



CookChildren's SM

Health Plan



Denton, Hood, Johnson, Parker, Tarrant and Wise Counties

Vision and Medical Optometry Provider Manual

Administered by

**National Vision Administrators, L.L.C.
(NVA)**

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National Vision Administrators (NVA) provides flexible vision care programs that are customized to meet the needs of our clients, yet also help serve the needs of our eye care professionals. NVA maintains vision care professional networks including ophthalmologists, optometrists, and opticians in all 50 states and Puerto Rico.

NVA recognizes the eye care professional as the primary component of vision care delivery and has incorporated the following services to better assist you, the eye care professional:

- No enrollment fees
- Use of your own on-site laboratory with option for a dedicated laboratory
- Twice-monthly payment cycles
- Web site services: request authorizations, submit claims and view claims history
- Dedicated toll-free line for use by NVA participating eye care professionals only
- Integrated Voice Response system to speed access to eligibility and payment information related to provided services
- Responsive Network Support department with eye care professional service "Help Desk"
- Specially trained Eye care Professional Service Representatives devoted to assisting our participating eye care professionals.

NVA has entered into an agreement to provide vision benefit services to the Children's Health Insurance Program (CHIP), Medicaid STAR and STAR Kids members of Cook Children's Health Plan (CCHP). Children in Texas without health insurance are able to get low cost or free health coverage from the CHIP. The CHIP program covers office visits, prescription drugs, dental care, eye exams, eyeglasses and much more.

STAR is a managed care Medicaid program through which most people in Texas get their Medicaid coverage.

STAR Kids is a new Texas Medicaid managed care program that will provide Medicaid benefits, beginning November 1, 2016, to children and adults 20 and younger who have disabilities. Participation in the STAR Kids program is required for those who are 20 or younger, covered by Medicaid, and meet at least one of the following:

- Get Supplemental Security Income (SSI).
- Get SSI and Medicare.
- Get services through the Medically Dependent Children Program (MDCP) waiver.
- Get services through the Youth Empowerment Services (YES) waiver.
- Live in a community-based intermediate care facility for individuals with an intellectual disability or related condition (ICF/IID) or nursing facility.
- Get services through a Medicaid Buy-In program.
- Get services through any of the following Department of Aging and Disability Services (DADS) intellectual and developmental disability (IDD) waiver programs.
 - Community Living Assistance and Support Services (CLASS)
 - Deaf Blind with Multiple Disabilities (DBMD)
 - Home and Community-based Services (HCS)
 - Texas Home Living (TxHmL)

The service area for the CCHP Program includes Denton, Hood, Johnson, Parker, Tarrant and Wise Counties.

The ability to serve participants effectively is dependent on the quality of the provider network. By joining the network, you are helping us serve eligible individuals by providing high-quality and accessible services and supports. You and your office staff represent one of the most critical components of our service delivery approach.

This manual is intended to serve as an extension of our provider agreement. It includes valuable information to help you and your office staff understand our program and provides helpful tips on how to work with members.

Quick Reference Phone List

General Mailing Address

National Vision Administrators
P.O. Box 2187
Clifton, NJ 07015

Departments

Provider Services (CHIP & STAR) for member eligibility, benefits, claims status, payments, complaints, or general questions
888-830-5630

Provider Services (STAR Kids) for member eligibility, benefits, claims status, payments, complaints, or general questions
888-552-4639

Network Development/Credentialing

E-mail address for Provider Services Department for change of address, telephone number or to add associate(s)

providers@e-nva.com or credentialing@e-nva.com

Paper Claims, Medical & Ancillary Prior Approval Requests, Complaints and Appeals

Email:

CookVisionCare@e-nva.com

Mail:

National Vision Administrators
P.O. Box 2187
Clifton, NJ 07015

Peer to Peer Discussion Requests

PriorApprovals@e-nva.com

Lab Order Inquiries for checking on the status of an order or making changes to an order
888-522-2020

Translation Services

NVA provides translation services for members who speak languages other than English. Call Member Services at 877-636-2576 (CHIP), 877-236-0661 (STAR), and 877-866-0384 (STAR Kids) for assistance. A Member Services Representative will put you in touch with someone who speaks their language.

TDD (Hearing Impaired)

888-820-2990

Fraud Hotline

888-328-0421

Provider Responsibilities

Patient Eligibility and Verification

Plan Eligibility

Any person who is enrolled in a Plan's program is eligible for benefits under the Plan.

Member Identification Card

CCHP members receive identification cards from the Plan. Participating Providers are responsible for verifying that Members are eligible at the time services are rendered and to determine if recipients have other health insurance.

NVA recommends that each Vision or Eye Care office make a photocopy of the member's identification card each time treatment is provided. It is important to note that the health plan identification card is not dated and it does not need to be returned to the health plan should a member lose eligibility. Therefore, **an identification card in itself does not guarantee that a person is currently enrolled in the health plan.**

To be sure that a member is eligible for benefits at the time of service, you may verify eligibility with NVA, either by utilizing the on-line system, or by telephone (see below).

Member Identification Card Samples

CCHP CHIP

ID Card Sample

CookChildren's Health Plan		CHIP/CHIP PERINATE NEWBORN Member Identification Card Tarjeta de identificación de socio	
Member name: Nombre de miembro	DOB: Fecha de nacimiento	Plan eff. date: Fecha de efectivo	PCP phone: Teléfono de PCP
Member ID no: Número de ID individual			
PCP: PCP			
PCP effective date: Fecha de efectivo del PCP			
RX benefit: Beneficio de Farmacia	Co-pay*: Copago	Benefit: Beneficio	Co-pay*: Copago
Brand: Marca		OPV: Visita de oficina	
Generic: Genérico		ER: Emergencia	

*Co-payments and cost-sharing do not apply to CHIP Perinate Newborn Members
Copagos e costos compartidos no aplican para CHIP Perinate recién nacidos.

TDI

In case of emergency, call 911 or go to the closest emergency room. After treatment, call your child's PCP within 24 hours or as soon as possible.
En caso de emergencia, llame al 911 o vaya a la sala de emergencias más cercana. Después de recibir tratamiento, llame al PCP de su hijo dentro de 24 horas o tan pronto como sea posible.

Member services hours: 8 a.m. to 5 p.m. at 662-885-2247 or 1-800-964-2247
Horario de Servicios para Miembros: 8 a.m. a 5 p.m.

To leave a message (24 hours/7 days a week): 662-885-2247 or 1-800-964-2247
Para dejar un mensaje (24 horas al día, 7 días a la semana)

For vision, call National Vision Administrators at 1-877-930-2576
Para visión, llame a National Vision Administrators

Behavioral health services hotline: Beacon Health at 1-855-481-7045
(Available 24 hours, 7 days a week)
Línea gratuita para Servicios de la Salud Mental: Beacon Health al 1-855-481-7045

24-hour nurse advice line: 1-866-671-2665
Línea de Consejo de Enfermeros disponibles 24 horas al día

For member pharmacy information: 1-800-964-2247
Para información sobre Farmacias para Miembros

For pharmacies and prescribers only: 1-877-908-6023

Send claims to:
Cook Children's Health Plan
P.O. Box 961295
Fort Worth, TX 76161

Note: This card does not guarantee coverage. Call 1-800-964-2247 to confirm member eligibility.

Nota: Esta tarjeta no garantiza cobertura. Llame a 1-800-964-2247 para confirmar elegibilidad.

CCHP STAR (Medicaid)

CookChildren's Health Plan		Member Identification Card (Tarjeta de identificación de socio)	
Member Name: Nombre de miembro	DOB: Fecha de nacimiento	Plan eff. Date: Fecha de efecto	PCP Phone: Teléfono de PCP
ID no: Número de ID individual			
PCP: PCP			
PCP Effective Date: Fecha de efecto de PCP			
Member Services: (8 a.m. – 5 p.m.) Horario de Servicios para Miembros: 8 a.m. a 5 p.m.	662-885-2247 or 1-800-964-2247		
To leave a message (24 hours/7 days a week): Para dejar un mensaje (24 horas al día, 7 días a la semana)	662-885-2247 or 1-800-964-2247		

In case of emergency, call 911 or go to the closest emergency room. After treatment, call your PCP within 24 hours or as soon as possible.
En caso de emergencia, llame al 911 o vaya a la sala de emergencias más cercana. Después de recibir tratamiento, llame al PCP de su hijo dentro de 24 horas o tan pronto como sea posible.

For vision, call Opticare at 1-888-835-7612
Para visión llame a: Opticare

Behavioral Health Services Hotline: Beacon Health at 1-855-481-7045
(Available 24 hours, 7 days a week)
Línea gratuita para Servicios de la Salud Mental: Beacon Health al 1-855-481-7045

24 Hour Nurse Advice Line: 1-866-671-2665
Línea de Consejo de Enfermeros disponibles 24 horas al día

For Member Pharmacy Information: Call CCHP at 1-800-964-2247
Para información sobre Farmacias para Miembros

For Pharmacies and Prescribers ONLY: Call 1-877-908-6023

Send Claims to:
Cook Children's Health Plan
P.O. Box 961295
Fort Worth, TX 76161

Note: This card does not guarantee coverage. Call 1-800-964-2247 to confirm member eligibility.
Nota: Esta tarjeta no garantiza cobertura. Llame a 1-800-964-2247 para confirmar elegibilidad.

CCHP STAR Kids

CookChildren's Health Plan		STAR KIDS Member Identification Card Tarjeta de identificación de socio	
Member Name: Nombre de miembro	DOB: Fecha de nacimiento	Plan eff. Date: Fecha de efecto	PCP Phone: Teléfono de PCP
ID no: Número de ID individual			
PCP: PCP			
PCP Effective Date: Fecha de efecto de PCP			
Service Coordinator Coordinador de Servicios	662-303-0004 and 1-844-843-0004, option 3		
Member Services (8 a.m. – 5 p.m.): Horario de Servicios para Miembros: 8 a.m. a 5 p.m.	662-303-0004 and 1-844-843-0004		
To leave a message (24 hours/7 days a week): Para dejar un mensaje (24 horas al día, 7 días a la semana)	662-303-0004 and 1-844-843-0004		

In case of emergency, call 911 or go to the closest emergency room. After treatment, call your child's PCP within 24 hours or as soon as possible.
En caso de emergencia, llame al 911 o vaya a la sala de emergencias más cercana. Después de recibir tratamiento, llame al PCP de su hijo dentro de 24 horas o tan pronto como sea posible.

For vision, call National Vision Administrators at 1-877-930-2576
Para visión llame a: National Vision Administrators

Behavioral health services hotline: Beacon Health at 1-855-481-7045
(Available 24 hours, 7 days a week)
Línea gratuita para Servicios de la Salud Mental: Beacon Health al 1-855-481-7045

24-hour nurse advice line: 1-866-671-2665
Línea de consejo de enfermeros disponibles 24 horas al día

For member pharmacy information: 662-303-0004 and 1-844-843-0004
Para información sobre farmacias para miembros

For pharmacies and prescribers only, call Navitus: 1-877-908-6023

Send claims to:
Cook Children's Health Plan
P.O. Box 961295
Fort Worth, TX 76161

Long-term care benefits only: You receive primary, acute and behavioral health services through Medicare.
You receive only long-term care services through Cook Children's Health Plan.
Para servicios y atención a largo plazo solamente: usted recibe sus servicios primarios, agudos, y del comportamiento de Medicare. Usted recibe solamente servicios y atención a largo plazo por Cook Children's Health Plan.

Eligibility System

The most convenient method of accessing eligibility is by utilizing NVA's Vision and Eye Care interactive website (www.e-nva.com). After logging in, you will have the opportunity to verify eligibility for any member. Once verified, you will receive a control number, for any covered service (**routine services only**) provided within thirty (30) days of the date of verification. This number should be maintained as it will be required for future inquiry and to track claims payment.

Participating providers who do not have access to the internet may also access eligibility information and receive control numbers by calling the Customer Service Department at 888-830-5630 (CHIP/STAR) or 888-552-4639 (STAR Kids).

When verifying eligibility, you will be provided with patient specific benefit information which may include:

- Examination Only
- Materials Only
- Examination and Materials
- Medical Services
- Copayments if applicable

For Medical Services, you may verify eligibility using the NVA portal; however, no control number will be provided for medically necessary services

Self-Referral Benefit

The routine vision examination benefit is available to covered members without the requirement for a referral from the member's Primary Care Provider (PCP).

Availability and Accessibility

Appointment Availability

Access to Providers must be available to Members for routine, urgent, and emergent care as follows:

Waiting times for appointments:

- emergency services must be provided upon Member presentation at the service delivery site, including at non-network and out of area facilities
- treatment for an Urgent Condition, including urgent specialty care, must be provided within twenty four (24) hours
- routine primary care must be provided within fourteen (14) days
- Primary Care Providers must make referrals for specialty care on a timely basis, based on the urgency of the Member's medical condition, but no later than thirty (30) days

Acceptable after-hours coverage:

1. office telephone is answered after-hours by an answering service that meets language requirements of the Major Population Groups and that can contact the Provider or designated practitioner. All calls answered by an answering service must be returned within thirty (30) minutes
2. office telephone is answered after normal business hours by a recording in the language of each of the Major Population Groups served, directing the patient to call another number to reach the Provider or another provider. Someone must be available to answer the designated provider's telephone. Another recording is not acceptable
3. office telephone is transferred after office hours to another location where someone will

answer the telephone and be able to contact the Provider or another designated provider, who can return the call within thirty (30) minutes.

Monitoring Access

NVA is required to systematically and regularly verify that Covered Services furnished by network providers are available and accessible to Members in compliance with the standards established by the Texas Health and Human Services Commission (Texas HHSC). NVA will periodically utilize a mandatory challenge survey to verify Provider information and monitor adherence to provider requirements.

At a minimum, the challenge survey will include verification of the following elements:

- provider name
- address
- phone number
- office hours
- days of operation
- practice limitations
- languages spoken
- provider type / provider specialty
- length of time a patient must wait between scheduling an appointment and receiving treatment
- accepting new patients

NVA will enforce access and other network standards as required by the Health and Human Services Commission and take appropriate action with noncompliant providers.

EMERGENCY SERVICES

Nothing contained in this manual is intended to prevent, or retard, the provision of medically necessary services when a provider determines that the patient is at risk and that a medical emergency exists.

Statement on Medical Emergencies from Cook Children's Health Plan (CCHP)

Emergency Care – CCHP pays for emergency care in and out of the area. Emergency care is defined as health care services provided in a hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

- placing the patient's health in serious jeopardy;
- serious impairment to bodily functions;
- serious dysfunction of any bodily organ or part;
- serious disfigurement; or
- in the case of a pregnant woman, serious jeopardy to the health of the fetus.

The Provider should render care if appropriate or immediately direct the member to call 911 or go to the nearest emergency room or comparable facility if the provider determines an emergency medical condition exists. If an emergency condition does not exist, the provider should direct the member to a CCHP participating office. CCHP does not require that the member receive approval from the health plan or the PCP prior to accessing emergency care. To facilitate continuity of care, CCHP instructs members to notify their PCP as soon as possible after receiving emergency care. Providers are not required to notify CCHP Care Management about emergency care services

Routine, Urgent and Emergency Conditions

NVA follows the Texas Health and Human Services Commission definition of emergency medical condition and emergency behavioral health condition. Based on the following definitions, CCHP Members may call 911 or seek care from any provider in an office, clinic, or emergency room. Treatment for emergency conditions does not require prior authorization or a referral from the Member's Primary Care Provider. Emergency Care staff should contact the Member's Primary Care Physician or NVA's toll free at 888-830-5630 (CHIP/STAR) or 888-552-4639 (STAR Kids) if a Member presents with an emergent condition.

Routine Care

Routine care means health care for covered preventive and medically necessary health care services that are non-emergent or non-urgent.

Urgent Condition

Urgent condition means a health condition including an urgent behavioral health situation that is not an emergency but is severe or painful enough to cause a prudent layperson, possessing the average knowledge of medicine, to believe that his or her condition requires medical treatment evaluation or treatment within twenty four (24) hours by the Provider or designee to prevent serious deterioration of the Member's condition or health.

Emergency Medical Condition

An emergency medical condition means a medical condition manifesting itself by acute symptoms of recent onset and sufficient severity (including severe pain), such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical care could result in:

- placing the patient's health in serious jeopardy
- serious impairment to bodily functions
- serious dysfunction of any bodily organ or part
- serious disfigurement

Requirements for Scheduling Appointments

Eye Care Providers shall offer member access to covered services 24 hours a day 7 days a week. Such access shall include regular office hours on weekdays and availability by telephone outside of such regular hours including weekends and holidays.

