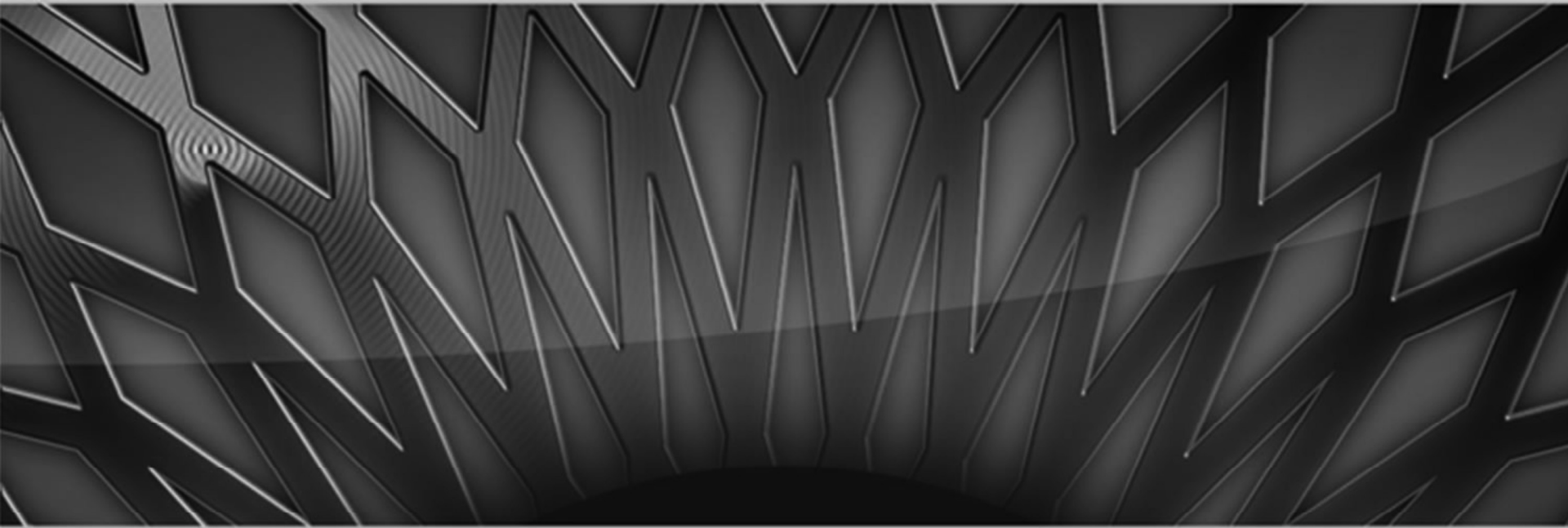




PREMIER
EYE CARE

A Health Network One Company



Devoted & Wellcare
Provider In-Service
Routine Vision and Medical (*as applicable*)

PROVIDER IN-SERVICE

Thank you for joining our network to provide valuable services to our **Devoted & Wellcare Medicare Members**.

Please ensure your staff is aware of your participation.

About Premier Eye Care

Premier has over 30 years of experience in eye care management. We are responsible to build a network of committed eye care providers in each state. We are dedicated to Medicaid and Medicare beneficiaries.

We accept full Health Plan delegation for Network Management, Claims Payment, Customer Service, Provider Credentialing, Provider Appeals and Utilization Management.



Member ID Cards

Each Member receives an Identification Card from the Health Plan in order to provide them access to services from the network of participating providers. The following is a representation of a Wellcare Member ID Card and Devoted Member ID Card.



Reminder: Your Routine Vision & Medical claims should be submitted to Premier Eye Care.



