



Provider Office Reference Manual

For the provision of vision and eye care services to enrollees of:

Anthem Blue Cross and Blue Shield Medicaid

P.O. Box 527
Thiensville, WI 53092

www.eye-quest.com

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(eyeQuest is a vision and eye care services product of DentaQuest, Inc. and its affiliates)

eyeQuest Key Contact Telephone Numbers

EyeQuest Provider Services

P.O. Box 527
Thiensville, WI 53092

Phone: 1-888-696-9551

Fax: 1-888-696-9552

Email Addresses

Vision Team

visionteam@dentaquest.com

Authorization

authorizations@dentaquest.com

Medical Prior Approvals

medicalapprovals@dentaquest.com

Provider Services

providerservices@dentaquest.com

Grievances and Appeals

DL-VisionSpecialist@greatdentalplans.com

Credentialing

P.O. Box 527
Thiensville, WI 53092

Fax: 262-241-4077

Claims

Paper claims should be sent to:

eyeQuest
Attn: Vision Claims Processing
P.O. Box 527
Thiensville, WI 53092

Fax: 1-888-696-9552

Fraud Hotline

1-800- 237-9139

TDD (Deaf or hard of hearing)

1-800-466-7566

eyeQuest Member Services:

KY Adult & Children's Medicaid 1-855-343-7405



The Kentucky Patient's Bill of Rights and Responsibilities

State law requires that your health care provider or health care facility recognizes your rights while you are receiving medical care and that you respect the health care provider's or health care facility's right to expect certain behavior on the part of you the patient. You may request a copy of the full text of this law from your health care provider or health care facility. A summary of your rights and responsibilities are as follows:

- ❖ A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
- ❖ A patient has the right to a prompt and reasonable response to questions and requests.
- ❖ A patient has the right to know who is providing medical services and who is responsible for his or her care.
- ❖ A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- ❖ A patient has the right to know what rules and regulations apply to his or her conduct.
- ❖ A patient has the right to be given by the vision and eye care provider, information concerning diagnosis, planned course of treatment, alternatives, risks and prognosis.
- ❖ A patient has the right to refuse any treatment, except as otherwise provided by law.
- ❖ A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- ❖ A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- ❖ A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- ❖ A patient has the right to impartial access to vision and eye care treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.
- ❖ A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to receive treatment.
- ❖ A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
- ❖ A patient has the right to express grievances regarding any violation of his or her rights, as stated in Kentucky law, through the grievance process of the medical care provider or medical care facility which served him or her and to the appropriate state licensing agency.
- ❖ A patient is responsible for providing to his or her medical care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters related to his or her health.
- ❖ A patient is responsible for reporting unexpected changes in his or her condition to the medical care provider.
- ❖ A patient is responsible for reporting to his or her vision and eye care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- ❖ A patient is responsible for following the treatment plan recommended by his or her medical care provider.
- ❖ A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the medical care provider or medical care facility.
- ❖ A patient is responsible for his or her actions if he or she refuses treatment or does not follow the medical care provider's instructions.
- ❖ A patient is responsible for assuring that the financial obligations of his or her medical care are fulfilled as promptly as possible.
- ❖ A patient is responsible for following vision and eye care facility rules and regulations affecting patient conduct.



Office Reference Manual
Table of Contents

Section	Page
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Contents

EyeQuest Provider Services	3
1.00 Patient Eligibility Verification Procedures.....	3
1.01 Member Eligibility	3
1.02 Member Identification Card.....	3
1.03 Verifying Eligibility.....	4
1.04 Benefits.....	4
2.00 Claims Submission Procedures (claims filing options)	4
2.01 Electronic Claim Submission Utilizing eyeQuest’s Internet Website	4
2.02 Paper Claim Submission	5
2.03 Coordination of Benefits (COB).....	5
2.04 Filing Limits	6
2.05 Receipt and Audit of Claims	6
2.06 Claims Appeals.....	6
3.00 Health Insurance Portability and Accountability Act of 1996 (HIPAA)	6
4.00 Inquiries, Complaints, Grievances and Provider Appeals	7
5.00 Quality Improvement Program.....	9
6.00 Fraud and Abuse	10
7.00 Credentialing/Recredentialing.....	10
8.00 Standard of Care — Routine Eye Care	10
8.01 Examination Standards	10
8.02 The Patient Record	11
9.00 Quality Initiatives	12
9.01 Diabetic Dilated Fundus Exam – CPT II, Chart Documentation, Notifying the PCP	12
9.02 Glaucoma Screening – Submitting supplemental billing code G0117	13
10.00 Utilization Management – General Provisions.....	13
10.01 Limitations to Delivery of Service	13
11.00 Utilization Management – Protocols and Procedures	14
APPENDIX A (Attachments)	19

Provider Change Form	20
Eligibility Verification Request Form.....	21
eyeQuest- Medical and Surgical Prior Approval Request / Determination	22
PATIENT FINANCIAL RESPONSIBILITY NOTICE AND DISCLAIMER.....	23
MEDICAID FINANCIAL RESPONSIBILITY NOTIFICATION.....	24
DIABETIC RETINAL EYE EXAM SUMMARY	25
APPENDIX B-Health Plan Specific Program Details	26

1.00 PATIENT ELIGIBILITY VERIFICATION PROCEDURES

1.01 Member Eligibility

Active members are those who are enrolled in a Health Plan's program at the time of service. Such enrollees are eligible for benefits under the Plan Certificate.

1.02 Member Identification Card

Health Plan members receive identification cards from the Plan. The member does not need to present an ID card for services to be rendered. Participating providers are responsible for verifying members are eligible at the time services are rendered and to determine if recipients are active on a covered plan and/or have other health insurance. A sample ID card is located in Appendix B.

eyeQuest recommends each provider office make a photocopy of the member's identification card, if available. It is important to note the health plan identification card is not dated; **therefore, an identification card in itself does not guarantee a person is currently enrolled in the Health Plan.**

To be sure a member is eligible for benefits at the time of service, verify eligibility with eyeQuest online, by fax or by telephone (see below).

1.03 Verifying Eligibility

i. Using the Internet:

The most convenient method of verifying eligibility is eyeQuest's interactive website, www.eye-quest.com. When you log in, you will have the opportunity to verify eligibility for any member. Once verified, you will receive a control number for any covered service provided within thirty (30) days of the date of verification. Although not required to receive payment, this number should be maintained in the member record as it may be required for future inquiry and to track claims payment.

ii. Using the Fax Form:

Participating providers who do not have access to the Internet may also verify eligibility information and receive control numbers by faxing requests to 1-888-696-9552. Typical turnaround time is less than 24 hours. A sample Eligibility Request Form is in Appendix A on page A-3.

lii. Calling eyeQuest Customer Service:

When immediate eligibility verification is necessary, call our vision team at 1-888-696-9551.

When verifying eligibility you will be provided with patient-specific benefit information which may indicate eligibility status for:

- Examination only
- Materials only
- Examination and materials
- Medical and surgical services (there may be coverage limitations by eyeQuest)

NOTE: The routine vision examination and optical benefit is available to covered members without the requirement for a referral from the member's primary care provider (PCP). Please see specific Plan details for referral requirements for medical and surgical care.

1.04 Benefits

Member-specific vision and eye care benefits are defined by the individual Health Plan client and type of plan. Please refer to Plan-specific sections in this manual.

2.00 CLAIMS SUBMISSION PROCEDURES (CLAIMS FILING OPTIONS)

eyeQuest currently receives vision and eye care claims in two possible formats. These formats include:

- (i) Electronic claims via eyeQuest's provider website (www.eye-quest.com)
- (ii) Paper claims submitted on standard claim forms (e.g. CMS/HCFA1500)

2.01 Electronic Claim Submission Utilizing eyeQuest's Website

Participating providers may submit routine exam and optical claims directly to eyeQuest by utilizing the eyeQuest web portal. Submitting claims via the website is quick and easy. It is especially easy if you have already accessed the site to check a member's eligibility prior to providing the service and received a control number.

First-time users should use the claims tutorial to get started. The tutorial is found on the web portal and shows the step-by-step process for entering and submitting claims.

Visit www.eye-quest.com to submit claims, then follow these steps;

- Log in using your eyeQuest user number and password
- Select the examining provider from the pull down menu
- Select "Submit Claims"
- Select the "control number" (you will see the hyperlink) provided
- Be sure to verify the claim is for the correct patient
- Enter the valid CPT, HCPCS and ICD codes for the specific services provided

NOTE: You will not have to enter HCPCS codes for frames or lenses ordered from the contract laboratory. You will only need to enter applicable exam and dispensing codes.

