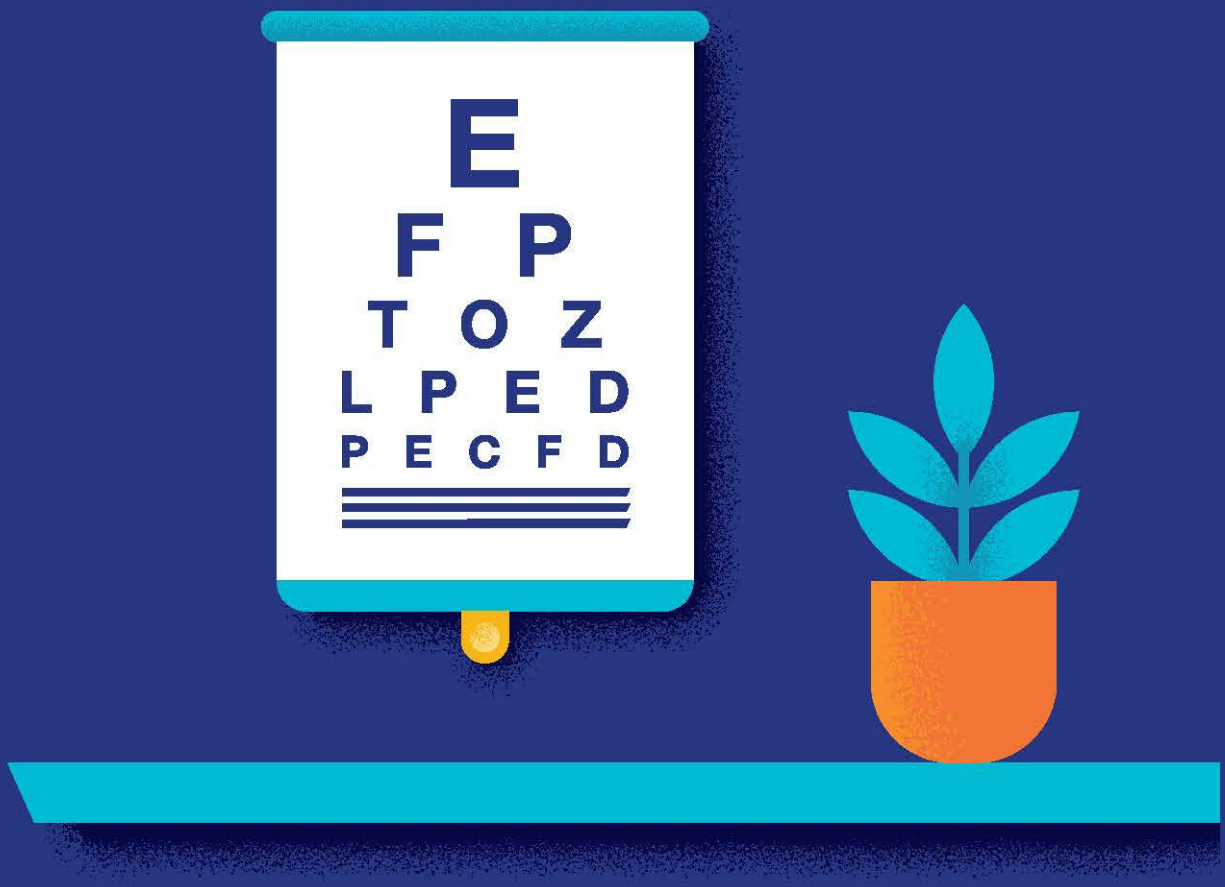


Provider Reference Guide

UnitedHealthcare Community Vision Network
March Vision Network

United Healthcare | MARCH Vision Care

Disclaimer:

Provider Reference Guide Notice of Updates effective January 2024:

Section 1: General information

- 1.3 – Updated the Registration section with new One Healthcare ID requirement

Section 3: Billing and claims procedures

- 3.1 – Added claim requirements for Ohio providers under Paper claims section; added link to our Claim Denial Quick Reference Guide in the Clean claim definition section
- 3.2 – Added language regarding the use of accurate and detailed ICD-10 codes for all diagnosis codes
- 3.5 – Telemedicine language update

About the Provider Reference Guide

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

This version of the Provider Reference Guide ("PRG") was revised in June 2024. Reviews and updates to this guide are conducted as necessary and appropriate. Update notifications are distributed as they occur through provider newsletters. Recent newsletters and a current version of this guide are on marchvisioncare.com. To request a current copy of the PRG on CD, please visit our "Contact Us" webpage at marchvisioncare.com>Provider resources>Contact us for your state-specific Provider Relations phone number.

Terms used in this manual include the following:

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

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

Exhibits[1]

Ohio Department of Medicaid providers only:

[1]All Exhibit forms and documents linked above can also be found on marchvisioncare.com/forms.aspx

1.1 Contact information

General website	marchvisioncare.com
Provider website	providers.eyesynergy.com
Lab and Contact Lens orders	providers.eyesynergy.com
Provider Resources	marchvisioncare.com/providerresources.aspx

Please visit our "Contact Us" webpage at marchvisioncare.com>Provider resources>Contact us for your state-specific Provider Relations phone number and hours of operation. Notice of call center closures will be posted on providers.eyesynergy.com prior to the date of closure.

Our primary method of communication is email. At least one network provider's email address is required for each office location. It is your responsibility to maintain an updated email address to ensure you receive important updates and information from us.

Indiana only – FSSA, OMPP, and MLTSS information

- **FSSA** – Indiana's health care and social services funding agency, Family and Social Services Administration (FSSA), is used to consolidate and better integrate the delivery of human services by state government. For more information on FSSA, please visit https://www.in.gov/fssa/.

- **OMPP** – The FSSA's Office of Medicaid Policy and Planning (OMPP) efficiently and effectively administers Medicaid programs for the state of Indiana. To find out more about OMPP, please visit their website at https://www.in.gov/fssa/ompp/about-ompp/.

- **MLTSS** – The Indiana Pathways for Aging Program is a managed long-term services and support (MLTSS) program where the FSSA will partner with health plans to coordinate MLTSS benefits and an individual's other benefits such as Medicare.

1.2 Provider contracting

Contracting with us can help grow your patient base and make your practice thrive.

Benefits of being part of our vision networks:

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

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

Ohio only – Medicaid Addendum

The Ohio Department of Medicaid (ODM) Medicaid Addendum supplements the Base Contract or Agreement between the managed care organization and provider and runs concurrently with the terms of the Base Contract or Agreement. The Addendum is limited to the terms and conditions governing the provision of and payment for health services provided to Medicaid members. Attachments are only needed when providers are offering different services or practitioners through this plan contract than are identified in the PNM system. Attachment A is needed for all PCPs to identify the providers' capacity and service location. Attachment A is also required when a provider has specific practitioner affiliates identified in the PNM who are agreeing to provide services under this plan contract. Attachment C is only required when the contract between the managed care entity and the provider includes

particular specialties rather than all specialties the provider identified in the PNM system. The most current Medicaid Addendum is posted on the ODM website here: https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/managed-care/mc-policy/managed-care-program-appendix/managed-care-program- addenda. The addendum must be completed, along with the MCO provider contract.

1.3 Providers.eyesynergy.com

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

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

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

Registration

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

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

Required Training

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

Sign in

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

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

As an additional safety feature, you are required to either call or contact your Account Administrator to have your password reset after 5 failed log-in attempts.

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

1.4 Provider trainings

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

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

1.5 Clinical Care and Coordination Program

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

Program certification criteria

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

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

1.6 Interactive Voice Recognition System

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

- Eligibility and benefits
- Confirmation numbers
- Claim status

You may access the IVR System by calling the appropriate state-specific phone number found on our “Contact Us” webpage (marchvisioncare.com>Provider resources>Contact us). Select the provider option and follow the prompts to verify eligibility and benefits, request a confirmation number, or check claim status.

