EVALUATION CHECKLIST FOR MANAGED CARE VISION PLANS

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Evaluation Checklist For Analysis of Managed Care Plans: Michigan.

INTRODUCTION:

Optometrists today are faced with many challenges in practice management. One major area of challenge is in the area of insurance/managed care plans. Optometrists are being asked to accept new insurance plans and join various managed care plans on a monthly basis. The choice of accepting or rejecting these plans can determine the future financial success or failure of a practice.

How can an optometrist evaluate these plans to determine what plans will benefit the practice? The following study looks at a checklist, being evaluated by the Michigan Optometric Association, to help optometrists evaluate managed care plans effectively. We will apply the survey to several widely accepted and established vision plans to see how readily information is available. Also, this will give baseline data to compare with future plans. We will also discuss what other information might be available in evaluating a plan.

PURPOSE:

To develop and apply a functional survey of managed care vision plans to evaluate different areas such as:

1) Elements of the contract
2) Doctor responsibility
3) Quality control
4) Patient eligibility
5) Access
6) Benefits
7) Reimbursements

Several vision plans will be contacted and provider packages will be requested to help complete the surveys.

Vision Service Plan (VSP)

ELEMENTS OF CONTRACT

1. What is the length of the contract with the managed care system?
   Two years. Renewed automatically for successive one-year terms.

2. Do you have the opportunity to renegotiate each year?
   No. Automatic one year renewals, unless otherwise terminated.

3. Does the contract refer to other documents, which are incorporated by reference, such as articles of incorporation or bylaws?
   Yes, failure to comply with these documents may lead to loss of membership in the plan.

4. Does the contract cover all agreements between the parties or are there other written or oral agreements?
   The contract governs all agreements between parties.

5. Can you review the quality assurance and utilization review procedures prior to contracting with the managed care system?
   Yes, if a provider reference is not available simply call VSP for a copy of the Quality Management/Utilization section.

6. Does the contract allow the use of your name in managed care system brochures of advertising?
   Yes, your name is printed in a Member Doctor List.

7. Can the managed care system make changes in any documents without prior notice?
   Yes, the Member Doctor will comply with all VSP policies and guidelines. This includes utilization/quality management and credentialing. The Member Doctor agrees to comply with the applicable provisions of all VSP agreements as they may be amended from time to time.

8. Under what circumstances can the managed care system terminate your participation?
   90 day written notice from VSP to providing doctor or failure of Member Doctor to comply with VSP policy, procedures, or rules may lead to immediate termination.

9. How and under what circumstances can you terminate your participation?
   90 day written notice to VSP.

10. What notice is given to patients if the contract is terminated?
    Member Doctor is responsible for notifying patients that they no longer participate with VSP.

11. Will you be required to provide services if the managed care system ceases to exist?
No.

DOCTOR RESPONSIBILITIES

1. Does your malpractice insurance cover any liability assumed through the contract?
Yes, VSP requires each member doctor to individually maintain a minimum of one million per occurrence and three million aggregate of professional liability (malpractice) insurance.

2. Does the contract require a certain amount of malpractice insurance?
Yes, one million per occurrence, and three million aggregate. VSP requires that the certificate include the words "professional liability of malpractice insurance."

3. What are the eye care benefits offered by the managed care system?
VSP's standard plan includes the following:
Comprehensive eye exam
Necessary spectacle lenses
Frame (up to a group-specified allowance)
Contact lens plans- These benefits can provide either full coverage for contact lenses in lieu of glasses or in addition to the glasses provided under the Standard Plan.

4. How often are enrollees eligible for eye care services?
Every one or two years, depending on the VSP plan.

5. Are primary and preventive care examinations covered for enrollees of all age?
Yes, as long as they are eligible for services under their specific plan.

6. As a provider for the managed care system, what types of services are you required to provide the patient?
Under VSP's standard plan, which is the benchmark for vision care plans, the patient is entitled to a fully covered comprehensive eye exam, necessary spectacle lenses, and a frame up to a group-specified allowance. The plan also provides courtesy discounts on additional services. VSP also has a Primary Eyecare Plan that provides coverage for the management of ocular or systemic conditions that produce ocular or visual symptoms. It also covers the management of certain progressive conditions that are associated with potential vision loss.
As a VSP member doctor you are required to provide 24-hour access to VSP patients via answering machine/service or pager. The message should include instructions on how and where to obtain services from a VSP doctor.

