



March 2026

Indiana Medicaid Provider Manual



Introduction	4
About Indiana Medicaid	5
About Indiana Medicaid	5
About Indiana Pathways for Aging	5
Fully Integrated Dual Eligible (FIDE) plan	6
Recognizing Indiana members	6
Requirements.....	7
Participation requirements and responsibilities	7
Credentialing and recredentialing	13
Locum tenens doctors	16
Location requirements	17
Access to care/emergencies	19
Interacting with members	20
Member confidentiality and privacy	26
Non-discrimination	27
Cultural competency and language assistance	27
Medicare and Medicaid participation	28
Mobile providers	29
Remote vision care exam	31
Network terminations and suspensions	32
Payments	35
Members with medical and vision benefits	36
Claims.....	36
Coordination of benefits (COB)	38
Submitting claims	39
Voiding and correcting claims	42
Claim payments and withholds	43
Claim denials	43
Services and materials	44
Eye exam services	44
Contact lenses	46
Frames and lenses	51
Limitations and exclusions	56
Compliance and Quality Assurance (QA).....	58
Definitions.....	58
Provider post-service claim appeals process	58
Provider audits.....	59
Fraud, Waste & Abuse (FWA) prevention.....	62
Annual training requirements	65
Returning to the network after involuntary termination by EyeMed	66
Health plan information.....	68

CareSource	69
About CareSource.....	69
Interacting with CareSource members.....	69
CareSource provider requirements.....	71
CareSource claims.....	71
CareSource routine services and materials	72
Compliance and quality assurance (QA).....	72



Introduction

EyeMed Vision Care® administers the routine vision network for some health plans supporting Indiana Medicaid and the Indiana PathWays for Aging program. See the [Health plan information section](#) for the latest list of health plans and their unique coverage details.

Although relevant provisions are summarized here as appropriate, you are contractually obligated to adhere to and comply with all the terms listed in this provider manual, your provider agreement, the [Indiana Health Coverage Program \(IHCP\) Provider Reference Modules](#) and all federal and state regulations applicable to providers. While this manual contains basic information, the Indiana Health Coverage Program (IHCP) requires that you fully understand and apply IHCP requirements when administering covered services. Refer to in.gov/pathways/providers/ for more information about the Indiana PathWays for Aging program.

This Provider Manual is confidential and should not be shared with third parties.

Effective Date: [Jan. 1, 2026]



About Indiana Medicaid

About Indiana Medicaid

The **Indiana Health Coverage Programs (IHCP)** is the state's Medicaid program. IHCP oversees various programs, including Health Indiana Plan (HIP) and Hoosier Healthwise (HHW).

- **Healthy Indiana Plan (HIP)** is a health-insurance program for qualified adults aged 19 to 64 who meet specific income levels.
- **Hoosier Healthwise (HHW)** is a health care program for children up to age 19 and pregnant individuals.

About Indiana Pathways for Aging

The Indiana Family and Social Services Administration (FSSA) launched a new program (**Indiana PathWays for Aging**) in July 2024 for Hoosiers aged 60 and over who receive Medicaid (or Medicaid and Medicare) benefits. Research shows that most older adults—75% or more—want to age at home and in their communities. The state's goal is to support Hoosiers to age in the location of their choice. The program lets qualifying Hoosiers pick a health plan. And that plan helps them to get high-quality services and support their need to live independently.

The Indiana Pathways for Aging population includes members in the following 3 categories based on Medicaid and Medicare eligibility and enrollment alignment:

- **"Medicaid Only"** includes members who are solely Medicaid eligible and enrolled in only Indiana Pathways for Aging.
- **"Dual Eligible – Aligned"** includes dually eligible members who are enrolled in both Indiana Pathways for Aging and the exclusively aligned companion D-SNP.
- **"Dual Eligible – Unaligned"** includes dually eligible members who are enrolled in Indiana Pathways for Aging and any unaligned Medicare service delivery system. This would include enrollment in traditional Medicare, any non-SNP Medicare Advantage Plan, Chronic Condition Special Needs Plans (C-SNPs), and Institutional Special Needs Plans (I-SNPs).

The following facilities count as long term services and supports:

- Nursing facility
- Home health services (see [42 CFR 440.70](#))
- Home and Community Based Services (HCBS)

Fully Integrated Dual Eligible (FIDE) plan

- **About FIDE plans.** A Fully Integrated Dual Eligible (FIDE) plan is a type of Medicare Advantage plan that serves members who are eligible for both Medicaid and Medicare (dual eligibles).
 - Through Indiana Medicaid and Indiana's Pathways for Aging program, the state's Medicaid managed long-term services and supports (MLTSS) program can designate affiliated D-SNPs as FIDE SNPs. This integration allows these plans to coordinate Medicare and Medicaid benefits more seamlessly.
- **FIDE plans with vision benefits.** Some of our members are enrolled in a FIDE plan. Refer to the [Health plan information section](#) for information on which health plans offer FIDE benefits.

Recognizing Indiana members

Member ID cards

- **Indiana ID cards.** Members may receive state Medicaid eligibility cards and may present these providers.
 - Presentation of an ID card does not guarantee eligibility. Eligibility should always be verified before any services are rendered.
- **Health plan member ID cards.** Members enrolled in a Managed Care Entity (MCE) may also receive member ID cards from their health plan. Refer to the [Health plan information section](#) for a sample of member ID cards.
 - You should use the member's health plan member ID card instead of the state-provided one.
 - Presentation of an ID card does not guarantee eligibility. Eligibility should always be verified before any services are rendered.

Verifying eligibility

- **Identification verification.** You must verify that the person receiving care is the same individual listed on the eligibility card.



Requirements

You're expected to provide certain levels of service and follow rules for interacting with members.

Participation requirements and responsibilities

Medicaid enrollment

- **Enrollment with Indiana Medicaid.** Routine vision is a self-referral service for Indiana Medicaid. To provide routine vision care for Indiana Medicaid and Indiana PathWays for Aging members through EyeMed, you must enroll with Indiana Medicaid via the [IHCP Provider Healthcare Portal](#). **If you aren't enrolled with Indiana Medicaid, you cannot provide services through EyeMed.**
 - For more information, refer to the [IHCP Provider Enrollment Transactions page](#) and the [IHCP Provider Enrollment Module](#).
- **Effective date of Medicaid enrollment.** Your IHCP effective date is the date the IHCP Provider Enrollment Unit receives your enrollment application. You can bill for services rendered to IHCP members starting on your enrollment effective date, subject to the claim filing limit of 180 days from the date of service. For a claim to be considered, the dates of service must be on or after your enrollment start date.
- **Effective date of EyeMed Indiana Medicaid and Indiana PathWays for Aging enrollment.** You will be effective with EyeMed on the first of the month following the receipt of a complete network participation request.
- **Retroactive enrollment.** A retroactive enrollment date of no more than 180 days may be considered for approval. Refer to the [IHCP Provider Enrollment Module](#) for more information.
- **Medicaid provider types.**
 - **Optometrists (Type 18)** may be enrolled as billing, group or rendering providers linked to a group. Per [IC 25-1-9-5](#), optometry groups must be owned by optometrists. You must provide a copy of your current license from the appropriate state's licensing agency.
 - **Opticians (Type 19)** are enrolled as billing or rendering providers linked to an optometrist group. Opticians can't enroll as a group provider.

- **Medicaid revalidation.** You must revalidate every at least every 5 years. You are encouraged to complete revalidation via the [IHCP Provider Healthcare Portal](#). If you don't intend to revalidate your enrollment, complete the disenrollment process on the [IHCP Provider Healthcare Portal](#) or submit the [IHCP Provider Disenrollment Form](#).
 - Refer to the [IHCP Provider Enrollment Module](#) for more information about revalidation.
 - IHCP doesn't reimburse for services rendered after your enrollment is end dated due to failure to revalidate by the specified date.
 - You'll receive written notification of your revalidation deadline. If you're registered with the [IHCP Provider Healthcare Portal](#), you'll also receive a notice on your portal account.
 - All revalidations require screening activities associated with the provider's assigned risk level, such as site surveys or criminal background checks, as described in the [Risk Category Requirements matrix](#).
 - You are required to revalidate your enrollment with Medicare and the IHCP separately. Revalidating with Medicare will not revalidate your IHCP enrollment.
- **Provider screening requirements.** The following disclosing individuals must be screened as part of Medicaid enrollment:
 - **An individual or groups of individuals with a 5% or greater direct or indirect ownership interest in the provider.**
 - **An agent**, who is any person who has been delegated the authority to obligate or act on behalf of a provider, such as a fiduciary agent or contractor.
 - **An individual who is on the Board of Directors of a provider entity.**
 - **An individual who is a managing employee**, such as a general manager, business manager, administrator, director or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of the institution, organization or agency, either under contract or through some other arrangement, whether or not the individual is a W-2 employee.
- **Provider fingerprinting and criminal history check.** Medicaid providers in Indiana are identified as "high", "moderate" and "limited" risk levels. If you are identified as a "high" risk, you must undergo a fingerprint-based criminal background check through the state-authorized vendor. Background checks for "high" risk providers are required for any person with a 5% or greater direct or indirect ownership or controlling interest in the business. Refer to the [IHCP Provider Enrollment Module](#) and the [Provider Enrollment Risk Levels and Screening page](#) for more information.

- **Exclusion screening.** EyeMed does not participate with any individual or entity who has been excluded from participation in federal health care programs, who have a relationship with excluded providers and/or who have been terminated from a government program (including Medicare and Medicaid). Refer to the [Medicare and Medicaid participation section](#) for more information.
- **Ownership disclosure.** You agree to furnish to EyeMed, the health plan or IHCP the following information during enrollment, revalidation, and within 35 days after any change in ownership:
 - The name and address of any person (individual or corporation) with ownership or control interest. The address for corporate entities must include (as applicable) the primary business address, every business location and PO Box address.
 - Date of birth and Social Security Number (SSN) (in the case of an individual).
 - Other Tax Identification Number, in the case of corporation, with an ownership or control interest or of any subcontractor in which the disclosing entity has a 5% or more interest.
 - Whether the person (individual or corporation) with an ownership or control interest is related to another person with ownership or control interest as a spouse, parent, child or sibling; or whether the person (individual or corporation) with an ownership or control interest of any subcontractor in which the disclosing entity has a 5% or more interest is related to another person with ownership or control interest as a spouse, parent, child or sibling.
 - The name of any other fiscal agent or manage care entity in which an owner has an ownership or control interest in an entity that is reimbursable by Medicaid and/or Medicare.
 - The name, address, date of birth and SSN of any managing employee.
- **State requirements of Medicaid enrollment.** As part of the Medicaid enrollment process, you'll also need to meet IHCP's criteria below.
 - Be licensed, registered or certified by the appropriate professional regulatory agency pursuant to state or federal law, or otherwise authorized by the Indiana Family and Social Services Administration (FSSA) or the Indiana State Department of Health (ISDH).
 - Have a National Provider Identifier (NPI).
 - Complete and submit the IHCP provider agreement and all other applicable sections of the enrollment application to IHCP, including dated signatures, where applicable, as required by the FSSA.
 - Be eligible to participate in all applicable federal and state programs.
 - Have a successful outcome of any unannounced site visits for provider types considered at moderate or high risk for fraud.

- Notify IHCP Provider Enrollment and EyeMed with **10 business days** of any changes in your license, certification, and permit, and within **30 business days** of any changes in any other information. Refer to the [IHCP Provider Enrollment Module](#) for more information.

Minimum participation requirements

- **Criminal offense notification.** FSSA or the Office of Medicaid Policy and Planning (OMPP) may deny or terminate an individual's or entity's eligibility to participate as a Medicaid provider in Indiana if the agency finds that you have been convicted of any offense the agency determines is inconsistent with the best interest of IHCP members or the Medicaid program.
 - Felony crimes against persons, such as murder, rape, assault and other similar violent crimes.
 - Financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other crimes of criminal neglect, misconduct or fraud.
 - A criminal offense that may subject members to an undue risk of harm.
 - Sexual misconduct that may subject members to an undue risk of harm.
 - A crime involving a controlled substance.
 - Abuse or neglect of a child or adult.
 - A crime involving the use of a firearm or other deadly weapon.
 - Crimes directly related to the provider's ability to provide services under the Medicaid program.
- **TPA and DEA certification/licensing.** You need to have either a TPA certificate or DEA license.
 - You can use diagnostic pharmaceutical agents (DPAs) if the member's age, condition type and severity and other contributing factors justify it.
 - Use therapeutic pharmaceutical agents (TPAs) as appropriate when a member has a condition that requires them, but you must get the member's consent. You can also refer them to another health care professional as stated in their medical care plan. As with DPAs, document member refusals or referrals.
- **Professional liability insurance.** Contracted and affiliated eye care professionals must maintain professional liability insurance in the amount of \$1,000,000 per occurrence and \$3,000,000 aggregate.
 - In states that have limitations on liability, state law applies.
 - An umbrella policy can meet these requirements.
- **Commercial liability insurance.** You must maintain commercial liability insurance in the amount of \$1,000,000 per occurrence and \$2,000,000 in aggregate.

Your responsibilities under EyeMed

- **Information updates.** You must keep your information up-to-date by using our [online form](#).
- **Leaving the network.** If you want to opt out of the EyeMed Indiana Medicaid network, complete our [online Network Request form](#).
- **Full-service locations.** All participating provider locations must offer both exams and materials.
- **Open to new patients.** All locations must accept new patients.
- **Member eligibility and access.** You can't turn away members and must represent yourself as an in-network provider to them. You can't submit claims for out-of-network services on behalf of members if you participate in their network(s).
- **Claims.** Submit all required claims information.
- **Disparagement.** Do not publicly share your concerns/issues about EyeMed, the MCE or Indiana Medicaid. Instead, follow the provider complaints and appeals processes.
- **Information verification.** When EyeMed asks you to report or verify information, you must do so in a timely, accurate and complete manner. You may be asked to supply signed confirmation.
 - You must also ensure your enrollment information on file with IHCP is complete and current and notify IHCP of any changes within 30 business days of the change (10 business days for licensure, certification or permit changes).