Registration

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

Sign in

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

1.7 Electronic funds transfer (EFT)

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

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

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

Provider benefits

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

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

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

1.8 Provider change notification

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

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

Please report all changes by mail or email to:

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

Email: visionnominations@uhc.com

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

Verifying your information

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

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

North Carolina Medicaid

In addition to notifying us of demographic changes described above, provider changes must also be made through NCTracks via the Manage Change Request process. To access NCTracks, please visit the website at www.nctracks.nc.gov/.

2.1 Eligibility and benefit verification

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

Confirmation numbers

A confirmation number is an 11-digit identification number received when your office verifies member benefits and eligibility. Verification is obtained by:

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

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

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

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

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

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

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

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

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

Covered benefits

You can access a list of covered benefits by:

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

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

Methods of verification

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

2.2 Non-covered services

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

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

Acceptable waivers

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

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

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

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

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

3.1 Claim submission

Preferred method

You are encouraged to submit claims electronically at providers.eyesynergy.com, our web-based solution for electronic transactions. Providers.eyesynergy.com helps reduce claim errors resulting in faster processing times.

Ohio only – Additional options for claim submission, eligibility, and claim status

In addition to providers.eyesynergy.com, you may use the options below for the services provided to Ohio Department of Medicaid members:

- Providers may submit claims, eligibility inquiries, claim status inquiries, and associated attachments through the Provider Network Management (PNM) system at https://managedcare.medicaid.ohio.gov/managed-care/centralized-credentialing.
- Providers may submit claims, eligibility inquiries, claim status inquiries, and associated attachments using Electronic Data Interchange (EDI) by being a trading partner (TP) authorized by ODM or by contracting with an ODM authorized TP at https://medicaid.ohio.gov/resources-for-providers/billing/trading-partners/trading-partners.
- If you have a rejected claim that has been resubmitted and paid, the original rejected claims will be cancelled in our system. Please note that this will not affect your resubmitted claim and/or payments.

Clearinghouse submissions

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

Ohio only – Clearinghouse requirements for Medicaid claims

- UnitedHealthcare Community Plan Medicaid claims only – use Optum payor ID 83572
- Molina Medicaid claims only – use Availity payor ID 0007316

Paper claims

A $2.00 processing fee* is imposed for all paper claim submissions, excluding corrected claims and COB claims. Paper claims are accepted if submitted on an original red CMS-1500 form that is typed or computer-generated with clear, legible black ink. Paper claims that are handwritten, contain light ink, or submitted on a copied CMS-1500 form are not acceptable and will be returned. Paper claims in the approved format can be mailed to:

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

***The $2.00 processing fee does not apply to the following states: Indiana and North Carolina.**

Ohio only – Paper claims

- The Ohio Department of Medicaid (ODM) does not accept hard copy paper claims.
- All Medicaid providers are required to submit claims through:
  - Providers.eyesynergy.com (recommended method of claim submission); or
  - ODM's Provider Network Management (PNM) portal.

Clean claim definition

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

Claims submitted for payment should include:

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

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

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

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

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

Please comply with the enrollment requirements of your state Medicaid agency to ensure you are eligible for Medicaid claims payment. The Affordable Care Act mandates that state Medicaid agencies require all furnishing ordering, referring, and prescribing providers enroll as participating providers.

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

3.2 American Medical Association CPT coding rules

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

- Providers can use a new eye examination billing code for an initial examination of a new patient. A provider may also bill for a new member examination if a member has not been examined for 3 consecutive years by that provider/group.
- A routine examination for an established patient in subsequent years can be billed as a follow up examination
- Providers can continue to bill this way unless the member has not been examined for 3 consecutive years at that office, at which time the service may be billed with a new member examination code as indicated above
- A medical examination may be billed if the member has the benefit as indicated in our State-Specific PRG
- Follow-examinations for the same medical condition noted above may be billed based on the acuteness of the condition and the documented services provided
- According to **Medicare Carriers Manual Section 15501.1 H,** if more than one evaluation and management (face-to-face) service is provided on the same day to the same patient, whether by the same provider or more than one provider in the same specialty in the same group, only one evaluation and management service may be billed. Optometrists and Ophthalmologists from the same group are considered the same specialty, for

covered services provided within the scope of optometry, in each applicable state. Therefore, a comprehensive eye examination and a medical examination, such as a diabetic eye evaluation, may not be billed on the same date of service. Instead of billing two examinations separately, providers should select a level of service representative of the combined visits and submit the appropriate code for that level. The less extensive procedure is bundled into the more extensive procedure.

- The services furnished and associated medical record documentation must meet the definition of the CPT code billed
- This is important when providers bill the highest levels of visit and consultation codes.

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

- The patient may not have been examined by a provider in the practice within the past 3 years
- The history must meet the CPT code's definition of a comprehensive history
- All components of an examination need to be recorded, including dilation or equivalent

The provider may use professional discretion whether to dilate at subsequent visits for existing patients, but dilation is expected at the initial visit and at least every 3 years.

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

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

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

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

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

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

In an effort to improve HEDIS and Star Ratings performance, we require you to submit CPT II and ICD-10 codes, on claims, to demonstrate performance and diagnosis for diabetic members: Please see Exhibit O: HEDIS/Stars Performance Reporting for more information.

3.3 Billing for replacements and repairs

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

- RA (Replacements)
- RB (Repairs)

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

Indiana Medicaid – Billing for replacements and repairs

Repair or replacement covers the part of the eyeglasses that is broken or damaged. Members are not entitled to a new pair of eyeglasses if the lenses or frames can be repaired or replaced.

Use the following guidelines for billing:

- Providers must use the modifier **U8 to bill for repair of eyeglasses**
- Providers must use the modifier **U8** to bill for the replacement lenses or frames if a member needs replacement eyeglasses due to loss, theft, or damage beyond repair before the established frequency limits
- Providers must include documentation in the member's medical record to substantiate the need for replacement frames or lenses
- Documentation that eyeglasses have been lost, stolen, or broken beyond repair must include a signed statement by the member detailing how the eyeglasses were lost, stolen, or broken
- Providers must use the modifier **SC** when billing for replacement lenses or frames if a member needs replacement eyeglasses due to a change in prescription before the established frequency limits

Use of either replacement modifier indicates that the appropriate documentation is on file in the member's record to substantiate the need to replace lenses or frames. Replacement of eyeglasses must be for medical necessity.

3.4 Billing for glaucoma screenings

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

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

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

3.5 Telemedicine

We cover telemedicine routine vision exams consistent with an in-person exam when those telemedicine exams meet our expectations and requirements as listed in the Exhibit G: Clinical Practice guidelines.

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

Additional credentialing may be required, including verification of licensure in states where members are located. Once approved to submit claims, use Place of Service Code 02 with the codes below on your electronic (EDI) claim, paper claim, or claims submitted via the portal. Claims for materials must be filed separately with the appropriate Place of Service Code. Members must be informed in advance when exams are performed via telemedicine.

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

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

3.6 Frame warranty

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

If you determine that the defective frame is covered under the warranty, please contact us at the appropriate state-specific phone number found on our "Contact Us" webpage at marchvisioncare.com>Provider resources>Contact us. Please do not send broken glasses to us or the contracted lab.

3.7 Guidelines for patient-supplied frames

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

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

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

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

3.8 Order cancellations

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

- **Members** are responsible for the cost of frames and/or lenses if the order is cancelled by the member after the order has been completed by the lab
- **Providers** are responsible for the cost of frames and/or lenses if the order is incorrect due to provider error
- In the event of an error, do not resubmit a corrected order. Please reach out to us by visiting our "Contact Us" webpage at marchvisioncare.com>Provider resources>Contact us for your state-specific Provider Relations phone number.