Premier Managed Services & States

Wellcare Medicare

Routine Vision Only States:

AR, AZ, CA, CT, KS, LA, ME, MS, OR, WA, WI

Routine Vision and Optometry Medical States:

GA, IA, IL, IN, MI, MO, NC, NE, NJ, NV, OK, PA, TN, TX

Routine Vision and Medical/Surgical States:

DE, FL, HI

Devoted Medicare

Routine Vision Only States:

AZ & TX

Routine Vision and Medical/Surgical States:

AR, CO, FL, GA, HI, IA, IN, KY, LA, NC, NE, NM, OK, OR, PA, SC, VA, WA

***Routine Vision Services:** Yearly Wellness Eye Exam, Glasses and Contacts*

***Optometry Medical Services:** Medical Services performed by an Optometrist to the full extent of their licensure as allowed by their state.*

***Medical/Surgical Services:** Medical Services performed by an Ophthalmologist or Optometrist to the full extent of their licensure as allowed by their state.*

Refer to your Welcome Email for the list of Plans you are participating with





Routine Vision Services



Devoted & Wellcare

Comprehensive Annual Routine Eye Exam

A comprehensive eye exam is an important part of caring for a member's overall health. During an annual comprehensive eye exam, health care providers will look for eye diseases, perform tests to check the vision sharpness, determine prescription strength (refraction), examine how eyes work together, and check eye pressure. Providers will also dilate eyes for signs of other serious health conditions.

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

- Visual Acuity test/Refraction – glasses prescription
- 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



Devoted & Wellcare Covered Services

Routine Vision Benefits:

Comprehensive Annual Eye Exam – Zero Copay

Eyewear Allowance Plans: Amounts vary by plan type and service area

Routine Vision Benefit Sheets for each Plan are provided separately

Member may use their Allowance toward any prescriptive eyewear in the optical shop and would be responsible for the amount over the Allowance.

Devoted: Members may choose Multiple pairs of Eyewear (Glasses **AND** Contacts) up to their Allowance amount.

Wellcare: Members may choose Multiple pairs of Eyewear (Glasses **OR** Contacts) up to their Allowance amount.

Eyewear Benefit allows a member to use their Allowance on different days within the calendar year if they have a balance left over.

Member's Allowance is calculated against the provider's full retail price.

The Standard or Deluxe (dependent on Allowance Plan) Contact Lens Fitting exam is a covered benefit when the member chooses the Contact Lens Eyewear option and is paid to you in addition to the comprehensive eye exam.

The Contact Lens Fitting exam (92310) does not count against the allowance.



PREMIER
EYE CARE

Devoted & Wellcare Covered Services Continued...

Glasses after Cataract Surgery:

- In addition to the Routine Vision Benefit Allowance, Members are entitled to one pair of Post Cataract Surgery Eyeglasses per eye per lifetime at no cost. These selections are limited to Value Frames and Single/Bifocal/Trifocal lenses.
- If the member has two separate cataract operations, the member cannot reserve the benefit for after the second surgery and purchase two eyeglasses after the second surgery.
- If a member chooses to upgrade their frame, they forfeit the frame benefit only, and are responsible for the full retail cost of the frame.
- Members that forfeit the frame benefit are still eligible for standard lenses only.

Non-Covered Services:

- These are services not covered or specifically excluded by the benefit plan. Members may only be billed for non-covered services when a signed form is obtained from the Member acknowledging their understanding of the total charges as well as their responsibility for payment prior to performing services.



Wellcare Spendables Card

Members will receive a pre-loaded Wellcare Spendables® Card via CareCredit.

Members may use the Spendables Card towards eye related services.

Examples: co-pays, deductibles, eyewear and the balance for covered services rendered but outside of their benefit limit.



Full details on the Spendables Card amounts, limitations and restrictions are outlined in a separate flyer included in the In-Service Package.



Frequently Asked Questions

- **Do I have to use a specific lab for Eyewear?** No specific Lab is required. You may use your Lab of choice.
- **Do I have to use a specific frame selection?** No. We do not require that you use a specific frame kit, although a selection of “value frames and single vision or bifocal lens” should be available to the Member.
- **Must a Member select the Value Frame?** Many members prefer to stay within the Allowance provided by the Plan; however their Benefit allows them to select the frames of their choice. The member will be responsible for costs above their Allowance.
- **Are authorizations required for Routine Vision services?** No. They are not required for claims payment. However, by utilizing our web portal you can ensure the member is eligible on the date of service and also verify if they may have utilized their benefits. This will help reduce the risk that you provide services to a Member who is not eligible or may have already utilized their benefits. You can do this on line in one easy transaction.



