UPMC Vision *Advantage*

Provider Manual

UPMC Health Plan

Table of Contents

UPMC Health Plan

Welcome

Welcome to UPMC Vision *Advantage,* a provider-friendly vision plan committed to quality coverage for its members and clients.

UPMC Vision *Advantage* was founded as part of UPMC Health Plan,* a leading regional health insurer. UPMC Vision *Advantage* works hard to avoid placing barriers between providers and patients. We consider the providers in our network to be leaders in the quality of care they provide. Our goal as an insurer is to work with our providers to make sure our members get quality vision care and regular preventive services, as well as to reduce unnecessary procedures.

This document is intended to serve as the main resource for information about UPMC Vision *Advantage* products, services, and claims processes, as well as a reference for providers when questions arise. If certain situations require further explanation, you should call the Vision Benefits Advisory Team Monday through Friday from 8 a.m. to 5 p.m. at UPMC Vision *Advantage* (Commercial): **1-877-648-9621.**

Other tools, including vision payment policies and plan documents, can be accessed through a registered UPMC Vision *Advantage* portal account. To register for an account, visit us online at **www.upmchealthplan.com/vision.**

UPMC Vision *Advantage* will update this manual and post revisions as needed. The back of this manual lists the copyright date and the edition to indicate the timeliness of the information.

**The term UPMC Health Plan or "the Plan" collectively refers to UPMC Health Plan Inc., UPMC Health Benefits Inc., and UPMC Vision Advantage.*

Advantages of participating

UPMC Vision *Advantage* is dedicated to fostering a mutually beneficial relationship with participating vision providers by offering the following business incentives:

- Rapid payment of claims and reimbursement
- Competitive fee schedule
- Live support from an organization known for excellent customer service
- No prior authorization required for claims
- Simple, easy claims filing
- Payments mailed directly to participating providers; electronic funds transfer (EFT) payments available
- Dedicated Network Manager assigned to your practice to assist with operational issues and contractual questions

Key contacts

The following chart includes all the important telephone and fax numbers listed in the UPMC Vision *Advantage* Office Manual. Before calling the Vision Benefits Advisory Team, please have your tax identification number available.

UPMC Vision *Advantage* contacts

Vision Benefits Advisory Team	1-877-648-9621
UPMC Vision *Advantage* Web Services UPMC Vision *Advantage* Website	1-877-648-9621 or hponline@upmc.edu **www.upmchealthplan.com/vision**
Vision Network Management (for notifying the Plan of vision practice changes)	Changes may be submitted online by visiting **www.upmchealthplan.com/vision** or faxing them to **412-454-8225.** Notification should be sent on letterhead. It can also be mailed to: UPMC Vision *Advantage* Attention: Network Development U.S. Steel Tower 14th Floor 600 Grant Street Pittsburgh, PA 15219
Member Services TTY Services	1-888-499-6914 711
Fraud and Abuse Hotline (for UPMC Vision *Advantage*) TTY Services	1-866-372-8301 711

You can save time by using the UPMC Vision *Advantage* portal. This secure online service allows providers to check member eligibility and benefits, submit claims for reimbursement, submit vision benefit requests (preauthorizations) for member care, check the status of a claim, and review policies and procedures. You must register to use the portal.

You can access the UPMC Vision *Advantage* portal through **www.upmchealthplan.com/vision.** Providers can find the following information on the website:

- Instructions for updating practice information online
- Member plan documents
- Vision office manual
- Vision information—links to other plan documents for providers

If a call is in reference to a specific member, you will need to have the subscriber's Social Security number or the patient's name and date of birth.

To view information about an eligible member, providers need one of the following:

- Subscriber's Social Security number and member's/ patient's date of birth, or
- The member's name and date of birth

Product at a glance

UPMC Vision *Advantage* is a Preferred Provider Organization (PPO) plan that gives members the freedom to choose any provider for care. Members have a combination of deductibles, coinsurance, and copayments for both in-network and out-of-network benefits. Members receive the highest level of benefits and lowest out-of-pocket costs when they use a UPMC Vision *Advantage* participating provider.

There are many different cost-sharing structures based on the plan the employer selects. Benefit levels can vary by deductibles and coinsurance, benefit choices, and benefit maximums.

Some plans may change over time due to employer benefit changes, regulatory requirements, or policy requirements.

For the latest updates and variations, visit our website at **www.upmchealthplan.com/vision** or call the Vision Benefits Advisory Team at **1-877-648-9621,** Monday through Friday from 8 a.m. to 5 p.m.

Under the Affordable Care Act (ACA), select UPMC Health Plan members will have access to pediatric vision essential health benefits (EHB). Pediatric vision EHB for individual and some small group participants will be administered by UPMC Vision Care administered by National Vision Administrators for plan years effective beginning January 1, 2017. Dependents through age 19 enrolled in a commercial individual or small group plan are eligible for the pediatric vision EHB administered by UPMC Vision Care.

To check your participation in the UPMC Vision Care network, please call **1-877-262-7870.**

Verifying eligibility

You can verify member eligibility online at the UPMC Vision *Advantage* provider portal. To view information about an eligible member, you will need the subscriber's Social Security number or the member's name and date of birth. Once you've entered this information, you will have access to the member's plan information, including benefits, plan documents, and the date such benefits take effect. You can also verify eligibility by calling the Vision Benefits Advisory Team.

Verifying eligibility does not guarantee claim payment, nor does it confirm benefits or exclusions. Members must acknowledge their financial responsibility in writing before you provide services.

Coordination of benefits

Coordination of benefits (COB) is a provision to prevent overpayment when a member is covered by more than one vision plan. If a member has coverage under two group vision plans, one as the employee and the other as the spouse of an employee, the group plan covering the member as a subscriber is primary. The plan covering the member as a dependent is secondary.

For questions about determining primary coverage, call the Vision Benefits Advisory Team.

