Contents

Introduction

Welcome to Williams Group! Due to the complicated and ever-changing practices of insurance, Williams Group does not warrant or guarantee the information contained herein.

This insurance manual is meant to be a guide and template for developing your clinics' specific insurance manual.

Each office should review policies and procedures from each of the vision plans and companies they accept in office, to ensure all information is current and applicable.

Williams Consulting Group, Inc. will not be responsible for any conflicts that may arise as a result of this insurance manual.

Quick Reference Guide

Insurance Accepted

Advantra Freedom
Aetna
Blue Cross Blue Shield
Care Improvement Plus
Cigna
Coventry
EyeMed
Freedom Network
Freedom Network Select
GEHA
Golden Rule
Humana
- Commercial PPO
- Medicare PPO
- Humana HMO

Medicare
National Vision Administrators (NVA)
Preferred Health Professionals
Railroad Medicare
Spectera/UHC Vision
Tricare
United Health Care
UMR

Union Plans

Call the Benefits Department to Check Benefits and Eligibility

Carpenter's District Council KC
Construction Industry Laborers
Greater KC Laborers
MoKan Iron Workers
MoKan Teamsters
Pipefitters Local Union #533
Plumber's Local Union #8

Plans we do not accept and are <u>unable</u> to submit claims to:

Avesis
Vision Care Direct

(Please note, with these plans you may advise the patient to check with insurance to determine out-of-network benefits and how to submit for reimbursement.)

Basic Practices

Scheduling Appointment and Gathering Information

1. Document all required patient demographic information in practice management software
2. Request patient's medical and vision payor information:
3. Payor name (i.e. Medicare, BCBS, VSP)
4. Electronic payor ID # (Medical Insurances)
5. Verify address and insurance provider phone number
6. Verify additional information regarding each insurance:
7. Member's Full Name
8. Member's Insurance ID Number
9. Member's Date of Birth
10. Subscriber's Full Name
11. Subscriber's Date of Birth
12. Subscriber's Social Security Number

Checking Eligibility and Benefits

1. Verify all information has been entered correctly from initial request
2. Determine reason for appointment; i.e. routine/medical
3. Access vision plan website to determine eligibility for exam and materials
4. Access health plan website to determine medical insurance eligibility, copay, deductible, co-insurance and if there is routine vision examination coverage with medical insurance
5. If unable to find member or patient, try using the information you have to search other vision plans or contact patient to update information
6. If a primary care manager referral is required, request the referral prior to examination

Check-In Insurance Processes

1. Greet patient at appointment
2. Request copy of health and vision insurance cards, driver's license
3. Patient signs privacy policy, financial agreement, consent to treat forms
4. If insurance and benefits eligibility verification was not performed prior to exam, verify and pull authorization prior to examination (see individual insurance guidelines on checking eligibility and benefits within this document)
5. Ensure all insurance benefits and authorizations are accessible to all staff; verify referrals from PCM are documented, when necessary

Check-Out Insurance Processes

1. Review exam charges, CPT codes, diagnoses provided by doctor
2. Collect copay, deductible or co-insurance amounts at time of service
3. Ensure all documentation is completed and signed off within exam prior to billing insurance
4. If billing for materials, collect copays or charges associated with these products at time of service
5. Payment arrangements, although not recommended, must be discussed and approved by management and require a signed agreement between the organization and the patient

Filing Electronic and Paper Claims (Example)
Note: you must file electronic claims prior to running/printing paper claims.

Otherwise, all of your electronic claims will print also and you have a mess on your hands.

1. Main Compulink Screen → Function → Insurance Activities → Billing
    a. Output: list
    b. Change threshold date to date before
    c. Form: hcfa1500
    d. Neicansi
2. Work through claims listed and correct claim all claims on errors report
    a. Check diagnosis codes to insurance benefits
    b. Check diagnosis codes to tests billed
    c. Verify information on claim correct
3. Check Emdeon (change healthcare website) and correct any claims listed as denied
    a. Erase claim sent date from each line item in patient ledger so the claim will resend once you have adjusted or corrected the information
4. Main Compulink Screen → Function → Insurance Activities → Billing
    a. Output: emc claim file
    b. Change threshold date to date before
    c. Form: hcfa1500
    d. Neicansi
5. Pull up Neicansi from mlb desktop to send claims
6. Main Compulink Screen → Function → Insurance Activities → Billing
    a. Put hcfa 1500 claims forms in printer
    b. Type: paper claims
    c. Change threshold date to date before
    d. form: hcfa1500

Things to watch for: (make this section specific to your practice common errors)

- ✓ Medical VS. Routine Vision Dx Pointer
- ✓ Tricare - If referral on file, make sure it is attached to the claim. Send 1TCReport to provider and date in referral sources tab
- ✓ Cigna - If RV covered: only send with refractive diagnoses, enter your medical diagnosis codes into the "Internal Notes" box in line item ledger
- ✓ Mo-Kan Iron Workers claims must be sent to CIGNA
- ✓ BCBS & Post Ops - Remove dates from the assumedd/relinquished boxes in line item. Leave notes in Box 19
- ✓ Watch OCT Diagnosis Codes compared to type of OCT ran... Example: Glaucoma would not be billed for an OCT Retina
- ✓ Watch for Medicare secondary claims to come through on list, this will happen only if you forget to "file → send" when posting a Medicare check
- ✓ Tricare - Do not bill with Q17 codes, delete them out of ledger
- ✓ Healthscope - Send as paper claim because clearinghouse denying with refraction

Patient Forms

Advanced Beneficiary Notice
Insert Practice Master Copy of ABN(s)

Consent to Treat
Insert Practice Master Copy of Consent to Treat

Consent to Treat/Special Testing
Insert Practice Master Copy of Consent to Treat/Special Testing

Consent to Treat Minor
Insert Practice Master Copy of Consent to Treat Minor

Financial Agreement
Insert Practice Master Copy of Financial Agreement

Privacy Notice
Insert Practice Master Copy of Privacy Notice

Insurance Keywords and Terminology

Copay – A Copayment or copay is defined as the fixed amount a patient pays for a covered service directly to a provider such as an office visit or basic materials covered by the material copay on most vision plans

Deductible – The deductible is the amount that a patient must pay "out-of-pocket" before the insurance will pay for any expenses

Co-insurance – Co-insurance refers to the portion or percentage of the "allowable charge" that the patient must pay to the provider *after* they meet their deductible for any services rendered

Out-of-Pocket Maximum - The out-of-pocket maximum is the set amount of money that a patient or insured individual must pay in covered medical costs in a given year. After this maximum amount is met, in most cases, the insured will not pay any copays once this is met. It is important to note that the "health insurance out-of-pocket maximum" does not apply to any services or materials billed to a vision plan

Contracted Allowable – Otherwise known as the allowed amount, is the amount agreed upon by the provider that they will accept as payment from a particular insurer as signified on the fee schedule and is typically less than the provider's usual and customary charges for a given service

Fee Schedule – The fee schedule is the list of all listed services that an insurer will allow a provider to bill them for along with the corresponding maximum allowed amount that they have agreed to pay the provider for those services

Coordination of Benefits – Coordination of benefits, sometimes referred to as COB, is the process of determining which of two or more insurers will have the primary responsibility of paying a claim and what amount the other insurers will pay

Primary – The primary insurer is the company that the initial charges for services rendered will be billed to *first*, and is usually responsible for the largest amount of payment to the provider

Secondary – The secondary insurer is the company that receives the remainder of the "allowed amount" of charges after the primary insurer pays their contracted portion. After the secondary pays the remainder of charges owed, if any, are billed to any tertiary insurers or directly to the patient

Tertiary – A tertiary insurer is defined as any remaining insurers or payors that have agreed to pay remaining charge amounts, prior to the patient being billed, after both the primary and secondary insurers have paid their allowed amounts

Health/Medical Insurance – Health insurance is defined as the insurance that allows for a provider to bill for health or medically related reasons or diagnosis. In eye care

health diagnosis may include, but aren't limited to, Cataracts, Diabetic Retinopathy, Glaucoma, Macular Degeneration, and Dry Eye Syndrome

Vision Insurance/Plans – A vision plan or insurance is once that is billed for non-medically related conditions of the eye such as Hyperopia, Myopia, Astigmatism, and presbyopia. In most cases a vision plan is also who a provider bills for a portion of materials such as glasses or contact lenses and contact lens services

Explanation of Benefits (EOB) – The EOB is a statement sent to the provider by the insurer detailing what services or materials were paid for on their behalf along with any applicable reasoning for why a particular charge may have been denied or not paid

Current Procedural Terminology (CPT) Code – A CPT code is the medical billing code used to represent a particular service or product offered by a provider, in order to bill to a particular insurer/payor

Diagnosis Code – This is signified as International Classification of Disease, better known as ICD or ICD-10 currently. The ICD-10 code is used as a tool to most commonly identify disease, disorders, or symptoms that could indicate the reason for a particular patient being seen or charges being billed

CPT Modifiers – Modifiers are used to provide additional information about a procedure, service, or product being billed. The most common modifiers added to CPT codes in ophthalmic practices are RT & LT to signify which eye the service or product was for, -24 used to signify an exam performed during the global billing period of a surgery yet is unrelated to the surgery.

