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PROVIDER MANUAL

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SECTION I: WELCOME LETTER

Welcome to OptiCare Managed Vision

Welcome to OptiCare Managed Vision (OptiCare). OptiCare values your involvement in its health plan network of participating Providers and looks forward to working with Providers to deliver quality vision benefits with a high level of Member satisfaction.

This manual will provide the necessary reference material to answer frequently asked questions and contains information regarding filing claims, as well as an overview of the OptiCare website.

Provider Affairs Mission Statement

All programs, policies, and procedures are designed with OptiCare's mission statement in mind:

“A company committed to excellence by building and sustaining quality Provider partnerships through innovation, communication and education to support our clients.”

Background

OptiCare has provided comprehensive and affordable eye care services since 1986. Our number one objective is keeping the “care” in our eye care program. Through exclusive agreements with national and regional managed care organizations, OptiCare Providers deliver all forms of eye care to Members in both Commercial and Government sponsored healthcare programs.

How to Use This Manual

OptiCare is committed to working with our Provider community and Members to provide a high level of satisfaction in delivering quality healthcare benefits. We are dedicated to provide comprehensive information through this Provider Manual as it relates to OptiCare's operation, benefits, and guidelines to Providers. In doing so, OptiCare will make the Provider Manual available to Providers via the OptiCare website and upon a Provider's request. OptiCare will post changes to the Provider Manual on its website or provide Providers with applicable state required prior written notice of material changes to the Provider Manual. Please contact OptiCare if you need further explanation on any of the topics discussed in this manual.

Providers may contact OptiCare on-line or by phone as shown in Appendix: Plan Specifics. OptiCare's Customer Relations standard office hours are from 8:00 a.m. to 8:00 p.m. (EST).

Update Your E-Mail Address

Providers can update the e-mail address for their practice by completing a form available on-line (www.opticare.com).

Welcome to the OptiCare network!

SECTION II: GENERAL INFORMATION

Website Overview

The OptiCare website can significantly reduce the number of telephone calls Providers need to make. Utilizing the website allows immediate access to current Provider and Member information twenty-four (24) hours a day, seven (7) days a week. The OptiCare website is located at www.opticare.com.

Access to Eye Health Manager

Participating Providers have access to the secure online portal, Eye Health Manager. User name and password information is included in the Provider Welcome Letter or upon request. The Eye Health Manager is available at www.opticare.com/logon. Upon initial login, the Provider will be prompted to assign an e-mail address to the user name before access is allowed to Eye Health Manager tools and resources.

Provider Tools:

- Verify member eligibility and benefits
- File claims
- Review claim status
- Download, research and reprint Explanation of Benefits/Explanation of Payments
- Request/submit secure, HIPAA-compliant Pre-Authorization

Provider Resources:

- Provider Manual
- Plan Specifics
- Policies and Procedures
- Forms
- Educational Webinar Schedule
- Group Benefit Information
- Newsletters
- Announcements

Rights and Responsibilities

Providers

Providers have the right and responsibility to:

- Make a complaint or file an appeal against OptiCare and/or a Member.
- File a complaint on behalf of a Member, with the Member's consent.
- Have access to information about OptiCare's Quality Improvement program, including program goals, processes, and outcomes that relate to Member care and services.
- Contact OptiCare with any questions, comments, or problems.

- Not discriminate against Members on the basis of race, color, national origin, disability, age, religion, mental or physical disability, or limited English proficiency.
- Provide clear and complete information to Members, in a language they can understand, about the health condition and treatment, regardless of cost or benefit coverage, and allow the Member to participate in the decision-making process.
- Maintain the confidentiality of Member's personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality.
- Give Members a notice that clearly explains their privacy rights and responsibilities as it relates to the Provider's practice/office/facility.
- Provide Members with an accounting of the use and disclosure of their personal health information in accordance with Health Insurance Portability and Accountability Act (HIPAA).
- Allow Members to request restriction on the use and disclosure of their personal health information.
- Provide Members, upon request, access to inspect and receive a copy of their personal health information, including medical records.
- Allow a Member who refuses or requests to stop treatment the right to do so, as long as the Member understands that by refusing or stopping treatment the condition may worsen or be fatal.
- Allow Members to appoint a parent, guardian, family member, or other representative if they cannot fully participate in their own treatment decisions.
- Follow all state and federal laws and regulations related to Member care and Member rights.
- Participate in payor data collection initiatives, such as Health Employer Data Information Set and other contractual or regulatory programs.
- Review clinical practice guidelines.
- Disclose overpayments or improper payments to OptiCare.
- Provide Members, upon request, with information regarding office location, hours of operation, accessibility, and languages spoken, including the ability to communicate with sign language.
- Notify OptiCare of any demographic changes.
- Follow OptiCare's established policies and procedures as well as those established by the Payors.
- Receive prompt payment for clean claims.
- Resubmit a claim with additional information.
- Obtain information regarding the status of claims.
- Ensure disclosure form is signed for non-covered service(s) by all parties prior to rendering service(s).
- Disclose to OptiCare any Provider or professional corporation ownership interest in any independent ancillary facility prior to referring Members.

Members

These Member Rights and Responsibilities are established by OptiCare. This list is not all-inclusive. OptiCare acknowledges Member Rights and Responsibilities of its Payors and will adhere to Member Rights and Responsibilities, if listed, in the Plan Specifications.

Members have the right to:

- Access all covered services.
- Participate in making decisions regarding vision health, regardless of cost or benefit coverage, including the right to refuse treatment.
- Make a complaint or file an appeal against OptiCare and/or a Provider.
- Request and receive a copy of Member's medical record.
- Request that the Member's medical record be corrected.
- Expect that the Member's medical record and care be kept confidential as required by law.
- Exercise these rights without adversely affecting the way OptiCare and its network Providers treat the Member.
- Allow or refuse personal information be sent to another party for other uses unless the release of information is required by law.
- Receive timely access to care.

