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You asked for it! A completely searchable, online provider manual. Just select the topic you want to read about, our use the search, to see our policies, processes and other guidelines for participating on the network.

The Provider Manual is part of your contract by reference, so be sure to take some time familiarize yourself with its contents.

Updated November 2017
About the manual

The provider manual is designed with you in mind. We’ve made it as easy as possible for you to navigate. Links will take you right to other relevant topic areas or to download forms and reference tools.

This version of the EyeMed Vision Care Professional Provider Manual supersedes any prior manual you have received from EyeMed, The Eye Care Plan of America (ECPA) or Cole Managed Vision. The information contained in this manual is subject to change. EyeMed reserves the right to revise these policies and procedures at our sole discretion and at any time. EyeMed will notify participating providers of any such revision on our secure provider website prior to implementation. All applicable laws and regulations supersede the provisions of this manual. This Provider Manual is confidential and should not be shared with third parties. The provisions of this version of the Provider Manual are effective January 1, 2018, except in the states of Tennessee and Washington, where they will take effect the later of the effective date or 60 days from the production date whichever is greater.
How to find us

We’re here to help when you need it. Want to know how to file a claim? Want to learn more about credentialing? Shoot us an email, pick up the phone or send us a fax. We’re here for you. Be sure to include your provider ID and the correspondence reference number on any messages.

Download our Contact Us Reference.
Section 1
The basics

Let’s get started. First, thanks for being part of our network. We’re committed to helping our members see life to the fullest, and you’re an important part of that. Here we’ll discuss a few housekeeping items, things to keep in mind to make working with us as simple as can be.
How we help your practice

We’re in this together

We’re both in the business of helping people with their vision so they can enjoy life. Since you’re committed to taking care of them, we’re committed to taking care of you. We’ll try to connect you with our members and keep business simple for you through things like this:

- Letting members know you’re a participating provider
- Allowing you to display your online scheduling link on our provider locator
- Giving you 24/7 online access to important resources to support your patients and help you grow your business
- Letting you search for groups in your area
inFocus site

Stay in the know

We’re big on keeping you informed. Find information when you need it at our one-stop online shop — inFocus. By investing just a few minutes a month, you’ll find what you need to simplify your administration and grow your practice through your participation on our network. We’ll even send you an email when we add new information so you won’t miss a thing. For more about inFocus, see our overview.

Be sure to register your practice’s primary email on inFocus so we can add you to the distribution list. You can even add emails for your staff on the Manage Profile menu so they receive updates, too.
Speaking of communications

We won’t stalk you, but we do like to keep the lines of communication open. We’ll contact you in one of these ways:

- **inFocus**: All of our communications, along with training and other helpful tools, reside on this site.
- **Biweekly communication digests**: Twice a month we’ll send a summary of what we’ve added to inFocus.
- **Email**: Urgent messages for you and your staff.
- **Fax and mail, including direct mail campaigns**: For high priority topics, we may send you mail or fax communications.

Our contract and credentialing organizations might contact you sometimes, too.
Promoting your practice

Not just another face in the crowd

Want to make sure our members and your patients know you’re on the network? We have 3 free and easy tools you can use to make sure your practice stands out.

1. **Window clings** – Email us at to request 1 or more free clings to let the world know you accept our plans
2. **Use our logo in ads or on your website** – You’re welcome to use our logo. Request it now.
3. **Add a link to your online scheduler to our locator** – Do you have a real-time appointment scheduler online? Make sure our members know about it by adding the link to our provider locator. Here’s how:
   - On the online claims system, go to Manage My Profile in the left-hand navigation.
   - Select Location Details from the sub-menu. At the bottom of this screen you’ll see the online scheduler submission.
   - Once you submit the URL, we’ll verify it works within 5 business days, then activate it on our provider look-up website.
4. **If you participate in the Safety Eyewear Program**, go to the online claims system, and go to Manage My Profile to indicate that you offer safety.

Looking for an online scheduling solution? 4PatientCare offers special pricing for our network providers.
Register for online claims

Stake your claim

We’ve made submitting claims a snap with our online claims system. But, before you can take advantage of the system, you’ll have to register for access to the site. We’ve made that easy too. Simply complete our online form to request access to the claims system.

We’ll talk more about everything you can do on the site in the Getting Paid section of this manual.
Registering with labs

Signing up for eyewear orders

When using our lab network, be sure to register your location with the lab(s) you plan to use. You’ll need to call the lab to set up an account first. Detailed contact information for labs is available in our Lab Network Listing. It’s simple.

- Click on Manage My Profile > Lab Accounts from the menu located in the left-hand column of the online claims system.
- From the Lab Accounts page you can search/review existing lab account relationships or set up new accounts by location.

You can download step-by-step instructions, as well.

Safety Eyewear Program

Safety Eyewear Program orders for members will be manufactured at a specific network of labs that are safety-certified and equipped to carry the eligible frames. To service EyeMed safety patients, you must register with at least 1 of the participating safety labs.

To register for a certified safety lab, log in to the online claims system and choose Register for Labs from the menu on the left. Select the option that says “safety.” See more information about how to register with a lab.
Complete your practice profile so members see the whole picture

Once you’re set up on the Online Claims System, be sure to take a few minutes to complete your practice profile. Our provider locator includes detailed information about participating provider locations: hours of operation, products and services you offer, and some available frame brands. If you participate in the Safety Eyewear program, be sure to select “safety eyewear” under available products.

But we can’t provide all of these details if you don’t tell us about them!

Here’s how you’ll do it:

- Once you’re logged on to the online claims system, go to Manage My Profile > Location Details on the left-hand menu.
- If you have more than one location, you’ll select from a drop-down box.
- All you have to do is use the drop-down boxes to select the hours your location is open each day.
- For products, services and frames (including safety eyewear), you’ll click on each item to move it to the right-hand box. Anything in the right-hand box will display on the locator.

Access detailed training, including a step-by-step walkthrough, in our special section of inFocus.
Training

Need a crash course?

We hear our system is so easy to use no training is needed. But if you do need some help, we have lots of tools to make your life easier. Once you register, you can find detailed training guides on how to file claims online and use our automated phone system right here on this site.
Keeping information up to date

Change is good, but we need to know about it

Just as we promise to keep you updated on all things EyeMed via this site and other communications, we also ask that you keep us updated on changes to your practice, especially alterations to your email, locations and staff. Alert us of these updates using our online form.

State and federal laws require you verify the information we have on file.

You must notify us of changes to your practice within **10 business days**. This includes data such as names, address, telephone number and doctors.

**Email addresses**

A valid email address is required to make sure you don’t miss important updates.

You are required to have a valid email address on file. It will be used to send communications and for log-in to our communications website, inFocus. When you sign up for the network, we'll use the email on file for contracting to set up your user name on inFocus. You'll receive an email prompting you to set up your password.

Once you’re logged in to the site, you can provide additional email addresses for communications and update email addresses through the User Center.

**Directory verification**

State and federal laws require you to verify that we have the correct information on file and displayed on the provider locator members use to locate participating providers. Failure to verify the information could result in disciplinary action or termination from the network.

To verify your information, go to Requirements > Provider Verification on inFocus. Review the information on the page and click either yes or no to indicate if the data is correct. Make this a quarterly habit.

**CAQH profile**

We use information from your CAQH profile to populate some aspects of our Enhanced Provider Search, including ADA compliance. To ensure we’re always displaying the correct information, make sure your CAQH profile is also up-to-date. It’s a best practice to check your profile at least once a quarter.

**Notifying credentialing vendors**

Changes you make in our system aren’t passed on to our credentialing vendors, so you’ll need to notify them of changes separately.
Notifying your labs

Likewise, we don’t share your contact information with optical labs, so you’ll need to contact any labs you work with directly, including EyeMed’s network labs, and update them of changes to your shipping and billing address, phone/fax number and email address.

Refer to our network lab directory for lab contact information.
Fraud, waste & abuse prevention

Network providers must complete Fraud, Waste and Abuse prevention training with all staff each year, unless you’re contracted directly with Medicare. Visit the Requirements section of the site to let us know you’ve completed your training and for more information, including free training materials.

Annual CMS Fraud, Waste and Abuse and Compliance Training

The Centers for Medicare and Medicaid Services (CMS) requires you to complete at hire and annually thereafter compliance training related to fraud, waste and abuse (FWA) awareness. The requirement applies to everyone working within your location and for anyone who has at least a 5% ownership in your business. If you also subcontract work to other suppliers or vendors, they, too, must complete CMS FWA & Compliance annual training. Please keep records of all training at your location in case of audit. This requirement affects you as a provider of vision services to our Medicare Advantage and Managed Medicaid members.

Exclusion testing and documentation

EyeMed networks include Medicare Advantage and Medicaid Managed members. Just like we check your credentials before contracting with you, you also need to check any individual or entity that you intend to hire, sub-contract, or add into your practice ownership to make sure that they are not excluded from receiving federal funds. Everyone who conducts work for you needs to be able to provide services. If they appear on any one of the exclusion lists below, you will need to remove them from any EyeMed work. You will need to keep records of your exclusion testing effort and be able to produce supporting documentation if requested. Monthly, check these websites to check the exclusion status of your team and any potential new additions before you add them to your team:

1. The Office of Inspector General’s List of Excluded Individuals and Entities or LEIE at https://exclusions.oig.hhs.gov/.
2. System for Award Management or SAM at https://www.sam.gov, see “search records.”

Our Fraud, Waste & Abuse prevention goals

- To effectively pursue the prevention, investigation and prosecution of health care fraud, waste or abuse
- To recover overpayments on behalf of our clients
- To comply with state and federal regulations and clients’ requirements for preventing fraud

Provider Education & Resources

Be sure you’re using our provider resources to stay in the know about all of our policies and guidelines. Here are some of the resources we have available:

- inFocus. Access the resources you need to remain in compliance 24/7 through inFocus. Make sure you and your staff spend a few minutes each month reviewing the latest news and updates.
**Provider Manual**: Take time to familiarize yourself with the contents of the manual, which details our policies, processes and other guidelines for participating on the network. Remember your contract requires you to comply with the policies and procedures found in the Provider Manual.

**Training**: We’ve created user guides that will walk you step-by-step through every process you’ll use in the online claims system.

**CMS Annual FWA Training**: The Centers for Medicare and Medicaid Services (CMS) requires annual compliance training related to fraud, waste and abuse awareness. This requirement affects you as a provider of vision services to our Medicare Advantage members.

### Indicators and Examples of Provider Fraud, Waste & Abuse

The following is a non-exhaustive list of examples of situations that may constitute provider fraud:

- Billing for services not provided
- Billing the same service and diagnosis on the same date of service to multiple plans
- Upcoding or unbundling services to gain greater reimbursement
- Providing something to the member that was not necessary (treatment, supplies, medicines, procedures, etc.) for the purpose of billing the benefits company
- Making an intentional misrepresentation on your claim about the nature of services or charges, the sequence dates of service, filing for an altered or falsified diagnosis to obtain coverage, the provider of services (i.e. filing a claim indicating a provider that is in the member’s network, but it is not the provider that supplied the service), the recipient of services (i.e. filing a claim under an eligible member when the service was received by an ineligible member)
- Stating medical necessity for routine services
- Diagnosis or treatment out of scope of the provider’s practice

### Best Practices to Prevent Fraud, Waste & Abuse

- **DO** maintain complete and accurate records. Remember you have a responsibility to maintain complete and accurate records, either in hard copy or electronically, for a period of 10 years (or longer if state or federal requirements say so) and to cooperate during our audits to furnish those records. If we don’t have sufficient documentation to validate the services and/or materials filed on your claim(s), we will collect the claim reimbursement to correct this overpayment either by requesting a refund or by withholding future payments where permitted by law.
- **DO** ensure that all information submitted on authorizations and claims is accurate. Remember you are responsible – we will hold you responsible for claims submitted by you, your employees and agents of your practice. If we identify any misleading or false information included on your claim(s), we may consider that a false claim resulting in recoupment and disciplinary action up to and including termination from the network.
- **DO** speak up if you notice suspicious activity. If you discover that your office currently or previously committed any improper billing practices, we encourage you to proactively communicate this to us and we will take this into consideration during our review.

### Consequences of Identified Fraud, Waste or Abuse

- Identified fraud, waste or abuse may result in some or all of following:
- Provider education and warning
- Monitoring of the provider’s submitted claims activity and/or implementation of a Corrective Action Plan
- Comprehensive provider audit and/or quality review of the provider’s claim activity
- Withholding of the provider’s claim payments or demand for restitution for recovery of overpayments
- Termination of the provider from the network
- Reporting of suspected fraudulent activity to comply with state and federal regulations and/or clients’ requirements
Recredentialing 101

After initial credentialing, we’ll need you to complete recredentialing every 24 to 36 months to make sure items that can change or expire over time remain valid.

We use 2 companies to help us out with credentialing: The Council for Affordable Quality Healthcare (CAQH) and Aperture, a credentials verification organization (CVO).

The process begins 90 days prior to the recredentialing date. You’ll get a letter and the online claims system will notify you when it’s time to begin. Then it’s up to you to do 4 simple things:

- **Step 1** Verify and update your demographic information
- **Step 2** Resubmit current licensure
- **Step 3** Show proof of liability insurance
- **Step 4** Provide a copy of your professional certification documents

All providers are reviewed by our credentialing committee before being approved for credentialing or recredentialing. A detailed chart listing the participation and documentation requirements by provider type is available in the Credentialing Requirements. See your Rights During Credentialing.

To make things go even quicker, make sure you let CAQH know about any changes to your practice information. You can contact them at:

**CAQH**

Phone: 888.599.1771  
Fax: 866.293.0414  
Website  
Email: caqh.udphelp@acgs.com
Adding a new provider

New doctors who join your practice need to be credentialed before seeing EyeMed members and submitting claims under their name. Complete our to get started. First, go to our online forms center. It’ll take 30 to 45 days to complete the credentialing process. Don’t forget to let us know to associate the doctor to your location, too, so you can file claims.

See all of our credentialing requirements and your Rights During Credentialing.
Leaving the network

Time to say goodbye

If you decide to leave the network, simply go to our forms page and complete the Termination of Tax ID or Location form. The amount of notice required varies depending upon the terms of your contract. Refer to Appendix 9 of your contract for more information.

The Policies and Procedures section outlines your responsibilities upon termination.

60 day notice is required to leave network
Section 2
What we expect from you

You should document your own policies that demonstrate your compliance with these requirements so you can provide us proof in writing should a member ever file a complaint against your practice.

Our members—your patients—deserve a great experience whether they’re in Abilene, Albuquerque or Anchorage. In this section we’ll discuss our requirements and guidelines relative to your practice, eye exams, contact lenses and eyeglasses. We’ve tried to keep it simple.
About your location

- Mobile providers
- Required instruments
- Hygiene
- Telemedicine
- Office cleanliness
- Safety measures
- Disabilities
- Complete vision services
- Hours and after-hours policies
- Arranging back-up
- Member confidentiality

You’ll need to maintain a minimum amount of professional liability insurance per location. For more information, head to the Policies and Procedures section.
Mobile providers

All Mobile Providers who wish to participate in an EyeMed network must go through a Mobile Provider application and approval process. You may not provide in-network covered services to EyeMed members prior to having your application approved, being credentialed and signing a participation agreement with EyeMed.

EyeMed has categorized Mobile Providers into 2 types:

- Category 1: Those who increase access to care to otherwise underserved populations. EyeMed generally accepts Mobile Providers who fall in this category.

- Category 2: Those who provide a service of convenience to members who already have adequate access to care. EyeMed only accepts providers in this category under certain circumstances.

Mobile Providers are generally required to have a “brick and mortar” location that provides comprehensive eye exams in addition to any Mobile services to ensure that members have access to continuity of care.

Mobile Providers must recertify compliance with EyeMed’s requirements every 2 years.

Contact the Customer Care Center to receive a copy of the Mobile Provider application and/or Mobile Provider policy. Once a completed Initial Mobile Provider Application package is received, it will take a minimum of 30-60 days for the process to be complete. If the provider performing eye exams is not a current EyeMed provider, he or she must also complete the credentialing process.
Required instruments

We want our members to see every detail of their lives. That’s why we require participating providers to have the following instruments on site and in working order to properly serve our members:

- Phoropter or trial lenses
- Visual acuity testing distance and near charts and/or projector
- Retinoscope, autorefractor or wavefront analyzer
- Keratometer/ophthalmometer/topographer
- Ophthalmoscope: Direct and binocular indirect with condensing lens
- Tonometer
- Biomicroscope
- Lensometer
- Radiuscope/keratometer attachment, if rigid contact lenses are prescribed or managed
- Color vision testing system
- Stereopsis testing
- Diagnostic pharmaceutical agents within expiration dates
Hygiene

Germs beware

Reducing the spread of infection and illness helps everyone. That’s why we require you to properly clean exam rooms, laboratories, dispensing areas, offices and waiting areas.

It’s also important you:

- Discard contact lenses, contact lens solution, DPAs and TPAs after their expiration date
- Store pharmaceuticals in a secure and sanitary place away from food and beverages
- Properly secure and maintain medical waste containers
- Clean clinical equipment with alcohol wipes in front of the member before each use
- Disinfect diagnostic contact lenses after each use

Staff are often in direct contact with members, so it’s important that they wash their hands (in front of the member whenever possible) prior to examining the member, and periodically use an alcohol-based hand sanitizer between interactions.

Staff should also use gloves, biohazard disposal, trash receptacles and general office disinfectant, not only to reduce the spread of infection, but to also ensure safe handling and disposal of medical waste.
Keeping your office clean

Cleanliness is next to godliness

It’s not all about germs. Please keep exam lanes, the contact lens and eyewear dispensaries and public areas as clean and clear of clutter as possible. Your reception area should provide seating for at least 5 patients, and areas where members obtain services or discuss vision care or health information should offer privacy and confidentiality. You should also post your license and certifications in plain sight or make them otherwise available to members per state law.

5 seats needed in waiting room
Safety measures

Safety first

Members shouldn’t have worry about safety when they’re in your office. That’s why we require all participating providers to offer a safe and secure environment. At a minimum, this includes having:

- Adequate lighting in public areas
- Safe and secure flooring and fixtures
- Hand-held fire extinguishers up to local and state fire codes with current inspection tags
- A complete first aid kit that includes the following, at a minimum:
  - Adhesive bandages
  - Adhesive tape
  - Ammonia inhalants
  - Antibiotic ointment
  - Antihistamine
  - Antiseptic towelettes
  - Eye wash solution
  - First aid/burn cream
  - Latex gloves
  - Pain reliever
  - Scissors
  - Sterile eye pads
  - Sterile gauze pads
- Prescription pads kept in a secured location
- Medical waste container
- Any other safety equipment recommended by state or local emergency preparedness ordinances

Pop quiz... What’s the most commonly missed item on location audits? A medical waste container.
Disabilities

Everyone should have access to eye care

We strongly believe everyone has the right to see the beauty of the world around them, and that everyone should have easy access to eye care. Your locations must be accessible and able to accommodate the needs of members with disabilities per the Americans with Disabilities Act (ADA).
Complete vision services

We want our members to have the total experience. That’s why we require participating provider locations to be full service – offering both exams and materials.
Hours, after-hours and emergency care policies

An eye care emergency is a physical condition involving one or both eyes which, if untreated or if treatment is delayed, may reasonably be expected to result in irreversible vision impairment. Examples of eye care emergencies include severe eye pain, any penetrating injury to the eye, chemical contact with the eye (particularly alkaline substances), sudden total loss of vision in one or both eyes or sudden loss of vision to a degree that prohibits mobility. Lost or broken eyeglasses or contact lenses, regardless of the strength of the prescription, does not constitute an eye care emergency.

Whether you open your doors at sunrise or take a bit more time to start your day, communicating your hours is important. While every practice sets its own hours, we ask you to post and maintain reasonable business hours, and you must ensure members can receive eye care services within 2 weeks of their request. If the doctor’s hours are different from the dispensary’s, both sets of hours need to be posted.

You should perform urgent care services the same day and offer after-hours support—via mobile phone, pager or an answering system—to members seeking emergency eye care.

You should perform urgent care services the same day and offer after-hours support—via mobile phone, pager or an answering system—to members seeking emergency eye care. Have in place referral instructions ready to relay to members who present or contact you with an emergency eye care need outside your scope of practice during your office hours and after hours.

California requirements

In California, Senate Bill 137 requires providers to respond to appointment requests as follows:

- Urgent care appointments (no prior authorization required) – 48 hours or 2 days
- Urgent care appointment (prior authorization required) – 96 hours or 4 days
- Non-urgent doctor appointment – 15 business days (we require appointments within 14 business days)

During normal business hours, the wait time for a patient to speak by telephone with a knowledgeable and competent staff person can’t exceed 10 minutes.

You’re also required to have (or arrange for) telephone triage or screening services on a 24/7 basis through which patients can get help to determine how urgent their condition is. Patients should receive return calls from this line within a reasonable timeframe, not to exceed 30 minutes.

During non-business hours, you must have an answering service or a telephone answering machine that provides instructions on how patients can obtain urgent or emergency care including, when applicable, how to contact another vision provider who has agreed to be on-call to triage or screen by phone, or, if needed, deliver urgent or emergency care.
You must coordinate interpreter services with scheduled appointments to ensure interpretation is provided at the time of the appointment if needed.
Arranging backup

While you’re away

Remember, all fill-in doctors need to be credentialed.

Everyone needs a break from time to time. When you’re out of the office for 7 consecutive days or more, you must arrange for coverage by another EyeMed-credentialed participating network provider. (Shorter absences are up to your discretion.) Be sure to contact us via email to let us know who’ll be filling your shoes before they start seeing our members. We’ll need to associate the provider to your location. Claims will be paid to the Federal Tax ID indicated in the email or on the form you submit.
Member confidentiality

Your lips are sealed

It’s critical (and the law!) to protect patient medical records and other confidential health information. Should a member complain about confidentiality while in your care, we’ll ask you for your written confidentiality and HIPAA procedures.

You might not think of the computer when you think PHI, but the data we provide on members in the online claims system is considered PHI. When using the computer, be sure to protect the information from prying eyes by keeping the screen facing away from common areas, and by locking your screen when you need to step away. These small extra steps will go a long way in protecting your patients’ privacy.

Misdirected PHI

If you happen to receive something from us that has PHI for a member you aren’t currently treating, destroy it immediately or safeguard it for as long as it’s in your possession. Please call us at 888.581.3648 to let us know you received the PHI in error, and, if for some reason you can’t destroy the information, let us know that, too.

This should be a no-brainer, but we have to say it anyway: You’re not permitted to use or re-disclose misdirected PHI.
Life as an in-network provider

As a participating provider, you’ve agreed to see our members, and to accept the negotiated fees as detailed in the fee schedules that are part of your contract. See more about what you’ll be paid. What’s that mean, exactly? A few important things:

You can’t turn away members if you participate on their network
You can’t submit claims to us for out-of-network services on behalf of the member if you’re on the network
You can’t charge members more than you would free-to-choose customers (that includes having 2 different price sheets for insurance and non-insurance patients)
We ask you to play nice. Please don’t disparage us to members; instead, bring any issues you have to us through our Quality Assurance process.
You can’t market directly to member groups and their employees as it relates to your participation on the network. We’ll promote your practice on our member materials for you. In-office signage and most advertising is fine, but we don’t permit direct contact with our members or clients who have not previously received care or purchased eyewear from you. See our logo usage agreement for more details about advertising.

Speaking of networks, we have a few. To see which ones you participate on, go to the online claims system and:

- Click on Manage My Profile from the left-hand menu
- Select Networks from the sub-menu

You can also call us at 888.581.3648 if you’re ever unsure.

If you’re interested in being on other networks, visit our forms page. Before deciding to add the location(s) to the requested network, we’ll evaluate it to see if we need more providers in the area. Our goal is to maintain a specific ratio of providers to the population (unless prohibited by state law) to provide access for members while still protecting in-network providers’ volume. There’s no guarantee we’ll add a new location you open, even if you currently have one or more participating locations. We’ll evaluate the need of every new location, even those operated by providers who already participate on the network. Should you be denied participation in an additional network, you can appeal the decision by emailing us or sending a written appeal to Quality Assurance at 4000 Luxottica Place, Cincinnati, OH 45040.

You’re also welcome to apply to the Aetna Vision Network.
Search for groups near you

Sneak peek

You asked for it, and now it’s available! We have a new tool that lets you search for groups with the most members in key demographic areas. We have more than 9,000 clients, so there’s no way to show all of them or to cover every city. But you can see what groups have members in the large metropolitan areas near you. Check it out now.

For the Safety Eyewear Program, once nearby employers in your community become eligible, you’ll be able to search for groups enrolled in the program through this tool.
ID cards

Our members are easy to spot

It’s easy to pick out our members in a crowd because we give most of them 2 ID cards, which include all the information you need to find the member’s plan and benefits in our system. Our more tech-savvy members might present their ID cards on a mobile device.

It’s worth noting that members don’t have to show their ID card, although we recommend they do. Don’t refuse services to a member simply because they don’t have an ID card. You can still look them up in the system.

While some cards might look different than others, the key information is the same. Finding the information you need is simple. A sample ID card is provided below.

![Sample ID card](image)

Some members might also have a Spanish version of the card:

![Spanish ID card](image)

Some groups don’t allow us to print member ID numbers on cards because of security concerns. Some clients use “private label” ID cards that don’t include the EyeMed logo. See the full list of reseller/private label groups.
Safety Eyewear Program

You should also take note that members may or may not have an ID card specific to the safety eyewear plan, and may present their routine ID card at time of service. Be sure to check the system for Safety Eyewear Program eligibility, especially if they don't present an ID card.
Member benefits

“What are my benefits?”

We provide several resources where members can learn about their available vision benefits and how they work.

But even though these resources are available, members might come to your office with questions about their benefits or features of their vision plan. When that happens, send them to us:

www.eyemed.com/members Mobile optimized version available

- Specific benefits and eligibility
- Plan or group restrictions
- Wellness information
- Explanation of benefits
- View/print an ID card (if the plan provides)

866.9EYEMED or the number on the Member ID card, if applicable

- Benefits and eligibility
- For questions about specific group features

To learn more about our plans, be sure to read the How Our Plans Work section.
Notification of non-covered services

We’re sure you have a lot to offer members that isn’t covered by our plans. Maybe it’s special testing or optomap®*. Whatever it is, it’s important that members understand when you’re providing any services that are not covered under their plan.

For all members, a verbal notification is sufficient when their vision benefits do not cover a service or item. However, you should note in the patient file that you had a conversation about what services are and are not covered by the member’s vision benefits.

If the member is part of a Medicare plan, do not issue an Advanced Beneficiary Notice (or ABN form) as these forms do not apply to Medicare Advantage plans or protect you from liability. Keep a copy in the file in case there are questions later.

*optomap® is a registered trademark of Optos plc.
Contact lens services

- Contact lens evaluations
- When members don’t complete fit and follow-up
- Standard and premium contact lens fittings

See How Our Plans Work for an explanation of contact lens benefits, and Getting Paid for details on filing claims for contact lens fit and follow-up and materials.
Contact lens evaluations

3, 2, 1, contact (lenses)

A “new contact lens wearer” is a new patient at your practice, or a patient who hasn’t worn contact lenses in the past 12 months. An “existing contact lens wearer” is a patient who has worn contact lenses within the last 12 months or is an established patient at your practice.

Many of our members shelve their specs for contact lenses. When treating these patients, you should perform contact lens compatibility tests, diagnostic evaluations and diagnostic lens analyses to determine if contact lenses are right for a member or if their contact lens prescription has changed. We know evaluations for new contact lens wearers differ from those for existing contact lens wearers, so be sure to indicate if the patient is a “new” or “existing” lens wearer in your paperwork. Below are detailed requirements for contact lens evaluations.