Credentialing and Re-credentialing

NVA, in conjunction with the Plan, has the sole right to determine which Providers (O.D., M.D., D.O., or Opticians) it shall accept and continue as Participating Providers. Providers must be enrolled with Medical Assistance and have a valid Medicaid number, which shall be verified by NVA. The purpose of the credentialing plan is to provide a general guide for the acceptance, discipline and termination of Participating Providers. NVA considers each Provider's potential contribution to the objective of providing effective and efficient Vision and Eye Care services to Members of the Plan.

NVA's credentialing process adheres to National Committee for Quality Assurance (NCQA) guidelines as the guidelines apply to ancillary services.

Nothing in this Credentialing Plan limits NVA's sole discretion to accept and discipline Participating Providers. No portion of this Credentialing Plan limits NVA's right to permit restricted participation by a vision office or NVA's ability to terminate a Provider's participation in accordance with the Participating Provider's written agreement, instead of this Credentialing Plan.

The Plan has the final decision-making power regarding network participation. NVA will notify the Plan of all disciplinary actions enacted upon Participating Providers.

Discipline of Providers

NVA believes in and works hard to maintain positive professional relations with our provider network. In rare instances, it may become necessary to discipline a provider up to and including termination from the program. NVA maintains the right to take such action under the terms of the Provider Agreement that all providers are required to sign prior to beginning participation.

Re-credentialing

Network Providers are re-credentialed at least every 36 months as required by the plan.

Note: The aforementioned policies are available upon request by contacting NVA's Provider Services Department at 888-830-5630 (CHIP/STAR) or 888-552-4639 (STAR Kids) or via e-mail at providers@e-nva.com.

Practice Guidelines - ROUTINE CARE

Examination Standards

An intermediate or 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/numerical findings where appropriate.

A. Current Status

1. Patient demographics (age/DOB, 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.

B. 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 the best corrected visual acuity at distance and near.
3. Gross and quantitative evaluation of color vision and the accommodative and binocular abilities of the patient.

C. Eye Health Assessment

1. Evaluation of external structures: lids, lashes, conjunctiva, gross visual fields, and pupil anatomy and responses (direct, indirect, accommodative, and afferent defects).
2. Bio-microscopic examination of the cornea, 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 when professionally indicated.

D. Disposition

1. List all diagnoses, prescriptions and treatment recommendations including, but not limited to:
 - a. Refractive and eye health diagnoses.
 - b. Eyeglass and contact lens prescriptions.
 - c. Medications prescribed and/or treatment plans.
 - d. Patient education on their ocular status and any increased risk factors for any personal or family conditions.
 - e. Recall/re-examination/referral recommendations
2. Doctor's signature and date

The Patient Record

A. Organization

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

- a. Patient's first and last name.
- b. Parent or guardian's name, if appropriate.
- c. Date of Birth.
- d. Gender.
- e. Race.
- f. Address.
- g. Telephone number/numbers.
- h. Emergency contact person and telephone number.
- i. Primary care physician.
- j. Medicaid 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 Non-Covered 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 routine examination, the patient examination record should contain all of the information including the recording of all of the detailed qualitative and quantitative information as described in the examination standards, above.

Emergency and non-routine examination visits should contain all of the relevant clinical data and history to adequately describe the

situation/condition at hand and support the diagnoses and treatments provided as appropriate for the situation.

C. Compliance

All entries in the record are 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 (7) years or the time period required by the State Board of Registration, whichever is greater. For minors, records must be maintained until they reach majority (age 18), plus seven (7) years at minimum.

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

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

VISION AND EYE CARE GUIDELINES

The following are guidelines to be applied in the delivery of services to members. The purpose of these guidelines is to set forth the general guidelines of the professions; however, the plans may have specific guidelines which should be followed.

Recommended Eye Care

Patient Age Group	Recommended Eye Exam
Birth to 24 months	First exam by six months of age
Ages 2 to 5 years	Exam at age 3
Ages 6 to 21 years	Before first grade (then at least every 2 years)

Persons in certain high-risk categories, however, should follow their Provider's advice on how often they need professional care. Examples of these include:

Patient Age Group	Recommended Eye Exam
Birth to Age 5	Low birth weight infants Mothers who had rubella AIDS-related infection Substance abuse Other medical problems during pregnancy High degree of near-sightedness High degree of farsightedness or astigmatism Family history of eye disease Suspicion of eye turn (strabismus)
Ages 6 to 21 years	Children failing to progress educationally Exhibiting reading or learning disabilities Diagnosed with diabetes or hypertension

	Family history of glaucoma Difficulty with vision Drugs with ocular side effects
--	--

Cultural Competency

Sensitivity and Awareness

Cultural and linguistic competency is defined as a set of linguistic, human interaction, and ethnic, cultural, and physical and mental disability awareness skills that permit effective communication and interaction among human beings. The term culture, in this definition, also includes the beliefs, rituals, values, institutions and customs associated with racial, ethnic, religious or social groups and individuals of all nationalities. Understanding and maintaining sensitivity to all of the factors that impact human behavior, attitudes and communications is integral to assuring the provision of quality, compassionate and effective health care services to the Members of Cook Children's Health Plan.

Cultural (or multicultural) competency is addressed in this plan from two perspectives:

- human interaction and sensitivity and
- culturally effective health care services to CCHP members by network providers

Physicians and other health care practitioners are compelled to understand the customs, rituals, and family values of the various cultural groups (in addition to assuring effective linguistic translations/communications) of their patients in order to provide quality and effective health care.

Within the service area of CCHP, many diverse cultural groups are represented. It is the beliefs, customs, languages, rituals, values and other aspects of the North Texas regional population which must be understood and addressed by NVA staff and affiliated providers in order to provide quality service and quality, effective care. NVA will, as part of this Plan, conduct an education and training program on cultural competency described below:

Employee Training - NVA hires a diverse group of employees in all levels of our organization. NVA does not discriminate with regard to race, religion or ethnic background when hiring staff. All new employees will be trained on this Plan. All employees will have access to the Plan as a guide for providing culturally competent services to Members.

Provider Training – NVA contracts with a diverse provider network. NVA's providers speak a wide array of languages including Spanish, Vietnamese, Chinese and Hindi to name a few. NVA's Provider Directory includes the languages spoken in the provider offices to assist Members with selecting a provider that would meet their needs as well as having the ability to directly speak to the provider in their language.

Providers should educate themselves about the health care issues common to different cultures and ethnicities. When an encounter with a patient is difficult due to cultural barriers, they should prepare for future visits by researching and asking for the patient's input.

Language Translation Services

NVA provides several options for the non-English speaking or hearing impaired Members (or their parents). NVA will coordinate language translation services with the provider as needed. These

options are described in the sections below.

In House Translation Services

NVA employs bilingual staff members in the Member Services and Claims departments. NVA's bilingual staff are available for Spanish translation services Monday through Friday from 8:00AM-5:00PM by calling toll free 888-830-5630 (CHIP/STAR) or 888-552-4639 (STAR Kids).

Language Line Solutions

NVA subscribes to Language Line Solutions translation services for spoken languages around the world. This service is available to our Members 24 hours per day, 7 days per week. NVA have been trained on how to access this line in order to communicate with Members from essentially all ethnic groups.

Covered Services

Examination

Star Members

Eligible members under age 21 are covered for one (1) routine eye examination, consistent with CPT codes 92002, 92004, 92012 or 92014 with Refraction (92015) once in each benefit period, which is the fiscal year (September 1st to August 31st).

Adults are covered as of age 21.

Eligible members age 21 and above are covered for one (1) routine eye examination, consistent with CPT codes 92002, 92004, 92012 or 92014 with Refraction (92015) once every two years, which is based on the fiscal year (September 1st to August 31st of the following year).

CHIP Members

Eligible members are covered for one (1) routine eye examination, consistent with CPT codes 92002, 92004, 92012 or 92014 with Refraction (92015) in each benefit period, which will vary based on the members enrollment date. *Please note: CHIP members are covered until the last day of the month in which they turn 19 years of age.*

This examination is available without the need for referral and should include a refraction and dilation (when professionally indicated).

STAR Kids Members

Eligible members are covered for (1) routine eye examination, consistent with CPT codes 92002, 92004, 92012, or 92014 with Refraction (92015) once in each benefit period, which is the fiscal year (September 1st to August 31st). If a comprehensive examination cannot be completed within the allotted time due to difficulties with a particular patient, a second visit may be scheduled to complete an examination. One of these visits may be billed as a 92004 and the other as an E/M 992XX visit. Additional follow-up visits may be provided as needed as level 1 or 2 (992XX) visits.

Additional Examinations – Child or Adult

When an additional examination, within the same benefit period, is required due to a referral from a physician, school nurse, etc., or due to a required change of prescription of at least +/- 0.50 diopters or 10° of axis, a Prior Approval request must be completed through the NVA website portal or the Routine Prior Approval Form (see page 58-59) must be signed and submitted.

Medical and Ancillary Services

NVA is the responsible party for all vision and eye care related services provided by participating optometrists. Members requiring medical eye services, including ancillary diagnostic testing, may receive such services, and all claims must be submitted on a CMS 1500 form directly to NVA at the billing address provided in the Contact Section of this manual. All Medical and Ancillary Services are subject to the Utilization Management and Prior Authorization processes as outlined in this manual.

For Medical Claims, please use the following address:

NVA-Health Plans
P.O. Box 2187
Clifton, NJ 07015

Dispensing

In instances where a patient requires eyeglasses to correct vision with a minimum prescription of +/- .50 or equivalent NVA uses codes 92340, 92341, or 92342 to generate a dispensing fee payment to you in accordance with the fee schedule. You do not need to include the code 92340, 92341, or 92342 on your claim as this will be automatically generated by the system when using the provider portal.

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

Dispensing Services Include:

- Prescribing and ordering proper lenses
- Assisting in the selection of a frame.
- Verifying accuracy of completed eyeglasses.
- Proper fitting and adjustment.
- Periodic re-adjustment – minor repairs (screws, nose pads, etc.).

Minor repairs, which will not require a replacement frame ordered, but will involve your provision of additional materials such as pads, temples, or temple covers from your own laboratory supplies, which will be reimbursed once every 60 days for children and once every 24 months for adults (age 21 or greater) with submission of code 92370.

Contact Lens Fitting – Medically Necessary Contact Lenses

Patients requiring fitting of contact lenses for the correction of certain qualifying medical conditions, including Keratoconus, CPT 92072 and acute corneal disease / bandage lenses, CPT 92071 may be eligible for coverage. In all cases, a medical Prior Approval request is required to ensure coverage. In emergency situations, bandage lenses may be provided at the time of the visit and the Prior Approval request may be submitted with the claim. Both CPT 92071 and 92072 may NOT be submitted for the same date of service.

NVA also provides coverage for other situations in which spectacle correction is not adequate to correct vision including Aniseikonia, Aphakia, Anisometropia > 2.00 diopters, spectacle prescriptions > \pm 12.00 diopters or other conditions in which best acuity cannot be corrected beyond 20/50 with conventional spectacles and other qualifying ocular diseases.

You must obtain Prior Approval for the fitting of Medically Necessary Contact Lenses and materials. Follow the same procedure as for additional examinations above and be sure to complete the form found on page 58-59. (These page numbers may change depending on formatting.)

Reimbursement for fitting will be in accordance with the Medicaid Fee Schedule then in effect.

Please use the appropriate HCPCS code for the materials provided (V2500-V2530) along with the PAS number on your claim. You will need to include the HCPCS code(s) for contact lenses as they are not ordered from the contract laboratory.

Payment will be made to you for the fitting as well as the materials, and you should order the lenses from your usual sources.

Contact Lens Fitting – Cosmetic Contact Lenses

Patients wishing to obtain cosmetic contact lenses may do so if they meet the following requirements:

- May be provided in lieu of eyeglasses for the material benefit period.
- Up to 1 replacement pair (**children only**) will be permitted in every 12 months for lost or damaged lenses.
- Up to 1 replacement pair (**children only**) every 12 months will be permitted for prescription changes of equal to or greater than 0.50 diopters.
- Minimum age for contact lenses is 15 unless the provider can document need and ability to wear and handle lenses appropriately.
- Minimum prescription requirements of \pm 3.00 D.
- No colored lenses (except handling tint) or other lenses designed to change the appearance of the eye.
- No lenses intended as costume lenses.
- No lenses which are approved for overnight wear.
- Provider has the right to refuse to fit any individual who does not demonstrate the appropriate need or ability to care for lenses properly, including those who fail to show up for required follow up visits.

This service should be billed with fitting code 92310 and the appropriate materials code (V2500 to V2531). A trial fitting that is unsuccessful and does not provide an appropriate, usable contact lens prescription and contact lenses for the patient for the full benefit period, in lieu of all eyeglass benefits for the full benefit period, will not be covered and will not be reimbursed.

The contact lens benefit will include the initial fitting visit, the patient instruction and training on proper lens wear and care, and all necessary follow up visits for the full benefit period (12 months for patients under 21, and 24 months for those ages 21 and above). The benefit will also include a supply of lenses appropriate for 12 months of regular daily wear of contact lenses.

We recommend that you complete the Cosmetic Contact Lens Section of the Non-covered Services Agreement for every cosmetic contact lens patient, or their parent, explaining and re-affirming their decision to proceed with contact lenses in lieu of all eyewear benefits for the entire benefit period and that you retain this patient or parent signed statement in their medical record.

Reimbursement

The cosmetic contact lens fee (see Forms Section) will be the total fee paid by NVA for this service and materials.

The balance of your charges for the materials provided will be the complete responsibility of the patient.

Contract Laboratory

The provision of materials (frames and lenses) is an essential part of this program. NVA maintains a primary emphasis on providing quality services within budgetary constraints and, for this reason, will utilize the services of a contract laboratory to provide plan covered frames and spectacle lenses, as well as a range of lens options. The laboratory has been selected on the basis of its professional reputation, volume production capabilities, and economics.

Ordering

Accessing the laboratory to place your eyeglass order is easy. The most efficient way is through the internet at www.e-nva.com. Once you log on with your Provider name and password (first time Providers will need their TIN, zip code and location suffix which is provided by provider relations, and an e-mail address to obtain a Provider name and password) you will have a range of services available, including:

- Verify member eligibility and receive authorizations.
- Submit claims for payment.
- Place eyeglass orders.
- Track claims.
- Track eyeglass orders.
- Benefit Description – Covered Services.
- Electronic copy of Provider Manual.
- Forms.
- Codes and Fees

You may also fax eyeglass orders to the laboratory directly at 888-522-2022. To call the laboratory directly, please use 888-830-5630 and select option #5. This number is reserved for customer service contact as telephone orders are not accepted, except in emergencies.

Update: December 2015

In compliance with Texas Bill 684, if you prefer to use a laboratory other than Classic you may do so. NVA will reimburse you according to the following fee schedule for these services. You will be responsible for ensuring availability of an adequate Medicaid frame collection in your office. This must consist of a minimum of 30 frames (10 male, 10 female and 10 unisex) with both metal and zyl choices in appropriate styles and sizes.

All fees include dispensing fee

Frame	\$13
SV Lenses *	\$23
Bifocals *	\$31
Trifocals *	\$41
Tints (with MPA)	\$5

UV Coating (with MPA)	\$5
Press on Prism (with MPA)	\$20
Frames	

Samples

If utilizing the contract laboratory, an initial set of sample frames will be sent prior to the plan implementation date to each contracted office. Only one set per office will be provided. Samples are sent at no cost and remain the property of the plan. The samples will be reviewed as part of the office audit process, and your office will be billed for missing samples.

Plan Covered Frames – No Charge to Members

The selection contains appropriate styles for children and teens, in a variety of materials, colors, styles, and sizes, and it is your responsibility to ensure that all applicable styles are shown to beneficiaries. Frames ordered through the contracted laboratory will result in the standard dispensing fee paid to your office. You do not need to submit frame code V2020/V2025 or lens codes as this will be automatically generated by the laboratory system, when using the provider portal.