Policies and Procedures

Under the Provider Participation Agreement, Providers have agreed to follow policies and procedures established by OptiCare as well as the guidelines outlined in this Provider Manual. Pertinent OptiCare policies are posted at www.opticare.com. The Provider may request copies of OptiCare's policies by calling Customer Relations at the number listed in Appendix: Plan Specifics.

Provider Performance Standards

Providers are expected to maintain high standards of Member/Patient care, well-documented and legible records, and a state-of-the-art facility. Providers should ensure Member satisfaction and avoid generating complaints, over-utilization, unbundling, or up-coding of procedures.

Provider performance is continually monitored through ongoing quality assessment, trending analysis, and utilization review.

Providers failing to meet established quality standards of care or service may be placed on review status, sanctioned, or terminated, depending on the significance of the deviation. If OptiCare determines that there is a possibility of a health risk to a Member, OptiCare has the undisputed right to place the participation privileges of the Provider's office involved on a temporary

suspension pending review. Quality of care issues are referred to the Peer Review Committee.

Accesses to Care

The following accesses to care standards have been established for optometrists and ophthalmologists by OptiCare’s Quality Improvement Committee:

Appointment Wait Time

Routine Eye Examination	Within two (2) weeks
Sub-Acute Problem	Within two (2) weeks
Chronic Problem	Within four (4) weeks
Urgent (Not life-threatening, but a problem needing care within twenty-four (24) hours)	Within the same office day

Time in Waiting Room

Scheduled	After thirty (30) minutes, patient must be given an update on waiting time with an option of waiting or rescheduling appointment; maximum waiting time is sixty (60) minutes
Work-ins ¹	After forty-five (45) minutes, patient must be given an update on waiting time with an option of waiting or rescheduling; maximum waiting time is ninety (90) minutes

¹ Called that day prior to going to the Provider Office

Response Time Returning Calls after Hours

Urgent	Twenty (20) minutes
Other	One (1) hour or next working day based on circumstances

Availability

Office Hours	Posted business hours
After Hours	Twenty-four (24) hours/day coverage for medical/surgical eye care

Acceptance of New Members

Providers accepting new Members may not discriminate based on coverage. Provider must supply thirty (30) days written notice to OptiCare before no longer accepting new Members.

Specialty Care

Members requiring specialty care should be directed to a participating Provider.

Medical Office Space

Provider agrees that the medical office space will be maintained in accordance with OptiCare's policies and procedures, as well as with applicable federal and state laws. OptiCare's policy is available via the Eye Health Manager (www.opticare.com).

Verification of Member Eligibility

Providers should verify Member eligibility prior to delivering service at each visit. Members are not required to present a Member ID card to receive covered services. Presentation of a Member ID card does not guarantee eligibility.

OptiCare offers two (2) ways to verify eligibility twenty-four (24) hours per day/ seven (7) days per week via the Eye Health Manager (www.opticare.com/logon) or Interactive Voice Response System (refer to Customer Service phone number listed in Appendix: Plan Specifics).

Medical Records

Recordkeeping Requirements

OptiCare requires all Providers to maintain sound medical record keeping practices that are consistent with industry standards and the Provider Participation Agreement. Records must be legible, current, detailed, organized, and comprehensive to ensure effective patient care and quality review. Medical records need to be identifiable by the Member or family name and accessible to the Provider as services are rendered.

OptiCare does not require the Provider to use specific forms for medical record documentation. Various professional organizations have created templates that can improve documentation processes. OptiCare encourages use of standardized forms for documentation as a method to improve continuity and coordination of care for Members.

Audits

OptiCare may audit record keeping practices and individual Member records in conjunction with on-going quality improvement activities or as a result of Member complaints.

OptiCare encourages Providers to request medical records that document care previously provided to Members who are new to the Provider's practice. This will

assist in ensuring the Member receives continuous care, as well as help determine the most appropriate course of treatment.

Confidentiality

Providers should maintain confidentiality of medical records and treatment information in accordance with state and federal laws including the Health Insurance Portability and Accountability Act (HIPAA). Medical records should be kept in a secure location, accessible only by authorized personnel. Providers must periodically train their staff about Member information confidentiality.

Health Insurance Portability and Accountability Act (HIPAA)

To improve the efficiency and effectiveness of the health care system, HIPAA, Public Law 104-191, includes Administrative Simplification provisions that require the United States Health and Human Services Department to adopt national standards for electronic health care transactions, code sets, unique health identifiers, and security. OptiCare has the responsibility to protect the privacy of personally identifiable health information by adhering to all federal and state laws, industry standards, and professional ethics.

Notice of Privacy Practices

OptiCare follows privacy practices established by HIPAA and other state and federal guidelines.

OptiCare's Notice of Privacy Practices is available on the OptiCare website (www.opticare.com).

National Provider Identifier (NPI)

The NPI is mandated by HIPAA. It is a unique identification number used by health care Providers when submitting claims for reimbursement. Providers, Payors, and health care clearinghouses are required to use the NPI numbers in the administrative and financial transactions specified by HIPAA. The NPI contains information about the health care Provider, such as the type of health care provided or the state where the health care Provider is located; and does not include embedded identifiers. The NPI must be used in connection with the electronic transactions identified in HIPAA. The NPI does not:

- Replace state-issued licenses and certifications verifying a Provider's licensing or qualifications.
- Replace Social Security Number, Individual Tax ID number, or Employer ID for tax purposes.

The NPI number can be accessed by visiting the Center for Medicare & Medicaid Services' website and typing in "National Provider Identifier" into the search option. This will bring up options to apply for a NPI number.

Member Liability

Providers are responsible for collecting all copayments, coinsurance, or deductibles applicable to covered services provided to Members according to Appendix: Plan Specifics from members.

Providers may also collect fees associated with non-covered services from the Member, if applicable, based on the Member's benefit program. The Member must be advised of and acknowledge in writing any non-covered vision services rendered by the Provider. The generic (not state specific) Non-Covered Services Liability Acknowledgement form is located on the OptiCare website (www.opticare.com). Please note that some states require a state specific Non-Covered Services Liability Acknowledgement Form. This form must be maintained in the Member's medical record.