Your rights and responsibilities under Indiana Medicaid

- **Provider rights under Indiana Medicaid.** You have the right to not be prohibited or otherwise restricted when acting with the lawful scope of your practice, from advising or advocating on behalf of a member who is your patient, regarding the following:
 - The member's health status, medical care, treatment options or social supports including any alternative treatment that may be self-administered, regardless of whether benefits for such care are provided under Medicaid;
 - Any information the member needs in order to decide among all relevant treatment and service options;
 - The risks, benefits, and consequences of treatment or non-treatment; and
 - The member's right to participate in decisions regarding their health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

- **Provider responsibilities under Indiana Medicaid.** By participating in Indiana Medicaid, you have certain responsibilities you must meet. Refer to IHCP for more information. You have the responsibility to:
 - Sign and abide by the IHCP Provider Agreement.
 - Ensure your enrollment information on file is complete and current, and to notify the IHCP of any changes within 30 business days of the change (10 business days for licensure, certification, or permit changes).
 - Screen potential employees and contractors to determine whether they are excluded individuals prior to hiring or contracting them and on a periodic basis afterwards. You are expected to review the calculation of overpayments paid to excluded individuals or entities by Medicaid. You must:
 - Screen all employees and contractors to determine whether any of them have been excluded.
 - Search the [Exclusions Database](#) periodically to capture exclusions and reinstatements that have occurred since the last search.
 - Report to IHCP any exclusion information discovered by calling the IHCP Provider and Member Concerns Line at 800.457.4515.
 - Stay informed of current communications and policy updates, you must enroll in the [IHCP Email Notifications](#) (sign up to receive news and updates on the home page at in.gov/medicaid/providers). If you are already enrolled, you should verify that your email address on file is correct.
 - Abide by the IHCP provider reference modules, which are updated periodically. Updates to policies or procedures that occur after the effective date indicated on the module are announced in provider bulletins, banner pages and news items. Changes to the provider modules, as well as provider bulletins, banner pages and news items shall be binding upon publication to the official Indiana Medicaid website at www.in.gov/medicaid/providers.
 - Comply with and adhere to the following laws:
 - All applicable state and federal laws regarding member rights as set forth in 42 CFR 438.100.
 - 42 CFR 438.102, which relates to provider-enrollee communications.
 - Section 1557 of the Affordable Care Act and 45 CFR 92.1.
 - 42 CFR 1002 on exclusion and debarment screening.
 - Have a plan in place to ensure your staff take member rights into account when furnishing services.
 - Meet the OMPP provider qualification requirements set out in the IHCP provider manual.

- Offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid Fee For Service (FFS), if you only serve Medicaid members.
- Meet standards for timely access to care and services, taking into account the urgency of the need for services as required therein.
- Not discriminate against individuals on the basis of race, color, age, national origin, sex, sexual orientation, gender identity, genetic information, income status, Indiana Medicaid and/or Indiana PathWays for Aging membership or disability.
- Not use any policy or practice that has the effect of discriminating based on the above criteria.
- Ensure members and individuals with disabilities are accommodated to actively participate in the provision of services and have physical access to facilities, procedures and exams.
- Provide accommodations to members and individuals with disabilities at no cost to afford such individuals an equal opportunity to benefit from the covered services.
- Not terminate enrollment nor encourage a member to disenroll because of their health care needs or a change in their health care status. A member's health care utilization patterns may not serve as the basis for disenrollment.
- Screen your owners and employees against the federal exclusion databases (such as LEIE and EPLS).

Credentialing and recredentialing

Before providers can legally deliver service to members, they must complete credentialing, which verifies that the provider meets our participation requirements. You'll complete recredentialing every 3 years so we can verify the validity of your provider status.

These credentialing and recredentialing requirements apply to all doctors who will provide care to EyeMed members, including Locum tenens providers.

Credentialing and recredentialing overview and requirements

- **Credentialing and recredentialing vendors.** We use the following companies during credentialing and recredentialing:
 - The Council for Affordable Quality Healthcare (CAQH).
888.599.1771
866.293.0414
<https://proview.caqh.org/Login>

caqh.udphelp@acgs.com

- Gemini Diversified Services, a Credentials Verification Organization (CVO).
- You must ensure your CAQH profile is up to date, as we rely on that information to confirm requirements. You'll verify your information and provide proof of your license, liability insurance and professional certifications to CAQH.
- **Credentialing and recredentialing requirements.** You must meet the below requirements to participate on our network. We'll confirm you meet the criteria during credentialing and re-verify during recredentialing. Documentation is required for some items as indicated.

Criteria	Documentation Required	Required for OD	Required for MD/DO
Submission of a complete, signed and dated state-specific application for participation in network	✓	✓	✓
Satisfactory work history for prior 5 years with explanation of any gaps of 6 months or more, unless state law requires otherwise		✓	✓
Recredentialing: 3 years' work history only			
Signed and dated attestation of completeness, accuracy and release of information	✓	✓	✓
Valid, unencumbered license in state(s) of practice	✓	✓	✓
Minimum professional liability insurance for all states in which provider practices, as indicated below, or state statutory cap, state regulations or as required by our contractual agreement with plan <ul style="list-style-type: none"> ● Optometrist or ophthalmologist – \$1 million per occurrence and \$3 million aggregate <i>Requirement can be met with separate umbrella policy.</i>	✓	✓	✓
No exclusion from Medicare/Medicaid in the last 5 years		✓	✓
Not opted out of Medicare/Medicaid		✓	✓
No conviction of a criminal offense that reasonably calls into question a provider's ability to practice		✓	✓
No more than a combined total of 3 liability and/or malpractice claims resulting in settlements within the last 5 years		✓	✓
No reported sanctions on the provider's license within the last 5 years, excluding advertising violations, soliciting patients door to door, establishing temporary		✓	✓

Criteria	Documentation Required	Required for OD	Required for MD/DO
offices and/or delay in reporting continuing education credits*			
Operation of all equipment (in clean and working condition) used in the course of patient care and management		✓	✓
No history of EyeMed chart/site evaluation failures in the past 5 years*		✓	✓
No more than 3 adverse events within the past 3 years*		✓	✓
Practice open to new members		✓	✓
Graduation from an accredited school or college of optometry (optometrists) or an accepted professional medical or osteopathic school and completion of an accredited residency program in ophthalmology (ophthalmologist)	✓	✓	✓
No history of insurance fraud*		✓	✓
List of other states where provider is or has been licensed, registered or certified	✓	✓	✓
Operation of a practice with normal business hours and after-hours coverage	✓	✓	✓
No office location subleased from or affiliated with a corporate-owned retail optical chain not accepted in our network (subject to state regulations)		✓	✓
A valid TPA Certification and/or DEA Certification as indicated by state regulations	✓	✓	
A valid DEA Certification or CDS Certification as indicated by state regulations	✓		✓
Demonstrated board certification (if applicable)	✓		✓

Abbreviations: OD = optometrist, MD/DO = ophthalmologist. Credentialing does not apply to opticians.

Starting the credentialing and recredentialing process

- **Credentialing after contracting.** After completing contracting, we will begin the credentialing process.
- **Credentialing of providers new to your practice.** Use our online form to begin credentialing for new providers in your practice and/or to associate Locum tenens providers to your practice.
- **Recredentialing notification.** You'll receive a letter, and the [EyeMed online claims system](#) will notify you when it's time to begin recredentialing.
- **Verification and documentation.** You will provide all verification and documentation to our credentialing vendors. They may contact you directly to

request additional information if needed. Some items require verification from the primary source (for instance, from the school you graduated from).

Credentialing and recredentialing status and timing

- **Credentialing and recredentialing status.** You'll receive email updates as you move through the process and upon completion. You can also check the status of credentialing or recredentialing on our communications portal, inFocus.
- **Credentialing timing.** Initial credentialing takes up to 45 days.
- **Recredentialing timing.** If your profile is not complete, preventing completion of recredentialing within 90 days, you will be removed from the network.
 - If you do not provide missing information within 90 days, you may have to reapply to the network as a new provider.
- **Completing credentialing and recredentialing.** After receiving confirmation from our vendors that you meet our requirements, our credentialing committee reviews all providers. You cannot serve EyeMed members UNTIL you are fully credentialed and approved. You'll be notified by email when you can begin seeing members.

Your rights during credentialing and recredentialing

- **Right to review information.** You can request to review any information submitted with the application at any time. You can also request a copy of the information received from the CVO.
- **Right to correct erroneous information.** If the information we receive from the CVO differs from what's on the application, we'll contact you. You'll have 15 business days from the date of receipt to respond. This lets you correct any inaccurate information from the CVO submitted by third parties through the primary source verification process.
- **Right to be informed of your application status.** You can request to be informed of the status of your application at any stage of the process. The CVO will respond by phone, fax or email.

Locum tenens doctors

You must arrange for back-up if you'll be out of the office for 7 consecutive days or more. The Locum tenens doctor must file claims under their own National Provider Identifier (NPI).

- The doctor must be credentialed with EyeMed.
- Use our [online form](#) to associate the doctor with your location so claims can be filed.

Location requirements

Network providers must have a physical location and make sure all offices have the required instruments listed below on-site and in working order. All locations must also meet hygiene and safety measures.

Required instruments

- Phoropter or trial lenses
- Visual acuity testing distance and near charts and/or projector
- Retinoscope, autorefractor or wavefront analyzer
- Keratometer/ophthalmometer/topographer
- Ophthalmoscope: direct and binocular indirect with condensing lens
- Tonometer
- Biomicroscope
- Lensometer
- Color vision testing system
- Stereopsis testing
- Diagnostic pharmaceutical agents within expiration dates

Office cleanliness requirements

- **Proper cleaning** of exam rooms, laboratories, dispensing areas, offices and waiting areas.
 - Use gloves, biohazard disposal receptacles, trash receptacles and office disinfectant to reduce the spread of infection and to ensure safe handling and disposal of medical waste.
 - Wash hands (in front of the member whenever possible) prior to examination and use an alcohol-based hand sanitizer between interactions.
 - Keep exam lanes, contact lens and eyewear dispensaries and public areas as clean and clear of clutter as possible.
 - Clean clinical equipment with alcohol wipes in front of the member before each use.
 - Disinfect diagnostic contact lenses after each use.
- **Pharmaceutical storage.** Store pharmaceuticals in a secure, sanitary place away from food and beverages.
- **Contact lenses, solutions and pharmaceutical expiration.** Discard contact lenses, contact lens solution, DPAs and TPAs after their expiration date.
- **Medical waste containers.** Properly secure and maintain medical waste containers.

Safety and security

- **Environmental safety.** You're required to operate a safe and secure environment. At a minimum, this includes having:
 - Adequate lighting in public area.
 - Safe and secure flooring and fixtures.
 - Hand-held fire extinguishers up to local and state fire codes with current inspection tags.
 - A complete first-aid kit that, at a minimum, includes:
 - Adhesive bandages
 - Adhesive tape
 - Ammonia inhalants
 - Antibiotic ointment
 - Antihistamine
 - Antiseptic towelettes
 - Eye wash solution
 - First-aid/burn cream
 - Latex gloves
 - Pain reliever
 - Scissors
 - Sterile eye pads
 - Sterile gauze pads
 - Medical waste container(s).
 - Any other safety equipment recommended by state or local emergency preparedness ordinances.
- **Prescription pad security.** Keep prescription pads secure at all times.

Americans with Disabilities Act (ADA)

- You are expected to meet federal and state accessibility standards as defined in the Americans with Disabilities Act of 1990.

Other location requirements

- **Seating.** Provide adequate seating for patients in your reception area and provide an area that offers privacy and confidentiality for discussion of vision care or health information.
- **Licenses and certifications.** Post your license and certifications in plain sight or make them otherwise available to members per state law.
- **Business hours.** Display and maintain reasonable business hours. If the doctor's hours are different from the dispensary's, post both sets of hours.
- **On-site inspections.** Per [42 CFR 438.3\(h\)](#), you must allow duly authorized agents of the state or federal government, including CMS, the Office of Inspector General, the Comptroller General and their designees, at any time, access your premises, physical facilities and equipment to inspect, audit, monitor, examine, excerpt, transcribe, copy or otherwise evaluate the performance of your contractual activities. You must produce all records or documents, including but not limited to financial, member or administrative records, books, contracts, and computer or other electronic systems requested as part of such review or audit.

- Failure to permit access to provider locations for any site visits will result in denial or termination of enrollment.
- Medicaid providers in Indiana are identified as “high”, “moderate” and “limited” risk levels. If you are identified as a “high” or “moderate” risk level provider, an IHCP representative will make an unannounced pre-enrollment site visit to verify your information submitted and determine compliance with federal and state enrollment requirements. After enrollment has been activated, an unannounced post-enrollment site visit will be conducted within the first year.
- Refer to [the IHCP Provider Enrollment Module](#) for more information.

Access to care/emergencies

Appointment and wait time standards

- **Appointment wait standards.** You must offer non-urgent appointments with EyeMed members within 2 weeks of a request.

After-hours access

- **24-hour phone access.** All offices must have (or arrange for) telephone triage or screening services on a 24/7 basis through which patients can get help to determine the urgency of their condition. Patients should receive return calls from this line within a reasonable timeframe, not to exceed 30 minutes.

Urgent and emergency care

- **Urgent care services.** You must perform urgent care services the same day as requested. Refer to the [Health plan information section](#) for specific requirements by health plan.
- **Emergency care.** Your location must have referral instructions on hand to give members who have an emergency eye care need outside your scope of practice during your office hours and after hours. In addition, offer after-hours support—via mobile phone, pager or an answering system—to members seeking emergency eye care.
- **Definition of eye care emergency.** We define an eye care emergency as a physical condition involving 1 or both eyes which, if untreated or if treatment is delayed, may reasonably be expected to result in irreversible vision impairment.
- **Examples of eye care emergencies.** Eye care emergencies include the below. Lost or broken eyeglasses or contact lenses, regardless of the strength of the prescription, do not constitute eye care emergencies.
 - Severe eye pain.