NOTE: Plan specific limitations may not allow you to enter claims for medical services electronically. If the online portal does not offer this option, medical claims should be submitted to eyeQuest on printed HCFA 1500 forms.

If you have questions or problems submitting claims or accessing the website, please contact our Vision Team at 1-888-696-9551 or via email at visionteam@dentaquest.com.

2.02 Paper Claim Submission

- The Claim Control Number should be listed on line 10D. Obtain the control number when verifying eligibility on the web portal.
- Always include the practice name and the rendering provider name.
- Approved procedure codes (CPT, CPT II and HCPCS) must be used to define all services.
- Up to four ICD-9/10 codes may be submitted and all relevant codes should be included. Professional services without at least one ICD-9/10 code will be denied.
- Affix the proper postage when mailing bulk documentation. eyeQuest does not accept postage due mail. This mail is returned to the sender and will result in payment delay.
- Paper claims should be mailed to the following address:

eyeQuest
Attention: Vision Claims Processing
P.O. Box 527
Thiensville, WI 53092

2.03 Coordination of Benefits (COB)

Patients with "other primary insurance coverage"

Often patients/members presenting for services will be covered under another program or Plan that is their primary carrier for vision and eye care. Since Medicaid is always the payer of last resort, providers should routinely ask if their Medicaid patients have any other coverage.

In the case where a patient has other coverage or when the eyeQuest client (Anthem Blue Cross and Blue Shield Medicaid) is determined to be the secondary insurance carrier, a copy of the primary carrier's Explanation of Benefits (EOB) must be submitted with any claim submitted to eyeQuest. Examples of COB may include claims where Medicare is the primary payer when the member is covered by a vision plan through work or dependent coverage, for no-fault insurance carriers and for worker's compensation claims.

***NOTE:** When payment from the primary carrier meets or exceeds a provider's contracted rate or fee schedule, eyeQuest will consider the claim paid in full and no additional payment will be made on the claim. For electronic claim submissions, the payment made by the primary carrier must be indicated in the appropriate COB field.*

2.04 Filing Limits

The Kentucky claim filing limit is 365 days. Any claim submitted beyond the designated timeliness period will be denied for untimely filing. If a claim is denied for untimely filing, the provider cannot bill the member. If eyeQuest is the secondary carrier, the timely filing limit begins with the date of payment or denial from the primary carrier.

2.05 Receipt and Audit of Claims

In order to ensure timely, accurate remittances from each participating provider, eyeQuest performs a clean claim audit of all claims upon receipt. This audit validates member eligibility, procedure codes and provider identifying information. When potential problems are identified, your office may be contacted and asked to assist in resolving the issue.

2.06 Claims Appeals

See Section 4 of this manual for details on claim appeals.

3.00 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

As a health care provider, your office is required to comply with all aspects of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations in effect as indicated in the final publications of the various rules covered by HIPAA.

eyeQuest has implemented various operational policies and procedures to ensure it is compliant with the Privacy, Administrative Simplification and Security Standards of HIPAA. One aspect of our compliance plan is working cooperatively with our providers to comply with the HIPAA regulations. In relation to the Privacy Standards, eyeQuest has previously modified its provider contracts to reflect the appropriate HIPAA compliance language. These contractual updates include the following, in regard to record handling and HIPAA requirements:

- Maintenance of adequate vision/medical, financial and administrative records related to covered services rendered by provider in accordance with federal and state law.
- Safeguarding of all information about members according to applicable state and federal laws and regulations. All material and information, in particular information relating to members or potential members, which is provided to or obtained by or through a provider, whether verbal, written, tape or otherwise, shall be reported as confidential information to the extent confidential treatment is provided under state and federal laws.
- Neither eyeQuest nor provider shall share confidential information with a member's employer absent the member's consent for such disclosure.
- Provider agrees to comply with the requirements of HIPAA relating to the exchange of information and shall cooperate with eyeQuest in its efforts to ensure compliance with the privacy regulations promulgated under HIPAA and other related privacy laws.

Provider and eyeQuest agree to conduct their respective activities in accordance with the applicable provisions of HIPAA and such implementing regulations.

In relation to the Administrative Simplification Standards, you will note the benefit tables included in this ORM reflect the most current coding standards (CPT-5 and HCPCS). Effective the date of this manual, eyeQuest will require providers to submit all claims with the proper CPT-5 or HCPCS codes listed in this manual. In addition, all paper claims must be submitted on the current approved claim form. (ICD-10 will become effective in 2014.)

Note: Copies of eyeQuest's HIPAA policies are available upon request by contacting eyeQuest at 1-888-696-9551 or via email at visionteam@dentaquest.com.

4.00 INQUIRIES, COMPLAINTS, GRIEVANCES AND PROVIDER APPEALS

eyeQuest adheres to state, federal and Plan requirements related to processing inquiries, complaints and grievances. Each level is defined as follows:

A. Definitions:

Inquiry: An inquiry is the first contact with the Plan (verbal or written) expressing dissatisfaction from the member, an attorney on behalf of a member or a government agency.

Complaint: A complaint is any oral or written expression of dissatisfaction by an enrollee submitted to the Health Plan or to a state agency and resolved by close of business the following day. Possible subjects for complaints include, but are not limited to, the quality of care, the quality of services provided, aspects of interpersonal relationships such as rudeness of a provider or health plan employee, failure to respect the enrollee's rights, health plan administration, claims practices, or provision of services that relates to the quality of care rendered by a provider pursuant to the Health Plan's contract. A complaint is an informal component of the grievance system. A complaint is the lowest level of challenge and provides the Health Plan an opportunity to resolve a problem without its becoming a formal grievance. Complaints must be resolved by close of business the day following receipt or be moved into the grievance system.

Grievance: An expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include, but are not limited to, the quality of care, the quality of services provided and aspects of interpersonal relationships such as rudeness of a provider or health plan employee or failure to respect the enrollee's rights.

Appeal: A formal request from an enrollee to seek a review of an action taken by the Health Plan pursuant to 42 CFR 438.400(b). An appeal is a request for review of an action.

Unless otherwise required by Agency and Plan, eyeQuest processes such inquiries, complaints, grievances and appeals consistent with the following:

B. Complaints/Grievance Review Process

eyeQuest's Complaints/Grievance Coordinator receives member and provider inquiries, complaints, grievances and appeals. The coordinator investigates the issues, compiles the findings, requests patient records (if applicable), sends the records to the eye care consultant for review and determination (if applicable) and obtains a resolution. The appropriate individuals are notified of the resolution (i.e. Plan, member and provider as applicable). The complaint is closed and maintained on file for tracking and trending purposes.

C. Provider Appeals

Contracted providers have a right to file an appeal for claims, authorizations and/or preservice medical necessity denial determinations. This can be done by submitting a request for appeal in

writing with a narrative and supporting documentation to eyeQuest via mail or fax. All provider appeals should be sent to the attention of:

eyeQuest Provider Appeals
P.O. Box 527
Thiensville, WI 53092
Provider Appeals Fax Line: 1-888-696-9552

Denied Claims Appeals

A claim appeal may be filed for any adverse post-service decision assessed against a provider by eyeQuest. Providers must file their appeal within 180 days of the date notification of denial was made. eyeQuest will acknowledge your appeal within five business days of receipt. eyeQuest will resolve your appeal within 30 calendar days of receipt. Please note that appeals for preservice denials may be filed provided that member consent is obtained and shall be deemed a member appeal by eyeQuest. Provider claim appeals may be submitted to eyeQuest in writing at:

eyeQuest Provider - Grievances and Appeals
P.O. Box 527
Thiensville, WI 53092
Phone: 1-888-696-9551
Fax: 1-888-696-9552

D. Member Complaints/Grievances/Appeals:

Anthem Blue Cross and Blue Shield Medicaid (Anthem) members must file a complaint, grievance and/or appeal directly with Anthem. There are two ways members can file: by phone or mail.

