PREMIER
EYE CARE
A Health Network One Company

PROVIDER MANUAL

Premier Eye Care

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Welcome to Premier Eye Care

We are pleased you joined our network of providers.

Introduction

Founded in 1994, Premier Eye Care (Premier) provides expert management of total eye care from routine exams to complex ocular surgical procedures.

In partnership with providers and health plans, our comprehensive network provides services to Medicare and Medicaid Members. We offer an integrated network of providers that include optometrists, ophthalmologists, ocular subspecialists, optical centers, as well as ambulatory surgical centers, anesthesia and eye care pharmacy services.

We are licensed as a Third Party Administrator and Utilization Review Organization in multiple states. We have received NCQA's Utilization-Management and Credentialing Accreditation. We are compliant with all applicable federal and state laws and regulations, including HIPAA, CMS and state Medicaid agency requirements. We accept full Health Plan delegation for Network Management, Claims Payment, Customer Service, Provider Credentialing, and Utilization Management.

By focusing on improving access to preventive care and facilitating access to the right care at the right time in the proper setting, we improve health outcomes, better the lives of members and reduce costs for the Health Plans we serve.

Premier has the expertise, the experience, and the agility to create new processes and services needed to remain on the cutting edge of keeping quality health care accessible and affordable. Health Plans and Providers consistently recognize Premier for our responsiveness and commitment to do whatever it takes to get the job done. We strive to deliver service excellence and exceed expectations.

NOTE: This manual replaces any previous versions. This manual is not intended to be a complete statement of all Premier's Provider polices or procedures. Other policies and procedures may be posted on our website, published in special notices or newsletters. Any section of this manual may also be updated. In the event of any inconsistency between information contained in this manual and the agreement between you or your facility and Premier, the terms of the agreement(s) shall prevail. For the purposes of this manual:

- The term “Member” refers to a person who is entitled to receive benefits administered by Premier, and may also be referred to as patient, individual or enrollee.
- The term “Practitioner” or “Provider” means any physician, facility, hospital, or other health care professional participating in Premier’s network.
- Member Benefit Plans are determined by each Health Plan for Medicare and Medicaid programs.

Our Vision and Mission

Our Vision is to provide the highest quality eye care services in partnership with members, providers and health care plans.

We are an innovative and dynamic organization dedicated to facilitating the delivery of professional and proactive health care to the communities we serve.

Premier is dedicated to a fundamental set of principles that inspires all that we do:

Partnership: Partner with Providers and Health Plans to provide quality, cost-effective healthcare solutions and unparalleled service.

Integrity: Earn the trust of those we serve by doing the right thing on a daily basis by keeping our commitments.

Teamwork: Display a collaborative approach to work together to meet the needs of our customers.

Respect: Treat members with respect and compassion while seeking to improve their health and quality of life.

Accountability: Maintain a passionate desire to excel in every aspect of our business, with each associate accepting personal responsibility for achieving organizational success.

Community: Support our communities through volunteerism and civic involvement.

Section I
The Provider Experience

The purpose of this Provider Manual is to give our participating Practitioners a guide to Premier's policies and procedures and each Health Plan's specific requirements. The Provider Manual is incorporated by reference into the Provider Agreement between you and Premier.

We realize the administrative requirements of managing a member's health care can be complex. We trust this will assist you in understanding these requirements and serve as a resource for answering questions you may have about participation, health plan programs, credentialing, utilization management, coding and claim filing guidelines.

Our Commitment to Service

Premier established the following core concepts in its approach to a positive provider experience:

- We share your mission and strive for the better health and continued well-being of patients.
- We deliver easy-to-use technology with online services that allow you to readily access patient information.
- We are dedicated to providing accurate and timely claim processing and payments to help you reduce administrative burden.
- We have a committed team who understands your practice operations and its challenges.
- We are your dedicated partner to succeed in today's healthcare environment.

Technology Tools

Premier takes advantage of cutting-edge technology to increase speed and efficiency while keeping program administration and Provider participation costs as low as possible. Our tools help to improve your office workflow and enhance your staff's productivity.

Paperless Environment

The paperless concept is a central component of Premier's attempt to eliminate paper transactions. Electronic transactions save time and cost and improve efficiency. We have ongoing efforts to enhance electronic transmission, submission and payment capabilities.

Provider Orientation and Education

Premier conducts new provider orientation via on-site visits, telephone conference, email or webinar within 30 days of the practitioner's credentialing approval. Orientation includes an overview of Premier's Provider Manual, Provider Web Portal, member benefits, health plan rules/protocols, Clinical guidelines, Quick Reference Guides by state and line of business.

On an ongoing basis, Premier provides additional training and updates to all practitioners on various topics via email, fax, webinars and telephone conferences. As deemed necessary, Premier will contact certain providers and provide specialized training on specific topics, e.g., billing issues, authorization guidelines, etc. In certain cases, Premier may initiate an onsite visit to address specific issues.

Provider Web Portal

Premier's Provider Web Portal allows participating Practitioners direct access to our online services. To register for our Provider Web Portal please go to our website at: www.premiereyecare.net and sign up as a new user.

Online access requires only an internet browser, a valid user ID, and a password. From an internet browser, Providers and authorized office staff can log in for secured access to the system anytime from anywhere to:

- Verify Member eligibility
- Verify Routine Vision Benefits
- Check Member Co-Payment information
- Check the status of your claims
- Obtain certain Authorizations that may be required
- Review the latest Premier clinical guidelines, Provider Manual, Quality Improvement program, Standards of Conduct, etc.
- Review provider training materials e.g., Fraud and Abuse awareness training requirements, Cultural Competence, Reporting Abuse, Neglect and Exploitation, etc.

The Provider Web Portal is our commitment to help Providers keep office costs low, access information efficiently, receive payments quicker, and submit claims and authorizations electronically. Note: If a claim is denied for Services Not Covered or Exceeds Member Benefit Limitations, the Member could potentially have liability.

Health Plan Quick Reference Guides (QRGs)

We have prepared QRGs for you by Health Plan. The QRGs give you a quick overview of the particular Health Plan's protocols and requirements with specifics by plan and line of business.

- Important Provider Services Phone Numbers
- What is covered (i.e. Medical, Routine Vision)
- When to obtain an Authorization
- How to coordinate Part B drugs administered in the office
- Claims information

QRGs (by Health Plan) are posted on our Provider Web Portal. Please log in to the Provider Web Portal to access the QRGs.

Provider Satisfaction

Your satisfaction is important to us and we encourage you to participate in our annual online provider satisfaction surveys. Watch the web-portal and your email for survey announcements. Survey data is analyzed and reported to Premier's Quality Improvement Committee where improvement opportunities are evaluated and acted upon.

If You Have a Complaint

If you have a complaint that unrelated to claims payment, for example, a complaint about a certain Premier policy or process, courtesy of our Provider Services representatives, or a complaint about a Health Plan member, please contact our Network Management Team via mail, telephone 1-855-787-2020 or email NetworkManagement@premiereyecare.net

Our Network Management Team will help resolve your complaint. They will contact all necessary parties to help resolve your issue. We aim to provide first call resolution whenever possible. If an issue requires research and follow-up, a Premier team member will respond to you as soon as possible.

Generally, you have 45 calendar days to file a written complaint that is not about claims issues. We will acknowledge receipt of your complaint within 3 business days, give you a status report every 15 calendar days and resolve all complaints within 90 calendar days of receipt and send you written notice of the disposition and the basis of the resolution within three (3) business days of resolution.

Our Service Standards

Premier's Provider Services Team aims to provide resolution of issues on the first call.
Our response time goals are as follows:

- Answer call within 30 seconds
- Respond to voice mail messages within 24 hours
- Respond to urgent call within one hour

Premier will track and trend the type of issues that you or your staff bring to our attention so we can determine the root cause and proactively correct the underlying issue.

Premier offers IVR (interactive voice recording) service after hours and all hours on weekends and holidays in all states to provide the option to leave a voicemail and Premier Representatives will return all voicemails the next business day.

Please note that Premier and the Health Plan may provide available information concerning an individual's status, eligibility of benefits, or level of benefits. The receipt of such information shall not be deemed to be a promise or guarantee of payment nor of Member's eligibility to receive benefits.

Section II
Member Eligibility and Services

Member Eligibility Verification

We encourage you to log into our **Provider Web Portal** by entering your username and password on the upper right-hand corner of www.premiereyecare.net to check member eligibility and benefits.

Access to Member Eligibility Information

- To access the eligibility information, simply go to the Provider Web Portal and log in with your username and password.

- Our Provider Service team is also available to you Monday through Friday from 8:00 am to 5:00 pm in each time zone (please reference page 46 for the Provider Services number for your State).

The eligibility information received from either of these sources will be the same; however, the **Provider Web Portal is available 24 hours a day, 7 days a week**.

If a new Member presents to your office without their Health Plan ID card please use the Provider Web Portal to verify eligibility.

Member ID cards

Each Member has a unique Member ID number that will be needed for most transactions. Please remind your office staff to:

- Make a copy of both sides of the ID card and of a Photo ID for your records
- Ask the member if there are any changes to their address or plan information
- Ensure that you are a participating provider for that member's plan
- Verify the Member's co-payment amounts

Presentation of a Health Plan ID card is not a guarantee of an individual's status or eligibility to receive benefits. Please verify *current* eligibility by checking our Provider Web Portal or by calling us. In addition, all payments are subject to the terms of the contract under which the individual is eligible to receive benefits.

Covered Services

Medical eye care services are available to all Medicare and Medicaid Members. Prior Authorization from Premier is required for all medical services. Please see each Health Plan's authorization requirements attached.

Routine vision benefits (annual eye exam and eyewear) vary by Health Plan and by line of business. You can verify member's eligibility and benefits on the portal.

Section III
Physician Responsibilities

Non-Discrimination

A Practitioner's responsibility is to provide or arrange Medically Necessary Covered Services for Members without regard to race, ethnicity, national origin, religion, sex, age, mental or physical disability such as ESRD, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information or source of payment.

Further, a Practitioner should treat Premier's Health Plan Members in the same manner and in accordance with the same standards as the Practitioner's other patients.

Availability and Accessibility

Practitioners should ensure that appointment standards are adhered to in an effort to ensure accessibility of needed services, maintain Member satisfaction and reduce unnecessary use of alternative services such as an emergency room. Providers should have hours of operation that do not discriminate against particular types of Members or Members with special needs.

Practitioners are to make necessary and appropriate arrangements with a credentialed practitioner to ensure the availability of urgent/emergent services to Members on a 24 hours per day, 7 days week basis. This is to include after-hours services or when the Practitioner is otherwise unavailable.