Prescriptions

Drugs

If applicable, Providers have the responsibility to abide by the prescription formulary or preferred drug list designated by the Payor when prescribing medications for Members.

Corrective Lenses

Providers are required to release written prescriptions for corrective lenses unless this requirement contradicts state law.

Referrals

Primary Care Physician Referrals

OptiCare does not typically require Primary Care Physician referrals for in-network eye care. If a referral is required, details are included in the Appendix: Plan Specifics.

Reporting to Primary Care Physicians

When applicable, the Provider should partner with the Primary Care Physician to deliver specialty care to Members. A key component of the Provider's responsibility is to maintain ongoing communication with the Member's Primary Care Physician.

Providers should supply a complete written report of findings to the Member's Primary Care Physician within one (1) week following examination and treatment. If urgent or emergent follow up is required, the Provider shall provide a verbal report to the Member's Primary Care Physician within twenty-four (24) hours.

Provider Practice/ Office Information Changes

Providers should notify OptiCare when a change occurs in the Provider's practice/office by using the Provider Update Form. This form allows OptiCare to maintain accurate information about the Provider's practice. OptiCare uses this data when processing Provider claims and updating its Payors for the purposes of developing and maintaining their Provider directories.

Examples of changes include:

- Moving office location(s)
- Opening an additional office
- Changing the business name and/or Tax ID number
- Deleting Providers from an office

The Provider Update Form is available on the OptiCare website at www.opticare.com. OptiCare must receive all applicable changes thirty (30) days in advance of the effective date.

When adding a Provider to an existing practice, please contact Network Management at the phone number listed in Appendix: Plan Specifics.

Marketing — Name, Symbol, Service Mark

If prior written approval is obtained, Provider, OptiCare and the Payors have the right to use each other's name, symbol, and service mark for the use of Provider directories or for marketing purposes.

Non-Disparaging Language

Providers must refrain from making false, misleading, or inaccurate statements relating to OptiCare or its Payors. Disputes are to be handled between OptiCare and the Provider. Providers may reference the Quality Improvement Program for more details on the complaint process.

Provider Credentialing/ Re-Credentialing

Credentialing

Providers who want to join OptiCare's Provider Network must meet the following criteria for eligibility:

- The optometrist or ophthalmologist must be currently licensed to practice his/her profession in the state and within the service area of the plan, if applicable. Optometrists and ophthalmologists must hold a therapeutic pharmaceutical agent certification and DEA/DPS/BNDD Certification, if applicable in that state, to be considered for medical/surgical panels.

- The Provider must agree to meet the standards of care and service as specified by the appropriate quality committees within OptiCare. At the time of re-credentialing the Provider profile (report card) information must meet or exceed the OptiCare Quality Assurance requirements. The following items are reviewed: adverse events, Member complaints, unprofessional behavior, utilization patterns, and quality of care issues.
- The optometrist or ophthalmologist must maintain professional liability coverage in the amounts required by OptiCare. The minimum requirement is \$1 million per occurrence and \$3 million aggregate or as required by state law. Providers must not have a history of denial of liability coverage.
- Ophthalmologists must be board eligible with the American Board of Ophthalmology, at a minimum, for initial credentialing. Ophthalmologists must be board certified at the time of re-credentialing.
- Optometrists and ophthalmologists must have no unresolved disciplinary reviews or restrictions relating to his/her license. The Credentialing Committee will assess resolved disciplinary reviews.
- Ophthalmologists must have clinical privileges that are in good standing at the hospital designated as the primary admitting facility, if applicable. They must have admitting privileges at a participating facility. Surgery centers are not acceptable.
- Providers must not have greater than six (6) months of unaccounted time gaps in work history.
- Ophthalmologists must have graduated from an accredited medical school and have completed an accredited residency. Optometrists must have graduated from an accredited optometry school.
- Providers should not have significant sanctions reported through Medicaid, Medicare, or appear on the Office of Inspector General's List of Excluded Individuals and Entities.
- Providers must not have a history of criminal conviction or indictment.
- Providers must not be engaged in the use of illegal drugs or in treatment for substance abuse.

OptiCare does not discriminate against Providers who serve high-risk populations or who specialize in the treatment of costly conditions. OptiCare does not discriminate against Providers based on age, sex, race, religion, sexual orientation, and/or national origin. To avoid any possible discriminatory actions,

Credentialing Committee Members are provided the minimal information required for making a decision.

Re-credentialing

All Providers are re-credentialed every thirty-six (36) months unless otherwise required by the Payor. Reminder notices are distributed three (3) months and one (1) month prior to the expiration of the Provider's credentials.

Voluntary Termination from the Network

Providers may voluntarily terminate from the OptiCare network according to the Provider Participation Agreement. For a termination request to be approved, a written notice of intent to end participation must be mailed to OptiCare. Additionally, Providers are obligated to make available, upon request, Member records in order to facilitate the transfer of care.

Providers must continue to provide service to Members until the termination effective date and until such time as OptiCare is able to transfer Members to another participating Provider.

Please refer to OptiCare's Participating Provider Agreement for written notification timeframes.

SECTION III: CLAIMS

OptiCare is committed to equipping Providers with the best tools possible to support their administrative needs for filing, processing, and claims.

Filing Claims

Providers can file claims online via the Eye Health Manager (www.opticare.com), electronically via Emdeon, or by mail.

Eye Health Manager

Providers are allowed direct data entry into OptiCare's claim system. This method of filing provides immediate confirmation of claim receipt. Access to the site is restricted and password-protected. To obtain a username and password, contact Network Management at (800) 531-2818.