- Any penetrating injury to the eye.
- Chemical contact with the eye (particularly alkaline substances).
- Sudden total loss of vision in one or both eyes.
- Sudden loss of vision to a degree that prohibits mobility.
- **Emergency eyewear.** If a member has an eye care emergency requiring eyewear, follow our [emergency lab process](#).

Interacting with members

You must follow the below requirements when interacting with EyeMed members.

Member rights and responsibilities

- **Member rights.** Indiana Medicaid and Indiana Pathways for Aging members have the following rights:
 - Be treated with dignity and respect when getting health care services.
 - Be given privacy for them and their medical records.
 - Be given easy-to-understand explanations of their medical problems and treatment choices.
 - Stay involved in decisions about their treatment choices.
 - Get care 24 hours a day, 7 days a week.
 - Get timely answers to their complaints or appeals.
 - Appeal decisions made about health care they receive.
 - Use buildings and services that meet the standards of the Americans with Disabilities Act (ADA).
 - Get a second opinion from a different doctor.
 - Request and receive a copy of their medical records and request that they be corrected.
 - Be free from any action of being held against their will or cut off from others when these actions are intended to pressure them into doing something, punish them or show revenge against them or make it easier for the medical personnel.
 - Exercise their protected rights and to not be discriminated against if they choose to exercise their rights.
 - Receive information relating to information on the managed care program and plan in which they are enrolled;
 - Be treated with respect and with due consideration for their dignity and privacy;
 - Receive information on available treatment options and alternatives, presented in a manner appropriate to their condition and ability to understand;

- Participate in decisions regarding their health care, including the right to refuse treatment;
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other federal regulations on the use of restraints and seclusion;
- Request and receive a copy of their medical records, and request they be amended or corrected, as specified in the HIPAA Privacy Rule set forth in [45 CFR parts 160 and 164, subparts A and E](#), which address security and privacy of individually identifiable health information; and
- Be furnished health care services in accordance with [42 CFR 438.206 through 438.210](#), which relate to service availability, assurances of adequate capacity and services, coordination and continuity of care, and coverage and authorization of services.
- Review their care plan.
- For those members who are receiving HCBS, the right to have and review their service plan (of care) as outlined in [42 CFR 441.301\(b\)\(1\)\(i\)](#).
- For those members who are receiving home and community based long-term services and supports, the right to request a fair hearing outlined in [42 CFR 431 Subpart E](#) when an individual is not given the choice of home and community-based waiver services as an alternative to institutional level of care, who are denied the service(s) of their choice or the provider(s) of their choice, or whose services are denied, suspended, reduced, or terminated. The right to request a fair hearing includes providing a notice of action per [42 CFR 431.210](#).

Member assistance

- **Transportation services.** Transportation may be covered by an MCE.
 - Transportation benefits may cover emergency ambulance services, non-emergency transportation, lodging, meals and/or a travel attendant.
 - Some transportation services may require prior authorization or approval.
 - Members should contact their MCE to learn more about or request transportation. Refer to the [Health plan information section](#) for additional information.

Marketing guidelines

- **Direct marketing.** You can't market directly to members as it relates to your participation in the network. We don't permit direct contact with members who have not previously received care or purchased eyewear from you.

- **Representation.** You can't represent yourself as an extension of EyeMed, MCE or Indiana Medicaid to members in person or in writing (e.g., letters, promotional materials).
- **Sharing of information.** You can't share EyeMed, MCE or Indiana Medicaid information (e.g., group lists, member lists, group benefits, member benefits) with members outside of individual doctor-patient relationships.
 - You can't use the list of groups near you on inFocus to promote your practice with members.
- **Inducement.** You can't induce members to seek care from you through gifts, rewards or free items unless legally permitted. Consult your legal counsel for guidance on federal and state anti-kickback regulations.
- **Logo usage.** You can use EyeMed's logo in your marketing and in-office signage according to the terms of the [logo usage agreement](#), which you must complete before using the logo. You can't use logos of health plans for which we're providing routine vision services for Medicaid members.
- **Provider Solicitation.** Solicitation or a fraudulent, misleading or coercive offer by a provider to supply a service to an IHCP member is not allowed as specified in [405 IAC 5-1-4](#). Examples of provider solicitation include:
 - Door-to-door solicitation;
 - Screenings of large or entire inpatient populations, except where such screenings are specifically mandated by law;
 - Any other type of inducement or solicitation to cause a member to receive a service that the member doesn't want or doesn't need.
- **Dissemination of information.** Upon request from the state, you must distribute information prepared by FSSA, its designee or the federal government to your patients.

Pricing and communicating costs

- **Price sheets.** You can't charge members more than you would charge patients who do not have vision care benefits, and you can only use 1 price sheet.
- **Cost transparency.** You must make members aware of their costs when you're providing services that are not covered under their plan.
- **Non-covered services notification.** You must notify members before rendering non-covered services that the member will be paying out-of-pocket.
 - IHCP providers are prohibited from charging a member, or the family of the member, for any amount not paid as billed for an IHCP-covered service. According to [42 CFR 477.15](#), acceptance of IHCP payment in full is a condition of participation in the IHCP. For more information on charging Indiana Medicaid or Indiana PathWays for Aging members for noncovered services, see the [Provider Enrollment module](#).

- Refer to the [non-covered items section](#) for additional rules on non-covered items.
- **Missed appointments.** If an Indiana Medicaid or Indiana PathWays for Aging member misses a scheduled appointment, document the missed appointment in the member's medical record and conduct outreach to the member by performing minimum reasonable efforts to contact the member. You may not bill the member for missed or broken appointments.
- **Charging a member.** You are prohibited from charging a member, or the family of the member, for any amount not paid as billed for a covered IHCP service. Provider acceptance of payment from the Contractor as payment in full is a condition of participation in the IHCP.
 - You can bill a member only when the following conditions have been met:
 - The service rendered is determined to be non-covered by the IHCP;
 - The member has exceeded the program limitations for a particular service;
 - The member must understand, before receiving the service, that the service is not covered under the IHCP, and that the member is responsible for the charges associated with the service; and
 - You must maintain documentation that the member voluntarily chose to receive the service, knowing that the IHCP did not cover the service. A generic consent form is not acceptable unless it identifies the specific procedure to be performed, and the member signs the consent before receiving the service.

Documentation and record-keeping requirements

- **Office policy for dismissing a Medicaid member.** You must establish and document a process for transferring a Medicaid member from your practice. This process must detail how your office will handle member transfers without discrimination. This process can't be based solely on the member filing a grievance, appeal or request for a fair hearing or other action by the member related to coverage, or any reason not permissible under applicable law.
- **Notation of coverage discussion.** Note in the patient file that you had a conversation about what services are and are not covered by the member's vision benefits.
- **Refusal of pharmaceuticals or services.** Document when a member refuses any DPAs, TPAs or services you recommend.
- **Record retention.** You must secure and retain member records (both clinical and financial) either electronically or in hard copy for longer of:
 - The period required under applicable laws, rules and regulations.

- Adults: 10 years from the date of the last visit or the date of the completion of any audit by the Centers for Medicare and Medicaid (CMS), unless superseded by state law.
- Minors: 28 years from the date of birth.
- Deceased patients: 6 years from the date of death.
- Inactive records are to remain accessible for a period of time that meets state and federal guidelines.
- Financial records must be maintained for a period of 10 years following submission of financial data to the IHCP. A provider must disclose this financial data when the information is to be used during the rate determination process, as well as during audit proceedings.
- **Record-keeping requirements.** Your records must be kept in a detailed and comprehensive manner that conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and facilitates an accurate system for follow-up treatment. Records must be legible, signed (manually or electronically) and dated. In accordance with [405 IAC 1-1.4-2](#), your medical records must include, at a minimum:
 - Identity of the individual to whom service was rendered.
 - Identity, including dated signature or initials, and position of employee rendering the service, if applicable.
 - Date that the service was rendered to the member.
 - The member's diagnosis.
 - A detailed statement describing services rendered, including duration of services rendered.
 - The location at which the services were rendered.
 - Amount claimed through the IHCP for each specific service rendered.
 - Written evidence of physician involvement, including signature or initials, and personal patient evaluation to document the acute medical needs.
 - A current plan of treatment and progress notes, as to the medical necessity and effectiveness of treatment and ongoing evaluations as to assess progress and refine goals, if applicable.
- **Record availability.** Your records are subject to prepayment and post payment review and must be openly and fully disclosed and produced to the FSSA, ISDH or authorized representatives with reasonable notice and request. This notice and request can be made in person, in writing, or orally, although some situations may require a request to review records without notice.
- **Access to and audit of contract records.** The state or federal government may inspect and audit any of your financial, care management, member, administrative or other records. There are no restrictions on the right of the state or the federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services and

the reasonableness of their costs or for any purpose the state or federal government deems necessary for administration or operation of the program.

- When requested by the state or federal government, you must:
 - Provide access to electronic records in any circumstance when you use electronic records;
 - Provide and make available staff to assist in the audit or inspection effort;
 - Provide adequate space on the premises to reasonably accommodate the state or federal personnel conducting the audit or inspection effort.
 - Provide timely and reasonable access to a recipient's personnel for the purpose of interview and discussion related to such documents.
- The state or federal government may perform off-site audits or inspections to ensure that you are compliant with contract requirements.
- All inspections or audits shall be conducted in a manner as will not unduly interfere with your activities. All information so obtained will be accorded confidential treatment as provided under applicable law.
- If you fail to keep and maintain detailed and accurate medical records, you may be required to repay FSSA or EyeMed for amounts paid corresponding to the services rendered for which accurate and detailed medical records are not timely provided.
- FSSA may authorize additional time for responding to medical records requests made by EyeMed or FSSA. If you fail to submit records in a timely manner, it may result in the assessment of an overpayment and/or other non-compliance remedies.
- **Member access to records.** You must provide a copy of the member's medical record upon reasonable request by the member at no charge. You must also facilitate the transfer of the member's medical record to another provider at the member's request.
- **Financial records.** Financial records should address matters of ownership, organization and operation of your financial, medical and other record-keeping systems.
 - Accounting records pertaining to your contract must be retained until final resolution of all pending audit questions and for 1 year following the termination of any litigation relating to your contract if the litigation has not terminated within the 10-year period.
- **Availability of accounting records.** Authorized representatives or agents of the state and federal government must have access to your accounting records upon reasonable notice and at reasonable times during the

performance and/or retention period of your contract for purposes of review, analysis, inspection, audit and/or reproduction.

- You must file with the State Insurance Commissioner the financial and other information required by the Indiana Department of Insurance (IDOI).
- You must make copies of any accounting records pertaining to your contract available within 10 calendar days of receiving a written request from the state for specified records. If you don't meet this requirement, you must provide transportation, lodging and subsistence at no cost, for all state and/or federal representatives to carry out their audit functions at your offices.
- FSSA, IDOI, the FSSA Office of Medicaid Policy and Planning (OMPP) and other state and federal agencies and their respective authorized representatives or agents must have access to all accounting and financial records of any individual, partnership, firm or corporation insofar as they relate to transactions with any department, board, commission, institution or other state or federal agency connected with your contract.
- **Record confidentiality.** You must follow all HIPAA and state and federal requirements related to the confidentiality of, and access to, medical records.

Member confidentiality and privacy

- **State and federal laws.** You must follow all applicable state and federal laws and regulations restricting unauthorized access, use, destruction and release of member information that includes Protected Health Information (PHI) (which includes but is not limited to data from [EyeMed online claims system](#)), Personally Identifying Information (PII) and credit card data.
- **Member privacy rights.** Members are afforded the privacy rights permitted under HIPAA and other applicable federal, state and local laws and regulations, and applicable contractual requirements.
 - The privacy policy conforms with [45 CFR \(Code of Federal Regulations\)](#), which provides member privacy rights and places restrictions on uses and disclosures of PHI (§ 164.520, 522, 524, 526, and 528).
- **Member privacy requests.** Members may make requests related to their PHI ("privacy requests") in accordance with federal, state and local law.

Non-discrimination

- **Non-discrimination laws.** You must comply with all relevant federal and state nondiscrimination provisions.

Cultural competency and language assistance

You must provide services in a culturally competent manner to all members, including those with Limited English Proficiency (LEP) or reading skills, diverse cultural and ethnic backgrounds, physical and mental abilities and health conditions.

Cultural competency

- **Cultural respect and service orientation.** Respect and provide services in a manner that meets member cultural preferences and needs.
- **Cultural competency training.** You must complete cultural competency training annually to help all staff members understand how to deliver care across cultures.
 - EyeMed includes cultural competency in the training module that all providers must complete by December 31 of each year. See our [Annual Training Requirements section](#) for more details.
- **Cultural competency resources.** The federal Office of Minority Health (OMH) offers information on providing culturally competent services on their website, thinkculturalhealth.hhs.gov. CMS has also developed an online [Health Care Language Services Implementation Guide](#) to help your office meet these standards.
- **Health equity and cultural competency.** Per [42 CFR 438.206](#), you must participate in the state's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency (LEP) and diverse cultural and ethnic backgrounds.
 - Per [42 CFR 438.204](#), at the time of enrollment with EyeMed, the state will provide the race, ethnicity and primary language of each member. You should use this information to ensure the delivery of services in a culturally humble way.
 - You must also ensure all services are delivered through a health equity lens, meaning you are able to address barriers experienced and identified by specific populations.

Interpretation and translation requirements

- **Reporting of languages spoken.** Report all languages spoken in your office, including American Sign Language (ASL), so we can include this information on

our provider directory. You can provide this information in the “Manage My Profile” section of the [EyeMed online claims system](#).