Member's Plan	Telephone	Mail
Anthem Blue Cross and Blue Shield Medicaid	1-855-690-7784 (TTY 1-800-855-2880)	<p>Medical Necessity Appeals: Medical Appeals Anthem Blue Cross and Blue Shield Medicaid P.O. Box 61599 Virginia Beach, VA 23466-1599</p> <p>Payment Appeals: Payment Disputes Anthem Blue Cross and Blue Shield Medicaid P.O. Box 61599 Virginia Beach, VA 23466-1599</p> <p>Complaints, Appeals and Grievances Department P.O. Box 61116 Virginia Beach, VA 23466-1116</p>

Medicaid members not satisfied with the final decision by Anthem Blue Cross and Blue Shield Medicaid may request a review by the Kentucky Department of Insurance (DOI) Consumer Protection Program. The person appealing (i.e., member or provider) must contact DOI within 365 days of the date of notice of determination. Call DOI toll free (KY only) at 1-800-595-6053 or send a letter to:

Kentucky Department of Insurance
 Consumer Protection Division
 P.O. Box 517
 Frankfort, KY 40602-0517

Kentucky Medicaid members also have the right to ask for a Medicaid Fair Hearing at any time during the appeals process. To request a Medicaid Fair Hearing, send a letter to:

Cabinet for Health and Family Services Department for Medicaid Services Division of
 Administration and Financial Management
 275 East Main Street, 6W-C
 Frankfort, Kentucky 40621-0001

5.00 QUALITY IMPROVEMENT PROGRAM

eyeQuest currently administers a Quality Improvement (QI) Program modeled after National Committee for Quality Assurance (NCQA) standards. The NCQA standards are adhered to as the standards apply to ancillary services. The QI program includes:

- Provider credentialing and re-credentialing
- Member satisfaction surveys
- Provider satisfaction surveys
- Random chart audits
- Member complaint monitoring and trending
- Peer review process
- Site reviews and medical record reviews

- Quality indicator tracking (e.g., complaint rate, appointment waiting time, access to care, etc.)

A copy of eyeQuest's QI Program is available upon request by contacting eyeQuest's Vision Team via email at visionteam@dentaquest.com.

6.00 FRAUD AND ABUSE

eyeQuest is committed to detecting, reporting and preventing potential fraud and abuse. Fraud and abuse are defined as follows:

Fraud: Intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under federal or state law.

Member Abuse: Intentional infliction of physical harm, injury caused by negligent acts or omissions, unreasonable confinement, sexual abuse or sexual assault.

Provider Fraud: Provider practices that are inconsistent with sound fiscal, business or professional practices, and result in unnecessary cost to the program, or in reimbursement for services that are not clinically appropriate, medically necessary or that fail to meet professionally recognized standards for vision care and/or eye care may be referred to the appropriate state or federal regulatory agency.

Member Fraud: If a provider suspects a member of ID fraud, drug-seeking behavior, or any other fraudulent behavior, it should be reported to eyeQuest. Contact eyeQuest's Fraud and Abuse Hotline at 1-800-237-9139 or proceed as follows:

To report suspected fraud and/or abuse in Kentucky Medicaid, call the Consumer complaint Hotline toll-free at 1-800-595-6053 or complete a Medicaid Fraud and Abuse Complaint Form, which is available online at http://insurance.ky.gov/Documents/NAIC_Rep_Form_Oct_03.docx.

7.00 CREDENTIALING/REREDENTIALING

eyeQuest, in conjunction with the Plan, has the sole right to determine which providers (O.D., M.D., D.O.) it shall contract with as participating providers. Providers must meet all eyeQuest and Plan-specific criteria for participation before going through the formal credentialing process. The purpose of the Credentialing Program is to provide a general guide for the acceptance, discipline and termination of participating providers. eyeQuest's credentialing policies adhere to or exceed NCQA standards.

Recredentialing

Network providers are recredentialled according to standard policies and procedures at least every 36 months, or as required by a specific state or Plan.

Note: Complete credentialing policies are available upon request by contacting eyeQuest's Vision Team via email at visionteam@dentaquest.com.

8.00 STANDARD OF CARE — ROUTINE EYE CARE

8.01 Examination Standards

A comprehensive eye examination shall include all of the following items and all findings shall be completely and legibly documented in the patient's record with quantitative findings where appropriate.

Current Status

1. Basic patient demographics (age/date of birth, gender, race)

2. Personal and family medical and ocular history
3. All current medications and medication allergies
4. Patient's assessment of current vision status; use of eyeglasses or contact lenses
5. Chief complaint/reason for visit/history of present illness

Vision Assessment

1. Visual acuities in each eye at distance and near with or without correction
2. Objective and subjective refraction at distance and near with recorded best corrected visual acuity at distance and near
3. Gross and quantitative evaluation of the accommodative, motility and binocular abilities of the patient.

Eye Health Assessment

1. Evaluation of external structures: lids, lashes, conjunctiva, gross visual fields, and pupil anatomy, symmetry and responses (direct, consensual, accommodative and afferent defects)
2. Bio-microscopic examination of the cornea, conjunctiva, iris, lens, anterior chamber, anterior chamber angle estimation and measurement of the intra-ocular pressure (specifying instrument and time)
3. Ophthalmoscopic examination of the internal eye structures including the vitreous, retina, blood vessels, optic nerve head (including C/D ratios), macula and peripheral retina
4. Dilated / binocular indirect ophthalmoscopic retinal examination should be performed routinely in all patients, unless contraindicated

Impression and Disposition

Summary of all diagnoses, prescriptions and treatment recommendations, including but not limited to:

- Refractive and eye health diagnoses
- Eyeglass and contact lens prescriptions
- Medications prescribed and/or treatment plans
- Patient education on their ocular status and any increased risk factors for any personal or family conditions
- Recall/re-examination/referral recommendations

Provider Signature

The medical record is not complete without appropriate, dated signature of the examining doctor.

8.02 The Patient Record**A. Organization**

The patient record should have areas for documentation of the following registration and administrative information:

- a. Patient's first and last name
- b. Parent or guardian's name, if appropriate
- c. Date of birth
- d. Gender
- e. Race
- f. Address
- g. Telephone number(s)
- h. Emergency contact person and telephone number
- i. Primary care physician
- j. Health Plan ID number or other identification number

In addition to the patient registration information, the patient record must contain the examination data from all prior visits, all ancillary test results, consultation requests and reports, copies of all Prior Approval Requests and Noncovered Services Agreements, and all eyewear and/or contact lens specifications.

Each individual page of the patient record must contain the patient's name and/or identification number and the date the care recorded on that sheet was provided.

B. Content

For every comprehensive eye examination, the patient examination record should contain all of the information including the recording of all the detailed qualitative and quantitative information as described in the examination standards, 8.01, above.

Emergency and nonroutine examination visits should contain all the relevant clinical data and history to adequately describe the presenting condition and support the diagnoses and treatments provided as appropriate for the situation.

C. Compliance

All entries in the record should be legible and located consistently within the record.

Symbols and abbreviations used in the record must be uniform, easily understood and are commonly accepted within the profession.

The entire patient record should be maintained as a unit for at least the most recent seven years or the time period required by any state or federal regulations, whichever is greater.

The patient record should be maintained in a format that will allow the doctor to make the entire record available to eyeQuest for routine Quality Assurance review activities.

Electronic Medical Records (EMR) utilizing default settings must ensure the defaults are appropriate for the specific patient or are modified to present an actual and accurate clinical picture.

9.00 QUALITY INITIATIVES

9.01 Diabetic Dilated Fundus Exam – CPT II, Chart Documentation, Notifying the PCP

All eye doctors are aware of the importance of and clinical indications for providing all diagnosed diabetic patients with a full dilated retinal exam not less than annually. Our Health Plan clients are charged with measuring and monitoring the frequency with which their diabetic members receive this service. As the vision services network administrator, eyeQuest is obligated to help promote access to this service and to encourage our providers to provide documentation of the examination and findings. CMS has implemented the use of specific CPT II codes on applicable claims submitted to payers to improve the capability of documenting this exam. Per CMS guidelines, eyeQuest requires our providers to submit these additional service codes for all diabetic patients examined. The process and procedures are detailed below.

1. For all patients presenting with a medical history positive for diabetes, perform the usual eye exam including dilation and retinal evaluation;
2. Document the findings of the exam in the medical record per your usual protocol;
3. Submit the claim for services with the following documentation:
 - a. Use the applicable exam CPT-4 code, (e.g., 92004, 92014)
 - b. Include the additional (applicable) CPT II code 2022F, and if the patient was previously seen and there was no evidence of diabetic manifestations, also include code 3072F (see below)
 - c. Select and include the applicable diabetes diagnosis code(s) (e.g., 250XX);
4. Summarize the findings in the *eyeQuest Diabetic Summary Form* (or use your own letter) and submit the summary of findings to the member's PCP and eyeQuest by fax.

INDICATE THE APPLICABLE CPT II CODE(S) FOR THE MOST RECENT VISIT

CODE	DESCRIPTION
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2022F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist, documented and reviewed
3072F	Low risk for retinopathy (no evidence of retinopathy at last retinal exam)

9.02 Glaucoma Screening – Submitting supplemental billing code G0117

Current quality initiatives include the provision of a glaucoma screening for patients in certain high-risk groups and the collection of data substantiating the receipt of the screening. eyeQuest requires all providers to submit the applicable supplemental HCPCS code when billing the eye exam when the conditions and components of this screening are met.