Emergency Services

Non-ASC **Providers** shall make Emergency Covered Services available to Members on a twenty-four (24)-hour, seven (7)-day-a-week basis. Emergency services may be provided without prior verification of eligibility or pre-authorization. Emergency services, where the primary diagnosis is ophthalmic are covered for services necessary to screen and stabilize member. Emergency care, where the primary diagnosis is ophthalmic, is covered when prudent layperson acting reasonably would have believed that an emergency existed. The **Provider** must, however, contact Premier Provider Services the next business day to report emergency admissions. If **Premier** determines such services to be non-covered services, **Provider** may directly bill Member and **Premier** has no liability or responsibility for payment.

a) During **Premier** business hours follow protocol outlined above in Section 2.14 Emergency Services. After **Premier** business hours, call **Premier Provider Services** at 1-800-738-1889 and inform them that you are requesting "Emergency Authorization."

b) If the **Plan** or **Premier** determines such services to be Non-Contracted Services, (a) **Provider** may directly bill Members for the amount of the Emergency services; and (b) **Premier** will have no liability or responsibility to **Provider** for the payment of Emergency Services and **Provider's** sole recourse shall be to recover payment from Members.

Appointment Scheduling

All Practitioners must comply with these appointment scheduling requirements:

- Schedule Non-Emergent visits within one (1) month
- Schedule Routine Sick Care within one (1) week
- Schedule Urgent Care within one (1) day (24 hours)
- Schedule Emergent Care referrals immediately

No member shall wait more than 30 minutes for a scheduled appointment. If the waiting time is expected to exceed the 30-minute standard, the office shall offer the member the choice of waiting or rescheduling the appointment.

HEDIS® - Healthcare Effectiveness Data and Information Set

HEDIS® is a tool used by Health Plans to measure performance on important indicators of care and services. HEDIS® standards currently include one eye-related indicator:

- Diabetic Retinal Exam (DRE) screening

Premier collaborates with its Health Plan partners to help them increase their DRE (Dilated Retinal Exam) screening rate and attain the highest star rating possible for this HEDIS® measure. Premier has a full-time HEDIS® team dedicated to pro-active physician and member outreach. Members with Diabetes Mellitus are encouraged to utilize their routine vision (comprehensive annual exam) benefit, annually. During the comprehensive annual exam, a dilated retinal exam is performed as well as a complete eye heath evaluation. The results of the dilated retina exam are sent to the member's PCP to close the DRE gap. For members who do not utilize their annual routine vision benefit, we work directly with the Members' PCPs to

arrange mobile screenings and perform outreach to Members in need of screening. We provide state-of-the-art tools and up-to-date Member utilization information to the Health Plans and the Members' PCPs to help them identify and reach out to Members in need of screening. We have proven success in positively impacting HEDIS® scores and star ratings for our Health Plans. More importantly, these efforts also help improve the health status of members.

Premier also has a "Tele-Vision" program: Premier has purchased, portable, light weight, user friendly, non-mydriatic retinal cameras for use by our health plans' PCPS. Premier trains the PCP staff on how to use the retinal camera and upload the retinal photos to our secure HEDIS® web portal. Premier's network optometrists interpret the photos to identify the presence or absence of diabetic retinopathy. The diagnosis is shared with the Member's PCPs who will refer the member for treatment.

Communication with PCPs

Specialists are responsible for treating Members referred to them by the Members' PCP and for sending the findings back to the PCP. It is very important that you report the results of all eye examinations to the member's PCP and to Premier via claims or encounter data. This information must be reported for all health plan members.

Either a detailed letter, copy of the medical record or a pre-printed form with circled testing and diagnoses is acceptable. This information may be mailed or faxed to the PCP's office. Pre-printing the form may be the easiest way to ensure ease of communication.

In addition to the specific member demographic information, the following information must be on your follow up form, detailed letter or medical record chart notes to the PCP:

Findings included (check as appropriate):

- ___ no diabetic retinopathy
- ___ background diabetic retinopathy
- ___ proliferative diabetic retinopathy
- ___ no glaucoma
- ___ glaucoma
- ___ glaucoma suspect
- Additional Notes as needed

Practice Information Changes (changes to office and/or billing Information)

It is important for us to maintain accurate and up-to-date office and billing information for you. Please notify us promptly of any changes to your office hours, locations, billing information, etc. You may send a letter or complete the Provider Information Update Form and mail, email or fax it to the addresses or number indicated on the form along with a W-9 form and a CMS 1500 form (boxes 25, 32, and 33 only). Please notify us whenever any of the following changes:

- Office Address change
- Payment Address change
- Federal Tax ID number (attach W9 form)
- Group affiliation/ownership
- Medicare number or Medicaid number
- NPI
- Telephone number, including daytime and 24 hour numbers
- Fax number
- Email address
- Hours of operation
- Provider joins or leaves a Group Practice
- Wheelchair access
- Name changes, mergers or consolidations
- Languages spoken
- Accepting new patients' status
- Patient age restrictions (if any)
- Primary Contact change
- Website information
- Covering physicians

Please give us 30 days prior notice so we can ensure accurate data is submitted to the Health Plans to display in their provider directory and to avoid impacts to claims processing.

Medical Records

Physicians must maintain Member records in accordance with federal, state, and accreditation requirements, as well as standards established by Premier and cooperate with peer review organizational medical record review.

Physicians must respond promptly to all requests for medical records by Premier or Health Plans in order to comply with regulatory requirements or to provide additional information regarding medical records where a Member has filed a grievance or appeal. Physicians must transfer the

Member's medical records to a new provider in a timely manner when a Member requests a transfer.

Premier reviews medical records from its network providers periodically against Premier's medical record standards, to assess quality, content, organization, confidentiality, and completeness of documentation. Premier may contact a provider office to request records from time to time for this purpose.

The medical records should include at least the following:

- Member identification (member name on each page)
- Problem list noting chief complaint, significant eye history, family eye history and medical conditions, allergies and adverse reactions
- Evidence of exams and clinical testing pertinent to the member's presenting complaints
- Current summary sheets of relevant eye care medical history including current medications, past surgeries, past diagnoses and medications
- Consultation reports, test and surgery reports that are easily accessible and in a uniform location
- Treatment plan consistent with diagnosis
- Evidence of medically appropriate treatment
- Continuity and coordination of care with the member's optometrist and/or primary care physician
- Prescribed medications, including dosages and dates of initial prescription or refills
- Evidence that the member has not been placed at risk by a diagnostic or therapeutic procedure
- Signature and date for every visit

Physicians must maintain the confidentiality of Members' personal information and medical records. Confidential information includes a Member's personal and financial information, and any communication between the Member and provider and any communication with other clinical persons involved in the Member's medical care, including any information pertaining to AIDS/HIV or mental health care.

Continuity of Care

In the event of termination from our network, Practitioners must ensure continuity of care for any Member who is undergoing an active course of treatment. You must notify us of any Members who are undergoing an active course of treatment when you terminate. For Members in an approved active treatment status, continuity of care will continue through the authorized course of treatment or until the Member selects another practitioner, not to exceed six (6) months after the Practitioner's termination, except that a terminating Practitioner may refuse to

continue to provide care to a health plan member who is abusive or non-compliant. Premier or the Member's Health Plan will pay for the approved services under the same terms and conditions as under the Premier Provider Agreement; all other terms of the terminated agreement continue unless otherwise agreed between the parties. This does not apply to Practitioners terminated for cause.

Balance Billing

Members are required to pay only their applicable copayments, deductibles or co-insurance as listed in the Explanation of Payments (EOP). Members may ***NOT*** be "balance billed" for:

- The difference between actual billed charges and your contracted reimbursement rate
- Covered services denied for lack of information
- Failure to obtain prior authorizations that result in payment denial
- Covered service that is not medically necessary
- Missed appointments

Non-Covered Services

These are services not covered or specifically excluded by the Members' benefit plan. Members may only be billed for non-covered services when a signed waiver is obtained from the Member acknowledging total charges as well as their responsibility for payment prior to performing services. Signed forms, such as Advanced Beneficiary Notice of Non-coverage (ABN), must be obtained in situations where the service is expected not to be covered under the Health Plan benefits.

Withholding Eyewear

Providers are not to withhold Eyewear (glasses/contacts) awaiting claims payment from Premier, as this would create an undue burden for members by increasing the wait time in receiving their Eyewear. Eyewear must be released to members once they become available. Providers may only withhold Eyewear when they are awaiting payment from members for outstanding balances associated with their Eyewear order.

Missed Appointments

Medicare:

Devoted, Centene (WellCare) and UItimate do not allow Providers to bill Members for missed appointments. The following Health Plans allow a charge for missed appointments:

- CarePlus
- Humana
- SOLIS

Participating Practitioners may charge a fee for missed appointments for CarePlus, Humana, and SOLIS Medicare Members, provided such fees apply uniformly and are the same amount for all Medicare and non-Medicare patients. Providers should have patients sign a consent of awareness regarding the office policy on missed appointments.

Medicaid:

Providers are not allowed to charge Medicaid Members for missed appointments. To avoid missed appointments, you can remind the Member of his/her appointment via phone or postcard. If you send letters to members who have missed appointments, you may wish to include the following or similar language:

- "We missed you when you did not come for your appointment on (month/date). Regular check-ups are needed to keep your eyes healthy"
- "Please call to reschedule another appointment. Call us ahead of time if you cannot keep the appointment. Missed appointments are very costly to us. Thank you for your help"

Maximum Out of Pocket (MOOP) Responsibility for Members

Please note that Medicare Advantage Members have an annual Maximum Out-of-Pocket limit (MOOP), i.e., the copayments they pay each year is limited to a specific amount. Once a Member reaches the MOOP(s) the member is no longer required to pay any more copayments for the rest of the year. If a Member presents a letter or explanation of benefits statement from the Health Plan certifying that the Member has reached her MOOP, Practitioners should not collect any further copayment(s) from that Member. If Premier is informed by the Health Plan that the Member has reached his/her MOOP for the year, we will not deduct the Member's copayment amount from our reimbursement and the Practitioner is responsible for reimbursing the Member. We will notify you in these instances.

Cultural Competency

Cultural competency is the ability to effectively provide health care services to persons of diverse cultural backgrounds. Culture is a predominant force in shaping values and behaviors. Practitioners should provide all services in a culturally competent manner. This includes respect, awareness and acceptance of differences in world views, not making assumptions about people and situations and removing language barriers for those with limited English proficiency or reading skills and those from a different cultural or ethnic background. Cultural competency means to listen to the patient to find out about their beliefs on health and illness, while understanding your own culture, values and world views. Adapting to different cultural beliefs and practices requires flexibility and recognition of others view point. This cultural awareness allows you to see the entire picture and improves the quality of care and health outcomes of your patients. Please review the Cultural Competence training presentations we have included in our Web Portal; we encourage you to provide this training to all your clinical and non-clinical staff.

Members with Disabilities or Special Communication Needs

Practitioner offices must meet Americans with Disabilities Act (ADA) accessibility guidelines. Practitioners must be able to accommodate Members with disabilities and/or special communication needs. To ensure effective communication with individuals with hearing or vision impairments, Practitioners must provide appropriate auxiliary aids and services, which may include qualified interpreters, assistive listening devices, note takers, written materials for individuals with hearing impairments; and qualified readers, taped texts, and Braille or large print materials for individuals with vision impairments.