- **Translation and interpretation of materials.** Provide free oral, ASL and Braille interpretation and/or written translation of your practice materials and service delivery upon member request.
- **Member preferred languages.** Note the patient’s preferred languages in your patient documentation so your staff knows to communicate and provide oral and written information in their preferred language.
 - Use an interpreter, when necessary, to ensure patients understand all options and are able to make informed decisions.
 - Call us at 888.581.3648 to access free interpreter services. Normal business hours are from 8 am to 11 pm ET Monday through Saturday and 11 am to 8 pm ET on Sunday).
 - Customize, print and make available copies of section 1557 of the Affordable Care Act’s Notice of Nondiscrimination and Statement of Nondiscrimination in the most common languages your practice encounters. Translated versions are available online at <https://www.hhs.gov/civil-rights/for-individuals/section-1557/translated-resources/index.html>.
- **Oral interpretation services.** Per [42 CFR 438.10\(d\)](#), you must arrange for oral interpretation services to your patients free of charge for services you provide. This requirement is not limited to prevalent languages. It also includes interpretation services for the deaf and hard of hearing.
 - Oral interpretation services include, but are not limited to:
 - Member services helpline;
 - 24-hour nurse call line;
 - Transportation;
 - Assessment and stratification;
 - Prevention and wellness programs(s);
 - Care management;
 - Complex case management; and
 - Right Choices Program.
 - You must notify your patients of the availability of these services and help arrange them.

Medicare and Medicaid participation

EyeMed requires network providers to be eligible to participate in federal healthcare programs, including Medicare and Medicaid. Providers found on any preclusion lists will be removed from our networks.

Medicare information

- **Medicare opt-outs and exclusions.** If you do not remain enrolled in Medicare or Opt-out, you will be immediately removed from all EyeMed networks. If you are either excluded or precluded from participation in programs that receive federal funding, you can't participate in EyeMed networks.

Medicaid information

- **Medicaid enrollment.** You must be enrolled in the state Medicaid agency program. Your Medicaid ID number is key for participation in this program, and we must monitor the accuracy of it on a regular basis. If you are excluded by the state for participation in the Medicaid program or fall under any Medicare exclusion/preclusions above, you can't participate in EyeMed networks.

Exclusion screening and documentation

- **Exclusion from receiving federal funds.** You must make sure any individual or entity you intend to hire, sub-contract or add into your practice ownership is not excluded from receiving federal funds.
 - If they appear on the below exclusion lists, they will not be able to provide services to EyeMed members:
 - [The Office of Inspector General's \(OIG\) List of Excluded Individuals and Entities \(LEIE\)](#)
 - [System for Award Management \(SAM\)](#)
 - Any services provided by excluded individuals must be refunded to and/or obtained by the state and/or EyeMed.
 - If the excluded individual is the provider or owner, all amounts paid for services rendered following their exclusion will be refunded.
 - FSSA reserves the right to immediately disenroll you if you become ineligible to participate in Indiana Medicaid or Indiana PathWays for Aging.
 - OMPP reserves these right to immediately disenroll you if you, your rendering providers or your owners/operators become ineligible to participate in IHCP.
- **Monthly monitoring.** You should check websites monthly for the exclusion status of any current or prospective team members.

Mobile providers

EyeMed will contract with providers who practice in mobile settings only when specific requirements are met.

Definitions and categories

- **Definition of mobile providers.** We define a mobile provider as a third party who performs eye exams and/or dispenses materials at a location(s) other than a contracted brick-and-mortar location(s). Mobile providers include, but are not limited to:
 - Vision vans.
 - Temporary eye clinics.
 - Those who serve patients at nursing homes or other care facilities.
- **Mobile provider categories.** EyeMed has categorized mobile providers as:
 - **Category 1:** Those who increase access to care to otherwise underserved populations. EyeMed generally accepts mobile providers who fall in this category.
 - **Category 2:** Those who provide a service of convenience to members who already have adequate access to care. EyeMed only accepts providers in this category under certain circumstances.

Application process

- **Mobile provider application.** All mobile providers who want to participate in an EyeMed network must go through a mobile provider application and approval process.
 - Fill out the [online application form](#). Select “Special Programs/Documents.”
 - Once a completed initial mobile provider application package is received, it takes a minimum of 30-60 days to complete the process.
 - We will deny claims submitted for mobile providers that have not been pre-approved through this process.
- **Recertification.** Mobile providers must recertify compliance with EyeMed’s requirements every 2 years.
- **Doctor credentialing.** If approved, doctors performing exams will also need to be credentialed.

Requirements

- **Brick and mortar location.** You’re required to have a brick-and-mortar location that provides comprehensive eye exams in addition to mobile services to ensure that members have access to continuity of care, or document alternate arrangements to provide timely appropriate sequential care through participating network providers without additional cost to the member or to EyeMed.

- **Follow-up information.** Leave clear, legible contact information, exam findings, follow-up notes and recommendations with the patient after every patient encounter.
- **Continuity of care.** Provide/ensure appropriate medical eye care follow-up and/or ensure continuity of care with other medical providers, as indicated.
- **Equipment.** Have and maintain the required equipment at both the physical office location and mobile setting. We may request proof of equipment.
- **Requirement to report changes.** Report any material changes to information submitted in your original mobile provider application within 30 days and provide written program and protocol revision descriptions as appropriate. Any finding of falsification of this information or failure to report material changes is grounds for immediate termination.

Remote vision care exam

Remote vision care exams may be helpful to provide access to care to under-served populations, specifically members who live in geographies without reasonable access to conventional eye care practices. EyeMed will contract with remote vision care exam providers only when specific requirements are met.

Application process

- **Remote vision care exam provider application.** All providers who want to offer remote vision care exams as an EyeMed network provider must complete the remote vision care exam application and approval process.
 - Fill out the [online application form](#). Select “Special Programs/Documents,” then select YES for the question “Are you a remote vision care provider.”
 - Once a completed initial remote vision care exam provider application is received, it takes a minimum of 30-60 days to complete the process.
 - We will deny claims submitted for remote vision care exam providers who have not been pre-approved through this process.
- **Doctor credentialing.** If approved, doctors performing exams will also need to be credentialed.

Requirements

- **Brick and mortar location.** You must have a fully licensed and accredited brick-and-mortar location where patient data is collected (the Originating Site). A credentialed provider who is a licensed optometrist or ophthalmologist must be available for in-person care at the Originating Site at least 1 day per week.

- **Prior patient relationship.** Before performing any remote vision care exam service, the provider performing the service must establish a doctor-patient relationship via one of the following means:
 - A prior in-person examination
 - An examination using synchronous remote vision care exams incorporating both audio and visual connections between the provider and member¹
 - Consultation with or referral from another EyeMed participating provider who has established or will establish a doctor-patient relationship with the patient, and who intends to manage the patient's care. If the provider is rarely or never personally at or near the Originating Site, they may establish a relationship with 1 or more participating providers near the Originating Site who are willing to manage the patient's in-person care needs. The selection of such a provider will remain the choice of the member.
- **Quality of care.** Remote vision care exam providers will be held to the same standards of appropriate care as, and the level of care must be equal to, providers offering in-person service.
- **Licensing and credentialing.** The doctor providing the care must comply with state law regarding the need for licensure or registration in the state where the Originating (patient) Site is located as well as the Distant (provider) Site.
- **Informed consent.** Prior to initiation of the remote vision care exam service, the provider must inform the member that the service will be conducted without the optometrist or ophthalmologist being physically present (in-person) and the member must consent to receiving care via remote vision care exam.
- **Privacy and security.** You need to have privacy and security measures in place that meet healthcare industry standards.
- **Audio and video systems.** Remote vision care exam providers must use interactive audio and video telecommunications systems that permit real-time interaction between the patient at the Originating Site and the provider at the Distant Site.

Network terminations and suspensions

Termination and deactivation from Indiana Medicaid

- **Managed care disenrollment.** Deactivation or termination from IHCP, whether voluntary or involuntary, results in your immediate disenrollment from Indiana

¹ <https://www.ama-assn.org/system/files/2018-10/ama-chart-telemedicine-patient-physician-relationship.pdf>

Medicaid and Indiana PathWays for Aging and EyeMed's Indiana Medicaid network.

- **Voluntary termination process from IHCP.** You may voluntarily end your IHCP enrollment at any time. Requests for voluntary deactivation must be submitted via the [IHCP Provider Healthcare Portal](#) or by mail, using the [IHCP Provider Disenrollment Form](#).
 - If "Other" is selected as the reason for deactivation, you must clearly state the reason for the deactivation request.
 - The deactivation date is the date the disenrollment form is signed, unless otherwise requested.
- **Involuntary termination or deactivation from IHCP.** The FSSA or its fiscal agent may deactivate or terminate your IHCP enrollment for the following reasons:
 - License or certification expiration, suspension or revocation;
 - Conviction of Medicaid or Medicare fraud;
 - Violation of federal or state statutes or regulations;
 - Name matched against the following:
 - U.S. Department of Health & Human Services (HHS) Office of Inspector General (OIG) exclusion list
 - System for Award Management (SAM) exclusion list
 - TIBCO MFT (Managed File Transfer)
 - Breach of any provisions in the IHCP Provider Agreement;
 - Returned mail;
 - No claim activity for more than 18 months.
- **Payment for services after IHCP deactivation or termination.** You have up to 90 days from the date of service to file claims for service dates that fall within your eligibility period. Per [IC 12-15-22-4](#), you are no longer eligible for payment for services rendered for dates of service after the date of deactivation or termination from IHCP.
- **Appealing IHCP termination or deactivation.** Under [IC 4-21.5-3-7](#) and [405 IAC 1-1.4-12](#), you have the right to appeal deactivation or termination. To preserve an appeal, you must specify the reason for the appeal in writing and file the appeal with the ultimate authority for the agency within 15 calendar days of receipt of a notification letter.
 - Send the appeal to:

MS07
Office of Medicaid Policy and Planning
Secretary, Indiana Family and Social Services Administration
402 W. Washington St., Room W374
Indianapolis, IN 46204

- For more information, refer to the [IHCP Provider Enrollment Module](#).

Voluntary terminations from the EyeMed network

- **Voluntary termination process.** You can request to be removed from the network, which we call a voluntary termination, with 60 days advance notice by completing our online [Termination of Tax ID or Location form](#).

Involuntary terminations from the EyeMed network

- **Definition of involuntary terminations.** Involuntary terminations occur when we terminate your participation.
- **Reasons for involuntary termination.** EyeMed can involuntarily terminate you for reasons listed in your provider contract or for the following additional reasons:
 - Commission of fraud, waste or abuse.
 - Providing false or misleading information upon initial or subsequent application, credentialing or recredentialing and/or contracting.
 - A pattern or practice of unprofessional or inappropriate conduct toward members.
 - When termination is deemed necessary to protect against the risk of imminent danger to the health or welfare of our members.
- **Involuntary termination process.** In the event of an involuntary termination, you'll receive a written notice specifying the date of termination from the network, any applicable appeal rights and processes.
 - Providers terminated due to license suspensions, terminations or lapses are considered removed from the network as of the date the license was terminated.

Responsibilities upon termination

- **Removal from locator.** Once you're no longer participating on the network, we'll remove your location(s) from our automated locator services effective the day of termination.
- **Claims payment.** We'll process all claims submitted before the termination date and within claim-filing limits.
- **Referrals and follow-up care.** Provide referral instructions for follow-up care or clinical record requests when necessary.
- **Outstanding balances.** You're responsible for paying any outstanding balances owed for lab materials orders or withholds.



Payments

Reimbursements

- **Medicaid fee schedule.** You'll be paid according to the EyeMed Fee Schedule for Indiana Medicaid provided with your contract or contract amendment.
 - You must accept EyeMed's payment in full for services rendered except when authorized by Medicaid.
 - You may not, under any circumstances, seek additional payment from a member nor accept additional payment for covered services or materials, even if the member has signed an agreement to do so.
- **Dispensing fees.** Refer to your Medicaid fee schedule for your dispensing fees.
 - Reimbursement for the dispensing service includes the vision provider's services in selecting, ordering, verifying and aligning/fitting of eyeglasses.
 - Routine follow-up and post-prescription visits (e.g., for minor adjustments) are considered part of the dispensing service and are not separately reimbursable.
 - Safety eyewear options included in the frame kit have the same dispensing fees as dress eyewear.
- **Medically necessary contact lenses.** Refer to your Medicaid fee schedule for contact lens reimbursements.

Non-covered items

- **Charging members for non-covered services.** Per [Code of Federal Regulations, Title 42, Part 447, Subpart A, Section 447.15](#) and [405 IAC 1-1-3 \(i\)](#), you can't charge any IHCP member or the family of a member for any amount not paid for covered services following a reimbursement determination by IHCP.
- **Non-covered items.** You can only bill a member for non-covered services if the member was informed in advance, verbally and in writing, that the service(s) was not covered by Medicaid and the member agrees to accept the responsibility for payment. You should obtain a signed statement or form which documents the member was verbally informed of the out-of-pocket expense.
 - If you don't have a consent waiver, you may use our [Non-Covered Service Fee Acceptance Form](#) as an example.



Claims

Members with medical and vision benefits

Note: This policy is not intended to interfere or infringe on the professional judgment and decision-making of the participating eye care professional providing covered services as defined. All eye care professionals should adhere to their usual and customary coding and billing procedures in accordance with the American Medical Association's Current Procedural Terminology (CPT) coding guidelines, consistent with evidence-based medicine and accepted standards of care for eye care professionals.

In situations where members have eye exam benefits through both their medical and vision plan, network providers should use their professional judgment, as well as chief complaint and case history to determine if services are routine eye or medical eye care.

- **Patients lacking a specific complaint related to a medical condition.** If the **patient does not have a specific complaint related to a medical condition**, it is most appropriate to bill the vision plan (EyeMed) for the routine eye visit.
 - If during a visit where the patient presented without a medical-related complaint you discover the patient has a medical condition and your prescribed treatment plan would require medical eye care, inform the patient of their condition and their need for the diagnostic testing and/or treatment anticipated, then schedule the patient for a follow-up medical eye care visit.
 - Follow-up medical eye care should be billed to the patient's medical plan.
- **Patients requesting vision plan exam based on presenting problem.** If the **patient asks for the exam to be billed to the vision plan based on a presenting problem**, explain to the patient the needed care and coverage/billing options under their medical plan, possible out-of-pocket payments or possible referral options.
- **Patients with no reported medical conditions.** When the **patient reports no medical conditions**, the coverage of services rendered by an eye care professional depends on the purpose of the examination or service and not the ultimate diagnosis of the patient's condition.
 - When a patient goes to their physician for an eye examination with no specific complaint related to a medical condition, the expenses for the

examination are likely not covered under the patient's medical benefit, even though a pathological condition was discovered as a result of the eye examination.