<table>
<thead>
<tr>
<th>Required Test (√)</th>
<th>New Wearer</th>
<th>Existing Wearer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Contact lens-related history</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>2. Keratometry and/or corneal topography</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>3. Anterior segment analysis with dyes</td>
<td>As Indicated</td>
<td>As Indicated</td>
</tr>
<tr>
<td>4. Biomicroscopy of eye and adnexa</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>5. Biomicroscopy with lens. Fluorescein pattern (rigid lenses) orb. Movement and/or Centration (soft lenses)</td>
<td>√</td>
<td>As Indicated</td>
</tr>
<tr>
<td>6. Over-refraction</td>
<td>As Indicated</td>
<td>As Indicated</td>
</tr>
<tr>
<td>7. Visual acuity with diagnostic lenses</td>
<td>√</td>
<td>As Indicated</td>
</tr>
<tr>
<td>8. Determination of contact lens specifications determined to obtain the final prescription</td>
<td>As Indicated</td>
<td>As Indicated</td>
</tr>
<tr>
<td>---</td>
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</tr>
<tr>
<td>9. Member instructions and consultations</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>10. Proper documentation with assessment and plan</td>
<td>√</td>
<td>√</td>
</tr>
</tbody>
</table>

If a member files a complaint about the evaluation process, we’ll look for supporting documentation as outlined in the contact lens audit scorecard.
When members don’t complete fit and follow-up

Lack of closure

Some members won’t complete the contact lens fit and follow-up evaluation for any number of reasons. To reduce the likelihood that a member doesn’t return for their fit and follow-up evaluation, we recommend you:

- Explain why the contact lens fit and follow-up benefit is important and why they should use it.
- Provide an overview of the contact lens fit and follow-up process and explain the member’s responsibilities.
- Explain that the fit and follow-up evaluation is required before you can provide the final prescription.
- Don’t obtain an authorization for the materials benefit in our system until the member completes the contact lens fit and follow-up process.

If you’ve completed an authorization for contact lens materials and the member either doesn’t complete the fit and follow-up process or doesn’t purchase contact lenses, you’ll have to void the authorization for contact lenses so the member’s eyewear benefit eligibility re-sets in our system.
Standard and premium contact lens fittings

What’s the difference?

The contact lens fit and follow-up billing should generally follow the type of lens you dispense.

You can also bill the following situations as premium fittings:

- Contact fittings started as a toric fit with multiple visits due to astigmatism, in which you ultimately prescribe spherical lenses
- Toric soft lens fittings
- Fitting of spherical lens(es) used in a monovision application
- Prescribing or dispensing an extended-wear lens to a member who intends to wear the contact lens as extended wear

Any other situations outside the definition of premium fittings are considered standard.

Some plans have different benefits for premium versus standard contact lens fittings. In some cases, fit and follow-up services are funded, meaning the member only has to pay a copay. It’s important to check the member’s benefits before filing the claim so you collect the appropriate out-of-pocket amount from the member.
Members with medical and vision benefits

EyeMed members entering a participating provider’s office often have both vision and medical plan benefits. Network providers should use their professional judgment combined with discussions with the patient to determine whether to file an eye examination claim or, potentially, other service(s) with us or through the patient’s medical carrier. When determining what coverage to submit the claim, providers should consider the following:

Patient presents with no reported medical conditions

The coverage of services rendered by an eye care professional is dependent on the purpose of the examination or service rather than on the ultimate diagnosis of the patient’s condition. When a patient goes to his/her physician for an eye examination with no specific complaint related to a medical condition, the expenses for the examination are likely not covered under the patient’s medical benefit even though as a result of the eye examination the eye care professional discovered a pathological condition. Under these circumstances, the eye examination should be billed to the vision plan if the patient presented without a specific complaint related to a medical condition.

Patient’s eligibility to receive eye exam service and provider’s contractual agreement to provide the eye exam service

Every patient who has an eligible benefit for a comprehensive eye examination is entitled to receive this benefit during the coverage period from a contracted provider. As a participating provider with EyeMed, you are under legal agreement with us to provide requested covered services and/or deliver materials to our members. If you recommend that the eye care service(s) provided be billed to the patient’s medical plan, it must be fully disclosed to the patient as to the reason for the recommendation to bill the medical plan and what the possible deductible and/or copay out-of-pocket expenses could be. If the patient initially presents without a specific complaint related to a medical condition, it is most appropriate to bill the vision plan (EyeMed) for the visit. If during a visit that the patient presented without a medical-related complaint you discover the patient has a medical condition and your prescribed treatment plan would require medical eye care, you should inform the patient of their condition and their need for the diagnostic testing and/or treatment anticipated, and you should schedule the patient for a follow-up medical eye care visit. The follow-up medical eye care should be billed to the patient’s medical plan.

Patient disclosure statement

Following your explanation of the entity to be billed, the patient should acknowledge this explanation by signing a Disclosure Form. The form should state:

- The medical reason (diagnosis) that a claim is being filed with the medical benefit.
The potential cost (out-of-pocket expense), which would include the deductible and/or copay. It is understood that the provider may not be able to definitively determine the amount, therefore listing the provider’s usual and customary charges for the service(s) would be an acceptable disclosure.

Patient requests a vision plan examination based on presenting problem

Should an EyeMed member insist that a vision plan claim be submitted and the presenting problem, in your professional judgment, would indicate the need for another service and/or procedure, you may elect to refuse to provide the comprehensive eye examination under the vision plan. It is expected that you would explain the needed care and coverage/billing options under the patient’s medical plan, possible out-of-pocket payment with the patient or possible referral options. The reasons for the refusal of care should be clearly documented in the patient’s clinical record, and we recommend you contact us at 888.581.3648 to inform of the refusal of care and the reason.

Medical eye care and referrals

If you are a participating provider for the patient’s medical plan, inform the patient of your participating status. If you are not a participating provider, it is important to inform the patient that your practice’s usual and customary fees will be charged and to disclose those proposed fees. If the patient elects to be referred to a participating provider, please make every effort to refer appropriately and provide the subsequent professional with all relevant information concerning your findings that will lead to the best outcome possible for the patient.

Note: This policy is not intended to interfere or infringe on the professional judgment and decision-making of the participating eye care professional providing covered services as defined. All eye care professionals should adhere to their usual and customary coding and billing procedures in accordance with the American Medical Association’s Current Procedural Terminology (CPT) coding guidelines and consistent with evidence-based medicine and accepted standards of care for eye care professionals.
Language assistance

When it comes to eye health, communication is critical. It’s important to do what you can to prevent language barriers from being barriers to vision care. Be prepared to provide language assistance to members with limited English proficiency.

Hearing-impaired individuals can call our TDD number at 866.308.5375.

If you practice in California, be sure to comply with the California Language Assistance program.
Eye exam services

- Comprehensive eye exam guidelines
- Pupillary dilation
- Treating diabetic members
- Referrals
- Eyeglass prescriptions

See how our eye exam benefits work. The Getting Paid section will explain how to file exam claims.
Eye exam guidelines

The eyes have it

We don’t have to tell you how important a comprehensive eye exam is to overall eye health. We’ve created a reference guide that explains our comprehensive eye exam guidelines.
Pupillary dilation

Eyes wide open

We follow industry standard language related to services definitions, such as that defined by CPT-92004/14 for a Comprehensive Eye Exam. The language related to dilation is broad and, therefore, may benefit from clarification. The language “It often includes, as indicated, examination with cycloplegia or mydriasis” may not provide sufficient information for providers to indicate the expectations of dilation for our members.

Retinal imaging doesn't replace dilation.

The EyeMed Quality Assurance Committee believes that there are a number of member characteristics and conditions that typically require dilation, including diabetes. Read more about caring for diabetic members.

Note: This policy is not intended to interfere or infringe on the professional judgment and decision-making of the participating eye care professional providing covered services as defined.

If the member refuses to be dilated, document the refusal in their file.

Dilation is considered a covered service as long as it's done within 30 days of the initial eye examination (to accommodate those situations when the member decides they can’t have dilation on the day of the original eye exam). If the patient returns for dilation after the 30 days have elapsed, you can charge the member your normal U&C for the dilation.
Treating diabetic members

Special care required

Members who have diabetes require special care. When we perform a chart audit on a diabetic member’s records, we’ll be looking to make sure you’ve taken the additional steps below. Our diabetic audit scorecard tells you exactly what we’ll be looking for.

- Either dilate the patient’s eyes or document that a dilated fundus exam was performed within the past 12 months.
- Submit all applicable Disease Diagnosis Codes for members with diabetes.
- Document if a diabetic member refuses dilation.
- Counsel and educate all diabetic members on the connection between diabetes and eye health, as well as the importance of an annual eye exam.
- Communicate clinical findings to the member’s physician(s) after providing a comprehensive eye exam and/or treating the diabetic eye. You can use a Summary of Diabetic Clinical Findings form (we even have one you can use free of charge).

If the member is covered by our Diabetic Eye Care plan, follow these procedures.
Referrals

This isn’t my bag

When members require further diagnostic testing or treatment you don’t offer, refer them to a physician for follow-up care. Whenever possible, refer the member to a physician or other professional who is part of their health plan. Note the referral and any follow-up communication in the member’s record. You should also keep a referral log separate from your patient records and be able to provide it to us upon request.
Eyeglass prescriptions

The FTC requires you to provide (at no cost) a copy of the eyeglass prescription immediately after you complete an eye exam. You can find more on this in our Policies and Procedures.
Contact lens materials

When it’s time to give the members their contact lenses, dispense only those that meet the patient’s needs and industry standards.

Put it in writing: Written instructions for contact lens use

In addition to following FTC rules about contact lens prescriptions, also make sure the prescription hasn’t expired and still meets the member’s eye health and vision needs before dispensing contact lenses.

You should give members written instructions on how to handle, clean, maintain and wear their contact lenses at no charge. You might want to use a contact lens care and handling agreement form to document that the member received this information.
Frames

It’s a frame-up

For many of our members, glasses are still the way to go. We’ve got a few rules when it comes to “framing” our members, including:

- Dispense only frames that meet ANSI Z80.5 Spectacle Frame Standard except safety eyewear dispensed under the Safety Eyewear Program, which must meet ANSI Z87.1 safety standards.
- Maintain/display at least 100 prescription frames priced $130 or less, from any manufacturer
- We reimburse the cost of any frames that can be fitted with prescription lenses. This reimbursement includes the eyeglass case and any postage.

Please also see our guidelines about sunglasses. If you participate on the EmblemHealth Medicaid network in New York, please see the EmblemHealth Medicaid section for details about the required frame kits or frame selection for this plan.

When you use our lab network, you’ll supply your own frames.

There are unique requirements for safety frames. Refer to the Safety Eyewear Program section for more details on these requirements.
Reading glasses

Prescription spectacles for reading, where the lenses are fabricated by a network laboratory, are covered under the EyeMed benefit. Over-the-counter readers are not covered.
Designer frames

Haute couture

Some of our members prefer the designer look. We know that many of these high-end brands have restrictions on which frames can be discounted and which can’t. Most of the time, these apply only to true discounts (not funded plans like our benefits). Ultimately, it’s up to you to be aware of the restrictions on the frames you carry. If your dispensary doesn’t permit our members to apply a discount to a manufacturer’s frames, it’s your responsibility to provide a written policy from the manufacturer that explicitly states the brand is excluded from managed vision care members, and you should present that policy to members.

For more information on how to calculate frame payments, check out the Getting Paid section.
Inventory requirements for Pediatric Vision Benefits

Several of our health plan clients offer children’s vision care as an Essential Health Benefit (EHB) to meet the requirements of the Affordable Care Act. Some of these plans will be administered by us on behalf of the health plan. Read more about these plans.

To receive fully covered corrective eyewear, the members of these plans will need to choose from a selection of frames that you make available to the member. You’ll need to have a minimum of 35 frames in your dispensary that meet the following criteria:

- A total wholesale acquisition cost of at least $19
- 20% to 40% (or at least 5 units) each of girl, boy and unisex styles
- Eye size assortment as follows

<table>
<thead>
<tr>
<th>Eye size</th>
<th>Minimum # of units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 46</td>
<td>6</td>
</tr>
<tr>
<td>46 to 47</td>
<td>6</td>
</tr>
<tr>
<td>48 to 49</td>
<td>2</td>
</tr>
<tr>
<td>50 to 51</td>
<td>1</td>
</tr>
<tr>
<td>52 and higher</td>
<td>1</td>
</tr>
</tbody>
</table>

In most cases, if a member chooses a frame outside of your designated selection, the frame is not covered by the plan and becomes a free to choose transaction (meaning you can charge the member your regular retail price, and you won’t file a claim).
Plano sunglasses

EyeMed’s frame eyewear allowance only applies towards the purchase of eyewear with prescription lenses. Members can’t use our lens benefit for plano sunglasses unless the member’s plan includes such benefits. It’s possible for members to use their 20% discount on non-covered items toward the purchase of plano sunglasses.

Here are guidelines and best practices to ensure your office is properly administering the benefit:

- In general, members can’t use benefits on plano sunglasses. It’s possible members will want to use their frame allowance to purchase frames for prescription sunglasses, which is okay.
- Members can only use the frame benefit to purchase frames that hold a prescription lens. RXable sun frames with plano sun lenses – whether or not the lenses were obtained using their lens benefit – are plano sunglasses, and are not covered.
- The frame benefit does not cover ophthalmic frames without prescription lenses. These are sometimes called “fashion eyewear.”
- If the member doesn’t purchase prescription lenses at the same time they purchase the RXable frame, you must remove the plano lenses from the frame before selling them.
  - If you remove the lenses, the member must acknowledge the plano lenses were removed and that removing the lenses may void the manufacturer’s warranty. A copy of the acknowledgment should be kept on file.
- If the member has already used their benefit for lenses or contact lenses, but still has the frame benefit available, he or she can use the additional pair discount, but only to purchase a complete pair of eyewear (frame and prescription lens at the same time). Plano sunglasses are not eligible for the complete pair discount. Instead, you should apply a 20% discount since this is a non-covered item.
- Health plan audits, member complaints or trends that make us suspect abuse could trigger evaluations. If that happens, we’ll ask you for a copy of the transaction and the lab invoice to make sure you followed our guidelines. For more about audits and potential disciplinary actions, see the Policies and Procedures section.
Sports goggles

Frames designed for use as protective eyewear in sports (often called sports goggles) are not part of our standard benefit. However, members receive a 20% discount off the purchase of sports goggles as part of their discount on additional services.
Lenses

Lenses come in all types of materials, coatings and options. Here’s how we classify lenses. We consider standard lenses to be uncoated, CR-39 plastic single vision, bifocals (ST 25 and 28) and trifocals (7×28).

We consider any other lens types premium lenses.

Unless your contract allows otherwise, you’re required to use our contracted labs (or, when applicable, you may provide single vision in-office finishing) to produce eyewear for members. See the Ordering Eyewear section for more about working with these labs and using in-office finishing. If you use another lab or in-office finishing to produce eyewear, lenses must meet current ANSI standards.

When dispensing safety eyewear, lenses will need to meet different standards. Refer to the Safety Eyewear Program section for more information on safety lens requirements.

See the most current product catalogs for complete lists of lenses and treatments available through our lab network.
Progressive lenses

Member out-of-pocket costs for progressives depend on whether the lenses are classified as standard or premium. Some plans’ benefit structures further segment premium progressive lenses into tiers. Refer to our progressive & anti-reflective classifications for our current classifications by product. Effective January 1, 2018, new classifications will apply. This list includes most available brands on the market. We reserve the right to make changes to the products on each tier and the member out-of-pocket costs. When using network labs, you’ll need to order from the selection available in the Product Catalogs.

This list includes most available brands on the market. Depending on the situation, you might be able to dispense any lens on this list. However, when using network labs, you’ll need to order from the selection available in the Essilor Product Catalog for EyeMed and the Luxottica Lab Services catalog for EyeMed.

You can learn more about member payments for progressive lenses, including costs for scheduled premium progressives, in How Our Plans Work. The Getting Paid section explains more about filing claims for these lenses.

For progressives that are part of the Safety Eyewear Program, please refer to the Safety Eyewear Program Product catalogs for a complete list of available safety lenses and treatments.
Anti-reflective

Anti-reflectives are classified as either standard or premium based on the product type. With some plans, members will pay a fixed cost for anti-reflective. See our current classifications of progressive lenses and anti-reflective treatments. Effective January 1, 2018, new classifications will apply.

When using network labs, you’ll need to order from the selection available in the Essilor Product Catalog for EyeMed and the Luxottica Lab Services catalog for EyeMed.

For more information about anti-reflective benefits, such as member payments when the plan has scheduled out-of-pocket costs, see How Our Plans Work. You’ll find more details about filing claims for lens options including anti-reflective in Getting Paid.
Eyewear warranties

Our benefits don’t include product warranties, but you’re welcome to offer members the option to purchase an extended protection plan through your office. If you offer warranties, be sure to keep a copy of the warranty and the member’s signature on file in case of a complaint. Warranties should clearly identify the timeframe, terms and conditions.

EyeMed offers one such program, called SpecProtect Eyewear PlanSM. SpecProtect is an eyewear protection program for eye care professionals. You sell the plan to patients, they come back to you to fix their broken glasses, and SpecProtect reimburses you for your repair costs. There’s no cost to enroll, and you receive free sales support. To learn more, visit www.specprotect.com. You can also sell SpecProtect to non-EyeMed members.

Of course, you should always honor manufacturer and lab warranties when it comes to defective lenses and frames. Contracted labs will honor all manufacturer warranties. You can contact the lab that manufactured the materials for further information.
Each member is different. We have a variety of benefits as unique as our members. In this section we’ll give you an overview of the plans we offer and explain how to make them work in the real world. Relax; there won’t be a test.
Plan overview

We’ve got members covered

Need to know how to file claims for these benefits, or want to know more about your reimbursements? See the Getting Paid section.

It’s not rocket science. Our plans are based on some basic benefit concepts: **copayments**, **allowances**, and **member out-of-pocket costs**.
Member payment

Members will pay you copays or a fixed cost for certain covered services and items. Some materials (usually frames and contact lenses) also have allowances, which is the amount covered by the plan. The member is only responsible for paying the copay indicated by their plan; you can’t charge the member more than the copay amount for any items that have copays. If the member chooses eyewear that costs more than that allowance, you’ll collect that “overage” after applying a discount to the remaining cost.

For other items, members simply receive discounts off your retail price. You’ll collect the amount after the discount.

You can find members’ specific payment responsibilities for their plans in the Member Benefits section of the online claims system or by calling us at 888.581.3648.
Plan frequencies

Depending on the plan, members can only use their benefits once every year or two. The allowable frequency of the eye exams could be different than that of frames or lenses. That’s why it’s important to check eligibility before you get too far into the eye care process.

There are no limits on discounted items purchased, including discounts on additional pairs of glasses and other services, if applicable.
Discount only plans

Example discount plans

- Anthem/Blue View Vision
- Ameritas
- Coventry Health Plan/GHP
- Delta Dental
- GVS
- HAPA
- HealthNet
- Humana
- MetLife
- Optima Health
- Regence BCBS
- Tufts Health Plan

Some plans just give members savings on eye exams or purchases. Anyone in the member’s family can enjoy these discounts, too.

Discount plan members might not have ID cards, and the best way to view available discounts is through a Plan Search in our claims system. View our discount plan schedules.

Once a group has migrated to our updated claims process, you won’t be able to use the Plan Search feature, at least for the time being. Instead, when you search for the member in our system, the Additional Discounts tab will provide a summary of available discounts.

We’ve included a list of some of the largest groups that offer discount plans (not a complete list). Many groups that have
discount plans also have funded benefits.
In-network savings on additional pairs and more

All members are also eligible for additional, unlimited savings on vision-related purchases after they use their initial benefit. These vary a little, but generally members receive:

- 35% or 40% off additional complete pairs of glasses (frames, lenses and lens options purchased together at the same time) except with the Safety Eyewear Program where additional complete pairs are 20% off.
- 20% off frames, lenses or lens options purchased separately
- 20% off non-covered items such as cleaning cloths and contact lens solution
- 15% off conventional contact lenses

For Aetna plans, follow Aetna’s discount schedule.

Members can use their discount to save 20% off plano sunglasses. You can find more information on plano sun discounts here.

If you practice in Nevada, be sure to check out the additional discounts available to Health Plan of Nevada members. Members can use these discounts any time during the plan year. If the member got their initial exam or materials at a different provider, you still need to honor these discounts.

Some states may prohibit eye care plans from requiring eye care providers to accept these discounts on non-covered services. If you practice in any of these states, your provider contract will reflect any exceptions.
Ordering eyewear for discounted transactions

You don’t have to use our lab network when members receive discounts on eyewear, but you can take advantage of EyeMed’s lab pricing by ordering the materials through our lab network. You can use this option for both discounts on additional pairs, or when the member has a discount plan.

For additional pairs, simply click the Additional Discounts tab on the Member Details page of the online claims system. The system will calculate the member cost and allow you to send the order to the lab.

When the member has a discount only plan, you’ll look up the Group Name instead of the member’s information. You’ll then be able to enter the member’s details, see the member cost and order the eyewear through the online claims system.

Detailed instructions are available under Downloads > Training.

You can also use the lab of your choice for discount plan orders and pay privately.

There’s no need to file claims for discount plans (including discounts on additional purchases), either. If plans include a combination of funded benefits and discounts (for example, an exam copays with materials discount), only file a claim for the funded portion of the benefit. For more on this, refer to the Getting Paid section.
Materials only plans

Hold the exam, please

Some clients opt for our materials-only plans to supplement exam benefits they might offer employees through medical coverage or other sources. These members can still get an eye exam at your office, but the exam won't be covered under our plan. If the member has eye exam coverage through a different plan, and you accept that plan, you can bill the eye exam to the other insurer.

Sometimes this can get confusing. To make it simpler, we recommend you follow these steps:

- Use the name and date of birth to search for the member in our system.
- Look on the member’s ID card or online benefit summary to determine if the plan includes an exam. Our E and F plans don’t include exam benefits.
- When members have materials-only plans, consider contacting them before their appointment to remind them their exam won’t be covered by their EyeMed plan. This will help avoid late cancellations for you and surprises for them.
- Encourage members to contact us in advance to confirm their vision benefits. Our phone number is published on ID cards and member websites.
Exam only plans

Like Materials Only Plans, Exam Only Plans provide benefits for an eye exam only. If the member needs eyewear, he or she may have benefits available through a different carrier. If not, you should follow our standard discount schedules for materials, depending on the network.

The Safety Eyewear Program is typically a materials only benefit, so an eye exam is usually not covered under this plan. If employers choose, they can add an exam benefit to the program.
Eye exam benefits

The core of the plan

Members will have a copay for eye exams (though the copay could be $0) that covers all of the components listed in our comprehensive eye exam guidelines, including refraction and dilation. We’ll subtract any copayments from your reimbursement. Note that refraction cannot be billed separately except in the case of clients for whom we coordinate benefits. See more about our policy on refraction.

If a member asks for a recheck of the lenses, we require you to verify the lenses and, if necessary, the refraction, within the first 45 days of receiving new eyewear based on that prescription, at no additional charge to the member.
Retinal imaging benefits

A picture’s worth a thousand words

Some plans include a benefit or discount for retinal imaging. When they do, members will pay:

- $39 (or your standard office charge if it’s less) on a retinal imaging screening, or
- A $0, $10, $20 or $30 copay (you’ll be reimbursed up to $39 after the copay)

If the member has a benefit or discount for retinal imaging, you’ll see it on the Member Details screen, or it will be included in the member details supplied over the phone or via fax.

If the member doesn’t have any benefits or discounts for retinal imaging and you want to recommend this service, make sure the member is aware of any additional costs. This conversation should include clear statements that their benefit does not provide coverage for this service. Make a note of your conversation in the member’s file.

Two bits of fine print:

- If your practice doesn’t offer retinal imaging, you’re exempt from this benefit. We don’t require you to purchase new equipment for this benefit.
- Retinal imaging doesn’t replace dilation. Dilation is still a part of a comprehensive eye exam. See our Comprehensive Eye Exam Guidelines for more information.
Frame benefits

Holding it together

Most plans have an allowance for frames. That means the member has a certain amount to apply toward the purchase of the frames. If they go over, you should apply a 20% discount to the amount over the allowance and collect the remaining 80% from the member. Members can use their benefit on any frame in your dispensary. See how we handle designer frames.

Here’s an example. If the frame allowance is $150, and the frame costs $175, you collect $20.

For more about frame requirements, see the Frames section of What We Expect from You.

The frame allowance for Pediatric Vision Benefits members applies only to a pre-selected selection of frames. Learn more.

Refer to the Safety Eyewear Program section for safety frame requirements.
Lens benefits

I can see clearly now

Our lens benefit applies to prescription lenses that improve members’ vision. We don’t have a minimum prescription requirement, but at least 1 lens (in a pair) has to have a prescription to qualify for the benefit. Our plans do not cover plano lenses of any kind, even those designed to block blue light.

Our benefits cover both standard and premium lenses. Most often, members will pay a copay that covers the entire cost of standard lenses (though some plans have $0 copays or allowances that can be applied to eyewear packages). For premium lenses, apply a 20% discount to any fees over the standard lens fee, then, charge members the total amount over the standard lens fee.

For locations using our lab network, we only cover lenses available in the Essilor Product Catalog for EyeMed or the Luxottica Lab Services catalog for EyeMed.

EmblemHealth Medicaid members may qualify for medically necessary bifocal lenses. The EmblemHealth Medicaid section provides more information about that benefit.
Member payments for progressive lenses

Member payment for progressives depends on the product dispensed. With some plans, members will pay a fixed cost for premium progressives. The amount they owe depends on the type of premium progressives they purchase. The chart below shows what members pay for each type (or “schedule”). See our current classifications of progressive lenses and anti-reflective treatments. Effective January 1, 2018, new classifications will apply.

### Progressive price list*

<table>
<thead>
<tr>
<th>Schedule</th>
<th>Member out-of-pocket (Excludes lens copay)</th>
<th>Corresponding service code for claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard progressive (add-on to bifocal)</td>
<td>$65</td>
<td>V2781</td>
</tr>
<tr>
<td>Premium progressives (add-on to bifocal) as follows:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schedule 1</td>
<td>$85</td>
<td>V2781TG</td>
</tr>
<tr>
<td>Schedule 2</td>
<td>$95</td>
<td>V278122</td>
</tr>
<tr>
<td>Schedule 3</td>
<td>$110</td>
<td>V278125</td>
</tr>
<tr>
<td>Schedule 4</td>
<td>80% of charge less $55*, plus bifocal copay**</td>
<td>V2781 S0581</td>
</tr>
</tbody>
</table>

Note that this is the standard member payment, excluding the copayment. The amount the member pays may vary depending on the plan. Refer to their member benefits details in the online claims system for exact amounts.

*The online claims system refers to this as the bifocal allowance

**Providers in Alaska, Hawaii, California, Oregon and Washington receive 80% of charge less $70, plus bifocal copay

Please refer to the Essilor Product Catalog for EyeMed or the Luxottica Lab Services catalog for EyeMed to see the lenses available through the contracted lab you plan to use.

For more details about lens products, see the Lens section of What We Expect from You.
Adding to base lenses

Putting it all together

To calculate the member’s payment, you’ll add the charges for any lens options to the copayment for the base lens.

For add-ons that are eligible for the 20% discount, it gets a little trickier. You’ll charge the member the base lens copay. Then, figure out how much the add-on would cost after the discount. Now add the discounted add-on charge to the member copay.

When the lens add-on material automatically includes some other lens add-on — think scratch-coating inherent in polycarbonate or UV and scratch-resistant coating in a photochromic lens — the member only has to pay for the main add-on. The Lens and Option Charge Back Schedule includes more detailed information about how to handle these charges.
Anti-reflective lenses

Member out-of-pocket costs for anti-reflectives depend on whether they’re considered standard or premium. Some plans’ benefit structures segment premium anti-reflectives lenses into tiers. Refer to our progressive & anti-reflective classifications for our current classifications by product. Effective January 1, 2018, new classifications will apply. This list includes most available brands on the market. We reserve the right to make changes to the products on each tier and the member out-of-pocket costs. When using network labs, you’ll need to order from the anti-reflectives available in the Product Catalogs.

Please refer to the Essilor Product Catalog for EyeMed and the Luxottica Lab Services catalog for EyeMed to see the coatings available through the contracted lab you plan to use.