Providers choosing to provide frames through their own laboratory must maintain a collection of frames from Modern Optical, Capri Optics and Hart Specialties at no cost to the member, as well as the following:

- Agree – black 52
- Care – pink 46
- Chill – black/blue 51
- Cosmo – black 52
- Parallel – blue fade 53
- Visa – blue 54
- US 74 – purple 51
- US75 – black 54
- Miraflex Nick 53 Color D
- Miraflex New Baby 2 Color J
- Specs4Us Model 4 Navy 43
- Specs4Us Model 13 Wine 51

Non-Plan Frames

It is also possible that a patient will want to use their own frame. Although the contract laboratory will accept member's frames, please check them carefully as the laboratory maintains the right to refuse a frame that is non-ophthalmic, old, cracked, and shows signs of excessive wear or when it believes it is likely to break during lens insertion. Please be sure that patients understand that the contract 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 member's frame was selected. This will place the lens order and hold it for arrival of the frame. It will also generate payment of the lens only dispensing fee to your office although no frame allowance is paid. You do not need to include the code M2025 on your claim as this will be automatically generated by the laboratory system, when using the provider portal.

Traceable Means – Shipping

When shipping to the laboratory (non-plan covered frames and member frames), it is strongly advised that you use a traceable means. The contract laboratory is not responsible for replacing frames lost in transit. The maximum amount for which the laboratory will be responsible for lost or damaged frames is \$50.00.

Lenses

Plan lenses will be provided by the contract laboratory and should be ordered in the same manner as frames, unless you have opted to utilize your choice laboratory.

Standard single vision, bifocal, and trifocal (Flat top, round seg, or executive style) lenses are covered and will be automatically filled CR-39, unless you specify a different material such as polycarbonate, which is strongly recommended. *As a reminder, only Flat top 28 and 35 bifocals and Flat top 7 x 28 trifocals are available as polycarbonate lenses. Executive, Flat top 25 and round segment bifocals are available only in CR-39.*

Polycarbonate is strongly recommended for children and will be provided automatically for everyone under 21 years of age, at no cost. For Adults (age 21 and over), all lenses will be fabricated using plastic (CR-39). For adults, polycarbonate lenses can be provided without a prior authorization for prescriptions with power in at least one meridian greater than or equal to -5.25/+4.00 diopters.

One of the advantages of utilizing a contract laboratory is the elimination of the need for the provider offices to code claims with HCPCS for materials supplied by the laboratory. As a result, you do not need to include the lens codes or option codes with this program, as they will be automatically generated by the laboratory system if utilizing the provider portal.

Standard single vision, bifocal, and trifocal (Flat top, round seg or executive style) lenses are covered.

Lens options – Plan Paid

Certain lens options may be covered with Prior Approval, when medically or professionally indicated not for cosmetic reasons. They include:

- Tints
- UV Coating
- Press on prisms
- High Index Lenses (STAR)

STAR and STAR Kids members may be covered with Prior Approval, when medically or professionally indicated for:

- Specialty Frames
- High Index Lenses

Please submit for Prior Approval in instances when one of these services is required.

Please remember that you do not need to include the HCPCS code for options (see above) when utilizing the provider portal.

Additionally, for adults over age 20, polycarbonate for prescriptions with power in at least one meridian of -5.25/+4.00 diopters, **Prior Approval Is Not Required.**

Replacement Eyeglasses and Contact Lenses

Eyeglasses

STAR Members age 21 and above who require replacement of lost or broken eyeglasses are not eligible for replacement under the Texas Medicaid program.

Members under 21 years of age who require replacement or repair of broken eyeglasses may receive such replacement with Prior Approval.

Replacement will also be made when there is a change of prescription of + .50 diopters or 10° shift in axis. Prior Approval is also required.

Please complete the Prior Approval form with your claim. Payment for dispensing replacements will be made in full provided sixty (60) days have passed between dispensing dates.

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

Contact Lenses – Cosmetic Contact

Replacements for lost or damaged contact lenses, or with a significant change in Rx (=/- .50 diopters), may be made with Prior Approval for both children and adults.

Contact Lenses – Medically Necessary

Members age 21 and above who require replacement of lost or damaged medically necessary contact lenses are eligible for replacement with Prior Approval.

Members under 21 years of age who requires replacement of lost or damaged medically necessary contact lenses may receive such replacement with Prior Approval.

Replacement of medically necessary contact lenses for members will be as follows:

- Replacement for lost or damaged lenses with Prior Approval.
- Replacement will also be made when there is a change of prescription of + .50 diopters or 10° shift in axis. Prior Approval is also required.

Please complete the Prior Approval form.

Texas Utilization Management

Overview

The priority in NVA programs is to allow patients easy access to the care that they require. This is best achieved by providing the doctors simple straightforward guidelines to follow in rendering and billing for the care that the patients require.

Our full eye care benefit encompasses both routine vision care (examination and dispensing of eyewear), as well as medical optometry. Our program allows access to both components for the patients while allowing the providers to bill for the appropriate service provided. We also appreciate the need for simplicity and consistency for the provider's office and staff in working with this program. For this reason, we have constructed a protocol that is applicable to all patients, in all programs, and to all providers.

We pay for services rendered under the scope of licensure and qualification, when provided by a participating optometrist. Ophthalmologists may also participate in the Routine Vision Program and will be reimbursed at the same rates as optometrists.

We will allow patients freedom of choice in the selection of their eye care provider. Patients may self-refer to your office for care, without the need for a referral or 'gate-keeper'. It is our belief, and practice at NVA, that optometrists should be treated as trustworthy professionals. As such, we expect our doctors to provide the care that the 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 fees listed in the Provider Agreement. Because all offices that provide routine vision care will be required to provide eyewear dispensing services as well, we do not anticipate that there will be many occasions when patients present to your office to fill an 'outside' eyewear prescription. Therefore, we expect our dispensing offices to be willing, on these rare occasions, to provide dispensing services to patients not examined in the office.

We anticipate developing a good working relationship with the doctors in Texas and hope to have some of our providers participate on our Texas Professional Advisory Committee, working hand in hand with some of NVA's current eye care professional staff and consultants.

Professional Staff

Carl Moroff, O.D., Chief Vision Officer
Barnet Shuman, O.D., M.P.H., F.A.A.O., Optometric Consultant
Daniel Townsend, M.D., F.A.A.O., Ophthalmology Consultant
Debbie Hettler, O.D. M.P.H., F.A.A.O., Optometric Consultant
Aaron Lee, O.D., Optometric Consultant

Operational Protocols and Policies

All initial patient visits should be considered as a routine vision care visit, and a comprehensive examination should be provided. A description of our comprehensive examination is included on page 11 of this manual. Medical examinations should be billed as 992XX codes. **Temporary 'S' codes will not be allowed, and all claims with 'S' codes will be denied.**

The comprehensive examination should be coded as one of the following: 92002, 92004, 92012, or 92014 except in the following situations when a 992XX (E and M) code could be used:

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.
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 Rx 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.
5. When a second office visit is needed to complete an examination on a STAR Kids member due to the physical or developmental abilities or limitations of the patient.

In all of these situations, the claims will be subject to retrospective review.

In the situations noted above, which require a more extensive ocular examination, bills may be submitted with a 992XX code. In these cases, refraction (92015) and eyeglass dispensing (92430-92432) codes will not be allowed. If such codes are submitted, the entire submission will be considered to be a routine examination and will be denied.

The exception to this denial process will be medical conditions in which vision is not correctable to normal levels of at least 20/30, and the appropriate first line treatment is to allow the patient and the doctor time to assess less expensive and less invasive treatment options, including corrective eyeglasses or medically necessary contact lenses. These conditions will be identified by the appropriate ICD-10 diagnosis code accompanying the claim submission. These exception codes will include a limited number of conditions, such as cataract, macular degeneration, retinopathy, and keratoconus. In these cases, refraction (92015) may be billed as a stand-alone procedure and be reimbursed at our current contracted rate.

Our protocol for expediting prompt payment to the doctors for these medical office visits is to utilize payment by automated system processing of all 99201, 99202, 99203, 99211, 99212 and 99213 coded services. Any requests for a higher service level (i.e., 99204, 99205, 99214 or 99215) will require Prior Approval. If the Prior Approval for Services (PAS) Form does not reach us by fax at 973-574-2430, or by email to priorapprovals@e-nva.com, by the second business day after the claim has been submitted, it will be denied.

It is expected that in the course of providing an annual comprehensive eye examination, a minor medical eye condition may be discovered. Some such conditions include dry eye, headache, asthenopia, 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 (codes 992XX). This examination should be considered to be a comprehensive eye examination and should be billed as such – code 92002, 92004, 92012, or 92014. The exception to this rule will be the 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, this visit may be billed as a medical office visit (992XX). A routine examination may be re-scheduled at any time after this condition has been fully resolved, but in no case, less than 7 days after this medical office visit.

Ancillary services or testing, scheduled for the convenience of the doctor or the patient on a day other than on 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. Ancillary services must be billed on a CMS 1500 as these codes will not be available on the Provider Website.

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. The exception to this is for services provided at an Emergency Room when a provider is called for a consult, in which case, reimbursement will be in accordance with the Medicaid Fee Schedule.

All services provided must meet our criteria for utilization and patient care, whether by Prior Approval or by retrospective review.

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

Referrals

All patient referrals for further evaluation or care must be made to an approved NVA or CCHP panel provider. Any non-emergency referrals to a provider or facility outside of the current approved NVA and CCHP provider network will require Prior Approval. A copy of all referrals should be sent to the member's primary care physician (PCP).

Program Limitations

As with all health care programs, there are some limitations to coverage for which you should be aware. Most are listed in the categories below.

1. Services which are the responsibility of another insurer and not the responsibility of NVA or CCHP should be billed directly to the responsible party. NVA or CCHP will not pay these claims.
 - Automobile accidents
 - Job-related/Workers Compensation claims
2. Services which are not covered by this program are the complete financial responsibility of the patient. NVA and CCHP will not pay these claims. These services, supplies, and materials include:
 - Refractive surgery, its complications, and post-operative care, including but not limited to:
 - Lasik
 - PRK
 - Intacs
 - Clear lens extractions.
 - Implantable contact lenses.
 - Radial Keratotomy.
 - Services provided as part of clinical trials.
 - Experimental procedures.

- Unspecified services (any CPT XX999).
- Low vision services or devices – “A patient who requires low vision aids or who experiences vision-related difficulty with daily living activities or with employment may be referred to the DARS Division for Blind Services for evaluation and any appropriate resources.”

UTILIZATION REVIEW AND PRIOR MEDICAL APPROVAL

(Patients have the right to access an Ophthalmologist or therapeutic Optometrist without the need for referral or Prior Authorization)

One of the challenges we all face in the current health care system is finding the most appropriate balance between providing the care that the 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 make sure there is no misunderstanding is the area of baseline testing. The comprehensive eye examination benefit is an important baseline procedure. This service provides the doctor and patient a great deal of information about their 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, ultra-sonography, 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 do not rise to the level of medically necessary procedures in an otherwise healthy, asymptomatic patient. For this reason, these procedures will not be considered to be covered services when provided as 'baseline testing', and payment will be denied.

The following criteria describe the recommended guidelines for the most commonly available services in question.

These guidelines should be followed for the provision of care. When Prior Approval for Services (PAS) is required, these criteria will be utilized by NVA in making a determination on the PAS request.

At any point in the Prior Approval for Service (PAS) process, that a provider wishes to discuss a request for services for a specific patient, with one of the peer reviewers, a consulting optometrist, that can be accomplished. This discussion may occur before the initial PAS is requested, when additional information is requested by the peer reviewer or after an initial review decision is pending. NVA will work with the requesting provider to determine a date and time that is convenient for both the provider and the peer reviewer to discuss the PAS in question. In order to initiate this process, the provider should email NVA at PriorApprovals@e-nva.com with the request at NVA at _____.

Emergency Treatment

Appropriate medical care for patients may require emergency treatment that cannot wait for a prior approval 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 the care has been provided, the office may submit a Prior Approval Form. This Retrospective Approval will ensure that your claim for this service will be authorized for payment.

The same criteria and process will be utilized for this retrospective review as is used for the usual Prior Approval process.

Second Opinions

Texas Medicaid rules allow patients to seek a second opinion for medical or surgical treatment. NVA and Cook Children's Health Plan both support this policy. It is not always possible for us to know that a patient is seeing you for a second opinion. As such, the system may not recognize your billing as a valid second opinion visit and may instead deny it as a duplicate service billing.

To avoid this potential denial, your office may submit for Prior Approval. This Prior Approval will ensure that your claim for this service will be authorized for payment. The same criteria and process will be utilized for this retrospective review as is used for the usual Prior Approval process.

Emerging Technology

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

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

Utilization Review and Prior Approvals

Prior Approval Information

A full description of the Prior Approval process and criteria are available as a searchable document on our website at: e-nva.com

General Information Required to Initiate a PA Request

The information listed below must be included on all PA requests in order for the process to be initiated:

1. Member Name
2. Member ID
3. Member date of birth
4. Requesting provider's name
5. Requesting provider's National Provider Identifier (NPI)
6. Service Requested – (CPT or HCPCS)
7. Service Requested start and end date(s)
8. Quantity of services units requested based on CPT or HCPCS requested
9. Rendering provider's name
10. Rendering provider's NPI
11. Rendering provider's Tax ID number

PA Process and Notices

- PA must be submitted in writing and must have documentation required to make a determination of medical necessity.
- After a determination, notification of the decision is sent to the requesting provider and the affected member within the timeframes defined above and as modified by the section describing PA Request with Incomplete Information
- Based on the decision rendered members and providers may receive:
 - Adverse Benefit Determination Notice (including appeal and State Fair Hearing rights) or
 - Approval Letter

PA Documentation

Documentation which may be submitted (as relevant):

1. Complete Prior Authorization Form
2. Complete Medical Record (the most recent, comprehensive eye examination), including patient demographics, Date of Service and all clinical notes, including all qualitative and quantitative testing results
3. Qualitative and quantitative Results of all ancillary testing (i.e., Corneal Topography) performed
4. All relevant prescription information including best corrected visual acuity in each eye as well as previous prescription (when a change is to be noted)
5. All other data, values or clinical notes relevant to the services or materials requested

You may submit additional statements or other documentation in support of your request.

Prior Authorization Criteria

CPT 68761: Punctal Plugs

Approval Criteria:

- Significant dry eye symptoms impacting vision or overall comfort
- Decreased tear break-up time
- Failure of first line treatments, nutritional supplements, and treatment of Meibomian gland dysfunction to eliminate the patient's symptoms
- Failure to eliminate patient symptoms by intensive use of ocular lubricants

- Success with temporary punctal plugs will be required as well before permanent plugs can be deemed to be appropriate
- The patient must be in good enough physical and mental health to be able to tolerate and benefit from this procedure
- The procedure is reasonably expected to ameliorate all of the conditions and symptoms noted above
- The patient has been apprised of the risks and benefits of the procedure and has signed a release/informed consent form to that effect
- This procedure will require a medical prior approval for any patient under the age of twenty-one (21)

Patients over the age of 20 – Prior Authorization not required.

