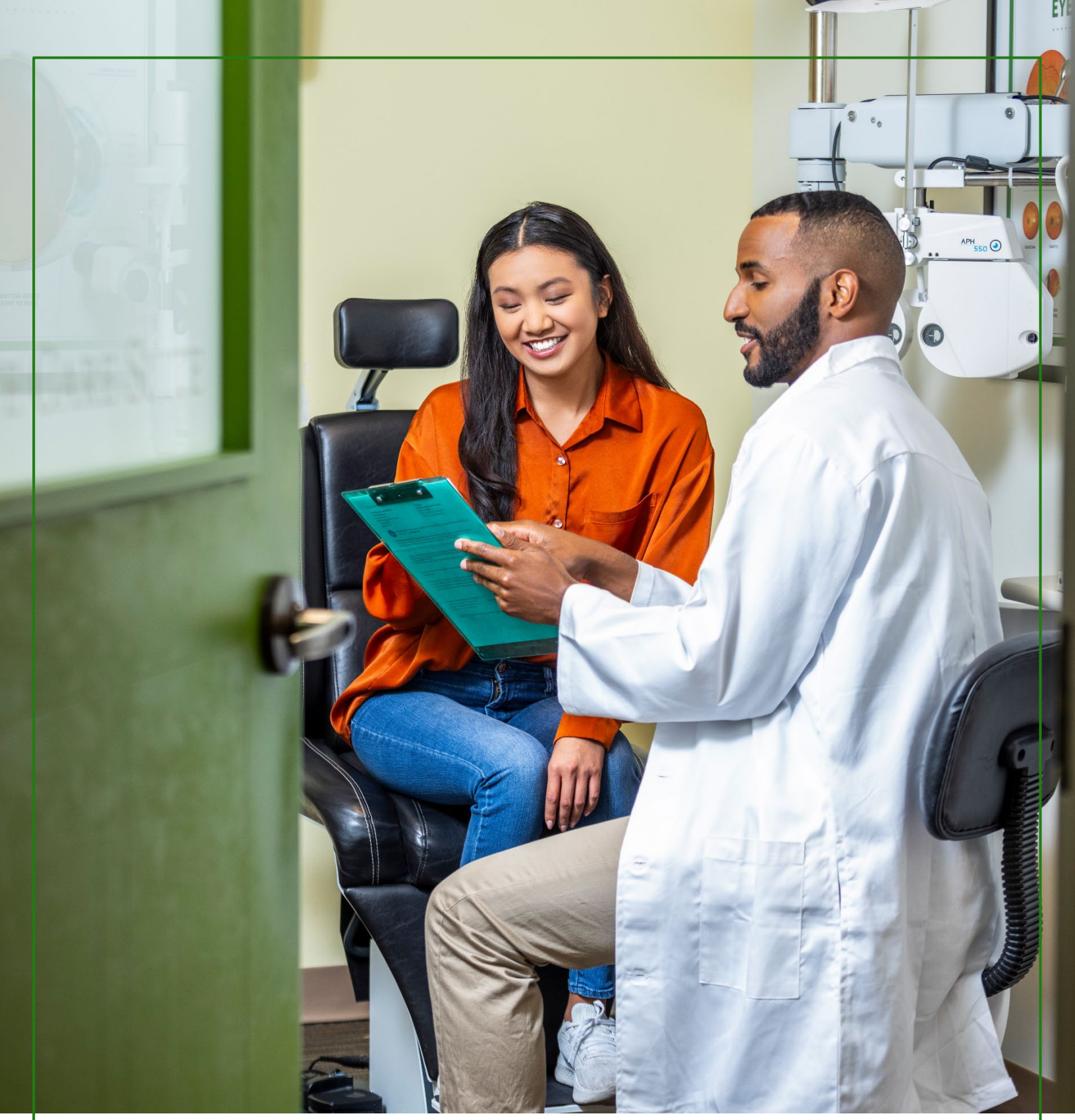


July 2025

TrueCare™ MississippiCAN and CHIP Provider Manual

EyeMed

Introduction

EyeMed Vision Care® administers the routine vision network for some health plans in Mississippi. See the Health plan 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 and all federal and state regulations applicable to providers. While this manual contains basic information, the Mississippi Division of Medicaid (DOM) requires that you fully understand and apply DOM requirements when administering covered services. Please refer to https://medicaid.ms.gov/mesa-portal-for-providers/ for more information about Mississippi DOM.

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

Effective Date: **July 1, 2025**

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

The Mississippi DOM administers the Mississippi Medicaid program.

Several programs comprise Mississippi's Medicaid program. Mississippi DOM determines member eligibility for the program. A brief overview of the relevant programs are included below. For more information on additional programs and requirements, please visit the Mississippi DOM website.