If you dispense an anti-reflective not on our list (including “house brands”), charge the member based on the A/R treatment that most closely matches the features and benefits of the anti-reflective you’re dispensing.
Anti-reflective with backside UV

A/R lenses that include backside UV

- Crizal EZ
- Crizal Alize
- Crizal Avance
- Crizal Sapphire
- Crizal SunShield (with or without mirrors)
- Prevencia
- Xperio UV (with or without mirrors)
- VISO XC + w/UV
- VISO Prevencia

Some lens manufacturers offer anti-reflective lenses with backside UV coatings. We consider the UV an additional lens add-on.

We recommend following the guidelines below to make sure you’re paid correctly and that members pay the right out-of-pocket costs:

- Because UV protection is already included in premium products (such as polycarbonate and high-index lenses), members don’t pay a separate $15 charge for UV coating. However, for these back-side UV products, the member is responsible for a $15 charge as a result of the additional coating.
- Youth packages available through Essilor labs use Crizal Kids UV or Crizal
Prevencia Kids. Both include backside UV, but you won't charge extra for the coating when members choose these packages.
Aspheric lenses

Aspheric lenses are covered as a premium add-on to polycarbonate lenses. Members will pay the polycarbonate charge, if any, then 80% of the retail cost of the upcharge for aspheric. When filing the claim, select polycarbonate as the material, then check the box for “Extra Charge for Other Premium Add-Ons.”
Member payments for lens options

Members pay a fixed amount for the common lens options. Some plans will fully or partially fund these lens options, which means the member will pay less (or nothing at all) and we’ll reimburse you.

<table>
<thead>
<tr>
<th>Lens option</th>
<th>Standard member cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>UV coating</td>
<td>$15</td>
</tr>
<tr>
<td>Tint (solid or gradient)</td>
<td>$15</td>
</tr>
<tr>
<td>Standard scratch-resistant coating</td>
<td>$15</td>
</tr>
<tr>
<td>Standard polycarbonate</td>
<td>$40</td>
</tr>
</tbody>
</table>

(Member payments for Insight plans will differ.)

Polycarbonate lenses are often funded, especially for children under age 19. When that’s the case, the member pays a copay or has no charge, and we’ll pay you $40 (less any member copay) when you file the claim. Similarly, members may pay $75 for photochromic lenses. Polycarbonate is typically a covered benefit for safety eyewear. There is no additional reimbursement for dispensing polycarbonate on Safety Eyewear Program claims.

For any other lens options, the member receives a 20% discount off your U&C. Always check the member’s benefits for their exact payments. Some plans have “non-standard” or funded lens options, or the member may be covered by a different type of plan. The online claims system can help if you’re unsure what to charge.

We cover only specific lens options for Medicaid members, and the options must be medically necessary. Refer to the Medicaid section for more information.

You can find more information on the lens treatments available at contracted labs in the Essilor Product Catalog for EyeMed and the Luxottica Lab Services catalog for EyeMed.

If you sell lenses as packages that bundle multiple add-ons with the lens, that’s okay, but make sure you’re charging the member for each of the individual lens add-ons (unless the add-on is inherent to the lens material).
Contact lens benefits

Fit and follow-up services

We don’t reimburse differently for new/existing contact lens evaluations, and the benefit includes contact lens training and instruction. Also, you can’t charge members additional fees for training and education. The contact lens fitting should take place during the same visit as the exam except for package plans.

If the member requires more than 2 follow-up visits, you may charge them for the extra visits. As always, it’s important to let the member know in advance if you intend to charge them for these additional visits and make sure you note the conversation in the member’s file.

Medically necessary contact lens benefits cover unlimited follow-up visits.

Contact lens materials

Contact lenses work a lot like frames: there’s generally an allowance for the benefit. The balance has to be used all at once (it’s usually not a declining balance) unless the plan specifically indicates otherwise. In the case of contact lenses, though, the discount on the balance over the allowance is 15%, and it applies to conventional lenses only. There’s no discount for disposable contact lenses that go over the allowance.

Here’s an example. If the contact lens allowance is $105, the disposable contacts cost $150, then you collect $45.

Here’s another. The contact lens allowance is $105, the disposable contacts cost $150, so you collect $45.

For more information about contact lens materials and fit and follow-up, see the Contact Lens section of What We Expect from You. And don’t forget to follow the Fairness to Contact Lens Consumers Act.

Contact lens benefits are in place of eyeglass lenses. Yes, that means the member could be eligible for contact lenses and frames. In that case, the member should pay the full price for the eyeglass lenses after any discounts. Also, be careful of our policies about plano sunglasses.
Allowances that combine fit and follow-up with materials

The contact lens allowance for some plans covers the fit and follow-up services and the materials.

You may have patients who are covered by a plan with an allowance for the fit and follow-up and contact lens materials combined (though we no longer sell these plans to new groups). We administer the contact lens fit and follow-up benefit for these plans differently than other plans we offer, making it a little confusing sometimes.

Here’s how it works:

One allowance is split between the professional fitting and the contact lens material cost. You’ll apply the member’s copay and allowance to the combined services and materials (only one copayment, if applicable, should be charged for fit/follow-up and materials).

A good rule of thumb is to charge the member your full U&C for the fit and follow-up services so the entire allowance can be saved for the materials. (Of course, you’ll want to let the member know this so they aren’t surprised about the fit and follow-up fee.)

If that’s not possible, you’ll deduct the U&C for the fit and follow-up from the allowance. The remaining amount will be available to apply to the cost of contact lenses. For example, if the member has a $100 allowance, and your U&C fee is $80 for a premium fit/follow-up, $20 remains for the contact lens materials.

Remember, if the member is getting conventional contact lenses, he or she will save 15% off the remaining balance of the cost of the fit, follow-up and conventional materials combined.

To make sure the claim is paid correctly, be sure to follow the special process.
Medically necessary contact lens benefits

Blue View Vision calls these non-elective contact lenses, but they’re the same thing.

Many of our plans include benefits for contact lenses when the member’s vision and spectacle prescription meet one of the following:

- Anisometropia of 3D in meridian powers.
- High Ametropia exceeding –10D or +10D in meridian powers.
- Keratoconus when the member’s vision is not correctable to 20/25 in either or both eyes using standard spectacle lenses. For the purposes of our benefit, there are 2 types of keratoconus as defined in our ectasia scale.

- **Emerging/Mild**: Contact lenses in this tier are anticipated to include, however not be limited to, scleral, semi-scleral and hybrid designs/materials. The below severity scale applies:
  - Multiple spectacle remakes
  - Unstable topography
  - Light sensitivity/glare issues
  - Signs including Fleischer ring, Vogt’s striae and scissor reflex with retinoscopy
  - No scarring
  - Topography (steep K <53D)
  - Corneal thickness >475 microns

- **Moderate/Severe**: Patients who begin in the emerging or mild categories and are not successful with contact lens materials and keratoconus designs may be elevated into this moderate/severe tier. Contact lenses in this tier are anticipated to include however not be limited to scleral, semi-scleral and hybrid designs/materials. Patients who qualify as moderate/severe will have all of the emerging/mild symptoms, plus:
  - Mild to no scarring or some scarring
  - Topography (steep K of 53D or higher)
  - Corneal thickness up to 475 microns
  - Refraction not measurable
  - Vision improvement other than keratoconus for members whose vision can be corrected by two lines on the visual acuity chart when compared to the best corrected standard spectacle lenses.

It’s expected that many new keratoconus contact lens patients will fall into the emerging/mild tier. Patients who have been successful and satisfied with contact lens designs and/or materials that are not in the moderate/severe tiers will likely remain in contact lenses in the emerging/mild tier. The eye doctor should use his or her best judgment to provide the appropriate materials/design for the best quality eye health, comfort and vision for patients who have previously worn contact lenses for keratoconus but who are not successful with their current contact lenses.

If you initially fit a keratoconus patient in an emerging/mild tier keratoconus contact lens but it is not possible to achieve quality eye health, comfort and/or vision, refit the patient with contact lenses in the moderate/severe tier and submit a corrected claim reflecting the moderate/severe keratoconus fee. We will adjust the claim and pay the difference, if any, under the medically necessary contact lens benefit guideline.

We’ll be looking to see that the documented spectacle prescription supports the qualifying condition submitted. You’re responsible for determining if members qualify based on your exam and evaluation.
However, they can’t use this benefit for conditions not listed above, even if you determine that contact lenses are necessary to correct other vision issues.

Because of the specialized nature of the materials, medically necessary contact lens benefits cover unlimited follow-up visits.

When a member’s vision impairment doesn’t meet one of the conditions, you may suggest an alternative solution to the member. For instance:

- Using the standard contact lens benefit up to the limits of coverage.
- Submitting a claim to the member’s medical coverage.

Tufts has different criteria for medically necessary contact lenses. Members of Pediatric Vision Benefits plans in California may qualify for medically necessary contact lenses for additional conditions.

Medicaid members have different criteria for medically necessary contact lenses. Please refer to the Medicaid section for the list of qualifying conditions.

Just like disposable and conventional contact lenses, medically necessary contact lens benefits may have a copay. Members who qualify can use the benefit once a benefit year based on member’s eligibility and can’t exceed any annual supply limits defined by contact lens manufacturer replacement guidelines. Most often, the medically necessary contact lenses will be paid in full for the member, which means you won’t collect any money from the member.

This bundled benefit covers the materials, fitting and unlimited follow-up visits. Dispense contact lenses that have been manufactured to meet only the most current industry standards. When filling an existing contact lens prescription, make sure the prescription is current and meets the member’s vision needs prior to supplying contact lens materials.

**Medically necessary contact lens claims**

The materials and fit and follow-up services for medically necessary contact lens benefits must be submitted on one claim. Most plans allow you to file these claims online. Simply look for the tab called Medically Necessary on the Member Benefits page. Click the tab, select the services and file online. Our online claims system user guides walk you through this process.

If the Medically Necessary tab does not display, you’ll need to file the claim in hard copy following the process below:

- **Confirm member eligibility** by calling us at 888.581.3648.

- **Complete the Medically Necessary Contact Lens Form.** Don’t submit medically necessary contact lens claims online. When completing the form, enter a single contact lens fitting code to indicate the qualifying condition. Include a material contact code on the same claim and same date of service. Submit applicable diagnosis codes if the member has either keratoconus or anisometropia. For all claims, include the applicable vision and high-risk diagnosis codes.

- **Fax the completed form** to 866.293.7373. Make sure you’ve completed everything we need, including:
  - Authorization number.
  - Fitting code indicating the qualifying condition.
  - Material code.
Medically necessary contact lens claim codes

When filling out the claim, use these codes to indicate the qualifying condition:

<table>
<thead>
<tr>
<th>Qualifying criteria</th>
<th>Medically necessary contact lens codes*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anisometropia</td>
<td>92310AN</td>
</tr>
<tr>
<td>High ametropia</td>
<td>92310HA</td>
</tr>
<tr>
<td>Keratoconus</td>
<td>92072</td>
</tr>
<tr>
<td>Vision improvement</td>
<td>92310VI</td>
</tr>
<tr>
<td>Pediatric aniridia**</td>
<td>92310AI</td>
</tr>
<tr>
<td>Pediatric aphakia**</td>
<td>92310AP</td>
</tr>
<tr>
<td>Pediatric corneal and post-traumatic disorder (filed as vision improvement)**</td>
<td>92310VI</td>
</tr>
<tr>
<td>Pediatric pathological myopia**</td>
<td>92310PM</td>
</tr>
</tbody>
</table>

*Submit a single fit code with a material code on 1 claim with 1 date of service.

**Applies only to members of Pediatric Vision Benefits in California. Pediatric corneal and post-traumatic disorder and pediatric pathological myopia pertain only to members of Health Net’s PPO in California.

If you put more than one diagnosis on the claim, we’ll reimburse based on the lowest paying condition. We’ll pay you standard contact lens fit and follow-up reimbursements if the claim doesn’t include one of the above condition-related fitting codes.

Today, CPT procedural codes for contact lens fitting are limited to keratoconus (92072). CPT has not designated codes for anisometropia, high ametropia and vision improvement. If the covered condition is either keratoconus or anisometropia, submit the applicable diagnosis codes listed in ICD-10. For all claims, include the applicable refractive and high-risk diagnosis codes.

Medically necessary contact lens payments

To help prevent abuse of the benefit and make sure you’re getting paid appropriately for your time, reimbursements for medically necessary contact lenses vary depending on which condition the member has.

<table>
<thead>
<tr>
<th>Qualifying criteria</th>
<th>Provider reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anisometropia</td>
<td>95% of U&amp;C up to $700</td>
</tr>
<tr>
<td>Condition</td>
<td>Reimbursement Details</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>High ametropia</td>
<td>95% of U&amp;C up to $700</td>
</tr>
<tr>
<td>Keratoconus - Mild/Moderate</td>
<td>95% of U&amp;C up to $1,200</td>
</tr>
<tr>
<td>Keratoconus - Advanced/Ectasia</td>
<td>95% of U&amp;C up to $2,500</td>
</tr>
<tr>
<td>Vision improvement</td>
<td>95% of U&amp;C up to $2,500</td>
</tr>
<tr>
<td>Pediatric aniridia*</td>
<td>95% of U&amp;C up to $3,730</td>
</tr>
<tr>
<td>Pediatric aphakia*</td>
<td>95% of U&amp;C up to $5,800</td>
</tr>
<tr>
<td>Pediatric pathological myopia*</td>
<td>95% of U&amp;C up to $700</td>
</tr>
</tbody>
</table>

*Applicable only to members of Pediatric Vision Benefits in California. Pathological myopia pertains only to Health Net members.

In most cases, you can’t bill the member for the amount over your reimbursement for medically necessary contact lenses.

Non-standard plans pay according to the available plan benefit. You may not bill members for any difference between your U&C fees and the plan’s reimbursement unless the plan benefits specifically say the member is responsible for payment above the allowance. We review the fee schedule at least once a year. You’re welcome to submit cases for fee review to our Quality Assurance department at eyemedqa@eyemed.com. Make sure you include supporting statements, lab fee documents and clinical documentation for consideration at annual fee review.

Process & record evaluations for medically necessary contact lenses

We’ll periodically review clinical records to make sure you’re correctly applying the medically necessary contact lens benefit. We’ll be looking to see that the documented prescription supports the qualifying condition submitted. If the record doesn’t support this condition, we’ll recoup any overpayment by withholding payment on future claim(s) where law permits.

As you may know, we can consider any inaccurate submission to be a false claim. Falsifying information or filing false claims can result in disciplinary action up to and including termination from our network. If we believe you’ve filed a false claim, we might also have to report it to regulatory and law enforcement agencies as appropriate.

See our full Quality Assurance process and disciplinary actions.
Materials allowance plans

Bundle up

They’re not all that common, but they do exist. We’re talking about materials allowance plans. With these plans, instead of individual copays and charges for lenses and lens options, or a single allowance for frames, there’s one allowance that will be applied to the entire eyewear purchase. If the complete pair of glasses costs more than the allowance, the member will pay you the remaining amount, less a 20% discount.

Aetna allowance plans work a little differently. See the Aetna plan information for more information. Also, check out the discount plan schedules to see a few other plans that combine allowances and discounts.

Here’s an example.
If the eyewear allowance is $300, and the total eyewear cost is $350, you collect $40.
Health Care Reform: Pediatric Vision Benefits

We could write a whole book about Health Care Reform. We’ll leave that for the experts, but we do want to tell you more about our Pediatric Vision Benefits, the product that some of our health plan clients will use to provide children’s vision benefits mandated under the Affordable Care Act (ACA), also known as Health Care Reform.

Background

Insurance carriers providing insurance for “small” companies (the maximum number of employees varies by state) and individuals are required to provide coverage for the Essential Health Benefits (EHBs) identified by the government. One of the EHBs for children is vision care. The EHB differs somewhat by state but generally includes eye care and corrective eyewear as needed.

The vision benefits must be embedded in a medical plan rather than offered as a standalone vision plan offered by companies like us. However, several of the health plans who already use our network for vision benefits are turning to us to help them provide the vision care EHB to their medical members. View the list of clients who are offering these plans.
Pediatric Vision Benefits – eyewear benefits

To meet the ACA requirements and ensure consistency of eyewear products, members will have to select from a specific selection of frames. See the details of our inventory requirements.

*Members will have no out-of-pocket cost if they choose from the inventory selection. If they decide they want a frame outside the selection, they’ll have to pay your regular U&C, and the transaction will be considered “free to choose.”*

For contact lenses, members will receive a six-month, three-month or annual supply of contact lenses, depending on the modality, at no cost.

<table>
<thead>
<tr>
<th>Replacement frequency</th>
<th>Amount dispensed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly</td>
<td>6 month supply</td>
</tr>
<tr>
<td>2-week</td>
<td>6 month supply</td>
</tr>
<tr>
<td>Daily disposable</td>
<td>3 month supply</td>
</tr>
<tr>
<td>Conventional</td>
<td>Annual supply (one pair)</td>
</tr>
</tbody>
</table>

If the member’s cost for contact lenses is more than the $140 allowance, please charge the member the remaining amount in a separate transaction.

To help guide you with dispensing, we’ve compiled a list of brands you can dispense according to these requirements without exceeding a $140 retail value.

In California and Washington, some health plans cover an entire annual supply of any type of contact lens. Be sure to read the notes in the online claims system to make sure you’re giving the member the correct benefits.

Because the benefit is based on amount dispensed rather than an allowance, you should not balance the bill the member if you dispense more than the indicated amount (for instance, an annual supply of monthlies). Instead, submit the claim for the allowed amount only. The remaining supply should be handled in a separate transaction that is not covered by the EyeMed benefit.
Pediatric Vision Benefits fee schedule

You’ll get paid standard fees for eye exams, contact lens fit & follow-up and lenses. In order to meet the ACA’s requirement for no annual limits on contact lenses or eyeglasses, we’ve had to modify the benefit and payment structure for contact lenses and frames. See the Pediatric Vision Benefits Fee Schedule.
Identifying Pediatric Vision Benefits

Members with Pediatric Vision Benefits will not be issued EyeMed ID cards. Instead, they’ll have medical plan ID cards. Please refer to the list of clients who are offering these plans so you’ll recognize these members when the time comes.

You’ll look up members the same way you would any EyeMed member. You’ll know it’s a Pediatric Vision Benefits plan because the Member Details page will include a note like the one below.

You’ll also notice the Member Benefits display for the frame and contact lens benefits will have a $0 member pay. That simply means the member has no out-of-pocket cost for those materials.
Pre-deductible plans

Many of the health plans will require members to meet deductibles before qualifying for Pediatric Vision Benefits. Before they meet the deductibles, members will be placed in pre-deductible plans. This means the member will pay you in full based on your negotiated rates with us. The Member Details page for the member will tell you exactly what the member owes you. Health plans need to track the members’ spending, so you should go ahead and file the claim like you normally would. However, you won’t receive any reimbursement from us.

You’ll know a member is part of a pre-deductible plan because the note on the Member Details screen will say so.
Special processes for Pediatric Vision Benefits

Multiple pair benefits (Kansas, Kentucky and New York only)

Some health plans will cover a medically necessary second pair of eyewear for Pediatric Vision Benefits members Kansas, Kentucky and New York. In Kentucky and New York, the vision change/loss must be due to one of the following conditions:

- Diabetes
- Keratoconus
  - Significant Rx Change/Progressive myopia/astigmatism
  - .75D sphere
  - 1.00D cylinder
  - For NY, this includes any significant Rx change/progressive myopia
- Cataracts
- Post cataract
- Prescription medication
- Other medical conditions that after review could reasonably cause a change in refractive status

You’ll need to provide documentation of the vision change/loss each time a new prescription is needed sooner than the standard 12-month interval.

Kentucky multiple pair benefits

Qualifying members in Kentucky receive one additional pair of prescription spectacle lenses of the appropriate power to provide the best possible visual acuity. The frame can be the current frame, if usable, or a new frame that meets the benefit guideline.

New York multiple pair benefits

The benefit covers prescription spectacle lenses or contact lenses in New York. The member is not restricted to 2 pairs only and can receive new glasses or contact lenses for each prescription change.

View the instructions for obtaining approvals and filing claims for Pediatric Vision Benefits multiple pair benefits in Kentucky and New York.
Kansas multiple pair benefits

Members of Pediatric Vision Benefits plans in Kansas receive additional pairs of covered eyewear based on the doctor’s recommendation. There are no special criteria or processes.

Additional covered conditions for medically necessary contact lenses (California only)

Members of Pediatric Vision Benefits plans in California can qualify for medically necessary contact lenses if they have the following conditions:

- Pediatric aniridia
- Pediatric aphakia

Health Net covers 2 additional conditions. For more about that, click here.

These are in addition to our standard qualifying conditions for medically necessary contact lenses.

See the process for filing claims for these benefits.
Other benefits

Above and beyond

Here we’ll give you information about special benefits you might not see a lot, but which can be vital to members’ eye care
EyeMed KidsEyes

Think of the children

Groups can choose to provide additional coverage for children age 18 and under through KidsEyes plans. Children covered by these plans receive:

- 2 comprehensive eye exams in the same benefit year.
- 1 additional covered pair of eyeglass lenses, if the child’s vision changes within the same benefit year.
- Funded polycarbonate lenses.
- 40% off additional pairs of glasses.
- 20% off plano sunglasses.

Clients can add the KidsEyes benefits to any plan. You’ll be able to tell if the member is eligible because plan frequencies and benefit levels will be based on age. Just follow what displays on the Member Details page of our online claims system.
Diabetic Eye Care plans

Addressing a serious health care issue

Our clients can include benefits for medical eye care services for members with type 1 or type 2 diabetes as an add-on to one of our vision plans. Members diagnosed with type 1 or type 2 diabetes, or who have diabetic eye disease (such as diabetic retinopathy), are eligible for additional services when their plan sponsor includes the benefits.

For the member to qualify for our Diabetic Eye Care plan, one of these diagnoses must be present:

- E11.9 – E10.8
- E08.65 – E13.39
- E08.311

When members meet these criteria, they’ll receive benefits for these diagnostic services:

- Fundus Photography – bilateral
- Extended Ophthalmoscopy – unilateral
- Gonioscopy – bilateral
- Scanning Laser – bilateral

These services fall under the following service codes:

- 92020
- 92134
- 92225
- 92226
- 92250
- 99211
- 99212
- 99213
- 99214
- 99215

If you don’t offer these services or want to refer the member for follow-up care, you can do so—just remember to note the referral in the member’s record.

To see your payments for each service, download the Diabetic Fee Schedules.

Please see how to submit claims for our Diabetic Eye Care benefits.
Working with medical coverage for diabetic eye care

Members might have coverage for the same follow-up services through both our Diabetic Eye Care plan and a medical plan. Our diabetic benefits allow for consistent eye care for the member, even if the participating provider who completed the eye exam is not on the member’s medical plan.

If you also participate on the member’s medical network, please discuss billing options with the member. Members are ultimately responsible for deciding which plan to bill and will pay any applicable copayments, allowances and/or deductibles. See Working with Members for more questions to ask when this situation occurs.
Post-cataract eyewear benefits

Lenses after surgery

To help address vision improvements after cataract surgery, some plans cover an additional pair of lenses or glasses after the member has cataract surgery. Special processes apply so we can confirm that the member had surgery and is eligible for coverage. See the full details.

Tufts Health Plan has a special benefit and process for post-cataract eyewear.
Low vision benefits

Severe vision impairment

Some plans include a low vision benefit for members who have severe eye health and visual problems not correctable with conventional vision correction techniques. A full list of low vision plans is available here. See the Getting Paid section for more information on the approval and claims submission process.

To be added to our list of providers who provide low vision services to members, complete and submit a Low Vision Notification Form.

Our low vision benefit covers supplemental testing and low vision aids, with pre-approval. To qualify for low vision, the member must meet 1 of these criteria:

- Best-corrected acuity is 20/200 or less in the better eye with best conventional spectacle or contact lens prescription.
- A demonstrated constriction of the peripheral fields in the better eye to 10 degrees or less from the fixation point.
- The widest diameter subtends an angle less than 20 degrees in the better eye.

Benefits cover both supplemental testing and low vision aids as described below.

Low vision supplemental testing

We consider low vision supplemental testing to be a diagnostic evaluation beyond a comprehensive eye exam. It should include a history of difficulties related to:

- Reading
- Activities in the kitchen
- glare problems
- Travel vision
- Workplace
- Viewing television
- School requirements
- Hobbies and interests

Preliminary tests may include other assessments such as color vision and contrast sensitivity.

When conducting low vision supplemental testing, take measurements of the member’s visual acuity using special low vision test charts. These charts include a larger range of letters or numbers to more accurately specify a starting point for determining the level of impairment.

You can also evaluate visual fields by performing a specialized refraction, thoroughly examining each eye. You may prescribe various treatment options, including low vision aids, as well as inform the member of other resources for vision and lifestyle changes.

Low vision aids
Our low vision benefit covers the following low vision aids:

- Spectacle-mounted magnifiers. A magnifying lens mounted in spectacles (called a microscope) or on a special headband, which allows use of both hands to complete close-up tasks such as reading.
- Hand-held or spectacle-mounted telescopes. Miniature telescopes used for seeing longer distances such as across the room to watch television, or that can be modified for near tasks such as reading.
- Hand-held and stand magnifiers. Tools that help with short-term reading, such as price tags, labels and instrument dials. These magnifiers can be equipped with lights.
- Video magnification. Tabletop (closed-circuit television) or head-mounted systems that enlarge reading material on a video display. Some systems can be used for distance applications. Image brightness, size, contrast and foreground/background color and illumination can be customized.

We’ll consider low vision aids other than those listed above on a case-by-case basis. To request other low vision aids, send us the Low Vision Approval Request Form and email it to us or fax it to 866.552.9115.
Safety Eyewear Program powered by EyeMed

EyeMed is now offering safety plans for those clients who desire it, in addition to routine vision care. The Safety Eyewear Program Powered by EyeMed offers vision benefits to those employees who need on-the-job protective eyewear. It’s sold separately to new and existing clients in addition to their routine vision plan.

No action is necessary until we notify you that an employer near your practice chooses to participate in the Safety Eyewear Program.

Through the Safety Eyewear Program, we aren’t accepting orders or claims for current safety eyewear patients enrolled in routine vision plans. A few of our existing groups allow members to use their routine benefits on safety eyewear:

- AmericanGreetings
- National IAM Benefits Trust
- Northern Michigan University
- Quad Graphics
- Railroad Employees national vision plan
- Vibracoustic

You won’t use the lab network for these groups. The Exceptions to the Rule section provides additional information about how to handle these claims.
Safety program member eligibility and benefits

Member eligibility

Only the employee who is enrolled in the Safety Eyewear Program is eligible. Dependents are not eligible for safety eyewear benefits.

Member benefits

Safety plans include the following coverage:

- **A frame allowance** - If members buy a frame that exceeds the allowance, apply a 20% discount to the overage, and collect the remainder from the member, as you would with routine vision care. When filing the claim online, the system will calculate the member out-of-pocket.

- **Lens copay** - Refer to the Member Benefits Display in the online claims system for the member’s specific copay amounts, if any. Refer to the standard [Lens Options Schedule](#) for member out-of-pocket costs for progressives.

- **Lens add-ons** - Lens add-ons are available and will vary depending on the member’s benefit. If the patient chooses an option that’s covered under their plan, charge the plan copay amount, otherwise follow the standard [Lens Options Schedule](#) for member payment. Polycarbonate is typically a covered benefit for safety eyewear.

- **Additional pair discount** - Members receive 20% off additional complete pairs of safety eyewear. This can’t be submitted through the system. Simply apply the discount at the point of sale as you do for other EyeMed discounts.

Exclusions

The following are excluded and are not covered under the Safety Eyewear Benefit:

- Plano safety glasses
- Contact lenses
- Everyday eyewear instead of safety certified frames and lenses
- Any frame, lens or lens option that does not meet current ANSI Z87.1 safety standards
- Materials obtained by other means than those approved as part of the program

Is the exam covered?

The Safety Eyewear Program is typically a materials only benefit, so an eye exam is usually not covered under this plan. If employers choose, they can add an exam benefit to the program. You’ll be reimbursed your standard contracted eye exam rate for the network.
In most cases, safety patients will be eligible for a comprehensive eye exam under other sources, such as medical coverage or routine vision benefits. Double check exam eligibility under any available plan for that member. If the member is still eligible for eye exam coverage through a different plan, and you accept that plan, you can bill the eye exam to the other plan.