When UPMC Vision *Advantage* is the secondary payer, claims are accepted with the Explanation of Benefits (EOB) from the primary carrier. The secondary claim must be received within 90 days of the primary EOB remittance date or up to the new claim filing limit, whichever is greater. Claims submitted after these deadlines will be denied for untimely filing.

Members cannot be billed for the Plan's portion of the claims submitted after these deadlines; however, they may be billed for copayments, coinsurance, and/or deductibles. For further assistance, contact the Vision Benefits Advisory Team.

To assist with timely and accurate processing of COB claims and to minimize adjustments and overpayment recoveries, the Plan requires the following information:

- Insured's ID number
- Insured's name
- Patient name
- Relationship to member
- Other insurance name
- Other insurance phone
- Other insurance address
- Effective date of coverage
- Term date of coverage, if applicable
- Type of coverage (e.g., medical, auto insurance, hospital only, vision, workers' compensation, major medical, prescription, or supplemental)

If you see that a member's other vision insurance coverage information for a member is missing or incorrect, please notify the Vision Benefits Advisory Team immediately.

Preauthorization

A vision benefit request, also referred to as a preauthorization, is a process where a provider requests a service before treatment begins. Preauthorization lets members know what vision benefits are available to them. Upon submission, we will issue a request number that can be used for tracking purposes.

Preauthorizations are not a guarantee of payment. Payment is based on the member's eligibility and plan enrollment at the time services are rendered.

Vision benefit requests are only valid for 90 days. UPMC Vision *Advantage* does not require submission of vision benefit requests. Vision benefit requests may only be submitted through the UPMC Vision *Advantage* portal.

Benefits

Eye exams

Fully covered, routine screening exams with refraction are generally available for the member once every 12- or 24-month benefit period depending on the member's specific plan.

- New Patient (S0620)
  - o Routine eye exam, including refraction for a new patient
- Established Patient (S0621)
  - o Routine eye exam, including refraction for an established patient

"S" codes are to be used by optometrists and ophthalmologists for routine vision services and billed to the vision benefit carrier. CPT-4 codes are to be used when billing medical services and should be submitted to the medical insurance carrier. All medically necessary services should be billed to the medical insurance carrier.

Frames (V2020)

Patient's frame allowance (retail costs)

The patient may apply the frame allowance to any frame. When billing for frames, use code V2020. The amount should reflect the entire retail frame cost. The Plan will reimburse the provider 70 percent of the patient's frame allowance. The additional 30 percent is a contractual discount to the Plan and cannot be billed to the patient. Charge any remainder above the patient's frame allowance to the patient. You can collect this amount at the time of service.

Lenses

The Plan has established a schedule of maximum allowance for various types of corrective lenses. For a copy of the most current fee schedule, call the Vision Benefits Advisory Team or your Network Manager. Please note that the allowance is per lens and not per pair.

Corrective eyewear includes single lens (V2100-V2121), bifocals (V2200-V2221), trifocals (V2300-V2321), and progressive lenses (V2781).

Reimbursement for progressive lenses represents the base cost of the progressive lens. Any additional fees may be charged to the member. Polycarbonate lenses (V2784), single or multifocal, will be allowed for children up to age 19.

You can bill them as one unit only; the Plan will reimburse for them in addition to lens allowance.

For lens and lens options not covered by a UPMC Vision *Advantage* benefit plan, the provider may bill the patient. Please refer to the UPMC Vision *Advantage* fee schedule that was included in the materials sent to your office.

Comprehensive contact lens evaluation (S0592)

The fitting of a contact lens includes the instruction and training of the wearer and incidental revision of the lens during the training period.

For a standard contact lens evaluation, the provider will accept reimbursement as payment in full and will not balance bill the patient. For a specialty contact lens evaluation, the provider may bill the patient the difference between the provider's billed charge and the Plan/member allowance. To receive reimbursement, the charge for a contact lens fitting fee should be a separate line item on the claim form.

Contact lenses (V2500-V2531, S0500)

Patient's contact lens allowance

For contact lenses, the Plan will reimburse the provider 100 percent of the billed charges up to the member's allowance. The provider may bill the patient the difference between the provider's billed charges and the Plan/member's allowance.

Dealing with services that are not covered

If you determine that a member requires noncovered services, UPMC Vision *Advantage* expects you to discuss possible options with the member. If you determine these services are of a medical nature, you should submit the charges to the member's medical carrier for consideration. If the member elects to receive a noncovered procedure(s) or treatment(s), the member must agree in writing that he or she will be financially responsible for these services before treatment begins. If the member will be subject to collection action upon failure to make the required payment, the terms of the action must be kept in the member's treatment record. Failure to comply with this procedure will subject the provider to sanctions up to and including termination from the network.

A standard form is not required. You may use a current office form or create a letter. The form should contain the following information:

- Practice information
- Member's name
- Member's ID number
- Procedure code and description of service(s)
- Fee charged
- Provider's signature
- Member's signature
- Statement of agreement and amount
- Date

Claims procedures

Deadlines

The Plan accepts new claims for services up to 365 days after the date of service. When UPMC Vision *Advantage* is the secondary payer, claims are accepted with the Explanation of Benefits (EOB) from the primary carrier. This secondary claim must be received within 90 days of the primary EOB remittance date or up to the new claim timely filing limit, whichever is greater. Claims submitted after these deadlines will be denied for untimely filing.

Members cannot be billed for the Plan's portion of the claims submitted after these deadlines; however, they may be billed for copayments, coinsurance, and/or deductibles. For further assistance, contact the Vision Benefits Advisory Team at **1-877-648-9621.**

Follow these guidelines to avoid the most common claims billing problems:

- If you are billing on a paper claim form, make sure that the values submitted fall within the correct block or field on the claim form.
- Include all required substantiating documentation.
- Make sure there is no missing or incomplete information.
- Make sure there are no invalid, incorrect, or expired codes (e.g., the use of single-digit instead of double-digit place-of-service codes).
- Include an Explanation of Benefits (EOB) for a member who has other coverage.

