AvMed Medicare HMO Provider Manual

EYE MANAGEMENT

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Appointment Scheduling

1. Appointments for AvMed Medicare HMO members may be scheduled by the member's Primary Care Physician (PCP), or the member may also schedule an appointment himself.
2. Members do not require a referral from their PCP or EMI before seeing a general ophthalmologist.
3. Following an initial visit, PCPs should receive a written statement of your findings and recommendations on the EMI Report of Ophthalmic Consultation (See Section 1, Provider Policies). Contact with the member's PCP should continue throughout their course of treatment.
4. A member should be given an appointment within three weeks from the date that they contacted your office for a routine well-care appointment, two weeks for a routine symptomatic diagnosis, 24 hours for an urgent diagnosis and immediately for emergency care.

Co-Payments and Co-Insurance

1. Your office will be responsible for collecting co-payments and co-Insurance, if applicable. Each office visit by a member, including initial and follow-up visits, must be charged a co- payment and co-insurance, if applicable, at the time service is provided.

Surgery and Outpatient Diagnostics

1. Surgical procedures performed in your office do not require an authorization from EMI.
2. All surgical procedures must be performed in a participating AvMed facility.
3. Any procedures not performed in a participating AvMed facility shall be denied unless written approval is obtained by both EMI and AvMed.
4. A complete listing of participating AvMed facilities can be obtained by visiting the AvMed website at www.avmed.org/.
5. Any pre-operative testing must be coordinated with the PCP's office.
6. Any diagnostic tests that are to be performed outside the Specialist's office (e.g., MRI, CT scan, X-Ray, etc.) must be performed at a participating facility and coordinated with the PCP's office.
7. Please refer to Appendix A for a complete listing of surgical procedures that require an authorization from EMI.
8. You must complete the **Surgical Control Number Request Form** (refer to Appendix A) and fax your request to EMI at 305-868-7640 or 800-922-4132. You may be required to submit a copy of the patient's chart, a dictation and photos or test results, if applicable.

Claims

Claim Submission:

The preferred method of claims submission is through our Web Portal. Providers may use the HN1/HS1 Web Portal (www.healthsystemone.com) to submit claims. The Web Portal provides your office the ability to check the status of your submitted claims 24/7 regardless of the method of submission (paper, electronic, Web Portal entry). If you wish to sign up, please visit myemifl.com/pwp to register for an account.

Please note that it is very important that you include the referring provider NPI and Name on all claim submissions. Omission of this information will cause delays and possible denials in payment.

Electronic Claims should be submitted via:

Payer ID 65062-Health Network One.

Paper claims should be mailed to: Eye Management, Inc.

P.O. Box 21730
Fort Lauderdale, FL 33335-1730

Do not send the claims directly to the patient's health plan as they will be denied, and your reimbursement will be delayed. The health plan will not forward these claims to EMI.

Consultative Services (Sub-Specialty Services)

1. In the event that you wish to refer a patient for Sub-Specialty ophthalmology services, or wish to refer a patient for specific treatment (retina, cornea, oculo-plastics, etc.), you may use the **EMI Subspecialty Service Request Form** (refer to Appendix A).
2. You may fax the form to the subspecialist or give the form to your patient.
3. A referral is always necessary for subspecialty ophthalmology services. The subspecialist will be required to include the referring provider's name and NPI on their claims submission documentation.
4. All referrals from the general ophthalmologist to the subspecialist will be valid for one-hundred and eighty (180) days.
5. As a subspecialist, if a member is at your office for a scheduled appointment, do not turn the patient away, or delay care. Please contact EMI directly for further assistance.

Non-Covered Services

Covered benefits are defined by AvMed as those services which are deemed medically necessary pursuant to the member's health plan benefit design and definition, and not for cosmetic purposes. Please note that **contact lenses, non-traditional IOLs (e.g. multi-focal, accommodating IOLs) and refractive services are NOT COVERED** under this Agreement.

1. In the event that a member requests that your office perform a refraction and/or contact lens fitting, EMI has provided you with the Vision Services Fee Information form (refer to the Provider Policy section of this manual). This form explains to the member that refractive services are not covered under their medical eye care benefits and they are responsible in full for the cost of any refractive services provided by you.
2. The member must be adequately informed prior to receiving non-covered benefits that he/she will be responsible for payment of such services.
3. The form may never be used to collect monies in advance of, or for services which may be covered by the member's health plan benefits.
4. Please contact our office if you need further clarification about covered and non- covered services.

Ordering Injectable Medication

Step Therapy

- Insurers are encouraged by the Centers for Medicare & Medicaid Services (CMS) to implement step therapy programs to ensure Medicare patients try lower-cost medications before certain higher-cost medications are approved.
- Step Therapy promotes safe and effective use of medications, reduces inappropriate use of medications and helps lower costs.
- If a prescribed drug does not meet Step Therapy criteria, it will not be approved until your patient has tried an alternative medication(s).
- An exception process in place for specific circumstances that may warrant a need for a non-preferred product and are only available if process exception criteria are met.

The table below indicates the injectable drugs used in the treatment of choroidal and retinal vascular disorders. The preferred product must be used first. Exceptions to the use of the preferred product must be submitted through the health plan's specialty pharmacy, **CVS specialty.**

Drug Class	Preferred Product(s)	Non-Preferred Product(s)*
Retinal Disorders Agents	Avastin	Beovu
		Eylea
		Lucentis

1. There is no pre-authorization required when using the preferred drug, Avastin.
2. EMI will reimburse you directly for Avastin.
3. You must bill EMI for **both** the administration of the drug, CPT Code 67028, and the pharmaceutical agent, Avastin HCPS code J9035.
4. If the non-preferred product(s) is obtained through CVS specialty you must continue to submit the CPT Code 67028 to EMI for the administration of the drug.
5. Providers must obtain authorizations for the non-preferred injectable drugs from NovoLogix by logging into Novologix via the AvMed Provider portal at www.avmed.org.
6. The dispensing of the drug will be delivered directly to you by CVS specialty.
7. The non-preferred drugs are not directly reimbursable and may only be obtained from CVS specialty.

A copy of the CVS Caremark Specialty Medication Delivery Program Physician Enrollment Form, **Retinal Disorders/Ocular Specialty Enrollment Form for the Non-Preferred Product(s)** and **Specialty Pharmacy Services Enrollment Form** (for all other injectable pharmaceutical agents, *excluding* those included in Step Therapy- e.g. Oculinum (Botulinum Toxin Type A) are included in **Appendix A**.