If you need additional resources to communicate with Members who have special communication needs, such as sign-language interpreter, language interpreter or translator, you may contact the Member's health plan Customer Service Team for referrals to community-based and Health Plan resources, e.g., you may also use the state relay service (711) for TTY communication with the hearing impaired. We recommend professional interpreters (such as Language Line) for patients with limited English proficiency as friends or family may be reluctant to discuss certain issues or may inadvertently omit vital information.

Advance Medical Directives

Health Plans provide written information to their Members concerning Advance Medical Directives. Some Members may have signed a Living Will, Power of Attorney or Health Care Proxy to give someone else legal authority to make medical decisions on their behalf. Providers are required to comply with federal and state laws regarding Advance Medical Directives.

Dual Eligible Members

Dual Eligible Members are Members who have both Medicare and Medicaid. For certain dual eligible, Medicaid supplements Medicare-covered services by paying for Medicare premiums, members' cost-sharing requirements and long-term care services. Dual Eligible Members typically do not have any cost-sharing requirements for Medicare/Medicaid covered services.

The Balanced Budget Act of 1997 prohibits the collection of any cost share amount directly from the Dual Eligible individual. You must accept Premier's payment per the terms of your agreement. Members do not have a cost share and cannot be balanced billed.

Member Transportation Benefit

Please be aware that Medicaid Members and certain Medicare Advantage Members have access to transportation services through their Health Plan. Members who have this benefit and who need transportation to your offices should be advised to contact their Health Plan or the transportation vendor designated by their Health Plan.

Reporting "Adverse Events", Abuse and Neglect

Premier's contracted Health Plans are required to report "Adverse Events" to their state licensing agencies. Practitioners are also responsible for reporting Adverse Events directly to the state in which they are licensed. Each state has its own reporting requirements. A reportable Adverse Event is any death and any incident that may negatively impact the health, safety, or welfare of a health plan member, for example, physical or sexual abuse, neglect, exploitation, elopement/missing from a facility, major illness or serious injury a patient suffers during or as a result of medical treatment, permanent disfigurement, surgery to repair damage from a planned surgical procedure where the damage was not a specified risk of the planned procedure, major medication incidents, etc. Please refer to your state's list of reportable Adverse Events.

In the unlikely event that a reportable Adverse Event occurs to one of our Health Plan members, you must report the event to Premier within 24 hours of the incident so we can report to the member's Health Plan to ensure that our Health Plans meet their reporting obligations. Please include the member's identity, description of the incident and outcomes including the current status of the member. In the state of Florida, practitioners must also report adverse incidents directly to the Agency for Health Care Administration immediately but not more than 24 hours after the incident.

In addition, network practitioners must immediately report to Premier as well as the appropriate state agency/hotline any suspected abuse, neglect and exploitation of members. Documentation related to the suspected abuse, neglect or exploitation, including the reporting of such, must be

kept in a file, separate from the member's case file and designated as confidential; these files shall be made available to the appropriate state agencies upon request.

Please refer to the Training Presentation on "How to Report and Document Abuse, Neglect and Exploitation posted on the Premier online Web Portal in the Provider Download section.

Education and Marketing to Members

Providers must comply with the following:

- A Provider can assist a recipient in an objective assessment of his/her needs and potential options to meet those needs
- May engage in discussions with a patient who seeks advice concerning enrollment in a particular health plan. However, Providers must remain neutral when assisting with enrollment decisions.

Providers may:

- Display health plan-specific materials in their office (health plans must approve or obtain state approval first)
- Make available and/or distribute state or federal approved marketing materials as long as the Provider does the same for all of the plans with which (s)he participates
- Display posters or other materials in common areas such as the Provider's waiting room
- Announce new health plan affiliations
- Co-sponsor events such as health fairs and advertise indirectly with a health plan via television, radio, posters, fliers and print advertisement
- Provide the names of the Managed Care Plans with which they participate
- Refer their patients to other sources of information, such as the Managed Care Plan, the enrollment broker or the local Medicaid Area Office
- Share information with patients from the Agency's website or CMS' website

Providers are prohibited from:

- Verbally, or in writing, comparing benefits or Providers networks among health plans
- Assisting with health plan enrollment or disenrollment
- Offering marketing/appointment forms
- Making phone calls to direct or attempt to persuade patients to enroll in a Managed Care Plan based on financial or any other interests of the Provider
- Mailing marketing materials on behalf of the Managed Care Plan
- Offering anything of value to induce recipients/Members to select them as their Provider
- Offering inducements to persuade patients to enroll in the Managed Care Plan

- Conducting health screening as a marketing activity
- Accepting compensation directly or indirectly from the Managed Care Plan for marketing activities
- Distributing marketing materials within an exam room setting
- Giving the Managed Care Plan with which they contract, or any other entity lists of their Medicaid patients or the membership of any Managed Care Plan

All subcontractors and Providers providing marketing and/or information materials (printed, web-based etc.) to their patients require AHCA's approval prior to use. In such case, the materials should be submitted to Premier to send to the health plan to obtain approval.

Section IV
Credentialing

The Credentialing process is mandatory for participation in Premier's network. Premier is delegated responsibility for credentialing all contracted Practitioners. Practitioners are accepted for participation if they meet Premier's credentialing requirements and business needs. All applications and the credentialing process must satisfy NCQA standards, and other accreditation agency credentialing standards when contractually required. The credentialing process must also satisfy state and Health Plan requirements.

Premier does not discriminate; credentialing decisions are not based on an applicant's race, ethnic or national identity, gender, age, sexual orientation, origin, color, disability, or the type of procedure or patient (e.g. Medicaid) in which the Practitioner specializes. Premier, in conjunction with the Health Plan, has the right to determine which Practitioners it shall accept as Participating Practitioners. Premier's credentialing criteria is available upon request.

Credentialed Practitioner and Provider types

- Medical Doctors (MDs)
- Osteopathic Doctors (DOs)
- Optometric Doctors (ODs)
- Free Standing Ambulatory Surgery Centers (ASCs)

Credentialing Process

A practitioner who is interested in participation with Premier Eye Care is invited to submit a credentialing application for review by Premier's Credentialing Committee. The Credentialing Committee may request further information from the applicant. The Committee may defer a decision pending receipt of additional information from the applicant and/or the outcome of an investigation of the applicant by a hospital, licensing board, or government agency. The Committee will recommend any other action it deems appropriate.

The Credentialing Committee has the discretion and authority to accept a practitioner without restrictions, accept a practitioner with restrictions or decline to accept a practitioner.

All practitioners are required to execute a participation agreement with Premier.

Premier communicates with Health Plans that have delegated the credentialing function to Premier and reports credentialing actions to them in a timely manner. Health Plans retain the

right to approve, suspend and terminate individual practitioners, providers and sites from their network.

Practitioners electing to serve Medicare Advantage members must also:

- Meet applicable Medicare regulations and have an active participation agreement with CMS to provide services under Medicare.
- Not be precluded or excluded from participation in federal health care programs nor employ or contract with individuals excluded from participation in federal health care programs.
- Not have opted-out of the Medicare program nor employ or contract with individuals who have opted-out of the Medicare program.

Practitioners electing to serve Medicaid members must also:

- Meet applicable state Medicaid requirements and have an active Medicaid Provider ID from their respective state (Florida or Hawaii).
- Not be precluded or excluded from participation in federal health care programs nor employ or contract with individuals excluded from participation in federal health care programs.
- Not be excluded from, or have opted out of, participation in the state Medicaid program nor employ or contract with individuals who have opted out of the state Medicaid program.
- Comply with all federal and state Medicaid agency criminal background screening requirements for participation in the Medicare and Medicaid programs. This may include fingerprint-based screening and screening for certain owners and employees of the practice.
- Enrollment status with AHCA is “Fully Enrolled” or “Limited Enrolled”.

Initial Credentialing

Practitioners must successfully complete the credentialing process and receive notification that they have been credentialed before they may begin to deliver health care services to Members. Premier accepts applications completed through the CAQH (Council for Affordable Quality Healthcare) website, Premier’s credentialing application or specific state required applications when applicable. In addition to the application, practitioners will also be asked to share credentialing documents including but not limited to DEA certificate, CDS certificate, and malpractice certificate. Premier may also request Health Plan, state or Premier forms including but not limited to ages seen, ophthalmology specialty, practitioner ownership, portal access, reference letter and practitioner attestation form. Primary source verification is conducted to ensure that practitioners have the legal authority and relevant education, training and

experience to provide quality care. Practitioners are initially credentialed for thirty-six (36) months.

Re-credentialing

Credentialed Participating Practitioners must be re-credentialed every thirty-six (36) months. Premier accepts applications completed through the CAQH (Council for Affordable Quality Healthcare) website, Premier's credentialing application or specific state required applications when applicable. In addition to the application, practitioners will also be asked to share credentialing documents including but not be limited to DEA certificate, CDS certificate, and malpractice certificate. Premier may also request Health Plan, state or Premier forms including but not limited to ages seen, ophthalmology specialty, practitioner ownership, portal access, references letter and practitioner attestation form. Primary source verification is conducted to ensure that providers have the legal authority and relevant experience to provide quality care. Practitioners are considered to be re-credentialed for thirty-six (36) months.

If a Practitioner fails to return the re-credentialing application by the re-credentialing due date the practitioner will be terminated from the Premier network. The practitioner will no longer be participating and claims received will not be processed for payment.

Practitioner Rights

Practitioners are afforded specific rights in the credentialing process; applicants for credentialing and re-credentialing have the right to:

- Upon request, review information submitted by outside sources in support of the initial or re-credentialing application to the extent permitted by law.
- Be notified when information obtained from other sources varies substantially from that provided by the applicant
- Correct erroneous information obtained in the credentialing process
- Upon request, be informed of the status of the credentialing or re-credentialing application
- Receive notice of the credentialing decision within 60 calendar days of the decision.

Professional Liability Insurance

Premier's credentialing policies require non-ASC Providers to have professional liability coverage in compliance with applicable State laws. Premier requires ASC's to have general liability coverage of $1 million/$2 million and professional liability coverage of $1 million/$3 million.

Updating Credentials

Premier maintains up-to-date copies of certain credentialing documents. These include, but are not limited to, License, DEA Certificate, CDS Certificate, Liability Coverage and Board Certification. Premier updates these documents using online resources where possible. If Premier is unable to retrieve the information online, Premier will request the document from the practitioner.

Premier participates in Continuous Query, a process of ongoing inquiry of the National Practitioner Data Bank. Premier receives automatic notifications when the Data Bank receives a new report. Practitioners are contractually required to notify Premier of adverse actions taken against them in accordance with the law, licensing requirements, and/or contractual agreements.

Council for Affordable Quality HealthCare (CAQH)

Premier encourages its practitioners to actively participate with the Council for Affordable Quality HealthCare (CAQH) and use the CAQH online credentialing application and attestations. Participation with CAQH is an efficient use of time for a busy provider office.

Section V
Utilization Management

Premier has a utilization management program, which includes development and review of clinical guidelines, pre-service approvals (prior authorization) criteria, member triage protocols, etc. Clinical decision support criteria are used to ensure that members receive medically appropriate services.