Electronic filing methods

UPMC Vision *Advantage* encourages you to submit claims electronically for payment. There are several options for electronic submission:

Individual claim entry

Individual claim entry is available to network providers with a UPMC Vision *Advantage* provider portal account. If you don't have an account, you can register as a new provider or user. This feature allows you to submit vision claims and preauthorizations from our website.

Electronic data interchange (EDI)

UPMC Vision *Advantage* accepts electronic claims in data file transmissions. Electronic claim files sent directly to the Plan are permitted only in the Health Insurance Portability and Accountability Act (HIPAA) standard formats.

Providers who have existing relationships with clearinghouses such as Emdeon can continue to transmit claims in the format produced by their billing software.

The clearinghouses are then responsible for reformatting these claims to meet HIPAA standards and forwarding the claims to the Plan. For providers submitting through Emdeon, please use payer ID **25184.**

For all EDI submissions, you must provide the National Provider Identifier (NPI) number. The NPI is an identification number that is government-mandated for electronic health care transactions and paper claims in some states. In addition, the member's identification number is necessary, along with the patient's name and demographic information. When care is coordinated, the referring provider's name and NPI or UPIN also are required.

A closer look at direct EDI submissions

Providers are able to submit claims directly without incurring clearinghouse expenses. These claims are loaded into batches and immediately posted in preparation for adjudication.

In order to submit EDI files directly to the Plan, providers must:

- Have an existing submitter account or register for a new provider or submitter account.
- Use billing software that allows the generation of a HIPAA-compliant 837P file.
- Have a sample 837P file containing only UPMC Vision *Advantage* claims exported from the billing system.
- Have a computer with Internet access.
- Have the ability to download and install a free Active-X secure FTP add-on.
- Complete testing with UPMC Vision *Advantage*.

Support for electronic submission is provided by our Vision Benefits Advisory Team. For direct EDI submitters, contact our EDI support team via email at **hpedinotify@upmc.edu.**

Paper claim filing methods

Submit claim forms to:

UPMC Vision *Advantage*
PO Box 1600
Pittsburgh, PA 15230-1600

Vision claim form

CMS-1500 claim forms for vision services performed in a vision office. Provider-specific billing forms are not accepted.

To access a copy of the most current ADA claim form, visit the forms section of the UPMC Vision *Advantage* website, **www.upmchealthplan.com/vision.**

Explanation of required fields in CMS-1500 claim form

The fields below are required in order for UPMC Vision *Advantage* to process a claim.

Insured's/Subscriber's ID number—11-digit member ID number

Patient's name—last name, first name, and middle initial

Patient's birthdate—date of birth in month/day/year format

Patient's gender

Insured's name—last name, first name, and middle initial of policy holder

Patient's address—current address, including city, state, and ZIP code; also patient's telephone number

Patient's relationship to the insured—applicable relationship box should be marked

Insured's address—insured's current address, including city/state/ZIP code; also insured's telephone number

Patient's status—mark applicable status box(es)

Other insured name field (if applicable)—indicates the name of the member's other insurance carrier, if applicable, to ensure appropriate coordination of benefits. List the insured's first and last name and middle initial.

Patient's condition related to (if applicable)—check boxes if condition is related to work, auto, or other

Insured's policy or group information—list the insured's policy or group number, date of birth, gender, employer's name or school name, and insurance plan name or program name

Patient's release—indicates if patient has signed release of information from provider

Authorized signature—indicates if patient's signature authorizing payment to provider is on file

Referring physician's name—first and last name of referring physician; if patient self-directed, please print "NONE"

Referring physician's ID number—Universal Physician Identification Number (UPIN)

Diagnosis or nature or illness or injury—minimum of one diagnosis code (ICD-9 coding)

Date(s) of service—(from/to) in month/day/year format

Procedures, services, and modifier or HCPCS code and modifier (if applicable)

Diagnosis code—indicates diagnosis code or diagnoses that apply to service on a given line

Charges—amount charged for services

Days or units—number of times service was rendered

Federal tax ID number of provider rendering service

Patient's account number—provider-specific ID number for patient (up to 12 digits)

Total of all charges on bill

Amount paid by patient and third-party payers

Balance due—current balance due from insured
Signature of provider/supplier; should include degree or credentials (Please make sure the signature is legible.)

Name and address of facility—name of facility where services were rendered (if other than home or provider's office)

Physician's billing information—billing physician's name, address, and telephone number; also list the PIN number (six-digit ID number assigned to the physician by UPMC Vision *Advantage*)

Alert—rejected claims

Rejected claims—those with missing or incorrect information—cannot be resubmitted. A new claim form must be generated for resubmission.

Codes and modifiers

UPMC Vision *Advantage* annually updates all fee schedules with HCPCS code additions and deletions.

Reimbursement

UPMC Vision *Advantage* processes all properly submitted claims within 45 days from the date they are received.

Pennsylvania Insurance Department regulations stipulate that a claim is paid when the Plan mails the check or electronically transfers the funds.

In the event UPMC Vision *Advantage* fails to remit payment on a properly submitted claim within 45 days of receipt of that claim, interest at the rate set forth by the United States Secretary of the Treasury, as published in the Federal Register, will be added to the amount owed on the clean claim. UPMC Vision *Advantage* shall not be required to pay interest that is calculated to be less than $2.

Alert—balance billing

Providers are only permitted to balance bill members for the difference between their charge and the UPMC Vision *Advantage* reimbursement under the following circumstances:

- If a member has completed the financial liability waiver and elects to have a non-covered service performed.*
- If a specialty contact lens comprehensive evaluation (fitting) is required, the provider may bill the patient the difference between the provider's billed charge and the Plan/member allowance.
- Contact lens—the provider may bill the patient the difference between the provider's billed charges and the Plan's/member's allowance.
- Frames—any remaining balance above the patient's frame allowance. (This does not include the 30 percent contractual plan discount.) This can be charged to the patient.
- Progressive lens—reimbursement represents the base cost of the progressive lens. Any lens option may be charged to the member.
- EHB members are not to be balance billed for covered services received in-network, unless otherwise specified. Providers may bill EHB members for services received that are not part of the EHB plan or exceed the benefit maximum.