- **Mississippi Health Benefits for Children** are available for children from birth to age 19. Some children may be eligible for Medicaid. Other children whose families make too much money to qualify for Medicaid may be eligible for the Children's Health Insurance Program (CHIP).
- **Children's Health Insurance Program (CHIP)** provides insurance coverage for uninsured children up to age 19 whose family income does not exceed 209% of Federal Poverty Level (FPL). Families may earn up to 209% of the FPL and be eligible for CHIP. A child must be determined ineligible for Medicaid before eligibility for CHIP can be considered. Children with current health insurance coverage at the time of application are not eligible for CHIP.
- **MississippiCAN,** also known as the Mississippi Coordinated Access Network, is the Mississippi managed care program for Medicaid. For more information, visit the Mississippi DOM website.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)/Well-Child

- About EPSDT. EPSDT is the component of Mississippi Medicaid that provides comprehensive and preventive health care services for children ages 0 to 20 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. The Mississippi DOM pays for all medically necessary services for EPSDT-eligible members in accordance with Part 223 of Title 23, without regard to service limitations and with medical necessity.
- Well-child benefits. CHIP members receive well-child benefits. Well-child benefits cover many of the same services as EPSDT.

Recognizing TrueCare members

Member ID cards

- Health plan member ID cards. Members enrolled in a Coordinated Care Organization (CCO) will receive member ID cards from their health plan. Refer to the Health plan information section for a sample of member ID cards.
    - 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.

Verifying eligibility

- 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 Mississippi Medicaid. To provide routine vision care for Medicaid members through EyeMed, you must be enrolled and credentialed with Mississippi Medicaid via the MESA portal. **If you aren't enrolled and credentialed with Mississippi Medicaid, you cannot provide services through EyeMed.**
- Medicaid revalidation. You must revalidate every five years via the MESA portal. You will receive a revalidation notification letter 180 days prior to your next revalidation due date. A detailed description of the revalidation process can be found here.
- Medicaid recredentialing. You must be recredentialed by Mississippi Medicaid at least every three years, unless otherwise required by regulatory or accrediting bodies or a shorter term as determined by the Credentialing Committee. A recredentialing notice letter will initiate the process with you. The letter will provide instructions for completing the recredentialing process and will indicate the due date.
- Provider screening requirements. The following disclosing individuals must be screened as part of Medicaid enrollment:
    - An individual or groups of individuals with a five percent 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.
- Exclusion screening. EyeMed does not participate with any individual or entity who has been excluded from participation in federal health care programs, who have a relationship with excluded providers and/or who have been terminated from a government program (including Medicaid). Refer to the Medicaid participation section for more information.

- Ownership disclosure. You agree to furnish to EyeMed, the health plan or DOM 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 P.O. Box address.
    - Date of birth and Social Security Number (SSN) (in the case of an individual).
    - Other Tax Identification Number (TIN), in the case of corporation, with an ownership or control interest or of any subcontractor in which the disclosing entity has a five percent 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 five percent 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 managed care entity in which an owner has an ownership or control interest in an entity that is reimbursable by Medicaid.
    - The name, address, date of birth and SSN of any managing employee.
- State requirements for Medicaid enrollment. As part of the Medicaid enrollment process, you'll also need to meet Mississippi's criteria below.
    - Group providers must ensure that each of their individual practitioners/providers are enrolled, and the individual providers have the same servicing address as the affiliated group.

Minimum participation requirements

- Therapeutic Pharmaceutical Agents (TPAs) and Drug Enforcement Administration (DEA) certification/licensing. You need to have either a TPA certificate or DEA license.
    - You can use diagnostic pharmaceutical agents (DPAs) if the member's age, condition type and severity and other contributing factors justify it.
    - Use TPAs as appropriate when a member has a condition that requires them, but you must 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 under EyeMed

- Information updates. You must keep your information up to date by using our online form.
- Leaving the network. If you want to opt out of the EyeMed TrueCare network, complete our online Network Request form.
- Full-service locations. All participating provider locations must offer both exams and materials.
- Open to new patients. All locations must accept 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, TrueCare or Mississippi 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.

Your responsibilities under Mississippi Medicaid

- Provider responsibilities under Mississippi Medicaid. By participating in Mississippi Medicaid, you have certain responsibilities you must meet. Refer to the Mississippi DOM's Medical Assistance Participation Agreement for more information.

Credentialing and recredentialing

State regulation, Mississippi Code 43-13-117, requires DOM to develop a single, consolidated credentialing process for providers, and requires managed care entities to accept the DOM credentialing for managed care enrollment. Consequently, the state of Mississippi is responsible for Credentialing/Recredentialing providers that participate in the managed care programs (Mississippi Coordinated Access Network (MSCAN) and/or Mississippi Children's Health Insurance Program (MSCHIP). Credentialing/Recredentialing standards are set by national accrediting agencies and state and federal regulating bodies, and credentialing will be conducted when you elect to participate in MississippiCAN and/or CHIP.

Recredentialing of providers actively enrolled in the managed care programs must be conducted at least every three years, unless otherwise required by regulatory or accrediting bodies or a shorter term as determined by the DOM Credentialing Committee. A recredentialing notice will be sent to you providing instructions for the recredentialing process and a due date for completion. You must submit all required supporting documentation and be successfully recredentialed to continue participating in our network.

During the recredentialing process, you will be required to review and update application information as needed and electronically sign the Mississippi Medicaid Provider Agreement and Acknowledgement of Terms of Participation. All required documents must be uploaded. You may be subject to additional screening activities as determined by the DOM. The recredentialing process incorporates re-verification and identification of any changes in your (individual/organization) licensure, sanctions, certifications (including, but not limited to, malpractice experience, sanction history, hospital privilege related or other actions). This information is reviewed to assess whether you continue to meet the standards set by national accrediting agencies and state and federal regulating bodies, including the National Committee for Quality Assurance (NCQA).