3.9 Non-covered lens options

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

Medicaid:

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

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

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

Medicare:

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

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

3.10 Billing and calculation of Medicare allowance

A set dollar amount is typically allowed to cover frames, lenses, and/or contact lenses provided to Medicare members. This is known as an "allowance" or an "allowance-based benefit". You should bill the current and appropriate HCPCS codes for frames, lenses, and/or contact lenses along with the usual and customary charges for those codes. The allowance does not apply to routine eye exams. Routine eye exams are paid separately. The member is responsible for charges exceeding their benefit allowance.

Frames and lenses

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

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

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

Contact lenses

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

3.11 Claim filing limits

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

State	Medicaid	Medicare	Medicare-Medicaid Plan (MMP)
Alaska	365	365	-
Arizona	-	365	-
California	365[1]	365	365[1]
Connecticut	90	365	-
Delaware	90	365	-
District of Columbia	365	365	-
Florida	180	365	-
Illinois	180	365	365
Indiana	90	365	-
Kentucky	365	365	-
Maryland	180	365	-
Massachusetts	-	365	365
Michigan	365	365	365
Minnesota	180	365	-

Missouri	180	365	-
Nebraska	180	365	365
New Jersey	180	365	-
New Mexico	180	365	-
New York	180	365	-
North Carolina	365	365	365
Ohio	365[2]	365	365
Oklahoma	-	365	365
Pennsylvania	180	365	-
South Carolina	180	365	365
Utah	365	365	-
Virginia	180	365	-
Washington	365	365	-
Wisconsin	365	365	-

[1]If the filing age of the claim is between 7 and 9 months, a 25% penalty is applied. If the filing age is between 10 and 12 months, a 50% penalty is applied.

[2] Timely filing requirements are currently 365 days from the date of service for all provider types with further details outlined in Appendix S of the provider agreement for the duration of the PHE. Once the PHE ends and Appendix S is terminated, providers will be subject to the timely filing requirements in rule 5160-1-19 of the Ohio Administrative Code.

Proof of timely filing

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

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

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

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

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

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

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

3.12 Prompt claim processing

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

State	Medicaid	Medicare	Medicare-Medicaid Plan (MMP)
Alaska	30	60	-
Arizona	-	60	-
California	45 working days	60	45 working days

Connecticut	45	60	-
District of Columbia	30	60	-
Delaware	30	60	-
Florida	EDI 15, paper 20	60	-
Illinois	30	60	60
Indiana	EDI 21, paper 30	60	-
Kentucky	30	60	-
Maryland	30	60	-
Massachusetts	-	60	60
Michigan	45	60	60
Minnesota	30	60	-
Missouri	30	60	-
Nebraska	EDI 30, paper 45	60	-
New Jersey	EDI 30, paper 40	60	-
New Mexico	EDI 30, paper 45	60	-
New York	EDI 30, paper 45	60	-
North Carolina	30	60	-
Ohio	30	60	30
Oklahoma	-	60	-
Pennsylvania	45	60	-
South Carolina	EDI 20, paper 40	60	60
Utah	30	60	-
Virginia	30	60	-
Washington	30	60	-
Wisconsin	30	60	-

[1]At least 90% of all clean claims will be processed or paid within 15 business days of the receipt date.

3.13 Corrected claims

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

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

Please mail corrected claims to:

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

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

State	Medicaid	Medicare	Medicare-Medicaid Plan (MMP)
Alaska	60 days from original	365	-

	denial/payment date		
California	545	365	365
Delaware	180	365	-
District of Columbia	365	365	-
Florida	365	365	-
Illinois	360	365	365
Indiana	90 days from original denial/paid date	365	-
Kentucky	730	365	-
Maryland	270	365	-
Massachusetts	-	365	365
Michigan	455	365	365
Minnesota	365	365	-
Missouri	730	365	-
Nebraska	90 days from original denial/paid date	365	365
New Jersey	270	365	-
New Mexico	180	365	-
New York	150	365	-
North Carolina	90 days from original denial/paid date	365	-
Ohio	240	365	365
Oklahoma	-	365	365
Pennsylvania	180	365	-
South Carolina	180	365	365
Utah	365	365	-
Virginia	180	365	-
Washington	730	365	-
Wisconsin	365	365	-

3.14 Provider disputes

We're here to help and are committed to supporting you and your practice. You can reach to our Customer Service department by visiting our "Contact Us" webpage at marchvisioncare.com>Provider resources>Contact us for your state-specific phone number. In addition to contacting Customer Service, our Provider Dispute Resolution Process provides a mechanism for you to communicate disputes in writing. You may submit your Provider Appeals electronically by using the Provider Appeal Resolution online form on providers.eyesynergy.com.

The following is applicable to all states except Florida, Indiana and New Jersey. Please see the sections below for information pertaining to these states.

Provider dispute types

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

Provider dispute resolution process

1. Submit the Provider Dispute Resolution Request Form (Exhibit B) or a written summary of your dispute including supporting documentation. This serves as your first level of appeal/reconsideration.
2. We will acknowledge receipt of all participating provider disputes in different ways:
   a) Electronic disputes received from participating providers will be acknowledged by us within 2) working days of the date we receive it
   b) Paper disputes received from participating providers will be acknowledged by us within fifteen 15 working days of the date we receive it
3. Provider disputes that do not include all required information will be returned to the submitter for completion within 45 working days from the date of receipt
4. An amended dispute which includes the missing information may be submitted to us within 30 working days of receipt of the request for additional information
5. Amended disputes not received within thirty 30 working days will be closed and acknowledged within 45 working days from the date the request for additional information was due
6. A written determination explaining the reasons for its determination will be issued within 45 working days from the date of receipt of the dispute or receipt of the requested information (amended dispute).
7. Providers may appeal a second level decision of the Provider Dispute Resolution Process directly to the health plan. Providers have 60 calendar days to file for a claim appeal from the date of the provider remittance advice/reconsideration decision.

Please submit your request by mail to:

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

Submit your request electronically using the Provider Dispute Form.

Missouri providers – State Fair Hearing provider appeal

A state provider appeal must be submitted no later than 90 calendar days from the date a provider appeal resolution is upheld by UHC that is not resolved wholly in favor of provider.

A MO HealthNet Provider Appeal Form and copy of the UHC final decision should be sent by email, fax or mail to:

- Email: MHD.PROVIDERAPPEAL@dss.mo.gov
- Fax: (573) 526-3946
- Mail: MO HealthNet Division
  Attn: Provider Appeals
  P.O. Box 6500
  Jefferson City, MO 65109

An acknowledgment letter of receipt of the state appeal will be sent within 10 business days. A decision letter of the state appeal will be sent within 90 days of receiving all requested information from provider. For additional questions regarding state appeals, providers can call the Constituent Services Unit at (573) 751-3425.

Timeframes to file an appeal with the Administrative Hearing Commission:

- 30 calendar days from state decision – claim must be at least $500.00
- 90 calendar days from state decision for cumulative claims – claims must total at least $500.00

Provider dispute process – Florida only

Provider dispute resolution process concerning claim issues

1. Allow providers ninety (90) days from the date of final determination of the primary payer to file a written complaint for claims issues;We have 30 calendar days to respond or request additional information.
2. Within three (3) business days of receipt of a claim complaint, notify the provider (verbally or in writing) that the complaint has been received and the expected date of resolutionThe appeal review is conducted by a panel of 1 or more individuals selected by the Managed Care Organization.
3. Within thirty (30) days of receipt of a claim complaint, provide written notice of the status of the complaint to the provider and every thirty (30) days thereafter, using the Notice of Status Letter Template provided by the Agency.
4. Provide written notice of the status of Agency submitted claim issues to the Agency within fifteen (15) business days of receipt. For Agency submitted claims issues that require additional time to research, the Managed Care Plan must submit a written request to the Agency within three (3) business days of receipt of the complaint, and shall include:
    a. An explanation for the need of an extension; and
    b. Expected time needed beyond the initial fifteen (15) business days for research and response.
    c. Approval of extension is contingent upon Agency review.
5. Resolve all denied claims complaints within sixty (60) days of receipt, in accordance with s. 641.3155, F.S., and provide written notice of the disposition and the basis of the resolution to the provider within three (3) business days of resolution.
6. Resolve all other claim related complaints within ninety (90) days from the date of receipt and provide written notice of the disposition and the basis of resolution to the provider within three (3) business days of resolution.

