CENTENE™

VISION SERVICES

2026

Provider Manual

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SECTION I: WELCOME

Welcome to Centene Vision

Welcome to Envolve Vision, doing business as Centene Vision Services. We value your involvement in our health plan network of participating providers and look forward to working with you to deliver quality vision benefits with a high level of member satisfaction.

This manual will provide the necessary reference material to answer frequently asked questions and contains information regarding filing claims, as well as an overview of our website.

Provider Affairs Mission Statement

All programs, policies, and procedures are designed with our mission statement in mind:

"A company committed to excellence by building and sustaining quality provider partnerships through innovation, communication, and education to support our clients."

Background

Centene Vision has provided comprehensive and affordable eye care services since 1986. Our number one objective is keeping the "care" in our eye care program. Through exclusive agreements with national and regional managed care organizations, Centene Vision providers deliver all forms of eye care to members in both commercial and government-sponsored healthcare programs.

About This Manual

Centene Vision is committed to working with our provider community and members to provide a high level of satisfaction in delivering quality healthcare benefits. We are dedicated to providing comprehensive information through this provider manual as it relates to our operations, benefits, and guidelines to providers. In doing so, we will make our provider manual available to providers via the Centene Vision website and upon a provider's request. We will post changes to the provider manual on our website or provide applicable state-required prior written notice of material changes to the provider manual. Please contact us if you need further explanation on any topics discussed in this manual.

Providers may contact us online or by phone as shown in *Appendix: Plan Specifics*. Our Customer Service standard office hours are from 8 a.m. to 8 p.m., unless otherwise indicated in the plan specifics.

Update Your Email Address

Providers can update the email address for their practice by completing a form available online at centenevision.com.

Welcome to the Centene Vision network!

SECTION II: GENERAL INFORMATION

Website Overview

The Centene Vision website can significantly reduce the number of telephone calls providers need to make. Gain immediate access to current provider and member information 24/7. Our website is located at centenevision.com.

Common Links

Home Page	centenevision.com
Eye Health Manager (secure provider portal)	centenevision.com/logon
Vision Policies	centenevision.com/policies
ID Card Copies and Phone Numbers	centenevision.com/mystate
Commonly Used Provider Forms	centenevision.com/forms
Find A Vision Provider	centenevision.com/fap

Access to Eye Health Manager

Participating providers have access to the secure online portal, Eye Health Manager. Username and password information is included in the provider welcome letter or upon request. The Eye Health Manager is available at centenevision.com/logon. Upon initial login, the provider will be prompted to assign an email address to the username before allowing access to Eye Health Manager tools and resources.

Provider Tools (refer to your plan specifics for state Medicaid variances, as applicable):

- Verify member eligibility and benefits.
- File claims.
- Review claim status
- Download, research, and reprint Explanation of Benefits (EOB)/Explanation of Payments (EOP).
- Request/Submit secure, HIPAA-compliant pre-authorization.

Provider Resources:

- Provider Manual
- Plan Specifics
- Policies and Procedures
- Forms
- Educational Webinar Schedule

- Group Benefit Information
- Newsletters
- Announcements

Rights and Responsibilities

Providers

Providers have the right and responsibility to:

- Have access to information about our Quality Improvement program, including program goals, processes, and outcomes that relate to member care and services.
- Contact us with any questions, comments, or problems.
- Make a complaint or file an appeal against us and/or a member.
- File a complaint on behalf of a member, with the member's consent.
- Not discriminate against members on the basis of age, sex, race, color, religion, sexual orientation, and/or national origin, disability, mental or physical disability, or limited English proficiency.
- Provide clear and complete information to members, in a language they can understand, about the health condition and treatment, regardless of cost or benefit coverage, and allow the member to participate in the decision-making process.
- Maintain the confidentiality of member's personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality.
- Give members a notice that clearly explains their privacy rights and responsibilities as it relates to the provider's practice/office/facility.
- Provide members with an accounting of the use and disclosure of their personal health information in accordance with the Health Insurance Portability and Accountability Act (HIPAA).
- Allow members to request restriction on the use and disclosure of their personal health information.
- Provide members, upon request, access to inspect and receive a copy of their personal health information, including medical records.
- Allow a member who refuses or requests to stop treatment the right to do so, as long as the member understands that by refusing or stopping treatment the condition may worsen or be fatal.

- Allow members to appoint a parent, guardian, family member, or other representative if they cannot fully participate in their own treatment decisions.
- Follow all state and federal laws and regulations related to member care and member rights.
- Participate in payor data collection initiatives, such as Healthcare Effectiveness Data Information Set (HEDIS®) and other contractual or regulatory programs. [HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).]
- Review clinical practice guidelines.
- Disclose overpayments or improper payments to us.
- Provide members, upon request, with information regarding office location, hours of operation, accessibility, and languages spoken, including the ability to communicate with sign language.
- Notify us of any demographic changes.
- Follow our established policies and procedures as well as those established by the payors.
- Receive prompt payment for clean claims.
- Resubmit a claim with additional information.
- Obtain information regarding the status of claims.
- Ensure disclosure form is signed for non-covered service(s) by all parties prior to rendering service(s).
- Disclose to us any provider or professional corporation ownership interest in any independent ancillary facility prior to referring members.

Members

These member rights and responsibilities are established by Centene Vision. This list is not all-inclusive. Centene Vision acknowledges member rights and responsibilities of its payors and will adhere to member rights and responsibilities, if listed, in the plan specifications. Please refer to the individual payor's member handbook or evidence of coverage document for the full list of member rights and responsibilities.

Members have the right to:

- Access all covered services.
- Participate in making decisions regarding vision health, regardless of cost or benefit coverage, including the right to refuse treatment.
- Make a complaint or file an appeal against us and/or a provider.

- Request and receive a copy of member's medical record.
- Request that the member's medical record be corrected.
- Expect that the member's medical record and care be kept confidential as required by law.
- Exercise these rights without adversely affecting the way Centene Vision and its network providers treat the member.
- Allow or refuse personal information be sent to another party for other uses unless the release of information is required by law.
- Receive timely access to care.

Policies and Procedures

Under the Provider Participation Agreement, providers have agreed to follow policies and procedures established by Centene Vision as well as the guidelines outlined in this provider manual. Pertinent Centene Vision policies are posted at centenevision.com/policies. The provider may request copies of our policies by calling Customer Service at the number listed in *Appendix: Plan Specifics*.

Provider Performance Standards

Providers are expected to maintain high standards of member/patient care, well-documented and legible records, and a state-of-the-art facility. Providers should ensure member satisfaction and avoid generating complaints, over-utilization, unbundling, or upcoding of procedures.

Provider performance is continually monitored through ongoing quality assessment, trending analysis, and utilization review.

Providers failing to meet established quality standards of care or service may be placed on review status, sanctioned, or terminated, depending on the significance of the deviation. If we determine that there is a possibility of a health risk to a member, we have the undisputed right to place the participation privileges of the provider's office involved on a temporary suspension pending review. Quality of care issues are referred to the Peer Review Committee.