Laboratory Specimens

Quest Diagnostics, Inc. is the participating lab covered under AvMed. There is no out-of-network lab benefit for HMO members. Use Quest Diagnostics for your members' lab needs. When you require specimen analysis for an AvMed member complete the appropriate lab requisition form and include the following information:

1. The specific test code for each test ordered.
2. Any and all applicable diagnosis code(s).
3. Specify that you are an AvMed provider.
4. Give your name and address and they will send a courier to your office.
5. All billing is handled between Quest Diagnostics, Inc. and AvMed.
6. Your office or the member will not be financially responsible for these costs.
7. Do not send specimens to any other laboratory, or to the member's PCP.
8. You may contact Quest Diagnostics at (866) 697-8378 – Laboratory Direct or 800-786-6890 – Client Services

Visit **www.questdiagnostics.com** for patient service center locations, and to order lab tests and view results through the Quest Diagnostics Care360 Physician Portal. Ordering physicians may also schedule appointments on behalf of the member by calling Quest Diagnostics or accessing the website at **www.questdiagnostics.com/appointment**. While appointments are not required, they may ease patient wait times associated with testing and improve compliance.

AvMed Drug Formulary

For an up-to-date copy of the AvMed Drug Formulary please refer to **www.avmed.org.**

AvMed Hospital Listing

For an up-to-date listing of the AvMed participating facilities please refer to **www.avmed.org.**

Appendix A

Surgical Procedures which Require Authorization from EMI

Below you will find a Listing of Surgical Procedures which require authorization from EMI for AvMed Medicare Advantage Members:

ProcCode	ProcDesc
0449T	Insertion of aqueous drainage device 1st
11900	Injection, intralesional; up to and including 7 lesions
14060	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less
15820	BLEPHAROPLASTY LOWER EYELID
15821	BLEPHAROPLASTY LOWER EYELID HERNIATED FAT PAD
15822	BLEPHAROPLASTY UPPER EYELID
15823	BLEPHAROPLASTY UPPER EYELID W/EXCESSIVE SKIN
31231	Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)
65778	Amniotic Membrane Sutureless Placement on the Ocular Surface
65780	OCULAR SURFACE RECONSTRUCTION AMNIOTIC MEMBRANE
66183	Insert anterior drainage device
66988	XCAPSULAR CATARACT RMVL INSJ LENS PROSTH 1 STG
66991	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure)
67900	REPAIR BROW PTOSIS
67901	RPR BLEPHAROPTOSIS FRONTALIS MUSC SUTR/OTH MATRL
67902	RPR BLEPHAROPT FRONTALIS MUSC AUTOL FASCAL SLING
67903	RPR BLEPHAROPTOSIS LEVATOR RESCJ/ADVMNT INTERNAL
67904	RPR BLEPHAROPTOSIS LEVATOR RESCJ/ADVMNT XTRNL
67906	RPR BLEPHAROPTOSIS SUPERIOR RECTUS FASCIAL SLING
67908	RPR BLPOS CONJUNCTIVO-TARSO-MUSC-LEVATOR RESCJ

SURGICAL CONTROL NUMBER REQUEST FORM

This form is to be used by all ophthalmologists when requesting a surgical control number for a member. The form must be faxed to EMI at 1 (800) 922-4132. All fields must be completed in order for a surgical control number to be issued.

Date of Request (mm/dd/yyyy)	Patient Last Name	Patient First Name
Patient Date of Birth (mm/dd/yyyy)	Health Plan	Patient ID

Contact Person Last Name	Contact Person First Name
Name of Surgeon Last Name	Name of Surgeon First Name

Referring Provider Last Name	Referring Provider First Name	Referring Provider NPI

Surgical Procedure(s)			
CPT Code(s)	CPT Code(s)	CPT Code(s)	CPT Code(s)
ICD-10 Code(s)	ICD-10 Code(s)	ICD-10 Code(s)	ICD-10 Code(s)

Facility/Hospital Name			Facility/Hospital NPI
Facility/Hospital Address			Facility TIN
City		State	Zip
Date of Surgery	Place of Service: ☐ Outpatient Facility ☐ Inpatient Hospital		Surgeon NPI

A surgical control number will be faxed to your office within 72 hours of the receipt of your request. If you have not received the request within this time frame, or for any Urgent/STAT requests, or if you require further clarification of this information, please contact EMI at 1 (800) 329-1152.

SUBSPECIALTY SERVICE REQUEST FORM

Please give this form to your patient and/or the Subspecialist.

Date of Request (mm/dd/yyyy)	Patient Last Name	Patient First Name
Patient Date of Birth (mm/dd/yyyy)	Health Plan	Patient ID

Contact Person Last Name	Contact Person First Name
Referring Provider Last Name	Referring Provider First Name
Referring Provider NPI	Subspecialist NPI
Phone	Fax

PHYSICIAN REFERRED TO

Subspecialist Last Name	Subspecialist First Name	
Address		
City	State	Zip
Phone	Fax	Appointment Date & Time

TENTATIVE DIAGNOSIS

Brief Case History/Reason for Referral

Signature of Referring Physician

Last Name, First Name (Please Print)

AvMed Embrace better health.®

CVS Caremark Specialty Medication Delivery Program

Dear Physician:

Thank you for your interest in participating in AvMed's Specialty Medication Delivery Program. This program is administered through AvMed's exclusive specialty pharmacy, CVS Caremark. Both organizations are committed to a medication delivery program that is simple, efficient and convenient for your office and for our members.
There are many drugs available for your office. These drugs are listed on the *Specialty Medication List*. Once you have elected to enroll in the program, it's as simple as completing the CVS Caremark referral form, faxing it directly to CVS Caremark and the medication will be delivered to your office (all AvMed prior authorization criteria remains in effect).

If you choose to enroll in the Specialty Medication Delivery Program, the following instructions will apply:

1) Complete and fax CVS Caremark Specialty Rx Referral Form directly to CVS Caremark using the fax number listed on the form. CVS Caremark will deliver the drug(s) to your office **(please allow 48 hours for delivery)**.
2) CVS Caremark will bill AvMed for the drug(s).
3) After administration of the drug to our member, your office can submit a claim to AvMed for the administration. Please note that delivery of drug(s) could be delayed if all requested information is not provided on the Referral RX Form faxed to CVS Caremark.

If you would like to enroll in the Specialty Medication Delivery Program for the drug(s) listed on the attached drug list, please complete and sign the **Specialty Medication Delivery Enrollment Form** attached to this fax. Fax the form to the number listed in the black bar near the bottom of the form. Your office will be notified of the date your enrollment will become effective via return fax. Please be advised that participation in this program requires that all medications listed on the attached drug list are obtained through CVS Specialty Phamracy. If you choose to not participate in this program then you will no longer be able to order **any** of the listed medications through CVS Specialty Pharmacy.

If you have any questions or would like to discuss the program in more detail, please contact Brenda Mamay in AvMed's Clinical Pharmacy Management Department by calling 352-337-8844.

Sincerely,
Avmed Health Plans

Brenda Mamay
Pharmacy Technician
Clinical Pharmacy Department
AvMed
Direct: 352.337.8844 x40268
Brenda.Mamay@avmed.org

Clinical Pharmacy Management
4300 NW 89th Boulevard
Gainesville FL 32606

AvMed Embrace better health.

