INSURANCE

Operations Guide

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Prepare

Overview, Insurance Demographics, & Eligibility Verification

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COMMON TERMS/QUESTIONS

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- **Subscriber/insured:** Primary enrollee on the insurance policy.
- **Dependent:** Usually, a spouse or child of an insured. Anyone else that is on the primary policy holder's plan.
- **Allowable amount (aka Fee Schedule):** The maximum amount an insurance company will pay for a covered service.
- **Prior authorization:** Permission required for some services depending on the insurance provider, an insurance company's "permission slip" before care is given.
- **Contractual Write-offs:** The difference between what a provider charges for a service and what the insurance company has agreed to pay (the allowable amount) under their contract. In other words, it's the portion of the bill the provider is not allowed to collect from the patient because of their agreement with the insurance company.
- **Usual & Customary (U&C):** The retail cost of a service or product.
- **Copay:** A set dollar amount determined by the insurance provider that a patient pays at *every visit* for a covered service until their out-of-pocket maximum is met.
- **Deductible:** The amount a patient pays each year before their insurance begins to cover costs. If their deductible has NOT been met, the patient is responsible for the insurance allowed amount for each service, not the full retail price of the service.
- **Co-insurance:** The patient's share of the cost, shown as a percentage, paid after their deductible is met. Example: the insurance plan may pay 80% of the service, but the patient is still responsible for the other 20%, even after their deductible is met.
- **Out-Of-Pocket Maximum: T**he most a patient would pay for covered services in a plan year. After patients spend this amount on copays, coinsurance, and deductibles, their health plan pays 100% of the costs of covered benefits. They do not have to pay a copay or coinsurance once out-of-pocket maximum has been met.
- **What is the difference between coinsurance, copay, and deductible?**
  - Patients pay their deductible first.
  - Then, they pay coinsurance (a percentage) until they reach their out-of-pocket maximum.
  - Copays are flat fees paid at every visit (unless being seen as part of Cataract post-op care) and may apply separately from the deductible.
- **Is it legal to waive deductibles and copays?**
  - No. Waiving patient responsibility is not legal and may be considered insurance fraud. We must collect the full patient portion as required by the insurance plan.
  - When a claim is submitted, the insurance company applies the patient's share toward their deductible or visit limits. If we waive or write off that amount, the insurance still gives the patient credit as if they paid—meaning they receive benefits they haven't earned.
    - EXAMPLE: A service costs $100. The patient owes a $10 copay, and insurance pays $90. If you do not collect the $10 copay, the insurance still counts it toward the patient's deductible even though it wasn't paid. We do not get the money we are owed, and the patient gets credit for $10 that they never paid.

CONSULTATIVE SELLING PATIENT JOURNEY

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Consultative selling (needs-based selling) focuses on understanding and addressing the specific needs of the patient. It involves identifying the patient's goals, challenges, and pain points, and then positioning our products as the solution that best meets those needs.

LEARN about the patient by reviewing history and insurance, even before they arrive. When in clinic, facilitate a conversion around lifestyle, pain points, and needs. Ensure this information is travels with the patient.

LISTEN actively during patient hand-off and ensure to ask additional questions to understand the patients needs. This will guide your sales approach and what products and services to recommend today.

LEAD with a single recommendation for each product to meet lifestyle or prescription needs. Assume the sale and create value. Showcase our preferred products and share the benefits with the patient.

	Prepare	Learn	Listen	Lead	Review	After
STANDARDS	Fill the Books Insurance Welcome	Get To Know Your Patient Consultation	Hand Off Consider Solutions (Product + Service + Referrals)	Assume The Sales Recommend Products	Accurate Entry OneSight Thank You	Order Management Pick Up Optical Expert
TOOLS + RESOURCES	Data Capture Fill The Books	Patient Questionnaire Intake Form	OD Hand Off Observation	LensSimulator SmartShopper Lens Portfolio Guide Contact Price Card Promotions	EyeRuler2 Patient Referral	Take Action Tab Eyewear Analysis
KPI IMPACT	**Exam Growth** Fill Rate No Show Rate	**Sales** Comp Sales	**Retail Capture** OD Productivity Average $ Patient	**Multiples** Sun Avg $ Spec Unit/Lens Avg $ CL, Annual Supply	**EPP** EyeRuler Grateful Patient Google Review	**Google Review** RTFT Reject Dwell

PREPARE
INSURANCE

	Actions	What Does It Sound Like
Capture Medical + Vision	PCC: (can also be done at time of appointment scheduling) • Capture all insurances (Routine + Medical Primary, Medical Secondary) for all patients regardless of exam type. • Document in EHR. • At check-in, scan all insurance cards (front and back).	Team Member: I know you're coming in for a medical exam, but I'd like to update/confirm our records. Do you still have VSP as well as Blue Cross for medical? I don't see a routine insurance carrier on file. Do you have routine coverage along with medical?.....Please make sure to bring all insurance cards with you.
Eligibility/ Pre-Auth	PCC: • Use Trizetto or carrier's website to confirm eligibility, copays, and/or deductibles within 24-48 hours prior to patient arrival. • Document in E.H.R or via office protocols (make sure it's clearly documented and easily found by all team members).	Team Member: Great- now that we have your insurance details, we will check authorization ahead of time and collect copays/deductibles at the time of your visit. Of course, if you add or change services, we will update you on what you can expect to pay.
Co-Pay + Deductible	PCC: (at check in) • Educate patient on copays (or potential copays). • Inform patient that you will be collecting copays at some point during the visit. • Confirm eligibility and copays are clearly visible for the team (listed on routing sheet, printed and on clipboard, etc.).	Team Member: Mrs. Smith, it looks like you have an overall $10 copay for the routine exam. If you choose to add a contact lens exam or imaging, there will be additional fees that the technicians will review with you as needed.

Note: If your patient reschedules their appointment, cancel your original authorization and pull a new one for the rescheduled appointment.

Insurance Process Overview

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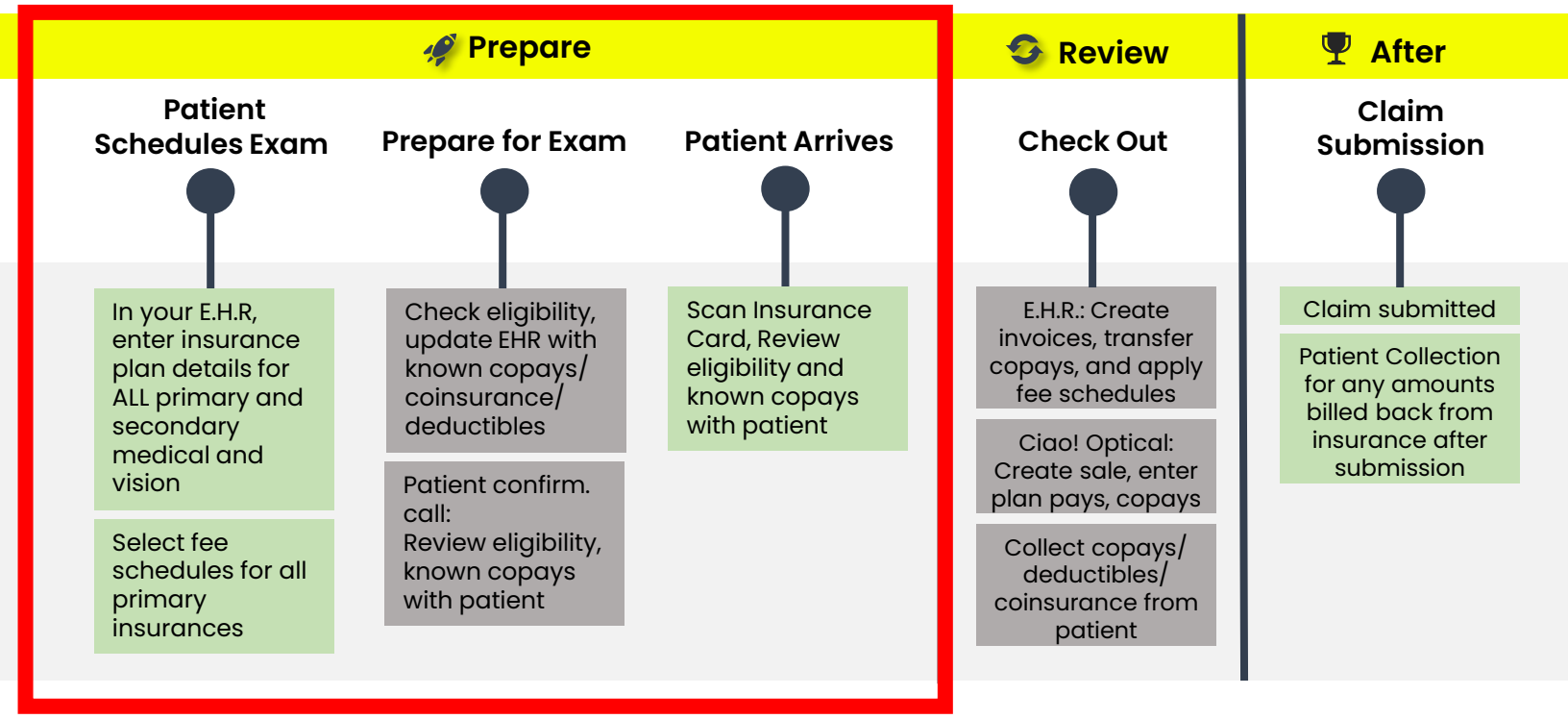
Below is a high-level overview of the insurance process



- **Eligibility must be verified PRIOR to the patient's appointment.**
  - **Check Trizetto and/or Insurance carriers' website ahead of time to know the patient copay/deductible/coinsurance.**
- All copays/coinsurance/deductibles must be collected at the time of service.
  - We do not do back bill (i.e., you can not bill the insurance carrier to see what is covered and then send the patient an invoice.)
- ALL services must be recorded in BOTH the E.H.R. AND Ciao! Optical (point-of-sale).
- ROUTINE: Balances are zeroed out in the EHR. Claims are billed directly out of Ciao! Optical or through insurance portals.
- Claim submission will vary depending on office and insurance. Refer to your insurance guide or consult your billing team for claim billing responsibility.
- Improper billing may result in unnecessary write-offs and a greater chance of aging patient balances.
- MEDICAL: Balances are left in the EHR. Claims are billed and reconciled out of the EHR. Materials being billed directly to medical carriers should also be entered into the EHR.
- SECONDARY: Medical billers will manage secondary claim filing once primary insurance has been billed.
- Any overpayments will be refunded.

Click HERE to be redirected to the Patient Journey to watch RevolutionEHR How-To-Videos.

Entering Insurance

RevolutionEHR

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Entering Insurance
RevolutionEHR

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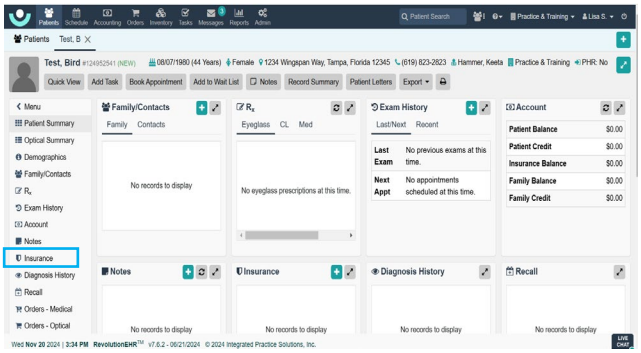
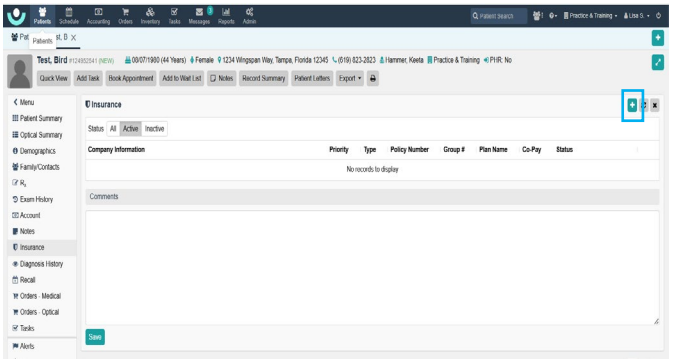
- Confirm the patient's name in the E.H.R. is **exactly as it appears** on the insurance card, including any middle initial. If primary and secondary cards list the name differently, use the name from the primary card.
- **Always enter insurance information for Primary, Secondary, Medical, and Routine insurances.**
- There are several ways to open the insurance screen — from the schedule pod, patient search, or during check-in/encounter. Use the method that works best for you. Steps 2 and 3 are the same no matter how you access the insurance screen.

1 Once the patient is pulled up, Click **insurance** from the navigation bar on the left side of the screen.



2 Click the **+** icon on the right side to add an insurance plan.



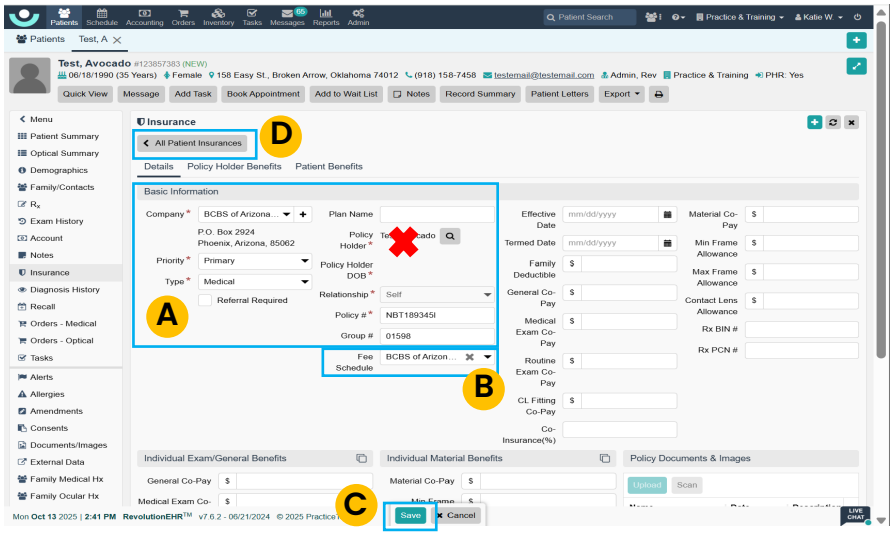
3

A. Select the **Insurance Company, Priority**, and **Type** from the Dropdown menus. Use the claims address and payer ID listed on the card to ensure the correct plan is selected. Enter the **ID number without** dashes, spaces, or special characters. Include the **group number** if listed.

B. Select the correct **Fee Schedule** for Primary Medical and Routine. DO NOT assign a fee schedule to any secondary insurances.

C. Select "Save" at the bottom of the Screen.

D. To add additional insurance, click "All Patient Insurances" and repeat steps 1-3.



Primary Medical + Routine: Confirm the correct fee schedule is selected. This will be important during check-out.

Do NOT assign a fee schedule to secondary insurances.

Select the correct policy-holder, but make sure you update the member ID if it is not the same for each member (i.e. 01, 02 at the end). NOTE: If you select a policy-holder, the fee schedule will be pulled from the policy-holder's insurance demographics.

Tip: You can enter additional details by scrolling down on the page and it will print on your routing/fee slip!

Entering Insurance

Eclips

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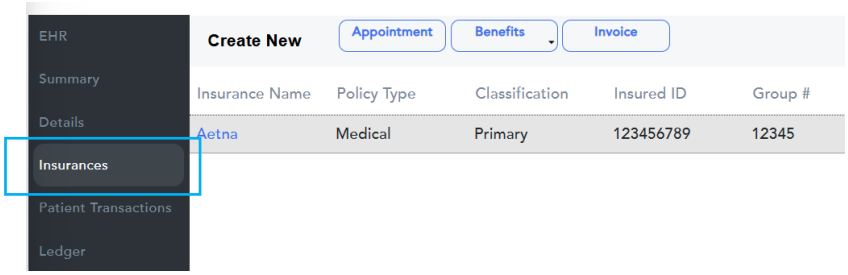
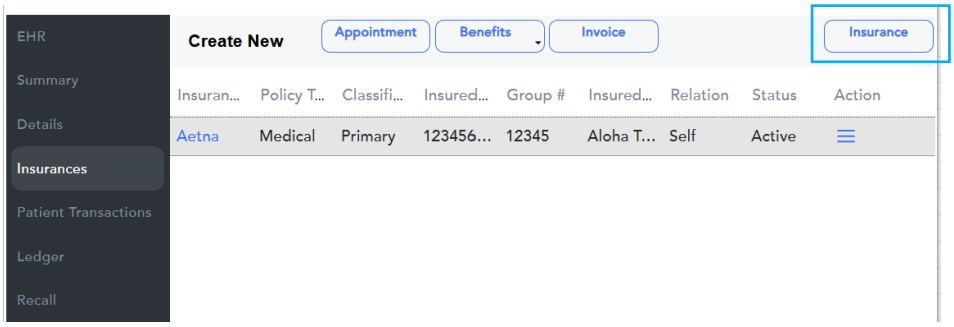
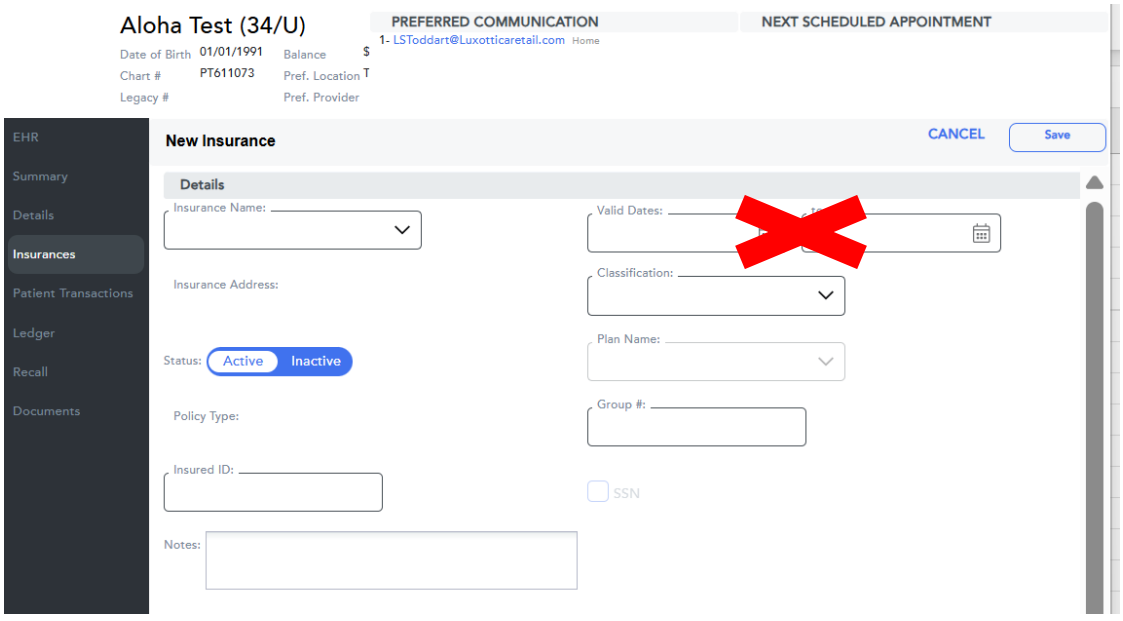
1. Access The Patient Either From The **HOME** Or **PATIENT Tab**
   Once The Patient Is Pulled Up, Select Insurance On Left Side To Enter The Insurance Section



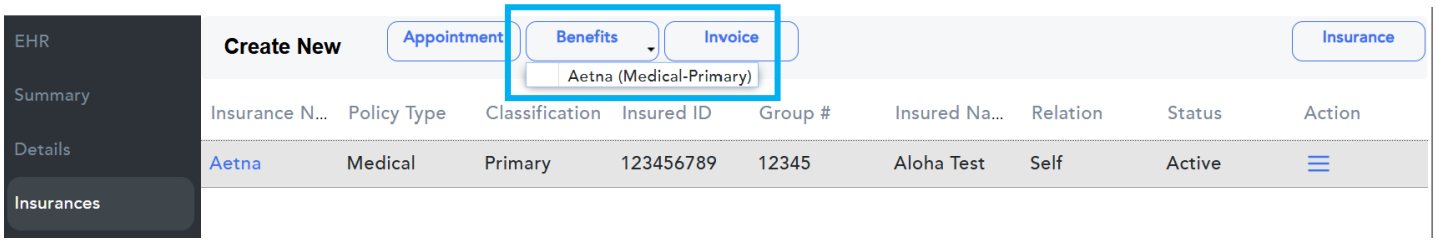
2. Click "Insurance" On The Top Right To Add A Plan



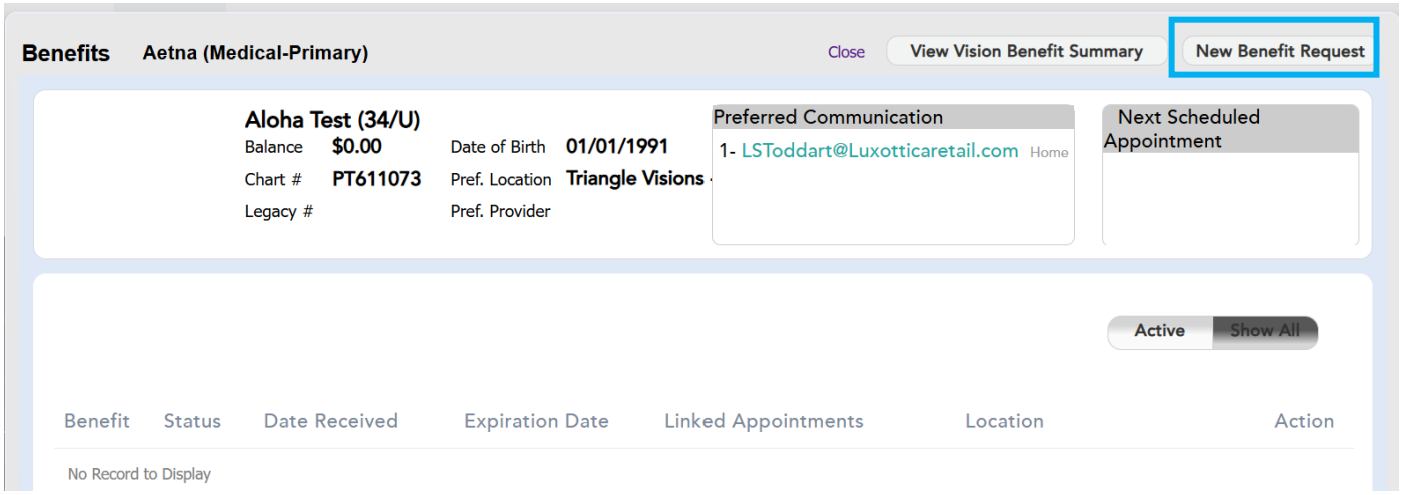
3. Complete all fields accurately and Save. Repeat this step for each insurance (Medical, Routine, Primary, Secondary, etc.):
   - Insurance Name
   - Status
   - Policy Type (Medical, Vision)
   - Insured ID **(NO special characters or spaces)**
   - **DO NOT** enter Valid dates- it will not print on glance sheets if dates are not current
   - Classification (Primary, Secondary, Tertiary)
   - Primary Member information (Note- if member has different ID, you must enter the correct info)
   - Address (this will already be populated if the patient has completed DIF)



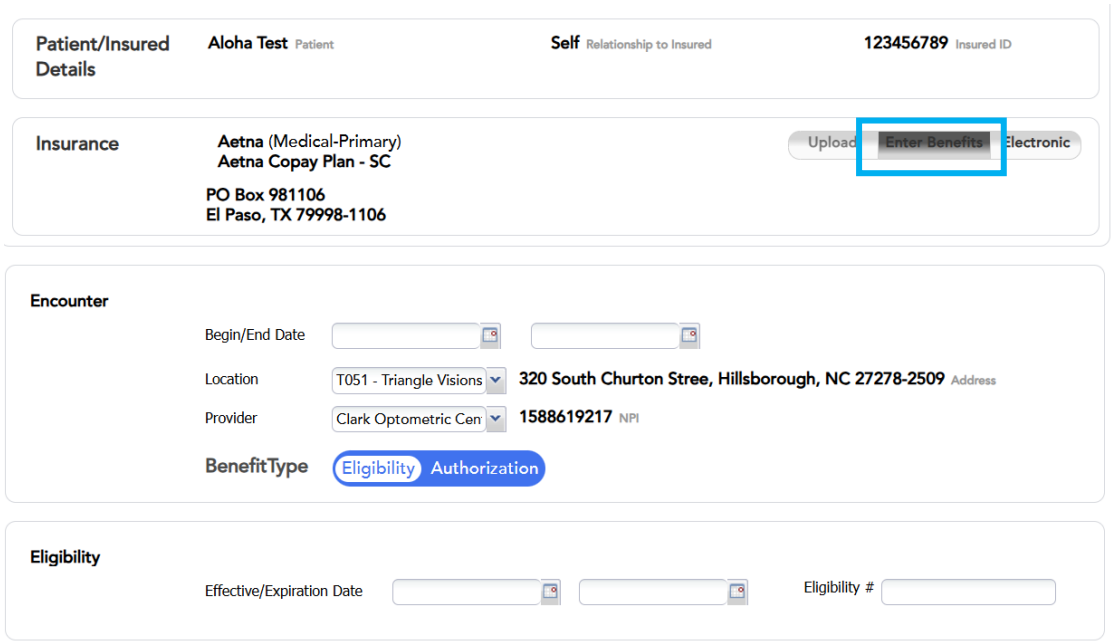
4 When you verify eligibility, enter the patient benefits into the chart for easy access. From the Insurance tab, click "Benefits" then select the insurance you are verifying.



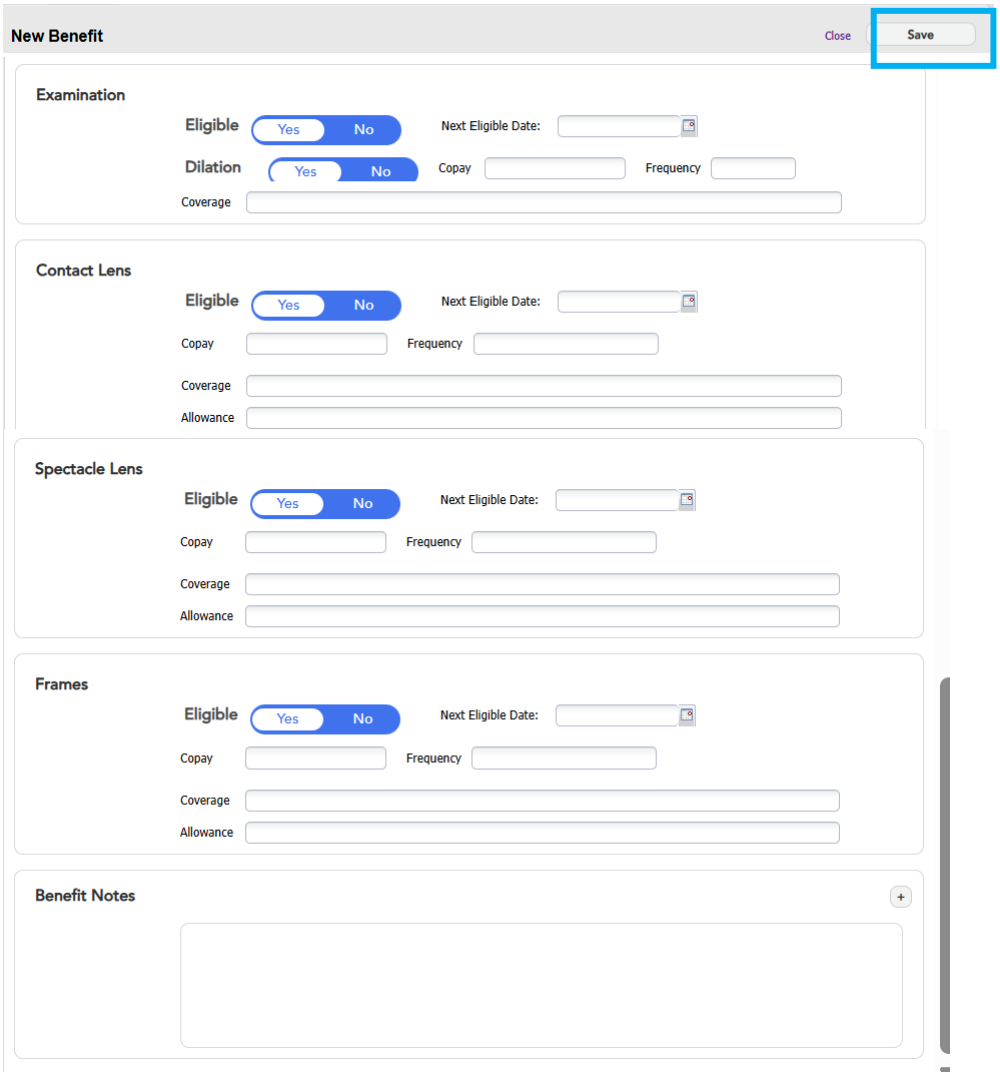
5 Click "New Benefit Request" in the upper right corner.



6 Confirm "Enter Benefit" is selected, then select location, provider, Benefit Type, Eligibility date and (if applicable) Eligibility/Authorization #.



7 Enter eligibility information for each commodity (Exam, Contact Lens, Spectacle Lens, Frames, any special notes, then click “Save”.



SCAN INSURANCE CARDS

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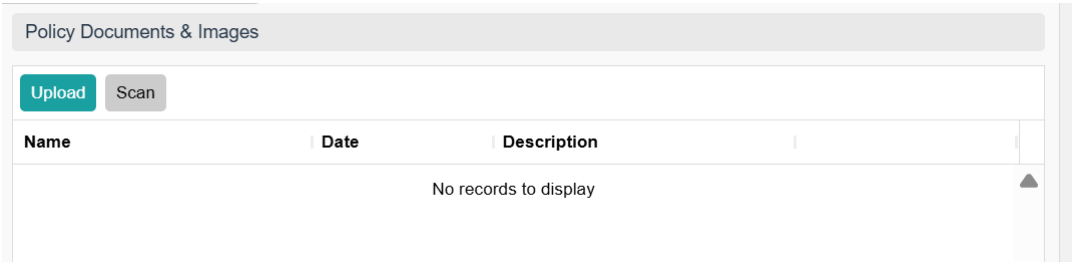
ALL Insurance cards should be scanned (front and back) into the patient's insurance demographics under "Policy Documents & Images" in the E.H.R.

You can either upload a saved document from your computer or click "Scan" to directly scan the patient's card into the chart from your desktop scanner.



Scanning a patient's insurance card into the patient record is a small step that prevents a lot of downstream problems. It ensures correct billing, faster claims, fewer denials, and better patient experience — while protecting the practice legally and financially.

•**Accurate billing & claims submission** — the insurer name, member ID, group number, payer phone, and billing address on the card are needed to submit claims correctly. One wrong digit can cause a denial or delayed payment.

•**Verify coverage & eligibility** — the card shows plan type and sometimes the effective date; staff can check eligibility and benefits before services are provided.

•**Coordination of benefits** — having the card helps identify primary vs. secondary payers and avoid misrouting claims.

•**Prior authorization / referrals** — plan details (e.g., HMO vs. PPO, referring physician requirements) determine whether prior auth or referrals are needed.

•**Identify patient relationship to subscriber** — card often shows whether patient is the subscriber or a dependent (spouse/child) — important for billing and balance responsibility.

•**Reduce patient frustration** — fewer billing errors and re-bills means better patient satisfaction and fewer collection issues.

•**Proof for audits & appeals** — an image of the card supports appeals, audits, or disputes with payers.