A Health Network One Company

Routine Vision vs Medical

As a Premier provider you participate in our Routine Vision network. You will also participate with us for Medical Services if you see members in these states:

Wellcare: DE, FL, GA, HI, IA, IL, IN, MI, MO, NC, NE, NJ, NV, OK, PA, TN, TX
Devoted: AR, CO, FL, GA, HI, IA, IN, KY, LA, NC, NE, NM, OK, OR, PA, SC, VA, WA

Devoted & Wellcare Medicare members are eligible for a “free” annual, routine vision benefit, with a zero copay at one of our participating vision provider offices. If at the conclusion of the routine vision exam, if there is any reason to refer to a medical eye provider or subspecialist, then, the Premier vision provider is instructed to have the Member contact their PCP to coordinate care with a medical eye provider (optometrist or ophthalmologist). *In states Premier manages Medical Services, you may see the member for Medical Services.* The Member Triage Protocol outlines how Medicare members access eye care.

Premier does not define the Health Plan benefits, we administer the vision benefits as defined by the Plan. As outlined in the Member Triage Protocol on the next slide, **proper triaging is dependent on the reason for the visit (chief complaint), not the final diagnosis.**

Unlike Medicare, where a medical diagnosis is required to be reimbursed for a comprehensive eye exam, with Devoted & Wellcare Medicare Advantage Plans, the reason for the visit (chief complaint) determines whether a member is utilizing their “free” routine eye exam benefit or a medical eye visit.



The next slides outline how Devoted & Wellcare Medicare members access eye care.

Member Triage Protocol

Below outlines how Devoted & Wellcare Medicare members access Routine Vision care.

Routine Vision	
If the member presents with symptoms of: <ul style="list-style-type: none">• Blurry Vision• Headaches• Failed vision screening• Failed driver's test• Diabetes with no eye problems• DRE screening• Need for new eyeglasses or contact lens prescription	Member is directed to the Routine Vision Network. <p>Members have open access for your services or any participating routine vision provider.</p> <p>Note: If a member is complaining about blurry vision, with no other medical eye complaint, and the last exam was more than 12 months ago, the member is entitled to utilize their free annual routine vision benefit with a zero copay, regardless of the final diagnoses.</p>

Example: You see a member today who is complaining of blurred distance vision, but at the end of your exam, you diagnose member with myopia, cataracts, and glaucoma suspect. Based on the chief complaint, today's exam falls under routine vision according to the member triage protocol, and considered a free routine eye exam.



Member Triage Protocol

Medical states

Below outlines how Devoted & Wellcare Medicare members access Medical eye care.

Medical/Surgical	
If the member presents with symptoms of: <ul style="list-style-type: none">• 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 a Medical Eye Care Provider. <p>For Medical, PCPs should contact Premier Eye Care directly at 1-800-738-1889 for the initial medical/surgical eye care referral to a Premier medical provider.</p> <p>For all subsequent visits, procedures, tests, surgeries, lasers, etc, the Premier Medical Eye Provider is responsible to obtain prior authorizations directly from Premier Eye Care.</p>

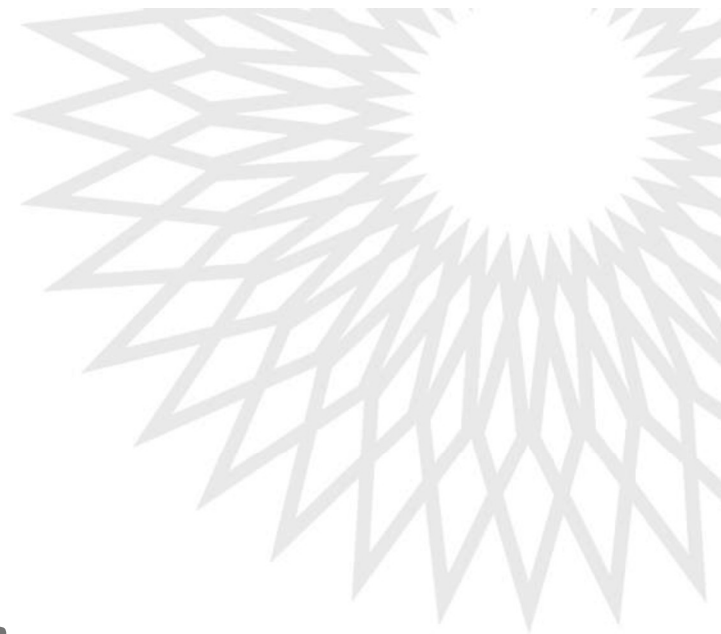
In Routine Vision Only states:
Devoted: AZ & TX

Wellcare: AR, AZ, CA, CT, KS, LA, ME, MS, OR, WA, WI

For Medical Eye Care, the Member should be directed to contact their PCP who is responsible for coordinating their Medical Eye Care with an in-network Optometrist or Ophthalmologist.