- Under these circumstances, the eye examination should be billed to the vision plan if the patient presented without a specific complaint related to a medical condition.
- If you recommend that the eye care service(s) provided be billed to the patient's medical plan, it must be fully disclosed to the patient as to the reason for the recommendation to bill the medical plan and the possible deductible and/or copay out-of-pocket expenses.
- **Refusal to provide services under the vision plan.** Should an EyeMed member insist that a vision plan claim be submitted and the presenting problem, in your professional judgment, would indicate the need for another service and/or procedure, you may elect to refuse to provide the comprehensive eye examination under the vision plan.
 - Clearly document the reasons for any refusal of care in the patient's clinical record and contact us at 888.581.3648 to inform us of the refusal of care and the reason.
- **Disclosure form.** Following your explanation of the entity to be billed, the patient should acknowledge this explanation by signing a Disclosure Form that states:
 - The medical reason (diagnosis) a claim is being filed with the medical benefit.
 - The potential cost (out-of-pocket expense), which would include the deductible and/or copay. It's understood you may not be able to definitively determine the amount; therefore, listing your usual and customary charges for the service(s) would be an acceptable disclosure.
- **Eye exams covered by medical plan.** If you deem the eye exam would be covered by the medical plan:
 - If you're a participating provider for the patient's medical plan, inform the patient of your participating status.
 - If you are not a participating provider, inform the patient that your practice's usual and customary fees will be charged, and disclose those proposed fees.
- **Referrals to medical providers.** If the patient elects to be referred to a participating medical provider, make every effort to refer appropriately and provide the subsequent professional with all relevant information concerning your findings that will lead to the best possible outcome for the patient.

Coordination of benefits (COB)

COB policies

- **Primary payer.** Medicaid is considered the payer of last resort.
 - Federal regulations require you to bill all identifiable financial resources available for payment, including Medicare, prior to billing Medicaid.

COB process

- **Submitting COB claims.** File COB claims in hard copy using a CMS 1500 form. You must attach a copy of the primary plan's explanation of benefits/remittance advice. Refer to the submitting claims section below for more information.
 - You must include the Medicaid member ID on the paper claim.

TPL guidance

- **Third party liability (TPL).** You are responsible for submitting the member's claim to the potentially liable third party prior to submitting for Medicaid payment. Medicaid funding will be used as a source of payment for covered services only after all other sources of payment have been exhausted and will be the payor of last resort unless specifically prohibited by applicable state or federal law.

If you find:	Then a case member may be eligible for:
A case member is over 65 or blind or disabled	Medicare and Medicare supplemental policies
A case member, absent parent, stepparent, dependent child, new spouse of an absent parent, or anyone else who is legally or voluntarily responsible for a case member is EMPLOYED or UNION MEMBER	Employment-related health insurance
A case member, spouse of a case member, absent parent or stepparent is ACTIVE-DUTY MILITARY or a VETERAN	Military health insurance for active duty, retired military and their dependents coverage
A case member has been in an accident or otherwise accidentally injured: INJURY/TRAUMA/ACCIDENT	<ul style="list-style-type: none">• Workman's compensation• Homeowner's insurance• Automobile insurance• Liability insurance

Submitting claims

Claims submission

- **Claims submission process.** We strongly encourage the use of [EyeMed online claims system](#) for expedited receipt and claims processing for eligible services to. Or, you can submit claims electronically using 837 inbound format through outside clearinghouses.
 - If you decide to use electronic data interface (EDI), you'll be reimbursed according to the fees listed under the Claims Submitted Outside the Online Claims System section of your fee schedule.
 - To begin the process of setting up EDI, contact us at 888.581.3648.
- **Submitting claims for medically necessary services.** If you find a medical reason for an eye exam after these members' eye exam benefits have been used, file the claim using the medically necessary tab in the [EyeMed online claims system](#).
 - Indicate one of the below reasons when submitting the claim:
 - **Prescription (RX)** - Patient has a diopter or medical condition that necessitated a medically necessary lens option for adequate vision correction.
 - **Situational (ST)** - Patient has a circumstantial clinical need that required a specific treatment for adequate vision correction.
 - **Previous Order (PO)** - Patient is unable to wear multi-focal lenses.
 - Refer to our [Medicaid claim filing job aid](#) for more information.
- **Fraud warnings.** A person who knowingly and with intent to defraud an insurer, files a statement of claim containing any false, incomplete or misleading information commits a felony.
- **False Claims Act.** All claims are also subject to [The False Claims Act \(31 U.S.C. §§ 3729 et. seq.\)](#). Any provider who submits false claims, statements, or documents may be prosecuted under applicable federal or state laws.

Timely filing

- **Timely filing.** All Indiana Medicaid and Indiana PathWays for Aging claims must be submitted within 90 days of the date the service is rendered or delivered. 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.
- **Exceptions to timely filing.** Timely filing limits are automatically waived in the instances of eligibility updates/retroactivity, agency error or any other condition established by FSSA in rule or policy.

Claims codes

- **Eye exam codes.** We use CPT codes 92004 and 92014 for eye exams because they describe specific definitions of what a comprehensive eye exam should include.
- **Medically necessary eyewear claims (lenses and replacement pairs).** When filing claims for Medicaid exams and eyewear that require medical necessity, you can use the [EyeMed online claims system](#) but will need to provide additional information. NOTE: Contact lenses follow a different process. Refer to the [Hard Copy Claims section](#) of this manual for instructions.
 - The optometrist or ophthalmologist is responsible for determining the service is medically necessary, appropriate and within the scope of current medical practice and Medicaid limitations.
 - Always include a medical necessity reason code.
 - Indicate the appropriate diagnosis code for a qualifying condition as defined in EyeMed Fee Schedule for [state] Medicaid.
 - Filing [online](#):
 - Use the “Routine” tab in the [EyeMed online claims system](#) for medically necessary lens options on the member’s first pair of glasses.
 - Select the appropriate diagnosis code and reason code on the “Usual and Customary” screen.
 - For replacement eyewear, use the ST code.
 - Use the “Medically Necessary” tab in the [EyeMed online claims system](#) for additional eye exams, replacement eyewear or second pairs of glasses in lieu of bifocals.
- **Refraction code.** Refraction (CPT 92015) is billed separately and is reimbursed separately from the eye exam.
- **ICD-10 code reporting.** We require you to submit **all** applicable ICD-10 diagnosis codes when filing a claim.
 - The [EyeMed online claims system](#) lets you note primary and high-risk diagnoses, including abnormal pupil, age-related macular degeneration, cataract, diabetes, diabetic retinopathy, glaucoma, hypercholesterolemia and hypertension.

Hard copy claims

- **Hard copy claim submission.** Some circumstances may require hard copy claims.
 - If you send us a hard copy claim for materials that should have been submitted to a lab through [EyeMed online claims system](#), we’ll reimburse you according to the Claims Submitted Outside of Our Claims System fee schedule on your network schedules. You’ll be responsible for all lab

and eyewear fabrication costs, and you can't balance bill the member except for member out-of-pocket allowable under the buy-up eyewear program.

- **Medically necessary eyewear claims (lenses and replacement pairs).** When filing claims for Medicaid exams and eyewear that require medical necessity, you can use the [EyeMed online claims system](#) but will need to provide additional information. (Note that contact lenses follow a different process. Refer to the [Contact Lens section](#) of this manual for instructions.)
 - The optometrist or ophthalmologist is responsible for determining that the service is medically necessary, appropriate and within the scope of current medical practice and Medicaid limitations.
 - Always include a medical necessity reason code.
 - Indicate the appropriate diagnosis code for a qualifying condition as defined in EyeMed Fee Schedule for Indiana Medicaid.
 - Filing online:
 - Use the "Routine" tab in the [EyeMed online claims system](#) for medically necessary lens options on the member's first pair of glasses.
 - Select the appropriate diagnosis code and reason code on the "Usual and Customary" screen.
 - For replacement eyewear, use the ST code.
 - Use the "Medically Necessary" tab in the [EyeMed online claims system](#) for additional eye exams, replacement eyewear or second pairs of glasses in lieu of bifocals.
 - Filing in hard copy:
 - When filing paper claims, use the RP reason code modifier only.
 - Include the modifier "RP" along with the V code for medically necessary lens options.
 - Include the modifier "BU" along with the V code for lenses and options purchased as a buy-up.
- **Preferred claims codes.** Use our [Preferred Claims Codes](#) to ensure proper processing. We might also deny codes not on this list based on the member's plan and benefits.
- **Faxing claims.** Fax hard copy claims to 866.293.7373.
- **Mailing claims.** Mail hard copy claims to:
 - EyeMed/FAA
 - PO Box 8504
 - Mason, OH 45040-7111

Voiding and correcting claims

You can correct or void routine eye exam or contact lens by submitting a revised CMS 1500 form to us.

Corrected or voided claim process

- **Online claims system.** Locate and void the claims within the online claims system. Once the claim is voided, you can submit a new claim, if necessary.
- **Faxing corrected or voided claims.** Fax a corrected CMS 1500 form to us at 866.293.7373 with "CORRECTED CLAIM" written on the top.
- **Mailing voided or corrected claims.** You can mail corrected CMS 1500 forms to:
 - EyeMed Vision Care/FAA
 - PO Box 8504
 - Mason, OH 45040
- **Voiding or correcting claims with lab orders.** You can't correct or void claims for eyewear if the lab has already started the order. If you used the lab network and need to cancel the materials portion of a claim, you must void the entire claim.
 - First, call the lab to cancel the order. The lab will confirm if a cancellation is required and process the cancellation if needed. If the lab determines the order doesn't need to be canceled, no further action is needed.
 - Allow 24 hours for the cancellation to flow through our system. If you don't see the member eligibility reopen after 2 business days, please contact the lab to escalate the issue.
 - Once the eligibility is reset to "Yes," proceed by refiling the claim and submitting the correct order.
- **Member eyewear returns.** If a member returns eyewear, the member may be eligible for a free remake depending on the reason for the return.
 - When members return their glasses, we need to know why.
 - **Returns for poor quality or non-adapt.** Refer to our [remake policy](#) to replace the glasses.
 - **Change in frame style or "no questions asked" return policy.** Call us at 888.581.3648 if the member is taking advantage of your practice's "no questions asked" satisfaction guarantee or simply wants to change the frame. We can reinstate the member's benefits at your request, but you'll be charged for the lab work based on [the Lens and Options Chargeback Schedule](#).

Claim payments and withholds

Payments and withholds

- **Claims payments.** A wholly owned subsidiary of EyeMed, First American Administrators, Inc. (FAA), processes all claims.
- **Withholds.** If we overpay you as part of a claim correction or complaint resolution, we'll withhold funds overage from a future payment.
 - Plans for which we administer Medicaid benefits may request withholds if they find errors during audits. We'll notify you if this happens.

Claims payment process

- **Payment turnaround time.** You'll be paid within 30 business days of submitting a clean claim. We'll adjust the claims process timing as required by state law.
 - For 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.
- **Payment frequency.** Claims are paid electronically by FAA at least once per week.
- **Payment methods.** We pay claims by electronic funds transfer (EFT) or check.
 - Use our [online form](#) to sign up for or change any of your direct deposit details, like account number.
- **Remittance advices.** Remittance advices summarize your payments and will show any withholds applied because of incorrect or voided claims. These are available for download from [EyeMed online claims system](#).

Claim denials

- **Denial notification.** If a claim is denied for missing information, we'll send you a letter within 30 days explaining why we denied it, and request that you correct and resubmit it.
 - You'll be paid only when you resubmit the claim within the appropriate timeframe, and the resubmission is accepted.
 - You can collect payment from members for denied claims with member liability *only* if we determine they weren't eligible for benefits at the time of service.
- **Lab charges on denied claims.** If you used the lab network and the materials portion of your claim is denied, you'll be billed for the cost of the materials and any associated lab charges.



Services and materials

Eye exam services

Note: This policy is not intended to interfere or infringe on the professional judgment and decision-making of the participating eye care professional providing covered services as defined.

Covered eye exam services

- **Benefit frequency.** Refer to the [EyeMed online claims system](#) to verify member eligibility and benefit frequency prior to providing services. With attestation of medical necessity, additional routine comprehensive eye exams may be covered.
- **Benefits overview.** Eye exam benefits cover the components listed in our Routine Eye Exam Guidelines, including refraction and dilation. You must follow Federal Trade Commission (FTC) guidelines regarding eyeglass prescriptions, and you must refer patients according to the American Optometric Association standard of care guidelines for any follow-up care resulting from your exam findings.

Refraction and dilation

- **Reimbursement.** We don't reimburse separately for any services included in a comprehensive eye exam (including dilation and refraction).
- **Refraction as part of eye exam.** Refraction is a component of the covered services available to eligible members. It is billed and reimbursed separately from the eye exam.
- **Dilation.** The routine eye exam benefit includes dilation when professionally indicated and performed within 30 days of the initial eye exam.
 - Retinal imaging doesn't replace dilation.
 - You must dilate all members who have diabetes.
 - If the member refuses to be dilated, document the refusal in their patient file.

Second opinions

- **Second opinions.** If a member wants a second opinion, ask them to complete a written request for a second opinion and submit it directly to EyeMed Quality

Assurance at eyemedqa@eyemed.com. We will then reach out to you to request records for the initial visit and to hear your point of view.

Eye exam requirements

- **Eye exam components.** You must provide the services below as part of an eye exam:

Case history

- Chief complaint
- Ocular disease history (including prescriptive and non-prescriptive medications)
- Family history: general and ocular
- Occupational/lifestyle: use of vision; glasses or contact lenses
- General medical history (including medications)
- Allergies, including medication allergies

General patient observation

- Neurological: orientation (time/place/person)
- Psychiatric: mood and affect (depression/anxiety/agitation)

Clinical and diagnostic testing and evaluation

- Examination of orbits
- Test visual acuity
- Gross visual field testing by confrontation or other means
- Ocular motility
- Binocular testing
- Slit lamp examination of irises, cornea(s), lenses, anterior chambers, conjunctivae and sclera
- Examination of pupils
- Measurement of intraocular pressure
- Ophthalmoscopic examination with pupillary dilation, as indicated, of the following:
 - Optic disc(s) and posterior segment
 - Macula
 - Retinal periphery
 - Retinal vessels
 - Vitreous
 - Other examinations (must specify)

Note: Pupillary dilation is required for members with diabetes.