Insurance Card Breakdown

Group # - The group number signifies the company that the policy was issued to

Issuer # - If listed, represents the unique number that the provider will use to bill the correct insurer

ID # - Represents the unique member ID required to locate the member's benefits through the insurer

Name – This can be either the Primary Person on the insurance policy, followed by the name of the insured or just the name associated with the specified member ID.

Primary Care – This is the amount of copay reserved for the insured member's primary care physician for generic office visits *only*.

Specialist – This is the copay required for ALL other providers, including optometrists & ophthalmologists, for specialty services as deemed by the insurance benefit.

Usual & Customary Fees

Insert Practice U&C Fee Sheet

Contact Lens Fitting Fees

Insert Practice U&C Contact Lens Fitting Fees Sheet

Your office can charge both private pay and insurance plan contact lens patients' a 92310. Other procedure codes may be used if fitting a specialty contact lens.

It is imperative that you visit the patients' vision plan website to ensure you are submitting the fees correctly on the day of service.

For VSP refer to the VSP Vision Care Guide to Elective and Necessary Contact Lens Benefits. For EyeMed refer to the Provider Manual

A Contact Lens Evaluation fee is necessary annually for new or existing contact lens users to receive a contact lens prescription. This evaluation fee is a separate fee from annual routine or comprehensive eye examination fees.

Contact lenses are medical devices that can cause serious consequences, such as infection, inflammation, permanent damage and loss of vision if not fit and taken care of properly. Examining a contact lens patient takes additional time and expertise. For that reason, there are separate, additional charges for contact lens examinations that patients without contact lenses do not pay.

If a patient has vision insurance, the exam co-pay is for the comprehensive examination only – NOT the contact lens evaluation. Unless the vision care provider offers some reimbursement towards the contact lens evaluation and/or lenses, the patient is responsible for the contact lens evaluation fee on the date of service

Exam Documentation & Sign Off by Provider

12 Examination Elements

1. Visual Acuity
2. Gross or Confrontation Visual Fields
3. Extraocular Motility
4. Conjunctiva (Bulbar and Palpebral)

5. Ocular Adnexa (Lids, Lacrimal Gland, Lacrimal Drainage, Orbits and Preauricular Nodes)
6. Pupil and Iris (Size, Shape, Direct and Consensual Reactions)
7. Cornea (Slit-Lamp Exam; Tear Film, Epithelium, Stroma and Endothelium)
8. Anterior Chamber (Slit-Lamp Exam; Depth, Cells and Flare)
9. Lens (Clarity, Anterior Capsule, Posterior Capsule, Cortex and Nucleus)
10. Intraocular Pressure
11. Optic Nerve/Discs (Cup-to-Disc Ratio, Appearance and Nerve Fiber Layer)
12. Retina and Vessels (Dilated Examination unless Contraindicated)

Level of Examination Determination

12 Elements + Documentation of Time, Place, Person and Mood	Comprehensive Exam
9-12 Elements	Detailed Exam
6-8 Elements	Expanded Problem-Focused Exam
1-5 Elements	Problem-Focused Exam

Vision Insurances

Davis Vision

Contact & Provider Manual Information

1. Log onto www.idocDavisVision.com
    a. Located the Provider Manual on the left side of the page
    b. Click Section
    c. Click Contacting Davis Vision

Benefits, Eligibility, Authorization

1. There are several tabs on the left side of the website that include quick reference information on Authorizations/Claims, Enrollment Confirmations, Orders, Benefit Alerts, My Davis Vision and Support. If you are not able to locate the answers you are looking for refer to #2
2. Log onto www.idocDavisVision.com
    a. Located the Provider Manual on the left side of the page
    b. Click Section 6
    c. Click Fees, Eligibility and Authorization

Outstanding Authorizations

1. There are several tabs on the left side of the website that include quick reference information on Authorizations/Claims, Enrollment Confirmations, Orders, Benefit Alerts, My Davis Vision and Support. If you are not able to locate the answers you are looking for refer to #2
2. Log onto www.idocDavisVision.com
    a. Located the Provider Manual on the left side of the page
    b. Click Section 6
    c. Click Fees, Eligibility and Authorization

Filing an Electronic Claim

1. There are several tabs on the left side of the website that include quick reference information on Authorizations/Claims, Enrollment Confirmations, Orders, Benefit Alerts, My Davis Vision and Support. If you are not able to locate the answers you are looking for refer to #2
2. Log onto www.idocDavisVision.com
    a. Located the Provider Manual on the left side of the page
    b. Click Section 7
    c. Click Order Entry and Claim Submission

Medically Necessary Contact Lens Benefits

1. There are several tabs on the left side of the website that include quick reference information on Authorizations/Claims, Enrollment Confirmations, Orders, Benefit Alerts, My Davis Vision and Support. If you are not able to locate the answers you are looking for refer to #2
2. Log onto www.idocDavisVision.com

Reviewing and Posting a Payment

1. There are several tabs on the left side of the website that include quick reference information on Authorizations/Claims, Enrollment Confirmations, Orders, Benefit Alerts, My Davis Vision and Support. If you are not able to locate the answers you are looking for refer to #2
2. Log onto www.idocDavisVision.com

Contract & Fee Schedule

1. There are several tabs on the left side of the website that include quick reference information on Authorizations/Claims, Enrollment Confirmations, Orders, Benefit Alerts, My Davis Vision and Support. If you are not able to locate the answers you are looking for refer to #2
2. Log onto www.idocDavisVision.com
    a. Located the Provider Manual on the left side of the page
    b. Click Section 4
    c. Click Vision Care Benefit

Resubmission Instructions

1. There are several tabs on the left side of the website that include quick reference information on Authorizations/Claims, Enrollment Confirmations, Orders, Benefit Alerts, My Davis Vision and Support. If you are not able to locate the answers you are looking for refer to #2
2. Log onto www.idocDavisVision.com
    a. Located the Provider Manual on the left side of the page
    b. Click Section 8
    c. Click Doctor Patient Relations

Coordination of Benefits

1. Log onto www.idocDavisVision.com
    a. Located the Provider Manual on the left side of the page
    b. Click Section 8
    c. Click Doctor Patient Relations

Timely Filing Requirements

1. There are several tabs on the left side of the website that include quick reference information on Authorizations/Claims, Enrollment

Confirmations, Orders, Benefit Alerts, My Davis Vision and Support. If you are not able to locate the answers you are looking for refer to #2

2. Log onto www.idocDavisVision.com
    a. Located the Provider Manual on the left side of the page
    b. Click Section 2
    c. Click Rights and Responsibilities

FAQs

EyeMed
Contact & Provider Manual Information
Provider Relations Phone Number & Fax Number
EyeMed Claims Mailing Address
City, State, Zip