7. Does the contract language require you to:

a. See a certain number of patients per day? No.

b. See all patients referred to you by the managed care system? Yes. Patients are not required to see you by the plan. They choose participating doctors from a Member Doctor's list.

c. Spend a prescribed number of hours on managed care system patients per week? No.

d. Limit your patient load to only managed care system referrals?
No.

e. Refer only to participating providers for higher level care? No. If you participate in one of VSP'S standard plans. Yes, if you participate in VSP MEDALLIANCE Plan.

f. Perform specific procedures on certain types of patients? Yes, practice guidelines are in place ensuring a minimum battery of tests are performed. Additional testing is done at the Doctor's discretion.

g. Perform services even if unnecessary? As stated above, minimum testing must be done on every VSP patient.

h. Refer only to participating providers for higher level care? This only applies with VSP MEDALLIANCE Plan.

i. Tell patients what services are or are not covered under the benefit program? Yes. Patients must be informed prior to services rendered if they are not eligible. Non-covered services are offered to VSP members at discounted rates.

j. Use only participating laboratories? Yes, VSP contracted laboratories must be used when VSP orders are being filled.

k. Provide a substitute doctor when you are absent? A VSP Member Doctor must staff each office at least 16 hours per week.

l. Alter your normal office hours of schedule? No. VSP requires participating doctors to maintain office hours that will enable VSP patients adequate and reasonable access to vision services. Member Doctor(s) must be physically in attendance in at least one office being used to provide vision care services to VSP patients for a minimum of sixteen hours per week.

8. Are there any procedures, which require prior approval from the managed care system?
Yes. Eye exams, lenses, and frames.

9. Does the plan require the provider have certain instrumentation or equipment?
Yes, you must have the minimum instrumentation necessary to provide services at the comprehensive level.

10. Does the contract require you obtain hospital privileges? No.

11. Are enrollees free to choose providers from a list of participating providers? Yes.

12. Must enrollees be referred by the managed care system through a gatekeeper to be eligible? No.

13. Is your professional judgement/action affected by the managed care contract?
No. As stated before a minimum battery of tests need to be performed on each VSP patient. More, if the doctor deems necessary.

14. Can the contract be modified by the managed care system without notification?
Yes, all VSP agreements may be amended from time to time.

15. Does the contract restrict your referral patterns?
No, if you do not participate in VSP MEDALLIANCE Plan. If you do, however, participate in MEDALLIANCE; referrals for secondary and tertiary care must be made within the system.

16. Can you work for/contract with another managed care system coincidentally?
Yes.

QUALITY CONTROL ISSUES

1. Does a peer review your decisions?

All VSP member doctors are subject to a Quality Management Provider Review, which may consist of an on-site office inspection, a mail-in internal review and/or a focus review. Licensed professionals who are versed in VSP policies and procedures perform QM Provider Reviews.

2. Is there a review process for complaints from patients and providers?

Yes. All grievances/complaints from any source(e.g., member, provider, group) addressing patient care, quality or access to care are referred to the Quality management Department. A letter will be sent to the person submitting the grievance/complaint within one business day, acknowledging the receipt of the grievance/complaint. Copies of the letter and the member's complaint/grievance will be forwarded to the appropriate parties, as required.

3. Does the managed care system monitor your utilization?

Yes, VSP requires participating doctors to furnish case records upon request by VSP for 'reasonable' purposes.

4. Do you know the standard of care against which your services will be reviewed?

Yes, VSP requires comprehensive services be rendered to it's members. This level of care requires appropriate evaluation and recording of data in each of these areas:

Health Status of The Visual System
- External/Internal exam
- Pupils/EOM's
- Biomicroscopy/Gross VF's/Tonometry

Refractive Status Evaluation
- Visual acuity
- Subjective refraction/Accommodation
- Keratometry or Retinoscopy

Binocular Function Testing(at least one)
- Cover test, NPC, Phorias, Stereopsis
- Vergences, Fusion, Fixation disparity
- Prism reflex test, Hirschberg

Diagnosis/Treatment Plan

5. Does the contract require that you participate in peer review activities?

Yes.

6. If you provide services, which are deemed unnecessary by the managed care system, will you be denied compensation?

Yes. Additional testing may be included at your discretion without additional compensation from VSP.

7. What services, if any, require preauthorization by the plan?

VSP's eyecare benefit plans are designed to cover services and materials that are necessary to the visual health and welfare of the patient. Certain vision care services require prior authorization. Services and materials requiring prior authorization include:

Medically necessary contact lenses
Low power Rx's(less than +/- 0.38 diopters)
Interim benefits/update of eligibility
Remakes not covered under VSP's redo policy
Medically necessary lens options
Vision therapy
Low vision aids

8. Does preauthorization guarantee payment?

No, an authorization does not guarantee payment of the claim. VSP can only issue payment after a claim has been received and reviewed in accordance with eligibility and medical-necessity requirements.

9. What are the procedures for referring patients for secondary and tertiary level care?

If you determine that a VSP patient needs additional care beyond the routine vision exam, follow these steps for referral to the primary care physician(PCP) or tertiary provider:

1. Provide your findings, in writing, to the physician you are referring the patient to.

2. Keep a copy of the findings in the patient's chart.

3. If there is a medical emergency of the eye, call the PCP or tertiary provider. If you are unable to contact the PCP or tertiary provider, send the patient to a hospital. Important- Treat patients only within the scope of their VSP benefits. If additional care is required, refer the patient to his/her PCP.