Provider dispute resolution process concerning non-claim issues

1. Allow providers forty-five (45) days from the date the issue occurred to file a written complaint for issues that are not about claims.
2. Within three (3) business days of receipt of a complaint, notify the provider (verbally or in writing) that the complaint has been received and the expected date of resolution Within thirty (30) days of receipt.
3. Document why a complaint is unresolved after thirty (30) days of receipt and provide written notice of the status to the provider every thirty (30) days thereafter using the Notice of Status Letter Template provided by the Agency.
4. Resolve all complaints within ninety (90) days of receipt and provide written notice of the disposition and the basis of the resolution to the provider within three (3) business days of resolution.

Please submit your request by mail to:

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

Submit your request electronically using the Provider Dispute Form.

Provider dispute process – Indiana only

Provider dispute resolution process

7. Providers have 60 calendar days to file an informal dispute. Disputes must be in writing (paper, portal, email, etc.), not taken over the phone.
8. We have 30 calendar days to respond or request additional information

9. If the dispute is not resolved to your satisfaction, you will have 60 calendar days after the end of the 30 calendar day period to submit a formal appeal. The appeal must be in writing.
10. The appeal review is conducted by a panel of 1 or more individuals selected by the Managed Care Organization.
11. The panel's written determination must be issued within 45 calendar days. Failure to respond within 45 calendar days shall have the effect of an approval.

Please submit your request by mail to:

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

Submit your request electronically using the Provider Dispute Form.

Provider dispute process – New Jersey only

Provider dispute types – New Jersey only

- Claim
- Request for reimbursement of overpayment
- Seeking resolution of a billing determination

Provider dispute resolution process – New Jersey only

1. Submit the Provider Dispute Resolution Request form also known as the Health Care Provider Application to Appeal a Claims Determination (HCAPAA) form in Exhibit K or a written summary of your dispute including supporting documentation
2. The Provider Dispute Resolution form may be received by us within 90 calendar days from participating provider's receipt of our claims determination which is the basis of the appeal
3. We will acknowledge receipt of participating provider disputes 15 calendar days of the date we receive it.
4. Provider disputes that do not include all required information will be returned to the submitter for completion within 30 calendar days from the date of receipt
5. An amended dispute which includes the missing information may be submitted to us within 30 working days of receipt of the request for additional information
6. Amended disputes not received within 30 working days will be closed and acknowledged within 45 working days from the date the request for additional information was due
7. A written determination explaining the reasons for its determination will be issued within 30 calendar days from the date of receipt of the dispute or receipt of the requested information (amended dispute).
8. If the parties are unable to resolve the dispute in accordance with this payment dispute resolution mechanism, any matters remaining in controversy shall be subject to arbitration in accordance with the Program for Independent Claims Payment Arbitration ("**PICPA**") administered by the New Jersey Department of Banking and Insurance. The PICPA provides that the Participating Provider may initiate an arbitration proceeding within 90 calendar days following the date the Participating Provider dispute was completed or should have been completed by us. More information for the PICPA is available at https://njpicpa.maximus.com.

Please submit your request by mail to:

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

Submit your request electronically using the Provider Dispute Form.

3.15 Overpayment of claims

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

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

***Illinois: 18 months**
***Minnesota: 60 days**
***New Jersey: 45 days**

3.16 Balance billing

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

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

3.17 Coordination of Benefits

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

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

We process COB claims in accordance with the applicable provider services agreement and governing entity regulations. When we are the secondary payor, we are responsible for the difference between 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 with other insurance payor information can be submitted through your clearinghouse, via eyeSynergy at providers.eyesyenrgy.com, and can also be submitted as paper claims on a CMS 1500 form. COB paper claims are not subject to the $2.00 paper claim processing fee.

Please mail COB claims to:

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

4.1 Access standards

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

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

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

The following are additional state-specific requirements. In the event of a conflict between any standard above and those of a particular state, the more stringent standard shall apply.

California
Distance standard:
- 1 provider within 15 miles or 30 minutes

Appointment wait time:
- Appointments for routine, non-urgent eye examinations and eyeglass or contact lens fittings and dispensing are available within 15 business days

Indiana
Distance standard:
- 2 providers within 60 miles of the member's residence

Missouri
Appointment type access/Appointment standard:
- Routine care appointments without symptoms within 30 calendar days

Urgent/Emergent care after hours:
- Providers must refrain from directing members to call 911 as the only option for after hour access

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

4.2 Access monitoring

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

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

5.1 Protocol for member grievances and appeals

Definitions

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

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

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

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

Ohio only: Providers are required to assure the immediate health and safety of members when becoming aware of abuse, neglect, exploitation, misappropriation greater than $500, and accidental/unnatural deaths. If actions were not taken to assure the immediate health and safety of the member, the provider will do so immediately. Such actions may include calling police or EMS, reporting to county Adult Protective Services (APS), the county Public Child Services Agency (PCS) or regulatory agencies such as the Ohio Department of Health. Providers are required to report these types of incidents to the MCO within 24 hours of becoming aware of the incident.

5.2 Potential quality issue

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

- The investigation of the potential quality issue is conducted by the Quality Management Department and documented in the case file
- The potential quality issue is presented to the Chief Medical Officer/Optometrist reviewer for evaluation and recommendations
- If it is determined that a potential breach in quality exists, the case may be referred for further levels of review, which include outside specialists, peer review, credentialing, or the Legal Department

- Upon completion of the medical review, the case is assigned a Severity Level that demonstrates the severity of breach in quality, along with the outcome and required intervention, if appropriate. Please refer to Exhibit G for Severity Levels of various issues and possible actions.

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

6.1 Member rights

Each member has rights and responsibilities:

Members have the right to be treated equally.
Our vision networks 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

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

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

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

Members have the right to help to make decisions about their health care and to refuse or accept a treatment or procedure. The only exception to this right is when it is an emergency and there is no time to get their informed consent without risking their health.

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

Ohio only: Member's right to amend or correct medical records must be in accordance with OAC rule 5160-26-05.1.

Members have the right to keep their medical records private.
They may ask us to send them a statement that describes our privacy and confidentiality policies and procedures. Please visit our "Contact Us" webpage at marchvisioncare.com>Provider resources>Contact us for your state-specific Provider Relations phone number and reach out to us.

Members have the right to file appeals or complaints about their provider, the care you received, UnitedHealthcare | March Vision Care, or their health plan. They may contact their Health Plan at the number on the back of your Identification Card for assistance.

6.2 Member responsibilities

It is a members' responsibility to:

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

7.1 Quality Management Program

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

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

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

7.2 Coordination with Primary Care Providers

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

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

7.3 Clinical decision making

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

7.4 Medical charting for eye care services

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

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

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

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

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

Paper charts

- The encounter must record critical general health care information and the traditional refractive data
    - Details of a patient's medicine list and a formal review of systems are critical elements of the eye exam

- Notes on pulse, blood pressure, and body mass index
- You must query about tobacco use and alcohol use
- Assess patient orientation to time and place
- Rate the patient's emotional state during the exam

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

Electronic Medical Records

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

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

Critical elements of an eye exam

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

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

Element 1: Reason for visit
What is expected: The patient should be directly questioned as to why they presented for the encounter. The patient should be asked about issues with their eyes and vision or other problems that may be related to the visual system. The answers to these questions should be documented in the medical record.

Element 2: Review of systems
What is expected: Each of the following systems should be queried and the patient's response recorded. For all positive responses, additional questioning may be indicated.