Emdeon

Providers may submit claims electronically through Emdeon using payor ID number 56190, listed as OptiCare Managed Vision. The payor ID# should be placed in 2010BB Loop/NM109 segment. Use "PI" as the ID Code Qualifier in NM108. Place the rendering Provider ID in 2310B Loop/REF02 segment. Use "N5" as the Reference Number Qualifier in REF01. To set up an account to submit claims electronically, call Emdeon at (800) 845-6592.

Mail

All claims submitted to OptiCare by mail for payment must be filed on an original CMS 1500 form. Forms must be completed and legible for payment processing.

Mailing Address:

OptiCare
[Insert Payor Name]
PO Box 7548
Rocky Mount, NC 27804

Faxing Claims

OptiCare does not accept faxed claims unless mandated by state-specific legislation.

General Filing Guidelines

OptiCare follows all CMS claims submission guidelines and HIPAA coding standards. The following guidelines must be followed when submitting a claim to OptiCare.

- All claims must be received within the claim-filing period defined within *Appendix: Plan Specifics*. OptiCare strongly encourages submission

as soon as services are rendered. If not received within the claim-filing period, OptiCare will deny the claim for late submission.

- File claims with the correct subscriber ID number, including the correct alpha prefix or suffix, if applicable.
- File claims under the subscriber's name on the ID card, not his or her nickname.
- Claims should include the Referring or Ordering Provider information in Item 17, 17a, and 17b of the CMS 1500 form or the equivalent electronic and Eye Health Manager field.
- Claims must include Tax ID number in Item 25 of the CMS 1500 form or the equivalent electronic and Eye Health Manager field. This number should be the Tax ID number or Social Security number reported to OptiCare on the Provider's W-9.
- Claims must have the Provider's name/signature in Item 31 of the CMS 1500 form or the equivalent electronic field. OptiCare will return the claim if we are unable to read the Provider's signature. Do not submit a facility or practice name in the signature field.
- Claims must have the address or physical location where services were rendered in Item 32 of the CMS 1500 form or the equivalent electronic field if different from Provider billing address as listed in Item 33.
- Providers must submit their NPI number in Item 24J of the CMS 1500 form or the equivalent electronic field.
- Claims should be filed using current, valid, and appropriate diagnosis codes, and should be coded to the highest level of specificity available.
- Proper sequencing order of the diagnoses codes must be etiology followed by manifestation in Item 21 of the CMS 1500 form or equivalent electronic field. The diagnosis pointer in Item 24E must reference the primary reason for performing the service in the first position.
- When a Member presents for a routine eye examination with no complaints, regardless of the final diagnosis, the Provider must file the visit as a routine eye examination. Subsequent services to treat the medical diagnosis may be filed as medical visits. The coverage of services rendered by a Provider is dependent on the purpose of the examination rather than on the final diagnosis.

- Providers must submit medical records and a dictated letter signed by the servicing provider detailing the reason for performing the service when billing modifier 59 to bypass National Correct Coding Initiative Edits.
- Use current valid CPT/ HCPCS service codes. If there is no suitable CPT/ HCPCS service code or if the CPT/ HCPCS service code is unlisted, give a complete description in Item 19 or the equivalent electronic field.
- Use current valid CPT/ HCPCS modifiers when necessary.
 - When multiple modifiers are billed on a single service line on a claim, use modifier 99 in Item 24D and place the additional modifiers directly after modifier 99.
 - When using modifier 50 to indicate a bilateral service was performed, submit 1 billed unit in Item 24G or the equivalent electronic field.
- Indicate how many times each service was performed and make sure the units are consistent with the CPT/ HCPCS service code.
- Claims must contain a pre-certification or referral number if applicable in Item 23 of the CMS form or the equivalent electronic field.
- When submitting an accident diagnosis, include the date that the accident occurred in Item 14 of the CMS 1500 form or equivalent electronic field.
- When documenting significant changes in vision and/or requesting replacement eyewear (if applicable for Payor) indicate the previous and current prescriptions in Item 19 of the CMS 1500 form or equivalent electronic field.
- When filing for Coordination of Benefits, submit the primary insurance information in Items 9a – d of the CMS form or the equivalent electronic field. A copy of the primary Explanation of Benefit/Payment should accompany the CMS 1500 form when filing for Coordination of Benefits.
- Paper claims must be filed using the following guidelines or the claim may be returned for corrections:

- Use only an original red-ink-on-white-paper CMS 1500 claim form. Faxed and/or copied claims are not accepted as a claim submission.
 - Submit typed or computer-printed forms.
 - Do not print, handwrite, or stamp additional information on the form.
 - Do not staple, clip, or tape anything to the claim form.
 - Do not use liquid white-off. Use only lift-off correction tape when making corrections.
 - Do not use highlights, Post-it notes, labels, or stickers.
 - Claims forms must be clear and legible.
 - Include the Payor name in Item 11c on the claim form.
 - **Handwritten claims are not accepted. If your office is unable to meet this standard, contact Customer Relations and/or Network Management at the phone numbers listed in Appendix: Plan Specifics.**
- Claims (initial filings, resubmissions, and/or appeals) may require additional information that must accompany the CMS 1500 form for the claim to be considered a “clean claim”. The following is a listing of attachment/description requirements:
 - A description on a full sheet of paper or write a description in Item 19 of CMS 1500 form for 92499, V2599, or any other unlisted procedure.
 - Referral forms do not need to be submitted with the claim, unless indicated in Appendix: Plan Specifics.
 - An invoice for consideration of wastage for botox injections, if applicable.
 - A copy of the optical lab invoice and prescription when billing for non-standard eyewear (frames and lenses) and/or additional lens features (i.e. high-powered index lenses, polycarbonate lenses, etc.), if applicable.
 - Office notes/medical records/operative notes signed by the rendering Provider for changes in diagnosis, procedure codes, or rendering Provider.

Place of Service Codes

The Provider must use the standard place of service codes as defined by Centers for Medicare & Medicaid services when requesting authorizations and filing claims for payment. A current list of the valid place of service codes may be viewed on the Centers for Medicare & Medicaid Services’ website.