Access to Care

The following accesses to care standards have been established for optometrists and ophthalmologists by our Quality Improvement Committee:

Appointment Wait Time

Routine Eye Examination	Within two weeks

Sub-Acute Problem	Within two weeks
Chronic Problem	Within four weeks
Urgent (Not life-threatening, but a problem needing care within 24 hours)	Within the same business day (24 hours in TX)

Time in Waiting Room

Scheduled	After 30 minutes, patient must be given an update on waiting time with an option of waiting or rescheduling appointment; maximum waiting time is 60 minutes
Work-ins[1]	After 45 minutes, patient must be given an update on waiting time with an option of waiting or rescheduling; maximum waiting time is 90 minutes

[1] Called that day prior to going to the provider office

Response Time Returning Calls after Hours

Urgent	20 minutes
Other	One hour or next working day based on circumstances

Availability

Office Hours	Posted business hours
After Hours	24 hours/day coverage for medical/surgical eye care

Acceptance of New Members

Providers accepting new members may not discriminate based on coverage. Provider must supply 30 days written notice to us before no longer accepting new members.

Specialty Care

Members requiring specialty care should be directed to a participating provider.

Medical Office Space

Provider agrees that the medical office space will be maintained in accordance with our policies and procedures, as well as with applicable federal and state laws. Our policy is available via the Eye Health Manager at centenevision.com/logon.

Verification of Member Eligibility

Providers should verify member eligibility prior to delivering service at each visit. Members are not required to present a Member ID card to receive covered services. Presentation of a Member ID card does not guarantee eligibility. For examples of each health plan's member ID cards, please visit the applicable state page on our website.

To verify member eligibility, please use one of the following methods:

1. **Log on to Eye Health Manager.** Our secure provider portal (centenevision.com/logon) lets you search by date of service and either of the following: Member name and date of birth, or member ID and date of birth. Our secure portal lets providers access a list of eligible members who have selected their services or were assigned to them.

2. **Call the automated member eligibility IVR system.** Call Customer Service from any touch-tone phone and follow the appropriate menu options to reach our automated member eligibility-verification system 24 hours a day. The system prompts you to enter the member ID and the month of service to check eligibility.

3. **Call Centene Vision Customer Service.** If you cannot confirm a member's eligibility using the methods above, call Customer Service. Follow the menu prompts to speak to a Customer Service representative to verify eligibility before rendering services. Customer Service will need the member name, member ID, and date of birth to verify eligibility.

Eligibility changes can occur throughout the month. Please use one of the above methods to verify member eligibility on the date of service. Verification of eligibility is not a guarantee of payment. Payment can be made only after the claim has been received and reviewed in light of eligibility, medical necessity and other limitations or exclusions. Additional rules may apply to some benefit plans.

Medical Records

Recordkeeping Requirements

Centene Vision requires all providers to maintain sound medical record-keeping practices that are consistent with industry standards and the Provider Participation Agreement. Records must be legible, current, detailed, organized, and comprehensive to ensure effective patient care and quality review. Medical records need to be

identifiable by the member or family name and accessible to the provider as services are rendered.

With the exception of TX, we do not require the provider to use specific forms for medical record documentation. Various professional organizations have created templates that can improve documentation processes. We encourage use of standardized forms for documentation to improve continuity and coordination of care for members.

Audits

Centene Vision may audit record-keeping practices and individual member records in conjunction with ongoing quality improvement activities or as a result of member complaints.

We encourage providers to request medical records that document care previously provided to members who are new to the provider's practice. This will assist in ensuring the member receives continuous care, as well as help determine the most appropriate course of treatment.

Confidentiality

Providers must maintain confidentiality of medical records and treatment information in accordance with state and federal laws including the Health Insurance Portability and Accountability Act (HIPAA). Medical records should be kept in a secure location, accessible only by authorized personnel. Providers must annually train their staff about member information confidentiality.

Health Insurance Portability and Accountability Act (HIPAA)

To improve the efficiency and effectiveness of the healthcare system, HIPAA, Public Law 104-191, includes Administrative Simplification provisions that require the United States Health and Human Services Department to adopt national standards for electronic healthcare transactions, code sets, unique health identifiers, and security. Centene Vision has the responsibility to protect the privacy of personally identifiable health information by adhering to all federal and state laws, industry standards, and professional ethics.

Centene Vision complies with all federal and state laws and regulations relating to HIPAA and expects network providers to adhere to HIPAA rules as well. We require all contracted practitioners' offices to maintain and follow appropriate policies and procedures to ensure the confidentiality of member records and information. For additional details about HIPAA, visit the U.S. Department of Health and Human Services' website.

HIPAA Security Rules and Applications

Confidentiality: Protected Health Information (PHI) and electronic PHI (e-PHI) are not disclosed or available to unauthorized persons.

Centene Vision asks provider office callers for their name, Tax ID number and/or NPI number to verify identity. Callers requesting patient information must also provide member name, date of birth, and member ID or Social Security number before we share member-related information.

Integrity: e-PHI is not altered or destroyed in an unauthorized manner.

Patient data should be backed up to prevent loss in case of system crashes. Controls should be in place to identify data changes due to human error or electronic failures. Clinical notes cannot be modified or deleted, but addendums can be added. Patients have the right to ask for a change in their medical records.

Availability: Data or information is accessible and usable upon demand by an authorized person.

We enable only authorized, registered users to access the provider portal containing patient information. The portal is available 24/7.

Protect against threats or disclosures: Potential threats or disclosures to e-PHI that are reasonably anticipated must be identified and protected.

All email correspondence that includes patient name and personal health details must be sent via secure email**. Providers should always encrypt emails containing patient details when initiating an email to us.** Centene Vision can initiate a secure, encrypted email to providers who can then reply while maintaining the security of the email. Call Customer Service for details.

In addition, the email subject line should not contain member name or ID. That information should be included only within the body of the email that is sent securely. Remember to employ the minimum necessary rule when submitting member data. This means using only the specific data required when submitting documents and other information to us. Please ensure that any supporting documentation you submit has been redacted to include only the minimum necessary. For example, if submitting an Explanation of Payment (EOP) as evidence for an appeal, please be sure to only include the information for the member in question and redact any other member data.

Staff compliance: People employed by provider offices and health plans (covered entities under HIPAA) adhere to rules.

At least one staff person must be designated as a security official responsible for implementing HIPAA requirements, ensuring training is completed by all staff upon

hiring and annually, overseeing compliance, and carrying out appropriate sanctions for violations.

Source: Department of Health & Human Services

Notice of Privacy Practices

Centene Vision follows privacy practices established by HIPAA and other state and federal guidelines.

Our Notice of Privacy Practices is available on our website at centenevision.com.

National Provider Identifier (NPI)

The NPI is mandated by HIPAA. It is a unique identification number used by healthcare providers when submitting claims for reimbursement. Providers, payors, and healthcare clearinghouses are required to use the NPI numbers in the administrative and financial transactions specified by HIPAA. The NPI contains information about the healthcare provider, such as the type of healthcare provided or the state where the healthcare provider is located; and does not include embedded identifiers. The NPI must be used in connection with the electronic transactions identified in HIPAA. The NPI does not:

- Replace state-issued licenses and certifications verifying a provider's licensing or qualifications.
- Replace Social Security Number, Individual Tax ID number, or Employer ID for tax purposes.