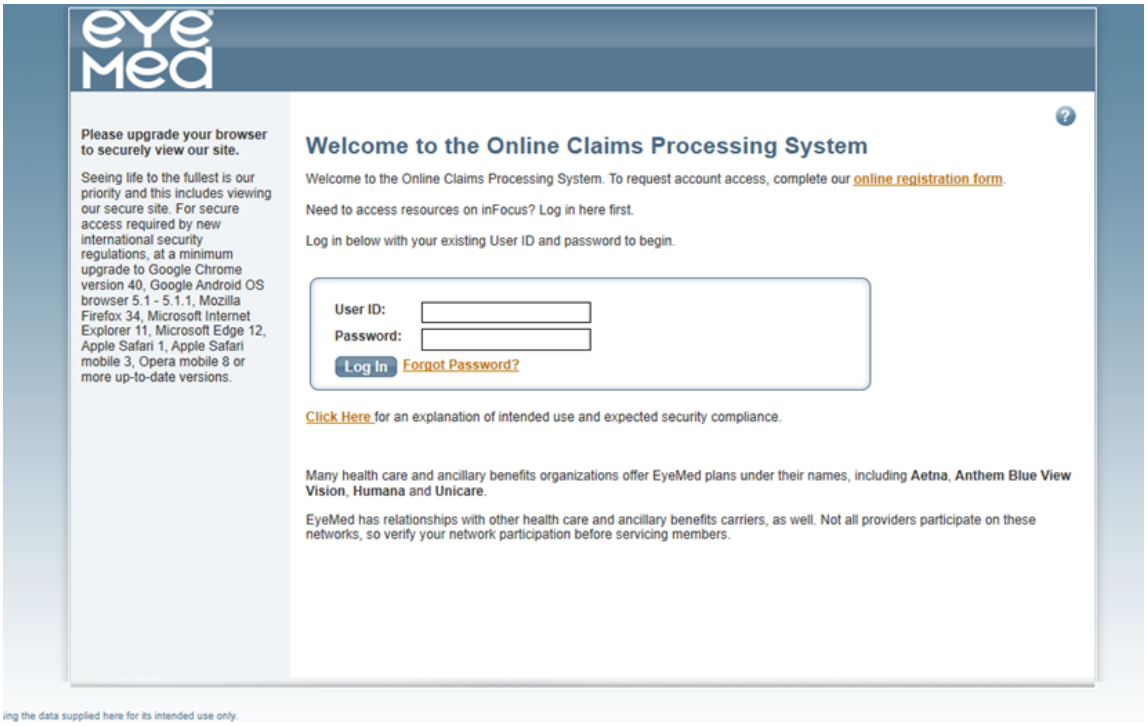
Go to www.eyemed.com and select provider

1. *Select EyeMed InFocus to login and find provider manual and contact information*
2. *Select Submit Claims (Login) to login into provider claims portal*

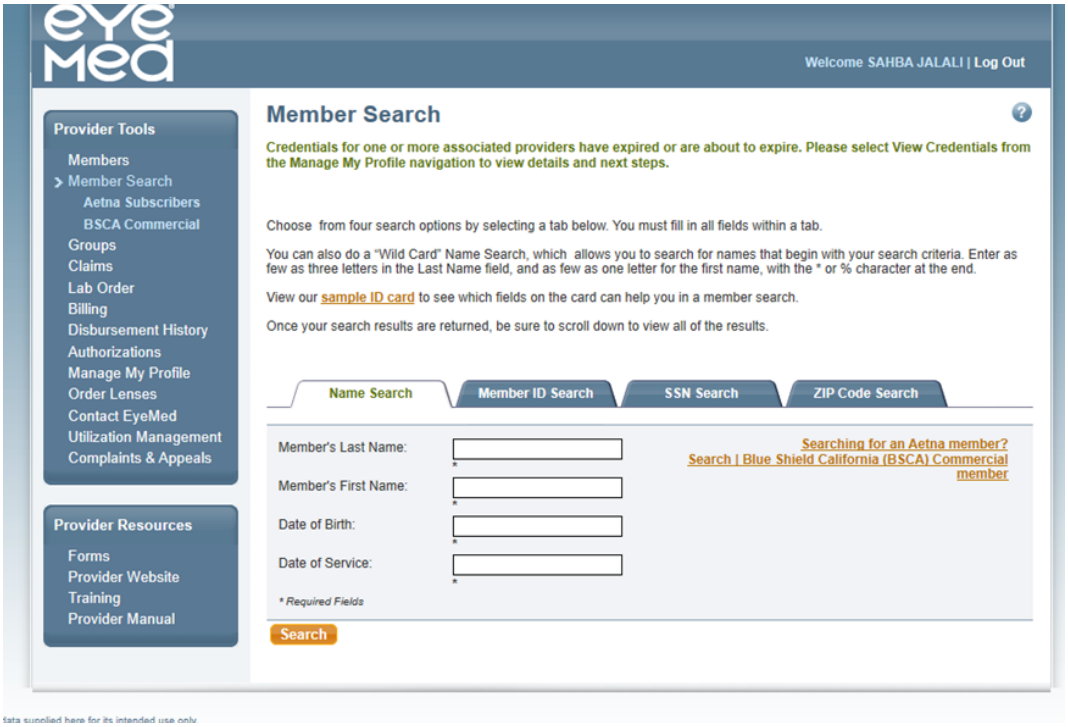
January 2020 EyeMed Provider Manual

Benefits, Eligibility, Authorization

1. To check eligibility, go to www.eyemed.com and select provider
2. Login to provider claims portal

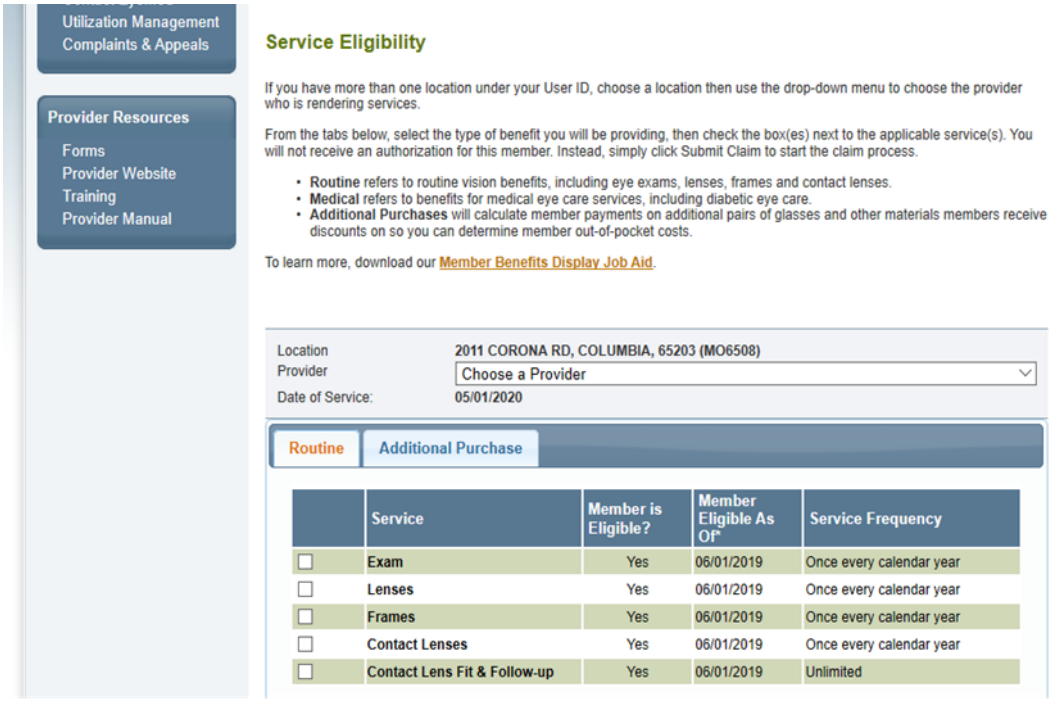


3. Enter member or patient information to search for patient by name, date of birth and date of service, select “Member ID” to search for patient by member ID number or select one of your other search options to find the member or patient



4. Verify patient information is exactly as it is entered into your practice management software

5. Verify services and materials that your patient is eligible for and print member benefit information sheet



Outstanding Authorizations

1. Log into EyeMed Claims Portal
2. Choose **Authorizations from** left side tab
3. Click on **Open Authorizations**
4. Search by Authorization Number, Tax ID, Location or Provider
5. Select preferred method
6. Input Information
7. Search

Filing an Electronic Claim

1. Login to EyeMed Claims Portal
2. Search for patient by preferred method, reference the *Benefits, Eligibility, Authorization* section
3. Select the appropriate doctor and the services or materials you are billing for
4. Enter the exam information and refraction
5. If patient has ordered materials, enter the frames, lenses, or contact lenses information
6. Enter your U&C charges for the services and materials provided
7. After reviewing the chargebacks, reimbursements and patient responsibility amount, click "Submit Claim" at the bottom of the page to ensure the claim is submitted for processing
8. Review the claim summary and print or document within your practice management software that you have submitted the claim
9. If you filed for glasses, print a packing slip to send to lab for processing
10. Verify no claims are left unsubmitted by reviewing the open authorization section at the end of each day, see section on *Outstanding Authorizations* above