10. Is there a fair, non-bias, appeals process for disputing decisions made by the 'utilization review program'?

Yes. A member doctor may appeal the results of a review according to the following guidelines:

1. If the doctor requests a hearing on a timely basis, he/she receives a notice stating:

the place, time and date of hearing, notice to be given 30 days prior to hearing date;
A list of witnesses, if any, expected to testify at the hearing on behalf of VSP.

2. During the hearing, the doctor has the right:

To have an attorney present;

To have a copy of the recording of the proceedings made and provided to the doctor upon payment of copying costs;
To call, examine and cross examine witnesses;
To present any relevant evidence, regardless of its admissibility in a court of law;
To submit a written statement to the close of the hearing.

3. Finally, upon completion of the hearing, the doctor has the right to receive a copy of the final decision, within 14 days.

11. Who develops the standards of care?
VSP.

12. Are on-site visits performed?
Yes.

13. Does the plan provide a Provider Manual?
Yes. The VSP Provider Reference manual.

PATIENT ELIGIBILITY

1. Does the plan provide members with identification cards?
   No.

2. Are all families' members listed on the card or provided with individual cards?
   N/A.

3. Is sufficient information on the card to determine benefit levels?
   N/A.

4. How is member eligibility verified?
   To determine if the patient is eligible for VSP vision services a provider must obtain authorization from VSP. When you obtain authorization, you receive a description of the patient's plan, coverage and current eligibility for benefits. When you contact VSP, you will need to have the patient's name and date of birth, the date of service and the member's Social Security number or group-assigned identification number. You also receive a VSP authorization number, also called a Benefit Request number, which is a unique number assigned to an individual claim for a specific VSP patient.

5. Is the plan responsible for erroneous verification of eligibility?
   No. An authorization does not guarantee payment of the claim. VSP only issues payment when a claim has been received and reviewed in accordance with eligibility and medical-necessity requirements.

6. Is the plan benefit manual clear on eye care services?
   Yes.

ACCESS

1. How do patients access eye care? Can patients access you directly. Is a referral necessary via a gatekeeper? If referral is necessary, does the patient have freedom of choice? Does the gatekeeper have the choice of referring to either an optometrist or an ophthalmologist?

Eye care is accessed simply by calling a VSP participating provider listed in the Member Doctor's List. No referral is necessary for optometric service. Patients may choose any eye care provider who participates with VSP, either optometrist or ophthalmologist.

2. Must the provider use certain secondary and tertiary level specialists?
Only if the patient is enrolled in VSP MEDALLIACE Plan. This in-house network requires all referrals to secondary/tertiary providers be made within the system. If the patient does not participate with MEDALLIANCE he/she may be referred to sub-specialists of the referring doctor's choosing.

3. What advertising methods does the plan utilize?
Member Doctor's List.

4. Can the provider directly advertise to the enrollees?
No, not under any circumstances.

BENEFITS

1. What are the covered vision care benefits?

Comprehensive eye exam every 12 or 24 months, necessary ophthalmic lenses, frames. Many groups provide coverage for contact lenses in place of or in addition to eyeglasses.

To be eligible for contact lenses, the patient must first be eligible for spectacle lenses.

2. Does the plan require you to function as a refractionist or as a primary care practitioner?

Primary care practitioner. VSP requires you to perform a comprehensive eye exam.

3. If you are to function as a refractionist, what are your liabilities for failure to diagnose conditions not detected because a full eye health examination was not performed?

N/A.

4. Are the plan's vision care benefits sufficient to promote quality of care?

Yes.

5. Can your practice ethically conform to the rules and standards of the plan?

Yes.

6. Can enrollees use benefit allowances to 'trade up' to better eyewear/contact lenses?

Yes, frame coverage is a set dollar amount. If patients want more expensive frames they are charged the difference. Contact lenses are first given a discount, then the insurance coverage is added to that discount. The patient then pays the difference.

REIMBURSEMENT

1. How will you be paid?
   Per occurrence.

2. If paid 'per occurrence' are the fees based on usual and customary charges?
   Yes, each member doctor indicates his/her professional service fees on VSP's fee survey form. From these fees, VSP determines each member doctor's professional fees for providing coverage to VSP patients. VSP then provides an Assigned Fee Report to you indicating fee reimbursement.

3. How much of your fees does the managed care system retain?
   None.

4. Does the contract allow the managed care system to make changes in the negotiated fee schedule without prior notice of consent?
   Yes, VSP's Board of Directors establish maximum amounts that can be reimbursed for services. These confidential maximum allowances apply to an entire state/region and are reviewed by the board periodically.