CPT 76513: Ultrasound Biomicroscopy, UBM

Approval Criteria:

- Where direct visualization with slit lamp is not feasible, for example, structures behind the iris which cannot be directly seen using routine examination techniques.
- Other conditions for which this procedure may be indicated include:
 - Anterior segment neoplasms
 - Adhesions and synechiae
 - Ciliary body disorders
 - Dislocated lens or IOL
 - Glaucoma
 - Iris abnormalities
 - Trauma to the globe

CPT 76514: Corneal Pachymetry

Approval Criteria:

Diagnosis Codes							
H40001	H40002	H40003	H40011	H40012	H40013	H40021	H40022

H40023	H40031	H40032	H40033	H40041	H40042	H40043	H40051
H40052	H40053	H40061	H40062	H40063	H4010X0	H4010X1	H4010X2
H4010X3	H4010X4	H401110	H401111	H401112	H401113	H401114	H401120
H401121	H401122	H401123	H401124	H401130	H401131	H401132	H401133
H401134	H401190	H401191	H401192	H401193	H401194	H401210	H401211
H401212	H401213	H401214	H401220	H401221	H401222	H401223	H401224
H401230	H401231	H401232	H401233	H401234	H401310	H401311	H401312
H401313	H401314	H401320	H401321	H401322	H401323	H401324	H401330
H401331	H401332	H401333	H401334	H40141	H40142	H40143	H401510
H401511	H401512	H401513	H401514	H401520	H401521	H401522	H401523
H401524	H401530	H401531	H401532	H401533	H401534	H4020X0	H4020X1
H4020X2	H4020X3	H4020X4	H40211	H40212	H40213	H402210	H402211
H402212	H402213	H402214	H402220	H402221	H402222	H402223	H402224
Diagnosis Codes (cont'd)							
H402230	H402231	H402232	H402233	H402234	H402290	H40231	H40232
H40233	H40241	H40242	H40243	H4031X0	H4031X1	H4031X2	H4031X3
H4031X4	H4032X0	H4032X1	H4032X2	H4032X3	H4032X4	H4033X0	H4033X1
H4033X2	H4033X3	H4033X4	H4041X0	H4041X1	H4041X2	H4041X3	H4041X4
H4042X0	H4042X1	H4042X2	H4042X3	H4042X4	H4043X0	H4043X1	H4043X2
H4043X3	H4043X4	H4051X0	H4051X1	H4051X2	H4051X3	H4051X4	H4052X0
H4052X1	H4052X2	H4052X3	H4052X4	H4053X0	H4053X1	H4053X2	H4053X3
H4053X4	H4061X0	H4061X1	H4061X2	H4061X3	H4061X4	H4062X0	H4062X1
H4062X2	H4062X3	H4062X4	H4063X0	H4063X1	H4063X2	H4063X3	H4063X4
H40811	H40812	H40813	H40821	H40822	H40823	H40831	H40832
H40833	H4089	H409	H42	H44511	H44512	H44513	Q150

CPT 83861: Tear Osmolarity Testing

Approval Criteria:

- This procedure is necessary for the diagnosis, treatment and monitoring of well documented significant dry eye disease as defined as:
 - Significant dry eye symptoms impacting vision or overall comfort
 - Decreased tear production as measured by Schirmer testing (if available)

- Decreased tear break-up time
- Failure of first line treatments, nutritional supplements, and treatment of Meibomian gland dysfunction to eliminate the patient's symptoms
- Failure to eliminate patient symptoms by intensive use of ocular lubricants

CPT 92012, 92014: Eye Examination for additional patient

Approval Criteria:

- The limitation for examination can be exceeded for clients who are birth through 20 years of age only when:
 - The parent, teacher, or school nurse requests the refraction testing and it is medically necessary
 - There is a significant change in vision, and documentation supports a diopter (d) change of 0.5d or greater in the sphere, cylinder, prism measurements, or axis changes
- Over 21 years of age and older. The limitation for examination can be exceeded for clients who are 21 years of age and older only when: there is a significant change in vision, and documentation supports a diopter change of 0.50d or more in the sphere, cylinder, prism measurements, or axis changes:
 - A cylinder axis change of at least 20 degrees for a cylinder power of 0.50-0.62 diopters
 - A cylinder axis change of at least 15 degrees for a cylinder power of 0.75-0.87 diopters
 - A cylinder axis change of at least 10 degrees for a cylinder power of 1.00-1.87 diopters

CPT 92015: Refraction

Approval Criteria:

- If a medical eye examination (99200 CPT) uncovers an unexplained reduction in vision and a refraction is necessary to determine whether the reduced vision

is due to uncorrected refractive error or another underlying medical issue such as:

- Keratoconus
- Macular degeneration
- Cataract
- Diabetes
- For Amblyopia follow-up visits (99212), refraction (92015) may be indicated, and may be provided without prior authorization

Denial Criteria:

- Refraction is an included component of every routine comprehensive examination (92002-92014) and will not be processed or paid as a stand-alone item (CPT 92015)
- Medical eye examinations (99200 CPT codes), in general, will not involve the prescription and provision of eyeglasses or contact lenses and in most cases refraction (92015) will not be a necessary or reimbursable service with a 99200-visit code

CPT 92020: Gonioscopy

Approval Criteria:

Diagnosis Codes							
H40001	H40002	H40003	H40011	H40012	H40013	H40021	H40022
H40023	H40031	H40032	H40033	H40041	H40042	H40043	H40051
H40052	H40053	H40061	H40062	H40063	H4010X0	H4010X1	H4010X2
H4010X3	H4010X4	H401110	H401111	H401112	H401113	H401114	H401120
H401121	H401122	H401123	H401124	H401130	H401131	H401132	H401133
H401134	H401190	H401191	H401192	H401193	H401194	H401210	H401211
H401212	H401213	H401214	H401220	H401221	H401222	H401223	H401224
H401230	H401231	H401232	H401233	H401234	H401310	H401311	H401312
H401313	H401314	H401320	H401321	H401322	H401323	H401324	H401330
H401331	H401332	H401333	H401334	H40141	H40142	H40143	H401510
H401511	H401512	H401513	H401514	H401520	H401521	H401522	H401523
H401524	H401530	H401531	H401532	H401533	H401534	H4020X0	H4020X1

H4020X2	H4020X3	H4020X4	H40211	H40212	H40213	H402210	H402211
H402212	H402213	H402214	H402220	H402221	H402222	H402223	H402224
H402230	H402231	H402232	H402233	H402234	H402290	H40231	H40232
H40233	H40241	H40242	H40243	H4031X0	H4031X1	H4031X2	H4031X3
H4031X4	H4032X0	H4032X1	H4032X2	H4032X3	H4032X4	H4033X0	H4033X1
H4033X2	H4033X3	H4033X4	H4041X0	H4041X1	H4041X2	H4041X3	H4041X4
H4042X0	H4042X1	H4042X2	H4042X3	H4042X4	H4043X0	H4043X1	H4043X2
H4043X3	H4043X4	H4051X0	H4051X1	H4051X2	H4051X3	H4051X4	H4052X0
H4052X1	H4052X2	H4052X3	H4052X4	H4053X0	H4053X1	H4053X2	H4053X3
H4053X4	H4061X0	H4061X1	H4061X2	H4061X3	H4061X4	H4062X0	H4062X1
H4062X2	H4062X3	H4062X4	H4063X0	H4063X1	H4063X2	H4063X3	H4063X4
H40811	H40812	H40813	H40821	H40822	H40823	H4089	H409
H42	Q150	-	-	-	-	-	-

CPT 92025: Corneal Topography

Procedure code 92025 is considered medically necessary to diagnose, monitor, and treat various visual conditions such as, but not limited to the following:

- Corneal abrasion
- Corneal irregularities
- Corneal disease
- Corneal injury
- Keratoconus

Approval Criteria:

Diagnosis Codes						
H18501	H18502	H18503	H18509	H18511	H18512	H18513
H18519	H18521	H18522	H18523	H18529	H18531	H18532
H18533	H18539	H18541	H18542	H18543	H18549	H18551
H18552	H18553	H18559	H18591	H18592	H18593	H18599

CPT 92060: Sensori - Motor Examination

The prior authorization request must provide documentation that supports the description of a Sensori-motor examination:

- "A sensorimotor examination consists of measurements of ocular alignment in more than 1 field of gaze along with a sensory test of binocular function with interpretation and report.
- A sensorimotor examination detects, assesses, monitors, and/or manages strabismic conditions including esotropia, exotropia, and hypertropia. These conditions can have important visual, developmental, and/or systemic implications.
- The sensorimotor examination is necessary to diagnose strabismus, in follow-up to detect improvement or progression in the strabismic condition, and also to determine whether optical correction is affecting the strabismic condition.
- Information from the sensorimotor examination is used to plan medical, optical, and surgical treatments.
- The sensorimotor examination is defined by CPT to be beyond the scope of the basic eye motor component of the ophthalmic examinations (92002-92014) or the single system Evaluation/Management (E/M) service (99201-99253). Measurement of the ocular alignment in one position is needed for a comprehensive eye examination. The sensorimotor examination is an expanded examination which requires additional time, effort, and expertise in measurement of the ocular deviation in various fields of gaze, different distances, and/or with and without optical correction. The sensorimotor examination also includes at least one appropriate sensory test in patients who are able to respond."

CPT 92065: Vision Training / Orthoptics / Pleoptics

Approval Criteria:

Diagnosis Codes							
H50011	H50012	H50021	H50022	H50031	H50032	H50041	H50042
H5005	H5006	H5007	H5008	H50111	H50112	H50121	H50122
H50131	H50132	H50141	H50142	H5015	H5016	H5017	H5018
H5021	H5022	H50311	H50312	H5032	H50331	H50332	H5034
H50411	H50412	H5042	H5043	H5051	H5052	H5053	H5054
H5055	H50611	H50612	H5069	H50811	H50812	H5089	H5111

H5112	H518	H53011	H53012	H53013	H53021	H53022	H53023
H53031	H53032	H53033	H53041	H53042	H53043	H53049	H5501
H5502	H5503	H5504	H5509	H5581	H5582	H5589	-

Up to an additional 6 services may be reimbursed with prior authorization for a total of 12 services per lifetime.

The provider must attest that current therapy has resulted in an improvement with presenting symptomatology over the course of treatment, including, but not limited to:

- Blurred vision
- Double vision
- Amblyopia
- Accommodation or near point of convergence measurements

CPT 92071: Medically Necessary Contact Lenses – Corneal Disease

CPT 92072: Medically Necessary Contact Lenses – Keratoconus

Approval Criteria:

- The following documentation must be submitted with a request for non-prosthetic contact lenses and must be signed and dated by the prescribing physician or optometrist:
 - Diagnosis causing the refractive error (such as keratoconus)
 - Include the current and new prescriptions supporting a change of 0.5d or more in the sphere, cylinder, or prism measurements
 - Indicate which eyes to be treated
 - Specify the procedure codes requested
- A contact lens fitting for the placement of a corneal bandage lens may be medically necessary for eye protection and pain control due to a disease process or an injury. Procedure codes 92071 and 92072 may be reimbursed for the fitting of the corneal bandage for treatment and management.

CPT 92081, 92082, 92083: Visual Fields

Approval Criteria:

- For the diagnosis, treatment, and monitoring of a wide range of eye and neurologic diseases or conditions
- When an issue affecting the patient's visual field is discovered during this initial examination / evaluation process for which a more formal visual field study is indicated it may be performed without a prior approval for an adult patient
- These procedures will require a medical prior approval for any patient under the age of twenty-one (21) except when provided as a part of a comprehensive interdisciplinary evaluation of a post-concussion / mTBI patient
- A PAS will be required for any repeated visual field study on an adult patient within 12 months

Denial Criteria:

- A gross evaluation of the visual fields 92081 is considered to be included as part of every comprehensive examination and not to be billed as a separate service

CPT 92100: Serial Tonometry

Serial tonometry can be a useful tool in the diagnosis and classification of glaucoma. For PAS review, the rationale for this procedure must be based on clinical findings of progression of disease in concert with apparently normal or adequately controlled IOP.

CPT 92132: Optical Coherence Tomography – anterior segment

CPT 92133: Optical Coherence Tomography – optic nerve

CPT 92134: Optical Coherence Tomography – retina

Their benefits do not exist when performed as routine baseline or screening procedures. Since most of the conditions for which these procedures are indicated do not significantly impact the pediatric and adolescent populations, these procedures will require a medical prior approval for any patient under the age of twenty-one (21).

Approval Criteria:

- To establish an initial baseline for future reference to enable the doctor to monitor the possible progression of anterior or posterior segment conditions that are known to progress or worsen
- An initial OCT for an adult patient that meets this criteria does not require a PAS, but all repeated OCTs will require a Prior Authorization
- This procedure will require a medical prior approval for any patient under the age of twenty-one (21) except for documentation by CPT 92134, for potential medication induced issues caused by Rheumatoid Arthritis treatment with Plaquenil or Aralen
- For patients over age 20, OCTs will require a PAS for any second procedure performed within a 12-month period

Denial Criteria:

- These procedures may not be provided on the same days as CPT 92250
- When performed as routine baseline or screening procedures

CPT 92201: Extended ophthalmoscopy (peripheral)

CPT 92202: Extended ophthalmoscopy (central)

Approval Criteria:

- A detailed examination of the entire retina with a report, diagnosis and drawing due to a finding of a significant retinal disorder requiring additional documentation

CPT 92250: Fundus Photography

Approval Criteria:

- Retinal photography (procedure code 92250) is considered medically necessary when a clinical condition exists that is subject to change in extent, appearance, or size and where such change would directly affect the management of client care. These conditions include, but are not limited to the following:
 - Macular degeneration
 - Glaucoma
 - Hypertension

- Neoplasms of the retina
- Choroid (benign or malignant)
- Retinal hemorrhages
- Ischemia
- Retinal detachment
- Choroid disturbances
- Diabetic retinopathy
- Assessment of recently performed retinal laser surgery
- For any patient under the age of twenty-one (21) for potential medication induced issues caused by Rheumatoid Arthritis treatment with Plaquenil or Aralen

Denial Criteria:

- Fundus photography performed for a routine screen of a normal eye, in the absence of a clinical condition, that is subject to change in extent, appearance or size is not a benefit of Texas Medicaid

CPT 92260: Ophthalmodynamometry

CPT 92265: Ocular electro myography

CPT 92270: Electro oculography

CPT 92273: Electroretinography (ERG), interpretation and report; full field (ffERG)

CPT 92274: Electroretinography (ERG), interpretation and report; multifocal (mfERG)

CPT 0509T: Electroretinography (ERG) – this is currently a non-covered service

CPT 95930: Visual evoked potential (CNS)) – not a covered service for amblyopia

CPT 0464T: Visual evoked potential (glaucoma) is currently a non-covered service

Approval Criteria:

- To evaluate reasonable suspected problems in the central nervous system that may be the cause for a patient's current visual or ocular dysfunctions that cannot be determined by any other clinical or diagnostic procedures
- These procedures will not be approved as baseline documentation procedures

CPT 92285: External Ocular Photography

Approval Criteria:

- To establish a baseline for future reference to enable the doctor to monitor the possible progression of anterior segment conditions that are known to progress or worsen
- External/anterior segment photography will not be considered appropriate to document abnormalities or variants that do not pose any risk of progression, loss of vision, or any compromise to the health of the eye or the patient
- External/anterior segment photography will not be considered appropriate to document chronic or acute inflammatory or infectious processes for which treatment or referral has been initiated

CPT 92286: Specular Microscopy

Approval Criteria:

- Documented diagnosis of endothelial compromising corneal disease or condition

Denial Criteria:

- Specular microscopy will not be considered appropriate to document abnormalities or variants that do not pose any risk of progression, loss of vision, or any compromise to the health of the eye or the patient
- Specular microscopy will not be considered appropriate to document corneal status as a baseline for contact lens patients

CPT 92310 – 92326: Contact lenses in lieu of eyeglasses

Approval Criteria:

- Keratoconus

- Anisekonia
- Anisometropia (≥ 2 diopters)
- Unable to correct to 20/70 with conventional spectacles
- Rx of ≥ 12.0 diopters
- Aphakia

A full medical record must be provided that documents any of the above criteria sufficiently, with any PAS request.

HCPCS V2410 & V2430: Aspheric Lenses

Approval Criteria:

Aspheric lenses may be prescribed for patients when the laboratory determines that it is unable to fabricate appropriately the combination of all of the patient's prescription components, power, cylinder, axis, prism and add power into the frame selected for this patient.

HCPCS V2718: Press on prism – Fresnel

Approval Criteria:

Supplied when at least 2 diopters of prism are required, and adaptation is of clinical concern and documented. PAS is required, with documentation of current RX and proposed prism addition / RX change.

HCPCS V2745: Tinted lenses

Approval Criteria:

- Significant Photophobia (must be clinical and documented)
- Aniridia
- Coloboma
- Albinism
- Chorio-retinitis
- Cataracts
- Keratitis
- Corneal Opacities or scarring

HCPCS V2755: U-V Coating

Approval Criteria:

Diagnosis Codes						
H2701	H2702	H2703	H27111	H27112	H27113	H27121
H27122	H27123	H27131	H27132	H27133	Q123	Z961

U-V tinting is not billable in conjunction with polycarbonate lenses (V2784).