Authorizations are required for *Medical Services*.



Medical Services

Routine Vision Only Providers disregard



Medical Services: Devoted

Devoted Medical/Surgical States:

AR, CO, FL, GA, HI, IA, IN, KY, LA, NC, NE, NM, OK, OR, PA, SC, VA, WA

- Office Visits
- Ophthalmic Diagnostic Tests
- In-office procedures
- Eye Injections
- Lasers
- Surgeries

For Devoted HMO and PPO:

- No Authorizations are required for Office Visits and Diagnostic Testing.
- Authorizations are required for surgeries, lasers and eye injections.



Medical Services: Wellcare

Wellcare Medical/Surgical States:

DE, FL, HI

Office Visits
Ophthalmic Diagnostic Tests
In-office procedures
Eye Injections
Lasers
Surgeries

Wellcare Optometry Medical States:

GA, IA, IL, IN, MI, MO, NC, NE, NJ, NV, OK, PA, TN, TX

- Medical Office Visits
- Ophthalmic Diagnostic Tests

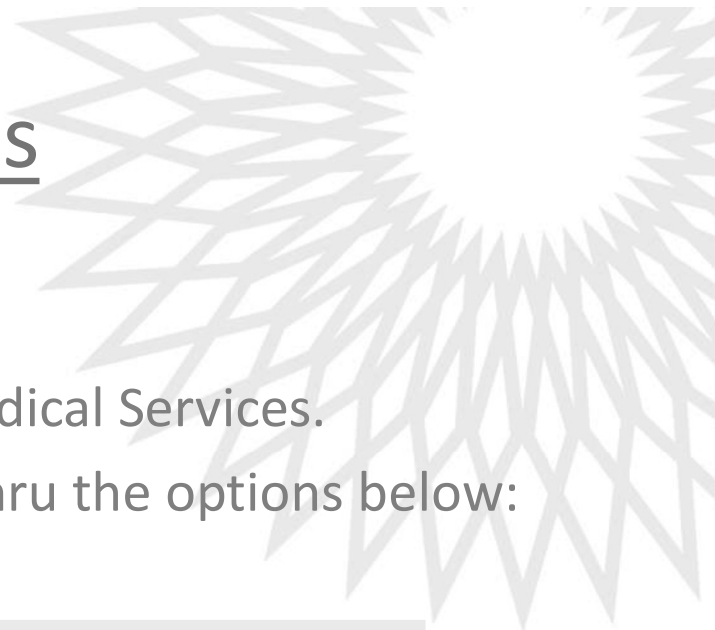
For Wellcare:

- Authorizations are required for all medical services



Authorizations

Routine Vision Only States disregard



Authorizations are required for Medical Services.
Your office may request an authorization thru the options below:

Online Premier Portal	<u>www.premiereyecare.net</u>
Phone	1-800-738-1889, option 4, 2
Fax	1-800-523-3788



Example of a Premier Authorization



PREMIER
EYE CARE

UNIQUE INSIGHT.
BETTER SOLUTIONS.

REFERRAL AUTHORIZATION FORM PATIENT INFORMATION

Patient Name: JOHN SMITH	Date of Birth: 03/03/1933
Address: 123 MAIN ST BOCA RATON, FL 33333	Home Phone: 561-123-4567
Payer ID: HEALTHPLAN NAME	Plan ID: 123 Patient ID: 123456789
PCP Name: ABC PCP	

REFERRED TO PROVIDER

Name: Jones, John	Specialty: OPHTHALMOLOGY
Address: 1234 Tree Lane Road Boca Raton, FL 33333	Phone: 954-123-4567 Fax: 954-987-6543