•**Legal / compliance recordkeeping** — keeping accurate payer info is part of good medical recordkeeping; ensure it's stored in a HIPAA-compliant way.

Confirming Eligibility

ROUTINE VISION PLANS

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Post Integration:

You may have the same Eyefinity login as before, or you may be assigned a new login. Confirm the correct login with your billing manager.

- Check Eyefinity for all coverage details
- Print the benefit summary ahead of exam (whenever possible)
- Verify you order glasses from the correct lab
- Resources: Product index, plan pays, out of pocket, etc.

For VSP, pull **separate authorizations** for exam (first auth) and materials (second auth).

- Confirm you have entered the correct authorization for the applicable service:

Auth #1- Exam

OR

Auth #2- Materials

EYEFINITY SUPPORT – Click the box to view the video:

How to Check Eligibility & Authorize Benefits (4 min)

Administering Contact Lens Exam Copay with Materials Allowance (3 min)

How to Read the Patient Record Report (7 min)

How to Determine Frame Coverage and Patient Cost (3 min)

Calculating Lens Option Coverage and Patient Cost (4 min)

Determine Contact Lens Coverage & Patient Cost (4 min)

Contact Lens Exam Copay with Materials Allowance Benefit Examples (4 min)

Submitting Claims Exam Only (7 minutes)

Submitting Claims Exam and Basic Glasses (9 minutes)

Submitting Claims Glasses with Enhancements (8 minutes)

Submitting Claims Exam and Contacts (7 minutes)

Post Integration:

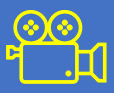
You may have the same login as before, or you may be assigned a new login. Confirm the correct login with your billing manager.

- Check Insurance portal for all coverage details
- Print the benefit summary ahead of exam (whenever possible)
- Verify you order glasses from the correct lab

.

Confirming Eligibility

MEDICAL PLANS



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Trizetto

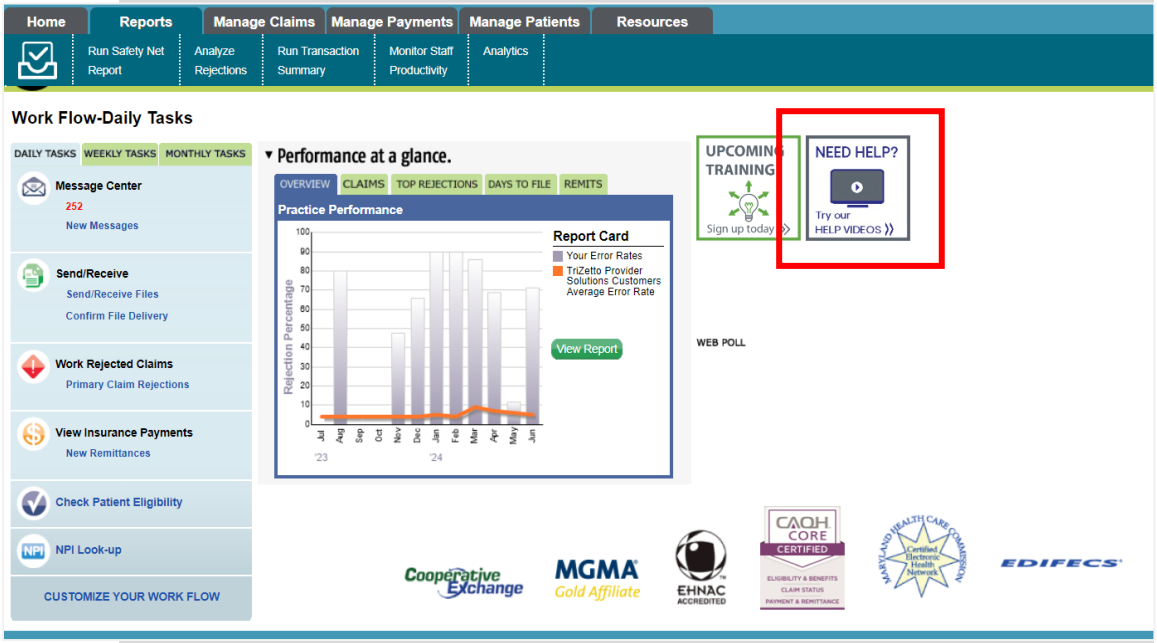
Trizetto Access

- All team members checking eligibility should have their own Trizetto login.
- If you hire a new employee or need access changes, contact your Billing Manager.
- A valid email and cell phone number is required for two-factor authentication.
- Trizetto does not integrate with your ELID- meaning it will not update when you reset your password from the Ciao! Toolkit.
- If you do not log in for 90 days, your account will be deactivated. Contact your Billing Manager for assistance.

Checking Eligibility

- Use Trizetto to verify each patient's insurance eligibility, deductible, and copay **before** the Date of Service (DOS).
- All insurance payors should be available in Trizetto. If any payors are missing, contact your Medical Billing Manager.
- You can also use the insurance carrier's website or Availity to confirm copays and eligibility if needed.

Once logged in, on the home page there are video tutorials to help you navigate the system.



TRIZETTO NAVIGATION

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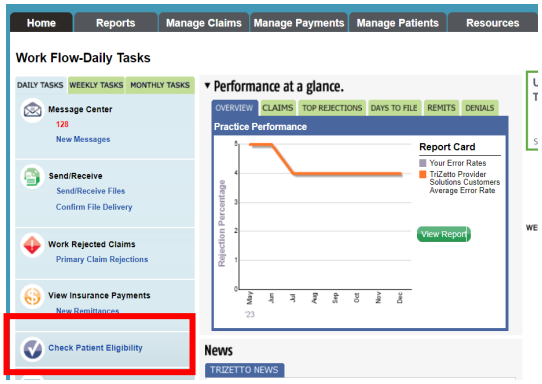
To Login to Trizetto, follow the steps below:

1. Access the Trizetto website via the link in Toolkit (pg 1)

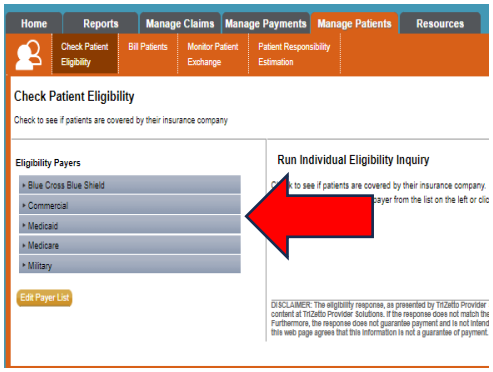
2. Log in with your unique User ID & Password

3. You can check patient Eligibility from the home page or by selecting the **Manage Patients Tab**



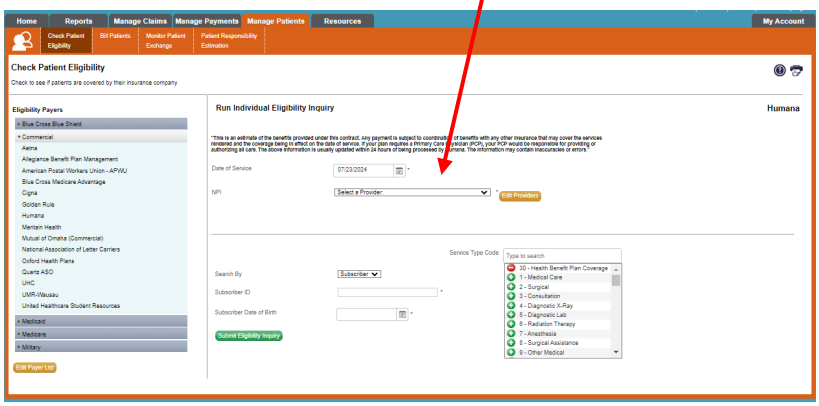
4. Select Run Individual Inquiry

5. Select Payor



Note- if payor or group not listed- email Tracy Martinez

6.
   - Select the **Carrier** from the drop downs on the left
   - Select the **Date Of Service** & **Provider**
   - Enter Subscriber or Dependent **ID Number** and **DOB**
   - On the right side, under **Service Type Code,** confirm:
     - **98** is added for **Office Visit Specialist**
     - **AL** for **Vision**
     - **1** for **Medical Care**



Click to add this search feature

It's added and system will search (clicking will remove search)

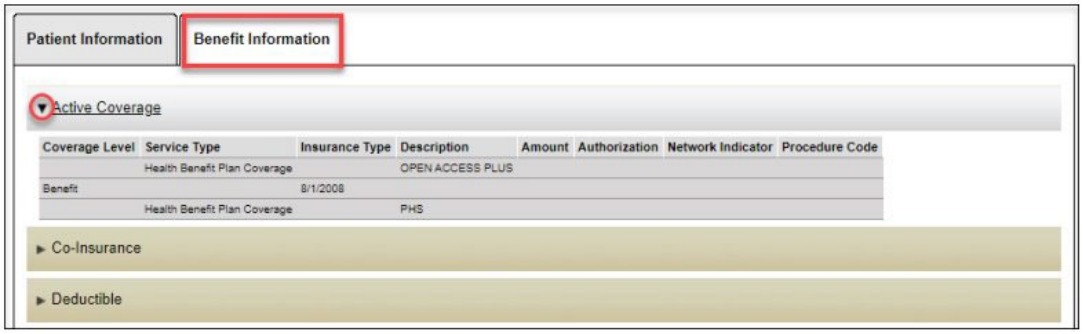
7

- Once a transaction has been submitted, a response screen will be displayed containing the patient's eligibility information
- You will see a message stating **Active Coverage** or **Inactive Coverage**
- This information can be printed by using the printer icon in the upper right-hand corner
- This information will also be stored for up to 18 months under the **Search Eligibility Transaction History** link in your **Check Patient Eligibility** section
- You can also save and upload to the patient's profile in RevolutionEHR

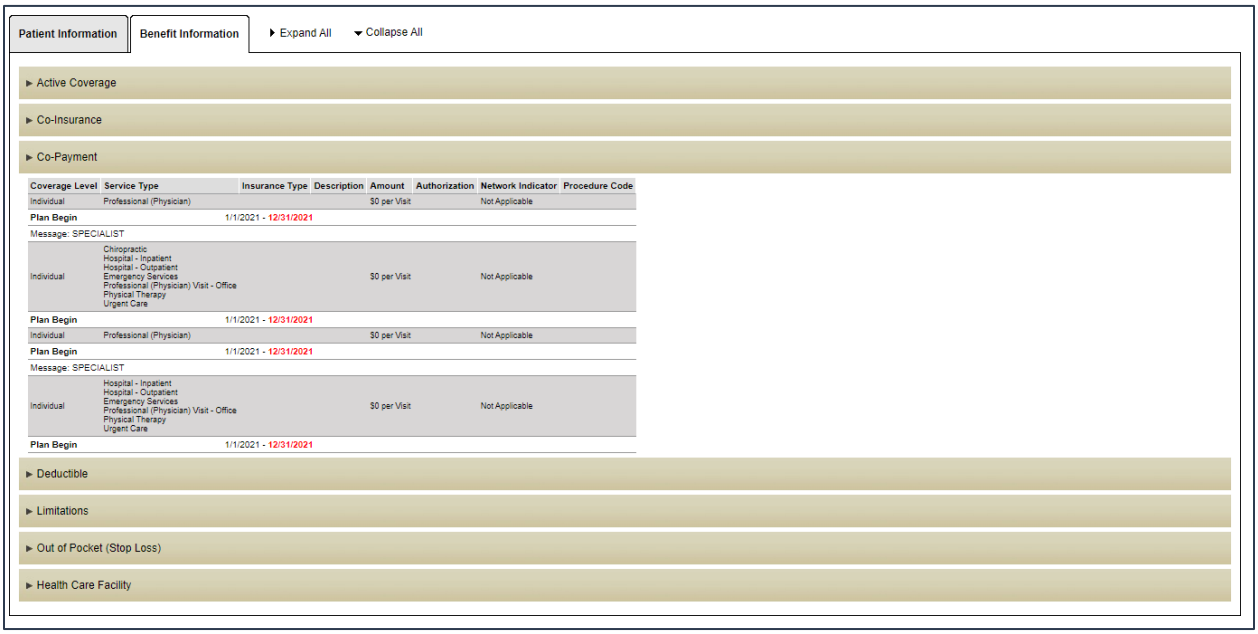
- If a patient's eligibility inquiry doesn't return information, you will see an error message (e.g., payor system down, patient not active, invalid patient or provider information, etc.)
- The error message will guide you on next steps (e.g., contact payor directly, try again if completing in preparation, etc.).

8

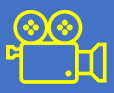
- Navigate to the **Benefit Information** Tab to view coverage details such as **Copays and Deductibles**
- If searching a medical plan, it will show you the vision carrier but not check eligibility



- Review the information and notate the deductibles, copay amount and any other pertinent information (deductible amounts, remaining balances, etc.) in RevolutionEHR



DETERMINING PATIENT RESPONSIBILITY



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Patient has BCBS with a Specialist Copay for services:

Optometrist are considered "Specialist" when it comes to Medical Insurance. We will collect the Specialist Copay.

- In this example, the patient has a $50 Specialist Copay

Commercial Insurance - Copay Plan ($50)				
	U&C Fee	Allowed $	Ins $	Patient OOP
99214	$ 150.00	$ 83.50	$ 33.50	$ 50.00
92134	$ 100.00	$ 37.15	$ 37.15	$ -
92083	$ 120.00	$ 43.75	$ 43.75	$ -

Patient has BCBS with a Deductible/Co-Insurance plan for services:

If the patient has NOT met their annual deductible, they are responsible for paying the allowed amounts for each service.

- In this example, the patient has not met their deductible. The insurance company will not pay any additional money for this claim. If we do not collect the money from the patient, we will not get any payment for services.

Commercial Insurance - Deductible Plan - NOT Met				
	U&C Fee	Allowed $	Ins $	Patient OOP
99214	$ 150.00	$ 83.50	$ -	$ 83.50
92134	$ 100.00	$ 37.15	$ -	$ 37.15
92083	$ 120.00	$ 43.75	$ -	$ 43.75

Patient has BCBS with a Deductible/Co-Insurance plan for services:

If the patient has met their annual deductible, they are responsible for paying the co-insurance % of the allowed amounts for each service.

- In this example, the patient has met their deductible and has a 20% co-insurance.

Commercial Insurance - Deductible Met. 20% - Co-Ins				
	U&C Fee	Allowed $	Ins $	Patient OOP
99214	$ 150.00	$ 83.50	$ 66.80	$ 16.70
92134	$ 100.00	$ 37.15	$ 29.72	$ 7.43
92083	$ 120.00	$ 43.75	$ 35.00	$ 8.75

Patient has BCBS and has met their Out-of-Pocket Maximum/Limit for the year:

- In this example, the patient has met their out-of-pocket maximum and is NOT required to pay any Copay or Co-Insurance for service. (Except non-covered services)

Commercial Insurance - Deductible AND Out of Pocket Max Met				
	U&C Fee	Allowed $	Ins $	Patient OOP
99214	$ 150.00	$ 83.50	$ 83.50	$ -
92134	$ 100.00	$ 37.15	$ 37.15	$ -
92083	$ 120.00	$ 43.75	$ 43.75	$ -
92015	$ 50.00	$ -	$ -	$ 50.00
92310	$ 80.00	$ -	$ -	$ 80.00

Traditional (Part A and Part B) VS Medicare Advantage Plans (Part C):

Traditional (standard) Medicare, Part A and Part B are administered and run by the federal government. Part A covers hospital care and Part B covers for doctor visits. (Red, white and blue card with an eagle at the top).

If a patient has Part A coverage only then we do not file to Medicare because Part A will not apply to TeamVision Office Visits. Traditional Medicare has a yearly deductible that the patient must meet before Medicare will pay. The deductible period starts every year on January 1st and changes every year. Once the patient has met his or her deductible then Medicare will start to pay 80% of their allowable amount for each charge. The patient is responsible for the 20% of the U&C fees unless they have a secondary supplemental insurance.

Traditional Medicare does not cover for a refraction (92015) because they consider a refraction as routine vision. Traditional Medicare only covers for medical diagnoses. They will not cover any routine diagnosis codes.

Part C, also known as Medicare Advantage, is administered and run by private insurers. A Medicare Advantage plan is a policy obtained through an insurance company such as: Aetna, United Healthcare, BlueCross BlueShield, etc.

These plans REPLACE standard Medicare and follow Medicare guidelines - aside from some plans covering a refraction.

With a Medicare Advantage plan, instead of the patient being subject to a Medicare deductible and 20% co-insurance, they usually have fixed copay rates. (Ex: $45 Specialist Office Visit) Medicare Advantage plans are simply a different way of getting Part A and Part B coverage.

Traditional (Part A and Part B) Examples:

Example 1: Patient comes in for routine eye exam (no medical diagnosis) and wants an updated prescription for glasses.

- Patient pays 100% for both comprehensive visit and refraction.

Example 2: Patient comes in, and Doctor codes visit as medical (medical diagnosis required). Patient also wants to update prescription for glasses.

- Patient is responsible for 100% of allowable amount for office visit if deductible has not been met, or 20% of allowable amount if they have met their deductible.
- Patient is responsible for 100% of refraction charge because this is not a covered benefit.

Deductible NOT met				
	Allowed $	Medicare	Secondary	Patient OOP
99214	$ 83.50	$ -	$ -	$ 83.50
92015	$ 50.00	$ -	$ -	$ 50.00
92134	$ 37.15	$ -	$ -	$ 37.15
92083	$ 43.75	$ -	$ -	$ 73.75

Deductible MET w/Secondary				
	Allowed $	Medicare	Secondary	Patient OOP
99214	$ 83.50	$ 66.80	$ 16.70	$ -
92015	$ 50.00	$ -	$ -	$ 50.00
92134	$ 37.15	$ 29.72	$ 7.43	$ -
92083	$ 43.75	$ 35.00	$ 8.75	$ -

Deductible MET w/o Secondary				
	Allowed $	Medicare		Patient OOP
99214	$ 83.50	$ 66.80		$ 16.70
92015	$ 50.00	$ -		$ 50.00
92134	$ 37.15	$ 29.72		$ 7.43
92083	$ 43.75	$ 35.00		$ 8.75

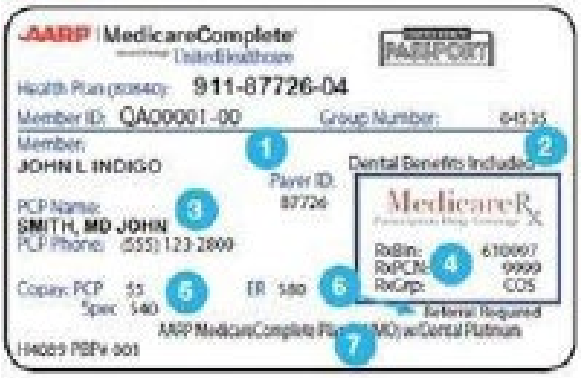
Medicare Advantage Plans (Part C):

These plans REPLACE traditional Medicare.

Part C, also known as Medicare Advantage, is administered and run by private insurers. Medicare care advantage plans follow Medicare guidelines but may provide more coverage than traditional Medicare including coverage for refractions.

Medicare Advantage plans will usually have fixed copay rates. You will always collect the specialist copay.

Medicare Advantage plans are simply a different way of getting Part A and Part B coverage.



Medicare Supplement Plans (Most common Plans are F or G):

A Medicare Supplement Plan is always secondary to traditional Medicare.

Some plans will cover both Medicare's deductible and coinsurance.
In most cases Plan F will cover both.

Some will not cover Medicare yearly deductible such as Plan G and Plan N.

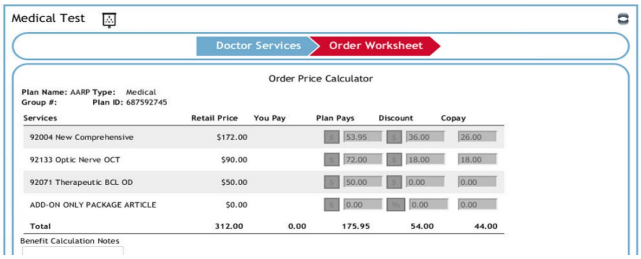
However, benefits will need to be verified as there are different variations of each plan type

Patients will always tell you their secondary covers the deductible, but that is NOT the case. If their secondary does pay, we will send a refund to the patient.

- **How do we manage plans that do cover one visit outside of their deductible?** Treat this as you would any other patient with a medical plan noted in the outlined process. Collect any known copays or amounts owed at the time of service provided.
- **What do we do if a patient wants to pay $0 at time of service and see what's covered by insurance first?** We will collect known patient responsibility amounts up front (include copays, coinsurance, deductibles, etc.). It's the patient's responsibility to pay at the time of service provided.
- **What do we do if a patient has an outstanding balance and is coming in for another service and/or follow-up?** Patient collection is managed on the back-end with RevolutionEHR, Trizetto, and the Assignment Billing Team. The process can vary by location, so confirm the proper processing method with your Medical Biller.
    - Patients can be directed to the payment link on their statement.
    - If the site has access to Transaction Express, credit card payments for patient statements can be collected using the Transaction Express portal.
    - Cash or Checks for patient statement payments should be deposited into the NCNO account.
- **How does secondary coverage work within this process?** Secondary insurance policy information must be entered into RevolutionEHR. **You will not assign charges to the secondary plan in the EHR or Ciao! Optical**. Only the primary is attached to the order. Your Medical Billing Manager will manage the claims process for any secondary plans after primary filing has been completed.
- **What do I do if a fee schedule is missing in my E.H.R.?** Connect with your Medical Biller to add this to your E.H.R.

Ciao! Optical Formula (Only used with Generic/Bill Actual Plans):

Retail Price (RP) - Plan Pays (PP) = Discount (D)



1. Copay Column = What the patient pays us
    - This is its own column and not part of the above formula
    - This could be an overall copay or any out-of-pocket expense the patient is expected to pay
2. Plan Pays = What the insurance pays us
    - Service Fee = Plan Pays when it's a covered item
3. If there is a dollar amount in the copay column, the formula "RP = PP + D" applies
    - Example: For Crizal Rock (not covered by VSP), the patient is charged $85 and this is input in the copay column in Ciao.
    - If there is an amount in the copay column, then you need to make sure that there are numbers in the PP & D columns (above formula).
    - The discount would be the retail price of Crizal Rock line, and the plan pays would be $0 because patient is paying for this add-on.

ROUTINE INSURANCE

Invoicing, Processing, and Filing

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CONSULTATIVE SELLING PATIENT JOURNEY

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Consultative selling (needs-based selling) focuses on understanding and addressing the specific needs of the patient. It involves identifying the patient's goals, challenges, and pain points, and then positioning our products as the solution that best meets those needs.

LEARN about the patient by reviewing history and insurance, even before they arrive. When in clinic, facilitate a conversion around lifestyle, pain points, and needs. Ensure this information is travels with the patient.

LISTEN actively during patient hand-off and ensure to ask additional questions to understand the patients needs. This will guide your sales approach and what products and services to recommend today.

LEAD with a single recommendation for each product to meet lifestyle or prescription needs. Assume the sale and create value. Showcase our preferred products and share the benefits with the patient.

	Prepare	Learn	Listen	Lead	Review	After
STANDARDS	Fill the Books Insurance Welcome	Get To Know Your Patient Consultation	Hand Off Consider Solutions (Product + Service + Referrals)	Assume The Sales Recommend Products	Accurate Entry OneSight Thank You	Order Management Pick Up Optical Expert
TOOLS + RESOURCES	Data Capture Fill The Books	Patient Questionnaire Intake Form	OD Hand Off Observation	LensSimulator SmartShopper Lens Portfolio Guide Contact Price Card Promotions	EyeRuler2 Patient Referral	Take Action Tab Eyewear Analysis
KPI IMPACT	**Exam Growth** Fill Rate No Show Rate	**Sales** Comp Sales	**Retail Capture** OD Productivity Average $ Patient	**Multiples** Sun Avg $ Spec Unit/Lens Avg $ CL, Annual Supply	**EPP** EyeRuler Grateful Patient Google Review	**Google Review** RTFT Reject Dwell

PREPARE
INSURANCE

	Actions	What Does It Sound Like
Capture Medical + Vision	PCC: (can also be done at time of appointment scheduling) • Capture all insurances (Routine + Medical Primary, Medical Secondary) for all patients regardless of exam type. • Document in EHR. • At check-in, scan all insurance cards (front and back).	Team Member: I know you're coming in for a medical exam, but I'd like to update/confirm our records. Do you still have VSP as well as Blue Cross for medical? I don't see a routine insurance carrier on file. Do you have routine coverage along with medical?.....Please make sure to bring all insurance cards with you.
Eligibility/ Pre-Auth	PCC: • Use Trizetto or carrier's website to confirm eligibility, copays, and/or deductibles within 24-48 hours prior to patient arrival. • Document in E.H.R or via office protocols (make sure it's clearly documented and easily found by all team members).	Team Member: Great- now that we have your insurance details, we will check authorization ahead of time and collect copays/deductibles at the time of your visit. Of course, if you add or change services, we will update you on what you can expect to pay.
Co-Pay + Deductible	PCC: (at check in) • Educate patient on copays (or potential copays). • Inform patient that you will be collecting copays at some point during the visit. • Confirm eligibility and copays are clearly visible for the team (listed on routing sheet, printed and on clipboard, etc.).	Team Member: Mrs. Smith, it looks like you have an overall $10 copay for the routine exam. If you choose to add a contact lens exam or imaging, there will be additional fees that the technicians will review with you as needed.

Insurance Process Overview

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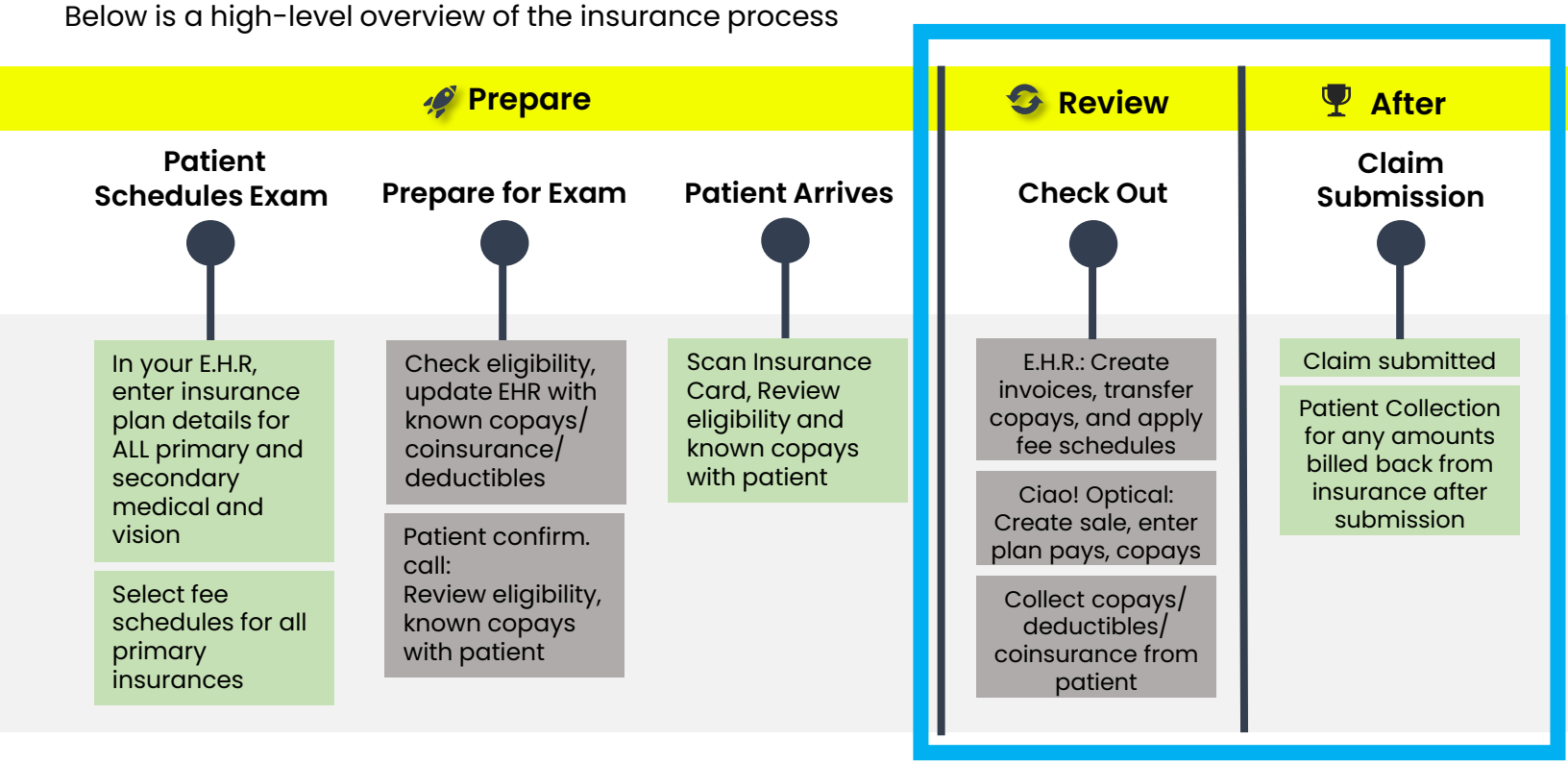
Below is a high-level overview of the insurance process



- Eligibility must be verified PRIOR to the patient's appointment.
  - Check Trizetto and/or Insurance carriers' website ahead of time to know the patient copay/deductible/coinsurance.
- **All copays/coinsurance/deductibles must be collected at the time of service.**
  - **We do not do back bill (i.e., you can not bill the insurance carrier to see what is covered and then send the patient an invoice.)**
- **ALL services must be recorded in BOTH the E.H.R. AND Ciao! Optical (point-of-sale).**
- **ROUTINE: Balances are zeroed out in the EHR.**
- **Claim submission will vary depending on office and insurance. Refer to your insurance guide or consult your billing team for claim billing responsibility.**
- **Improper billing may result in unnecessary write-offs and a greater chance of aging patient balances.**
- MEDICAL: Balances are left in the EHR. Claims are billed and reconciled out of the EHR. Materials being billed directly to medical carriers should also be entered into the EHR.
- SECONDARY: Medical billers will manage secondary claim filing once primary insurance has been billed.
- Any overpayments will be refunded.

Click HERE to be redirected to the Patient Journey to watch RevolutionEHR How-To-Videos.

BALANCES IN THE E.H.R.

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	Medical Insurance	Routine Insurance	Private Pay/Non-Covered Services
E.H.R. Fee Schedule	Apply the Medical Fee Schedule • If copay is owed, transfer copay to patient that pulls from insurance amount owed, the plan pays will be reduced. • If deductible, transfer whatever the patient is paying to the deductible from the insurance plan pays. The plan pays may be $0. Claim will be filed to show patient applied money towards their deductible.	Apply Routine Fee Schedule which will zero out balance	N/A
Copay in the E.H.R.	• Bulk assign to medical carrier > Apply Fee Schedule > Enter Patient Copayment • Leave Insurance invoice as pending- **DO NOT AUTHORIZE** • Complete second invoice for services that are considered patient responsibility	Do not transfer. There are no patient balances left in the E.H.R.	N/A
Balance Left in EHR	Insurance amount owed – After Fee Schedule and Patient Payment Applied	None (discounted down to zero)	Record patient payment.
Ciao Optical!	Post in Ciao! • If copay, make sure that's in the copay column and that the amount patient pays is correct • If deductible, amount also goes copay. If the insurance amount from EHR is $0, there is $0 in plan pays.	Record in Ciao!	Both invoices should be $0 – patient paid
$0 patient balance should be left in E.H.R. (medical insurance balance only)			

Optomap:

- Private pay: Assign to patient and record as paid in E.H.R.
- Routine: Discount services in E.H.R
- Medical: Assign to medical invoice. Transfer copay/coinsurance/deductible to patient, and record as paid in E.H.R.

