APRIL 2023

# Louisiana Medicaid Provider Manual

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# 2023 UPDATES

Updates to the 2023 Louisiana Medicaid Provider Manual can be found below.

| Status | Topic | Summary | Location | Effective Date |
|---|---|---|---|---|
| New | Client-Specific Information | Added lab network requirements information in the Aetna Better Health of Louisiana section. | Client-Specific Information, page 73 | TBD |
| New | Footer | Added new footer with effective date and state. | Every page | 04/01/2023 |
| Addition | Documentation | Added language around notation of coverage discussion. | Requirements, page 25 | 04/01/2023 |
| Addition | Medicare and Medicaid Participation | Added language around state Medicaid agency enrollment. | Requirements, page 29 | 04/01/2023 |
| Update | Telemedicine | Renamed "Telemedicine" to "Remote vision care exam." | Requirements, page 30 | 04/01/2023 |
| Addition | Third-Party Liability | Added table clarifying third-party liability. | Claims, page 38 | 04/01/2023 |
| Addition | Product Catalogs | Added links to Louisiana product catalogs. | Services and Materials, page 52 | 04/01/2023 |
| Update | Quality Assurance | Combined all QA definitions into one section. | Quality Assurance, page 58 | 04/01/2023 |
| Addition | Covered Services | Added benefit information for Aetna Better Health of Louisiana regarding adult benefits. | Client-Specific Information, pages 72-73 | 04/01/2023 |
| Addition | Limitations and Exclusions | Added limitations and exclusions for Aetna Better Health of Louisiana regarding adult benefits. | Client-Specific Information, pages 73-74 | 04/01/2023 |
| Update | Client-Specific Information | Streamlined information in the Aetna Better Health of Louisiana section. | Client-Specific Information, pages 71-83 | 04/01/2023 |

# INTRODUCTION

EyeMed Vision Care® administers the routine vision network for some health plans in Louisiana. See the Client-Specific Information section for the latest list of health plans and their unique coverage details.

Although relevant provisions are summarized here as appropriate, you are contractually obligated to adhere to and comply with all the terms listed in this provider manual, your provider agreement, the Louisiana Provider Manual, and all federal and state regulations applicable to providers. While this manual contains basic information, the Louisiana Department of Health (LDH) requires that you fully understand and apply LDH requirements when administering covered services. Please refer to https://ldh.la.gov/ for more information about LDH.

Additionally, you are responsible for ensuring that all employees read and adhere to the policies and regulations explained in this manual and on https://ldh.la.gov/.

This Provider Manual is confidential and should not be shared with third parties.

Effective Date: April 201, 2023

# ABOUT MEDICAID IN LOUISIANA

The Medicaid Program is a joint federal/state program, established and administered by the State of Louisiana, that provides medical benefits to low-income individuals and families.

The Louisiana Bureau of Health Services Financing (BHSF), an agency under the Louisiana Department of Health (LDH), administers the Louisiana Medicaid program. Over a million residents in Louisiana receive health care coverage through Medicaid, most of whom are children under 19.

Several programs comprise Louisiana's Medicaid Program. A brief overview of the relevant programs are included below, but for more information on additional programs and requirements, please visit https://ldh.la.gov/page/220.

- **Act 421-Children's Medicaid Option/TEFRA** is a program that helps families with children younger than 19 years old who have a disability receive care in their home rather than an institution.
- **LaCHIP** is a health insurance program that provides health coverage to uninsured children up to age 19. It is a no-cost health program that pays for hospital care, doctor visits, prescription drugs, shots and more.
- **LaCHIP Affordable Plan** is a health insurance program for uninsured children in moderate income families whose income is too much to qualify for regular LaCHIP.
- **Value-added vision benefit for adults** is not currently covered by Louisiana's Medicaid program, but some Managed Care Organizations (MCOs) may cover them. Refer to the Client-specific information section for details.
- **Chisholm**. Class members in Chisholm v. LDH (Case 2:97-cv-03274) are defined as follows: All current and future beneficiaries of Medicaid in the state of Louisiana under age 21 who are now on or will in the future be placed on the Developmental Disabilities Request for Services Registry.
    - You must comply with all court-ordered requirements as directed by LDH, including, but not limited to, guidance provided in the Chisholm Compliance Guide.
    - The target population is defined as follows:
        - Medicaid-eligible individuals over age 18 with serious mental illness (SMI) currently residing in nursing facilities;
        - Individuals over age 18 with SMI who are referred for a Pre-Admission Screening and Resident Review (PASRR) Level II evaluation of nursing facility placement during the course of your agreement with LDH, or have been referred within 2 years prior to the effective date of your agreement with LDH;
        - Excludes those individuals with co-occurring SMI and dementia, where dementia is the primary diagnosis.

# Services for children/EPSDT

- **About EPSDT.** EPSDT is the component of Louisiana Medicaid that provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, developmental and specialty services.
    - EPSDT was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA '89) legislation and includes periodic screening, vision, dental, and hearing services. In addition, Section 1905(r)(5) of the Social Security Act (the Act) requires that any medically necessary health care service listed at Section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population.
    - The acronym stands for:
        - Early: Assessing and identifying problems early.
        - Periodic: Checking children's health at periodic, age-appropriate intervals.
        - Screening: Providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems.
        - Diagnostic: Performing diagnostic tests to follow up when a risk is identified.
        - Treatment: Control, correct or reduce health problems found.
- **EPSDT coverage for vision.** Medicaid recipients under the age of 21 are eligible for checkups, including a health history, physical exam and vision checks/screens. They are available both on a regular basis and whenever additional health treatment or services are needed. EPSDT screens may help to find problems, which need other health treatment or additional services.
    - Children under 21 are entitled to receive all medically necessary health care, diagnostic services, treatment and other measures covered by Medicaid to correct or improve physical conditions. This includes a wide range of services not covered by Medicaid for recipients over the age of 21.
- **Periodicity schedule.** The American Academy of Pediatrics publishes periodicity schedules that identify minimum guidelines for EPSDT screenings. You can view updated schedules on their website at http://brightfutures.aap.org/clinical_practice.html. ABHLA adheres to the schedule with the following two exceptions, which are aligned with the Louisiana Medicaid program:
    - The Louisiana Medicaid EPSDT screening guidelines and policies apply to individuals under 21 years of age; and
    - The Louisiana Medicaid schedule has stricter requirements for lead assessment and blood lead screening. See lead screening.

- **Provider responsibility.** You are responsible for reading and adhering to all applicable requirements in the Louisiana Medicaid provider manual for EPSDT, which can be found at https://ldh.la.gov/page/1890.

# Types of Louisiana Medicaid members

- **Member eligibility.** The Bureau of Health Services Financing (BHSF), within the Louisiana Department of Health (LDH), is responsible for determining Medicaid eligibility.
- **Eligibility categories.** Individuals who are certified for Medicaid are classified into various eligibility categories or groups based on specified criteria. These criteria may affect provider reimbursement. The regulations contained in Title 42 of the Code of Federal Regulations define the groups of people and the services a state must cover to qualify for federal matching payments. States define their programs to meet these federal requirements, and coverage of groups and benefits specified under federal law.
- **Categorically Needy.** Members classified as Categorically Needy must meet all requirements, including the income and resource requirements. Payment for all covered services or equipment furnished to these members and billed to BHSF shall be considered payment in full.
    - Members determined to be Categorically Needy include:
        - Families who meet Low-Income Families with Children (LIFC) eligibility requirements.
        - Pregnant women with family income at or below 200% of the Federal poverty level.
        - Children under age 19 with family income up to 250% of the Federal poverty level.
        - Caretakers (relatives or legal guardians who take care of children under the age of 18,or 19 if still in high school).
        - Supplemental Security Income (SSI) recipients.
        - Individuals and couples who are living in medical institutions and who have a monthly income up to 300% of the SSI income standard (Federal benefit rate).
- **Medically Needy.** Medically Needy is an optional program, however, states that elect to include this program are required to include certain children under the age of 18 and pregnant women who would be eligible as Categorically Needy if not for their income and resources.
    - Members may qualify as regular Medically Needy or Spend-down Medically Needy.
        - Regular Medically Needy recipients are those individuals or families who meet all LIFC related categorical requirements and whose income is within the Medically Needy Income Eligibility Standard (MNIES).
        - Spend-down Medically Needy members are those individuals or families who meet all LIFC or SSI related categorical requirements and whose resources fall within the Medically

Needy resource limits, but whose income has been spent down to the MNIES.

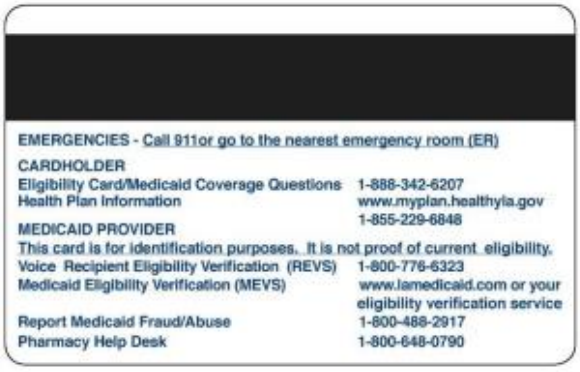
- Medically Needy recipients are identified on the Medicaid Eligibility Verification System (MEVS) and Recipient Eligibility Verification System (REVS). MEVS and REVS denote the appropriate eligibility information based on the provider type of the inquiring provider.
- Service restrictions apply to Medically Needy benefits and eligibility for service coverage should be verified.
- Information detailing the other recipient categories and eligibility groups may be obtained by accessing the Medicaid Eligibility Manual on the LDH website.
- You should refer members with questions regarding eligibility to the Louisiana Medicaid and LaCHIP Assistance Line at 225.342.0555 or toll-free at 877.252.2447.

- **Retroactive Eligible.** Members may be eligible for benefits for the 3 months prior to the date of their Medicaid application provided they meet the eligibility criteria.
  - When a member has paid you for a service for which they would be entitled to have payment made under Medicaid, you may opt to refund the payment to the member and bill Medicaid for the service. The member must furnish a valid Medicaid identification card for the dates of services provided during the timely filing period.
  - If you choose not to refund the payment to the member, you should direct them to the MMIS Retroactive Reimbursement Unit to request a refund:

    MMIS Retroactive Reimbursement Unit
    PO Box 91030
    Baton Rouge, LA 70821-9030
    Phone: 225.342.1739
    Toll free: 1.866.640.3905
    http://dhh.louisiana.gov/index.cfm/page/1202

# Recognizing Louisiana Medicaid members

- **Medicaid ID cards.** Members may receive state Medicaid eligibility cards and may present these to participating providers.
  - Presentation of an ID card does not guarantee eligibility. Eligibility should always be verified before any services are rendered.
  - A sample ID card is provided below.


- **Health plan member ID cards.** Members enrolled in a Managed Care Organization (MCO) will also receive member ID cards from their health plan.
    - See the Client-Specific Information section for a sample of member ID cards.
    - Presentation of an ID card does not guarantee eligibility. Eligibility should always be verified before any services are rendered.
- **Identification verification.** You must verify that the person receiving care is the same individual listed on the eligibility card.

# REQUIREMENTS

You're expected to provide certain levels of service and follow rules for interacting with members.

## Participation requirements and responsibilities

### Medicaid enrollment

- **Enrollment with Louisiana Medicaid.** You must enroll for Louisiana Medicaid through www.lamedicaid.com to provide routine vision care for Louisiana Medicaid members through EyeMed. **Enrollment with Louisiana Medicaid does not constitute a contract with EyeMed.**
    - If you have questions about registering, you can:
        - Refer to the provider enrollment portal documentation for detailed enrollment instructions.
        - Call Gainwell Technologies at 833.641.2140, Monday to Friday, between 8 am and 5 pm CT.
        - Email Gainwell Technologies at louisianaprovenroll@gainwelltechnologies.com.
    - You should receive an invitation letter from Gainwell Technologies, the state's fiscal intermediary, to register on the online portal.
        - If you don't have your letter or the information needed to enroll, email Gainwell Technologies to request a reprinted letter be mailed. Email requests must include your name and NPI. You may send multiple provider requests in a single email. Reprinted letter requests will only be accepted by email. No other form of submission is accepted. You will receive a confirmation email from Gainwell when the submission is received. That email will include an anticipated turnaround time for the response.
    - You can check your enrollment status using the Provider Portal Enrollment Lookup Tool on www.lamedicaid.com. If you are not shown in results, you are not required to enroll at this time. You will be sent an invitation letter later.
        - If your information has not been processed within 15 business days, please contact Gainwell Technologies using the contact information above. You can ask for a status update on enrollment and any next steps needed to complete the process.
- **Louisiana Medicaid enrollment provider types.** Refer to "Section 46.3: Provider Requirements" in the Louisiana Vision (Eyewear) Provider Manual for more information on types of providers.
- **Linking professionals to group practice.** You must submit a completed provider enrollment (PE-50) form to request for linkage of an individual professional practitioner to a group practice provider number. If you have an active Medicaid provider number, a group linkage (LNK-01) form must

be completed and must include the effective date of the linkage. The form must be signed by the professional practitioner who is officially enrolled under the number being linked. The PE-50 and the LNK-01 forms can be found at www.lamedicaid.com.
    - If you change group affiliation, you must notify Gainwell Technologies to ensure payments are sent to the correct provider/group. Payments and remittance advices may be delayed due to incorrect mailing addresses on the Medicaid file. When submitting a change of address for linkage or office relocations, the request should include:
        - A request that your file be updated with the current information;
        - The 7-digit provider number;
        - An indication of whether the change is for a physical address and/or a "pay-to" address; and
        - The original signature of the provider who is officially enrolled under the provider number (stamped signatures/initials are not accepted).
- **Provider screening requirements.** The following disclosing individuals must be screened as part of Medicaid enrollment:
    - **An individual or groups of individuals with a 5% or greater direct or indirect ownership interest in the provider.**
    - **An agent**, who is any person who has been delegated the authority to obligate or act on behalf of a provider, such as a fiduciary agent or contractor.
    - **An individual who is on the Board of Directors of a provider entity**.
    - **An individual who is a managing employee**, such as a general manager, business manager, administrator, director or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of the institution, organization or agency, either under contract or through some other arrangement, whether or not the individual is a W-2 employee.
- **Provider screening intervals.** Per CMS requirements, you must be screened by the state at the following intervals:
    - When you initially apply for and submit an application to become a Medicaid provider;
    - Upon reenrollment (reactivation of a previously closed provider number) in the state's Medicaid program; and
    - At least once every 5 years to revalidate your enrollment, which is similar to the recredentialing process that EyeMed completes every 3 years. You must also still complete the credentialing process with EyeMed every 3 years.
- **Additional requirements of Medicaid enrollment.** As part of the Medicaid enrollment process, you'll also need to meet the criteria below. You must:

- Be enrolled to participate in Louisiana Medicaid and meet all licensing and/or certification requirements inherent to your profession.
- Abide by all applicable state and federal laws and regulations and policies established by the Centers for Medicare and Medicaid Services (CMS) and the Louisiana Department of Health (LDH).
- Adhere to all the requirements of administrative rules governing the Medical Assistance Program found in the Louisiana Register.
- Comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- Comply with Title VI and Title VII of the 1964 Civil Rights Act (where applicable), not to discriminate based on race, color, creed or national origin.
- Comply with Section 504 of the Rehabilitation Act of 1973.
- Adhere to all federal and state regulations governing the Medicaid Program including those rules regulating disclosure or ownership and control requirements specified in the 42 CFR 455, Subpart B.

- **Medicaid revalidation.** You will be notified by LDH or Gainwell Technologies when it's time for you to log into the portal for your initial enrollment and when you are due for revalidation. You must revalidate your enrollment with the state at least once every 5 years, which is similar to the recredentialing process that EyeMed completes every 3 years.
- **National Provider Identifier.** As a provision of HIPAA, you must obtain and use your NPI number on all claims submissions. Although HIPAA regulations address only electronic transactions, Louisiana Medicaid requires both the NPI number and the legacy 7-digit Medicaid provider number on hard copy claims.
- **Taxpayer identification.** An Employer Identification Number (EIN), also known as a Federal Taxpayer Identification Number (TIN), is assigned to a business by the Internal Revenue Service (IRS). Refer to "Section 46.3: Provider Requirements" in the Louisiana General Information & Administration Provider Manual for more information.
  - You must report any change in the TIN to Gainwell Technologies via the provider enrollment portal, email at louisianaprovenroll@gainwelltechnologies.com or phone at 833.641.2140 (Monday to Friday, from 8 a.m. to 5 p.m. CT).
  - You must also notify EyeMed via inFocus if your TIN changes.
- **Ownership disclosure.**
  - **Notification to LDH**. You must submit a new provider enrollment packet on www.lamedicaid.com when a change in ownership (CHOW) or change in business organization (change from corporation to LLC, partnership, etc.) and a transfer of stock greater than 5% occurs. Refer to "Section 1.1: Provider Requirements" in the Louisiana General Information & Administration Provider Manual for more information.
  - **Notification to EyeMed and/or the health plan.** You agree to furnish to EyeMed and/or the health plan the following information

during enrollment, revalidation, and within 35 days after any change in ownership:

- The name and address of any person (individual or corporation) with ownership or control interest. The address for corporate entities must include (as applicable) the primary business address, every business location and PO Box address.
- Date of birth and Social Security Number (SSN) (in the case of an individual).
- Other Tax Identification Number, in the case of corporation, with an ownership or control interest or of any subcontractor in which the disclosing entity has a 5% or more interest.
- Whether the person (individual or corporation) with an ownership or control interest is related to another person with ownership or control interest as a spouse, parent, child or sibling; or whether the person (individual or corporation) with an ownership or control interest of any subcontractor in which the disclosing entity has a 5% or more interest is related to another person with ownership or control interest as a spouse, parent, child or sibling.
- The name of any other fiscal agent or manage care entity in which an owner has an ownership or control interest in an entity that is reimbursable by Medicaid and/or Medicare.
- The name, address, date of birth and SSN of any managing employee.