Conditions of Coverage:

Medicare provides for annual coverage for glaucoma screening for eligible beneficiaries in the following high risk categories:

- Individuals with diabetes mellitus
- Individuals with a family history of glaucoma
- African-Americans age 50 and older
- Hispanic-Americans age 65 and older

Components of the Glaucoma Screening include:

1. A dilated eye examination with an intraocular pressure measurement; and
2. A direct ophthalmoscopy examination or a slit-lamp bio-microscopic examination.

The following HCPCS code applies for a Glaucoma Screening:

G0117 – glaucoma screening for high-risk patients furnished by an optometrist or ophthalmologist

10.00 UTILIZATION MANAGEMENT – GENERAL PROVISIONS

Overview

The priority of eyeQuest programs is to allow patients easy access to the care they require. This is best achieved by giving our participating providers simple, straightforward guidelines to follow in rendering and billing for the care patients require. We also appreciate the need for simplicity and consistency for the provider’s office and staff in working with this program.

10.01 Limitations to Delivery of Service

eyeQuest contracts with Managed Care Organizations (MCOs) for delivery of specific eye care services ranging from routine vision care to medical eye care, and in some cases, surgical services. Providers should always refer to the plan-specific Benefit Summary to determine the extent, limitations and range of “Covered Services” for a specific client or health plan. The subjects in this section may not apply to all Plans or clients.

Medical Management

One of the challenges we all face in the current health care system is finding the most appropriate balance between providing the care patients need and the entire scope of services that we are able to provide. Deciding what services are useful and which are truly necessary is what utilization management is all about.

One area in which we need to ensure there is no misunderstanding is baseline testing. Our comprehensive eye examination benefit is an important baseline procedure. This service provides a great deal of information about the patient’s eyes, health, vision, binocular functions and appropriate self-care. What is not necessary for every patient is the full scope of advanced documentation technologies that exist in the doctors’ offices. Many of these technology-driven procedures, such as pachymetry, fundus photography,

corneal topography, nerve fiber layer and retinal tomography, OCT, HRT, GDx, ultrasonography, wave front analysis, macula pigment density testing, tear film chemistry and others still being developed are wonderful adjuncts to our knowledge base for diagnosis and treatment of specific disease processes; however, they are not medically necessary procedures in an otherwise healthy, asymptomatic patient. For this reason, these procedures will not be covered when provided as baseline testing and payment will be denied.

Medical Prior Approval Process

eyeQuest uses Medical Prior Approval (MPA), a prospective authorization process, to assess medical necessity for all surgical procedures. MPA is sometimes used for certain ancillary services including:

- Pachymetry
- Fundus and anterior segment photography
- Corneal topography
- OCT
- HRT
- GDx
- Echography
- Punctal occlusion
- Medically necessary contact lens services
- Replacement eyewear
- Additional eye exam in excess of the state or Plan mandated frequency limits
- Specific optical services (beyond the standard, covered services as defined in a Plan Summary or state designated Benefit Program) when medically necessary

NOTE: Since the MPA requirements differ for each Program and Plan, the provider should always review the Plan Specific sections of this manual to ascertain the limit of covered services, and to verify when MPA is required for a specific procedure or service.

Our medical management staff and professional consultants utilize criteria established by CMS, the American Optometric Association (AOA), American Academy of Ophthalmology, Local Carrier Policy, and other standardized protocols to make applicable MPA determinations.

Claim Analysis and Physician Profiling

Along with the MPA process, eyeQuest utilizes a variety of retrospective procedures to assess and analyze the overall delivery system for waste, fraud and abuse. Such procedures include:

- Provider profiling
- Claim analysis
- MPA approval and denial rates
- Medical record review

All providers are subject to retrospective review and medical record audits at the discretion of eyeQuest.

Emerging Technologies

As research and technology advances and diagnostic and treatment modalities change, eyeQuest will work with our provider network to ensure that these guidelines and criteria remain current and appropriate.

We know unique conditions and situations will arise in clinical patient care. For this reason, eyeQuest is always available to review any individual request for MPA for services that, by generally accepted medical standards, would not be covered, but may be appropriate in a unique situation.

11.00 UTILIZATION MANAGEMENT – PROTOCOLS AND PROCEDURES

When a payer contract provides for a comprehensive program, our full eye care benefit will encompass routine vision care, (examination and dispensing of eyewear), as well as medical and possibly surgical management. **Although subject to payer specific contractual limitations and exclusions, a typical program will allow covered members access to all eye care services allowing participating providers to provide and bill for the appropriate service provided. eyeQuest will reimburse all contracted doctors for covered services, without regard to provider classification (physician or optometrist). We allow patients freedom of choice in the selection of their eye care provider. Patients seeking routine vision care services may self-refer to any participating office for care, without the need for a referral or gate-keeper.**

It is our belief and practice at eyeQuest, that doctors should be treated as trustworthy professionals. As such, we expect our doctors to provide the care patients need and bill for their services appropriately, i.e., not attempt to make a routine examination a medical service to receive higher reimbursements.

Optometrists and ophthalmologists may both provide routine vision care if they so choose; however, this will require the provision of both examination and eyewear dispensing services in the doctor's office at the standard contracted fees listed in the Provider Agreement. Because all offices that provide routine vision care will be required to provide eyewear dispensing services as well, the office will need to be aware of the protocols for supply and delivery of optical products. See Plan specific benefits for more information on the provision of optical services.

Routine Exam vs. Medical Exam

It is assumed that most initial patient visits are patients presenting for routine, periodic refractive exams. As such, they should be treated as a routine eye exam visits for the purposes of billing. It is expected that these patients will receive a comprehensive examination, including refraction and eyeglass prescription where applicable.

In this case the comprehensive examination should be coded as one of the following eye exam codes: 92002, 92004, 92012 or 92014.

There will be exceptions to this rule; e.g. when a patient initially presents with a chief complaint or concern meeting any of the following criteria. In these cases, the provider should most often bill using a 992XX (E/M) code:

1. The patient presents with an acute condition (infection, pain, trauma, sudden, acute or unexplained vision loss, etc.) which requires urgent evaluation and treatment and precludes the provision of a comprehensive examination, including refraction.
2. The patient presents for a follow-up visit for ongoing treatment or monitoring of a previously diagnosed medical condition as well as post-operative care not included in the global surgical fee coverage parameters.
3. A condition is discovered during the examination, including unexplained reduced corrected visual acuity, which requires more extensive evaluation, additional testing and/or treatment, but does not merely require a change in prescription to correct.
4. The patient presents for monitoring the development of an ophthalmologic manifestation of systemic disease, such as diabetes, sarcoidosis, sickle cell disease, ocular side effects of systemic medications and others.

NOTE: Primary "medical" encounters/examinations should always be billed using 992XX codes. In all of these situations, the claims will be subject to retrospective review. In the clinical situations noted above, which require a more extensive ocular examination, claims may be submitted with a 992XX code. When a refraction (92015) is submitted with this service it will account for the patient's annual examination benefit where applicable.

Our protocol for expediting prompt payment to the doctors for these medical office visits is to utilize payment by automated system processing of all 99201, 99202, 99203, 99211, 99212 and 99213 coded services. There may be instances where submittal of the medial record is required for payment of level 4 or level 5 E/M services.

Incidental Medical Findings

In the course of virtually any eye exam a doctor can find some type of incidental medical condition. Examples include conditions such as dry eye, long standing strabismus or amblyopia, headache, long standing PVD, Asthenopia, pinquecula, blepharitis, folliculosis, or seasonal allergic conjunctivitis. These additional (non-refractive error) findings will not by themselves justify the reporting of this encounter as a medical eye examination. **The basis for reporting the service code (CPT) for any exam shall be primarily contingent on the patient's entering chief complaint, not incidental findings.** The examination should be considered a comprehensive eye examination and should be billed as such using code 92002, 92004, 92012 or 92014, unless otherwise justified. The exception to this rule will be a situation in which the symptoms or findings are significant enough to prevent the completion of a comprehensive eye examination, including refraction. In this exceptional situation the visit may be billed as a medical office visit using the appropriate level 1, 2 or 3 E/M code (992XX). A routine examination may be rescheduled at any time after this condition has fully resolved.

Ancillary services or testing scheduled for the convenience of the doctor or the patient on a day other than the day of the comprehensive examination or medical office visit, shall be considered to have been provided as part of the initial examination or medical office visit and will not generate an additional office visit fee for the day on which the ancillary procedures are actually performed.