CLINICAL DATA

Primary Diagnosis:	H40.033
Secondary Diagnosis:	
Symptoms:	FFS_CAT_SX_Fee
Service Requested:	For Service Surgeries
Referral Category:	20220920P0100000 09/20/2022 to 10/20/2022
Authorization Number:	1
Requested Dates of Service:	
Approved # Visits:	
Procedure Code:	68984, 68982
Urgency:	Routine

REQUESTING PROVIDER

Name: Jones, John	Phone: 9541234567	Fax: 9549876543
-------------------	-------------------	-----------------

This authorization is not a GUARANTEE for payment. Benefits are subject to the member eligibility at the time of service. It is the provider's responsibility to verify member eligibility prior to rendering service. For questions regarding this authorization please contact our office at 1-800-738-1889.

IMPORTANT: This facsimile transmission contains confidential information, some or all of which may be protected health information as defined by the federal Health Insurance Portability & Accountability Act (HIPAA) Privacy Rule. This transmission is intended for the exclusive use of the individual or entity to whom it is addressed and may contain information that is proprietary, confidential and/or exempt from disclosure under applicable law. If you are not the intended recipient (or employee or agent responsible for delivering this facsimile transmission to the intended recipient), you are hereby notified that any disclosure, dissemination, distribution or copying of this information is strictly prohibited and may be subject to legal restriction or sanction. Please notify the sender by telephone (number listed above) to arrange the return or destruction of the information and all copies.



PREMIER
EYE CARE

Provider Web Portal

Our on-line tools help to improve your office workflow and enhance your staff's productivity. We take advantage of cutting edge technology to increase speed and efficiency while striving to keep Provider participation costs as low as possible.

- **Please go to: www.premiereyecare.net**
- Log in using your User ID and Password
- Verify member eligibility and benefits
- View and/or print the Provider Manual
- View and/or print Protocols & Educational Materials
- Check Claims Status

If you need to add users, you may register for additional User names and Passwords at: www.premiereyecare.net

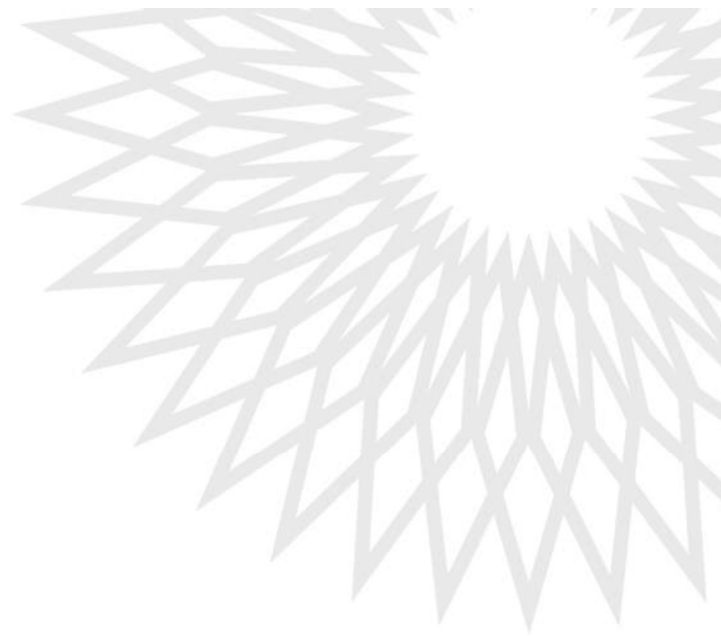


To view or print the Provider Manual, Protocols, Educational Materials or Clinical Guidelines on the Premier Portal:

Go to: Support/ Provider Documents/ Provider Manuals and Documentation

The screenshot shows the Premier Eye Care portal interface. On the left is a vertical navigation menu with the following items: Home, Inquiry, Input Authorizations, Work Lists, Messages/Email, Information, Support (highlighted with a black background and a grey arrow pointing to it from the left), a sub-menu for Support (containing Provider Documents, Help, Preferences, and Changes, with a grey arrow pointing to Provider Documents), Administration Maintenance, Other Links, and Sign Off. On the right is the 'USER MANUALS' section, which contains a tree view of folders: Manuals (expanded), Provider Manuals and Documentation (expanded), CarePlus Protocols, Clinical Guidelines (with a grey arrow), Compliance (with a grey arrow), Educational Flyers (with a grey arrow), Forms, Hawaii - 'Ohana, Humana Protocols (expanded), Magellan Protocols, Premier Portal Training (with a grey arrow), Prestige Protocols, Simply Protocols (expanded), and WellCare Protocols (with a grey arrow). The Premier Eye Care logo and tagline 'PREMIER EXPERTISE. PREMIER SERVICE.' are visible at the top left of the page.





