident to Determine Whether there is a Violation of Law/Regulation/MARCH® Policy

The Chief Executive Officer or his/her designee will investigate all credible incidents of suspected fraud that are reported and all credible incidents that are uncovered pursuant to the auditing and monitoring program. The investigation will involve interviews and document review. In the case where employee fraud is suspected, the Chief Executive Officer will determine whether the employee should be removed from his/her duties until the investigation is completed and whether or not immediate steps should be taken to prevent the destruction of documents or other evidence relevant to the investigation. The Chief Executive Officer shall record the progress of the investigation, including the results of interview and document reviews.

Take Appropriate Remedial Measures

If fraudulent activity has occurred, the Chief Executive Officer will consult with the manager of the department in which the fraudulent activity has occurred to determine the appropriate action necessary to correct the matter. The following remedial measures will be taken, as applicable:

1. Deny/Recoup Payment - If the fraudulent activity involves payment to a provider or to a member, the payment will be denied if not yet made, and will be recouped if already made.
2. Terminate Contract/Discipline Employee Appropriately - If appropriate, contracts with providers will be terminated, and employees will be disciplined. Corrective action will be based upon the individual circumstances and the severity of the incident. All personnel will be disciplined similarly, regardless of their position within MARCH®.
3. File Appropriate Reports - If fraudulent behavior constitutes a reportable offense, a report will be made to the appropriate entity. Examples include reports required by the National Practitioner Data Bank.
4. Notify Appropriate Government Agencies - See below.
5. Take Further Remedial Measures - In order to decrease the possibility that fraud will reoccur, the Chief Executive Officer will educate MARCH® personnel and participating providers regarding how to avoid the recurrence of any fraudulent activities that are discovered. In addition, the Chief Executive Officer will undertake additional investigations or other actions if it appears there may be a continuing pattern of fraud.

Procedures for Referring Suspected Fraud to the Appropriate Government Agency

MARCH® is committed to aggressively investigate suspected fraud and is committed to referring fraud for prosecution as appropriate. At least annually, MARCH® shall submit a report to the Department of Managed Health Care regarding MARCH®'s adherence to its anti-fraud plan generally and the results of investigations conducted by MARCH® regarding suspected fraud.

The Chief Executive Officer will discuss the findings of fraud investigations with legal counsel to determine whether or not a violation of federal or state law or health care program requirements has occurred, whether or not the conduct should be disclosed to a governmental agency, and, if so, to which agency. Such disclosure will observe the following guidelines:

1. Providers that are found to be in violation of state licensing requirements will be reported to the appropriate state licensing board.
2. Plan employees, providers or members who are found to be in violation of other state laws will be reported to the District Attorney's Office.
3. Providers that are found to be in violation of a federal, criminal, civil or administrative law related to a federal health care program will be reported to the Office of Inspector General, Department of Justice or the Centers for Medicare and Medicaid Services, as appropriate.
4. Plan employees, providers or members who are found to be in violation of other federal laws will be reported to the Department of Justice/U.S. Attorney's Office.

Anti-Fraud Plan Oversight

MARCH®'s Board of Directors is responsible for overseeing MARCH®'s anti-fraud plan. The Chief Executive Officer is responsible for implementing MARCH®'s anti-fraud plan and will make quarterly reports to Board of Directors regarding anti-fraud activities to enable the Board of Directors to monitor the anti-fraud plan and recommend any necessary changes.

9.1 Credentialing and Re-Credentialing

All potential providers are required to submit their CAQH number for credentialing.

CAQH ProView

MARCH® accepts CAQH numbers for the purpose of credentialing which 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 MARCH® permission on the CAQH ProView site to access the provider's record.

Please ensure the following documents are up-to-date:

- Completed W-9 form.
- State license.
- Current malpractice face sheet showing expiration dates, limits and provider's name.
- Curricula vita/resume to include work history if application does not cover last five (5) years.
- Board certificate (if applicable).
- CDS, CSR certificate, and/or DEA certificate (if applicable).

Credentialing Process

Upon receipt of the CAQH number, credentialing information is reviewed by the Credentialing Coordinator for completeness. All data, licenses and certificates are electronically confirmed by the applicable regulatory agencies, and any provider not in good standing with his/her respective regulatory agency is pended. The confirmed CAQH number is forwarded to the Professional Review Committee Chairperson for review and consideration. If consideration is favorable, the provider is approved. If the consideration is not favorable, the information is sent back to the Credentialing Coordinator with recommendations for further review.