  - Failure to timely report a change in ownership may result in fines and/or recoupment of any and all payments made in the interim of the change of ownership taking place and LDH approving the action.

## Minimum participation requirements

- **TPA and DEA certification/licensing.** You need to have either a TPA certificate or DEA license.
  - You can use diagnostic pharmaceutical agents (DPAs) as long as the member's age, condition type and severity and other contributing factors justify it.
  - Use therapeutic pharmaceutical agents (TPAs) as appropriate when a member has a condition that requires them, but get the member's consent. You can also refer them to another health care professional as stated in their medical care plan. As with DPAs, document member refusals or referrals.
- **Professional liability insurance.** Contracted and affiliated eye care professionals must maintain professional liability insurance in the amount of $1,000,000 per occurrence and $3,000,000 aggregate.
  - In states that have limitations on liability, state law applies.
  - An umbrella policy can meet these requirements.
- **Commercial liability insurance.** You must maintain commercial liability insurance in the amount of $1,000,000 per occurrence and $2,000,000 in aggregate.

## Your responsibilities

- **Full-service locations.** All participating provider locations must offer both exams and materials.
- **Open to new patients.** All locations must accept eligible new patients.
- **Member eligibility and access.** You can't turn away members and must represent yourself as an in-network provider to them. You can't submit claims for out-of-network services on behalf of members if you participate in their network(s).
- **Claims.** Submit all required claims information.
- **Disparagement.** Do not publicly share your concerns/issues about EyeMed, the health plan or Louisiana Medicaid. Instead, follow the provider complaints and appeals processes.
- **Information verification.** When EyeMed asks you to report or verify information, you must do so in a timely, accurate and complete manner. You may be asked to supply signed confirmation.

## Network participation

- **EyeMed information updates.** You must keep your information up-to-date by using our online form.
- **Reporting changes to LDH.** You must report any changes that may impact your Medicaid enrollment status to Gainwell Technologies via the provider enrollment portal or email at louisianaprovenroll@gainwelltechnologies.com. Each change request requires the original signature (no stamped signatures or initials) of the individual provider or an authorized representative of an enrolled entity. Third party billers/agents cannot request changes to your enrollment records. Report any changes in:
    - Your mailing or physical address and/or telephone number.
        - If the provider type requires a license, you must submit a copy of the updated license showing the new physical address with the change request.
        - An individual Medicaid provider number can only have 1 pay-to address. This address is where you would like to receive all Medicaid documents related to claims billed under the provider number. If you furnish services at multiple locations, the pay-to address must be the address of your main location.
        - Your telephone number should be a number where you or your authorized agent may be contacted for questions. It shouldn't be the corporate office unless all information is maintained at that location.
        - Failure to furnish accurate information for your provider file may result in closure of your Medicaid provider number. If mail is returned and you can't be located, your provider number will be closed pending updated information. Once the number has been closed, a complete enrollment packet may be required to re-activate the number.

- Internal operations that affect the originally reported information. This includes changes in administrators, board of directors or other major management staff for federally qualified health centers, rural health clinics and any other facilities in which you are enrolled. Failure to provide timely notification could result in payment delays.
    - BHSF doesn't allow informal agreements between parties. For additional information regarding reporting changes in operational structure, please contact Gainwell Technologies via the provider enrollment portal, email at louisianaprovenroll@gainwelltechnologies.com or phone at 833.641.2140, Monday to Friday, from 8 a.m. to 5 p.m. CT.
- A decision to discontinue accepting Medicaid.
- A business closure.
- Licensing status. You must submit a copy of the updated license with the change request.
- Your name. The correspondence must include your current name, new name and the effective date of change. If a license is required, the updated license must be submitted with the notification.
- Medicare certification, provider number or status. A claim will not crossover unless the correct Medicare provider number is in the Medicaid Management Information System (MMIS).
- Account information affecting Electronic Funds Transfer (EFT) or direct deposit.
    - Changes must be submitted with a copy of a voided check (deposit slips are not accepted).
    - Failure to update EFT information may result in payments being sent to incorrect accounts.
    - A hard copy check won't be reissued until the inappropriately routed funds are returned to LDH's account.
- Death of a provider. The Medicaid provider number of a deceased provider can't be used for any reason.
- Group affiliation changes.

- **Leaving the network.** If you want to opt out of the Louisiana Medicaid network, complete our online Network Request form.

# Credentialing and recredentialing

Before providers can legally deliver service to members, they must complete credentialing, which verifies that the provider meets our participation requirements. You'll complete recredentialing every 3 years so we can verify the validity of your provider status.

These credentialing and recredentialing requirements apply to all doctors who will provide care to EyeMed members, including fill-in providers.

### Credentialing and recredentialing overview and requirements

- **Credentialing and recredentialing vendors.** We use the following companies during credentialing and recredentialing:
    - The Council for Affordable Quality Healthcare (CAQH).
      888.599.1771
      866.293.0414
      https://proview.caqh.org/Login
      caqh.udphelp@acgs.com
    - Gemini Diversified Services, a Credentials Verification Organization (CVO).
    - You must ensure your CAQH profile is up to date, as we rely on that information to confirm requirements. You'll verify your information and provide proof of your license, liability insurance and professional certifications to CAQH.
- **Credentialing and recredentialing requirements.** You must meet the below requirements to participate on our network. We'll confirm you meet the criteria during credentialing and re-verify during recredentialing. Documentation is required for some items as indicated.

| Criteria | Documentation Required | Required for OD | Required for MD/DO |
|---|---|---|---|
| Submission of a complete, signed and dated state-specific application for participation in network | ✓ | ✓ | ✓ |
| Satisfactory work history for prior 5 years with explanation of any gaps of 6 months or more, unless state law requires otherwise<br><br>Recredentialing: 3 years' work history only | | ✓ | ✓ |
| Signed and dated attestation of completeness, accuracy and release of information | ✓ | ✓ | ✓ |
| Valid, unencumbered license in state(s) of practice | ✓ | ✓ | ✓ |
| Minimum professional liability insurance for all states in which provider practices, as indicated below, or state statutory cap, state regulations or as required by our contractual agreement with plan<br>• Optometrist or ophthalmologist – $1 million per occurrence and $3 million aggregate<br>*Requirement can be met with separate umbrella policy.* | ✓ | ✓ | ✓ |
| No exclusion from Medicare/Medicaid in the last 5 years | | ✓ | ✓ |
| Not opted out of Medicare/Medicaid | | ✓ | ✓ |
| No conviction of a criminal offense that reasonably calls into question a provider's ability to practice | | ✓ | ✓ |
| No more than a combined total of 3 liability and/or malpractice claims resulting in settlements within the last 5 years | | ✓ | ✓ |
| No reported sanctions on the provider's license within the last 5 years, excluding advertising violations, soliciting patients door to door, establishing temporary offices and/or delay in reporting continuing education credits* | | ✓ | ✓ |
| Operation of all equipment (in clean and working condition) used in the course of patient care and management | | ✓ | ✓ |
| No history of EyeMed chart/site evaluation failures in the past 5 years* | | ✓ | ✓ |
| No more than 3 adverse events within the past 3 years* | | ✓ | ✓ |
| Practice open to new members | | ✓ | ✓ |
| Graduation from an accredited school or college of optometry (optometrists) or an accepted professional medical or | ✓ | ✓ | ✓ |

| Criteria | Documentation Required | Required for OD | Required for MD/DO |
|---|---|---|---|
| osteopathic school and completion of an accredited residency program in ophthalmology (ophthalmologist) | | | |
| No history of insurance fraud* | | ✓ | ✓ |
| List of other states where provider is or has been licensed, registered or certified | ✓ | ✓ | ✓ |
| Operation of a practice with normal business hours and after-hours coverage | ✓ | ✓ | ✓ |
| No office location subleased from or affiliated with a corporate-owned retail optical chain not accepted in our network (subject to state regulations) | | ✓ | ✓ |
| A valid TPA Certification and/or DEA Certification as indicated by state regulations | ✓ | ✓ | |
| A valid DEA Certification or CDS Certification as indicated by state regulations | ✓ | | ✓ |
| Demonstrated board certification (if applicable) | ✓ | | ✓ |

*Abbreviations: OD = optometrist, MD/DO = ophthalmologist. Credentialing does not apply to opticians.*

## Starting the credentialing and recredentialing process

- **Credentialing after contracting.** After completing contracting, we will begin the credentialing process.
- **Credentialing of providers new to your practice.** Use our online form to begin credentialing for new providers in your practice and/or to associate fill-in providers to your practice.
- **Recredentialing notification.** You'll receive a letter and the online claims system will notify you when it's time to begin recredentialing.
- **Verification and documentation.** You will provide all verification and documentation to our credentialing vendors. They may contact you directly to request additional information if needed. Some items require verification from the primary source (for instance, from the school you graduated from).

## Credentialing and recredentialing status and timing

- **Credentialing and recredentialing status.** You'll receive email updates as you move through the process and upon completion. You can also check the status of credentialing or recredentialing on our communications portal, inFocus.
- **Credentialing timing.** Initial credentialing takes up to 45 days.
- **Recredentialing timing.** If your profile is not complete, preventing completion of recredentialing within 90 days, you will be removed from the network.
    - If you do not provide missing information within the 90 days, you may have to reapply to the network as a new provider.
- **Completing credentialing and recredentialing.** After receiving conformation from our vendors that you meet our requirements, our credentialing committee reviews all providers. You cannot serve EyeMed members UNTIL you are fully credentialed and approved. You'll be notified by email when you can begin seeing members.

### Your rights during credentialing and recredentialing

- **Right to review information.** You can request to review any information submitted with the application at any time. You can also request a copy of the information received from the CVO.
- **Right to correct erroneous information.** If the information we receive from the CVO differs from what's on the application, we'll contact you. You'll have 15 business days from the date of receipt to respond. This lets you correct any inaccurate information from the CVO submitted by third parties through the primary source verification process.
- **Right to be informed of your application status.** You can request to be informed of the status of your application at any stage of the process. The CVO will respond by phone, fax or email.

# Fill-in doctors

You must arrange for back-up if you'll be out of the office for 7 consecutive days or more. The fill-in doctor must file claims under his or her own National Provider Identifier (NPI).

- The doctor must be credentialed with EyeMed.
- Use our online form to associate the doctor with your location so claims can be filed.

# Location requirements

Network providers must have a physical location and make sure all offices have the required instruments listed below on-site and in working order. All locations must also meet hygiene and safety measures.

### Required instruments

- Phoropter or trial lenses
- Visual acuity testing distance and near charts and/or projector
- Retinoscope, autorefractor or wavefront analyzer
- Keratometer/ophthalmometer/ topographer
- Ophthalmoscope: direct and binocular indirect with condensing lens
- Tonometer
- Biomicroscope
- Lensometer
- Color vision testing system
- Stereopsis testing
- Diagnostic pharmaceutical agents within expiration dates

### Office cleanliness requirements

- **Proper cleaning** of exam rooms, laboratories, dispensing areas, offices and waiting areas.
    - Use gloves, biohazard disposal receptacles, trash receptacles and office disinfectant to reduce the spread of infection and to ensure safe handling and disposal of medical waste.

    - Wash hands (in front of the member whenever possible) prior to examination, and use an alcohol-based hand sanitizer between interactions.
    - Keep exam lanes, contact lens and eyewear dispensaries and public areas as clean and clear of clutter as possible.
    - Clean clinical equipment with alcohol wipes in front of the member before each use.
    - Disinfect diagnostic contact lenses after each use.
- **Pharmaceutical storage.** Store pharmaceuticals in a secure, sanitary place away from food and beverages.
- **Contact lenses, solutions and pharmaceutical expiration.** Discard contact lenses, contact lens solution, DPAs and TPAs after their expiration date.
- **Medical waste containers.** Properly secure and maintain medical waste containers.

## Safety and security

- **Environmental safety.** You're required to operate a safe and secure environment. At a minimum, this includes having:
    - Adequate lighting in public area.
    - Safe and secure flooring and fixtures.
    - Hand-held fire extinguishers up to local and state fire codes with current inspection tags.
    - A complete first-aid kit that, at a minimum, includes:
        - Adhesive bandages
        - Adhesive tape
        - Ammonia inhalants
        - Antibiotic ointment
        - Antihistamine
        - Antiseptic towelettes
        - Eye wash solution
        - First-aid/burn cream
        - Latex gloves
        - Pain reliever
        - Scissors
        - Sterile eye pads
        - Sterile gauze pads
    - Medical waste container(s).
    - Any other safety equipment recommended by state or local emergency preparedness ordinances.
- **Prescription pad security.** Keep prescription pads secure at all times.

## Americans with Disabilities Act (ADA)

- You are expected to meet federal and state accessibility standards as defined in the Americans with Disabilities Act of 1990.

## Other location requirements

- **Seating.** Provide adequate seating for patients in your reception area and provide an area that offers privacy and confidentiality for discussion of vision care or health information.
- **Licenses and certifications.** Post your license and certifications in plain sight or make them otherwise available to members per state law.
- **Business hours.** Display and maintain reasonable business hours. If the doctor's hours are different from the dispensary's, post both sets of hours.

### Site inspections

- **On-site inspections.** As part of your provider agreement with LDH, you agree to allow inspection of your facilities and allow for inspection of all records by governmental authorities, including but not limited to, LDH, the State Attorney General's Medicaid Fraud Control Unit and the Department of Health and Human Services. You also must allow inspections of your facilities and records by EyeMed and the health plan.

# Access to care/emergencies

### Appointment and wait time standards

- **Appointment wait standards.** You must offer non-urgent appointments with EyeMed members within 2 weeks of a request.

### After-hours access

- **24-hour phone access.** All offices must have (or arrange for) telephone triage or screening services on a 24/7 basis through which patients can get help to determine the urgency of their condition. Patients should receive return calls from this line within a reasonable timeframe, not to exceed 30 minutes.

### Urgent and emergency care

- **Urgent care services.** You must perform urgent-care services the same day as requested. Refer to the Client-Specific Information section for specific requirements by health plan.
- **Emergency care.** Your location must have referral instructions on hand to give members who have an emergency eye care need outside your scope of practice during your office hours and after hours. In addition, offer after-hours support—via mobile phone, pager or an answering system—to members seeking emergency eye care.
- **Definition of eye care emergency.** We define an eye care emergency as a physical condition involving 1 or both eyes which, if untreated or if treatment is delayed, may reasonably be expected to result in irreversible vision impairment.
- **Examples of eye care emergencies.** Eye care emergencies include the below. Lost or broken eyeglasses or contact lenses, regardless of the strength of the prescription, do not constitute eye care emergencies.

- Severe eye pain.
- Any penetrating injury to the eye.
- Chemical contact with the eye (particularly alkaline substances).
- Sudden total loss of vision in one or both eyes.
- Sudden loss of vision to a degree that prohibits mobility.

- **Emergency eyewear.** If a member has an eye care emergency requiring eyewear, follow our emergency lab process.

# Interacting with members

You must follow the below requirements when interacting with EyeMed members.

### Marketing guidelines

- **Direct marketing.** You can't market directly to members as it relates to your participation in the network. We don't permit direct contact with members who have not previously received care or purchased eyewear from you.
- **Representation**. You can't represent yourself as an extension of EyeMed, the health plan or Louisiana Medicaid to members in person or in writing (e.g., letters, promotional materials).
- **Sharing of information**. You can't share EyeMed, the health plan or Louisiana Medicaid information (e.g., group lists, member lists, group benefits, member benefits) with members outside of individual doctor-patient relationships.
  - You can't use the list of groups near you on inFocus to promote your practice with members.
- **Inducement.** You can't induce members to seek care from you through gifts, rewards or free items unless legally permitted. Consult your legal counsel for guidance on federal and state anti-kickback regulations.
- **Logo usage**. You can use EyeMed's logo in your marketing and in-office signage according to the terms of the logo usage agreement, which you must complete before using the logo. You can't use logos of health plans for which we're providing routine vision services for Medicaid members.

### Provider responsibilities

- **Provider responsibilities under Medicaid.** By participating in Louisiana Medicaid, you must:
  - Know the terms of the provider agreement, program standards, statutes and the penalties for violations.
  - Be familiar with each Louisiana Medicaid manual revision upon issuance, which are posted under each manual on https://ldh.la.gov/page/1890.

- Ensure your employees have knowledge and understanding of and have access to the pertinent information in the manual which is necessary to perform their duties.
- Read the Medicaid news bulletins posted on https://ldh.la.gov/news/category/3. You can subscribe to the newsletter using this online form.
    - Notification of programmatic changes through a rule, manual chapter revision, provider notice, as well as the newsletter is considered formal notification and you can be held accountable for information contained therein.
- Provide goods, services and supplies which are medically necessary in the scope and quality fitting the appropriate standard of care.
- Maintain all necessary and required licenses or certificates.
- Allow for inspection of all records by us and/or governmental authorities including, but not limited to, LDH, the State Attorney General's Medicaid Fraud Control Unit and the Department of Health and Human Services.
- Maintain confidentiality of health care information subject to applicable laws and safeguard against the disclosure of information in the recipient's medical records.
- Bill other insurers and third parties prior to billing Medicaid.
- Report and refund any and all overpayments.
- Accept the Medicaid payment as payment in full for services rendered to Medicaid members, providing for the allowances for co-payments authorized by Medicaid. A member may be billed for services that have been determined as non-covered or exceeding the services limit for members over 21 years of age. Members are also responsible for all services rendered after their eligibility has ended.
- Agree to be subject to claims review.
- Accept liability for any administrative sanctions or civil judgments by the buyer and seller of a provider.
- Allow inspection of the facilities.
- Post bond or a letter of credit, when required.
- Be familiar with the federal laws, rules, regulations and policies concerning fraud and abuse, which are outlined in the Louisiana Medicaid provider manuals.
- Have a unique identifier, such as a National Provider Identifier (NPI), if you provider services.
- Schedule appointments with the minimum appointment availability standards in mind for all Medicaid members.