Claim Submissions



Submit your claims to Premier

Electronically: Our payer ID number is: **65054**.

Direct Data Entry “DDE” (optional free service):

- Premier has partnered with Smart Data Solutions (SDS) to offer electronic claims submissions.
- SDS is responsible for assigning the required User IDs and Password access.
- To obtain a user ID and password, please call the SDS team toll free number 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 and Last Name, Phone Number and Email Address.
 - SDS will provide technical, educational assistance and help desk support.

Paper claims:

- Paper Claim Submission via CMS-1500 Health Insurance Claim Form - In order to maintain HIPAA compliance, only original CMS-1500 claim forms will be accepted.
- Claims should be mailed to the following address:

PREMIER EYECARE
P.O. Box 21503
Eagan, MN 55121



How to Begin the Electronic Claims Submission (ECS) process

- Premier encourages you to send your claims using ELECTRONIC SUBMISSION. This is a more efficient method, eliminates paper and utilizes a faster delivery method.
- Our payer ID number is: **65054**. *Keep this number available as you will use it to direct your electronic claims to us.
- You may select any clearinghouse of your choice to work with you in submitting claims.



ELECTRONIC FUNDS TRANSFER (EFT)

Premier claims payment is issued through VPAY: www.vpayusa.com

Default Method of Payment: VCard

The default method of payment through VPAY is Virtual Credit Card (referred to as VCard). If you elect to continue receiving the default payment by VCard, processing fees will be assessed at the rate outlined in your merchant agreement with your acquiring bank.

EFT and Paper Check:

If your organization prefers a different form of payment, such as EFT (Direct Deposit) or Paper Check, please email support@vpayusa.com or call 1-855-388-8374 to change your payment method preference with VPAY.

If your practice already receives payments from VPAY through another vendor; then your current payment method with VPAY will remain in place.



Claims Inquiries

Once you submit your claims electronically, it is important to follow up on them to ensure they were received at Premier. Work with your clearinghouse to identify any rejected claims. Often, we see offices forget about the rejected claims notices that are sent to the submitter using a 277 transaction.

Avoid the delay and have your claims paid faster by working your rejected claims.

If you need assistance with your claims, please contact our Claims Support Team:

- **Email:** ClaimsSupport@premiereyecare.net or
- **Phone:** 1-800-738-1889 Option 5, Option 2



Claims Filing Tips – Routine Vision

Providers must select one 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, H52.531 – H52.533, H52.539, H52.6, H52.7, or Z01.00 – Z01.01, Z01.020, Z01.021(**Z01.01** & **Z01.021** must include a secondary diagnosis code).

***Box 17 and 17b:** Claims for Eyeglasses or Contact Lenses must include the Examining and/or Referring Physician's **Name and Individual/Type1 NPI in Box 17 and 17b. This info can be yours.**

***RT/LT Modifiers for Eyeglass Lenses:** Bill with Modifier RT and LT with 1 unit on each line. OR bill with No Anatomical Modifiers with 2 units.

***Contact Lenses: V2599** for non-disposable and **V2520 - V2523** for disposable contacts.

***Lenses only:** If the member wishes to utilize their benefit for Lenses only, please bill with CPT Code: **S0595**

All Routine Vision Exams must be coded as follows:

New Patient Routine Vision Exam: 92004 or

Established Patient Routine Vision Exam: 92014

Adhere to Timely Filing Limits and remember to re-work any claims rejected by EDI.

Corrected Claims may be sent electronically; use electronic resubmission code 7 – Box 22 for **EDI claims.**

For **Paper Claims** - Indicate “corrected claim” in Box 19.