Re-Credentialing Process

All providers are re-credentialed every three (3) years. The Provider Services Agreement stipulates automatic yearly renewal. The provider must forward to MARCH® on an annual basis a current photocopy of his or her yearly state license renewal and malpractice insurance. Failure to provide updated information may affect claims payments. Membership in good standing is re-confirmed.

Health Plan Credentialing Process

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

9.2 National Provider Identifier

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

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

9.3 Disclosure of Criminal Conviction, Ownership and Control Interest

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

Prior to participation, all potential providers must accurately complete and sign the Disclosure of Ownership and Control Interest Statement Form. This form can be completed online at www.marchvisioncare.com, select "Provider Resources", and then "Forms." Select the "Disclosure of Ownership and Control Interest Statement" link and chose "All Other States" from the drop down menu. The MARCH® Disclosure form is also available as Exhibit L of this Mississippi Provider Reference Guide.

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

In order to comply with these Federal Regulations MARCH® Vision Care has suspended payments to providers who have failed to comply and have not submitted a valid and completed disclosure form to MARCH® Vision Care.
Providers who have not returned a completed disclosure form will receive a claim denial with an explanation code "REJDSAN - DISCLOSURE FORM ON FILE IS INCOMPLETE OR EXPIRED. COMPLETE DISCLOSURE FORM REQUIRED FOR PAYMENT. DO NOT BILL MEMBER."

10.1 Cultural Competency

MARCH® Vision Care shall ensure that all health plan members receive equitable and effective treatment in a culturally and linguistically appropriate manner. As a health care provider, MARCH® expects 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.

11.1 Secure Transmission of Protected Health Information (PHI)

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

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

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

Exhibits

Exhibit A Non-Covered Service Fee Acceptance Form

Exhibit B Provider Dispute Resolution Request Form

Exhibit C MARCH® Lab Order Form

Exhibit D Potential Quality Issue Severity Levels

Exhibit E Potential Quality Issue Referral Form

Exhibit F Clinical Practice Guidelines

Exhibit G MARCH® Wholesale / Retail Fee Schedule

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

Exhibit I Examination Record Template

Exhibit J Disclosure of Ownership and Control Interest Statement

Exhibit K Performance Measurement & Reporting

Non-Covered Service Fee Acceptance Form

I _____, a member of _____wish to obtain and pay for _____, a service which is not covered as a covered benefit under the Medicaid 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 Program under which I have coverage at the time it was provided, even if Medicaid did not pay Dr. _____ for the service because he or she did not satisfy Medicaid 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 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 bajo el cual tengo cobertura, aunque Medicaid no le haya pagado al/a la Dr(a). _____ el servicio porque él o ella no cumplió con los requisitos de facturación de Medicaid.

Confirmo que recibí una copia de este acuerdo.

_____
Firma del miembro

_____
Nombre en letra de imprenta

_____
Fecha

MARCH Vision Care

Provider Dispute Resolution Request Form

Instructions:

- Please complete the form below. Fields with an asterisk (*) are required.
- Be specific when completing DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed.
- Mail the completed form to: MARCH Vision Care, 6701 Center Drive West, Suite 790, Los Angeles, CA 90045

Provider Name*:	**Provider Tax ID #/Medicare ID #*:**
Provider Address:	

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

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

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

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

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

For MARCH use only.	
Tracking Number:	Provider ID:
Contracted:	Non-Contracted:

Provider Dispute Resolution Request Form

(For use with multiple "like" claims)

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

Page ___ of ___

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

MARCH Lab Order Form Instructions

Lab order forms may be submitted online through eyeSynergy®.

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

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

Information on the Mississippi contracted lab is as follows:

State(s)	Contact Information	Contact Information
Mississippi	Classic Optical Laboratories, Inc.	3710 Belmont Avenue Youngstown, OH 44505 Phone (888) 522-2020 MARCH Vision Care fax: (855) 640-6737

MARCH Vision Care

MARCH 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: _____

Provider name: _____ Phone Number: _____

Address: _____

Material to Order Check all that apply.

Frame Only ☐ 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
Right			
Left			

Materials:

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

Segment Style

☐ SV
☐ FT28
☐ FT35
☐ FT45
☐ PAL Standard
☐ PAL Standard Short
☐ PAL Premium
☐ PAL Premium Short
☐ Trifocal 7x28
☐ Trifocal 8x35
☐ Round 22 or 24
☐ Slab Off

Coating Options:

☐ Solid
☐ Gradient
☐ Double Gradient
Color: _____% or Density #1 #2 #3

☐ Mirror Coating
☐ Scratch Coating
☐ UV

Mirror Type: _____
☐ AR Standard
☐ AR Premium

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).