Medically Necessary Contact Lens Benefits

1. Login to EyeMed Claims Portal
2. Verify member or patient has benefits for medically necessary contact lenses
3. The materials and fit and follow-up services for medically necessary contact lens benefits must be submitted on 1 claim.
4. Download and complete the Medically Necessary Contact Lens Claim Form from EyeMed InFocus; review qualifications for medically necessary benefits by reviewing the provider manual
5. *Fax completed form to **866.293.7373** or mail to:*

EyeMed Vision Care
P.O. Box 8504
Cincinnati, OH 45040

Qualifying Criteria (January 2020 Provider Manual)

Conditions	***Medically Necessary Contact Lens Codes***
Anisometropia (3D in spherical equivalent or more)	**92310 AN**
High Ametropia (exceeding +/- 10D in spherical equivalent in either eye)	**92310HA**
Keratoconus (where the patient is not correctable to 20/30 in either or both eyes; review the EyeMed Provider Manual for specific dx codes)	**92072**
Vision Improvement (for patient whose vision can be corrected two lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses)	**92310VI**
**Reference Provider Manual to Verify this Section Relates to your Practice Location*	

Reimbursement for Medically Necessary Contact Lenses (January 2020 Provider Manual)

Qualifying Criteria	***Provider Reimbursement***
Anisometropia (3D in spherical equivalent or more)	**95 % of retail up to $700**
High Ametropia (exceeding +/- 10D in spherical equivalent in either eye)	**95 % of retail up to $700**
Keratoconus – Mild/Moderate	**95 % of retail up to $1200**
Keratoconus – Advanced/Ectasia	**95 % of retail up to $2500**
Vision Improvement (for patient whose vision can be corrected two lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses)	**95 % of retail up to $2500**
**Reference Provider Manual to Verify this Section Relates to your Practice Location*	

Reviewing and Posting a Payment

1. Download the User Guide 6 Working with Claims and User Guide 7 Reconciliation documents from EyeMed
    a. Click Provider Resources in the orange box on the right side of the website
    b. Enter your InFocus user name and password which was set up by provider (this is different from your EyeMed UN/password)
    c. Click Training Resources in the yellow box
    d. Click Online Claim Systems User Guides
        i. Select User Guide 6 Working with Claims
        ii. Select User Guide 7 Reconciliation
2. Payment turnaround time
    a. Paid within 30 business days of submitting a clean claim
        i. EyeMed adjust the claims process timing as required by state law
        ii. Lab orders, the turnaround time begins when the lab lets us know the order has shipped; exam portions of claims are not paid until the materials are shipped from the lab
3. Payment frequency
    a. Claims are paid electronically by FAA at least once per week.
4. Payment methods - electronic funds transfer (EFT) or check
    a. *NOTE: If you are receiving payment by check, quickly look into signing up for EFT by accessing the online form to sign up or change your direct deposit details to avoid an administrative fee for payment by check*

Contract & Fee Schedule

1. Contact EyeMed for the Fee Schedule your office has accepted

Coordination of Benefits

2. Download the Coordination of Benefits document from EyeMed
    a. Click Provider Resources
    b. Enter your InFocus user name and password
    c. Click Provider Manual
    d. Click Getting Paid
        i. Submitting Claims
            1. Coordinating Benefits

Timely Filing Requirements

All claims must be submitted within 180 calendar days of the date of service. If you do not file the claim in this time period, it will be denied and you will not be able to collect money from the member.

FAQs

National Vision Administration (NVA)

Contact & Provider Manual Information
Benefits, Eligibility, Authorization
Outstanding Authorizations
Filing an Electronic Claim
Medically Necessary Contact Lens Benefits
Reviewing and Posting a Payment
Contract & Fee Schedule
Coordination of Benefits
Timely Filing Requirements
FAQs

Spectera
Contact & Provider Manual Information

Benefits, Eligibility, Authorization

1. Check schedule & make list of each patient using Spectera listing name, birthdate & SS#; have two windows of your EPM open to navigate between patient files & website for Spectera.
2. Go to www.spectera.com website to verify eligibility; enter your user name and password in the upper left-hand corner
3. Finding your patient:
    a. Select individual or family
    b. Click search
    c. Review Patient Eligibility and Benefits by clicking "Verify Patient Benefits"
    d. Add Patient(s) to Patient Queue by clinking the "+"

Filing an Electronic Claim

1. Download Updated Guide to Spectera.com for full instructions
    a. Click Online Training Center
    b. Click Training PDF's (There are also videos available in this location)
    c. Located Updated Guide to Spectera.com
        i. Click Open PDF

Medically Necessary Contact Lens Benefits

1. Necessary contacts are covered in full for members after any applicable copay
2. Claims for necessary contacts must be submitted per the instructions in the provider manual
3. Reimbursement rates for necessary contact lens fitting and evaluation services are capped at $500; reimbursement rates for necessary contact lenses are capped at $1,500

Reviewing and Posting a Payment

1. Refer to the Provider Manual for full instructions
    a. Click Plan Resources
    b. Click Network Administration Manual
        i. Table of Contents
            1. Claims

Contract & Fee Schedule

1. Enter the Contract and Fee Schedule your practice has accepted

Coordination of Benefits

1. Refer to the Provider Manual for full instructions.
    a. Click Plan Resources
    b. Click Network Administration Manual
        i. Table of Contents
            1. Claims

Timely Filing Requirements

Claims must be filed within 90 days as described in your provider contract

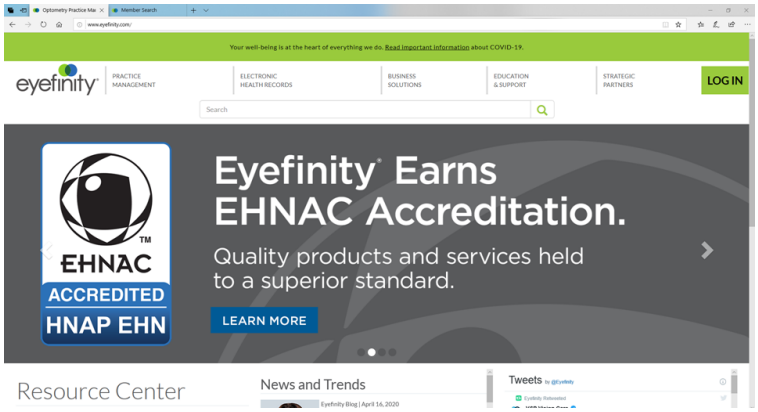
FAQs

VSP
Contact & Provider Manual Information

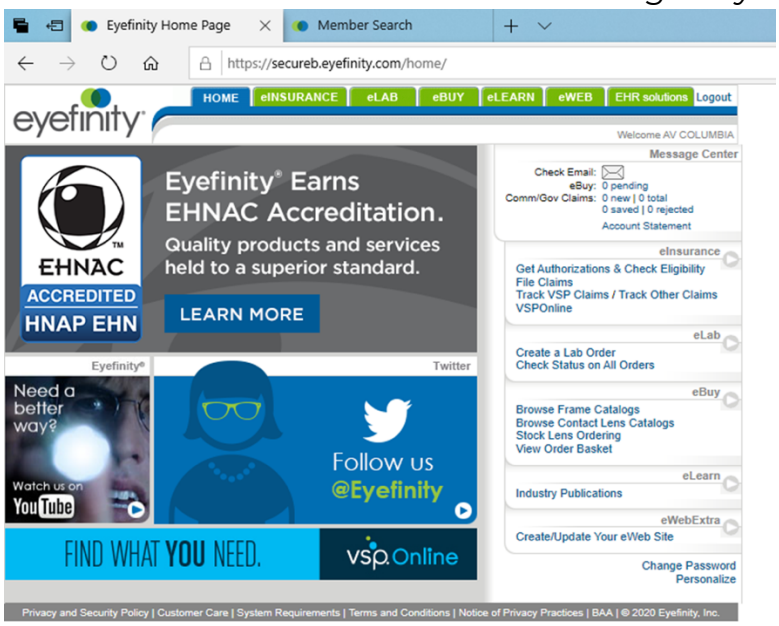
Service	Number	Notes
Provider Services	**800.615.1883**	Representatives are available to answer questions from: Monday - Friday 5:00 a.m. to 8:00 p.m. PST Saturday - 7:00 a.m. to 8:00 p.m. PST Sunday - 7:00 a.m. – 7 p.m. PST You may also refer VSP members to vsp.com. After dialing, you'll be greeted by our Interactive Voice Response (IVR) system. After the salutation, you may reach a representative by selecting from the following options: Press 1: Eligibility and authorization information Press 2: All other inquiries
Provider Relations	**provider network development@ vsp.com**	Provider Relations will answer the following questions: Becoming a VSP Provider, revenue generating opportunities and training opportunities for doctors and staff. Credentialing/recredentialing and updating practice information.
Member Services (Patients)	**800.877.7195**	Representatives are available to answer questions from patients: Monday - Friday 5:00 a.m. to 8:00 p.m. PST Saturday - 7:00 a.m. to 8:00 p.m. PST Sunday - 7:00 a.m. – 7 p.m. PST You may also refer VSP members to vsp.com.
Correspondence VSP PO Box 997100 Sacramento, CA 95899-7100	**In-Network Claims** VSP PO Box 385020 Birmingham, AL 35238-5020	**Out-of-Network Claims** VSP PO Box 358018 Birmingham, AL 35238-5018