5. Does level of enrollment in the managed care system affect the capitation fee?
   N/A.

6. Do the patients pay deductible or co-payments?
   Co-payments. Any co-payments are indicated at the time you obtain authorization. Some patients have a 'total' co-payment, while others have 'split' co-payments applicable to specific services(e.g., exam, lenses or frame)..

7. As a contracted provider, are you mandated to collect co-payments from the patient?
   Yes, you may not waive co-payments.

8. Who bills the patient, you or the managed care system. What is your recourse if the patient does not pay?
   VSP requires prior approval before you provide vision care services. Authorization includes a description of the patient's plan, coverage and current eligibility for benefits. An authorization does not guarantee payment of the claim. Payment is only issued after eligibility and medical-necessity requirements have been met.

9. How is balanced billing viewed?
   Balance billing is fine, but there are ceilings on what fees can be charged to patients.

10. Are non-covered services clearly defined. Is the patient liable for payment of non-covered Services. Can you charge the usual and customary fees for extras not covered by the plan?

Yes, the patient is liable for payment of non-covered services and products, but at a discounted fee. Discounted materials are a private transaction between you and the patient. The patient is fully responsible for the payment of any discounted items.

11. Does the plan contract contain a 'most favored nation 'clause that could affect participation in reimbursement levels from other plans for which you are a provider?

No. The only time other programs are considered is when the patient is covered by more than one plan. Then coordination of benefits has to be determined.

12. If paid by 'capitation', what are the assumptions used to determine capitation levels?

N/A.

13. Is the provider accepting risk?

N/A.

14. What referred services are paid from your capitation fee?

N/A.

15. What referred services are paid from the risk pool?

N/A.

16. How are other providers reimbursed?

Per claim.

17. Are physicians and optometrists reimbursed under an equal fee schedule?

Payment is based on usual/customary fee. VSP determines each member doctor's professional fees for providing services to VSP patients.

18. Must you submit claims within a defined time period. How long does the plan have to process claims and issue payment. Can you seek payment from the patient if the managed care system fails to pay the claim?

Claims must be submitted in a timely fashion, usually within six months of service. VSP reimburses providers by check via the U.S. mail according to your state's established pay schedule. VSP's payment schedule includes a cutoff date-the date by which claims need to be processed in order to be paid on your next check. Cutoff typically falls five to ten days before the last day of the month. Claims received at least three working days prior to the cutoff usually will be paid on the upcoming check. Be sure to inform patients in advance that they may have financial responsibility for services provided without authorization.

19. If you are a Medicare par provider, will the managed care system contract jeopardize your participation with Medicare patients?

No, this only becomes an issue when a patient has Medicare in addition to VSP coverage. In this case coordination of benefits will have to be determined. Generally if the patient is actively employed and has Medicare, VSP is primary, and Medicare secondary. If he/she is retired Medicare is primary, and VSP secondary.

20. Is the provider required to bill other primary payers before billing the managed care plan?

Again this is a Coordination of Benefits issue and is beyond the scope of this survey. Refer to VSP Provider reference manual, or call VSP provider support for specifics.

21. What are the circumstances where the patient can be billed?

When authorization is denied, and patient is notified in advance he/she may be liable for expenses incurred.

22. Can the provider bill the patient for services, which have been denied through the plan's utilization review program if the patient agrees in advance?

Yes.

23. Can bills be amended after submission?

Yes. If an error in payment amount is noticed write to VSP within five days after your check arrives. Include photocopies of your check statement and the Doctor's Copy of the claim form.

24. Can the provider's usual billing form be used?

No.

25. Can you use the standard HCFA 1500 claim form?

Yes, the HCFA-1500 is a federal form that meets guidelines the Health Care Financing Administration has established for collecting health care information. VSP uses two paper claim forms. The HCFA-1500, and the BASIC form. Certain VSP plans and groups require use of the HCFA-1500 form.

26. How quickly are clean claims paid?

Claims are usually processed within three working days after VSP receives them. Payment checks are mailed to providers according to your state's established pay schedule. Cutoff dates typically fall five to ten days before the last day of the month. Claims received within three working days of the cutoff usually are paid on the upcoming check.

27. Is electronic billing available. Is any cost involved, either monthly or per claims?
Electronic billing is available through VSP's Internet Doctor Communication(IDC). This service takes advantage of the state-of-the- art communication capabilities via the Internet. To expedite claims be sure to:

Enter the correct date of service
Indicate valid codes for the service/materials
Use valid and complete diagnosis codes
Indicate patient out-of-pocket expenses if coordinating benefits

No additional out-of-pocket to the provider is incurred for this service.

28. Is electronic billing required?
No, electronic billing is only one way to submit claims.

CONCLUSION

VSP overall was not very helpful with providing information or answering questions. Whenever I called to talk with a representative I always felt as if I were trying to extract top secret information. They were very reserved and suspicious regarding my intentions, and very reluctant to share information. Even though I made it very clear that I was a student trying to put together a survey that would ultimately make it easier for potential future providers to evaluate VSP services.