Any professional services provided at a location other than the doctor's office will be reimbursed up to a maximum of what the reimbursement would be if the service had been provided in the doctor's office. All services provided must meet our criteria for utilization and patient care, whether by MPA or by retrospective review

Any medical services that are necessitated due to prior treatment or surgery for a noncovered service will be considered a continuation of the episode of care for the noncovered service and the claim for these services will be denied.

Referrals

All patient referrals for further evaluation or care must be made to an approved eyeQuest or Health Plan participating provider. Any nonemergency referrals to a provider or facility outside of the current approved eyeQuest or Health Plan provider network will require MPA. **In certain cases, PCP referral coordination is required.** Please refer to the Plan-specific sections for additional details.

Additional Program Limitations

As with all health care programs, there are some limitations to coverage. Although not complete, most are listed in the categories below.

1. Services that are the responsibility of another insurer and not the responsibility of eyeQuest should be billed directly to the responsible party. eyeQuest and the Plan will not pay these claims as the primary payer. They include:
 - Automobile accidents
 - Job-related/workers' compensation claims
 - Instances where Medicare is the primary payer
2. Services not covered by this program are the complete financial responsibility of the patient. Except where specifically indicated as a "covered service," eyeQuest and the Plan will not pay these claims. These services, supplies and materials include:

- Refractive surgery, its complications, and postoperative care, including but not limited to:
 - Lasik
 - PRK
 - Intacs
 - Clear lens extractions
 - Implantable contact lenses
 - Radial keratotomy
 - Any cosmetic surgery, including but not limited to:
 - Cosmetic Blepharoplasty
 - Botox
 - Collagen fillers
 - Intraocular lenses not covered by primary Medicare
 - Services provided as part of clinical trials
 - Experimental procedures
 - Unspecified services (any CPT XX999)
 - Low vision services or devices
3. Services not covered by the eyeQuest Agreement with the Health Plan. Payment for specific routine and/or medical services or procedures is limited by the provisions and exclusions of any such Agreement. Providers may look to another payer for reimbursement for such excluded services.

Miscellaneous Medical Management Protocols (only applies only to contracts where eyeQuest is the payer for such services)

eyeQuest fully appreciates that certain patients require extensive diagnostic and treatment services to manage their ophthalmic condition(s). We are also aware that certain additional testing and procedures are not contributory to the diagnosis and management of their eye problem. Knowing certain procedures are subject to overutilization, we have established certain restrictive protocols for payment of these services. Providers will not be reimbursed for the services below without full clinical justification. All cases are subject to peer review for payment. See Plan Specific Benefits for other reimbursement limitations.

- Extended ophthalmoscopy (this code is not reimbursable when billed with retinal photography)
- Retinal photography (this code is not reimbursable when billed with extended ophthalmoscopy)
- Punctal occlusion
- Posterior segment OCT or imaging
- Anterior Segment OCT (this service is not reimbursable)
- Topography

Emergency Treatment

Appropriate medical care for patients may require emergency treatment that cannot wait for an MPA process to be completed. In all situations, the doctor should provide the care that is appropriate for the patient in a time and manner consistent with good, accepted medical practice.

After care has been provided, the office may submit for a retrospective review of the service provided. This retro-review will ensure your claim for this service will be authorized for payment.

Second Opinions

In many states, Medicaid rules allow patients to seek a second opinion for medical or surgical treatment. As it is not always possible for us to know a patient is seeing a doctor for a second opinion, the system may deny that claim as a duplicate service billing.

To avoid this potential denial, offices providing second opinions should attempt to submit for a MPA. This will ensure that such claims will be authorized for payment. If a claim is rejected by the system, an MPA

should be requested before the bill is resubmitted for payment. The same criteria and process will be utilized for the retrospective review as is used for the usual MPA process.

Clinical Criteria for Common Procedures

The Company uses clinically relevant criteria for determining the medical necessity of certain procedures. Such protocols have been developed through the use of American Academy of Ophthalmology (AAO) or AOA best practice standards; CMS, Local Carrier Policy, Peer Review Committees, and common consensus of qualified ophthalmologists and optometrists. Representative examples for the more common procedures may be included in the Plan specific sections.

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APPENDIX A (ATTACHMENTS)

General Definitions

The following definitions apply to the *eyeQuest Office Reference Manual*:

- A. "Benefits" are the services members are eligible to receive under a Plan Certificate of coverage.
- B. "Contract" means the document specifying the services provided by eyeQuest to:
- A Medicaid beneficiary, directly or on behalf of a Plan, as agreed upon between the State or its regulatory agencies or Plan and eyeQuest (a "Medicaid Contract")
 - A Medicare beneficiary, directly or on behalf of a Plan, as agreed upon between the Center for Medicare and Medicaid Services ("CMS") or Plan and eyeQuest (a "Medicare Contract")
- C. "Covered Services" are those vision or eye care services or supplies that satisfy all of the following criteria:
- Provided or arranged by a participating provider to a member;
 - Authorized by eyeQuest in accordance with the Plan Certificate; and
 - Submitted to eyeQuest according to eyeQuest's filing requirements.
- D. "eyeQuest Service Area" shall be defined as the specific counties within the state which the Plan has contracted with eyeQuest to provide covered services.
- E. "Medically Necessary" means a service or benefit is medically necessary if it is compensable under the Kentucky Medicaid Program and if it meets any one of the following standards:
- The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.
 - The service or benefit will, or is reasonably expected to, reduce or ameliorate, the physical, mental, or developmental effects of an illness, condition, injury or disability.
 - The service or benefit will assist the individual in achieving or maintaining maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities that are appropriate for individuals of the same age.
 - Determination of medical necessity for covered care and services must be documented in writing.
- The determination is based on medical information provided by the member, the member's family/caretaker and the eye doctor and PCP, as well as any other providers, programs or agencies that have evaluated the member.
- All such determinations must be made by qualified and trained health care providers. A health care provider who makes such determinations of medical necessity is not considered to be providing a health care service under this Agreement.
- F. "Member" means any individual who is eligible to receive covered services pursuant to a contract and the eligible dependents of such individuals. A member enrolled pursuant to a Commercial Contract is referred to as a "Commercial Member." A member enrolled pursuant to a Medicaid Contract is referred to as a "Medicaid Member." A member enrolled pursuant to a Medicare Contract is referred to as a "Medicare Member."
- G. "Participating Provider" is a vision or eye care professional or facility or other entity, including a provider that has entered into a written agreement with eyeQuest, directly or through another entity, to provide vision or eye care services to selected groups of members.
- H. "Plan" is an insurer, health maintenance organization or any other entity that is an organized system which combines the delivery and financing of health care and which provides basic health services to enrolled members for a fixed prepaid fee.
- I. "Plan Certificate" means the document that outlines the benefits available to members.
- J. "Primary Care Practitioner (PCP)" is a specific physician, physician group or other health professional designated by a Plan operating under the scope of his/her licensure, and who is responsible for supervising, prescribing, and providing primary medical services; locating, coordinating and monitoring other medical care and rehabilitative services; and maintaining continuity of care on behalf of a member.

Provider Change Form

Please find the Provider Update and Change Form on the web portal at www.eye-quest.com in the “Forms” area.

Eligibility Verification Request Form Routine Vision

Patient Information

Member Identification Number	Patient Birth Date / /	Age
Patient Name (Last, First, Middle)		Sex (M/F)

Provider Information

Provider Number-NPI	Provider Name	
eyeQuest User Number	Office Name	
Street Address		Telephone Number ()
City/State		ZIP Code

Please provide authorization for the above referenced member.

Signature of Requesting Provider

Date

For office use only:

Approval Authorization # _____ Denial: _____

Type: Examination Only _____ Reason: _____
 Materials Only _____
 Examination and Materials _____

Approved by: _____

Date: _____

eyeQuest- Medical and Surgical Prior Approval Request / Determination

Submit by facsimile to: 1-888-696-9552 or email to: eyequest@dentaquest.com	KENTUCKY	Submittal Date: ____/____/____
Primary Carrier/Coverage? ____ Anthem Blue Cross and Blue Shield Medicaid		
Member Identification #		
Patient Name:		Date of Birth:
Provider/Dr. NPI:		eyeQuest User ID:
Provider/Dr. Name:		Office Name:
Address:		Phone Number:
City:		Fax Number:

PROCEDURE/SERVICE(S) REQUESTED

<u>CPT/ICD-9(10)</u>	<u>Specified Eye</u>	<u>Place of Service</u>	<u>ASC or Facility Name</u>
/	OD OS OU	___ Office ___ Facility	
/	OD OS OU	___ Office ___ Facility	
/	OD OS OU	___ Office ___ Facility	
/	OD OS OU	___ Office ___ Facility	

Are patient records included? **Y** or **N**

Request is: ___std.(14d) ___urgent(3d) ___emergent/stat (24hrs)

Additional information/comments (if urgent or stat request, indicate reason and proposed surgical date):

Submitting Office Contact Person:	Phone:
-----------------------------------	--------

Determination / Disposition

¹[] BILL MEDICARE INITIALLY WHEN MEDICARE IS THE PATIENT'S PRIMARY COVERAGE

Request is deferred pending:

[] Secondary review [] Receipt of additional information; specifically:

--

REQUEST REVIEWED BY:

SIGNED

DATE OF DETERMINATION

--

ALLOW TWO DAYS TO RECEIVE AN INITIAL DETERMINATION IN ALL NON-URGENT CASES

PATIENT FINANCIAL RESPONSIBILITY NOTICE AND DISCLAIMER

Directions and Use

eyeQuest has included the following Patient/Member *Financial Responsibility Notification* form for use when members request professional or optical services not covered under the Plan Certificate. Members may be billed for noncovered services if they willingly elect to receive such noncovered services, understand the financial responsibility involved in receiving such services and agree to be financially responsible for such services in advance of delivery.

