Provider Office Reference Manual

For the provision of vision and eye care services provided by:

Humana Healthy Horizons in Kentucky

[PO Box 433]
[Milwaukee, WI 53201-0433]

[https://vision-providers.dentaquest.com/PWP/Landing]

EyeQuest Key Contact Telephone Numbers

EyeQuest Provider Services
[PO Box 433
Milwaukee, WI 53201-0433]
[Phone: 844-870-3978]
[Fax: 1-888-696-9552]

Email Addresses
Provider Services
[EyeQuestProviderServices@dentaquest.com]

Claims and Authorizations
[EyeQuest@dentaquest.com]

Grievance and Appeals
[VisionCGA@dentaquest.com]

Credentialing
[PO Box 433
Milwaukee, WI 53201-0433]
[Phone: 1-800-233-1468]
[Fax: 262-241-4077]

Claims
Paper claims should be sent to:

[EyeQuest
Attn: Vision Claims Processing
PO Box 433
Milwaukee, WI 53201-0433
Fax: 1-888-696-9552]

Fraud Hotline
[1-800- 237-9139]

TDD (Deaf or hard of hearing)
[1-800-466-7566]

EyeQuest Member Services:
[1-855-343-7405]

Providers must recognize Kentucky Member Rights and Responsibilities as detailed in the following document.

The Kentucky Patient's Bill of Rights and Responsibilities

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

- A patient has the right to be treated with courtesy and respect, with appreciation of his or her individual dignity, and with protection of his or her need for privacy.
- A patient has the right to a prompt and reasonable response to questions and requests without any communication or physical barriers per contract.
- A patient has the right to know who is providing medical services and who is responsible for his or her care.
- A patient has the right to assistance with medical records in accordance with applicable state and federal laws.
- A patient has the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- A patient has the right to know what patient support services are available, including whether an interpreter is available if he or she does not speak English.
- A patient has the right to know what rules and regulations apply to his or her conduct.
- A patient has the right to be given by the vision and eye care provider, information concerning diagnosis, planned course of treatment, alternatives, risks and prognosis.
- A patient has the right to refuse any treatment, except as otherwise provided by law.
- A patient has the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for his or her care.
- A patient has the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- A patient has the right to receive a copy of a reasonably clear and understandable, itemized bill and, upon request, to have the charges explained.
- A patient has the right to impartial access to vision and eye care treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.
- A patient has the right to treatment for any emergency medical condition that will deteriorate from failure to receive treatment.
- A patient has the right to know if medical treatment is for purposes of experimental research and to give his or her consent or refusal to participate in such experimental research.
- A patient has the right to voice grievances and receive access to the grievance process, receive assistance in filing an appeal, and request a state fair hearing from their medical insurer and/or the Department of Medicaid.
- A patient is responsible for providing to his or her medical care provider, to the best of his or her knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters related to his or her health.
- A patient is responsible for reporting unexpected changes in his or her condition to the medical care provider.
- A patient is responsible for reporting to his or her vision and eye care provider whether he or she comprehends a contemplated course of action and what is expected of him or her.
- A patient is responsible for following the treatment plan recommended by his or her medical care provider.
- A patient is responsible for keeping appointments and, when he or she is unable to do so for any reason, for notifying the medical care provider or medical c a r e facility.
- A patient is responsible for his or her actions if he or she refuses treatment or does not follow the medical care provider's instructions.
- A patient is responsible for assuring that the financial obligations of his or her medical care are fulfilled as promptly as possible.
- A patient is responsible for following vision and eye care facility rules and regulations affecting patient conduct.

Statement of Provider Rights and Responsibilities

Providers shall have the right to:

1. Communicate with patients, including Members, regarding vision treatment options.
2. Recommend a course of treatment to a Member, even if the course of treatment is not a covered benefit, or approved by Plan/EyeQuest.
3. File an appeal or complaint pursuant to the procedures of a Plan/EyeQuest
4. Supply accurate, relevant, factual information to a Member in connection with an appeal or complaint filed by the Member.
5. Object to policies, procedures, or decisions made by the Plan or EyeQuest.
6. If a recommended course of treatment is not covered, e.g., not approved by Plan or EyeQuest, the Provider must notify the Member in writing and obtain a signature of waiver if the Provider intends to charge the Member for such a non-compensable service prior to treatment.
7. To be informed of the status of their credentialing or recredentialing application, upon request.

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OFFICE REFERENCE MANUAL

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1.00 PATIENT ELIGIBILITY VERIFICATION PROCEDURES

1.1 Member Eligibility

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

1.2 Member Identification Card

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

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

To be sure a member is eligible for benefits at the time of service; verify eligibility with EyeQuest online or by telephone.

1.3 Verifying Eligibility

Eligibility should be verified via the EyeQuest portal. Please see the Portal Tutorial linked in the portal menu for instructions.

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

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

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

1.4 Benefits

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

2.0 Claims Submission Procedures (claims filing options)

Optometry

- All contracted Optometry providers should submit all claims to EyeQuest.

Ophthalmology

- All contracted Ophthalmologists should submit all **routine** service claims to EyeQuest.
- OTHER service claims outside the scope of **routine** care should be submitted to **Humana Healthy Horizons in Kentucky**.

EyeQuest currently receives vision and eye care claims in three possible formats.

These formats include:

- Electronic claims via EyeQuest's provider portal
- Electronic claims via clearinghouse using TriZetto Provider Solutions
- Paper claims submitted on standard claim forms (e.g. CMS/HCFA1500)

2.1 Electronic Claim Submission Utilizing EyeQuest's Website

Participating providers may submit routine exam and optical claims directly to EyeQuest by utilizing the EyeQuest web portal. Submitting claims via the website is quick and easy. Please review the Portal Tutorial linked in the portal menu for instructions.

If you have questions or problems submitting claims or accessing the website, please contact our Provider Services team at [EyeQuestProviderServices@dentaquest.com]

2.2 Paper Claim Submission

- Always include the practice name and the rendering provider name.
- Approved procedure codes (CPT, CPT II and HCPCS) must be used to define all services.
- Up to four ICD-10 codes may be submitted and all relevant codes should be included. Professional services without at least one valid ICD-10 code will be denied.
- Affix the proper postage when mailing bulk documentation. EyeQuest does not accept postage due mail. This mail is returned to the sender and will result in payment delay.
- Paper claims should be faxed to [888-696-9552], emailed to [EyeQuest@dentaquest.com], or mailed to the following address:

EyeQuest
Attention: Vision Claims Processing
[PO Box 433
Milwaukee, WI 53201-0433]

2.3 Coordination of Benefits (COB)

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

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

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

2.4 Filing Limits

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

2.5 Receipt and Audit of Claims

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

2.6 Claims Appeals

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

3.0 Appointment Availability/ Appointment Waiting Time

Providers must be available within the appointment availability standards prescribed by EyeQuest.

3.1 Appointment Access & Availability Standards

Appointment Access & Availability Standards – Providers are required to meet appointment availability standards. Surveys are conducted randomly throughout the year to ensure providers are meeting these standards. If you are not able to provide appointments within these standards, please notify your Provider Engagement Representative:

- Urgent care appointments within 48 hours of request
- Routine care appointments within 30 days of request

3.2 Changes in your practice

In order for EyeQuest to maintain its records, and to ensure the appropriate members are referred to or can reach you, it is required that you notify us if there are any changes to your practice. Please use the Provider Change Form linked in the menu of the portal to report any of the following:

- New or terminated providers
- Moves or additional locations
- Change in correspondence address
- Change of business name, tax ID, and/or ownership
- Hours of operation
- Phone/fax/email address changes
- Changes to member populations seen

3.3 Material Change Notification

EyeQuest communicates with all participating providers any material changes to the existing provider contract following regulatory guidelines. If a material change is made, the provider will be provided with at least 90 days' notice the of following information:

- Effective date of the change
- Description of the change to the existing contract
- Notification of providers option to accept or reject the change
- Contact information for a representative at **Humana Healthy Horizons in Kentucky** or EyeQuest to discuss the change

Additionally, the provider has the opportunity to request a meeting to discuss concerns about the change with EyeQuest. If EyeQuest has cause to make three or more material changes to a contract in a rolling 12-month period, the participating provider may request an updated copy of the contract for informational purposes. This updated contract with changes consolidated will have no effect on the terms and conditions of the contract.