For the Safety Eyewear Program, the patient’s prescription must be valid to dispense eyewear. Based on your professional judgment, you can require a new eye exam prior to dispensing the safety eyewear.

What materials are covered?

All prescribed materials must meet current American National Standards Institute (ANSI) Z87.1 standards for safety.

Employer safety-certified material requirements

Employers may have specific guidelines regarding allowable safety materials for their employees based on work conditions or specific job functions. Discuss with your patient if their employer has any specific material needs or if their employer has provided them with guidelines. See the notes in the Service Restriction Section in the Member Details page in the online claims system for plan specific information.
Recognizing members with the safety benefit

Identifying Safety Eyewear Program members is easy. In the online claims system, go to Member Search. Note that a member’s name could appear more than once, particularly if they're eligible for other benefits. To ensure you’re choosing the correct plan, be sure to look for “SAFETY” in the plan name.

You should also take note that members may or may not have an ID card specific to the safety eyewear plan, and may present their routine ID card at time of service. Be sure to check the system for Safety Eyewear Program eligibility, especially if they don't present an ID card.
Registering for safety labs

Safety Eyewear Program orders for members will be manufactured at a specific network of labs that are safety-certified and equipped to carry the eligible frames. To service EyeMed safety patients, you must register with the participating safety lab.

To register for a certified safety lab, log in to the online claims system and choose Register for Labs from the menu on the left. Then select the option to Set up Essilor Lab. Select the options that says “safety.” See more information about how to register with a lab.

If you use the EyeMed lab network, side-shields (built-in or removable) and a frame case will be provided with every safety eyewear order.
Available safety frames

All prescribed materials must meet current American National Standards Institute (ANSI) Z87.1 safety standards.

Providers using the lab network can order from a selection of ANSI-certified safety frames available from the participating network of labs. See the full Safety Frame Catalog. All Safety Eyewear Program frames should be ordered through participating labs and will be supplied by the labs. All safety frames come with side shields (built-in or removable) at no additional charge. For replacement side-shields, call Hilco OnGuard at 800.955.6544.

I use the EyeMed lab network:

Have your patient choose a frame from the Safety Frame Catalog. The most recent catalog will always be available on inFocus.

Sample frame kits may be available to providers in geographies where employers participate in the Safety Eyewear Program. In this case, EyeMed will contact you to inform you of the demand for safety eyewear in your geography, and you will be sent a safety frame kit to keep in your practice.

Before you place an order, note that the frames in the frame kit are for display only and should not be sent to the lab. The kit includes a sampling of available frames. Refer to the Safety Frame Catalog for the full list of available frames, materials and colors. When placing the order in the online claims system, you’ll choose “Frame at Lab.”

I don’t use the EyeMed lab network:

If you don’t use the EyeMed lab network, members with safety eyewear benefits may choose from the selection of safety-certified frames you offer. You must offer a frame selection of at least 8 ANSI-approved frames that meet the following criteria:

- Unisex or at least 4 men’s frames and 4 women’s frames
- Varied material types
- Varied eye sizes
- Complimentary side-shields
- Complimentary eyeglass case
- Manufactured at a safety-certified lab
- Include the ANSI required markings

Hilco OnGuard offers qualifying safety eyewear frames. Call them at 800.955.6544 for more information.
Available safety lenses

Corrective safety lenses must meet or exceed current ANSI Z87.1 standards and are available in lens types such as single vision, bifocal and progressive. Note that certain industries have specific material requirements.

If you’re using the EyeMed lab network, you can dispense only those lens items included in the safety lens catalog. Please refer to the safety lens catalog for a complete list of available safety lenses and treatments.

Lens add-ons

Lens add-ons are available and will vary depending on the member’s benefit. If the patient chooses an option that’s covered under their plan, charge the plan copay amount, otherwise follow the standard Lens Options Schedule for member payment. Polycarbonate is typically a covered benefit for safety eyewear.
Safety Eyewear Program lab policies

Emergency lab orders for safety eyewear when using the lab network

If you use the EyeMed lab network, you’ll have to use a CMS 1500 claim form with the applicable service codes to submit an Emergency Service claim. Indicate the word “SAFETY” at the top of the form and include a valid diagnosis code based on their prescription, so we pay you correctly. Diagnosis codes are not specific to safety. Once you complete the form, fax it to 866.293.7373. If the word “SAFETY” doesn’t appear at the top of the page, your claim could be denied.

See the In Case of Emergency section of the Provider Manual for more information.

Remakes and redos

You can request a first-time remake from the network lab at no charge within 6 months of the date of delivery for the reasons stated in the Provider Manual under the Refunds, Returns and Remakes section.

Process a remake or redo as a lens only order. If a member wants to change a frame only, he or she is responsible for the cost to change the frame, and you’ll handle it as a private pay transaction. Please work with the lab for remake procedures to find out if you need to return the frame with the remake.

Eyewear can be remade in the case of damage or quality issues with the frame at no cost. This falls under the manufacturer’s product warranty and should be handled between you and the lab.

Returns, exchanges and voids

Returns, exchanges and voids are not processed as part of the Safety Eyewear Program, with the exception of voids in the case a member cancels his or her order before the order is in the manufacturing process. In this case, follow our normal void process in the Provider Manual Voiding Claims section.
Promoting your participation in the Safety Eyewear Program

Don't miss out on the opportunity to promote that you offer safety eyewear.

1. Log in to the online claims system
2. In the left navigation bar, select Administration and then Location Details. Select the practice location that you wish to update.
3. Under the Products section, click Safety Eyeglasses in the list of Available Products to add this as a Selected Product. Once you select this product, your practice will appear as a location that offers safety eyeglasses and accepts the safety benefit in member-facing communication and tools, including the EyeMed Enhanced Provider Locator tool.

Refer to the Update Your Smart Locator Profile job aid for more details.
Getting paid for the Safety Eyewear Program

You will receive a $25 dispensing fee for each pair of complete safety glasses. There is no additional reimbursement for dispensing polycarbonate.

You’ll receive your standard payments for lens options as listed in the standard Lens Options Schedule except for polycarbonate as noted above. Lens and Options Charge Backs will apply for all safety eyewear orders.

For complete information, see the Safety Fee Schedules.
Video display terminal (VDT) benefits

The trouble isn’t in your set

Some plans offer members an additional benefit for video display terminal (VDT) refractions that are not usually covered by the comprehensive eye examination/standard refraction benefit. Members will usually pay a copay, and we’ll reimburse you for refraction. Refer to our list of VDT plans.

Instructions on submitting claims for VDT benefits are available here.
Medical Eye Care plans

More than routine

We provide coverage for Medical Eye Care services for Fallon Health Care Plans, Tufts and Optima (Sentara) health plan members to promote consistent eye health care services. Medical Eye Care plans cover urgent eye care conditions and progressive eye conditions usually covered by the medical plan. The member simply pays the exam copay at the point of service. Please refer to the Fallon and Tufts sections of the manual to download fee schedules for primary eye care plans.

When you also participate in members’ health plan

If you also participate in the member’s health plan’s network, you may file a claim with the medical plan for secondary coverage. Please discuss billing options with the member before deciding which direction to go, as the member is ultimately responsible for deciding which plan to bill, and will pay any applicable copayments, allowances and/or deductibles. See instructions for determining where to file claims.

When you don’t participate in the members’ health plan

If you’re not part of the member’s health plan’s network, provide professional services only up to the limit of your professional license. Submit the claim as instructed.
Medical/Surgical Eye Care

EyeMed administers both medical and surgical eye care benefits for some health plans. Doing so gives you the opportunity to practice to the full extent of your license and to be part of more coordinated patient care. You’ll be able to file claims with us for these expanded services for members without having to schedule additional appointments or work with a different carrier.

Utilization management and pre-authorizations

Some medical and surgical procedures require review and pre-authorization through our utilization management process before you can provide the services.

You’re required to obtain pre-authorization for the below 6 surgical procedures and injections.

- Intravitreal injections: J0178, J0585, J0586, J0588, J2778, J3396, J3490, J7313, J7316, J2503
- Blepharoplasty and ptosis repair: 15822, 15823, 67900-67914
- Botulinum toxin (Botox): J0585, J0586, J0588:
- Cataract surgery: 66982 & 66984
- Glaucoma Surgery: 65850 & 65855
- Unlisted procedures 66999, 67299, 67399, 67999, 68399, 68899, 92499

Please refer to the Medical/Surgical section of inFocus for the most current clinical guidelines that apply to each.

To request a pre-authorization, complete the online form available on the online claims system.

You’ll be notified of approval or denial for standard, non-urgent requests within 14 calendar days.

If any of the above services also requires a facility authorization, we’ll obtain that for you. However, if any other medical eye care services require a facility authorization, you’ll need to obtain that directly from CareMore. Contact CareMore’s Utilization Management department at 888.291.1358 (Option 3, Option 3, Option 2).

Expedited requests

Expedited pre-authorizations are available only if the standard UM decision turnaround time:

- Could seriously jeopardize the life or health of the consumer or the ability of the consumer to regain maximum function
- Would, in the opinion of a physician with knowledge of the consumer’s medical condition, subject the member to severe pain that cannot be adequately managed without the requested care or treatment.

You can request expedited decisions, which are rendered within 72 business hours, by indicating that it’s an
expedited request on the pre-authorization form available through inFocus.

**Emergency services**

Emergency services do not require pre-authorization. You must notify us by completing the pre-authorization online request form on the next business day following the emergency care or by calling 866.652.0038. You’ll need to attach to the form any medical records related to the emergency care.

**UM appeals**

When you or your patient are not satisfied with a denied UM decision, you can request an appeal along with additional medical information. The request will be reviewed by a clinical peer reviewer not involved in the initial denial determination and not a subordinate of the initial clinical peer reviewer. Follow the instructions on the determination letter.

Standard UM appeals are determined within 30 calendar days of the receipt of the request. Expedited appeal requests will be reviewed and determined within 72 hours of receipt. Both you and the patient will receive notification of the appeal decision.

**Claims filing**

**Medical and surgical eye care services**

We recommend you file claims for medical and surgical procedures using standard 837 electronic claims submission. If you aren’t set up for 837, you can submit in hard copy using a CMS 1500 form. Fax the completed form to 866.293.7373 and write “MEDICAL SERVICES” on the top of the form.

You can submit multiple dates of service and multiple service lines on the same claim, but only 1 provider should be listed on each claim.

For services that do not require pre-authorization, we’ll match the procedure and diagnosis codes for relevance.

**Routine vision care**

When providing routine vision care services, you’ll use the online claims system like you normally do. You’ll file routine vision claims separately from medical/surgical eye care services.

**Co-management**

Co-management is allowed as long as the surgeon who receives pre-authorization for the surgery uses the co-management modifiers. These modifiers need to be on the claims submitted by both the surgeon and optometrist.

Co-management guidelines are the same as Medicare.

Please refer to the Medical/Surgical section of inFocus for the most current clinical guidelines, access to pre-authorization forms and other important information about the program.
Non-standard plans

You may be able to decline participation in specific plans that require additional administrative procedures. Call us at 888.581.3648 to request non-standard opt-out forms.
Limitations and exclusions

What we don’t cover

Our plans don’t cover everything. A partial list of plan limits and exclusions are listed below.

- Orthoptic or vision training, low vision aids and any associated supplemental testing, unless specifically covered by the plan.
- Aniseikonic lenses.
- Medical and/or surgical treatment of the eye, eyes or supporting structures.
- An eye or vision exam, or any corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under a plan. See Exceptions to the Rule for the plans that cover safety eyewear as part of their routine vision plan. Some clients may offer the Safety Eyewear Program Powered by EyeMed in addition to their routine vision plan.
- Services provided as a result of any workers' compensation law or similar legislation or required by any governmental agency or program, whether federal, state or subdivisions.
- Plano lenses and plano sunglasses (except for 20% discount).
- 2 pairs of glasses instead of bifocals (does not apply to D or C plan members).
- Services or materials provided by any other group benefit plan providing vision care.
- Services rendered after the date and insured person ceases to be covered under the policy, except when vision materials ordered before coverage ended are delivered, and the services rendered to the insured person are within 31 days of such an order.
- Lost or broken lenses, frames, glasses or contact lenses, until the benefit resets.
- Not all materials are available at all provider locations.
- Members can’t combine benefits with any discount, promotional offer or other group benefits plans.
- Allowances are one-time use benefits unless otherwise noted.
- Members can’t use remaining balances for additional pairs unless the plan provides a declining balance benefit.

We’ll notify you of any changes to this list. Insurance companies who underwrite our plans may have additional limitations and exclusions.
Section 4
Getting paid

Admit it, you came to this section first, didn’t you? That’s okay. This is important stuff. In this section we’ll give the specifics on how to submit various claims, what information must be on those claims and when you can expect payment.
How much will I get paid?

Reimbursement information was included with your contract, either when you first started on the network or when you signed your new contract with us. When you file claims online, you’ll see exactly what you’ll be paid for the member’s specific services and materials. You can view copies of your contract and fee schedule here on inFocus.

Reimbursements for progressives and lens options are detailed in the Lens Option Schedules.

If you’re using our lab network, you’ll be responsible for lab/lens charge backs, which are listed in the Lens and Option Charge Back Schedule. On the other hand, when using in-office finishing, you’ll receive an additional $7 dispensing for single vision lenses.
Lens and options payments

Reimbursements for progressives and lens options are detailed in the Lens Option Schedules. There is no additional reimbursement for dispensing polycarbonate for claims filed under the Safety Eyewear Program.

If you’re using our lab network, you’ll be responsible for lab/lens charge backs, which are listed in the Lens and Option Charge Back Schedule. On the other hand, when using in-office finishing, you’ll receive an additional $7 dispensing for single vision lenses. Learn more about in-office finishing.

If you practice in Alaska, California, Hawaii, Oregon or Washington, you’ll receive an additional $15 on base lenses to account for higher costs of living in these states, unless incorporated into your fee schedules. The additional payment pertains to online and paper claims but doesn’t apply to Select plans.
Frame payments

When you submit lab orders through our online claims system, frames reimbursements include a frame dispensing fee and a frame payment amount. The frame dispensing fee is listed on the fee schedule.

We calculate the frame payment amount using a market-based frame factor, the retail frame allowance and the retail frame price. The frame factor is indicated on the top line of the Fee Schedule. Here’s an example when using our lab network:

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Benefit: $120 Frame Allowance</td>
<td>$120</td>
</tr>
<tr>
<td>Frame Retail Price: $175</td>
<td></td>
</tr>
<tr>
<td>Frame Factor (FF) on Network Schedule: 2.6</td>
<td></td>
</tr>
</tbody>
</table>

\[
\text{\$120 allowance / 2.6 "frame factor"} = \text{\$46.15}
\]

\[
\text{Scheduled dispensing fee} + \text{\$20.00} = \text{\$66.15}
\]

\[
\text{Member out-of-pocket cost($175 - \$120 = \$55; \$55 \times 80\% = \$44)} + \text{\$44.00} = \text{\$110.15}
\]

When you don’t use a contracted lab to make eyewear, you’ll be paid according to the amounts listed under the Claims Submitted Outside of Our Claims System section on your fee schedules.

For Pediatric Vision Benefits, you’ll receive a flat payment for frames. For more details, see the Pediatric Vision Benefits fee schedule.
Low vision payments

When you provide the low vision supplemental testing and low vision aids, we’ll reimburse 100% of U&C up to the member’s allowance amount, which varies by plan. You can’t balance bill the member for any amount over the allowance, unless the benefit indicates that you can.
Submitting claims

How do I get paid?

To receive payment, you’ll have to file claims. Everything you need to know about claims is right here.

Claims contact information

- **phone**: 888.581.3648
- **fax**: 866.293.7373
- **mail**: EyeMed/FAA
  PO Box 8504
  Mason, OH
  45040-7111
- **online**: eyemed.com
  select Providers, then Log In
Dual eligible members

Some members are eligible for both Medicare and Medicaid. When treating these members, don’t collect copays. Instead, accept the payment amount from the Medicare Advantage payer in full or bill the state. See the legal language in our Policies and Procedures. The same section also includes the unique dual eligible language that applies to Humana plans.
Timely filing

For most plans, you have 180 days from the service date to submit the claim or file corrected claims. For Medicare members, you have 12 months to file the claim. If you don’t file the claim in time, you can’t go back to collect the money from the member.

Some plans have shorter filing periods. We recommend you check the plan’s claim filing period when you confirm benefits and eligibility. If you have any questions about claim filing timelines, call us at 888.581.3648.

These plans have unique filing limits:

<table>
<thead>
<tr>
<th>Plan name</th>
<th>Filing limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcatel-Lucent</td>
<td>15 months from date of service</td>
</tr>
<tr>
<td>Anthem (Blue View Vision)</td>
<td>12 months from date of service</td>
</tr>
<tr>
<td>AT&amp;T Ameritech</td>
<td>90 days after the end of calendar year</td>
</tr>
<tr>
<td>AT&amp;T Vision Plan Enhanced</td>
<td>90 days after the end of calendar year</td>
</tr>
<tr>
<td>AT&amp;T Vision Care</td>
<td>15 months from date of service</td>
</tr>
<tr>
<td>AT&amp;T Retiree Vision &amp; Low Vision</td>
<td>6 months from date of service</td>
</tr>
<tr>
<td>BCBS North Carolina</td>
<td>18 months from date of service</td>
</tr>
<tr>
<td>CBS Corporation</td>
<td>June 30th of the year following the year services are provided</td>
</tr>
<tr>
<td>Frito Lay</td>
<td>2 years from date of service</td>
</tr>
<tr>
<td>Hewlett Packard</td>
<td>18 months from date of service</td>
</tr>
<tr>
<td>Quaker Foods</td>
<td>2 years from date of service</td>
</tr>
<tr>
<td>SAMBA</td>
<td>2 years from date of service</td>
</tr>
<tr>
<td>Time Warner</td>
<td>2 years from date of service</td>
</tr>
<tr>
<td>Tropicana Products</td>
<td>2 years from date of service</td>
</tr>
</tbody>
</table>

(This list is subject to change.)

If you participate on the EmblemHealth Medicaid network in New York, claims must be filed within 90 days, and corrected claims must be submitted within 45 days of denial.
Electronic data interface – EDI

We offer providers the ability to submit claims electronically using 837 inbound format through outside clearinghouses. You will need to accept an alternative fee schedule, as you will not be able to submit lab orders using 837. To begin the process, contact us at 888.581.3648.
Coordinating benefits

Working together

We’re the primary vision benefits carrier and don’t take payments from other providers when we calculate payments. We’ll coordinate benefits only for the following plans as long as you submit the proper paperwork (including an EOB or remittance from another carrier showing non-payment of a portion of the claim):

- Accenture
- Anthem (Blue View Vision)
- AT&T
- Delta Dental of Kansas (Surency)
- Enterprise Holdings
- Humana
- Kohler Co.
- Northeast Delta Dental
- Operating Engineers
- Samba
- Schneider National
- State of Illinois
- Tufts

The FEDVIP plan through Aetna has a unique coordination of benefits policy.

Medicaid follows different coordination of benefits guidelines. See the Medicaid section in Exceptions to the Rule for more information.

So what do you if the member has a different idea than you do about where to file the claim? See our guidelines here.
The claims process

Down to business

Before you get started, you have to sign up for our online claims system. Providers tell us it’s easy to use, but in case you need help, everything you need to know about it is in the Basics section of inFocus. Step-by-step instructions for submitting online claims are part of our system user guides.

Step 1: Do they have EyeMed benefits?

We know how it goes when you ask patients if they have any vision benefits. They open a wallet, show you a bunch of insurance cards and say “Pick one.” How do you sort through the dizzying array of logos? It may actually be easier than you think. If they have EyeMed benefits (with or without an ID card), file the claim with us. We’re also the routine vision plan for many health and dental companies. [View the full list of “private label” or reseller groups.]

Step 2: Are they covered?

Eligibility is important. Luckily, it’s easy to find out who is covered under our plans. We encourage you to verify members’ coverage before the member’s appointment. This way, you’ll know exactly what the member’s benefits are.

[If the member has a common name (think John Smith), double-check that you have the right person by verifying the person’s plan name and address so you don’t accidentally file the claim under the wrong person.]

Just use the Member Search function of our online claims system. For best results, search by the member’s name and DOB. We don’t collect SSN info for all members, so that’s not a good way to search. Remember that ID card? It may have a member ID on it, or it might not. Don’t confuse the group number, which has 7 digits and usually starts with the number 9, with the member ID. You can use the Member ID to search for members.

Some plans may still require authorizations. Authorizations don’t guarantee payment. If you authorize services and the member ends up canceling, be sure to void the authorization online or by calling us at 888.581.3648.

If the member isn’t covered under our plans — or if their coverage has expired before the date of service — they’re responsible for all payments.

Step 3: Back to the claims system

After the appointment, you’ll need to file the claim. Submitting claims online is easy, and it’s the fastest way to get paid. Plus, you don’t have to look for a pen. We’ve combined claims submission and lab ordering into one easy-to-use system.
When filing claims for contact lens fitting and follow-up, make sure it’s on the same claim with either the eye exam or the contact lenses, and on the same date of service.

After the services have been provided, you’ll go back to the online claims system at www.eyemed.com and sign in. Not everyone can use our lab network yet. If you can order eyewear through our contracted labs, all of the options you need will be available when you log into the system.
Coding claims

Most claims codes are pretty standard, and you won’t need to know them if you use the online claims system (all the hard work is done on the back end). For hard copy claims and special processes, we ask you to use our Preferred Claims Codes. We might also deny codes not on this list, based on the member’s plan and benefits.

Eye exam codes

In case you’re wondering, we use CPT codes 92004 and 92014 for eye exams because they describe specific definitions for what a comprehensive eye exam should include. We don’t work with any employer groups that recognize S0620 or S0621 codes — so don’t use these codes — because their definition of an eye exam is limited to the title.

Diagnosis and procedure codes

20% of claims on average should have high-risk diagnosis codes

An annual eye exam is the entry point into the health care system for many people. Employers can use information from a comprehensive eye exam to provide valuable health information to members, health plans and disease management consultants working on their behalf.

This is why we require participating providers to submit all applicable ICD-10 diagnosis codes when filing a claim. The online claims system allows you to note primary and high risk diagnoses, including abnormal pupil, ARMD, cataract, diabetes, diabetic retinopathy, glaucoma, hypercholesterolemia and hypertension. You should report these based on information you get from the patient’s history, any reported medications and your clinical findings during your evaluation.

You can also use CPT II codes to denote the patient’s risk for diabetic retinopathy.

You should select the appropriate code(s) even though you are just providing routine vision care services. The diagnosis codes are not tied to the services you provide. These codes don’t impact how members apply their benefit or what we reimburse you, but they do help us add a more thorough approach to health and wellness for employer groups.
Hard copy claims

Drop it to paper

We’re not an authorized forms supplier, so we can’t give you CMS 1500 forms. But, we know a guy. Check here for more information.

Using the online claims system is the fastest way to submit claims and get paid, but in some circumstances you’ll have to submit a hard copy of a CMS 1500 form. You’ll read more about these situations below.

When submitting hard copy claims, be sure to include the primary and secondary diagnosis codes on the form, as we need these to comply with HEDIS reporting requirements. Using other codes can delay your payment. When filing vision exam claims, be sure to include all relevant high-risk diagnosis codes. And if you indicate in box 29 of the form that the member paid in full, we’ll reimburse the member instead of you.

Make sure you haven’t already started the claim online. Even if you haven’t hit the Submit button yet, we’ll deny hard copy claims when an online claim is already in-process for the same transaction.

Labs can’t accept hard copy, manual or paper orders for providers who are contracted on our updated business model. If labs receive any claim forms, they’ll return them to you unprocessed.

Any plans, services or materials requiring a CMS 1500 hard copy submission are not eligible for lab ordering.

As we mentioned earlier, you have to submit claims requiring lab orders directly through our online claims system. If you send us a hard copy claim for materials that should have been submitted to a lab though our online claims system, we’ll reimburse you according to the new modified reimbursement schedule located on the various network schedules. In this situation, you’re responsible for all lab and eyewear fabrication costs, and you can’t bill the member for the balance.
Health plan claims

You’ll file Aetna and Anthem (Blue View Vision) claims through our system. We share more about this in the Exceptions to the Rule section.

Billing the same service on the same date of service to multiple entities is not appropriate.

We consider duplicate billing of a claim for the same service (CPT code) on the same date of service to multiple entities inappropriate billing. We’ve discovered this billing practice is common in some offices who then request a withhold if both the medical and vision plan approve and pay the claims. We understand errors can occur, however, if we see a pattern of this billing practice, we’ll report it to the medical plan in question to be investigated. We’ll also place the practice in a level of non-compliance that could lead to termination from the network.
Special claims processes

Out of the ordinary

Some things just have to be different. Certain situations require special procedures, usually because we need to look for specific requirements during the claims process. You can see exactly what’s covered by these benefits in the How Our Plans Work section.
Refraction-only claims

Our plans don’t cover refraction separate from the eye exam (except for VDT plans or Fallon Community Health Plan). (Refer to our Comprehensive Eye Exam Guidelines for the full list of services covered under the exam.) We consider the refraction (CPT 92015) part of a comprehensive eye exam. The only time we’ll reimburse you for refraction by itself is when we’re contracted to coordinate benefits for the group. Please refer to the Coordination of Benefits section for a list of groups refraction-only claims apply to. You can view more about our policy on refraction.

Should this happen, here’s the process to follow:

- Collect only the medical carrier’s eye exam copay from the member, if applicable. Don’t collect any exam copays that would apply under our plan.
- After you receive payment from the medical carrier, submit a CMS 1500 form with only the refraction code (leave the exam off) and attach a copy of the EOB from the primary payer showing that an exam was rendered. We’ll reimburse you your U&C for the refraction up to the maximum exam reimbursement.

Claims for refraction services can’t be submitted to us when Tufts Health Plan covers the member.
Fit and follow-up-only claims

Most plans require you to file the contact lens fitting with the routine exam, but some exceptions do apply. Please contact us at 888.581.3648 to determine whether the fitting should be filed on the claim with the exam or the materials.

We'll process fit and follow-up-only claims only when the member files an exam claim with their medical carrier and the fitting is denied. Here's the process if you have to file such a claim:

- After you receive payment from the medical carrier, submit a CMS 1500 form along with the member's medical plan explanation of benefit statement showing the medical carrier's payment.
- We'll reimburse you for the fitting if the plan has a reimbursable fitting benefit and the member is eligible.

We can't reimburse fitting only claims submitted on behalf of members who are covered by an Anthem Blue View Vision or Tufts Health Plan.
Post-cataract eyewear claims

Claims for post-cataract benefits must include details about the member's surgery, so you can't obtain an authorization online. You'll supply the date of the surgery and the eye operated on over the phone at 888.581.3648 (the representative will record the surgery information in the authorization notes). You can proceed to file the claim online, but you will not use a contracted lab for eyewear fabrication.
Pediatric Vision Benefit claims

You’ll file claims online for Pediatric Vision Benefits and use a contracted network lab to make the lenses. If the plan is a pre-deductible plan, you will still submit an online claim for tracking purposes, but you won’t use the lab network, and you won’t receive a payment from us.

Pediatric Vision Plan – Medically Necessary Second Pairs of Glasses

As described earlier, members of Pediatric Vision Benefits plans in Kentucky and New York may be eligible for one or more additional pairs of eyewear if they meet certain qualifying conditions. Follow the process below to file claims for these benefits:

- Contact the call center at 888.581.3648 so we can verify the member’s coverage and eligibility.
- If the benefit is available, you’ll receive an authorization number and a Medically Necessary Additional Pairs of Glasses claim form.
- Complete the form and fax it to 866.293.7373.
- Contact the member to return and order glasses or contact lenses.
- If the Member/Dependent is denied for Medical Exception services, we’ll send you a written explanation of the denial determination.

You won’t use a contracted network lab to make medically necessary additional pairs of glasses.