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: _____

Potential Quality Issue - Severity Levels

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

Potential Quality Issue Referral Form

Identifying Data

Member name: _____ DOB: _____ Member ID number: _____

Provider name: _____ NPI : _____

Provider address: _____ Phone number: _____

Group/plan: _____ Phone number: _____ PR number: _____

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

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

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

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

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

_____

_____

_____

_____

_____

_____

_____
Referring Staff Signature

_____
Department

_____
Date

_____
Phone Number

Forward this completed form and any additional documentation (i.e., copy of complaint/grievance) to the Quality Management Department by fax (855) 640-6735. To maintain confidentiality of this referral, please do not copy completed form.

Clinical Practice Guidelines

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

MARCH is committed to providing high quality services to its members. MARCH does not pressure health care providers or institutions to render care beyond the scope of their training or experience. The Quality Improvement Committee has adopted the following guidelines for its providers:

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

EYEGLASS DISPENSING/FITTING

- Assist with frame 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® or fax order to MARCH.
- Monitor laboratory for appropriate turnaround time and follow up with MARCH as necessary.
- When materials have been received, measure lens power, PD, and Seg Height and physically inspect frame and lenses for manufacturer defects.
- Promptly contact the member when the eyewear has passed inspection.
- Adjust frame as needed to assure proper fit and alignment of lenses.
- Discuss proper use.

CONTACT LENSES FITTING

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

Clinical Criteria*

The Mississippi benefit-specific 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.	▪ The member has a prescription of +/-8.00; or ▪ Permanently reduced vision in one eye to less than 20/60; or ▪ A facial deformity or disease that interferes with eye glass fit; or ▪ A documented occupational hazard.
Ultra Violet Coating	Need is substantiated in member's medical record by clinical data	▪ Provided to members with aphakia, albinism, members that have clinical evidence of macular degeneration, or are taking medicine that makes them more sensitive to ultra violet light.
Replacement Due To Outgrown Glasses	Need is substantiated in member's medical record by clinical data	▪ Available for children under 18 when the member's pupil distance is wider than the frame's mechanical optical center by greater than 5mm. ▪ Available when the new frame size is at least 3mm larger than the existing frames.
Second Opinion Examination	Need is substantiated in member's medical record by clinical data	▪ Available when medical chart review of the first examination shows inadequate examination, documentation, or when clinical issues are not adequately addressed.
High Index lenses (Higher than Polycarbonate)	Need is substantiated in member's medical record by clinical data	▪ Available when weight of a standard prescription could cause facial development issues (primarily for children). ▪ Available when lab cannot practically produce lenses with a lower index lens.
Allergy To Certain Frames	Need is substantiated in member's medical record by clinical data	▪ Alternative frame to be provided when a provider documents a rash or other adverse reaction to all MARCH frame kit materials.
SLAB Off/Prism	Need is substantiated in member's medical record by clinical data	▪ Available for bifocal or trifocal prescriptions that generate greater than 2 prism diopters of imbalance at the reading plane.
Safety Frames	Need is substantiated in member's medical record by clinical data	▪ Used with polycarbonate lenses based on polycarbonate criteria noted above; and ▪ Member is in and around a hazardous environment where, in the discretion of the patient, (parent) and the provider, extra ocular safety measures are required ▪ These would be considered "deluxe frames" and covered by MARCH. ▪ These must meet ANSI standards.
Non-Standard Frames	Need is substantiated in member's medical record by clinical data	▪ Used when member has facial parameters where standard frames do not fit correctly. ▪ Used when optical correction will not fit practically in a standard frame.

