20/20 Hearing Care NETWORK

2024

PROVIDER MANUAL

Welcome to 20/20 Hearing Care Network, Inc Provider Services Manual which will allow you and your staff to find important information pertaining to requesting authorizations, electronic lab orders, and electronic submission of claims. As information is updated by 20/20 Hearing Care Network, we will communicate this information to you via 2020hearingnetwork.com and through our provider services staff. We are pleased to provide you with the tools and resources necessary to deliver excellent hearing care services as participating network providers.

Please contact our staff with any questions at **844-575-4327**

1. Important Information regarding the use of this manual.

In the event of a conflict between your provider agreement and this manual, the manual shall control unless the agreement directs otherwise. If there is a conflict, this manual and all federal and state regulations and statutes shall prevail. 20/20 retains the right to modify this manual to ensure that we remain in compliance with federal and state regulations and statutes. This manual shall be amended as needed.

2. WHAT IS MEDICAID (MMA)

Florida Medicaid is a program that provides medical coverage to low-income individuals and families. The State of Florida and Federal government share in the cost of the program. The State of Florida administers the program through the Agency for Health Care Administration (AHCA). Medicaid eligibility in Florida is determined by either Department of Children and Families (DCF) or Social Security Administration (SSI recipients). DCF determines Medicaid eligibility for parent and care-takers relatives for children. In addition, children, pregnant women, former foster care individuals, non-citizens with medical emergencies and aged or disabled individuals not currently receiving SSI.

In 2011 Florida Legislature passes House Bill 7107, creating part IV of Chapter 409, F.S. to establish the Florida Medicaid program as a statewide Medicaid Managed Care (SMMC) which includes two programs; one for medical assistance (MMA) and one for long-term care (LTC). Only members who meet requirements and living in a region with authorized Managed Care plans are eligible to enroll and receives these services.

3. WHAT IS MEDICARE ADVANTAGE (MA)

“Medicare Advantage” is the program alternative to standard Medicare Part A and Part B fee-for-service coverage; generally referred to as “traditional Medicare.”

MA offers Medicare beneficiaries several product options (similar to those available in the commercial market), including health maintenance organization (HMO), preferred provider organization (PPO), point-of-service (POS) and private fee-for-service (PFFS) plans.

4. REQUEST FOR AUTHORIZATION

Requests for authorization can be found on our website, https://hearing.mirrahealthcare.com. You and your staff are assigned a unique username and password (HIPAA) to access the website. Our provider services department is available to assist with any questions pertaining to the website 844-575-4327.

5. ORDERS

The https://hearing.mirrahealthcare.com secure website also enables you to submit your hearing exam claims and hearing aid orders.

6. CLAIMS PROCESSING

Our website, https://hearing.mirrahealthcare.com enables providers to submit claims via the process noted in Orders above. Provider triggers a mandatory 30-day trial period in portal when dispense date is confirmed. Claims are processed at the close of trial period provided no return or exchange.

The following is required for all claim submissions:

a. Member name, gender, date of birth, and relationship to subscriber
b. Member ID
c. Date of Service, place of service and number of services (units) rendered.
d. Current CPT, HCPCS and ICD10 codes with modifiers where appropriate.
e. Rendering providers NPI number. The NPI number must match the one registered with Medicaid in your Provider Registration data.
f. Facility Tax ID and NPI number
g. Facility location and billing address and phone number
h. Additional insurance coverage (i.e. Medicare for Dual SNP members)
i. Taxonomy code(s) are required for all claim submissions. The Taxonomy code must match the one registered with Medicaid in your Provider Registration data.

If you need to correct and re-submit a claim, please resubmit a new claim indicating the correction being made. Hand written claim re-submissions will not be accepted.
"Clean" claims are paid weekly (within 7 days of receipt).

NOTE: Claims may be rejected or denied when submitted without an NPI or with an invalid NPI, depending on the method of submission.

Your reimbursement rate is based upon your contractual agreement with 20/20.

You may reach our claims department at 844-575-4327.

Be sure to request the patient ID care at the time of visit and confirm they are eligible. Eligibility should be verified monthly since patients keep their cards even during months when they are no longer eligible for services.

You may always contact our Provider Services Department to check if you have any questions. **844-575-4327**

7. Medical Necessity

Determination of medical necessity means the medical or allied care, goods or services furnished or ordered must meet the following conditions:

a. To protect life, to prevent significant illness or significant disability or to alleviate severe pain.
b. Be individualized, specific and consistent with the current symptoms /diagnosis of the illness or injury and not in excess of the patient needs.
c. Be consistent with the generally accepted professional medical standards determined by the Medicaid program.
d. Provide the level of service safely and for which no equally effective and conservative or less costly treatment available.
e. Provider services in a manner not intended for the convenience of the recipient, caretakers or provider.

8. Provider Requirements

All services require prior authorization in advance of providing services. Clinical Peer Review may be required for certain services. 20/20 may requests additional information, documentation or discussion with their providers. When additional documentation is requested, you or your staff must provide all requested documentation within 24 business hours.

9. HEDIS Documentation

HEDIS documentation must be submitted to the Primary Care Practice (PCP) following the patient exam.