Benefits, Eligibility, Authorization

1. Login to Eyefinity.com



2. Select *Get Authorizations & Check Eligibility*



3. Search by *Subscriber First Name, Last Name, DOB and Last 4 of SSN* OR *Full ID* and select *Search*
4. Select Patient Name
5. Pull Authorization for All Services or for Services/Materials needed for the date of service
6. Print *Patient Record Report* and *Lens Enhancements*
7. Highlight necessary pieces of information for quick review and share information with team

Outstanding Authorizations

1. Login to Eyefinity.com
2. Select *VSPOnline*
3. Under Quick Link and Tools, select *View Outstanding Authorizations*
4. View outstanding authorizations by either the issue date or date range (can only view 90 days), *search;* retrieve, delete or replace outstanding authorizations or view reports

Filing an Electronic Claim

1. Verify the authorization is pulled for correct services
2. Determine if patient has a Signature or Choice plan
3. Log onto VSP website
4. On the homepage select VSP online
5. In upper left-hand corner click on calculators - claim payments
6. Determine if exam is finalized, if not correct authorization for materials only
    a. If exam is finalized, enter exam fee in exam fee slot per VSP assigned fee report
7. Once lens style is determined, enter lens dispensing fee per VSP assigned fee report
8. Enter frame dispensing fee per plan per VSP assigned fee report
9. Figure wholesale frame amount and enter into frame allowance slot
10. Enter covered lens option service fee per VSP assigned fee report
11. Enter patient copayment per VSP authorization
12. Depending on lens material and add-ons follow the plan sheet under patient copay to determine patient cost for each material and add on
13. Enter patient frame overage amount in correct slot
14. Enter non covered lens options chargebacks following each plan sheet
15. Enter patient copayment amount
16. Click calculate
17. Patient pay amount MUST match what was charged to patient
18. Once Calculator sheet is complete click print
19. Click on e-Insurance tab at the top of the page
20. On the lower right side of page click the circle next to 'CMS' and enter correct authorization number
21. Enter date of service of exam
22. Click box next to “I attest”
23. Under exam type enter procedure code Dr. has chosen
24. Click box next to refraction
25. In the EHR determine if patient was dilated during the exam choose correct option
26. Choose which Dr. patient saw for their exam

27. Click boxes next to lens and frame, depending on which service patient is getting
28. Choose the correct vision type in dropdown menu
29. In material dropdown, choose which material you have put the patient in
30. In lens dropdown, enter the correct lens the doctor prescribed to patient
31. If there is a need for a balanced lens, be sure to click that at this time
32. As you work down the page, determine which add-ons patient is getting and click the dropdown menus in the appropriate location.
33. Select lab from dropdown
34. Most can be lab of choice but some may be required to use a VSPOne lab
35. Enter patient Rx as shown in EHR
36. Be sure to enter any prism as RX by Dr in EHR
37. PD's must be entered, and typically taken monocularly
38. Be sure to enter Seg Height for all progressive lenses
39. In supplier dropdown menu, determine if patient is getting a new frame, using their own frame, or if you are having the lab supply the frame.
40. Enter frame information, click search and choose correct frame or enter in information if requested
41. On the top of the page click Calculate and Continue
42. Re-enter exam information
43. Enter any medical issues patient may have or enter "NONE" (if there are none to report on)
44. Enter diagnosis codes that are found in the EHR
45. Enter usual and customary charges next to the correct codes on the CMS form
46. Enter patient amount under CMS form in correct box, this should match the calculator sheet
47. If need be, re-enter this patient amount in the FSA box
48. Scroll down and determine patient sex
49. Enter patient address when requested
50. Enter sex of the member when requested
51. At top of the page click 'save'
52. After saved, at top of page click 'report'
53. Once window opens, choose 'savings plan' tab. This will show you what the patient's responsibility is and the patient MUST pay this amount. Print savings plan, service report, and packing slip.
54. Close window and at top of original page click submit if claim is ready to be processed

55. A pop-up box will come up and ask if you want to view reports, click NO as you have already printed all the information needed

Medically Necessary Contact Lens Benefits

Visually Necessary Specialty Contact Lenses
If billing with CPT code 92072*, 92311*, 92312* or 92313* – or one of these diagnosis codes:
*Codes may not be billed together on the same claim.

Description	**ICD-10 Codes:**
Absence of iris (Aniridia)	Q13.1
Achromatopsia	H53.51
Adherent leukoma	H17.00 through H17.03
Albinism	E70.30
Aphakia	H27.00 through H27.03
Band keratopathy	H18.421 through H18.429
Breakdown (mechanical) of other ocular prosthetic devices, implants and grafts	T85.318A through T85.318S
Bullous keratopathy	H18.10 through H18.13
Central corneal opacity	H17.10 through H17.13
Coloboma of iris	Q13.0
Congenital aphakia	Q12.3
Congenital corneal opacity	Q13.3
Corneal ectasia	H18.711 through H18.719
Corneal scars and opacities	H17.00 through H17.9, A18.59
Corneal staphyloma	H18.721 through H18.729
Corneal transplant failure	T86.841
Corneal transplant rejection	T86.840
Corneal transplant status	Z94.7
Corrosion of cornea and conjunctival sac	T26.60XA through T26.62XS
Deep vascularization of cornea	H16.441 through H16.449
Displacement of other ocular prosthetic devices, implants and grafts	T85.328A through T85.328S
Endothelial corneal dystrophy	H18.51
Enophthalmos due to atrophy of orbital tissue	H05.419
Epithelial (juvenile) corneal dystrophy	H18.52

Folds and rupture in Bowman's membrane	H18.311 through H18.319
Graft-versus-host disease	D89.813
Granular corneal dystrophy	H18.53
Keratitis	H16.001 through H16.079
Keratoconus, stable	H18.611 through H18.619
Keratoconus, unspecified	H18.601 through H18.629
Keratoconus, unstable	H18.621 through H18.629
Keratoconjunctivitis sicca, in Sjogren's syndrome	M35.01
Keratomalacia	H18.441 through H18.449
Lattice corneal dystrophy	H18.54
Localized vascularization of cornea	H16.431 - H16.439
Macular corneal dystrophy	H18.55
Minor opacity of cornea	H17.811 through H17.819
Nodular corneal degeneration	H18.451 through H18.459
Ocular laceration and rupture with prolapse or loss of intraocular tissue	S05.20XA through S05.22XS
Ocular laceration without prolapse or loss of intraocular tissue	S05.30XA through S05.32XS
Other calcareous corneal degeneration	H18.43
Other congenital corneal malformations	Q13.4
Other corneal degeneration	H18.49
Other corneal scars and opacities	H17.89
Other hereditary corneal dystrophies	H18.59
Other injuries of eye and orbit	S05.8X1A through S05.8X9S
Other keratitis	H16.8
Other mechanical complication of other ocular prosthetic devices, implants and grafts	T85.398A through T85.398S
Other tuberculosis of eye	A18.59
Penetrating wound with foreign body	S05.50XA through S05.52XS
Peripheral corneal degeneration	H18.461 through H18.469
Peripheral opacity of cornea	H17.821 through H17.829
Pupillary abnormality	H21.561 through H21.569
Recurrent erosion of cornea	H18.831 through H18.839
Unspecified corneal deformity	H18.70
Unspecified corneal degeneration	H18.40

Unspecified corneal membrane change	H18.30
Unspecified corneal scar and opacity	H17.9
Unspecified hereditary corneal dystrophies	H18.50 through H18.59
Unspecified injury of unspecified eye and orbit	S05.90XA through S05.92XS
Vitamin A deficiency with xerophthalmic scars of cornea	E50.6

Covered Contacts and Base Visually Necessary Contact Lens Maximums

HCPCS	Annual Replacement[1]	Planned Replacement[1]	Daily Replacement[1]
V2500*	$251	—	—
V2501*	$385	—	—
V2502*	$491	—	—
V2503*	$405	—	—
V2510*	$450	—	—
V2511*	$650	—	—
V2512*	$750	—	—
V2513*	$500	—	—
V2520	$375	$525	$750
V2521	$525	$650	$810
V2522	$537	$650	$1000
V2523	$475	$600	$625
V2530*	$499	—	—
V2531*	$987	—	—
V2599**	$1,150	$1,500	—
Piggyback	$1,150	$1,500	—

[1]Annual Replacement is 1-2 units. Planned Replacement is 3-360 units. Daily Replacement is 361+ units.