Specialty Medication Delivery Program

Physician Enrollment Form

(If additional physicians in your group want to participate in this program, please copy this form and have each physician submit their own request on a separate copy of this form).

Complete all requested information (please print clearly):

Physician's Name: ______________________________

Address: ______________________________

City: ______________________________ **Zip:** ______________

Physicians Telephone #: ______________________________

Physician's Facsimile #: ______________________________

Physician's AvMed Provider #: ______________________________

Physician's DEA #: ______________________________ **NPI#:** ______________

Physician's Specialty: ______________________________

Contact Person's Name: ______________________________

Contact Person's Telephone #:
(if different from physician's) ______________________________

Contact Person's Fascimile #:
(if different from physician's) ______________________________

By completion of this form and by my signature below, I am indicating my desire to participate in AvMed Health Plans' Specialty Medication Delivery Program. I agree that all medications on the attached Specialty Medication list will be ordered through CVS Caremark.
I understand that I will not be able to bill AvMed for these drugs upon my enrollment and any claim for medications included in this program will deny if a claim is submitted in error. ***I will be notified of the date my enrollment will become effective by return of this form from AvMed*** *(enrollment could take approximately 2 weeks).*

Physician's Signature (required)**:** ______________________________

Date Signed (required)**:**

Fax Completed Enrollment Form to 352.337.8737

This section is for AvMed's use only.
Date notified: ☐ Pharmacy Dept. ☐ CVS Caremark ☐ Physician

Your enrollment in the **Specialty Medication Delivery Program** will become effective on:

____.

Use the following form to order replacement drugs from CVS Caremark.

Specialty Pharmacy Services Enrollment Form

Fax Referral To: 1-800-323-2445 **Phone: 1-866-638-8311**
Email Referral To: customerservicefax@caremark.com

Six Simple Steps to Submitting a Referral

❶ PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name: ______________________________
Address: ______________________________
City, State, ZIP: ______________________________
Preferred Contact Method: ☐Phone (to primary # provided below) ☐Text (to cell # provided below) ☐Email (to email provided below)
Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.
Primary Phone: __________ ☐Home ☐Cell ☐Work
Alternate Phone: __________ ☐Home ☐Cell ☐Work
DOB: __________ Gender: ☐Male ☐Female
Email: ______________________________
Last Four of SSN: __________ Primary Language: __________

❷ PRESCRIBER INFORMATION

Prescriber's Name: ______________________________
State License #: __________ NPI #: __________
DEA #: __________
Group or Hospital: ______________________________
Address: ______________________________
City, State, ZIP: ______________________________
Phone: ______________________________
Fax: ______________________________
Contact Person: ______________________________
Contact's Phone: ______________________________

❸ INSURANCE INFORMATION

Please fax copy of prescription and insurance cards with this form, if available (front and back)

❹ DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: __________
Ship to: ☐Patient ☐ Office ☐ Other: __________

Diagnosis (ICD-10):
Code: ______ Description: ______________________ Code: ______ Description: ______________________
Code: ______ Description: ______________________ Code: ______ Description: ______________________
For additional ICD-10 information, please visit www.CVSspecialty.com/ICD10

Patient Clinical Information:
Allergies: ____________________ Weight: __________ lb/kg Height: __________ in/cm
Concomitant Medications: ______________________________
Additional Comments: ______________________________

Nursing: Specialty pharmacy to coordinate injection training/home health nurse visit as necessary? ☐ Yes ☐ No
Injection training is not necessary. Date training occurred: __________
Reason: ☐ MD office training patient ☐ Pt already independent ☐ Referred by MD office to alternate trainer

❺ PRESCRIPTION INFORMATION

MEDICATION	DOSE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐				
☐				
☐				
☐				
☐				
☐				
☐				
☐				

☐ Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

PHYSICIAN SIGNATURE REQUIRED

❻ X ______________________________ X ______________________________
PRODUCT SUBSTITUTION PERMITTED (Date) DISPENSE AS WRITTEN (Date)

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments.
Plan member privacy is important to us. Our employees are trained regarding the appropriate way to handle members' private health information.
This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with CVS/caremark®.
75-36813A 122215

Retinal Disorders/Ocular Specialty Enrollment Form

Fax Referral To: 1-800-323-2445
Email Referral To: Customer.ServiceFax@CVSHealth.com
Phone: 1-800-237-2767

Six Simple Steps to Submitting a Referral

1 PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name: ______________________________ DOB: ______________
Address: ______________________________ City, State, ZIP Code: ______________
Gender: ☐ Male ☐ Female
Preferred Contact Methods: ☐ Phone (to primary # provided below) ☐ Text (to cell # provided below) ☐ Email (to email provided below)
Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.
Primary Phone: ______________________ Alternate Phone: ______________
If **Minor**, Parent/Caregiver/Guardian Name (Last, First): ______________________
Relationship to minor: ______________
Email: ______________________ Last Four of SSN: ________ Primary Language: ______________

2 PRESCRIBER INFORMATION

Prescriber's Name: ______________________ State License #: ______________
NPI #: ___________ DEA #: ___________ Group or Hospital: ______________________
Address: ______________________ City, State, ZIP Code: ______________
Phone: ______________ Fax______________ Contact Person: ______________ Contact's Phone: ______________

3 INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back)

4 DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: ______________________ Ship to: ☐ Patient ☐ Office ☐ Other: ______________

Diagnosis (ICD-10):
ICD-10 Code: ___________ Diagnosis: ______________ Affected eye(s): ☐ Right Eye ☐ Left Eye ☐ Both Eyes

Patient Clinical Information:
Allergies: ______________________ Height: ________in/cm Weight: _______lb./kg

Durysta: Can only be used once per lifetime per eye.
Has the patient received a prior **Durysta** implant in the treatment eye? ☐ Yes ☐ No

Iluvien:
Prior corticosteroid treatment **required** per the FDA labeled indication for **Iluvien**:
Medication prescribed ______________________ Date prescribed ______________________

Susvimo:
Previous response to at least 2 intravitreal injections of a vascular endothelial growth factor (VEGF) inhibitor medication are required per the FDA labeled indication for **Susvimo:**
Medication prescribed ______________________ Date prescribed ______________________
Medication prescribed ______________________ Date prescribed ______________________

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Retinal Disorders/Ocular Specialty Enrollment Form

Please Complete Patient and Prescriber Information

Patient Name: ______________________ Patient DOB: ______________________
Prescriber Name: ______________________ Prescriber Phone: ______________________