For authorizations, please contact Premier directly (See Quick Reference Guide for 800 number) and follow the prompts or you may use our on-line Web-Portal for certain authorizations. See details in the Health Plan Section with specific requirements for authorizations by line of business.

Medicare and Medicaid Coverage Guidelines

Premier follows Medicare and Medicaid coverage guidelines, including the Medicare national and local coverage determinations contained in the Medicare Policy Benefit and/or Medicare Claims Processing Manuals, Medicare Managed Care Manual, Medicare National Coverage Decisions (NCDs) and Local Coverage Decisions (LCDs) as well as respective state legislation and guidance such as the state Medicaid Provider Manuals. Some of Premier's Health Plans may also have developed coverage criteria for certain services in the absence of, or to supplement, Medicare/Medicaid guidelines; in these cases, Premier will follow those Health Plan's coverage criteria.

Clinical Practice Guidelines

Premier has also adopted the clinical practice guidelines developed by the American Optometric Association (AOA) and the preferred practice patterns developed by the American Academy of Ophthalmology (AAO). These evidence-based clinical practice guidelines are available on the AOA and AAO websites.

The clinical practice and preferred practice patterns are not fixed protocols that must be followed, but are intended for health care professionals and providers to consider. While they identify and describe generally recommended courses of intervention, they are not presented as a substitute for the advice of a physician or other knowledgeable health care professional or provider. Individual patients may require different treatments from those specified in a given guideline. Guidelines are not entirely inclusive or exclusive of all methods of reasonable care that can obtain/produce the same results. While guidelines can be written that consider variations in clinical settings, resources, or common patient characteristics, they cannot address the unique

needs of each patient nor the combination of resources available to a particular community or health care professional or provider. Deviations from clinical practice guidelines may be justified by individual circumstances. Thus, guidelines must be applied based on individual patient needs using professional judgment.

Occasionally, we develop our own criteria on topics or conditions not covered by these guidelines. These are available on our Web Portal. We encourage our entire network of Practitioners to review these guidelines and submit suggestions and feedback on the guidelines to our Medical Director.

Premier makes its clinical guidelines publicly accessible to all practitioners on the Premier Eye Care website under the Resources tab, Medical Coverage Guidelines: https://www.premiereyecare.net/resources/. During new practitioner orientation, Premier sends new network practitioners via email a link to the provider web portal and instructions on how to access the clinical guidelines. Network practitioners and health plan members may also request a print or electronic copy via telephone, mail, email or fax (at no cost to you).

Medical Necessity

Whether or not a medical, surgical or diagnostic eye care service must be pre-approved by Premier or by the Member's Health Plan, it must still be Medically Necessary. Medical Necessity is defined by Medicare, Medicaid or the Health Plan, but generally services must:

- Be necessary to protect life, to prevent significant illness, disability, or to alleviate severe pain.
- Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs.
- Be consistent with generally accepted professional medical standards.
- Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available.
- Be furnished in a manner not primarily intended for the convenience of the member, the member's caretaker or the provider.

In Florida, Florida Statutes s.409.9131 (2) (b) provides: "Medical necessity" or "medically necessary" means any goods or services necessary to palliate the effects of a terminal condition or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity, which goods or services are provided in accordance with generally accepted standards of medical practice. For purposes of determining Medicaid reimbursement, the agency is the final arbiter of medical necessity. In making determinations of medical necessity, the agency must, to the maximum extent possible, use a physician in active practice, either employed by or under contract with the agency, of the

same specialty or subspecialty as the physician under review. Such determination must be based upon the information available at the time the goods or services were provided.

The fact that a physician has prescribed or recommended medical care or services does not, in itself, make such care or services Medically Necessary.

When deciding whether to approve a particular service, (whether it is a prior, concurrent or retrospective review), or whether to pay a claim, Premier will consider all submitted documentation or may request additional documentation to ensure the service is Medically Necessary. We will also consider appropriateness of the requested service, the member's individual circumstances and the applicable contract language concerning benefits and exclusions.

Management of Injectable Eye Drugs

Premier is not delegated by any Health Plan for pharmaceutical management. Our client Health Plans' Pharmacy & Therapeutics (P&T) Committees develop and publish their own formularies and procedures for requesting exceptions, substitutions, step therapy protocols, etc. The Health Plans distribute the formularies and updates to their members and practitioners. Premier is delegated to arrange for medical eye care services by some of its client Health Plans. Medical eye care includes intravitreal (eye) injections.

Guidelines for Physician Assistants

Premier recognizes that many practices are hiring licensed Physician Assistants (PA) as medical professionals to be part of their health care team. Although Premier does not contract or credential directly with PAs, we have implemented guidelines for PAs working under the supervision of a participating physician.

Guidelines - Physician oversight:

- The supervising physician is to initiate the Member's Plan of Care that the PA carries out.
- The supervising physician does not need to be physically present when the PA is rendering services, but must be available by means of telephonic and/or electronic modalities.
- The supervising physician must be certain that the PA is knowledgeable and skilled to perform the services assigned.
- The decision to permit the PA to perform a service under direct or indirect supervision is made by the supervising physician.
- All services performed by the PA must be documented in the patient's medical record.
- The supervising physician shall delegate only services to the PA which are within the

supervising physician's scope of practice.
- The supervising physician is available to provide a review of patient encounters with feedback given to the PA after care is delivered.

Guidelines - General:

- The PA must be authorized and qualified to furnish the services performed.
- The services provided by the PA must be reasonable and necessary.
- All services that require authorization must be obtained by the physician/group.
- The PA must be an employee of the contracted physician/provider group.
- The PA should clearly identify their title to Health Plan Members and honor any Member's request to be seen by a physician rather than the PA.

If your office includes the services of a PA, it is important to have a thorough understanding of our PA billing guidelines. Claim submission guidelines for PAs are located under Section VII – Claims.

Routine Vision (routine eye exam and materials)

During an annual comprehensive eye exam, health care providers will perform a refraction to determine the best eyeglass prescription, and a complete eye health examination, including a glaucoma screening, cataract evaluation and a dilated retinal examination. A dilated retina exam is required during the member's initial presentation, and thereafter, whenever medically indicated. If dilation is not performed because of contraindication (s), the *reason(s) shall be noted i**n** the patient's medical record.*

A comprehensive eye and vision examination may include, but is not limited to, the following tests:

- Visual Acuity test/Refraction
- Eye pressure check/Glaucoma Screening
- Dilation/Dilated Retina Exam (DRE)
- Confrontation Visual Field Exam – Gross check of patient's peripheral vision
- Pupil response to light/dark
- Gross eye muscle testing
- Cornea evaluation
- Eyelid and adnexa evaluation

Eye Care Access

Depending on the reason for the visit, members may access you for their care. This is not diagnosis driven, but "reason for the visit" driven. Therefore, it does not matter what the final

diagnosis is, but rather what was the purpose of the eye exam initially. Claims must therefore be billed based on the reason for the visit.

Authorizations

Premier does not require a "Prior Authorization" for Routine Vision services.

This does not include medical necessity review when state guidelines require medical necessity be met for certain services or eyewear, such as Polycarbonate lenses, Contact Lenses/Fittings, and Frames/Lens replacements. Therefore, special services requiring Medical Necessity review for Medicaid Members will continue to require prior authorization. The Special Services Form utilized for medically necessary services is located on our Web-Portal.

Eligibility

You will be responsible for verifying the Member's eligibility and available benefits prior to services being rendered. Practitioners can log into our Provider Web Portal, enter the member information and the service requested (eye exam only, eye exam and materials, etc.) and obtain eligibility and benefit information instantly.

Checking Member eligibility, Member's benefit/allowance for eyewear, and whether the Member has already used this benefit is critical to help reduce the risk of providing services to a Member that is not eligible.

- Please use the Provider Web Portal to verify eligibility and benefits.
- Benefit information posted on the portal is refreshed nightly. Updated benefits will be reflected the next business day.
- We encourage you to submit your claims as soon as possible.

Prior Authorizations for Medical/Surgical Eye Care

All medical/surgical eye care services must be Medically Necessary and appropriate and meet our triage protocol/clinical guidelines; not all services require Prior Authorization; please see each Health Plan's QRG for details.

For services that require Prior Authorization, Premier has specific utilization criteria and a review process to ensure services are medically necessary and appropriate.

Requests for Prior Authorization may be submitted via our Web Portal, fax or a call to our Provider Service line. You must include the Member's diagnosis(es), the services to be provided

and sufficient justification for the proposed treatment codes. We will contact you to request additional records if the documentation you submit is insufficient.

Non-emergency services that require Prior Authorization should not be started before you receive confirmation of approval from us. If you provide non-emergency treatment without obtaining Prior Authorization, you will be financially responsible if the Prior Authorization request or claim is denied and you may not balance bill the Member, the State or anyone else.

We respond to your Prior Authorization requests as expeditiously as the Member's condition requires. We will notify you via fax or phone of our decision. On average, we take no more than 24 hours to respond to "expedited" requests and no more than 3 days to respond to "standard" requests. "Expedited" requests are those that must be approved or denied within 48/72 hours (48 for Medicaid members; 72 for Medicare members) because a Member or his/her physician believes that waiting for a decision under the standard time frame could place the Member's life, health, or ability to regain maximum function in serious jeopardy. "Standard" requests are those that must be approved or denied within 7/14 calendar days (7 for Medicaid members/14 for Medicare members); our average turnaround time is approximately 3 days. ***Please do not mark your requests "stat", "expedited" or "urgent" unless the Member's life, health, or ability to regain maximum function is in serious jeopardy.***

For Florida Medicaid members, providers are required to obtain authorization of any Medically Necessary service to Members under the age of 21 years when the service is not listed in the service-specific Medicaid Coverage and Limitations Handbook or fee schedule, or is not a covered service of the plan; or the amount, frequency, or duration of the service exceeds the limitations specified in the service-specific handbook or the corresponding fee schedule.

Any approvals we issue will be honored for 30 days from the date they are issued for routine services and 60 days for surgical procedures. An approval does not guarantee payment. The Member must be eligible at the time the services are provided. The Provider should verify eligibility at the time of service.

For authorizations, please contact Premier directly and follow the prompts.

If you are in:	Call us at:
Florida	800-738-1889
Hawaii	855-879-1447
Texas	855-879-1455

AR, CO, DE, GA, IL, IN, KY, IA, MI, MO, NC, NE, NJ, NV, OK, OR, PA, SC, TN and WA, please refer to pages 60 – 61 for your State designated Premier Phone number.

For expedited requests that meet the expedited requirements for Florida and Hawaii, please fax Medical Surgical form to: 561-962-0356

If, after appropriate medical review, we do not believe a request meets medical criteria for approval, we will contact you to offer a peer-to-peer discussion. If we deny the request, you and the member will receive a denial letter (Notice of Adverse Benefit Determination or Notice of Medical Non-Coverage) with an explanation for the denial and any appeal rights.

Availability of Peer-to-Peer Discussion

Treating providers have access to Premier's medical director at all times for a peer-to-peer discussion concerning the treating provider's request. Our medical director(s) may also contact you to discuss your request or offer alternatives to the service requested; however, you may also contact us at 1-800-738-1889 at any time during the Prior Authorization process to request a peer-to-peer discussion. Premier's medical director may also refer a request to a medical consultant with expertise in the relevant field when the service requested involves new technology/drugs, services that may be considered experimental/investigational for particular diagnoses or when it is questionable whether the patient meets Medical Necessity criteria.