The NPI number can be accessed by visiting the Centers for Medicare & Medicaid Services (CMS) website and typing in National Provider Identifier (NPI) into the search option. This will bring up options to apply for an NPI number.

Member Liability

Providers are responsible for collecting all copayments, coinsurance, or deductibles applicable to covered services provided to members according to *Appendix: Plan Specifics* from members.

Centene Vision reimburses only services that are medically necessary and covered through the health plan program. Providers are not allowed to "balance bill" for covered services if the provider's usual and customary charge for covered services is greater than our fee schedule.

Providers may collect fees associated with non-covered services from the member, if applicable, based on the member's benefit program. The member must be advised of and acknowledge in writing any non-covered vision services rendered by the provider. The generic (not state-specific) Non-covered Services Liability Acknowledgement form is

located on our provider portal at centenevision.com/logon. Please note that some states require a state specific Non-covered Services Liability Acknowledgement Form. This form must be maintained in the member's medical record.

Prescriptions

Drugs

If applicable, providers have the responsibility to abide by the prescription formulary or preferred drug list designated by the payor when prescribing medications for members.

Corrective Lenses

Providers are required to release written prescriptions for corrective lenses unless this requirement contradicts state law.

Referrals

Primary Care Physician Referrals

Centene Vision does not typically require Primary Care Physician (PCP) referrals for in-network eye care. If a referral is required, details are included in the *Appendix: Plan Specifics*. Please indicate any referring, ordering, prescribing or attending providers in the claims or encounters submission as applicable.

Reporting to Primary Care Physicians

When applicable, the provider should partner with the PCP to deliver specialty care to members. A key component of the provider's responsibility is to maintain ongoing communication with the member's PCP.

Providers should supply a complete written report of findings to the member's PCP within one week following examination and treatment. If urgent or emergent follow-up is required, the provider shall provide a verbal report to the member's PCP within 24 hours.

Provider Practice/Office Information Changes

Providers must notify us when a change occurs in the provider's practice/office by using the Provider Update Form. This form allows us to maintain accurate information about the provider's practice. We use this data when processing provider claims and updating its payors for the purposes of developing and maintaining their provider directories.

Examples of changes include:

- Moving office location(s)
- Opening another office
- Changing the business name and/or Tax ID number
- Removing providers from an office location only*

*Please refer to the **Voluntary Termination from the Network** section of this manual for information related to removing providers from Centene Vision's provider panel.

The Provider Update Form is available on our website at centenevision.com/logon. We must receive all applicable changes 30 days in advance of the effective date.

When adding a provider to an existing practice, please contact Network Management at the phone number listed in *Appendix: Plan Specifics*.

Marketing — Name, Symbol, Service Mark

If prior written approval is obtained, provider, Centene Vision, and the payors have the right to use each other's names, symbols, and service marks for the use of provider directories or for marketing purposes.

Non-Disparaging Language

Providers must refrain from making false, misleading, or inaccurate statements relating to Centene Vision or its payors. Disputes are to be handled between us and the provider. Providers may reference the Quality Improvement Program for more details on the complaint process.

Provider Credentialing/Re-credentialing

Credentialing

To become a participating provider, all applicants must be fully credentialed and approved by our Credentialing Committee. The credentialing and re-credentialing process helps maintain a high-quality healthcare delivery system by validating the professional competency and conduct of providers. This includes verifying licensure, board certification, education, and identification of adverse actions, including malpractice or negligence claims, through the applicable state and federal agencies and the National Practitioner Data Bank. Participating providers must meet the criteria established by each health plan, as well as government regulations and standards of accrediting bodies.

We perform this process for most of our network providers; however, some states (including GA, IL, NC, MS and OH) contract with a vendor to provide a centralized credentialing verification process. This section is specific to the Centene Vision credentialing and re-credentialing process; please refer to your state's documentation for those states who perform this process separately.

Providers who want to join our Provider Network must meet the following criteria for eligibility:

- The optometrist or ophthalmologist must be currently licensed to practice his/her profession in the state and within the service area of the plan, if applicable. Optometrists and ophthalmologists must hold a therapeutic

pharmaceutical agent certification and DEA/DPS/BNDD Certification, if applicable in that state, to be considered for medical/surgical panels.

- The provider must agree to meet the standards of care and service as specified by the appropriate quality committees within Centene Vision. At the time of re-credentialing the provider profile (report card) information must meet or exceed our Quality Assurance requirements. The following items are reviewed: adverse events, member complaints, unprofessional behavior, utilization patterns, and quality of care issues.

- The optometrist or ophthalmologist must maintain professional liability coverage in the amounts required by Centene Vision. The minimum requirement is $1 million per occurrence and $3 million aggregate or as required by state law. Providers must not have a history of denial of liability coverage.

- Ophthalmologists that are not board certified are restricted to routine care only at the time of credentialing. A provider who is registered to sit for the boards will be given a two-year grace period to complete and pass the oral and written exams. The provider must notify us in writing within one month of the pass or fail of each exam. Should the provider fail an exam and not become board certified within the two-year grace period, Centene Vision will terminate the provider upon receiving notification.

- Optometrists and ophthalmologists must have no unresolved disciplinary reviews or restrictions relating to his/her license. The Credentialing Committee will assess resolved disciplinary reviews.

- Ophthalmologists must have clinical privileges that are in good standing at the hospital designated as the primary admitting facility, if applicable. They must have admitting privileges at a participating facility or a statement of inpatient admission coverage from on file. Surgery centers are not acceptable.

- Providers must not have greater than six months of unaccounted time gaps in work history.

- Ophthalmologists must have graduated from an accredited medical school and have completed an accredited residency. Optometrists must have graduated from an accredited optometry school.

- Providers should not have significant sanctions reported through Medicaid, Medicare, or appear on the Office of Inspector General's List of Excluded Individuals and Entities.

- Providers must not have a history of criminal conviction or indictment.

- Providers must not be engaged in the use of illegal drugs or in treatment for substance abuse.

Centene Vision does not discriminate against providers who serve high-risk populations or who specialize in the treatment of costly conditions. We do not discriminate against providers based on age, sex, race, religion, sexual orientation, and/or national origin. To avoid any possible discriminatory actions, Credentialing Committee members are provided the minimal information required to make a decision.

As a standard practice of Centene Vision, a provider candidate has the right to review information submitted in support of their credentialing application. A provider candidate also has the right to correct erroneous information submitted or information obtained by a primary source agency. A provider also has the right to be informed of the status of their credentialing/re-credentialing application. Any questions pertaining to this notice should be directed to the Centene Vision Credentialing Unit.

Re-credentialing

All providers are re-credentialed every 36 months unless otherwise required by the health plan. Please refer to plan specifics under Provider Credentialing, as applicable. Reminder notices are distributed three months and one month prior to the expiration of the provider's credentials.