In the event the provider would like to oppose the material change to the contract, the provider should submit any objections in writing within 30 days of receiving the notification of the change. An EyeQuest representative will then work to come to an agreement on the change over the following 30 days. If an agreement cannot be reached between EyeQuest and the provider, providers will have 30 days to terminate the contract and provide notice to members to prevent any gaps in care caused by this dissolution.

4.0 Health Insurance Portability and Accountability Act of 1996

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

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

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

- Provider agrees to comply with the requirements of HIPAA relating to the exchange of information and shall cooperate with EyeQuest in its efforts to ensure compliance with the privacy regulations promulgated under HIPAA and other related privacy laws.

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

In relation to the Administrative Simplification Standards, you will note the benefit tables included in this ORM reflect the most current coding standards (CPT-5 and HCPCS). Effective the date of this manual, EyeQuest will require providers to submit all claims with the proper CPT-5 or HCPCS codes listed in this manual. In addition, all paper claims must be submitted on the current approved claim form. (ICD-10 will become effective in 2015.)

Note: Copies of EyeQuest's HIPAA policies are available upon request by contacting [EyeQuestProviderServices@dentaquest.com.]

5.0 Inquiries, Complaints and Grievances

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

A. Definitions:

Complaint/Grievance: An expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include, but are not limited to, the quality of care, the quality of services provided and aspects of interpersonal relationships such as rudeness of a provider or health plan employee or failure to respect the enrollee's rights. An enrollee can file a grievance anytime from the date of an event occurred. The health plan must provide the enrollee with written notice of receipt of the grievance within 5 business days of receipt of the grievance.

B. Complaints/Grievance Review Process

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

EyeQuest – Complaints and Grievances
[PO Box 2906
Milwaukee, WI 53201]
Email: [VisionCGA@dentaquest.com]
Fax: [1-262-837-3452]

6.0 Provider Appeals

Unless otherwise required by Agency and Plan, EyeQuest processes such appeals consistent with the following:

A. Appeal: A formal request seeking a review of an action taken by the Health Plan pursuant to 42 CFR 438.400(b). An appeal is a request for review of an adverse benefit determination as it relates to Covered Services, services provided, or the payment for a service

B. Provider Appeals

Contracted providers have a right to file an appeal for any adverse benefit determination as defined above. This can be done by submitting a request for appeal in writing with a narrative and supporting documentation to EyeQuest via mail or fax.

C. Denied Claims Appeals

A claim appeal may be filed for any adverse post-service decision assessed against a provider by EyeQuest. Providers must file their appeal within 60 days of the date notification of denial was made. EyeQuest will acknowledge your appeal within five business days of receipt. EyeQuest will resolve your appeal within 30 calendar days of receipt. Please note that appeals for preservice denials may be filed provided that member consent is obtained and shall be deemed a member appeal by EyeQuest.

All provider appeals should be sent to the attention of:

EyeQuest Provider Appeals
[PO Box 2906
Milwaukee, WI 53201]
Email: [VisionCGA@dentaquest.com]
Fax: [1-262-837-3452]

D. External Review and Administrative Hearing for the Provider

Under Kentucky statute and regulation 907 KAR 17:035, you have the right to an external independent third-party review. Providers may submit a request for an external independent third-party review within 60 calendar days of receiving an MCO's final decision from the MCO's internal appeal process. Provider requests pursuant to 907 KAR 17:035 will not be considered for dates of service prior to 12-1-2016.

The sixty (60) day count shall begin on the:
1. Date that the notice was received electronically, if received electronically;
2. Date that the notice was received via fax, per the date and time documented on the fax transmission, if the notice was faxed; or
3. Post mark date on the envelope containing the notice, if the notice was sent via postal mail. An additional three (3) days shall be added when the service is by mail.

This request must be submitted to the MCO via one of the contact options designated below. DMS will also post the MCO contact information on their website at http://www.chfs.ky.gov/dms/. Requests are not accepted verbally. Additional information will not be considered by the third-party reviewer.

Please send your request to one of the following:

Email: **[**GAMedicaidRightfax@humana.com]

Fax: **[800-949-2961]**
Mail: **Humana Healthy Horizons in Kentucky**
[Grievance and Appeal Department
P.O.Box 14546
Lexington, KY 40512-4546]

If the decision is against the member, Humana Healthy Horizons may recover the cost of the services the member received while the appeal was pending. This process also applies to all EPSDT appeals decisions
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E. State Hearings for the Member

The member or the member's authorized representative may request a hearing. A provider may not request a hearing on behalf of a member unless the member deems, in writing, the provider to be his or her authorized representative.

The member must exhaust all levels of resolution and appeal within the appeal system prior to filing a request for a hearing with the Kentucky Cabinet for Health and Family Services.

The member or his or her representative shall submit a request for a state fair hearing to the CHFS within

120 days of the final appeal decision by Humana Healthy Horizons. When a hearing is requested, Humana Healthy Horizons will provide to the CHFS and the member, upon request, all documentation held by Humana Healthy Horizons related to the appeal, including but not limited to any transcript(s), records or written decision(s) from participating providers or delegated entities.

An administrative law judge at the Division of Administration (DOA) will conduct the state fair hearing. When the hearing is complete, the Director of DOA will report the results of the hearing decision to the member, to Humana Healthy Horizons and to CHFS.

Implementation of such a hearing decision shall not be the basis for termination of enrollment by Humana Healthy Horizons.

After exhausting both the appeal process with Humana Healthy Horizons and the hearing process, an enrollee has a right to independent review in accordance with the State Fair Hearing process.

F. Continuation of Benefits during Appeals or State Fair Hearings

Humana Healthy Horizons is required to continue a member's benefits while the appeals process or the state fair hearing is pending if all of the following are true:

- The request for continuation of benefits is submitted to Humana on or before the latter of the two: within 10 calendar days of mailing the notice of action or the intended effective date of proposed action by Humana Healthy Horizons
- The appeal involves the termination, suspension or reduction of a previously authorized course of treatment
- Services were ordered by an authorized provider
- The original period covered by the original authorization has not expired
- The member requests an extension of benefits.

G. Member Complaints/Grievances/Appeals:

Members must file a complaint, grievance and/or appeal directly with Humana.

Member's Plan	Telephone	Mail
Humana Healthy Horizons in Kentucky	800-444-9137	Humana Healthy Horizons in Kentucky Grievances and Appeals P.O. Box 14546 Lexington, KY 40512-4546

7.0 Quality Improvement Program

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

- Provider credentialing and re-credentialing
- Member satisfaction surveys
- Provider satisfaction surveys
- Random chart audits
- Member complaint monitoring and trending
- Peer review process
- Site reviews and medical record reviews
- Quality indicator tracking (e.g., complaint rate, appointment waiting time, access to care, etc.)

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

8.00 Fraud and Abuse

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

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

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

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

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

To report suspected fraud and/or abuse in Kentucky Medicaid, call the Consumer complaint Hotline toll-free at 1-800-595-6053 or complete a Medicaid Fraud and Abuse Complaint Form, which is available online at http://insurance.ky.gov/Static_Info.aspx?Static_ID=2

9.00 Credentialing/Recredentialing

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

Recredentialing

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

Note: Complete credentialing policies are available upon request by contacting EyeQuest's Vision Team via email at [EyeQuestProviderServices@dentaquest.com.]