Your service location will also be revalidated with the submission of your recredentialing application. Service location(s) for which a recredentialing application is not submitted will be required to revalidate every three years.

If you fail to comply with the recredentialing requirements, your enrollment in the Mississippi Medicaid program(s) will be terminated by the DOM. A new application will be required for you to re-enroll in the Mississippi Medicaid program.

Additional Information can be found at MESA's Medicaid Portal for Providers.

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 areas.
    - Safe and secure flooring and fixtures.
    - Hand-held fire extinguishers up to local and state fire codes with current inspection tags.
    - A complete first-aid kit that, 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.
- On-site inspections. DOM retains the right to conduct announced and unannounced site visits.

Access to care/emergencies

Appointment and wait time standards

- Appointment wait standards. You must offer non-urgent appointments with EyeMed members within two 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 Health plan 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 one or both eyes which, if untreated or if treatment is delayed, may reasonably be expected to result in irreversible vision impairment.
- Examples of eye care emergencies. 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.

Member rights and responsibilities

- Member rights. Under Mississippi Medicaid, members have the following rights:
  - Choose the provider they wish to use to receive services, as long as that provider accepts Medicaid.
  - To not be discriminated against based on race, age, gender, color, national origin, or disability. This includes distinction made on the basis of race or disability with respect to waiting room, hours for appointments or order of seeing patients. Refer to Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973 for more information.
- Member responsibilities. Under Mississippi Medicaid, members have the following responsibilities:
  - Report all changes in either income or resources that could affect their eligibility within 10 days after the change happens (or within 10 days after the member realizes the change has taken place.)
  - Report any and all types of health insurance or third party coverage policies.

Member assistance

- Member Medicaid enrollment. Members who need assistance enrolling in Medicaid should call the Mississippi DOM's Office of Eligibility at 1-800-421-2408.
- Transportation services. Transportation may be covered by an 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 Health plan information section for additional information.

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, TrueCare or Mississippi Medicaid to members in person or in writing (e.g., letters, promotional materials).
- Sharing of information. You can't share EyeMed, TrueCare or Mississippi 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.

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 one 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 Mississippi 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 dismissing 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.
- 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 retention. You must secure and retain member records (both clinical and financial) 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: Six years from the date of death.

- Inactive records are to remain accessible for a period of time that meets state and federal guidelines.

- Record-keeping requirements. You must maintain auditable records that document the services you provide and bill under the program.
  - Medical records must be legible, appropriate, and correct.
  - All entries must be:
    - Written, entered or otherwise compiled on appropriate provider documentation forms.
    - Made without a space between entries.
    - Made in a permanent form and cannot be in pencil.
  - Corrective tape, corrective liquid, erasers or other obliteration methods cannot be used to remove or change information in the medical record.
  - Entry corrections in the medical record must be documented as follows:
    - Draw a single line through the error, to ensure the error entry is still legible.
    - Document the current date and time the error was lined through and initials of who lined out the entry.
    - Document the correct information as a new entry on the next available line or in the next available space including:
      - The date and time of the new entry,
      - The date and time the correct information occurred, and
      - The details of the correct information.
  - Late entries are defined as entries that are not completed in the same business day as the date of service and must be documented as follows:
    - Identify the new entry as a "late entry" in the medical record.
    - Document the current date and time when the late entry is actually being written in the medical record and not the date and time the event/incident actually occurred.
    - Document the late entry event/incident and refer to the date and time the event/incident actually occurred within the late entry.
    - Document information as soon as possible.
  - The vision medical record documentation must contain the following on each member:
    - Date(s) of service,
    - Demographic information,
    - Current medical history,
    - Examination and/or treatment rendered,
    - Specific name/type of all diagnostic studies, and the result/finding of the studies,
    - Specific order for all lenses, lens coating, and ocular prosthetics, and
    - Provider's signature.
- Record availability.

    - You must make these records available to representatives of the following agencies upon request:
        - Department of Health and Human Services (DHHS)
        - Centers for Medicare and Medicaid Services (CMS)
        - DOM
            - DOM's staff must have immediate access to your physical service location, facilities, records, documents, books, prescriptions, invoices and any other records relating to licensure, medical care and services rendered to members, and billings/claims during regular business hours, defined as 8 a.m. to 5 p.m., Monday through Friday, and all other hours when your employees are normally available and conducting business.
            - DOM's staff must have immediate access to any administrative, maintenance, and storage locations within, or separate from, the service location.
        - Attorney General Mississippi Medicaid Fraud Control Unit (MFCU)
- Member access to records. Members have the right to inspect and obtain a copy of their records during regular business hours.
- Release of records to third parties. You may disclose records or information acquired under the Medicaid program only when:
    - The record or information is to be used in connection with a claim, or
    - To verify the utilization of Medicaid benefits; and
    - The disclosure is necessary for the proper performance of the duties of any employee of:
        - Mississippi DOM
        - Any public or private agency or organization under an agreement with DOM in regard to meeting requirements of the Medicaid program,
        - The Attorney General Medicaid Fraud Control Unit,
        - A duly authorized legal hearing, or
        - Representative of the Secretary of Health and Human Services office.
- Record confidentiality. You must follow all HIPAA and state and federal requirements related to the confidentiality of, and access to, medical records.