5 PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DOSE & DIRECTIONS	QUANTITY/REFILLS
☐ Beovu	Vial	**Induction dose:** ☐ Inject 6 mg monthly for the first three doses ☐ Other: ____________ **Maintenance dose:** ☐ Inject 6 mg every 8 to 12 weeks ☐ Other: ____________	Quantity: ________ Refills: ________
☐ Durysta	1 applicator	☐ To be injected by physician as directed ☐ Other: ____________	Quantity: ________
☐ Eylea	☐ Vial ☐ PFS	☐ Inject 2 mg (0.05 mL) every 4 weeks (monthly) for the first 3 injections followed by 2 mg (0.05 mL) once every 8 weeks ☐ Inject 2 mg (0.05 mL) every 12 weeks (3 months) after one year of effective therapy with regular assessment ☐ Inject 2 mg (0.05 mL) every 4 weeks (monthly) for the first 5 injections followed by 2 mg (0.05 mL) once every 8 weeks ☐ Inject 2 mg (0.05 mL) every 4 weeks (monthly) ☐ Other: ____________	Quantity: ________ Refills: ________
☐ Iluvien	1 applicator	☐ To be injected by physician as directed ☐ Other: ____________	Quantity: ________
☐ Lucentis	☐ 0.3 mg/0.05 mL single-dose PFS ☐ 0.3 mg/0.05 mL single-dose vial ☐ 0.5 mg/0.05 mL single-dose PFS ☐ 0.5 mg/0.05 mL single-dose vial	☐ Prepare and administer 0.3 mg by intravitreal injection into affected eye(s) once a month (approximately 28 days) ☐ Prepare and administer 0.5 mg by intravitreal injection into affected eye(s) once a month (approximately 28 days) ☐ Other: ____________	Quantity: ________ Refills: ________
☐ Ozurdex	1 applicator	☐ To be injected by physician as directed ☐ Other: ____________	Quantity: ________ Refills: ________
☐ Retisert	1 implant	☐ To be implanted by physician as directed ☐ Other: ____________	Quantity: ________
☐ Susvimo	1 implant	☐ To be implanted by physician as directed ☐ Other: ____________	Quantity: ________ Refills: ________
☐ Vabysmo	6 mg	☐ To be injected by physician as directed ☐ Other: ____________	Quantity: ________ Refills: ________
☐ Visudyne	Vial	☐ To be infused by physician as directed ☐ Other: ____________	Quantity: ________ Refills: ________
☐ Other: ________	Other: ________	Other: ____________	Quantity: ________ Refills: ________
☐ Yutiq	0.18 mg (single dose implant)	☐ To be injected by physician as directed ☐ Other: ____________	Quantity: ________ Refills: ________

☐ Patient is interested in patient support programs **STAMP SIGNATURE NOT ALLOWED** Ancillary supplies and kits provided as needed for administration

6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

"Dispense As Written" / Brand Medically Necessary / Do Not Substitute / No Substitution / DAW / May Not Substitute **Prescriber's Signature:** ____________ **Date:** ________	May Substitute / Product Selection Permitted / Substitution Permissible **Prescriber's Signature:** ____________ **Date:** ________

CA, MA, NC & PR: Interchange is mandated unless Prescriber writes the words "**No Substitution**" ____________ **ATTN: New York and Iowa providers,** please submit electronic prescription

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing above, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by telephone and destroy all copies of this communication and any attachments.
Plan member privacy is important to us. Our employees are trained regarding the appropriate way to handle members' private health information.
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Payment Policies

- Payment of General Ophthalmological Services
- Documentation Requirements
- Other Payment Policies
- Diagnostic Tests

Payment of General Ophthalmological Services

An ophthalmological eye examination includes many components. The following section was written to furnish the provider with a clear understanding of what documentation Eye Management, Inc. (EMI) requires from the provider to substantiate the level of coding used. Ophthalmological examinations can be divided into intermediate and comprehensive services.

An intermediate eye examination (**CPT codes 92002 and 92012)** pertains to the evaluation of a new or existing condition, respectively, complicated by a new diagnostic or management problem not necessarily relating to the primary diagnosis. The intermediate eye exam includes the following components:

- a medical history with focus on ophthalmologic history
- general medical history including medicines
- external ocular and adnexal examination
- other diagnostic procedures as indicated
- use of mydriasis

These codes should be used when the examination reveals:

- no ocular pathology, or;
- pathology which does not require high level decision making, or;
- pathology which does not require treatment, or;
- refractive errors when no other complex ocular pathology is present.

These codes should also be used when:

- the exam is problem focused, not comprehensive (as described on the following pages), and is being billed in conjunction with other testing (such as a refraction, 92015, an extended ophthalmoscopy, 92225, a visual field, 92083, etc.)

The 92012 code should also be used when:

- the examination is for follow-up during a course of treatment and requires only a problem focused exam, or;
- a complex follow-up examination (92014) has been performed within the last six months for the same condition.

A comprehensive eye examination **(CPT codes 92004 and 92014)** requires a general evaluation of the complete visual system, and **must include all of the following** to be considered comprehensive:

- a complete medical and ocular history
- general medical observation
- external and ophthalmoscopic examination
- examination with cyclopegia or mydriasis and tonometry
- ALWAYS includes initiation of diagnostic and treatment program as indicated

An ophthalmoscopic exam is considered appropriate in patients with the following conditions:

- previously diagnosed ocular pathology
- ocular or periocular symptoms such as ocular pain, tearing, discharge, swelling, decreased vision not related to refractive disorders, etc. (decreased vision or ocular discomfort related to refractive errors are considered non-complex and should be billed as a 92002 or 92012, with a 92015 if a refraction is performed)
- neurologic abnormalities which could affect the eye, periocular regions or visual system (i.e. blepharospasm, stroke) and/or local or systemic disorders affecting the eye, periocular regions, or visual system (i.e. Sarcoid, Systemic Lupus, Diabetes, intracranial tumor).
- traumatic injury to the ocular region, periocular region or skull

Documentation Requirements

The documentation for an intermediate exam will **include a minimum** of two sections of the comprehensive examination depending on the symptoms which drove the exam.

The documentation for a comprehensive exam **must include all of the following** in order to be considered comprehensive, (if the exam is deficient in any area, it will be considered intermediate):