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

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

Element 4: Ocular history; family history; orientation, mood and affect
What is expected: A detailed list of the patient's previous eye problems and procedures should be listed. The family history should query medical problems including diabetes, hypertension, thyroid problems and cancer in addition to eye problems such as cataracts, glaucoma, and macular degeneration. The patients should be asked if they know the day, date, and their current location. The clinician should note the validity and assess whether the patient's mood or affect is normal or abnormal.

Element 5: Entering visual acuity at distance and near
What is expected: A measurement of visual acuity both uncorrected and with the patient's habitual correction should be performed at both distance and near.

Element 6: Entering tests, including vital signs and external examination
What is expected: Measurement of the following:
- Height
- Weight
- Body mass index
- Blood pressure for patients age 13 and older
- Pulse
- Testing of pupil response
- Direct
- Consensual
- Swinging flashlight
- Extra ocular muscle testing
- Cover test
- Visual field
- Confrontation
- Automated test

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

Element 8: Near point testing
What is expected: Testing may include measurements of accommodation and/or convergence as well as additional testing as determined by the provider (e.g. evaluation of saccadic eye movements).

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

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

Element 11: Biomicroscopy
What is expected: Use of the slit lampbiomicroscope to inspect all anterior segment eye structures including the lids and lashes, tear film, cornea, anterior chamber, angle grade, iris, and lens. The documentation must be individualized based on the findings of the examination. Cloned language in electronic health records should be carefully reviewed and revised to be consistent with the rest of the documentation in the record.

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

Element 13: Optic nerve head evaluation
What is expected: The optic nerve must be visualized, and details recorded at each visit. The details of the evaluation of the optic nerve should include all aspects of the nerve itself, including cup to disc ratio, disc margin, disc size, color, thickness, and vessel caliber. The exam may be performed with a minimum of a fundus lens, or a direct ophthalmoscope, indirect ophthalmoscope, or photographically.

Element 14: Dilated fundus examination
What is expected: A thorough inspection of the optic nerve, macula, vascular tree, and retinal surface with a fundus lens and biomicroscope, a binocular indirect ophthalmoscope and/or a wide-angle retinal imaging system. Document the method of examination. Although retinal imaging is acceptable in some cases, it is not a substitute for a binocular physical retina examination. All providers must be licensed and capable to dilate the pupil and perform the physical retina examination.

Element 15: Diagnosis
What is expected: These can be a refractive diagnosis such as myopia, astigmatism, emmetropia, hyperopia, or presbyopia or medical eye diagnoses such as cataract, corneal dystrophy, choroidal nevus, or glaucoma. Pertinent systemic medical diagnoses such as diabetes should also be listed.

Element 16: Assessment, management, and treatment plan
What is expected: The provider should summarize the overall examination and clarify the points that need to be managed in this section. The treatment/management plan should spell out the steps to be taken to address the chief concerns identified in the clinical findings.

- In **healthy patients**, this can be as simple as, “Normal Exam, return in 1 year for re-examination.”
- For **patients with refractive error**, the verbiage can include the diagnosis and be stated as “Myopia, order glasses to be used for distance only, return in 1 year.”
- For **patients with pathology**, this section should be more specific and address patient education, glasses, contact lenses, low-vision aids, medications prescribed with directions for use, referrals, recommended testing, time frames, and follow-up schedules.

Other clinicians, reviewers, and any party evaluating this clinical encounter will look to this section to determine the important clinical points of the case and identify the plan of action and recommended follow-up.

Element 17: Legible records
What is expected: Records that are easily deciphered, following a consistent examination sequence, that are complete and document all findings, clinical decisions, and any continuity of care recommendations. If using electronic medical records, it is important to review any “pre-populated” and/or “cloned” default data for accuracy, attest to the doctor personally reviewing history and medications and review all recorded data to ensure it reflects the examination findings and recommendations. A signature is required on all charts, if electronic it needs to be time and date stamped.

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

- Visual Acuity testing Charts
  - Distance
  - Near
- Color Vison Plates
- Stereo Plate
- Hand equipment (Occluders, Saccade/ Pursuit targets, PD stick, Maddox rod, Prism bars, Flippers)
- Blood Pressure Measuring Device
- Height and Weight measuring device
- Keratometer
- Lensometer

- Refractor
    - Phoropter or Trial Frame and Lens
- Biomicroscope (Slit Lamp)
    - Slit lamp Condensing lenses (78, 90)
    - Gonio lenses
- Tonometer
- Ophthalmoscope (Direct and Indirect)
    - Condensing lenses (20, 28)

8.1 Fraud, Waste, and Abuse (FWA)

Training of providers concerning the detection of health care fraud

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

Training of our participating providers

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

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

Sanction list monitoring

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

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

Document retention

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

Reporting Suspected Fraud, Waste, or Abuse

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

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

9.1 Credentialing and re-credentialing

CAQH ProView

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

The use of CAQH ProView will expedite the credentialing process and decrease the amount of paperwork for you and your staff. To expedite credentialing, please provide us with your CAQH number as soon as possible. CAQH ProView does not accept paper applications. Be sure to give "UHC Vision Networks: Spectera and March" permission on the CAQH ProView site to access your record to avoid delays. You will be notified when the review has been completed.

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

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

Medicaid ID requirement

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

Credentialing process*

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

*Some states may have their own credentialing process that you must adhere to. Please follow the credentialing process required by your state.

Re-credentialing process

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

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.

North Carolina only – Provider Credentialing Transition Period

The state of North Carolina has a Provider Credentialing Transition Period. It is defined as the period before a Provider Data Management/Credential Verification Organization ("PDM/CVO") has achieved full implementation. During the Provider Credentialing Transition Period, a North Carolina Department of Health and Human Services' ("NCDHHS") Provider Data Contractor, who is certified by the NCQA, will provide a North Carolina Medicaid Credentialed File inclusive of all North Carolina Medicaid and North Carolina Health Choice enrolled providers, including relevant enrollment and credentialing information.

During the Transition Period, Objective Quality Standards shall be applied to contracted providers no less frequently than every 5 years consistent with the NCDHHS policy and procedure.

Ohio only – Credentialing and recredentialing process

Ohio Department of Medicaid is responsible for credentialing all Medicaid managed care providers. The credentialing and recredentialing processes are paired with enrollment and revalidation, respectively, in the Provider Network Management system. This process adheres to National Committee for Quality Assurance (NCQA) and CMS federal guidelines for both processes and the types of providers who are subject to the credentialing process.

Please note, you are not able to render services to Medicaid members until you are fully screened, enrolled, and credentialed (if required) by Ohio Medicaid. For a complete list of provider types that require credentialing, please refer to Ohio Administrative Code (OAC) rule 5160-1-42.

For individual providers, the general guidance is that licensed providers who can practice independently under state law are required to go through this process. Medical students, residents, fellows, and providers who practice strictly in an inpatient setting are exempt from credentialing. It is recommended that you begin the contracting process with each managed care organization (MCO) you wish to participate with while you are enrolling and being credentialed at ODM, in order to be able to render services as of your effective date. While the credentialing process is being centralized at the state Medicaid level, you are still required to contract with the MCOs.

When you submit your initial application to be an Ohio Medicaid provider, you can designate managed care organization interest in the PNM system. Once your application is submitted, demographic data for your provider is transmitted automatically to the MCOs so they can start contracting with you.

For additional Ohio-specific information on provider enrollment, please refer to Exhibit P.

Indiana only – Provisional requirements

If a decision on a clean credentialing application is not made within 15 business days of receipt of the application, we will provisionally credential the provider. To be considered provisionally credentialed, a provider must meet the standards established by NCQA. Full credentialing will continue and be completed within 30 days.