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 EyeMed 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. DOM's Notice of Privacy Practices outlines how medical information about a member may be used and disclosed, and how members can access this information.

Non-discrimination

- Non-discrimination laws. You must comply with all relevant federal and state nondiscrimination provisions.

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 EyeMed online claims system.

- Translation and interpretation of materials. Provide free oral, ASL and Braille interpretation and/or written 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.
    - Call us at 1-888-581-3648 to access free interpreter services. Normal business hours are from 8 a.m. to 11 p.m. ET Monday through Saturday and 11 a.m. to 8 p.m. ET on Sunday).
    - 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.

Medicaid participation

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

Medicaid information

- Medicaid enrollment. You must be enrolled in the state Medicaid agency program. Your Medicaid ID number is key for participation in this program, and we must monitor the accuracy of it on a regular basis. If you are excluded by the state for participation in the Medicaid program or fall under any Medicare exclusion/preclusions, you can't participate in EyeMed networks.

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 (OIG) 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.

Mobile providers

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

Definitions and categories

- 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 two 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 underserved 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 provider application 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 one 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 one or more participating providers near the Originating Site who are willing to manage the

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

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 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.
- 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

Terminations from Mississippi Medicaid

- Medicaid termination. Per the Miss. Code Ann. §43-13-121, the Mississippi DOM may deny or revoke your enrollment in the Medicaid program if any of the following are found to be applicable to you , your agent, a managing employee or any person having an ownership interest equal to five percent (5%) or greater in your organization:
    - Failure to truthfully or fully disclose any and all information required, or the concealment of any and all information required, on a claim, a provider application or a provider agreement, or the making of a false or misleading statement to the division relative to the Medicaid program.
    - Previous or current exclusion, suspension, termination from or the involuntary withdrawing from participation in the Medicaid program, any other state's Medicaid program, Medicare or any other public or private health or health insurance program. If the division ascertains that a provider has been convicted of a felony under federal or state law for an offense that the division determines is detrimental to the best interest of the program or of Medicaid beneficiaries, the division may refuse to enter into an agreement with that provider, or may terminate or refuse to renew an existing agreement.
    - Conviction under federal or state law of a criminal offense relating to:
        - The delivery of any goods, services or supplies, including the performance of management or administrative services relating to the delivery of the goods, services or supplies, under the Medicaid program, any other state's Medicaid

program, Medicare or any other public or private health or health insurance program.
        - The neglect or abuse of a patient in connection with the delivery of any goods, services or supplies.
        - The unlawful manufacture, distribution, prescription or dispensing of a controlled substance.
        - Fraud, theft, embezzlement, breach of fiduciary responsibility or other financial misconduct.
    - Conviction under federal or state law of a criminal offense punishable by imprisonment of a year or more that involves moral turpitude, or acts against the elderly, children or infirm.
    - Sanction for a violation of federal or state laws or rules relative to the Medicaid program, any other state's Medicaid program, Medicare or any other public health care or health insurance program.
    - Revocation of license or certification.
    - Failure to pay recovery properly assessed or pursuant to an approved repayment schedule under the Medicaid program.
    - Failure to meet any condition of enrollment.
- Appealing Medicaid termination. You may request a formal administrative hearing to appeal a decision by DOM relating to disallowances, withholding of funds, refusals in the renewal of a provider agreement, terminations of provider agreements, suspensions of provider participation and more. Refer to DOM Administrative Code, Title 23: Medicaid, Part 300, Appeals for more information.

Voluntary terminations from the 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 the 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.
    - 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.
- Member notification. You must notify all Medicaid beneficiaries, families and/or sponsors in writing within 48 hours of notice of termination of Medicaid participation.
- 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 Mississippi Medicaid provided with your contract amendment.
    - You must accept EyeMed's payment in full for services rendered except when authorized by Medicaid.
    - You may not, under any circumstances, seek additional payment from a member nor accept additional payment for covered services or materials, even if the member has signed an agreement to do so.

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.

Claims

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, as well as chief complaint and case history to determine if services are routine eye or medical eye care.

- 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 routine eye 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 1-888-581-3648 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. We don't reimburse separately for any services included in a comprehensive eye exam (including dilation).
- Refraction. Refraction is billed and reimbursed separately from the eye exam.

COB/refraction only exception process

- Submitting COB claims. File COB claims in hard copy using a CMS 1500 form. You must attach a copy of the primary plan's explanation of benefits/remittance advice. Refer to the submitting claims section below for more information.

Submitting claims

Claims submission

- Claims submission process. We strongly encourage the use of EyeMed online claims system for expedited receipt and claims processing for eligible services to. 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 1-888-581-3648.
- 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 EyeMed 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.
- 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. All claims must be submitted within 180 days of the date the service is rendered or delivered. 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.
- Exceptions to timely filing. The Mississippi DOM allows some exceptions to the timely filing requirement.
    - **Resubmitting denied claims.** Claims filed within the appropriate time frame but denied may be resubmitted for reconsideration to EyeMed within 90 calendar days from the date of denial.
    - **Retroactive eligibility.** Claims can be processed if the beneficiary's Medicaid eligibility is approved retroactively by the Mississippi DOM or the SSA.