An optometrist decides whether to bill medical or routine insurance based on **the reason for the visit and the diagnosis.**

Routine insurance (like VSP or EyeMed) is used when the primary purpose of the visit is a vision exam:

- Checking eyesight, updating glasses or contact lens prescription
- Managing general eye health without a medical complaint
- Example: "Blurry vision" or "needs new glasses."
- Routine Diagnosis Codes typically begin with H52.*XXX* or Z01.*XX*
- Common Routine Exam and Diagnosis Codes:

Exam Codes	
92014, 92004	Comprehensive Exam
92012, 92002	Intermediate Exam
92015	Refraction

Diagnosis Codes	
Hyperopia	
H52.00	Unspecified Eye
H52.01	Right Eye
H52.02	Left Eye
H52.03	Bilateral
Myopia	
H52.10	Unspecified Eye
H52.11	Right Eye
H52.12	Left Eye
H52.13	Bilateral

Diagnosis Codes	
Regular Astigmatism	
H52.229	Unspecified Eye
H52.221	Right Eye
H52.222	Left Eye
H52.223	Bilateral
Irregular Astigmatism	
H52.219	Unspecified Eye
H52.211	Right Eye
H52.212	Left Eye
H52.213	Bilateral

- **Medical insurance** (like Blue Cross, Aetna, or Medicare) is used when the patient has a medical complaint or diagnosis affecting the eyes or vision.
  - Example: Red eyes, diabetes, cataracts, dry eye, glaucoma, eye pain, or infections.
  - Medical Diagnosis Codes vary greatly based on condition.
  - **If a doctor assigns a medical diagnosis to a covered service, it MUST be billed to the medical insurance.**
- **Non-Covered (Private Pay) Services-** Coverage varies per patient. Refer to your patient's individual benefit summary to determine the services being provided are covered by their plan. A few common services that **may not be covered:**
  - 92015 Refraction for Medicare patients
  - S9986 Optomap/Retinal imaging photos
  - Specialty Contact Lens Fittings
  - Some Vision Therapy Services
  - Late Cancellation/No show fees

GENERAL RULE: If the diagnosis code does not start with H52 or Z01, there is a HIGH likelihood it is medical.

MULTIPLE INVOICES

CIAO! Optical

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Eye care, together.

Multiple Invoices in Ciao! Optical

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WHAT: When multiple invoices are created for the same patient in Ciao! Optical, it inflates the true number of exams being performed by the office. Anything that is selected in the dropdown menu in Ciao! Optical (Exam or Add-on only package) counts toward your location's exam count. Whenever possible, all services should be listed together on the same invoice in Ciao! Optical.

> EXAMPLE: Patient Suzy Q comes in, and you process one invoice for exam, one for refraction, and one for Optomap. This will look like Suzy Q received three exams on your office report. Instead, bill out all three services on one invoice so they only count as one exam.

WHY: Accurate exam counts help Doctors and Field teams strategize and set appropriate goals for each location. It also makes processing in Ciao! Optical more efficient and saves time for your location.

HOW: There are only three situations where staff **should enter multiple invoices** in Ciao! Optical:

1. Contact Lens Fittings

- **VSP plans with a 15% discount only**. These are true discount plans, not billable insurance.
- Create a separate private pay invoice and use discount code 30638 in X-Store.

2. Optomap Retinal Photos

- For **VSP Medicaid** and **Community Eyecare** plans, if Optomap is included on the same invoice, the entire claim will be denied.
- Enter Optomap/non-covered services on a separate private pay invoice in Ciao! Optical.

3. Medical and Routine Services on the Same Day

- Medical and routine insurance cannot be combined on a single invoice in Ciao! Optical.
- Create two separate invoices in Ciao! Optical—one for each insurance type.
- This is a common occurrence and, unfortunately, cannot be avoided.

For all other circumstances, private pay/non-covered services can be added to an insurance invoice. Make sure to enter the plan pays amount as $0 and the full retail amount in the “Copay” column on the Order Worksheet.

EXAMPLE #1- All Services- Same Invoice

This patient has a Standard VSP Choice Plan with $10 exam copay, $60 CL Fitting, Optomap not covered. For bill-actual plans, manually enter the plan pays, discounts, and copays for each item being billed to insurance.

- 92014 Est Comprehensive is a covered service with a $10 copay
- 92310 CL Fit Level 1 is a covered service with a $60 copay
- 92015 Refraction is a covered service with a $0 copay
- Optomap is a NON-COVERED/PRIVATE PAY service
  - PLAN PAYS = $0
  - DISCOUNT = Full Retail Price
  - COPAY = Full Retail Price

Note: If you use an auto-calc plan, you may have to manually edit the benefit to adjust Optomap/non-covered services accordingly.

EXAMPLE #2: Optomap Retinal Photos - Separate Invoice

VSP Medicaid or Community Eyecare ONLY; Optomap not covered; For all other insurances, Optomap can be added to the SAME invoice as other covered services.

INSURANCE INVOICE Doctor Services > Order Worksheet

Order Price Calculator

DO NOT PUT OPTOMAP ON INSURANCE INVOICE

Plan Name: VSP-TRU **Type:** Assignment
Group #: **Plan ID:** 1836481

Services	Retail Price	Extended Price	Plan Pays	Discount	Copay
92014 Est Comprehensive	$150.00		$ 40	$ 110	10
92015 Refraction	$41.00		$ 11	$ 30	0.00
Eye Exam	$0.00		$ 0.00	$ 0.00	0.00

Benefit Calculation Notes

PRIVATE PAY INVOICE Doctor Services > Order Worksheet

Category	QTY	Item#	Description	Retail Price
Dr. Service				
	1	20500004745180	OD Service Add On Only - REG	$0.00
	1	20500001865928	Optomap	$39.00
	1	20500000523652	ADD-ON ONLY PACKAGE ARTICLE	$0.00
			TOTAL:	$39.00

Main Promotion

Current Offer:

Deal Code:

Associate Sale

Promotion Savings $0.00

YOU PAY: **$39.00**

EXAMPLE #3: Contact Lens Fitting Discount - Separate Invoice

VSP 15% discount only on CL Fitting

INSURANCE INVOICE — Doctor Services › Order Worksheet

Order Price Calculator

Plan Name: VSP-TRU **Type:** Assignment
Group #: **Plan ID:** 1836481

DO NOT PUT CL FITTING ON INSURANCE INVOICE

Services	Retail Price	Extended Price	Plan Pays	Discount	Copay
92014 Est Comprehensive	$150.00		$ 40	$ 110	10
92015 Refraction	$41.00		$ 11	$ 30	0.00
Eye Exam	$0.00		$ 0.00	$ 0.00	0.00

Benefit Calculation Notes

PRIVATE PAY INVOICE — Doctor Services › Order Worksheet

Category	QTY	Item#	Description	Retail Price
Dr. Service				
	1	20500001866369	92310 CL Fit Level 1	$100.00
			TOTAL:	$100.00

Main Promotion

Current Offer:

Deal Code:

Associate Sale

Promotion Savings $0.00

YOU PAY: **$100.00**

IN X-STORE for CL Fitting

1. • **Click F3-** Add a Discount
   • Select Discount Type

Enter discount code found on Promo Card.

EXAMPLE #4: Routine & Medical - Separate Invoice

Both Medical and Routine services on the same day; Private Pay services (i.e. iWellness OCT) can be added to either invoice if other rules previously described do not apply.

ROUTINE INSURANCE INVOICE Doctor Services | Order Worksheet

Order Price Calculator

Plan Name: VSP-TRU **Type:** Assignment
Group #: **Plan ID:** 1836481

Services	Retail Price	Extended Price	Plan Pays	Discount	Copay
92014 Est Comprehensive	$150.00		$ 40	$ 110	10
92015 Refraction	$41.00		$ 11	$ 30	0.00
Eye Exam	$0.00		$ 0.00	$ 0.00	0.00

Benefit Calculation Notes

MEDICAL INSURANCE INVOICE Doctor Services | Order Worksheet

Order Price Calculator

Plan Name: MEDICAL CIGNA-TRU **Type:** Assignment
Group #: **Plan ID:** 1836466

Services	Retail Price	You Pay	Plan Pays	Discount	Copay
OD Service Add On Only - VC NEW	$0.00	$0.00	$ 0.00	$ 0.00	0.00
92083 Visual Field Extended	$80.00	$80.00	$ 8	$ 72	50
92250 Fundus Photography	$80.00	$80.00	$ 35	$ 45	0.00
IWellness OCT	$20.00	$20.00	$ 0.00	$ 20	20
ADD-ON ONLY PACKAGE ARTICLE	$0.00	$0.00	$ 0.00	$ 0.00	0.00
Total	**180.00**	**180.00**	**43.00**	**137.00**	**70.00**

Benefit Calculation Notes

Non-covered service:
Plan Pays = $0
Copay = Full Retail Price

ROUTINE INVOICING

RevolutionEHR

TeamVision
Eye care, together.

ROUTINE INVOICING
RevolutionEHR

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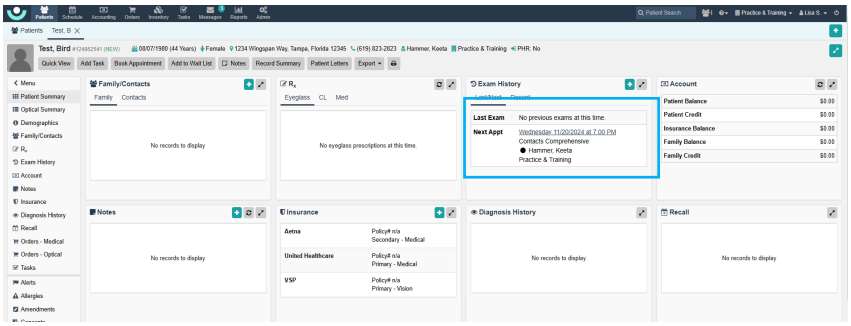
Follow these steps to check out/invoice a routine vision insurance carrier.

Important notes:

- Do not manually create invoices to add services, use the ones coded by your doctors.
- NO patient or insurance balances are left in the E.H.R. for Routine services.

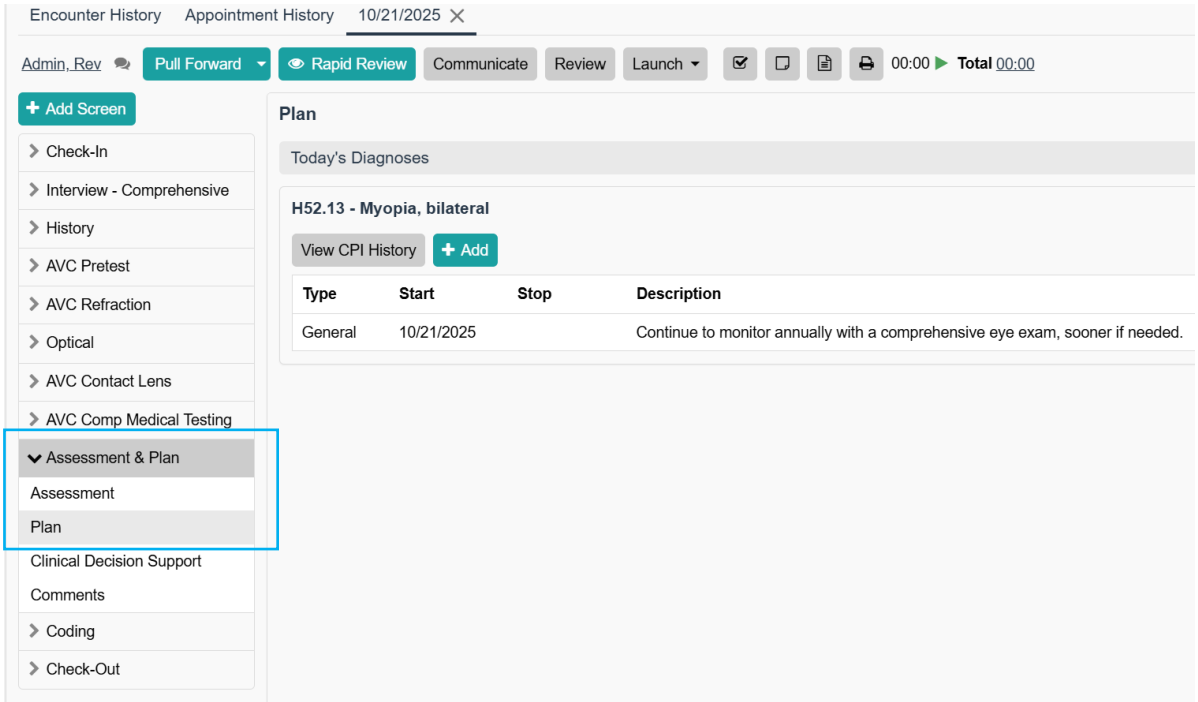
1 Select the hyperlinked **Encounter** from the Exam History tile.



2 From the navigation bar within the encounter, click the **Assessment & Plan** tab, then click **Plan.**

Listen

- This provides a quick overview of the doctor's diagnoses and care plan. It serves as a handoff to keep you informed of patient needs after the exam, such as sales opportunities, follow-ups, education, or referrals.
- Take note of any important information or action items that may need follow-up from this section.



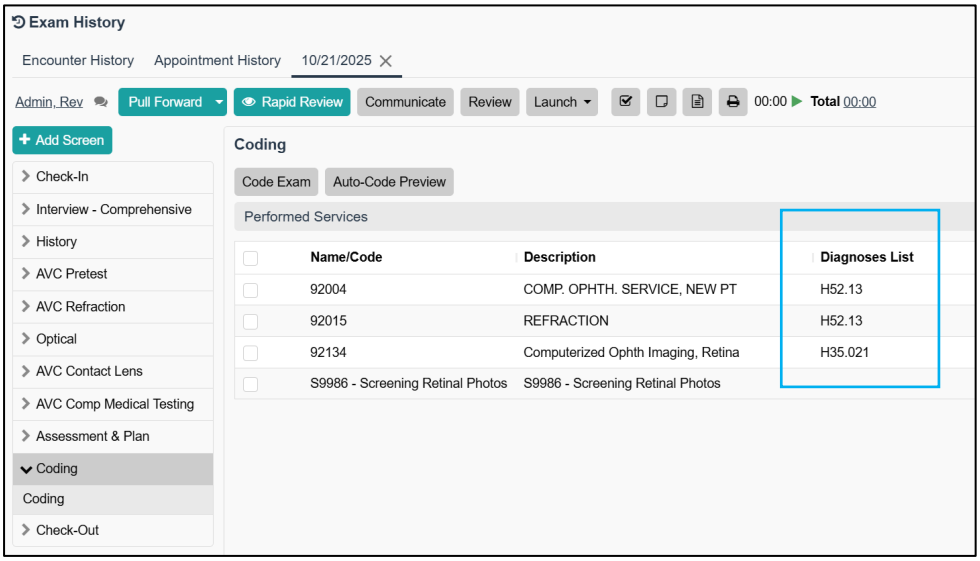
3 From the navigation bar within the encounter, click the **coding** tab.

- This is where you will review the services that were provided and determine responsible payer.
- **NOTE: If a doctor codes a service with a medical diagnosis, it must be billed to medical insurance.**

In the example below, based on the service and diagnosis codes, there are:

- Two routine services (92004, 92015)
- One medical service (92134)
- One private-pay non-covered service (S9986)

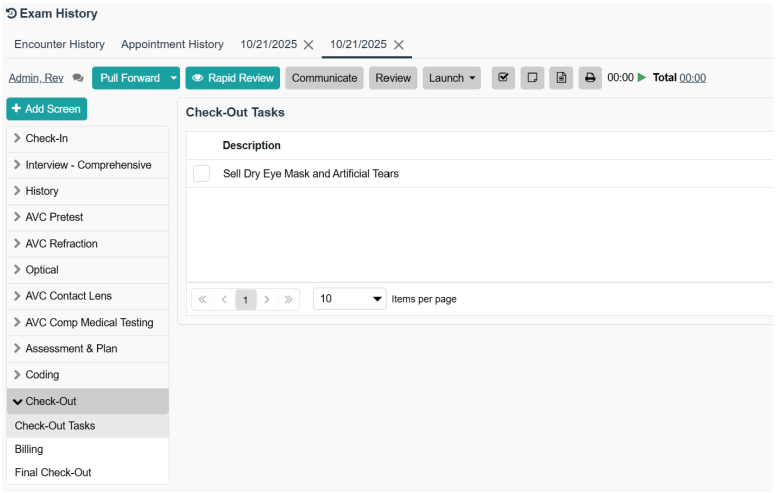
Review



4 From the navigation bar within the encounter, click the **check out** tab.

- If your OD has entered **check out tasks** you must complete those before you go to billing.

Review



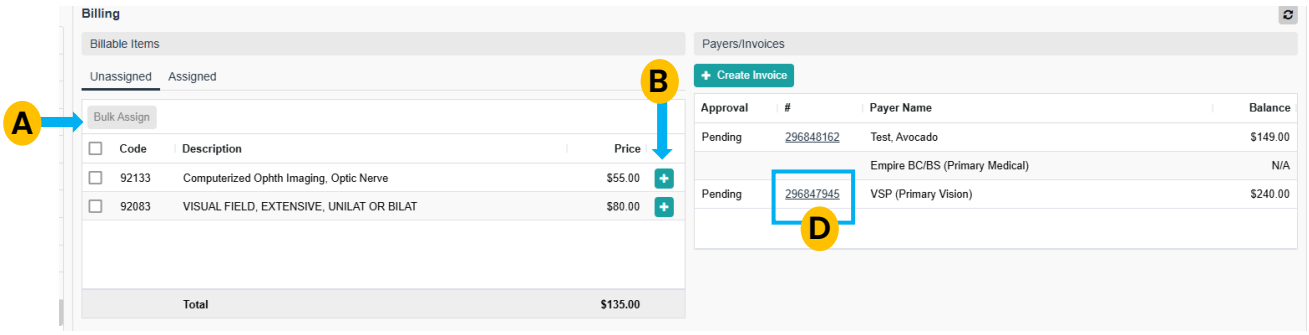
5 Once check-out tasks have been completed, navigate to the **Billing** section.

A. Select multiple services and Bulk Assign **OR**

B. Use the + symbol to assign individual services to the correct Payer

C. Repeat for each payer until all services have been assigned. There should be no services under "Billable Items". These become Unassigned Items on your end of day report.

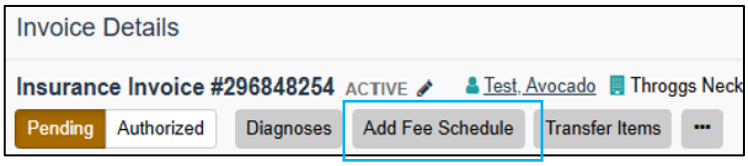
D. This will generate a **pending** invoice. Click the hyperlinked **invoice number** next to the routine payer to open the invoice.

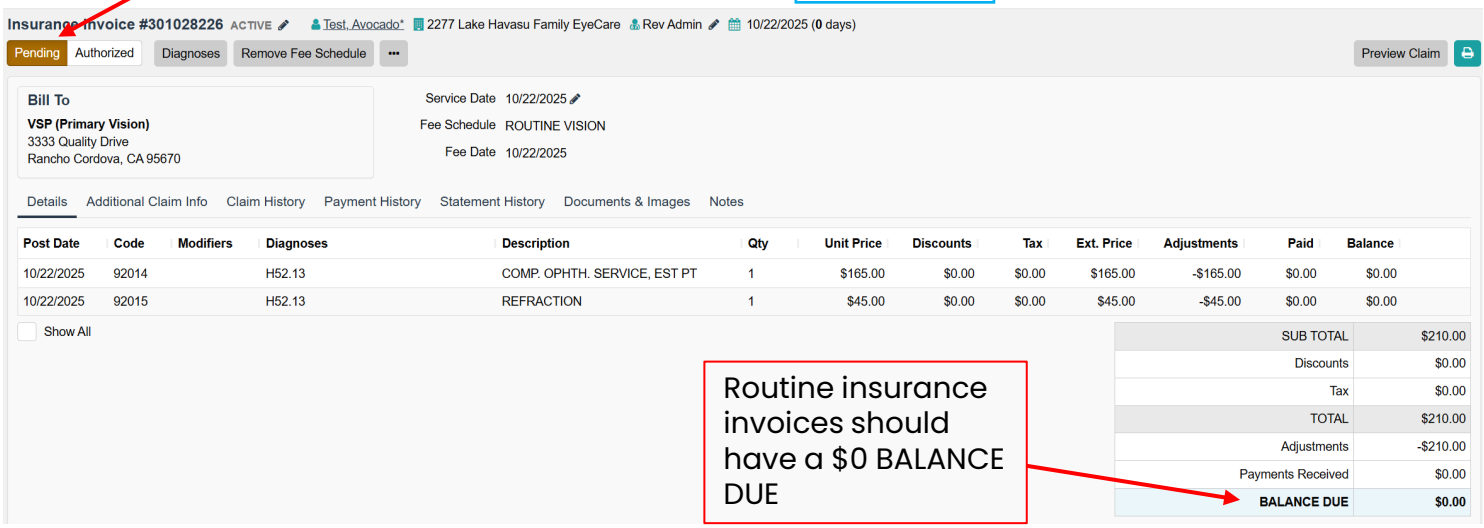


6 Click **add fee schedule.**

- Routine fee schedules write off 100% of the balance, leaving $0 on the insurance invoice. Routine insurance is not managed in the E.H.R.
- If the button is not available, it means that a fee schedule has not been added in the patient demographics section
- DO NOT transfer patient copays for routine insurance carriers. Routine insurance is not managed in the E.H.R. If a patient does NOT pay their routine copay, make a note in the E.H.R. and follow up with your biller for next steps.

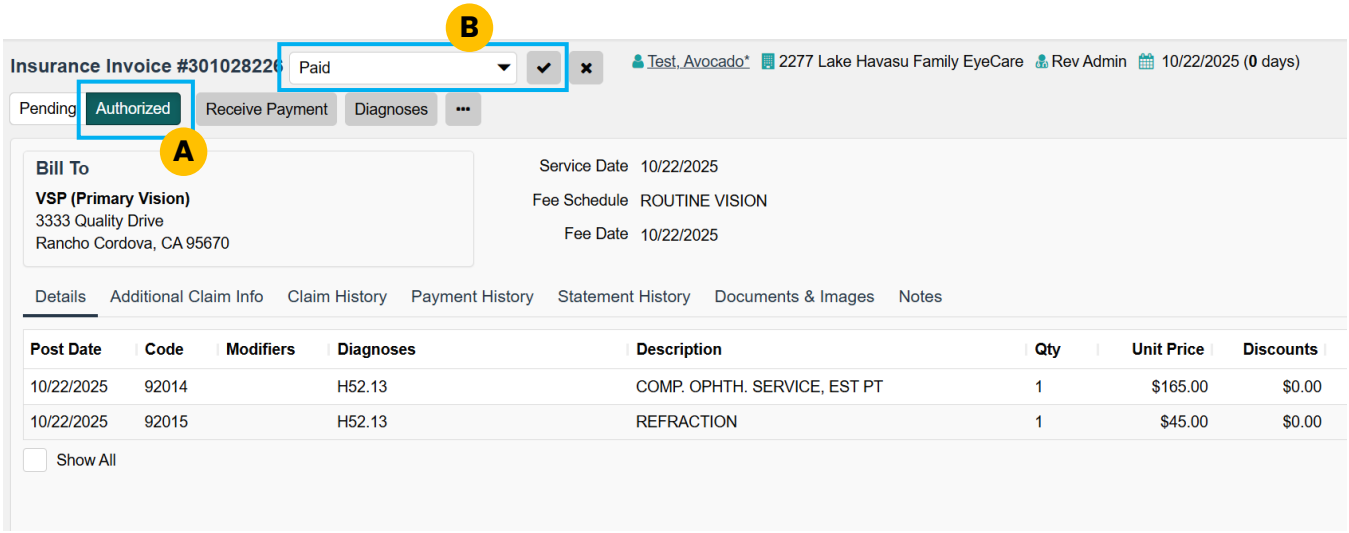
Invoice must be in pending status to apply fee schedule.



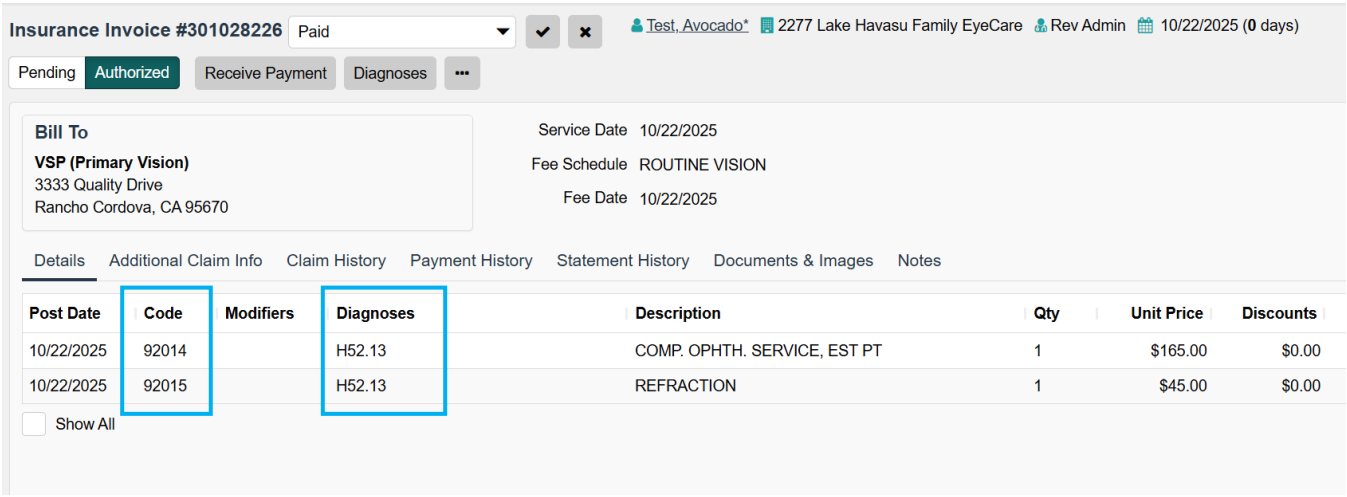


Routine insurance invoices should have a $0 BALANCE DUE

7 Authorize the invoice and select the pencil next to “Active” to mark the invoice as “Paid”.



8 Print or make note of the Service Codes and Diagnoses prior to closing the invoice. You will need this information to enter the services into Ciao! Optical.



All tendering occurs in Ciao! Optical, but some patients may request a more detailed receipt with diagnosis codes for HSA/FSA submission. Invoices may be printed out of the E.H.R. and provided to patients for this purpose.

Send payments to:
2277 Lake Havasu Family EyeCare 2277 Swanson Ave Suite 100 Lake Havasu City AZ 86403 (928) 855-5026

Invoice

Service Date	Invoice Date	Invoice #
10/22/2025	10/22/2025	301028226

Patient	Patient #
Avocado Test	123857383

Provider	Tax ID
Admin, Rev	202146274

Bill To
VSP 3333 QUALITY DRIVE RANCHO CORDOVA CA 95670

Code	Description	Price	Qty	Disc	Tax	Adjs	Paid	Balance
92014	COMP. OPHTH. SERVICE, EST PT Diagnoses: H52.13	$165.00	1	$0.00	$0.00	-$165.0	$0.00	$0.00
	Fee Schedule - Third party discount - Fee reduced/Participating Provider : ($165.00)							
92015	REFRACTION Diagnoses: H52.13	$45.00	1	$0.00	$0.00	-$45.00	$0.00	$0.00
	Fee Schedule - Third party discount - Fee reduced/Participating Provider : ($45.00)							

Sub-Total	$210.00
Discounts	$0.00
Tax	$0.00
Total Amount	$210.00
Adjustments	-$210.00
Payments Received	$0.00
Credits Granted	$0.00
Balance Due	**$0.00**

ROUTINE INVOICING

Eclips

TeamVision
Eye care, together.

ROUTINE INVOICING
Eclips

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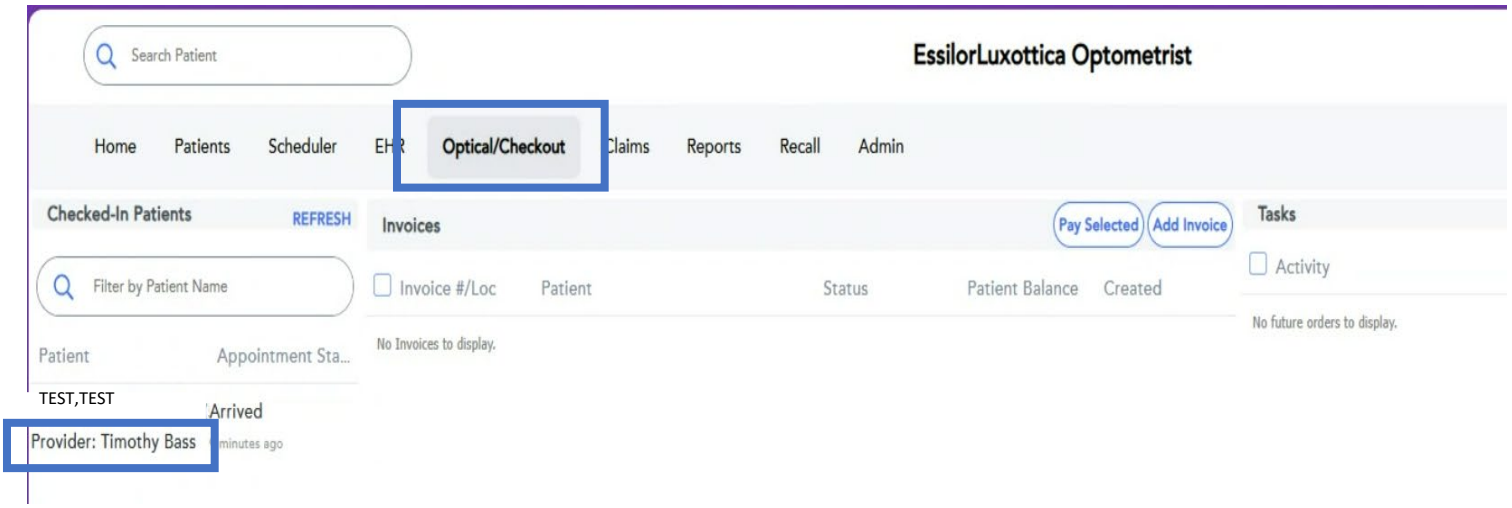
Follow these steps to check out/invoice a routine vision insurance carrier.