- Visual Acuity (does not include determination of refractive error). This will typically include a description noted by a large capital "V" in two or three designations without correction (SC-meaning without any visual aids), with correction (CC-meaning with visual aids in use at the time of exam), or best corrected (BC- meaning the best obtainable eyeglass prescription in place). A designation of "N" is a visual acuity test performed at near, while the traditional visual acuity test is performed at the equivalent of a distance of 20'.
- Gross visual field testing by confrontation using the standard confrontation approach described by the term "full to finger counting" or FTFC.
- Ocular motility test including primary gaze alignment. This is a sensory motor exam which should be documented with comments such as: straight (ortho); esophoria or esotropia (E', ET) in a latent or manifest form, exodeviation, exophoria, or exotropia (X, XT); or full ductions and versions (full D&V).
- Examination of ocular adnexae including lids, lacrimal glands, lacrimal drainage, orbits and preauricular lymph nodes. Documentation should include comments regarding the ocular adnexae and lids such as the absence or presence of ptosis, lagophthalmos, blepharitis, lid margin scaling, aberrant lashes, stagnation of tear flow, etc.
- Examination of pupils and irises including shape, direct and consensual reaction (afferent pupil), size, and morphology. Documentation of this component usually may be made in the form of PERLA (pupils equally reactive to light and accommodation).
- Anterior segment performed through a slit lamp examination (biomicroscopy) and involves: inspection of the corneas including epithelium, stroma, endothelium, tear film; inspection of the anterior chambers including depth, cells, flare; and inspection of the lenses including clarity, anterior and posterior capsule, cortex, and nucleus; inspection of bulbar and palpebral conjunctivae. Documentation may include "2+ injection", "white and quiet". Documentation about the cornea might include "clear" or demonstrate an inflammatory process of any of the epithelial, stromal, or endothelial layers. Documentation about the anterior chamber should have a comment with regard to its depth and the status of its inflammatory state. Documentation about the iris should be included and might include transillumination defects or rubeosis, and the lens will have comments regarding clarity with respect to cataract changes, be they cortical, nuclear, or posterior subcapsular.
- Measurement of intraocular pressures (for glaucoma). Documentation is typically noted with a capital letter "T" and numbers listed to the side in a vertical arrangement. The right eye is always listed above the left eye. This recording is in millimeters of mercury and, typically, the instrument chosen for the exam is noted.A small "a" reflects Goldman applanation, an "s" which is rarely seen is the Schiotz indentation tonometer, and an "NCT" is one of the air driven noncontact tonometers. "TP" reflects use of a Tonopen.
- Ophthalmoscopic fundus examination with or without dilation to examine the optic discs including size, C/D ratio, appearance and nerve fiber layer; and the posterior segments including retina and vessels. This component of the exam may be performed using the direct method which assesses the optic nerve head, macula, vessels and retina or the indirect method which includes all of the previous plus the peripheral retina.

In review, documentation is the key to the level of reimbursement which will be made. If an exam is essentially normal, but documentation is not made to indicate that each anatomical structure of the eye (as described above) was assessed, the reviewer will assume that the assessment was therefore not made, and the exam will most likely be considered intermediate.

Furthermore, if a comprehensive exam is billed and then individual components are additionally billed (unbundled), the exam will be considered intermediate (problem focused) and the separate components billed will be reimbursed based on documentation (see sections on individual procedures billed as a separate component).

Other Payment Policies

E/M Coding-New Patient Visit

While it may be the practice of a physician to code a new patient visit using the E/M codes
99204 or 99205 it is our policy to adjudicate these codes as a comprehensive ophthalmologic exam for the purpose of reimbursement for the following reason:

These codes carry specific time criteria and a problem focus. For example, a 99204 involves a comprehensive history, a comprehensive exam, and medical decision making of moderate complexity which requires the physician to typically spend forty-five minutes face-to-face with the patient. Whereas a 92004 is a comprehensive ophthalmologic exam with the initiation of a diagnostic and treatment program. This code more often reflects the ophthalmologist's actual exam.

If you bill a 99204 or 99205 it will be reimbursed to reflect the more appropriate ophthalmologic examination which corresponds to the diagnostic findings. Understandably, there may be times when the higher E/M code is indicated. In these circumstances, if a claim has been adjusted and you feel it was inappropriate, you may dispute the determination following the dispute process outlined in your Provider Manual.

Vision Exams (92015)

Vision exams are not a covered benefit by a medical eye care provider under the AvMed member's medical eye care benefits. Please refer to page 8 of the Provider manual for more information.

Billing For Follow-Up Exams (92012 & 92014)

A comprehensive follow-up exam will not be paid more than once every six months. If a 92014 is billed within a six-month period it will be reimbursed as a 92012, intermediate services.

Payment of Procedures as Separate Components of an Exam

Payment of Gonioscopies (92020)

A Gonioscopy is considered part of a comprehensive ophthalmological exam unless performed as a separate procedure (not on the same day as a comprehensive exam).

Payment of Sensorimotor Exams (92060)

A 92060 will be considered included in a comprehensive or intermediate exam. It may be billed as a separate procedure only if a comprehensive or intermediate exam is not billed on the same day as the 92060.

Payment of Extended Ophthalmoscopies (92201 & 92202)

These codes have been identified by many insurance carriers as being frequently overused. EMI has therefore; set forth the following policy regarding payment of these procedures. An ophthalmoscopy is considered part of a general exam and is not considered to be separately payable. If a comprehensive exam code is used, a separate billing for a 92201 or 92202 on the same day will not be paid. However, if the ophthalmologist performs an extended ophthalmoscopy in conjunction with an intermediate level exam (92002, 92012), it may be billed as a separate procedure. **The following documentation should be noted in the patient record and may be requested by EMI upon retrospective review.**

A detailed drawing, with detailed notes describing the optic nerve, macula, vessels, retina, vitreous, and all pathology and the medical necessity of performing the extended ophthalmoscopy. If no pathology is present, or the medical necessity is not documented, and/or the drawing is not detailed (only a few lines with no explanation), payment will not be made for a 92201 or a 92202 as a separate procedure. All of the criteria must be met for the extended ophthalmoscopy to be considered a separate billable service.

See *Payment of Fundus Photography (92250) for additional guidelines.*

Payment of Fluorescein Angiographies (92235)

A fluorescein angiogram will be paid unilaterally (paid for both the left and right eye) whether the test was performed on one or both eyes. Fluorescein angiography performed within 30 days of indocyanine green angiography will be denied as not medically necessary, unless there is documentation in the patient's medical record of co-existing diseases.

Payment of Indocyanine Green Angiography (92240, 92242)

This test has been proven to be useful in the diagnosis and treatment of a certain number of choroidal neovascular membrane disorders. It will be paid on a limited basis when certain criteria are met. There must be documentation in the patient's record that there is evidence of retinal disease on previous fluorescein angiography (FA). Medical documentation must be included with the claims submission.

In addition, Indocyanine Green Angiography will be paid bilaterally. EMI will reimburse for one eye only, whether the test was performed on one or both eyes. There is no supporting evidence to substantiate the frequency of repeat exams, but discretion should be used since this is an invasive procedure, and follow-up diagnostics can often be obtained with an FA alone.

Payment of Fundus Photography (92250)

Reimbursement shall be made for fundus photography when it is indicated to document the baseline of a fundal abnormality. CPT 92250 is defined as bilateral so reimbursement is for both eyes. It will not be reimbursed on subsequent exams unless the pathology has caused a change to occur, and documentation of such change is medically necessary. Both interpretation and a report in addition to the photo must be documented in the patient record and included with the claim submission. In addition, fundus photography will not be reimbursed when performed on the same day as extended ophthalmoscopies (92201, 92202).

Payment for ERG (92273/92274) and VEP/VER (95930) Testing

EMI will pay for eletroretinogram (ERG) when one of the following conditions is present: unexplained visual loss, hereditary retinal degeneration/dystrophies, retinal vascular occlusion when the diagnosis is in doubt (not diabetic retinopathy or senile macular degeneration), drug toxicity (e.g. plaquenil) or occult macular degeneration when the diagnosis cannot be confirmed with prior fluorescein or ICG angiography.