## Pricing and communicating costs

- **Price sheets.** You can't charge members more than you would charge patients who do not have vision care benefits, and you can only use 1 price sheet.
- **Cost transparency.** You must make members aware of their costs when you're providing services that are not covered under their plan.
- **Non-covered services notification.** You must notify members before rendering non-covered services that the member will be paying out-of-pocket. Refer to the non-covered items section for additional rules on non-covered items.
- **Missed appointments.** If a member of a Louisiana Medicaid plan misses a scheduled appointment, document the missed appointment in the member's medical record and conduct outreach to the member by performing minimum reasonable efforts to contact the member. You may not bill the member for missed or broken appointments.

## Documentation and record-keeping requirements

- **Office policy for transferring a Medicaid member.** You must establish and document a process for transferring a Medicaid member from your practice. This process must detail how your office will handle member transfers without discrimination. This process can't be based solely on the member filing a grievance, appeal or request for a fair hearing or other action by the member related to coverage, or any reason not permissible under applicable law.
- **Record retention.** You must secure and retain member records (medical, fiscal, professional and business records) either electronically or in hard copy for longer of:
    - The period required under applicable laws, rules and regulations.
    - Adults: 10 years from the date of the last visit or the date of the completion of any audit by the Centers for Medicare and Medicaid (CMS), unless superseded by state law.
    - Minors: 28 years from the date of birth.
    - Deceased patients: 6 years from the date of death.
    - Inactive records are to remain accessible for a period that meets state and federal guidelines.
    - Upon agency closure, all provider records must be maintained according to applicable laws, regulations and LDH record retention requirements, which can be found at https://ldh.la.gov/page/1890. You must notify LDH of the location of the records.
- **Record-keeping requirements.** You are required to maintain records of all appointments and should reflect all procedures performed on those appointments. Medical, fiscal, professional and business records for Medicaid members may be paper, magnetic material, film or electronic, except as otherwise required by law or Medicaid policy.
    - If you maintain electronic records, you must develop and implement a policy to comply with applicable state and federal laws and regulations to ensure each record is valid and secure.

- Records must:
  - Have consistent organization and documentation in member medical records.
  - Be maintained in a legible, current, organized and detailed manner that permits effective member care and quality review. The record must be legible to someone other than the writer. A second reviewer should evaluate any record judged illegible by one physician reviewer.
  - Be immediately and completely available for review and copying by us, LDH and federal officials at your place of business, or you must forward copies of records to us or LDH upon written request without charge.
  - Reflect the different aspects of member care, including ancillary services.
  - Be made available electronically, where applicable and required by regulatory agencies.
  - Comply with all applicable laws and regulations pertaining to the confidentiality of member medical records, including, but not limited to, obtaining any required written member consents to disclose confidential medical records for complaint and appeal reviews.
  - Have signed and dated entries by the responsible licensed provider. The responsible licensed provider will countersign care rendered by ancillary personnel. Alterations of the record will be signed and dated.
    - You must correct records using the legal method for any error made. The legal method is to draw a line through the incorrect information, write "error" by it and initial the correction. Do not use correction fluid.
  - Be signed and dated at the time of service. Rubber stamp signatures must be initialed.
- Records must include:
  - A detailed account of each beneficiary's visit indicating what services were provided.
  - Member identification information on each page of the medical record (i.e., name, Medicaid Identification Number).
  - Identifying demographics including the member's name, address, telephone number, employer, Medicaid Identification Number, gender, age, date of birth, marital status, next of kin and, if applicable, guardian or authorized representative.
  - Initial history for the member that includes family medical history, social history, operations, illnesses, accidents and preventive laboratory screenings (the initial history for members under age 21 should also include prenatal care and birth history of the member's mother while pregnant with the member).

        - Past medical history for all members that includes disabilities and any previous illnesses or injuries, smoking, alcohol/substance abuse, allergies and adverse reactions to medications, hospitalizations, surgeries and emergent/urgent care received.
        - Immunization records (recommended for adult members if available).
        - Current problem list. The record will contain a working diagnosis, as well as a final diagnosis and the elements of a history and physical examination, upon which the current diagnosis is based. In addition, significant illness, medical conditions and health maintenance concerns are identified in the medical record.
        - Recommendations for specialty care, as well as vision care and results thereof.
        - Current medications, therapies and other prescribed regimens.
        - Reports from referrals, consultations and specialists.
        - Emergency/urgent care reports.
        - Documentation related to requests for release of information and subsequent releases.
        - Documentation that reflects that diagnostic, treatment and disposition information related to a specific member was transmitted to the PCP and other providers, as appropriate, to promote continuity of care and quality management of the member's health care.
        - Copies of all attestations of medical necessity and any additional supporting documentation.
    - Documentation of individual encounters must provide adequate evidence of, at a minimum:
        - History and physical examination (appropriate subjective and objective information is obtained for the presenting complaints)
        - Plan of treatment
        - Diagnostic tests
        - Therapies and other prescribed regimens
        - Follow-up (encounter forms or notes have a notation, when indicated, concerning follow-up care, call or visit. Specific time to return is noted in weeks, months or as needed. Unresolved problems from previous visits are addressed in subsequent visits.)
        - Referrals or recommendations for specialty or vision care, and results thereof
        - Other aspects of patient care, including ancillary services
    - You must retain fiscal records relating to services you have rendered to members, regardless of whether the records have been produced manually or by computer.

- **Record-keeping sanctions.** If you fail to comply with the documentation and retention policy, you are subject to sanctions and recoupment of Medicaid payments. Payments will be recouped for services that lack the required signatures and documentation.
- **Notation of coverage discussion.** Note in the patient file that you had a conversation about what services are and are not covered by the member's vision benefits.
- **Refusal of pharmaceuticals or services.** Document when a member refuses any DPAs, TPAs or services you recommend.
- **Record availability.** Authorized state and federal agencies or their authorized representatives may audit or examine your records without prior notice. This includes but is not limited to the following governmental authorities: LDH, the state Attorney General's Medicaid Fraud Control Unit and the Department of Health and Human Services.
    - You must allow access to all Medicaid recipient records and other information that cannot be separated from the records. If requested, you must also furnish, at your expense, legible copies of all Medicaid related information to the BHSF, federal agencies or their representatives.
    - Failure to produce these records on demand by the Medicaid program or its authorized designee will result in sanctions against the provider.
- **Request for medical information from member, family member or insurance company.** If you receive a request for medical bills or other information from the member or someone acting on their behalf, such as an attorney, insurance company, etc., the information may be released with the proper authorization from the member. Information requested by an insurance company with whom a claim has been filed may be filed directly with the carrier.
- **Request for medical information from attorneys.** You must promptly comply with requests from a member's attorney when requested in case of personal injuries.
    - You should follow the following procedures:
        - Obtain a signed authorization from the member before giving any report (verbal or written).
        - Compile the requested information and forward it to the attorney. A statement may be enclosed for copying the records.
        - Mail a copy of the written request and authorization to the Bureau's TPL Trauma Unit.
    - Medical information concerning a member that is released by you must contain the following statements/information:
        - The person is a Medicaid recipient.
        - The recipient's Medicaid identification number.
        - The bill has been paid by Medicaid or will be submitted to Medicaid for payment.

    - If you furnish medical information to attorneys, insurers or anyone else, you must obtain a 3" x 3" ANNOTATION STAMP and must ensure that all outgoing medical information bears the stamp, which notifies the receiver that services have been provided under Louisiana's Medicaid program. A sample of this stamp is located on https://www.lamedicaid.com/ along with the notification form.
- **Record confidentiality.** You must follow all HIPAA and state and federal requirements related to the confidentiality of, and access to, medical records.
- **Destruction of records.** Records may be destroyed once the required record retention period has expired. Confidential records must be incinerated or shredded to protect sensitive information. Non-paper files, such as computer files, require special means of destruction. Disks or drives can be erased and reused, but care must be taken to ensure all data is removed prior to ruse. Commercially available software programs can be used to ensure all confidential data is removed.
    - In the event records are destroyed or partially destroyed in a disaster such as a fire, flood or hurricane, and rendered unreadable and unusable, such records must be properly disposed of in a manner which protects recipient confidentiality. A letter of attestation must be submitted to the fiscal intermediary documenting the event/disaster and the manner in which the records were disposed.

### Member assistance

- **Transportation services.** Transportation may be covered by a MCO.
    - Transportation benefits may cover emergency ambulance services, non-emergency transportation, lodging, meals and/or a travel attendant.
    - Some transportation services may require prior authorization or approval.
    - Members should contact their MCO to learn more about or request transportation. Refer to the Client-Specific Information section for transportation services contacts for the MCOs for which we administer routine vision benefits.
- **Communication services.** Some MCOs may have additional communication services for members who have disabilities or whose primary language isn't English. Refer to the Client-Specific Information section for more information.

# Member confidentiality and privacy

- **State and federal laws.** You must follow all applicable state and federal laws and regulations restricting unauthorized access, use, destruction and release of member information that includes Protected Health Information (PHI) (which includes but is not limited to data from our online claims system), Personally Identifying Information (PII) and credit card data.
- **Member privacy rights.** Members are afforded the privacy rights permitted under HIPAA and other applicable federal, state and local laws and regulations, and applicable contractual requirements.
    - The privacy policy conforms with 45 CFR (Code of Federal Regulations), which provides member privacy rights and places restrictions on uses and disclosures of PHI (§ 164.520, 522, 524, 526, and 528).
- **Member privacy requests.** Members may make requests related to their PHI ("privacy requests") in accordance with federal, state and local law.
- **Member confidentiality.** All Medicaid recipient and applicant records and information are confidential. You are responsible for maintaining confidentiality of health care information subject to applicable laws.

# Non-discrimination

- **Non-discrimination laws.** You must comply with all relevant federal and state nondiscrimination provisions, including:
    - Title VI and Title VII of the Civil Rights Act of 1964 (where applicable), which prohibits discrimination based on race, color, creed or national origin.
    - Section 504 of the Rehabilitation Act of 1973, which prohibits discrimination based on disability.
    - The Age Discrimination Act of 1975, as implemented by regulations at 45 CFR part 91.
    - The Americans with Disabilities Act.
    - Federal laws and regulations designed to prevent or ameliorate FWA, including, but not limited to, applicable provisions of federal criminal law.
    - The False Claims Act (31 U.S.C. §§ 3729 et. seq.).
    - The Anti-Kickback Statute (section 1128B(b) of the Social Security Act).
    - HIPAA administrative simplification rules at 45 CFR parts 160, 162, and 164.

# Cultural competency and language assistance

You must provide services in a culturally competent manner to all members, including those with Limited English Proficiency (LEP) or reading skills, diverse

cultural and ethnic backgrounds, physical and mental abilities and health conditions.

## Cultural competency

- **Cultural respect and service orientation.** Respect and provide services in a manner that meets member cultural preferences and needs.
- **Cultural competency training.** You must complete cultural competency training annually to help all staff members understand how to deliver care across cultures.
    - EyeMed includes cultural competency in the training module that all providers must complete by December 31 of each year. See our Annual Training Requirements section for more details.
- **Cultural competency resources.** The federal Office of Minority Health (OMH) offers information on providing culturally competent services on their website, thinkculturalhealth.hhs.gov. CMS has also developed an online Health Care Language Services Implementation Guide to help your office meet these standards.

## Interpretation and translation requirements

- **Reporting of languages spoken.** Report all languages spoken in your office, including American Sign Language (ASL), so we can include this information on our provider directory. You can provide this information in the "Manage My Profile" section of the online claims system.
- **Translation and interpretation of materials.** Provide free oral, ASL and Braille interpretation translation of your practice materials and service delivery upon member request.
- **Member preferred languages.** Note the patient's preferred languages in your patient documentation so your staff knows to communicate and provide oral and written information in their preferred language.
    - Use an interpreter, when necessary, to ensure patients understand all options and are able to make informed decisions.
    - Call us at 888.581.3648 to access free interpreter services. Normal business hours are from 7:30 am to 11 pm ET Monday through Saturday and 11 am to 8 pm ET on Sunday).
    - Members can use their family members as interpreters, but you still need to make them aware interpreter services are available to them. If they do opt for a family member or friend, this shouldn't compromise the effectiveness of the service or violate a member's confidentiality.
    - Customize, print and make available copies of section 1557 of the Affordable Care Act's Notice of Nondiscrimination and Statement of Nondiscrimination in the most common languages your practice encounters. Translated versions are available online at https://www.hhs.gov/civil-rights/for-individuals/section-1557/translated-resources/index.html.

# Medicare and Medicaid participation

EyeMed requires network providers to be eligible to participate in federal healthcare programs, including Medicare and Medicaid. Providers found on any preclusion lists will be removed from our networks.

### Medicare exclusion

- **Medicare opt-outs and exclusions.** Providers who do not remain enrolled in Medicare will be immediately removed from all EyeMed networks. Providers excluded from participation in programs that receive federal funding cannot participate in EyeMed networks.

### State Medicaid Agency enrollment

- **Medicaid enrollment.** You must be enrolled in the state Medicaid agency. Your ID number is key for participation in this program, and we must monitor the accuracy of it on a regular basis.

# Mobile providers

EyeMed will contract with providers who practice in mobile settings only when specific requirements are met.

**Definition of mobile providers.** We define a mobile provider as a third party who performs eye exams and/or dispenses materials at a location(s) other than a contracted brick-and-mortar location(s). Mobile providers include, but are not limited to:

- Vision vans.
- Temporary eye clinics.
- Those who serve patients at nursing homes or other care facilities.

**Mobile provider categories.** EyeMed has categorized mobile providers as:

- Category 1: Those who increase access to care to otherwise underserved populations. EyeMed generally accepts mobile providers who fall in this category.
- Category 2: Those who provide a service of convenience to members who already have adequate access to care. EyeMed only accepts providers in this category under certain circumstances.

### Application process

- **Mobile provider application.** All mobile providers who want to participate in an EyeMed network must go through a mobile provider application and approval process.
    - Fill out the online application form. Select "Special Programs/Documents."

    - Once a completed initial mobile provider application package is received, it takes a minimum of 30-60 days to complete the process.
    - We will deny claims submitted for mobile providers that have not been pre-approved through this process.
- **Recertification.** Mobile providers must recertify compliance with EyeMed's requirements every 2 years.
- **Doctor credentialing.** If approved, doctors performing exams will also need to be credentialed.

### Requirements

- **Brick and mortar location.** You're required to have a brick-and-mortar location that provides comprehensive eye exams in addition to mobile services to ensure that members have access to continuity of care, or document alternate arrangements to provide timely appropriate sequential care through participating network providers without additional cost to the member or to EyeMed.
- **Follow-up information.** Leave clear, legible contact information, exam findings, follow-up notes and recommendations with the patient after every patient encounter.
- **Continuity of care.** Provide/ensure appropriate medical eye care follow-up and/or ensure continuity of care with other medical providers, as indicated.
- **Equipment.** Have and maintain the required equipment at both the physical office location and mobile setting. We may request proof of equipment.
- **Requirement to report changes.** Report any material changes to information submitted in your original mobile provider application within 30 days and provide written program and protocol revision descriptions as appropriate. Any finding of falsification of this information or failure to report material changes is grounds for immediate termination.

# Remote vision care exam

Remote vision care exams may be helpful to provide access to care to under-served populations, specifically members who live in geographies without reasonable access to conventional eye care practices. EyeMed will contract with remote vision care exam providers only when specific requirements are met.

### Application process

- **Remote vision care exam provider application.** All providers who want to offer remote vision care exams as an EyeMed network provider must complete the remote vision care exam application and approval process.

- Fill out the online application form. Select "Special Programs/Documents," then select YES for the question "Are you a telemedicine provider."
- Once a completed initial remote vision care exam package is received, it takes a minimum of 30-60 days to complete the process.
- We will deny claims submitted for remote vision care exam providers who have not been pre-approved through this process.

- **Doctor credentialing.** If approved, doctors performing exams will also need to be credentialed.

## Requirements

- **Brick and mortar location.** You must have a fully licensed and accredited brick-and-mortar location where patient data is collected (the Originating Site). A credentialed provider who is a licensed optometrist or ophthalmologist must be available for in-person care at the Originating Site at least 1 day per week.
- **Prior patient relationship.** Before performing any remote vision care exam service, the provider performing the service must establish a doctor-patient relationship via one of the following means:
  - A prior in-person examination
  - An examination using synchronous remote vision care exams incorporating both audio and visual connections between the provider and member[1]
  - Consultation with or referral from another EyeMed participating provider who has established or will establish a doctor-patient relationship with the patient, and who intends to manage the patient's care. If the provider is rarely or never personally at or near the Originating Site, they may establish a relationship with 1 or more participating providers near the Originating Site who are willing to manage the patient's in-person care needs. The selection of such a provider will remain the choice of the member.
- **Quality of care.** Remote vision care exam providers will be held to the same standards of appropriate care as, and the level of care must be equal to, providers offering in-person service.
- **Licensing and credentialing.** The doctor providing the care must comply with state law regarding the need for licensure or registration in the state where the Originating (patient) Site is located as well as the Distant (provider) Site.
- **Informed consent.** Prior to initiation of the remote vision care exam examination service, the provider must inform the member that the service will be conducted without the optometrist or ophthalmologist being physically present (in-person) and the member must consent to receiving care via remote vision care exam.

[1] https://www.ama-assn.org/system/files/2018-10/ama-chart-telemedicine-patient-physician-relationship.pdf

- **Privacy and security.** You need to have privacy and security measures in place that meet healthcare industry standards.
- **Audio and video systems.** Remote vision care exam providers must use interactive audio and video telecommunications systems that permit real-time interaction between the patient at the Originating Site and the provider at the Distant Site.

# Network terminations and suspensions

### Voluntary terminations from EyeMed network

- **Voluntary termination process.** You can request to be removed from the network, which we call a voluntary termination, with 60 days advance notice by completing our online Termination of Tax ID or Location form.