Refraction

- Objective refraction (retinoscopy or auto-refraction) and subjective refraction*
- Resultant best (corrected) visual acuities, distance and near

Color vision testing*

Stereopsis testing*

Case presentation

- Assessment
- Management plan
- Professional reports* (i.e., driver's license, health physical)
- Visual acuities and tonometry findings
- Photographs and findings, if applicable.
- Diagnosis (ICD) codes

ICD-10 diagnosis codes should include diagnosis from the patient's history, the patient's reported medications and/or your clinical findings. List the primary diagnosis first followed by all secondary diagnosis codes determined in the exam (especially those including diabetes, diabetic retinopathy, hypertension and glaucoma).

*As indicated.

Note: In some cases, exam may be completed with other instrumentation because of member limitations.

- **Eyeglass prescriptions.** You must follow FTC guidelines related to the release of eyeglass prescriptions.

Referrals

- **Self-referral services.** Most services in managed care require referral from a primary medical provider (PMP). Self-referral services are an exception. The managed care entity reimburses any IHCP-enrolled providers for eye care services (except surgical services) rendered by a licensed optometrist or physician.

Contact lenses

Covered benefits

- **Medically necessary contact lens benefits.** The benefit covers contact lens materials when medically necessary.
- **Benefit frequency and annual supply limits.** Refer to the [EyeMed online claims system](#) to verify member eligibility, benefit frequency and annual supply limits. Members who qualify can't exceed annual supply limits defined by contact lens manufacturer replacement guidelines.
- **Member out-of-pocket.** You may not bill members for any difference between your retail fees for contact lenses and EyeMed's Medicaid reimbursement.

Components of contact lens fitting/evaluation

- **Initial diagnostic evaluations.** When treating contact lens patients, perform compatibility tests, diagnostic evaluations and diagnostic lens analyses to determine if contact lenses are right for a member, or if their contact lens prescription has changed.
- **Contact lens evaluation requirements.** Your contact lens evaluation must follow the below requirements depending on whether the patient has worn contact lenses in the past.
 - A “new contact lens wearer” is a new patient at your practice, or a patient who hasn’t worn contact lenses in the past 12 months.
 - An “existing contact lens wearer” is a patient who has worn contact lenses within the last 12 months and is an established patient at your practice.

	New Wearer	Existing Wearer
	Required Test (✓)	
Contact lens-related history	✓	✓
Keratometry and/or corneal topography	✓	✓
Anterior segment analysis with dyes	As Indicated	As Indicated
Biomicroscopy of eye and adnexa	✓	✓
Biomicroscopy with lens <ul style="list-style-type: none"> • Fluorescein pattern (rigid lenses) orb. • Movement and/or centration (soft lenses) 	✓	As Indicated
Over-refraction	As Indicated	As Indicated
Visual acuity with diagnostic lenses	✓	As Indicated
Determination of contact lens specifications determined to obtain the final prescription	As Indicated	As Indicated
Member instructions and consultations	✓	✓
Proper documentation with assessment and plan	✓	✓

Follow-up care, training and education

- **Follow-up visits.** The benefit covers unlimited follow-up visits.
- **Training and education.** You can’t charge members additional fees for training and education, which should include written instructions on how to handle, clean, maintain and wear their contact lenses.
- **Trial or adaption period.** The benefit covers a 1- to 3-month trial or adaption period, including a fitting warranty providing for adjustments in the contact lens parameters by exchange or modification of the materials.

Qualifying conditions

- **Minimum qualifications for eligibility.** A member's vision and spectacle prescription must meet the below criteria to qualify for contact lens benefits under the program. Members can't use this benefit for conditions not listed, even if you determine that contact lenses are necessary to correct other vision issues.
 - Members with severe facial deformity who are physically unable to wear eyeglasses.
 - Members who have severe allergies to all frame materials
 - Anisometropia of 3D in meridian powers.
 - High Ametropia exceeding -10D or +10D in meridian powers.
 - Keratoconus when the member's vision is not correctable to 20/25 in either or both eyes using standard spectacle lenses. For the purposes of our benefit, there are 2 types of keratoconus as defined in our ectasia scale.
 - **Emerging/Mild:** Contact lenses in this tier are anticipated to include, however not be limited to, soft toric, rigid gas permeable, scleral, semi-scleral and hybrid designs/materials. The below severity scale applies:
 - Multiple spectacle remakes
 - Unstable topography
 - Light sensitivity/glare issues
 - Signs including Fleischer ring, Vogt's striae and scissor reflex with retinoscopy
 - No scarring
 - Topography (steep K <53D)
 - Corneal thickness >475 microns
 - **Moderate/Severe:** Patients who begin in the emerging or mild categories and are not successful with contact lens materials and keratoconus designs may be elevated into this moderate/severe tier. Contact lenses in this tier are anticipated to include however not be limited to scleral, semi-scleral and hybrid designs/materials. Patients who qualify as moderate/severe will have all of the emerging/mild symptoms, plus:
 - Mild to no scarring or some scarring
 - Topography (steep K of 53D or higher)
 - Corneal thickness up to 475 microns
 - Refraction not measurable
 - Vision improvement other than keratoconus for members whose vision can be improved by 2 lines or more on a standard visual acuity chart

with contact lenses when compared to the best correction attainable with standard spectacle lenses.

Documentation requirements

- **Establishing qualification for benefit.** You're responsible for determining if members meet the qualifying criteria based on your exam and evaluation.
- **Prescription requirements.** The following must be included on a prescription for contact lenses:
 - Complete description of the contact lens(es) parameters.
 - Material of the contact lens(es).
 - Manufacturer of the contact lens(es).
 - Material discard and replacement schedule.
 - Number of lenses required to provide a 1-year supply.
 - Prescription expiration date.
- **Spectacle prescription.** The documented spectacle prescription must support the qualifying condition submitted.
- **Supporting documentation.** We may also ask you for additional supporting documentation.
- **Audits and clinical records reviews.** We'll periodically review clinical records to make sure you're correctly applying the medically necessary contact lens benefit. We'll be checking whether the documented prescription supports the qualifying condition submitted on the original claim.
 - If the clinical record doesn't support the reported condition, we can recoup any overpayment by withholding payment on future claim(s) where law permits.
 - We can consider any inaccurate submission to be a false claim. Falsifying information or filing false claims can result in disciplinary action up to and including termination from our network. We might also have to report it to regulatory and law enforcement agencies as appropriate.

Contact lens materials dispensing requirements

- **Valid contact lens prescription.** Before dispensing contact lenses, make sure the member's prescription hasn't expired and still meets the member's eye health and vision needs before dispensing contact lenses.
- **FTC Fairness to Contact Lens Consumers Act.** You must follow the FTC Fairness to Contact Lens Consumers Act ([15 U.S.C. §§ 7601-7610](#)).
- **Minimum industry standards.** Dispense contact lenses that have been manufactured to meet the most current industry standards.

- **Filling existing prescriptions.** When filling an existing contact lens prescription, make sure the prescription is current and meets the member's vision needs prior to supplying contact lens materials.

Contact lens claims

- **Contact lens claims.** The materials and fit and follow-up services for contact lens benefits must be submitted on 1 claim. File the claim in hard copy following the process below:
 1. Complete our [Indiana Medicaid Medically Necessary Contact Lens claims form](#).
 - Enter a single contact lens fitting code to indicate the qualifying condition.
 - Include a material contact code on the same claim and same date of service.
 - Include the applicable refractive and high-risk diagnosis codes on all contact lens claims.
 - For keratoconus or anisometropia, submit the applicable diagnosis codes listed in ICD-10.
 - When filling out the claim, indicate the member's qualifying condition. CPT procedural codes for contact lens fitting are limited to keratoconus and aphakia. CPT has not designated codes for other qualifying conditions, so you should use the codes listed on our [\[Indiana Medicaid Medically Necessary Contact Lens claims form\]](#) to indicate the qualifying condition:

*Submit a single fit code with a material code on 1 claim with 1 date of service.

2. Fax the completed form to 866.293.7373 or mail to:
EyeMed Vision Care/FAA
PO Box 8504
Cincinnati, OH 45040

Replacement contact lenses

- **Replacement lenses due to loss or damage.** If medically necessary, members are eligible for replacement lenses if the original lenses have been lost, stolen or damaged beyond repair.

Frames and lenses

Eyeglass benefits

- **Frame and lens benefits.** A complete pair of eyeglasses is a Medicaid covered benefit. Refer to the [EyeMed online claims system](#) to see a member's eligibility, benefits, frequency and whether they have any applicable copayments.

Ophthalmic frames

- **Frame collection.** Members must choose an ophthalmic frame from the Medicaid-covered frame collection. After you register with Classic Optical in our system, you'll receive a frame kit (if you don't already have one) to aid members in choosing frames.
 - The collection is for display and try-on use only.
 - Do not send frames to the lab.
 - If a frame manufacturer discontinues production of a frame that is listed as a benefit, you may use the discontinued frame from your sample kit.
- **Previously used frames.** Members cannot use previously used frames. Instead, order a complete pair of eyewear.

Lenses

- **Standard lenses.** We consider standard lenses to be uncoated, CR-39 plastic single vision, bifocals (Round 22, FT 25, FT 35 and Executive) and trifocals (FT-7x28). Any other lens types and options are covered only when medically necessary.
- **Polycarbonate.** Polycarbonate lenses are covered when a corrective lens is medically necessary.
 - Member must have at least 1 of the below to qualify for polycarbonate lenses:
 - Carcinoma in one eye, and the healthy eye requires a corrective lens.
 - Only 1 eye, and that eye requires a corrective lens.
 - Had eye surgery and still requires the use of a corrective lens.
 - Retinal detachment or is post-surgery for retinal detachment and requires a lens to correct a refractive error of 1 or both eyes.
 - A cataract in 1 eye or is post-cataract-surgery, and requires a lens to correct a refractive error of 1 or both eyes.
 - Low vision or legal blindness in 1 eye with normal or near normal vision in the other eye.

- Other conditions for which the optometrist or ophthalmologist has deemed polycarbonate lenses to be medically necessary.
 - In all these situations, 1 or both eyes must be affected by an intractable ocular condition. IHCP covers the polycarbonate lens only to protect the remaining vision of the healthy eye when it is medically necessary to correct a refractive error. Patient charts must support medical necessity. IHCP monitors the use of these lenses in post-payment reviews.
- **Tints.** Per [405 IAC 5-23-4 \(2\)](#), IHCP covers tint numbers 1 and 2 (including rose A, pink 1, soft lite, cruxite and velvet lite), subject to medical necessity. IHCP may reimburse for tints 1 and 2 only, billed with the following procedure code and modifiers:
 - V2745 U1 – Addition to lens; tint, any color, solid, gradient or equal, excludes photochromatic, any lens material, per lens; rose 1 or 2, plastic.
 - V2745 U2 – Addition to lens; tint, any color, solid, gradient or equal, excludes photochromatic, any lens material, per lens; rose 1 or 2, glass.
- **Progressive, transitional and anti-reflective lenses.** If a member chooses to upgrade to progressive lenses, transitional lenses, antireflective coating or tint number other than 1 and 2, you can bill the basic lens V code to the IHCP. You can bill the upgrade portion to the member only if you gave the member appropriate advance notification of noncoverage and if a separate procedure code for the service exists.
- **Anti-reflective treatments.** Anti-reflective treatments are not a Medicaid covered benefit.
- **Oversized lenses.** Oversized lenses are not a Medicaid covered benefit, except when medical necessity is documented.
- **Safety lenses.** The IHCP covers safety lenses only for corneal lacerations and other severe intractable ocular or ocular adnexal disease.
- **Non-prescription lenses.** Non-prescription ophthalmic lenses and frames are not a covered benefit.

Medically necessary lenses and options

- **Covered lens options.** Members qualify for tinted/dyed lenses, UV protection, aspheric and mid-index as a covered benefit only when medically necessary based on the doctor's professional opinion.

Lab network requirements

- **Medicaid lab.** All glasses must be ordered from Classic Optical, *even if you do not normally use the lab network.*

- **Dispensing fees on lab orders.** The dispensing fee is automatically included with the lab transaction and does not need to be entered as a separate transaction or line item.
- **Lab registration.** You must register for Classic Optical before submitting an order. Instructions for registering for a lab are available on our provider portal at eyemedinfoocus.com.
- **Eyeglass cases and postage.** Your reimbursement includes the eyeglass case and any postage.
- **Good financial standing.** You must stay in good financial standing with the network labs, even related to non-EyeMed orders.
 - If you don't stay in good financial standing with labs, your claim may be paid according to the fees listed under "Claims Submitted Outside of Our Online Claim System" on the back of your fee schedules.
- **Online lab ordering.** You must submit all lab orders through [EyeMed online claims system](#).
 - Labs do not accept CMS 1500 forms or 837 inbound.
 - If you submit a hard copy claim for eyewear that should have been ordered through the lab network, you will be reimbursed according to the fees listed under Claims Submitted Outside of Our Online Claims System on the fee schedules you received as part of your contract.
- **Lab responsibilities.** The lab will make lenses based on the member's prescription and options indicated on the claim, insert the lens into the selected frame from the Medicaid collection and ship the completed pair to your office.
- **Frame at lab.** Because Classic Optical will be providing the frames and lenses for non-buy-up purchases, you will submit those lab orders as "Frame at Lab" jobs.
- **Lab order turnaround time.** Classic Optical will ship the product to you within 7 business days from the time the order is submitted.
 - If you do not receive your product within 7 business days, contact Classic Optical.

Emergency eyewear orders

- **Qualifying reasons for emergency eyewear orders.** An emergency occurs when, in your professional judgment, there's a critical patient visual need that cannot be addressed through normal contract lab services. Examples include:
 - A member's safety and/or well-being is at risk without the immediate delivery of prescription eyewear.
 - The member is unable to function at work or school and doesn't have an alternate pair of glasses or contact lenses.