VSP does however, have a provider reference manual that is very well thought out. It is comprehensive, and answers most of the important provider questions. It is easy to read and very well organized.

I would encourage anyone who is considering becoming a VSP provider, gain access to a copy of the reference manual, read it, then call VSP with specific questions. They seem to be much more receptive to this.

Blue Cross Blue Shield Michigan

ELEMENTS OF CONTRACTS

1. What is the length of the contract with the managed care system?
No contract.

2. Do you have the opportunity to renegotiate each year?
No.

3. Does the contract refer to other documents, which are incorporated by reference, such as articles of incorporation or bylaws?
N/A.

4. Does the contract cover all agreements between the parties of ate there other written or oral agreements?
N/A.

5. Can you review the quality assurance and utilization review procedures prior to contracting with the managed care system?
N/A.

6. Does the contract allow the use of your name in managed care system brochures of advertising?
Yes.

7. Can the managed care system make changes in any documents without prior notice?
Are you bound by these changes?
Can you terminate the contract if the changes are unacceptable? Yes.

8. Under what circumstances can the managed care system terminate your participation?
Fraud.

9. How and under what circumstances can you terminate your participation?
Writing a letter stating you no longer wish to participate.

10. What notice is given to patients if the contract is terminated?
N/A.

11. Will you be required to provide services if the managed care system ceases to exist?

DOCTOR'S RESPONSIBILITIES

1. Does your malpractice insurance cover any liability assumed through the contract?
Yes.

2. Does the contract require a certain amount of malpractice insurance?
Yes.

3. What are the eye care benefits offered by the managed care system?
Exams, lenses, frames, and contact lens allowances.

4. How often are enrollees eligible for eye care services?
Every year or two depending on the contract.

5. Are primary and preventive care examinations covered for enrollees of all ages?
Not if more often than one year.

6. As a provider for the managed care system, what types of services are you required to provide the patient?

-primary care office service.
Yes, vision care program.

-services in a hospital setting, extended care facility or ambulatory care.
No.

-"on call" provider
No.

7. Does the contract language require you to:

a. see a certain number of patients/day.
No.

b. see all patients referred to you by the managed care system.
No referrals.

c. spend a prescribed number of hours on managed care system patients/week.
No.

d. limit your patient load to only managed care system referrals.
No.

e. refer only to participating providers for higher level care.
No, but the ophthalmologist needs to see the patient within 60 days of the optometrist's examination.

f. perform specific procedures on certain types of patients. (practice guidelines).
Yes, exams must include; patient history, external examination of the eye, subjective refraction, visual acuity, biomicroscopic evaluation, ophthalmoscopic exam, intra-ocular pressures, dialation if medically necessary, summary of findings.

g. perform services even if unnecessary.

h. tell patients what services are or are not covered under the benefit program.
Not stated in provider's manual.

i. use only participating laboratories.
No.

j. provide a substitute doctor when you are absent.
No.

k. alter your normal office hours or schedule.
No.

8. Are there any procedures, which require prior approval from the managed, care system?
Yes, medically necessary contact lenses.

9. Does the plan require the provider have certain instrumentation or equipment?

10. Does the contract require you obtain hospital privileges?
No.

11. Are enrollees free to choose providers from a list of participating providers?
Yes.

12. Must enrollees be referred by the managed care system through a gatekeeper to be eligible?
No.

13. Is your professional judgement/action affected by the managed care contract?
No.

14. Can the contract be modified by the managed care system without notification?

15. Does the contract restrict your referral patterns?
No.

Can you use the sub-specialist of your choice or only the plan's participating sub-specialist?
Yes.

16. Can you work for/contract with another managed care system coincidentally?
Yes.

QUALITY CONTROL ISSUES

1. Does a peer review your decisions?
For disputes involving medical necessity, you may submit a written request for an external peer review.

2. Is there a review process for complaints from patients and providers?

3. Does the managed care system monitor your utilization?

4. Do you know the standard of care against which your services will be reviewed?

5. Does the contract require that you participate in peer review activities?

6. If you provide services, which are deemed unnecessary by the managed care system, will you be denied compensation?

7. What services, if any, require precertification by the plan?

8. Does preauthorization guarantee payment?

9. What are the procedures for referring patients for secondary and tertiary level care?

10. Is there a fair, non-bias, appeals process for disputing decisions made by the "standard of care" / " utilization review" program?

11. Who develops the standards of care?

12. Are on-site visits performed?

13. Does the plan provide a Provider Manual?
Yes.

PATIENT ELIGIBILITY

1. Does the plan provide members with identification cards?
Yes, BCBSM issues identification cards.

2. Are all families' members listed on the card or provided with individual cards?
Each individual is issued a card.

3. Is sufficient information on the card to determine benefit levels?
No, the provider must contact BCBSM through the CARENplus computerized telephone system.