Electronic funds transfer

If you are interested in an electronic payment using our electronic funds transfer (EFT), you will need to provide UPMC Vision *Advantage* with a voided check and the completed EFT form, which is available in this manual.

Send your EFT agreement to:

UPMC Insurance Services Division
Attn: Claims Payable Department
U.S. Steel Tower, 12th Floor
600 Grant Street
Pittsburgh, PA 15219
Agreements can also be faxed to **412-454-7744.**

For your reference, an initial setup form is included at the end of this manual.

Multiple payee addresses

The Plan does not honor multiple payee addresses. Providers are required to submit a single payee address per tax ID number.

Explanation of payment (remittance advice)

The Explanation of Payment (EOP), referred to on the statement as a "remittance advice," is a summary of claims submitted by a provider. It shows the date of service and procedure performed, as well as all payment information. For additional questions pertaining to the EOP, please contact the Vision Benefits Advisory Team at **1-877-648-9621.**

[*]Please see page 6 for non-covered services.

Claim follow-up

To view claim status online, go to **www.upmchealthplan.com/vision.** Existing users can log in through the UPMC Vision *Advantage* provider portal.

New users will be asked to register. To check the status of a claim without going online, call the Vision Benefits Advisory Team.

Denials and appeals

All denied claims are reported on the EOP. It will indicate whether you have the right to bill the member for the denied services and if the member is financially responsible for payment.

If you disagree with the Plan's decision to deny payment of services, you must appeal in writing to the appeals coordinator within 30 business days of receipt of the denial notification. Your request must include the reason for the appeal and any relevant documentation, which may include the member's medical record.

Appeals should be submitted to:

UPMC Vision *Advantage*
Provider Appeals
PO Box 2906
Pittsburgh, PA 15230-2906

All appeals undergo the Plan's internal review process, which meets all applicable regulatory agency requirements. You will receive written notification in all situations in which the decision to deny payment is upheld.

Overpayment

If the Plan has paid in error, you may return the Plan's check or write a separate check from your account for the full amount paid in error. You should include a copy of the remittance advice, supporting documentation noting the reason for the refund, and the Explanation of Benefits (EOB) from other insurance carriers, if applicable.

Send refunds to the General Accounting Department at this address:

UPMC Vision *Advantage*
General Accounting Department
U.S. Steel Tower, 12th Floor
600 Grant Street
Pittsburgh, PA 15219

The Plan can also deduct the overpayment from future claims if you choose not to return our check or send in your check for the amount due.

See Vision disputes on page 13.

Provider standards and procedures

Guidelines for patient record documentation

Per UPMC Vision *Advantage* policy, all patient records must be retained as required by applicable state law. UPMC Vision *Advantage* requires participating network providers to maintain member records in a manner that is accurate, timely, well-organized, confidential, and readily accessible by authorized personnel.

Consistent and complete documentation in the patient record is an essential component of quality patient care. Patient records should be maintained and organized in a manner that assists with communication among providers to facilitate coordination and continuity of patient care.

The Plan has adopted standards for patient record documentation, which are designed to promote efficient and effective treatment. The Plan periodically reviews patient records to comply with our internal quality requirements or in the event of a quality of care concern or complaint.

Patient record confidentiality and security

- Store patient records in a secure location that can be locked and protected when not being used, but still permits easy retrieval of information by authorized personnel only.
- Ensure the confidentiality, availability, and integrity of electronic vision records.
- Periodically train vision office staff and consistently communicate the importance of patient record confidentiality.

Basic information

- Place the member's name or ID number on each page of the patient record.
- Include marital status and address, the name of employer, and home and work telephone numbers.
- Include the author's identification in all entries in the patient record. The author identification may be a handwritten signature, a unique electronic identifier, or his or her initials.
- Date all entries.
- Ensure that the record is legible to someone other than the writer.

Patient history

- Indicate significant illnesses and medical conditions on the problem list.
- List all medications and prominently note medication allergies and adverse reactions in the record. If the patient has no known allergies or history of adverse reactions, providers should appropriately note this in the record.

Treatment

- Document clinical evaluation and findings for each visit.
- Document vision care services provided.
- Document patient prescriptions.

Follow-up

- Note the specific time of recommended return visit in weeks, months, or as needed.

Review

In the event of a quality of care concern, a UPMC Vision *Advantage* representative may visit your office to review the records of UPMC Vision *Advantage* members.

Access

You are required to comply with UPMC Vision *Advantage*'s rules for reasonable access to patient records during the agreement term and upon termination allowing:

1. The following parties' access to member records: UPMC Vision *Advantage* representatives or their delegates, the member's subsequent provider(s), or any authorized third party, including employees or agents of the Department of Insurance or employer group sponsor. A maintenance period of five years from the last date of service or as otherwise required by state law.
2. Members to have access to their records at no charge and upon request in accordance with HIPAA.

Copies

UPMC Vision *Advantage* has the right to request copies of the member's complete record. You may not charge a fee for the patient records when records are required by UPMC Vision *Advantage* or by the member upon transferring to another provider.

Provider credentialing

Credentialing

Credentialing is the process of assessing and validating the qualifications and practice history of a provider. All providers in our network must be credentialed prior to joining UPMC Vision *Advantage.* Their application attests to their ability to practice and provide proof of insurance liability.

All vision providers must be re-credentialed within three years of the date of their last credentialing approval.

The re-credentialing process is the same as the initial credentialing process, except that providers are also evaluated on their professional performance, judgment, and clinical competence. Criteria used for this evaluation may include, but are not limited to, the following:

- Compliance with the Plan's policies and procedures
- Plan sanctioning related to utilization management, administrative issues, or quality of care
- Member complaints
- Member satisfaction survey
- Participation in quality improvement activities
- Quality of care concerns

You will receive your application for reappointment approximately six months before your re-credentialing date.

Alert—reappointments

Failure to return the completed reappointment application and supporting documentation within the requested time limit may result in termination from the network.