Voluntary Termination from the Network

Providers may voluntarily terminate from our network according to the Provider Participation Agreement. For a termination request to be approved, a written notice of intent to end participation must be mailed to us. For your convenience, providers may fill out and submit the *Provider Termination from Panel Request* form on our website at centenevision.com/forms. Additionally, providers are obligated to make available, upon request, member records to facilitate the transfer of care.

Providers must continue to provide service to members until the termination effective date and until such time as we are able to transfer members to another participating provider. Please refer to our Participating Provider Agreement for written notification time frames.

SECTION III: CLAIMS

Centene Vision is committed to equipping providers with the best tools possible to support their administrative needs for filing and processing claims. This section is specific to the Centene Vision claims process; please refer to your state's documentation for those states who perform this process separately.

Filing Claims

Providers can file claims online via the Eye Health Manager at centenevision.com/logon, electronically via Change Healthcare, or by mail.

Eye Health Manager

Providers are allowed direct data entry into our claim system. This method of filing provides immediate confirmation of claim receipt. Access to the site is restricted and password protected. Contracted providers may obtain a username and password. To become contracted, please contact Network Management at 800-531-2818; choose option 4.

Change Healthcare

Providers may submit claims electronically through Change Healthcare using Payor ID number 56190, listed as Centene Vision. The Payor ID# should be placed in 2010BB Loop/NM109 segment. Use "PI" as the ID Code Qualifier in NM108. Place the rendering Provider ID in 2310B Loop/REF02 segment. Use "N5" as the Reference Number Qualifier in REF01. To set up an account to submit claims electronically, call Change Healthcare at 800-845-6592.

Mail

All claims submitted to us by mail for payment must be filed on an original CMS 1500 form. Forms must be completed and legible for payment processing.

Mailing Address:

Centene Vision, Inc.
[Insert Health Plan Name]
PO Box 7548
Rocky Mount, NC 27804

Faxing Claims

We do not accept faxed claims unless mandated by state-specific legislation.

General Filing Guidelines

Centene Vision follows all CMS claims submission guidelines and HIPAA coding standards. The following guidelines must be followed when submitting a claim to us.

- All claims must be received within the claim-filing period defined within *Appendix: Plan Specifics*. We strongly encourage submission as soon as services are rendered. If not received within the claim-filing period, we will deny the claim for late submission.

- All services provided must be included on the CMS 1500 claim form. Billed amounts should be consistent with the provider's usual and customary charges.

- File claims with the correct subscriber ID number, including the correct alpha prefix or suffix, if applicable.

- File claims under the subscriber's name on the ID card, not his or her nickname.

- Claims must include the referring or ordering provider information in Items 17, 17a, and 17b of the CMS 1500 form or the equivalent electronic and Eye Health Manager field.

- Claims must include Tax ID number in Item 25 of the CMS 1500 form or the equivalent electronic and Eye Health Manager field. This number should be the Tax ID number or Social Security number reported to us on the provider's W-9.

- Claims must have the provider's name/signature in Item 31 of the CMS 1500 form or the equivalent electronic field. We will return the claim if we are unable to read the provider's signature. Do not submit a facility or practice name in the signature field.

- Claims must have the address or physical location where services were rendered in Item 32 of the CMS 1500 form or the equivalent electronic field if different from provider billing address as listed in Item 33.

- Providers must submit their NPI number in Item 24J of the CMS 1500 form or the equivalent electronic field.

- Claims should be filed using current, valid, and appropriate diagnosis codes, and should be coded to the highest level of specificity available.

- Proper sequencing order of the diagnosis codes must be etiology followed by manifestation in Item 21 of the CMS 1500 form or equivalent electronic field. The diagnosis pointer in Item 24E must reference the primary reason for performing the service in the first position.

- When a member presents for a routine eye examination with no complaints, regardless of the final diagnosis, the provider must file the visit as a routine eye examination. Subsequent services to treat the medical diagnosis may be filed as medical visits. The coverage of services rendered by a provider is dependent on the purpose of the examination rather than on the final diagnosis.

- Providers must submit medical records and a dictated letter signed by the servicing provider detailing the reason for performing the service when billing modifier 59 to bypass National Correct Coding Initiative edits.

- Use current valid CPT/HCPCS service codes. If there is no suitable CPT/HCPCS service code or if the CPT/HCPCS service code is unlisted, give a complete description in Item 19 or the equivalent electronic field.

- Use current valid CPT/HCPCS modifiers when necessary.

    - When multiple modifiers are billed on a single service line on a claim, use modifier 99 in Item 24D and place the additional modifiers directly after modifier 99.

    - When using modifier 50 to indicate a bilateral service was performed, submit 1 billed unit in Item 24G or the equivalent electronic field.

- Indicate how many times each service was performed and make sure the units are consistent with the CPT/HCPCS service code.

- Claims must contain a pre-certification or referral number if applicable in Item 23 of the CMS form or the equivalent electronic field.

- When submitting an accident diagnosis, include the date that the accident occurred in Item 14 of the CMS 1500 form or equivalent electronic field.

- When documenting significant changes in vision and/or requesting replacement eyewear (if applicable for payor) indicate the previous and current prescriptions in Item 19 of the CMS 1500 form or equivalent electronic field.

- When filing for Coordination of Benefits, submit the primary insurance information in Items 9a – d of the CMS 1500 form or the equivalent electronic field. A copy of the primary EOB/EOP should accompany the CMS 1500 form when filing for Coordination of Benefits.

- Paper claims must be filed using the following guidelines or the claim may be returned for corrections:

    - Use only an original red-ink-on-white-paper CMS 1500 claim form. Faxed and/or copied claims are not accepted as a claim submission.

    - Submit typed or computer-printed forms.

    - Do not print, handwrite, or stamp additional information on the form.

    - Do not staple, clip, or tape anything to the claim form.

- Do not use liquid white-off. Use only lift-off correction tape when making corrections.
- Do not use highlights, Post-it notes, labels, or stickers.
- Claims forms must be clear and legible.
- Include the payor name in Item 11c on the claim form.
- Handwritten claims are not accepted. If your office is unable to meet this standard, contact Customer Service and/or Network Management at the phone numbers listed in *Appendix: Plan Specifics*.

- Claims (initial filings, resubmissions, and/or appeals) may require additional information that must accompany the CMS 1500 form for the claim to be considered a "clean claim." The following is a listing of attachment/description requirements:
  - A description on a full sheet of paper or write a description in Item 19 of CMS 1500 form for 92499, V2599, or any other unlisted procedure.
  - Referral forms do not need to be submitted with the claim, unless indicated in *Appendix: Plan Specifics*.
  - An invoice for consideration of wastage for Botox injections, if applicable.
  - A copy of the optical lab invoice and prescription when billing for non-standard eyewear (frames and lenses) and/or additional lens features (i.e., high-powered index lenses, polycarbonate lenses, etc.), if applicable.
  - Office notes/medical records/operative notes signed by the rendering provider for changes in diagnosis, procedure codes, or rendering provider.

Place of Service Codes

The provider must use the standard place of service codes as defined by CMS when requesting authorizations and filing claims for payment. A current list of the valid place of service codes may be viewed on the CMS website.