Retrospective Reviews

Services that would normally require a Prior Authorization, but are performed in an emergency situation, are subject to a Retrospective Review. All retrospective authorization determinations are made and communicated within 5 business days, unless stipulated differently by Medicare, Medicaid or the Health Plan. Any claims for Retrospective Review submitted without the required documents will be denied and must be resubmitted for reimbursement. An authorization number will be provided to the submitting office for your records.

Second Opinions

A member may request a second medical or surgical opinion. Treatment not authorized by Premier or the Member's Health Plan shall be at Member's expense. Practitioners must request second opinions from another Premier network Practitioner unless a required specialist is not available. All requests for second opinions must be pre-authorized by Premier.

Utilization Management (UM) Decisions

Premier's Utilization Management Team bases its decision-making only on appropriateness of care, service, and the Member's benefits/coverage. Premier does not reward Practitioners or

other individuals for issuing denials of coverage or care and does not encourage any coverage decisions that result in underutilization of health care services.

It is Premier's practice to ensure our contracted Practitioners are making treatment decisions based upon Medical Necessity and an individual Member's situation. Practitioners are never offered, nor should they ever accept, any kind of financial incentives or any other encouragement to influence their treatment decisions.

Random Chart Audits

From time to time, Premier, it's Health Plans and/or a federal or state regulatory agency may request medical records or supporting documentation in connection with a claim, a Prior Authorization request, an audit, a Member's grievance or appeal, or for HEDIS®, reimbursement or other purposes. Providers must cooperate with all such audits. We will give you advance notice of such audits wherever possible and make appropriate arrangements to minimize disruption to your practice. You may be asked to supply copies of select patient medical charts, or allow us or our designated representative(s)/auditor access to our Members' medical records (paper or electronic). We may conduct random chart audits to verify compliance with medical record-keeping requirements as well as the accuracy of the claims/encounter data submitted.

All audits will be conducted in accordance with any applicable state or federal laws or requirements and with any provisions set forth in the Premier Provider Agreement.

If Premier does not receive a requested chart within 10 business days. Premier will follow up with a second request letter and/or a telephone call to the Provider. The Provider is reminded of the contractual obligation to participate with Premier's' Quality initiatives and audit requirements. If a third request letter is warranted, the Provider may be referred to the Peer Review Committee for noncompliance with the medical record request.

Health Plan Medical Record Requests

When a Member files a complaint/grievance or appeal with his/her Health Plan, the Health Plan may request the Member's medical records. You must respond promptly to all such requests for medical records to enable the Member's Health Plan to review the case and respond to the Member within the timeframes required by Medicare or Medicaid. Premier expects full cooperation and timely submission of these records in order to ensure compliance.

Section VI
Medication Management

Each Health Plan has a Preferred Drug List (Formulary) to promote clinically appropriate utilization of medications. Health Plans have a Pharmaceutical and Therapeutics committee that reviews and selects medications based on effectiveness, safety and cost.

Preferred Drug list

Please refer to each Health Plan's Preferred Drug List (on their website). We have included the Health Plan's website address in our QRGs. Note that not all Health Plans approve the same drugs or have the same number of tiers. It is the Practitioner's responsibility to become familiar with each Health Plan's requirements and processes in order to obtain approvals.

Generic Substitution / Member Copayments

According to the Food and Drug Administration (FDA), a generic drug is identical or bioequivalent to its brand-name counterpart in dosage form, safety, strength, route of administration, quality, performance characteristics and intended use. Generic drugs are less expensive than their name-brand equivalents and generally require little or no Member co-payment. ***Generic drugs assist your patients to better afford medications*** that are necessary to improve their health.

Prior Authorization for Prescription Drugs

Drugs administered in your office (Medicare Part B drugs including injectables and specialty drugs) may require prior authorization or a medical exception for coverage. If a drug on the Health Plan's Preferred Drug List requires prior authorization then your office staff will need to request and receive approval from Premier or the Health Plan (per QRG). Example: eye injections need prior approvals, and Premier will coordinate getting the approvals with the Members' Health Plans or their PCPs.

Some Medicare Part D (outpatient) drugs also require prior authorization. The Health Plan's pharmacy benefit company or the pharmacy may contact you if a Member presents a prescription for an outpatient drug that requires prior authorization.

Section VII
Claims

Claims Adjudication and Payment

We are dedicated to delivering accurate and timely claim processing and payments to help reduce your administrative burden.

Premier accepts claims in these formats:

- Electronic Claims Submission
- Direct Data Entry (DDE) accessible via Smart Data Solutions (SDS)
- HIPAA Compliant 837P File Submissions
- Paper

Electronic (Electronic Data Interchange) Claims Submission via Clearinghouse

Premier encourages you to send your CMS 1500 claims electronically. This is faster, more efficient, and eliminates paper. You may submit electronic (EDI) claims via a clearinghouse of your choice. Premier has selected Change Healthcare as Premier's claims clearinghouse partner. If you use a different clearinghouse, please ensure that your current vendor has a "trading agreement" in place with Change Healthcare. If you use Change Healthcare's Office or Claim Manager (Practice Management System), your system should reflect Premier as a Payer option. These are clearinghouses you may use (this is not a complete list):

Availity	Gateway EDI	Sage	ENS
AllScripts/PayerPath	Relay Health	Claim Logic	

The clearinghouse checks the data for completeness and accuracy; claims missing certain information are rejected and your submitter receives notification via a "277 file". You must correct and re-submit these claims. Once the clearinghouse accepts your claims, it will send you an acknowledgement electronically. Our claims system then imports the claims data, checks the data for completeness, analyzes for clinical and coding accuracy and appropriateness, as well as audits against product and benefit limits. The system will also review claims for services that require pre-authorizations, and automatically matches the claim service to the appropriate Member record for efficient claims processing.

Pass-Through Claims

Premier adheres to applicable federal and state laws regarding claims processing timelines. Under certain payer agreements, claims are adjudicated and paid by the health plan according to the health plan payment rules. In these scenarios, Premier submits claims received from you to our health plan partners for final review and approval. Once approved by the health plan for payment, we promptly remit payment to you.

You may see a claim status that indicates "Hold for Payment". This means that we have submitted the claim to the health plan and we are pending final determination from them. At this stage, you don't need to resubmit or follow up unless notified. Please note, these claims are adjudicated pursuant to the health plans claims processing guidelines, which are always included in the explanation of payment.

How to Begin the Electronic Claims Submission process

Getting started is easy. First, make sure Premier has your office locations and NPI numbers. If this information needs to be submitted, please contact the Network Management Team for an Update Form. Claims will reject if Premier does not have your office locations and NPI numbers set up in our system.

Next, contact a clearinghouse of your choice and work with them to set you up to submit your claims electronically. **Our Payor ID is 65054.** If you have questions, please contact us at 1-800-738-1889.

Helpful Tips:

- Once you submit your claims electronically, please **work with your clearinghouse to identify any rejected claims. Very often, billing offices forget about the rejected claims notices that are sent to your clearinghouse using a 277 transaction.**
- Correct all rejected claims and re-submit promptly.
- Track the status of your claims on our Web Portal. Once we accept your claim, we will post claims status information on the portal usually by the next business day. This gives you access to your claims status 24/7.

If you need help with electronic submissions, please contact us at 1-800-738-1889.

Direct Data Entry (DDE) Electronic Claims Submission directly to Premier

Direct Data Entry (DDE) allows you to directly enter claims electronically without paying a clearinghouse. This eliminates paper, saves you time and money and expedites processing and claims payment timeliness. We are pleased to offer you this additional electronic solution that leverages the latest technology for direct claims submission. Best of all, it is at no cost to you.

How to Begin the Direct Data Entry Claims Submission process:

Premier has partnered with Smart Data Solutions (SDS) to offer this service. SDS will give you login access, user ID and password. To obtain a user ID and Password, please call the SDS team directly at: 855-297-4436, option 2. You can also sign up by emailing: Stream.Support@sdata.us

- Include the following: Practice Name, Tax ID, Contact Person's First Name and Last Name, Phone Number and Email Address.

SDS will also provide technical, educational assistance and help desk support.

Using DDE, you log into to the SDS software to:

- Key information directly into an online claim form
- Submit claims electronically to Premier
- Save claims without submitting and resume later when you are ready
- Review transactions and check claims status
- Make changes online to your claims and submit corrected claims
- Submit transactions via a secure clearinghouse portal

DDE is ideal for those practices that want to electronically submit claims directly to Premier. We encourage you to set up a DDE connection today and begin enjoying the benefits of faster payment cycles and increased claim processing accuracy.

Electronic Remittance Advice (ERA)

Providers can obtain ERAs through Smart Data Solutions (SDS). Premier issues 835 ERA's through SDS. Providers can sign up for an account with SDS and enroll for 835 ERA; there is no cost to the provider to sign up with SDS. To sign up please call the SDS team directly at: 855-297-4436, option 2. You can also sign up by emailing: Stream.Support@sdata.us

HIPAA Compliant 837P File Submissions

For Providers who are unable to submit electronically via a clearinghouse or via DDE, on a case-by-case basis, Premier can work with you to receive your claims directly via a HIPAA Compliant

837P file. Please contact our EDI Team at PremierEDI@premiereyecare.net or by phone at 1-800-738-1889 Ext 208.

Paper Claim Submission on CMS-1500 Health Insurance Claim Forms

CMS only allows paper claims in limited circumstances. Only original CMS-1500 and UB-04 Claim forms will be accepted. All other forms will be rejected. If you need the current forms, please visit the AMA website at www.ama-assn.org for ordering information.

Mail your claims to:
Premier Eye Care
Attention: Claims Processing
P.O. Box 21503
Eagan, MN 55121

Please note: Fax Claims are not accepted. Only Electronic Submissions or Original "Red Claims" are accepted.

Electronic Funds Transfer (EFT)

Premier offers the option of receiving your claims payments through EFT (Electronic Funds Transfer). You have the option to receive your payments through an automated bank deposit process.

Premier claims payment is issued through VPAY: www.vpayusa.com . VPAY allows participating providers to sign up for this service. You may visit their website to learn more about the process. To change your payment method preference with VPAY you may email: support@vpayusa.com or call 1-855-388-8374. If your practice already receives payments from VPAY through another vendor, then your current payment method with VPAY will remain in place.

Clean Claims

Clean claims must include the following:

- Member name
- Member date of birth
- Member health plan and ID number
- Treating Provider Name

- Payee (Billing Provider)
- Federal Tax ID number
- NPI number of Provider
- Date(s) of service
- Location of service
- Approved Procedure codes as published in the current CPT book
- Approved ICD 10 Diagnosis codes
- The treating Provider's Medicaid ID # Medicare #

Timely Filing Limits

Premier's timely filing limit is 60 calendar days as stated in the terms of your agreement; this is measured from the date of service to the date we receive your claim.