Reporting practice changes

Please notify UPMC Vision *Advantage* of any additions, practice changes, or corrections within 30 days of their implementation. You can submit changes by mail or online.

Any mail or fax notifications must be typewritten on business letterhead and include the following information:

- Participating provider name
- Office address
- Billing address (if different from office address)
- Phone number
- Fax number
- Office hours
- Effective date
- W-9 tax form

Fax all changes to Network Development at 412-454-8225 or mail to:

UPMC Vision *Advantage*
Network Development
U.S. Steel Tower, 14th Floor
600 Grant Street
Pittsburgh, PA 15219

Changes may also be submitted online at **www.upmchealthplan.com/vision.**

Leaving the network

You must give UPMC Vision *Advantage* at least 90 days' written notice before voluntarily leaving the network.

In order for your notice to be considered valid, you are required to send termination notices by certified mail (return receipt requested) or overnight courier. In addition, you must supply copies of medical records to the member's new provider and facilitate the member's transfer of care at no charge to the Plan or member.

UPMC Vision *Advantage* will notify affected members in writing that their vision provider is no longer participating in the network.

Provider responsibilities

Providers have a responsibility to:

- Maintain the confidentiality of members' protected health information, including vision records and histories, and adhere to state and federal laws and regulations regarding confidentiality and security.
- Comply with all federal and state requirements concerning the handling and reporting of breaches of security.
- Give members a notice that clearly explains their privacy rights and responsibilities as they relate to the provider's practice/office/facility.
- Provide members with the opportunity to request an accounting of the use and disclosure of their personal health information in accordance with HIPAA.
- Allow members to request restriction on the use and disclosure of their protected health information.
- Obtain and report information regarding other insurance coverage to the Plan.
- Follow all state and federal laws and regulations related to patient care and patient rights.
- Participate in Plan data collection initiatives and other contractual or regulatory programs.
- Review clinical practice guidelines distributed by the Plan.
- Notify the Plan in writing if the provider is leaving or closing a practice.
- Disclose to the Plan overpayments or improper payments.
- Provide members, upon request, with information regarding the provider's professional qualifications such as specialty, education, residency, and board certification status, if applicable.
- Conduct their practice in accordance with the Plan's Code of Conduct and Ethics.
- Immediately report any compliance concerns and/or issues.
- Be alert to possible violations of the law, regulations, and/or accreditation standards, as well as to any other type of unethical behavior.

Compliance

UPMC Vision *Advantage* must comply with various laws, regulations, and accreditation standards in order to operate as a licensed vision insurer. In order to meet these requirements, as well as combat cost trends in the health care industry such as fraud, abuse, and wasteful spending, UPMC Vision *Advantage* has established a Compliance Program.

The Plan's Compliance Program serves to assist contracted providers, staff members, management, and our Board of Directors with promoting proper business

practices. Proper business practices include identifying and preventing improper or unethical conduct.

UPMC Vision *Advantage* has established a 24/7 Help Line for contracted providers, staff members, and other entities to call and report compliance concerns and/or issues without fear of retribution or retaliation. The Help Line number is **1-877-983-8442.** Callers may remain anonymous if they wish.

The success of UPMC Vision *Advantage*'s Compliance Program relies in part upon the actions you and other contracted providers take. It is critical that you be aware of the goals and objectives of the UPMC Vision *Advantage*'s Compliance Program, as well as your responsibilities as a provider.

UPMC Vision *Advantage* prohibits retaliation against contracted providers who raise, in good faith, a compliance concern and/or issue, or any other question about inappropriate or illegal behavior. The Plan also prohibits retaliation against contracted providers who participate in an investigation or provide information relating to an alleged violation.

For any questions regarding UPMC Vision *Advantage*'s Compliance Program and/or a contracted provider's responsibilities contact Mary Hentosz, Associate Vice President of Compliance, at **412-454-5204.**

Your role in HIPAA Privacy & Gramm-Leach-Bliley Act Regulations

All UPMC Vision *Advantage* policies and procedures include information to ensure the Plan complies with the HIPAA regulations and the Gramm-Leach-Bliley Act.

Hospitals and providers subject to HIPAA are trained to understand their responsibilities under these privacy regulations—as is the staff at UPMC Vision *Advantage.*

The Plan has incorporated measures in all of its departments to make sure prospective, current, and former members' protected health information, individually identifiable health information, and personally identifiable financial information are maintained in a confidential manner, whether that information is in oral, written, or electronic format. Plan employees may use and disclose this information only for those purposes permitted by federal legislation (for treatment, payment, and health care operations); by the member's written request; or if required to disclose such information by law, regulation, or court order.

An authorization form permitting the disclosure of protected health information for a purpose other than treatment, payment, and heath care operations is available from the Plan's Member Services Department or from the UPMC Vision *Advantage* website. This form complies with the core elements and statements required by HIPAA Privacy Rules. This form must be completed, signed, and returned to the Plan before the Plan will release information.

Providers are required to give to their patients UPMC Health Plan's Notice of Privacy Practices under HIPAA. UPMC Health Plan's Privacy Statement and Notice of Privacy Practices can be viewed at **www.upmchealthplan.com/vision.**

Americans with Disabilities Act Compliance

Providers' offices are considered places of public accommodation and, therefore, must be accessible to individuals with disabilities. Providers' offices are required to adhere to the Americans with Disabilities Act (ADA) guidelines, Section 504 of the Rehabilitation Act of 1973, and other applicable laws. Providers may contact the Vision Benefits Advisory Team at **1-877-648-9621** to obtain copies of these documents and other related resources.

The Plan requires that network providers' offices or facilities comply with this act. The office or facility must be wheelchair-accessible or have provisions to accommodate people in wheelchairs. Patient restrooms should be equipped with grab bars. Handicapped parking must be available near the provider's office and be clearly marked.