4. How is member eligibility verified?
Eligibility verified with the contract number on identification card, first and last name of the BCBSM subscriber, patient's birth year, and the patient's first name.

5. Is the plan responsible for erroneous verification of eligibility?
Not found in handbook.

6. Is the plan benefits manual clear on eye care services?
Yes, a long list of covered and noncovered services are listed in provider manual along with seven charts of "benefit/reimbursement" for participating providers.

ACCESS

1. How do patients access eye care?
   Can patients access you directly?

Yes.

   Is a referral necessary via a gatekeeper?

No.

If referral is necessary, does the patient have freedom of choice or does the gatekeeper make their choice?

The patient has the choice.

Does the gatekeeper have the choice of referring to either an optometrist or an ophthalmologist?

2. Must the provider use certain secondary and tertiary level specialists?

No.

3. What advertising methods does the plan utilize?

None.

4. Can the provider directly advertise to the enrollees?

Yes.

BENEFITS

1. What are the covered vision care benefits?
The reimbursement depends on the plan for covered benefits for exams, frames, contact lenses, tints, and prism/slab off.

2. Does the plan require you to function as a refractionist or as a primary care practitioner?
Both a primary care practitioner and refractionist.

3. If you are to function as a refractionist, what are your liabilities for failure to diagnose conditions not detected because a full eye health examination was not performed?
N/A.

4. Are the plan's vision care benefits sufficient to promote quality of care?
Yes.

5. Can your practice ethically conform to the rules and standards of the plan?
Yes, the examination is within comprehensive standards.

6. Can enrollees use benefit allowances to "trade up" to better eyewear/contact lenses?
Yes.

REIMBURSEMENT

1. How will you be paid?
Per occurrence.
Yes.
Yearly capitated fee per patient.
No.

2. If paid "per occurrence" are the fees based on:
Usual and customary charge.
Yes.
Prevailing charge.
No.
Discounted fee schedule.
No.
The providers usual fee and the "maximum payment level" is the basis for reimbursement for vision tests. The "maximum payment level" corresponds to 85 percent of aggregate (total) charges for a particular service called the 85 percent Test of Performance or 85 percent TOP.

3. How much of your fees does the managed care system retain?
None.

4. Does the contract allow the managed care system to make changes in the negotiated fee schedule without prior notice or consent?
N/A.

5. Does level of enrollment in the managed care system affect the capitation fee?
N/A.

6. Do the patients pay deductible or copayments?
Yes, $5.oo/ exam and $7.50/ frame and/or lenses(materials).

7. As a contracted provider, are you mandated to collect deductibles or copayments from the patient?
Can the provider wave deductibles and copayments if desired?

8. Who bills the patient, you or the managed care system?
What is your recourse if the patient does not pay?
For participating doctors, the doctor bills only for copays and deductibles. Non-participating doctors bill the patient directly.

9. How is balanced billing viewed?
Balanced billing allowed for extras but not for exam fees.

10. Are non-covered services clearly defined?
Is the patient liable for payment of non-covered services?
Yes, the patient is responsible for additional costs.
Can you charge usual and customary fees for extras not covered by the plan?
Yes.

11. Does the plan contract contain a "most favored nation" clause that could affect participation in reimbursement levels from other plans for which you are a provider?
No.

12. If paid by "capitation", what are the assumptions used to determine capitation levels?
N/A
13. Is the provider accepting risk?

14. What referred services are paid from your capitation fee?
N/A.

15. What referred services are paid from the risk pool?
Secondary care.
Tertiary care.
Emergency room care.
Treatment provided outside the geographical covered area.
N/A.

16. How are other providers reimbursed?
On a per case basis.

17. Are physicians and optometrists reimbursed under an equal fee schedule?

18. What you submit claims to the managed care system for payment:
Must you submit claims within a defined time period?
How long does the plan have to process claims and issue payment?
60 days.
Are you entitled to interest if the payment is delayed by the managed care system?
Yes, 12 percent per year.

Can you seek payment from the patient if the managed care system fails to pay the claim?

19. If you are a Medicare par provider, will the managed care system contract jeopardize your participation with Medicare patients?

20. Is the provider required to bill other primary payers before billing the managed care plan?

21. What are the circumstances where the patient can be billed?

22. Can the provider bill the patient for services, which have been denied through the plan's utilization review program if the patient agrees in advance?