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

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

* QIC approval 2/24/2017

MARCH Wholesale / Retail Fee Schedule

CPT Code	Modifier	Description	Wholesale Per Pair Rate	Retail Max Per Pair Rate
V2744	0L	Photochromatic TF 7X28	$60.00	$110.00
V2744	1L	Photochromatic PAL Standard	$70.00	$110.00
V2744	2L	Photochromatic PAL Standard Mini	$80.00	$110.00
V2744	3L	Photochromatic PAL Premium	$70.00	$110.00
V2744	4L	Photochromatic PAL Premium Mini	$80.00	$110.00
V2744	5L	Photochromatic SV	$70.00	$90.00
V2744	6L	Photochromatic Round Bifocal (22 or 24)	$32.00	$50.00
V2744	L1	Photochromatic GLASS SV	$46.00	$70.00
V2744	L2	Photochromatic GLASS Multifocal	$46.00	$70.00
V2744	L3	Photochromatic HI-INDEX 1.60 SV	$50.00	$72.00
V2744	L4	Photochromatic HI-INDEX 1.60 Multifocal	$52.00	$72.00
V2744	L5	Photochromatic HI-INDEX 1.67 SV	$50.00	$80.00
V2744	L6	Photochromatic HI-INDEX 1.67 Multifocal	$52.00	$80.00
V2744	L8	Photochromatic FT28	$82.00	$110.00
V2744	L9	Photochromatic FT35	$88.00	$110.00
V2745		Tint - All Colors and Density	$12.00	$20.00
V2745	TG	Tint Type - Solid, Gradient, Multi Gradient	$12.00	$20.00
V2750		Anti-Reflective Coating Standard	$38.00	$50.00
V2750	TG	Anti-Reflective Coating Premium	$48.00	$58.00
V2755		UV Treatment	$12.00	$25.00
V2760	L1	Scratch Resistant Coating SV	$12.00	$24.00
V2760	L2	Scratch Resistant Coating BF	$14.00	$25.00
V2760	L3	Scratch Resistant Coating TF	$14.00	$25.00
V2760	L4	Scratch Resistant Coating PAL	$14.00	$25.00
V2761		Mirror Coat - Any Type, Solid, Gradient	$50.00	$100.00
V2762	L1	Polarized SV	$36.00	$60.00
V2762	L2	Polarized BF	$40.00	$65.00
V2762	L3	Polarized TF	$44.00	$75.00
V2762	L4	Polarized PAL**	$50.00	$75.00
V2770		Occluder Lens/Frosted	$20.00	$30.00
V2780		Oversize Lens	$10.00	$23.00
V2781	L1	PAL Standard	$46.00	$60.00
V2781	L2	PAL Standard MINI	$50.00	$65.00
V2781	L3	PAL Premium	$56.00	$75.00
V2781	L4	PAL Premium MINI	$60.00	$75.00
V2782	L1	HI-INDEX 1.60 SV Lens, 1.54-1.65 P/1.60-1.79G	$26.00	$45.00
V2782	L2	HI-INDEX 1.60 BF Lens, 1.54-1.65 P/1.60-1.79G	$30.00	$47.00

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

Rates listed are per pair.

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

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

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

Sending a Secure Email to MARCH Vision Care for PHI Related Data

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

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

Secure Your E-Mail Traffic

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

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

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

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

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

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

☞NOTE:

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

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

Step 2: Generate a Certificate Request

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

Step 3: Acquire the Certificate

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

Step 4: Install the Certificate

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

Step 5: Create an SMTP Connector

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

To create an SMTP connector in Exchange 2000 or Exchange 2003

1. In Exchange System Manager, right-click **Connectors**, and then click **New SMTP Connector**.

2. Type a name for the connector (for example, MicrosoftOnline).
3. On the **General** tab, select **Forward all e-mail through this connector to the following smart host**, and then type **mail.global.frontbridge.com**.

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

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

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

To create a Send connector in Exchange 2007

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

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

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

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

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

Step 6: Enable TLS

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

To enable TLS

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

Eye Examination Record MARCH Vision Care

Patient Name: **DOS:**

Last name First Name Middle Initial

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

Review of Systems

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

Vision:

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

Current RX:	OD	OS

External Exam:

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

Refractions:

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

Patient Name: **DOS:**

Last name First Name Middle Initial

Near Testing:	Add:

Slit Lamp Examination:

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

Intra Ocular Pressure

OD	OS	Time:	
Method: AP	Puff	Tono	FT

Gonioscopy:	OD	OS

Medicines: Prop	Tetra	Fluress	NaF	Myd	Paradryn	Cyclo	Other:	

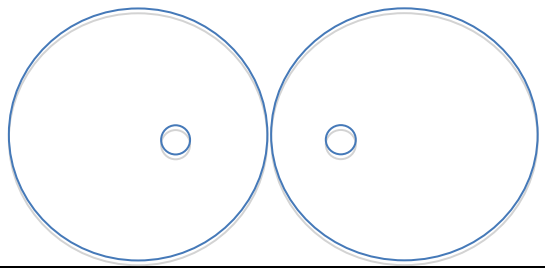
Fundus:

Direct	Indirect	Slit Lamp Lens	Photo

Nerve:

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

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



Diagnosis Impression:	
Assessment:	
Management Plan:	

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

Disclosure of Ownership and Control Interest Statement

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

Provider Entity Information

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

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

Section I

Are there any individuals or organizations with an Ownership or Control Interest of 5% or more in the Provider Entity? ___**Yes**___**No**

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

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

Name/Title	DOB	Address	SSN or TIN	% Interest

Section II

Does the Provider Entity's owner have an Ownership or Control Interest in any other provider or entity? ___**Yes** ___**No**

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

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

Section III

Does the Provider Entity have a Direct or Indirect Ownership Interest in any Subcontractor of 5% or more that another individual or organization also has an Ownership or Controlling Interest? ___**Yes** ___**No**

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

Name/Title	DOB	Address	SSN or TIN	% Interest

Disclosure of Ownership and Control Interest Statement

Section IV

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

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

Name of individual	Relationship

Section V

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

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

Name/Title	DOB	Address	SSN

Section VI

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

Name of Supplier/Subcontractor	Address	Owner	Transaction Amount

Section VII

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

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

Name/Title	DOB	Address	SSN	% Interest

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

_____ _____

Signature Title (indicate if authorized Agent)

_____ _____

Name (please print) Date

Instructions and Definitions for Disclosure of Ownership and Control Interest Statement

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

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

INSTRUCTIONS

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

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

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

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

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

Section III: Ownership and Control Interest Information in Subcontractor:

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

Section IV: Relationship:

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

Section V: Criminal Convictions:

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

Section VI: Business Transactions:

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

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

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

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

Section VII: Managing Employees:

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

DEFINITIONS

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

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

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

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

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

Other Entity: any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XV III, or XX of the Act. This includes:
(a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health
clinic, or health maintenance organization that participates in Medicare (title XV III);
(b) Any Medicare intermediary or carrier; and

(c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of,
health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.

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

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

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

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

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

Performance Measurement & Reporting

In an effort to improve HEDIS and Star Ratings performance, MARCH® Vision Care requires providers to submit CPT II* and ICD-10 codes, on claims, to demonstrate performance and diagnosis of the following for diabetic members:

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

CPT II codes - Retinal or dilated eye exam

Code	Description
2022F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed.
2024F	7 standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed.
2026F	Eye imaging validated to match diagnosis from 7 standard field stereoscopic photos results documented and reviewed.
3072F	Low risk for retinopathy (no evidence of retinopathy in the prior year)

ICD-10 codes - Diabetic retinopathy

Diagnosis	Type 1	Type 2
Unspecified DR with DME	E10.311	E11.311
Unspecified DR without DME	E10.319	E11.319
Mild NPDR without DME	E10.3299**	E11.3299**
Moderate NPDR without DME	E10.3399**	E11.3399**
Severe NPDR without DME	E10.3499**	E11.3499**
PDR without DME	E10.3599**	E11.3599**

NEGATIVE or low risk for retinopathy:
Please always include two CPT II codes when the patient is negative or low risk for retinopathy, one from the 2022F - 2026F range PLUS 3072F.

POSITIVE for retinopathy:
Please always include one CPT II code from the 2022F-2026F range PLUS the appropriate ICD-10 code.

*CPT II codes are tracking codes used for performance measurement. They should be billed in the CPT/HCPCS field of CMS-1500 forms and submitted on the same claim as the CPT I code(s). CPT II codes do not have relative value and can be billed with a $0.00 charge amount.
**Please note that the 7th character (9) indicates unspecified eye. Providers should use the correct digit to indicate which eye the condition applies to, or bilateral, if known.

IMPORTANT:

- Always bill the appropriate ICD-10 diagnosis code when submitting your claim. In particular, please include any medical diagnosis codes including, but not limited to, diabetes at the highest level of specificity.
- A patient's medical record should always support the CPT I, CPT II and ICD-10 codes billed.

Diabetes ICD-10 codes commonly billed by optometrists and ophthalmologists

Diagnosis	Type 1	Type 2
Unspecified DR with DME	E10.311	E11.311
Unspecified DR without DME	E10.319	E11.319
With diabetic cataract	E10.36	E11.36
With hyperglycemia	E10.65	E11.65
With other diabetic arthropathy	E10.618	E11.618
With other diabetic ophthalmic complication	E10.39	E11.39
With other specified complication	E10.69	E11.69
With unspecified complications	E10.8	E11.8
Without complications		E11.9

Normal billing rules still apply. The requirements listed in this document should be included in your billing process.