9.2 National Provider Identifier

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

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

9.3 Disclosure of criminal conviction, ownership and control interest

For Idaho, New Jersey, New York, and South Carolina Only:

In accordance with 42 CFR, Part 455, Subpart B and as required by CMS:

- Individual physicians and other healthcare professionals must disclose criminal convictions

- Facilities and businesses must additionally disclose ownership and control interest

Disclosures are required **prior to payment for any services rendered to Medicare or Medicaid enrollees.**

You must accurately complete and sign the Disclosure of Ownership and Control Interest Statement Form prior to participation. Our Disclosure form is available as Exhibit N of this Provider Reference Guide. This form can be used for the states listed above, except South Carolina. Please visit marchvisioncare.com > Provider Resources > Forms for the appropriate form to use for South Carolina.

The Disclosure of Ownership and Control Interest Statement is to be submitted with your initial credentialing and recredentialing application (every 3 years), with the exception of South Carolina. South Carolina requires annual renewal 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 35 days of a request for this information. If you are 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, we have suspended payments to providers who have failed to comply and have not submitted a valid and completed disclosure form to us. If you do not return a completed disclosure form, you 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."

The Centers for Medicare & Medicaid Services (CMS) requires you to verify the accuracy of their information included in the health plan's provider directory on a quarterly basis. You are encouraged to verify your demographic information through providers.eyesynergy.com. When logging into your account, you will see a banner on the top of your screen regarding your demographic information. Click on that banner to be redirected to the demographic verification page where you can quickly verify your information and submit the form electronically. The online verification option is only available to registered and active providers.eyesynergy.com users.

10.1 Language Assistance Program (LAP)

Access to interpreters

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

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

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

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

You shall not:

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

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

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

To assist in this area, you are encouraged to:

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

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

Telephonic interpreting services

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

California and Indiana:
Language Assistance Program is the responsibility of the Health Plan. You may request interpreters for members whose primary language is not English, by contacting our Customer Service department using your state-specific phone number found on our "Contact Us" webpage.

A Customer Service Representative will require the following information:

Member Information:
- Member name and identification number
- Language requested

Provider information:
- Provider name and telephone number
- Office address

Face-to-face and American Sign Language interpreting services

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

Please visit contact our Customer Service Department marchvisioncare.com>Provider resources>Contact us) at the appropriate state-specific phone number to schedule these services. A Customer Service representative will request the information outlined above for telephonic requests, in addition to the following:

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

New Mexico:
- Oral interpreter services are available in all languages, not just top languages we have identified
- We shall inform Members of the availability of free interpreter services, sign language and TDD/TTY services, and inform Members on how to access services

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

Medical record documentation for LAP

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

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

Documentation of provider/staff language capabilities

Interpretive services pursuant to the Language Assistance Program have not been delegated to its providers in some states including California. The provider directory lists fluent languages spoken by providers. This information is received via self-reported Provider Demographic Forms updated on a quarterly basis, or whenever there is a demographic change. The information you provide will be used to update our provider database, which is used to generate our provider directories and to provide members with online and automated information to assist them in identifying provider offices that may meet their language needs.

Translation of written material

Translations of written informational material such as applications, consent forms, denial notices, and explanation of payments are available through the member's Health Plan (the number on the back of their Identification Card). Please visit our "Contact Us" webpage at marchvisioncare.com>Provider resources>Contact us for your state-specific Provider Relations phone number.

Additional Language Assistance Program information for providers

Exhibit E	Tips for Documenting Interpretive Services for Limited English Proficient (LEP) Members: Notating the Provision or The Refusal of Interpretive Services

11.1 Cultural competency

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

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

What is cultural competency?

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

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

It also defines health care expectations such as:

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

And why is it important?

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

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

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

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

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

Ohio only – Cultural competency and linguistics services

Cultural competency information as well as languages spoken by office location will be collected in Ohio Department of Medicaid's (ODM) Provider Network Management (PNM) system and will be utilized to populate ODM's centralized provider directory. Additionally, this information for credentialed providers will be transmitted to

the managed care organizations on a weekly basis for them to align their directories with the information contained in the PNM.

Indiana only – Cultural competency and linguistics services

Cultural competency information as well as languages spoken by office location will be collected by the state and will be utilized to populate the state's centralized provider directory. Additionally, this information for credentialed providers will be transmitted to the managed care organizations on a weekly basis for them to align their directories with the information from the state.

12.1 Secure transmission of Protected Health Information (PHI)

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

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

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

Exhibits[1]

Exhibit A Non-Covered Service Fee Acceptance form

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

Exhibit C Prison Industry Authority (PIA) Optical Lab information

Exhibit D Lab Order form

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

Exhibit F Member Grievance form for California members only (English and Spanish)

Exhibit G Potential Quality Issue Severity Levels

Exhibit H Potential Quality Issue Referral form

Exhibit I Clinical Practice guidelines

Exhibit J Wholesale/Retail fee schedule

Exhibit K Health Care provider application to Appeal a Claims Determination (HCAPAA)

Exhibit L Sending a secure email to UnitedHealthcare | March Vision Care for PHI related data

Exhibit M Examination Record template

Exhibit N Disclosure of Ownership and Control Interest Statement

Exhibit O HEDIS/Stars Performance Reporting

Exhibit P Ohio Department of Medicaid Provider enrollment and contracting information

Ohio Department of Medicaid providers only:

Medicaid forms

Medicaid Addendum

Medicaid Out-of-Network Provider Application

Medicaid Provider Agreement

Policies & Guidelines

[1]All Exhibit forms and documents linked above can also be found on marchvisioncare.com/forms.aspx

— Exhibit C —

Prison Industry Authority (PIA) Optical Lab Information

Lab	Contact information	County code	
Valley State Prison for Women Prison Industry Authority Optical Laboratory	CCWF/VSPW 23370 Road 22 Chowchilla, CA 93610-4329 Phone (800) 377-8953 Fax (559) 665-5147	Calaveras = 5 Fresno = 10 Imperial = 13 Inyo = 14 Kern = 15 Kings = 16 Los Angeles = 19 Madera = 20 Mariposa = 22 Merced = 24 Mono = 26 Monterey = 27	Orange = 30 San Benito = 35 San Diego = 37 San Joaquin = 39 Stanislaus = 50 Tulare = 54 Tuolumne = 55 Ventura = 56
California State Prison – Solano Prison Industry Authority Optical Laboratory	2100 Peabody Road Vacaville, CA 95687-6615 Phone (800) 700-9861 Fax (707) 454-3214	Alameda = 1 Alpine = 2 Amador = 3 Butte = 4 Colusa = 6 Contra Costa = 7 Del Norte = 8 El Dorado = 9 Glenn = 11 Humboldt =12 Lake = 17 Lassen = 18 Marin = 21 Mendocino = 23 Modoc = 25 Napa = 28	Nevada = 29 Placer = 31 Plumas = 32 Riverside = 33 Sacramento = 34 San Bernardino = 36 San Francisco = 38 Santa Clara = 43 Santa Cruz = 44 Shasta = 45 Sierra = 46 Siskiyou = 47 Solano = 48 Sonoma = 49 Sutter = 51 Tehama = 52 Trinity = 53 Yolo = 57 Yuba = 58

— Exhibit E —

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

California law requires that health plans and insurers offer free interpreter services to both limited English proficient members and health care providers. It also ensures that the interpreters are professionally trained and are versed in medical terminology and health care benefits.