Modifiers

The provider must use the standard modifier codes; CPT codes as defined by the American Medical Association and the HCPCS codes as maintained by the CMS when requesting authorizations and filing claims for payment. A current list of the valid modifier codes may be viewed on the CMS website.

Claims Processing

Coordination of Benefits

When a member is covered by more than one payor, we will coordinate benefits with other plans to reduce the member's out-of-pocket expenses. Centene Vision adheres to the coordination of benefits regulations set forth by the National Association of Insurance Commissioners as adopted by the state where the service is rendered.

When we are the secondary payor, the primary payor information is required for calculation of the secondary payment. When submitting claims electronically or through the website, the appropriate coordination of benefit field(s) must be completed. The provider may also submit a clean CMS 1500 form and a copy of the EOB from the primary payor.

Third Party Liability/Coordination of Benefits

Third-party liability refers to any other health insurance plan or carrier (for example, individual, group, employer-related, self-insured or self-funded, or commercial carrier, automobile insurance, or worker's compensation) or program that is or may be liable to pay all or part of the healthcare expenses of the member. Medicare is always primary to Medicaid coverage.

Centene Vision providers shall make reasonable efforts to determine the legal liability of third parties to pay for services furnished to health plan members. Providers must submit the claim to the primary insurance for consideration and submit a copy of the Explanation of Benefits (EOB) or Explanation of Payment (EOP), or rejection letter from the other insurance when the claim is filed. If this information is not sent with an initial claim filed for a member, the claim will pend and/or deny until this information is received.

After receiving the primary insurer's EOB, submit a claim for any remaining balance to us with the EOB statement within the regulatory guidelines for the applicable state and product.

For EDI submissions, indicate the Primary Carrier information along with the Other Carrier payment amounts per service line. Please attach a copy of the Primary Carrier EOB.

Payments to providers will not exceed the contracted rate in the provider agreement. Claims are considered paid in full when the primary insurer's payment meets or exceeds the contracted rate.

If the provider is unsuccessful in obtaining necessary cooperation from a member to identify potential third-party resources, the provider shall inform us that efforts have been unsuccessful. We make every effort to work with the provider to determine liability coverage.

If third-party liability coverage is determined after services are rendered, we coordinate with the provider to pay any claims that may have been denied for payment due to third-party liability. If Centene Vision is aware of other coverage information which is primary coverage, we will deny any claim submitted without the accompany EOB from the primary payer. The provider may resubmit their claim according to the process above after the primary payer has processed the claim.

Global Surgical Period

Centene Vision follows CMS global period guidelines for all surgical services. The global periods are indicated in the National Physician Fee Schedule, available on the CMS website. Reimbursement for surgical procedures includes:

- Pre- and post-operative visits
- Patient's history and physical
- Any inpatient visits
- Complications following surgery
- Local and topical anesthesia administered by the physician
- Intra-operative services
- Supplies

Major surgeries have a one-day preoperative period and a 90-day postoperative period. Minor surgeries have either a zero or a 10-day postoperative period. Providers in the same group practice are covered under a single global fee for pre- and postoperative services.

Co-management of Care

When a provider, other than the surgeon, is providing the pre/postoperative care, it must be documented at the time of the pre-certification request and billed accordingly using the guidelines below.

Co-management of care requires the following:

- Co-management services must be indicated at the time of the pre-certification request, including the co-managing provider.
- The surgeon should bill for the surgery only using modifier 54.

Providers should bill the preoperative portion of the global period using the following guidelines:

- Date of service must be the date the surgery was performed.
- The claim must include the surgical procedure code, including modifier 56.

Providers should bill the postoperative portion of the global period using the following guidelines:

- Date of service must be the date the surgery was performed.
- The claim must include the surgical procedure code, including modifier 55.
- Indicate assumed and relinquished dates in Item 19 of the CMS 1500 form or electronic equivalent.

Non-covered Services

Non-covered services vary by payor; refer to the *Appendix: Plan Specifics* for details.

After-Hours Office Visit

Centene Vision does not reimburse providers for this service, because it is considered by the CMS to be a "bundled" service. Bundled services are not payable, nor should they be reported, even when performed incidental to or in combination with another service.

Telehealth Consultations

Telehealth coverages vary by state and plan; telehealth claims should be submitted with indication of Telehealth and only services which could be completed remotely.

Billing for Missed Appointments

Centene Vision does not cover charges for missed appointments. Commercial and Medicare members may be billed for missed appointments only if this is the standard office procedure, the member has previously received a written statement of this procedure, or it is posted in a prominent location in the office.

Medicaid members may not be billed for missed appointments.

Verifying Claim Status

Claim status can be obtained via the Eye Health Manager at centenevision.com/logon.

Correcting Claims

A corrected claim is defined as a claim that is being re-filed with necessary, additional information that enables the proper adjudication of the claim. In most instances, the original claim was initially submitted without all proper elements necessary to process the claim, resulting in a denial for additional information.

Corrected claims must include all services rendered on the date of service. Include the appropriate Resubmission Code and original claim number in Item 22 of the CMS 1500 claim form or equivalent electronic field or indicate CORRECTED CLAIM and the original claim number on web.

Payment of Claims

Providers have the following two options to receive payments:

Mail

Providers will receive checks by mail with or without the EOB/EOP Statement depending upon their specified preference.

Electronic Funds Transfer

Centene Vision has partnered with PaySpan Health to deliver Electronic Funds Transfers (EFTs), Electronic Remittance Advice (ERAs). PaySpan Health is a free solution to enable online presentment of remittance/vouchers, straightforward reconciliation of payments to empower our providers to reduce costs, speed secondary billings, improve cash flow, and help the environment by reducing paper usage. Instructions to register for PaySpan Health are below.

How to Register for PaySpan

- Call 877-331-7154, Option 1 from 8 a.m. to 8 p.m. ET for your unique registration code.
- Go to payspanhealth.com and click the **Register Now** button.
- Enter your Registration Code and click **Submit**.

Payment Methodologies

Centene Vision complies with all applicable prompt payment laws regarding the processing and payment of clean claims. Covered procedures are subject to our payment methodologies for both commercial and government sponsored programs based on: Medicare Physicians Fee Schedule, The National Correct Coding Policy Manual for part B Medicare Carriers, and local Medicare Carrier Policies in addition to our coding guidelines. These guidelines are intended to incorporate and, in specific instances, include the requirements of CMS guidelines. Additional resources for payment methodologies administered by us may include, but are not limited to:

- American Medical Association's CPT Manual
- American Academy of Ophthalmology Preferred Practice Patterns
- State Medicaid Guidelines
- Input from board-certified doctors of ophthalmology
- Current medical literature

Payment Discrepancies

The provider should call the Customer Service number listed in the plan specifications when a payment discrepancy is discovered.

When we notice that an overpayment has been made, a written request for reimbursement will be sent to the provider. Adjustment(s) on future EOB/EOP will be made if reimbursement is not received within 45 days from the date of the request and funds are available for retraction.

Incorrect payments made on governmental programs (Medicaid and Medicare) may be retracted without prior written notification.