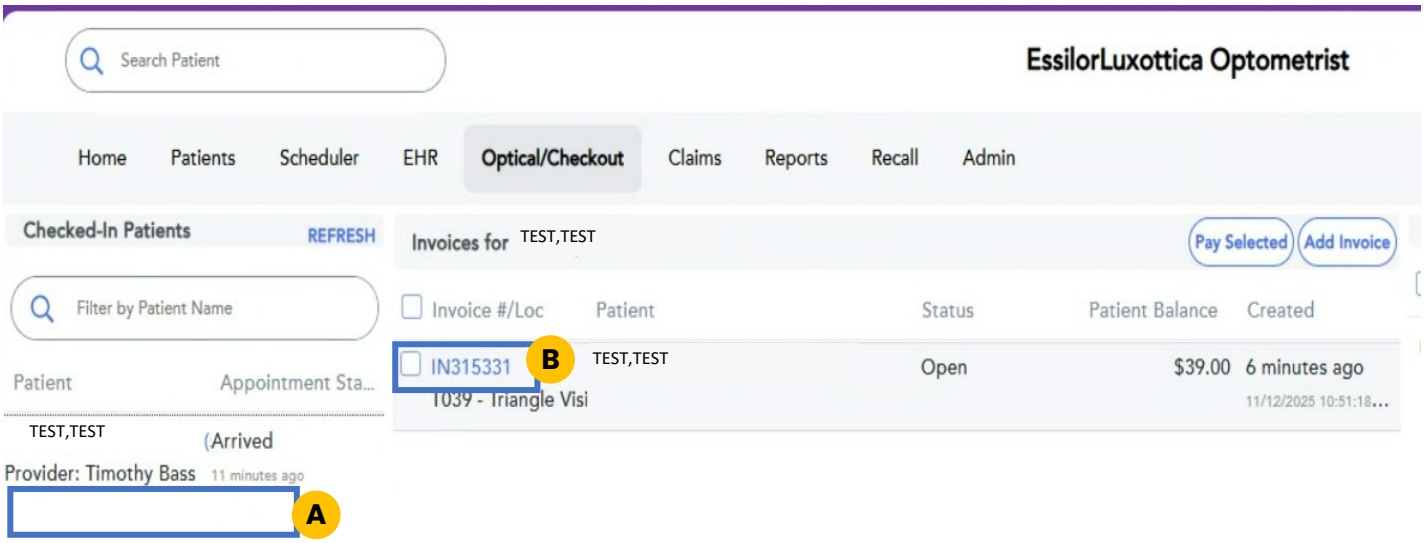
Important notes:

- Do not manually create invoices to add services, use the ones coded by your doctors.
- NO patient or insurance balances are left in the E.H.R. for Routine services.
- You must have at least one diagnosis code on each service line.

1. Navigate to **Optical/Checkout** tab. The patient should have "Provider:____" listed under their name indicating an invoice has been created.



2. Click under the Provider listed in the blank area to open the invoices on the right side of the screen. Then, Click the Blue Invoice Number to open the invoice.

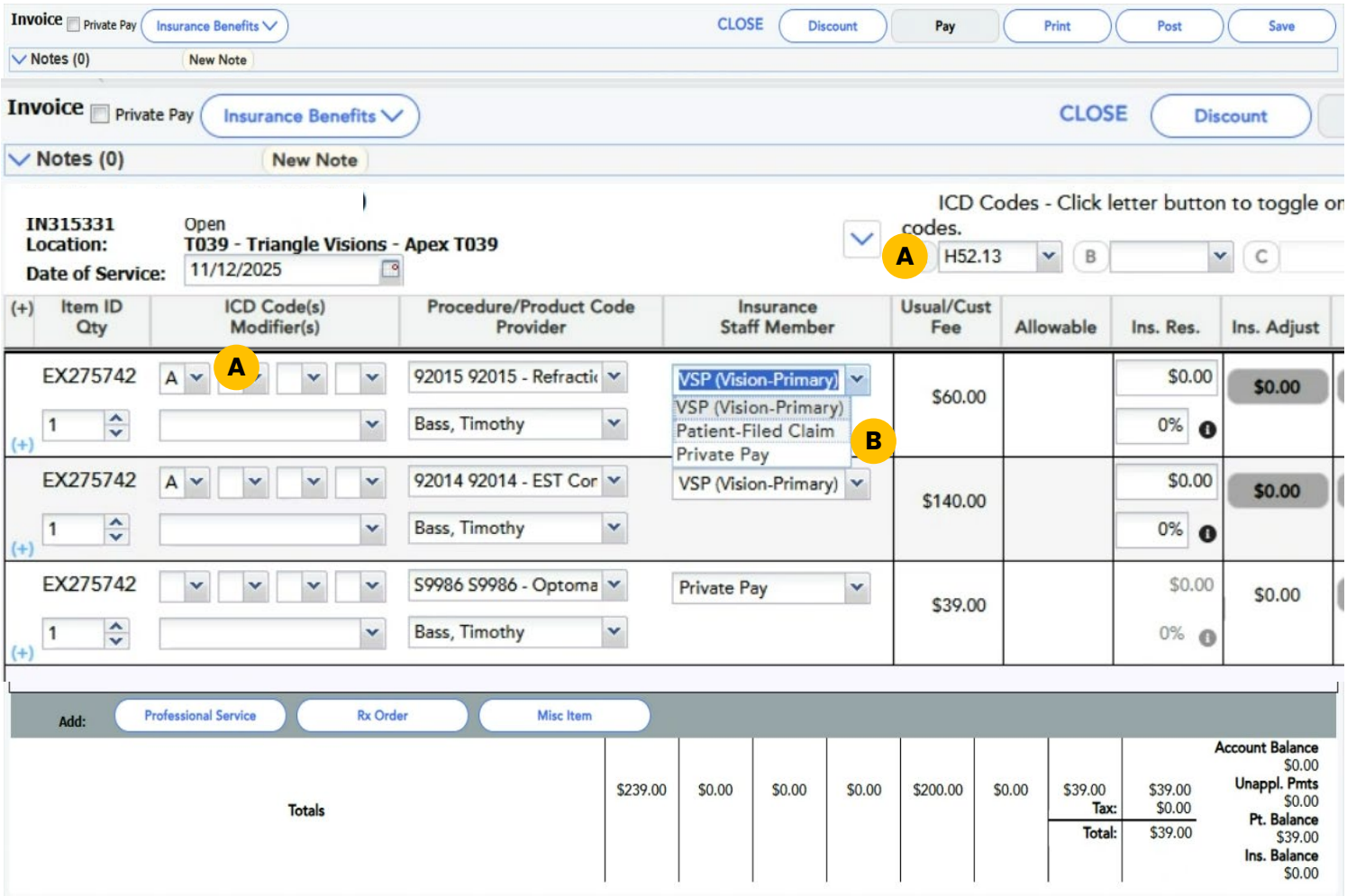


3 The doctor will pre-assign the insurance to each service. Verify that the correct insurance is selected (routine/medical).

A To determine whether it is medical or vision, look at the diagnosis codes listed and assigned to each service.

NOTE: If a doctor codes a service with a medical diagnosis, it must be billed to medical insurance.

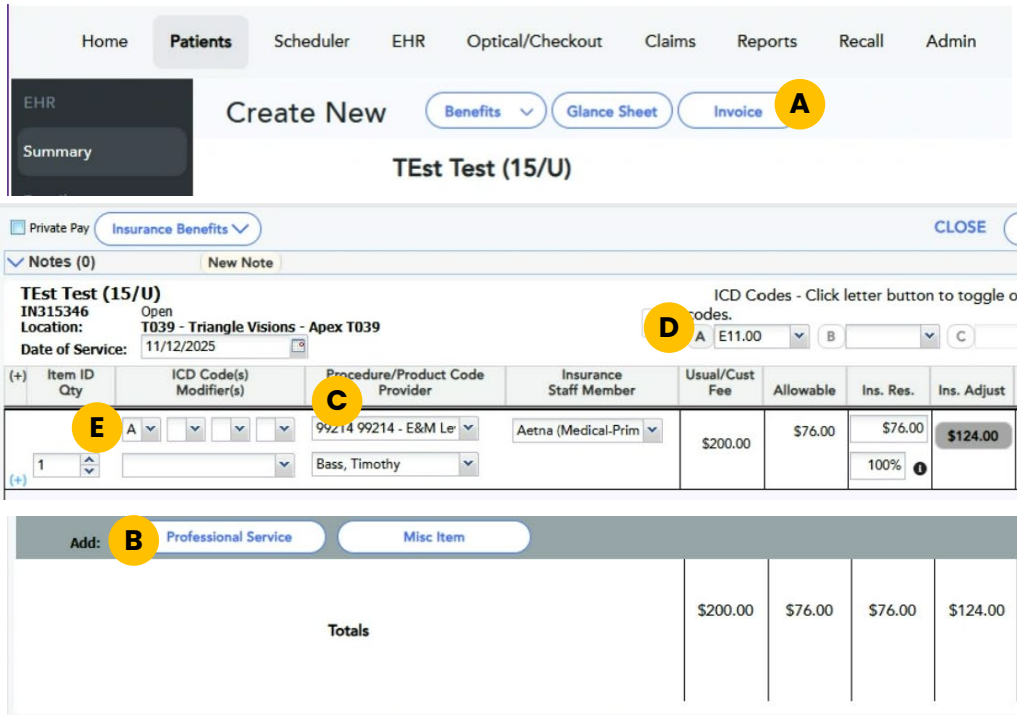
B If necessary, change insurance using dropdown. Fee schedules (allowable) are automatically calculated based on Plan selection in the Insurance Demographics. **For routine, the full U&C is written off to $0. DO NOT TRANSFER PATIENT COPAYS.**



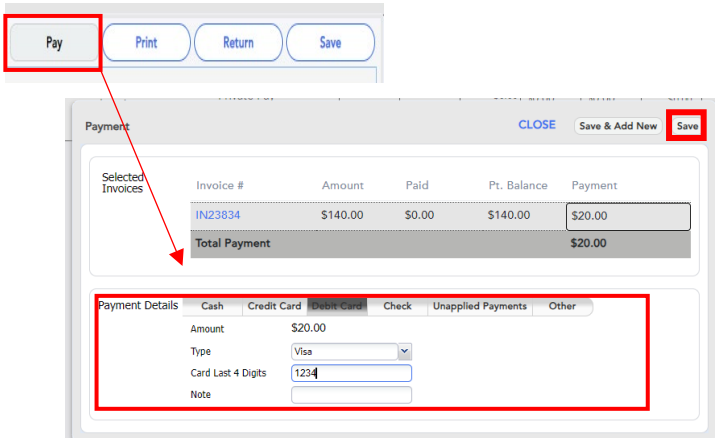
Review

4 If the invoice does not code over from the exam, you may have to manually create and invoice from the patient summary screen.

- **A** Click “invoice” from the patient summary screen.
- **B** Add Professional services
- **C** Type in Procedure code
- **D** Add diagnosis code
- **E** Add diagnosis pointer

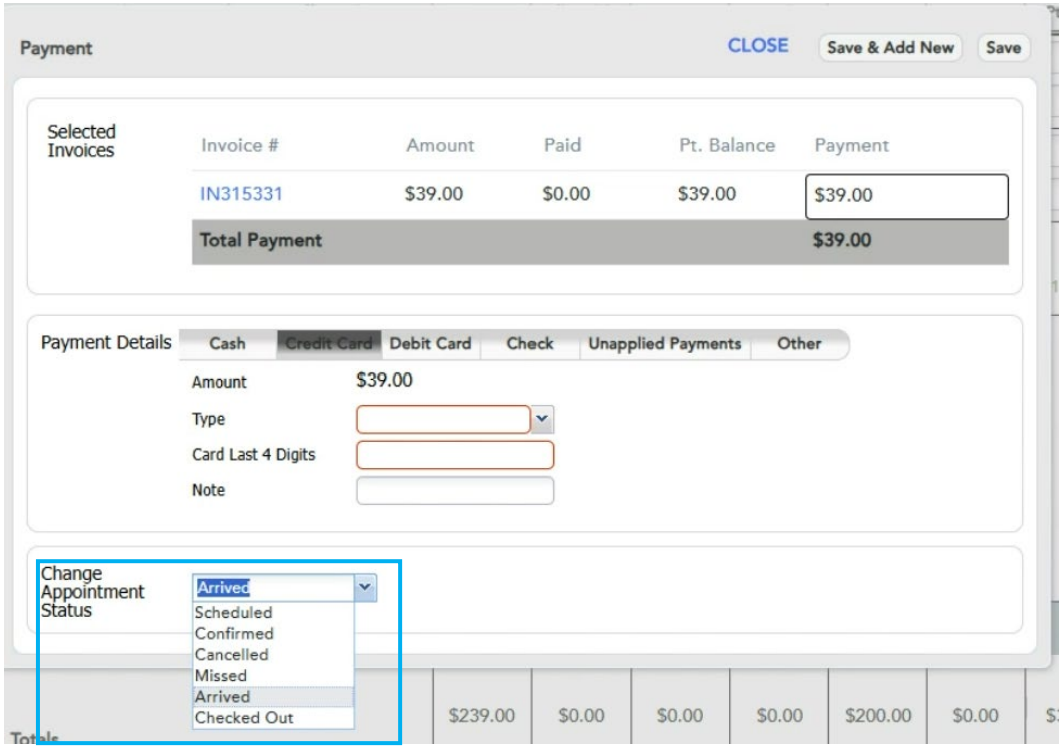


5 For private pay items, click “pay” at the top to receive payment



6 Once all items have been applied and paid, “Change Appointment Status” to “Checked out” on the payment screen.

Click Save and close.



ROUTINE INVOICING

CIAO! Optical

TeamVision
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ROUTINE INVOICING
CIAO! Optical

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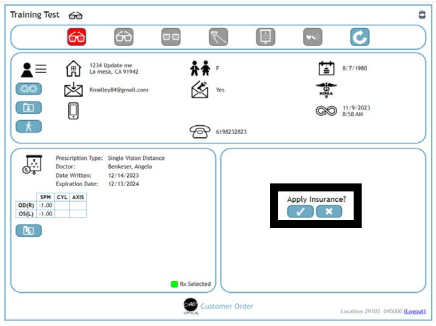
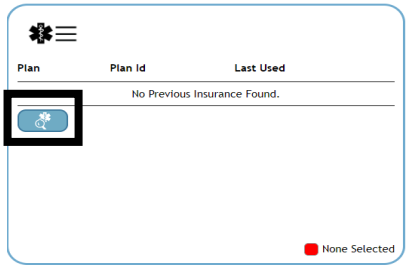
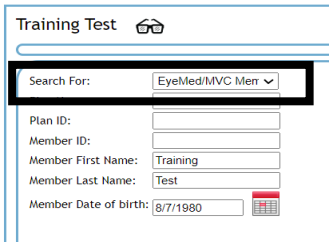
1. Click the Checkmark to indicate you'd like to apply insurance.



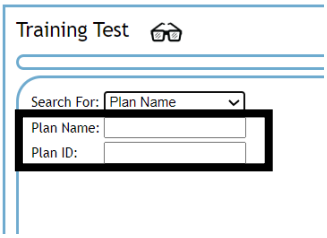
2. Click the blue the Search button.



3. On the Search For pulldown bar, change it to Plan Name



4.
- Fill in the Plan Name or Plan ID from your Google Doc
- Click the Search button (Magnifier)

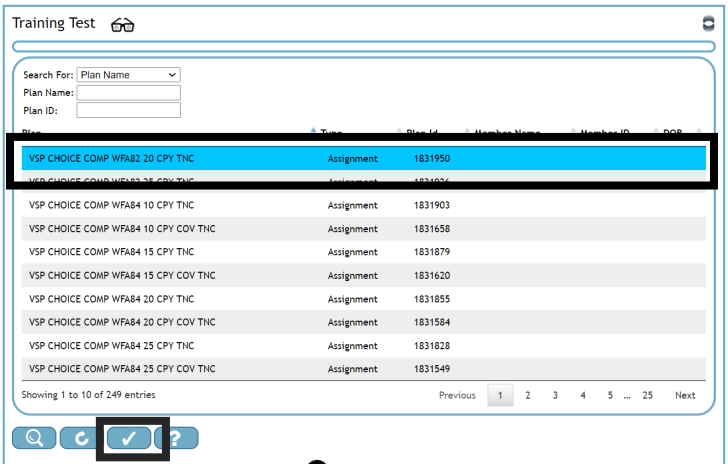


Tip: When searching by Plan Name on your Google Doc, reduce the number of plans by typing in **key words**.

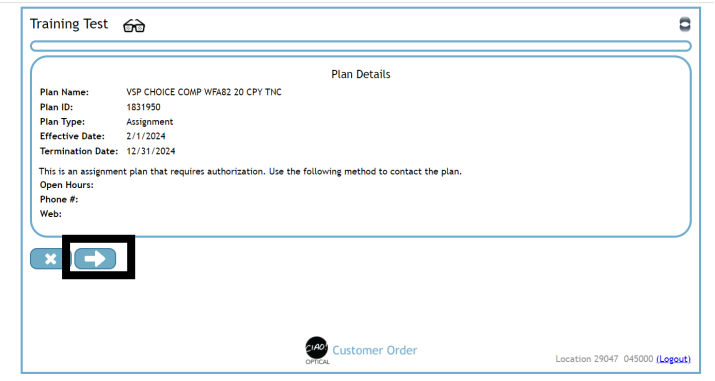
Refer to your Google doc for naming conventions- each practice group could be different.

Some Plans will Auto-Calculate. Others are Bill Actual. Refer to your Site Insurance Binder for your location's specific billing protocols per payer.

5. Select the plan from the listing and click the Checkmark.



6. Confirm you've selected the correct plan and click the Arrow forward.



7 Complete the Insurance Demographics Screen:

A Checkmark the service you are currently entering and enter Material Authorization number
- If carrier does not issue authorizations, enter 1234

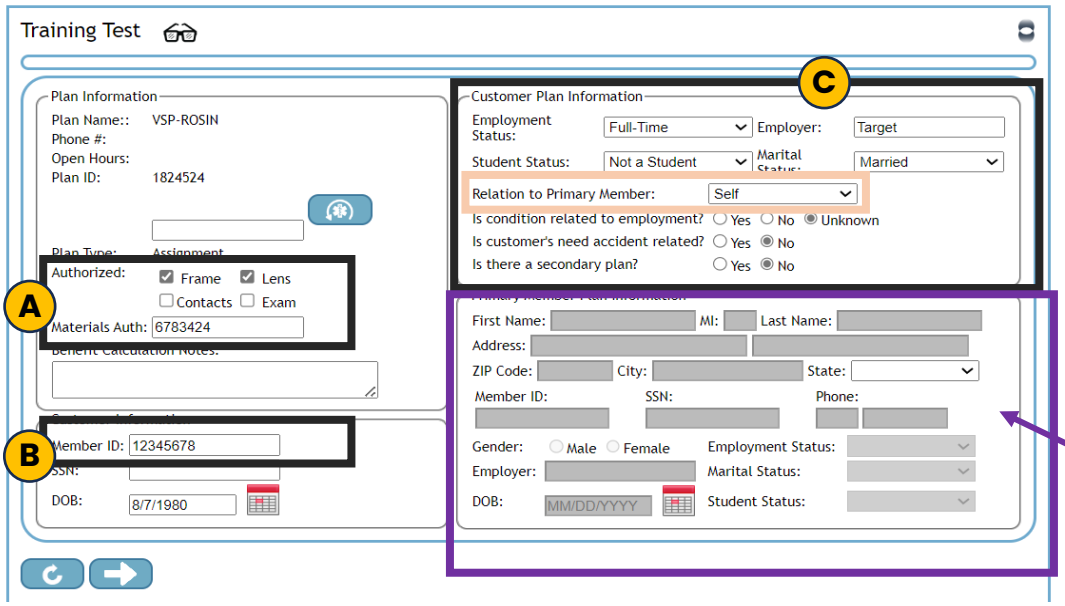
B Enter the Member ID number.

C Complete all fields for Customer Plan Information
- For Primary Member indicate Self
- For Dependents, complete the Primary Member Plan Information for your billing team

D Click the Arrow forward button.

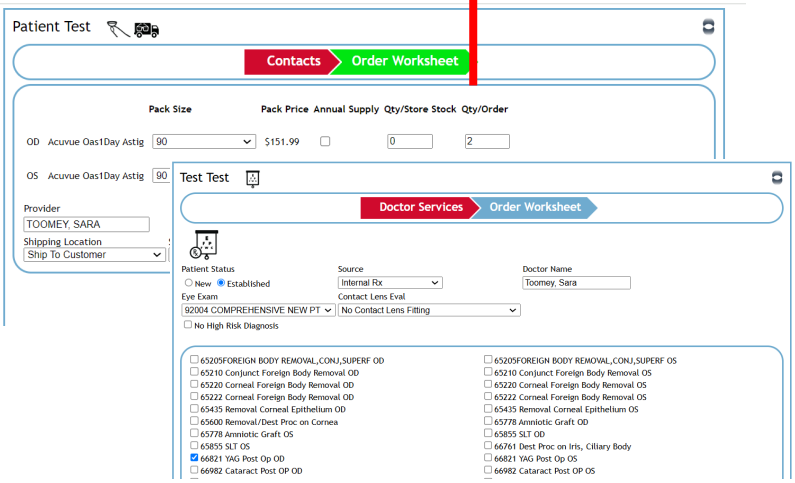
Reminder- Exam and Materials must have separate auth entered in Ciao! for VSP

Some offices use these fields in varying ways for specific insurance plans. Always verify special circumstances with your billing team.

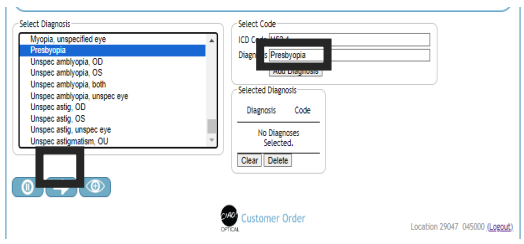


Complete bottom field when it is not the primary subscriber.

8 Enter all services being billed to the ROUTINE insurance and add the appropriate diagnosis code. Click the Arrow to move to the next screen.

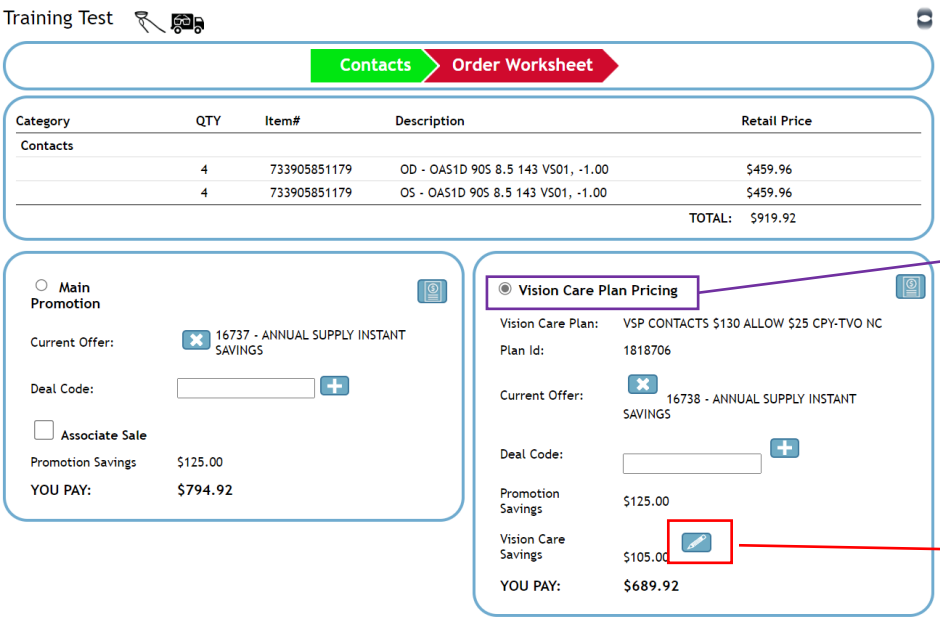


Note: Enter the diagnosis code provided in your E.H.R. for those services.



9 **Auto-Calc plans:** Ciao! will calculate the patient out of pocket expenses. Select the Radio Button and continue.

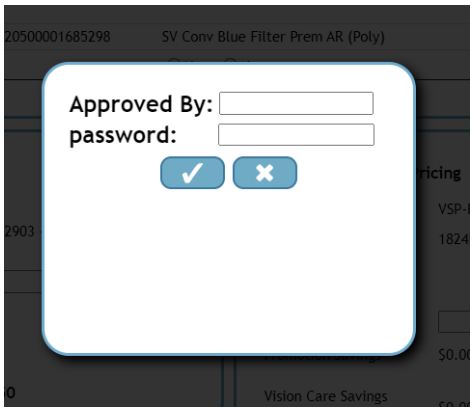
Bill Actual Plans: Click the blue pencil to edit the benefits.



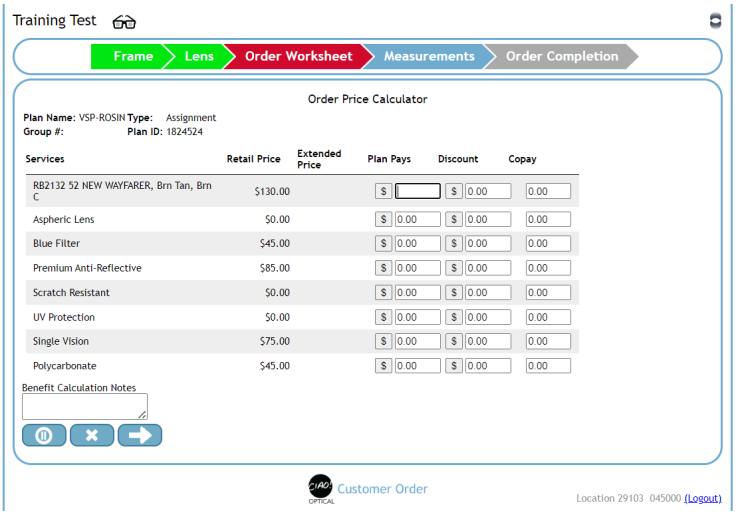
Auto-Calc: Radio button to select insurance pricing

Bill Actual: Edit benefits

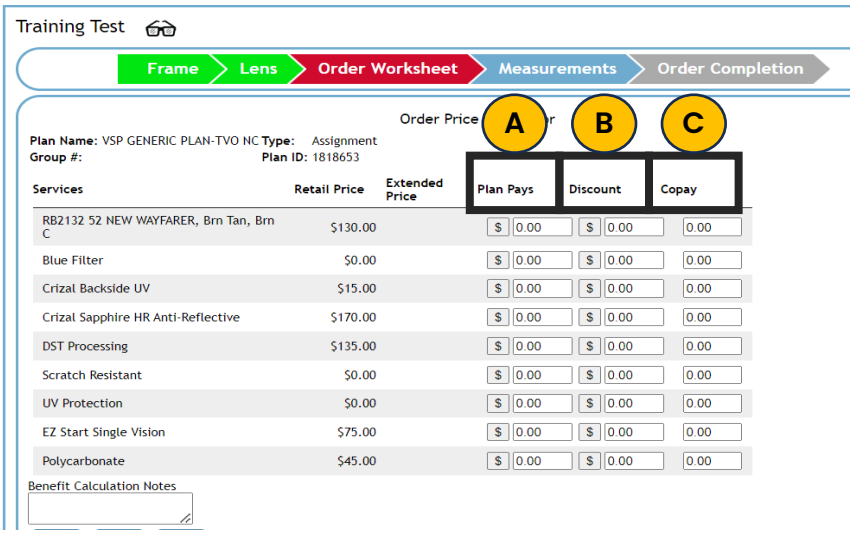
10 Enter your EssilorLuxottica Network Credentials



11 You will now see the Benefit Order Worksheet. **See next page for how to edit benefits.** Once you have finished editing benefits, click the Arrow to return to the main Order Worksheet screen.



Editing the benefits (BILL ACTUAL PLANS ONLY):



A **Plan Pays:** These amounts will be found in your insurance book or on the patient's benefit eligibility summary depending on the insurance.

B **Discount** Retail Price- Plan Pays column = the amount you list in the Discount column

C **Copay:** Patient copays and/or any out-of-pocket(OOP) expenses owed by the patient

Examples of different places you will find the plan pays for Routine Payers

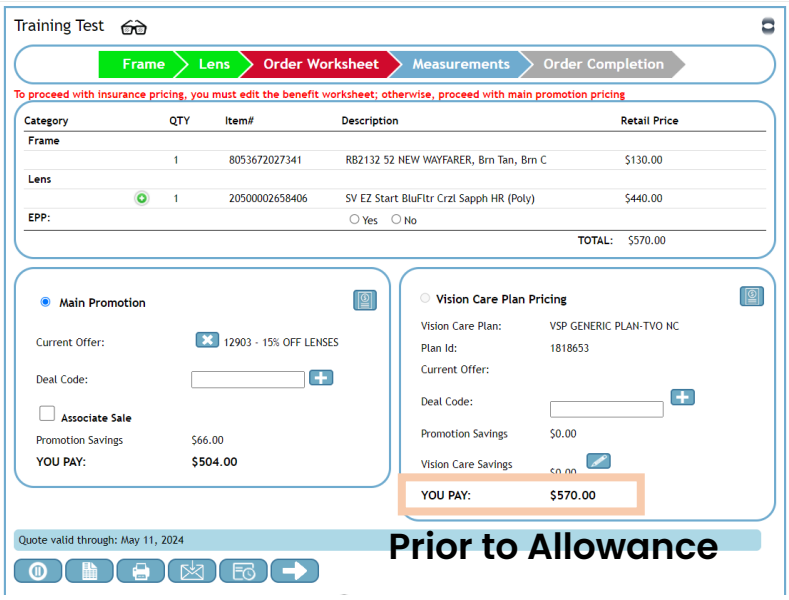
Patient Benefit Eligibility from insurance provider

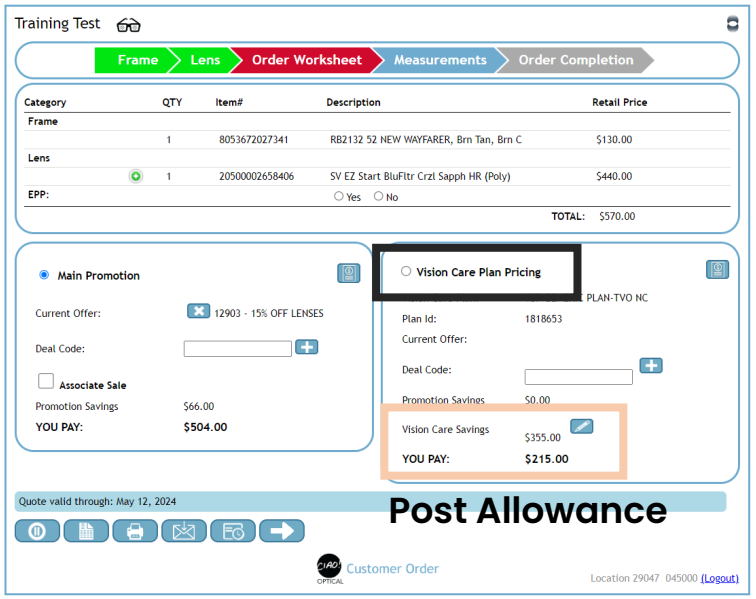
Insurance Binder

VSP Reimbursements	SIGNATURE PLAN	CHOICE PLAN
EYE EXAMINATIONS	**PLAN PAYS**	**PLAN PAYS**
Comprehensive Exam: New 92004 | Est. 92014	$54.40	$49.60
Intermediate Exam: New 92002 | Est. 92012	$21.40	$22.60
Refraction: 92015 ONLY	$13.60	$12.40
MATERIAL DISPENSING	**PLAN PAYS**	**PLAN PAYS**
Single Vision Lenses	$30	$17
Bifocal Lenses**	$39	$21.50
Trifocal Lenses	$44.84	$24.50
Lenticular Lenses	$62.78	$34.30
New Frame	$34	$20.50

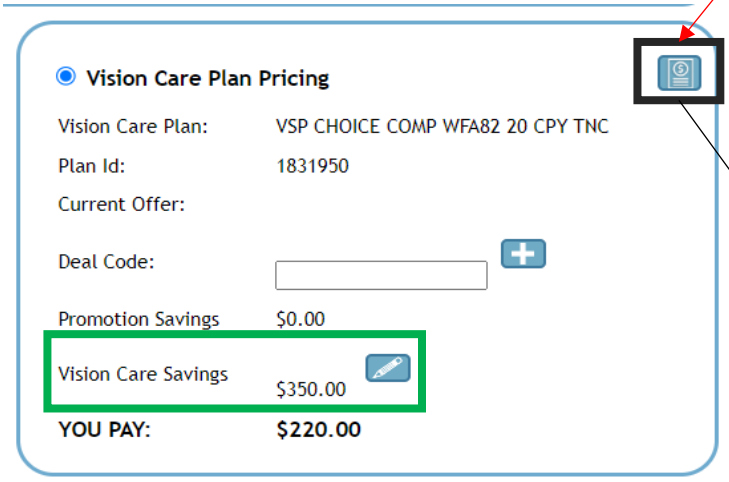
	PATIENT PAYS	PLAN PAYS	
Exam (92004, 92014, 92015)	$15 copay	92004 - $175 92014 - $151	92015 - $0
CL Fit & CLs (Combined Benefit) (92071, 92310, 92317, S0592)	100% of U&C over insurance contribution	Complete 130 = Up to $130 Complete 140 = Up to $140	
Frames (V2020, V2025)	100% of U&C over insurance contribution	Complete 130 = Up to $130 Complete 140 = Up to $140	
Lenses	SV, BF, TF = $15 copay Progressive = $15 copay + (Prog U&C-TF U&C) Poly = $25 copay for 16 & under	SV, BF, TF = 100% of U&C – copay	Prog = 100% of TF U&C - Copay

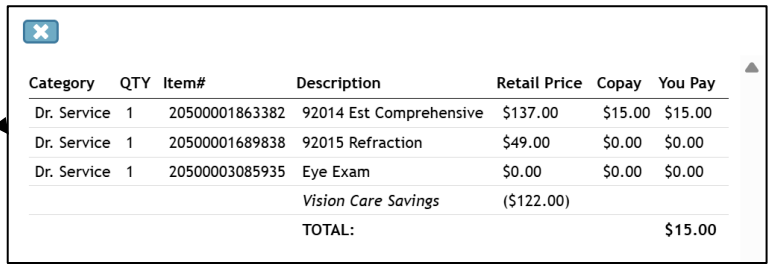
12 Confirm the **YOU PAY** amount is what you expect the patient to pay for the services/materials.