Modifiers

The Provider must use the standard modifier codes; CPT codes as defined by the American Medical Association and the HCPCS codes as maintained by the Centers for Medicare & Medicaid Services when requesting authorizations and filing claims for payment. A current list of the valid modifier codes may be viewed on the Centers for Medicare & Medicaid Services' website.

Claims Processing

Coordination of Benefits

When a Member is covered by more than one Payor, OptiCare will coordinate benefits with other plans to reduce the Member's out-of-pocket expenses. OptiCare adheres to the coordination of benefits regulations set forth by the National Association of Insurance Commissioners as adopted by the state where the service is rendered.

When OptiCare is the Secondary Payor, the Primary Payor information is required for calculation of the secondary payment. When submitting claims electronically or through the website, the appropriate coordination of benefit field(s) should be completed. Provider may also submit a clean CMS 1500 form and a copy of the Explanation of Benefits from the Primary Payor.

Providers may visit the OptiCare website to reference the policy titled "Coordination of Benefits Payment Methodology" for more information.

Global Surgical Period

OptiCare follows Centers for Medicare & Medicaid Services global period guidelines for all surgical services. The global periods are indicated in the National Physician Fee Schedule, available on the Centers for Medicare & Medicaid Services' website. Reimbursement for surgical procedures includes:

- Pre- and Postoperative visits
- Patient's history and physical
- Any inpatient visits
- Complications following surgery
- Local and topical anesthesia administered by the physician
- Intra-operative services
- Supplies

Major surgeries have a one-day preoperative period and a ninety (90)-day postoperative period. Minor surgeries have either a zero (0) or a ten (10)-day postoperative period. Providers in the same group practice are covered under a single global fee for pre- and postoperative services.

Co-Management of Care

When a Provider, other than the surgeon, is providing the pre/postoperative care, it must be documented at the time of the pre-certification request and billed accordingly using the guidelines below.

Co-management of care requires the following:

- Co-management services must be indicated at the time of the pre-certification request, including the co-managing Provider.
- The surgeon should bill for the surgery only using modifier 54.

Providers should bill the preoperative portion of the global period using the following guidelines:

- Date of service must be the date the surgery was performed.
- The claim must include the surgical procedure code, including modifier 56.

Providers should bill the postoperative portion of the global period using the following guidelines:

- Date of service must be the date the surgery was performed.
- The claim must include the surgical procedure code, including modifier 55.
- Indicate assumed and relinquished dates in Item 19 of the CMS 1500 form or electronic equivalent.

Non-Covered Services

Non-covered services vary by Payor; refer to the Appendix: Plan Specifics for details.

After-Hours Office Visit

OptiCare does not reimburse Providers for this service, because it is considered by the Centers for Medicare & Medicaid Services to be a “bundled” service. Bundled services are not payable, nor should they be reported, even when performed incidental to or in combination with another service.

Telephone Consultations

Billing for telephone consultations is not covered.

Billing for Missed Appointments

OptiCare does not cover charges for missed appointments. Commercial and Medicare Members may be billed for missed appointments only if this is the standard office procedure, the Member has previously received a written statement of this procedure, or it is posted in a prominent location in the office.

Medicaid Members may not be billed for missed appointments.

Verifying Claim Status

Claim status can be obtained via the Eye Health Manager (www.opticare.com/logon).

Correcting Claims

A corrected claim is defined as a claim that is being re-filed with necessary, additional information that enables the proper adjudication of the claim. In most instances, the original claim was initially submitted without all of the proper elements necessary to process the claim, resulting in a denial for additional information.

Corrected claims must include all services rendered on the date of service. Indicate CORRECTED in Item 19 of the CMS form, web submission, or applicable electronic field for Emdeon.

Payment of Claims

Providers have the following two (2) options to receive payments:

Mail

Providers will receive checks by mail with or without the Explanation of Benefit/Explanation of Payment Statement depending upon their specified preference.

Electronic Funds Transfer

To receive electronic claim payments, send a completed electronic funds transfer agreement (available at www.opticare.com) along with a voided check to:

OptiCare
Attn: Accounting
PO Box 7548
Rocky Mount, NC 27804

Payment Methodologies

OptiCare complies with all applicable prompt payment laws regarding the processing and payment of clean claims. Covered procedures are subject to OptiCare's payment methodologies for both commercial and government sponsored programs based on: Medicare Physicians Fee Schedule, The National Correct Coding Policy Manual for part B Medicare Carriers, and local Medicare Carrier Policies in addition to OptiCare's coding guidelines. These guidelines are intended to incorporate and, in specific instances, include the requirements of the Centers for Medicare & Medicaid Services guidelines. Additional resources for payment methodologies administered by OptiCare may include, but are not limited to:

- American Medical Association's CPT Manual
- American Academy of Ophthalmology Preferred Practice Patterns
- State Medicaid Guidelines
- Input from board-certified doctors of ophthalmology
- Current medical literature

Payment Discrepancies

The Provider should call Customer Solutions at (800) 531-2818 when a payment discrepancy is discovered. Providers also have the option of filling out OptiCare's Claims Refund Request Form located at www.opticare.com/logon, click on *Online Forms* and *Claims Refund Request Form*.

When OptiCare notices that an overpayment has been made, a written request for reimbursement will be sent to the Provider. Adjustment(s) on future Explanation of Benefits/ Explanation of Payments will be made if reimbursement is not received within 45 days from the date of the request and funds are available for retraction.

Incorrect payments made on governmental programs (Medicaid and Medicare) may be retracted without prior written notification.

Claim Appeal Process

Providers may appeal a claim that has been denied in whole or in part for disputes relating to claim payments.

Claim appeals must be submitted with the following information:

- A completed CMS 1500 form for claim in question
- A completed Claim Appeal Request Form (www.opticare.com)
- A copy of the Explanation of Benefit/ Explanation of Payment in which the claim in question is listed
- Any other documentation (primary explanation of benefit, authorizations, referrals, etc.)
- Corrected claims should not be submitted as an appeal

The Claim Appeal mailing address is:

OptiCare
 Attn: Claims Appeal Committee
 PO Box 7548
 Rocky Mount, NC 27804

Decisions made by the Appeals Committee are final and based on the supporting documentation received from the Provider's office.