Claim Appeal Process

Medicaid, Exchange, Health Insurance Marketplace

Providers may appeal a claim that has been denied in whole or in part for disputes relating to claim payments or non-payments.

Non-Medicare claim appeals must be submitted with the following information:

- A completed CMS 1500 form for claim in question.
- A completed Claim Appeal Request Form from centenevision.com/forms.
- A copy of the EOB/EOP in which the claim in question is listed.
- Any other documentation (primary explanation of benefit, authorizations, referrals, etc.).
- Corrected claims should not be submitted as an appeal.

Centene Vision accepts claim appeal requests by email at visionappealsandrecons@centene.com or by mail. The claim appeal mailing address for non-Medicare claims is:

Centene Vision
Attn: Claim Appeal
PO Box 7548
Rocky Mount, NC 27804

Medicare

All Medicare appeals or claim reconsiderations must be received within 120 days of the date of the Explanation of Payment (EOP). Submissions must include documentation of the original claim or remittance notification showing the denial, any clinical records, and other documentation that supports the provider's argument for reimbursement. Please call Customer Service with any questions.

Medicare Claims Reconsiderations

Contracted providers do not have Medicare appeal rights; however, Centene Vision has a reconsideration process for review of any contracted provider claim issues. To request a reconsideration of a Medicare claim, providers should mail the documentation listed above as indicated below or email the request to visionappealsandrecons@centene.com.

Medicare Provider Appeals

Non-contracted providers have Medicare appeal rights. Requests for appeals must be accompanied by a completed and signed Waiver of Liability (WOL) statement; along with the above documentation mailed to the applicable address as indicated in the applicable plan specific. The WOL statement can be found at: Model Waiver of Liability form | Guidance Portal (hhs.gov). Requests for payment appeals must be filed within 60 calendar days of the Explanation of Payment (EOP).

For additional information on the appeal process, refer to policy and procedures available on our website, centenevision.com.

SECTION IV: UTILIZATION MANAGEMENT

This section is specific to the Centene Vision Utilization Management process; please refer to the member's health plan provider documentation if the member's medical benefit is responsible for coverage of surgical or medical vision services.

Clinical Criteria and Decisions

Centene Vision has established clinical criteria for determining medical necessity. All clinical criteria are evaluated annually by the Medical Directors through a formal process. The Quality Improvement Committee also reviews and approves the clinical criteria annually.

We utilize the most recent editions of the following references to annually re-evaluate all clinical criteria, in addition to input from board certified doctors of ophthalmology, including but not limited to:

- American Academy of Ophthalmology Preferred Practice Patterns
- American Medical Association CPT Manual
- National Correct Coding Initiative Edits
- Medicare Physician Fee Schedule
- Current medical literature

Clinical policies are published on our website, centenevision.com/policies.

Utilization Management decisions are based on appropriateness of care, service, and existence of coverage. Centene Vision does not reward individuals conducting utilization reviews for issuing denials of coverage or service. Financial incentives for Utilization Management decision makers do not encourage decisions that result in underutilization.

The provider, in conjunction with the member, is responsible for making all clinical decisions regarding the care and treatment of the member. Centene Vision's Medical Directors are responsible for making medically necessary decisions in accordance with covered benefits and established criteria. Failure to obtain authorization for services that require approval will result in payment denials.

Authorizations

Services requiring authorization vary by the member's health plan contract; please refer to *Appendix: Plan Specifics* for details.

Centene Vision accepts authorization requests through our Eye Health Manager at centenevision.com/logon, by fax, or by mail. The Pre-authorization Request form is available on our website. Changes to previously authorized services require approval and must be submitted by fax with applicable supporting documentation.

Authorizations – Ocular Injectables

When covered benefits, Centene Vision requires pre-authorization for all anti-VEGF ocular injectables other than bevacizumab (Avastin®). The Anti-VEGF Pre-authorization Request Form, along with supporting medical records documenting that the member has met all approval criteria, must be submitted for a pre-authorization request to be considered. This form and information can be found on our website, centenevision.com/forms.

Authorization will last for 12 months and will be tied to the rendering physician. Should the patient need to receive treatment for a longer period of time or through a different provider, an additional pre-authorization must be obtained. Retrospective authorization requests following claim denial may not be approved.

Many payors use a drug formulary or designated pharmaceutical vendor. The payor's website should be referenced prior to writing a prescription.

Out-of-Network Eye Care Services and Facilities

Centene Vision coordinates out-of-network care for members when delegated. Out-of-Network care may be approved if there are no participating providers or facilities to provide the necessary care. All requests should be submitted using the Pre-authorization Request form located on our website, centenevision.com/forms. Requests are considered for the following situations, but are not limited to:

- Prior surgery was performed, and continuing care is medically necessary for continuity.
- Interruption in the treatment plan would jeopardize the member's recovery time.

Providers should use participating facilities whenever possible. For non-participating facility approval, the Facility Name & Address field of the form should be completed in full by the rendering provider and faxed to the number provided on the form. If the payor does not approve the requested facility, we may deny the requested service depending upon health plan requirements.

Utilization Management Appeals

Providers will receive specific instructions within their denial letter on how to file an appeal for a denied authorization. In most cases, providers must file authorization appeals with the member's health plan acting as an authorized representative. Expedited appeals may be filed when the time allowed to process a standard appeal could jeopardize the life and health of the member. Find more in the Eye Health Manager provider portal, centenevision.com/logon, under Provider Resources, Policies and Procedures.

Emergency Care

Centene Vision defines emergency care as any healthcare service provided in a hospital emergency facility (or comparable facility) to evaluate and stabilize medical conditions of recent onset and severity (including severe pain), if such condition would lead a prudent

layperson (possessing an average knowledge of medicine and health and acting prudently) to believe that failure to get immediate medical care might result in:

- Placing the person's health in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part
- Serious disfigurement
- In the case of a pregnant woman, serious jeopardy to the health of the fetus

Emergency room/urgent care services do not require preauthorization.

Centene Vision will follow payor and/or state required language in reference to emergency care if it varies from the above definition. Check the Plan Specifics for specific payor information. If more information is required in reference to policies and procedures, please refer to our website, centenevision.com/policies.

Assistant Surgeon

Centene Vision allows assistant surgeon services for procedures identified by CMS as potentially requiring an assistant surgeon. Providers must submit a Pre-authorization Request form for both the primary surgeon and the assistant surgeon for all services that require authorization.

Routine Eye Examination

When performing a preventive (routine) eye examination, the eye care provider performs a complete visual system examination, including history, examination, diagnosis, and initiation of management. Included within each part of the evaluation is a series of tests particularly suited for the detection, diagnosis, and initiation of appropriate therapy for eye disorders.

The exam elements listed below are basic areas of evaluation and are not meant to exclude additional exam components that might be appropriate.

- History
- Assessment of relevant aspects of patient's mental and physical status
- Visual fields by confrontation
- Best corrected visual acuity (with refraction[1] when indicated)
- External examination
- Pupillary function
- Ocular alignment and motility
- Slit-lamp biomicroscopy examination
- Intraocular pressure measurement

- Fundus examination (generally requires dilated pupils unless contraindicated, slit-lamp, and diagnostic lenses)

[1]Refractions are separately reportable unless specifically included with the description of a service (e.g., S0620 & S0621).