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

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

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

– Exhibit G –

Potential quality issue – Severity levels

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

— Exhibit I —

Clinical practice guidelines

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

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

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

Eyeglass dispensing/fitting

- Assist with frame fashion selection
- Evaluate frame for appropriate eye size, bridge, and A, B, and ED for required lenses
- Take physical measurements including PD, Seg Height
- Order materials via providers.eyesynergy.com or fax order to us at (855) 640-6737.
- Monitor laboratory for appropriate turnaround time and follow up with us and the member as necessary
- When materials have been received, measure lens power, PD, and Seg Height and physically inspect frame and lenses for manufacturer defects
- Promptly contact the member when the eyewear has passed inspection
- Adjust frame as needed to assure proper fit and alignment of lenses
- Discuss proper use

Contact lenses fitting

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

Care standards: Diabetes

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

New patients

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

Established patients

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

Care for patients with diabetes

The following actions will assure the care required for patients with diabetes:

- The history should include the name and, if available, contact information of the Primary Care Physician (PCP), or the provider managing the diabetes
- The history should include a list of all diabetes medications
- The HA1c should be documented in the chart. This may come from the patient, a lab report, or the PCP
- Dilation is required every year

- All common eye changes that result from diabetes should be documented in the medical record. These include, but are not limited to, retinopathy, dry eye, blepharitis, cataract, and low-tension glaucoma
- The retina examination must be detailed, and subtle background changes should be noted
- Education and counseling about blood sugar control and the required numbers to prevent vision loss should be emphasized

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

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

Management of glaucoma

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

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

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

- NH photo
    - Every 6 months

Advanced glaucoma

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

Clinical criteria*

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

Benefit	Available when	Clinical criteria
Eyewear after eye surgery	Determined to be medically necessary	The stable refractive prescription changes are more than +/-0.75 diopters in any meridian or more than 20 degrees of axis shift or a change in add power greater than 0.50 diopters
Oversize lens	Needed for physiological reasons	The pupillary distance is 70mm or greater or other facial or ocular anomalies requiring a large lens
Trifocal lens	Member has a special need due to a job training program or extenuating circumstances	The base prescription is greater than +/- 1.00 and a bifocal greater than or equal to 2.00
Necessary contact lens	Such lenses provide better management of a visual or ocular condition than can be achieved with spectacle lenses, including, but not limited to the diagnosis of	Irregular astigmatism; unilateral aphakia; keratoconus when vision with glasses is less than 20/40; corneal transplant when vision with glasses is less than 20/40 or anisometropia that is greater than or equal to 4.00 diopter
Color tinting	Light sensitivity which will hinder driving or seriously handicap the outdoor activity of such member is evident	The member has photophobia, aniridia, uveitis, corneal dystrophy, cataracts, albinism, or use a medication that has a side effect of photophobia
Single vision eyeglasses in lieu of bifocals	Need is substantiated in member's medical record by clinical data	The need for distance correction > +/- 1.50 diopter AND Net combination of distance RX and bifocal > +1.00 or -2.00 AND you are unable to tolerate a multifocal len
Progressive lenses	Need is substantiated in member's medical record by clinical data	Epilepsy, childhood disorders with multiple impairments
Transitions lenses	Need is substantiated in member's medical record by clinical data	Chronic iritis or uveitis, albinism
Polycarbonate lenses	Need is substantiated in member's medical record by clinical data	▪ The member has a prescription of +/-8.00 ▪ Permanently reduced vision in one eye to less than 20/60 ▪ A facial deformity or disease that interferes with eye glass fit ▪ A documented occupational hazard
Ultra-violet coating	Need is substantiated in member's medical record by clinical data	▪ Provided to members with aphakia, albinism, members that have clinical evidence of macular degeneration, or are taking medicine that makes them more sensitive to ultra-violet light
Replacement due to outgrown glasses	Need is substantiated in member's medical record by clinical data	▪ Available for children under 18 when the member's pupil distance is wider than the frame's mechanical optical center by greater than 5mm ▪ Available when the new frame size is at least 3mm larger than the existing frames
Second opinion examination	Need is substantiated in member's medical record by clinical data	▪ Available when medical chart review of the first examination shows inadequate examination, documentation, or when clinical issues are not adequately addressed
High index lenses (Higher than polycarbonate)	Need is substantiated in member's medical record by clinical data	▪ Available when weight of a standard prescription could cause facial development issues (primarily for children) ▪ Available when lab cannot practically produce lenses with a lower index lens
Allergy to certain frames	Need is substantiated in member's medical record by clinical data	Alternative frame to be provided when a provider documents a rash or other adverse reaction to all UnitedHealthcare | March Vision Care 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 UnitedHealthcare | March Vision Care ▪ These must meet ANSI standards
Non-standard frames	Need is substantiated in member's medical record by clinical data	▪ Used when member has facial parameters where standard frames do not fit correctly ▪ Used when optical correction will not fit practically in a standard frame
Low vision rehabilitation	Need is substantiated in member's medical record by clinical data	▪ Visual loss with best corrected visual acuity of 20/50 or worse in the better eye ▪ Constriction of visual fields to be less than 20 degrees or hemianopia ▪ Limited contrast sensitivity due to underlying pathology ▪ Initial consult codes of 97241 – 97245 or 99244 ▪ Maximized medical treatment of conditions such as, but not limited to, diabetic retinopathy, macular degeneration, optic atrophy, and glaucoma ▪ Diagnosis codes consistent with low vision pathology. Under certain circumstances, medical records may be requested. If requested, they need to demonstrate that medical, surgical, and other treatments that have been tried and failed. They must have a diagnosis as noted below AND reduced vision. The appropriate diagnosis codes are necessary, including, but not limited to: ▪ D49.81 ▪ G.35 ▪ H47.099 ▪ H33.08-H33-303 ▪ E11.319, E10,319 ; H35.00-H35.443 ▪ H40.001-H40-2234 ▪ H53.40-H53-483 ▪ H54.2-H54.60 ▪ H46.00-H47.333 ▪ H55.00-H55.01 ▪ Or others by pre-approval ▪ A low vision rehabilitation request form must be completed and submitted ▪ Before proceeding, prior approval is required

Dilation of eyes	Initial examination required. Subsequent examinations as follows:	▪ All new members require a dilated fundus exam, a wide-angle photograph, or equivalent image (if acceptable per state/federal regulation). Diabetics require dilation every year at a minimum, more often if they have retinopathy. Members with other certain pathology such as lattice degeneration, choroidal nevi, or retinoschisis for example, may also need a dilated exam every year or as medically indicated. Dilation of members with no risk factors thereafter should be based on the professional judgment of the provider or every 3 years, whichever occurs first.
Polarized lenses	Need is substantiated in member's medical record by clinical data	▪ Chronic iritis, uveitis, or other active inflammatory eye disease with fixed and dilated pupils or aniridia
Necessary contact lens replacement	Such lenses provide better management of a visual or ocular condition than can be achieved with spectacle lenses (see criteria above)	▪ The member meets criteria as noted above for necessary contact lens and there is: -Change of +/- 1.00 diopter in power -Change of 0.50 mm in base curve -Change of 0.30 mm in optic zone -Change of 0.75 mm in peripheral curve radius -Change of 0.30 mm in peripheral curve width
Replacement glasses when a member can not adapt to bifocals	Member has presbyopia and unable to adapt to bifocal	▪ Members should attempt to make the adjustment to bifocal lenses for a minimum of 2 weeks ▪ When lens manufacturers and/or the laboratory provides a warranty for "non-adapts", this should be used. When two pairs of glasses is the solution, each pair must have a sphere power of at least +/- 1.00 or a cylinder power of greater than +/-0.75 in at least one eye. In cases where one of the final single vision Rx calculation yield lower powers, the member will just be entitled to distance only or near distance only glasses. ▪ The frame used for the bifocals will be reused for one of the new single vision glasses
Medically necessary contact lenses and glasses for Aphakia In children aged 2 weeks To 12 years	Post surgically, for children born with a visually significant Cataract(s), or other medical eye problems that result in pediatric aphakia	Coverage for either medically necessary contact lenses **or** glasses in a given benefit period, but not both except for the following circumstances: ▪ The patient has greater than three (3) diopters of astigmatism in one or both eyes and requires this correction over the contact lens or lenses ▪ The patient has vision less than 20/200 in the poorer eye, or pathology where 20/200 or less is expected but cannot be measured (ie. PHPV, RD, macula scarring, coloboma involving the posterior pole) and a spectacle lens is needed for protection of the good eye