For additional information on the appeal process refer to policy and procedures available on the Opticare website (www.opticare.com).

SECTION IV: MEDICAL MANAGEMENT

OptiCare's Medical Management Program ensures OptiCare provides efficient, high quality service to its Payors. The primary goal of the Medical Management Program is to identify opportunities for Provider education and training by:

- Continually assessing the current claim processes and policies to determine if procedures adhere to current industry standards and Payor/state/federal regulations.
- Promoting efficient utilization of ophthalmologic services (routine and medical) through retrospective review. These activities include, but are not limited to review of required documentation to support medical necessity, benefit exceptions, appropriate levels of care, and appropriate use of diagnostic services.
- Continuous monitoring of trends in Provider billing behaviors to ensure appropriate coding and to identify inappropriate billing patterns and potential waste, abuse, and fraud.

Current policies may be viewed through the OptiCare website (www.opticare.com).

Utilization Management

Clinical Criteria

OptiCare has established clinical criteria for determining medical necessity. All clinical criteria are evaluated annually by the Medical Directors through a formal process. The Quality Improvement Committee also reviews and approves the clinical criteria annually.

OptiCare utilizes the most recent editions of the following references to annually re-evaluate all clinical criteria in addition to input from board certified doctors of ophthalmology, but are not limited to:

- American Academy of Ophthalmology Preferred Practice Patterns
- American Medical Association CPT Manual
- National Correct Coding Initiative Edits
- Medicare Physician Fee Schedule
- Current medical literature

Current policies are published on the OptiCare website (www.opticare.com).

Routine Eye Examination

When performing a preventative (routine) eye examination, the duly licensed eye care provider performs a complete visual system examination, including history,

examination, diagnosis, and initiation of management. Included within each part of the evaluation is a series of tests particularly suited for the detection, diagnosis, and initiation of appropriate therapy for eye disorders.

The exam elements listed below are basic areas of evaluation and are not meant to exclude additional exam components that might be appropriate.

- History
- Assessment of relevant aspects of patient's mental and physical status
- Visual fields by confrontation
- Best corrected visual acuity (with refraction¹ when indicated)
- External examination
- Pupillary function
- Ocular alignment and motility
- Slit-lamp biomicroscopy examination
- Intraocular pressure measurement
- Fundus examination (generally requires dilated pupils unless contraindicated, slit-lamp, and diagnostic lenses)

¹Refractions are separately reportable unless specifically included with the description of a service (e.g. S0620 & S0621).

Clinical Decisions

Utilization Management decisions are based on appropriateness of care, service, and existence of coverage. OptiCare does not reward individuals conducting utilization reviews for issuing denials of coverage or service.

The Provider, in conjunction with the Member, is responsible for making all clinical decisions regarding the care and treatment of the Member. OptiCare's Medical Directors are responsible for making medically necessary decisions in accordance with covered benefits and established criteria. Failure to obtain authorization for services that require approval will result in payment denials.

Authorizations

Authorization requirements vary according to the Payor, please refer to Appendix: Plan Specifics for details.

OptiCare accepts authorization requests through the Eye Health Manager (www.opticare.com), by fax, or by mail. The Pre-Authorization Request form is available on the OptiCare website. Changes to previously authorized services require approval and must be submitted by fax with applicable supporting documentation.

Assistant Surgeon

OptiCare allows assistant surgeon services for procedures identified by Centers for Medicare and Medicaid Services as potentially requiring an assistant surgeon.

Providers must submit a Pre-Authorization Request form for both the primary surgeon and the assistant surgeon for all services that require authorization.

Emergency Care

OptiCare defines emergency care as any health care service provided in a hospital emergency facility (or comparable facility) in order to evaluate and stabilize medical conditions of recent onset and severity (including severe pain), if such condition would lead a prudent layperson (possessing an average knowledge of medicine and health and acting prudently) to believe that failure to get immediate medical care might result in:

- Placing the person's health in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part
- Serious disfigurement
- In the case of a pregnant woman, serious jeopardy to the health of the fetus

Emergency room/urgent care services do not require preauthorization.

OptiCare will follow Payor and/or state required language in reference to emergency care, if it varies from the above definition. Check the Plan Specifics for specific Payor information. If more information is required in reference to policies and procedures, please refer to the OptiCare website (www.opticare.com).

Out-of-Network Eye Care Services and Facilities

OptiCare coordinates out-of-network care for Members, when delegated by the Payor. Out-of-Network care may be approved if there are no participating Providers or facilities to provide the necessary care. All requests should be submitted using the Pre-Authorization Request form located on the OptiCare website (www.opticare.com). Requests are considered for the following situations, but are not limited to:

- Prior surgery was performed and continuing care is medically necessary for continuity.
- Interruption in the treatment plan would jeopardize the Member's recovery time.

Providers must use participating facilities. For non-participating facility approval, the Facility Name & Address field of the form should be completed in full by the rendering Provider and faxed to the number provided on the form. If the Payor does not approve the requested facility, OptiCare will not approve the requested service.

Pharmaceuticals

To determine coverage and protocol related to injectable ocular drugs; refer to the applicable Payor Plan Specifics. Policies and procedures are available on the OptiCare website (www.opticare.com).

Many Payors utilize a drug formulary or designated pharmaceutical vendor. The Payor's website should be referenced prior to writing a prescription.

Utilization Management Appeals

Providers will receive specific instructions within their denial letter on how to file an appeal. Expedited appeals may be filed when the time expended in a standard appeal could jeopardize the life and health of the Member. Additional information is available on the OptiCare website (www.opticare.com) under Policies and Procedures.