EPSDT

When applicable, providers should submit diagnoses and relevant clinical documentation demonstrating medical necessity under our clinical policies or relevant clinical documentation with services they believe are medically necessary under applicable Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements.

Fraud, Waste, and Abuse Prevention

Centene Vision takes the detection, investigation, and prosecution of fraud, waste and abuse very seriously. CMS definitions for FWA are defined as follows:

Fraud: Intentional deception, misrepresentation or omission made by someone with knowledge that it may result in benefit or financial gain. Examples of fraud:

- The health plan is billed for services never rendered.
- Documents are altered to gain a higher payment.
- Dates, descriptions of services, or the beneficiary's identity are misrepresented.
- Someone falsely uses a beneficiary's ID card.

Waste: Providing medically unnecessary services.[1,2] Includes any practice that results in unnecessary use or consumption of financial or medical resources due to inefficiency. Example of waste:

- Providers submitting duplicate claims/services without allowing time for claim to be completed.

Abuse: A practice inconsistent with accepted business or medical practices or standards that results in unnecessary costs. Examples of abuse may include:

- Billing for services that were not medically necessary.

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[1] Module: 10 Medicare and Medicaid Fraud and Abuse Prevention, 2014 National Training Program, Centers for Medicare & Medicaid Services

[2] Medicare Fraud & Abuse: Prevention, Detection, and Reporting, Centers for Medicare & Medicaid Services, August 2014

- Charging excessively for services or supplies.
- Misusing codes on a claim, such as upcoding or unbundling codes.

The primary difference between fraud and abuse is intention.

We perform ongoing claims audits that may result in taking actions against those providers who, individually or as a practice, commit waste, abuse, and/or fraud. These actions include but are not limited to:

- Remedial education and/or training to prevent the billing irregularity
- More stringent utilization review
- Recoupment of previously paid monies
- Termination of provider agreement or other contractual arrangement
- Recommendation of civil and/or criminal prosecution
- Any other remedies available

Fraud, Waste and Abuse Training

Centene Vision expects all providers and staff who provide services to complete FWA Training within 30 days of hire and annually thereafter. Training is available via Education (centenevision.com), or a comparable training will be accepted. Providers should be prepared to provide evidence of training completion if requested for auditing purposes. We expect all providers and staff to comply with applicable laws and regulations, including but not limited to the following:

- Federal and State False Claims Act
- Whistleblower Protection Act
- Healthcare Fraud Statute
- Anti-Kickback Statute
- Physician Self-Referral Law (Stark Statute)
- HIPAA
- Social Security Act
- U.S. Criminal Codes

Reporting Fraud, Waste, and Abuse

Centene Vision requires reporting of violations and suspected violations on the part of its employees, associates, persons or entities providing care or services to all health plan members. Examples of such violations include bribery, false claims, conspiracy to commit fraud, theft or embezzlement, false statements, mail fraud, healthcare fraud, obstruction of a state and/or federal healthcare fraud investigation, money laundering, failure to provide

medically necessary services, marketing schemes, prescription forging or altering, provider illegal remuneration schemes, compensation for prescription drug switching, prescribing drugs that are not medically necessary, theft of the prescriber's DEA number or prescription pad, identity theft or members' medication fraud.

If a provider suspects another provider is inappropriately billing us or if a member is receiving unnecessary services, please contact Centene Vision's FWA hotline as indicated below. Centene Vision takes all reports of potential FWA seriously and investigates all reported issues.

Providers are required to cooperate with the investigation of suspected fraud and abuse by our Special Investigations Unit (SIU) department, state and federal government agencies, and local law enforcement agencies. If you suspect fraud and abuse by us, a member, or a provider, it is your responsibility to report this immediately.

You may report suspected cases of fraud and abuse anonymously. You may also report confidentially without fear of retaliation.

- Special Investigation Unit Email: CDVSIU@centene.com
- FWA Hotline: 866-685-8664
- Report online: centenevision.com/report

SECTION V: QUALITY IMPROVEMENT PROGRAM

The Quality Improvement Program ensures the coordination, safe delivery and evaluation of the high quality, cost-effective routine and medical eye care required by payors for their covered members. Our Quality Improvement Program assures the timely identification, assessment, and resolution of known or suspected deficiencies in the quality of care or services received by members and to prevent their reoccurrence by continuous monitoring, evaluation, and improvement of routine and medical eye care services.

Program Scope

Centene Vision develops performance thresholds and benchmarks, based on current practice standards and scientific studies. The Quality Improvement Department develops, monitors, and conducts internal operational evaluations. Quality deficiencies, individual concerns, and patient safety issues are identified and monitored by the Quality Improvement Department using the following resources:

- Concerns, complaints, and grievances of members, providers, and/or payors
- Delegating payor input (solicited and unsolicited)
- High-risk care and service evaluation (e.g., diabetic studies)
- High volume care and service evaluation
- Internal audits for Claims, Credentialing and Customer Service departments
- Monitoring of established practice guidelines through review of medical records and utilization indicators
- Member satisfaction surveys (as delegated)
- Member access evaluations
- Payor satisfaction surveys
- Provider inquiries
- Provider office procedure review
- Provider satisfaction surveys
- Re-credentialing
- Retrospective chart review
- Site visits (Quality of Service Issues)
- Provider profiling
- Telephone abandonment rates and delay to answer statistics
- Utilization data evaluation

Centene Vision investigates identified quality issues. Providers in question have the right to see all documents related to the case and the right to respond to all issues and have their

responses recorded. Providers may appeal decisions pertaining to their cases, and have their case reviewed by a Peer Review Committee.

Committee Structure

The Quality Improvement Program committee structure is comprised of several committees to assist in performing duties, to provide guidance and direction and to promote the goals and objectives of the Quality Improvement Program as a whole.

Credentialing Committee

The Credentialing Committee develops comprehensive credentialing standard operating procedures, reviews applications, and makes credentialing decisions.

Grievance Committee

The Grievance/Appeals Committee objectively hears grievances or appeals that are not able to be resolved through an informal process.

Peer Review Committee

The Peer Review Committee reviews complaints pertaining to quality of care and service issues.

Utilization Management Committee

The Utilization Management Committee oversees the development, research, and implementation of claim payment policies and other programs as mandated by state or federal legislation, in addition to monitoring quality, quantity, and cost-effectiveness of care.

Healthcare Effectiveness Data and Information Set

Healthcare Effectiveness Data and Information Set (HEDIS®[1]) is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA) that allows comparison across payors. HEDIS® gives purchasers and consumers the ability to distinguish between payors based on comparative quality in addition to cost differences. We support our payors through data analysis and access to clinical expertise to improve HEDIS® compliance rates.

Our website HEDIS® Training and Tips page, centenevision.com/hedis contains a full description and a list of requirements related to our HEDIS® participation.

Complaint Procedures

This section is specific to the Centene Vision complaint process; please refer to your state's documentation for those states who perform this process separately.