U-V coating may also be approved for:

- Cataracts
- Aphakia
- Acute or chronic corneal disease
- Systemic photosensitizing medication
- Len subluxation (H27.0 – H27.139)

HCPCS V2783: High Index Lenses

Approval Criteria:

High index lenses are available by prior approval if they meet both of the following requirements:

- Supplied in prescriptions of +/- 9.00 diopters (total power) in any meridian
- Supplied only if polycarbonate is not available for the required Rx

HCPCS V2784: Polycarbonate Lenses

Approval Criteria:

Polycarbonate lenses may be reimbursed for adult clients with a medical or physical condition such as, but not limited to the following:

- Cerebral palsy
- Down's syndrome
- Motor ataxia
- Multiple sclerosis
- Brain trauma
- Marfan's syndrome
- Muscular dystrophy
- Balance disorders
- Amblyopia
- Epilepsy
- Parkinson's disease
- Ocular prostheses
- Autism
- Seizure disorder

In addition to the medical or physical conditions identified above, polycarbonate lenses also may be reimbursed when the client meets the following criteria:

- Lens power in at least one meridian of -5.25/+4.00 diopters or more and the eyeglasses are not functional in regular standard glass or plastic lens materials due to weight, thickness, or aberration
- Monocular vision with functional vision in one eye
- Retinal detachment or risk for retinal detachment (e.g. lattice degeneration, history of retinal detachment in the family, posterior vitreous detachment)

Approval Criteria:

Diagnosis Codes							
F840	F843	F845	F848	F849	F951	G20	G2111
G2119	G213	G214	G218	G3183	G3184	G35	G40001
G40009	G40019	G40101	G40109	G40111	G40119	G40201	G40209
G40211	G40219	G40301	G40309	G40311	G40A01	G40A09	G40A11
G40A19	G40B01	G40B09	G40B11	G40B19	G40401	G40409	G40411
G40419	G40501	G40509	G40801	G40802	G40803	G40804	G40813
G4089	G40901	G40909	G40911	G40919	G7100	G7101	G7102
G7109	G7111	G7112	G7113	G7114	G7119	G7120	G7121
G71220	G71228	G7129	G713	G718	G720	G722	G723
G7241	G7249	G7281	G7289	G729	G737	G800	G801
G802	G804	G808	G809	H33001	H33002	H33003	H33011
Diagnosis Codes (cont'd)							
H33012	H33013	H33021	H33022	H33023	H33031	H33032	H33033
H33041	H33042	H33043	H33051	H33052	H33053	H33191	H33192
H33193	H3321	H3322	H3323	H33301	H33302	H33303	H33311
H33312	H33313	H33321	H33322	H33323	H33331	H33332	H33333
H3341	H3342	H3343	H338	H53001	H53002	H53003	H53011
H53012	H53013	H53021	H53022	H53023	H53031	H53032	H53033
H53041	H53042	H53043	H53049	H540X33	H540X34	H540X35	H540X43
H540X44	H540X45	H540X53	H540X54	H541131	H541132	H541141	H541142
H541151	H541152	H541213	H541214	H541215	H541223	H541224	H541225
H542X12	H542X21	H542X22	H54413A	H54414A	H5442A3	H5442A4	H54512A
H5452A2	H8101	H8102	H8103	H8109	H8110	H8111	H8112
H8113	H8120	H8121	H8122	H8123	H81311	H81312	H81313

H81319	H81391	H81392	H81393	H81399	H814	H8301	H8302
H8303	H8309	H8311	H8312	H8313	H8319	H832X1	H832X2
H832X3	H832X9	P100	P101	P104	P108	P524	P526
P528	Q8740	Q87410	Q87418	Q8742	Q8743	Q900	Q901
Q902	Q909	S06890A	S06890D	S06890S	S06891A	S06891D	S06891S
S06892A	S06892D	S06892S	S06893A	S06893D	S06893S	S06894A	S06894D
S06894S	S06895A	S06895D	S06895S	S06896A	S06896D	S06896S	S06899A
S06899D	S06899S	S069X0A	S069X0D	S069X0S	S069X1A	S069X1D	S069X1S
S069X2A	S069X2D	S069X2S	S069X3A	S069X3D	S069X3S	S069X4A	S069X4D
S069X4S	S069X5A	S069X5D	S069X5S	S069X6A	S069X6D	S069X6S	S069X9A
S069X9D	S069X9S	T8521XA	T8521XD	T8521XS	T8522XA	T8522XD	T8522XS
T8529XA	T8529XD	T8529XS	T85310A	T85310D	T85310S	T85311A	T85311D
T85311S	T85318A	T85318D	T85318S	T85320A	T85320D	T85320S	T85321A
T85321D	T85321S	T85328A	T85328D	T85328S	T85390A	T85390D	T85390S
T85391A	T85391D	T85391S	T85398A	T85398D	T85398S	T8579XA	T8579XD
T8579XS	T85890A	T85890D	T85890S	T85898A	T85898D	T85898S	-

MEDICAID (STAR & STAR Kids) UTILIZATION REVIEW PROCESS

Prior authorization is not a guarantee of payment. All services are subject to the plan provisions, limitations/exclusions, and member eligibility at the time the services are rendered. Services requiring prior authorization are not eligible for reimbursement by NVA if authorization is not obtained and cannot be billed to the member. The decision to render medical services lies with the member and the treating provider.

Prior Authorization Determinations

UM Case Managers process service requests in accordance with the **clinical** immediacy of the request. If priority is not specified on the referral request, the request will default to routine status.

- Routine – within three (3) business days of receipt of all the necessary information.
- Urgent – within one (1) business day of receipt of all the necessary information.
- Emergent – within one (1) hour of receipt of all the necessary information

Medical Necessity Screening Criteria

In the event that criteria are not published in this provider manual for proposed services, other resource guidelines (i.e., Texas Medicaid Providers Manual, internally developed criteria, etc.) are used to determine medical necessity and appropriate level of care. Criteria utilized in the medical necessity review of a service request will be faxed to you upon request.

Notices of Action

NVA must notify members and providers when it takes an Action. An Action includes the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; or the denial, in whole or in part, of payment for a service. Only the NVA Chief Vision Officer or designee may render a denial for lack of medical necessity (adverse determination).

CHIP UTILIZATION REVIEW PROCESS

Prior authorization is not a guarantee of payment. All services are subject to the plan provisions, limitations/exclusions, and member eligibility at the time the services are rendered. Services requiring prior authorization are not eligible for reimbursement by NVA if authorization is not obtained and cannot be billed to the member. The decision to render medical services lies with the member and the treating provider.

Prior Authorization Determinations

UM Case Managers process service requests in accordance with the **clinical** immediacy of the request. If priority is not specified on the referral request, the request will default to routine status.

- Routine – within three (3) business days of receipt of all the necessary information.
- Urgent – within one (1) business day of receipt of all the necessary information.
- Emergent – within one (1) hour of receipt of all the necessary information.

Providers have the opportunity for discussion with a NVA peer reviewer, (licensed optometrist or ophthalmologist), to discuss the services or materials requested in a Prior Authorization, for a specific patient. The NVA staff will coordinate the discussion between the provider and peer reviewer.

Reconsideration Process

NVA providers will have the opportunity to provide additional documentation/ information for an NVA peer reviewer, (licensed optometrist or ophthalmologist) for reconsideration of an initial negative decision regarding the services or materials requested in a Prior Authorization, for a specific patient. The additional information may include, but not be limited to reports, consultations and examination records from any licensed provider, medical, social, psychological or educational, for the specific patient involved. In order to ensure a complete review of the reconsideration, these materials must be submitted through the normal Prior Authorization process, but noted and identified by the provider, as additional information for the specific PA determination in question.

All utilization management and prior authorization criteria are available to any provider by contacting Michele Dorsen VP of Provider relations at 973-574-2539.

Medical Necessity Screening Criteria

In the event that criteria are not published in this provider manual for proposed services, other resource guidelines (i.e., Texas Medicaid Providers Manual, internally developed criteria, etc.) are used to determine medical necessity and appropriate level of care. Criteria utilized in the medical necessity review of a service request will be faxed to you upon request.

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NVA must notify members and providers when it takes an Action. An Action includes the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; or the denial, in whole or in part, of payment for a service. Only the NVA Chief Vision Officer or designee may render a denial for lack of medical necessity (adverse determination).

Medicaid/CHIP Billing and Claims

CLAIMS SUBMISSION PROCEDURES (CLAIM FILING OPTIONS)

NVA receives vision and eye care claims in two (2) possible formats. These formats include:

- Electronic claims via NVA's Provider website (www.e-nva.com).
- Paper claims [CMS (HCFA) 1500 required].

Clean claims must be submitted and received by NVA **within 95 days** from the date of service and must include your NVA Provider number and individual Provider's NPI number. **Claims received after the 95-day filing limit will be denied.**

Electronic Claim Submission Utilizing NVA's Internet Website

Participating Providers may submit claims directly to NVA by utilizing NVA's Provider Website. Submitting claims via the website is very quick and easy. It is especially easy if you have already accessed the site to check a Member's eligibility prior to providing the service and received a control number **(strongly recommended)**.

If you have not used the provider website before, you must register using your tax ID, zip code, email address and suffix code (this is a 4-digit number that was provided to you in your welcome letter). If you do not have the suffix code, you may contact the Provider Services department, and a replacement will be provided.

Once you have logged in using your user name and password, you may verify eligibility, obtain authorizations, view your authorizations, place your lab order, and submit claims.

To submit a claim enter the patient's ID#, or name and date of birth, or select the corresponding authorization number. At this point, you will need to select the examining provider from the drop down box. Enter all the applicable information, choose the appropriate CPT and ICD-10 codes, and hit submit to submit the claim. You will receive a confirmation statement when the claim is submitted.

If you have questions on submitting claims or accessing the website, please contact our Provider Services Department at 888-830-5630/ 888-552-4639 or providers@e-nva.com.

Paper Claim Submission

- NVA requires that a CMS (HCFA) 1500 Claim Form be used for submission of all medical services, including ancillary services (i.e., Visual Fields – CPT 92081).
- Member name and identification number must be listed on all claims submitted.
- Member control number should be noted. Please place this number on line 10D of the form.
- The patient's date of birth must also be listed. If the member identification number is missing or miscoded on the claim form, the patient cannot be identified. This could result in the claim being returned to the submitting Provider office, causing a delay in payment.
- The Provider and office location information must be clearly identified on the claim. Frequently, if only the Provider signature is used for identification, the Provider's name cannot be clearly identified. Please include either a typed Provider (practice) name or the NVA Provider identification number and provider specific NPI number.
- The date of service must be provided on the claim form for each service line submitted.
- Approved Vision and Eye Care codes (CPT and HCPCS), as contained in this agreement, must be used to define all services.
- Up to 4 ICD-10 codes must be submitted on all claims. Claims for Professional services without at least one ICD code will be denied.
- Affix the proper postage when mailing bulk documentation. NVA does not accept postage due mail. This mail is returned to the sender and will result in delay of payment.

Paper claims for routine services should be mailed to the following address:

NVA - Claims
P.O. Box 2187
Clifton, NJ 07015

For Medical Claims, please use the following:

NVA - Medical Claims Department
P.O. Box 2187
Clifton, NJ 07015

Coordination of Benefits (COB)

When NVA is the secondary insurance carrier, a copy of the primary carrier's Explanation of Benefits (EOB) must be submitted with the claim. The payment made by the primary carrier must be indicated in the appropriate COB field, on a CMS 1500 Form. When a primary carrier's payment meets or exceeds a provider's contracted rate or fee schedule, NVA will consider the claim paid in full and no further payment will be made on the claim. Examples of Coordination of Benefits may include no fault insurance carriers and worker's compensation claims. Only paper (CMS-1500) claim forms may be utilized to report a claim with COB information.

Filing Limits

Any claim received beyond the timely filing limit of **95 days** will be denied for "untimely filing." If a claim is denied for "untimely filing," the provider cannot bill the member. If NVA is the secondary carrier, the timely filing limit begins with the date of payment or denial from the primary carrier.

Receipt and Audit of Claims

In order to ensure timely, accurate remittances to each participating Provider, NVA performs an 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 problem. Please contact our Provider Services Department with any questions you may have regarding claim submission or your remittance.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

As a healthcare provider, your office is required to comply with all aspects of the HIPAA regulations in effect as indicated in the final publications of the various rules covered by HIPAA.

NVA has implemented various operational policies and procedures to ensure that 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, NVA has previously modified its provider contracts to reflect the appropriate HIPAA compliance language. These contractual updates include the following, in regard to record handling and HIPAA requirements:

- Maintenance of adequate vision/medical, financial and administrative records related to covered services rendered by Provider in accordance with federal and state law.
- Safeguarding of all information about Members according to applicable state and federal laws and regulations. All material and information, in particular information relating to Members or potential Members, which is provided to or obtained by or through a Provider, whether verbal, written, tape, or otherwise, shall be reported as confidential information to the extent confidential treatment is provided under state and federal laws.
- Neither NVA 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 the Health Insurance Portability and Accountability Act ("HIPAA") relating to the exchange of information and shall cooperate with NVA in its efforts to ensure compliance with the privacy regulations promulgated under HIPAA and other related privacy laws.

Provider and NVA 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 that the benefit tables included in this Provider Manual reflect the most current coding standards (CPT-5 and HCPCS). Effective the date of this manual, NVA 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 diagnosis codes must be provided.

Note: Copies of NVA's HIPAA policies are available upon request by contacting NVA's Provider Services Department at 888-830-5630/ 888-552-4639, or via e-mail at providers@e-nva.com.

STAR Kids Care Management and Service Coordination

Cook Children's Health Plan's Care Management and Service Coordination Program encompasses:

- medical management (utilization management, case management/service coordination)
- disease/population health management)
- population management (predictive modeling, risk assessments/health screenings, preventive care reminders).

The Care Management/Service Coordination program leverages the integration of all program functions to deliver a "member-centric" model of care management.

Primary Care Providers (PCP) are responsible for all primary care services within the scope of the provider's practice and are responsible for coordinating all health care services required by the Member Service Coordination Teams. A Primary Care Provider must assess the medical and behavioral health needs of Members for referral to specialty care providers, provide referral care as needed, coordinate the Member's care with specialty providers after the referral, and serve as a Medical Home to Members. The Medical Home concept establishes a relationship between the Primary Care Physician and the patient in which the physician provides comprehensive primary care to the patient and facilitates partnerships between the physicians, patient, acute care and other care providers when appropriate. **Primary Care and Specialty Care Providers shall work together to maintain ongoing communication regarding the Member's care and treatment.**

Cook Children's Health Plan employs a team approach to Service Coordination to ensure Members receive the most effective level of support through a coordinated approach to care. Service Coordination Teams include nurses, social workers, behavioral health specialists and integrated case management specialists

Purpose of Service Coordination

Service Coordination provides the Member with initial and ongoing assistance identifying, selecting, obtaining, coordinating, and using covered services and other supports to enhance the Member's well-being, independence, integration in the community and potential for productivity. Service Coordination must be used to:

- provide a holistic evaluation of the Member's individual dynamics, needs and preferences;
- educate and help provide health-related information to the Member, the Member's legally authorized representative (LAR), and others in the Member's support network;
- help identify the Member's physical, behavioral, functional, and psychosocial needs;
- engage the Member and the Member's LAR and other caretakers in the design of the member's Individual Service Plan (ISP);
- connect the Member to covered and non-covered services necessary to meet the member's identified needs; monitor to ensure the Member's access to covered services it timely and appropriate;
- coordinate covered and non-covered services; and
- intervene on behalf of the Member if approved by the Member.

Service Coordination Levels

A named Service Coordinator is furnished to a Member when the health plan determines one is required through an assessment of the Member's health and support needs. Additionally, a named Service Coordinator is furnished to all Members who request one.

CCHP provides three levels of Service Coordination to its Members. Service Coordination levels are designated by the Member's service needs, medical complexity, and psychosocial needs/issues with our most clinically complex Members receiving the most intensive level of Service Coordination to meet their needs. Because a Member's health status may change, the Service Coordination Teams are designed to service a Member at any level of need, but coordination levels are designated and tracked in our comprehensive care coordination system to ensure appropriate tracking and service delivery by service level and identified Member needs.

CCHP provides the following for all STAR Kids Members:

- A description of Service Coordination
- A phone number to contact if the Member needs Service Coordination or is experiencing problems with Service Coordination
- The name of their Service Coordinator, if applicable
- The phone number and email address of their named Service Coordinator or Information on how to reach a Service Coordinator if the Member does not have a named Service Coordinator
- The minimum number of contacts the Member will receive every year
- The types of contacts the Member will receive and instructions on how to request additional Service Coordination assistance at any time
- How to access a Member Advocate if the Member has complaints about a Service Coordinator.

If the named Service Coordinator changes, CCHP notifies Members or their LARs within five business days of the name and phone number of their new Service Coordinator. Within this same time period, CCHP posts the new Service Coordinator's information on the portal or website Members use to obtain plan information. Members and LARs have the option of requesting CCHP assign a different Service Coordinator to the Member. If the Member or LAR express a concern or dissatisfaction with a Service Coordinator, the appropriate Manager or Team Lead of Service Coordination will assure the Member or LAR that their concerns will be investigated and to expect a follow-up call the next business day. The Member or LAR will be provided the Manager's or Team Lead's contact information should they need further assistance. Finally, the Member or LAR will be offered the ability to file a formal complaint at any time and offered assistance by the Member Care Advocate in doing so.