10. Patient Confidentiality

20/20 members have a right to privacy and confidentiality. In accordance with HIPAA regulations, you and your staff are expected to adhere to the confidentiality of patient data of all records and information about their healthcare. Confidential information should only be disclosed to business associates and affiliates who need that information to fulfill our obligations and to facilitate improvements to the members healthcare. We expect you and your staff to adhere to this requirement and respect and protect the privacy laws. Requests for medical records are sent to you and your staff and should be responded to within 24 business hours.

11. Access to Records

You must provide access to any medical, financial or administrative records related to the services you provide to our members within 7 calendar days of our request or sooner if it pertains to cases involving fraud, waste and abuse, a member's grievance/appeal or state or federal or accreditation agencies. You must maintain your records for 10 years or longer if required by applicable state and federal regulations.

12. Medical Record Standards

You must minimally adhere to the following record standards:

a. Medical records must contain patient identifying information including the member name, date of birth, ID# and gender. If there is a legal

guardian it should be included on the record.

b. Each page of the record must have the member's name and ID #.
c. Each record shall include patient medical history, including any significant illness(s) and current medical condition.
d. Each record must indicate the chief complaint/purpose of the visit. You must also include your objective, diagnosis, findings or impressions.
e. Each record must include testing or hearing aid(s) ordered and referral report when indicated.
f. Each record must indicate any fitting/dispensing instructions.
g. Each record must include the disposition, instructions to the patient and if follow-up is required. Each record must contain of summary of the patients' current diagnosis or problems.
h. All entries must include the disposition, recommendations, instructions to the patient, indicate follow-up if necessary and the outcome of the visit.
i. Each record must be legible and signed and dated by the rendering provider. The signature must contain DOH License designation i.e., AuD, M.D. or H.A.S.

13. Member Availability/Accessibility to Services

The following access to care should be followed:

- **Routine Screening Exams** – Available within one month
- **Emergency care** – within 24 hours a day/seven days a week (emergency call after hours)
- **Urgent Care** – within one day

You must offer the same number of office hours to Medicaid Members that you do for all other insurances.

14. Follow Practice Protocols

You and your staff are required to adopt practice protocols regulated by CMS & AHCA. All state and federal statutes and regulations must be adhered to.

PROVIDER EDUCATION

CMS General Compliance Training Program

20/20 requires you and your staff adherence to CMS Compliance. You may find the Compliance Training Program on the 2020hearingnetwork.com website.

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedCandDGenCompdownload.pdf

Fraud, Waste and Abuse

20/20 requires you and your staff adherence to CMS and AHCA requirements pertaining to Fraud, Waste and Abuse. You may find our Policy on the 2020hearingnetwork.com website.

Code of Conduct

20/20 requires you and your staff adherence to CMS and AHCA requirements pertaining to Code of Conduct. You may find our Policy on the 2020hearingnetwork.com website.

Cultural Competency

20/20 requires you and your staff to adhere to the written Cultural Competency requirements found on the 2020hearingnetwork.com website. You and your staff must ensure services are provided in a culturally competent manner to members, including those the limited English proficiency, Hearing and Speech Disabilities, Health Literacy, Customs, Religion, Ethnicity.

Abuse, Neglect & Exploitation (Health, Safety and Welfare Education)

20/20 requires you and your staff adherence to CMS and AHCA requirements pertaining to Abuse, Neglect & Exploitation. You may find our

Policy on the 2020hearingnetwork.com website.

Medicaid Provider Training

20/20 requires you and your staff adherence to AHCA Medicaid Provider Training. You may find the training programs on the 2020hearingnetwork.com website

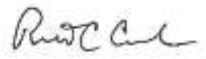
Statewide Medicaid Managed Medical Assistance (MMA) Program 2020hearingnetwork.com Medicaid Provider Compliance Program and Provider Self Audits 2020hearingnetwork.com

OIG and SAM Employees/Contractors/Volunteers Exclusion Lists
You are required to meet all Federal and State Compliance regulations regarding OIG/SAM Exclusion Screenings for pre-hire employees and all other employees on a monthly basis. Monthly OIG/SAM exclusions screenings must be verified via OIG and SAM websites. Your reports must be kept on file for 10 years. To avoid Civil Monetary Penalties, health care entities need to screen their employees ensure that new hires and current employees are not on the excluded list.

OIG has the authority to exclude individuals and entities from Federally funded health care programs pursuant to section 1128 of the Social Security Act (Act) (and from Medicare and State health care programs under section 1156 of the Act) and maintains a list of all currently excluded individuals and entities called the List of Excluded Individuals/Entities (LEIE). Anyone who hires an individual or entity on the LEIE may be subject to civil monetary penalties (CMP).

https://oig.hhs.gov/exclusions/tips.asp
https://exclusions.oig.hhs.gov/
https://oig.hhs.gov/exclusions/supplement_archive.asp
https://oig.hhs.gov/faqs/exclusions-faq.asp

APPROVED BY:



Signature **Date** 5/1/2024

Robert C Coppola OD
President, 20/20 Hearing Care Network

Revision Record			
Revision Date	Version Number	Revised By	Revision description
7/2019	1.0	Robert Coppola OD	Initial Review, update and approval
6/2020	2.0	Robert Coppola OD	Annual approval
5/2021	3.0	Robert Coppola OD	Annual approval
5/4/2022	4.0	Robert Coppola OD	Annual review and approval
5/3/2023	5.0	Robert Coppola OD	Annual review and approval
5/1/2024	6.0	Robert Coppola OD	Annual review and approval