1. Review eligibility for Visually Necessary Contact Lens Benefits
    a. Click on e-Insurance tab at the top of the page
    b. On the lower right side of page click the circle next to 'CMS' and enter correct authorization number
    c. Enter date of service of exam and 'contact lens reason'
    d. Click Continue tab at top of page
    e. Fill out glasses' prescription on next page

f. Click 'Calculate HCPCS' and there will be a pop-up screen that will automatically state if this patient has been approved or not for MNCL.
    i. If approved, there is no more to do besides finalize the billing with appropriate codes and charges. Once approved, you will only charge the MNCL copay found on their original authorization report. The remaining fit fee and the entire year supply of contact lenses will be covered with that copay.
    ii. If it is denied, you will treat patient as a normal contact lens sale with VSP allowance.

Reviewing and Posting a Payment

1. Login to Eyefinity.com
2. Select *VSP Online*
3. Select *Administration -> Explanation of Payment*
4. Select and review the most recent explanation of payment

To learn how to review and understand a VSP Payment, login to Eyefinity.com and select VSP Online -> Training and Support -> Understand Payment or select the link here: https://doctor.vsp.com/pr/html/training-understand-payment.htm

Contract & Fee Schedule

1. Login to Eyefinity.com
2. Select *VSP Online*
3. Select *Administration -> Network Doctor Agreements & Practice/Doctor Updates*

Coordination of Benefits

***When a VSP plan is primary**, submit the claim as you would in the absence of any other plan.*

QUICK TIP: If your patient isn't eligible for a service on the primary plan, the secondary plan may be used as primary for that service

When VSP is Both Primary and Secondary
Submitting the claim electronically:

1. Get authorizations for both primary and secondary benefits
2. Submit the claim using the primary authorization. Mark "No" for question 11D on the "Diagnosis and Services" page
3. Complete the Diagnosis and Services and Invoice Services pages as you normally would

IMPORTANT: Enter the secondary authorization number in the "VSP COB Secondary Authorization Number" field.

QUICK TIP: Be sure to enter the patient's chronic health conditions to VSP, we'll reimburse* you for the additional education and services you provide to patients.

For each patient identified, you can earn:
$5 for reporting diabetes and/or diabetic retinopathy.
$2 for reporting hypertension and/or high cholesterol.

*Payment won't exceed $5 and isn't cumulative. Additional reimbursement only applies to VSP Signature Plan® and VSP Choice Plan® claims billed with one of the following exam codes: 92002, 92004, 92012, 92014, S0620, or S0621.

Submitting the claim on paper:
Write the primary plan's authorization number in Box 23 and write "COB with ##### (secondary authorization #)" in Box 19, and submit the claim to VSP.

If materials are ordered, submit the claim form with a Materials Invoice Form to a contract lab. If no materials are ordered, send the claim directly to VSP at:

In-Network Claims	**Out-of-Network Claims**
VSP	VSP
PO Box 385020	PO Box 385018
Birmingham, AL 35238-5020	Birmingham, AL 35238-5018

VSP is Secondary to Another Vision Plan
If we're the secondary payor, bill us for your patient's out-of-pocket expenses. Examples are copays, coinsurance or charges for non-covered services by the primary carrier. We follow plan policies for reimbursing these charges. However, we don't pay more for approved services than what you would have received if we were the primary carrier.
VSP will coordinate the non-covered portion of the services (exam, refraction, materials) with a patient's routine benefits, if the claim includes a routine diagnosis in addition to a medical code. We'll only coordinate Primary EyeCare and Diabetic EyeCare Plus benefits with services provided for medical eyecare.

Submitting the Claim on paper
When you receive payment from the primary Vision Plan, submit the following information to us within six months from the issue date of the Explanation of Payment (EOP) or Explanation of Benefits (EOB) of the primary Vision Plan:

1. A copy of the EOP indicating patient expenses and/or service denials from the primary carrier. Don't send a summary
2. A copy of the original CMS-1500 claim form

VSP is Secondary to Health Plan or Medicare
Some patients may have coverage through their health plan or Medicare. If you participate on the patient's health plan, coordinate benefits between the health plan and VSP. In these situations, coordinating benefits will help your patients maximize their coverage. VSP will coordinate the non-covered portion (includes copay, coinsurance, deductibles on High Deductible Health Plans, and non-covered refractions).

Submitting the Claim – Routine Only or Medical and Routine Services
Submit the claim to the health plan carrier for the exam and refraction. Be sure to include a refractive diagnosis for the refraction and the appropriate diagnosis (medical and/or routine) for the exam, based on your professional opinion.

1. For us to consider payment under a WellVision exam benefit, the CPT code(s) billed to the primary carrier must include an appropriate exam code plus a routine or refractive diagnosis code for the refraction. Indication of post-cataract (presence of intraocular lens - diagnosis code Z96.1) will preempt the requirement for a routine or refractive diagnosis code for clients that offer a post-cataract material benefit to their members through VSP
2. A medical diagnosis code is required in the first positions to coordinate with Primary EyeCare or Diabetic Eyecare Plus as secondary. Refraction will be denied. See Paper Claim submission instructions
3. We'll pay up to the secondary exam allowance, less any copay, but not more than the patient's out-of-pocket expense

For Paper Claims
When you receive payment from the health plan, submit the following information to us within six months from the issue date of the Explanation of Payment (EOP) or Explanation of Benefits (EOB) of the primary carrier:

1. A copy of the EOP indicating patient expenses and/or service denials from the primary carrier; don't send a summary
2. A copy of the original CMS-1500 claim form

For Electronic Claims – Available for Routine Exam Only Claims
When you receive payment from the health plan, keep a copy of the original CMS-1500 form showing the exam and refraction services submitted to the health plan, along with the Explanation of Payment or Explanation of Benefits from the health plan/Medicare, in the patient's file. If the claim has additional services beyond an exam (with or without refraction and/or with or without retinal screening 92250 modifier 52), you'll need to submit on paper. If the patient has a covered retinal screening benefit with VSP and the health plan denied it, VSP will process it as primary and will require a paper claim.

NEW: If you are able to verify the health plan or Medicare's eligible services and non-covered patient responsibility amount at the time of billing, you can now submit the Secondary Plan exam only claim electronically on the same day. You'll still need to keep a copy of the original claim and Explanation of Payment or Explanation of Benefits in the patient's file.

If you are unable to verify the patient responsibility, wait until you receive payment from the health plan or Medicare before submitting the Secondary claim to avoid unnecessary claim corrections, as you are responsible for reconciling payments. For Medicare or Medicaid patients, overpayments must be corrected within 60 days.

Follow these instructions:

1. Provide the same diagnosis, exam, and refraction codes from primary claim
2. Select **Yes** (box 11d) there is another health benefit plan for eyecare. This will open a new section. Be sure to leave the field for **Secondary Authorization Number** blank
3. Skip the **Additional Information Detail** section (boxes 10, 15 – 18, 22 & 23). This section isn't needed.
4. Complete the **Other Insured** section as below:
5. Enter "Same" in box 9
6. Enter "NA" in box 9a
7. Enter primary health plan in box 9d
8. Click "Calculate and Continue" at the top left
9. List amount paid by primary carrier(s) in box 29
10. Enter this exact language in box 19: "secondary COB claim patient resp exam $XX.XX retinal screening $XX.XX" (Indicate the dollar amount of the patient's responsibility in place of the XX.XX). If retinal screening billed, list the patient responsibility separately.