### Involuntary terminations from EyeMed network

- **Definition of involuntary terminations.** Involuntary terminations occur when we terminate your participation.
- **Reasons for involuntary termination.** EyeMed can involuntarily terminate you for reasons listed in your provider contract or for the following additional reasons:
    - Commission of fraud, waste or abuse (FWA).
    - Providing false or misleading information upon initial or subsequent application, credentialing or recredentialing and/or contracting.
    - A pattern or practice of unprofessional or inappropriate conduct toward members.
    - When termination is deemed necessary to protect against the risk of imminent danger to the health or welfare of our members.
- **Involuntary termination process.** In the event of an involuntary termination, you'll receive a written notice specifying the date of termination from the network, any applicable appeal rights and processes.
    - Providers terminated due to license suspensions, terminations or lapses are considered removed from the network as of the date the license was terminated.

### Responsibilities upon termination

- **Removal from locator.** Once you're no longer participating on the network, we'll remove your location(s) from our automated locator services effective the day of termination.
- **Claims payment.** We'll process all claims submitted before the termination date and within claim-filing limits.
- **Referrals and follow-up care.** Provide referral instructions for follow-up care or clinical record requests when necessary.
- **Outstanding balances.** You're responsible for paying any outstanding balances owed for lab materials orders or withholds.

# PAYMENTS

## Reimbursements

- **Medicaid fee schedule.** You'll be paid according to the EyeMed Fee Schedule for Louisiana Medicaid provided with your contract amendment.
    - You must accept EyeMed's payment in full for services rendered except when authorized by Medicaid.
    - You cannot seek nor accept additional payment for covered services or materials, even if the member has signed an agreement to do so.
- **Frame dispensing fees.** Per the Medicaid fee schedule, you'll receive a $10.00 dispensing fee for dispensing frames.
    - Reimbursement for the dispensing service includes the vision provider's services in selecting, ordering, verifying and aligning/fitting of eyeglasses.
    - Routine follow-up and post-prescription visits (e.g., for minor adjustments) are considered part of the dispensing service and are not separately reimbursable.
- **Lens dispensing fees.** Per the Medicaid fee schedule, you'll receive $10.00 for single vision lens dispensing (per pair), $15.00 for bifocal lens dispensing (per pair) and $20.00 for trifocal lens dispensing (per pair).
- **Contact lenses.** If approved, contact lens materials and services will be reimbursed at 100% of the Louisiana Medicaid fee for service schedule.

## Copayments

- **Billing the member.** The following is a non-inclusive list of situations when the member cannot be billed for services rendered:
    - Charges above the Medicaid maximum allowable fee amount.
    - Claims denied due to provider error.
    - Errors made by BHSF, Gainwell Technologies or the Third Party Liability collections contractor or changes in state and federal mandates.
    - Service(s) denied because you failed to request prior authorization or failed to meet procedural requirements.
    - Claim balances remaining after another third-party source (such as Medicare, health insurance, TRICARE, etc.) has made payments.
    - Completion and submission of a Medicaid claim form.
    - Telephone calls and missed appointments.
    - Costs associated with copying medical records.
- **Member's responsibility.** The following is a non-inclusive list of situations when a member may be billed for services rendered:
    - The Medicaid member was ineligible on the date of service.
    - The service isn't covered under the scope of Medicaid or exceeds the program benefit limitations. See the Non-covered items section for rules on non-covered items.

- The member may be liable for the entire claim or a portion of the claim when it's determined that services weren't medically necessary.

## Non-covered items

- **Non-covered items.** You can only bill a member for non-covered services if the member was informed in advance, verbally and in writing, that the service(s) was not covered by Medicaid and the member agrees to accept the responsibility for payment. You should obtain a signed statement or form which documents the member was verbally informed of the out-of-pocket expense.
  - If you don't have a consent waiver, you may use our Non-Covered Service Fee Acceptance Form as an example.
- **Contact lenses.** A member may be billed for services that have been determined as non-covered or exceeding the services limit for members over 21 years of age. Members are also responsible for all services rendered after their eligibility has ended. You must inform the member both verbally and in writing that they are responsible for payment of the services.

# Members with medical and vision benefits

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

In situations where members have eye exam benefits through both their medical and vision plan, network providers should use their professional judgment combined with discussions with the patient to determine whether to file an eye exam claim or, potentially, other service(s), with us or through the patient's medical carrier.

- **Patients lacking a specific complaint related to a medical condition.** If the **patient does not have a specific complaint related to a medical condition**, it is most appropriate to bill the vision plan (EyeMed) for the visit.
    - If during a visit where the patient presented without a medical-related complaint you discover the patient has a medical condition and your prescribed treatment plan would require medical eye care, inform the patient of their condition and their need for the diagnostic testing and/or treatment anticipated, then schedule the patient for a follow-up medical eye care visit.
    - Follow-up medical eye care should be billed to the patient's medical plan.
- **Patients requesting vision plan exam based on presenting problem.** If the **patient asks for the exam to be billed to the vision plan based on a presenting problem**, explain to the patient the needed care and coverage/billing options under their medical plan, possible out-of-pocket payments or possible referral options.
- **Patients with no reported medical conditions.** When the **patient reports no medical conditions**, the coverage of services rendered by an eye care professional depends on the purpose of the examination or service and not the ultimate diagnosis of the patient's condition.
    - When a patient goes to their physician for an eye examination with no specific complaint related to a medical condition, the expenses for the examination are likely not covered under the patient's medical benefit, even though a pathological condition was discovered as a result of the eye examination.

    - Under these circumstances, the eye examination should be billed to the vision plan if the patient presented without a specific complaint related to a medical condition.
    - If you recommend that the eye care service(s) provided be billed to the patient's medical plan, it must be fully disclosed to the patient as to the reason for the recommendation to bill the medical plan and the possible deductible and/or copay out-of-pocket expenses.
- **Refusal to provide services under the vision plan.** Should an EyeMed member insist that a vision plan claim be submitted and the presenting problem, in your professional judgment, would indicate the need for another service and/or procedure, you may elect to refuse to provide the comprehensive eye examination under the vision plan.
    - Clearly document the reasons for any refusal of care in the patient's clinical record and contact us at 888.581.3648 to inform us of the refusal of care and the reason.
- **Disclosure form.** Following your explanation of the entity to be billed, the patient should acknowledge this explanation by signing a Disclosure Form that states:
    - The medical reason (diagnosis) a claim is being filed with the medical benefit.
    - The potential cost (out-of-pocket expense), which would include the deductible and/or copay. It's understood you may not be able to definitively determine the amount; therefore, listing your usual and customary charges for the service(s) would be an acceptable disclosure.
- **Eye exams covered by medical plan.** If you deem the eye exam would be covered by the medical plan:
    - If you're a participating provider for the patient's medical plan, inform the patient of your participating status.
    - If you are not a participating provider, inform the patient that your practice's usual and customary fees will be charged, and disclose those proposed fees.
- **Referrals to medical providers.** If the patient elects to be referred to a participating medical provider, make every effort to refer appropriately and provide the subsequent professional with all relevant information concerning your findings that will lead to the best possible outcome for the patient.

# Coordination of benefits (COB)

### COB policies

- **Primary payer.** Medicaid is considered the payer of last resort.
    - Federal regulations require you to bill all identifiable financial resources available for payment, including Medicare, prior to billing Medicaid.

- **Dilation and refraction.** We don't reimburse separately for any services included in a comprehensive eye exam (including dilation and refraction).

### COB process

- **Refraction-only claims (only for groups that permit coordination of benefits).** File refraction only-claims in hard copy following the below process:
    - Collect only the medical carrier's eye exam copay from the member, if applicable. Don't collect any exam copays that would apply under our plan.
    - After you're paid by the medical carrier, submit a CMS 1500 form with only the refraction code (leave the exam off) and attach a copy of the EOB from the primary payer showing that an exam was rendered. We'll reimburse you your retail charge for the refraction up to the maximum exam reimbursement, and the member will be ineligible for eye exam benefits until the next benefit cycle.
    - **NOTE**: If you do not follow this process, your claim will be denied and you may be responsible for returning money to the member.

### TPL guidance

| If you find: | Then a case member may be eligible for: |
|---|---|
| A case member is over 65 or blind or disabled | Medicare and Medicare supplemental policies |
| A case member, absent parent, stepparent, dependent child, new spouse of an absent parent, or anyone else who is legally or voluntarily responsible for a case member is EMPLOYED or UNION MEMBER | Employment-related health insurance |
| A case member, spouse of a case member, absent parent or stepparent is ACTIVE-DUTY MILITARY or a VETERAN | Military health insurance for active duty, retired military and their dependents coverage |
| A case member has been in an accident or otherwise accidentally injured: INJURY/TRAUMA/ACCIDENT | • Worker's compensation<br>• Homeowner's insurance<br>• Automobile insurance<br>• Liability insurance |

# Submitting claims

### Claims submission

- **Claims submission process.** You will use the online claims system to file claims, except when the benefits need special processing. Or, you can submit claims electronically using 837 inbound format through outside clearinghouses.

    - If you decide to use electronic data interface (EDI), you'll be reimbursed according to the fees listed under the Claims Submitted Outside the Online Claims System section of your fee schedule.
    - To begin the process of setting up EDI, contact us at 888.581.3648.
- **Submitting claims for medically necessary services.** If you find a medical reason for an eye exam after these members' eye exam benefits have been used, file the claim using the medically necessary tab in the online claims system.
    - Indicate one of the below reasons when submitting the claim:
        - **Prescription (RX)** - Patient has a diopter or medical condition that necessitated a medically necessary lens option for adequate vision correction.
        - **Situational (ST)** - Patient has a circumstantial clinical need that required a specific treatment for adequate vision correction.
        - **Previous Order (PO)** – Patient is unable to wear multi-focal lenses.
    - Refer to our Medicaid claim filing job aid for more information.
- **Fraud warnings.** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- **False Claims Act.** All claims are also subject to The False Claims Act (31 U.S.C. §§ 3729 et. seq.). Any provider who submits false claims, statements, or documents may be prosecuted under applicable federal or state laws.

## Timely filing

- **Timely filing.** To be reimbursed for services rendered, you must comply with the below timely filing guidelines established by Louisiana Medicaid. If you do not file the claim in this time period, it will be denied, and you will not be able to collect money from the member.
    - Medicaid claim submissions must be filed within 12 months of the date of service.
    - Claims for members who have Medicare and Medicaid coverage must be filed with the Medicare fiscal intermediary within 12 months of the date of service in order to meet Medicaid's timely filing regulations.
    - Claims that fail to cross over electronically from Medicare must be submitted hard copy to Medicaid within 6 months from the date on the Medicare Explanation of Medicare Benefits (EMOB), provided they were filed with Medicare within 1 year from the date of service.
    - Claims with third-party payment must be filed with Medicaid within 12 months of the date of service.
- **Claims exceeding the initial timely filing limit.** Medicaid claims received after the initial 1-year timely filing limit (1 year from the date of

service) cannot be processed unless you are able to furnish documentation that verifies timely filing.
    - Proof of timely filing may include 1 of the following:
        - An electronic Claims Status Inquiry (e-CSI) screen print indicating the claim was processed within the specified time frame.
        - A remittance advice (RA) indicating the claim was processed within the specified time frame.
        - Correspondence from the state or parish office concerning the claim and/or the member's eligibility.
    - All proof of timely filing documentation must reference the individual member and date of service. RA pages and e-CSI screen prints must contain the specific member information, your information and date of service to be considered proof of timely filing.
    - You must confirm the claim is legible in order to ensure accurate processing when resubmitting the claim and documentation.
    - Louisiana Medicaid doesn't accept the proof of timely filing:
        - Printouts of Medicaid Electronic Remittance Advice (ERA) screens.
        - Rejection letters accompanying returned claims.
        - Post Office "certified" mail receipts and receipts from other delivery carriers.
- **Claims beyond the 2-year timely filing limit.** Claims with dates of service 2 years old must be submitted to LDH for review and must be submitted with proof of timely filing within the initial 1-year filing limit.
    - These claims must meet 1 of the following criteria:
        - The member was certified for retroactive Medicaid benefits, and the claim was filed within 12 months of the date that retroactive eligibility was granted.
        - The member won a Medicare or SSI appeal in which he or she was granted retroactive Medicaid benefits.
        - The failure of the claim to pay was the fault of the fiscal intermediary or Louisiana Medicaid, rather than your fault, each time the claim was adjudicated.
    - In order to be considered for the 2-year override, requests must include a cover letter describing the criterion that has been met and supporting documentation. Requests that don't meet these requirements will be returned to you.
- **Exceptions to timely filing.** The following types of claims may be accepted or resolved outside the 365-day timely filing limit:
    - **Administrative Error**: This is where the failure to meet the filing deadline is caused by error or misrepresentation of the Medicaid health plan, EyeMed or LDH. In these cases, the Medicaid health plan shall extend the timely filing through the last day of the 6th month following the month in which the member, you or supplier

received notice from the Medicaid health plan that an error or misrepresentation was corrected.
    - **Retroactive Medicaid entitlement or retroactive Medicaid health plan enrollment:** This is where a member receives notification of Medicaid entitlement and/or health plan enrollment retroactive to or before the date the service was furnished. In these cases, the health plan shall extend timely filing to 365 calendar days from the date of service or 180 calendar days from the member's linkage add date in the member's 834 eligibility file, whichever is later.

## Claims codes

- **Eye exam codes.** We use CPT codes 92004 and 92014 for eye exams because they describe specific definitions of what a comprehensive eye exam should include.
- **Medically necessary eyewear claims (lenses and replacement pairs).** When filing claims for Medicaid exams and eyewear that require medical necessity, you can use the online claims system but will need to provide additional information. NOTE: Contact lenses follow a different process. Refer to the Hard Copy Claims section of this manual for instructions.
    - The optometrist or ophthalmologist is responsible for determining the service is medically necessary, appropriate and within the scope of current medical practice and Medicaid limitations.
    - Always include a medical necessity reason code.
    - Indicate the appropriate diagnosis code for a qualifying condition as defined in EyeMed Fee Schedule for Louisiana Medicaid.
    - Filing online:
        - Use the "Routine" tab in the online claims system for medically necessary lens options on the member's first pair of glasses.
            - Select the appropriate diagnosis code and reason code on the "Usual and Customary" screen.
        - For replacement eyewear, use the ST code.
        - Use the "Medically Necessary" tab in the online claims system for additional eye exams, replacement eyewear or second pairs of glasses in lieu of bifocals.
- **Refraction code.** We consider the refraction (CPT 92015) part of a comprehensive eye exam.
- **ICD-10 code reporting.** We require you to submit all applicable ICD-10 diagnosis codes when filing a claim.
    - The online claims system lets you note primary and high-risk diagnoses, including abnormal pupil, age-related macular degeneration, cataract, diabetes, diabetic retinopathy, glaucoma, hypercholesterolemia and hypertension.

## Hard copy claims

- **Hard copy claim submission.** Some circumstances may require hard copy claims.
    - If you send us a hard copy claim for materials that should have been submitted to a lab though our online claims system, we'll reimburse you according to the Claims Submitted Outside of Our Claims System fee schedule on your network schedules. You'll be responsible for all lab and eyewear fabrication costs, and you can't bill the member for the balance except for member out-of-pocket allowable under the buy-up eyewear program.
- **Medically necessary eyewear claims (lenses and replacement pairs).** When filing claims for Medicaid exams and eyewear that require medical necessity, you can use the online claims system but will need to provide additional information. (Note that contact lenses follow a different process. Refer to the Contact Lens section of this manual for instructions.)
    - The optometrist or ophthalmologist is responsible for determining that the service is medically necessary, appropriate and within the scope of current medical practice and Medicaid limitations.
    - Always include a medical necessity reason code.
    - Indicate the appropriate diagnosis code for a qualifying condition as defined in EyeMed Fee Schedule for Louisiana Medicaid.
    - Filing online:
        - Use the Routine tab in the online claims system for medically necessary lens options on the member's first pair of glasses.
            - Select the appropriate diagnosis code and reason code on the Usual and Customary screen.
            - For replacement eyewear, use the ST code.
        - Use the Medically Necessary tab in the online claims system for additional eye exams, replacement eyewear or second pairs of glasses in lieu of bifocals.
    - Filing in hard copy:
        - When filing paper claims, use the RP reason code modifier only.
        - Include the modifier "RP" along with the V code for medically necessary lens options.
        - Include the modifier "BU" along with the V code for lenses and options purchased as a buy-up.
    - A medically necessary claim without the requested information may be reviewed prior to or subsequent to payment.
- **Preferred claims codes.** Use our Preferred Claims Codes to ensure proper processing. We might also deny codes not on this list based on the member's plan and benefits.
- **Faxing claims.** Fax hard copy claims to 866.293.7373.
- **Mailing claims.** Mail hard copy claims to:

  EyeMed/FAA
  PO Box 8504

Mason, OH 45040-7111

# Voiding and correcting claims

You can correct or void routine eye exam or contact lens by submitting a revised CMS 1500 form to us.

### Corrected or voided claim process

- **Faxing corrected or voided claims.** Fax a corrected CMS 1500 form to us at 866.293.7373 with "CORRECTED CLAIM" written on the top.
- **Mailing voided or corrected claims.** You can mail corrected CMS 1500 forms to:

  EyeMed Vision Care/FAA
  PO Box 8504
  Mason, OH 45040
- **Voiding or correcting claims with lab orders.** You can't correct or void claims for eyewear if the lab has already started the order. If you used the lab network and need to cancel the materials portion of a claim, you must void the entire claim.
  - First, call the lab to cancel the order. The lab will confirm if a cancellation is required and process the cancellation if needed. If the lab determines the order doesn't need to be canceled, no further action is needed.
  - Allow 24 hours for the cancellation to flow through our system. If you don't see the member eligibility reopen after 2 business days, please contact the lab to escalate the issue.
  - Once the eligibility is reset to "Yes," proceed by refiling the claim and submitting the correct order.
- **Member eyewear returns.** If a member returns eyewear, the member may be eligible for a free remake depending on the reason for the return.
  - When members return their glasses, we need to know why.
    - **Returns for poor quality or non-adapt.** Refer to our remake policy to replace the glasses.
    - **Change in frame style or "no questions asked" return policy.** Call us at 888.581.3648 if the member is taking advantage of your practice's "no questions asked" satisfaction guarantee or simply wants to change the frame. We can reinstate the member's benefits at your request, but you'll be charged for the lab work based on the Lens and Options Chargeback Schedule.