As a participating provider, you have agreed to hold covered members harmless for Covered Services and should make best efforts to minimize out of pocket expenses. In certain circumstances, when the aforementioned requirements have been fulfilled, members may elect to receive a noncovered service and be financially responsible for such services. The Disclosure and Agreement form has been provided as an option for securing member consent of financial responsibility. Examples of circumstances where members may be billed include:

- Noncovered frames
- Noncovered lens types or options
- Noncovered professional services
- Additional eye wear, beyond the limits of the benefits (provider must first receive a prior denial)
- Additional eye exams beyond the limits of the benefits (provider must first receive a prior denial)
- Cosmetic contact lens related professional and materials services

Providers should proceed as follows when a member elects to purchase services or materials that have been determined to be noncovered:

1. Explain to the member what the covered services include.
2. Explain why the service the member is requesting is not a covered service.
3. Have the member verbally express their understanding that they will be responsible for payment of the optional service and how much they will be responsible to pay.
4. Review the completed Patient Financial Responsibility Notification form with the member and have them acknowledge their understanding. Have the member sign the form.
5. Keep the form in the patient record permanently.

MEDICAID FINANCIAL RESPONSIBILITY NOTIFICATION

Provider Name: _____

Provider may bill the member when the Plan or eyeQuest has denied prior authorization or the service is not covered. The following conditions must be met:

1. The member (patient) must be notified that the service to be rendered is their personal financial liability **in advance** of service delivery.
2. The notification by the provider is in writing, specific to the service being rendered, and clearly states that the member is financially responsible for the specific service.
3. A general patient liability statement signed by all patients or for all services is **not** sufficient for this purpose.

PROVIDER SECTIONList specific service(s) / product(s) to be rendered: _____

Date of Service: _____

List amount member will be responsible for: \$ _____

MEMBER SECTION

I understand that the service to be provided has not been approved by eyeQuest or Plan OR is **not** a covered service. I clearly understand that I will be billed by the provider for this service and that **I am financially liable**. The provider may not submit a bill to eyeQuest.

Member Name: _____

Member/Guardian Signature: _____ Date: _____

DIABETIC RETINAL EYE EXAM SUMMARY

1. Please complete this form for all patients with diabetes seen through your eyeQuest contract and send to:
 - eyeQuest (fax to 1-888-696-9552)
 - Member's PCP

2. Make a point of notifying the member's PCP to remind them of the need to refer all members with diabetes for annual dilated fundus exams.

INDICATE THE APPLICABLE CPT II CODE(S) FOR THE MOST RECENT VISIT

PATIENT/MEMBER INFORMATION	CONSULTING EYE DOCTOR
Patient Name:	Provider Name:
Health Plan Name:	Address:
Member ID#:	City: State: ZIP Code:
Date of most recent dilated exam:	

[x]	CODE	DESCRIPTION
2022F		Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed
3072F		Low risk for retinopathy (no evidence of retinopathy at last retinal exam)

If known, how was the patient referred to your office or what is the reason for the exam?

<input type="checkbox"/> ADA flyer	<input type="checkbox"/> Visual Symptoms	<input type="checkbox"/> Communication from Health Plan
<input type="checkbox"/> Physician recommendation	<input type="checkbox"/> Normal Recall Notice	<input type="checkbox"/> Other

<input type="checkbox"/> Diabetic by history (with no retinopathy)
<input type="checkbox"/> Background Diabetic Retinopathy (BDR)
<input type="checkbox"/> Diabetic Macular Edema (DME)
<input type="checkbox"/> Proliferative Diabetic Retinopathy (PDR)
<input type="checkbox"/> Other:

**Findings From Most Recent Eye Exam
Disposition**

<input type="checkbox"/>	Follow-up annually
<input type="checkbox"/>	Observation – Follow-up every _____ months
<input type="checkbox"/>	Recommend Retinal Specialist Consult
<input type="checkbox"/>	Recommend the following procedure(s):
<input type="checkbox"/>	-Panretinal Photocoagulation (PRP)
<input type="checkbox"/>	-Focal/grid laser
<input type="checkbox"/>	-Fundus photography
<input type="checkbox"/>	-Fluorescein angiography

FAX COMPLETED FORM (OR SIMILAR SUMMARY) TO EYEQUEST AND THE MEMBER'S PCP

APPENDIX B - HEALTH PLAN SPECIFIC PROGRAM DETAILS

The following section(s) will detail the benefits and protocols specific to individual payer (Health Plan) contracts.

Although certain procedures, policies and protocols will apply to all Plans (see Section A of this Manual), specific benefits may differ between the various programs. As you begin to deliver care to covered members, please refer to the Plan-specific sections for detailed explanation and delineation of:

- Program type
- Covered lives/ID card sample
- Covered services/member benefits
- Limitations and excluded (noncovered) services
- Routine exam and materials frequency limits
- Options for fabrication and supply of optical materials (including initial and replacement eyewear)
- Services requiring MPA
- Plan specific appeals and grievances
- Other

Appendix B

Although certain procedures, policies and protocols will apply to all Programs (see Section A of this manual), specific benefits may differ between the various lines of business. As you begin to deliver care to **Anthem Blue Cross and Blue Shield Medicaid** members, please refer to the following Plan-specific sections for detailed explanation and delineation of:

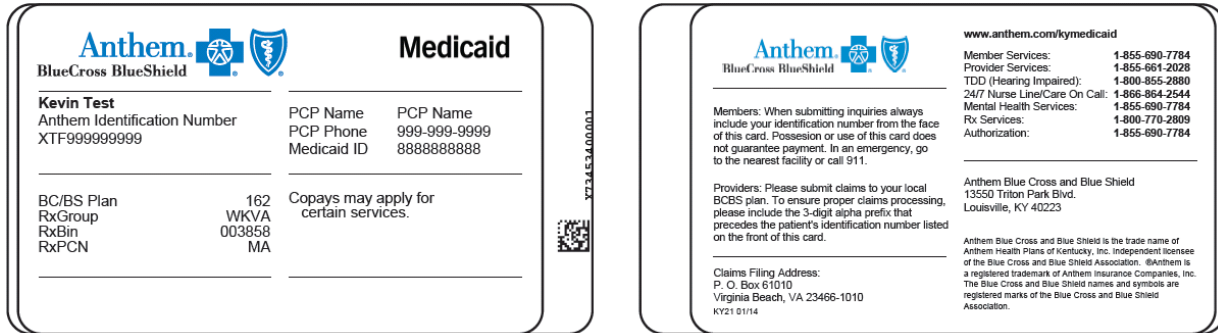
- Program type
- Covered lives/ID card sample
- Covered services/member benefits
- Limitations and excluded (noncovered) services
- Routine exam and materials frequency limits
- Options for fabrication and supply of optical materials (including initial and replacement eyewear)
- Services requiring Medical Prior Approval (MPA)
- Other

Program Type: Managed Care; Adult and Pediatric

Service Area: State of Kentucky; all applicable counties (Region 3 is excluded)

Covered Lives: Enrollees of the Anthem Blue Cross and Blue Shield Medicaid Program

ID Card Sample:



Verifying Eligibility: Providers should utilize the eyeQuest web portal for eligibility verification.

Covered Benefits: A summary of covered services and limitations for each line of business is found on the following pages.

Exclusive Optical Lab: eyeQuest has chosen **Classic Optical Labs (Classic)** as the exclusive provider of covered eyewear for this program.

Frame Selection: Each contracted provider office shall have a sample collection of standard frames that are approved for this program.