23. Can bills be amended after submission?
For how many days?

24. Can the provider's usual billing form be used?

25. Can you use the standard HCFA 1500 claim form?

26. How quickly are clean claims paid?
Within 60 days.

27. Is electronic billing available?
Any cost involved, either monthly or per claims?

28. Is electronic billing required?
No.

CONCLUSION

Obtaining information about vision plans with Blue Cross Blue Shield of Michigan was not as straight forward as expected especially for the Quality Control section. The information in the provider manual answered about half of the survey directly. Other information was obtained through practicing Optometrists who were familiar with BCBSM from past and present experiences.

CLOSING STATEMENT

The goal of the survey and applying the survey to specific vision plans was to determine how readily information was to the practitioner before actually signing a contract to provide services. Most of the answers to the survey were answered but completing the survey was more difficult than expected and often very frustrating. Several other plans besides VSP and BCBSM were attempted but the information provided by the managed care plans was not complete enough to even answer a portion of the survey.

Possible sources of information to complete the survey were directly from the vision plan, through the internet, and from practicing optometrists. The direct method proved to be difficult but the most fruitful option. All of the information was not clearly available in the provider packets. The internet did not help at all to clarify the information. Contacting the plans proved to be difficult and our calls were often met with a mistrusting nature.

With the number of insurance plans available today, the goal of the practitioner should be to have a clear understanding of contracts and responsibilities when accepting these plans for payment. The survey is a tool for comparing the many vision plans to a set standard giving the practicing Optometrist a forecast of future problems, which will affect the management decisions.

The amount of work necessary to complete the survey, for two of the best known plans in Michigan, was intensive and difficult. Therefore, the survey is not a good

strategy for evaluating insurance plans due to time and labor necessary. The information is not easily accessible to a busy practitioner.

Just because the survey is difficult to complete, what can be learned from examining each section of the survey? The answer to this question lies in how a specific Optometric practice currently does business. Some practices may be better suited to accepting any or all insurance carriers. Knowing chair cost is key to project potential revenues. Finally, what are the financial benefits of accepting a plan and how many patients will it affect?

Patient Eligibility, Access, and Benefits are important but the details can be worked out as patients utilize services. The important issues in the Doctor Responsibility section depend on how the insurance plans guidelines relate to current practice styles. Simply stated, what in my practice must change to work within the guidelines of a plan and what are the potential consequences for not changing?

The Elements of the Contract and the Quality Control sections were the most difficult sections of the survey to complete. These sections may not be of day-to-day importance but can become important given the right circumstances. It might be advisable for an attorney from the Michigan Optometric Association to review the Elements of the Contract section before signing with a plan. The peer review questions in the Quality Control section can be review by counsel if the need arises.

In conclusion, we do not feel that this survey is the ultimate answer for the practicing optometrist. If we were unable to answer some of the questions and spent a great deal of time and energy to answer the remainder of the questions when evaluating two of the most widely used plans in Michigan, how can a practicing optometrist use it to

evaluate plans in which information is not so readily available? But can a survey, which requires less work to complete properly, evaluate the complexities of a specific plan? The answer at the present time might be to evaluate two major areas; the number of lives covered by a plan and plan reimbursements compared to chair costs. Using the survey to further evaluate plans, which are acceptable to the above two standards, might be an effective way of evaluating plans.

APPENDIX A

MANAGED CARE SURVEY
ELEMENTS OF THE CONTRACT

1.What is the length of the contract with the managed care system?

2.Do you have the opportunity to renegotiate each year?

3.Does the contract refer to other documents, which are incorporated by reference, such as articles of incorporation or bylaws?

4.Does the contract cover all agreements between the parties of ate there other written or oral agreements?

5.Can you review the quality assurance and utilization review procedures prior to contracting with the managed care system?

6.Does the contract allow the use of your name in managed care system brochures of advertising?

7.Can the managed care system make changes in any documents without prior notice?
Are you bound by these changes?
Can you terminate the contract if the changes are unacceptable?

8.Under what circumstances can the managed care system terminate your participation?

9.How and under what circumstances can you terminate your participation?

10.What notice is given to patients if the contract is terminated?

11.Will you be required to provide services if the managed care system ceases to exist?

DOCTOR RESPOSIBILITY

1.Does your malpractice insurance cover any liability assumed through the contract?

2.Does the contract require a certain amount of malpractice insurance?

3.What are the eye care benefits offered by the managed care system?

4.How often are enrollees eligible for eye care services?

5.Are primary and preventive care examinations covered for enrollees of all ages?

6.As a provider for the managed care system, what types of services are you required to provide the patient?

-primary care office service.
-services in a hospital setting, extended care facility or ambulatory care.
-"on call" provider

7.Does the contract language require you to:

a. see a certain number of patients/day.
b. see all patients referred to you by the managed care system.
c. spend a prescribed number of hours on managed care system patients/week.
d. limit your patient load to only managed care system referrals.
e. refer only to participating providers for higher level care.
f. perform specific procedures on certain types of patients. (practice guidelines).
g. perform services even if unnecessary.

h. tell patients what services are or are not covered under the benefit program.

i. use only participating laboratories.
j. provide a substitute doctor when you are absent.

k. alter your normal office hours or schedule.