Service Coordinators must meet the following requirements as outlined below for each Service Coordination Level and must possess knowledge of the principles of most integrated settings, including federal and state requirements.

Level 1 Includes the Following Member Types:

- MDCP STAR Kids Members
- Members with Complex Needs or a history of developmental or behavioral health issues (multiple outpatient visits, hospitalization, or institutionalization within the past year)
- Members with SED or SPMI.
- Members at risk for institutionalization.

All Level 1 Members receive a minimum of four face-to-face Service Coordination contacts annually, in addition to monthly phone calls, unless otherwise requested by the Member or Member's LAR.

Level 2 Members:

- Members who do not meet the requirements for Level 1 classification but receive Personal Care Services (PCS), Community First Choice (CFC), or Nursing Services.
- Members the MCO believes would benefit from a higher level of service coordination based on results from the STAR Kids Screening and Assessment Instrument (SAI) and additional MCO findings.

- Members with a history of substance abuse (multiple outpatient visits, hospitalization, or institutionalization within the past year).
- Members without SED or SPMI, but who have another behavioral health condition that significantly impairs function

All Level 2 Members receive a minimum of two face-to-face and six telephonic Service Coordination contacts annually unless otherwise requested by the Member or Member's LAR.

Level 3 Members:

Level 3 Members include those who do not qualify as Level 1 or Level 2. All level 3 Members have access to service coordination services.

All Level 3 Members receive a minimum of one face-to-face visit annually and receive at least three telephonic service coordination outreach contacts yearly.

Service Planning and Authorization Requests

Service planning for a STAR Kids Member begins with the service coordination team's review of any existing and active services and any current Individual Service Plan (ISP). This review is documented in the care management software system.

Denials and Appeals

No Retaliation

NVA will not retaliate against any person filing a complaint against the health plan or appealing a decision made by the health plan.

Medicaid Member Notices of Action (Denials)

NVA must notify Members and providers when it takes an Action. An Action includes the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; or the denial, in whole or in part, of payment for a service. Only the NVA's Optometric Consultant may render a denial for lack of medical necessity (adverse determination).

Medicaid Member Appeals

Medicaid Standard Member Appeal

When NVA denies or limits a covered benefit (Action), the Member or his or her authorized representative may file an Appeal within thirty (30) days from receipt of the Notice of Action. The Member may request that any person or entity act on his or her behalf with the Member's written consent. A health care provider may be an authorized representative. A representative from NVA can assist the Member in understanding and using the Appeal process. The representative can also assist the Member in writing or filing an Appeal and monitoring the appeal through the process until the issue is resolved. Appeals received orally must be confirmed by a written, signed appeal by the Member or his or her authorized representative, unless an Expedited Appeal is requested.

Within five (5) business days of receipt of the appeal request, NVA will send a letter acknowledging receipt of the appeal request. The Member may continue receiving services during the appeal if the appeal is filed within ten (10) days of the Notice of Action or prior to the effective date of the denial, whichever is later. The Member is advised in writing that he or she may have to pay for the services if the denial is upheld. If the appeal resolution reverses the denial, NVA will promptly authorize coverage.

The Standard Appeal Process must be completed within thirty (30) calendar days after receipt

of the initial written request for appeal. The timeframe for a standard appeal may be extended for a period of up to fourteen (14) calendar days if the Member or his or her representative requests an extension or if NVA shows there is need for additional information and how the delay would be in the best interest of the Member. NVA provides the Member or his or her authorized representative with a written notice of the reason for the delay.

Appeals are reviewed by individuals who were not involved in the original review or decision to deny and are health care professionals with appropriate clinical expertise in treating the member's condition or disease. NVA provides a written notice of the appeal determination to the Appellant. If the appeal decision upholds the original decision to deny a service, Members receive information regarding their right to request an external review (Fair Hearing). The Member may request a State Fair Hearing at any time during or after the appeal process.

Medicaid Member Expedited Appeal

Members or their authorized representatives may request an Expedited Appeal either orally or in writing within thirty (30) days (or ten (10) days to ensure continuation of currently authorized services) from receipt of the Notice of Action or the intended effective date of the proposed Action. A representative from NVA can assist the Member in understanding and using the Appeal process. The representative can also assist the Member in writing or filing an Appeal and monitoring the appeal through the process until the issue is resolved.

If NVA denies a request for an Expedited Appeal, then NVA transfers the appeal to the standard appeal process, makes a reasonable effort to give the Appellant prompt oral notice of the denial, and follows up within two (2) calendar days with a written notice. Investigation and resolution of expedited appeals relating to an ongoing emergency or denial of a continued hospitalization are completed (1) in accordance with the medical immediacy of the case and (2) not later than one (1) business day after receiving the Member's request for Expedited Appeal.

Except for an Expedited Appeal relating to an ongoing emergency or denial of continued hospitalization, the time period for notification to the Appellant of the appeal resolution may be extended up to fourteen (14) calendar days if the Member requests an extension or NVA shows that there is a need for additional information and how the delay is in the Member's best interest. If the timeframe is extended, NVA will provide the Member with a written notice for the delay if the Member had not requested the delay.

When the timeframe is extended by the Member, NVA sends a letter acknowledging receipt of the Expedited Appeal request and the request for an extension. An individual who was not involved in the original review or decision to deny and is a health care professional with appropriate clinical expertise in treating the Member's condition or disease renders the appeal determination. NVA provides the Appellant a written notice of the appeal resolution. If the appeal decision upholds the original decision to deny a service, Members receive information regarding their right to request an external review (Fair Hearing).

Medicaid Members Access to State Fair Hearing

Can a Member ask for a State Fair Hearing?

If a Member, as a Member of the health plan, disagrees with NVA's decision, the Member has the right to ask for a Fair Hearing. The Member may name someone to represent him or her by writing a letter to NVA providing the name of the person the Member wants to represent him or her. A provider may be the Member's representative. The Member or the Member's representative must ask for the Fair Hearing within ninety (90) days of the date on NVA's letter that tells of the decision being challenged. If the Member does not ask for the Fair Hearing within ninety (90) days they may lose his or her right to a Fair Hearing.

To ask for a Fair Hearing, Member or the Member's representative should either call NVA at 877-236-0661 (STAR) 877-866-0384 (STAR Kids) or send a letter to:

National Vision Administrators
Attention: Health Plan Denial and Appeal Coordinator
PO Box 2187
Clifton, NJ 07015

If the Member asks for a Fair Hearing within ten (10) days from the time they receive the hearing notice from NVA, the Member has the right to keep getting any services denied, at least until the final hearing decision is made. If the Member does not request a Fair Hearing within ten (10) days from the time the Member gets the hearing notice, the service denied will be stopped.

If the Member asks for a Fair Hearing, they will receive a packet of information letting the Member know the date, time and location of the hearing. Most Fair Hearings are held by telephone. At that time, the Member or the Member's representative can tell why the Member needs the service NVA denied.

The Health and Human Services Commission (HHSC) will give the Member a final decision within ninety (90) days from the date the Member asked for the hearing. If the Member or the Member's representative is not satisfied with the outcome of NVA's Appeal Process, they may file a complaint with:

Texas Department of Insurance
Attention: Mail Code 103-6A
PO Box 149104
Austin, TX 78714-9104
Phone: 866-554-4926

Provider Complaint Process – Medicaid

Provider Complaint Process to NVA

A complaint is defined as dissatisfaction expressed by a complainant with any aspect of NVA's operation. The complaint process does not include appeals related to Medical Necessity or disenrollment decisions. A complaint does not include misinformation that is resolved promptly by supplying the appropriate information or clearing up a misunderstanding to the satisfaction of the complainant.

Providers that wish to file a complaint about NVA or one of the CCHP Members can do so by submitting their complaint in writing. Upon receipt of the complaint NVA will send an acknowledgement letter to the provider within five (5) business days. NVA will fully and completely respond to all provider complaints within thirty (30) calendar days of receiving the complaint. Telephone communication related to the complaint will be documented in a complaint log. Email and fax documentation related to the complaint will be retained by the health plan for a period of seven (7) years.

Providers may submit a written complaint as follows:

- Faxing a written complaint to: 973-574-2494
- Submitting a written complaint by email to: CookVisionCare@e-nva.come-nva.com
- Mailing a written complaint to:
National Vision Administrators, LLC
Health Plans - Complaints
1200 Route 46 West
Clifton, New Jersey 07013

Provider Complaint Process to Health and Human Services Commission

If the Provider is not happy with the resolution of the complaint, they have the right to file a complaint with the Health and Human Services Commission (HHSC). When filing a complaint

with HHSC, Providers must send a letter within sixty (60) calendar days of receiving NVA's resolution letter. The letter must explain the specific reasons you believe NVA's complaint resolution is incorrect. The complaint should include:

- All correspondence and documentation sent to NVA, including copies of supporting documentation submitted during the complaint process
- All correspondence and documentation you received from NVA
- All R&S reports of the claims/ services in question, if applicable
- Provider's original claim/billing record, electronic or manual, if applicable
- Provider internal notes and logs when pertinent
- Memos from the state or health plan indicating any problems, policy changes, or claims processing discrepancies that may be relevant to the complaint
- Other documents, such as certified mail receipts, original date-stamped envelopes, in service notes, or minutes from meetings if relevant to the complaint. Receipts can be helpful when the issue is late filing.

When filing a complaint with Health and Human Services Commission, providers must submit a letter to the following address:

Texas Health and Human Services Commission
Re: Provider Complaint
Health Plan Operations, H-320
PO Box 85200
Austin, TX 78708

Medicaid Member's Right to File Complaints to NVA

A Member, or the Member's authorized representative (Member), has the right to file a complaint either orally or in writing. NVA will resolve all complaints within thirty (30) calendar days from the date the complaint is received. If the Member needs help in filing a complaint, they can contact the Member Services Department and a Customer Care Representative will assist them.

Members can file a complaint with NVA by calling 877-866-0384 or in writing to:

National Vision Administrators, LLC
Health Plans- Complaints
1200 Route 46 West
Clifton, New Jersey 07013

Member's Right to File Complaints to Health and Human Services Commission

If the Member is not satisfied with the resolution of the complaint, they may also file a complaint directly with the Health and Human Services Commission (HHSC). The Member must send a letter to:

Texas Health and Human Services Commission
Re: Member Complaint
Health Plan Operations, H-320
PO Box 85200
Austin, TX 78708

No Retaliation

NVA will not punish a child or other person for:

- filing a complaint against NVA or
- appealing a decision made by NVA

Provider Complaints and Appeal Process – CHIP

PROVIDER COMPLAINT AND APPEAL PROCESS TO NVA AND TDI

For CHIP, Providers follow the same complaint process as described below for CHIP Members.

MEMBER COMPLAINT AND APPEAL PROCESS

Members (or their authorized representatives) who are not satisfied with their services can file a complaint with NVA. Members should call Member Services at 877-636-2576. If a member needs assistance with filing a complaint, a Member Services Representative will help you file your complaint. You may also send your complaint in writing to NVA. Mail your letter to:

National Vision Administrators
Attention: Health Plan Denial and Appeal Coordinator
PO Box 2187
Clifton, NJ 07015

NVA will send the member a letter within five (5) working days telling them that we have received their complaint. We will also include a complaint form with the letter if the complaint was filed orally. Within thirty (30) days of receiving your written complaint, NVA will mail you a letter with the outcome of the complaint. The resolution letter must include an explanation of NVA's resolution of the Complaint, a statement of the specific medical and contractual reasons for the resolution; and the specialization of any optometrist or other provider consulted. The resolution letter must also contain a full description of the process for Appeal, including the deadlines for the Appeals process and the deadlines for the final decision on the Appeal.

NVA shall investigate and resolve a complaint concerning an emergency or a denial of continued hospitalization in accordance with the medical immediacy of the case and not later than one business day after NVA receives the complaint.

If the member does not like the response to their complaint, they can contact NVA and request an "appeal" by asking for a hearing with the Complaint Appeal Panel. Every oral appeal received must be confirmed by a written, signed Appeal by the Member or his or her representative, unless the Member asks for an expedited appeal. The complainant has the right to appear before a Complaint Appeal Panel (CAP) where they normally receive health care or at another site agreed to by the complainant. The CAP is a group of people that includes equal numbers of:

- NVA Staff
- Physicians or other providers with experience in the area of care that is in dispute and must be independent of any physician or provider who made the prior determination.
- Enrollees (enrollees may not be NVA staff)
- If specialty care is in dispute, the panel must include a specialist in the field of care related to the dispute

Not later than the fifth (5) business day before the scheduled meeting of the panel, unless the complainant agrees otherwise, NVA will provide to the complainant or the complainant's designated representative:

- any documentation to be presented to the panel by the NVA staff;
- the specialization of any physicians or providers consulted during the investigation; and
- the name and affiliation of each NVA representative on the panel.

The complainant or designated representative if the enrollee is a minor or disabled is entitled to:

- appear in person before the CAP;
- present alternative expert testimony; and
- request the presence of and question any person responsible for making the disputed decision that resulted in the appeal.

Appeals relating to ongoing emergencies or denials of continued stays for hospitalization will be completed in accordance with the medical or dental immediacy of the case but in no event to exceed one business day after the request for appeal is received. At the request of the

complainant, NVA shall provide, in lieu of a CAP, a review by a specialist of the same or similar specialty as the physician or provider who would typically manage the medical condition, procedure or treatment and who has not previously reviewed the case. The physician or provider reviewing the appeal may interview the patient or the patient's designated representative and shall decide on the appeal. Initial notice of the decision may be delivered orally if followed by written notice not later than three days after the date of the decision.

The Complaint Appeal Panel only serves in an advisory role to NVA. NVA will consider the findings of panel and render our final decision. The appeals process must be completed not later than 30 calendar days after receipt of the written request for appeal.

WHAT CAN I DO IF NVA DENIES OR LIMITS MY REQUEST FOR AUTHORIZATION OF A COVERED SERVICE?

You may ask NVA for another review of this decision. NVA Member Services department can assist members with filing an appeal. Members can call 877-636-2576.

PROCESS TO APPEAL A CHIP ADVERSE DETERMINATION

Adverse Determinations

A denial is issued when medical necessity cannot be determined for a requested service or if the requested service is determined to be experimental or investigational. Only the NVA Consulting Optometrist can render an adverse determination. Prior to issuing an adverse determination, providers will be notified by telephone and/or fax of the pending denial and offered the opportunity to submit additional clinical information or to discuss the member's case with the Optometric Consultant. If you disagree with a decision, you have the right to access the NVA Medical Necessity Appeal Process.

Medical Necessity Appeals

NVA maintains an internal appeal process for the resolution of medical necessity appeal requests. NVA will send a letter that informs the member, the provider requesting the service, and the service provider of appeal rights, including how to access expedited and Independent Organization Review appeals processes at the time a service is denied. The member, the member's representative, or the member's health care provider may appeal an adverse determination (medical necessity denial) orally or in writing, unless the Member asks for an Expedited Appeal. Within five business days from receipt of an appeal, a letter acknowledging the date that the oral or written appeal was received is sent to the appellant. Included with the letter is a list of documents/information required to process the appeal. Every oral appeal received must be confirmed by a written, signed appeal. A one page appeal form is enclosed with the acknowledgment letter when the appeal request is oral. Standard appeals resolutions are resolved and communicated to the appellant no later than 30 calendar days from receipt of the appeal.

Specialty Review – Second Level Appeal

A second level of appeal is available to the provider requesting the denied service. The provider may request a specialty review in writing within ten business days of receipt of the first level appeal resolution upholding the denial. A provider in the same or similar specialty typically manages the specialty condition, procedure, or treatment under discussion and not involved in

previous determinations will review the adverse determination. Specialty review is completed within fifteen business days of receipt of the appeal request.

Expedited Appeal Process

Requests for expedited appeals can be requested orally or in writing. If NVA denies a request for expedited appeal, the appeal request will follow the first level appeal process as described above in Medical Necessity Appeals. Investigation and resolution of appeals relating to presently occurring emergencies care for life-threatening conditions, or denials of continued stays for hospitalization follow the Expedited Appeal Process. A provider not involved in previous determinations and in the same or similar specialty as typically manages the medical, dental, or specialty condition, procedure, or treatment under discussion reviews the adverse determination and all related denial and appeal documentation. Investigation and resolution of expedited appeals are completed based on the medical or dental immediacy of the condition, procedure or treatment but does not exceed one business day from the date all information necessary to complete the appeal is received. The appeal resolution is communicated to the appellant via telephone and in writing. NVA's Health Plans Specialist can assist members with filing an expedited appeal. Members can call 877-636-2576.