To facilitate processing accuracy and timeliness, Premier performs a review of all claims upon receipt. This includes validating filing timeliness, Member eligibility, procedure codes, and the Provider's identifying information.

Encounter Data Submission

Encounter data is typically submitted by providers who receive capitation payments. Encounter data are records of covered services provided to enrollees of a health plan and captures the interaction between a patient and provider who delivers services to a patient. CMS and many states require our Health Plans to submit this data electronically in a HIPAA-compliant format. This allows for a comprehensive view of all program services, utilization and expenditures. The encounter data is used to determine the risk status of the population enrolled in each Health Plan and payment to the Health Plan is adjusted accordingly.

Practitioners who receive capitation payments must submit encounter data using a HIPAA-compliant format for all capitated services rendered to Members within 30 days of the service date.

Coordination of Benefits (COB)

A Provider Office visit is often the first opportunity to identify a Member who may have multiple coverage plans. As you identify any opportunity to coordinate benefits, be sure to indicate this information in fields 9, 10 and 11 on the CMS-1500 claim form. Premier coordinates benefits with all types of insurance plans including health plans, worker's compensation, property & casualty and auto carriers.

If Premier is the secondary insurance carrier, a copy of the primary carrier's Explanation of Benefits/Payment must be submitted with the claim. For electronic claim submissions, the payment made by the primary carrier must be indicated in the appropriate COB field. When a primary carrier's payment meets or exceeds the Premier Provider's contracted rate or fee schedule, Premier will consider the claim paid in full and no further payment will be made on the claim.

Claims Inquiries

Premier's Provider Web Portal allows participating Providers direct access to our online services 24/7. You may review claims processing/payment status online. After reviewing the information online, if you still have any questions, please call our Claims Support Team for assistance (please reference page 46 for the Provider Services number for your State).

Medical Records Document Upload

When a claim is received that requires medical records that have not been submitted, we will send you an email with a link attached to easily upload the patient's medical records for a specific claim.

Once you are logged in, you may be asked to provide a Claim Number. Simply input the claim number for the medical records requested. After the claim number is entered, you will see a screen displaying information about the claim that Premier has requested medical records. Please review this information to ensure you are uploading documents for the correct patient and date of service.

You can either click and drag files from your computer, or click the "Browse" button to locate them. Multiple documents can be attached at once. When you are done, simply click "Submit Documents" to attach the documents to the claim. Premier will then review and process the claim accordingly.

Claim Payment Disputes

If a Practitioner wishes to dispute any reimbursement decision, please complete an Appeal Request Form (available from our online Web Portal, under "Manuals \ Provider Manuals and Documentation \ Forms \Provider Appeals Form") and submit that with all pertinent documentation within 90 calendar days of Premier's claim payment/denial to:

Premier Eye Care
Attention: Claims Disputes
P.O. Box 21503
Eagan, MN 55121

For Florida Medicaid, California and Hawaii providers, we will acknowledge receipt within three (3) business days. Premier will notify the provider verbally or in writing that the complaint has been received and the expected date of resolution. We will also provide written notice of the status to the provider every fifteen (15) days thereafter. We will resolve all Provider Complaints within thirty (30) days of receipt and provide written notice of the disposition and the basis of the resolution to the provider within three (3) business days of resolution. The decision is final. All other states may vary.

Appeals that are filed timely will be reviewed by the Premier Appeals Director, Medical Director and/or Appeals Committee. Premier's medical director reviews Provider Complaints that involve clinical issues or medical necessity.

Coding Requirements - Diabetic Retinopathy Coding

Diabetic Retinopathy coding is essential to our Health Plan partners as it affects the Risk Adjustment payments the Health Plans receive. Claims for Health Plan Members diagnosed with Diabetes Mellitus (DM), with or without Ophthalmic Manifestations must be submitted with appropriate coding to the highest level of specificity.

Diabetes documentation and coding must include:

- Type or cause of diabetes
  - Type 1 (E10)
  - Type 2 (E11)
  - If the type of DM is not documented in the medical record the default is category E11 (Type 2).
- Body system complications related to diabetes, such as retinopathy
- Specific complications, such as level of retinopathy and whether macular edema exists or not
- If the physician documents long-term/current insulin use, report Z79.4 as a secondary code.

ICD – 10 Codes for Diabetes Type 1 and Type 2		
Diagnosis	Diabetes Type 1	Diabetes Type 2
No Retinopathy	E10.9	E11.9
Mild NPDR with Macular Edema	E10.321	E11.321
Mild NPDR without Macular Edema	E10.329	E11.329
Moderate NPDR with Macular Edema	E10.331	E11.331

Moderate NPDR without Macular Edema	E10.339	E11.339
Severe NPDR with Macular Edema	E10.341	E11.341
Severe NPDR without Macular Edema	E10.349	E11.349
PDR with Macular Edema	E10.351	E11.351
PDR without Macular Edema	E10.359	E11.359

Physician Assistant Claim Guidelines

Premier does not credential or contract directly with PAs.

- PAs should submit claims under the participating physician's NPI (as if the supervising physician performed the service).
- Medical records may be signed by the PA only (the physician does not need to also sign).
- Payments will be made to the PAR physician/group at the full contracted rate.
- Please note: claims with the PA's name or NPI will deny as a non-par provider.

Locum Tenens

"*Locum tenens*" is the phrase historically used by CMS to describe what is now referred to as *a "fee for-time compensation arrangement"*. A locum tenens physician provides medical services to patients of a physician who is absent/on leave due to illness, pregnancy, vacation, military duty, continuing medical education, etc.

Claim's Guidelines:

- The contracted participating physician/group submits claims and receives payment in their name for services provided by the locum tenens physician.
- The CMS 1500 claim form must include the contracted physician's name and NPI with modifier **"Q6"** listed after the Exam CPT code in Box 24D.
- The contracted physician's NPI in listed in Box 24J on the CMS 1500 claim form.
- Additional services performed on that day do not require a Q6 modifier. However, if Q6 is included, Premier will process the claim as usual.
- Premier will continue to issue prior authorizations to the contracted physician/group. All requirements for prior authorization for claims payment must be adhered.
- Premier does request the par provider notify us when billing under locum tenens arrangements.

Premier follows CMS Guidelines and claims will be subject to retrospective audit:

- The contracted physician/group must adhere to all guidelines regarding locum tenens.
- The contracted physician/group must have a signed agreement with each locum tenens.

- The locum tenens physician can only provide services for up to 60 days without breaks even if patient services are not provided on some of those days. (Exception to the 60-day timeframe – the contracted physician is on active military duty).
- The 60-day period begins the first day the locum tenens sees a patient of the contracted physicians (the par physician must be absent the entire period the locum tenens is in place).
- At the end of the 60 days, a locum tenens situation cannot be renewed or extended with the same locum tenens physician. A new contract can be renewed with the same locum tenens physician if the contracted physician returns and sees patients for at least one day or the contracted physician can engage a different locum tenens physician.
- The locum tenens provider must have an NPI number and an unrestricted state license.
- The contracted physician must keep a record of the locum tenens' NPI and each medical service furnished by the locum tenens and make these records available to Premier upon request.
- All general principles of medical documentation apply; the record must verify that the services performed were medically necessary and otherwise covered in order for the contracted physician to receive reimbursement.

General Claims Filing Tips

- **Always verify current Member eligibility and whether Routine Vision benefits are available**.
- Ensure Prior Authorization is obtained, if required, and is listed on the claim in Field 23 on the CMS 1500 form.
- Adhere to Timely Filing Limits.
- **Ensure your office works all rejected claims.**
- All **Routine Vision claims** must include one of the following RV diagnosis codes in position 1 as the primary diagnosis: H52.00 – H52.03, H52.10 – H52.13, H52.201 – H52.209, H52.211 – H52.213, H52.219, H52.221 – H52.223, H52.229, H52.4, H52.7, or Z01.00 – Z01.01 (Note: Z01.01 must be billed with a secondary diagnosis code).
- Diagnosis Codes and Diagnosis Pointers: **Claims must contain an Ophthalmic ICD10 diagnosis code in the Primary position** (Field 21 and Field 24E of the CMS 1500 form).
- **RT/LT Modifiers for Eyeglass Lenses:** Only bill with Modifier RT and LT with 1 unit on each line when only 1 unit of a lens is billed. This is in addition to any other required modifiers. Otherwise, No Anatomical Modifiers is used; bill with 2 units.
- **Claims for Lenses only:** If the member wishes to utilize their RV Benefit Allowance for Lenses only, Code S0595 may be required to replace the Frame code. Please refer to the specific Health Plan rate sheets for more details as this option may not be available. If required, bill with S0595 with Modifier 22 and a charge amount of no less than $0.01. If required, all lenses, upgrades and add-ons must also be billed with Modifier 22.

- **Contact Lenses:** For plans that offer a Contact Lens benefit, this is in lieu of eyeglasses. Please use 92310 for the Contact Lens Fitting Exam, V2599 for non-disposable and V2520 – V2523 for disposable contacts. The contact fitting fee is payable in addition to the Member's allowance for the contact lenses. Note: Verify if contact lenses are covered under Member's Benefit Plan.
- **Referring Provider for Eyeglasses Claims:** All claims for eyeglasses are the result of a physician's initial exam and referral for lenses. The claim must include the Referring Physician's Name in Field 17 and Individual/Type1 NPI in 17b. **The information in these fields can be yours as the examining provider.**
- **Corrected Claims** may be sent electronically as long as the claim is within timely filing guidelines. Use resubmission **code 7 in box 22 for EDI claims**. Indicate "corrected claim" in box 19 for paper claims.
- **Coordination of Benefit** Claims are accepted electronically. Field 9, 9A, 9D, 11C, COB info payor 2, payor 3, and line level COB information must be filled out on the claim form.
- If you add a new provider to your practice, remember to have them credentialed with Premier before they begin treating patients to ensure payment of their claims.
- If you open a new location or practice site, contact us prior to submitting claims to avoid claim rejects. We must have your new location or office set up in our system to issue authorizations and process claims.
- Remember to list your NPI numbers on your claims. **Rendering Provider's NPI must be listed in Field 24J.** If you have a site location NPI it must be included Field 32A.
- If you use a billing office, that name and NPI number must be listed in Fields 33 and 33A. All NPI numbers submitted must match the information you have provided us or your claim will reject. Please reference NPPES.
- Field 24 E – **Diagnosis Pointer** - Enter the diagnosis code reference letter (pointer) as shown in Number 21. The reference letters should be A – L or multiple letters as applicable. A maximum of four Diagnosis Pointers are allowed in Field 24 E.
- Service Location NPI: Field 32A of the CMS-1500 is not required if it is the same NPI that is listed in Field 33A, provided the address in 33 is not a PO Box and Field 32 is not blank.

Missing codes can also result in the delay or denial of claim payment or result in the claim being returned to the submitting Provider office, causing a delay in payment. Always use the highest level of specificity when listing your diagnosis codes as required in the standard format.

Please note: Contracted Hawaii FQHCs may have special claims instructions that will be sent in your Welcome Packet. Please refer to these instructions as applicable.