8.Are there any procedures, which require prior approval from the managed, care system?

9.Does the plan require the provider have certain instrumentation or equipment?

10.Does the contract require you obtain hospital privileges?

11.Are enrollees free to choose providers from a list of participating providers?

12.Must enrollees be referred by the managed care system through a gatekeeper to be eligible?

13.Is your professional judgement/action affected by the managed care contract?

14.Can the contract be modified by the managed care system without notification?

15.Does the contract restrict your referral patterns?
Can you use the sub-specialist of your choice or only the plan's participating sub-specialist?

16.Can you work for/contract with another managed care system coincidentally?

QUALITY CONTROL ISSUES

1.Does a peer review your decisions?

2.Is there a review process for complaints from patients and providers?

3.Does the managed care system monitor your utilization?

4.Do you know the standard of care against which your services will be reviewed?

5.Does the contract require that you participate in peer review activities?

6.If you provide services, which are deemed unnecessary by the managed care system, will you be denied compensation?

7.What services, if any, require precertification by the plan?

8.Does preauthorization guarantee payment?

9.What are the procedures for referring patients for secondary and tertiary level care?

10.Is there a fair, non-bias, appeals process for disputing decisions made by the "standard of care" / " utilization review" program?

11.Who develops the standards of care?

12.Are on-site visits performed?

13.Does the plan provide a Provider Manual?

PATIENT ELIGIBILITY

1.Does the plan provide members with identification cards?

2.Are all families' members listed on the card or provided with individual cards?

3.Is sufficient information on the card to determine benefit levels?

4.How is member eligibility verified?

5.Is the plan responsible for erroneous verification of eligibility?

6.Is the plan benefits manual clear on eye care services?

ACCESS

1.How do patients access eye care?
    Can patients access you directly?
    Is a referral necessary via a gatekeeper?
If referral is necessary, does the patient have freedom of choice or does the gatekeeper make their choice?
Does the gatekeeper have the choice of referring to either an optometrist or an ophthalmologist?

2.Must the provider use certain secondary and tertiary level specialists?

3.What advertising methods does the plan utilize?

4.Can the provider directly advertise to the enrollees?

BENEFITS

1.What are the covered vision care benefits?

2.Does the plan require you to function as a refractionist or as a primary care practitioner?

3.If you are to function as a refractionist, what are your liabilities for failure to diagnose conditions not detected because a full eye health examination was not performed?

4.Are the plan's vision care benefits sufficient to promote quality of care?

5.Can your practice ethically conform to the rules and standards of the plan?

6.Can enrollees use benefit allowances to "trade up" to better eyewear/contact lenses?

REIMBURSEMENT

1.How will you be paid?
Per occurrence.
Yearly capitated fee per patient.

2.If paid "per occurrence" are the fees based on:
Usual and customary charge.
Prevailing charge.
Discounted fee schedule.
3.How much of your fees does the managed care system retain?
None.

4.Does the contract allow the managed care system to make changes in the negotiated fee schedule without prior notice or consent?

5.Does level of enrollment in the managed care system affect the capitation fee?

6.Do the patients pay deductible or copayments?

7.As a contracted provider, are you mandated to collect deductibles or copayments from the patient?
Can the provider wave deductibles and copayments if desired?

8.Who bills the patient, you or the managed care system?
What is your recourse if the patient does not pay?

9.How is balanced billing viewed?

10.Are non-covered services clearly defined?
Is the patient liable for payment of non-covered services?

Can you charge usual and customary fees for extras not covered by the plan?

11.Does the plan contract contain a "most favored nation" clause that could affect participation in reimbursement levels from other plans for which you are a provider?

12.If paid by "capitation", what are the assumptions used to determine capitation levels?

13.Is the provider accepting risk?

14.What referred services are paid from your capitation fee?

15.What referred services are paid from the risk pool?

Secondary care.
Tertiary care.
Emergency room care.
Treatment provided outside the geographical covered area.

16.How are other providers reimbursed?

17.Are physicians and optometrists reimbursed under an equal fee schedule?

18.What you submit claims to the managed care system for payment:
Must you submit claims within a defined time period?
How long does the plan have to process claims and issue payment?
Are you entitled to interest if the payment is delayed by the managed care system?
Can you seek payment from the patient if the managed care system fails to pay the claim?

19.If you are a Medicare par provider, will the managed care system contract jeopardize your participation with Medicare patients?

20.Is the provider requires to bill other primary payers before billing the managed care plan?

21.What are the circumstances where the patient can be billed?

22.Can the provider bill the patient for services, which have been denied through the plan's utilization review program if the patient agrees in advance?

23.Can bills be amended after submission?
For how many days?

24.Can the provider's usual billing form be used?

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