Provider Medicaid Requirements
The Department for Medicaid Services (DMS) only contracts with providers or entities qualified under 907 KAR 1:671 and 907 KAR 1:672 and approved by DMS to participate.

DMS reserves the right to approve or reject a contract with any prospective provider.

Providers are able to review what is needed to enroll online at: http://chfs.ky.gov/dms/provenr
Providers may find all forms needed at: http://chfs.ky.gov/dms/provenr/forms.htm
NPI verifications may be found at: https://npiregistry.cms.hhs.gov/registry/

10.0 Standard of Care — Routine Eye Care

10.1 Examination Standards

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

Current Status
1. Basic patient demographics (age/date of birth, gender, race)
2. Personal and family medical and ocular history
3. All current medications and medication allergies
4. Patient's assessment of current vision status; use of eyeglasses or contact lenses
5. Chief complaint/reason for visit/history of present illness

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

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

Impression and Disposition
Summary of all diagnoses, prescriptions and treatment recommendations, including but not limited to:
- Refractive and eye health diagnoses
- Eyeglass and contact lens prescriptions
- Medications prescribed and/or treatment plans
- Patient education on their ocular status and any increased risk factors for any personal or family conditions
- Recall/re-examination/referral recommendations

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

10.2 The Patient Record

A. Organization

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

- Patient's first and last name
- Parent or guardian's name, if appropriate
- Date of birth
- Gender
- Race
- Address
- Telephone number(s)
- Emergency contact person and telephone number
- Primary care physician
- Health Plan ID number or other identification number

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

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

B. Content

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

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

C. Compliance

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

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

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

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

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

10.3 Continuity of Care for Member Transfer

Member transfers from another MCO: If they have an existing authorization for vision treatment from their prior MCO, Humana Healthy Horizons or EyeQuest will honor that existing authorization for 90 days from the point of the member's effective date under Humana Healthy Horizons.

Member under care by an EyeQuest Network Provider: The provider can treat the member. All services prior approved by another MCO will be honored by EyeQuest as long as the treatment is rendered within 90 days of the member's transfer to Humana.

The provider will only need to submit a copy of the prior MCO's authorization determination along with

their claim to EyeQuest and use the keyword "TOC" for transfer continuation of care within the notes field. This keyword will allow the claim to suspend for review so that EyeQuest can validate that the services had been prior authorized. If all services rendered were substantiated against the prior MCO's authorization, the claim will process and pay completely.

Any services rendered that were not authorized by the member's prior MCO will require retrospective review by EyeQuest to substantiate medical necessity. If documentation to support the medical necessity of these additional services was not provided, the associated services would deny with indication that additional documentation was needed for review.

Member under care by a Non-EyeQuest Network Provider (if approved by Humana Healthy Horizons in Kentucky): The provider can treat the member. All services prior approved by another MCO will be honored by EyeQuest as long as the treatment is contractually within the EyeQuest scope of coverage and rendered within 90 days of the member's transfer to Humana Healthy Horizons in Kentucky.

EyeQuest will alert our Provider Engagement team to the situation so that provider recruitment can occur.

11.0 Quality Initiatives

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

All eye doctors are aware of the importance of and clinical indications for providing all diagnosed diabetic patients with a full dilated retinal exam not less than annually.

Additional Examination Coverage for Members with Diabetes

Members identified as having diabetes are eligible for annual (every 12months) routine eye exams, regardless of other symptoms or complaints. THIS ANNUAL VISIT DOES NOT REQUIRE PRIOR APPROVAL. To allow for claim payment providers should submit claims using the regular eye exam code (e.g. 92014), along with all applicable ICD-10 diagnosis codes (e.g. E10.9, E11.9).

Our Health Plan clients are charged with measuring and monitoring the frequency with which their diabetic members receive this service. As the vision services network administrator, EyeQuest is obligated to help promote access to this service and to encourage our providers to provide documentation of the examination and findings. CMS has implemented the use of specific CPT II codes on applicable claims submitted to payers to improve the capability of documenting this exam. Per CMS guidelines, EyeQuest requires our providers to submit these additional service codes for all diabetic patients examined. The process and procedures are detailed below.

1. For all patients presenting with a medical history positive for diabetes, perform the usual eye exam including dilation and retinal evaluation;
2. Document the findings of the exam in the medical record per your usual protocol;
3. Submit the claim for services with the following documentation:
   a. Use the applicable exam CPT-4 code, (e.g., 92004, 92014, S0620, S0621)
   b. Include the additional (applicable) CPT II code 2022F
   c. Select and include the applicable diabetes diagnosis code(s) (e.g., E10.9, E11.9);
4. Summarize the findings in the *EyeQuest Diabetic Summary Form* (or use your own letter) and submit the summary of findings to the member's PCP.

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

CODE	DESCRIPTION
2022F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist, documented and reviewed; **w/evidence of diabetic retinopathy**
2023F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist, documented and reviewed; **w/out evidence of diabetic retinopathy**
3072F	Absence of retinopathy at the most recent eye exam

11.2 Glaucoma Screening – Submitting supplemental billing code G0117

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

Conditions of Coverage:

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

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

Components of the Glaucoma Screening include:

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

The following HCPCS code applies for a Glaucoma Screening:
G0117 – glaucoma screening for high-risk patients furnished by an optometrist or ophthalmologist - Remember that this service is not separately reimbursable.

12.0 Utilization Management – General Provisions

Overview

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

12.1 Limitations to Delivery of Service

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

Medical Management

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

One area in which we need to ensure there is no misunderstanding is baseline testing. Our comprehensive eye examination benefit is an important baseline procedure. This service provides a great deal of information about the patient's eyes, health, vision, binocular functions and appropriate self-care. What is not necessary for every patient is the full scope of advanced documentation technologies that exist in the doctors' offices. Many of these technology-driven procedures, such as Pachymetry, fundus photography, corneal topography, nerve fiber layer and retinal tomography, OCT, HRT, GDX, ultrasonography, wave front analysis, macula pigment density testing, tear film chemistry and others still being developed are wonderful adjuncts to our knowledge base for diagnosis and treatment of specific disease processes; however, they are not medically necessary procedures in an otherwise healthy, asymptomatic patient. For this reason, these procedures will not be covered when provided as baseline testing and payment will be denied.

Medical Prior Approval Process

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

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

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

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

Claim Analysis and Physician Profiling

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

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

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

Emerging Technologies

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

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

13.0 Utilization Management – Protocols and Procedures

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

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

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

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

In this case the comprehensive examination should be coded as one of the following eye exam codes: 92002, 92004, 92012, 92014, S0620, or S0621

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

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

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

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

Incidental Medical Findings
In the course of virtually any eye exam a doctor can find some type of incidental medical condition. Examples include conditions such as dry eye, long standing strabismus or amblyopia, headache, long standing PVD, Asthenopia, pinquecula, blepharitis, folliculosis, or seasonal allergic conjunctivitis. These additional (non-refractive error) findings will not by themselves justify the reporting of this encounter as a medical eye examination. **The basis for reporting the service code (CPT) for any exam shall be primarily**

contingent on the patient's entering chief complaint, not incidental findings. The examination should be considered a comprehensive eye examination and should be billed as such using code 92002, 92004, 92012, 92014, S0620, or S0621, unless otherwise justified. The exception to this rule will be a situation in which the symptoms or findings are significant enough to prevent the completion of a comprehensive eye examination, including refraction. In this exceptional situation the visit may be billed as a medical office visit using the appropriate level 1, 2 or 3 E/M code (992XX). A routine examination may be rescheduled at any time after this condition has fully resolved.

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

A note on the use of wide field retinal imaging (e.g. Optomap) – Retinal photography (CPT 92250) of any type is not separately reimbursable when performed instead of a dilated fundus exam, or for documentation of normal retinal findings.