For multiple pair benefits in Kansas, you’ll file the claim online and use the lab network as usual.
VDT claims

When verifying VDT benefits in the online claims system, the standard plan and VDT plan will be listed as 2 separate plans. Simply select the member’s name associated with the VDT plan and use our normal authorization and claims process. When covered, order VDT eyewear through the lab network.

If you’re using a paper claim, use code 92015TG to bill the VDT refraction.
KidsEyes claims

File claims for KidsEyes as you would our standard vision plans.
Emergency Service claims when using the lab network

If you’re using our lab network, you’ll have to use a CMS 1500 claim form with the applicable service codes to submit an Emergency Service claim. In the special instructions area, indicate “Emergency Service” and the reason why it was an emergency.

You’re responsible for the total lab bill and should pay the lab directly. We’ll process the claim and pay you based on Appendix 4 of your professional agreement.

The Ordering Eyewear section describes the situations that qualify as Emergency Services through our lab network.
Diabetic Eye Care plan claims

Members of our Diabetic Eye Care plans have 2 separate Plan IDs. Their initial eye exam is covered under their routine vision plan. If follow-up care is required as a result of diabetes, file a claim for the additional services under the diabetic plan. The plan name in the online claims system identifies which member record to use for the diabetic eye care services.

You’ll want to review the details of Diabetic Eye Care plans.

Use a hard copy CMS 1500 form to submit claims for services covered by our Diabetic Eye Care plans. Indicate “Diabetic” on the top of the form and include a valid diagnosis code so we pay you correctly. Once you complete the form, fax it to 866.293.7373.
Medical eye care claims

We recommend you file claims for medical eye care using standard 837 electronic claims submission. If you aren’t set up for 837, you can submit in hard copy using a CMS 1500 form. Fax the completed form to 866.293.7373 and write “MEDICAL SERVICES” on the top of the form.

You can submit multiple dates of service and multiple service lines on the same claim, but only 1 provider should be listed on each claim.

For services that do not require pre-authorization, we’ll match the procedure and diagnosis codes for relevance. See the Medical/Surgical Plan section for more information about pre-authorization requirements.

Since medical eye care plans don’t cover materials, use of the lab network doesn’t apply.

Some services require pre-authorization. Review the Medical/Surgical Eye Care section for more information.

Fallon Community Health Plan (FCHP) and Tufts Health Plan do things differently. If you see their members, be sure to review the processes in the Exceptions to the Rule section.
Low vision claims

Because of the unique nature of low vision needs, we require pre-approval before extending low vision benefits. To obtain pre-approval for low vision benefits, fax the Low Vision Approval Request Form with the invoice or catalog sheet to 866.552.9115, or email it to us. If we approve the form, you’ll receive an approval letter and authorization. If we don’t approve the form, you’ll receive an explanation why.

Once you receive approval for low vision benefits, you can go ahead and submit the low vision benefit claim by faxing a completed CMS 1500 claim form to 866.293.7373. Make sure you include the following information:

- Your provider information.
- Proper diagnosis codes.
- Proper material codes.
- Authorization number.
- Stamped or handwritten line indicating “Low Vision Exam or Aids.”
- Your fax, phone and email address.
- Copy of the low vision approval letter.
- And don’t forget to sign the form.

We don’t accept low vision claims online, and you can’t use our lab network.
Contact lenses when the allowance includes both fit and follow-up and materials

As we explained in our overview of plans, contact lens benefits for some plans combine the fit and follow-up and materials into 1 allowance. How you file the claim depends on how you and the member decide to handle the allowance.

If you’re going to use the full allowance for materials

Don’t get an authorization for fit and follow-up services. Collect your full U&G from the member. The provider dispensing the contact lenses will collect any copayments and obtain the authorization/file the claim for the materials.

If you’re splitting the allowance between the fit and follow-up and materials

Submit the fit and follow-up with the eye exam claim. The materials provider will submit the claim for the contact lenses based on the remaining allowance amount. To make this work, both the exam and materials providers need to communicate with each other about the amount of the allowance used for the fit and follow-up.

Did you know?

We manually review all claims for these types of plans to ensure the benefit is applied correctly.
Safety eyewear lab ordering and filing claims

I use the EyeMed lab network

Submit lab orders to the safety-certified lab you selected through our online claims system. Select the member record associated with the plan and with the word “SAFETY” in the name. Select the appropriate lab. Then select the frame, lens and lens options from the drop-down menus. Refer to all safety catalogs and training materials. Safety-certified labs carry all safety frames so there’s no need to send in any frames with the orders. You can’t use in-office finishing or uncut lenses to fulfill a safety order. See claim system user guide for more details.

I don’t use the EyeMed lab network

If you don’t use the EyeMed lab network and you have an existing assortment of ANSI-certified safety frames, you can choose to continue to use your safety-certified lab partner to fulfill safety eyewear orders. File the claim through the online claims system.

You’re required to provide complimentary side-shields and a frame case with every safety eyewear purchase.

Hard copy safety eyewear claims

Using the online claims system is the fastest way to submit claims and get paid, but in some circumstances you may have to submit a hard copy of the CMS 1500 paper form for Safety Eyewear Program claims.

If you use our lab network, these circumstances include emergency safety eyewear orders. See below for Emergency Lab Orders When Using the Lab Network. Any safety eyewear claims submitted via paper will be paid based on the Safety Fee Schedule for non EyeMed lab orders.

Refer to the Hard Copy Claims section in the Provider Manual for more information.

837 claims

As always, you can submit claims using 837 inbound format.
Vision therapy claims

Two groups currently have coverage for vision therapy: State of Delaware and Tufts Health Plan. You can view the specifics of both plans in the Exceptions to the Rule section.

For vision therapy claims, you’ll use a CMS 1500 form and:

- File only 1 claim per date of service.
- Write a valid CPT code and the Plan ID on the claim form.
- Write “Vision Therapy” on the top of the form and in box 11c of the form.
- Fax the completed CMS 1500 claim form to 866.293.7373.
Medicaid claims

You'll file claims for Medicaid benefits online following our normal process.
Telemedicine claims

You can file the claim online as you normally would. You must comply with our telemedicine policy.
Surgical eye care claims

We recommend you file claims for surgical procedures using standard 837 electronic claims submission. If you aren’t set up for 837, you can submit in hard copy using a CMS 1500 form. Fax the completed form to 866.293.7373 and write “MEDICAL SERVICES” on the top of the form.

You can submit multiple dates of service and multiple service lines on the same claim, but only 1 provider should be listed on each claim.

For services that do not require pre-authorization, we’ll match the procedure and diagnosis codes for relevance.

See the Medical/Surgical Plans section for more about required pre-authorizations for some procedures and injections.
Correcting claims

Correcting claims when using our lab network

If you ordered eyewear through our lab network and need to make a correction, contact the lab directly. Changes made with lab are automatically transmitted to us when the order is shipped. Don’t worry, though; you’ll be asked to review and approve any changes entered by the lab.

The online claims system will let you know via a pop-up message if you need to review any claims. That way, you won’t have to make multiple calls to get paid. You can either follow the link on the message or use the “Action Required” search tab to review and update the claim(s). If you don’t update the information within 15 days, payment will be calculated from the final order details received from the lab.

You can’t modify materials claims or lab orders once the lab makes the eyewear. If you request a change to an order after the lab makes the eyewear, you’ll need to pay the lab directly.

Correcting claims not submitted to our lab network

If you aren’t using the lab network, you’ll submit corrected claims to us. Even if you only need to update one service, you’ll have to resubmit the entire claim. To correct a claim, send us a CMS 1500 form with “Corrected Claim” written on the top of the form. Fax it to us at 866.293.7373.

If the corrected claim is for medically necessary contact lenses, Diabetic Eye Care, low vision services or any other special benefits, just make sure the note on the claim says so. If you have any questions about how to correct a claim or about a claim we’ve returned, call us at 888.581.3648.

Once you’ve filed an eye exam claim with us, you can’t void it so you can file it with the member’s medical plan instead. You should make the determination of where to file the claim before treating the member. If, based on your professional judgment, you believe the exam should have been paid by the medical plan instead of EyeMed, submit a corrected claim or the claim will be voided by customer service if it is an exam only claim.

Once we receive a corrected claim, we’ll void the original claim (whether online or hard copy). Be sure to submit any corrected claims prior to the filing deadlines.

You don’t have to file a corrected claim if the member changes their type of lens since there would be no change to our payment to you. Just handle any refunds or additional payments directly with the member.
Voiding claims

On second thought

If you used the lab network and need to void the materials portion of a claim, you must void the entire claim. Contact the lab directly to cancel the materials portion of an order. Labs can cancel orders at their discretion, but they can’t void an order without your approval. When members return eyewear, call us at 888.581.3648 so we make sure the member’s eyewear eligibility is corrected. It’ll take about 24 business hours before the member will be able to use their eyewear benefits again.

If you need to make a change to an order, see Order Upgrades.

If you didn’t use the lab network, submit a corrected claim, indicating that the materials were returned, and we’ll void it.

Base lens charge backs on voids

You may be responsible for paying the charge back for the base lens if the lab has already pulled and cut the lens when you cancel the order. If you’re voiding the job because the member cancelled the order, you can charge the member this base lens fee. However, you’ll want to have a written policy on remakes and refunds so members know up-front that they could be responsible for these fees. In the event of a member complaint on this issue, we’ll ask you to show us this policy.

When members return eyewear

When members return their glasses, we’ll need to know why so we can take the appropriate steps.

Returns for poor quality or non-adapt

No worries! Refer to our remake policy to replace the glasses.

Change in frame style or “no questions asked” return policy

Give us a call at 888.581.3648 if the member is taking advantage of your practice’s “no questions asked” satisfaction guarantee or simply wants to change the frame. We can reinstate the member’s benefits at your request, but you’ll be charged for the lab work based on the Lens and Option Charge Back Schedule.

Medicaid medically necessary replacements

Some Medicaid members are eligible for medically necessary eyewear replacements. Refer to the Medicaid section of the provider manual for more details.

Safety Eyewear Program returns, exchanges and voids

Returns, exchanges and voids are not processed as part of the Safety Eyewear Program, with the exception
of voids in the case a member cancels his or her order before the order is in the manufacturing process. In this case, follow our normal void process above.
Claim payments
Receiving what’s due to you

Claims are considered “clean” and ready for payment when the eyewear has been shipped from the lab back to you.

We’ll pay you promptly, but no later than 30 business days from when we receive a “clean” claim. For lab orders, the lab will let us know when the order ships. Once it ships, we’ll process the claim within 30 days. Exam portions of claims are not paid until the materials are shipped from the lab. We’ll pay shipping charges from the lab to your office for the initial order and any subsequent transactions covered by our remake policy. You’ll be responsible for any shipping charges outside of the remake policy. We’ll adjust the claims process timing as required by state law.

Did you know?
A wholly owned subsidiary of EyeMed, First American Administrators, Inc. (FAA), processes all claims.

FAA (see sidebar) generates payments weekly. If you’re still getting paper checks, you’ll receive a Remittance Advice (RA). You can also view RAs online through the Payment History section of the online claims system.

Need help deciphering those RAs? Maybe our remittance advice quick reference guide will help.

Electronic payments via direct deposit

EyeMed pays claims only by electronic funds transfer (EFT). Register for EFT by completing our online request form. All you need is your bank account number, routing number, provider ID number and federal tax ID number.

It takes about a month to set up and test direct deposit.

Once we receive your completed direct deposit form and test the electronic payment, we’ll start depositing payments into your account beginning on the next reimbursement cycle. You can access RAs for direct deposit payments through our online claims system. Your bank may charge a fee for services related to direct deposits.

Electronic payments may appear on your statement under different names. Any of the below names are payments for EyeMed claims:

<table>
<thead>
<tr>
<th>Aetna Life</th>
<th>EyeMed MVC IPA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anthem/IBM</td>
<td>Fidelity Security Life</td>
</tr>
<tr>
<td>Assignment</td>
<td>Fidelity Security Life New York</td>
</tr>
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<td>--------------------------------</td>
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</tr>
<tr>
<td>Blue Cross Blue Shield Arizona</td>
<td>Heritage Vision Plans Inc.</td>
</tr>
<tr>
<td>Blue Cross Blue Shield North Carolina</td>
<td>Holding for Humana</td>
</tr>
<tr>
<td>Combined of America</td>
<td>Humana VCP</td>
</tr>
<tr>
<td>Combined of America New York</td>
<td>Sierra</td>
</tr>
<tr>
<td>EIC Resellers</td>
<td>Security Life</td>
</tr>
<tr>
<td>Eyexam</td>
<td>Standard Security Life New York</td>
</tr>
<tr>
<td>EyeMed MVC</td>
<td>Texas HMO- Cole</td>
</tr>
</tbody>
</table>

Return to the forms page to change any of your direct deposit details, like account number.

For help reconciling payments to claims, please visit our training page.

**Payment by check**

You can choose to have checks mailed to you, but you could be charged a 5% administrative fee for this service, per section 1.6 of your provider contract. The fees will be begin 45 days after you’re notified, except for tax entities contracted in Alabama, Maryland or Oregon. To change your payment preference, use our online form.
Claims denials

When our system rejects a claim, we’ll send you a letter explaining why we denied it within 30 days and request that you correct and resubmit it. For most plans, you have up to 180 days from the service date to return the corrected claim. See the claims filing limits to double-check specific plans. When a claim is denied, you’ll be paid only when you resubmit the claim within the appropriate timeframe, and it’s accepted.

You can collect payment from members for denied claims only if we determine they weren’t eligible for benefits at the time of service.

If you used the lab network and the materials portion of your claim is denied, you’ll be billed for the cost of the materials and any associated lab charges.

Withholds

If we overpay you as part of a claim correction or complaint resolution, we’ll withhold the overage from a future remittance payment. Some of our health plan clients may request withholds if they find errors during audits. We’ll notify you if this happens.

Researching claims

Our claims system allows you to look up claims and payments. Simply go to Payment History. You can also refer to our training documents for step-by-step instructions, or use this claims payment reference.

While we offer additional support over the phone, we can’t assist third party billing companies in claims or payment research requests.
Claims appeals rights

State of California

Your request for a review of an adverse benefit determination must be submitted within 180 days of the date of your Explanation of Payment.

A copy of the specific rule, guideline, or protocol relied upon in the adverse benefit determination will be provided free of charge upon request by you or your authorized representative. You may also review the documents relevant to your claim.

You may seek review by the California Department of Insurance of a claim that an insurer has contested or denied by contacting the California Department of Insurance Consumer Communications Bureau, 300 South Spring Street, South Tower, Los Angeles, CA 90013, or call the Consumer Hotline:

1-800-927-HELP (4357)
Out-of-State Callers: 1-213-897-8921
TDD: 1-800-482-4TDD (4833)
Internet: Web site address www.insurance.ca.gov

You have a right to enter into the dispute resolution process described in Section 10123.13 of Article 1. General Provisions – California Insurance Code.

You may have other alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and the California Department of Insurance.

State of Delaware

You have the right to seek review of our decision regarding the amount of your reimbursement. The Delaware Insurance Department provides claim arbitration services which are in addition to, but do not replace, any other legal or equitable right you may have to review of this decision or any right of review based on your contract with us. You can contact the Delaware Insurance Department for information about arbitration by calling the Arbitration Secretary at 302-674-7322 or by sending an email to: DOIarbitration@state.de.us. All requests for arbitration must be filed within 60 days from the date you receive this notice; otherwise, this decision will be final.

State of Illinois

If you are not satisfied with a coverage decision, you are entitled to a review (appeal) of the benefit determination. To obtain a review, you or your authorized representative should submit your request in writing to:

Member Appeals Coordinator
EyeMed Vision Care
4000 Luxottica Place
Your request for a review of an adverse benefit determination must be submitted within 180 days of the date of your Explanation of Payment.

A copy of the specific rule, guideline, or protocol relied upon in the adverse benefit determination will be provided free of charge upon request by you or your authorized representative. You may also review the documents relevant to your claim.

Notice of Availability: Part 919 of the Rules of the Illinois Department of Insurance requires that our company advise you that, if you wish to take this matter up with the Illinois Department of Insurance, it maintains a Consumer Division in Chicago at 122 S. Michigan Ave., 19th Floor, Chicago, Illinois 60603 (312-814-2420) and in Springfield at 320 West Washington Street, Springfield, Illinois 62767 (217-782-4515) or contact the Illinois Department of Insurance at http://insurance.illinois.gov/.

You may have other alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and the Illinois Department of Insurance.

Utilization Management appeals

Refer to the Medical/Surgical Eye Care section for information about appealing utilization management decisions.
Section 5
Ordering eyewear

We’re all about giving you broad choice and the flexibility you need to offer members an exceptional experience with their eyewear. That means being able to choose from a wide selection of network labs, an extensive choice of lenses or an In-Office Finishing program option for finished single vision lenses.
Working with contracted labs

In all, our lab network consists of more than 100 labs across the country. For a complete list of labs, check out our Lab Network Listing. We’ll update this list as new labs come on board.

When working with labs, you’re in control. You choose the labs you want to work with, and you maintain a direct and personal relationship with those labs.

Once you register with the lab(s), you’ll use them to produce lenses covered by the member’s funded materials benefits. See more information on how to register with a lab or make changes once you register.

Use of our lab network only applies if you’ve signed the new EyeMed contract.
Lab and lens catalog requirements

Unless your contract allows otherwise, you must use our network labs or single vision In-Office Finishing program (if applicable), and you’re required to order lenses listed in the Essilor or Luxottica Lab Services product catalogs for EyeMed when members use their funded benefits, except for:

- Stand-alone discount programs, materials-only discount plans and discounts on additional purchases after use of the funded benefit (although you can order eyewear materials for members with discounted materials through our lab network if you choose)
- Low vision materials
- Any other benefit that requires the submission of a CMS 1500 form
- Pediatric Vision Benefits pre-deductible plans (all other plans use the lab network)
- Pediatric Vision Benefits medically necessary multiple pairs
- Any plans or groups specifically excluded
- Emergency services/situations

You can choose to order eyewear for members with discounts on materials through our lab network.

Product catalogs

Product catalogs include a wide variety of lenses and treatments to meet members’ many lifestyles. So, how do you find out which labs carry which products? It’s simple.

The catalog you use will vary depending on which lab(s) you use. All product catalogs and the charges for specific lenses are available in the downloads section of inFocus.

In your professional judgment, if it’s necessary to prescribe a lens or lens add-on not in one of the product catalogs, send the job to the lab of your choice, and it will be treated as a private pay lab transaction. You can then submit a CMS 1500 form in hard copy to receive payment according to the amounts listed under the Claims Submitted Outside of the Online Claims System section on your fee schedules. You can’t balance bill the member for any difference in reimbursement from the schedule if you order a lens that’s not in one of our catalogs.

Some specialty lenses require additional measurements. If you order one of these specialty lenses, the online claims system will prompt you to select “required” or “optional” for certain specifications. Download a summary of these Specialty Lens Parameters.

Refer to the Safety Eyewear Program section for specific safety lens products.
Placing lab orders

You’ll submit lab orders right through our online claims system at the same time you file the claim. (See the Getting Paid section for more about this.) If you need a refresher on frame requirements, see the frames section of What We Expect from You.

When you place an order with a network lab, you’ll send the frame to the chosen network lab. If you’re sending the frame(s) directly from your location, include a copy of the order confirmation. You can request a confirmation from the lab in our online claims system. If you’re drop-shipping the frame from the manufacturer, make sure to include the member’s name with the frame order.

If you don’t send the frame to the lab within 90 days of the order, the lab will cancel the job and void the claim. You’ll need to re-enter the claim if you end up sending the frames after the 90-day period has elapsed.

Safety Eyewear Program orders are treated as frame at lab. Refer to the Safety Eyewear Program for available frames catalogs and requirements.
Reconciliation of negative balance on materials

Your claims sometimes include charge backs for the cost of materials ordered through the EyeMed lab network. This can result in a negative balance on your account. In most cases, the balance gets corrected over time through the regular claim and payment process.

But, if the balance remains outstanding for an extended period, you may receive an invoice from Optical Procurement Services (OPS)* to reconcile the difference. If this happens, specific payment instructions will be sent to you.

You can always review your account, or make a payment, on the Online Claims System. Refer to the Online Claims System user guides on inFocus for step-by-step instructions for viewing and paying invoices.

*Optical Procurement Services (OPS) is responsible for procurement of lenses and is the supplier of lab materials according to your EyeMed agreement.
Lens Only Program

EyeMed’s lens only program allows network providers to receive surfaced, edged lenses directly from contracted network labs without sending a frame. You’ll be able to use the Lens Only program for most jobs. Some frames or lens edging may necessitate sending the frame to the lab. If a lens only order is submitted and cannot be filled for a specific frame or lens, the lab may notify you if identified prior to starting the lens order.

Example exclusions from Lens Only program

- Three piece/drilled rimless
- Wrap frames (those with a base curve higher than 6)
- In-line/double groove frames
- U bevel frames (zyl frames with deep groove)
- Mini/shallow bevel frame (too small for standard bevel)

To participate in the lens only program, you’ll need a tracer calibrated within manufacturer tolerances and according to manufacturer suggested schedule, with the ability to download and transmit trace data in the Vision Council standard format. We may request tracer and calibration records during our Quality Assurance process.

Look for the “Lens Only w/ Trace” button in the online claims system.

You’ll submit lens only lab orders through our online claims system. You’ll need to upload a trace file in either text (.txt) or .xml format.
format using the Vision Council standard format. Due to tracer variances, minor finishing may be required to fit the lens.

Updates, archives and remakes

You can send a lens only job using a reference to an archived trace file, but you’ll need to put a prior order or invoice number in the reference field in the online system. If the lab needs an updated trace file, you’ll send it separately from the original order. Changes to Lens Only orders, once submitted to lab, may result in a private pay transaction if the order has been started.

Our standard remake policy applies to lens only orders, with the following exceptions:

- Lens fitting issues due to tracer calibration that exceed manufacturer tolerances or are outside the suggested calibration schedule.
- Damage or breakage during lens fitting.
- Fitting issues related to the trace data supplied for lens only jobs, unless caused by lab error.

Download our Lens Only program reference sheet for future reference.
Uncut lens program

EyeMed’s uncut lens program enables network providers to receive surfaced lenses directly from EyeMed contracted network labs, allowing you to control quality and complete the edging and mounting in-office. Not having to send the frame to the lab means you and your patients will experience shorter turnaround times. The uncut program will also reduce the charge back for edging services like such as roll polish and mounting of drill mounts/semi rimless groove.

Most products and services are eligible for uncut ordering. Restrictions and recommended options are below. To participate in the uncut lens program, you need an edger and must have the ability to edge and mount frames within manufacturer tolerances.

Anyone can participate in the Uncut Program. You’ll submit uncut lens lab orders through our online claims system. The program is initially only available through LLS. If you’re not already ordering from LLS, you’ll need to register with that lab first, then, when you submit a job through them, simply choose “uncut” as the job type from the available job type list. As other labs that you are already registered for have this service available, “uncut” will appear as a job type for those labs.

Non-qualifying jobs

- Tint
- Mirror
- Lab applied UV
- Glass
- Balanced lenses
- Slab off
- Certain complex frames that require specific mounting or bevels

Restrictions and recommendations

Remakes
Our standard remake policy applies to uncut lens orders, with the following exceptions:

- Damage or breakage during edging and/or mounting of the lens.
- If you are unable to complete the edging or mounting of the frame, causing you to send a frame to the lab to complete the job.

If you decide you will provide
an edge treatment service like a polish edge or a roll and polish, you must choose that option in the available treatments when placing the uncut order. This will generate the member benefit for the service where you can enter in the Usual and Customary charge. This will not trigger a charge back, as this service will be provided by you.

You’ll also need to choose a frame type for every uncut order placed through the online claims system. This is important for frame types such as drill mounts and semi-rimless groove to ensure the member benefit is applied correctly. If you decide to complete a drill mount or semi-rimless frame, you’ll see these options on the Usual & Customary screen. This will also ensure a charge back is not assigned to these frames, as you’re performing the mounting.
In case of emergency

Emergencies happen, and when they do you may use a non-contracted lab to meet urgent member needs. So, how do we define “emergency?” It’s when, in your professional judgment, there’s a critical patient visual need that cannot be addressed through normal contract lab services.

Here are examples of emergencies in which you can use a non-contracted lab.

- A member’s safety and/or well-being is at risk without the immediate delivery of prescription eyewear.
- The member is unable to function at work or school and doesn’t have an alternate pair of glasses or contact lenses.
- Lenses or lens options not in our product catalog that you deem necessary based on your professional judgment. When filing an emergency service claim, you’ll need to explain your professional justification.
- The member suffers a loss, theft or breakage of prescription eyewear, has no alternate pair and can’t wear contact lenses.

Just so you know, requests for faster turn-around time for convenience (such as to accommodate trips, vacations or other events), for a desire for faster service, or when the member has another serviceable pair of glasses or contact lenses, aren’t considered emergencies.

In emergency situation, you can send the job to the lab of your choice, and it will be treated as a private pay lab transaction. You can then submit a CMS 1500 form in hard copy to receive payment according to the amounts listed under the Claims Submitted Outside of Our Online Claims System section on your fee schedules. You can’t balance bill the member for any difference in reimbursement from the schedule if you order a lens that’s not in one of our catalogs.

See instructions on submitting hard copy claims for emergency circumstances.
Processing lab jobs

1 week is the average lab turnaround time.

The lab will make the lenses based on the member’s prescription and options you indicated on the claim. The lab will then manufacture and insert the lens into the frame you provided, and they’ll ship the completed pair back to your office. Our goal is for the lab to ship the product back to you within 1 week from the time the lab receives the frame.
Special services

Well, isn’t that special

In most cases, eyewear covered by specialized benefits like low vision should be produced outside the lab network. The How Our Plans Work section discusses these benefits in detail, and the Getting Paid section explains how to file those claims.

You can’t order low vision aids through our network labs. For more information on low vision aids, click here.

Some plans cover additional pairs of eyewear for members who have a prescription change as a result of cataract surgery. File these claims through our online claims system and use the contracted lab to make the new lenses. See the explanation of this benefit.
Stay in good financial standing with your lab

You’ll have to stay in good financial standing with the network labs you use when you have private pay transactions with them. If you don’t, your claim may be paid according to the fees listed under the heading Claims Submitted Outside of Our Online Claim System on the back of your fee schedules.
Refunds, returns and remakes

You and the member should be satisfied with the lab’s work. If you’re not satisfied with the end product, the lab will correct reasonable remake requests as outlined below. Any financial issues resulting from the manufacturer’s product warranty should be handled between you and the lab.

First-time remake requests

You can request from network labs 1 lens remake/re-do at no charge within 6 months of the date of delivery only for the following reasons:

- Power changes (excludes power changes resulting in plano lenses).
- Axis changes.
- Base curve changes.
- Segment height/segment style changes due to non-adaptation (i.e., FT28 to Executive).
- Lens style change (except when going from a lower to higher technology like from a bifocal to a progressive)
- Transcription errors (not including transcription errors involving tints, photochromics, frames or coatings).
- Material change (i.e., glass to plastic, plastic to poly, plastic to high index plastic or glass, etc.)
- Lab errors.
- Progressive lenses under warranty.

We know people change their mind about frame styles, but labs won’t do free remakes for changes to the frame only. If a member wants to change their frame, he or she is responsible for the cost to change the frame, and you’ll handle it as a private pay transaction. Fax the request to the lab and ship the new frame to the lab with the existing pair of glasses.

To qualify for a free first-time remake, return the lenses to the same lab (within 6 months of the original delivery date) along with the original invoice/shipping slip, an explanation of why you’re returning the lens and any supporting documentation.

If a member wants to change to a lesser technology from a more advanced lens type (for instance, from a progressive lens to a bifocal), you should work with the lab to determine any charges that will apply. In this situation, members are expected to pay any charges above and beyond the original order.

After your first request for a free remake, or requests submitted to the lab after 6 months from the original delivery, additional requests must be handled as a private pay transaction between you and the lab.

When the member can’t adapt to progressives

When a member can’t adapt to progressive lenses while they’re under warranty, the lab will remake the lenses 1 time at no charge with a fitting change in the same design and material (or lesser-priced design and material).