Reporting fraud and abuse to UPMC Vision *Advantage*

The Plan has established a hotline to report suspected fraud and abuse committed by any entity providing services to members. The hotline, **1-866-FRAUD-01 (1-866-372-8301),** is available 24 hours a day, seven days a week. Voice mail is available at all times. Callers may remain anonymous and may leave a voice mail message if they prefer. TTY users should call **711.**

Some common examples of fraud and abuse include:

- Billing for services that were never provided to the member.
- Billing more than once for the same service.
- Falsifying records.
- Performing and/or billing for inappropriate or unnecessary services.

You may report suspected fraud and abuse via the website at **www.upmchealthplan.com/vision** or the information may be emailed to **specialinvestigationsunit@upmc.edu.**

If reporting fraud and abuse by mail, please mark the outside of the envelope "confidential" or "personal" and send to:

UPMC Vision *Advantage*
Special Investigations Unit
PO Box 2968
Pittsburgh, PA 15230

You may report information anonymously via the website, email, or regular mail. The Plan's website contains additional information on reporting fraud and abuse.

Requirements and standards of care for vision offices

UPMC Vision *Advantage* has established standards that provider offices are expected to fulfill. The following summarizes those standards:

Standard of care

Network providers and vision specialists are expected to practice within the specified state board standard of care. You are expected to be aware of any state and federal laws that impact your position as an employer, a business owner, and a health care professional.

Parameters of care

UPMC Vision *Advantage* uses the American Academy of Ophthalmology and the American Optometric Association parameters as a guideline for appropriate vision care. You are expected to use all relevant training, knowledge, and expertise to treat our members.

Alert—termination

UPMC Vision *Advantage* requires notification of termination in writing 90 days before the change to avoid improper claims payment and incorrect directory information. Providers must give UPMC Vision *Advantage* at least 90 days' written notice before voluntarily leaving the network. In order for a termination to be considered valid, providers are required to send termination notices by certified mail (return receipt requested) or overnight courier. In addition, providers must supply copies of the vision records to the member's new provider and facilitate the member's transfer of care at no charge to UPMC Vision *Advantage* or the member. UPMC Vision *Advantage* will notify affected members in writing of a provider's termination, as applicable.

Vision disputes

If a provider disagrees with a decision by the Plan to deny coverage of care or services, the provider has the right to appeal that decision.

A request for an appeal must be submitted in writing within 30 calendar days of the denial notification. The request must include the reason for the appeal and other supporting documentation. The request for appeal should clearly state why the provider wishes to appeal.

Note that resubmitting a corrected claim due to minor error or omission is not an appeal. Corrections or resubmissions of claims due to minor errors or omissions should be sent to the customary claims address. *See Claims procedures on page 7.*

To answer any additional questions about the right to appeal or how to file an appeal, providers may call the Vision Benefits Advisory Team at **1-877-648-9621.**

Provider sanctioning

Sanctions are the consequences for noncompliance in UPMC Vision *Advantage*'s three areas of oversight. UPMC Vision *Advantage* PPO Plan follows a three-phase process for addressing the actions of providers who fail to observe the terms and conditions of the provider agreement or the Plan's policies and procedures.

Actions that could lead to sanctioning

Actions that could lead to sanctioning fall into three main categories: administrative noncompliance, unacceptable resource utilization, and quality of care concerns.

Administrative noncompliance

Administrative noncompliance is consistent or significant behavior that is detrimental to the success or functioning of the UPMC Vision *Advantage* PPO Plan. Examples include:

- Conduct that is unprofessional or erodes the confidence of members.
- Failure to coordinate or cooperate with the UPMC Vision *Advantage* PPO plan's administrative, quality improvement, post-treatment review, and reimbursement procedures.

Unacceptable resource utilization

Unacceptable resource utilization is a utilization pattern that deviates from acceptable standards and may adversely affect a member's quality of care.

Quality of care concerns

A quality of care issue may arise from an episode that adversely affects the functional status of a member or a pattern of practice that deviates from acceptable standards. For quality of care concerns, the Quality Improvement Committee (QIC) has developed a severity scale. This scale ranks cases that may involve a practice pattern deviating significantly from the norm.

The sanctioning process and focused monitoring of the provider remain in effect for no less than one year from the date UPMC Vision *Advantage* notifies the provider of the action. The Plan notifies the provider when the process and follow-up activities are satisfied and the sanctioning is no longer in effect. In instances of recurring similar noncompliance activities, UPMC Vision *Advantage* reserves the right to expedite the sanctioning process.

Termination

The QIC, as part of the sanctioning process, may recommend the termination of a provider's contract. The provider will be notified in writing by the UPMC Health Plan Medical Director and offered the opportunity to appear at a hearing, if appropriate. The termination process involves the following steps:

1. UPMC Vision *Advantage* notifies provider about termination. The notice will state that a professional review action is recommended and the reasons for the proposed action. The provider has the right to request a hearing within 30 calendar days.
2. Provider may request a hearing. If a hearing is requested, the provider will be given notice stating the place, time, and date of the hearing—to occur no later than 60 calendar days after the date of the notice—and the names of witnesses, if any, expected to testify on behalf of UPMC Vision *Advantage*.
3. QIC appoints an Appeals Committee. The QIC will appoint an Appeals Committee on an ad hoc basis. The QIC will not select anyone in direct economic competition with the provider who is the subject of the hearing—nor anyone who has previously voted on the action—to serve as members of the Appeals Committee.
4. The Appeals Committee conducts a hearing and makes recommendations. After the QIC recommends termination of participation status or other sanction, the Appeals Committee will hear the appeal from a provider if the QIC—in its sole discretion—offered the provider the opportunity to appeal. The Appeals Committee will conduct the hearing and recommend to the QIC that it accept, reject, or modify its original recommendation. The right to the hearing may be forfeited if the provider fails to appear without good cause.

   At the hearing, the provider has the right to:

   - Receive representation by an attorney or other person of the provider's choice.
   - Have a record made of the proceedings, copies of which may be obtained upon payment of any reasonable charges associated with the preparation of the records.
   - Call, examine, and cross-examine witnesses.
   - Present evidence determined to be relevant by the hearing officer regardless of its admissibility in a court of law.
   - Submit a written statement at the close of the hearing.