Note: Patients find insurance confusing, so a best practice is to **celebrate the VISION CARE SAVINGS** and share the out-of-pocket costs. If a patient requests to see how it was broken out by line item, click the dollar bill for fees





Category	QTY	Item#	Description	Retail Price	Copay	You Pay
Dr. Service	1	20500001863382	92014 Est Comprehensive	$137.00	$15.00	$15.00
Dr. Service	1	20500001689838	92015 Refraction	$49.00	$0.00	$0.00
Dr. Service	1	20500003085935	Eye Exam	$0.00	$0.00	$0.00
			Vision Care Savings	($122.00)		
			TOTAL:			$15.00

13 Click the checkered flag to bring the order to Active orders.

ROUTINE INSURANCE

Claim Filing

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ROUTINE CLAIM FILING
Overview

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There are four ways claims are filed for routine insurance:

1. Automatically from Ciao! (EyeMed/Aetna integrated insurance plans)
2. Automatically from Ciao! using Auto-calculation Plans (837 File: VSP, Spectera)
3. Manually by Mason Corporate Biller (Most materials, bill-actual plans)
4. Manually by Site Staff (Safety, Community, and specified bill-actual plans)

EyeMed/Aetna Routine:

- Ciao! Optical and EyeMed have a two-way communication stream
- Ciao! Optical tells you patient eligibility and plan coverage in real time
  - Will also provide family member names, eligibility, and coverage
- Once tendered, claim auto files to EyeMed

Automatic through Ciao! with Auto-calculation plan (837 Claim Filing: Exams and contact lenses only.)

- Occurs if routine carrier (e.g., VSP, Spectera, Versant) is set up for this type of claim filing
- Ciao! Optical: Auto-Calculation plans must be utilized
- Data entered into Ciao! Optical must be accurate or claims are denied (authorizations, member details and ID numbers, etc.)
- Data only flows one way- data extracted from Ciao! Optical and placed in a file (think excel spreadsheet) and is sent to carrier weekly (submitted on Thursdays)
  - This means, if a patient had services/materials on a Monday (VSP Auto-Calculation plan in Ciao!), and Tuesday you check the carrier's website, patient may still show as eligible since the claim won't be submitted until Thursday via 837 file)

Generated and sent every THURSDAY

ROUTINE CLAIM FILING
Corporate Mason Billing Team

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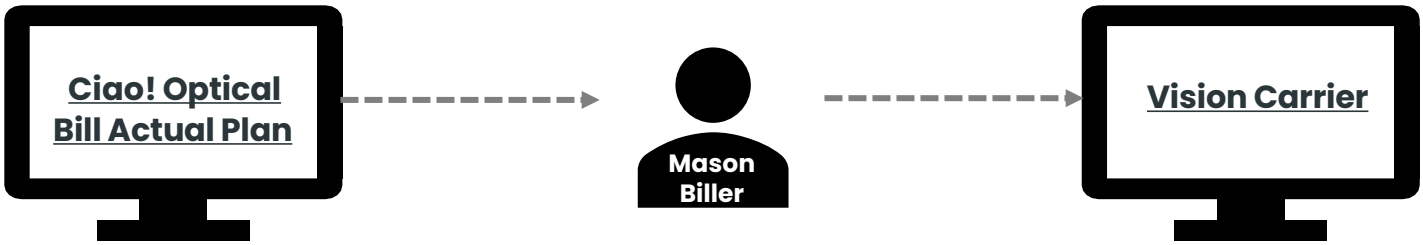
Manually By Mason Billing Team:



- You will be assigned a biller who is employed by the Mason Billing team to submit claims on your behalf.
- All VSP (and most other routine carrier) glasses and bill-actual plans will be billed by the Mason Billing Team.
- The biller will pull data from Ciao! Optical to submit the claim; therefore, it is critical that the correct authorization, member ID, and all patient details are accurate in Ciao! Optical.
- Your Frame and Lens selection must be part of the TeamVision assortment.
    - i.e., you cannot bill your patient for a Varilux lens in Ciao! and order Shamir lenses in Eyefinity.
    - You cannot customize shapes and sizes of Silhouette through insurance labs.
- Your biller will provide you three ways to communicate with them:
    1. Additional Info Sheet (shared excel document)
    2. Email
    3. Teams chat
- NEW LOCATIONS: The Billing Team will begin billing the next business day from the Date of Service (DOS) or your Go-Live date.
    - E.g., Mon 12/2 is DOS, Billing Team starts filing 12/2 claims on 12/3

Additional Info Sheet:

- **Purpose:** Primary form of communication between site and biller, helps track billing accuracy, service speed, and capture data if incorrectly processed in Ciao!
- **VSP Orders:** ALL VSP optical orders must be listed by the site on the Site VSP tab.
- **Other Carriers:** Orders with modifiers, special conditions, or specific notes for your biller should be added to the Non-VSP Tab for your site.
- **Packing slips:**
    - The Additional info sheet will be initialed and highlighted green when the packing slips are ready.
    - The site will login to Eyefinity, print the packing slip, and (if necessary) ship frame to Insurance lab.

If the order has not been billed by the end of day 5 (After DOS), email Christina (Teena) Diggs, Market Manager, Biller, Jennifer Morgan, & Katie Worley.

ROUTINE CLAIM FILING
Site Filing

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There may be certain plan types that your location will be responsible for billing on-site. These may be handled as routine or medical plans depending on how you submit and get paid by the third-party payer. Your insurance binder will list “Site” next to these plans. Some examples include:

- Safety plans
- Community Programs
- Workers Compensation not provided through a medical carrier
- Medically Necessary contact lens claims
- Plans that require specialized paperwork or invoicing
- If claims have gone past 5 days for timely filing with the Mason Billing team

There are certain circumstances under which your site will be asked to bill routine claims. Always communicate with your Market and Billing Manager if you are unsure who is responsible for claim filing.

ROUTINE CLAIM FILING
Denied Claims

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All denials are currently being resolved by the Mason Billing Team. Your Field Leader/PM will be updated with current denial trends due to incorrect Ciao! Optical Entry.

For all claims, denials will occur if:

1. Incorrect Data is entered into Ciao! Optical:
    - Incorrect plan selected
    - Member ID missing or incorrect
    - Primary member details missing or incorrect
    - Authorization numbers and diagnosis missing or incorrect
2. Incorrect Provider selected in Ciao! Optical:
    - The provider must be credentialed with the carrier at the location you are at.
3. The correct Authorization must also be entered into Ciao! Optical for services being billed.
4. Patient not eligible for services
    - **If your patient reschedules their appointment, cancel your original authorization and pull a new one for the rescheduled appointment**.

For Auto Calc Plans, when the claim is denied, you will be mailed a copy of the EOB. The posting team will also receive a copy.

- Weekly, reporting is sent to the collections team.
- The collections team will reach out to the practice if further information is needed.

ROUTINE CLAIM FILING
Billing Examples

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Centralized billing has been established to free you up to spend more time with your patients and to create consistency amongst the brand. This is an evolving process, and updates will happen along the way. When this occurs, we will update this guide.

Claim Filing Overview For VSP and Spectera		
Service	Plan Selected in Ciao!	How Claim Is Submitted To Carrier
Exam	Auto Calculation Plan	• Data pulled from Ciao! and sent directly to VSP for filing (837 File) • Site does not need to file claim
Exam	Bill Actual Plan	• Mason biller will file claim based on data in Ciao! Optical • Site does not need to file claim
$60 Contact Lens Fitting Fee	Auto Calculation Plan	• Data pulled from Ciao! and sent directly to VSP for filing (837 File) • Site does not need to file claim
$60 Contact Lens Fitting Fee	Bill Actual Plan	• Mason biller will file claim based on data in Ciao! Optical • Site does not need to file claim
Updated 15% off Contact Lens Fitting Fee	• Charge as cash pay on separate invoice and apply discount code 30638 in Ciao! • Can tender together with Routine Exam	• Will not be filed with carrier as VSP will not reimburse • Note: If fit attached to VSP Claim it will deduct from the patient's CL Allowance
Contact Lenses (under $1000 U&C)	Auto Calculation Plan	• Data pulled from Ciao! and sent directly to VSP for filing (837 File) • Site does not need to file claim
Contact Lenses (Over $1000 U&C)	Bill Actual Plan	• Mason biller will file claim based on data in Ciao! Optical • Site does not need to file claim
Medically Necessary Contact Lenses	CLICK HERE to access the Medically Necessary Guide	
Eyeglasses	Bill Actual Plan	• Mason biller will file claim based on data in Ciao! Optical • Sites adds to add-info sheet, does not bill
Eyeglasses	Auto Calculation Plan TVO & Rosin only	• Data pulled from Ciao! and sent directly to VSP for filing (837 File) • Site does not need to file claim
If you have any questions, attend TVOps Office Hours or partner with your Field Leader!		

ROUTINE CLAIM FILING
FAQ

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Below answers many of the frequently asked questions regarding the billing process:	
How will I communicate with my biller?	Use two tools daily: • Additional Info Sheet (Excel) • Teams Chat (for questions)
How should I use my Additional Info Sheet?	• ANY notes for your biller should be added (i.e. forgot to put in measurements, had to remake in Ciao!, new order/auth #, etc.) • **List all VSP optical orders on the Site VSP tab.** • For other carriers, use the Non-VSP tab. • Add any Exams with special instructions (i.e. special condition boxes, coordination of benefits) to the non-VSP tab.
How frequently should I check my Additional Info Sheet?	• Someone in the practice should check the Additional Information Sheet daily and respond/update.
How do I know if there is an issue with a claim/order?	• The biller will mark the order in red on the Info Sheet. • If the site does not response in 1–2 days, the biller will follow up via email and Teams.
How long should I quote my patient for eyeglass orders?	• Quote at least 10 business days (3 weeks preferred). • Under-promise and over-deliver.

How and when will I get my packing slip?	• The order will be marked green on the add info sheet when ready.
	• Site logs in and prints packing slip from Eyefinity.
	• For urgent orders, the biller will send within 2–3 hours of notification (next day if after 5 PM EST).
	• If an order is not marked green/billed by Day 5 (after DOS):
	  • Contact your biller directly
	  • Site is then allowed to bill the claim & change it green

Who do I contact if my location is struggling with routine billing processes?	• Review the training videos and documentation in Ciao! Toolkit • Partner with other locations or your Field Leader • Connect directly with your site's routine biller • If concerns are still not resolved, email Christina Diggs with your Field Leader, Jennifer Morgan and Katie Worley on CC • Provide specific examples when bringing billing challenges to leadership

Session 3

Medical Insurance Invoicing & Processing

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CONSULTATIVE SELLING PATIENT JOURNEY

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Consultative selling (needs-based selling) focuses on understanding and addressing the specific needs of the patient. It involves identifying the patient's goals, challenges, and pain points, and then positioning our products as the solution that best meets those needs.

LEARN about the patient by reviewing history and insurance, even before they arrive. When in clinic, facilitate a conversion around lifestyle, pain points, and needs. Ensure this information is travels with the patient.

LISTEN actively during patient hand-off and ensure to ask additional questions to understand the patients needs. This will guide your sales approach and what products and services to recommend today.

LEAD with a single recommendation for each product to meet lifestyle or prescription needs. Assume the sale and create value. Showcase our preferred products and share the benefits with the patient.

	Prepare	Learn	Listen	Lead	Review	After
STANDARDS	Fill the Books Insurance Welcome	Get To Know Your Patient Consultation	Hand Off Consider Solutions (Product + Service + Referrals)	Assume The Sales Recommend Products	Accurate Entry OneSight Thank You	Order Management Pick Up Optical Expert
TOOLS + RESOURCES	Data Capture Fill The Books	Patient Questionnaire Intake Form	OD Hand Off Observation	LensSimulator SmartShopper Lens Portfolio Guide Contact Price Card Promotions	EyeRuler2 Patient Referral	Take Action Tab Eyewear Analysis
KPI IMPACT	**Exam Growth** Fill Rate No Show Rate	**Sales** Comp Sales	**Retail Capture** OD Productivity Average $ Patient	**Multiples** Sun Avg $ Spec Unit/Lens Avg $ CL, Annual Supply	**EPP** EyeRuler Grateful Patient Google Review	**Google Review** RTFT Reject Dwell

PREPARE
INSURANCE

	Actions	What Does It Sound Like
Capture Medical + Vision	PCC: (can also be done at time of appointment scheduling) • Capture all insurances (Routine + Medical Primary, Medical Secondary) for all patients regardless of exam type. • Document in EHR. • At check-in, scan all insurance cards (front and back).	Team Member: I know you're coming in for a medical exam, but I'd like to update/confirm our records. Do you still have VSP as well as Blue Cross for medical? I don't see a routine insurance carrier on file. Do you have routine coverage along with medical?.....Please make sure to bring all insurance cards with you.
Eligibility/ Pre-Auth	PCC: • Use Trizetto or carrier's website to confirm eligibility, copays, and/or deductibles within 24-48 hours prior to patient arrival. • Document in E.H.R or via office protocols (make sure it's clearly documented and easily found by all team members).	Team Member: Great- now that we have your insurance details, we will check authorization ahead of time and collect copays/deductibles at the time of your visit. Of course, if you add or change services, we will update you on what you can expect to pay.
Co-Pay + Deductible	PCC: (at check in) • Educate patient on copays (or potential copays). • Inform patient that you will be collecting copays at some point during the visit. • Confirm eligibility and copays are clearly visible for the team (listed on routing sheet, printed and on clipboard, etc.).	Team Member: Mrs. Smith, it looks like you have an overall $10 copay for the routine exam. If you choose to add a contact lens exam or imaging, there will be additional fees that the technicians will review with you as needed.

Insurance Process Overview

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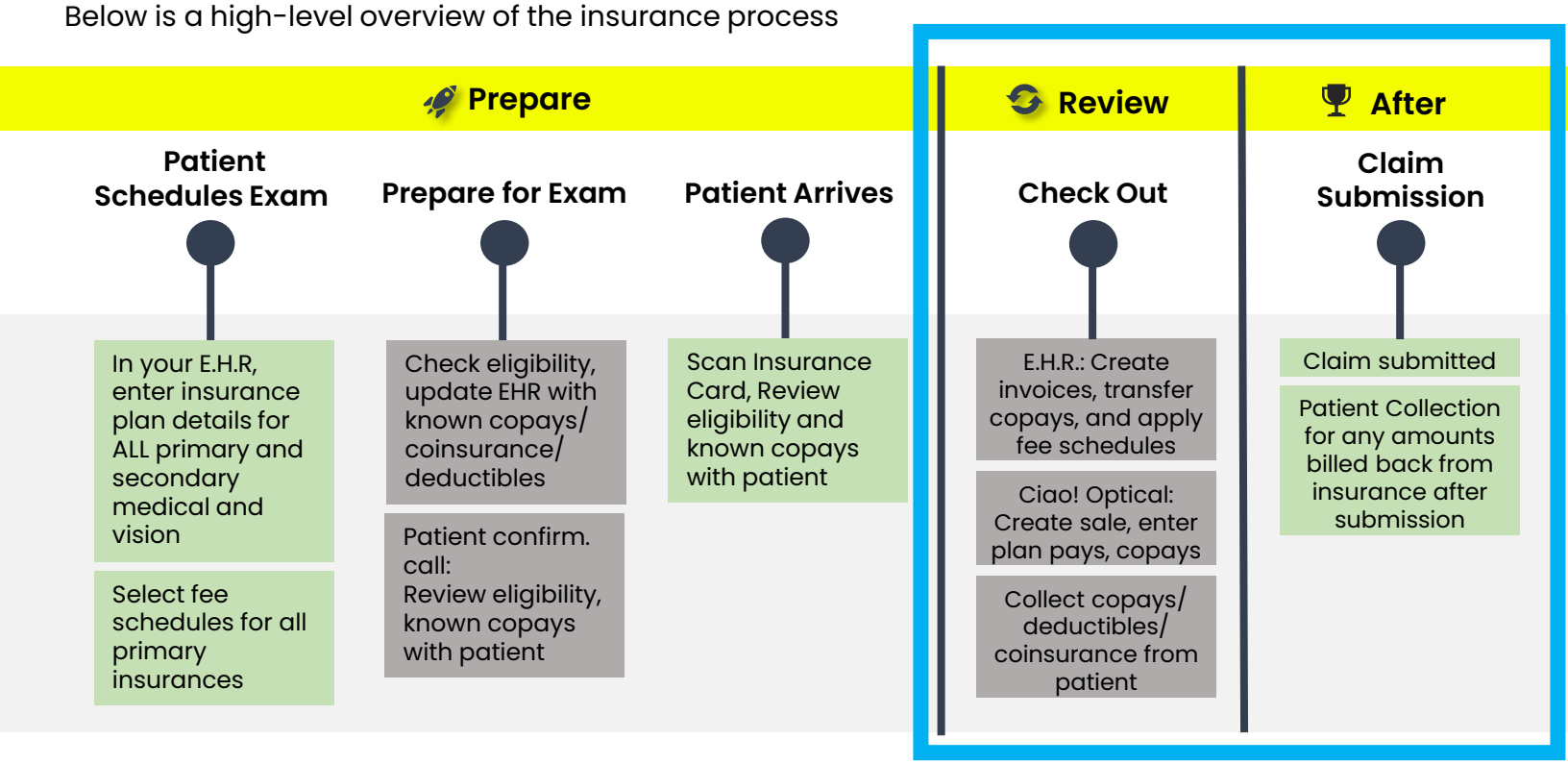
Below is a high-level overview of the insurance process



- Eligibility must be verified PRIOR to the patient's appointment.
  - Check Trizetto and/or Insurance carriers' website ahead of time to know the patient copay/deductible/coinsurance.
- **All copays/coinsurance/deductibles must be collected at the time of service.**
  - **We do not do back bill (i.e., you can not bill the insurance carrier to see what is covered and then send the patient an invoice.)**
- **ALL services must be recorded in BOTH the E.H.R. AND Ciao! Optical (point-of-sale).**
- ROUTINE: Balances are zeroed out in the EHR.
- Claim submission will vary depending on office and insurance. Refer to your insurance guide or consult your billing team for claim billing responsibility.
- **Improper billing may result in unnecessary write-offs and a greater chance of aging patient balances.**
- **MEDICAL: Balances are left in the EHR. Claims are billed and reconciled out of the EHR. Materials being billed directly to medical carriers should also be entered into the EHR.**
- **SECONDARY: Medical billers will manage secondary claim filing once primary insurance has been billed.**
- **Any overpayments will be refunded.**

Click HERE to be redirected to the Patient Journey to watch RevolutionEHR How-To-Videos.

BALANCES IN THE E.H.R.

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	Medical Insurance	Routine Insurance	Private Pay/Non-Covered Services
E.H.R. Fee Schedule	Apply the Medical Fee Schedule • If copay is owed, transfer copay to patient that pulls from insurance amount owed, the plan pays will be reduced. • If deductible, transfer whatever the patient is paying to the deductible from the insurance plan pays. The plan pays may be $0. Claim will be filed to show patient applied money towards their deductible.	Apply Routine Fee Schedule which will zero out balance	N/A
Copay in the E.H.R.	• Transfer Patient Copayment AFTER fee schedule has been applied • **Patient invoice:** Authorize and Receive payment • **Insurance invoice:** **DO NOT AUTHORIZE-** leave as pending	Do not transfer. There are no patient balances left in the E.H.R.	• Complete second invoice for services that are considered patient responsibility
Balance Left in EHR	Insurance amount owed – After Fee Schedule and Patient Payment Applied	None (discounted down to zero)	Record patient payment.
Ciao Optical!	Post in Ciao! • If copay, make sure that's in the copay column and that the amount patient pays is correct • If deductible, amount also goes copay. If the insurance amount from EHR is $0, there is $0 in plan pays.	Record in Ciao!	Both invoices should be $0 – patient paid
$0 patient balance should be left in E.H.R. (medical insurance balance only)			

Optomap:

- Private pay: Assign to patient and record as paid in E.H.R.
- Routine: Discount services in E.H.R
- Medical: Assign to medical invoice. Transfer copay/coinsurance/deductible to patient, and record as paid in E.H.R.

An optometrist decides whether to bill medical or routine insurance based on **the reason for the visit and the diagnosis.**

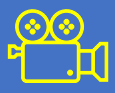
- **Medical insurance** (like Blue Cross, Aetna, or Medicare) is used when the patient has a medical complaint or diagnosis affecting the eyes or vision.
  - Example: Red eyes, diabetes, cataracts, dry eye, glaucoma, eye pain, or infections.
  - Medical Diagnosis Codes vary greatly based on condition.
  - Common Optometric-related medical conditions listed below:

Category	Common Diagnoses	Diagnosis Codes
External Eye	Dry Eye Syndrome	H16.223 / H16.229
	Allergic Conjunctivitis	H10.021 / H10.023
	Blepharitis	H01.00X–
	Hordeolum (Stye)	H00.019 / H00.029
Visual Symptoms	Blurred vision / Visual disturbance	H53.8
	Double vision (Diplopia)	H53.2
	Eye pain	H57.10
Retina / Optic Nerve	Diabetic Retinopathy	H35.0– / E11.329
	Macular Degeneration	H35.3–
	Optic Nerve Disorder	H47.20 / H47.239
Glaucoma	Primary Open-Angle Glaucoma	H40.113
	Unspecified Glaucoma	H40.009
Cataracts	Age-Related Nuclear Cataract	H25.13
	Posterior Subcapsular Cataract	H25.043
Systemic Conditions	Diabetes Mellitus (no complication)	E11.9
	Hypertension	I10
	Long-term Insulin Use	Z79.4

GENERAL RULE: If the diagnosis code does not start with H52 or Z01, there is a HIGH likelihood it is medical.

MEDICAL INVOICING

RevolutionEHR



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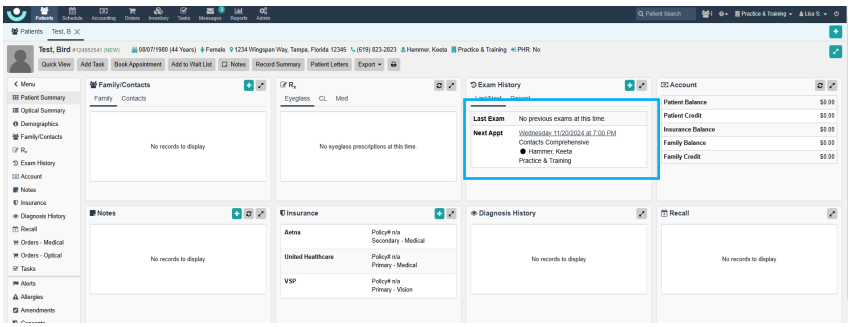
All MEDICAL carriers are billed through RevolutionEHR. There are also some Routine vision carriers that are billed out of the E.H.R. and therefore categorized and managed the same way as normal medical carriers.

Important notes:

- Do not manually add services to invoices, use the ones coded by your doctors.
- NO patient balances are left in the E.H.R.
- **Insurance balance** remains on the invoice in the E.H.R.
- DO NOT create invoices for secondary medical carriers. it will be sent automatically or by your biller to secondary once primary has been billed).
    - Enter secondary into demographics but do not select a fee schedule.
    - If the secondary medical insurance has a copay, collected at the time of service and apply to the primary medical invoice.

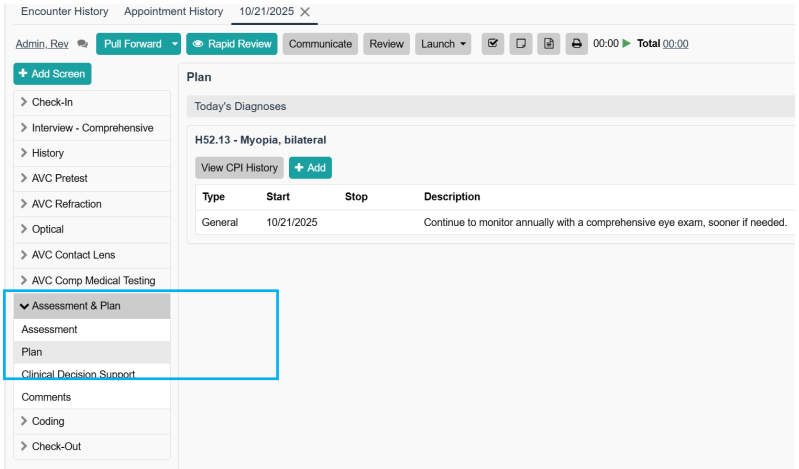
1 Select the hyperlinked **Encounter** from the Exam History tile.



2 From the navigation bar within the encounter, click the **Assessment & Plan** tab, then click **Plan.**

Listen

- This provides a quick overview of the doctor's diagnoses and care plan. It serves as a handoff to keep you informed of patient needs after the exam, such as sales opportunities, follow-ups, education, or referrals.
- Take note of any important information or action items that may need follow-up from this section.



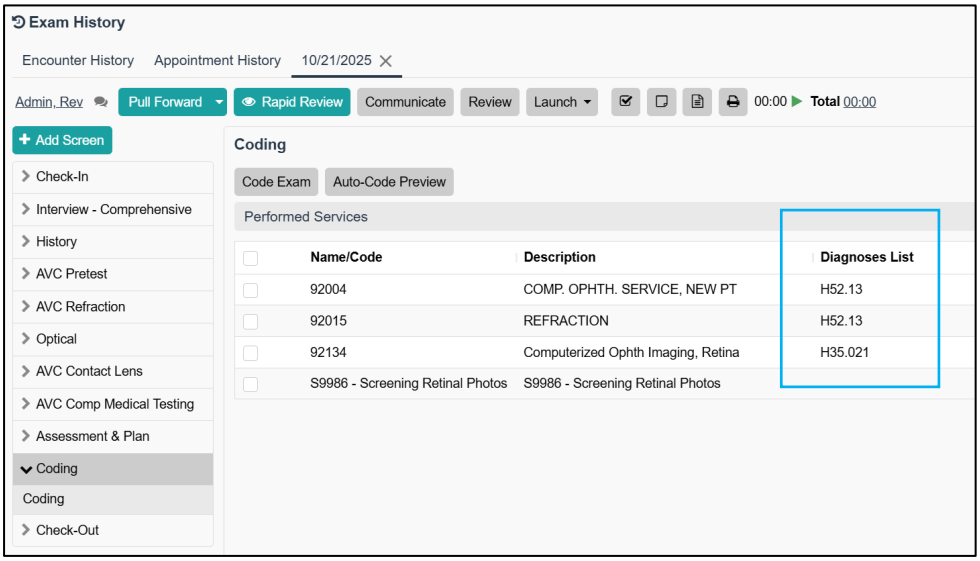
3 From the navigation bar within the encounter, click the **coding** tab.

- This is where you will review the services that were provided and determine responsible payer.
- **NOTE: If a doctor codes a service with a medical diagnosis, it must be billed to medical insurance.**

In the example below, based on the service and diagnosis codes, there are:

- Two routine services (92004, 92015)
- One medical service (92134)
- One private-pay non-covered service (S9986)

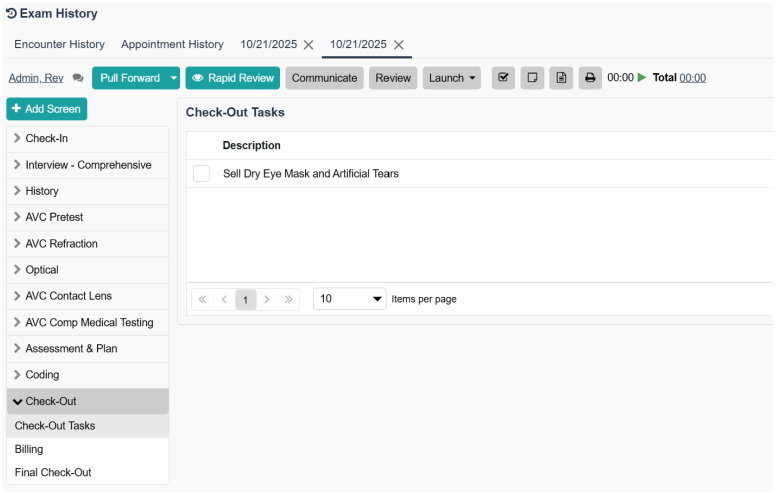
Review



4 From the navigation bar within the encounter, click the **check out** tab.

- If your OD has entered **check out tasks** you must complete those before you go to billing.

Review



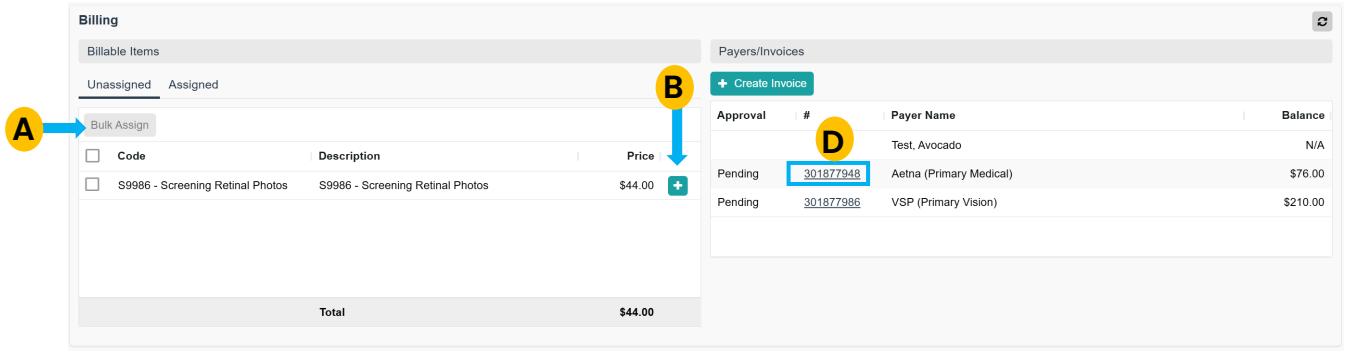
5 Once check-out tasks have been completed, navigate to the **Billing** section.