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

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

EPSDT

EyeQuest has established a protocol for making determinations for coverage of vision services that comply with state and CMS specific EPSDT criteria. These guidelines as they apply to enrollees under age 21, provide direction for how the Company reviews and communicates the approval of vision services. In all applicable cases, the company reviews the request for payment of services based on common standards for medical necessity. Determination shall not be solely dependent or contingent on state specific Medicaid program coverage limitations.

Referrals

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

Additional Program Limitations

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

1. Services that are the responsibility of another insurer and not the responsibility of EyeQuest should be billed directly to the responsible party. EyeQuest and the Plan will not pay these claims as the primary payer. They include:
   - Automobile accidents
   - Job-related/workers' compensation claims
   - Instances where Medicare is the primary payer
2. Services not covered by this program are the complete financial responsibility of the patient. Except where specifically indicated as a "covered service," EyeQuest and the Plan will not pay these claims. These services, supplies and materials include:
   - Refractive surgery, its complications, and postoperative care, including but not limited to:
     - Lasik
     - PRK
     - Intacs
     - Clear lens extractions

  - Implantable contact lenses
  - Radial keratotomy
- Any cosmetic surgery, including but not limited to:
  - Cosmetic Blepharoplasty
  - Botox
  - Collagen fillers
  - Skin tag removal
- Intraocular lenses not covered by primary Medicare
- Services provided as part of clinical trials
- Experimental procedures
- Unspecified services (any CPT XX999)
- Low vision services or devices

3. Services not covered by the EyeQuest Agreement with the Health Plan. Payment for specific routine and/or medical services or procedures is limited by the provisions and exclusions of any such Agreement. Providers may look to another payer for reimbursement for such excluded services.
4. Miscellaneous Medical Management Protocols (*applies only to contracts where EyeQuest is the Payer for such services*). EyeQuest fully appreciates that certain patients require extensive diagnostic and treatment services to manage their ophthalmic condition(s). We are also aware that certain additional testing and procedures are not contributory to the diagnosis and management of their eye problem. Knowing certain procedures are subject to overutilization, we have established certain restrictive protocols for payment of these services. Providers will not be reimbursed for the services below without full clinical justification. All cases are subject to peer review for payment. See Plan Specific Benefits for other reimbursement limitations.
   - Extended ophthalmoscopy (this code is not reimbursable when billed with retinal photography)
   - Retinal photography (this code is not reimbursable when billed with extended ophthalmoscopy)
   - Punctal occlusion
   - Posterior segment OCT or imaging
   - Anterior Segment OCT (this service is not reimbursable for angle estimation)
   - Topography

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

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

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

To avoid this potential denial, offices providing second opinions should attempt to submit for an MPA. This will ensure that such claims will be authorized for payment. If a claim is rejected by the system, an MPA should be requested before the bill is resubmitted for payment. The same criteria and process will be utilized for the retrospective review as is used for the usual MPA process.

Clinical Criteria for Common Procedures
The Company uses clinically relevant criteria for determining the medical necessity of certain procedures. Such protocols have been developed through the use of American Academy of Ophthalmology (AAO) or AOA best practice standards; CMS, Local Carrier Policy, Peer Review Committees, and common consensus of qualified ophthalmologists and optometrists. Representative examples for the more common procedures may be included in the Plan specific sections. Providers (and members) are welcome to ask for any EyeQuest Clinical Guidelines by contacting EyeQuest Provider Services.

Translator Services
Members have the right to timely access to care that does not have any communication or physical access

barriers. This includes having interpreters, if needed, during appointments with their vision provider and when talking to their vision plan. Interpreters include people who can speak in their native language, help someone with a disability, or help the Member understand the information. Please contact us for interpretation services should there be a language barrier with an EyeQuest patient.

13.1 Authorization Review

KRS 304.17A-600 to 304.17A-633 requires written procedures for coverage and utilization review determinations to be accessible on insurers' Web sites -- Preauthorization review requirements for insurers. (Effective January 1, 2020)

Access to Clinical Criteria

Requesting Participating Providers and Members can request applicable guidelines and clinical criterion by contacting the EQ UM department.

Time Frames

Unless specified differently by the Plan or regulation, determinations are completed within the following time frames from the receipt of the request:

a. Standard: two (2) business days
b. Emergent/Urgent: 24 hours
    - EyeQuest does not require any authorization for emergency services.
    - Emergent/Urgent authorizations from Ophthalmologists should be sent directly to Humana Healthy Horizons.

Denial and Approval Letters

Written notification of the approval within the following time frames:

a. Two (2) business days of a standard 2-day preauthorization determination.
b. Same day of an urgent 24-hour preauthorization determination.
    - Electronic notification via provider portal and/or email.

Authorization Listing

a. When adding or removing a preauthorization, a request is sent to the client/ State for review and approval.

b. After approvals are granted, the latest version of the authorization listing is updated in the ORM and made visible online that will reflect an effective or term date of the authorization.

c. In accordance with KRS 304.17A-603(4) (a) & (b). EyeQuest will not deny a claim for failure to obtain preauthorization requirements if the preauthorization was posted with an effective date at the time of the date of service referenced on the claim.

14.0 KENTUCKY Medicaid Copayment

There are no copayments applicable for members who receive Covered eye care services from an EyeQuest contracted provider.

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APPENDIX A (ATTACHMENTS)

General Definitions

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

A. "Benefits" are the services members are eligible to receive under a Plan Certificate of coverage.

B. "Contract" means the document specifying the services provided by EyeQuest to:
   - A Medicaid beneficiary, directly or on behalf of a Plan, as agreed upon between the State or its regulatory agencies or Plan and EyeQuest (a "Medicaid Contract")
   - A Medicare beneficiary, directly or on behalf of a Plan, as agreed upon between the Center for Medicare and Medicaid Services ("CMS") or Plan and EyeQuest (a "Medicare Contract")

C. "Covered Services" are those vision or eye care services or supplies that satisfy all of the following criteria:
   - Provided or arranged by a participating provider to a member;
   - Authorized by EyeQuest in accordance with the Plan Certificate; and
   - Submitted to EyeQuest according to EyeQuest' s filing requirements.

D. "EyeQuest Service Area" shall be defined as the specific counties within the state which the Plan has contracted with EyeQuest to provide covered services.

E. "Medically Necessary" or Medical Necessity means covered services which are medically necessary as defined under 907 KAR 3:130, meet national standards, if applicable, and provided in accordance with 42 C.F.R. 440.230, including children services pursuant to 42 U.S.C. 1396d(r). If it meets any one of the following standards:
   - The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition, or disability.
   - The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental, or developmental effects of an illness, condition, injury or disability.
   - The service or benefit will assist the individual in achieving or maintaining maximum functional capacity in performing daily activities, considering both the functional capacity of the individual and those functional capacities that are appropriate for individuals of the same age.
   - Determination of medical necessity for covered care and services must be documented in writing.

   The determination is based on medical information provided by the member, the member's family/caretaker and the eye doctor and PCP, as well as any other providers, programs or agencies that have evaluated the member.

   All such determinations must be made by qualified and trained health care providers. A health care provider who makes such determinations of medical necessity is not considered to be providing a health care service under this Agreement.

F. "Member" means any individual who is eligible to receive covered services pursuant to a contract and the eligible dependents of such individuals. A member enrolled pursuant to a Commercial Contract is referred to as a "Commercial Member." A member enrolled pursuant to a Medicaid Contract is referred to as a "Medicaid Member." A member enrolled pursuant to a Medicare Contract is referred to as a "Medicare Member."

G. "Participating Provider" is a vision or eye care professional or facility or other entity, including a provider that has entered into a written agreement with EyeQuest, directly or through another entity, to provide vision or eye care services to selected groups of members.