Upon completion of the hearing, the provider has the right to receive the written recommendation of the Appeals Committee from the Plan, including a written statement giving the basis of the decision.

Member administration

Member and provider satisfaction surveys

The Plan conducts annual surveys of both member and provider satisfaction. Participation by members and providers enables the Plan to develop quality improvement plans.

The surveys assess:

- Access to care and/or services.
- Overall satisfaction with the Plan.
- Provider availability.
- Quality of care received.
- Responsiveness to administrative processes.
- Responsiveness to inquiries.

Quality Improvement Program

The goal of the Quality Improvement Program is to continually examine the UPMC Vision *Advantage* PPO plan's clinical and administrative operations in an effort to continuously improve the Plan's ability to deliver high quality, timely, safe, and cost-effective care.

The Quality Improvement Program operates in accordance with the guidelines established by the National Committee for Quality Assurance (NCQA), the Pennsylvania Department of Health, and the Pennsylvania Insurance Department.

The program critically assesses the Plan's performance regarding customer service, provider satisfaction, credentialing, pharmacy, preventive services, utilization of resources, and various health care initiatives.

The doctors who serve on the QIC are at the center of the program. This committee, made up of both academic and community doctors, operates directly under the auspices of the board of directors. The QIC is vital to the Plan because it develops and evaluates clinical and operational standards for providers.

The Vision Agreement requires providers to comply with the UPMC Vision *Advantage* PPO plan's Quality Improvement Program on quality improvement initiative, including HEDIS data collection.

Glossary

A

Adjudication—Claim processing procedures to determine benefits.

Affordable Care Act (ACA)—Referred to collectively as the Patient Protection and Affordable Care Act of 2010 as amended by the Health Care and Education Reconciliation Act of 2012.

Allowance—The benefit amount that UPMC Vision *Advantage* calculates for each covered service. It includes the amount UPMC Vision *Advantage* pays, as well as the member's coinsurance, if any.

Appeals—Procedures provided for participating providers who disagree with UPMC Vision *Advantage* claim decisions.

B

Benefit plan—The schedule of benefits establishing the terms and conditions pursuant to which members enrolled in UPMC Vision *Advantage* products receive covered services. A benefit plan includes, but is not limited to, the following information: a schedule of covered services; if applicable, copayment, coinsurance, deductible, and/or out-of-pocket maximum amounts; excluded services; and limitations on covered services (e.g., limits on amount, duration, or scope of services).

Benefits—Vision services received by enrolled members for which all or part of the cost is authorized and paid for by UPMC Vision *Advantage*.

Bifocal lens—Having one portion of the lens correct for near vision and one for distant vision (a bifocal eyeglass lens).

C

Claim—Request for payment for services rendered.

Claim form—Document that may be used as a claim for payment.

Clean claim—A claim for payment for a health care service that has no defect or impropriety. A defect or impropriety includes lack of required substantiating documentation or a particular circumstance requiring special treatment that prevents timely payment from being made on the claim. The term does not include a claim from a health care provider who is under investigation for fraud and abuse regarding that claim.

Clearinghouse—An intermediary that receives claims from providers or other claimants and translates the data from a given format to one that is acceptable for the intended payer and then forwards the processed claim to the payer.

Coinsurance—The portion of the provider's fee for which the member is responsible. This amount is indicated on the explanation of benefits (EOB).

Complaint—A dispute or objection regarding a network provider or the coverage, operations, or management policies of a managed care plan that has not been resolved by the managed care plan and has been filed with the Plan or with the Pennsylvania Department of Health or the Pennsylvania Insurance Department.

Contact lens—A thin lens designed to fit over the cornea and usually worn to correct defects in vision.

Coordination of benefits (COB)—Rules that determine payment of claims when the member has other vision coverage in addition to UPMC Vision *Advantage*.

Copayment—Cost-sharing arrangement in which the member pays a specified flat amount for a specific service (such as an office visit or prescription drugs).

Covered services—Health care services for which a vision plan is responsible for payment according to the benefit package purchased by the member or group sponsor.

Credentialing—The Plan's review procedure that requires potential or existing network providers to meet certain standards in order to begin or continue participation in the network of the Plan. The credentialing process may include examination of a provider's certifications, licensures, training, privileges, and professional competence.

D

Date of service—For purpose of determining coverage, the date a service is completed.

Dependent—Person covered by someone else's vision plan. In a payer's policy of insurance, a person other than the subscriber eligible to receive care because of a subscriber's contract.

E

Electronic claims submission (ECS)—The process of transmitting insurance claims electronically from

an office, billing service, or clearinghouse to an insurance company.

Electronic data interchange (EDI)—The electronic transmission of strategically important business data in a standard syntax by means of computer-to-computer exchange via a standard online transmission method.

Eligibility—The rules set forth by the subscriber to determine which members may be enrolled in the vision program.

Essential Health Benefit (EHB)—A set of health care services that must be covered by certain plans. Services include pediatric vision coverage.

Explanation of Benefits (EOB)—Computer generated notice mailed to members and providers explaining benefit determinations (e.g., type of service received, the allowable charge, the amount billed, cost-share amount, etc.) If a service is not paid for, the EOB also explains why payment was not allowed and how to appeal that decision.

Explanation of Payment (EOP)—A summary of covered services for which the Plan paid a provider. Also known as a remittance advice, the EOP shows the date of service, diagnosis, and procedure performed as well as all payment information, including explanation codes for those claims denied or returned for correction.

F

Frames—A structure that holds corrective lenses.

H

HEDIS—Healthcare Effectiveness Data and Information Set.

HIPAA (Health Insurance Portability and Accountability Act)—Federal legislation that defines standard formats for health insurance transactions.

L

Lens—A piece of glass or plastic used to correct impaired vision or protect the eye.

Lens options—Additional features/coatings, tints, scratch resistant, polarized, etc. which can be added to a standard eyeglass lens.

M

Maximums—Total dollar amount (per member) in a benefit year.