# Claim payments and withholds

### Payments and withholds

- **Claims payments.** A wholly owned subsidiary of EyeMed, First American Administrators, Inc. (FAA), processes all claims.
- **Withholds.** If we overpay you as part of a claim correction or complaint resolution, we'll withhold funds overage from a future payment.
    - Plans for which we administer Medicaid benefits may request withholds if they find errors during audits. We'll notify you if this happens.

### Claims payment process

- **Payment turnaround time.** You'll be paid within 30 business days of submitting a clean claim. We'll adjust the claims process timing as required by state law.
    - For lab orders, the turnaround time begins when the lab lets us know the order has shipped.
    - Exam portions of claims are not paid until the materials are shipped from the lab.
- **Payment frequency.** Claims are paid electronically by FAA at least once per week.
- **Payment methods.** We pay claims by electronic funds transfer (EFT) or check.
    - Use our online form to sign up for or change any of your direct deposit details, like account number.
- **Remittance advices.** Remittance advices summarize your payments and will show any withholds applied because of incorrect or voided claims. These are available for download from our online claims system.

# Claim denials

- **Denial notification.** If a claim is denied for missing information, we'll send you a letter within 30 days explaining why we denied it, and request that you correct and resubmit it.
    - You'll be paid only when you resubmit the claim within the appropriate timeframe, and the resubmission is accepted.
    - You can collect payment from members for denied claims with member liability ***only*** if we determine they weren't eligible for benefits at the time of service.
- **Lab charges on denied claims.** If you used the lab network and the materials portion of your claim is denied, you'll be billed for the cost of the materials and any associated lab charges.

# SERVICES AND MATERIALS

## Eye exam services

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

### Covered eye exam services

- **Louisiana Medicaid covered services.** Medicaid may reimburse for the visual services described in the Louisiana Vision (Eye Wear) Medicaid provider manual.
    - Medicaid-covered eyewear services must be medically necessary and available to eligible Medicaid beneficiaries who met the following criteria:
        - Under the age of 21; and
        - Aged 21 years and older ONLY if the member receives both Medicare and Medicaid, and Medicare covers the required eyewear. In this instance, Medicaid may pick up a calculated portion of the payment as a Medicare crossover claim.
    - Adults who are over 21 years of age may be covered as a Value-Added group by health plans. Please refer to the Client-Specific Information section for more information.
- **Eligibility verification.** It's your responsibility to verify Medicaid eligibility for each beneficiary, and you can do so using EyeMed's Online Claims System. The member must be eligible for each date of service.
- **Benefit frequency.** Refer to EyeMed's Online Claims System to verify member eligibility and benefit frequency prior to providing services. With attestation of medical necessity, additional routine comprehensive eye exams may be covered.
- **Benefits overview.** Eye exam benefits cover the components listed in our Routine Eye Exam Guidelines, including refraction and dilation. You must follow Federal Trade Commission (FTC) guidelines regarding eyeglass prescriptions, and you must refer patients according to the American Optometric Association standard of care guidelines for any follow-up care resulting from your exam findings.
- **Same-day or subsequent day follow-up office visit policy.** A separate same-day or subsequent-day follow-up optometrist or ophthalmologist office visit is allowed for the purpose of the delivery and final adjustment to the visual axis and anatomical topography of Medicaid-covered eyewear. Presence of the physician is not required. Documentation in the member's record should reflect that the member returned for a separate visit on the same day or subsequent day for the purpose of the delivery and final adjustment of the eyewear and must include a description of the services provided.

## Refraction and dilation

- **Refraction as part of eye exam.** Refraction is a component of the covered services available to eligible members and must be performed in conjunction with a comprehensive examination.
- **Dilation.** The routine eye exam benefit includes dilation when professionally indicated and performed within 30 days of the initial eye exam.
    - Retinal imaging doesn't replace dilation.
    - You must dilate all members who have diabetes.
    - If the member refuses to be dilated, document the refusal in their patient file.

## Second opinions

- **Second opinions.** If a member wants a second opinion, ask them to complete a written request for a second opinion and submit it directly to EyeMed Quality Assurance at eyemedqa@eyemed.com. We will then reach out to you to request records for the initial visit and to hear your point of view.

## Eye exam requirements

- **Eye exam components.** You must provide the services below as part of an eye exam:

### Case history

- Chief complaint
- Ocular disease history (including prescriptive and non-prescriptive medications)
- Family history: general and ocular
- Occupational/lifestyle: use of vision; glasses or contact lenses
- General medical history (including medications)
- Allergies, including medication allergies

### General patient observation

- Neurological: orientation (time/place/person)
- Psychiatric: mood and affect (depression/anxiety/agitation)

### Clinical and diagnostic testing and evaluation

- Examination of orbits
- Test visual acuity
- Gross visual field testing by confrontation or other means
- Ocular motility
- Binocular testing
- Measurement of intraocular pressure
- Ophthalmoscopic examination with pupillary dilation, as indicated, of the following:
    - Optic disc(s) and posterior segment

- Slit lamp examination of irises, cornea(s), lenses, anterior chambers, conjunctivae and sclera
- Examination of pupils
    - Macula
    - Retinal periphery
    - Retinal vessels
    - Vitreous
    - Other examinations (must specify)

*Note: Pupillary dilation is required for members with diabetes.*

**Refraction**

- Objective refraction (retinoscopy or auto-refraction) and subjective refraction*
- Resultant best (corrected) visual acuities, distance and near

**Color vision testing***

**Stereopsis testing***

**Case presentation**

- Assessment
- Management plan
- Professional reports* (i.e., driver's license, health physical)
- Visual acuities and tonometry findings
- Photographs and findings, if applicable.
- Diagnosis (ICD) codes

*ICD-10 diagnosis codes should include diagnosis from the patient's history, the patient's reported medications and/or your clinical findings. List the primary diagnosis first followed by all secondary diagnosis codes determined in the exam (especially those including diabetes, diabetic retinopathy, hypertension and glaucoma).*

*As indicated.

Note: In some cases, exam may be completed with other instrumentation because of member limitations.

- **Eyeglass prescriptions.** You must follow FTC guidelines related to the release of eyeglass prescriptions.

## Referrals

- **Referrals not required.** Referrals are not required for routine vision care services provided under our plans.
    - For routine, non-urgent or preventative care visits, a member should be able to schedule an appointment within 2 weeks. A PCP referral for in-network eye care and vision services is not required.

# Contact lenses

## Covered benefits

- **Medically necessary contact lens benefits.** The benefit covers contact lens materials, fitting and follow-up visits for up to 90 days when medically necessary.
    - Contact lenses will only be considered when medically necessary and no other means can restore vision.
    - Medicaid reimburses for rigid or soft contact lenses. If either soft or rigid lenses could be used, Medicaid will approve the least expensive type.
    - Medicaid may reimburse for continuous wear lenses when the member can't wear normal soft lenses.
    - Medicaid doesn't reimburse for contact lenses for cosmetic purposes.
- **Benefit frequency and annual supply limits.** Refer to EyeMed's Online Claims System to verify member eligibility, benefit frequency and annual supply limits. Members who qualify can't exceed annual supply limits defined by contact lens manufacturer replacement guidelines.
- **Member out-of-pocket.** You may not bill members for any difference between your retail fees for contact lenses and EyeMed's Medicaid reimbursement.

## Components of contact lens fitting/evaluation

- **Initial diagnostic evaluations.** When treating contact lens patients, perform compatibility tests, diagnostic evaluations and diagnostic lens analyses to determine if contact lenses are right for a member, or if their contact lens prescription has changed.
- **Contact lens evaluation requirements.** Your contact lens evaluation must follow the below requirements depending on whether the patient has worn contact lenses in the past.
    - A "new contact lens wearer" is a new patient at your practice, or a patient who hasn't worn contact lenses in the past 12 months.
    - An "existing contact lens wearer" is a patient who has worn contact lenses within the last 12 months and is an established patient at your practice.

| | New Wearer | Existing Wearer |
|---|---|---|
| | Required Test (✓) | |
| Contact lens-related history | ✓ | ✓ |
| Keratometry and/or corneal topography | ✓ | ✓ |
| Anterior segment analysis with dyes | As Indicated | As Indicated |
| Biomicroscopy of eye and adnexa | ✓ | ✓ |

| | New Wearer | Existing Wearer |
|---|---|---|
| | Required Test (✓) | |
| Biomicroscopy with lens<br>• Fluorescein pattern (rigid lenses) orb.<br>• Movement and/or centration (soft lenses) | ✓ | As Indicated |
| Over-refraction | As Indicated | As Indicated |
| Visual acuity with diagnostic lenses | ✓ | As Indicated |
| Determination of contact lens specifications determined to obtain the final prescription | As Indicated | As Indicated |
| Member instructions and consultations | ✓ | ✓ |
| Proper documentation with assessment and plan | ✓ | ✓ |

## Follow-up care, training and education

- **Follow-up visits.** The benefit covers unlimited follow-up visits.
- **Training and education.** You can't charge members additional fees for training and education, which should include written instructions on how to handle, clean, maintain and wear their contact lenses.
- **Trial or adaption period.** The benefit covers a 1- to 3-month trial or adaption period, including a fitting warranty providing for adjustments in the contact lens parameters by exchange or modification of the materials.

## Qualifying conditions

- **Minimum qualifications for eligibility.** A member's vision and spectacle prescription must meet the below criteria to qualify for contact lens benefits under the program. Members can't use this benefit for conditions not listed, even if you determine that contact lenses are necessary to correct other vision issues.
    - An unusual eye disease or disorder exists which is not correctable with eyeglasses;
    - Nystagmus, congenital or acquired but not latent monocular, where there is significant improvement of the visual acuity with contact lens wear;
    - Irregular cornea or irregular astigmatism (doesn't apply if the member has had previous refractive surgery);
    - Significant, symptomatic anisometropia; and
    - Aphakia (post-surgical).

## Documentation requirements

- **Establishing qualification for benefit.** You're responsible for determining if members meet the qualifying criteria based on your exam and evaluation.
- **Prescription requirements.** The following must be included on a prescription for contact lenses:
    - Complete description of the contact lens(es) parameters.

    - Material of the contact lens(es).
    - Manufacturer of the contact lens(es).
    - Material discard and replacement schedule.
    - Number of lenses required to provide a 1-year supply.
    - Prescription expiration date.
- **Spectacle prescription.** The documented spectacle prescription must support the qualifying condition submitted.
- **Supporting documentation.** We may also ask you for additional supporting documentation.
- **Audits and clinical records reviews.** We'll periodically review clinical records to make sure you're correctly applying the medically necessary contact lens benefit. We'll be checking whether the documented prescription supports the qualifying condition submitted on the original claim.
    - If the clinical record doesn't support the reported condition, we can recoup any overpayment by withholding payment on future claim(s) where law permits.
    - We can consider any inaccurate submission to be a false claim. Falsifying information or filing false claims can result in disciplinary action up to and including termination from our network. We might also have to report it to regulatory and law enforcement agencies as appropriate.
- **Attestation of medical necessity.** All Medically Necessary Contact Lenes (MNCL) require provider's attestation of medical necessity with appropriate diagnosis code(s) and criteria as defined in state administrative code. The attestation must clearly indicate whether it is on behalf of a new MNCL fitting or replacement lenses.

## Contact lens materials dispensing requirements

- **Valid contact lens prescription.** Before dispensing contact lenses, make sure the member's prescription hasn't expired and still meets the member's eye health and vision needs before dispensing contact lenses.
- **FTC Fairness to Contact Lens Consumers Act.** You must follow the FTC Fairness to Contact Lens Consumers Act (15 U.S.C. §§ 7601-7610).
- **Minimum industry standards.** Dispense contact lenses that have been manufactured to meet the most current industry standards.
- **Filling existing prescriptions.** When filling an existing contact lens prescription, make sure the prescription is current and meets the member's vision needs prior to supplying contact lens materials.

## Contact lens claims

- **Contact lens claims.** The materials and fit and follow-up services for contact lens benefits must be submitted on 1 claim. File the claim in hard copy following the process below:
    1. Complete our Louisiana Medicaid Medically Necessary Contact Lens claims form.

- Enter a single contact lens fitting code to indicate the qualifying condition.
- Include a material contact code on the same claim and same date of service.
- The materials and fit and follow-up services for medically necessary contact lens benefits must be submitted on 1 claim.
- Include the applicable refractive and high-risk diagnosis codes on all contact lens claims.
- Refer to the Louisiana Medicaid Medically Necessary Contact Lens claims form for the current codes.

2. Fax the completed form to 866.293.7373 or mail to:
   EyeMed Vision Care/FAA
   PO Box 8504
   Cincinnati, OH 45040

### Replacement contact lenses

- **Replacement lenses due to loss or damage.** Members are eligible for replacement of medically necessary contact lenses (MNCL) if the original MNCL have been lost, stolen or damaged beyond repair.

# Frames and lenses

### Eyeglass benefits

- **Frame and lens benefits.** A complete pair of eyeglasses is a Medicaid covered benefit. Refer to EyeMed's Online Claims System to see a member's eligibility, benefits, frequency and whether they have any applicable copayments.
  - If a complete pair of eyeglasses (frames and lenses) is delivered to a Medicaid member on the same date of service, you must bill for all components of the eyeglasses. You may not bill Medicaid for lenses only and let the member pay for the frames, or vice versa. You may dispense replacement lenses to a complete pair of eyeglasses that a member already owns.

### Ophthalmic frames

- **Frame collection.** Members must choose an ophthalmic frame from the Medicaid-covered frame collection. After you register with Classic Optical in our system, you'll receive a frame kit (if you don't already have one) to aid members in choosing frames.
  - The collection is for display and try-on use only.
  - Do not send frames to the lab.
  - If a frame manufacturer discontinues production of a frame that is listed as a benefit, you may use the discontinued frame from your sample kit.

    - Medicaid members must be offered a choice between metal or plastic frames. The frames must be sturdy and nonflammable. Both the metal and non-metal frames must carry at least a 1-year manufacturer's warranty.
- **Deluxe frames.** Deluxe frames require prior authorization and will only be considered when medically necessary, i.e., child has a wide nose bridge due to a medical syndrome or a child has a small head and regular frames would not fit, etc.

## Lenses

- **Standard lenses.** We consider standard lenses to be uncoated, CR-39 plastic single vision. Any other lens types and options are covered only when medically necessary.
- **Single vision lenses.** Single vision lenses are covered if at least 1 lens exceeds +1.00 sphere, -0.50 sphere or +/-0.50 cylinder. Only spheres or compounds +/- cyl series, properly transposed to find price brackets, should be prescribed.
- **Bifocal/trifocal lenses.** Bifocal/trifocal lenses will only be considered when medically necessary. Bifocal/trifocal lenses requested for convenience won't be authorized.
- **Polycarbonate.** Polycarbonate lenses are covered for members only when medically necessary. Should a member desire polycarbonate lenses, the member is responsible for paying the applicable amount out-of-pocket. Prior to rendering polycarbonate lenses, you must notify members that the polycarbonate lenses must be paid out-of-pocket and have the member or their legal guardian sign a consent waiver. Refer to the Non-Covered Items section for additional rules on non-covered items and an example waiver.
- **Progressive lenses.** Standard progressive lenses are covered for members when medically necessary.
- **Anti-reflective treatments.** Anti-reflective treatments are not a Medicaid covered benefit.
- **Oversized lenses.** Oversized lenses are not considered a Medicaid covered benefit.
- **Product catalogs.** The Louisiana Medicaid product catalogs (Essilor LA Medicaid Lens Design Tool and Essilor LA Medicaid Lens Add-On Tool) define the lenses and treatments available through our lab network for Louisiana Medicaid members.
- **Non-prescription lenses.** Louisiana Medicaid does not cover non-prescription ophthalmic lenses and frames.

## Medically necessary lenses and options

- **Covered lens options.** Members qualify for photochromic, tinted/dyed lenses and aspheric as a covered benefit only when medically necessary based on the doctor's professional opinion.

## Lab network requirements

- **Aetna Better Health of Louisiana (ABHLA).** ABHLA Medicaid follows 2 different processes for labs, depending on the age of the member. Refer to the Client-Specific section for more information.
- **Medicaid lab.** All glasses for Medicaid members between 0-21 years old must be ordered from Classic Optical, ***even if you do not normally use the lab network***.
- **Dispensing fees on lab orders.** The dispensing fee is automatically included with the lab transaction and does not need to be entered as a separate transaction or line item.
- **Lab registration.** You must register for Classic Optical before submitting an order. Instructions for registering for a lab are available on our provider portal at eyemedinfocus.com.
- **Eyeglass cases and postage.** Your reimbursement includes the eyeglass case and any postage.
- **Good financial standing.** You must stay in good financial standing with the network labs, even related to non-EyeMed orders.
    - If you don't stay in good financial standing with labs, your claim may be paid according to the fees listed under "Claims Submitted Outside of Our Online Claim System" on the back of your fee schedules.
- **Online lab ordering.** You must submit all lab orders through our online claims system.
    - Labs do not accept CMS 1500 forms or 837 inbound.
    - If you submit a hard copy claim for eyewear that should have been ordered through the lab network, you will be reimbursed according to the fees listed under Claims Submitted Outside of Our Online Claims System on the fee schedules you received as part of your contract.
- **Lab responsibilities.** The lab will make lenses based on the member's prescription and options indicated on the claim, insert the lens into the selected frame from the Medicaid collection and ship the completed pair to your office.
- **Frame at lab.** Because Classic Optical will be providing the frames and lenses for non-buy-up purchases, you will submit those lab orders as "Frame at Lab" jobs.
- **Lab order turnaround time.** Classic Optical will ship the product to you within 7 business days from the time the order is submitted.
    - If you do not receive your product within 7 business days, contact Classic Optical.