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 EyeMed 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 Mississippi Medicaid.
    - Filing online:
        - Use the "Routine" tab in the EyeMed 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 EyeMed online claims system for additional eye exams, replacement eyewear or second pairs of glasses in lieu of bifocals.
- Refraction code. Refraction (CPT 92015) is billed separately and is reimbursed separately from the eye exam.
- ICD-10 code reporting. We require you to submit all applicable ICD-10 diagnosis codes when filing a claim.
    - The EyeMed 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 EyeMed 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 balance bill the member 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 EyeMed 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 Mississippi Medicaid.
    - Filing online:
        - Use the "Routine" tab in the EyeMed 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 EyeMed 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 will be reviewed prior 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 1-866-293-7373.
- Mailing claims. Mail hard copy claims to:

  EyeMed/FAA
  P.O. 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 1-866-293-7373 with "CORRECTED CLAIM" written on the top.

- Mailing voided or corrected claims. You can mail corrected CMS 1500 forms to:
  EyeMed Vision Care/FAA
  P.O. 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 two 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 1-888-581-3648 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 EyeMed 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

- Benefit frequency. Refer to the EyeMed 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.

Refraction and dilation

- Refraction. Refraction is a component of the covered services available to eligible members. It Is billed and reimbursed separately from the eye exam.
- 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
- Slit lamp examination of irises, cornea(s), lenses, anterior chambers, conjunctivae and sclera
- Examination of pupils
- Measurement of intraocular pressure
- Ophthalmoscopic examination with pupillary dilation, as indicated, of the following:
  - Optic disc(s) and posterior segment
  - 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

- Routine vision services. Referrals are not required for routine vision care services provided under our plans.

Contact lenses

Covered benefits

- Medically necessary contact lens benefits. The benefit covers contact lens materials, fitting and unlimited follow-up visits when medically necessary.
- Benefit frequency and annual supply limits. Refer to the EyeMed 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 Required Test (✓)	Existing Wearer
Contact lens-related history	✓	✓
Keratometry and/or corneal topography	✓	✓
Anterior segment analysis with dyes	As Indicated	As Indicated
Biomicroscopy of eye and adnexa	✓	✓
Biomicroscopy with lens • Fluorescein pattern (rigid lenses) orb. • 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 one to three 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.
  - Keratoconus
  - Keratoglobus
  - Irregular cornea astigmatism
  - Nystagmus
  - Progressive myopia over six diopters, where contact lens will improve visual acuity or retard the progressive myopia and lessen the frequency of prescription changes

- Hyperopia over 3.5 diopters, where contact lenses will improve visual acuity
- Anisometropia greater than three diopters or greater than 2.5, if there is documented intolerance to glasses as a result of anisometropia
- Disease or deformity of the nose, skin, or ears that precludes the wearing of eyeglasses
- Post-operative cataract surgery, or
- Treatment as a result of eye surgery, other than cataracts, which must be provided within six months of the surgery to be covered.

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 one-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.

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 prior authorization requirements

- Prior authorizations. Prior authorization is required for all contact lenses. The request must properly document that one of the diagnoses listed under Minimum qualifications for eligibility is involved, and it must reflect that conventional eyeglasses are not an acceptable method of correction.

Contact lens claims

- Contact lens claims. The materials and fit and follow-up services for contact lens benefits must be submitted on one claim. File the claim in hard copy following the process below:
    1. Complete our Mississippi 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.
        - Include the applicable refractive and high-risk diagnosis codes on all contact lens claims.
            - For keratoconus or anisometropia, submit the applicable diagnosis codes listed in ICD-10.
        - When filling out the claim, indicate the member's qualifying condition. CPT procedural codes for contact lens fitting are limited to keratoconus and aphakia. CPT has not designated codes for other qualifying conditions, so you should use the below codes to indicate the qualifying condition:

Qualifying criteria	Medically necessary contact lens codes*
Anisometropia/antimetropia	92310AN
Aphakia	92311AP or 92312AP
Aniridia	92310AI
Irregular cornea, other conditions	92310VI
Keratoconus	92072

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

    2. Fax the completed form to 1-866-293-7373 or mail to:
        EyeMed Vision Care/FAA
        P.O. Box 8504
        Cincinnati, OH 45040

Replacement contact lenses

- Replacement lenses due to loss or damage. The Mississippi DOM does not cover replacement of lost or stolen contact lenses.

Frames and lenses

Eyeglass benefits

- Frame and lens benefits. A complete pair of eyeglasses is a Medicaid covered benefit. Refer to the EyeMed online claims system to see a member's eligibility, benefits, and frequency limitations.

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.
- Previously used frames. Members cannot use previously used frames. Instead, order a complete pair of eyewear.