H. "Plan" is an insurer, health maintenance organization or any other entity that is an organized system which combines the delivery and financing of health care and which provides basic health services to enrolled members for a fixed prepaid fee.

I. "Plan Certificate" means the document that outlines the benefits available to members.

J. "Primary Care Practitioner (PCP)" is a specific physician, physician group or other health professional designated by a Plan operating under the scope of his/her licensure, and who is responsible for supervising, prescribing, and providing primary medical services; locating, coordinating, and monitoring other medical care and rehabilitative services; and maintaining continuity of care on behalf of a member.

EYEQUEST — MEDICAL AND SURGICAL PRIOR APPROVAL REQUEST/DETERMINATION

Submit by facsimile to: 1-888-696-9552 or email to: EyeQuest@dentaquest.com	KENTUCKY	Submittal Date: _____/_____/_____

Primary Carrier/Coverage?	**_____Humana Healthy Horizons in Kentucky**		
Member Identification #			
Member Name:		**Date of Birth:**	
Provider/Dr. NPI:		**EyeQuest User ID:**	
Provider/Dr. Name:		**Office Name:**	
Address:		**Phone Number:**	
City:		**Fax Number:**	

PROCEDURE/SERVICE(S) REQUESTED

CPT/ICD-(10)	Specified Eye	Place of Service	ASC or Facility Name
/	**OD OS OU**	**_____Office _____Facility**	
/	**OD OS OU**	**_____Office _____Facility**	
/	**OD OS OU**	**_____Office _____Facility**	
/	**OD OS OU**	**_____Office _____Facility**	

Are patient records included? Y or N

Additional information/comments (*if this is an urgent or stat request* *PA is not required*):

Submitting Office Contact Person:	**Phone:**

DETERMINATION/DISPOSITION

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

Request is deferred pending: [ ] Secondary review [ ] Receipt of additional information; specifically:

REQUEST REVIEWED BY:	SIGNED:	DATE OF DETERMINATION:

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

PATIENT FINANCIAL RESPONSIBILITY NOTICE AND DISCLAIMER

Directions and Use

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

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

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

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

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

MEDICAID FINANCIAL RESPONSIBILITY NOTIFICATION

Provider Name: _____

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

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

PROVIDER SECTION

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

_____

Date of Service: _____

List amount member will be responsible for: $_____

MEMBER SECTION

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

Member Name: _____

Member/Guardian Signature:_____ Date: _____

APPENDIX B - HEALTH PLAN SPECIFIC PROGRAM DETAILS

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

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

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

Humana Healthy Horizons in Kentucky

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

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

Program Type: Managed Care; Adult and Pediatric

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

Covered Lives: Enrollees of Humana Healthy Horizons in Kentucky

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

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

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

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

Ordering Eyewear: Placing your eyeglass orders is easy. The most efficient way is through the web portal. Once you register an account you will have access to a range of lab services including:

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

Additional details on supply and ordering eyewear through Classic is available in the EyeQuest web portal. Providers will find step-by-step instructions for ordering and supply of eyewear in the Portal Tutorial linked in the portal menu.

Submitting Claims: All claims will be submitted from the EyeQuest web portal. Claim submittal tutorial and detailed instructions for submitting claims is found in the Portal Tutorial.

Humana Healthy Horizons in Kentucky **MEDICAID CHILD and CHIP PROGRAM ENROLLEES** **Benefit Summary and Limitations – at a glance (for participating providers) Effective (ver.03.01.24)**	
Exam Services:	**KENTUCKY Medicaid CHILDREN , AND KY CHIP MEMBERS**
Eye Exam - Routine	• One exam (e.g. 92004, 92014) and refraction (92015) per Calendar Year. • No Exam benefit limitation for **foster children** per relocation requirement Additional coverage payable when medically indicated, and with prior authorization.
Optical Services:	***Covered glasses to be produced and supplied by Classic Optical****
Frames; standard	• One frame every Calendar Year. • No benefit limitation for **foster children** per relocation requirement
Lenses; standard	• One pair of lenses every **Calendar Year**. • Standard Covered lenses include SV, Bifocal, Trifocal, and Progressive Addition lens types • Polycarbonate/scratch coated lenses are covered as the standard material for all eyewear, if ordered by the provider (no PA required) • No benefit limitation for **foster children** per relocation requirement
Non-standard Lenses and optical features	According to KY 907 KAR 1:632, Nonstandard lens materials and features may be covered ONLY when medically indicated and necessary. *"The department shall not reimburse for:* *(1) Tinting if not medically necessary;* *(2) Photochromics if not medically necessary;* *(3) Anti-reflective coatings if not medically necessary;* *(4) Other lens options which are not medically necessary;* *(5) Low vision services;* *(6) A press-on prism if not medically necessary; or* *(7) A service with a CPT code or item with an HCPCS code that is not listed on the Kentucky Medicaid Vision Fee Schedule"*[1] Elective lens upgrades are not covered by Ky Medicaid or Anthem. See *section on coverage of non-standard Optica*l Services in this manual for additional details on the provision of elective lens features.
Replacement Eye Wear	One pair of replacement eyeglasses within the same calendar year period may be provided WITH prior authorization from EyeQuest, and if the need meets the criteria below. **Criteria: Rx change of not less than 0.50D,** loss or breakage of original pair, and medical necessity for replacement must be established.

Medically Necessary Contact Lenses [*Be advised that Humana Healthy Horizons members are not eligible for elective, non-medically necessary, contact lenses*]	KY DMS now covers up to a one-year supply of medically necessary contact lenses for adult and child recipients. Pursuant to KY administrative code 907 KAR 1:632 as of 1/1/23 KY DMS has established that "*the department shall reimburse for contact lenses substituted for eyeglasses if a medical indication prevents the use of eyeglasses*"[1] **Coverage is limited to a one-year (365 days) supply of conventional or disposable lenses, including 2, 4, 6, 12, 30 and 90 multipack lens types. Providers should bill EyeQuest using the applicable HCPCS code for contact lenses.** **Contact lens fitting and dispensing (e.g. 92310, 92313, 92072), is covered and payable once per calendar year for members who qualify for contact lenses. Additional coverage if indicated.** Coverage annually when such lenses provide superior, functional therapeutic management of a specified visual or ocular condition. Diagnosis including, but not limited to: • Keratoconus when vision with glasses is WORSE than 20/40 • Other corneal irregularity from any condition when vision with glasses is less than 20/40 • Anisometropia that is greater than or equal to 4D • Refractive Error > (+) 8.00D or (-) 10.00D total in any meridian • Other indications may apply [1] Multifocal lenses are not considered medically indicated in all cases. Bill EyeQuest for all approved, medically necessary contact lenses using regular V codes (e.g. V2531). Do not bill code V2599 for any contact lenses. Applicable KY DMS required modifiers are necessary for contact lens billing and reimbursement. See below for sample claims and additional mandated billing details.
Optometric Medical Eye Care Services	• Covered as indicated and necessary, subject to pre-certification, retrospective review and frequency limitations, where applicable.
Referral Requirements	• No referral is required for access to annual, routine eye care services or other optometric services.

Members identified as having diabetes are eligible for annual (every 12 months) routine eye exams, regardless of other symptoms or complaints. THIS ANNUAL VISIT DOES NOT REQUIRE PRIOR APPROVAL. To allow for claim payment providers should submit claims using the regular eye exam code (e.g. 92014), along with all applicable CPT II (e.g. 2022F), and ICD-10 diagnosis codes (e.g. E10.9, E11.9).

[1]This language is excerpted verbatim from KY 907 KAR 1:632, 907 KAR 1:631

2See Exhibit II in this Manual for Classic Lab lens medically necessary upgrades availability.