## Emergency eyewear orders

- **Qualifying reasons for emergency eyewear orders.** An emergency occurs when, in your professional judgment, there's a critical patient visual need that cannot be addressed through normal contract lab services. Examples include:

    - A member's safety and/or well-being is at risk without the immediate delivery of prescription eyewear.
    - The member is unable to function at work or school and doesn't have an alternate pair of glasses or contact lenses.
    - Lenses or lens options not in our product catalog that you deem necessary based on your professional judgment. When filing an emergency service claim, you'll need to explain your professional justification.
    - The member suffers a loss, theft or breakage of prescription eyewear, has no alternate pair and can't wear contact lenses.
- **Ineligible reasons for emergencies.** The following are not considered eligible emergencies:
    - Requests for faster turnaround time for convenience (such as to accommodate trips, vacations or other events).
    - A desire for faster service.
    - When the member has another serviceable pair of glasses or contact lenses.
- **Labs for emergency orders.** You may use a Medicaid qualified lab of your choice, including a non-contracted lab, for emergency eyewear orders. It will be treated as a private pay lab transaction.
- **Emergency eyewear claims.** Submit a CMS 1500 form in hard copy to receive payment according to the amounts listed under the Claims Submitted Outside of Our Online Claims System section on your fee schedules.
- **Balance billing.** Don't balance bill the member for any difference in reimbursement from the schedule if you order a lens that's not in one of our catalogs. You can, however, charge the member for buy-up options as appropriate.

### Lab order refunds, returns and remakes

- **One-time free remake.** You can request a no-charge remake from a network lab 1 time per job within 6 months of the date of delivery.
- **Reasons for no-charge remake.** The following reasons qualify for a no-charge remake:
    - Power changes (excludes power changes resulting in plano lenses).
    - Axis changes.
    - Base curve changes.
    - Segment height/segment style changes due to non-adaptation, i.e., FT28 to Executive.
    - Lens style change, except when going from a lower to higher technology like from a bifocal to a progressive.
    - Transcription errors, not including transcription errors involving tints, photochromics, frames or coatings.
    - Material change.
    - Lab errors.
    - Progressive lenses under warranty.

- **Ineligible reasons for free remake.** You can't receive a free lens remake from the lab for the following:
    - No change in lens prescription.
    - Subsequent remakes after the first 1, excluding lab errors.
    - Patients' upgrade requests.
    - Errors made during lab order process.
    - Any lenses with upgrades.
    - Changes requested after 6 months of delivery.
- **Lab errors.** Remakes for lab errors are processed free of charge.
- **Manufacturer warranties.** Classic Optical will honor any manufacturer warranties. Any financial issues resulting from the manufacturer's product warranty should be handled between you and the lab.
- **Process for free remakes.** Return the lenses to Classic Optical within 6 months of the original delivery date along with the original invoice/shipping slip, an explanation of why you're returning the lens and any supporting documentation.
- **Frame change process.** Members are responsible for the cost to change a frame.
    - Handle it as a private pay transaction.
    - Fax the request to the lab and ship the new frame to the lab with the existing pair of glasses.
- **First-time progressive lens non-adapt.** When a member can't adapt to progressive lenses while they're under warranty, the lab will remake the lenses 1 time at no charge in the same design and material (or lesser-priced design and material).
- **Additional progressive lens non-adapts.** If the member still can't adapt to the remade glasses with progressive lenses, request another remake to switch the member back to lined bifocals, but you'll have to pay full invoice cost for this additional remake. If this happens, follow the same remake/return process outlined above. Note – This may qualify for a replacement/medically necessary pair under the Medicaid plan.
- **Requests for additional remakes.** Additional requests must be handled as a private pay transaction between you and the lab.
- **Non-deliverable eyeglasses.** You should make 3 documented attempts to schedule delivery of the eyeglasses. If the 3 attempts are not successful, you should reach out to EyeMed at 888.581.3648 for assistance coordinating eyeglasses delivery with the health plan or the member.

## Eyewear replacements and repairs

- **Eyewear repair and replacement policy.** You may dispense a replacement frame to a complete pair of eyeglasses, which a member already owns. Replacement frames should not be billed to Medicaid if the frame is covered by the 1-year manufacturer's warranty.
    - If eyeglasses are damaged, the first line of coverage is to utilize the manufacturer's warranty.

- For services that don't require prior authorization, you should fill the prescription, i.e., order the glasses from the manufacturer and dispense the glasses to the member, prior to filing for payment. You shouldn't hold the eyewear until payment is received.
- The eyewear date of delivery is the date of service on the claim form.
- You may not require a payment/deposit for eyewear pending payment from Medicaid. Payment from Louisiana Medicaid must be for medically necessary services and must be accepted as payment in full.
- Eyewear may not be upgraded for cosmetic purposes under any circumstances. Medicaid covers medically necessary eyewear.
- Medicaid doesn't cover any eyewear, initial or replacement that is to be used as "spare" or "back-up" eyewear. The member may choose to purchase (out of pocket) duplicate eyewear to be used as "spare" or "back-up" eyewear.

- **Replacement limits.** Eyewear is limited to 3 pairs per year without review. Billing for the 4th and subsequent pairs must have documentation attached justifying the need for more than 3 pairs of eyewear per year.
  - If you find a medical reason for a 4th pair (or more) of eyewear, file the claim using the medically necessary tab in the online claims system. Indicate one of the below reasons when submitting the claim:
    - Prescription (RX) - Patient has a diopter or medical condition that necessitated a medically necessary lens option for adequate vision correction.
    - Situational (ST) - Patient has a circumstantial clinical need that required a specific treatment for adequate vision correction
    - Previous Order (PO) – Patient is unable to wear multi-focal lenses.
    - Refer to our Medicaid claim filing job aid for more information.
- **Lens rechecks.** If a member asks for a lens recheck, verify the lenses and, if necessary, the refraction, within the first 45 days of receiving new eyewear based on that prescription, at no additional charge to the member.

## Eyewear warranties and return policies

- **Defective lenses and frames.** Honor manufacturer and lab warranties pertaining to defective lenses and frames.
- **Medicaid eyewear guarantee.** Frames and lenses furnished by Classic Optical are guaranteed for 90 days.
- **Warranties for lenses purchased through network labs.** Contracted labs will honor all manufacturer warranties. Contact Classic Optical for further information.

### Return policies

- **Return policies for lenses purchased from network labs.** Specific return policies apply to eyewear manufactured through the lab network. Refer to the lab section for details.
- **Practice return policies.** If you have a specific return policy in place at your practice, you must share it with members when you dispense the eyewear.

# Limitations and exclusions

Plan limits and exclusions include:

- Orthoptic or vision training, low vision aids and any associated supplemental testing.
- Aniseikonic lenses.
- Medical and/or surgical treatment of the eye(s) or supporting structures.
- Services provided as a result of any workers' compensation law.
- Plano lenses and plano sunglasses.
- Services or materials provided by any other group benefit plan providing vision care.
- Services rendered after the date an insured person ceases to be covered under the policy, except when vision materials ordered before coverage ended are delivered, and the services rendered to the insured person are within 31 days of such an order.
- Not all materials are available at all provider locations.
- Members can't combine benefits with any discount, promotional offer or other group benefit plans.

We'll notify you of any changes to this list. Louisiana Medicaid or the MCO could have other limitations not listed here.

# COMPLIANCE AND QUALITY ASSURANCE (QA)

## Definitions

- **Post-service claim appeal/dispute:** a request for review by the MCO of post-service payment-related claim matters.
- **Clinical appeal:** an appeal is a review by an MCO of an adverse benefit determination.
- **Complaint or grievance:** a complaint or grievance means an expression of dissatisfaction about any matter pertaining to administrative issues and nonpayment related matters.
    - You may access this process by filing a written complaint.
    - Providers are not penalized for filing complaints.
    - Any supporting documentation should accompany the complaint.
- **Claim inquiry:** a question about a claim that does not include a request to change a claim payment.
- **Claims correspondence:** when you receive a request for further information to finalize a claim. Examples include medical records, itemized bills and primary plan explanations of payment (EOP).

## Provider post-service claim appeals process

- **Inquiries and correspondence.** Claim inquires and correspondences are NOT considered claim appeals. If you have questions concerning these, call 888.581.3648 for assistance.
- **Claims appeals.** A claim must be submitted prior to following this process.
    - If your claim has been finalized but you disagree with the amount you were paid or you disagree with the denial of your claim, you may request a post-service claim appeal.
    - If you are not satisfied with the payment of your submitted claim, you are entitled to a review (appeal) of the claim determination. To obtain a review, submit your request in writing to:

      Provider Appeals Coordinator
      EyeMed Vision Care
      4000 Luxottica Place
      Mason, OH  45040
      Fax: 513.492.3259
      eyemedqa@eyemed.com
- **Appeals timing.** Your request for an appeal must be submitted within 180 days of the date of your Remittance Advice.
- **Timely filing requests.** EyeMed will consider reimbursement of a claim that has been denied due to failure to meet timely filing deadlines only if

you can provide proof of submission within the timely filing limits, or if you can show good cause.

# Provider audits

## Audit overview

- **Reasons for audits.** EyeMed is required to demonstrate that members receive quality eye care. Audits and associated reporting let us provide data that demonstrates consistent eye care that meets specific standards.
- **Healthcare Effectiveness Data and information Set (HEDIS) audits.** We help collect HEDIS data through HEDIS audits.
- **Disciplinary actions.** Audits could result in disciplinary actions as justified by the findings.
- **Audit selection.** Our Quality Assurance team selects participating providers and/or locations for facility, clinical, financial and/or process audits.
- **Scoring process.** Professional reviewers score each clinical record to determine an average.
- **Medicaid audits.** Refer to the Provider Manual for your state's Medicaid program for audit processes related to Medicaid programs.

## Types of audits and scoring

| Evaluation type | What we're looking for | Scoring |
|---|---|---|
| **Facility** | • Areas of physical access, instrumentation and overall facility condition<br>• 2 sections: Required equipment and facility environment | Required equipment:<br>• 100% required to pass<br><br>Facility section:<br>• 100 – Excellent<br>• 99 to 80 – Satisfactory<br>• Less than 80 – Progressive Disciplinary Action |
| **Clinical records** | • Assessment of member records<br>• Financial evaluation | • 100 to 90 – Good to Excellent<br>• 89 to 80 – Satisfactory<br>• 79 to 0 – Fail: Progressive Disciplinary Action |
| **Financial** | • Financial document evaluation reviews claims against payment and member records<br>• Financial claim evaluation reviews a provider and/or location's claim history to reveal billing patterns | • 100 – Excellent<br>• 99 to 80 – Satisfactory<br>• 79 to 0 – Fail: Progressive Disciplinary Action |
| **Process** | • Review of clinical and business practices for a specific reason, such as adherence to clinical | • 80% required to pass |

| Evaluation type | What we're looking for | Scoring |
|---|---|---|
| | coverage criteria or application of a benefit and compliance with lab ordering, In-Office Finishing and emergency service policies | |
| **HEDIS** | • Collection of HEDIS data to assess and compare quality of care | NA |

## Audit process

- **Record availability.** You must make members' clinical, financial and administrative records available to us or other authorities that are reviewing quality of care at no charge to us or the member.
- **Audit documentation submission.** You will be asked to submit all audit documentation through a secure online form available at https://audit.eyemedonline.com in the timeline indicated on the audit request.
- **Consequences for non-response.** If you don't respond to our requests for information within the specified time, we will take action to recoup the reimbursements on those audited claims.
- **Forwarding address upon leaving network.** If you leave your practice or our network, provide us with a forwarding address so members can get copies of their clinical and administrative records if needed.

## Audit disciplinary action

| Noncompliance level | Reasons |
|---|---|
| **Level 1 noncompliance** | • Non-response to QA request or notice<br>• Billing and/or claim filing errors<br>• Lower than expected quality of service and/or materials, standards of optometric care and/or professional behavior<br>• Failure to follow our quality, contractual or administrative protocols<br>• Violating the terms of our Provider Agreement |
| **Level 2 noncompliance** | • Continued Level I noncompliance<br>• Provider/member conflict: if your practice requires Provider Appeal, Peer Review or QA intervention |
| **Level 3 noncompliance** | • Continued noncompliance with our rules and standards that includes a "notice of involuntary termination" review from the Peer Review |

- **Timing to respond to equipment failures.** If you fail an equipment evaluation, you'll have 10 business days to correct any issues or face disciplinary action. We'll remove you from the network if you don't respond or correct equipment issues within 30 days.
- **Member refunds.** If we determine the member is due a refund, and you don't reimburse the member or reinstate their benefit, we may reimburse

them on your behalf and deduct the amount from future payments to your account, where permitted by law.

- **Corrective action plans.** You may be subject to re-evaluation or a corrective action plan if you fail or score less than "excellent" on audits. Facility audit failures are subject to accelerated disciplinary action, and the corrective action plan must be completed within 30 days.
- **Overpayment collections.** If we find any overpayments during a financial record audit, we'll collect the overage from future claim payments as allowed by law.
- **Fraud, waste and abuse violation disciplinary actions.** For suspected fraud, waste or abuse, additional actions, including involuntary termination, may be taken.

# Fraud, Waste & Abuse (FWA) prevention

## Overview

EyeMed follows the Centers for Medicare and Medicaid Services (CMS) requirements and other industry standards related to preventing FWA. Our FWA prevention goals are:

- To effectively pursue the prevention, investigation and prosecution of healthcare FWA.
- To recover overpayments on behalf of our clients.
- To comply with state and federal regulations and clients' requirements for preventing fraud.

## LDH overview

- **Medicaid FWA oversight.** Federal regulations require that Louisiana Medicaid establish criteria that are consistent with principles recognized as affording due process of law for identifying situations where there may be fraud or abuse, for arranging prompt referral to authorities and for developing methods of investigation or review that ascertain the facts without infringing on the legal rights of the individuals involved. You must understand and follow Louisiana's Medicaid policy concerning fraud and abuse.
- **Program integrity functions.** The purpose of the FWA section is to assure the programmatic and fiscal integrity of the Louisiana Medical Assistance Program. For LDH to receive federal funding for Medicaid services, federal regulations mandate that LDH perform certain program integrity functions. These functions include:
    - Provider enrollment
    - Fraud and abuse detection
    - Investigations
    - Enforcement
    - Administrative sanctions
    - Payment Error Rate Measurement (PERM)

- **Mandates.** The mandates that direct the primary integrity functions can be found in:
    - Federal laws and the Code of Federal Regulations.
    - RS 46:437.1 - 440.3, the Medicaid Assistance Program Integrity Law (MAPIL).
    - Title 50, Part I, Subpart 5, Chapter 41 of the Louisiana Administrative Code (LAC 50:I.Chapter 41) – the Surveillance Utilization Review System (SURS) Rule.
- **LDH detection and investigation.** EyeMed will cooperate with health plan partners and LDH to support their investigation activities. You can find more information about LDH-managed fraud detection, investigations and sanctions in the LDH provider manual, available at https://www.lamedicaid.com/Provweb1/about_medicaid/fraud.htm.
- **HIPAA Privacy and Security regulations.** The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires more standardization and efficiency in the health care industry. HIPAA requires you to:
    - Use the same health care transactions, code sets and identifiers.
    - Release of patient protected health information (PHI) without knowledge or consent.
    - Provide safeguards to prevent unauthorized access to protected health care information.
    - Use a standard national provider number, called the National Provider Identifier (NPI) for identification on all electronic standard transactions.

## Definitions

- **Fraud.** A matter of law rather than of ethics or abuse of privilege. The definition of fraud that governs between citizens and government agencies is found in Louisiana R.S. 14:67 and Louisiana R.S. 14:70.01. Legal action may also be mandated under Section 1909 of the Social Security Act as amended by Public Law 95-142 (HR-3). Federal law also defines what is considered criminal conduct within federally funded programs. You should be aware of the applicable laws and regulations.
    - If an individual is found guilty, prosecution for fraud and the imposition of a penalty are prescribed by law and are the responsibility of the law enforcement officials and the courts. All such legal action is subject to due process of law and to the protection to the rights of the individual under the law.
    - **Provider fraud.** Cases involving 1 or more of the following situations constitutes sufficient grounds for a provider fraud referral:
        - Billing for services, supplies or equipment which are not rendered to, or used for, Medicaid members.
        - Billing for supplies or equipment which are clearly unsuitable for the member's needs or are so lacking in quality or sufficiency for the purpose as to be virtually worthless.

        - Claiming costs for non-covered or non-chargeable services, supplies or equipment disguised as covered items.
        - Materially misrepresenting dates and descriptions of services rendered, the identity of the individual who rendered the services or the recipient of the services.
        - Duplicate billing of the Medicaid program or of the member, which appears to be a deliberate attempt to obtain additional reimbursement.
        - Arrangements by providers with employees, independent contractors, suppliers, and other, and various devices such as commissions and fee splitting, which appear to be designed primarily to obtain or conceal illegal payments or additional reimbursement from Medicaid.
        - **NOTE**: The above list is not all inclusive, but is rather illustrative of practices which may be considered criminal activities
    - **Member fraud.** Cases involving 1 or more of the following situations constitute sufficient grounds for a recipient fraud referral:
        - The misrepresentation of facts in order to become or to remain eligible to receive benefits under Louisiana Medicaid or the misrepresentation of facts in order to obtain greater benefits once eligibility has been determined.
        - The transferring (by a member) of a Medicaid Eligibility Card to a person not eligible to receive services under Louisiana Medicaid or to a person whose benefits have been restricted or exhausted, thus enabling such a person to receive unauthorized medical benefits.
        - The unauthorized use of a Medicaid Eligibility Card by a person not eligible to receive medical benefits under Medicaid.
        - **NOTE**: The above list is not all inclusive but is rather illustrative of practices which may be considered criminal activities.
- **Abuse and incorrect practices.** Abuse of Louisiana Medicaid by either providers, members or others includes practices which are not criminal acts and which may even be technically legal, but which still represent the inappropriate use of public funds.
    - **Provider abuse.** Cases involving 1 or more of the situations listed below constitute sufficient grounds for a provider abuse referral:
        - The provision of services that are not medically necessary.
        - Flagrant and persistent overuse of medical or paramedical services with little or no regard for the member's medical condition or needs or for the doctor's orders.
        - The unintentional misrepresentation of dates and descriptions of services rendered, of the identity of the member of the services or of the individual who rendered the services in order to gain a larger reimbursement than is entitled.