EMI will pay for visual evoked potential (VEP) or visual evoked response (VER) when one of the following conditions are met: unexplained visual loss, multiple sclerosis, optic nerve or pathway disease, suspected functional visual loss.

Documentation supporting the medical necessity should be legible, maintained in the patient's medical record, and must be included with the claim submission.

Payment of Color Vision Examinations (92283)

Color vision testing with pseudoisochromatic plates is not considered a separately reimbursable procedure and is included in a comprehensive and limited exam.

Payment of External Ocular Photography (92285)

The use of this code is frequently overused. While the physician may elect to perform this procedure for the documentation of any external pathology, there is generally no medical indication for this. Therefore, this code will be reimbursed on a limited basis for pathology which requires the documentation by photography of the condition prior to a surgical procedure, i.e. pre-authorization for procedures such as blepharoptosis, removal of basal cell carcinoma, severe ectropion or entropion. External photography of pterygiums, benign lesions or cysts of the lids, or pingueculi are expected to be used to document and/or monitor the progression of ocular surface pathology, interpretation and a report should be included in the patient's medical record and may be subject to retrospective review.

Bi-Lateral Reimbursement of Certain Diagnostic Tests

These procedures are paid on a bilateral basis by EMI. While it may be performed on both eyes, it is considered one service when performed on both eyes on the same day and includes the following: 76519, 92136, and 92285.

Payment During the Post-Operative Period

All testing and exams performed following a surgical procedure shall be considered included in the global surgical fee following the procedure, unless the patient returns during the post-operative period with an unrelated chief complaint.

Payment of A Repeat Surgery During the Post-Operative Period

Any pathology requiring repeat surgery or laser which is identified within the 90 day post-operative period will be reimbursed at 50% of the payable amount unless it is performed for a problem with a new diagnosis. Laser surgery is described as one or more sessions.

Payment of Multiple Surgical Procedures on the Same Eye, Same Day

Multiple procedures on the same eye performed on the same day will be reimbursed in the following manner: the primary procedure will be reimbursed at the full fee schedule rate; subsequent procedures will be paid at 50/50/50/50/and by report % of the payable amount. Procedures that have been unbundled (are a component of another billed procedure) will be re-bundled and will not be considered for further reimbursement. In certain retinal and oculoplastic procedures, there are no accurate CPT codes to describe all of the components of a particular series of procedures. In this case, if a component is included as part of each billed procedure; the cost of the component will be deducted from each subsequent procedure before the 50/50/50/50/and by report adjustment is made.

Payment of ECCE with Insertion of IOL, Complex (66982, 66987- with endoscopic cyclophotocoagulation, 66989 – with insertion of intraocular anterior segment aqueous drainage device, without extraocular reservoir, internal approach)

The code for complex cataract surgery is intended to differentiate the extraordinary work performed during the intraoperative or postoperative periods in this subset of cataract operations versus that performed in routine cataract surgery. The indications for use of this code are as follows:

1. A miotic pupil which will not dilate sufficiently to allow adequate visualization of the lens in the posterior chamber of the eye and which requires complex devices or techniques not generally used in routine cataract surgery. These must be implantable devices, not simply stretching devices.
2. The presence of a disease state that produces lens support structures that are abnormally weak or absent and which requires complex devices or techniques not generally used in routine cataract surgery.
3. Mature cataract requiring blue to complete the capsulorhexis.
4. Pediatric cataract surgery or surgery performed if the patient is in an amblyogenic developmental stage (decreased vision in one or both eyes without detectable anatomic damage to eye).

The preoperative clinical notes and the operative report must accompany all claims submitted for payment and provide documentation of the medical necessity of the procedure. Claims received without the proper documentation will be paid at zero. The provider must resubmit the claim with the required documentation for review. The medical necessity of this complex procedure must be evident in the documentation submitted for payment approval. Those claims submitted with the code of 66982 that do not meet the above criteria will be paid at the lesser rate paid for the code of 66984, routine cataract surgery. Those claims submitted with the code of 66987 that do not meet the above criteria will be paid at the lesser rate paid for the code of 66988, routine cataract surgery with endoscopic cyclophotocoagulation. Those claims submitted with the code of 66989 that do not meet the above criteria will be paid at the lesser rate paid for the code of 66991 routine cataract with insertion of intraocular anterior segment aqueous drainage device, without extraocular reservoir, internal approach.

Payment of Chalazion Incision and Intralesional Injection (67800 and 11900)

The usual and customary treatment for chalazion can be medical or surgical. Warm compresses and topical antibiotics are often used for medical treatment. Surgical incision and drainage is also appropriate initial treatment for a chalazion. Some doctors may use steroid injections for small chalazia as an initial treatment, although this is unusual.

EMI will reimburse for a chalazion incision and drainage (67800) when performed alone. EMI will reimburse for the intralesional injection of steroids when performed alone. However, EMI will not pay for both procedures when performed on the same day.

Payment of Sutureless Placement of Amniotic Membrane on the Ocular Surface; Without Sutures (65778)

Amniotic tissue has been used in a variety of surgical procedures to cover a defect on the surface of the eye and facilitate wound healing as well as decreasing inflammation. There must be documentation in the patient's record to support the use of amniotic membrane as a biological corneal bandage and may be subject to retrospective review*. Use of amniotic membrane within the postoperative period of a prior surgery, not requiring a return to the operating room and not pre-planned is subject to

the principles for global surgery and will not be reimbursed separately. Do not report CPT codes 65778 or 65779 in conjunction with CPT codes 65430, 65435, and 65780.

*Please reference First Coast Service Options, Inc. Local Coverage Determination (LCD): Amniotic Membrane-Sutureless Placement on the Ocular Surface (L36237)

Payment of Aqueous Shunts and Stents for Glaucoma (66183, 0449T &, 66988, 66991)

EMI recognizes that first-line treatment of glaucoma typically involves pharmacologic therapy. Surgical intervention may be indicated in individuals with glaucoma when the target IOP cannot be reached pharmacologically. Minimally invasive glaucoma surgeries (MIGS) may be an alternative to trabeculectomy, the most established surgical procedure for glaucoma.

Ab externo (outside the eye) MIGS meet the definition of medical necessity as a method to reduce intraocular pressure in individuals with glaucoma where medications have failed to adequately control intraocular pressure. Use of ab externo aqueous shunt for all other conditions, including in individuals with glaucoma when intraocular pressure is adequately controlled by medications, is considered experimental or investigational and is not payable by EMI.

Ab interno (inside the eye) MIGS meet the definition of medical necessity as a method to reduce intraocular pressure in individuals with glaucoma where medical therapy has failed to adequately control intraocular pressure.