*Commercial, retailer offices may be contracted to supply their own materials
Non-covered lenses are not supplied by Classic Optical

Humana Healthy Horizons in Kentucky **MEDICAID PROGRAM - ADULT ENROLLEES** **Benefit Summary and Limitations – at a glance (for participating providers) (ver.082023)**	
Exam Services:	**KENTUCKY MEDICAID - ADULT RECIPIENT**
Eye Exam – "Routine"	• One exam (e.g. 92004, 92014, S0620, S0621) and refraction (92015) per calendar yr. Additional coverage payable when medically indicated, and with prior authorization.
Optical Services:	***Covered glasses to be produced and supplied by Classic Optical*****
Frames; standard *Lenses; standard*	One pair of covered-in-full eyeglasses per Medicaid guidelines (e.g. per 1 pair per calendar year*). Covered –in-full glasses include standard frames and lenses: Single Vision, or FT multifocal in CR-39 or Polycarbonate/scratch coated material. Std. lenses also "*Includes coverage of progressive lens prescriptions*" if requested. [1]. No PA is required to obtain standard glasses (e.g. from Classic Lab)** in these cases.
Non-standard Lenses and optical features – require medical necessity for coverage[2]	According to KY 907 KAR 1:632, Nonstandard lens materials and features may be covered ONLY when medically indicated and necessary. "*The department shall not reimburse for:* *(1) Tinting if not medically necessary;* *(2) Photochromics if not medically necessary;* *(3) Anti-reflective coatings if not medically necessary;* *(4) Other lens options which are not medically necessary;* *(5) Low vision services;* *(6) A press-on prism if not medically necessary; or* *(7) A service with a CPT code or item with an HCPCS code that is not listed on the Kentucky Medicaid Vision Fee Schedule*"[1] Elective lens upgrades are not covered by KY Medicaid. See Exhibit II-Clinical Criteria and section on non-covered eyewear in this manual for additional details on coverage of elective lens option upgrades.
Replacement Eye Wear	One pair of replacement eyeglasses within the same CALENDAR YR may be provided WITH prior authorization from EyeQuest, if the need meets the criterion below. **Criteria: Rx change of not less than 0.50D**, Loss or breakage of original pair AND Medical necessity for replacement must be established.
Elective Contact Lens coverage.	➢ **Members are not eligible for coverage of elective contact lenses or elective contact lens fitting and dispensing services.** ➢ **See details below on coverage of Medically Necessary contact lenses as provided for by DMS.** ➢ **Do not bill EyeQuest with code V2599 – This code is not valid for contact lens services.**

Medically Necessary Contact Lenses *[Be advised that Humana Healthy Horizons members are not eligible for elective contact lenses]**	KY DMS now covers up to a one-year supply of contact lenses per calendar year for adult recipients. Pursuant to KY administrative code 907 KAR 1:632 as of 1/1/23 KY DMS has established that Adult recipients are eligible for contact lenses when meeting certain medically necessary guidelines and criteria, as follows: *Coverage annually when such lenses provide superior, functional therapeutic management of a specified visual or ocular condition. Diagnosis including, but not limited to:* • *Keratoconus when vision with glasses is WORSE than 20/40* • *Other corneal irregularity from any condition when vision with glasses is less than 20/40* • *Anisometropia that is greater than or equal to 4D* • *Refractive Error > (+) 8.00D or (-) 10.00D in any meridian* • *Other indications may apply* [1] **Coverage is limited to a one-year (12 month) supply of conventional or disposable lenses, including 2, 4, 6, 12, 30 and 90 multipack lens types.** *Multifocal lenses are not considered medically indicated in all cases. **Contact lens fitting and dispensing (e.g. 92310, 92313, 92072), is covered and payable once per calendar year for members who qualify for contact lenses. Additional professional services may be covered when medically indicated.** Bill EyeQuest for all approved, medically necessary contact lenses using regular V codes (e.g. V2531)*. **Do not bill code V2599 for any contact lenses**. Applicable KY DMS required modifiers are necessary for contact lens billing and reimbursement. See below for sample claims and additional mandated billing details.
Optometric Medical Eye Care Services	• Covered as indicated and necessary, subject to pre-certification, retrospective review, and frequency limitations, where applicable. • Providers should review the applicable KY Administrative code (e.g. 907 KAR 1 632) for clarity on medical necessity. Covered medical services may also be limited by what is defined as a covered service in the *KY Dept. for Medicaid Services Vision Program Fee Schedule*.

Members identified as having diabetes are eligible for annual routine eye exams, regardless of other symptoms or complaints. THIS ANNUAL VISIT DOES NOT REQUIRE PRIOR APPROVAL. To allow for claim payment providers should submit claims using the regular eye exam code (e.g. 92014), along with all applicable ICD-10 diagnosis codes (e.g. E10.9, E11.9).

[1]This language is excerpted verbatim from KY 907 KAR 1:632

[2]See Exhibit II in this Manual for Classic Lab lens upgrades availability and associated fees.

*as of 9/1/23

**Commercial, retailer offices may be contracted to supply their own materials

CONTACT LENS CLAIM EXAMPLE (per 3/1/24 KY DMS revisions)*

DOS	Billed Code	Mod 1	Mod 2	Mod 3	Billed Amount	Billed Units	Allowable	Total Payable	What does this claim cover?
1/2/2024	V2521	U3	RT		350.00	1	326.52	326.52	this fee covers 4 boxes of 6 lenses to cover a 1 year supply of **2 WEEK** replacement lenses; for the right eye
1/2/2024	V2521	U3	LT		350.00	1	326.52	326.52	this fee covers 4 boxes of 6 lenses to cover a 1 year supply of **2 WEEK** replacement lenses; for the left eye
								$ 653.04	total payable for this claim

DOS	Billed Code	Mod 1	Mod 2	Mod 3	Billed Amount	Billed Units	Allowable	Total Payable	What does this claim cover?
1/2/2024	V2523	U3	RA	RT	90.00	1	85.29	85.29	this fee covers 1 REPLACEMENT box of 6 lenses to cover a 3 MONTH supply of **2 WEEK** disposable lenses; for the right eye
								$ 85.29	total payable for this claim

*Please refer to the KY DMS Vision Fee Schedule for reimbursement rates and additional coding details.

COVERED PROFESSIONAL SERVICES[1]

Optometry and Ophthalmology[2]

Office Visits	92002 – 92004 92012 – 92014 92015, S0620, S0621 99202 - 99215 99211 – 99215 992xx	New Patient; eye exam Established Patient; eye exam Determination of Refractive Error New Patient; evaluation and management Established Patient; evaluation and management Consultation Codes
Diagnostic Services	76512 76514 76519 83516/83861 92020 92025 92060 92065, 92066 92081-92083 92100 92136 92133, 92134 92201, 92202 92250, 92285, 92286 95930 92499 92273-74	B-Scan/A-Scan Pachymetry B Scan In office administered Labs Gonioscopy Topography Sensorimotor exam Orthoptics Visual Fields Tonometry; serial (LIMITED INDICATIONS) IOL Calculation-will not be reimbursed if cataract surgery is not performed Scanning OCT; optic nerve or retina Ophthalmoscopy; extended (not payable if billed with 92250) Photographic documentation (fundus screening is not covered) VEP (LIMITED INDICATIONS)
Office or facility-based surgery and procedures (not an all-inclusive list)	66983*, 66982*, 66984* 66821, 65855, 66761, 65778 68801, 68810, 65205-65222, 65778 66030, 67820, 67914 11900 w/J3301 68761 96110, 96111 96116 96121 97110, 97112	Within scope of O.D. Practice: Surgical Procedures, epilation, foreign body removal, et al. Amniotic Membrane, Punctal Occlusion, Surgical Co-management only,* Vision Therapy

	92310-92313	Medical fitting and supply of lenses, per K Y DMS defined
Contact Lens:	92317	benefits
Medical	92071	For Management of Surface Disease
	92072	For Management of Keratoconus
	V2500-V2531	HCPCS

[1] Covered services and covered codes are subject to change and subject to coverage limitations by the State and member benefits as defined by the Plan. Always refer to your EyeQuest Office Reference Manual for specific Plan benefits and precertification requirements as this list may not be complete.