        - The solicitation or subsidization of anyone by paying or presenting any person money or anything of value for the purpose of securing patients. (Providers, however, may use lawful advertising that abides by BHSF rules and regulations).
        - **NOTE**: This list is not all-inclusive, but is rather illustrative of practices that are abusive or improper
    - **Member abuse.** You are required to report cases of member abuse to BHSF. Cases involving 1 or more of the following situations constitute sufficient grounds for a recipient abuse referral:
        - Unnecessary or excessive use of the prescription medication benefits of Louisiana Medicaid.
        - Unnecessary or excessive use of the physician benefits of the program.
        - Unnecessary or excessive use of other medical services and/or medical supplies that are benefits of the program.
- **Provider errors.** The following provider errors are commonly noted during investigations:
    - **Services Not Documented** – No documentation to support the billed services were ever provided to the member.
    - **Medical Necessity Not Supported** – Documentation in the record does not support the medical necessity of the service billed.
    - **Inferior Record Keeping** – Your records are not in compliance with the requirements of the Medicaid program.
    - **Up-coding** – Documentation in the record does not support the higher level of service billed.
    - **Unbundling of Services** – Services were billed individually when they should have been billed as part of a group of services

## Reporting fraud

- **Reporting FWA to EyeMed.** You should report suspicious behavior and incidents of FWA to EyeMed at:

  EyeMed Special Investigation Unit
  EyeMed Vision Care
  4000 Luxottica Place
  Mason, OH 45040
  eyemedSIU@eyemed.com
  Submit anonymously at luxotticaspeakup.com or calling 888.88S.EEIT (888.887.3348)
- **Reporting provider fraud to LDH.** You should report possible fraud and abuse in the Medicaid program and can do so anonymously. There are several ways you can alert the Louisiana Department of Health for investigation and swift punishment:
    - Call 800.488.2917 for provider fraud complaints. You are encouraged to give this phone number to any individuals who want to report possible cases of fraud or abuse.
    - Complete the Provider Fraud Form and submit it electronically.

- Submit your provider fraud complaint by mail to:
  Gainwell
  SURS Department
  8591 United Plaza Blvd.
  Baton Rouge, LA 70809
- Fax provider fraud complaints to 225.216.6129.

- **Reporting member fraud to LDH.** You should report possible fraud and abuse in the Medicaid program and can do so anonymously. There are several ways you can alert the Louisiana Department of Health for investigation and swift punishment:
  - Call 833.920.1773 for member fraud complaints. You are encouraged to give this phone number to any individuals who want to report possible cases of fraud or abuse.
  - Complete the Member Fraud Form and submit it electronically.
  - Submit your member fraud complaint by mail to:
    Customer Service Unit
    Louisiana Department of Health
    PO Box 91278
    Baton Rouge, LA 70821-9278
  - Fax member fraud complaints to 225.389.2610.
- **Reporting fraud to other state agencies.**
  - Contact the Louisiana Legislative Auditor (LLA) Hotline if you suspect the misappropriation (theft), FWA of public funds by anyone. View the flyer for more information.
  - Report unemployment insurance and workers' compensation fraud in Louisiana to the Louisiana Workforce Commission online or call 800.201.3362.
  - If you suspect someone is illegally receiving public assistance benefits (through the Food Stamp Program, Family Independence Temporary Assistance Program, Kinship Care Subsidy Program and Child Care Assistance Program) or is illegally using an Electronic Benefit Transfer (EBT) card, report it to the Louisiana Department of Children and Family Services online or call 888.524.3578.

## Exclusion screening and documentation

- **Exclusion from receiving federal funds.** You must make sure any individual or entity you intend to hire, sub-contract or add into your practice ownership is not excluded from receiving federal funds. If they appear on the below exclusion lists, they will not be able to provide services to EyeMed members:
  - The Office of Inspector General's List of Excluded Individuals and Entities (LEIE)
  - System for Award Management (SAM)
- **Monthly monitoring.** You should check websites monthly for the exclusion status of any current or prospective team members.

### Consequences of identified FWA

Identified FWA may result in *some or all* of the following:

- Provider education and warning
- Monitoring of the provider's submitted claims activity and/or implementation of a Corrective Action Plan
- Comprehensive provider audit and/or quality review of the provider's claim activity
- Withholding of the provider's claim payments or demand for restitution for recovery of overpayments
- Termination of the provider from the network
- Reporting of suspected fraudulent activity to comply with state and federal regulations and/or clients' requirements
- Medicaid program suspension

# Annual training requirements

You must complete upon joining the network and annually by December 31 compliance training related to FWA awareness. We must report compliance with these requirements to the health plans for which we are administering routine vision benefits.

### Your requirements

- **Who must take training.** The requirement applies to:
  - Everyone working within your location.
  - Anyone who has at least a 5% ownership in your business.
  - Anyone to whom you subcontract work.
- **Training topics.** Training should cover the following topics:
  - FWA prevention.
  - Compliance Program Effectiveness (federal).
  - HIPAA (federal and state privacy).
  - Information Security (federal OCR & state).
  - Cultural competency.
- **Additional topics.** Additional topics could be added in compliance with CMS requirements or state law.
- **Consequences for non-compliance.** You could be subject to disciplinary action and will be out of compliance with CMS or state regulatory agencies if you don't complete this process.

### Annual training process

- **Annual training period.** We'll notify you when the annual training period is open.
- **Training sources.** You can download training from our communications portal or use another source that meets CMS requirements.
- **Training attestation.** Once the training has been completed by everyone in your practice, you must attest that you meet the requirement by

logging in to our communications portal and going to My EyeMed > Annual Training.

# Returning to the network after involuntary termination by EyeMed

### Waiting period and approval

- **One year waiting period.** If you're involuntarily terminated from the network and wish to reapply, you can do so after 1 year subject to approval by our QA department and the probationary period.

### Application process

- **Application for returning to network.** You can request to reapply to the network in writing. Your request must acknowledge the reason for your termination and provide evidence of how you've addressed the issue that caused your removal from the network. You must also be in good financial standing with EyeMed and all affiliated entities.
- **Approval process.** Our Peer Review Subcommittee reviews reapplication requests from providers who were previously involuntarily terminated.
- **Next steps if approved.** If approved, you will:
    - Need to reapply to the network.
    - Be subject to network and credentialing rules and requirements at the time of reapplication.
    - Be under probation for 12 months following reinstatement.
- **Next steps if denied.** If your request to reapply is denied, we'll let you know why and explain the requirements to successfully re-enter the network. You may reapply again after 1 year following denial.

### Probationary period

- **Probationary period conditions.** If approved to re-join the network, you'll be admitted for a 12-month probationary period, during which you:
    - Agree to additional audits at your expense to monitor compliance with all EyeMed participation criteria and your corrective action plan.
    - Must utilize the EyeMed lab network unless prohibited by state law.
    - Must attest annually that all staff members have completed a minimum of 10 hours of continuing education related to proper coding, billing and/or FWA prevention.
- **Consequences for non-compliance during probationary period.** If you don't comply with all rules and standards during the probationary period, EyeMed can immediately terminate you from the network.
- **Readmittance after probationary period.** If you do comply with all rules and standards during this period, EyeMed will readmit you to the network in the same manner as all providers.

- **Circumstances prohibiting re-entry.** Some situations prohibit re-entry, including evidence of physical or potential harm to a member or alleged fraud.

# FEDERALLY QUALIFIED HEALTH CARE CENTERS AND RURAL HEALTH CENTERS

## Federally Qualified Health Care Centers (FQHCs)/Rural Health Centers (RHCs) services

- **FQHC/RHC services.** FQHCs/RHCs may provide other non-primary ambulatory services covered by Louisiana Medicaid that are not included in the listing of FQHC/RHC services in the FQHC and RHC provider manuals. These other ambulatory services may be provided by the FQHC/RHC if the FQHC/RHC meets the same standards as other enrolled providers of those services.
    - FQHCs/RHCs may provide EPSDT and vision care services for beneficiaries under the age of 21. These services are governed by the Medicaid policies and procedures; the policies and procedures for the FQHC/RHC services program don't apply to these "other" ambulatory services.
    - Billing must be submitted according to the policies and procedures for each program. These visits will be reimbursed at the all-inclusive PPS rate per visit.
- **FQHC and RHC provider requirements.** You are responsible for abiding by the terms in the Louisiana Medicaid provider manual, which can be found at https://ldh.la.gov/page/1890.
- **Service limits.** There is no annual limit placed on the number of FQHC or RHC visits (encounters) payable by Louisiana Medicaid for eligible beneficiaries.
- **Exclusions.** Medicaid policy doesn't provide for payment of follow-up visits occurring on the same date as a previously billed visit, consultation, emergency room care or hospital admission date.
    - Any services "incident to" an encounter code are not billable. These include, but re not limited to, the following:
        - Injections (allergy, antibiotic, steroids, etc.);
        - Laboratory tests performed on site, Peak Flow and Spirometry, Respiratory Flow Volume Loop, EKG testing and interpretation, and x-rays;
        - Immunizations;
        - Hearing/Vision screenings; and
        - Filling and/or obtaining prescriptions.

## Reimbursements

Refer to the fee schedules provided by EyeMed for payment amounts for FQHC) and[IG1] RHCs.

# FQHC and RHC claims submission

Encounter rate clinics (FQHCs and RHCs) must detail all services rendered at the visit on the encounter claim and detail those services in the medical record.

- **Paper claims.** Remit paper CMS 1500 forms to the following address:
  EyeMed Vision Care/First American Administrators
  P.O. Box 8504
  Mason, OH 45040-7111

- **Electronic claims.** FQHCs must submit electronic claims using 837I format.
  - EyeMed is directly connected with the below clearinghouses. If you don't already have an established connection with one of these clearinghouses, contact of them to get set-up.
  - If you prefer to utilize a clearinghouse not listed below, contact the clearinghouse of your choice and ask them to "hop" to one of these major vendors, and we'll have no problem connecting.

| Clearinghouse | Contact Information | EyeMed Payer ID |
|---|---|---|
| TriZetto (Gateway EDI, ClaimLogic and NHxS) | 800.969.3666, option 2 | 31165 |
| nThrive (MedAssets) | 800.390.7459 | 31165 |
| Change Healthcare (Relay Health) | 866.817.3813 | 85431 |
| TKSoftware | 317.228.0857 | 31165 |

# CLIENT-SPECIFIC INFORMATION

EyeMed administers routine and/or medical/surgical eye care services for Medicaid members enrolled in the following health plans. Please read below for client-specific provisions, including benefits information and member appeals processes.

# Aetna Better Health of Louisiana (ABHLA)

### ABHLA provider manual

Although relevant provisions are summarized here as appropriate, you are contractually obligated to adhere to and comply with all the terms listed in the ABHLA provider manual, as well as your provider agreement with ABHLA. You may request a hard copy form or a CD-ROM copy of the ABHLA provider manual by contacting ABHLA's Provider Experience Department at 855.242.0802.

### About ABHLA

- **About Aetna.** ABHLA was chosen by LDH to be one of the Healthy Louisiana Plans to arrange for care and services by specialists and providers including member engagement, which includes outreach and education functions, grievances, and appeals. Aetna is offered statewide.
- **Applying for participation in the ABHLA network.** You must be enrolled and screened with Louisiana Medicaid to participate in the ABHLA network. To apply for the ABHLA network, please visit www.AetnaBetterHealth.com/Louisiana and complete the provider application forms. For questions, please call the Provider Experience Department at 855.242.0802.
- **Out-of-network providers for medically necessary covered routine services.** When a member with a special need or services is not able to be served through a contracted provider, ABHLA will authorize service through an out-of-network provider agreement. ABHLA's Medical Management team will arrange care by authorizing services to an out-of-network provider and facilitating transportation through their medical transportation vendor when there are no providers that can meet the member's special need available in a nearby location. If needed, ABHLA's Provider Experience Department will negotiate a Single Case Agreement (SCA) for the service and refer the provider to their Network Development team for recruitment to join the provider network. The member may be transitioned to a network provider when the treatment or service has been completed or the member's condition is stable enough to allow a transfer of care. ABHLA will ensure the adherence to Medicaid law, which requires out-of-network providers to coordinate with the organization with respect

to payment and ensure that the cost to members is no greater than it would be if the services were furnished in network.

## Provider services

- **Provider appeals and grievances.** If you have a grievance, complaint or wish to file an appeal, you will use our process outlined in the Compliance and Quality Assurance section.
    - For information on ABHLA's grievances and appeals, please see "Chapter 18: Grievance System" in in the ABHLA provider manual
    - For questions, call ABHLA at 855.242.0802 between 7 am and 7 pm CT, Monday through Friday, or email LAProvider@aetna.com. ABHLA's Provider Experience Staff will respond within 48 business hours.
- **Provider secure web portal.** A new Secure Web Portal is a web-based platform that allows ABHLA to communicate member healthcare information directly with you. This portal is also used by Aetna Commercial and Medicare, allowing you to use one login for commercial, Medicare and Aetna Medicaid.
    - You can also use the Member Care Web Portal to access the member's care plan, other relevant member clinical data and securely interact with Care Management staff.

## Member ID cards

ABHLA members will have ID cards like the ones below. Members should present their ID card at the time of service.


## ABHLA vision coverage

ABHLA members have access to vision coverage as listed below. You must verify the member's benefits using the online claims system. These benefits will reset 12 months from the last date of service.

- **Covered services for members 21 and under.** Members 21 and under are eligible for:
    - 1 comprehensive eye examination per year. More frequent exams may be covered under the following circumstances:

        - Prescription change of at least +1.00/-0.50 diopters or 10 degrees of axis; or
        - Physician or school nurse requests the eye exam. There is no member copayment for the exam.
    - Eyewear is covered once per year. There is no member copayment for the eyewear. Members may receive at no cost a sturdy, nonflammable plastic or metal frame, and regular, single vision lenses. Contact lenses are covered in lieu of eyeglasses when medically necessary in accordance with the Louisiana Medicaid guidelines, and when no other means can restore vision.
- **Covered services for adults 21 and over.** Adults 21 and over are eligible for 1 comprehensive eye exam per year and a $150 eyewear allowance once every year. This can be used towards glasses or contact lenses. Members also receive 20% off any remaining balance over the $150 allowance.
- **Referrals.** Members don't need a referral to see an in-network vision provider.
- **Second opinions.** Members may request a second opinion from you. You should refer them to another network provider within an applicable specialty for the second opinion. There are no timeframes for referrals. If an ABHLA provider is not available, ABHLA will help the member get a second opinion from a non-participating provider at no cost to the member.

**Lab network requirements for ABHLA**

- **Members 21 and under (children).** For members aged 21 and under, you must follow the lab network requirements listed in the Frames and Lenses section above.
    - You must pick a frame from the Medicaid frame kit. This kit may have adult frames available, as the plan covers members up to the age of 21.
        - If you have not received a Medicaid frame kit, you must register with Classic Optical. Refer to the Registering for a Medicaid Lab job aid for step-by-step instructions.
    - When you select the frame from the drop-down in the online claims system, you are ordering the frame at the same time. Refer to the Filing Medicaid Claims job aid for more information.
- **Members over 21 (adults).** For adult members over the age of 21, you must submit the lab job the same way you would for a non-Medicaid member.
    - There is no Medicaid frame kit for adult members over the age of 21.
    - When you select the frame from the drop-down in the online claims system, you are NOT ordering the frame at the same time. Refer to the Submitting Non-Lab Claims job aid for more information.

- You must be registered with a valid lab account to order adult materials. Refer to the Registering for a Network Lab job aid for more information.

## Limitations and exclusions

- **Members under age 21 or CHIP members.** The following services/eyewear are not covered for Medicaid Members under age 21 or CHIP Members:
  - Tinted lenses and photochromic lenses, except when medically necessary in accordance with Louisiana Medicaid guidelines and prior approval is obtained from EyeMed.
  - Safety lenses and frames, except for polycarbonate lenses when medically necessary as described in your contract with ABHLA.
  - Aniseikonic lenses, blended or progressive bifocals, sunglasses, special occupational lenses, special coatings (i.e. hard, antireflective, antiscratch or mirror coating), oversize lenses over 75 mm, lamination of a lens or lenses, facets or other cosmetic grinds or polishes, except when medically necessary in accordance with Louisiana Medicaid guidelines and prior approval is obtained from EyeMed.
  - Lens styles and/or materials not listed as a covered benefit, except when medically necessary in accordance with Louisiana Medicaid guidelines and prior approval is obtained from EyeMed.
  - Special mountings (other than standard zyl, standard metal or standard half-eyes).
  - Orthoptics, vision training, low vision aids or any supplemental training, artificial eyes.
  - Nonprescription (plano) eyewear including sunglasses or eyewear with a prescription of less than that stated in your contract with ABHLA.
  - Medical eye care services and diagnostic procedures.
  - Any examination or corrective eyewear required by an employer as a condition of employment.
  - Conditions covered by worker's compensation.
  - Any services or materials provided by another vision plan or payor.
  - Contact lenses, except when medically necessary in accordance with Louisiana Medicaid guidelines and prior approval is obtained from EyeMed.
- **Members over age 21.** Additional services that are not covered for adults over 21 include the following:
  - Services rendered by out of network providers unless provider documentation of medical necessity has been received.
  - Anesthesiology services (professional and facility components).
  - Pharmaceutical agents (J codes).
  - Elective cosmetic and refractive surgical procedures.
  - Emergency room services.