Lenses

- Standard lenses. We consider standard lenses to be uncoated, CR-39 plastic single vision, bifocals (Round 22, FT 28, FT 35 and Executive) and trifocals (FT-7x28). Any other lens types and options are covered only when medically necessary.
- Polycarbonate and high index lenses. Polycarbonate and high index lenses are covered for members zero to 20 years old and are covered only when medically necessary for members 21+.
- Product catalogs. The Mississippi Medicaid product catalogs define the lenses and treatments available through our lab network for Mississippi Medicaid members.
    - **Mississippi Medicaid Product Catalogs**
        - Lens Design Tool – https://www.eyemedinfocus.com/wp-content/uploads/2025/05/Essilor-MS-Medicaid-Lens-Design-Tool.pdf
        - Lens Add On Tool – https://www.eyemedinfocus.com/wp-content/uploads/2025/05/Essilor-MS-Medicaid-Add-On-Tool.pdf

Medically necessary lenses and options

- Covered lens options. Members qualify for the following lens options as a covered benefit only when medically necessary based on the doctor's professional opinion:
    - Balance lenses
    - Glass/plastic slab off prism
    - Prism lenses
    - Fresnell prism press-on lenses
    - Special base curve
    - Tint photochromatic lenses
    - Tint, any color/solid/gradient
    - UV lenses
    - Occluder lenses
    - Oversize lenses
    - Polycarbonate lenses (Ages 21+)
    - High Index lenses (Ages 21+)

Lab network requirements

- Medicaid lab. All glasses 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.
- 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 EyeMed 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.
- Lab supplied. Because Classic Optical will be providing the complete pair of glasses, which includes the frames and the lenses, you will submit lab orders as "lab supplied" jobs.
- Lab order turnaround time. Classic Optical will ship the product to you within seven business days from the time the order is submitted.

- If you do not receive your product within seven 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

- Quality. The ultimate judgment as to the quality of work performed rests solely within your reasonable discretion and any reasonable dissatisfaction on your part will result in the correction of the defect, according to the below policy.
- Lab errors and remakes. Remakes for lab errors are processed free of charge up to six months from original Rx delivery.
  - Lenses that have been further processed, edged, tinted or coated after delivery to you will not be replaced or accepted for credit, unless you can clearly demonstrate that the unprocessed lens was defective.
- Process for remakes. Return the lenses to Classic Optical within six 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.

- Reasons for doctor remake. The below reasons qualify for a doctor remake. In these instances, you will be billed at private pay pricing, or this may also qualify for a replacement/medically necessary pair under the Medicaid plan. Refer to the Health plan information section for specific requirements by health plan.
    - 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, like 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.
- Reasons for a lab remake. The following reasons qualify for a lab remake:
    - Lab errors.
    - Progressive lenses under warranty.
    - Other frame or lens manufacturing warranties.
- 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.
- Frame change process. Members are responsible for the cost to change a frame.
    - Handle it as a private pay transaction.
    - Fax or call the request to the lab.
- 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 one 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.
- Cancellations. Prescription jobs are considered in manufacturing process as soon as the order has been submitted to the lab. Any cancellation of an Rx job will result in the job being billed to you at private pay pricing.
- Doctor redos. You are required to pay for doctor redos on the same job at the full private pay pricing, however, this may qualify for a replacement/medically necessary pair under the Medicaid plan. Refer to the Health plan information section for more information.

- Warranty/non-adapt PALs. While under warranty, jobs will be processed at no charge. To qualify, you must return the lenses with a copy of the original invoice/shipping slip. Contact the lab directly if you have any warranty questions.
- Non-adapt. Varilux will be remade one time at no charge in the same (or lesser priced) design and material. If the patient still can't adapt after the no-charge replacement, the lab will remake the same Rx into conventional lenses at full charge on the invoice. Contact the lab directly if you have any warranty questions.
- Upgrades. If you request additional options and the Rx job has to be cancelled and started over (see definition and timing above), EyeMed will be charged for the original cancel job and the new upgraded job will be billed directly to you at private pay rate.

Eyewear replacements and repairs

- Repairs and replacements for members ages 21 and older. Repairs and replacements are not covered.
- Repairs and replacements for members ages 20 and younger. Members ages zero to 20 with medical necessity are eligible for replacements and repairs.
- 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.
- Warranties for frames and 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:

- Eyeglasses solely for protective, fashion, cosmetic, sports, occupational or vocational purposes.
- More than one pair of eyeglasses every five years for adult members.
- Single vision eyeglasses in addition to multifocal eyeglasses.
- Progressive bifocals.
- Sunglasses.

- Upgraded frames.
- Eyeglass cases.
- Engraving.
- Contact lens supplies and/or solutions.
- Eyeglass or contact lens insurance.
- Lens coating, unless specified by a Utilization Management/Quality Improvement Organization (UM/QIO), DOM or designated entity.
- Dispensing fees.
- Contact lenses, unless specified by a UM/QIO, MS DOM or designated entity.
- Refractive surgery including, but not limited to, Lasik surgery, radial keratotomy, photorefractive keratectomy, and/or astigmatic keratotomy.
- Services and items requiring prior authorization for which authorization has been either denied or not requested.