Ordering Eyewear: Placing your eyeglass orders is easy. The most efficient way is through the web portal at <http://eye-quest.com>. Once you log on with your username and password (*first time users will need their eyeQuest user number, individual Provider NPI number and an email address to obtain a username and password*) you will have access to a range of lab services including:

- Verifying member eligibility for eyewear
- Placing eyeglass orders
- Tracking eyeglass orders

Additional details on supply and ordering eyewear through Classic is available in the eyeQuest web portal. Providers will find step-by-step instructions for ordering and supply of eyewear at www.eye-quest.com.

Submitting Claims: All claims will be submitted from the eyeQuest web portal. Claim submittal tutorial and detailed instructions for submitting claims is found on the web portal.

**Anthem Blue Cross and Blue Shield Medicaid
MEDICAID PROGRAM ENROLLEES**

Benefit Criteria and Limitations – at a glance (for participating providers)

Exam Services:	<u>Members Age 20 AND YOUNGER (1055)</u>	<u>Members Age 21 AND OLDER (1054)</u>
<i>Eye Exam - Routine</i>	<ul style="list-style-type: none"> • One exam every 12 months; service date to service date. • NO COPAYMENT APPLIES 	<ul style="list-style-type: none"> • One exam every 12 months; service date to service date. • NO COPAYMENT APPLIES
Optical Services:		
<i>Frames; standard</i>	<ul style="list-style-type: none"> • One frame every 12 months. • NO COPAYMENT APPLIES 	N/A
<i>Lenses; standard</i>	<ul style="list-style-type: none"> • One pair of lenses every 12 months. • Polycarbonate lenses are covered as the standard material for all eyewear • NO COPAYMENT APPLIES 	N/A
<i>Lenses; non-standard</i>	Nonstandard lens materials and features may be covered when medically indicated. See Clinical Criteria for Optical services in this manual for additional details on coverage.	N/A
<i>Replacement Eye Wear</i>	One pair of replacement eyeglasses within the 365-day period may be provided with prior authorization from eyeQuest. Criteria: Loss or breakage of original pair OR medical necessity for replacement must be established. KY EPSDT replacement criteria: replacement after two pairs have been dispensed within the benefit year.	N/A
<i>Medically Necessary Contact Lenses</i>	One pair annually in lieu of frame and lenses when such lenses provide superior, functional therapeutic management of a specified visual or ocular condition. Diagnosis including, but not limited to: <ul style="list-style-type: none"> • Keratoconus when vision with glasses is WORSE than 20/50 • Other corneal irregularity from any condition when vision with glasses is less than 20/50 • Anisometropia that is greater than or equal to 4D • Refractive Error > 8D in any meridian • Other indications may apply 	N/A
<i>Optometric Medical Eye Care Services</i>	<ul style="list-style-type: none"> • Covered as indicated and necessary, subject to precertification, retrospective review and frequency limitations, where applicable. • NO COPAYMENT APPLIES 	<ul style="list-style-type: none"> • Covered as indicated and necessary, subject to precertification, retrospective review and frequency limitations, where applicable. • NO COPAYMENT APPLIES
<i>Referral Requirements</i>	<ul style="list-style-type: none"> • No referral is required for access to annual, routine eye care services or other optometric services. 	<ul style="list-style-type: none"> • No referral is required for access to annual, routine eye care services or other optometric services.

Services covered with applicable frequency limitations and medical necessity restrictions

Code	Description
92002	Eye Exam, New Patient (Intermediate)
92004	Eye Exam; Comprehensive, New Patient
92012	Eye Exam, Established patient (Intermediate)
92014	Eye Exam; Comprehensive, Established Patient
92015	Refractive Exam
99201	Level I Office Visit
99202	Level II Office Visit
99203	Level III Office Visit
99204	Level IV Office Visit
99205	Level V Office Visit
99211	Level I Office Visit
99212	Level II Office Visit
99213	Level III Office Visit
99214	Level IV Office Visit
99215	Level V Office Visit
65205	Removal Foreign body. Conjunctival - no slit lamp
65210	Removal Foreign Body
65220	Removal Foreign Body; Corneal
65222	Removal Foreign Body; Conjunctival
65430	Scraping Of Cornea, Diagnostic
65435	Removal Of Corneal Epithelium
67820	Correction Of Trichiasis; Epilation
68761	Closure Lacrimal Punctum; By Plug
68801	Dilation Lacrimal Punctum
68810	Probing Nasolacrimal Duct
76511	Ophthalmic Ultrasound, Diagnostic, A-Scan Only
76512	Ophthalmic B-Scan
76514	Pachymetry
92020	Gonioscopy with Medical Reason And Report
92060	Sensorimotor Exam
92065	Orthoptic/Pleoptic Training
92081	Visual Field Exam, Limited
92082	Visual Field Exam, Intermediate
92083	Visual Field Exam, Extensive
92100	Serial Tonometry
92133	retinal imaging; optic nerve
92134	retinal imaging; retina
92140	Provocative Tests For Glaucoma
92225	Ophthalmoscopy; Extended
92226	Ophthalmoscopy; Extended; Subsequent
92250	Fundus Photography
92283	Color Vision Exam; Extended
92285	External Ocular Photography
92286	Specular Microscopy

Services not covered by eyeQuest

- Services provided by a non-network provider
- Medical services performed only by ophthalmologists
- Surgical services performed only by ophthalmologists
- Injectable or infused medications
- Any services that are considered investigational, experimental or associated with a clinical trial
- Radiology, imaging or radiation services
- Hospital-based consultations or surgery; including inpatient, outpatient and Emergency Department services
- Ocular prosthesis and ocularist services
- Low vision services and devices

A. Providing Covered-in-Full Eyewear:

(APPLIES TO ALL EYEWEAR THAT IS COVERED-IN-FULL BY THE BENEFIT PLAN AND SUPPLIED BY CLASSIC OPTICAL)

This section applies to eyewear supplied for members under the age of 21.

Members/patients requiring eyeglasses will select a frame from the standard sample kit, and also elect to receive standard, covered-in-full lenses. In these cases, the member will incur no out-of-pocket costs, the provider will proceed to order the materials from Classic as instructed, and the provider will automatically receive the designated dispensing fee (e.g., for 92340) from eyeQuest.

Dispensing payments will be made for approved replacements provided that 60 days from the original date of dispensing have passed.

Plan-covered Lenses:

All lenses will be provided by the eyeQuest designated optical laboratory (*Classic*). Standard lenses include single vision, bifocal and trifocal (flat-top) lenses. All lens orders will be automatically filled in polycarbonate material. If the provider feels the patient requires other medically necessary, non-elective optical features or non-standard materials, Medical Prior Approval is required. See below for additional details on procedures for obtaining approval.

Plan Covered Frames:

Only frames selected from the *Classic Optical* supplied samples are considered covered-in-full frames.

B. Providing Non-Plan Covered Eye Wear:

In some instances, members may desire to purchase noncovered lenses (or lens features, e.g., A/R coating), or they may wish to use their own frame or elect to purchase an upgraded frame directly from the provider. In these cases, the provider should proceed as indicated below.

Non-Plan Covered Lenses (elective upgrade):

If a member selects non-plan covered lenses, the provider shall proceed as follows:

- The provider should formally document that the member understands their financial responsibility for such elective and non-covered service(s), and they have opted to pay such out-of-pocket fees.
- The provider shall collect the applicable lens buy-up charges from the patient.
- If the member is ordering a Plan covered frame (with upgraded lenses), the provider will submit the order to *Classic* in the usual way. *Classic* will fabricate the lenses and ship the complete job to the provider.
- The provider will see the applicable lab charge as a debit on their next remittance advice from eyeQuest.*

Non-Plan Covered Frames (elective upgrade):

If a member elects to not use a plan covered frame, the provider shall proceed as follows:

- Forward the owned or purchased frame to *Classic* for lens supply. The frame should be sent via traceable shipping means; the cost of postage (to the laboratory) shall be payable by the provider. *Classic* is not responsible for replacing frames lost in transit, nor will they be responsible for replacement in the event of breakage. *Please be sure patients understand the laboratory is not responsible for breakage. A signed waiver is a good practice to follow.*
- When placing the laboratory order for lenses please indicate that a non-plan frame was selected. This will place the lens order and pend it for arrival of the frame.

- If the non-plan frame requires drilled mount or rimless mounting, the laboratory charges an additional fee of \$25.00. Please add this amount to the members charge for the frame as it will be deducted from your payment.
- In the rare event that a patient-owned frame is lost in transit back to the provider's office, Classic shall be responsible for not more than \$50 in reimbursement for replacement.

*See Exhibit II for a listing of allowable member charges and provider lab fees for elective lens and frame upgrades.