Claims Filing Tips – Eyewear “V” Codes

All Eyewear claims are the result of an optometrist or ophthalmologist issuing a Rx referral for eyewear. CMS requires that we track who issues the referral for eyewear. **Claims will be rejected if the Referring Provider’s Name and Type-1 NPI number in boxes 17 and 17b are incorrect or incomplete.** The information in these fields should be the provider that issued the Rx for eyewear.

All claims that include a V code, must have box 17 and 17b completed correctly. The requirements are as follows:

- Box 17 -list DN or DK followed by the optometrist’s name or ophthalmologist’s name at it appears on the NPPES registry- see example below. If the entire name does not fit, use the first initial of the first name and the entire last name. Please do not extend the name beyond the confines of this box. Do not run the name into item 17a or 17b.
- Box 17a - please leave blank
- Box 17b - list the optometrist or ophthalmologist’s Type 1 personal NPI only.
- Please note box 17b is always the Doctors Individual NPI (Type 1 NPI) and is not the practice NPI or corporate identity of the doctor. Type II NPIs are not accepted in box 17b. If you are unsure please log into the NPPES registry to confirm the information you are entering in box 17 and 17b match the registry listing. NPPES registry: <https://nppes.cms.hhs.gov/NPPESRegistry/NPIRegistryHome>



Claims Filing Tips – Diagnosis Pointer

All diagnosis codes must be linked to at least one of the service codes on the claim. Claims will reject when the Diagnosis code in Box 21 does not have a Diagnosis Pointer represented in Box 24E. Below is an illustration of a claim submitted accurately. Please utilize this in order to assist in filing claims correctly the first time.

Example: There are 3 diagnosis codes listed below in Box 21 of the CMS 1500 Form:

A. Z01.00 B. H25.13 C. H52.221

In the Diagnosis Pointer Field (Box 24E) below A, B and C are represented.

- Diagnosis A, Diagnosis B and Diagnosis C are pointing to CPT code 92014.
- Diagnosis A is pointing to CPT Code V2020
- Diagnosis A is pointing to CPT Code V2100
 - Note: ICD-10 should reflect “0” in the ICD Indicator box.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.	
A.	Z01.00		B.	H25.13		C.	H52.221		D.		0
E.			F.			G.			H.		
L.			J.			K.			L.		

	24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)			E. DIAGNOSIS POINTER
	From MM	DD	YY	To MM	DD	YY			CPT/HCPCS	MODIFIER		
1	10	28	16	10	28	16	11		92014			ABC
2	10	28	16	10	28	16	11		V2020			A
3	10	28	16	10	28	16	11		V2100			A

Remember:

- Each Diagnosis Code listed in Box 21 must have a Diagnosis Pointer indicated in Box 24E.
- Enter the Diagnosis Code alpha character (pointer) as applicable in Field 21.
- A maximum of four Diagnosis Pointers are allowed in Field 24E.
- If the diagnosis code is age/gender specific, it must be appropriate for the age/gender of the member submitted on the claim.



HEDIS® - Healthcare Effectiveness Data Information Set

- HEDIS® is a tool used by most Health Plans to measure performance on important dimensions of care and services. HEDIS® ensures health plans are offering quality preventive care and service to members.
- HEDIS® measures the Diabetic Retinal Exam indicator.
- Identified Devoted Medicare Members will be contacted throughout the year to ensure they receive these exams, as applicable.
- These Members may be calling your offices to schedule their annual routine eye exams including the diabetic retinal (DRE) screenings.
- When speaking with your offices, these members may state they need their annual routine eye exam, or diabetic eye screening. These are the same.
- They are in need of their annual routine eye exam benefit. As a Premier provider, you participate in the routine vision care of these members.
- It is vital that you schedule these appointments as soon as possible and submit your claims to Premier for processing.



QUICK REFERENCE GUIDE includes:

The QRG* is a separate attachment that summarizes the following:

- Provider Services #
- Member Customer Service #
- Premier Web portal www.premiereyecare.net
- Claims Submission Info
- Claims Timely Filing Limits Claims Appeals Info
- Health Plan Information (Name and Customer Service #)

*This is included in your Welcome Packet.





Thank you for your partnership.

Please email any questions to:
networkmanagement@premiereyecare.net

Please call with any questions to:
855-787-2020, option 2