Waste, Abuse, and Fraud Prevention

OptiCare has a comprehensive program designed to identify, prevent, reduce, and report Waste, Abuse, and Fraud that complies with state and federal laws.

Waste: To spend money or utilize benefits carelessly or uselessly; to allow benefits to be used inefficiently. Waste directly or indirectly results in unnecessary costs to the program due to carelessness or inefficiency.

Abuse: Actions inconsistent with accepted, sound medical, business, or fiscal practices. Abuse directly or indirectly results in unnecessary costs to the program through improper payments for services that are not medically necessary; do not meet professionally recognized standards for health care; or do not meet standards required by contract, statute, regulation, or previously sent interpretations to of any items listed.

Fraud: Intentional deception or misrepresentation that someone makes, knowing it is false, that could result in an unauthorized payment. Keep in mind the attempt itself is fraud, regardless of whether it is successful.

OptiCare conducts internal utilization management audits to ensure compliance with all applicable regulations. OptiCare also uses systems to identify possible Waste, Abuse, and Fraud through analyzing claims. If Waste, Abuse, and/or Fraud are detected through internal utilization management audits, internal systems or if an external referral is received, OptiCare's Special Investigation Unit will conduct a review which may result in actions against those who are found to have committed Waste, Abuse, and Fraud. OptiCare's actions may include the following:

- Provider education

- More rigorous Utilization Review
- Recover monies previously paid
- Report findings to appropriate Payor and/or regulatory agencies
- Termination from the OptiCare Network

Some of the most common Waste, Abuse, and Fraud submissions seen are:

- Unbundling of codes
- Up-coding
- Add-on codes without primary CPT
- Diagnosis and/or procedure code not consistent with Member's age/gender
- Claims for services not rendered

If a Provider suspects another Provider is inappropriately billing OptiCare or if a Member is receiving unnecessary services, please contact OptiCare's Fraud, Waste and Abuse hotline at (800) 361-9025. OptiCare takes all reports of potential Waste, Abuse, and Fraud seriously and investigates all reported issues.

SECTION V: QUALITY IMPROVEMENT PROGRAM

The Quality Improvement Program ensures the coordination, safe delivery and evaluation of the high quality, cost-effective routine and medical eye care required by Payors for their covered Members. OptiCare's Quality Improvement Program assures the timely identification, assessment, and resolution of known or suspected deficiencies in the quality of care or services received by Members and to prevent their reoccurrence by continuous monitoring, evaluation, and improvement of the routine and medical eye care services.

Program Scope

OptiCare develops performance thresholds and benchmarks, based on current practice standards and scientific studies. The Quality Improvement Department develops, monitors, and conducts internal operational evaluations. Quality deficiencies, individual concerns, and patient safety issues are identified and monitored by the Quality Improvement Department utilizing the following resources:

- Concerns, complaints, and grievances of Members, Providers, and/or Payors
- Delegating Payor input (solicited and unsolicited)
- High-risk care and service evaluation (e.g. diabetic studies)
- High volume care and service evaluation
- Internal audits for Claims, Credentialing, Customer Relations, Network Development, and Utilization Management, Enrollment, and Provider Maintenance departments
- Monitoring of established practice guidelines through review of medical records and utilization indicators
- Member satisfaction surveys (as delegated)
- Member access evaluations
- Payor satisfaction surveys
- Provider inquiries
- Provider office procedure review
- Provider satisfaction surveys
- Re-credentialing
- Retrospective chart review
- Site visits (Quality of Service Issues)
- Provider profiling
- Telephone abandonment rates and delay to answer statistics
- Utilization data evaluation

OptiCare investigates identified quality issues. Providers in question have the right to see all documents related to the case and the right to respond to all of the issues and have their responses recorded. Providers may appeal decisions

pertaining to their cases, and have their case reviewed by a Peer Review Committee.

Committee Structure

Quality Improvement Program Committee Structure:

The Quality Improvement Program committee structure is comprised of several committees to assist in performing duties, to provide guidance and direction and to promote the goals and objectives of the Quality Improvement Program as a whole.

Credentialing Committee

The Credentialing Committee develops comprehensive credentialing standard operating procedures, reviews applications, and makes credentialing decisions.

Grievance Committee

The Grievance Committee objectively hears grievances that are not able to be resolved through an informal process.

Claim Appeals Committee

The Claim Appeals Committee reviews claim processing disputes.

Peer Review Committee

The Peer Review Committee reviews complaints pertaining to quality of care and service issues.

Utilization Management Committee

The Utilization Management Committee monitors the quality, quantity, and cost-effectiveness of care.

Medical Management Committee

The Medical Management Committee oversees the development, research, and implementation of claim payment policies and other programs as mandated by state or federal legislation.

Corporate Compliance Committee

The Corporate Compliance Committee provides oversight to ensure all areas operate in a legal and ethical manner. This Committee is composed of the senior management team and is led by the Compliance Officer. The Compliance Officer reports directly to the Board of Directors.

Health Employer Data Information Set

Health Employer Data Information Set (HEDIS) is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA) which allows comparison across Payors. HEDIS gives purchasers and consumers the ability to distinguish between Payors based on comparative quality in addition to cost differences. OptiCare works with Payors to provide outreach calls to diabetic Members by helping them to schedule their annual eye exam.

The OptiCare website (www.opticare.com) contains a full description and a list of requirements related to OptiCare's HEDIS participation.

Complaint Procedures

OptiCare maintains an internal system for receiving and resolving oral and written complaints. The system has a process for acknowledgement and resolution of complaints. Throughout this section, OptiCare will use the term *complaint* to refer to complaints, grievances, concerns, and/or issues.

Complaint Definition

A complaint is defined as any dissatisfaction expressed orally or in writing, regarding any aspect of OptiCare's operation other than an adverse determination or claim issue. A complaint does not include a misunderstanding or misinformation that is resolved promptly by supplying the appropriate information or clearing up the misunderstanding.