Independent Review Organization Appeal

An Independent Review Organization (IRO) is an external organization that is selected by the Texas Department of Insurance (TDI) to review the request for appeal and render a decision on the request. An IRO appeal may be requested by the member, member's representative, or health care provider. Immediate access to an IRO review is available immediately for appeals relating to presently occurring emergencies, care for life-threatening conditions, or denials of continued stays for hospitalization without completion of the NVA Medical Necessity Appeals Process. IRO Request Forms are included all adverse determination letters or can be obtained by calling the Care Management Department.

The IRO makes its determination no later than:

- The 15th day after the date the IRO receives the information necessary to make the determination; or
- The 20th day after the date the IRO receives the request that the determination be made; and
- In the case of a life-threatening condition, not later than the 5th day after the IRO received the information necessary to make the determination; or
- The 8th day after the date the IRO receives the request that the determination be made.

If you are not satisfied with the outcome of the NVA Appeal Process, you can file a complaint with:

Texas Department of Insurance
Attention: Mail Code 103-6A
PO Box 149104 Austin, TX 78714-9104
Phone: 1-866-554-4926

No Retaliation

NVA will not retaliate against any person filing a complaint against NVA or appealing a decision made by NVA.

FILING COMPLAINTS WITH TDI

If I am not satisfied with the outcome, who else can I contact?

If NVA cannot settle your concern, you can file a complaint with the Texas Department of Insurance. You can call them at 1-800-252-3439 or write to:

STAR & STAR Kids Member Rights and Responsibilities

Member Rights

1. You have the right to respect, dignity, privacy, confidentiality, and nondiscrimination. That includes the right to:
 - a. Be treated fairly and with respect.
 - b. Know that your medical records and discussions with your providers will be kept private and confidential.
2. You have the right to a reasonable opportunity to choose a health care plan and Primary Care Provider. This is the doctor or health care provider you will see most of the time and who will coordinate your care. You have the right to change to another plan or provider in a reasonably easy manner. That includes the right to:
 - a. Be told how to choose and change your health plan and your primary care provider.
 - b. Choose any health plan you want that is available in your area and choose your primary care provider from that plan.
 - c. Change your primary care provider.
 - d. Change your health plan without penalty.
 - e. Be told how to change your health plan or your primary care provider.
3. You have the right to ask questions and get answers about anything you do not understand. That includes the right to:
 - a. Have your provider explain your health care needs to you and talk to you about the different ways your health care problems can be treated.
 - b. Be told why care or services were denied and not given.
4. You have the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:
 - a. Work as part of a team with your provider in deciding what health care is best for you.
 - b. Say yes or no to the care recommended by your provider.
5. You have the right to use each available complaint and appeal process through the managed care organization and through Medicaid, and get a timely response to complaints, appeals and fair hearings. That includes the right to:
 - a. Make a complaint to your health plan or to the state Medicaid program about your health care, your provider or your health plan.
 - b. Get a timely answer to your complaint.
 - c. Use the plan's appeal process and be told how to use it.
 - d. Ask for a fair hearing from the state Medicaid program and get information about how that process works.
6. You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:
 - a. Have telephone access to a medical professional 24 hours a day, 7 days a week to get any emergency or urgent care you need.
 - b. Get medical care in a timely manner.
 - c. Be able to get in and out of a health care provider's office. This includes barrier free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act.
 - d. Have interpreters, if needed, during appointments with your providers and when talking to your health plan. Interpreters include people who can speak in your native language help someone with a disability, or help you understand the information.
 - e. Be given information you can understand about your health plan rules, including the health care services you can get and how to get them.
7. You have the right to not be restrained or secluded when it is for someone else's

convenience, or is meant to force you to do something you do not want to do, or is to punish you.

8. You have a right to know that doctors, hospitals, and others who care for you can advise you about your health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
9. You have a right to know that you are not responsible for paying for covered services. Doctors, hospitals, and others cannot require you to pay copayments or any other amounts for covered services.

Member Responsibilities

1. You must learn and understand each right you have under the Medicaid program.
That includes the responsibility to:
 - a. Learn and understand your rights under the Medicaid program.
 - b. Ask questions if you do not understand your rights.
 - c. Learn what choices of health plans are available in your area.
2. You must abide by the health plans and Medicaid's policies and procedures. That includes the responsibility to:
 - a. Learn and follow your health plan's rules and Medicaid rules.
 - b. Choose your health plan and a primary care provider quickly.
 - c. Make any changes in your health plan and primary care provider in the ways established by Medicaid and by the health plan.
 - d. Keep your scheduled appointments.
 - e. Cancel appointments in advance when you cannot keep them.
 - f. Always contact your primary care provider first for your non-emergency medical needs.
 - g. Be sure you have approval from your primary care provider before going to a specialist.
 - h. Understand when you should and should not go to the emergency room.
3. You must share information about your health with your primary care provider and learn about service and treatment options. That includes the responsibility to:
 - a. Tell your primary care provider about your health.
 - b. Talk to your providers about your health care needs and ask questions about the different ways your health care problems can be treated.
 - c. Help your providers get your medical records.
4. You must be involved in decisions relating to service and treatment options, make personal choices, and take action to keep yourself healthy. That includes the responsibility to:
 - a. Work as a team with your provider in deciding what health care is best for you.
 - b. Understand how the things you do can affect your health.
 - c. Do the best you can to stay healthy.
 - d. Treat providers and staff with respect.
 - e. Talk to your provider about all of your medications.

If you think you have been treated unfairly or discriminated against, call the U.S. Department of Health and Human Services (HHS) toll-free at 800-368-1019. You also can view information concerning the HHS Office of Civil Rights online at [hhs.gov/ocr](https://www.hhs.gov/ocr).

CHIP MEMBER RIGHTS AND RESPONSIBILITIES

The following is a list of member rights received upon enrollment with CCHP:

MEMBER RIGHTS

1. You have the right to get accurate, easy-to-understand information to help you make good choices about your child's health plan, doctors, hospitals and other providers.
2. Your health plan must tell you if they use a "limited provider network." This is a group of doctors and other providers who only refer patients to other doctors who are in the same group. "Limited provider network" means you cannot see all the doctors who are in your health plan. If your health plan uses "limited networks," you should check to see that your child's primary care provider and any specialist doctor you might like to see are part of the same "limited network."
3. You have a right to know how your doctors are paid. Some get a fixed payment no matter how often you visit. Others get paid based on the services they give to your child. You have a right to know about what those payments are and how they work.
4. You have a right to know how the health plan decides about whether a service is covered or medically necessary. You have the right to know about the people in the health plan who decides those things.
5. You have a right to know the names of the hospitals and other providers in your health plan and their addresses.
6. You have a right to pick from a list of health care providers that is large enough so that your child can get the right kind of care when your child needs it.
7. If a doctor says your child has special health care needs or a disability, you may be able to use a specialist as your child's primary care provider. Ask your health plan about this.
8. Children who are diagnosed with special health care needs or a disability have the right to special care.
9. If your child has special medical problems, and the doctor your child is seeing leaves your health plan, your child may be able to continue seeing that doctor for three months and the health plan must continue paying for those services. Ask you plan about how this works.
10. Your daughter has the right to see a participating obstetrician/gynecologist (OB/GYN) without a referral from her primary care provider and without first checking with your health plan. Ask your plan how this works. Some plans may make you pick an OB/GYN before seeing that doctor without a referral.
11. Your child has the right to emergency services if you reasonably believe your child's life is in danger, or that your child would be seriously hurt without getting treated right away. Coverage of emergencies is available without first checking with your health plan. You may have to pay a co-payment depending on your income.
12. You have the right and responsibility to take part in all the choices about your child's health care.
13. You have the right to speak for your child in all treatment choices.
14. You have a right to get a second opinion from another doctor in your health plan about what kind of treatment your child needs.
15. You have the right to be treated fairly by your health plan, doctors, hospitals and other providers.
16. You have the right to talk to your child's doctors and other providers in private, and to have

your child's medical records kept private. You have the right to look over and copy your child's medical records and to ask for changes to those records.

17. You have the right to a fair and quick process for solving problems with your health plan and the plan's doctors, hospitals and others who provide services to your child. If your health plan says it will not pay for a covered service or benefit that your child's doctor thinks is medically necessary, you have a right to have another group, outside the health plan, tell you if they think your doctor or the health plan was right.
18. You have the right to know that doctors, hospitals, and others who care for your child can advise you about your child's health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
19. You have a right to know that you are only responsible for paying allowable copayments for covered services. Doctors, hospitals, and others cannot require you to pay any other amounts for covered services.

MEMBER RESPONSIBILITIES

You and your health plan both have an interest in seeing your child's health improve. You can help by assuming these responsibilities.

1. You must try to follow healthy habits. Encourage your child to stay away from tobacco and to eat a healthy diet.
2. You must become involved in the doctor's decisions about your child's treatments.
3. You must work together with your health plan's doctors and other providers to pick treatments for your child that you have all agreed upon.
4. If you have a disagreement with your health plan, you must try to first resolve it using the health plan's complaint process.
5. You must learn about what your health plan does and does not cover. Read your Member Handbook to understand how the rules work.
6. If you make an appointment for your child, you must try to get to the doctor's office on time. If you cannot keep the appointment, be sure to call and cancel it.
7. If your child has CHIP, you are responsible for paying your doctor and other providers co-payments that you owe them. If your child is getting CHIP
8. You must report misuse of the CHIP or CHIP Perinatal services by health care providers, other members, or health plans.
9. Talk to your child's provider about all of your child's medications.

Reporting Waste, Abuse, or Fraud By A Provider Or Client Medicaid Managed Care and CHIP

Do you want to report Waste, Abuse or Fraud?

Let us know if you think a doctor, dentist, pharmacist at a drug store, other health care providers, or a person getting benefits is doing something wrong. Doing something wrong could be waste, abuse, or fraud, which is against the law.

For example, tell us if you think someone is:

- Getting paid for services that weren't given necessary.
- Not telling the truth about medical condition to get medical treatment.
- Letting someone else use their Medicaid ID.
- Using someone else's Medicaid or CHIP ID.
- Not telling the truth about the amount of money or resources he or she has to get benefits.

To report waste, abuse, or fraud, choose one of the following:

- Call the OIG Hotline at 800-436-6184;
- Visit <https://oig.hhsc.state.tx.us/> Under the box labeled "I WANT TO" click "Report Waste, Abuse, and Fraud" to complete the online form; or
- You can report directly to your health plan:
 - o Cook Children's Health Plan
 - o PO Box 2488, Fort Worth, TX 76113
 - o (800) 964-2247

To report waste, abuse, or fraud, gather as much information as possible.

- When reporting about a provider (a doctor, dentist, counselor, etc.) include:
 - o Name, address, and phone number of provider
 - o Name and address of the facility (hospital, nursing home, home health agency, etc.)
 - o Medicaid number of the provider and facility, if you have it
 - o Type of provider (doctor, dentist, therapist, pharmacist, etc.)
 - o Names and phone numbers of the witnesses who can help in the investigation
 - o Dates of events
 - o Summary of what happened
- When reporting about someone who gets benefits, include:
 - o The person's name
 - o The person's date of birth, Social Security number, or case number if you have it
 - o The city where the person lives
 - o Specific details about the waste, abuse, or fraud

REPORTING ABUSE, NEGLECT, OR EXPLOITATION (ANE)

MEDICAID MANAGED CARE

Report suspected Abuse, Neglect, and Exploitation:

MCOs and providers must report any allegation or suspicion of ANE that occurs within the delivery of long-term services and supports to the appropriate entity. The managed care contracts include MCO and provider responsibilities related to identification and reporting of ANE. Additional state laws related to MCO and provider requirements continue to apply.

Report to the Department of Aging and Disability Services (DADS) if the victim is an adult or child who resides in or receives services from:

- Nursing facilities;
- Assisted living facilities;
- Home and Community Support Services Agencies (HCSSAs) – Providers are required to report allegations of ANE to both DFPS and DADS;
- Adult day care centers; or

- Licensed adult foster care providers

Contact DADS at 1-800-647-7418.

Report to the Department of Family and Protective Services (DFPS) if the victim is one of the following:

- An adult who is elderly or has a disability, receiving services from:
 - Home and Community Support Services Agencies (HCSSAs) – also required to report any HCSSA allegation to DADS;
 - Unlicensed adult foster care provider with three or fewer beds
- An adult with a disability or child residing in or receiving services from one of the following providers or their contractors:
 - Local Intellectual and Developmental Disability Authority (LIDDA), Local mental health authority (LMHAs), Community center, or Mental health facility operated by the Department of State Health Services;
 - a person who contracts with a Medicaid managed care organization to provide behavioral health services;
 - a managed care organization;
 - an officer, employee, agent, contractor, or subcontractor of a person or entity listed above; and
- An adult with a disability receiving services through the Consumer Directed Services option

Contact DFPS at 1-800-252-5400 or, in non-emergency situations, online at www.txabusehotline.org

Report to Local Law Enforcement:

- If a provider is unable to identify state agency jurisdiction but an instance of ANE appears to have occurred, report to a local law enforcement agency and DFPS.

Failure to Report or False Reporting:

- It is a criminal offense if a person fails to report suspected ANE of a person to DFPS, DADS, or a law enforcement agency (See: Texas Human Resources Code, Section 48.052; Texas Health & Safety Code, Section 260A.012; and Texas Family Code, Section 261.109).
- It is a criminal offense to knowingly or intentionally report false information to DFPS, DADS, or a law enforcement agency regarding ANE (See: Texas Human Resources Code, Sec. 48.052; Texas Health & Safety Code, Section 260A.013; and Texas Family Code, Section 261.107).
- Everyone has an obligation to report suspected ANE against a child, an adult that is elderly, or an adult with a disability to DFPS. This includes ANE committed by a family member, DFPS licensed foster parent or accredited child placing agency foster home, DFPS licensed general residential operation, or at a childcare center.