If the member still can’t adapt to the second (remade) glasses with progressive lenses, you can request another remake to switch the member back to lined bifocals, but you’ll have to pay full invoice cost for this.
additional remake. If this happens, follow the same remake/return process outlined above.

If you must cancel an order

Once you submit a lab order through our online claims system, it’s “in process.” If you cancel an order, the lab will bill you as a private pay transaction. See detailed instructions for voiding claims and canceling orders.

Frame changes

The first-time remake/re-do policy doesn’t cover frame changes if the error is your fault or if the member doesn’t like the frame. To make a frame change, fax the request to the lab and ship the new frame to the lab. The lab will handle this as a private pay transaction between you and the lab.
Order upgrades

If you need to apply any upgrades to your lens order after it’s been sent to the lab, 1 of 2 things will happen depending on whether the lab has started manufacturing the eyeglasses. In both cases, you’ll be asked to reconcile the order in our online claims system.

Jobs not in progress

The lab will modify the order if the manufacturing process hasn’t started yet.

Jobs already in progress

An order is considered in-progress as soon as it’s submitted. At this point, the lab determines whether the online post-order reconciliation process can apply to the order, or the lab can determine it’s too late to apply the reconciliation process and the job is subject to the one-time free remake policy.

Lab determinations about when a change can be made will be consistent among all orders, whether or not through EyeMed or private pay.
Lab order questions?

If you have a question about a lab order, you should contact the lab. Phone numbers are included in the network lab directory and on our contact us reference.
Express lab orders

For patients who need glasses in a hurry, EyeMed offers a lab for faster turnaround on common lens orders. The lens assortment features polarized, anti-reflective coatings, digital single vision and digital progressive designs. Luxottica Lab Services (LLS) Express features a frame-to-come option as well as express service option for lens-only orders.

As you work with LLS Express, here are a few things to note:

- The LLS Express catalog includes single vision and digital progressive lenses for lens only and frame-to-come jobs.
- Because LLS Express believes strongly in the vision benefits of anti-reflective coatings (A/R), all products ordered include either a standard or premium A/R. Select this option under the available treatment section when placing your lab order to ensure you’re paid correctly and there’s no delay in fulfilling the order.
- Charge backs remain the same for all products.
- LLS Express accepts frame-to-come and remote trace orders ("lens only").
- Express option for Lens Only Orders will arrive 24 to 48 business hours from the time the job and trace file is received by LLS Express. Express shipments will be shipped overnight for receipt Monday through Friday.
- Frame to come orders will be shipped 24 to 48 hours from the time the frame is received at the lab.
- If you do not see LLS Express under the Set Up Other Labs option, call LLS customer service at 855.522.4545. Once new accounts are created, you’ll need to accept the terms and conditions before submitting an order. You can register for both LLS and LLS Express at the same time.

Email LLS Express if you have additional questions about the program. More information about Luxottica Lab Services is available online at http://labservices.luxottica.com.
Single Vision In-Office Finishing Program

Our single vision In-Office Finishing program allows you the flexibility you may need to offer same-day service to a member. You’ll purchase finished single vision lenses directly from Nassau Vision Group so you can offer members faster turnaround on their eyeglasses by using your in-house edging equipment.

If you’re interested in the program, you must agree to the program requirements for each location where you’ll use it, including:

- All IOF jobs must use a lens purchased through our Lens Ordering link. **Orders from other outlets are not compliant with the ordering requirement.** Orders can be placed for individual replenishment or via bulk orders. You also don’t need to replace the lenses you use with the exact lens style used.
- Your IOF claim count will be compared with your orders through our Lens Ordering link. If we notice a discrepancy between the two, we will provide you with notice of the non-compliance. If you do not explain or correct the discrepancy, we may remove your access to the IOF program.

You’ll have to activate the program in the online claims system. Follow these steps:

- After logging in to our online claims system, go to Manage My Profile in the left-hand navigation.
- Select In-Office Finishing from the sub-menu.
- Follow the on-screen instructions to activate the program.

You can’t use In-Office finishing to fulfill a safety eyewear order.
Ordering products for In-Office Finishing

When you’re ready to buy lenses, simply log in to the online claims system and click Lens Ordering in the left-hand navigation under Provider Tools. You’ll go directly to a special website where you can order a range of single vision lens styles from Essilor’s Nassau Vision Group, including:

- Aspheric and non-aspheric options.
- High index, polycarbonate and trivex materials.
- Photochromics.
- A/R Coating, including Crizal® products.

If you need help with lens ordering for In-Office Finishing: email Nassau Vision Group or call them at 800.787.3214.

You’re not required to buy a large inventory of these lenses to keep on hand, though you’re welcome to do so. Note that the program requires you to order your replenishments through the EyeMed stock site, hosted by Nassau Vision Group. However, you don’t have to replace your lenses with the exact lens style used. Orders from other outlets do not count toward the ordering requirement.
In-Office Finishing claims stay simple

When it’s time to make the glasses for the member using In-Office Finishing, you’ll file the claim like you always do. The only difference is that you’ll click the In-Office Finishing button when you get to the lens entry section. You’ll still need to tell us a few things about the lenses, like coatings and style, but you won’t have to submit the order through our lab network.
In-Office Finishing payment

When you use our single vision In-Office Finishing program, we'll pay you an extra $7 single vision lens dispensing fee in addition to your dispensing fee and the member's payment (excluding declining balance and package plans).
Section 6
Exceptions to the rule

We’ve been told people like quirks, those unique traits and oddities that set us apart from one another. That’s a good thing. If we were all the same, the world would be a pretty boring place. In this section we’ll show slight variations that apply only to certain plans.
Private label plans

Their name, our plan

We work with several groups — mostly health plans and dental carriers — that offer EyeMed’s plans to their members under their own name. These members might not know they are using one of our plans, and their ID cards might have another plan name on them.

Rest assured, these are still our plans, just under a different name, and you should treat these individuals as you would any other member. That includes submitting their claims through our online claims system.

Remember to check an individual’s eligibility to confirm his or her benefits. To make it a bit easier, we’ve compiled a list of other organization names that might appear on member ID cards. Give us a call at 888.581.3648 if you have any questions or before turning away any potential members so we can verify their participation.
Blue View Vision (Anthem)

One of our largest private label resellers is Anthem, which markets routine vision plans under the names Blue View Vision, UniView Vision and other names.

Most Blue View Vision plans are pretty easy. You’ll follow the same process to look up members, request authorizations and file claims that you do with EyeMed members.

Our online reference tool walks you through the ins and outs of all of Blue View Vision’s products and includes sample ID cards, a list of product names and the latest news. (This link will only work if you’re on the Blue View Vision network.)

Each year Blue View Vision requires certain providers to verify the practice information on file with EyeMed. Visit the Provider Verification page to verify your practice information or to update your information on file. Failure to do so can result in termination from the Anthem network or removal from the in-network provider locator.

Blue View Vision post-cataract lens exceptions

Some Blue View Vision groups have additional coverage for eyewear after members have surgery for cataracts. When this applies, members are loaded into 2 plans — their routine vision care benefit and their post-cataract plan. The post-cataract plan will be clearly identified in the plan name (e.g., WellPoint POST-CAT).

Follow this process for post-cataract plans.
Aetna Vision Network

Through our relationship with Aetna, optometrists have the unique opportunity to be part of Aetna’s routine vision and medical networks. You’re welcome to add Aetna plans as long as you’ve agreed to Aetna’s Medical Addendum and Aetna Fee Schedules. To join the Aetna AVP network, complete our online request form. FAA administers Aetna’s Vision Network and pays claims on their behalf. You don’t have to participate on any other EyeMed networks to be part of the Aetna medical network.

Want to know more about Aetna? We’ve created a whole reference section just to help you (the link will only work if you’re on the Aetna Vision Network). If you still need help, call us at 888.581.3648.

Aetna Vision claims

If you’re a participating provider on the Aetna Vision Network, you’ll submit claims for routine eye exams through our online claims system. The member search process is slightly different. After logging in, select Aetna Members from the home page instead of immediately doing a member search.

As an Aetna Vision Network provider, you’re also an in-network provider for medical eye care services covered through members’ Aetna medical plan. You should submit claims for these services directly with Aetna.

Aetna Vision discounts

Aetna members receive savings on additional purchases according to Aetna’s discount schedule.

Aetna withholds

For Aetna members, eye exams are considered part of their medical plan. Because of this, deductibles and other benefits might not show up in our system when you perform the initial member search.

There are certain situations where Aetna determines that the member is responsible for payment. In this event, Aetna informs us that the vision claim is ineligible for payment, requiring us to withhold payment. Aetna then informs the member why Aetna denied the claim, and you’re responsible for billing the member for the amount that was denied.

Leaving the Aetna network

Once you no longer take Aetna routine vision plans through us, you’ll also be removed from the Aetna medical network.
If you decide you no longer want to take Aetna plans, we understand. Just let us know by completing our online form for Network Request.

Please see our special section about the FEDVIP program through Aetna for special coordination of benefits processes.

If you’re in New York, be sure to read about Aetna’s medically necessary eyewear benefits for Pediatric Vision Benefits members.
Client-specific plan rules

Every rule has its exceptions, and so do our plans. Following are a few exceptions we want to point out.
Vibracoustic

Frame and lens benefits from this routine plan can be applied toward safety eyewear. Members who use their frame and lens benefit toward the purchase of safety eyewear will not be eligible for a routine pair of glasses or contacts.

When filing these claims, use CPT codes for standard eyewear rather than for safety eyewear. You will not use the contracted lab network for safety eyewear under this plan, and you can file the claim using a CMS 1500 form.
FEDVIP (through Aetna)

As you probably know, the Federal Employees Dental & Vision Insurance Program (FEDVIP) is available to some federal and US Postal Service employees. Aetna Vision Preferred (AVP) is one of the voluntary vision benefits choices under FEDVIP.

Because the benefits are offered through Aetna, members will have AVP-branded ID cards like the one below.

Don’t use social security number to look up FEDVIP members; you’re likely to pull up the medical benefits instead of the vision.

FEDVIP members might also have Aetna for their medical benefits, so we offer a few tips to make sure you file claims correctly:
First off, ask for the member’s vision and medical plan ID cards because you’ll need to know the member’s medical plan for coordination of benefit reasons. More on that later.

Instead of using the Aetna search, you’ll want to look up these members using the regular EyeMed Member Search. Use the “W” ID on the member’s AVP card to most quickly find the member’s AVP benefit.

If you see the member is part of either the Aetna FEDVIP Standard 2 (Plan ID 9892399) or the Aetna FEDVIP High 2 (Plan ID 9892407) plans, you’ll know the person has Aetna for medical and vision. In this situation, you’ll file the claim with us through our online claims system.

Should the member give you a medical ID card other than Aetna, or the person’s plan is called Aetna FEDVIP Standard Plan or Aetna FEDVIP High Plan (Plan IDs 9885963 and 9885971 respectively), the member has medical benefits through a company other than Aetna.

The member’s medical benefits are primary if you participate on the medical network. You can file claims for any denied services with us using a CMS 1500 form as long as you attach the medical plan’s denial.

FEDVIP Coordination of Benefits process

It’s important to know all of this background information because the medical plan is primary in this situation. If you’re a participating provider on the medical network, file the eye exam and eyewear claim with the medical plan first. You can then submit any denied portion of the claim to us on a hard copy CMS 1500 form (be sure to attach the denial), and we’ll coordinate benefits.
If you’re not on the medical plan network, just file the claim with us.
AT&T

New!

Three of AT&T’s plans allow members to coordinate benefits. These plans include:

- AT&T Vision Plan 0001E - 9727074
- AT&T Vision Plan 0001E 2nd Pair - 9727082
- AT&T Retiree Vision Care-E - 9745993

AT&T members can’t coordinate benefits between their primary plan and their secondary pair plan. The secondary pair plan is only used for the second pair of glasses the member purchases.

All other AT&T plans follow our standard coordination of benefits policy.
American Greetings

Frame and lens benefits from this routine plan can be applied toward safety eyewear. Members who use their frame and lens benefits toward the purchase of safety eyewear will not be eligible for a routine pair of glasses or contacts.

Safety glasses for this plan are not available through network labs, and you will use a CMS 1500 form to submit the claim.
Johnson & Johnson

Johnson & Johnson members receive a paid-in-full annual supply, as defined by the manufacturer’s guidelines, of contact lenses manufactured/marketed by Johnson & Johnson (ACUVUE). Reimbursement is 100% up to MSRP. Refer to the member’s benefit for details.

For reference

MSRP 2018

Contact lens code modifier list
California (Health Net)

To allow for specific reporting of diabetic retinopathy, please use the below disease diagnosis codes for Health Net members:

- CPT II 3072F for low risk for retinopathy (no evidence of retinopathy in the prior year)
- CPT codes 92004, 92014, 92012 and 920002 or CPT II code 3072F for NO diabetic retinopathy
CareMore Health Plan Medical/Surgical Benefits

EyeMed administers routine vision and medical and surgical eye care benefits in the Tucson/Phoenix and Las Vegas markets for members of CareMore Health Plan, a Medicare Advantage plan.

You’ll now more easily remain a part of patients’ care by being able to perform a wide array of eye care up to the extent of your license. Refer to your CareMore Primary Eye Care fee schedules for a list of covered procedures.

Please refer to the [Medical/Surgical Eye Care section](#) for details about utilization management and other requirements of the program.

Recognizing CareMore members

CareMore members will present their Medicare Advantage ID card.
Referrals

Referrals from the member's primary care physician are no longer required for CareMore members to receive vision care through EyeMed participating providers.

Payment and claims

Medical and surgical eye care claims for CareMore members should be sent to the address below:

EyeMed Vision Care/FAA
Attn: Medical & Surgical Claims
P.O. Box 8526
Mason, OH 45040
Quad Graphics

Quad Graphics allows members to use their routine vision plan for safety eyewear. When filing these claims, use CPT codes for standard eyewear rather than for safety eyewear for this plan, and you can file the claim using a CMS 1500 form. Do not use the EyeMed lab network.
Railroad Employees National Vision Plan

Railroad Employees National Vision Plan allows members to use their routine vision plan for safety eyewear. When filing these claims, use CPT codes for standard eyewear rather than for safety eyewear. You will not use the contracted lab network for safety eyewear ordered under this plan.

In addition, the Railroad Employees National Vision plan members may have a benefit for contact lenses after cataract surgery. The benefit includes 1 paid in full contact lens per eye following surgery and is available once per each surgery the member has.

Follow this process to submit claims for these benefits:

- Submit a CMS 1500 form.
- Write “Railroad Employees Post-Cat Plan” on the top of the form.
- Put the date of the surgery on the claim form.
Northern Michigan University

Frame and lens benefits from this routine plan can be applied toward safety eyewear. Members who use their frame and lens benefit toward the purchase of safety eyewear will not be eligible for a routine pair of glasses or contacts.

When filing these claims, use CPT codes for standard eyewear rather than for safety eyewear. You will not use the contracted lab network for safety eyewear under this plan, and you can file the claim using a CMS 1500 form.
Xerox

Kids under age 13 can receive a second pair of covered lenses during the benefit year if they experience a diopter change of + or – 0.50 or more.
National IAM Benefits Trust

Frame and lens benefits from this routine plan can be applied toward safety eyewear. Members who use their frame and lens benefit toward the purchase of safety eyewear will not be eligible for a routine pair of glasses or contacts.

When filing these claims, use CPT codes for standard eyewear rather than for safety eyewear. You will not use the contracted lab network for safety eyewear for this plan, and you can file the claim using a CMS 1500 form.
Arizona

New! BCBS of Arizona

Blue Cross Blue Shield of Arizona (BCBSAZ) BluePreferred Eyewear plans provide a materials benefit for eyeglasses, contact lenses and contact lens fit and follow-up. Members receive eye exam benefits through their BCBSAZ medical plan. Because of this, you need to contract and be credentialed with BCBSAZ. You can begin this process by visiting their credentialing website.

If you’re not currently a participating provider for BCBSAZ, please refer members to a participating optometrist or ophthalmologist for eye exams. (They can find providers online or by calling 800.232.2345.) Once the eye exam has been performed by an in-network doctor, the member can return to your location for eyewear and, if applicable, contact lens fit and follow-up services.
SCAN Health Plan (California)

To allow for specific reporting of diabetic retinopathy, please use the below disease diagnosis codes for SCAN members:

- CPT II 3072F for low risk for retinopathy (no evidence of retinopathy in the prior year)
- CPT codes 92004, 92014, 92012 and 92002 or CPT II code 3072F for NO diabetic retinopathy
Blue Cross Blue Shield of Rhode Island

BCBSRI is one of several health plans using EyeMed’s Pediatric Vision Benefits for eyewear. The eye exam will be part of the member’s medical plan and will be reimbursed by BCBSRI. We’re expecting about 15,000 covered children under these plans, which will occur upon their 2014 renewal.

If you’re already participating with BCBSRI, file the eye exam claim with BCBSRI, then file the eyewear claim through EyeMed.
If you’re not participating with BCBSRI, the eye exam will be out-of-network for the member. You’re also welcome to apply to the BCBSRI network online.

Standalone Blue Cross Vision plans

BCBSRI began offering Blue Cross Vision plans using the EyeMed network on January 1, 2014. BCBSRI offers 2 allowance plans for eyewear and 3 standalone vision plans that cover both the eye exam and eyewear. The Blue Cross Vision plans will be offered to groups as they renew.

Blue Cross Vision members who have other BCBSRI coverage (like medical or dental) will present a BCBSRI card with EyeMed’s phone number, like the one that follows.

Members who have Blue Cross Vision without another type of BCBSRI coverage will receive a custom EyeMed ID card like the one below. Regardless of the ID card, you should file all eyewear claims through us for Blue Cross Vision members.
Health Net Pediatric Vision Benefits (California)

Health Net will cover an annual supply of contact lenses of any type under Pediatric Vision Benefits. (See the Pediatric Vision Benefits fee schedules for reimbursement information.) Health Net’s PPO members can also qualify for medically necessary contact lenses if they suffer from pathological myopia, corneal disorder or post-traumatic disorder, in addition to the other qualifying conditions.

View the process of submitting claims for covered additional pairs of eyewear for Pediatric Vision Benefits members.
Delaware – State of Delaware

The State of Delaware vision plan includes benefits for vision therapy evaluation and therapy sessions as detailed below:

<table>
<thead>
<tr>
<th>Vision care service</th>
<th>Patient payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam evaluation* - 1 every 12 months</td>
<td>$0</td>
</tr>
<tr>
<td>Therapy sessions** - Up to 10 every 12 months</td>
<td>25% of U&amp;C</td>
</tr>
<tr>
<td>Exam evaluation* - 1 every 12 months</td>
<td>$0</td>
</tr>
</tbody>
</table>

* CPT Code 92060: Sensorimotor examination with multiple measurements of ocular derivation, with interpretation and report.

** CPT Code 92065: Orthoptic and/or pleoptic training, with continual medical direction and evaluation.

To qualify for vision therapy benefits, the member must meet one or more of the following conditions:

Accommodative disorders

- Paresis of accommodation H52.54 – H525.29
- Complete internal ophthalmoplegia H525.11 – H525.19
- Spasm of accommodation H52.531 – H52.539

Amblyopia

- Strabismus amblyopia H53.031 – H53.039
- Refractive amblyopia H53.021 – H53.029

Non-strabismic binocular disorders

- Binocular vision disorder, unspecified H53.30
- Suppression of binocular vision H53.34
- Simultaneous visual perception without fusion H53.33
- Fusion with defective stereopsis H53.32
- Intermittent heterophoria, unspecified H50.30
- Heterophoria, unspecified H50.40
- Esophoria H50.51
- Exophoria H50.52
- Vertical hyperphoria H50.53
- Cyclophoria H50.54
- Alternating hyperphoria H50.55
- Spasm of conjugate gaze H51.0
- Convergence insufficiency or palsy H51.11
- Convergence excess or spams H51.12
- Anomalies of divergence H51.8

**Strabismus**

- Monocular esotropia with other noncomittances H50.041 - H5.0042
- Alternating esotropia H50.05
- Alternating esotropia with a pattern H50.06
- Alternating esotropia with v pattern H50.07
- Exotropia, unspecified H50.10
- Monocular exotropia H50.111 – H50.112
- Monocular exotropia w/ other noncomitances H50.141 – H50.142
- Alternating exotropia H50.15
- Alternating exotropia w/ other noncomitances H50.18
- Intermittent esotropia monocular H50.331 – H50.332
- Intermittent esotropia alternating H50.32
- Intermittent exotropia alternating H50.34
- Hypertropia H50.21 – H50.22
- Hypotropia H50.21 – H502.2
- Cyclotropia H50.411 – H50.412
- Monofixation syndrome H50.42
- Accommodative component in esotropia H50.43

See the process for submitting claims for vision therapy benefits.
Tufts Health Plan

Tufts Health Plan primary eye care exceptions

For Tufts, the primary diagnosis codes submitted on the claim will determine whether the exam is paid under the member’s routine vision care or primary eye care plan. Because we administer both plans for Tufts, it’s important to follow the guidelines below to ensure your claim is paid appropriately and quickly.

<table>
<thead>
<tr>
<th>Provider type</th>
<th>Primary diagnosis code*</th>
<th>Secondary diagnosis code*</th>
<th>Type of benefits</th>
<th>Claim filing process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Optometrist</td>
<td>Routine</td>
<td>Routine or Medical</td>
<td>Routine</td>
<td>Online Claims System</td>
</tr>
<tr>
<td></td>
<td>Medical</td>
<td>Routine or Medical</td>
<td>Medical Eye Care</td>
<td>CMS 1500 Form</td>
</tr>
<tr>
<td>Ophthalmologist</td>
<td>Routine</td>
<td>Routine or Medical</td>
<td>Routine</td>
<td>Online Claims System</td>
</tr>
<tr>
<td></td>
<td>Medical</td>
<td>Routine or Medical</td>
<td>Medical</td>
<td>Tufts medical claim process</td>
</tr>
</tbody>
</table>

*In most cases, if the member has a pre-existing high-risk medical condition, the primary diagnosis code will be for routine eye care. The medical condition would then be submitted as a secondary diagnosis code. If the member comes to you for treatment of complications or symptoms of a medical condition, or such symptoms prevent you from obtaining a quality refraction, the medical condition would be considered the primary diagnosis and the eye exam would be covered by the member’s medical eye care benefits.

Use the below as a guide for determining whether a condition is considered medical or routine:

<table>
<thead>
<tr>
<th>ICD-10 Diagnosis Codes</th>
<th>Primary Diagnosis</th>
<th>Age 18 or under</th>
<th>Over age 19</th>
</tr>
</thead>
<tbody>
<tr>
<td>H53.0001 – H53.029</td>
<td>Amblyopia</td>
<td>Medical</td>
<td>Routine</td>
</tr>
<tr>
<td>H50.000 – H50.008</td>
<td>Esotropia</td>
<td>Medical</td>
<td>Routine</td>
</tr>
<tr>
<td>H50.10 – H50.18</td>
<td>Exotropia</td>
<td>Medical</td>
<td>Routine</td>
</tr>
</tbody>
</table>

If any of the below diagnoses are listed as primary, the claim will be paid as medical.
<table>
<thead>
<tr>
<th>ICD-10 Diagnosis Codes</th>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>H26.0001 - H26.9</td>
<td>Cataract</td>
</tr>
<tr>
<td>E11.9 - E10.8, E08.15 - E13.39, E08.311</td>
<td>Diabetes</td>
</tr>
<tr>
<td>H40.0001 - H40.9</td>
<td>Glaucoma</td>
</tr>
<tr>
<td>H35.031 - H35.039, H01.001 - H01.009, H43.811 - H53.819</td>
<td>Other</td>
</tr>
</tbody>
</table>

If you put a medical diagnosis code in the primary diagnosis field of the claim, we’ll deny the claim.

View your for Tufts Primary Eye Care fee schedules for Massachusetts and New Hampshire.

Medicare preferred member therapeutic lens/post-cataract exception

Tufts Health Plan Medicare Preferred members are covered for one pair of standard eyeglasses or contact lenses if their prescription changes after cataract surgery.

After cataract surgery, the plan only covers corrective lenses or frames without a lens implant (tints, anti-reflective coating, UV lenses or oversized lenses), and only when a treating physician deems it medically necessary. No prior authorization is required.

These members are also covered for one pair of standard eyeglasses every year (includes standard frames and single-vision, bifocal or trifocal lenses) or contact lenses per prescription change for keratoconus, anisometropia (more than 3.0 diopters) or high myopia (more than 7.0 diopters). No prior authorization is required.

Commercial member therapeutic/post-cataract lens exceptions

Tufts Health Plan Commercial plan members must meet certain criteria to qualify for lenses only after cataract surgery. These members may also receive additional benefits for lenses if they meet a defined criterion that qualifies the eyewear as “therapeutic.”

Tufts Health Plan commercial member therapeutic/post-cataract lens qualifying conditions
- Conditions that result in the loss of the natural lens of the eye:
  - Aphakia
  - Post cataract surgery
- Additional conditions:
  - Keratoconus
  - Anisometropia (more than 3.0 diopters)
  - High myopia (more than 7.0 diopters)
  - Persistent epithelial defects
  - Post corneal transplant perforations
  - Aniridia

Therapeutic/post-cataract lens services are available to members who have a medical condition that has caused vision loss and requires a prescription change. The member must be under the care of a physician for one of the qualifying conditions listed here.

The first time a Tufts Health Plan commercial member uses the therapeutic/post-cataract lens benefit, there’s no pre-authorization required. Simply complete and fax a CMS 1500 claim form to 866.293.7373.

If a member wishes to use the therapeutic/post-cataract lens benefit for a second time in a calendar year, you should obtain prior authorization from Tufts Health Plan, unless the member is requesting the lens post-cataract surgery.

To request pre-authorization, fax a letter of medical necessity to the Tufts Health Plan Pre-certification Department at 617.972.9409.

If you receive approval for the benefit, complete a CMS 1500 form.
claim form for the service and fax it with a copy of the pre-authorization letter from Tufts Health Plan to 866.293.7373.

Vision therapy

Tufts Health Plan Commercial members are eligible for vision therapy benefits limited to a maximum of 30 visits per lifetime. Vision therapy is not covered for Tufts Health Plan Medicare Preferred members.

For Tufts Health Plan, the vision therapy CPT code is 92065 and you can only submit one claim per visit. To submit the claim, fax the completed CMS 1500 claim form to 866.293.7373.
Ohio

HealthSpan, an Ohio-based health plan owned by Mercy Health, requires you to submit a Patient Eye Care Report after performing an eye exam on one of its members. The form allows HealthSpan to collect important information about the member’s exam results and follow-up recommendations. Download the form [here](#), and fax it to 216.635.4476 when complete.
Michigan – Priority Health

New!

PriorityVision routine vision diagnosis codes

- Hyperopia H52.01 – H52.03
- Myopia H52.10 – H52.13
- Astigmatism, unspecified
  H52.201 – H52.209
- Regular astigmatism
  H52.221 – H52.229
- Irregular astigmatism
  H52.211 – H52.219
- Anisometropia H52.31
- Aniseikonia H52.32
- Presbyopia H52.4
- Transient refractive change
  H52.6
- Unspecified disorder of refraction and accommodation H52.7
- Emmetropia

Priority Health determines whether services are covered by routine vision or medical benefits based on the member’s diagnosis. Before quoting benefits or providing services to PriorityVision members, be sure to conduct a member search to access the member’s specific plan information. If you’re unsure about a specific benefit, you can call us at 888.581.3648.

If the member’s primary diagnosis is one of the codes listed here, file the claim with us. Any other codes are considered medical, and you...
should file the claims directly with Priority Health. When you file a medical eye care claim that includes refraction, you can submit the refraction services to us for reimbursement after Priority Health pays its portion of the claim.

For assistance with PriorityVision benefits, contact us at 888.581.3648.

Here’s the process for submitting the claim:

**Step 1 – File the medical eye care claim**

- Submit the claim to Priority Health for the comprehensive exam (92004), applicable medical diagnosis code(s) and refraction (92015).
- Priority Health will:
  - Reimburse you for the exam (92004/92014) with applicable medical diagnosis codes.
  - Deny the refraction (92015).
  - Provide documentation showing the refraction denial.