Prescription/ fitting check	Glasses are dispensed, including when a member has ongoing vision issues using new materials	▪ Included in the fitting fee/payment for materials for up to 45 days after member has received materials
Eye care of patient with Diabetes Mellitus	Person has Diabetes Mellitus	▪ UnitedHealthcare | March Vision Care adopted the American Optometric Association ("AOA") "Evidence-Based Clinical Practice Guidelines - Diabetes Mellitus" http://aoa.uberflip.com/i/374890-evidence-based-clinical-practice-guideline-diabetes-mellitus https://www.aoa.org/optometrists/tools-and-resources/clinical-care-publications/clinical-practice-guidelines
Extended ophthalmoscopy	When benefit includes medical within the scope of an OD	▪ Extended ophthalmoscopy codes are reserved for the meticulous evaluation of the eye in detailed documentation of a severe ophthalmologic problem needing continued follow-up, which cannot be sufficiently evaluated by photography ▪ In all instances extended ophthalmoscopy must be medically necessary. It must add information not available from the standard evaluation services and/or information that will demonstrably affect the treatment plan. It is not necessary, for example, to confirm information already available by other means. ▪ A detailed sketch must be included in the medical record and available upon request. The sketch should be a minimum size of 3-4" in diameter. All items noted must be identified (i.e., any findings must be drawn and labeled). Drawings in 4-6 standard colors are preferred. However, non-colored drawings are also acceptable. https://downloads.cms.gov/medicare-coverage-database/lcd_attachments/33567_6/APPENDIXA.pdf ▪ This is not payable on the same day as a fundus photo, Ophthalmic Ultrasound (B scan), Optical Coherence Tomography (OCT) or Fluorescein Angiography (FA)

* QIC approval 6/5/2019

— Exhibit L —

Sending a secure email to UnitedHealthcare | 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 UnitedHealthcare | March Vision Care. For any support questions please call Microsoft Support for more details.

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

Secure Your E-Mail Traffic

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

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

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

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

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

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

Note:

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

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

Step 2: Generate a certificate request

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

Step 3: Acquire the certificate

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

Step 4: Install the certificate

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

Step 5: Create an SMTP connector

Based on your current email environment, use one of the following procedures to create an SMTP connector or send connector.
Create an SMTP connector in Exchange 2000 or Exchange 2003

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

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

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

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

To create a Send connector in Exchange 2007

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

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

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

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

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

Step 6: Enable TLS

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

To enable TLS

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

— Exhibit M —

Sample eye examination record

DOS:

Patient Name:

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

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

Review of Systems

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

Vision:

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

Current RX:	OD	OS

External Exam:

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

Refractions:

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

Patient Name: **DOS:**

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

Near Testing:	Add:

Slit Lamp Examination:

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

Intra Ocular Pressure

OD	OS	Time:	
Method: AP	Puff	Tono	FT

Gonioscopy:	OD	OS

Medicines: Prop	Tetra	Fluress	NaF	Myd	Paradryn	Cyclo	Other:	

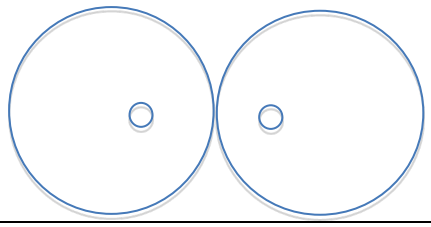
Fundus:

Direct	Indirect	Slit Lamp Lens	Photo

Nerve:

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

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



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

— Exhibit O —

HEDIS and Stars performance reporting

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

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

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

CPTII Code*	Description
2022F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy.
2023F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy.
2024F	7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy.
2025F	Seven standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy.
2026F	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; with evidence of retinopathy.
2033F	Eye imaging validated to match diagnosis from seven standard field stereoscopic retinal photos results documented and reviewed; without evidence of retinopathy.
3072F	Low risk for retinopathy (no evidence of retinopathy in the prior year).

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

Important:

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

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

* CPTII codes are tracking codes used for performance measurement. They should be billed in the CPT/HCPCS field on your claim form and submitted on the same claim as the CPT codes. CPTII codes do not have relative value and can be billed with a $0 charge amount.
** This list contains the most common ICD-10 codes.

— Exhibit P —

Ohio Department of Medicaid – Provider enrollment information

Provider enrollment

Pursuant to 42 Code of Federal Regulations (CFR) 438.602, the Ohio Department of Medicaid (ODM) is required to screen, enroll, and revalidate all managed care organization (MCO) network providers. This provision does not require MCO network providers to render services to fee-for-service (FFS) beneficiaries.

There are many resources available on the ODM website about the requirements to become a participating provider. Please visit https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/enrollment-and-support/enrollment-and-support for several useful documents that answer relevant questions.

Organizational provider types will be required to pay a fee. The fee does not apply to individual providers and practitioners or practitioner groups. The fee is a federal requirement described in 42 CFS 445.460 and in OAC 5160:1-17.8. The fee for 2022 is $631 per application and is not refundable. The fee will not be required if the enrolling organizational provider has paid the fee to either Medicare or another state Medicaid agency within the past five years. However, Ohio Medicaid will require that the enrolling organizational providers submit proof of payment with their application (see OAC 5160:1-17.8).

Provider termination, suspension and denial actions

For a list of termination, suspension and denial actions initiated by the state against a provider or applicant that allow for hearing rights, please refer to Ohio Revised Code 5164.38.

For a list of termination, suspension and denial actions initiated by the state Medicaid agency against a provider or applicant that allow for reconsideration, please refer to Ohio Administrative Code 5160-70-02.

Loss of licensure

In accordance with Ohio Administrative Code 5160-1-17.6, a Medicaid provider agreement will be terminated when any license, permit, or certification that is required in the provider agreement or department rule has been denied, suspended, revoked, not renewed or is otherwise limited and the provider has been afforded the opportunity for a hearing in accordance with the hearing process established by the official, board, commission, department, division, bureau, or other agency of state or federal government.

Enrollment and reinstatement after termination or denial

If a provider's Medicaid provider agreement is terminated or an applicant's application is denied, the applicant/provider should contact Ohio Medicaid via the Provider Enrollment Hotline (800-686-1516) to discuss the requirements to reapply. This process may include conversations with the ODM Compliance unit who will provide specific instruction on re-instatement requirements, if applicable.

Provider maintenance

The Provider Network Management (PNM) system serves as the source of truth for provider data for ODM and the MCOs. As a result, data in the PNM is used in both the plan's provider directory and ODM provider directory. To ensure provider information remains current it is important for providers to keep their information up to date in the PNM. Please remember, as an ODM provider and in accordance with your provider agreement, providers are responsible to notify ODM of changes within 30 days (see OAC 5160-1-17.2 F).

Updating the PNM: When there is a change in a provider's information, please log in to the PNM system, choose the provider you are editing, and click the appropriate button to begin an update. Self-service functions include location changes, specialty changes, and key demographic (e.g., name, NPI, etc.) changes. This information is sent to the MCOs on a daily basis for use in their individual directories. The provider must update their information in the PNM system first. The MCOs are required to direct providers back to the PNM if there are changes.

If you have questions or need assistance with your Ohio Medicaid provider enrollment, call the ODM Provider Hotline at 800-686-1516 through the interactive voice response (IVR) system. It provides 24 hour, 7 days a week access to information regarding provider information. Provider representatives are available via the IVR system weekdays from 8:00 a.m. through 4:30 p.m.

Provider resources

- Medicaid provider resources:
  https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/enrollment-and-support/enrollment-and-support

- Federal guidelines for enrollment and screening (42 CFR 455 Subpart E):
  https://www.law.cornell.edu/cfr/text/42/part-455/subpart-E

- Ohio Revised Code:
  https://codes.ohio.gov/ohio-revised-code/chapter-5160
  https://codes.ohio.gov/ohio-revised-code/chapter-3963

- Ohio Administrative Code:
  https://codes.ohio.gov/ohio-administrative-code/5160