- Lenses or lens options not in our product catalog that you deem necessary based on your professional judgment. When filing an emergency service claim, you'll need to explain your professional justification.
- The member suffers a loss, theft or breakage of prescription eyewear, has no alternate pair and can't wear contact lenses.
- **Ineligible reasons for emergencies.** The following are not considered eligible emergencies:
 - Requests for faster turnaround time for convenience (such as to accommodate trips, vacations or other events).
 - A desire for faster service.
 - When the member has another serviceable pair of glasses or contact lenses.
- **Labs for emergency orders.** You may use a Medicaid qualified lab of your choice, including a non-contracted lab, for emergency eyewear orders. It will be treated as a private pay lab transaction.
- **Emergency eyewear claims.** Submit a CMS 1500 form in hard copy to receive payment according to the amounts listed under the Claims Submitted Outside of Our Online Claims System section on your fee schedules.
- **Balance billing.** Don't balance bill the member for any difference in reimbursement from the schedule if you order a lens that's not in one of our catalogs. You can, however, charge the member for buy-up options as appropriate.

Lab order refunds, returns and remakes

- **Quality.** The ultimate judgment as to the quality of work performed rests solely within your reasonable discretion and any reasonable dissatisfaction on your part will result in the correction of the defect, according to the below policy.
- **Lab errors and remakes.** Remakes for lab errors are processed free of charge up to 6 months from original Rx delivery.
 - Lenses that have been further processed, edged, tinted or coated after delivery to you will not be replaced or accepted for credit, unless you can clearly demonstrate that the unprocessed lens was defective.
- **Process for remakes.** Return the lenses to Classic Optical within 6 months of the original delivery date along with the original invoice/shipping slip, an explanation of why you're returning the lens and any supporting documentation.
- **Reasons for doctor remake.** The below reasons qualify for a doctor remake. In these instances, you will be billed at private pay pricing, or this may also qualify for a replacement/medically necessary pair under the Medicaid plan.

Refer to the [Health plan information section](#) for specific requirements by health plan.

- Power changes (excludes power changes resulting in plano lenses).
- Axis changes.
- Base curve changes.
- Segment height/segment style changes due to non-adaptation, i.e., FT28 to Executive.
- Lens style change, like going from a lower to higher technology like from a bifocal to a progressive.
- Transcription errors, not including transcription errors involving tints, photochromics, frames or coatings.
- Material change.
- **Reasons for a lab remake.** The following reasons qualify for a lab remake:
 - Lab errors.
 - Progressive lenses under warranty.
 - Other frame or lens manufacturing warranties.
- **Manufacturer warranties.** Classic Optical will honor any manufacturer warranties. Any financial issues resulting from the manufacturer's product warranty should be handled between you and the lab.
- **Frame change process.** Members are responsible for the cost to change a frame.
 - Handle it as a private pay transaction.
 - Fax or call the request to the lab.
- **First-time progressive lens non-adapt.** When a member can't adapt to progressive lenses while they're under warranty, the lab will remake the lenses 1 time at no charge in the same design and material (or lesser-priced design and material).
- **Additional progressive lens non-adapts.** If the member still can't adapt to the remade glasses with progressive lenses, request another remake to switch the member back to lined bifocals, but you'll have to pay full invoice cost for this additional remake. If this happens, follow the same remake/return process outlined above. NOTE: This may qualify for a replacement/medically necessary pair under the Medicaid plan.
- **Requests for additional remakes.** Additional requests must be handled as a private pay transaction between you and the lab.
- **Cancellations.** Prescription jobs are considered in manufacturing process as soon as the order has been submitted to the lab. Any cancellation of an Rx job will result in the job being billed to you at private pay pricing.
- **Doctor redos.** You are required to pay for doctor redos on the same job at the full private pay pricing, however, this may qualify for a replacement/medically

necessary pair under the Medicaid plan. Refer to the [Health plan information section](#) for more information.

- **Warranty/non-adapt PALs.** While under warranty, jobs will be processed at no charge. To qualify, you must return the lenses with a copy of the original invoice/shipping slip. Contact the lab directly if you have any warranty questions.
- **Non-adapt.** Varilux will be remade one time at no charge in the same (or lesser priced) design and material. If the patient still can't adapt after the no-charge replacement, the lab will remake the same Rx into conventional lenses at full charge on the invoice. Contact the lab directly if you have any warranty questions.
- **Upgrades.** If you request additional options and the Rx job has to be cancelled and started over (see definition and timing above), EyeMed will be charged for the original cancel job and the new upgraded job will be billed directly to you at private pay rate.

Eyewear warranties and return policies

- **Defective lenses and frames.** Honor manufacturer and lab warranties pertaining to defective lenses and frames.
- **Warranties for frames and lenses purchased through network labs.** Contracted labs will honor all manufacturer warranties. Contact Classic Optical for further information.

Return policies

- **Return policies for lenses purchased from network labs.** Specific [return policies](#) apply to eyewear manufactured through the lab network. Refer to the [lab section](#) for details.
- **Practice return policies.** If you have a specific return policy in place at your practice, you must share it with members when you dispense the eyewear.

Limitations and exclusions

Plan limits and exclusions include:

- Lenses with decorative designs.
- Lenses larger than size 61 millimeters, except when medical necessity is documented.
- Fashion tints, gradient tints, sunglasses or photochromatic lenses.
- Orthoptic or vision training, low vision aids and any associated supplemental testing.

- Aniseikonic lenses.
- Medical and/or surgical treatment of the eye(s) or supporting structures.
- Services provided as a result of any workers' compensation law.
- Plano lenses and plano sunglasses.
- Services or materials provided by any other group benefit plan providing vision care.
- Services rendered after the date an insured person ceases to be covered under the policy, except when vision materials ordered before coverage ended are delivered, and the services rendered to the insured person are within 31 days of such an order.
- Not all materials are available at all provider locations.
- Members can't combine benefits with any discount, promotional offer or other group benefit plans.

We'll notify you of any changes to this list. Indiana Medicaid or the MCE could have other limitations not listed here.



Compliance and Quality Assurance (QA)

Definitions

- **Post-service claim appeal/dispute:** a request for review by the MCE of post-service payment-related claim matters.
- **Clinical appeal:** an appeal is a review by an MCE of an adverse benefit determination.
- **Complaint or grievance:** a complaint or grievance means an expression of dissatisfaction about any matter pertaining to administrative issues and nonpayment related matters.
 - You may access this process by filing a written complaint.
 - Providers are not penalized for filing complaints.
 - Any supporting documentation should accompany the complaint.
- **Claim inquiry:** a question about a claim that does not include a request to change a claim payment.
- **Claims correspondence:** when you receive a request for further information to finalize a claim. Examples include medical records, itemized bills and primary plan explanations of payment (EOP).

Provider post-service claim appeals process

- **Inquiries and correspondence.** Claim inquiries and correspondences are NOT considered claim appeals. If you have questions concerning these, call 888.581.3648 for assistance.
- **Claims appeals.** A claim must be submitted prior to following this process.
 - If your claim has been finalized but you disagree with the amount you were paid or the denial of your claim, you may request a post-service claim appeal.
 - If you are not satisfied with the payment of your submitted claim, you are entitled to a review (appeal) of the claim determination. To obtain a review, submit your request in writing to:
 - Provider Appeals Coordinator
 - EyeMed Vision Care
 - 4000 Luxottica Place

Mason, OH 45040

Fax: 513.492.3259

eyemedqa@eyemed.com

- **Appeals timing.** Your request for an appeal must be submitted within 180 days of the date of your Remittance Advice.
- **Timely filing requests.** EyeMed will consider reimbursement of a claim that has been denied due to failure to meet timely filing deadlines only if you can provide proof of submission within the timely filing limits, or if you can show good cause.

Provider audits

Audit overview

- **Reasons for audits.** EyeMed is required to demonstrate that members receive quality eye care. Audits and associated reporting let us provide data that demonstrates consistent eye care that meets specific standards.
- **Healthcare Effectiveness Data and Information Set (HEDIS) audits.** We help collect HEDIS data through HEDIS audits. Please provide all appropriate diagnosis codes as well as CPT I and CPT II procedures. Examples of applicable CPT II codes:
 - 2020F
 - 2021F
 - 2022F
 - 2023F
 - 2024F
 - 2025F
 - 2026F
 - 2033F
 - 3072F
- **Disciplinary actions.** Audits could result in disciplinary actions as justified by the findings.
- **Audit selection.** Our Quality Assurance team selects participating providers and/or locations for facility, clinical, financial and/or process audits.
- **Scoring process.** Professional reviewers score each clinical record to determine an average.
- **Medicaid audits.** Refer to the Provider Manual for your state's Medicaid program for audit processes related to Medicaid programs.

Types of audits and scoring

Evaluation type	What we're looking for	Scoring
Facility	<ul style="list-style-type: none"> • Areas of physical access, instrumentation and overall facility condition • 2 sections: Required equipment and facility environment 	Required equipment: <ul style="list-style-type: none"> • 100% required to pass Facility section: <ul style="list-style-type: none"> • 100 – Excellent • 99 to 70 – Satisfactory • Less than 70 – Progressive Disciplinary Action
Clinical records	<ul style="list-style-type: none"> • Assessment of member records • Financial evaluation 	<ul style="list-style-type: none"> • 100 to 90 – Good to Excellent • 89 to 70 – Satisfactory • 69 to 0 – Fail: Progressive Disciplinary Action
Financial	<ul style="list-style-type: none"> • Financial document evaluation reviews claims against payment and member records • Financial claim evaluation reviews a provider and/or location's claim history to reveal billing patterns 	<ul style="list-style-type: none"> • 100 – Excellent • 99 to 80 – Satisfactory • 79 to 0 – Fail: Progressive Disciplinary Action
Process	<ul style="list-style-type: none"> • Review of clinical and business practices for a specific reason, such as adherence to clinical coverage criteria or application of a benefit and compliance with lab ordering, In-Office Finishing and emergency service policies 	<ul style="list-style-type: none"> • 80% required to pass
HEDIS	<ul style="list-style-type: none"> • Collection of HEDIS data to assess and compare quality of care 	NA

Audit process

- **Record availability.** You must make members' clinical, financial and administrative records available to us or other authorities that are reviewing quality of care at no charge to us or the member.
- **Audit documentation submission.** You will be asked to submit all audit documentation through a secure online form in the timeline indicated on the audit request. Your audit request letter will include the link for the online form.
- **Consequences for non-response.** If you don't respond to our requests for information within the specified time, it may result on an automatic corrective action plan or we will take action to recoup the reimbursements on those audited claims.

- **Forwarding address upon leaving network.** If you leave your practice or our network, provide us with a forwarding address so members can get copies of their clinical and administrative records if needed.

Audit disciplinary action

Noncompliance level	Reasons
Level 1 noncompliance	<ul style="list-style-type: none"> • Non-response to QA request or notice • Billing and/or claim filing errors • Lower than expected quality of service and/or materials, standards of optometric care and/or professional behavior • Failure to follow our quality, contractual or administrative protocols • Violating the terms of our Provider Agreement
Level 2 noncompliance	<ul style="list-style-type: none"> • Continued Level 1 noncompliance • Provider/member conflict: if your practice requires Provider Appeal, Peer Review or QA intervention
Level 3 noncompliance	<ul style="list-style-type: none"> • Continued noncompliance with our rules and standards that includes a “notice of involuntary termination” review from the Peer Review

- **Timing to respond to equipment failures.** If you fail an equipment evaluation, you’ll have 10 business days to correct any issues or face disciplinary action. We’ll remove you from the network if you don’t respond or correct equipment issues within 30 days.
- **Member refunds.** If we determine the member is due a refund, and you don’t reimburse the member or reinstate their benefit, we may reimburse them on your behalf and deduct the amount from future payments to your account, where permitted by law.
- **Corrective action plans.** You may be subject to re-evaluation or a corrective action plan if you fail or score less than “excellent” on audits. Facility audit failures are subject to accelerated disciplinary action, and the corrective action plan must be completed within 30 days.
- **Overpayment collections.** If we find any overpayments during a financial record audit, we’ll collect the overage from future claim payments as allowed by law.
- **Fraud, waste and abuse violation disciplinary actions.** For suspected fraud, waste or abuse, additional actions, including involuntary termination, may be taken.

Fraud, Waste & Abuse (FWA) prevention

Overview

EyeMed follows the Centers for Medicare and Medicaid Services (CMS) requirements and other industry standards related to preventing FWA. Our FWA prevention goals are:

- To effectively pursue the prevention, investigation and prosecution of healthcare FWA.
- To recover overpayments on behalf of our clients.
- To comply with state and federal regulations and clients' requirements for preventing fraud.

Medicaid FWA prevention

- **Medicaid FWA oversight.** In accordance with [42 CFR 455](#) and [405 IAC 1-1.4-5](#), if OMPP Program Integrity receives a complaint of Medicaid fraud or abuse from any source or identifies any questionable practices, it must conduct a preliminary investigation to determine whether there is sufficient basis to warrant a full investigation. Program Integrity will determine if there is a credible allegation of fraud (CAF). A CAF may be an allegation that has been verified by the state of Indiana, from any source, including but not limited to the Fraud hotline or claims data mining. Program Integrity refers all CAFs to Indiana MFCU for a full investigation for potential criminal or civil prosecution.
- **Member fraud or abuse.** Member utilization review identifies members who use IHCP services more extensively than their peers. Members may be selected for utilization review based on their claim history. Reviews can also be initiated due to reports of potential overuse or abuse from various sources, such as providers and other agencies.

Reporting FWA

You are required to report all cases of suspected FWA, inappropriate practices and inconsistencies of which you become aware within the Medicaid program.

- **Reporting FWA to EyeMed:**

EyeMed Special Investigation Unit

EyeMed Vision Care

4000 Luxottica Place

Mason, OH 45040

eyemedSIU@eyemed.com

Submit anonymously at luxotticaspeakup.com or calling 888.88S.EEIT (888.887.3348).