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

Compliance and Quality Assurance (QA)

Definitions

- Post-service claim appeal/dispute: a request for review by the CCO of post-service payment-related claim matters.
- Clinical appeal: an appeal is a review by a CCO 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 inquiries and correspondences are NOT considered claim appeals. If you have questions concerning these, call 1-888-581-3648 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 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: 1-513-492-3259
        eyemedqa@eyemed.com

- Appeals timing. Your request for an appeal must be submitted within 30 calendar 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.
- Claim disputes. If a claim denial is not due to a provider's incorrect or inaccurate claim information, but the provider disagrees with the denial, the provider may submit a claim dispute. The dispute must be filed within 90 calendar days from the date of receipt of the claim decision notification, also referred to as the explanation of payment (EOP). If the claim dispute is not submitted in the required time frame, the claim will not be reconsidered, and the dispute will be denied. Examples of reasons for claim disputes:
  - Claim was paid for incorrect amount
  - Claim was denied for no authorization, but authorization was obtained
  - Claim was denied for no authorization, but no authorization was required for the service or benefit
  - Claim was denied for untimely filing in error (proof of timely filing must be attached)
  - Claim paid to wrong provider

  Although optional, it is recommended that the provider submits a dispute prior to an appeal. Providers may choose to bypass the dispute process and submit an appeal first; however, if the appeal is submitted first, the dispute step will be exhausted, and the provider cannot request a dispute after the submission of an appeal.

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. Please provide all appropriate diagnosis codes as well as CPT I and CPT II procedures. Examples of applicable CPT II codes:
  - 2020F
  - 2021F
  - 2022F
  - 2023F
  - 2024F
  - 2025F
  - 2026F
  - 2033F
  - 3072F

- 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 • 2 sections: Required equipment and facility environment	Required equipment: • 100% required to pass Facility section: • 100 – Excellent • 99 to 80 – Satisfactory • Less than 80 – Progressive Disciplinary Action
Clinical records	• Assessment of member records • Financial evaluation	• 100 to 90 – Good to Excellent • 89 to 80 – Satisfactory • 79 to 0 – Fail: Progressive Disciplinary Action
Financial	• Financial document evaluation reviews claims against payment and member records • Financial claim evaluation reviews a provider and/or location's claim history to reveal billing patterns	• 100 – Excellent • 99 to 80 – Satisfactory • 79 to 0 – Fail: Progressive Disciplinary Action
Process	• Review of clinical and business practices for a specific reason, such as adherence to clinical coverage criteria or application of a benefit and compliance with lab ordering, In-Office Finishing and emergency service policies	• 80% required to pass
HEDIS	• Collection of HEDIS data to assess and compare quality of care	N/A

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 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

Non-Compliance Level	**Reasons**
Level 1 non-compliance	• Non-response to QA request or notice • Billing and/or claim filing errors • Lower than expected quality of service and/or materials, standards of optometric care and/or professional behavior • Failure to follow our quality, contractual or administrative protocols • Violating the terms of our Provider Agreement
Level 2 non-compliance	• Continued Level I non-compliance • Provider/member conflict: if your practice requires Provider Appeal, Peer Review or QA intervention
Level 3 non-compliance	• Continued non-compliance 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 health care FWA.
- To recover overpayments on behalf of our clients.
- To comply with state and federal regulations and clients' requirements for preventing fraud.

Medicaid FWA prevention

- Medicaid FWA oversight. The Mississippi DOM's Program Integrity investigates activities relating to the prevention, detection and investigation of alleged provider and beneficiary fraud and/or abuse in the Medicaid program.
- HIPAA Privacy and Security regulations. The Mississippi DOM's Notice of Privacy Practices describes how medical information about members may be used and disclosed. It also explains how members can get access to this information.
- Fraud and abuse examples. Refer to MS DOM's website for examples of provider and member fraud and abuse.

Reporting FWA

You are required to report all cases of suspected FWA, inappropriate practices and inconsistencies of which you become aware within the Medicaid program.

- Reporting FWA to EyeMed:

  EyeMed Special Investigation Unit
  EyeMed Vision Care
  4000 Luxottica Place
  Mason, OH 45040
  eyemedSIU@eyemed.com
  Submit anonymously at luxotticaspeakup.com or calling 1-888-88S-EEIT (1-888-887-3348).
- Report to the Office of Medicaid Inspector General (OMIG). Call 1-877-873-7283 or reporting it online.
- Reporting FWA to Mississippi DOM:

  ATTN: Office of Program Integrity
  550 High Street, Suite 1000
  Jackson, MS 39201
  Toll-free phone: 1-800-880-5920
  Phone: 1-601-576-4162
  Fax: 1-601-576-4161
  Medicaid Fraud and Abuse Complaint Form
- Reporting FWA to health plans. You are required to report suspicious behavior and incidents of FWA to any health plans you are contracted with. Refer to the Health plan information section for contact information.

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 inFocus, 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 one year subject to approval by our Quality Assurance (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 one 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.

Health plan information

EyeMed administers routine and/or medical/surgical eye care services for Medicaid members enrolled in the following health plans:

- TrueCare MississippiCAN and CHIP

In addition to the manual above, please read below for important plan-specific provisions.