Centene Vision maintains an internal system for receiving and resolving oral and written complaints. The system has a process for acknowledgement and resolution of complaints.

Throughout this section, we will use the term *complaint* to refer to complaints, grievances, concerns, and/or issues.

Complaint Definition

A complaint is defined as any dissatisfaction expressed orally or in writing, regarding any aspect of Centene Vision's operation other than an adverse determination or claim issue. A complaint does not include a misunderstanding or misinformation that is resolved promptly by supplying the appropriate information or clearing up the misunderstanding.

Provider Complaint Process

Acknowledgement

When we receive an oral or written complaint from a provider, the complaint is thoroughly documented and logged for tracking purposes. A complaint acknowledgement letter is mailed within five business days. If the complaint is resolved within five business days, an acknowledgement/resolution letter will be mailed. All acknowledgement letters document the date the complaint was received and describe the complaint procedures and time frames.

Complaint Resolution Time Frame

All provider complaints should be resolved within the specified timeframe mandated by the state.

Depending on the circumstances and the amount of information needed to thoroughly investigate the complaint, the process may take up to 30 calendar days once all necessary information is gathered.

Notice of Resolution

After a determination is made, a complaint resolution letter will be mailed to the provider. The letter will include an explanation regarding the determination, state specific medical (clinical) and/or contractual reasons for the decision, the types (if any) of the physicians or other providers consulted in the determination process, and additional information regarding the internal appeals process.

Member Complaint Process

When a complaint is received from a member, or a provider on behalf of a member, the process defined below is followed while adhering to applicable state and/or federal mandated time frames. For payors who do not delegate member complaints, Centene Vision and the contracted provider will follow the complaint process as directed by the payor. Providers will adhere to the policies established by us if the payor has delegated member complaints.

Acknowledgement

Once we receive a complaint from a member an acknowledgement letter is mailed by the fifth business day. When a complaint is received from a payor on behalf of the member, it is not necessary for us to send the member a letter, acknowledgment and/or resolution, unless we are delegated member complaints for the payor. When a complaint is received from a state regulatory agency on behalf of the member, we will respond to the state regulatory agency using the agency mandated time frames. The acknowledgement letter will document receipt of the complaint, the date it was received, and describe the complaint procedures and time frames.

Complaint Resolution Time Frame

Centene Vision makes every effort to resolve all complaints within the specified timeframe mandated by the state.

Notice of Resolution

A complaint resolution letter is mailed to the appropriate party by the thirtieth calendar day after receipt of the complaint. This letter will explain the resolution of the complaint, state specific medical (clinical) and/or contractual reasons for the resolution, list the types of specialists consulted in the decision process (if any), describe the internal process for complaint appeals and time frames, and include additional contact information regarding the appeal process as directed by the payor.

Cultural Competency

Centene Vision is committed to providing culturally and linguistically appropriate eye care services in a manner that affirms, values, and respects the worth of the individual member. These services are to be provided to people of all cultures regardless of race, age, gender, ethnicity, socioeconomic status, sexual orientation, or religion. We promote superior quality eye care services with culturally competent staff, providers, and contractors. Centene Vision supports the development of healthy provider/member relationships to foster equitable treatment of all members and enhance cultural awareness. We have adopted the Culturally and Linguistically Appropriate Services Standards, as developed by the Department of Health and Human Services, Office of Minority Health, which serves as a key resource in providing culturally sensitive services.

Cultural Competency Defined

Cultural competency is a set of behaviors, policies, and attitudes that harmoniously come together in a system, agency, or among healthcare professionals to bolster effectiveness in cross-cultural situations. It is the willingness and ability of a system to value the importance of culture in the delivery of services to all segments of the population.

Provider Responsibilities

Providers are expected to be knowledgeable about the member's culture and to use this information in treating members. Providers are also expected to ask questions relating to the way family and cultural values influence healthcare decisions. Providers are encouraged to

use the Culturally and Linguistically Appropriate Service Standards to make their practices more culturally and linguistically accessible.

Increase Cultural Diversity

To develop culturally competent and proficient practices, providers must ensure:

- Medical care is provided with consideration of the members' race/ethnicity and language and its impact/influence of the members' health or illness.
- Treatment plans are developed and clinical guidelines are followed with consideration of the members' race, country of origin, native language, social class, religion, mental or physical attributes, heritage, acculturation, age, gender, sexual orientation, and other characteristics that may result in a different perspective or decision-making process.
- Members understand that they have access to medical interpreters, signers, and TDD/TTY services to facilitate communication without cost to them. For TDD/TTY services, please call 844-257-4142.
- Printed and posted materials are available in English, Spanish, and any other languages as required by the state.
- Office staff makes reasonable attempts to collect race and language specific member information. Staff will also explain race/ethnicity categories to a member so that the member is able to identify the race/ethnicity of themselves and their children.
- Office staff that routinely interact with members has access to and participates in cultural competency training and development annually.

Cultural Activities and Resources

Cultural Competency activities include the development of skills through training and use of self-assessment tools for providers and systems, which are made available via our website, centenevision.com/logon. **We encourage participating providers to complete the U.S. Department of Health and Human Services Physician Practical Guide to Culturally Competent Care,** which equips healthcare professionals with the skills necessary to better treat the diverse populations that they serve. This accredited educational program is available online and is free of charge. For training , visit thinkculturalhealth.hhs.gov, select *Education*, and then *Physicians*.

Non-Discrimination Notice

Envolve Vision Benefits, Inc. dba Centene Vision Services and its subsidiaries (collectively "Vision Services"), complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity). Vision Services does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity).

Vision Services

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters.
  - Written information in other formats (large print, audio, accessible electronic formats, and other formats).
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters.
  - Information written in other languages.
  - If you need these services, contact the Vision Services' Member Services Department at 800-334-3937 or 844-257-4142 (TTY).

If you believe Vision Services has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity), you can file a grievance with:

1557 Coordinator
PO Box 31384
Tampa, FL 33631

855-577-8234
TTY: 711

FAX: 866-388-1769

SM_Section1557Coord@centene.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our 1557 Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, D.C. 20201
800-368-1019 or 800-537-7697 (TDD)

Complaint forms are available at the Office for Civil Rights website.

This notice is available on the Vision Services website:
https://www.centenevision.com/nondiscrimination-notice.html.

REVISION HISTORY

Version	Revision Information	Date
2.10	• Updated language for TX providers under Access to Care and Recordkeeping Requirements sections • Updated information regarding Medicare Provider Appeals	

2.00	Originating from the 2024 Provider Manual:
	• Updated language, URLs, formatting to reflect Centene Vision brand
	• Added new sections:
	  ○ Revision History
	  ○ EPSDT
	• Updated several sections to refer to plan specifics for states that perform their own credentialing, claims, authorizations, complaints and provider information updates
	• Clarified language and verbiage in the following sections:
	  ○ Member Eligibility
	  ○ HIPAA
	  ○ Credentialing
	  ○ Fraud, Waste and Abuse
	• Revised Non Discrimination Notice language
		1/1/2025

Centene Vision Provider Manual

We welcome your input for future editions: cdvcommunications@centene.com