A. Select multiple services and Bulk Assign **OR**

B. Use the + symbol to assign individual services to the correct Payer

C. Repeat for each payer until all services have been assigned. There should be no services under "Billable Items". These become Unassigned Items on your end of day report.

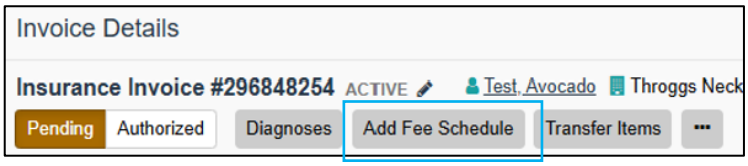
D. This will generate a **pending** invoice. Click the hyperlinked **invoice number** next to the primary medical payer to open the invoice.

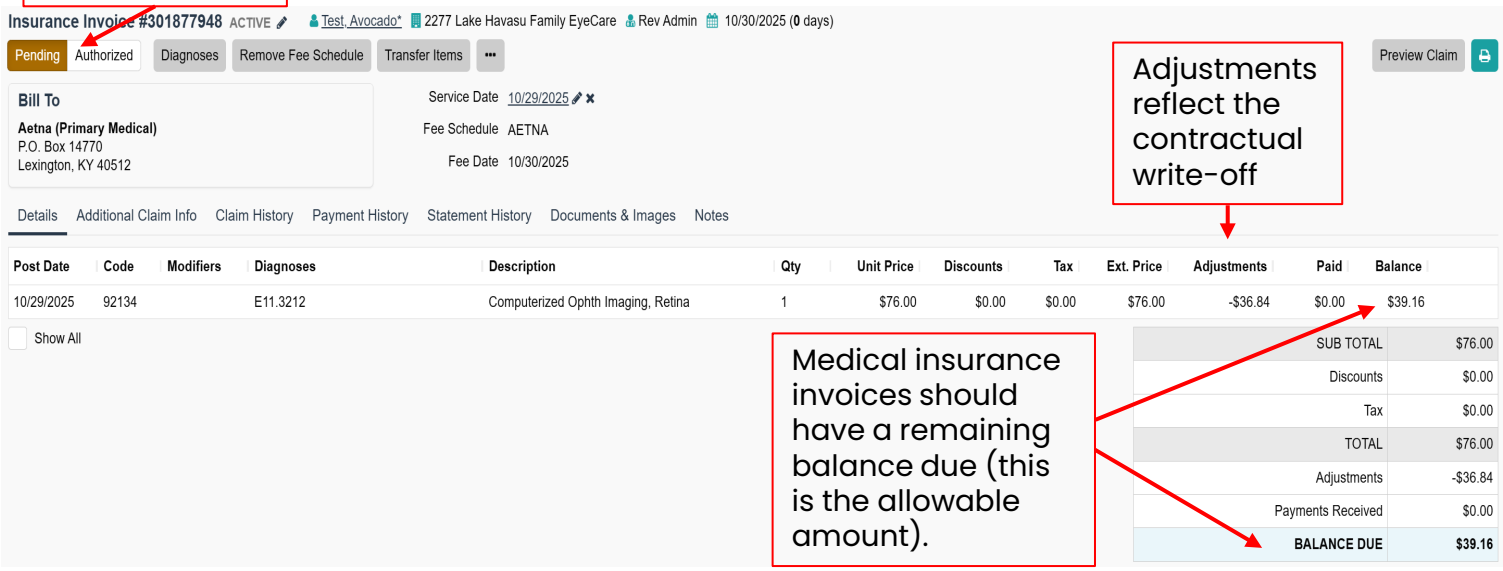


6 Click **add fee schedule.**

- Medical fee schedules write off the contractual amount agreed upon with the insurance. The remaining balance is the "allowable amount" we can collect from patient & insurance combined.
- If the fee schedule button is not available, it means that a fee schedule has not been added in the insurance demographics section. Go back and add prior to continuing with the invoice.

Invoice must be in pending status to apply fee schedule.

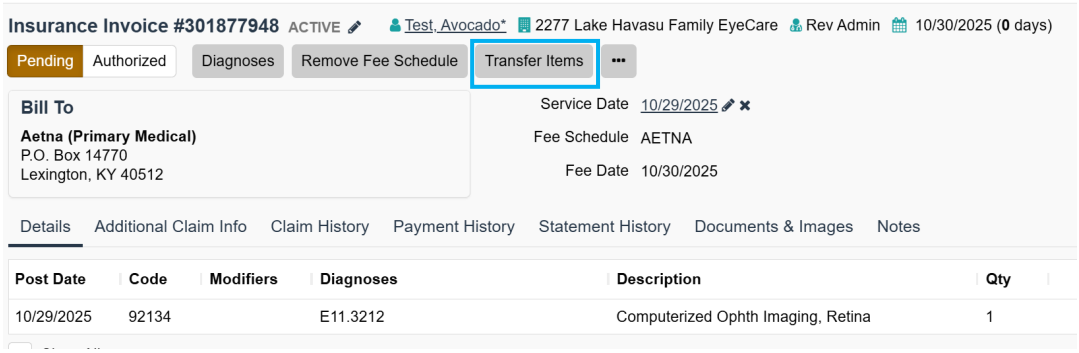




Adjustments reflect the contractual write-off

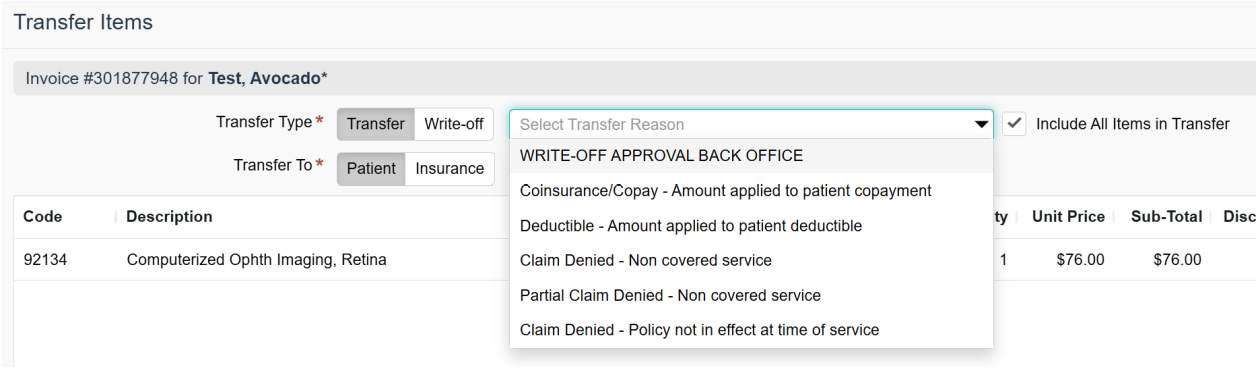
Medical insurance invoices should have a remaining balance due (this is the allowable amount).

7 If the patient owes a copay, coinsurance, or deductible, Click “Transfer Items”.



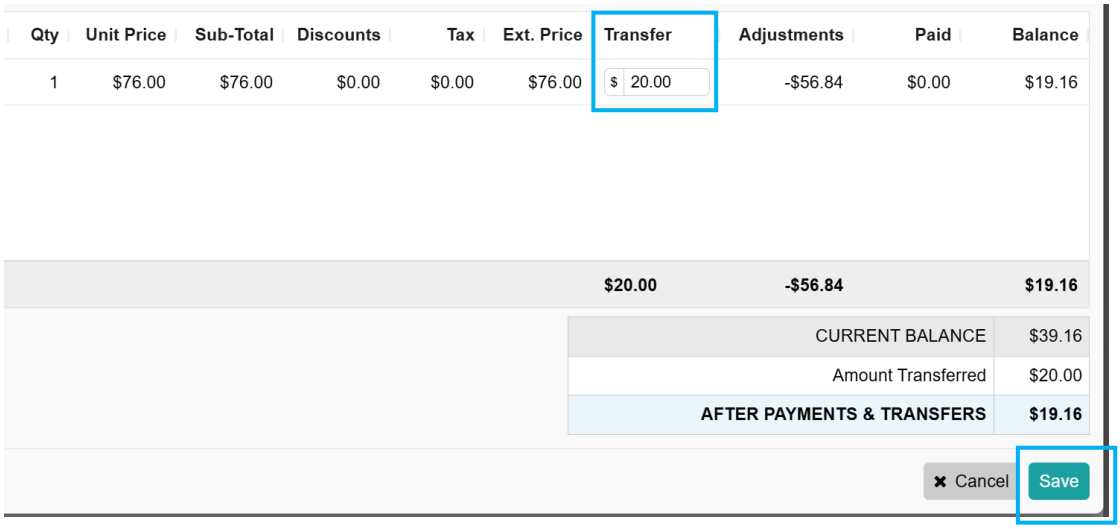
8 Select Transfer Reason and confirm that you are transferring to “Patient”.

NOTE: If there are already services assigned to the patient (i.e. non-covered items), it will transfer the copays to the existing invoice and combine them on one patient invoice.



9 Type the amount you want to transfer in the “Transfer” box then Save.

NOTE: The amount cannot be more than the balance on that line item. For example, if this patient had a $50 copay but the plan pays was only $39.16, you can only collect $39.16. If they had more than one service, you could split the copays to be able to collect the full amount.



MEDICAL INVOICING
RevolutionEHR

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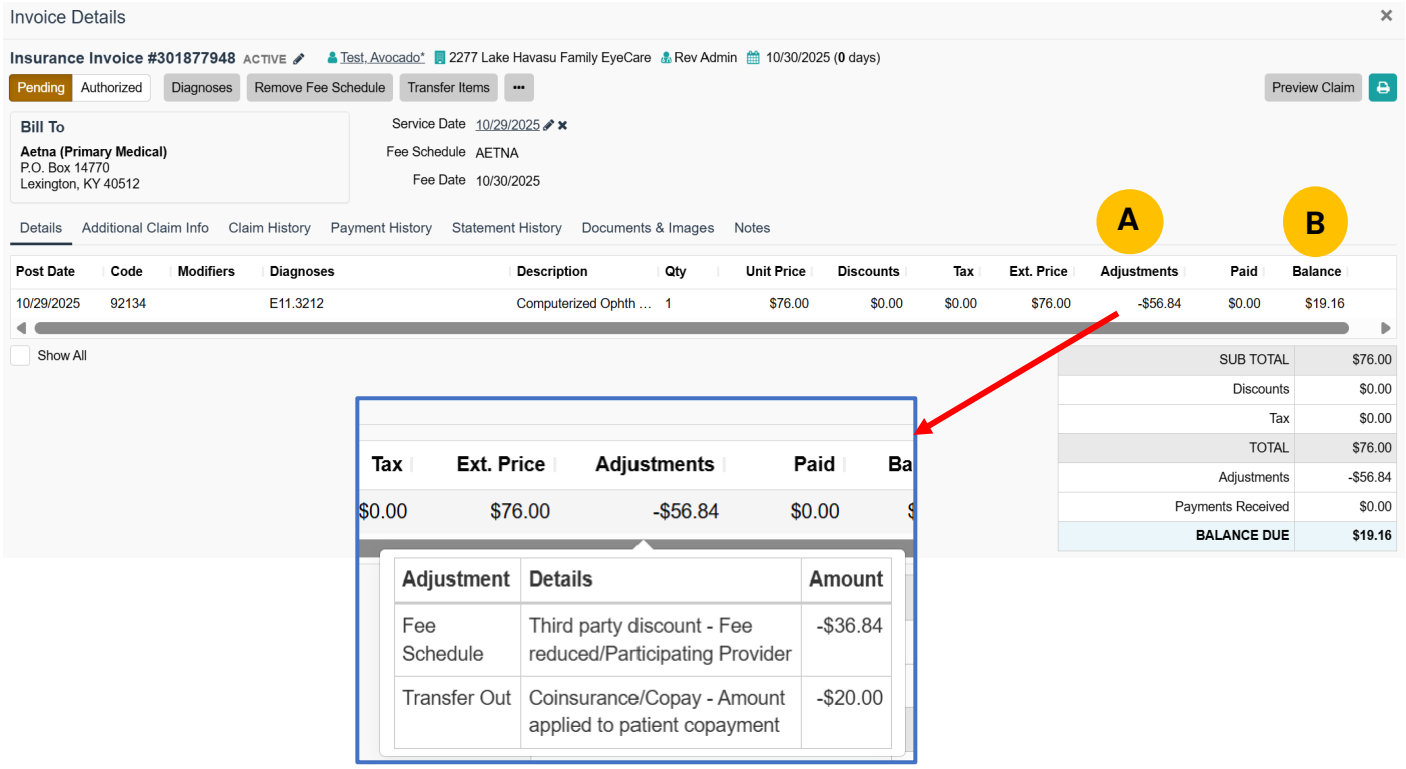
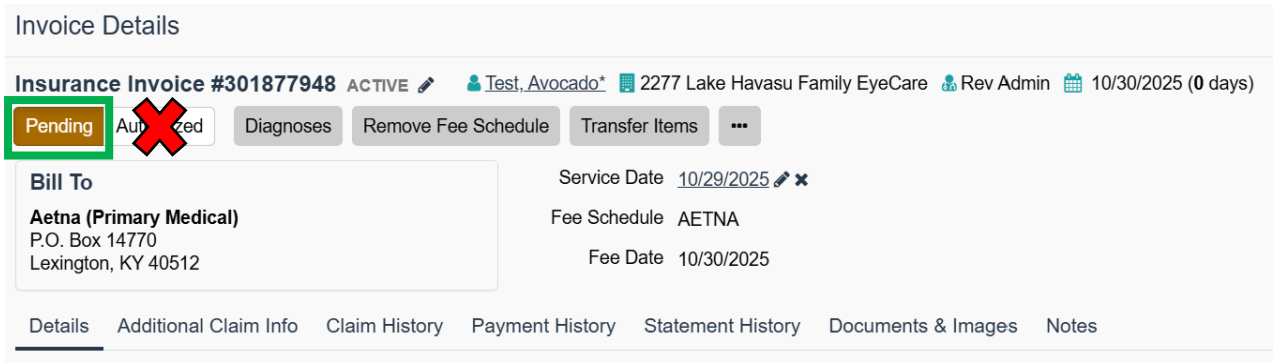
10 Your insurance invoice will now reflect the final billing for medical services:

A **Adjustments** now reflects both contractual write-offs (discounts) and patient responsibility. These amounts will be entered in two different fields in Ciao! Optical.

B **Balance Due** is now reduced and reflects the true amount that we expect to receive from the insurance. Use the "Balance" for each line item as the "Plan Pays" amount in Ciao! Optical.



11 **DO NOT AUTHORIZE THE MEDICAL INVOICE.** Your medical biller will review the invoice, add any modifiers or special codes required prior to authorizing and billing to the medical carrier. Close the invoice to return to the Checkout screen in the encounter.



IF THE PATIENT DOES NOT OWE ANYTHING, COMPLETE THE ENCOUNTER AND PROCEED TO "CIAO! OPTICAL ENTRY".

IF THE PATIENT OWES AND YOU HAVE A PATIENT INVOICE, TRANSFER SERVICES TO CIAO! OPTICAL, THEN PROCEED TO "PATIENT INVOICING IN E.H.R."

PATIENT INVOICING
RevolutionEHR

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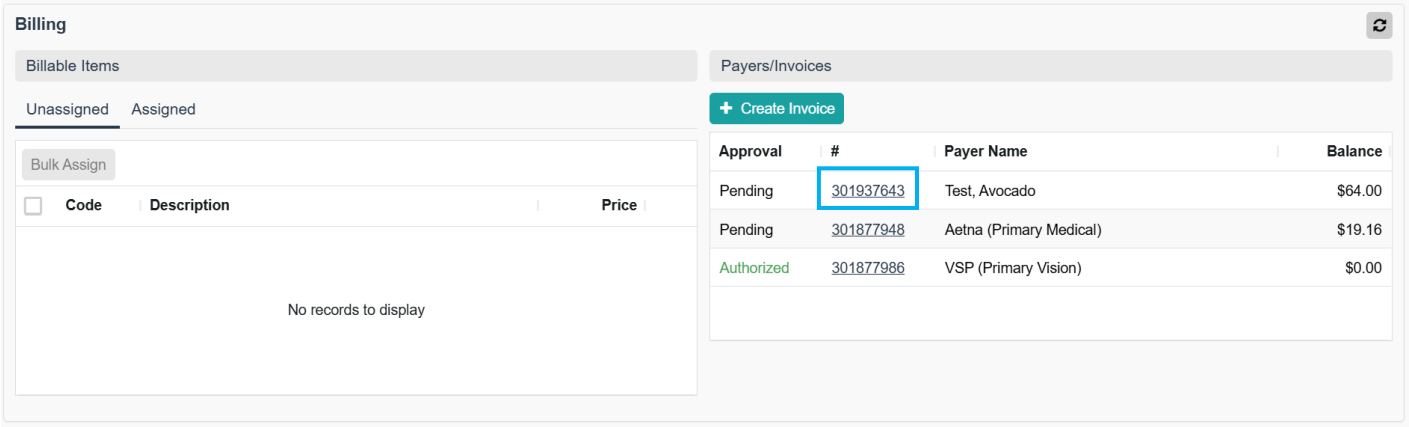
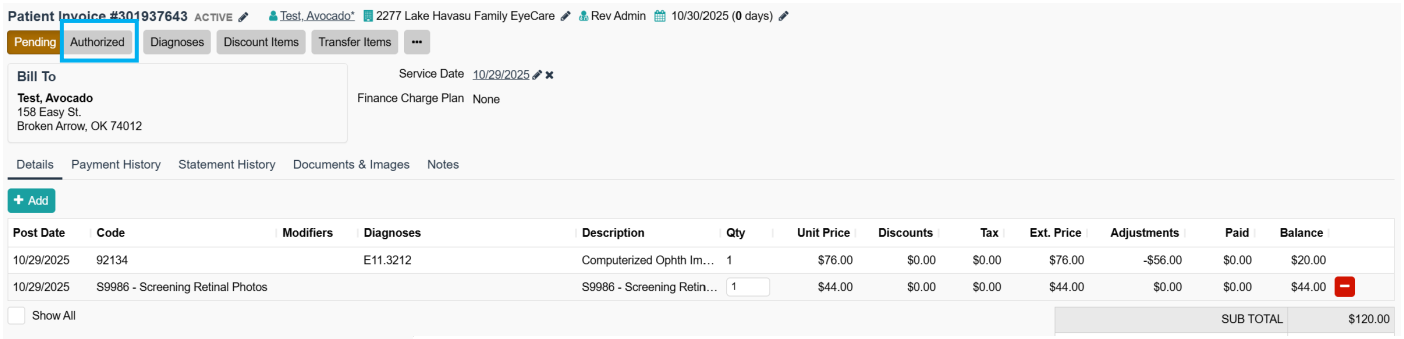
Once you have taken payment from the patient:

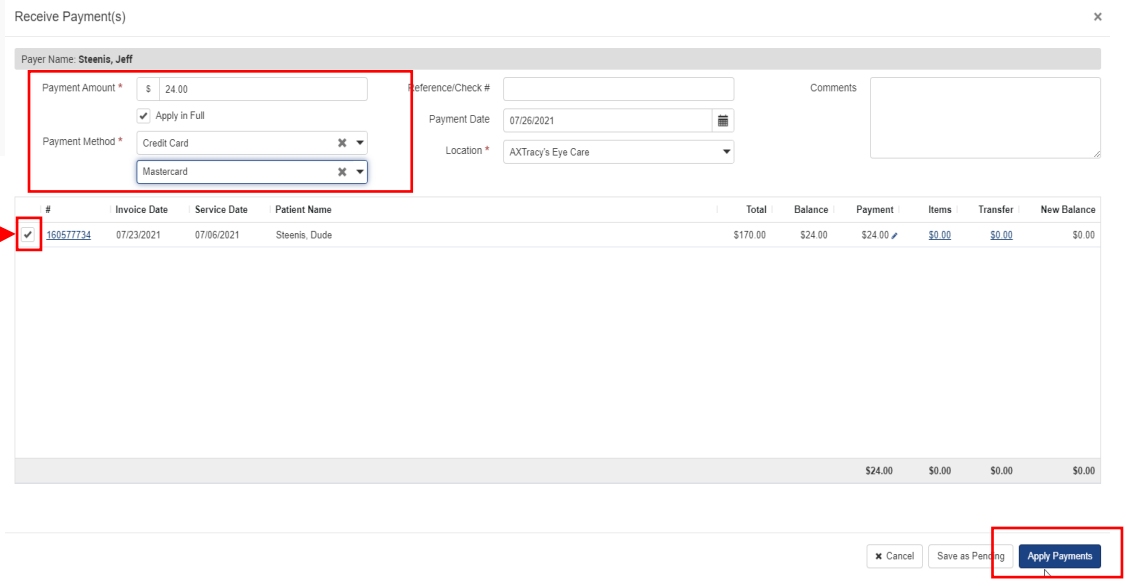
1 From the “Checkout” tab, click the hyperlink to open the Patient Invoice.



2 Complete your patient invoice.

- Authorize and Receive payment
- Balance should be zero (you’ve recorded payment)





1. Enter payment amount
2. Check Apply in Full
3. Select appropriate payment method
4. Check the box to the left of the invoice number
5. Apply payment

Invoices may be provided to patients. All tendering occurs with Ciao! Optical but invoices are available should someone ask or need it for HSA/FSA submission.

Send payments to:
Testing print name - as is
456 Main St Suite 2222
Fishers AL 36854
(000) 222-3333

Bill To
Jeff Steenis
123 Main St.
Cottage Grove WI 53527

Invoice

Service Date	Invoice Date	Invoice #
07/06/2021	07/23/2021	160577734

Patient	Patient #
Dude Steenis	18401829

Provider	Tax ID
Carroll, Dr. Kat OD	111111111

Code	Description	Price	Qty	Disc	Tax	Adjs	Paid	Balance
92004	COMP. OPHTH. SERVICE, NEW PT Diagnoses: H02.31	$140.00	1	$0.00	$0.00	-$120.0	$20.00	$0.00
	Billed to Insurance - Invoice 160576973 : ($140.00)							
	Transfer In - Coinsurance/Copay - Amount applied to patient copayment : $20.00							
92133	SCANNING COMPUTERIZED OPHTH IMAGING, OPTIC NERVE Diagnoses: H02.31	$30.00	1	$0.00	$0.00	-$26.00	$4.00	$0.00
	Billed to Insurance - Invoice 160576973 : ($30.00)							
	Transfer In - Coinsurance/Copay - Amount applied to patient copayment : $4.00							
PAYMENT	Credit Card (Mastercard) - 07/26/2021							-$24.00

Sub-Total	$170.00
Discounts	$0.00
Tax	$0.00
Total Amount	$170.00
Adjustments	-$146.00
Payments Received	$24.00
Credits Granted	$0.00
Balance Due	**$0.00**

MEDICAL INVOICING

Eclips

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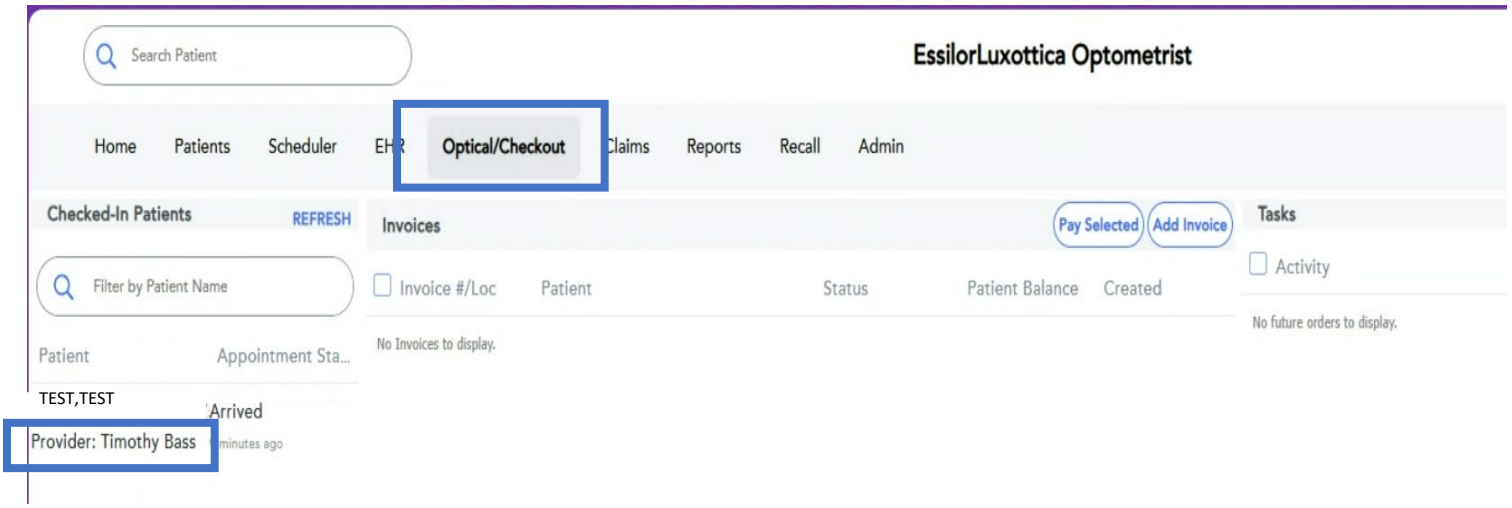
Follow these steps to check out/invoice a routine vision insurance carrier.

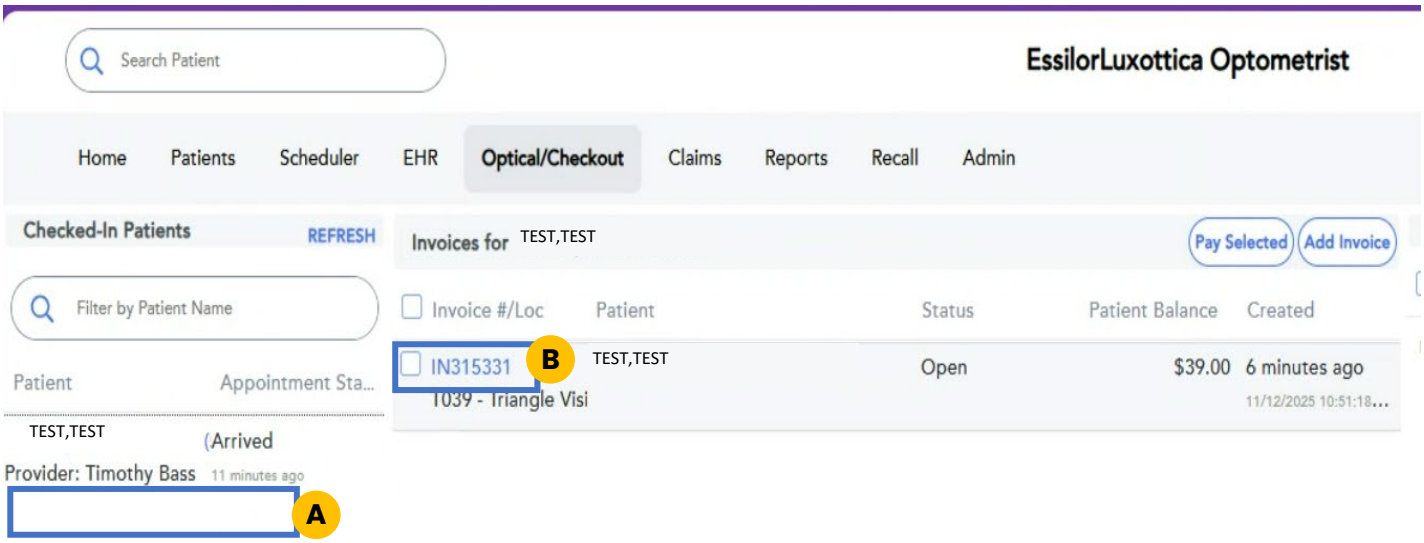
Important notes:

- Do not manually create invoices to add services, use the ones coded by your doctors.
- NO patient or insurance balances are left in the E.H.R. for Routine services.
- You must have at least one diagnosis code on each service line.

1. Navigate to **Optical/Checkout** tab. The patient should have "Provider:____" listed under their name indicating an invoice has been created.



2. Click under the Provider listed in the blank area to open the invoices on the right side of the screen. Then, Click the Blue Invoice Number to open the invoice.

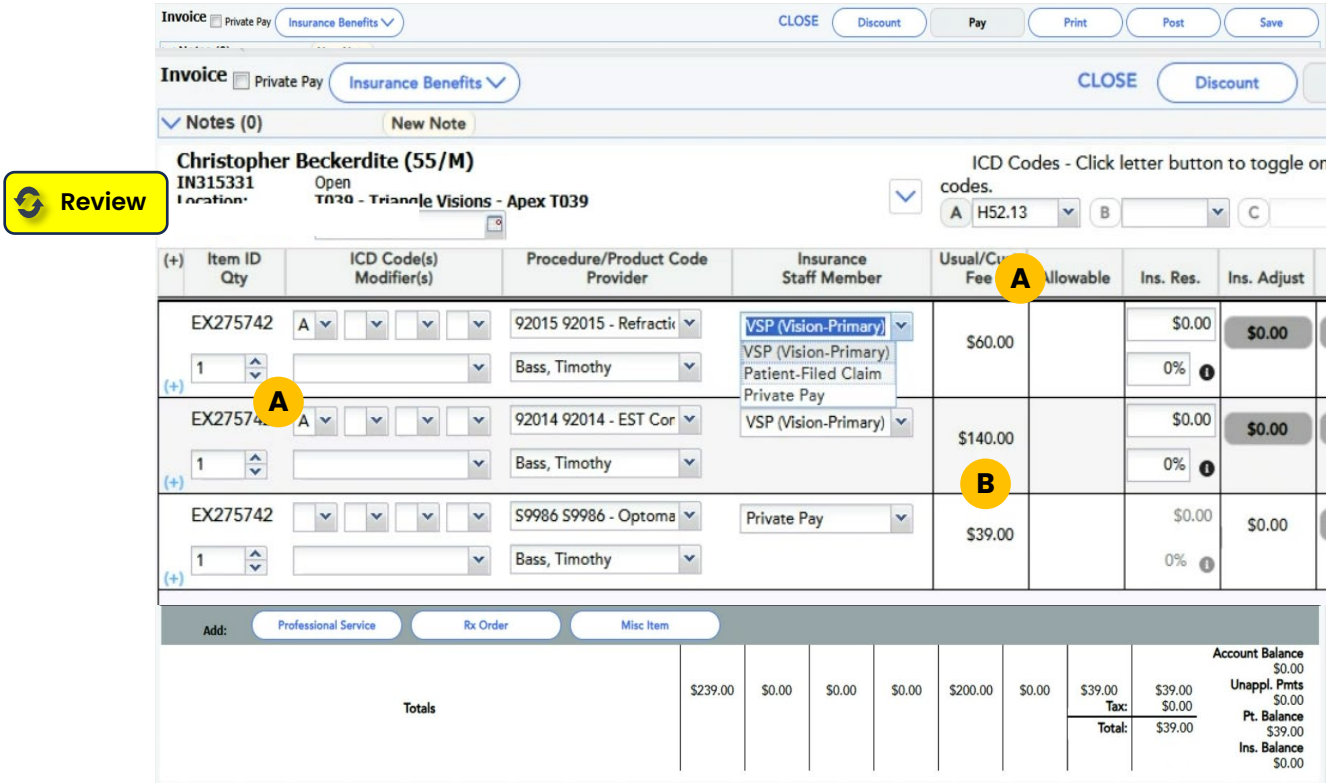


3 The doctor will pre-assign the insurance to each service. Verify that the correct insurance is selected (routine/medical).