TRUECARE

About TrueCare

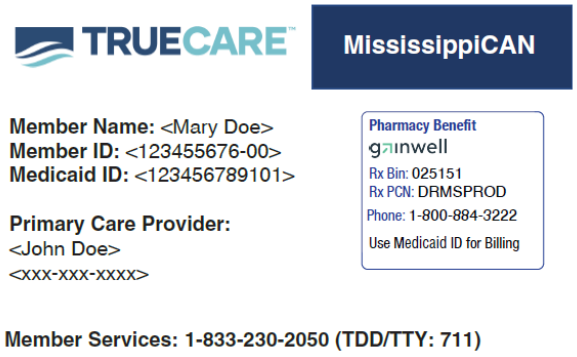
TrueCare provider manual

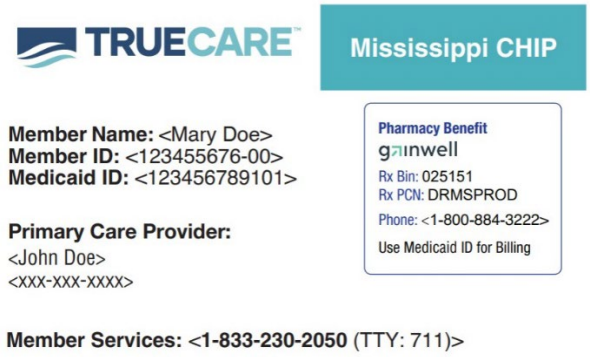
Although relevant provisions are summarized here as appropriate, you are contractually obligated to adhere to and comply with all the terms listed in the TrueCare™ provider manual, as well as your provider agreement with TrueCare.

Interacting with TrueCare members

Member ID cards

Each TrueCare member is issued an identification card. Members should show the card when they need care.





Member rights and responsibilities

- Member handbook. Members are urged to read the member handbook.

TrueCare provider requirements

Provider rights and responsibilities

- Provider manual. You should read the TrueCare provider manual.

TrueCare routine services and materials

TrueCare vision coverage

TrueCare members have access to vision coverage as listed below. You must verify the member's benefits using the EyeMed online claims system.

TrueCare Medicaid members aged 20 and younger are eligible for:

- Eye Exam. Two comprehensive eye examinations every state fiscal year. Refraction is billed separately. Additional exams are allowed if medically necessary.
- Pair of glasses. Two pairs of eyeglasses (frames and lenses) per state fiscal year. Any glasses beyond the limit must be medically necessary. Fitting is a separate service and is covered.
- Repair/replacements. Repairs and replacements are covered when medically necessary for members aged zero to 20.
- Contacts. Medically necessary contact lenses are covered with prior authorization.

TrueCare Medicaid members aged 21 and older are eligible for:

- Eye Exam. One comprehensive eye examination every state fiscal year. Refraction is billed separately.
- Pair of glasses. One pair of eyeglasses (frames and lenses) every state fiscal year. Fitting is a separate service and is covered.
- Repair/replacements. Repairs and replacements are not covered.
- Contacts. Medically necessary contact lenses are covered with prior authorization.

Hard copy claims

- CMS 1500 form. Use a CMS 1500 form for all hard copy claims.
- Hard copy claims submission. Send hard copy claims to the following:
    - Fax to 1-866-293-7373.
    - Mail to:

      EyeMed Vision Care/FAA
      Attention: Medical and Surgical Claims
      P.O. Box 8526
      Mason, OH 45040
- Primary and secondary diagnosis codes. Include primary and secondary diagnosis codes on hard copy claim forms. We need these to comply with HEDIS reporting requirements. Using other codes can delay your payment.
    - Report codes based on information from the patient's history, any reported medications and your clinical findings during your evaluation.
    - **Select the appropriate code(s) even though you are providing routine vision care services. The diagnosis code(s) are not tied to the services you provide**.

Voiding and correcting claims

- Overview. You can correct or void routine eye exam, contact lens or medical/surgical eye care claims by submitting a CMS 1500 form to us.
- Faxing corrected claims. Fax a corrected CMS 1500 form to us at 1-866-293-7373 with "CORRECTED CLAIM" written on the top.
- Mailing corrected claims. You can mail corrected CMS 1500 forms to:

  EyeMed Vision Care/FAA
  Attention: Medical and Surgical Claims
  P.O. Box 8526
  Mason, OH 45040

Compliance and quality assurance (QA)

Provider appeals, complaints and grievances

- Written provider appeals, complaints and grievances. For routine administrative grievance and appeals cases, you may send written appeals, complaints and grievances to the following:

  EyeMed Vision Care
  Attn: Quality Assurance Dept.
  4000 Luxottica Place
  Mason, OH 45040
  Fax: 1-513-492-3259.
  Email: AGeyemed@eyemed.com
- Verbal provider appeals, complaints and grievances. Verbal cases are managed through our Customer Service department at 1-888-581-3648. Our normal business hours are:
  - Monday through Saturday from 8 a.m. to 11 p.m. ET.
  - Sunday from 11 a.m. to 8 p.m. ET.

Medicaid fraud, waste and abuse (FWA)

- FWA information. You can find more information about TrueCare's policies regarding FWA in the TrueCare provider manual.
- 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. For more ways to report, refer to the Reporting FWA section above.
  - **Report to TrueCare** at:

    Call: 1-844-415-1272
    Write: TrueCare, ATTN: Program Integrity, P.O. Box 1940, Dayton, OH 45401-1940
    Fax: 1-800-418-0248
    Email: Fraud@MSTrueCare.com

1-888-581-3648
www.eyemedinfocus.com

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