Implantation of 1 or 2 ab interno aqueous stents approved by the FDA in conjunction with cataract surgery also meets the definition of medical necessity in individuals with moderate open-angle glaucoma treated with ocular hypotensive medication.

Use of ab interno stents for all other conditions, or when medical therapy has adequately controlled intraocular pressure, is considered experimental or investigational and is not payable by EMI.

Medical documentation must be submitted to EMI for pre-authorization approval prior to performing services. Services billed without prior authorization will be denied.

Billing/Coding Information:

66183 Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach

0449T Insertion of aqueous drainage device, without extraocular reservoir, internal approach, into the subconjunctival space: initial device.

66988 Extracapsular cataract removal with insertion of intraocular lens prosthesis; with endoscopic cyclophotocoagulation

66991 Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); with insertion of intraocular (eg, trabecular meshwork, supraciliary, suprachoroidal) anterior segment aqueous drainage device, without extraocular reservoir, internal approach, one or more

*Reference: First Coast Service Options, Inc. Local Coverage Determination (LCD): Micro-Invasive Glaucoma Surgery (MIGS) (L38233)

These payment policies are a composite of several sources. They were developed using the guidelines as set forth by Medicare, descriptions of billing using Current Procedural Terminology (CPT) written by the American Medical Association, and proposed and reviewed by the Eye Management, Inc. Quality and Utilization Review Committees.

EMI Provider Policies

- Provider Trainings
- Provider Code of Conduct
- Vacation Emergency Coverage
- Vacation/Emergency Notification Form
- Grievance Policy
- Provider Action Request Form
- Report of Ophthalmic Consultation
- Report of Ophthalmic Consultation Form
- Non-Covered Services
- Vision Services Fee Information Form
- Claims Dispute
- Claims Review/Dispute Form
- Claims Inquiries

Provider Trainings

All providers with EMI, are required to complete the Provider Trainings, within thirty days of their contract effective date and annually thereafter. The trainings can be located via the web at https://myemifl.com/trainings . You may complete the trainings on any desk top or mobile device for ease of access and completion. Your attestation will confirm that your office has received all mandatory trainings for the year. Should you want a copy of the trainings for your office, they can be downloaded from the attestation page. NOTE: For providers who function under more than one Tax ID; please be sure to complete an attestation for each Tax ID that is contracted with EMI.

Provider Code of Conduct

Eye Management, Inc. (EMI) vision is to "develop and market products, through our family of companies that facilitates access for consumers and payers to quality and cost effective healthcare". Our extensive network of providers help to support this vision by providing quality service to our clients. To ensure that we meet this goal, the Organization has established a set of business conduct guidelines based on the Organization's code of ethics.

Providers Conduct

EMI has built an all-encompassing specialty delivery system of quality physicians, providing the full service of benefits that meet our client's population. Our providers shall not abuse, neglect, exploit or maltreat members in anyway, whether by omission or through acts or by failing to deter others from acting. If the provider becomes aware that a member has been subjected to any abuse, neglect, exploitation or maltreatment, the Provider's first duty is to protect the member's health and safety.

Provider Education and Support

The provider network representatives, in addition to the provider manual, conducts ongoing training which may include webinars, and web based tutorials as deemed necessary by the Client or state agency to ensure compliance with client or state agency program standards. These standards include annual distribution of general compliance, HIPAA, Cultural Competency, FWA and any health plan specific trainings as applicable. EMI maintains evidence of annual training and all providers within our network are required to complete the training.

Provider Cultural Competency

EMI's participating providers, and their staff, will ensure that services are provided in a culturally competent manner to provide to all contracted health plan's members and practitioners specific to local cultures, demographics, and ethnicity. EMI has created the cultural competency policy to ensure that effective medical services are provided. EMI's participating providers, and their staff shall not discriminate on the basis of religion, gender, race, color, age or national origin, health status, pre-existing condition or need for health care services, and shall not use any policy practice that has the effect of such discrimination. This policy recognizes Section 1557 of the Affordable Care Act (ACA) and all other applicable national, state and/or local laws that prohibit the practice of discrimination.

Policies and Procedures

Should you as a provider like to receive a copy of the specific Policy and Procedure that governs any of the processes discussed in this Provider Manual, you can request it through your Provider Service Representative via email to augustem@healthnetworkone.com , or by calling our Provider Service Call Center at 305-614-0100 and selecting Option 2, or via the Contact Us link on our website https://www.myemifl.com/.

Vacation/Emergency Coverage

Your office is responsible for providing covered services on a 24 hour, 7-day per week basis (including emergencies). EMI must be notified in advance whenever your office will not be available to provide this coverage. The following Vacation/Emergency Notification Form has been created in order to provide EMI with this information. This form must be faxed to EMI at (305) 868-7640 or (800) 922-4132, Attention: Authorization Coordinator, prior to the time when you will be unavailable to provide covered services.

If your office is temporarily unavailable to provide coverage, you must arrange for a substitute physician. The substitute physician must be aware of his/her rights and obligations in providing covered services to a member. The substitute physician may not charge the patient any amount greater than their co-payment.

When a substitute physician will be providing covered services in your absence, EMI must be provided with the name of the substitute physician and the dates of coverage, prior to the start of the coverage. The Vacation/Emergency Notification Form should be used to provide EMI with this information.

If a member requires hospitalization by the substitute physician for covered benefits, he may only utilize authorized health plan facilities. Please instruct him to contact EMI prior to any facility usage.

Eye Management

VACATION/EMERGENCY NOTIFICATION FORM

Fax to EMI at (305) 868-7640 at least one week prior to physician's leave.

Date (mm/dd/yyyy)	Provider Last Name	Provider First Name

DATES HE/SHE WILL BE UNAVAILABLE TO SEE PATIENTS:

From [month/day/year and time (am/pm)]	To [month/day/year and time (am/pm)]

NAME AND TELEPHONE NUMBER OF COVERING PHYSICIAN(S) IF APPLICABLE:

Covering Provider Last Name	Covering Provider First Name	Phone Number
Covering Provider Last Name	Covering Provider First Name	Phone Number
Covering Provider Last Name	Covering Provider First Name	Phone Number
Covering Provider Last Name	Covering Provider First Name	Phone Number
Covering Provider Last Name	Covering Provider First Name	Phone Number

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Policy for Provider Inquires

When a provider has a specific inquiry or concern (e.g. question regarding an EMI policy or procedure; request for resolution to a claim inquiry; problem or question regarding a health plan policy or procedure), the provider may contact EMI at 800-329-1152, Option 2, or the provider may complete the following "Provider Action Request" and fax to EMI for resolution.

Our fax number is **(305) 868-7640 / (800) 922-4132**

This form should NOT be used to inquire about the status of claims or to dispute claim denials. Separate forms have been developed for this purpose. See Section "Claims Dispute" and "Claims Status Inquiries". This form can be used in the event that the provider does not receive a satisfactory response to a claim's status or a claim dispute in addition to the other reasons previously stated.