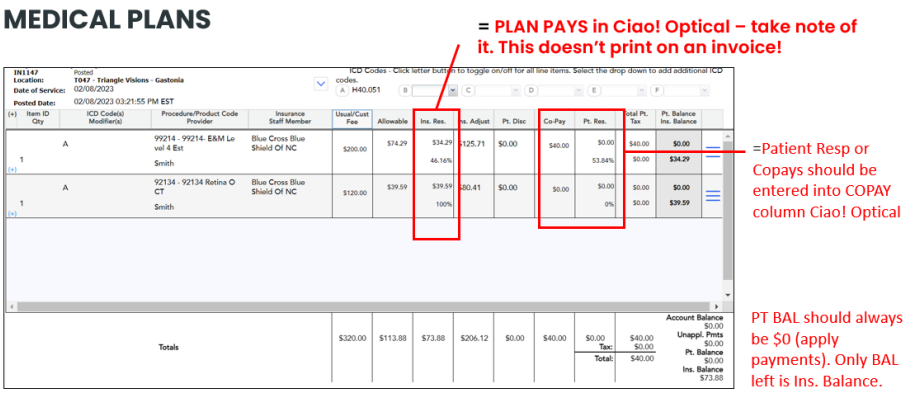
A To determine whether it is medical or vision, look at the diagnosis codes listed and assigned to each service.

NOTE: If a doctor codes a service with a medical diagnosis, it must be billed to medical insurance.

B If necessary, change insurance using dropdown. Fee schedules (allowable) are automatically calculated based on Plan selection in the Insurance Demographics. **For medical insurance, insurance balances will REMAIN in the E.H.R. Patient copays, deductibles, and coinsurance should be transferred to the patient accordingly.**



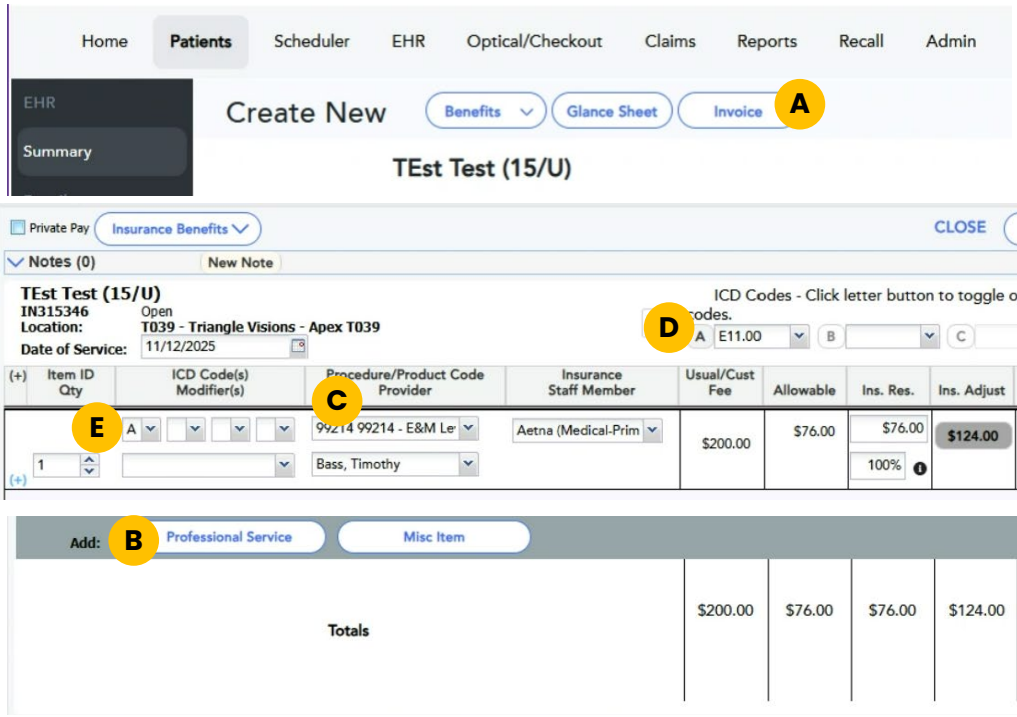
- For all medical insurance plans, ECLiPS will auto-calculate the insurance responsibility



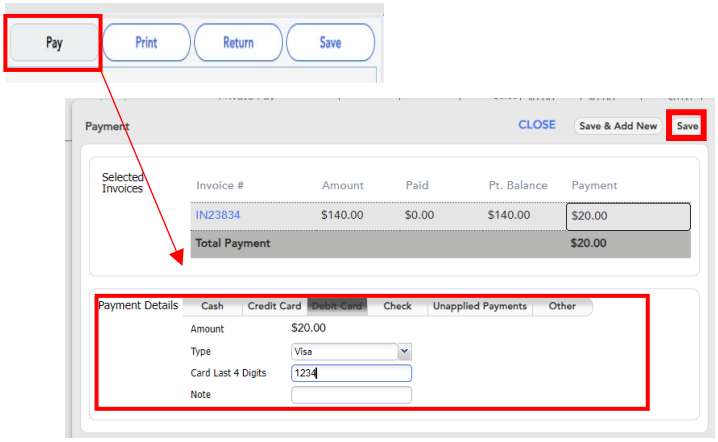
VERY IMPORTANT: In Ciao! Optical - DO NOT reduce Plan Pays by Copay Amount. We do this for Routine but not for Medical, this is already covered when you apply it in Eclips.

4 If the invoice does not code over from the exam, you may have to manually create and invoice from the patient summary screen.

- **A** Click “invoice” from the patient summary screen.
- **B** Add Professional services
- **C** Type in Procedure code
- **D** Add diagnosis code
- **E** Add diagnosis pointer

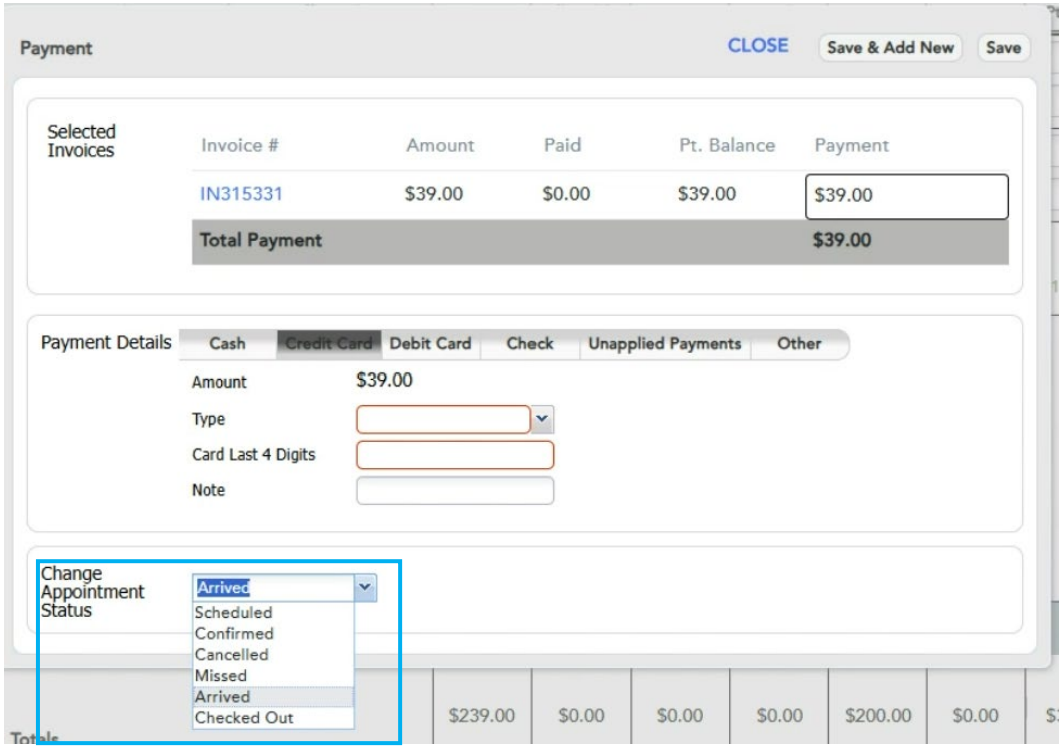


5 For private pay items, click “pay” at the top to receive payment



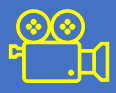
6 Once all items have been applied and paid, “Change Appointment Status” to “Checked out” on the payment screen.

Click Save and close.



MEDICAL INVOICING

Ciao! Optical



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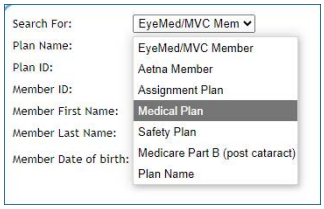
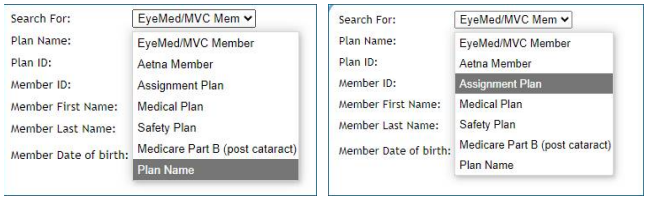
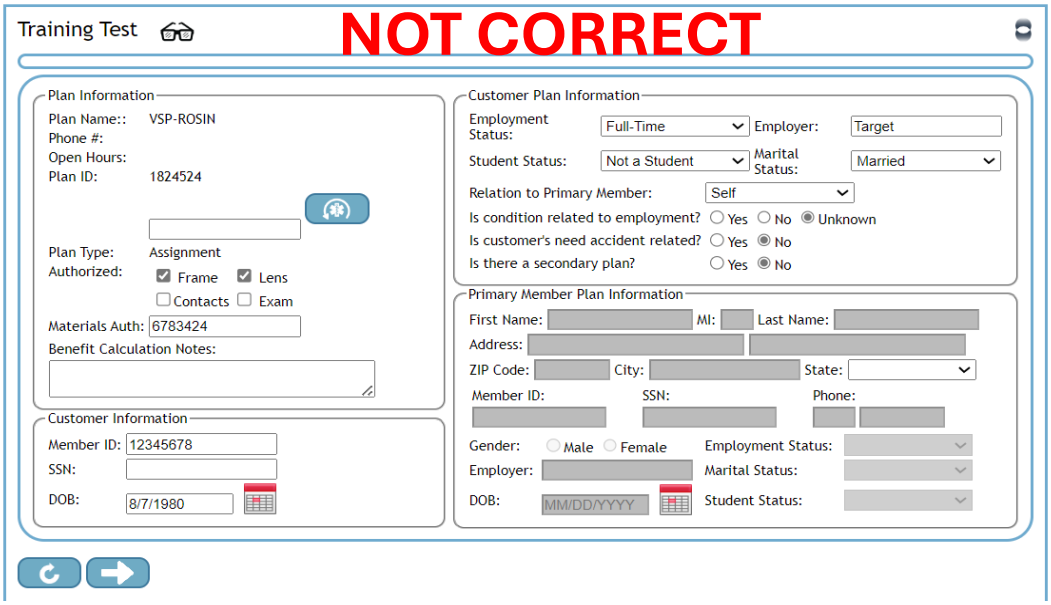
ALL services, whether the patient owes money or not, must be entered in BOTH your E.H.R and Ciao! Optical.

When choosing the medical insurance carrier in Ciao! Optical, it is important to pull the plan the correct way, via the **Medical Plan** dropdown.

- Selecting the medial carrier via Assignment Plan or Plan Name will have a negative impact on insurance billing and reporting.
- Because Medical plans are not billed out of Ciao! Optical, using the Medical Plan dropdown will bypass the patient demographics needed for routine vision carriers.
- All medical plans in Ciao! Optical are **Bill Actual,** meaning you must manually enter all services, plan pays, discounts, and copays/coinsurance/deductibles on the Order Worksheet in Ciao! Optical.

CORRECT	NOT CORRECT
	

If you see this screen when you are trying to bill out a MEDICAL plan in Ciao! Optical, you have not selected from the Medical Plan dropdown. Go back to the insurance search screen and try again.



MEDICAL INVOICING

Ciao! Optical

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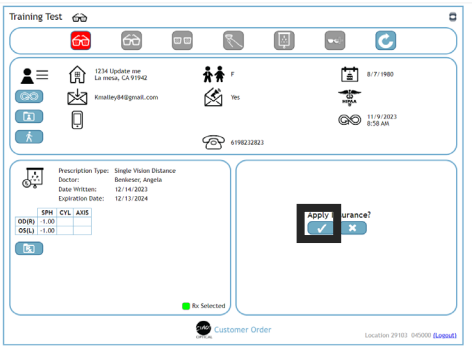
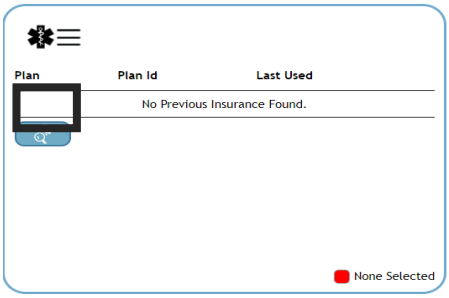
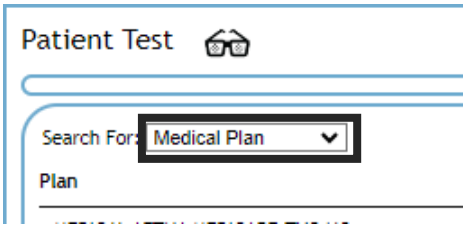
1 Click the Checkmark to indicate you'd like to apply insurance



2 Click the blue Search button

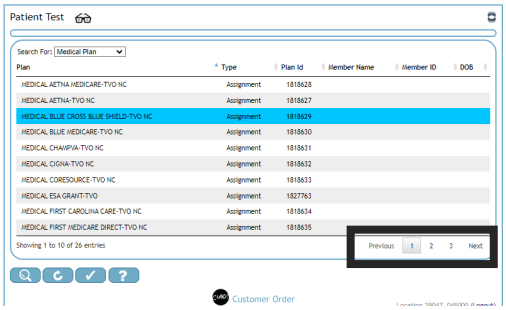


3 On the "Search For" pulldown, change it to "Medical Plan"

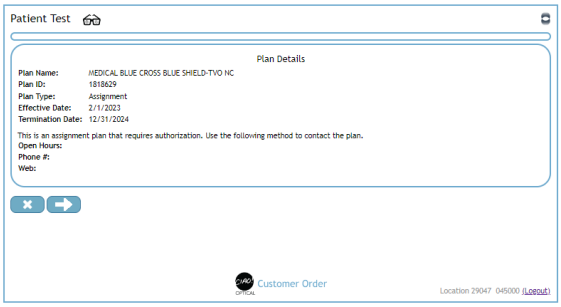


4

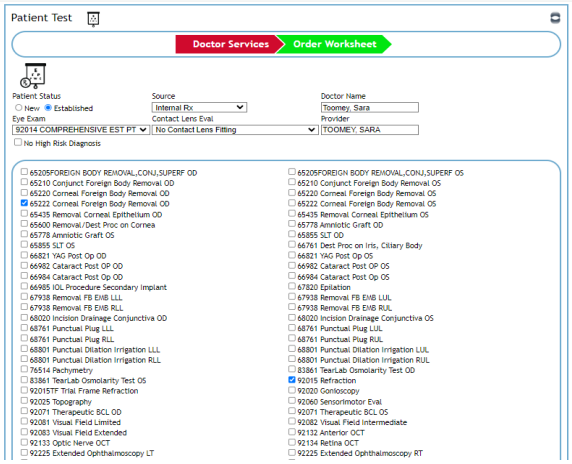
- Select the carrier you need to enter
- Note there are multiple pages



5 Arrow Forward through the Plan Details screen.

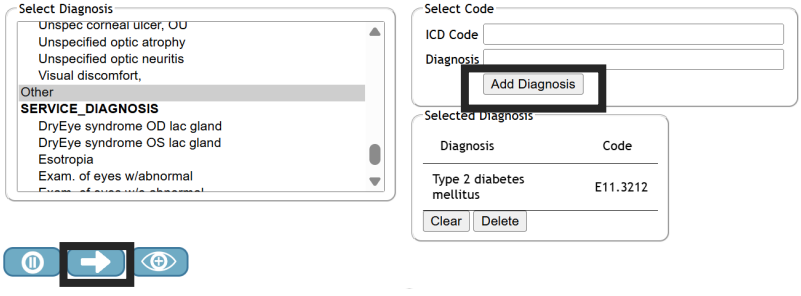


6 Use the E.H.R Invoice to select the services provided in Ciao! Optical



7 Enter the patient diagnosis and click arrow forward.

HINT: If you cannot find the diagnosis by description, select "Other" from the Diagnosis list then manually type in the ICD Code and Diagnosis.
ICD CODE= Letter/# combo (ex. E11.31)
Diagnosis=Description (i.e. Type 2 Diabetes)



8 Enter the Plan Pays, Discounts, and Patient Copays from the E.H.R. Invoice

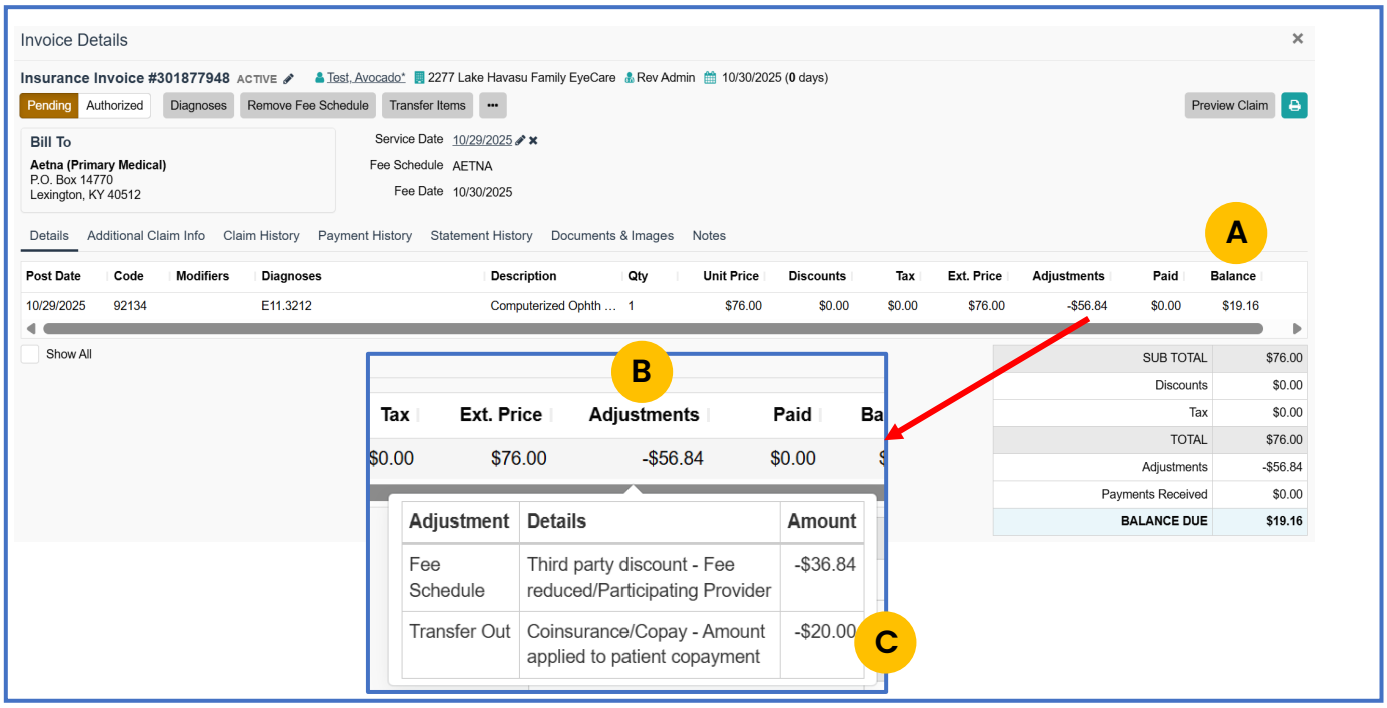
NOTE: In the discount column, click the **%** key to change it to a **$** or your Ciao! Equations will be off.

A **Plan Pays = Balance left on insurance invoice in E.H.R.**

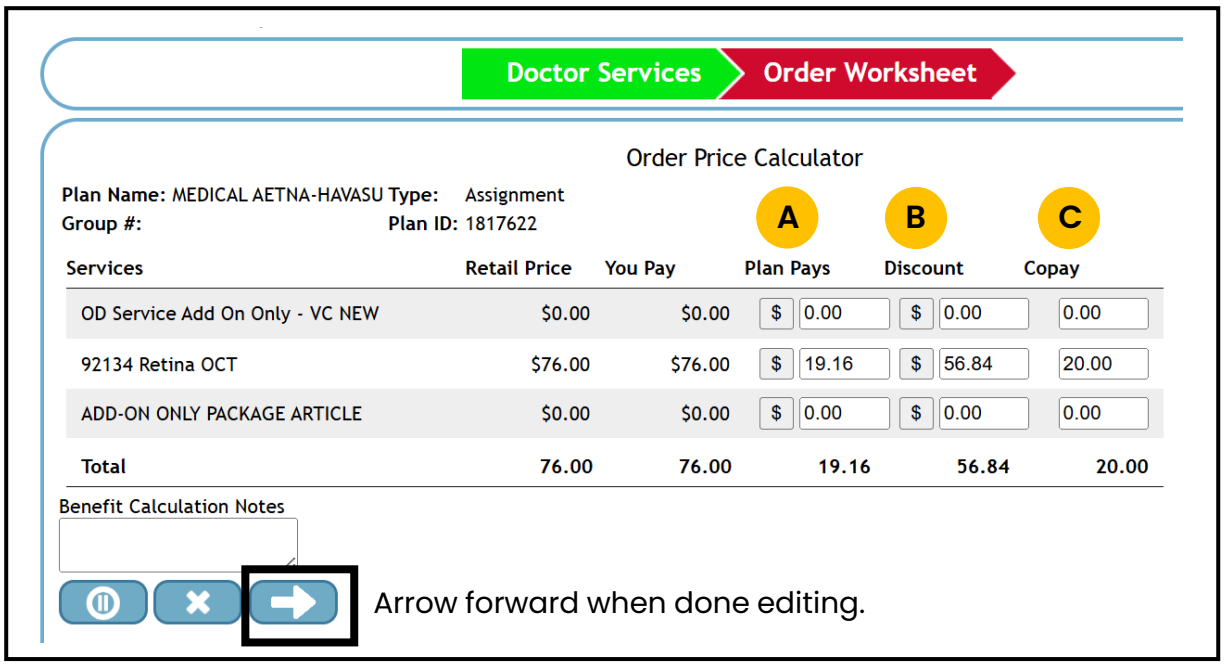
B **Discounts= Retail – Plan Pays**

C **Copays = Coinsurance, Copays, and Deductibles paid by the patient**

RevolutionEHR



CIAO! OPTICAL



MEDICAL INVOICING
Ciao! Optical

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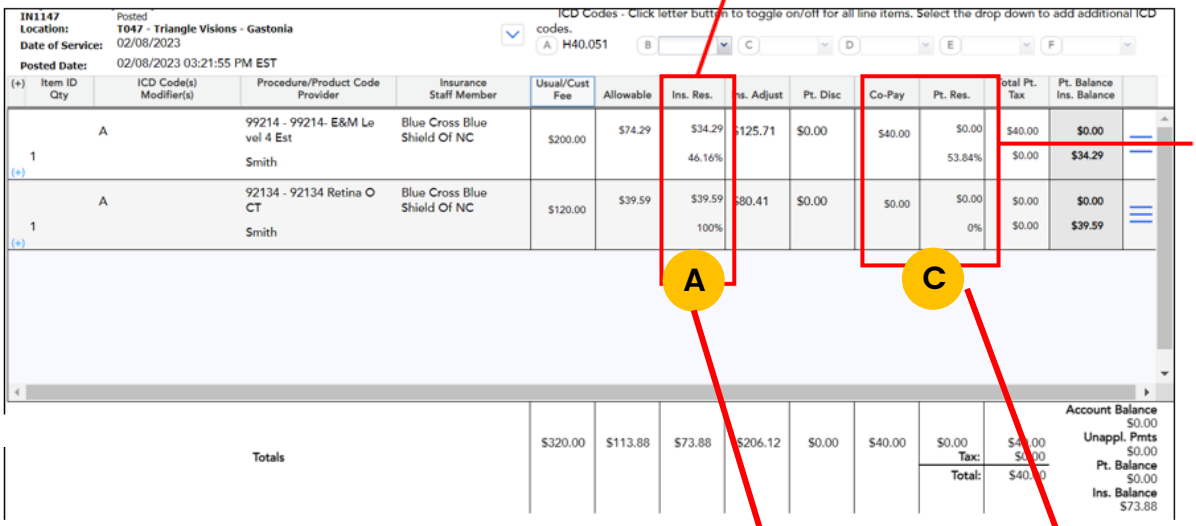
1 For all medical insurance plans, ECLiPS will auto-calculate the insurance responsibility

ECLIPS E.H.R

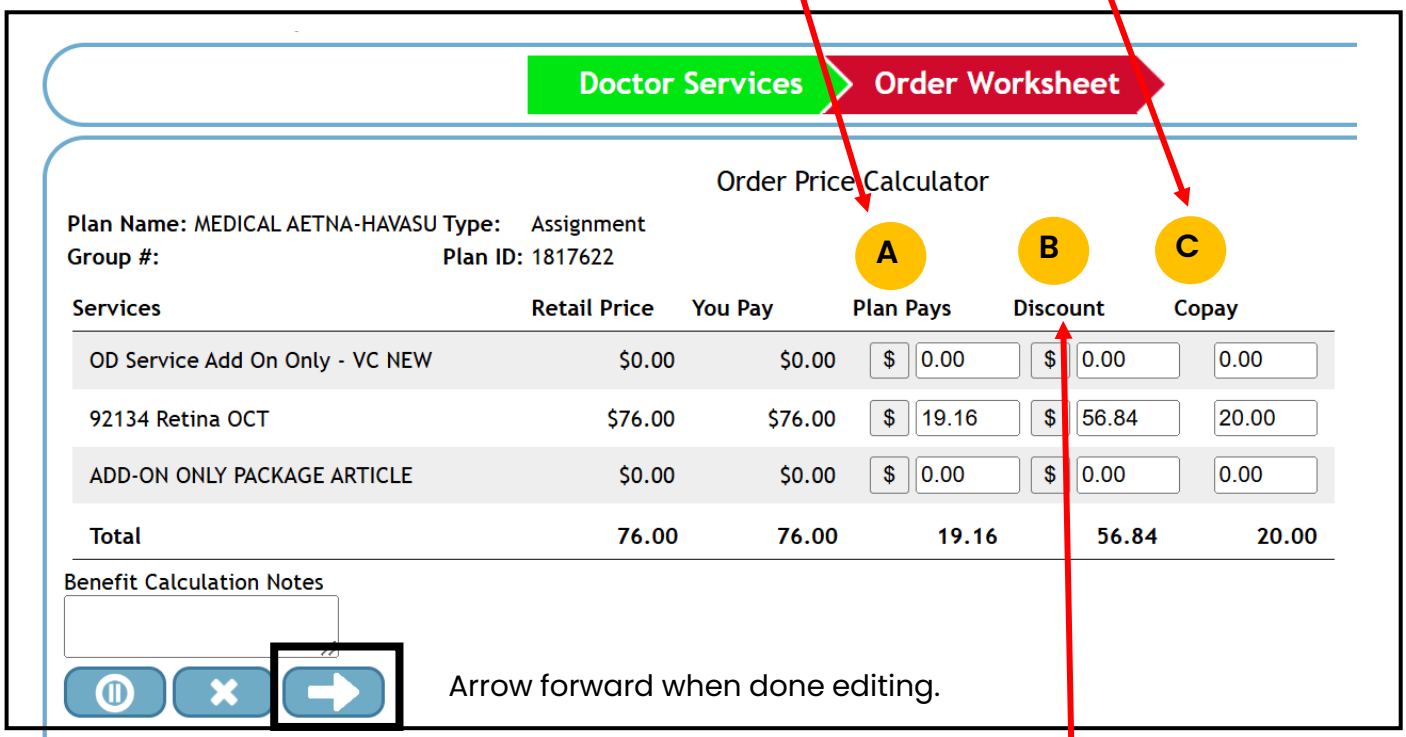
= PLAN PAYS in Ciao! Optical – take note of it. This doesn't print on an invoice!



=Patient Resp or Copays should be entered into COPAY column Ciao! Optical

PT BAL should always be $0 (apply payments). Only BAL left is Ins. Balance.

CIAO! OPTICAL

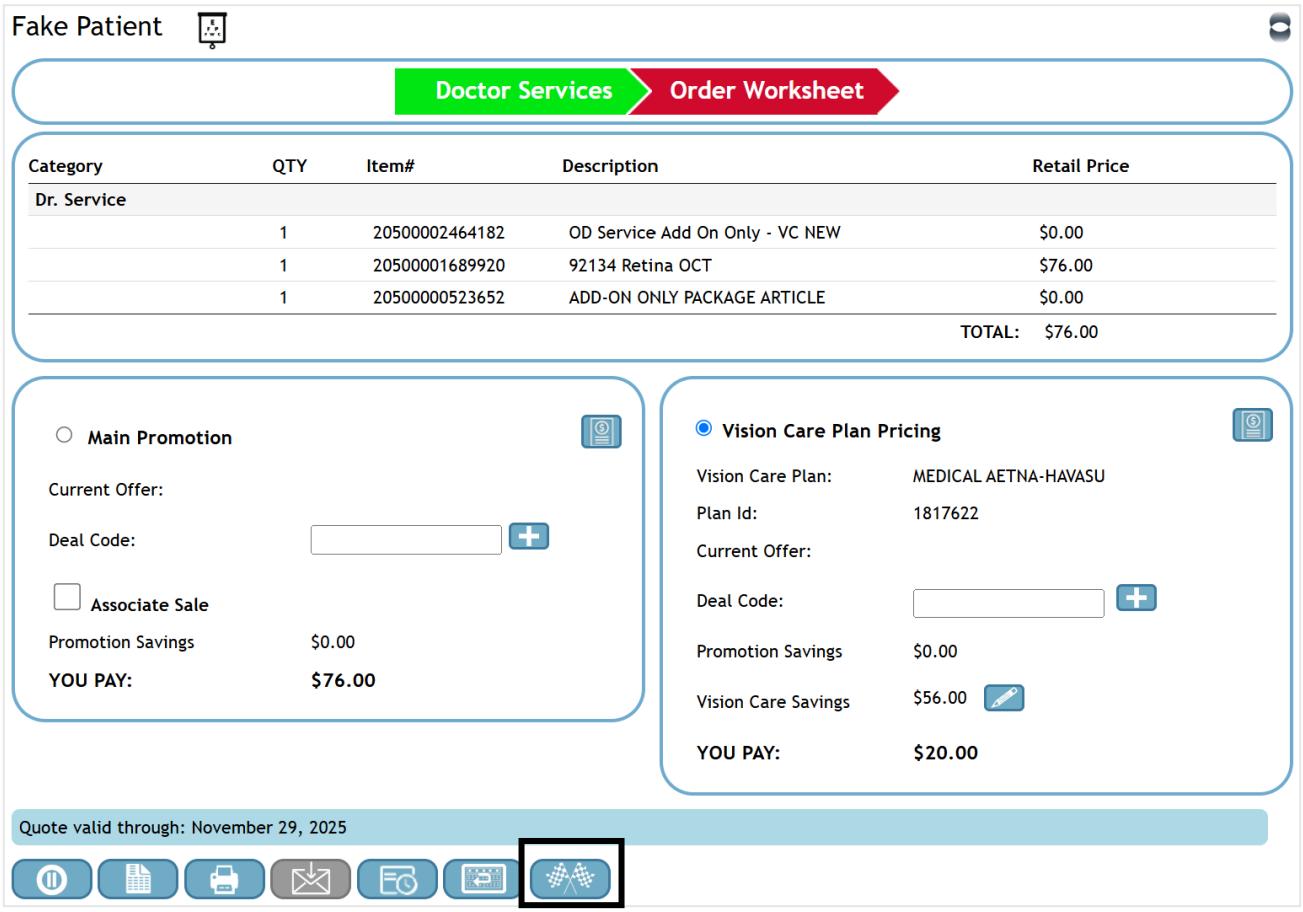


Arrow forward when done editing.