- **Report to the Office of Medicaid Inspector General (OMIG).** Call 877.873.7283 or [reporting it online](#).
- **Reporting FWA to IHCP/OMPP Program Integrity staff:**
MS07
OMPP Program Integrity 402 W. Washington St., Room W374
Indianapolis, IN 46204
800.457.4515, option 2
Program.Integrity@fssa.in.gov
- **Reporting FWA to health plans.** You are required to report suspicious behavior and incidents of FWA to any health plans you are contracted with. Refer to the [Health plan information section](#) for contact information.

Reporting abuse, neglect or exploitation of a member

- **Who must report.** Indiana is a mandatory report state, meaning everyone is required by law to report cases of suspected neglect, battery or exploitation (ANE) of an endangered adult to an APS unit or law enforcement.
- **Policies and procedure requirements for ANE.** You must have policies, protocols and training to ensure your staff:
 - Can recognize and screen members for signs of abuse, neglect, self-neglect and exploitation as defined in [455 IAC. 2-4-2](#); [455 IAC. 1-2-2\(g-h\)](#).
 - Screen of members for ANE; screening tools must be verified by the National Center on Elder Abuse or must be another evidence-based tool approved by the State.
 - Identify members who may be at risk of abuse, self-neglect and exploitation and in need of adult protective services (APS) or the services of the State Long-Term Care (LTC) Ombudsman or the Indiana Department of Health.
 - Support at-risk members, families, informal caregivers and guardians with resources on ANE prevention, including informal caregiver education and support and strategies to reduce member and informal caregiver social isolation.
 - Understand reporting requirements and report incidents involving member abuse, neglect, self-neglect and exploitation consistent with [IC 12-10-3-9](#).
 - Refer members- at risk or in need of services to the appropriate resource including the LTC Ombudsman, or other appropriate agency, such as an Area Agency on Aging.
 - Report within 24 hours to the state regarding incidents of ANE, including interventions underway and anticipated intervention.

- Update the member's care plan as needed to balance member needs for safety, protection, physical health and freedom from harm with overall quality of life and individual choice. Each issue of safety and risk shall be incorporated individually into the member's care plan.
- Ensure that members, families, informal caregivers and guardians and staff are provided educational materials on ANE prevention, recognition and reporting with training materials that are approved by the state.
- Follow-up to ensure that member needs are addressed on an ongoing basis.
- Follow up on intervention success will be done within a week and will be reported to the state.

Consequences of identified FWA

Identified FWA may result in *some or all* of the following:

- Provider education and warning.
- Monitoring of the provider's submitted claims activity and/or implementation of a Corrective Action Plan.
- Comprehensive provider audit and/or quality review of the provider's claim activity.
- Withholding of the provider's claim payments or demand for restitution for recovery of overpayments.
- Termination of the provider from the network.
- Reporting of suspected fraudulent activity to comply with state and federal regulations and/or clients' requirements.
- Medicaid program suspension.
- Educational contact to correct minor infractions, such as:
 - A letter from the IHCP detailing the inappropriate action.
 - A visit by an IHCP Provider Relations field consultant.
 - A visit by IHCP Program Integrity staff to explain program guidelines related to medical necessity and intensity and appropriateness of service, or to assist with administrative aspects of the program.
- On-site or in-house audit of medical records.
- Recoupment of improper reimbursements due to incorrect billing, insufficient or missing documentation, or lack of medical necessity for services rendered.
- Prepayment review of IHCP claims because of serious billing errors that show consistent lack of knowledge of IHCP rules, or lack of desire to abide by those rules.
- Referral for possible administrative sanctions for continuing noncompliance.
- Referral to the MFCU for further investigation and possible criminal or civil prosecution.

Annual training requirements

You must complete upon joining the network and annually by December 31 compliance training related to FWA awareness. We must report compliance with these requirements to the health plans for which we are administering routine vision benefits.

Your requirements

- **Who must take training.** The requirement applies to:
 - Everyone working within your location.
 - Anyone who has at least a 5% ownership in your business.
 - Anyone to whom you subcontract work.
- **Training topics.** Training should cover the following topics:
 - FWA prevention.
 - Compliance Program Effectiveness (federal).
 - HIPAA (federal and state privacy).
 - Information Security (federal OCR & state).
 - Cultural competency.
- **Additional topics.** Additional topics could be added in compliance with CMS requirements or state law.
- **Consequences for non-compliance.** You could be subject to disciplinary action and will be out of compliance with CMS or state regulatory agencies if you don't complete this process.

Annual training process

- **Annual training period.** We'll notify you when the annual training period is open.
- **Training sources.** For Information on training sources and attestation, please visit our [annual training instructions](#) page.
- **Training attestation.** Once the training has been completed by everyone in your practice, you must attest that you meet the requirement(s) by logging in to the [online claims system](#), selecting Provider Portal, then selecting My EyeMed, My Resource, then Annual Training.

Returning to the network after involuntary termination by EyeMed

Waiting period and approval

- **One year waiting period.** If you're involuntarily terminated from the network and wish to reapply, you can do so after 1 year subject to approval by our QA department and the probationary period.

Application process

- **Application for returning to network.** You can request to reapply to the network in writing. Your request must acknowledge the reason for your termination and provide evidence of how you've addressed the issue that caused your removal from the network. You must also be in good financial standing with EyeMed and all affiliated entities.
- **Approval process.** Our Peer Review Subcommittee reviews reapplication requests from providers who were previously involuntarily terminated.
- **Next steps if approved.** If approved, you will:
 - Need to reapply to the network.
 - Be subject to network and credentialing rules and requirements at the time of reapplication.
 - Be under probation for 12 months following reinstatement.
- **Next steps if denied.** If your request to reapply is denied, we'll let you know why and explain the requirements to successfully re-enter the network. You may reapply again after 1 year following denial.

Probationary period

- **Probationary period conditions.** If approved to re-join the network, you'll be admitted for a 12-month probationary period, during which you:
 - Agree to additional audits at your expense to monitor compliance with all EyeMed participation criteria and your corrective action plan.
 - Must utilize the EyeMed lab network unless prohibited by state law.
 - Must attest annually that all staff members have completed a minimum of 10 hours of continuing education related to proper coding, billing and/or FWA prevention.
- **Consequences for non-compliance during probationary period.** If you don't comply with all rules and standards during the probationary period, EyeMed can immediately terminate you from the network.

- **Readmittance after probationary period.** If you do comply with all rules and standards during this period, EyeMed will readmit you to the network in the same manner as all providers.
- **Circumstances prohibiting re-entry.** Some situations prohibit re-entry,



Health plan information

EyeMed administers routine and/or medical/surgical eye care services for Medicaid members enrolled in the following health plans:

- **CareSource (Healthy Indiana Plan and Hoosier Healthwise)**

In addition to the manual above, please read below for important plan-specific provisions.



CareSource

About CareSource

CareSource plans in Indiana

CareSource in Indiana offers routine vision benefits to **Medicaid** members in the **Healthy Indiana Plan (HIP)** and **Hoosier Healthwise (HHW)** plans.

CareSource provider manual

Although relevant provisions are summarized here as appropriate, you are contractually obligated to adhere to and comply with all the terms listed in the [CareSource Indiana Medicaid provider manual](#).

Interacting with CareSource members

Member ID cards

Each CareSource member is issued an identification card. Members should show the card when they need care. HIP and HHW members will have slightly different cards.

- **Healthy Indiana**

CareSource **HIP**
 Member Name: Jeff Doe
 Member ID (MID): 1480000000-00
 Member Services:
 1-844-607-2829 (TTY 1-800-743-3333 or 711)
 Member Services Hours:
 7 a.m. CT/8 a.m. ET - 7 p.m. CT/8 p.m. ET
 Monday - Friday

CareSource innovations
 RxBIN - 003858
 RxPCN - MA
 RxGRP - RXINN01

EMERGENCIES:
FOR EMERGENCIES CALL 911 OR GO TO THE NEAREST EMERGENCY ROOM (ER)
 For non-emergency visits to the ER, an \$8 copay may apply. If your health event is not life-threatening and you are not sure about going to the ER, call the RNs at **CareSource24[®], Nurse Advice Line for help** at 1-844-206-5947 (TTY: 1-800-743-3333 or 711).

BEHAVIORAL HEALTH CRISIS LINE: 1-833-227-3464
ESI PHARMACY HELP DESK: 1-800-416-3632
PROVIDER SERVICES: 1-844-607-2831
 Other co-payments may apply. Review member handbook or contact Member Services for specific amounts.

IN-MED-M-3556199

- **Hoosier Healthwise.**

CareSource **Hoosier Healthwise**
 Member Name:
 <First> <Last>
 Member ID (MID):
 <MID #>
 Member Services:
 1-844-607-2829 (TTY 1-800-743-3333 or 711)
 Member Services Hours:
 7 a.m. CT/8 a.m. ET - 7 p.m. CT/8 p.m. ET Monday - Friday

CareSource innovations
 RxBIN - 003858
 RxPCN - MA
 RxGRP - RXINN01

EMERGENCIES:
FOR EMERGENCIES CALL 911 OR GO TO THE NEAREST EMERGENCY ROOM (ER)
 If your health event is not life-threatening and you are not sure about going to the ER, call the RNs at **CareSource24[®], Nurse Advice Line for help** at 1-844-206-5947 (TTY: 1-800-743-3333 or 711).

BEHAVIORAL HEALTH CRISIS LINE: 1-833-227-3464
ESI PHARMACY HELP DESK: 1-800-416-3632
PROVIDER SERVICES: 1-844-607-2831

IN-MED-M-3674254

Member rights and responsibilities

- **Member handbook.** Members are urged to read the [CareSource member handbook](#).

Member assistance

- **Transportation services.** Transportation (ride) benefits are included for members in HIP or HHW Package A. Members can get unlimited rides and mileage repayment for various services. Members should call 844.607.2829 (TTY: 800.743.3333 or 711) for a ride at least 2 business days before their visit. For more information and transportation policy, refer them to the [CareSource member handbook](#).

Documentation and record-keeping requirements

- **Access to records.** CareSource Enterprise Quality Improvement may contact you to request medical records. CareSource is authorized to ask for PHI for health care operations, which includes quality issue reviews. You are expected to return medical record requests related to quality-of-care concerns within 14 days from the initial request. For more information, refer to your [CareSource provider manual](#).
- **Record-keeping requirements.** You must maintain medical and other records of all medical services provided to members for seven years, in accordance with Indiana Code (IC) 16-39-7-1. CareSource medical records standards are consistent, to the extent feasible, with NCQA accreditation standards for medical records. The records must at least be legible and must include the following:
 - Patient identification information (patient name or identification number) on each written page or electronic file record
 - Personal biographical data
 - Entry date
 - Provider identification
 - Allergies
 - Past medical history
 - Immunizations
 - Medical information
 - Consultations
 - Referrals
 - Medical conditions and health maintenance concerns
 - Written instructions for living wills or durable power of attorney for health care when the patient is incapacitated and has such a document
 - A record of outpatient and emergency care

- Specialist referrals
- Ancillary care
- Diagnostic tests and findings
- Prescriptions for medications
- Inpatient discharge summaries
- Histories and physicals, including a list of smoking and chemical dependencies, including alcohol, legal and illegal drugs (member consent required to share substance use information)
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services
- Laboratory and X-ray tests and findings
- **Member access to records.** Members have the right to request and receive a copy of their medical records and request to amend or correct the record at any time.

CareSource provider requirements

Provider rights and responsibilities

- **Provider manual.** You should read the [CareSource provider manual](#).

CareSource claims

CareSource coordination of benefits (COB)

- **Primary payer.** Medicaid is considered the payer of last resort.
 - Federal regulations require you to bill all identifiable financial resources available for payment, including Medicare, prior to billing Medicaid.

CareSource COB process

- **Submitting COB claims.** File COB claims in hard copy using a CMS 1500 form. You must attach a copy of the primary plan's explanation of benefits/remittance advice. Refer to the submitting claims section below for more information.
 - You must include the Medicaid member ID on the paper claim.

CareSource routine services and materials

CareSource vision coverage

CareSource members have access to vision coverage as listed below. You must verify the member's benefits using the [EyeMed online claims system](#). CareSource members are eligible for:

- **Eye Exam.** 1 comprehensive eye examination every year for members under 21 and every 2 years for members 21 and older.
- **Pair of glasses.** 1 pair of eyeglasses once every year for members under 21 and every 5 years for members 21 and older.
- **Repair/replacements.** Replacement eyeglasses are covered when medically necessary for CareSource members when eyeglasses have been lost, stolen, or broken beyond repair.
- **Contacts.** Medically necessary contact lenses.
- **Value Added Benefit.** Members 21 and older may receive 1 funded retinal image per calendar year.

Compliance and quality assurance (QA)

Provider appeals, complaints and grievances

- **Written provider appeals, complaints and grievances.** For routine administrative grievance and appeals cases, you may send written appeals, complaints and grievances to the following:
EyeMed Vision Care
Attn: Quality Assurance Dept.
4000 Luxottica Place
Mason, OH 45040
Fax: 513.492.3259.
Email: AGeyemed@eyemed.com
- **Verbal provider appeals, complaints and grievances.** Verbal cases are managed through our Customer Service department at 888.581.3648. Our normal business hours are:
 - Monday through Saturday from 8 am to 11 pm ET.
 - Sunday from 11 am to 8 pm ET.

Medicaid fraud, waste and abuse (FWA)

- **FWA information.** You can find more information about CareSource policies regarding FWA in the [CareSource provider manual](#).

- **Reporting suspected FWA.** You can report your suspicions of fraud, waste or abuse to the CareSource Program Integrity department. For more ways to report, refer to the [Reporting FWA section](#) above.
- **Report to anonymously to CareSource** by calling the CareSource Program Integrity Department at 844.415.1272.
 - When you report FWA, please give as many details as you can, including names and phone numbers. You may remain anonymous, but if you do, CareSource will not be able to call you back for more information. Your reports will be kept confidential to the extent permitted by law.

888.581.3648

www.eyemedinfoocus.com



IN-MED-P-4966731
Issued Date: 05/21/2026
OMPP Approved: 05/01/2026
© 2026 CareSource. All Rights Reserved