Claims Audits

Claims audits may be conducted by Premier, its Health Plan customers or a governmental, accreditation or regulatory agency. Participating Practitioners are required to participate in these audits and cooperate with all such parties or their designated auditors.

Audits are conducted to determine if claim/encounter data submissions and payments were accurate. Some audits focus on many elements of the claims process while others may be targeted reviews of specific issues. A typical audit includes not only a review of the claim itself, but also a review of the medical records or other supporting documents to substantiate the claim submitted.

Premier's or each Health Plan's audit team performs data analysis and audits periodically to ensure processing and payment accuracy and timeliness, and to identify errors, over- or under-payments. If we identify claims/encounter data submission errors, overpayment or underpayments during an audit, we will notify you and you may dispute our findings. If you do not file a timely dispute, then Premier may proceed with recovery of any overpayment as allowed by law, including offsetting the overpayment against future amounts due.

Adjustments

Premier may at any time retroactively adjust any payments previously made to Provider based on information received by Premier or a determination by Premier that the payment(s) were improperly paid or otherwise not due and owing pursuant to this Agreement. In exercising its right to make adjustments as outlined herein, Premier will notify Provider of the adjustment and has the right to reduce any currently owed or future payments to Provider in an amount equal to the adjustment amount(s). In addition, Premier has the right to separately invoice Provider for the amount of the adjustment(s), which Provider agrees to pay within thirty (30) calendar days of receipt of the invoice. Provider's failure to pay timely represents a default under this Agreement.

Sequestration

Claims and payments are subject to sequestration reductions in accordance with CMS guidelines. Premier applies a 2% reduction as passed on by the Health Plans to all applicable claims and services.

" The Budget Control Act of 2011 mandates, among other provisions, automatic across-the-board reductions in certain types of federal spending, referred to as sequestration. As a result, Medicare

claims with dates of service or discharge on or after April 1, 2013, are subject to a 2% reduction in Medicare payments."
https://www.aha.org/topics/medicare-sequestration-payment-reductions

Section VIII
Quality Improvement

Quality Improvement Program

Premier has a Quality Improvement (QI) Program in place to monitor, evaluate and facilitate the ongoing improvement of quality eye care services. The evidence-based QI Program provides for the collection and analysis of meaningful information and the identification and effective action towards improvement opportunities.

Premier's QI Program provides the infrastructure needed to improve key organizational processes such as credentialing and UM and to review and safeguard the quality of care and services provided. It is available on our Provider Web Portal and print copies are available upon request.

Quality Monitoring/Peer Review Process

While not all monitoring activities are addressed in this manual there are some that are generally of particular interest to Practitioners.

Premier monitors Practitioner sanctions, member complaints and quality issues between credentialing cycles and takes appropriate action when occurrences of poor quality are identified. Ongoing monitoring includes collecting and reviewing:

- Medicare/Medicaid sanctions
- Sanctions or limitations on licensure
- Complaints
- Medicare/Medicaid Opt-Out Listing
- Data Bank reports, including malpractice settlement reports

The Quality Improvement and Credentialing departments track the number, type and severity of complaints specific to each practitioner and the Credentialing Committee takes this into consideration when re-credentialing a practitioner. If we receive repeat complaints about office site quality (e.g., cleanliness or accessibility of office), we will conduct an on-site visit and may require remediation and ongoing monitoring.

Our medical director reviews all quality of care complaints. If the incident warrants, the medical director will refer the case to the Peer Review Committee. The Peer Review Committee will determine appropriate action up to and including termination. The medical director may also

immediately suspend a practitioner if the medical director believes that the health and safety of members warrants immediate suspension while a timely investigation is conducted. The Peer Review Committee is convened in a timely manner to determine the appropriate long-term action.

If involved in any such cases, you will be contacted by our medical director and given an opportunity to respond to allegations and participate in the peer review process. If any adverse action is taken by the Credentialing Committee, medical director or Peer Review Committee, you have the right to appeal and will be notified of your rights and instructions on how to initiate the process.

If a Practitioner does not comply with established credentialing criteria, or in the instances of confirmed quality concerns, Premier and the Health Plan will implement appropriate interventions, up to and including termination.

Should Premier suspend or terminate a Practitioner for quality reasons, we will make the required notifications, including to State licensing agencies and the Data Bank.

Section IX
Member Triage Protocol

Medical Services or Routine Vision Services

Medical Eye care:	**Medical / Surgical Eye Care**
Routine Vision:	**Routine eye exams, glasses and contact lenses (as allowable under Benefit Plan)**
If the member presents symptoms of: • Eye pain • Redness • Itchiness • Discharge • Bleeding • Sudden vision loss • Flashes/Floaters • On glaucoma meds • Diabetes with eye problems • Cataracts requiring surgery	**Member is directed to medical provider.** Please direct the member to contact their PCP to coordinate medical eye care.
If the member lacks the above symptoms and presents with: • Blurry Vision • Headaches • Failed vision screening • Failed driver's test • Diabetes with no eye problems • GSO/DRE screening • Need for new eyeglass or contact lens prescription	**Member is directed to the routine vision network.** Member has open access for services with any participating routine vision provider

Section X
References

Membership Types:

Medicare Advantage

Medicare is a federally funded program that provides health insurance coverage to people age 65 and older. It also covers younger people with permanent disabilities and end-stage renal disease. When Medicare's eligibility requirements are met, Medicare covers hospital stays, physician visits and prescription drugs through Parts A, B and D, respectively.

Medicare Advantage plans are private Health Plans that receive payments from Medicare to provide the full range of Medicare-covered benefits to enrollees. Medicare Advantage plans typically include all the benefits of original Medicare and may also include: Prescriptions, over-the-counter medicines, Dental, Transportation, Hearing services, Routine Eye exams and/or eyeglasses.

Medicaid

Medicaid provides health coverage to millions of Americans, including eligible low-income adults, children, pregnant women, elderly adults and people with disabilities. Medicaid is administered by states, according to federal requirements. The program is funded jointly by states and the federal government.

Medicaid can cover some people who are on Medicare, as well: low-income elderly and people with disabilities. These people are sometimes referred to as "**dual eligible".** For dual eligibles, Medicaid supplements Medicare-covered services by paying for Medicare premiums, members' cost-sharing requirements and long-term services and supports (LTSS).

Medicaid members may also include those suffering from mental illness and HIV AIDS.

In Florida, the Agency for Health Care Administration (AHCA) is responsible for Medicaid. AHCA successfully completed the implementation of the Statewide Medicaid Managed Care (SMMC) program in 2014. Under the SMMC program, most Medicaid recipients are enrolled in a health plan. Nationally accredited health plans were selected through a competitive procurement for participation in the program. Some of Premier's contracted health plans participate in the SMMC program.

HIPAA (Health Insurance Portability and Accountability Act) and HITECH (Health Information Technology for Clinical and Economic Health)

As a healthcare Provider, if you transmit any health information electronically, you are a HIPAA Covered Entity and your office is required to comply with all HIPAA and HITECH rules and regulations. HITECH requires Covered Entities to report Data Breaches involving Members' Protected Health Information (PHI) to the affected individuals and the Office for Civil Rights.

Premier is a Business Associate of the Health Plans it contracts with. Premier is subject to the same HIPAA standards and penalties as apply to Covered Entities, including the Data Breach reporting requirements.

Please ensure that your practice and office staff are HIPAA compliant. Providers should investigate and report all HIPAA violations involving Members to Premier immediately. In addition, Premier reminds Providers that as Covered Entities, they are also required to report Data Breaches to the Office for Civil Rights (www.hhs.gov/ocr)

Fraud, Waste and Abuse (FWA)

Premier is committed to detecting, reporting and preventing potential health care FWA. Premier has a FWA program that includes training, system edits, audits and other means to help detect and prevent FWA. Fraud, waste and abuse are defined as:

Fraud: Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, any health care benefit program.

Waste: Activities involving payment or the attempt to obtain reimbursement for items or services where there was no intent to deceive or misrepresent but the outcome of poor or inefficient billing or treatment methods causes unnecessary costs.

Abuse: Provider practices that are inconsistent with professionally recognized standards or that result in unnecessary cost.

Premier provides FWA training to its entire team upon hire and annually. Participating Providers are also required to provide FWA training to its employees upon hire and annually. CMS and the various state Medicaid agencies have FWA training materials and resources available to you on their respective websites. The CMS FWA training is available here:

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud_and_Abuse.pdf

CMS has also posted General Compliance Training on its MLN Provider Compliance webpage:

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedCandDGenCompdownload.pdf

Both training presentations can be completed online or downloaded.

Reporting FWA

Please report all suspected FWA involving any Member or Premier-contracted Health Plan to our Compliance director immediately. We also have a 24-hour toll free reporting hotline: 1-855-353-4953 for anyone who wishes to remain anonymous. Confidentiality will be respected to the extent possible.

The following is a list of federal and state governmental agencies that regulate the Medicare and Medicaid programs, to which cases may be referred.

Department of Health and Human Services Office-of-Inspector-General
Call: 800-447-8477
TTY: 800-377-4950
Online: https://forms.oig.hhs.gov/hotlineoperations/report-fraud-form.aspx
Email: HHSTips@oig.hhs.gov

Connecticut Medicaid Fraud Control Unit, Office of the Chief State's Attorney
Call: 860-258-5986
Online: https://portal.ct.gov/DCJ/Programs/Programs/Medicaid-Fraud-Control-Unit

Florida Bureau of Medicaid Program Integrity:
Call: 888-419-3456
Online: https://ahca.myflorida.com/mchq/mpi/

Florida Office of the Attorney General Medicaid Fraud Control Unit
Call: 866-966-7226

Florida Agency for Health Care Administration Fraud and Abuse Hotline
Call: 888-419-3456

Hawaii Department of the Attorney General Criminal Justice Division
Call: 808-586-1160
Online: http://ag.hawaii.gov/cjd/medicaid-fraud-control-unit/

Maine Fraud Investigation and Recovery Unit
Fraud Hotline: 866-348-1129
Email: fraud.dhhs@maine.gov

Michigan Department of Health and Human Services
Call: 313-226-4258. Suspected fraud and/or abuse is referred by the Office of Inspector General to the Michigan Department of the Attorney General, Medicaid Fraud Control Unit.

Ohio Department of Medicaid
Call: 614-466-0722
Online: https://forms.oig.hhs.gov/hotlineoperations/report-fraud-form.aspx

Rhode Island Department of Human Services Fraud Unit
Call: 401-574-8175
Online: Fraud Allegation Form | Office of Management and Budget (ri.gov)
By mail: Fraud Detection and Prevention Unit, One Capitol Hill, Providence, RI 02908

Tennessee Bureau of Investigation Medicaid Fraud Control Division
Call: 800-433-5454
E-mail: TBI.MedicaidFraudTips@tn.gov
Mail: Tennessee Bureau of Investigation, Medicaid Control Fraud Division, 901 R. S. Gass Blvd., Nashville, TN 37216
Online: TBI Medicaid Fraud Control Division Online Submission Form (tn.gov)

Texas Health and Human Services Inspector General
Call: **800-436-6184**
Online: Inspector General - Report Waste, Abuse & Fraud (state.tx.us)

Vermont Office of the Attorney General Program Integrity Unit
Call: 802-828-6611
Online: Medicaid Fraud Report Form - Office of the Vermont Attorney General

Provider FWA and Compliance Training

Providers who have met the FWA certification requirements through enrollment into Parts A or B of the Medicare program are deemed to have met the FWA training and education requirements; however, provider office staff involved in the administration or delivery of Medicare services must still receive training initial and annual training.