- Services rendered by out-of-network providers (unless prior authorized by EyeMed).
- Prosthetic eyes.
- Facilities for surgical eye care procedures.
- Any eyewear exceeding the benefit allowance.

- **Exclusions.** The scope of services to be arranged by you on behalf of AHBLA excludes the following:
  - Anesthesiology services (professional and facility components)
  - Pharmaceutical agents (J codes)
  - Elective cosmetic and refractive surgical procedures
  - Emergency room services
  - Services rendered by out-of-network providers (unless prior authorized by Contractor)
  - Prosthetic eyes
  - Facilities for surgical eye care procedures.

## Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

- **EPSDT.** Refer to the EPSDT section above or "Chapter 9: EPSDT" in the ABHLA provider manual for more information about EPSDT.

## Care coordination

- **Care coordination.** ABHLA has an Integrated Care Management (ICM) program that identifies and reaches out to their most vulnerable members. Refer to the ABHLA provider manual for more information on ICM and care coordination.
- **Continuity of care.** You are required to provide a notice before terminating your contract with ABHLA. You must also treat ABHLA members until the treatment course has been completed or care is transitioned. An authorization may be necessary for these services. Members who lose eligibility and continue to have medical needs must be referred to a facility or provider that can provide the needed care at no or low cost. ABHLA is not responsible for payment of services rendered to members who are not eligible. You may contact the ABHLA Care Management Department for assistance.
- **Members with special needs.** Refer to "Chapter 11: Members with Special Needs" in the ABHLA provider manual for more information.

## Urgent and emergency care

- **Urgent care services.** You are required to adhere to all appointment availability standards. In some cases, you may need to refer members to one of ABHLA's network urgent care centers (after hours in most cases). Refer the "Find a Provider" link on ABHLA's website and select an "Urgent Care Facility" in the specialty drop down list to view a list of participating urgent care centers located in network.
- **Urgent care services for members with special needs.** Refer to "Chapter 4: Provider Enrollment, Responsibilities and Important Info" in

the ABHLA provider manual for information on after-hours protocol for members with special needs. A non-urgent condition for an otherwise healthy member may indicate an urgent need for a member with special needs. You must have a system in place for members with special needs to reach you outside of regular office hours. ABHLA Nurse Line (855.242.0802) is available 24 hours a day, 7 days a week for members with an urgent or crisis situation.

## Member assistance

- **Interpretation services.** Telephone interpretive services, personal interpreters and ASL interpreters are provided at no cost to members or you. Call ABHLA's Member Service Department at 855.242.0802.
- **Transportation services.** ABHLA may cover non-emergency medical transportation (NEMT) and appointment transportation. Refer to "Chapter 6: Medical Transport" in the ABHLA provider manual for more information.

## Medical necessity

- **Medical necessity definition.** Medical necessity is defined as a service, supply or medicine that is appropriate and meets the standards of good medical practice in the medical community, as determined by you in accordance with ABHLA's guidelines, policies or procedures, for the diagnosis or treatment of a covered illness or injury, for the prevention of future disease, to assist in the member's ability to attain, maintain or regain functional capacity, or to achieve age-appropriate growth.
    - Any such services must be clinically appropriate, individualized, specific and consistent with the symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the member requires at that specific point in time.
    - Services that are experimental, non-demonstration approved, investigational or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary."
- **Medical necessity determination.** Determination of medical necessity for covered care and services, whether made on an attestation of medical necessity, concurrent review, retrospective review or on an exception basis, must be documented in writing. The determination is based on medical information provided by the member, their family/caregiver and their PCP, as well as any other providers, programs or agencies that have evaluated the member. Medical necessity determinations must be made by qualified and trained health care providers.

## Financial liability

- **Financial liability for payment of services.** You must not bill a member (or a person acting on their behalf) for payment of fees that are the legal obligation of ABHLA. You may, however, collect monies from members in accordance with the terms in the member's handbook, if applicable. When collecting money, you must:

- Not hold members liable for payment of any fees that are the legal obligation of ABHLA.
- Indemnify the member for payment of any fees that are the legal obligation of ABHLA for services you furnished them that have been authorized by ABHLA, as long as the member follows ABHLA's rules for accessing services described in the approved member handbook.
- Not bill a member for medically necessary services covered under the plan and to always notify members prior to rendering services.
- Clearly advise a member, prior to furnishing a non-covered service, of the member's responsibility to pay the full cost of the services.
- Verify the member is aware of their obligation to pay in full for non-covered services when referring a member to another provider for a non-covered service.

- **Copayments.** ABHLA has a contract with Healthy Louisiana to provide health care services with no cost sharing. This means members shouldn't be asked to pay a copay when they receive medical services.

## Member rights and responsibilities

- **Member handbooks.** Members are urged to read the ABHLA Integrative health services member handbook. You can also refer to "Chapter 8: Member Rights and Responsibilities" in the ABHLA provider manual for more information.
- **Member privacy rights.** ABHLA's privacy policy states that members are afforded the privacy rights permitted under HIPAA and other applicable federal, state and local laws and regulations, and applicable contractual requirements. ABHLA's privacy policy conforms with 45 C.F.R. (Code of Federal Regulations): relevant sections of the HIPAA that provide member privacy rights and place restrictions on uses and disclosures of protected health information (§164.520, 522, 524, 526 and 528).
- **Member rights and responsibilities investigations.** If ABHLA is made aware of an issue with a member:
  - Not receiving the member rights listed in this manual, ABHLA will initiate an investigation and report the findings to the Quality Management Committee and further action may be necessary.
  - Not demonstrating the responsibilities listed in this manual, ABHLA will make good faith efforts to address the issue with the member and educate them on their responsibilities.

## Provider rights and responsibilities

- **Provider manual.** You should read the ABHLA provider manual to understand your full rights and responsibilities as an ABHLA provider. Your rights are outlined in "Chapter 24: Provider's Bill of Rights", and your responsibilities are listed in "Chapter 4: Provider Enrollment, responsibilities and Important Info."
- **Missed or cancelled appointments.** If a member misses or cancels an appointment, you must:

- Conduct affirmative outreach to a member who misses an appointment by performing the minimum reasonable efforts to contact the member in order to bring the member's care into compliance with the standards.
- Notify ABHLA's Member Services Department when a member continually misses appointments.

- **Marketing restrictions.** You may inform your patients of the Healthy Louisiana Plan you have chosen to participate in, but Healthy Louisiana has strict prohibitions against patient steering, which you must observe.
  - You must strictly follow the requirements below:
    - You may inform your patients of all Healthy Louisiana Plans in which you participate, and can inform patients of the benefits, services and specialty care services offered through the Healthy Louisiana Plan in which you participate.
    - **You are not allowed to disclose only some of the Healthy Louisiana Plans in which you participate**. Disclosure of Healthy Louisiana Plan participation must be all or nothing.
    - You can display signage, provided by the Healthy Louisiana Plan, at your location indicating which Healthy Louisiana Plans are accepted there, but must include all Healthy Louisiana Plans in which you participate in this signage.
    - If you participate in only one Healthy Louisiana Plan, you can display signage for only one and can tell a patient that is the only Healthy Louisiana Plan you accept.
    - You **MAY NOT RECOMMEND** one Healthy Louisiana Plan over another Healthy Louisiana Plan and **MAY NOT OFFER** patients incentives for selecting one Healthy Louisiana Plan over another.
    - You **MAY NOT ASSIST** a patient in the selection of a specific Healthy Louisiana Plan. Additionally, patients may not use your fax machine, office phone, computer, etc., to make such a selection, except as required for the completion of a Medicaid application as a function of being an enrolled Medicaid Application Center.
    - Patients who need assistance with their Health Plan services should call the Member Services Hotline for the Plan in which they are enrolled, and those who wish to learn more about the different Healthy Louisiana Plans should contact the Healthy Louisiana Enrollment Broker at 1.855.229.6848 to receive assistance in making a Healthy Louisiana Plan decision.
    - Under **NO CIRCUMSTANCES** are you allowed to change a member's Healthy Louisiana Plan for them or request a Healthy Louisiana Plan reassignment on a member's behalf. **Members who wish to change their Healthy Louisiana Plan for cause must make this request to Medicaid**

**themselves through the Healthy Louisiana Enrollment Broker.**

- These prohibitions against patient steering apply to participation in the Healthy Louisiana programs. If you or a Health Plan is found to have engaged in-patient steering, you may be subject to sanctions such as, but not limited to monetary penalties, loss of linked patients and excluded from enrollment in Medicaid/Healthy Louisiana Plan network opportunities.

## Member appeals and grievances overview

- **Member complaints and grievances.** Member complaints and grievances is handled through ABHLA. Refer to "Chapter 18: Grievance System" in the ABHLA provider manual.

## Medicaid FWA prevention

- **Special Investigations Unit (SIU).** EyeMed partners with ABHLA's SIU to conduct proactive monitoring to detect potential FWA, and is responsible to investigate cases of alleged FWA.
- **Reporting suspected FWA.** You are required to report all cases of suspected FWA, inappropriate practices, and inconsistencies of which you become aware within the Medicaid program.
  - You can report suspected FWA to ABHLA by calling:
    - The ABHLA Compliance Hotline at 855.725.0288
    - ABHLA's SIU at 800.338.6361.
    - LDH at 800.488.2917.
    - The Federal Office of Inspector General in the U.S. Department of Health and Human Services at 800.447.8477.
  - You can report suspicious behavior and incidents of FWA to EyeMed at:

    EyeMed Special Investigation Unit
    EyeMed Vision Care
    4000 Luxottica Place
    Mason, OH 45040
    eyemedSIU@eyemed.com
    Submit anonymously at luxotticaspeakup.com or calling 888.88S.EEIT (888.887.3348)
  - If you provide your contact information, your identity will be kept confidential.
- **Best practice for preventing FWA.** Your best practice to prevent FWA is to:
  - Develop a compliance program
  - Monitor claims for accuracy – verify coding reflects services provided
  - Monitor medical records – verify documentation supports services rendered
  - Perform regular internal audits

- Establish effective lines of communication with colleagues and members
- Ask about potential compliance issues in exit interviews
- Take action if you identify a problem
- Remember that you are ultimately responsible for claims bearing your name, regardless of whether you submitted the claim.

- **Examples of provider FWA.** Examples of FWA include:
  - Charging in excess for services or supplier.
  - Providing medically unnecessary services.
  - Billing for items or services that should not be paid for by Medicaid.
  - Billing for services that were never rendered.
  - Billing for services at a higher rate than is actually justified.
  - Misrepresenting services resulting in unnecessary cost to ABHLA due to improper payments to providers, or overpayments.
  - Physical or sexual abuse of members.
- **Examples of member FWA.** Member fraud is reportable, and examples include:
  - Falsifying identity, eligibility or medical condition in order to illegally receive the drug benefit.
  - Attempting to use a member ID card to obtain prescriptions when the member is no longer covered under the drug benefit.
  - Looping (i.e., arranging for a continuation of services under another member's ID).
  - Forging and altering prescriptions.
  - Doctor shopping (i.e., when a member consults a number of doctors for obtaining multiple prescriptions for narcotic painkillers or other drugs. Doctor shopping might be indicative of an underlying scheme, such as stockpiling or resale on the black market.)
- **FWA risk for providers.** FWA can incur risk to you, such as:
  - Participating in illegal remuneration schemes, such as selling prescriptions.
  - Switching a member's prescription based on illegal inducements rather than based on clinical needs.
  - Writing prescriptions for drugs that are not medically necessary, often in mass quantities, and often for individuals that are not your patients.
  - Theft of a prescriber's Drug Enforcement Agency (DEA) number, prescription pad or e-prescribing login information.
  - Falsifying information in order to justify coverage.
  - Failing to provide medically necessary services.
  - Offering members, a cash payment as an inducement to enroll in a specific plan.
  - Selecting or denying members based on their illness profile or other discriminating factors.
  - Making inappropriate formulary decisions in which costs take priority over criteria such as clinical efficacy and appropriateness.

- Altering claim forms, electronic claim records, medical documentation, etc.
- Limiting access to needed services (for example, by not referring a member to an appropriate provider).
- Soliciting, offering or receiving a kickback, bribe or rebate (for example, paying for a referral in exchange for the ordering of diagnostic tests and other services or medical equipment).
- Billing for services not rendered or supplies not provided would include billing for appointments the members fail to keep.
- Double billing such as billing both ABHLA and the member, or billing ABHLA and another member.
- Misrepresenting the date services were rendered or the identity of the member who received the services.
- Misrepresenting who rendered the service, or billing for a covered service rather than the non-covered service that was rendered.

- **FWA ~~f~~risk for members.** FWA can incur risk to members, such as:
  - Unnecessary procedures may cause injury or death.
  - Falsely billed procedures create an erroneous record of the member's medical history.
- **FWA audits.** When post payment audits are complete with findings, SIU will issue an overpayment letter detailing the results of the review.
- **Elements of an effective compliance plan.** An effective compliance plan includes 7 core elements:
  - Written standards of conduct: Development and distribution of written policies and procedures that promote ABHLA's commitment to compliance and that address specific areas of potential FWA.
  - Designation of a compliance officer: Designation of an individual and a committee charged with the responsibility and authority of operating and monitoring the compliance program.
  - Effective compliance training: Development and implementation of regular, effective education and training
  - Internal monitoring and auditing: Use of risk evaluation techniques and audits to monitor compliance and assist in the reduction of identified problem area.
  - Disciplinary mechanisms: Policies to consistently enforce standards and addresses dealing with individuals or entities that are excluded from participating in the Medicaid program.
  - Effective lines of communication: Between the Compliance Officer and the organization's employees, managers and directors and members of the compliance committee, as well as related entities.
    - Includes a system to receive, record and respond to compliance questions, or reports of potential or actual non-compliance, will maintaining confidentiality.
    - Related entities must report compliance concerns and suspected or actual misconduct involving ABHLA.

    - Procedures for responding to detected offenses and corrective action: Policies to respond to and initiate corrective action to prevent similar offenses including a timely, responsible inquiry.
- **Relevant laws.** There are several relevant laws that apply to FWA. Please refer to each link for more information:
    - The Federal False Claims Act (FCA), codified at 31 U.S.C. §§ 3729-3733
    - Anti-Kickback Statute (AKA), codified at 42 U.S.C. § 1320a-7b
    - Self-Referral Prohibition Statute (Stark Law)
    - Red Flag Rule (Identity Theft Protection)
    - Health Insurance Portability and Accountability Act (HIPAA)
    - The Federal Program Fraud Civil Remedies Act (PFCRA), codified at 31 U.S.C. §§ 3801-3812
    - Section 6032 of the Deficit Reduction Act of 2005 (DRA), codified at 42 U.S.C. § 1396a(a)(68)
    - The Louisiana False Claims Act (LAFCA), otherwise known as the Medical Assistance Programs Integrity Law (MAPIL)
        - Criminal provisions of the MAPIL, codified at RS 46:437.1, 1997, No.1373, §1.
        - Civil provisions of the MAPIL, codified at RS 46:438.6 and RS 46:437.14
        - Whistleblower Protection and Cause of Action, codified at RS 46:440.3
        - Additional provisions: RS 46:438.3
    - Office of the Inspector General (OIG) and General Services Administration (GSA) Exclusion Program

## Member abuse and neglect

- **Mandated reporters.** As mandated by RS 14:403.2, you are considered a "mandated reporter" and are required to report any suspected incidences of physical abuse (domestic violence), neglect, mistreatment, financial exploitation and any other form of maltreatment of a member to the appropriate state agency. Refer to "Chapter 20: Member Abuse and Neglect" in the ABHLA provider manual for more information.
- **Immunity.** State law provides immunity from any criminal or civil liability because of good faith reports of child abuse or neglect.
- **Consequences of failure to report.** Any person who knowingly fails to report suspected abuse or neglect may be subject to a fine up to $1,000 or imprisonment up to 6 months.

## Member Medical records

- **Medical records standards.** ABHLA's standards for medical records have been adopted from the National Committee for Quality Assurance (NCQA) and Medicaid Managed Care Quality Assurance Reform Initiative (QARI). These are the minimum acceptable standards within the ABHLA provider network.

- **Medical record audits.** ABHLA, LDH or its appointed authority, or CMS may conduct routine medical record audits to assess compliance with established standards. Medical records may be requested when ABHLA is responding to an inquiry on behalf of a member or provider, administrative responsibilities or quality of care issues. You must respond to these requests promptly within 30 days of request. Medical records must be made available to LDH for quality review upon request and free of charge.
- **Confidentiality and accuracy.** You must safeguard/secure the privacy and confidentiality of and verify the accuracy of any information that identifies an ABHLA member. Original medical records must be released only in accordance with federal or state laws, court orders, or subpoenas. You must also:
    - Maintain accurate medical records and other health information.
    - Help verify timely access by members to their medical records and other health information.
    - Abide by all federal and state laws regarding confidentiality and disclosure of mental health records, medical records, other health information and member information.
- **Member privacy requests.** A privacy request must be submitted by the member or member's authorized representative. A member's representative must provide documentation or written confirmation that they are authorized to make the request on behalf of the member or the deceased member's estate. Except for requests for a health plan Notice of Privacy Practices, requests from members or a member's representative must be submitted to ABHLA in writing.
    - Members may make the following requests related to their PHI ("privacy requests") in accordance with federal, state, and local law:
        - Make a privacy complaint.
        - Receive a copy of all or part of the designated record set.
        - Amend records containing PHI.
        - Receive an accounting of health plan disclosures of PHI.
        - Restrict the use and disclosure of PHI.
        - Receive confidential communications.
        - Receive a Notice of Privacy Practices.

888.581.3648
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