Download our step-by-step guide to filling out your claim electronically.

Submitting the Claim – Medical Only Services
COB applies to the payment of medical eyecare benefits when a member is covered under two or more benefit plans. If a member has medical benefits under another plan, that plan is primary and VSP is secondary. You're responsible for verifying other coverage, as well as billing and collecting from other carriers. Follow Submitting the Claim on Paper instructions.

IMPORTANT: We'll only coordinate Primary EyeCare and Diabetic EyeCare Plus benefits with services provided for medical eyecare.

Timely Filing Requirements
Claims should be submitted within 180 days. It is the responsibility of the provider to receive an authorization for services prior to ensure patient is eligible for the services.

FAQs

Medical Insurances

Medical Submission Special Instructions

Cataract Global Submission

From Comanagment Essentials (Review of Optometry, October 1, 2015 Dr. John Rumpakis)

Co-management Coding

Example: Billing for 1st Eye

Dr. Jones performs procedure code 66984 on March 1st and cares for the patient through March 2nd. Dr. Smith assumes responsibility for the patient on March 3rd for the remainder of the global period.

Dr. Jones' claim contains:

- 03/01/2015 66984 -54
- 03/01/2015 66984 -55 assumed 03/02/2015, relinquished 03/02/2015

Dr. Smith's claim contains:

- 03/01/2015 66984 -55 assumed 03/03/2015, relinquished 05/30/2015

Diagnosis: H25.12 Age-Related Nuclear Cataract, Left Eye						
	Dates of Service	**Place of Service**	**Type of Service**	**Procedures, Services, Supplies (Explain Unusual Circumstances)**	**Diagnosis Code**	**Charges**	**Days or Units**
	From MM/DD/YY To MM/DD/YY			**CPT-HCPCS - Modifier**			
Surgeon:							
1	3/1/2015	11		66984-54-LT	A	XXX.XX	1
2	3/1/2015	11		66984-55-LT	A	XXX.XX	1
Co-managing Physician:							
1	3/1/2015	11		66984-55-LT	A	XXX.XX	1

Billing for 2nd Eye
Dr. Jones performs procedure code 66984 on the 2nd eye on May 1st and cares for the patient through May 2nd. Dr. Smith assumes responsibility for the patient on May 3rd for the remainder of the global period.

Dr. Jones' claim contains:

- 05/01/2015 66984 -79 -54
- 05/01/2015 66984 -79 -55 assumed 05/02/2015, relinquished 05/02/2015

Dr. Smith's claim contains:

- 05/01/2015 66984 -79 -55 assumed 05/03/2015, relinquished 07/30/2015

How to Bill Medicare for Cataract Surgery Post-Op
In your clinic use a -54 modifier on Medicare surgery claims to reduce the surgeon's fee by 20%. This reduction allows you to charge for your post-op care at the date that you assume responsibility. The normal post-op period is 90 days—starting the day of surgery. You will bill up to the date of transfer and then may bill for the care provided from that date forward.

Your office should receive a post-op exam (or a transfer-of-care notice) for each patient. This document will provide the office with the information needed to submit claims for post-op. The following are pointers to ensure billing is correct:

1. Provide at least one post-op exam or service before submitting global charge for the remainder of the 90-day period.
2. Medicare considers the office responsible for the patient's post-operative care from the "date of transfer" as noted on the form the surgeon's office send to the clinic. Bill retroactively to this date - but no more than 90 days from the day of surgery.
3. Use the same procedure code (CPT) shown in the letter received, along with a -55 modifier, using RT and LT to indicate the right or left eye.
4. Include the following information in the claim:
5. Surgeon's name
6. Surgeon's NPI number
7. Enter your post-op span date:
8. starting with the date of transfer; ending exactly 90 days from the day of surgery
9. Enter the diagnosis code used for surgery as noted on our post-op exam.

10. Date of surgery (not the day you see the patient)
11. Procedure or CPT code, 55 modifier, surgery eye (RT or LT)
12. Number of global billing units-usually 1 (Medicare prefers # of units vs. # of days)

The most common claim denial for ODs providing post-op care is code B.20 pertaining to box 19, so be precise when calculating this span date.

Calculation Tip—A simple method of calculating 90 days is to count 12 weeks forward on a calendar, then add 6 days. For example, if surgery was on Monday, count ahead 12 Mondays. Then, adding 6 days, the 90th day would be the next Sunday. A "Billing Span Calculator" is also available on our website.

YAG Laser Submission

A YAG capsulotomy is a special laser treatment used to improve your vision after cataract surgery. It is a simple, commonly performed procedure which is very safe. During your cataract operation, the natural lens inside your eye that had become cloudy was removed.

1. The surgeon will use a -54 modifier on surgery claims to reduce the surgeon's fee by 20%. This reduction allows your office to charge for the post-op care upon the date that your office assumes responsibility. The normal post-op period is 90 days—starting with the day of surgery. The surgeon will bill up to the date of transfer and then your office may bill for the care you provide from transfer date forward.
2. The following pointers will assist in billing correctly:
    a. Your office must provide at least one post-op exam or service before submitting a global charge for the remainder of the 90-day period.
    b. Medicare considers your office responsible for the patient's post-operative care from the "date of transfer" as noted in the patient's post-op letter from the surgeon. Bill retroactively to this date—but no more than 90 days from the day of surgery.
3. When sending global claims to Medicare, use the same procedure code (CPT) as the surgeon, along with a -55-modifier using RT and LT to indicate the right or left eye
    a. Include the following information—as contained in our post-op letter—on your HCFA 1500 claim form:
        i. Surgeon's name
        ii. Surgeon's NPI number
        iii. Enter your post-op span date; starting with the date of transfer and ending exactly 90 days from the day of surgery

Note: The most common claim denial for ODs providing post-op care is code B.20 pertaining to box 19, so be precise when calculating this span date.

(Calculation Tip—A simple method of calculating 90 days is to count 12 weeks forward on a calendar, then add 6 days. For example, if surgery was on Monday, count ahead 12 Mondays. Then, adding 6 days, the 90th day would be the next Sunday.)

4. Enter the diagnosis code used for surgery as noted on our post-op letter.
5. Date of surgery (per Medicare)
6. Date of transfer (all other insurances)
7. Procedure or CPT code 66821, 55 modifier, surgery eye (RT or LT)
8. Number of global billing units—usually 1 (Medicare prefers # of units vs. # of days)
9. If you are sending claims to insurance carriers other than Medicare, check with them first for billing instructions, as they may vary.

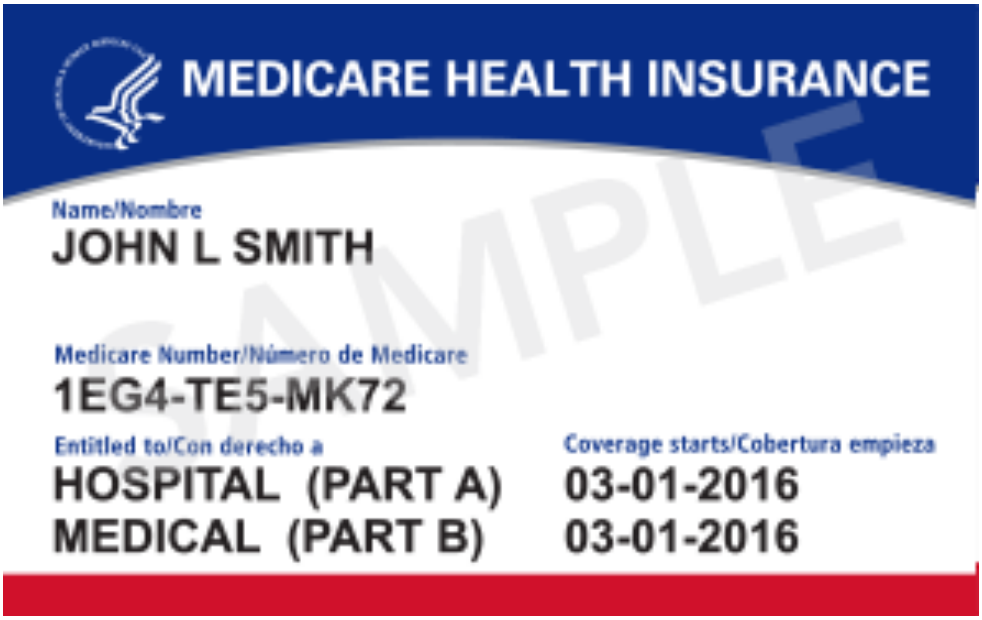
Aetna
Register online at www.aetna.com *and enter your practice information here*
Contact Information & FAQ
Benefits & Eligibility Verification
Electronic Claims Submission
Remittance Information
Claims and Appeals Information