**Step 2 – Submit the refraction claim to us for reimbursement**
- Submit a CMS 1500 form to us for refraction (92015) and attach Priority Health’s refraction denial.
- Send the claim to us at EyeMed/FAA, ATTN: Claims Department, PO Box 8504, Mason, OH 45040-7111, or via fax to 866.293.7373.
- We’ll reimburse you for the refraction up to our eye exam reimbursement rate.
- The member’s eye exam benefit through PriorityVision will be used, and the member will be ineligible for a routine eye exam until the next benefit period.
Blue Cross Blue Shield of Massachusetts

As of May 1, Blue Cross Blue Shield of Massachusetts (BCBSMA) is pleased to begin offering members Blue 20/20, a new standalone vision plan offered and managed by BCBSMA and powered by Blue 20/20. Plans use both EyeMed’s Access and Insight networks for routine vision exams, materials, and eyewear discounts.

Members with Blue 20/20 vision benefits will receive a separate, co-branded ID card (shown below).

Vision care providers should check eligibility and file claims for routine vision care covered under the Blue 20/20 plan through EyeMed’s online claims system.

When a member requires something other than routine vision care, they should seek medical care from a Blue Cross Blue Shield participating provider—Blue 20/20 does not provide coverage for medical care. For information about becoming a BCBSMA provider, visit https://provider.bluecrossma.com/Provider and click on Office Resources > Enrollment > Become a Blue Cross Provider.
Nevada – Health Plan of Nevada (HPN)

HPN members have different discounts on additional purchases than our other plans.

<table>
<thead>
<tr>
<th>Additional services</th>
<th>Member pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam</td>
<td>Balance over $5</td>
</tr>
</tbody>
</table>

*Lens (Standard)*

<table>
<thead>
<tr>
<th>Lens (Standard)</th>
<th>Member pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single vision</td>
<td>$35 Copay</td>
</tr>
<tr>
<td>Bifocal</td>
<td>$55 Copay</td>
</tr>
<tr>
<td>Trifocal</td>
<td>$90 Copay</td>
</tr>
<tr>
<td>Standard progressive lens</td>
<td>$100 Copay</td>
</tr>
<tr>
<td>Premium progressive lens</td>
<td>$100 Copay</td>
</tr>
<tr>
<td>Lenticular</td>
<td>$90 Copay</td>
</tr>
<tr>
<td>Other lens types</td>
<td>80% of Charge</td>
</tr>
</tbody>
</table>

*Frame*

<table>
<thead>
<tr>
<th>Frame</th>
<th>Member pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frame</td>
<td>Retail price of $0 - $130: 55% of Charge</td>
</tr>
<tr>
<td></td>
<td>Retail price over $130.01:</td>
</tr>
<tr>
<td></td>
<td>$71.50 Copay + 80% of balance over $130</td>
</tr>
</tbody>
</table>

*Lens options (in addition to standard lenses)*

<table>
<thead>
<tr>
<th>Lens options (in addition to standard lenses)</th>
<th>Member pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard polycarbonate</td>
<td>$35 Copay</td>
</tr>
<tr>
<td>Standard plastic scratch coating</td>
<td>$15 Copay</td>
</tr>
<tr>
<td>Tint</td>
<td>$12 Copay</td>
</tr>
<tr>
<td>UV treatment</td>
<td>$12 Copay</td>
</tr>
<tr>
<td>Standard anti-reflective (A/R) Coating</td>
<td>$45 Copay</td>
</tr>
<tr>
<td>Other coatings</td>
<td>80% of Charge</td>
</tr>
<tr>
<td>Service</td>
<td>Percentage of Charge</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>Glass</td>
<td>80% of Charge</td>
</tr>
<tr>
<td>Other lens options</td>
<td>80% of Charge</td>
</tr>
<tr>
<td><strong>Contact lenses</strong></td>
<td></td>
</tr>
<tr>
<td>Contact lens – conventional</td>
<td>85% of Charge</td>
</tr>
<tr>
<td>Contact lens – disposable</td>
<td>100% of Charge</td>
</tr>
<tr>
<td>Standard fit &amp; follow up</td>
<td>Balance over $5</td>
</tr>
<tr>
<td><strong>Non-scheduled items</strong></td>
<td></td>
</tr>
<tr>
<td>Non-scheduled Item – Retail</td>
<td>80% of Charge</td>
</tr>
</tbody>
</table>
Fallon Community Health Plan (FCHP)

Refraction reimbursement – MassHealth and NaviCare

You'll receive a separate reimbursement of $12.51 for refraction services performed during a comprehensive eye exam for members of Mass Health Routine (Group ID 9823253) and Navicare Routine (9823246).

You can file the claim for the refraction on our online claims system. Simply select Refraction as a service provided when filing the exam claim. If you need to file the claim in hard copy, use CPT code 92015. Make sure to file the refraction claim at the same time as the eye exam claim.

Fallon medical eye care

FCHP requires ophthalmologists to file claims for medical eye care services directly with them. Optometrists submit medical eye care claims to us following the normal process outlined in the Getting Paid section.

Whether you’re an optometrist or ophthalmologist, the primary diagnosis code must be a medical diagnosis for the claim to be filed as primary eye care. Any claims with routine vision diagnosis codes will be processed as a comprehensive eye exam through us.

See your primary eye care fee schedules for Fallon.

NaviCare Navigator

FCHP also offers 2 NaviCare programs. One of these programs is NaviCare HMO SNP, a Medicare Advantage Special Needs Plan. The other is NaviCare SCO, a Senior Care Options program.

Members of these programs have access to a single point of contact, called a Navigator, to organize services and care. The Navigator can authorize services not normally covered under the benefit plan, including increased benefit allowances, coverage of non-covered items or eligibility extensions.

When members use the service, the Navigator will contact you and explain the additional benefits. Go ahead and provide the indicated services at no additional charge to the member. We'll reimburse you.

If the member is still eligible in our system, you can submit the claim for all the services online. Your expected payment in the claims system will not include the additional services, however, we'll adjust your actual claim payment accordingly.

If the member is no longer eligible for any services according to our system (preventing you from filing an online claim), please submit the claim to us in hard copy using a CMS 1500 form.
New York

HealthNow Pediatric Vision Benefits

Members of HealthNow’s Pediatric Vision Benefits plans can receive new glasses or contact lenses for any prescription change (with no limit on the number of pairs). Use this process to submit claims.

HealthNow Continuity of Care

You’re required to forward all pertinent information relating to the health care of a member to any of the member’s providers for inclusion in the member’s medical record, and to notify such providers of any significant change in the member’s medical condition.

Aetna Pediatric Vision Benefits – New York Only

Aetna members can receive a 2nd pair of glasses or contact lenses for any prescription change, or if they meet any of the criteria for additional pairs of eyewear under the Pediatric Vision Benefits.
TRICARE through Humana Military

If you participate on TRICARE through Humana Military, special provisions apply. Please refer to the TRICARE section on inFocus to access training tools and provider manual materials related to the program.
Virginia

Humana Select and Humana Medicare Plans

Note the following provisions that apply to Humana Select and Humana Medicare plans in Virginia:

Virginia Medicaid Web Portal

DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility, claims status, payment status, service limits, service authorizations, and electronic copies of remittance advices.

Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: www.virginiamedicaid.dmas.virginia.gov. If you have any questions regarding the Virginia Medicaid Web Portal, please contact the Xerox State Healthcare Web Portal Support Helpdesk, toll free, at 866.352.0496 from 8:00 a.m. to 5:00 p.m. Monday through Friday, except holidays. The MediCall audio response system provides similar information and can be accessed by calling 800.884.9730 or 800.772.9996. Both options are available at no cost to the provider. Providers may also access service authorization information including status via KEPRO’s Provider Portal.

Copies of Manuals

DMAS publishes electronic and printable copies of its Provider Manuals and Medicaid Memoranda on the DMAS Web Portal. This link opens up a page that contains all of the various communications to providers, including Provider Manuals and Medicaid Memoranda. The Internet is the most efficient means to receive and review current provider information. If you do not have access to the Internet or would like a paper copy of a manual, you can order it by contacting Commonwealth-Martin at 804.780.0076. A fee will be charged for the printing and mailing of the manuals and manual updates that are requested.

“HELPLINE”

The “HELPLINE” is available to answer questions Monday through Friday from 8:00 a.m. to 5:00 p.m. Eastern time, except on holidays. The “HELPLINE” numbers are:

- 804.786.6273 Richmond area and out-of-state long distance
- 800.552.8627 All other areas (in-state, toll-free long distance)

Please remember that the “HELPLINE” is for provider use only. Please have your Medicaid Provider Identification Number available when you call.
Medicaid

EyeMed administers Medicaid plans for specific health plans in certain states. Not all providers on the EyeMed network participate on Medicaid networks, and participation is dependent on acceptance of a contract amendment and fee schedules specific to the plan or state.
Medicaid network participation

As a member of the Medicaid network, you need to follow both EyeMed and the State Medicaid agency processes and requirements.

Medicaid network participation requires that you’re “member ready” before we activate your participation on the locator. Member readiness requires that you:

- Are enrolled in your State Medicaid program in good standing with Medicaid ID
- Are registered with Medicaid-participating lab for the plan
- Have a Medicaid frame kit at your location and ready for use by members

If you would like to opt out of the Medicaid network, you can do so by completing our online Network Request forms.
Medicaid Provider ID

All providers (both the rendering provider and the billing provider) must be an enrolled Medicaid provider in good standing and have an active Medicaid ID prior to providing services to a Medicaid member. The Medicaid Agency in your state assigns this ID.
Medicaid eye exam benefits

Many Medicaid plans include additional eye exams when medically necessary due to a change in vision. Make sure to view the member’s plan benefits for qualifications. The additional medically necessary benefit will be covered if the member’s vision changes by greater than 0.50 diopter. To file the claim online for additional eye exams, use the Medically Necessary tab on the Member Benefits page and be sure to enter a medical necessity reason code on the U&C page of the claims filing process.
Medicaid eyewear

Frame selection and frame kit

To comply with the Medicaid benefit requirements, members will choose from a specific selection of frames, provide their own frame or purchase a new frame from your dispensary. Members must choose from the pre-selected frames from the Medicaid frame catalog.

You’ll receive a Medicaid Frame Kit for participating in the Medicaid Network at no cost after you register for a Medicaid-participating lab. The frames in the frame kit are for display only and should not be sent to the lab when placing orders. They represent a selection of the frames available in the Medicaid frame catalog. You’ll order both the frame and lenses when placing the lab order through the online claims system using the “Lab Supplied” frame option. For step-by-step instructions, refer to the claims system user guide for placing lab orders.

The frame kit is the property of the lab and should be used only in conjunction with Medicaid plans. If you decide to leave the program, you’ll need to return the kit to the lab at your expense. Kits and replacement frames can be ordered directly from the lab.

If you don’t use the EyeMed lab network, Medicaid members may choose from a selection of frames you offer. Your frame selection must include at least 36 ANSI-approved frames that meet the following criteria:

- 12 girls’ frames, varied materials
- 12 boys’ frames, varied materials
- 6 women’s frames, varied materials
- 6 men’s frames, varied materials
- Eye size assortment between 42 and 57

Patient-supplied frames

Members may supply their own ophthalmic frames provided that the frames are in good repair and able to hold the new lens or they may purchase a new frame in a separate transaction from their benefit transaction. If the member elects to provide their own frame, indicate “Patient Supplied” in the frame source field and “Frame to Come” or “Lens Only w/Trace” as the job type. Also enter the frame information as part of the order.

If you are sending the order as “Frame to Come,” you must send the frame to the lab using a shipping service with tracking capabilities and signature required to show the lab received the frame prior to filing any claim loss. The lab liability is limited to a maximum of $50 in the event a frame in a “frame to come” order is damaged, lost in transit back to the provider, or during the production process.

Refer to our Medicaid Claims Filing Job Aid for more information.
Lab registration and orders

To register for a Medicaid lab, log on to the online claims system and choose Register for Labs from the left-hand menu. Be sure to choose the option to “Set up Medicaid labs” or “Set up other labs.” For step-by-step instructions, see our claims system user guides.

Eyewear orders for Medicaid members will be manufactured at a specific network of labs equipped to carry the eligible frames and process frame at lab claims. The list of Medicaid labs is available here. LINK You must register for a Medicaid lab before you can service Medicaid patients. Once you register, you’ll receive your Medicaid frame kit within approximately 2 weeks.

Even if you don’t use the EyeMed lab network for your non-Medicaid member eyewear orders, you can register to use an EyeMed Medicaid lab for Medicaid members. Or, you can continue to use your lab partner or in-house finishing to fulfill Medicaid materials.

When placing orders for Medicaid members, you’ll use a specific product catalog of lenses, options and add-ons.

Lenses and options

**Polycarbonate.** Polycarbonate lenses are covered as the standard material for all eyewear. Polycarbonate lenses should be used whenever clinically appropriate.

**Two pairs in lieu of bifocals.** Patients 70 and over are eligible for 2 pairs of glasses, reading and distance, in lieu of bifocals. Patients 69 and under are eligible for 2 pairs of glasses, reading and distance, in lieu of bifocals only if you believe the member cannot tolerate bifocals. Use the Medically Necessary tab in the online claims system to file claims and/or place orders for the additional pair of glasses.

**Lens options.** Covered lens options vary from state to state. Please the Medicaid Client Details section to see what is considered medically necessary for each plan.

When submitting a claim online that includes medically necessary lens options, you must enter a medically necessary reason in the system on the U&C page for it to be paid. For the member’s first pair of covered glasses, you’ll use the Routine tab on the Member Benefits page. If you’re submitting a paper claim that includes medically necessary lens options, include the modifier “RP” along with the V-code below.

Contact lenses

Under the Medicaid plan, contact lenses are covered only for patients with a medical necessity that precludes them from wearing glasses. When members of Medicaid meet qualifying conditions, they can use their eyewear benefit for contact lenses in lieu of both frames and lenses. Please refer to the Medical Necessity Qualifying Conditions document for details.

The Medicaid medically necessary contact lens benefit covers the below materials:

**Medically Necessary Contact Lenses**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
</table>

May 2018
Proprietary and Confidential - For use by EyeMed network providers only

- TRADE SECRETS
You’ll be paid for medically necessary contact lenses based on the Medicaid fee schedule.

You can file these claims online by clicking on the Medically Necessary tab on the Member Benefit page of the claims system. You must indicate one of the qualifying diagnoses codes for the claim to be accepted. If you need to file a paper claim, you can do so using a CMS 1500 form. Just be sure you note the qualifying diagnosis and a reason code.

Replacement eyewear

The first time doctor redo policy at network labs does not apply to Medicaid members. If glasses need to be remade due to error during the ordering process, contact the lab directly to make arrangements to have the glasses remade at your cost.

However, Medicaid covers the replacement of lost or destroyed eyeglasses. The member is also eligible for covered replacement eyeglasses if the patient’s diopter changes by 0.50 or greater.

Replacement eyeglasses due to loss or breakage must duplicate the original prescription and frames. Coverage also includes the repair or replacement of eyeglass parts when the damage results from causes other than defective workmanship. Replacement parts must duplicate the original prescription and frames. Repairs to, and replacements of, frames and/or lenses must be rendered as needed.

Claims for replacement eyewear can be submitted in the online claims system under the “Medically Necessary” tab. Please select the appropriate diagnosis code and reason code on the U&C page of the claims.
submission process. For replacement eyewear, use the ST code (see below for more about medical necessity reason codes).

If you’re submitting a paper claim for a covered pair of replacement eyewear, please add the modifier “RP” even if the replacement is due to a diopter change. Discard broken or returned glasses.

Replacement contact lenses are covered when the contact lenses were initially covered as medically necessary, or if they meet medical necessity and the patient has experienced a diopter change of .50 or greater.

**Medical necessity guidelines**

Medical necessity can be met for any of the below reasons.

- **Prescription (RX)** – Patient has a prescription strength or medical condition that necessitated a medically necessary lens option for adequate vision correction.
- **Situational (ST)** – Patient has a circumstantial clinical need that required a specific treatment for adequate vision correction.
- **Previous Order (PO)** – Patient is unable to wear multi-focal lenses.

**Tips for filing medically necessary claims for Medicaid**

- Always include a reason code
- Indicate the appropriate diagnosis code for a qualifying condition
- When filing paper claims, use the RP reason code modifier only
- Use the Medically Necessary tab in the online claims system for contact lenses, additional eye exams, replacement eyewear or second pairs of glasses in lieu of bifocals
- Use the Routine tab in the online claims system for medically necessary lens options on the member’s first pair of glasses

EyeMed expects you to have appropriate documentation to support medically necessary claims. You should maintain
up-to-date, detailed and organized medical records documenting your clinical findings. EyeMed may request access to records as part of our audit process. We’ll be looking to see that the documented prescription supports the qualifying condition submitted. If the record doesn’t support this condition, we’ll recoup any overpayment by withholding payment on future claim(s) where law permits.

As you may know, we can consider an inaccurate submission to be a false claim. Falsifying information or filing false claims can result in disciplinary action up to and including termination from our network. If we believe you’ve filed a false claim, we might also have to report it to regulatory and law enforcement agencies as appropriate.

See the full Quality Assurance process for Medicaid.

Member liability for non-covered services and materials

Members can request services not covered or fully covered under the Medicaid plan. In those circumstances, you can bill the member, provided the member agrees in writing that he or she is willing to accept payment responsibility. If a member chooses non-covered materials, the member is fully responsible for the cost.

The provider must inform the member prior to rendering the non-covered service that the
service is not covered, and that member will be financially responsible. Failure to notify members at the time of service could result in you being financially responsible for the services even if the member verbally agreed to those services or paid for them up front.

To protect your practice from financial responsibility, have the member complete a signed waiver specifically listing the materials, services and costs not covered under Medicaid coverage, and acknowledgement that they are financially responsible for those items. Make sure the date of service, your practice information and a reason for the visit is listed. Give the member a copy and keep the original in the patient’s file. We have a sample waiver form available for you to use.
Medicaid claims filing limits

Medicaid claims must be filed no later than 90 days from the date of service. Rejected or denied claims can be corrected and resubmitted for provider payment within 45 days of denial.
Medicaid coordination of benefits

When a Medicaid member has benefits through multiple plans or “dual coverage,” you’ll need to know what plan is primary and what plan is secondary or tertiary. **Medicaid is always the payor of last resort.** You’ll file the claim with the primary plan first, then submit the claim to EyeMed as the secondary plan once an explanation of payment (EOP) and possibly a payment is received from the primary plan. Follow our normal coordination of benefits process.
Medicaid provider appeals and grievances

EyeMed’s Quality Assurance (QA) team will review any participating provider complaints or appeals of clinical issues. We’re committed to providing a fair and impartial review. We use an independent review process with different subject matter experts at each level of the appeal or complaint process.

You can appeal a ruling by our QA Team, by following the below process.

- Submit a written appeal to us within 45 business days from the resolution date.
- A subcommittee composed of individuals not involved in the original resolution will review the complaint.
- The subcommittee will communicate its decision in writing.

Other requirements of the Centers of Medicare and Medicaid Services Part C (Medicare Advantage & Managed Medicaid Plans) exist. All providers participating in an EyeMed network offers services to Medicare Advantage plan members and some to Managed Medicaid members.
Medicaid clients

Specific state and health plan requirements for Medicaid will be grouped by client name.
EmblemHealth Medicaid/HAARP

EmblemHealth Medicaid members reside in the Emblem Medicaid service area, which consists of the following New York counties: Brooklyn (Kings), Bronx, Queens, Manhattan (New York), Staten Island (Richmond), Nassau, Suffolk, Westchester.

Recognizing members

Emblem Medicaid NY members will have an EmblemHealth ID card.

*Just because a member shows you an EmblemHealth Medicaid ID card does not mean he or she is eligible for services and/or materials. Verify eligibility for the date of service to see the exact benefits available.

Lens options

Per state of New York regulation, a lens option is considered medically necessary only when it is required to provide adequate vision correction to a member. Refer to the list of the Qualifying Conditions for EmblemHealth Medicaid Medical Necessity.

When submitting a claim online that includes medically necessary lens options, you must enter a medically necessary reason in the system on the U&C page for it to be paid. For the member’s first pair of covered glasses, you’ll use the Routine tab on the Member Benefits page. If you’re submitting a paper claim that includes medically necessary lens options, include the modifier “RP” along with the V-code below.

Covered medically necessary lens options

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>V2715</td>
<td>Prism Out of Range</td>
</tr>
<tr>
<td>V2783</td>
<td>High Index</td>
</tr>
<tr>
<td>V2700</td>
<td>Balance Lens</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>----------</td>
<td>---------------------------------------</td>
</tr>
<tr>
<td>V2799</td>
<td>Center Thickness</td>
</tr>
<tr>
<td>V2025</td>
<td>Deluxe Frame</td>
</tr>
<tr>
<td>S1002</td>
<td>Multi Focal Glass</td>
</tr>
<tr>
<td>V243022</td>
<td>Multi Focal Plastic (1.50) Aspheric</td>
</tr>
<tr>
<td>V243022</td>
<td>Multi Focal Plastic (1.53-1.59) Aspheric</td>
</tr>
<tr>
<td>V243022</td>
<td>Multi Focal Plastic (1.60-1.66) Aspheric</td>
</tr>
<tr>
<td>V243022</td>
<td>Multi Focal Plastic (1.67-1.69) Aspheric</td>
</tr>
<tr>
<td>V243022</td>
<td>Multi Focal Poly Aspheric</td>
</tr>
<tr>
<td>S1002</td>
<td>Single Vision Glass</td>
</tr>
<tr>
<td>V241022</td>
<td>Single Vision Plastic (1.50) Aspheric</td>
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<td>V241022</td>
<td>Single Vision Plastic (1.70-1.74+) Aspheric</td>
</tr>
<tr>
<td>V241022</td>
<td>Single Vision Poly Aspheric</td>
</tr>
<tr>
<td>V2710</td>
<td>Slab Off</td>
</tr>
<tr>
<td>V2745UB</td>
<td>Tint Double Gradient</td>
</tr>
<tr>
<td>V2745/V2745UA</td>
<td>Tint Solid / Gradient</td>
</tr>
<tr>
<td>V2745UB</td>
<td>Tint Triple Gradient</td>
</tr>
<tr>
<td>V2300 – V2314</td>
<td>Trifocal Lens</td>
</tr>
</tbody>
</table>

Any lens options not listed above are not covered under the EmblemHealth Medicaid plan.
Independent Health Medicaid

Independent Health MediSource/MediSource Connect, Essential Plans 3 & 4 /Child Health Plus, State of New York

Independent Health Medicaid members will reside in the Independent Health Medicaid service area of Erie and Niagara counties in New York.

If you would like to opt out of the Independent Health Medicaid network, you can do so by completing our online Network Request form, which is available through www.eyemedinfocus.com.

Recognizing members

Independent Health Medicaid NY members will have an Independent Health ID card.

*Just because a member shows you an Independent Health Medicaid ID card does not mean he or she is eligible for services and/or materials. Verify eligibility for the date of service to see the exact benefits available.

Lenses and options

**Polycarbonate.** Polycarbonate lenses are covered as the standard material for all eyewear. Polycarbonate lenses should be used whenever clinically appropriate.

**Two pairs in lieu of bifocals.** Patients 70 and over are eligible for 2 pairs of glasses, reading and distance, in lieu of bifocals. Patients 69 and under are eligible for 2 pairs of glasses, reading and distance, in lieu of
bifocals only if you believe the member cannot tolerate bifocals. Use the Medically Necessary tab in the online claims system to file claims and/or place orders for the additional pair of glasses.

**Lens options.** Per state of New York regulation, a lens option is considered medically necessary only when it is required to provide adequate vision correction to a member. Refer to the list of the [Qualifying Conditions for New York Medicaid Medical Necessity](#).

When submitting a claim online that includes medically necessary lens options, you must enter a medically necessary reason in the system on the U&C page for it to be paid. For the member’s first pair of covered glasses, you’ll use the Routine tab on the Member Benefits page. If you’re submitting a paper claim that includes medically necessary lens options, include the modifier “RP” along with the V-code below.

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<td>V241022</td>
<td>Single Vision Plastic (1.60-1.66) Aspheric</td>
</tr>
</tbody>
</table>
Any lens options not listed above are not covered under the Independent Health Medicaid plan.

Contact lenses

Under the Independent Health Medicaid plan, contact lenses are covered only for patients with a medical necessity that precludes them from wearing glasses. When members of Independent Health Medicaid meet qualifying conditions, they can use their eyewear benefit for contact lenses in lieu of both frames and lenses. Please refer to the Qualifying Conditions for New York Medicaid Medical Necessity document for details.

The Independent Health medically necessary contact lens benefit covers the below materials:

**Medically Necessary Contact Lenses**

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>92310</td>
<td>Fitting of Contact Lens; bilateral; for medical necessity</td>
</tr>
<tr>
<td>92071</td>
<td>Premium Fitting of Contact Lens; Keratoconus; unilateral</td>
</tr>
<tr>
<td>92072</td>
<td>Fitting and dispensing of contact lens; bandage lens including supply of lens</td>
</tr>
<tr>
<td>V2500</td>
<td>Contact Lens Pmma; Spherical</td>
</tr>
<tr>
<td>V2501</td>
<td>Contact Lens Pmma; Toric/Prism</td>
</tr>
<tr>
<td>V2503</td>
<td>Contact Lens Pmma, for correction of color deficiency</td>
</tr>
<tr>
<td>V2510</td>
<td>Contact Gas Permeable; Spherical</td>
</tr>
<tr>
<td>V2511</td>
<td>Contact Toric Prism Ballast; gas perm</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>V2513</td>
<td>Contact Lens Extended Wear; gas perm</td>
</tr>
<tr>
<td>V2520</td>
<td>Contact Lens; Hydrophilic (1 or box of 6)</td>
</tr>
<tr>
<td>V2521</td>
<td>Contact lens; Hydrophilic toric (1 or box of 6)</td>
</tr>
<tr>
<td>V2530</td>
<td>Contact Lens; Hybrid</td>
</tr>
<tr>
<td>V2531</td>
<td>Contact Lens, Scleral</td>
</tr>
</tbody>
</table>

You’ll be paid for medically necessary contact lenses based on the Medicaid fee schedule.
Section 7
Policies and procedures

Warning...legal stuff ahead. In this section we’ll throw some legal terms your way and hit on some important topics, like how to comply with various regulations, handle member complaints and our evaluation and termination process. We promise to keep it as simple as we can.
Credentialing and recredentialing

Show us your credentials

Every 2 or 3 years we will confirm your qualifications through recredentialing. Want to know what to expect? Review our credentialing requirements for more information.

Any new doctors at your practice will need to be credentialed and associated to your location before they see members. Fill out our online form to start that process.
Rights during credentialing

During this process, you have the following rights:

- Right to review information. You can request to review any information submitted with the application at any time. You can also request a copy of the credentialing information received from the CVO.
- Right to correct erroneous information. If the information we receive from the CVO differs from what’s on the application, we’ll contact you. Then you’ll have 15 business days from the date of receipt to respond. This lets you correct any inaccurate information from the CVO submitted by third parties through the primary source verification process.
- Right to be informed of your application status. You can request to be informed of the status of your application at any stage of the credentialing process. The CVO will respond by phone, fax or email.

If you have any questions during the credentialing or recredentialing process, contact us. Or, you can reach us at:

Fax: 513.492.4999  
Phone: 888.581.3648  
EyeMed Vision Care  
ATTN: Credentialing Department  
4000 Luxottica Place  
Cincinnati, OH 45040
Other requirements

Rules to live by

We try to keep the rules to a minimum, but we have certain requirements other than those in the Provider Agreement and those credentialing requirements we already mentioned.

Insurance requirements

You must keep professional liability insurance in the amount of **$1,000,000 per occurrence** and **$3,000,000 aggregate**, except in those states that have limitations on liability. In these states, state law will apply. An umbrella policy can be used to meet these requirements.