Members—Individuals who are enrolled in and eligible to receive benefits from UPMC Vision *Advantage.*

N

Non-participating provider—A provider who has not signed a participating agreement with UPMC Vision *Advantage.*

National Provider Identifier (NPI)—An identification number that is a government-mandated requirement for electronic health care transactions and paper claims in some states.

O

Ophthalmologist—A physician (medical doctor) who specializes in all aspects of eye care, including diagnosis, treatment, and surgery of ocular diseases and disorders.

Optometrist—A specialist licensed to practice optometry, which is the health care profession concerned with examining the eye for defects and faults of refraction, with prescribing correctional lenses or eye exercises, with diagnosing diseases of the eye, and with treating such diseases or referring them for treatment.

Optician—A person who reads prescriptions for visual correction, orders lenses, and dispenses eyeglasses and contact lenses.

Out-of-network—Not in the Plan's network (e.g., a provider or facility that does not participate in the UPMC Vision *Advantage* network).

Out-of-network provider—A provider who has not signed a participating agreement with UPMC Vision *Advantage.*

Out-of-pocket—Total payments toward eligible expenses that a member funds for himself/herself and/or dependents, including copayments, coinsurance, and deductibles.

P

Participating provider—An authorized provider who has signed a participating agreement with UPMC Vision *Advantage.*

Polycarbonate lens—Any of various tough transparent thermoplastics characterized by high-impact strength and high softening temperature.

Preauthorization (vision benefit request)—Written estimate provided by UPMC Vision *Advantage* in response to a request by a provider or member for an estimate of coverage for future vision services.

Preferred Provider Organization (PPO)—Type of managed care in which providers and hospitals agree to provide services at contracted rates. The plan pays the network rates as long as the member sees a network provider. Typically, members do not need to file claims or coordinate their care through a PCP. When out-of-network providers are used, members pay more of their expenses and usually must file the claims.

Progressive lens—A progressive lens is used in eyeglasses to correct presbyopia and other disorders of accommodation. They are characterized by a gradient of increasing lens power, added to the wearer's correction for the other refractive errors. The gradient starts at the wearer's distance prescription at the top of the lens and reaches a maximum addition power, or the full reading addition, at the bottom of the lens.

R

Remittance advice—A summary of covered services for which the Plan paid a provider. Also known as an Explanation of Payment (EOP), the remittance advice shows the date of service, diagnosis, and procedure performed as well as all payment information, including explanation codes for those claims denied or returned for correction.

S

Subscriber—A person who has obtained the health insurance coverage under a health insurance plan; the policyholder.

U

UPMC Vision *Advantage*—A group vision insurance Preferred Provider Organization Plan.

Abbreviations

A

ACA—Affordable Care Act

C

CMS—Centers for Medicare & Medicaid Services

COB—Coordination of benefits

E

ECS—Electronic claims submission

EDI—Electronic data interchange

EHB—Essential Health Benefit

EOB—Explanation of Benefits

EOP—Explanation of Payment

H

HEDIS—Healthcare Effectiveness Data and Information Set

HIPAA —Health Insurance Portability and Accountability Act

I

ID—Identification

M

MD—Medical doctor (e.g., ophthalmologist)

N

NPI—National Provider Identifier

O

OD—Doctor of Optometry

P

PPO—Preferred Provider Organization

Q

QIC—Quality Improvement Committee

U

UPIN—Universal Provider Identification Number

Providers are responsible for the appropriate billing of services.

UPMC HEALTH PLAN

Our records indicate your company receives paper reimbursement checks from UPMC Insurance Services Division. We ask that you partner with UPMC Insurance Services Division in going green by switching to electronic funds transfer (EFT). In addition to helping the earth your company will receive reimbursements sooner if you enroll in EFT because the funds will be directly deposited into your bank account. Our Authorization for Electronic Reimbursement Application form is on the other side of this paper.

INSTRUCTIONS FOR COMPLETING THE AUTHORIZATION FORM

Please complete all lines of the authorization form to ensure accurate claims payment.

Note that the provider number is located on the top of the Explanation of Payment document that came with your check. If you have more than one number, please include all of them.

The bank routing number is the nine digit number located at the bottom of your check.

Please fax the **authorization form** and one copy of a **voided check** to **412-454-7744** or mail to:

UPMC Health Plan
Claims Payable Department, 12th Floor
U.S. Steel Tower
600 Grant Street
Pittsburgh, PA 15219

Applications will not be considered if this form is incomplete or not accompanied by a voided check.

If you have any questions about the Authorization for Electronic Reimbursement Application, please contact UPMC Health Plan Provider Services at **1-888-876-2756** Monday through Friday from 8 a.m. to 5 p.m.

Authorization for Electronic Reimbursement by UPMC Health Plan for Medical Services

If you are interested in receiving electronic funds transferred (EFT) payments, please complete this form.

Our Company (1) authorizes UPMC Health Plan to make payments for services by EFT, (2) certifies that it has selected the following depository institution, and (3) directs that all such EFT payments be made as provided below:

Name of organization: _____

Federal Tax ID number: _____

Organization's UPMC Health Plan provider number: _____

Depository institution: _____

Bank routing number: _____ Checking ❑ Savings ❑

Account number: _____

Account name: _____

**** Please include copy of voided check for account verification ****

Our Company acknowledges and agrees that terms and conditions of all agreements with UPMC Health Plan concerning the method and timing of payment for services shall be amended.

Our Company will give 30 days advance notice in writing to UPMC Health Plan of any changes in its depository institution or other payment instructions.

When properly executed, this authorization will become effective 15 days after UPMC Health Plan receives it.

Date: _____

_____

Print name

_____ _____

Authorized signature

UPMC Insurance Services Division authorized signature

_____ _____

Title

UPMC Health Plan finance manager

_____

Phone number

UPMC Health Plan

U.S. Steel Tower, 600 Grant Street
Pittsburgh, PA 15219

www.upmchealthplan.com

2020 VSN ADV MNL 19PV964321 (MCG) 11/22/19 120 SS