Blue Cross/Blue Shield
Register online at www.anthem.com or www.wellmark.com and enter your practice information here
Contact Information & FAQ
Benefits & Eligibility Verification
Electronic Claims Submission
Remittance Information
Claims and Appeals Information

Cigna
Register online at www.cignaforhcp.cigna.com and enter your practice information here
Contact Information & FAQ
Benefits & Eligibility Verification
Electronic Claims Submission
Remittance Information
Claims and Appeals Information

Medicaid
Update this section as it relates to your practice specific guidelines and information

Medicare
Update this section as it relates to your practice specific guidelines and information **www.cms.gov**



Medicare Beneficiary Identifiers (MBIs)
Medicare is a health insurance program for:

- People age 65 or older
- People under age 65 with certain disabilities
- People of all ages with End-Stage Renal Disease

Medicare has different parts that help cover specific services:
Medicare Part A (Hospital Insurance) - Part A helps cover inpatient care in hospitals, including critical access hospitals, and skilled nursing facilities (not custodial or long-term care). It also helps cover hospice care and some home health care. Beneficiaries must meet certain conditions to get these benefits. Most people don't pay a premium for Part A because they or a spouse already paid for it through their payroll taxes while working.

Medicare Part B (Medical Insurance) - Part B helps cover doctors' services and outpatient care. It also covers some other medical services that Part A doesn't cover, such as some of the services of physical and occupational therapists, and some home health care. Part B helps pay for these covered services and supplies when they are medically necessary. Most people pay a monthly premium for Part B.

Medicare Part D (Prescription Drug Coverage) - Medicare prescription drug coverage is available to everyone with Medicare. To get Medicare prescription drug coverage, people must join a plan approved by Medicare that offers Medicare drug coverage. Most people pay a monthly premium for Part D.

Contact Information & FAQ
Benefits & Eligibility Verification
Electronic Claims Submission
Remittance Information
Claims and Appeals Information

Medicare Replacement Plans
Update this section as it relates to your practice specific guidelines and information
Contact Information & FAQ
Benefits & Eligibility Verification
Electronic Claims Submission
Remittance Information
Claims and Appeals Information

United Healthcare
Register online at www.uhcprovider.com and enter your practice information here
Contact Information & FAQ
Benefits, Eligibility, Authorization
Electronic Claims Submission
Remittance Information
Claims and Appeals Information

Clearinghouse Information

Contact & Login Information

Enter Clearinghouse Information and Instructions Here

Clearinghouse Reports

The following reports are recommended to view and/or print on a daily basis.

1. Payor Report
2. Rejected Claims
3. Denied Claims
4. Electronic Remittance Advice
5. Workman's comp (if your office provides these services)

Revenue Cycle Management

Revenue Cycle Management (RCM) is the process of managing your office's claims processing, payment and revenue generation. Your office will require a key staff member to maintain the system. RCM service will assist your office in:

1. Care Management
2. Digital Infrastructure
3. Provider Help Desk
4. System Integration
5. Clinical Data Integration
6. Enterprise Data Warehousing
7. Business Process Services
8. Quality Assurance
9. ICD-10 Remediation and Testing
10. Rejected Claims
11. Denied Claims

Special Considerations

Union Claims Submission

This is a private benefit offered to an employee in a local union. The union can offer members a set amount to use toward eyecare when a benefit plan for Vision is not otherwise offered.

The ID card the patient will show the provider will not have a payor number on the back. Call or view submission directions on line, refer to card presented to the office.

Possible ways for the Union to receive submitted charges:

1. Itemized Statement from the Provider showing balance due
2. HCFA 1500 form with correct diagnosis and procedure codes and amount of claim

Workman's Comp

1. Establish a protocol that the office will follow on Workman's Comp claims:
    a. If your office will not file, present the patient a handout of services and send to the patient's employer HR department
    b. If you do file: Electronic? Does your clearing house accept WC claim? List a step by step instructions on how to submit and what information needs to be included.
    c. Check your state guidelines on Workman's Comp claims

Accounts Receivables

Insurance Accounts Receivables

Enter practice processes for managing insurance accounts receivables

Patient Accounts Receivables

Enter practice processes for managing patient accounts receivables

Patient Billing Processes

Balance Due -> ***"Sent Bill"*** -> ***"Sent Past Due"*** -> ***"Sent Final Notice"***
Bills are printed & mailed every Friday.

This is your final notice.
After the allotted 10 days, your account will be sent to **collections.** You will also be charged an additional $35 for this service making your account balance $_____.

PLEASE REMIT PAYMENT TODAY IN THE AMOUNT OF $_____.

If you have any questions or feel like we have made an error, please contact our Warrensburg office and speak with our *billing department.* (Insert Phone Number)

Please disregard this notice if you have already paid this amount in full.

All ***"Sent Final Notice"*** statements are sent with final notice sticker and following note:

- Patients are then contacted by phone the next week (usually prior to due date) as a ***reminder*** about final notice and payment due date, we always try to contact our patients
- If we are unable to reach the patient because phone number is not current and no email is on file, it is sent to collections after the final notice due date
- If you speak with a patient regarding billing, please make a note in the ledger; if necessary, make a note in ledger that says **"See Alert"** and further explain in alert message
- If patient is on a ***"Sent Final Notice"*** status, please refer call to billing department
- If payment has not been made on a final notice -> Sent to collections after due date unless a payment arrangement has been made by Billing Department or Management, and notated in patient ledger
- It is EXTREMELY important to collect properly on the date of service, when possible

Payment Plan Guidelines

When setting up a payment plan, please remember:

1. Get approval from management
2. Do **not** give payment plan to new patients without management approval & signature
3. Verify **all** contact information is correct and that the billing address is listed in account
4. Fill out payment plan form
5. Scan into patient account
6. Insert note into ledger

Other notes regarding payment plans:

- Must have ***first payment on date of signing***/filing payment plan
- **Must have first payment before ordering materials**
- **VSP Orders must be paid in full before ordered**
- If for a service after insurance paid/denied, please speak with management

Billing department sends statements and adjusts due date to meet with payment guidelines so it is important to make sure that a payment plan is on file in the ledger. If patient fails in keeping up-to-date with payment plan, Courtney/Michelle attempts to get in contact with patient once by phone, email, letter to notify of payment guidelines/collections.

Refunds and Unapplied Credits

Reasons for Refunds

1. Patient over paid
2. Patient returned glasses and ONLY wants a refund
3. Patient prepaid for products or services and cancelled appointment

How to Refund a Patient

1. Prepare instructions to refund a patient and document in practice management software
2. Make a print out of the financial refund
3. Write a refund check to the patient
4. Make a notation in the patient's chart with the check number, the amount and why the refund was submitted

How to Refund an Insurance Company

Periodically an insurance company may over pay for various reasons. Call the insurance company to verify the policy of returning the money to the company. DO NOT SEND THE REFUND until you have received a written request for the refund amount. This is your official notice of a refund request.

1. Document refund request in practice management software
2. Make a print out of the financials applied to the patient account

3. Write a refund check, date the document and notate amount, check number and reason
4. Update patient's account and follow action if other action is necessary or zero account

ICD-10 Coding

Utilize and print the most current ICD-10 Codes for your office. The reference list can be purchased at www.thecodingbooks.com.

Merit-Based Incentive Payment System (MIPS)

MIPS Resources

The Merit-Based Incentive Payment System (**MIPS**) is a new payment mechanism that will provide annual updates to physicians starting in 2019, based on performance in four categories: quality, resource use, clinical practice improvement activities and meaningful use of an electronic health record system.

There is a downloadable version of MIPS short cut guide in the Google drive for Practice Foundations Academy.

Important Resources

Insurance Login and Passwords

Referring Physicians

A referring physician is a physician who requests an item or service for the beneficiary for which payment may be made under the Medicare program. Ordering physicians is defined as a physician or when appropriate a non-physician practitioner who orders services for the patient. Create a list of all physicians your office utilizes for any service not provided in your office. You should create this list in your practice management software and EHR.