DPAs and TPAs

You can use diagnostic pharmaceutical agents (DPAs) as long as the member’s age, condition type and severity and other contributing factors justify it. We require you to document when a member refuses any DPAs you recommend.

Use therapeutic pharmaceutical agents (TPAs) as appropriate when a member has a condition that requires them, but get the member’s consent. You can also refer them to another health care professional as stated in their medical care plan. As with DPAs, document member refusals or referrals.

Medicare and Medicaid

As an eye care provider, you can decide whether and how you choose to participate in federal health care programs, including Medicare. There are 3 basic categories of providers: (1) Medicare participating, (2) Non-Medicare participating, and (3) Opted out of Medicare.

EyeMed requires network providers to be eligible to participate in Medicare Advantage members. Opting out of Medicare means Medicare will cover no services provided by you and no Medicare payment can be made to you. EyeMed conducts monthly reviews to determine whether network providers are included on Medicare’s opt-out lists. Providers who do not meet this requirement will be immediately removed from the EyeMed provider panel. Pursuant to CMS requirements, if you opt out of Medicare, there is a two-year waiting period before you can be reinstated.

While you have the discretion to “opt out” of participating in federal programs, doing so means that under federal law you cannot be reimbursed for rendering services to Medicare members, including those enrolled in Medicare Advantage plans.

PECOS

Effective January 1, 2019 all EyeMed providers must be registered in Medicare’s PECOS. Medicare Advantage plan participation requires Medicare enrollment as of January 1, 2019, to continue participating in the
EyeMed network. To register in PECOS you must be enrolled in Medicare in an approved status.

Medicare offers online enrollment for all ophthalmologists (CMS-855I-Physicians & Other Part B Suppliers), optometrists (CMS-855O-Ordering & Referring Providers) and opticians (CMS-855S-Provider & Supplier Organizations) through their Provider Enrollment, Chain and Ownership System (PECOS). You will have to disclose the names of all owners of at least 5% or more within your organization as part of the application requirement. Get a jump on this requirement and enroll now. Please send EyeMed your Medicare ID upon receipt.

Providers enrolled in Medicare must revalidate their enrollment record information every three - five years as directed and scheduled by CMS. CMS contacts providers slated for revalidation individually and you must complete the revalidation process by the last day of the designated month. If you are already a Medicare provider that has not registered your enrollment on PECOS, you will need to revalidate your enrollment.

For more information about PECOS or receive help go to https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/InternetbasedPECOS.html also see the “Who should I call?” download on the CMS website.

You may access Internet-based PECOS by using the User ID and password you established when you applied on-line to the National Plan and Provider Enumeration System (NPPES) for your National Provider Identifiers (NPIs). If you did not use NPPES to obtain your NPI go to https://nppes.cms.hhs.gov/#/. If you forgot your NPPES user ID, password or need assistance contact the NPI Enumerator at 800.465.3203 or customerservice@npienumerator.com.

State Medicaid Agency Enrollment

Effective January 1, 2018, all providers that wish to participate in a Medicaid Managed Care plan served by an EyeMed network must be enrolled in the State Medicaid Agency.

Files

Record maintenance
Maintain all member records (both clinical and financial) for 10 years (or longer if state or federal requirements say so). It’s up to you to decide if you want to keep these electronically or in hard copy, as well as how long you want to keep them beyond the 10-year timeframe.

Record confidentiality and HIPAA
You must keep medical records and other protected health information confidential. Your procedures govern the use, collection, verification and removal of member information, as well as how and when to release this information. By law, you need a member’s written consent or permission from the member’s legal guardian before releasing PHI.

If we receive a report of a HIPAA complaint against you, we’ll forward the complaint to you so you can address it within your HIPAA procedures. We’ll also consider this a member complaint.

Find more information on HIPAA.

Please remember that member demographic and plan information displayed in our online claims system is proprietary and confidential and shouldn’t be shared with non-members.
Record availability
Make members’ clinical and all administrative records available to us or other authorities that are reviewing quality of care or investigating a member complaint or appeal. In the event of a member complaint or an audit, you must also provide members’ clinical and financial records upon request.

If you leave your practice or leave our network, you need to provide us with a forwarding address so members can get copies of their clinical and administrative records if needed.

Sales tax
If you’re on our new contract, you’ll find more information on how to apply sales tax to member benefits in section 1.25 of our Provider Agreement.

If you’re in a state or region that charges sales tax on eyewear, you’ll need to complete and return the Uniform Sales and Use Tax Certificate to us. If you don’t return the form, and you’re in a taxable region, you’ll be charged sales tax on your lab orders.

Luxottica good standing policy
To be eligible for participation on our networks, you have to be in good standing with Luxottica Group and all relevant subsidiaries. This includes being current with all financial obligations and complying with all contractual commitments and policies.
Federal laws

Eyeglass and contact lens prescriptions

Follow all federal and state laws regarding issuing or releasing eyeglass and contact lens prescriptions.

The FTC requires you to provide (at no cost) a copy of the eyeglass prescription immediately after you complete an eye exam. The FTC also prohibits you from requiring members to purchase eyewear or contacts from you just because you conducted the eye exam. Finally, the FTC also prohibits you from placing disclaimers or waivers of liability on the prescriptions you give to your patients.

FTC contact lens requirements

When it comes to selling contact lenses, the FTC requires the following:

What you have to do for members:

- Give them a copy of their contact lens prescription after completing a contact lens fitting and/or follow-up.
- Provide or verify their prescription via electronic or other means.

What you can’t require members to do:

- Purchase lenses from you.
- Pay for the release or verification of a prescription.
- Sign a waiver or release to obtain a prescription.
- Pay up front for the eye exam (for those members who want their prescriptions).

You must verify a member’s prescription before selling contact lenses. The FTC requires you to verify this prescription in one of the following ways:

- Get confirmation from the prescriber that the prescription is accurate.
- If the prescriber verifies the prescription is inaccurate, they must provide the accurate prescription.
- The prescriber fails to communicate with you within 8 business hours (or as defined by the FTC).

You can’t alter a prescription; however you can exchange a private-label lens with an identical lens from the same manufacturer.

Consider the contact lens prescription valid for at least 1 year or longer from the “issue date,” depending on state law or other medical condition.

Any changes to the Fairness to Contact Lens Consumers Act will supersede this manual.
Americans with Disabilities Act

You’re responsible for complying with any elements of the ADA that pertain to your business.

Dual Eligible Members (Medicare and Medicaid)

For any members who are eligible for both Medicare and Medicaid, Owner Professional agrees that such members will not be held liable for Medicare Part A and Medicare Part B cost sharing when the State is responsible for paying such amounts. Further, Owner Professional agrees to: (i) accept the payment amount from MA Payers as payment in full, or (ii) bill the appropriate State source.

For Humana plans, the following language applies:

Regulatory Requirements for Joint CMS/State sponsored Medicare-Medicaid Financial Alignment Demonstration or its successor (“Demonstration”). The Demonstration will provide for managed care plan coordination of both the Medicare and Medicaid benefits for those Medicare Advantage Members who are dually eligible for both and who enroll in a health benefits plan offered by Plan pursuant to the Demonstration (“Demonstration Members”). In addition to any other Medicare Advantage requirements, you agree that:

a) Services will be provided in a culturally competent manner to all Demonstration Members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds.

b) Your locations shall be accessible and able to accommodate the needs of Demonstration Members with disabilities per the Americans with Disabilities Act (ADA).

c) Demonstration Members shall have zero cost share responsibility and Demonstration Members will not be held liable for same.

d) You agree to accept as payment in full for Covered Services rendered to Demonstration Members, the lesser of billed charges or EyeMed’s rates set forth in your contract with EyeMed.
State laws

State regulatory requirements

Should any state licensing or regulatory authority require specific tests, use of pharmaceutical agents or listed instrumentation not indicated in this manual, state statutes and regulations always prevail.

Each state also has specific claims-related fraud warning statements.

Arizona disclosure law

According to state law, any optometrists or ophthalmologists practicing in Arizona must meet the following requirements regarding disclosure of information to members:

- If a member asks for a list of direct pay prices (prices you would charge patients who have no vision benefits) for the 25 most commonly provided services you need to provide the list. If your practice is owned by an optometrist or ophthalmologist and you have fewer than 3 licensed doctors, you're exempt from this requirement.
- When members choose to pay you directly for a service rather than have you submit claims on their behalf, you must have them sign a waiver stating they understand their rights as a member of the plan.

California language assistance program

California law requires you to make it as easy as possible for those who do not speak English (or who don't speak the language very well) to use your services. That includes making sure these individuals can easily access language assistance resources and interpreters when needed.

If you practice in California, your employees must understand and comply with this law, including the following:

- Language availability: Prominently post a notice of language assistance in each of your locations. We have one you can use.
- Interpretation services: You can't rely on an employee to provide language assistance to members. Members have access to highly skilled, qualified interpreters through our interpreter service, available at no cost to you or them. Our interpreters are trained in medical and insurance terminology as well as diverse ethnic and language nuances.
- Members can use their family members as interpreters, but you still need to make them aware interpreter services are available to them. If they do opt for a family member or friend, this shouldn't compromise the effectiveness of the service or violate a member's confidentiality.
- Documentation: We recommend you capture language preference in patient files. Should a member refuse access to our language assistance services, you should make a note of it in the patient record.

Interpreter services are available for providers in California by calling 888.581.3648 during normal business hours: 7:30 a.m. to 11 p.m. ET Monday through Saturday and 11 a.m. to 8 p.m. ET on Sunday. When using this service you'll need the member's first and last name and their date of birth; or the member ID number and preferred language for the member (if known).
Grievance forms and language procedures are available to members by calling us at 888.581.3648. Or, members can contact the California Department of Managed Health Care's Help Center at 888.HMO.2219 or TDD 877.688.9891. The Help Center is open 24 hours a day, seven days a week to answer questions.
Quality assurance

We want all members to have a good experience. That’s what keeps patients coming back to your practice for vision care. We take quality assurance very seriously, which is why our Quality Assurance (QA) team reviews standards, guidelines and procedures.

Please see the Medicaid section of the provider manual for specific quality assurance policies related to that plan.

- Complaints & appeals
- Evaluations & audits
- Disciplinary action

An optometrist affiliated with or employed by us makes determinations on any decisions involving clinical and/or technical judgment.
Complaints and appeals

Our QA team reviews any member or participating provider complaints or appeals of clinical issues. We review all complaints or appeals about claims, application of benefits, plan benefits or other non-clinical issues.

We’re committed to hearing both sides of the story and providing a fair and impartial review. We use an independent review process with different subject matter experts at each level of the claim appeal or complaint.

If our members complain

You must cooperate and participate in helping us resolve member complaints through the following process:

- Member submits written complaint to our QA team. Most plans allow us 30 days to resolve member complaints, although some plans need a quicker resolution.
- The team reviews the complaint. They may request additional explanation and information from the member. If we feel the member hasn’t informed you of the complaint, we’ll recommend the member reach out to you to work things out.
- You’ll receive a summary of the complaint via email, fax or mail. We’ll ask that you provide us with copies of the member’s file and an explanation of the complaint within 5 business days. You’ll have the opportunity to tell us your side of the story, submit any supporting evidence and/or seek resolution with the member.
- Our QA team collects supporting information from you and the member and recommends a resolution. If you don’t respond to our requests for information, or if you don’t give us what we need, we’ll have to pursue disciplinary action.
- The team determines the resolution and notifies you and the member in writing within 30 days.

We don’t like conflict, and we’ll work to resolve all member complaints using all the information submitted by both parties. But, it’s important that you help us here. If you don’t assist during the investigation, we’ll hold you in “noncompliant” status.

If you don’t respond to our requests for information within the specified time, we’ll resolve the member complaint without your comments or perspective. We’ll also place you in progressive discipline, which can include involuntary termination from our network. More on our termination process in a bit.

How to respond to member complaints

It’s important you play an active role in the resolution process. Here’s how you can do that:

- Review the complaint in full.
- Submit an explanation that describes each issue listed in the complaint.
- Provide evidence — both clinical and administrative — that supports your position.
- Protect your business practices with written policies and procedures, and make those policies available to members before they pay.
- Get and keep member acknowledgments of your policies and procedures and submit those acknowledgments with the complaint response.
- Respond promptly to allow sufficient time to communicate with QA staff.
If we rule in the member’s favor, you must comply with our determination. If we determine the member is due a refund, and you don’t reimburse the member or reinstate their benefit, we may reimburse them on your behalf and deduct the amount from future payments to your account, where permitted by law. Read more about withholds.

When members submit written requests for second opinions, we’ll ask for your perspective and any supporting evidence or clinical records pertaining to the case. We’ll resolve the dispute and notify both parties. If we determine the provider owes the member a refund, and if the provider fails to reimburse the member, we’ll reimburse the member and deduct the amount from future payments to the providers where permitted by law.

**Member complaints on materials**

The process is the same when a member files a complaint against a lab making their materials. When this occurs, the QA team will work with you, the lab and the member to resolve the complaint.

**If you need to vent**

We want to make working with us as simple as possible. If you or your staff has a complaint about how we handle something or about our services and plans in general, we want to know about it. There are several things you can do:

- Call us at 888.581.3648. For most situations, our customer service team can help.
- If our customer service team can’t help, they’ll ask you to submit your complaint in writing to our QA team, along with any supporting documentation.
- QA will investigate your complaint and provide a written resolution within 30 days for most situations, but absolutely no later than 60 days. We may request additional information.

Please see the Medicaid section of the provider manual for specific quality assurance policies related to that plan.

Medical/Surgical Plan utilization management decisions also have unique quality assurance processes, which are detailed in [that section](#) of the manual.

**Want to appeal?**

Sometimes you might feel we didn’t get it right. If you want to appeal a ruling by our QA team, follow this process:

- You or the member must submit a written appeal to us within 30 business days from the resolution date.
- A subcommittee composed of individuals not involved in the original resolution will review the complaint appeal.
- The subcommittee will make its decision in writing within 30 days.
Evaluations and audits

Why we conduct audits

First off, why do we conduct audits? Clients require us to demonstrate that their employees receive quality eye care. Audits and the associated reporting allow us to provide data that demonstrates consistent eye care that meets specific standards. In some cases, such reporting is required by outside compliance agencies. We also believe audits help us better share the important role network providers play in your patients’ overall health and wellness. Our goal is not to “catch” anyone doing the wrong thing. In fact, it’s the opposite: we want to be able to share with others that the providers on the network consistently provide care and services that meet members’ expectations.

From time to time, our QA group randomly selects participating providers and/or locations for routine evaluations. These can be facility, clinical, financial and/or process audits. An audit can also be triggered by suspicious claim activity and/or a complaint of alleged fraud, waste or abuse about a participating provider and/or location.

When you’re asked to submit copies of patient records, you must do so at no charge to EyeMed.

Audit overview

<table>
<thead>
<tr>
<th>Evaluation type</th>
<th>What we’re looking for</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility</td>
<td>We’ll evaluate areas of physical access, instrumentation and overall facility condition. There are two sections in a facility evaluation: Required equipment and facility environment.</td>
</tr>
<tr>
<td>Clinical records</td>
<td>We want to ensure members receive comprehensive eye exams as listed in our <a href="#">Comprehensive Eye Exam Guidelines</a>. This evaluation includes an assessment of member records and a financial evaluation.</td>
</tr>
<tr>
<td>Financial</td>
<td>We’ll review claim submissions and/or member payment records to ensure you’re applying member benefits correctly. This includes a financial document evaluation — which reviews claims against payment and member records — and a financial claim evaluation that reviews a provider and/or location’s claim history to reveal billing patterns.</td>
</tr>
<tr>
<td>Process</td>
<td>We’ll review clinical and business practices for a specific reason, such as adherence to clinical coverage criteria or application of a benefit and compliance with lab ordering, In-Office Finishing and emergency service policies.</td>
</tr>
</tbody>
</table>
Evaluation type | What we’re looking for
---|---
HEDIS | We’ll collaborate with health plan clients to collect HEDIS data to assess and compare quality of care.

Want to see exactly what we’ll be looking for? Check out the sample audit forms:

- [Facility scorecard](#)
- [Clinical record scorecard](#)
- [Financial audit scorecard](#)
- [Diabetic process audit scorecard](#)
- [Contact lens process audit scorecard](#)

Please note that the scoring system and follow-up actions described in this manual apply only to random routine audits. See the Involuntary Termination and Fraud, Waste and Abuse sections for details about audits conducted in response to possible fraud, waste or abuse.

## Facility evaluation

We may conduct unannounced office evaluations to make sure your office and equipment are up to snuff. Facility evaluations may also include clinical record, process and financial evaluations.

We’re looking to see if you have all the required equipment and that it’s in good working order. If you fail an equipment evaluation, you’ll have 10 business days to correct any issues or face disciplinary action. We’ll have to remove you from the network if you don’t respond or correct equipment issues within 30 days. We score these evaluations as follows:

<table>
<thead>
<tr>
<th>Required equipment section score</th>
<th>Results</th>
<th>Follow-up action</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>Pass</td>
<td>Available for evaluation at next credentialing cycle</td>
</tr>
<tr>
<td>Less than 100%</td>
<td>Fail</td>
<td>Accelerated Disciplinary ActionCorrective Action Required (Not correcting issues within 30 days could result in immediate termination from network)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Facility section score</th>
<th>Results</th>
<th>Follow-up action</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Excellent</td>
<td>Available for evaluation at next credentialing cycle</td>
</tr>
</tbody>
</table>
Clinical record evaluation

When we look at your clinical records, we want to see that members received comprehensive eye exams according to our guidelines. During clinical record evaluations we look for documentation that you performed all appropriate tests and captured all relevant information during the eye exam: member history, assessment, plan and follow-up of referrals/consultations. Professional reviewers score each clinical record to determine an average.

<table>
<thead>
<tr>
<th>Score</th>
<th>Results</th>
<th>Follow-up action</th>
</tr>
</thead>
<tbody>
<tr>
<td>90-100</td>
<td>Good to Excellent</td>
<td>Available for evaluation at next credentialing cycle</td>
</tr>
<tr>
<td>80-89</td>
<td>Satisfactory</td>
<td>Available for re-evaluation during current credentialing cycle</td>
</tr>
<tr>
<td>0-79</td>
<td>Fail: Progressive Disciplinary Action</td>
<td>Re-evaluation within 3 months; Corrective Action Plan required</td>
</tr>
</tbody>
</table>

Financial evaluation

Financial evaluations review claim submissions, lab invoices and/or member payment records to make sure you’re applying member benefits correctly. During the financial document evaluation we review the claim against the payment records and member records to make sure the claim is accurate and reflects all documented services and correct benefits.

We’ll also look at your claim history to reveal billing patterns. Findings may warrant additional or deeper investigation to make sure you’re applying member benefits correctly.

The financial evaluation often includes a review of member clinical records. If we find any overpayments during our review, we’ll collect the overage from future claim payments as allowed by law. See our withholds process for more information.

We score these evaluations as follows:

<table>
<thead>
<tr>
<th>Score</th>
<th>Results</th>
<th>Follow-up action</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Excellent</td>
<td>Available for evaluation at next credentialing cycle</td>
</tr>
<tr>
<td>Score</td>
<td>Results</td>
<td>Follow-up action</td>
</tr>
<tr>
<td>-------</td>
<td>--------------------------------</td>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td>80-99</td>
<td>Satisfactory</td>
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</tr>
<tr>
<td>0-79</td>
<td>Fail: Progressive Disciplinary Action</td>
<td>Re-evaluation within 3 months Corrective Action Plan required</td>
</tr>
</tbody>
</table>

Process evaluation

Process evaluations look at diabetic member care, contact lens evaluations and follow-ups, medically necessary contact lens benefits, high dollar claims and medical versus vision claim billings.

Process evaluations help us make sure you’re identifying/treating members with chronic high-risk health conditions and applying member benefits correctly. We’ll also be checking for compliance with lab ordering policies like In-Office Finishing and emergency services.

Just like those easy electives you took in college, we score process evaluations as pass/fail with an 80% or above required to pass. We usually include a clinical record and financial evaluation with process evaluations.

Contact lens audits

We’ll check to make sure you provided all of the services required for contact lens evaluations according to the chart below.

<table>
<thead>
<tr>
<th>New Wearer</th>
<th>Existing Wearer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Required Test (√)</td>
<td></td>
</tr>
<tr>
<td>1. Contact lens-related history</td>
<td>√</td>
</tr>
<tr>
<td>2. Keratometry and/or corneal topography</td>
<td>√</td>
</tr>
<tr>
<td>3. Anterior segment analysis with dyes</td>
<td>As Indicated</td>
</tr>
<tr>
<td>4. Biomicroscopy of eye and adnexa</td>
<td>√</td>
</tr>
<tr>
<td>5. Biomicroscopy with lens</td>
<td></td>
</tr>
<tr>
<td>a. Fluorescein pattern (rigid lenses) or</td>
<td></td>
</tr>
</tbody>
</table>
b. Movement and/or Centration (soft lenses)  
✓  
As Indicated

6. Over-refraction  
As Indicated  
As Indicated

7. Visual acuity with diagnostic lenses  
✓  
As Indicated

8. Determination of contact lens specifications determined to obtain the final prescription  
As Indicated  
As Indicated

9. Member instructions and consultations  
✓  
✓

10. Proper documentation with assessment and plan  
✓  
✓

HEDIS audits

The Healthcare Effectiveness Data and Information Set (HEDIS) is a widely used set of performance measures in the managed care industry, developed and maintained by the National Committee for Quality Assurance (NCQA).

HEDIS allows consumers to compare health plan performance to other plans and to national or regional benchmarks. We help health plan clients collect HEDIS data through HEDIS audits.

If you receive a request for clinical records for a HEDIS audit, please respond promptly to the address listed on the request and include all clinical documents relating to the patient.
How to make evaluations easy on yourself

We’ve done a lot of evaluations over the years, and we’ve collected a few tips to make the process easier for everyone:

- Illegible records fail evaluations. If you doubt the reviewers can read the information, provide a typed and printed version in addition to the actual record.
- There are a lot of abbreviations out there. Some make sense, and some make us scratch our heads. It’s important you stick to standard ophthalmic/optometric abbreviations. We’ll consider any nonstandard abbreviations illegible and score accordingly.
- If you use a questionnaire to gather case history data, include it with the patient record.
- Consider assessing your own medical record forms from an outsider’s point-of-view. The chart record should contain a notes area for each component of a comprehensive eye exam, and a third-party reviewer should easily be able to locate this information.
- Don’t forget to include financial information and lab invoices.
- Make sure medically necessary contact lens records show both prior and final prescription.
- Maintain complete and accurate clinical and financial records. Remember you are responsible for maintaining all records, either in hard copy or electronically, for 10 years (or longer if state or federal requirements say so) and to cooperate during our audits to furnish these records. Failure to send sufficient documentation upon request will result in recoupment of the reimbursements for those claims.
- Review this excerpt from a sample request letter for a full list of what we may request for an audit. LINK
Disciplinary action

The not-so-fun stuff

Sometimes disciplinary action is necessary. We’ll try to help you comply with our standards, including educating doctors and staff on appropriate care, warning you of any problems or concerns and giving you any assistance you need to maintain compliance.

In most cases, we apply the following disciplinary process, however, when dealing with certain issues, we’ll speed up this process to fix the problem quickly, to prevent member dissatisfaction or because the severity warrants immediate involuntary termination. However, when dealing with suspected fraud, waste or abuse, additional actions, including involuntary termination, may be taken. See the Fraud, Waste and Abuse Prevention section for details on how we handle audits related to potential fraud, waste or abuse.

<table>
<thead>
<tr>
<th>Noncompliance level</th>
<th>Reasons</th>
</tr>
</thead>
</table>
| Level 1 noncompliance | • Non-response to QA request or notice  
• Billing and/or claim filing errors  
• Lower than expected quality of service and/or materials, standards of optometric care and/or professional behavior  
• Failure to follow our quality, contractual or administrative protocols  
• Violating the terms of our Provider Agreement |
| Level 2 noncompliance | • Continued Level I noncompliance  
• Provider/member conflict: if your practice requires Provider Appeal, Grievance subcommittee or QA intervention |
| Level 3 noncompliance | • Continued noncompliance with our rules and standards that includes a “notice of involuntary termination” review from QA Committee |
Contract termination

Your contract can be terminated by you or us for various reasons. If you decide to leave the network, you can complete the Termination of Tax ID or Location form, which is available by going to our forms page and selecting Termination of a Tax ID or Location. The amount of notice required varies depending upon the terms of your contract. Refer to Appendix 9 of your contract for more information.

Once you’re no longer participating on the network, we’ll remove your location(s) from our automated locator services and exclude you from future member materials directories or mailings effective the day of termination.

We’ll process all claims that you submitted before the termination date and within claim-filing limits per the plan design. If you leave the network, be sure to inform our members you’re no longer a participating provider before seeing them. Provide referral instructions for follow-up care or clinical record requests when necessary.

Involuntary terminations

In some cases, we may terminate your participation immediately (we call these involuntary terminations). We can terminate you involuntarily if you do any of the following:

- Lose or have your license suspended
- Commit fraud, waste or abuse
- Fail to comply with insurance requirements
- Submit false claims (which may include claims for services and/or materials not actually received and/or claims containing misleading or false information)
- Have any legal or government action against your practice
- No longer meet our contract requirements (which include provisions in this manual), including:
  - Providing false or misleading information upon contracting or renewal, credentialing, or initial or subsequent application to participate in an EyeMed network or program
  - A pattern or practice of unprofessional or inappropriate conduct towards our members or clients
  - Notification of a sanction, debarment or exclusion from the Medicare, Medicaid or FEHB programs against a provider, affiliated eye care professional, tax entity, or location
  - When termination is deemed necessary by EyeMed to protect against the risk of imminent danger to the health or welfare of EyeMed members
- File bankruptcy

Common reasons for termination

- Not responding to credentialing requests prior to the termination date
- Opting out of Medicare or
We both have responsibilities during the termination process. In the event of an involuntary termination, we’ll send you a written notice specifying the date of termination from the network and inform you of your appeal rights and the appeal process.

How to appeal an involuntary termination

In situations where involuntary terminations can be appealed, you can do so by submitting a fully documented, written statement, requesting reconsideration of the decision within 30 calendar days from the date of notification.

The QA Grievance subcommittee reviews involuntary termination appeals and you’ll receive written notification of their decision upon completion of their review.

Your status will remain active during the appeal process unless the termination was based on loss of license, loss of insurance, evidence of physical or potential harm to a member or alleged fraud reasonable suspicion of fraud.
How to rejoin the network after involuntary termination

Welcome back

If you’re involuntarily terminated from the network and wish to reapply, you can do so after one year from the involuntary termination date. You must request to reapply in writing, acknowledge the reason for your termination and provide evidence of how you’ve addressed the issue that caused your removal from the network. You must also be in good financial standing with EyeMed and all affiliated entities to be eligible for reinstatement.

The Quality Assurance subcommittee will review the reapplication request. If they approve the request, you’ll need to reapply to the network and will be subject to network and credentialing and recredentialing requirements at the time of reapplication.

If you’re approved for reinstatement to the EyeMed network and successfully complete the credentialing process, you’ll be under probation for 12 months following reinstatement, during which time the following conditions will apply:

- You must participate in the EyeMed Dispensing Model and you will not be eligible to participate in the In Office Finishing program to the extent permitted by applicable law.
- You must agree to additional audits at your expense to monitor compliance with all EyeMed participation criteria and your corrective action plan.
- You must attest annually to having completed a minimum of 10 hours of continuing education related to proper coding, billing and/or Fraud, Waste and/or Abuse prevention.
- If you don’t comply with all rules and standards during this period, the subcommittee can immediately terminate you from the network.
- If you do comply with all rules and standards during this period, the subcommittee will readmit you to the network in the same manner as all providers.

If the subcommittee denies your application, they’ll let you know why and explain the requirements to successfully re-enter the network. If the subcommittee denies your application, you may reapply again after 1 year. Some situations prohibit re-entry, including evidence of physical or potential harm to a member or alleged fraud and/or billing abuse.

Access the network application form to get started.
Provider manual glossary

Download our provider provider manual glossary, which provides our definitions to terms used throughout the manual.