[2] EyeQuest is not the payer for most surgery and certain professional services that are exclusively provided by an Ophthalmologist.

** Surgical Co-Management - Optometric post-operative co-management is reimbursable when provided according to CMS guidelines; Eligible Co-managed Codes – per CMS guidelines, Surgical Global Period: as defined*
Billing: claims should reflect the applicable post-operative management modifier - 55
Reimbursement Rate: 20% of allowable charges for co-managed procedures

NON-COVERED PROFESSIONAL SERVICES[1]

Optometry and Ophthalmology[2]
Kentucky

Diagnostic Services	92132 92145	Anterior segment OCT - Anthem CLINICAL GUIDELINES DO NOT ALLOW FOR THIS SERVICE AS MEDICALLY NECESSARY Corneal Hysteresis - not supported as medically indicated based on current peer reviewed literature
Office or facility-based surgery and procedures		• Cosmetic Surgical Procedures; including removal of skin lesions without demonstrated medical necessity. • Refractive Surgery of any kind • Co-management of any non-covered surgical procedure
Pathology/Radiology/Lab		Laboratory, radiology and pathology services are not reimbursed by EyeQuest
Low Vision Devices	V2600-V2615	Any nonstandard optical devices
Ocularist services	V27XX	Ocular prosthesis and ocularist services
Non-FDA Approved		No services without FDA approval and/or not covered by CMS

[1] Covered services are subject to coverage limitations by the State and member benefits as defined by the Plan. Always refer to your EyeQuest Office Reference Manual for specific Plan benefits and precertification requirements.

[2] EyeQuest is not the payer for most surgery and certain professional services that are exclusively provided by an Ophthalmologist. Some listed services may be covered services, ifand when provided by an Optometrist.

A. Providing Covered-in-Full Eyewear:
(APPLIES TO ALL EYEWEAR THAT IS COVERED-IN-FULL BY KY MEDICAID AND SUPPLIED BY CLASSIC OPTICAL)

This section applies to eyewear supplied for All Members (**Adult and Child**).
Members/patients requiring eyeglasses will select a frame from the standard sample kit, and also elect to receive standard, covered-in-full lenses. In these cases, the member will incur no out-of-pocket costs. the provider will proceed to order the materials from Classic as instructed, and the provider will automatically receive the designated dispensing fee (e.g., for 92340) from EyeQuest; i.e. the provider is not required to separately bill EyeQuest for the dispensing services.

Dispensing payments will also be made for approved replacements provided the replacement glasses are covered by Medicaid.

Plan-covered Lenses:
All covered lenses will be provided by the EyeQuest designated optical laboratory (*Classic*). Standard lenses include single vision, bifocal, trifocal (flat-top), and progressive lenses. Polycarbonate material is covered for children and adult glasses, when and if ordered by the provider. PA is not required for polycarbonate. If the provider feels the member/patient requires other medically necessary, non-elective optical features or non-standard materials, Prior Approval is required. See below for additional details on procedures for obtaining approval.

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

B. Providing Non-Plan Covered Eye Wear:
In some instances, members may desire to purchase non-covered lenses (or lens features, e.g., A/R coating), or they may wish to use their own frame or elect to purchase an upgraded frame directly from the provider. In these cases, the provider should proceed as indicated below.

Non-Plan Covered Lenses and or elective lens option upgrades are not covered. Members are welcome to purchase elective optical services if they are fully advised (with documented acknowledgement) of their financial responsibility.
Fees are based the provider usual and customary charges; whatever they wish to charge for these optional services. See Exhibit II for lab charge-back fees that will be debited from your remittance advice.

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

- The provider should clearly tell the patient/member that the requested optical service is not covered, and let the patient know what their out-of-pocket cost will be.
- The provider should formally document that the member understands their financial responsibility for such elective, non-covered service(s), and they have opted to pay such out-of-pocket fees.
- A signed Patient Responsibility form is recommended to avoid any misunderstanding later.
- The provider shall collect the applicable lens charges from the patient.
- Order the glasses with the optional services from Classic Optical in the usual way.
- Classic Optical will fabricate the glasses and send them back to your office for dispensing.
- Classic will bill EyeQuest for the optional buy-ups and EyeQuest will pass those costs along to the provider via a lab charge-back which will be detailed in your remittance advice
- The provider will be responsible any remake costs.

THE FINANCIAL TRANSACTION FOR NON-COVERED SERVICES IS BETWEEN THE PROVIDER AND THEIR PATIENT.

Non-Plan Covered Frames (elective upgrade):
If a member elects to not use a plan-covered frame, the provider shall proceed as follows:

- Forward the owned or purchased frame to *Classic* for lens supply. The frame should be sent via traceable shipping means; the cost of postage (to the laboratory) shall be payable by the provider. *Classic* is not responsible for replacing frames lost in transit, nor will they be responsible for replacement in the event of breakage. *Please be sure patients understand the laboratory is not responsible for breakage. A signed waiver is a good practice to follow*.
- When placing the laboratory order for lenses please indicate that a non-plan frame was selected. This will place the lens order and pend it for arrival of the frame.
- If the non-plan frame requires drilled mount or rimless mounting, the laboratory charges an additional fee of $25.00. Please add this amount to the members charge for the frame as it will be deducted from your payment.
- In the rare event that a patient-owned frame is lost in transit back to the provider's office, Classic shall be responsible for not more than $50 in reimbursement for replacement.

The Kentucky Medicaid Visual Services Program does not reimburse for:

- Low-vision therapy
- Low-vision devices
- Transition lenses-w/out medical indications
- Glass lenses

C. Providing the Adult Eyewear Benefit

As of January 1, 2023 the KY Medicaid program expanded eye wear coverage to adult recipients. The adult benefits mirror the child benefits, including full coverage for standard frames and lenses, as well as medically necessary contact lens coverage. See the KY Medicaid Adult Benefit Summary for additional details on the provision of this benefit.

D. Services Requiring Prior Approval (PA)

Although the majority of Covered Services are provided with no formal prior-approval, certain services require pre-approval to establish medical necessity. The specific services requiring Prior Approval, for this program, are detailed below.

Service Code	Description	Authorization Required	Notes
68020	Incision; conj; drainage of cyst	Pending state approval	
68040	Expression of conj follicle; e.g. for trachoma	Pending state approval	
66030	Injection of Medication; Ant. Chamber or eye	Pending state approval	
J7351	Intracameral Implant of Bimatoprost (Durysta)	Pending state approval	
65778	Placement of amniotic membrane; w/out suture	Y	All non-emergency cases
65855	Select Laser Trabeculoplasty	Y	All cases
66821	YAG Capsulotomy	Y	All cases
92065	Orthoptic/Pleoptic Training	Y	All cases
92072	Fitting of contact lens for the correction of keratoconus	Y	All cases
92250	Fundus Photography	Y	Only when exceeding two per 365 days
92083	Visual Field; threshold	Y	Only when exceeding two per 365 days
92133	OCT; optic nerve	Y	Only when exceeding two per 365 days
92134	OCT; retina	Y	Only when exceeding two per 365 days
92310	Fitting of contact lenses	Y	
92313	Fitting of contact lenses	Y	
92499	Unlisted Ophthalmological Service or Procedure	Y	All cases
95930	Visual Evoked Potential	Y	All cases
96110	Development Testing; Limited	Y	All cases
96112	Neurobehavioral status exam; additional hour	Y	All cases
96116	Neurobehavioral Status exam	Y	All cases
96121	Neurobehavioral status exam	Y	All cases
97110	Therapeutic procedure	Y	All cases