EMI will address all provider concerns upon receipt. All provider inquires will be logged and the provider may receive a reference number upon request.

Eye Management

PROVIDER ACTION REQUEST FORM

Date (mm/dd/yyyy)	Provider Last Name	Provider First Name

Contact Person in Providers Office Last Name	Contact Person in Providers Office First Name
Phone Number	Fax Number

EXPLAIN THE NATURE OF YOUR PROBLEM OR INQUIRY:

THE FOLLOWING TO BE COMPLETED BY EYE MANAGEMENT

Date Received	Started By	Department

Action Taken

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Report of Ophthalmic Consultation

As part of our Quality Improvement (QI) activities, EMI has created the EMI Report of Ophthalmic Consultation to be used by our providers as a tool for communication between themselves and the PCP. This form was created in collaboration with fellow ophthalmologists in the network. This form or a similar comprehensive exam report should be sent to the member's PCP following each exam.

A copy of the form follows for your reference.

EYE MANAGEMENT

REPORT OF OPHTHALMIC CONSULTATION

Date of Service (mm/dd/yyyy)	Patient First Name	Patient Last Name
Provider Last Name	Provider First Name	Provider Phone Number
Consulting Ophthalmologist First Name	Consulting Ophthalmologist Last Name	Consulting Ophthalmologist Phone Number

DIAGNOSIS/FINDINGS:

CONJUNCTIVA
____ 1. Conjunctivitis
____ 2. Conjunctival Hemorrhage
____ 3. Dry Eye
____ 4. Pinguecula
____ 5. Pterygium

CORNEA
____ 6. Corneal Abrasion
____ 7. Corneal Foreign Body
____ 8. Corneal Ulcer
____ 9. Keratitis

EYELIDS
____ 10. Blepharitis
____ 11. Chalazion
____ 13. Ectropion
____ 14. Entropion
____ 15. Neoplasm, Benign Eyelid
____ 16. Neoplasm, Malignant Eyelid
____ 17. Ptosis, Eyelid
____ 18. Trichiasis, without entropion

GLAUCOMA
____ 19. Glaucoma, Open Angle Primary
____ 20. Glaucoma Suspect
____ 21. Glaucoma, Narrow Angle
____ 22. Normal Tension

LACRIMAL
____ 23. Nasolacrimal Duct Obstruction
____ 24. Dacryocystitis

LENS
____ 25. Cataract, Primary
____ 26. Cataract, Secondary

MUSCLES
____ 27. Esotropia
____ 28. Strabismus
____ 29. Amblyopia

NEURO
____ 30. Bell's Palsy
____ 31. Nystagmus
____ 32. Optic Atrophy
____ 33. Optic Neuropathy

VISUAL
____ 34. Photophobia
____ 35. Pseudophakia (IOL)

RETINA
____ 36. Retinopathy, Diabetic
____ 37. Retinopathy, Hypertensive
____ 38. Retinal Tear
____ 39. Macular Degeneration
____ 40. Macular Retinal Edema
____ 41. Retinal Detachment
____ 42. Retinal Vein Occlusion

VITREOUS
____ 43. Vitreous Floaters/Opacity
____ 44. Vitreous Hemorrhage
____ 45. Vitreous Detachment

Other:

VISUAL ACUITY: 20/____ (OD) 20/____ (OS)

☐ NSAID:	☐ Beta Blocker Selective:	☐ Beta Blocker Non Selective:
☐ Parasympathomimetic:	☐ Steroid:	☐ Antibiotic/Steroid:
☐ CAI(carbonic anhydrase inhibitor):	☐ Prostaglandin analogue:	☐ Antibiotic:

☐ Other:

Treatment/Recommendations:

Physician Signature

☐ Referred to Optometrist for Vision/Refractive Care

☐ Follow up: ____ Day(s) ____ Week(s) ____ Month(s) ____ Year ____ PRN

Non-Covered Vision Services

Covered benefits by EMI ophthalmologists vary according to the member's health plan. Refer to the applicable health plan section of the Procedure Manual in the Index under "Non-Covered Services".

In the event that a member requests that your office perform a non-covered vision service, EMI has provided you with the following Vision Fee Information form.

This form explains to the member that the services you are providing are not covered under their benefit package and they are responsible in full for the cost of any non- covered services provided by you.

The member must be adequately informed prior to receiving non-covered vision services that they will be responsible for the payment of such services.

In addition to written consent by the member, EMI must be notified in advance and give written approval to charge the member for these services.

This form must be signed each time a non-covered vision service is provided.

Eye Management

VISION SERVICES FEE INFORMATION

Vision Services are not a covered benefit under your insurance plan medical benefit package, this includes: routine eye examinations to check vision problems, vision services, refractive examinations, and prescriptions for glasses and contact lenses. If you have requested that any of these services be performed by a network ophthalmologist, you will be charged his/her usual and customary fee to provide these services, and you will be required to pay this fee to the ophthalmologist at the time the service is rendered.

This information is being provided to you so that you may make an informed decision before receiving these services. We recommend that you contact your insurance carrier to obtain complete information regarding vision services available to you. At the time the services are performed, you will be required to pay for the vision services provided in addition to your usual co-payment if medical services were rendered at the same time. Because these services are not a covered benefit, you may not seek reimbursement for these services from your health plan at a later date.

This information is being provided to you so that you may make an informed decision before receiving these services. We recommend that you contact your insurance carrier to obtain complete information regarding vision services available to you.

I have read the above information and understand my financial responsibility.

Member Name (Printed)	Name of Legal Guardian (if Minor)
Signature	Date (mm/dd/yyyy)

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Claims Dispute

If a provider wishes to contest any claim payment, or reduction in reimbursement for specific procedures, the following actions must be taken within 60 days after receipt of the provider remittance or Explanation of Payment (EOP).

1. Attach all pertinent documentation supporting your dispute.
2. Submit a copy of the original claim (marked "COPY") and a copy of the EOP, which accompanied the original claim.
3. **Mail** all information "Attention Claims Review" to:

   Eye Management, Inc.
   P.O. Box 21730
   Fort Lauderdale, FL 33335

   Do not call the office, fax information, or direct the information to any other department.
4. All attempts will be made to answer your response within thirty business days or sooner. However, at times, a claims dispute may be forwarded to the Peer Review Sub-Committee in which case you will be notified of this action, and the time expected before a response will be forthcoming.
5. A dispute **must** be submitted within 60 days of receipt of the EMI EOP. Receipt of dispute after 60 days will not be considered.

Claims Status Inquiries

All claims status inquires must be made via the HS1 Provider Web Portal https://asp.healthsystemone.com/hs1providers. If you do not have a web portal account with EMI, please complete the form online at https://www.healthsystemone.com/pwp or at myemifl.com/pwp.

If you do not have access to the internet, you may also make any claims status inquires telephonically at one of the numbers below:

Miami-Dade County (305) 614-0133

Broward County (954) 335-8130

All other counties (877) 372-1273