CMS has developed and provided free General Compliance and FWA web-based training. These are available through the CMS Medicare Learning Network (MLN) at:

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html.

You may do the training online, or download the training presentations (PDF files) using this link.

For your convenience, we have also posted the CMS General Compliance and FWA training (PDF files) as well as Premier's Standards of Conduct on the Premier web portal also. Access the provider portal via www.premiereyecare.net, type in your username and password and click on "Support/Provider Download/Provider Manuals and Documentation/Compliance" on the left.

Identifying victims of Human Trafficking

Healthcare providers may encounter victims of human trafficking and have a unique opportunity to connect them with much needed support and services. Anyone in a healthcare setting may be in a position to recognize human trafficking.

The following is a list of potential indicators that medical providers may see in a patient who may be a victim of human trafficking. Please note that this list is not exhaustive. Each indicator taken individually may not imply a trafficking situation and not all victims of human trafficking will exhibit these signs. However, the recognition of several indicators may point to the need for referrals and further assessment.

Victims of human trafficking may exhibit any of the following:

- Shares a scripted or inconsistent history
- Is unwilling or hesitant to answer questions about the injury or illness
- Is accompanied by an individual who does not let the patient speak for themselves, refuses to let the patient have privacy, or who interprets for them
- Evidence of controlling or dominating relationships (excessive concerns about pleasing a family member, romantic partner, or employer)
- Demonstrates fearful or nervous behavior or avoids eye contact
- Is resistant to assistance or demonstrates hostile behavior
- Is unable to provide his/her address
- Is not aware of his/her location, the current date, or time

- Is not in possession of his/her identification documents
- Is not in control of his or her own money
- Is not being paid or wages are withheld

If you think you have come into contact with a victim of human trafficking, call the **National Human Trafficking Resource Center at 1-888-3737-888**. The NHTRC can help you identify and coordinate with local organizations that protect and serve trafficking victims. **To report online or access resources and referrals go to:** www.traffickingresourcecenter.org

Member Rights and Responsibilities

Premier and all of its network providers must comply with all applicable federal and state laws that pertain to enrollee (member) rights, including but not limited to: 42 CFR s.438.100, Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR Part 80, the Age Discrimination Act of 1975 as implemented by regulations 45 CFR Part 91, the Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972, Titles II and III of the Americans with Disabilities Act and section 1557 of the Patient Protection and Affordable Care Act. In addition to member rights described in Section III, e.g., non-discrimination, members have at least the following specific rights:

The right to—

(i) Receive information in accordance with 42 CFR § 438.10.

(ii) Be treated with respect and with due consideration for his or her dignity and privacy.

(iii) Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand.

(iv) Participate in decisions regarding his or her health care, including the right to refuse treatment.

(v) Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation;

(vi) Request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR § 164.524 and 164.526.

(vii) Be furnished health care services in accordance with 42 CFR s. 438.206 through 438.210.

(viii) Freely exercise his or her rights, and that the exercise of those rights does not adversely affect the way we treat the enrollee.

More specifically, Florida Medicaid members have the Right to:

- To get details about what the plan covers and how to use its services and the plan Providers
- To have their privacy protected
- To know the names and titles of doctors and others who treat them
- To talk openly about care needed for their health, no matter the cost or benefit coverage
- To freely talk about care options and risks involved
- To have this information shared in a way they understand
- To know what to do for their health after they leave the hospital or Provider's office
- To refuse to take part in research
- To create an Advance Directive
- To suggest ways the plan can improve
- To file complaints or Appeals about the plan or the care it provides
- To have a say in the plan's Member rights
- To have all these rights apply to the person who can legally make health care decisions for them
- To have all plan staff observe their rights
- To use these rights no matter what their sex, age, race, ethnic, economic, educational or religious background
- To receive information about the plan, its services, its practitioners and Providers, and Members rights and responsibilities
- To participate with practitioners in making decisions about their health care
- To a candid discussion of appropriate or medical necessary treatment options for their conditions, regardless of cost or benefit coverage
- To make recommendations regarding Member rights and responsibilities
- To be treated with respect and with due consideration for dignity and privacy
- To receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand
- To participate in decisions regarding health care, including the right to refuse treatment
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation
- To ask for and receive a copy of medical records, and ask that they be amended or corrected:
    - Requests must be received in writing from the Member or the person chosen to represent him or her
    - The records will be provided at no cost
    - The records will be sent within 14 days of receipt of the request

To be furnished health care services in accordance with federal and state regulations the state must make sure a Member is:

- Free to exercise their rights
- The exercise of those rights does not adversely affect the way the plan and its Providers or the state agency treat the Member

They have the Responsibility:

- To know how their plan works by reading their handbook
- To carry their ID card and Medicaid Gold Card with them at all times and to present them when they get health care services
- To get nonemergency care from a primary doctor, to get referrals for specialty care, and to work with those giving them care
- To be on time for appointments
- To cancel or set a new time for appointments ahead of time
- To report unexpected changes to their Provider
- To respect doctors, staff and other patients
- To help set treatment goals that they and their doctor agree to
- To follow the treatment plan they and their Provider agree on
- To understand medical advice and ask questions
- To know about the medicine they take, what it is for, and how to take it
- To provide information needed to treat them
- To make sure their doctor has their previous medical records
- To tell the plan within 48 hours, or as soon as they can, if they are in a hospital or go to an emergency room
- To supply information (to the extent possible) that the plan and its practitioners and Providers need in order to provide care
- To understand their health problems and participate in developing mutually agreed-upon treatment goals to the degree possible

Section XI
Forms

We have posted many of the forms and other resources you may need on our website.

Please visit our Provider Web Portal at www.prermiereyecare.net to download any forms you need (e.g., Electronic Claim Submission agreement, W-9, Request for Prior Authorization, etc.). To register for our Provider Web Portal please go to our website and sign up as a new user. If you need help accessing the Provider Web Portal, call us at 1-800-738-1889.

If you need a credentialing form, please contact us at credentialing@premiereyecare.net If you do not find the form you need, please contact us at providerservices@premiereyecare.net or call our Provider Service line for assistance (see Section XII for our telephone numbers by state). We will be happy to email or fax it to you.

Section XII
Premier Telephone Numbers

If you are in:	Call us at:
Alabama	855-865-9729
Arkansas	833-883-2336
Arizona	855-879-1453
California	833-883-2339
Connecticut	855-749-1908
Colorado	866-419-2193
Delaware	866-434-0032
Florida	800-738-1889
Georgia	866-419-0816
Hawaii	855-879-1447
Illinois	855-865-9723
Indiana	888-285-2863
Iowa	866-434-0024
Kansas	866-419-0861
Kentucky	866-419-1620
Louisiana	855-879-1451
Maine	800-299-6687
Massachusetts	866-419-1543

Michigan	888-208-8046
Missouri	866-419-1765
Mississippi	833-883-2335
North Carolina	855-865-9721
Nebraska	866-419-1782
New Hampshire	855-818-4779
New Jersey	866-434-0034
New Mexico	866-419-2019
Nevada	866-419-1955
New York	866-419-2057
Ohio	888-208-8289
Oklahoma	866-419-2161
Oregon	866-419-2195
Pennsylvania	866-419-2382
Rhode Island	866-434-0001
South Carolina	866-419-1009
Tennessee	833-611-7775
Texas	855-879-1455
Vermont	844-767-4227
Washington	844-235-2455
Wisconsin	866-419-1068

REVIEW/REVISION HISTORY	DATE
Adding IA to list of medical states (page 33) Updated location of Appeals Form (page 43) Updated Pass-Through claims section (page 38)	August 2025
Claims Adjustments, Sequestration, VPAY information, Provider Telephone Numbers	December 2024
Added in Optometry Medical States (page 33)	March 2024
Provider Telephone Numbers	December 2023
Medicaid Enrollment Status	August 2023
Ultimate – Missed Appointments	April 2023
Revised Section III (HEDIS®), Section IV Credentialing (insurance coverage for ASCs), Section V Coverage and Clinical Guidelines, Routine Vision requirements for DREs; added Tele-vision program	July 2022
Removed Telephone numbers for: AR, CA, IL, IN, LA, MS, NC, NH, WA	Jan 2022
Removed Simply Medicare from Missed Appointments section (page 19)	August 2021
Added New Provider Numbers: Rhode Island and Vermont Added FWA Contact Numbers: Rhode Island and Vermont	December 2020
Added Physician Assistant Guidelines Added Physician Assistant Claim Guidelines Added Locum Tenens Guidelines Added Medical Records Document Upload Information Added New Provider Numbers: Indiana, Michigan, New Hampshire, Ohio, Washington Added Language regarding Guidelines for Routine Vision Exams	December 2019

Added FWA Contact Numbers: Indiana, Michigan, New Hampshire, Ohio, Washington	
Updated Missed Appointment Policy for SOLIS Added Section on Withholding Eyewear Revised Language on the requirements for Medical Records – Member Identification	August 2019
Added Standards of Conduct Portal location Updated EFT website Added Devoted and SOLIS under Missed Appointments section. Added Department of health contact number for Arkansas, Maine, Mississippi, and Tennessee	January 2019
Added language for Identifying victims of human trafficking.	October 2018
Revised to add Florida Medicaid requirements for provider manuals	August 2018
Added Language on Utilization Management Updated Language on FQHC Billing Instructions	July 2018
Updated Section X (Training and Member Rights)	June 2018
Updated Non-Disposable and Disposable Contact lens V codes. Added language about member liability for denied claims for: • Services Not Covered • Exceeding Benefit Limitation Updated EDI Clearinghouse language Updated Claims Filing tips, telephone numbers, North Carolina numbers Updated Appointment Scheduling language Updated Missed Appointment Language Added language on Emergency Services	March 2018

Updated enrollment process for Direct Data Entry Updated Medicaid language in Section X Added language on IVR (Interactive voice recording) Added email address for EDI Team Updated language on Membership Types – Medicaid Added language on Education and Marketing to Members Added language on Medicaid Background screening requirements Updated language in Section IV – Credentialing	
Toll Free Premier Phone Number, Web Portal, Diabetic Retinopathy, Adverse Incidents reporting, FWA, Authorizations and Claims sections updated.	August 2017
Updated Premier Eye Care address	April 2016
Added reference to NCQA UM-CR certification; updated references to ICD-10, updated HEDIS® section (removed GSO references), updated If You Have a Complaint section, updated list of states and telephone numbers, DDE and paper claims sections	July 2015
Continuity of Care section, FWA reporting list and Premier telephone numbers/states updated	May 2015
Authorizations and Claims sections updated	October 2014