97112	Therapeutic procedure	Y	All cases
97530	Therapeutic activities; one-on-one contact	Y	All cases
V2410	Aspheric; single vision	Y	All cases
V2430	Aspheric; multifocal	Y	All cases
V2500	Contact Lens Pmma; Spherical	Y	All cases when requested for medical necessity
V2501	Contact Lens Pmma; Toric/Prism	Y	All cases when requested for medical necessity
V2502	Contact Lens Pmma; Bifocal	Y	All cases when requested for medical necessity
V2503	Contact Lens Pmma; for correction of color deficiency	Y	All cases when requested for medical necessity
V2510	Contact Lens; Gas Permeable; Spherical	Y	All cases when requested for medical necessity
V2511	Contact Lens; Gas Permeable; Toric Prism Ballast	Y	All cases when requested for medical necessity
V2512	Contact Lens; Gas Permeable; Bifocal	Y	All cases when requested for medical necessity
V2513	Contact Lens; Gas Permeable; Extended Wear	Y	All cases when requested for medical necessity
V2520	Contact Lens; Hydrophilic Spherical	Y	All cases when requested for medical necessity
V2521	Contact Lens; Hydrophilic Toric	Y	All cases when requested for medical necessity
V2522	Contact Lens; Hydrophilic Bifocal	Y	All cases when requested for medical necessity
V2523	Contact Lens; Hydrophilic Extended Wear	Y	All cases when requested for medical necessity
V2530	Contact Lens; Hybrid-Scleral Gas Impermeable (per lens)	Y	All cases when requested for medical necessity
V2531	Contact Lens; RGP Scleral Lens	Y	All cases when requested for medical necessity
V2744	Photochromatic add-on	Y	All cases
V2755	UV Filtration	Y	All cases
V2782/ V2783	High Index	Y	All cases

* Other conditions may be applicable in rare circumstances. Providers requesting coverage for nonstandard features should submit narrative request and full medical records for review .

Please use the appropriate CPT-4 Professional Services fitting code and applicable HCPCS code(s) for the materials provided (V2500-V2531).
Of note: PA is not required for dispensing of bandage contact lens

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

[2] In-office lab testing requires CLIA waiver and proof of a valid waiver certificate for reimbursement

Clinical Criteria and Guidelines

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

*PLEASE FIND INDIVIDUAL CRITERION ON THE EYEQUEST WEB PORTAL

Process for Obtaining the PA

Providers should utilize the EyeQuest web portal for submittal of PA requests[1]. To obtain pre-authorization for indicated services and surgeries proceed as follows:

1. For pre-certification of professional services complete the standard MPA Authorization Template form as indicated, using the applicable CPT, ICD codes and by adding contributory narrative comments when necessary.
2. For Precertification of optical services or eyewear (replacement, etc.), use the EyeQuest web portal for submittal of requested services
3. Attach the clinical/medical record documentation
4. Verify the submitted information is accurate and Fax to EyeQuest at: [1-888-696-9552].
5. EyeQuest Medical Management will make the initial determination and notify the requesting provider with a DENIAL OR APPROVAL. The PA reply will include an authorization number for the physician component and the facility; the authorization number will be the same for both entities.

[1]Note: If you do not have access to the web please complete and submit the manual MPA form to EyeQuest by facsimile, or send by secure email to [EyeQuest@dentaquest.com.] Fax: [1-888-696-9552]

Time Frames

Allow up to 2 BUSINESS **DAYS** for receipt of determination on a prior authorization request.

E. Quality Initiatives

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

All eye doctors are aware of the importance of and clinical indications for providing all diagnosed diabetic patients with a full dilated retinal exam, not less than annually. NOTE: No PA is required for members with diabetes who present annually for a routine (asymptomatic) eye exam.

HEDIS: Our Health Plan clients are charged with measuring and monitoring the frequency with which their diabetic members receive this service. To improve the capability of documenting this this exam, CMS has implemented the use of specific CPT II codes on applicable claims submitted to payers. Per those CMS guidelines EyeQuest is requiring our providers to submit these additional service codes for **all diabetic patients** examined. The process and procedures are detailed below.

1. For all patients presenting with a medical history positive for diabetes; perform the usual eye exam including dilation and retinal evaluation;
2. Document the findings of the exam in the medical record per your usual protocol;
3. Submit the claim for services with the following documentation:
   a. Use the applicable exam CPT-4 code, (e.g., 92004, 92014)
   b. Include the additional (applicable) CPT II code 2022F and 3072F
   c. Select and include the applicable diabetes diagnosis code, e.g., **E10.9, E11.9;**
4. Summarize the findings and submit the summary of findings to: (i) the member's PCP.

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

CODE	DESCRIPTION
2022F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist; documented and reviewed; WITH EVIDENCE OF DIABETIC RETINOPATHY
2023F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist, documented and reviewed; W/OUT EVIDENCE OF DIABETIC RETINOPATHY
3072F	Absence of retinopathy at most recent dilated retinal exam.

Glaucoma Screening — submitting supplemental billing code G0117

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

Conditions of Coverage:

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

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

Components of the Glaucoma Screening include:

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

The following HCPCS code applies for a Glaucoma Screening:

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

EXHIBIT II

Criteria for Medically Indicated Non-Standard Optical Services			
Service Description	**HCPCS**	**Basic Clinical Criterion for Coverage***	**LAB CHARGE-BACK FOR ELECTIVE OPTICAL BUY-UP (PER PAIR)****
Non-Standard Frame (e.g. miraflex type or style)	V2025	• **Age 5 or younger** • **Rx in a CHILD over + / - 5.00D** • **"Small face" or "wide bridge"** • **Downs syndrome or other "special needs"** • **C.P. or other developmental issues** • **Seizure disorders** • **Any provider noted history of "multiple breakage of standard frames"**	**N/A**
Polycarbonate	V2784	• **Polycarbonate is standard material; Covered for all Child and Adult members <u>if and when</u> ordered by the provider. NO PA IS REQUIRED.**	**N/A**
Aspheric; single vision Aspheric; bifocal	V2410 V2430	• **Refractive error ≥ + 5.00 diopters in any meridian**	**$60**
Photochromatic	V2744	• **Significant Photophobia with documented underlying etiology including any of the following diagnoses:** ○ **Aniridia** ○ **Iris Coloboma** ○ **Rod, Cone, or Choroidal Dystrophy** ○ **Ocular Albinism**	**$70 SV** **$85 MF**
Solid /Gradient Tint	V2745	• **Significant Photophobia with documented underlying etiology including any of the following diagnoses:** ○ **Aniridia** ○ **Iris Coloboma** ○ **Rod, Cone, or Choroidal Dystrophy** ○ **Ocular Albinism** ○ **Significant Corneal Opacities or scarring**	**$8**
Ultra Violet Coating	V2755	• **Aphakia; Pseudophakia** • **Systemic photosensitizing medication**	**$12**
A/R Coating	V2750	• **Noncovered service; no medical indications apply**	**$40**
Rimless Mount or Drill Mount (or other Mscll)	V2799	• **Noncovered service; no medical indications apply**	**$25**
Polarized	V2762	• **Noncovered service; no medical indications apply**	**$38**
Edge Polish or edge coat (deluxe lens feature)	V2702	• **Noncovered service; no medical indications apply**	**$12**
Prism	V2710, V2715, V2718	• **Covered to manage or correct diplopia or strabismus.** • **NO PA REQUIRED.**	**N/A**
Progressive lens	V2781	• **As of 1/1/23- This is a standard covered lens type for Adults and Children**	**N/A**

High Index; greater than or equal to 1.60.	V2782 V2783	**Covered when Rx is > +/- 8D total power in any meridian.** **Covered when Rx is > +/- 10D total power in any meridian.**	**$60** **$85**
*other, individual patient indications may apply. ** Providers are welcome to charge their patient their U & C fee for any non-covered, elective optical add-on features			