Provider Complaint Process

Acknowledgement

When OptiCare receives an oral or written complaint from a Provider, the complaint is thoroughly documented and logged for tracking purposes. When an oral complaint cannot be resolved within the initial five (5) business days, an acknowledgement letter is mailed with a complaint form that must be filled out and returned. When a written complaint is received and not resolved within five (5) business days an acknowledgement letter is mailed within five (5) business days. All acknowledgement letters document the date the complaint was received and describe the complaint procedures and timeframes.

Complaint Resolution Time Frame

All Provider complaints should be resolved within five (5) business days from the date of receipt. If the complaint is resolved within the first five (5) business days an Acknowledgement/Resolution letter is mailed by the Quality Improvement Department within five (5) business days.

Depending on the circumstances and the amount of information needed to thoroughly investigate the complaint, the process may take up to thirty (30) calendar days once all necessary information is gathered.

Notice of Resolution

After a determination is made, a complaint resolution letter will be mailed to the Provider. The letter will include an explanation regarding the determination, state specific medical (clinical) and/or contractual reasons for the decision, the types (if any) of the physicians or other Providers consulted in the determination process, and additional information regarding the internal appeals process.

Member Complaint Process

When a complaint is received from a Member, or a Provider on behalf of a Member, the process defined below is followed while adhering to applicable state and/or federal mandated time frames. For Payors who do not delegate Member complaints, OptiCare and the contracted Provider will follow the complaint process as directed by the Payor. Providers will adhere to the policies established by OptiCare if the Payor has delegated Member complaints.

Acknowledgement

Once OptiCare receives a complaint from a Member an acknowledgement letter is mailed by the fifth (5th) business day. When a complaint is received from a Payor on behalf of the Member, it is not necessary for OptiCare to send the Member a letter, acknowledgment and/or resolution, unless OptiCare is delegated Member complaints for the Payor. When a complaint is received from a state regulatory agency on behalf of the Member, OptiCare will respond to the state regulatory agency using the agency mandated timeframes. The acknowledgement letter will document receipt of the complaint, date it was received and describe the complaint procedures and timeframes.

Complaint Resolution TimeFrame

OptiCare makes every effort to resolve oral complaints within the initial call or within twenty-four (24) hours. If an oral complaint is not resolved a formal complaint Acknowledgement Letter with a Complaint Form is attached to the letter for the Member to complete and return. Once the completed complaint form is received, OptiCare has up to thirty (30) calendar days to investigate the complaint.

A written complaint resolved before the end of the fifth (5th) business day will not receive an Acknowledgment Letter. For written complaints not resolved by the end of the fifth (5th) business day, an Acknowledgment Letter is mailed to the Member. OptiCare has up to thirty (30) days to investigate the complaint.

Notice of Resolution

A Complaint Resolution Letter is mailed to the appropriate party by the thirtieth (30th) calendar day after receipt of the complaint. This letter will explain the resolution of the complaint, state specific medical (clinical) and/or contractual reasons for the resolution, list the types of specialists consulted in the decision

process (if any), describe the internal process for complaint appeals and timeframes, and include additional contact information regarding the appeal process as directed by the Payor.

For more information regarding the Provider and Member complaint process, view the policies and procedures on the OptiCare website (www.opticare.com).

Cultural Competency

OptiCare is committed to providing culturally and linguistically appropriate eye care services in a manner which affirms, values, and respects the worth of the individual Member. These services are to be provided to people of all cultures regardless of race, age, gender, ethnicity, socioeconomic status, sexual orientation, or religion. OptiCare promotes superior quality eye care services with culturally competent staff, Providers, and contractors. OptiCare supports the development of healthy Provider/Member relationships to foster equitable treatment of all Members and enhance cultural awareness. OptiCare has adopted the Culturally and Linguistically Appropriate Services Standards, as developed by the Department of Health and Human Services, Office of Minority Health, and serves as a key resource in providing culturally sensitive services.

Cultural Competency Defined

Cultural competency is a set of behaviors, policies, and attitudes that harmoniously come together in a system, agency, or among healthcare professionals to bolster effectiveness in cross-cultural situations. It is the willingness and ability of a system to value the importance of culture in the delivery of services to all segments of the population.

Provider Responsibilities

Providers are expected to be knowledgeable about the Member's culture and to use this information in treating Members. Providers are also expected to ask questions relating to the way family and cultural values influence healthcare decisions. Providers are encouraged to use the Culturally and Linguistically Appropriate Service Standards to make their practices more culturally and linguistically accessible.

Increase Cultural Diversity

To develop culturally competent and proficient practices, Providers must ensure:

- Medical care is provided with consideration of the Members' race/ethnicity and language and its impact/influence of the Members' health or illness.
- Treatment plans are developed and clinical guidelines are followed with consideration of the Members' race, country of origin, native language, social class, religion, mental or physical attributes, heritage,

acculturation, age, gender, sexual orientation, and other characteristics that may result in a different perspective or decision-making process.

- Members understand that they have access to medical interpreters, signers, and TDD/TTY services to facilitate communication without cost to them.
- Printed and posted materials are available in English, Spanish, and any other languages as required by the state.
- Office staff makes reasonable attempts to collect race and language specific Member information. Staff will also explain race/ethnicity categories to a Member so that the Member is able to identify the race/ethnicity of themselves and their children.
- Office staff that routinely interacts with Members has access to and participate in cultural competency training and development.

Cultural Activities and Resources

Cultural Competency activities include the development of skills through training and use of self-assessment tools for Providers and systems, which are made available via the OptiCare website(www.opticare.com). OptiCare encourages its participating Providers to complete the U.S. Department of Health and Human Services Physician Practical Guide to Culturally Competent Care, which equips healthcare professionals with the skills necessary to better treat the diverse populations that they serve. This accredited educational program is available online and is free of charge. For registration information, please visit <https://cccm.thinkculturalhealth.hhs.gov>. For additional information and resources related to Cultural Competency, please visit www.opticare.com.

APPENDIX: PLAN SPECIFICS