Cook Provider Fee Schedule (Lab Users)

Procedure Code	Description	Fee
<i>Eye Examination</i>		
92002	Exam New Patient (Intermediate)	\$50.00
92004	Exam New Patient	\$50.00
92012	Exam Existing Patient (Intermediate)	\$50.00
92014	Exam Existing Patient	\$50.00
<i>Spectacle Frames and Lenses</i>		
V2020	Vision Services Frames Purchase	Included
V2025	Vision Services Specialty Frames Purchase	Included
V2100	Lens Sphere Single Plano 4.0	Included
V2101	Single Vision Sphere 4.12-7.00	Included
V2102	Single Vision Sphere 7.12-20.00	Included
V2103	Sphero cylinder 4.00D/12-2.00D	Included
V2104	Sphero cylinder 4.00D/2.12-4D	Included
Procedure Code	Description	Fee
V2105	Sphero cylinder 4.00D/4.25-6D	Included
V2106	Sphero cylinder 4.00D/>6.00D	Included
V2107	Sphero cylinder 4.25D/12-2D	Included
V2108	Sphero cylinder 4.25D/2.12-4D	Included
V2109	Sphero cylinder 4.25D/4.25-6D	Included
V2110	Sphero cylinder 4.25D/Over 6D	Included
V2111	Sphero cylinder 7.25D/2.25-2.25	Included
V2112	Sphero cylinder 7.25D/2.25-4D	Included
V2113	Sphero cylinder 7.25D/4.25-6D	Included
V2114	Sphero cylinder Over 12.00D	Included
V2115	Lens Lenticular Bifocal	Included
V2118	Lens Aniseikonic Single	Included
V2121	Lenticular Lens, Single	Included
V2200	Lens Sphere Bifocal Plano 4.00D	Included
V2201	Lens Sphere Bifocal 4.12-7.0	Included
V2202	Lens Sphere Bifocal 7.12-20.	Included
V2203	Lens Sphcyl Bifocal 4.00D/.1	Included
V2204	Lens Sphcyl Bifocal 4.00D/2.1	Included
V2205	Lens Sphcyl Bifocal 4.00D/4.2	Included
V2206	Lens Sphcyl Bifocal 4.00D/Over	Included
V2207	Lens Sphcyl Bifocal 4.25/7D/.	Included
V2208	Lens Sphcyl Bifocal 4.25-7/2.	Included

V2209	Lens Sphcyl Bifocal 4.25-7/4.	Included
V2210	Lens Sphcyl Bifocal 4.25-7/OV	Included
V2211	Lens Sphcyl Bifocal 7.25-12/.25-	Included
V2212	Lens Sphcyl Bifocal 7.25-12/2.2	Included
V2213	Lens Sphcyl Bifocal 7.25-12/4.2	Included
V2214	Lens Sphcyl Bifocal Over 12.	Included
V2215	Lens Lenticular Bifocal	Included
V2218	Lens Aniseikonic Bifocal	Included
V2219	Lens Bifocal Seg Width Over	Included
V2220	Lens Bifocal Add Over 3.25D	Included
V2221	Lenticular Lens, Bifocal	Included
Procedure Code	Description	Fee
V2300	Lens Sphere Trifocal 4.00D	Included
V2301	Lens Sphere Trifocal 4.12-7.	Included
V2302	Lens Sphere Trifocal 7.12-20	Included
V2303	Lens Sphcyl Trifocal 4.0/.12-	Included
V2304	Lens Sphcyl Trifocal 4.0/2.25	Included
V2305	Lens Sphcyl Trifocal 4.0/4.25	Included
V2306	Lens Sphcyl Trifocal 4.00/>6	Included
V2307	Lens Sphcyl Trifocal 4.25-7/.	Included
V2308	Lens Sphcyl Trifocal 4.25-7/2.	Included
V2309	Lens Sphcyl Trifocal 4.25-7/4.	Included
V2310	Lens Sphcyl Trifocal 4.25-7/>6	Included
V2311	Lens Sphcyl Trifocal 7.25-12/.25-	Included
V2312	Lens Sphcyl Trifocal 7.25-12/2.25	Included
V2313	Lens Sphcyl Trifocal 7.25-12/4.25	Included
V2314	Lens Sphcyl Trifocal Over 12	Included
V2315	Lens Lenticular Trifocal	Included
V2318	Lens Aniseikonic Trifocal	Included
V2319	Lens Trifocal Seg Width >28	Included
V2320	Lens Trifocal Add Over 3.25D	Included
V2321	Lenticular Lens, Trifocal	Included
V2783	High Index 1.66 or greater	Included
Dispensing Services		
92340	Fitting of Spectacles	\$20.00
92341	Fitting of Spectacles	\$20.00
92342	Fitting of Spectacles	\$20.00
92370	Repair of existing Spectacles including materials/supplies	\$5.00
Options	Each of these options may be provided when Medically Necessary with Prior Approval of Services (PAS)	
V2745	Solid Tint	Included
V2718	Press On Prism	Included
V2755	UV Coating	Included
V2784	Polycarbonate Lenses (all children automatically and adults with -5.25 / +4.00)	Included (no PAS Required)

Medically Necessary Contact Lenses Services	When contact lenses are provided, they are in lieu of eyeglasses. Medically Necessary contact lenses require Prior Approval (PAS). Contact Lens fees are global fees, including fitting, follow up, I and R Training, and Materials.	
CPT	Service	
92310	Medically necessary fit Other Ocular Disease	Medicaid Fee Schedule
92311	Medically necessary fit Aphakia Unilateral	Medicaid Fee Schedule
92312	Medically necessary fit Aphakia Bilateral	Medicaid Fee Schedule
92313	Medically necessary fit Aphakia cornea scleral	Medicaid Fee Schedule
92071	Medically necessary fit Ocular Surface Disease	Medicaid Fee Schedule
92072	Medically necessary fit – Keratoconus	Medicaid Fee Schedule
HCPCS	Material	

V2500	PMMA Spherical	Medicaid Fee Schedule
V2501	PMMA Toric	Medicaid Fee Schedule
V2502	PMMA Bifocal	Medicaid Fee Schedule
V2510	Gas Perm Spherical	Medicaid Fee Schedule
V2511	Gas Perm Toric	Medicaid Fee Schedule
V2512	Gas Perm Bifocal	Medicaid Fee Schedule
V2513	Gas Perm Extended Wear	Medicaid Fee Schedule
V2520	Soft Spherical	Medicaid Fee Schedule
V2521	Soft Toric	Medicaid Fee Schedule
V2522	Soft Bifocal	Medicaid Fee Schedule
V2523	Soft Extended Wear	Medicaid Fee Schedule
V2530	Scleral Lens – Gas Impermeable	Medicaid Fee Schedule
V2531	Scleral Lens – Gas Permeable	Medicaid Fee Schedule
Cosmetic Contact Lens Services	When contact lenses are provided, they are in lieu of eyeglasses. Contact Lens allowances are global fees, including fitting, follow up, I and R Training, and Materials. The patient pays any amount over the allowance.	
HCPCS	Material	
92310	Cosmetic fit and Follow up - Initial	\$75 Allowance *
92326	Cosmetic fit and follow up - Replacement	\$75 Allowance *
V2500	PMMA Spherical	\$75 Allowance *
V2501	PMMA Toric	\$75 Allowance *
V2502	PMMA Bifocal	\$75 Allowance *
V2510	Gas Perm Spherical	\$75 Allowance *
V2511	Gas Perm Toric	\$75 Allowance *
V2512	Gas Perm Bifocal	\$75 Allowance *
V2513	Gas Perm Extended Wear	\$75 Allowance *
V2520	Soft Spherical	\$75 Allowance *
V2521	Soft Toric	\$75 Allowance *
V2522	Soft Bifocal	\$75 Allowance *
V2523	Soft Extended Wear	\$75 Allowance *

<i>Medical and or Ancillary Services</i>	Medically necessary services provided by a Plan Optometrist	Maximum of 100% of Medicaid Allowable Fees
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PRIOR AUTHORIZATION REQUEST FORM FOR ROUTINE SERVICES & MATERIALS

Intended Use: Use this form to request authorization by secure email, fax or mail when a service requires prior authorization of a medical optometry service.

Do not use this form to: 1) request an appeal; 2) confirm eligibility; 3) verify coverage; 4) request a guarantee of payment; 5) ask whether a service requires prior authorization; or 7) request a referral to an out of network provider.

Additional Information and Instructions:

Section I – Submission:

Please enter the information of the person filling out the form.

Section II – General Information:

Urgent reviews: Services should be provided immediately, then request an urgent review for a patient with a life-threatening condition, or for a patient who is currently hospitalized, or to authorize treatment following stabilization of an emergency condition. You may also request an urgent review to authorize treatment of an acute injury or illness, if the provider determines that the condition is severe or painful enough to warrant an expedited or urgent review to prevent a serious deterioration of the patient's condition or health.

Section IV – Provider Information:

- If the requesting provider's signature is required, you may not use a signature stamp.

Section VI – Clinical Documentation:

- Attach supporting clinical documentation (medical records, progress notes, etc.), if needed.

Note: If the requesting provider wants to be called directly about missing information needed to process this request, you may include the provider's direct phone number in the space given at the bottom of the request form. Such a phone call cannot be considered a peer-to-peer discussion. A peer-to-peer discussion must include, at a minimum, the clinical basis for the URA's decision and a description of documentation or evidence, if any, that can be submitted by the provider of record that, on appeal, might lead to a different utilization review decision.



PRIOR AUTHORIZATION REQUEST FORM FOR ROUTINE SERVICES & MATERIALS

SECTION I — PATIENT INFORMATION

Name:	Phone:	DOB:	Male	Female
Subscriber Name (if different):	Member ID #:	AGE:		

SECTION II — PROVIDER INFORMATION

Requesting Provider or Facility				
Name:				
NPI #:		Address:		
Phone:		Fax:		
Contact Name:			Phone:	
Requesting Provider's Signature and Date (required):				

SECTION III — SERVICES REQUESTED (WITH CPT OR HCPCS CODE) AND SUPPORTING DIAGNOSES (WITH ICD CODE)

Planned Service or Procedure	Code	Start Date	End Date	ICD-10 Code	Diagnosis Description

SECTION IV — CLINICAL DOCUMENTATION (Please include supporting Medical Records*)

Reason for additional services (check one)	
Replacement for Lost/Broken Eyeglasses	
Replacement for Lost/Broken Frame Only	
Replacement for Lost/Broken Lenses Only	
Medically Necessary Contact Lenses*	
Medically Necessary Tint*	
Medically Necessary UV Coating*	
Medically Necessary Press on Prisms*	
High Index 1.66 or greater*	
Change of Prescription	
Specialty Frames* (STAR Kids Only)	

Old Prescription		SPHERICAL	CYLINDRICAL	AXIS	PRISM	Additional Information
Distance	O.D.					
	O.S.					
Add	O.D.					
	O.S.					
New Prescription		SPHERICAL	CYLINDRICAL	AXIS	PRISM	Additional Information
Distance	O.D.					
	O.S.					
Add	O.D.					
	O.S.					



PRIOR APPROVAL REQUEST FOR MEDICAL & ANCILLARY SERVICES

Intended Use: Use this form to request authorization by secure email, fax or mail when a service requires prior authorization of a medical optometry service.

Do not use this form to: 1) request an appeal; 2) confirm eligibility; 3) verify coverage; 4) request a guarantee of payment; 5) ask whether a service requires prior authorization; or 7) request a referral to an out of network provider.

Additional Information and Instructions:

Section I – Submission:

Please enter the information of the person filling out the form.

Section II – General Information:

Urgent reviews: Services should be provided immediately, then request an urgent review for a patient with a life-threatening condition, or for a patient who is currently hospitalized, or to authorize treatment following stabilization of an emergency condition. You may also request an urgent review to authorize treatment of an acute injury or illness, if the provider determines that the condition is severe or painful enough to warrant an expedited or urgent review to prevent a serious deterioration of the patient's condition or health.

Section IV – Provider Information:

- If the requesting provider's signature is required, you may not use a signature stamp.

Section VI – Clinical Documentation:

- Attach supporting clinical documentation (medical records, progress notes, etc.), if needed.

***Note:** If the requesting provider wants to be called directly about missing information needed to process this request, you may include the provider's direct phone number in the space given at the bottom of the request form. Such a phone call cannot be considered a peer-to-peer discussion. A peer-to-peer discussion must include, at a minimum, the clinical basis for the URA's decision and a description of documentation or evidence, if any, that can be submitted by the provider of record that, on appeal, might lead to a different utilization review decision.*

EMERGENCY SERVICES

The Provider should render care if appropriate or immediately direct the member to call 911 or go to the nearest emergency room or comparable facility if the provider determines an emergency medical condition exists. If an emergency condition does not exist, the provider should direct the member to a CCHP participating office. CCHP does not require that the member receive approval from the health plan or the PCP prior to accessing emergency care. Prior approvals should be submitted to NVA after emergency services has been provided. To facilitate continuity of care, CCHP instructs members to notify their PCP as soon as possible after receiving emergency care. Providers are not required to notify CCHP Care Management about emergency care services.



PRIOR APPROVAL REQUEST FOR MEDICAL & ANCILLARY SERVICES

SECTION I — PATIENT INFORMATION

Name:	Phone:	DOB:	Male	Female
Subscriber Name (if different):	Member ID #:	AGE:		

SECTION II — PROVIDER INFORMATION

Requesting Provider or Facility	
Name:	
NPI #:	Address:
Phone:	Fax:
Contact Name:	Phone:
Requesting Provider's Signature and Date (required):	

SECTION III — SERVICES REQUESTED (WITH CPT OR HCPCS CODE) AND SUPPORTING DIAGNOSES (WITH ICD CODE)

Planned Service or Procedure	Code	Start Date	End Date	ICD-10 Code	Diagnosis Description

SECTION IV — CLINICAL DOCUMENTATION (Please include supporting Medical Records)

Prescription		SPHERICAL	CYLINDRICAL	AXIS	PRISM	Additional Information
Distance	O.D.					
	O.S.					
Add	O.D.					
	O.S.					
Best Visual Acuity		Acuity	Additional Information			
Distance	O.D.					
	O.S.					
Near	O.D.					
	O.S.					

NVA staff needing more information may call the requesting provider directly at: _____

Vision Care Eyeglass Patient (Medicaid Client) Certification Form

I, _____, certify that:
Printed name of Medicaid client

(Check all that apply:)

- ☐ I was offered a selection of serviceable glasses at no cost to me, but I desired a type or style of eyewear beyond Medicaid program benefits. *I will be responsible for any balance for eyewear beyond Medicaid program benefits.*

My selection(s) beyond Medicaid benefits were:

1. _____
2. _____
3. _____
4. _____

- ☐ The glasses that are being replaced were unintentionally lost or destroyed.

- ☐ I picked up/received the eyewear.

Medicaid client signature

Witness signature

Date

Date

Client Medicaid number

Provider TPI

Provider NPI

F00096

Effective Date_01152008/Revised Date_08072007

**Vision Care Eyeglass Patient (Medicaid Client) Certification Form
(Spanish)**

Yo, _____, declaro que:
Nombre del cliente de Medicaid

(Marque todos los que apliquen)

- ☐ Yo necesito reemplazar los lentes que tengo. Me ofrecieron una selección de lentes gratis, pero deseo otro tipo que no está incluido en el programa de Medicaid. *Yo entiendo que tendré que pagar por la diferencia.*

La selección(es) de lentes que escogí fue:

1. _____
2. _____
3. _____
4. _____

- ☐ Los lentes que van a ser reemplazados no fueron perdidos o destruidos intencionadamente.
- ☐ Yo recibí los lentes.

Firma del Cliente

Firma de Testigos

Fecha

Fecha


Número de identificación de Medicaid del
Cliente

Número de identificación del proveedor (TPI)

Número de identificación del proveedor (NPI)

F00096

Effective Date_01152008/Revised Date_08072007

		Order online www.e-nva.com		3710 Belmont Ave Youngstown, OH 44505 Fax (888) 522-2022																	
		Phone Number				Fax Number															
Please Print or Type	Provider Number									Authorization Number											
Provider Name																					
Provider Address																					
City											State				Zip						
MEMBER	Name – Last						First						Initial								
	Date of Birth												Date of Service								
	MM		DD		YYYY		MM		DD												
Poly Only Choices									Plastic Only Choices												
SV	Ft 28		Tri 7x28		Ft 25	Tri 7x25			RD	Exec											
R	Sphere		Cylinder		Axis		Dec		Prism		Prism Direction		Lens Base								
L																					
ADD L	Seg Hgt		Inset		Total		Rt. PD Far		Rt. PD Near												
							Lt. PD Far		Lt. PD Near												
Plan Frame V2020				Frame Name								Frame Manufacturer									
Member Frame M2025				Color								Eye		Bridge		Temple					
Lens Options																					
UV	Tint		Solid Tint Color						Select Density	10%											
										20%											
										30%											
Special Instructions																					

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

<input type="checkbox"/> PICA										PICA <input type="checkbox"/>																																																	
1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP <input type="checkbox"/> (SSN or ID) HEALTH PLAN FECA <input type="checkbox"/> (SSN) BLK LUNG OTHER <input type="checkbox"/> (ID)										1a. INSURED'S I.D. NUMBER (For Program in Item 1)																																																	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>										4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																							
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street)																																							
CITY					STATE					CITY					STATE																																												
ZIP CODE					TELEPHONE (Include Area Code) ()					ZIP CODE					TELEPHONE (Include Area Code) ()																																												
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:										11. INSURED'S POLICY GROUP OR FECA NUMBER																																							
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO										a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>																																							
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State)										b. EMPLOYER'S NAME OR SCHOOL NAME																																							
c. EMPLOYER'S NAME OR SCHOOL NAME										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO										c. INSURANCE PLAN NAME OR PROGRAM NAME																																							
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. RESERVED FOR LOCAL USE										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.																																							
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.																				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.																																							
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.																				SIGNED _____ DATE _____																																							
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																																							
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a. <input type="checkbox"/> 17b. NPI										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																							
19. RESERVED FOR LOCAL USE																				20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES																																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)																				22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.																																							
1. _____ 3. _____																				23. PRIOR AUTHORIZATION NUMBER																																							
2. _____ 4. _____																				24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #																																							
1																				NPI																																							
2																				NPI																																							
3																				NPI																																							
4																				NPI																																							
5																				NPI																																							
6																				NPI																																							
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>										26. PATIENT'S ACCOUNT NO.										27. ACCEPT ASSIGNMENT? (If gov't claim, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$										29. AMOUNT PAID \$										30. BALANCE DUE \$									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)										32. SERVICE FACILITY LOCATION INFORMATION										33. BILLING PROVIDER INFO & PH # ()																																							
SIGNED _____ DATE _____										a. NPI										b. NPI																																							

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

**NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION
(PRIVACY ACT STATEMENT)**

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101; 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0999. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.