NOTE: The Kentucky Medicaid Visual Services Program does not reimburse for:

- Low-vision therapy
- Low-vision devices
- Progressive lenses
- Transition lenses
- Glass lenses

c. Services Requiring Medical Prior Approval (MPA):

1. Replacement Eye Wear:

Medicaid program members may be eligible to receive replacement eye wear in the event of loss or when damaged beyond repair. The KY EPSDT Special Services Program provides for replacement eyewear in the event the vision program has paid for the initial pair(s). See below for specific criteria for coverage.

2. Additional Eye Exams (above the state- or Plan-mandated limit):

Medicaid members under the age of 21 may be eligible to receive additional eye exams when indicated and necessary, as indicated below.

Service	General Clinical Criteria for Approval*
Replacement of eyewear	<ul style="list-style-type: none"> • Glasses are lost or broken and not repairable; and/or • Prescription change of greater than .50 diopters
Subsequent eye exam within the benefit period	<ul style="list-style-type: none"> • Failed school screening and referred by school or PCP/pediatrician

3. Medically Necessary Optical Services (all optical services beyond the standard benefit require MPA)

Certain, nonstandard lens options may be covered when determined to be medically necessary. Kentucky Medicaid mandates prior authorization when the provider requests the following optical features:*

HCPCS	Description	General Clinical Criteria for Approval*
V2410	Aspheric lens; single vision	Over + 7.00 diopters of power
V2718	Press on Prism	Diplopia
V2744	Photochromatic Single Vision or MF (plastic)	Ocular Albinism; Aniridia
V2745	Solid Tint	Ocular Albinism; Aniridia
V2755	Ultraviolet Coating	Aphakia

V2782	High Index; up to 1.65	Greater than + or - 8 diopters of power in any meridian
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*Other conditions may be applicable in rare circumstances. Providers requesting coverage for nonstandard features should submit narrative request and full medical records for review (see MPA Form).

4. Contact Lens Services Requiring MPA

Members requiring contact lenses for medical necessity may receive a fitting, training and follow-up care in conjunction with contact lens materials, consistent with the services provided to your private patients. Contact lenses and contact lens services are covered when prior-authorized according to criteria established by Kentucky Medicaid. eyeQuest will authorize medically necessary contact lenses under the following conditions:

- To correct for aphakia;
- To correct high refractive errors, (greater than or equal to eight diopters);
- When there is a high degree of anisometropia (four diopters) where improved binocularity can be substantiated;
- To treat keratoconus, or in cases where there is a high corneal astigmatism or corneal irregularities when the visual acuity cannot be corrected to 20/50 in the better eye with spectacles and there is a significant improvement with contact lenses.

Please use the appropriate CPT-4 Professional Services fitting code and applicable HCPCS code(s) for the materials provided (V2500-V2530) along with the MPA number on your claim.

5. Special Optometric Procedures and Services Requiring MPA

One of the challenges in the current health care system is finding the most appropriate balance between providing the care patients need and the entire scope of services we are able to provide.

One area in which there should be no misunderstanding is the area of baseline testing. Certainly the comprehensive eye examination benefit is an important baseline procedure. What is not necessary for every patient is the full scope of advanced documentation technologies that exist in the doctors' offices. Many of these technology-driven procedures, such as pachymetry, fundus photography, corneal topography, nerve fiber layer and retinal tomography, OCT, HRT, GDX, echography, wave front analysis, macula pigment density testing, tear film chemistry and others are wonderful adjuncts to our knowledge base for diagnosis and treatment of specific disease processes; however, they would rarely rise to the level of medically necessary procedures in an otherwise healthy, asymptomatic patient. For this reason, these procedures will not be considered to be covered services when provided as "baseline testing" and payment will be denied.

D. Clinical Criteria

The following criteria describe the recommended guidelines for the most common ancillary and optical procedures provided. Although individual cases may present with unique indications and clinical justification, these guidelines should be followed for the provision of prudent, cost-effective care.

PLEASE FIND INDIVIDUAL CRITERION ON THE EYEQUEST WEB PORTAL

E. Quality Initiatives

Diabetic Dilated Fundus Exam — CPT II, Chart Documentation, Notifying the PCP

All eye doctors are aware of the importance of and clinical indications for providing all diagnosed diabetic patients with a full dilated retinal exam, not less than annually. Our Health Plan clients are charged with measuring and monitoring the frequency with which their diabetic members receive this service. To improve the capability of documenting this exam, CMS has implemented the use of specific CPT II codes on applicable claims submitted to payers. Per those CMS guidelines eyeQuest is requiring our providers to submit these additional service codes for all diabetic patients examined. The process and procedures are detailed below.

1. For all patients presenting with a medical history positive for diabetes; perform the usual eye exam including dilation and retinal evaluation;

2. Document the findings of the exam in the medical record per your usual protocol;
3. Submit the claim for services with the following documentation:
 - a. Use the applicable exam CPT-4 code, (e.g., 92004, 92014)
 - b. Include the additional (applicable) CPT II code 2022F and if the patient was previously seen and there was no evidence of diabetic manifestations your will also include code 3072F (see below)
 - c. Select and include the applicable diabetes diagnosis code, e.g., **250XX**;
4. Summarize the findings in the *eyeQuest Diabetic Summary Form* (or use your own letter) and submit the summary of findings to: (i) the member's PCP, and (ii) eyeQuest, by facsimile.
INDICATE THE APPLICABLE **CPT II** CODE(S) FOR THE MOST RECENT VISIT

CODE	DESCRIPTION
2022F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist; documented and reviewed
3072F	Low risk for retinopathy (no evidence of retinopathy at last retinal exam)

Glaucoma Screening — Submitting supplemental billing code G0117

Current quality initiatives include the provision of a glaucoma screening for patients in certain high-risk groups and the collection of data substantiating the receipt of the screening. eyeQuest requires all providers to submit the applicable supplemental HCPCS code when billing the eye exam, when the conditions and components of this screening are met.

Conditions of Coverage:

Glaucoma screening for eligible beneficiaries in the following high-risk categories:

- *Individuals with diabetes mellitus*
- *Individuals with a family history of glaucoma*
- *African-Americans age 50 and over*
- *Hispanic-Americans age 65 and over*

Components of the Glaucoma Screening include:

1. *A dilated eye examination with an intraocular pressure measurement; and*
2. *A direct ophthalmoscopy examination or a slit-lamp biomicroscopic examination.*

The following HCPCS code applies for a Glaucoma Screening:

G0117 – *“glaucoma screening for high-risk patients furnished by an optometrist or ophthalmologist”*

Exhibit II

eyeQuest Price List for Optional Optical Buy-up Services
(per pair)

Service Description	HCPSC Code	Member Charge if not covered as Medically Necessary	Additional Dispensing Fee to Provider	Lab Charge (Amount Deducted From Provider Payment)	NOTES AND COMMENTS
Aspheric; single vision	V2410	70.00	10.00	60.00	When not medically necessary
Aspheric; bifocal	V2430	70.00	10.00	60.00	
Photochromatic Single Vision	V2744	\$80.00	\$10.00	\$70.00	When not medically necessary
Photochromatic Multifocal	V2744	\$100.00	\$15.00	\$85.00	When not medically necessary
Solid Tint	V2745	\$10.00	\$2.00	\$8.00	When not medically necessary
Gradient Tint	V2746	\$12.00	\$2.00	\$10.00	Noncovered service
A/R Coating Generic	V2750	\$45.00	\$5.00	\$40.00	Noncovered service
A/R Coating Premium	V2751	\$70.00	\$8.00	\$62.00	Noncovered service
Ultra Violet Coating	V2755	\$15.00	\$3.00	\$12.00	When not medically necessary
Polarized Single Vision	V2762	\$40.00	\$2.00	\$38.00	Noncovered service
Polarized Multifocal	V2762	\$50.00	\$2.00	\$48.00	Noncovered service
Edge Polish	V2763	\$12.00	\$3.00	\$9.00	Noncovered service
Edge Coat	V2764	\$50.00	\$5.00	\$45.00	Noncovered service
Progressive; Standard	V2781	\$60.00	\$15.00	\$45.00	Noncovered service
Progressive; Premier	V2781	\$90.00	\$20.00	\$70.00	Noncovered service
Mid Index; less than or equal to 1.65 (excludes poly)	V2782	\$70.00	\$10.00	\$60.00	When not medically necessary covered when Rx is greater than +/- 8D
Hi Index; 1.66 or greater (excludes poly)	V2783	\$100.00	\$15.00	\$85.00	Noncovered service
Rimless Mount or Drill Mount (non-contract frame)	V2199	\$25.00	\$0.00	\$25.00	Noncovered service