B

Retail-Plan Pays = Discount

9 Click the Checkered Flags to bring the order to Ready Status on Active Orders List.



10 Collect payment on your credit card terminal, cash, check, or CareCredit and tender.

11 If the patient had an invoice in RevolutionEHR, return to the E.H.R. to receive payment and close out the patient invoice.

MEDICAL INVOICING

Examples

TeamVision
Eye care, together.

NO FEE SCHEDULE IN E.H.R.
Example-Medical

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For Medical Plans with no fee schedule in the E.H.R. (we may not know the reimbursement amount), no contractual write-offs will be applied.

In the E.H.R:

Bill To
Cigna (Primary Medical)
P.O. Box 182223
Chattanooga, TN 374227223

Service Date 11/19/2025
Fee Schedule None
Fee Date None

Details | Additional Claim Info | Claim History | Payment History | Statement History | Documents & Images | Notes

COPAY DISCOUNT

PLAN PAYS

+ Add

Post Date	Code	Modifiers	Diagnoses	Description	Qty	Unit Price	Discounts	Tax	Ext. Price	Adjustments	Paid	Balance
11/19/2025	67820			TRICHIASIS CORRECTION, EPILATION	1	$84.00	$0.00	$0.00	$84.00	-$50.00	$0.00	$34.00
11/19/2025	92060			SENSORIMOTOR EXAM	1	$105.00	$0.00	$0.00	$105.00	$0.00	$0.00	$105.00
11/19/2025	92071-LT			FITTING OF CL TO TREAT SURFACE ...	1	$62.00	$0.00	$0.00	$62.00	$0.00	$0.00	$62.00

Show All

SUB TOTAL	$251.00
Discounts	$0.00
Tax	$0.00
TOTAL	$251.00
Adjustments	-$50.00
Payments Received	$0.00
BALANCE DUE	**$201.00**

In Ciao! Optical:

Order Price Calculator

Plan Name: MEDICAL CIGNA-TOSLAND B **Type:** Assignment
Group #: **Plan ID:** 1816078

Services	Retail Price	You Pay	Plan Pays	Discount	Copay
OD Service Add On Only - VC NEW	$0.00	$0.00	$ 0.00	$ 0.00	0.00
67820 Epilation	$84.00	$84.00	$ 34	$ 50	50
92060 Sensorimotor Eval	$105.00	$105.00	$ 105	$ 0.00	0.00
92071 Therapeutic BCL OS	$62.00	$62.00	$ 62	$ 0.000	0.00
ADD-ON ONLY PACKAGE ARTICLE	$0.00	$0.00	$ 0.00	$ 0.00	0.00
Total	**251.00**	**251.00**	**201.00**	**50.00**	**50.00**

Adjustments in this case are copays that were transferred to the patient.

- **Plan Pays** = Retail Price
- **Discount** = Retail Price – Plan Pays
- **Copay** = Adjustments in E.H.R.

FEE SCHEDULE IN E.H.R.
Example - Medical

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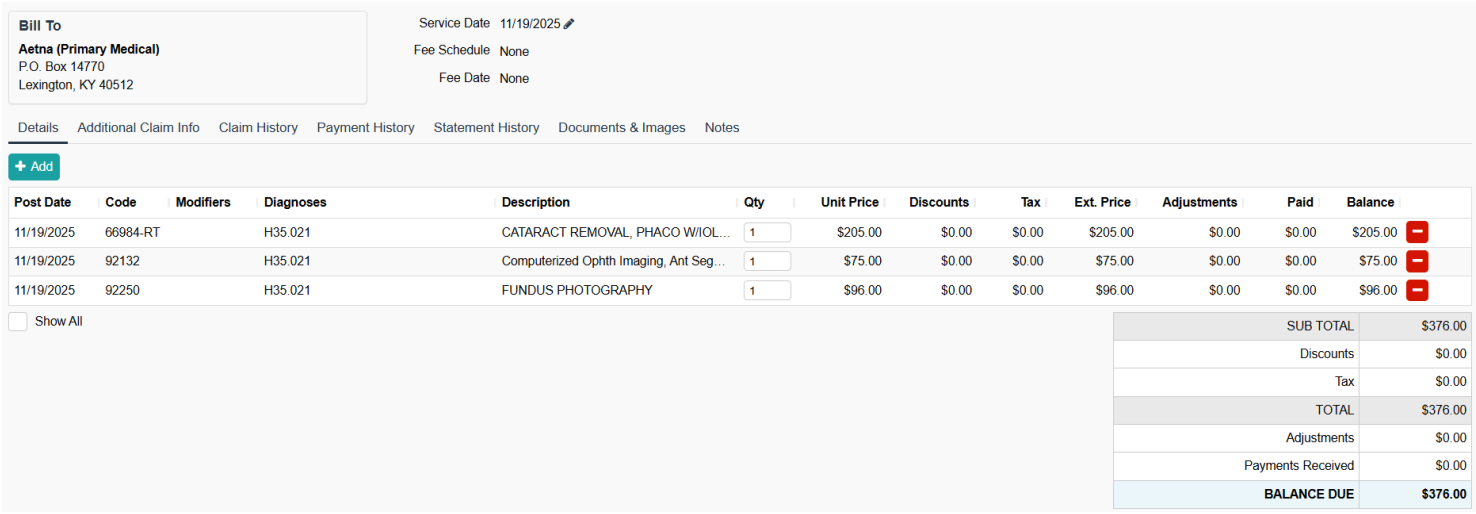
When we know what our allowable amount is for specific services, a fee schedule is available in the E.H.R.

Before Fee Schedule Applied:



Bill To
Aetna (Primary Medical)
P.O. Box 14770
Lexington, KY 40512

Service Date 11/19/2025
Fee Schedule None
Fee Date None

Details | Additional Claim Info | Claim History | Payment History | Statement History | Documents & Images | Notes

+ Add

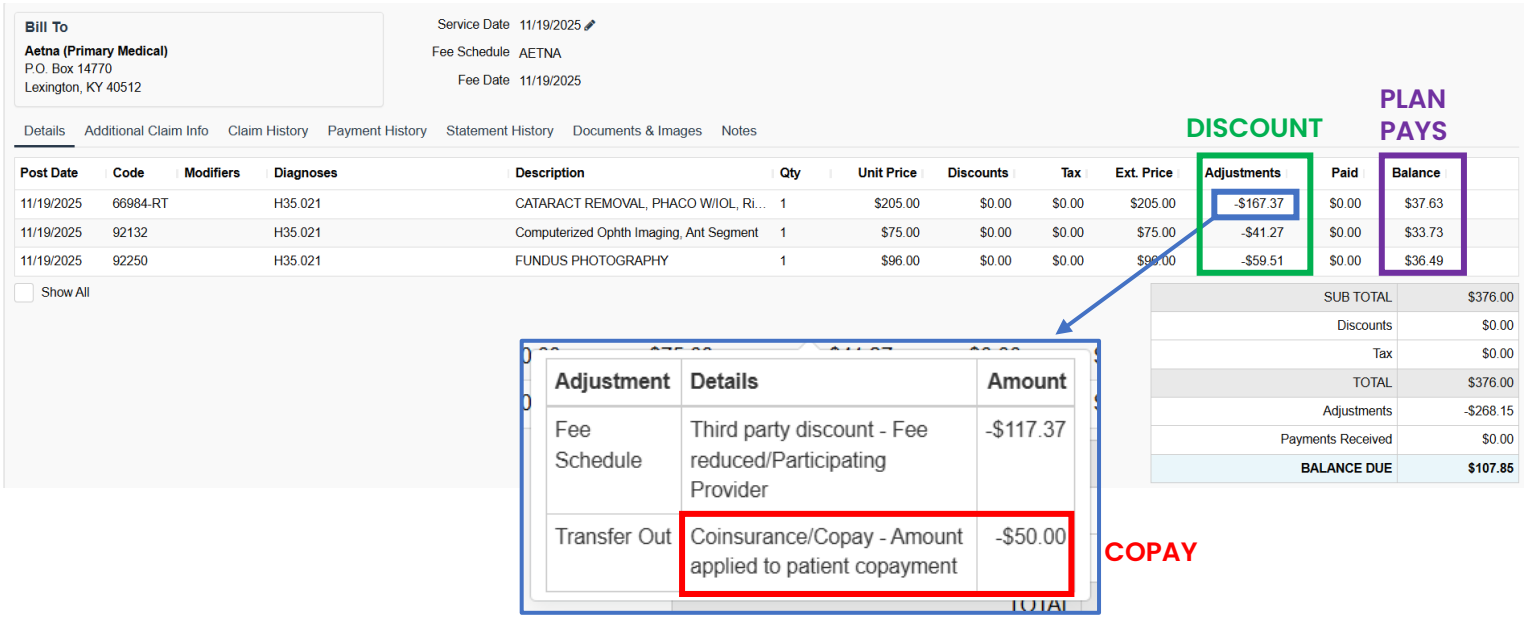
Post Date	Code	Modifiers	Diagnoses	Description	Qty	Unit Price	Discounts	Tax	Ext. Price	Adjustments	Paid	Balance
11/19/2025	66984-RT		H35.021	CATARACT REMOVAL, PHACO W/IOL...	1	$205.00	$0.00	$0.00	$205.00	$0.00	$0.00	$205.00
11/19/2025	92132		H35.021	Computerized Ophth Imaging, Ant Seg...	1	$75.00	$0.00	$0.00	$75.00	$0.00	$0.00	$75.00
11/19/2025	92250		H35.021	FUNDUS PHOTOGRAPHY	1	$96.00	$0.00	$0.00	$96.00	$0.00	$0.00	$96.00

Show All

SUB TOTAL	$376.00
Discounts	$0.00
Tax	$0.00
TOTAL	$376.00
Adjustments	$0.00
Payments Received	$0.00
BALANCE DUE	**$376.00**

The fee schedule automatically deducts any contractual write-offs, leaving only the allowable amount in the balance column. You must then transfer any patient copays, coinsurance, and deductibles.

After Fee Schedule is applied AND patient copay is transferred:



Bill To
Aetna (Primary Medical)
P.O. Box 14770
Lexington, KY 40512

Service Date 11/19/2025
Fee Schedule AETNA
Fee Date 11/19/2025

Details | Additional Claim Info | Claim History | Payment History | Statement History | Documents & Images | Notes

DISCOUNT

PLAN PAYS

Post Date	Code	Modifiers	Diagnoses	Description	Qty	Unit Price	Discounts	Tax	Ext. Price	Adjustments	Paid	Balance
11/19/2025	66984-RT		H35.021	CATARACT REMOVAL, PHACO W/IOL, Ri...	1	$205.00	$0.00	$0.00	$205.00	-$167.37	$0.00	$37.63
11/19/2025	92132		H35.021	Computerized Ophth Imaging, Ant Segment	1	$75.00	$0.00	$0.00	$75.00	-$41.27	$0.00	$33.73
11/19/2025	92250		H35.021	FUNDUS PHOTOGRAPHY	1	$96.00	$0.00	$0.00	$96.00	-$59.51	$0.00	$36.49

Show All

SUB TOTAL	$376.00
Discounts	$0.00
Tax	$0.00
TOTAL	$376.00
Adjustments	-$268.15
Payments Received	$0.00
BALANCE DUE	**$107.85**

Adjustment	Details	Amount
Fee Schedule	Third party discount - Fee reduced/Participating Provider	-$117.37
Transfer Out	Coinsurance/Copay - Amount applied to patient copayment	-$50.00

COPAY

IN CIAO! OPTICAL:

- **PLAN PAYS** = BALANCE from E.H.R.
- **DISCOUNT** = Retail – Plan Pays (also Adjustments column in E.H.R.)
- **COPAY** = Patient copay transferred out

HOW TO READ A CIAO! RECEIPT

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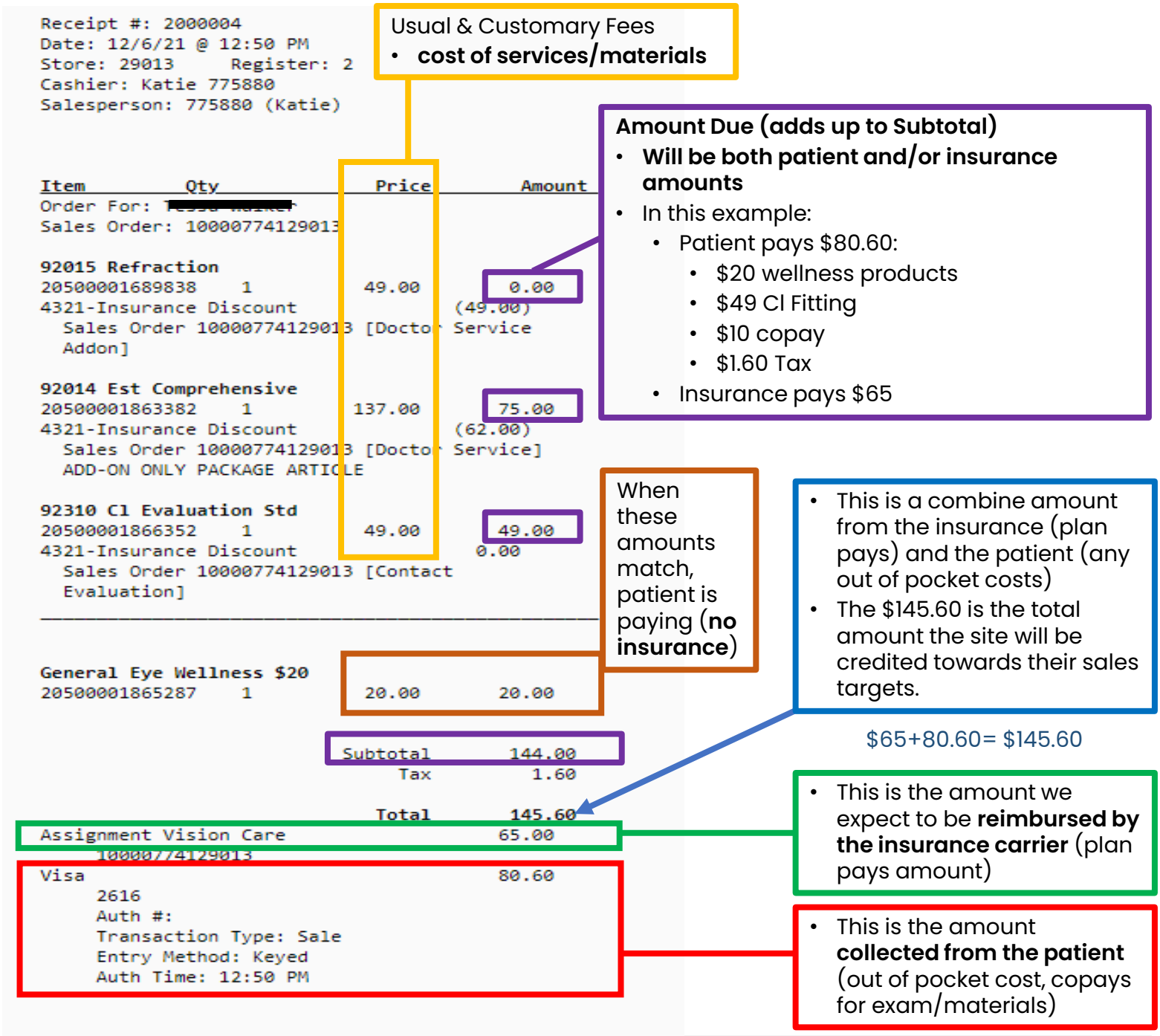
Funds are distributed on different lines based upon Usual & Customary and Insurance deductions. **At the time of Tender in Ciao! Optical, it is always a best practice to email & print the patient receipts.**

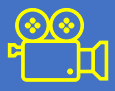


To reprint a receipt, you can:

- If it's the last transaction tendered, click F3 -Reprint Receipt
- Use Toolkit App and reprint (save as PDF and email if needed)
- Look up patient in the Ciao! Optical Back Office, Electronic Journal and reprint (Click HERE)
- Once you've completed the transaction, you can not email directly from Ciao! Optical

Claim Filing

Medical Insurance



TeamVision
Eye care, together.

MEDICAL CLAIM FILING

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You will be assigned a Medical Biller. They will schedule a post-integration meeting to review the billing process and preferred communication methods.

Claim Submission

- Your biller will pick up pending invoices in RevolutionEHR, scrub each claim, and submit it to the insurance carrier.
- Most claims are filed directly through **Trizetto Clearinghouse** in the EHR.
- Some carriers may require **paper CMS1500 forms**. In those cases, either your biller or the site will generate the form in RevolutionEHR and submit manually.

Payment Posting

- When payment and the EOB are received, your biller will post the payment in the EHR, clearing the insurance balance.
- The biller will review the EOB for patient responsibility (copay, coinsurance, or deductible) that was not collected at the time of service and transfer those balances to the patient for statement processing. *Note: Patients only receive statements for authorized invoices.*

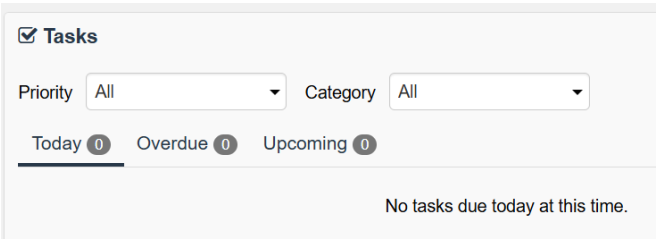
Denials

Your biller will review and resubmit any denied claims.

RevolutionEHR Tasks

- Your biller will use the **Tasks** feature to communicate billing needs, corrections, or deadlines.
- The manager can solve or reassign to a team member in the practice.
- Check tasks daily. Once task completed, you must click the complete button on the task which will notify your biller of the completion, notes, and any updates related to the task.

- **You must respond to your biller within 48 hours via email OR task completion.**
- If not resolved with 48 hours, the balance will be assigned to be patients' responsibility, and they will receive a statement to pay.



Tax IDs:

- Post integration, you will be notified if you have a change in Tax ID. This Tax ID will be listed on all insurance portals and claims.
- This could also mean you will have new insurance account numbers.
- Reach out to your insurance biller if you have any questions related to your Tax ID.

Session 4

Patient Collections, Site Audits, Common Billing Errors

TeamVision
Eye care, together.

CONSULTATIVE SELLING PATIENT JOURNEY

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Consultative selling (needs-based selling) focuses on understanding and addressing the specific needs of the patient. It involves identifying the patient's goals, challenges, and pain points, and then positioning our products as the solution that best meets those needs.

LEARN about the patient by reviewing history and insurance, even before they arrive. When in clinic, facilitate a conversion around lifestyle, pain points, and needs. Ensure this information is travels with the patient.

LISTEN actively during patient hand-off and ensure to ask additional questions to understand the patients needs. This will guide your sales approach and what products and services to recommend today.

LEAD with a single recommendation for each product to meet lifestyle or prescription needs. Assume the sale and create value. Showcase our preferred products and share the benefits with the patient.

	Prepare	Learn	Listen	Lead	Review	After
STANDARDS	Fill the Books Insurance Welcome	Get To Know Your Patient Consultation	Hand Off Consider Solutions (Product + Service + Referrals)	Assume The Sales Recommend Products	Accurate Entry OneSight Thank You	Order Management Pick Up Optical Expert
TOOLS + RESOURCES	Data Capture Fill The Books	Patient Questionnaire Intake Form	OD Hand Off Observation	LensSimulator SmartShopper Lens Portfolio Guide Contact Price Card Promotions	EyeRuler2 Patient Referral	Take Action Tab Eyewear Analysis
KPI IMPACT	**Exam Growth** Fill Rate No Show Rate	**Sales** Comp Sales	**Retail Capture** OD Productivity Average $ Patient	**Multiples** Sun Avg $ Spec Unit/Lens Avg $ CL, Annual Supply	**EPP** EyeRuler Grateful Patient Google Review	**Google Review** RTFT Reject Dwell

PREPARE
INSURANCE

	Actions	What Does It Sound Like
Capture Medical + Vision	PCC: (can also be done at time of appointment scheduling) • Capture all insurances (Routine + Medical Primary, Medical Secondary) for all patients regardless of exam type. • Document in EHR. • At check-in, scan all insurance cards (front and back).	Team Member: I know you're coming in for a medical exam, but I'd like to update/confirm our records. Do you still have VSP as well as Blue Cross for medical? I don't see a routine insurance carrier on file. Do you have routine coverage along with medical?.....Please make sure to bring all insurance cards with you.
Eligibility/ Pre-Auth	PCC: • Use Trizetto or carrier's website to confirm eligibility, copays, and/or deductibles within 24-48 hours prior to patient arrival. • Document in E.H.R or via office protocols (make sure it's clearly documented and easily found by all team members).	Team Member: Great- now that we have your insurance details, we will check authorization ahead of time and collect copays/deductibles at the time of your visit. Of course, if you add or change services, we will update you on what you can expect to pay.
Co-Pay + Deductible	PCC: (at check in) • Educate patient on copays (or potential copays). • Inform patient that you will be collecting copays at some point during the visit. • Confirm eligibility and copays are clearly visible for the team (listed on routing sheet, printed and on clipboard, etc.).	Team Member: Mrs. Smith, it looks like you have an overall $10 copay for the routine exam. If you choose to add a contact lens exam or imaging, there will be additional fees that the technicians will review with you as needed.

Insurance Process Overview

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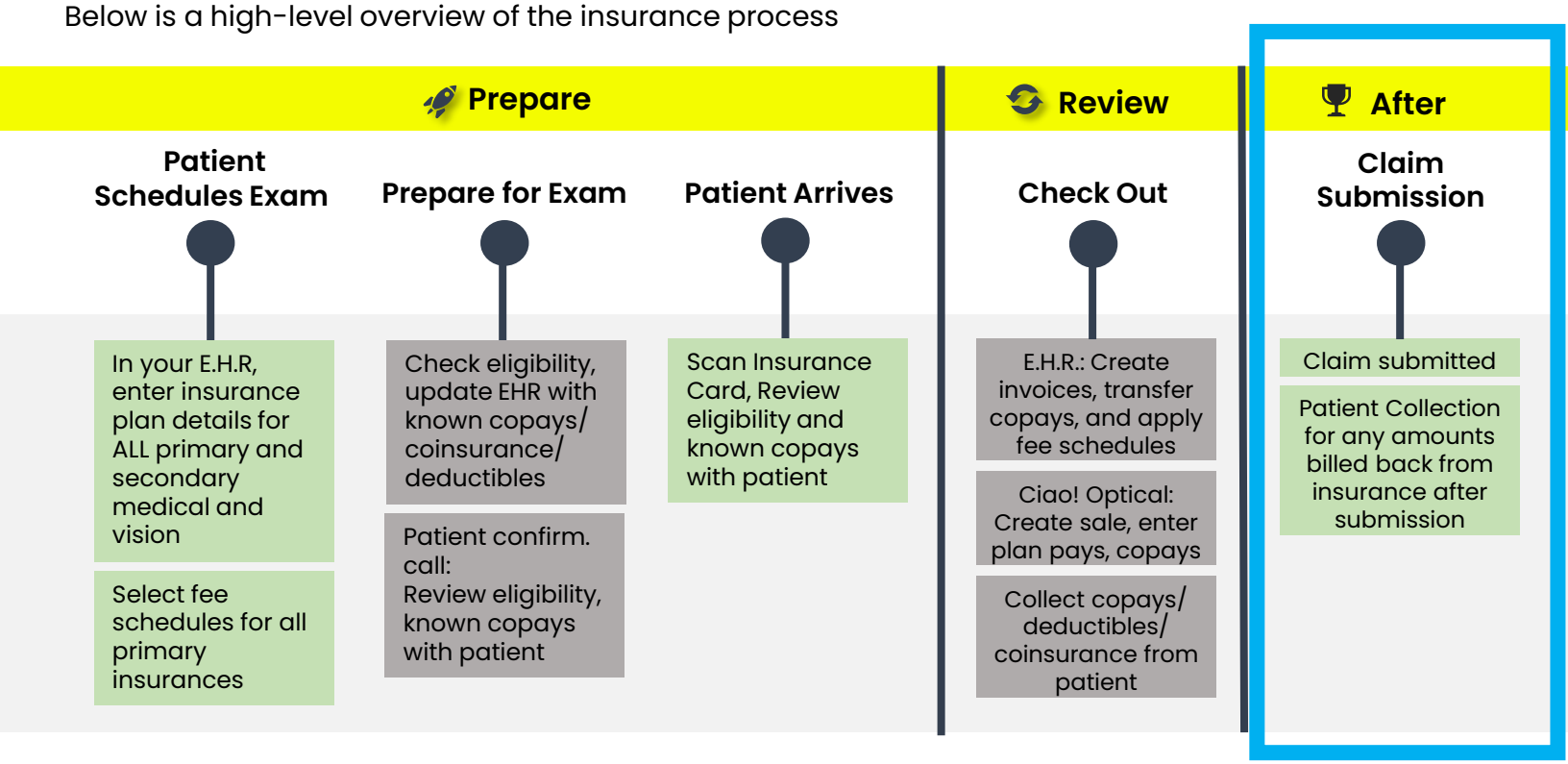
Below is a high-level overview of the insurance process



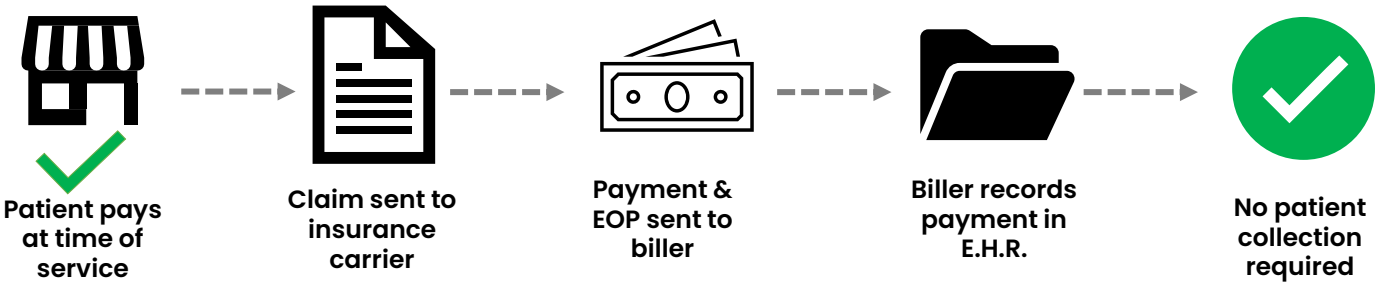
- Eligibility must be verified PRIOR to the patient's appointment.
  - Check Trizetto and/or Insurance carriers' website ahead of time to know the patient copay/deductible/coinsurance.
- **All copays/coinsurance/deductibles must be collected at the time of service.**
  - **We do not do back bill (i.e., you can not bill the insurance carrier to see what is covered and then send the patient an invoice.)**
- ALL services must be recorded in BOTH the E.H.R. AND Ciao! Optical (point-of-sale).
- ROUTINE: Balances are zeroed out in the EHR.
- Claim submission will vary depending on office and insurance. Refer to your insurance guide or consult your billing team for claim billing responsibility.
- **Improper billing may result in unnecessary write-offs and a greater chance of aging patient balances.**
- MEDICAL: Balances are left in the EHR. Claims are billed and reconciled out of the EHR. Materials being billed directly to medical carriers should also be entered into the EHR.
- SECONDARY: Medical billers will manage secondary claim filing once primary insurance has been billed.
- **Any overpayments will be refunded.**

Click HERE to be redirected to the Patient Journey to watch RevolutionEHR How-To-Videos.

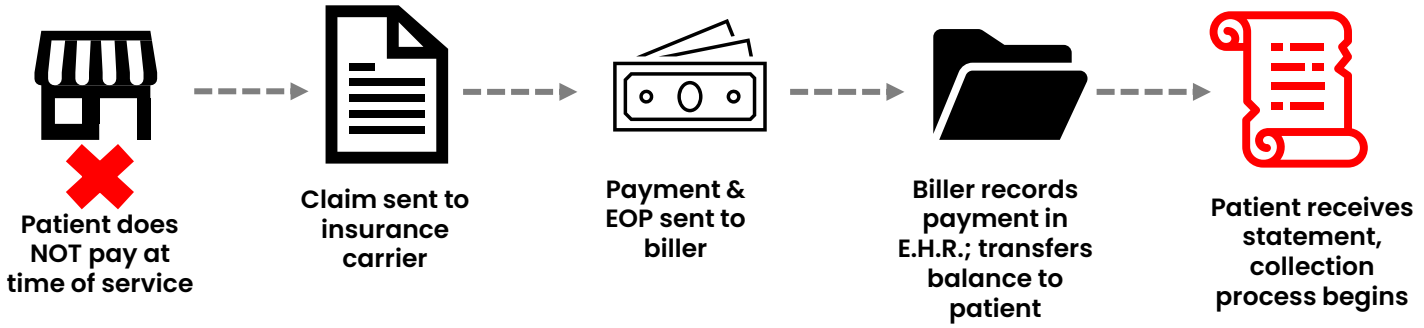
PATIENT COLLECTIONS

Patient Payment Process

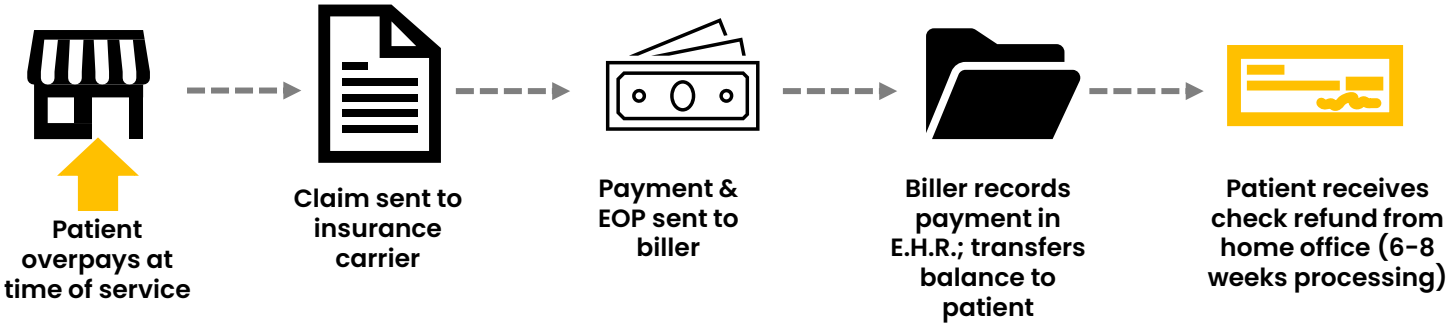
Known patient responsibilities (such as copays, coinsurance, and deductibles) **must be collected at the time of service.** If the patient **pays the correct amount** at the time of service, no further action is needed by the site. We cannot accept partial payments at time of service. If a patient needs assistance, encourage them to apply for CareCredit or reschedule for a later date.



If the patient **does not pay or pays too little** at the time of service, the patient will receive a statement for the balance owed after the biller receives the insurance payment/EOP. This will negatively affect patient aging and require more effort from the location to collect the statement balance.



If the patient **pays too much** at time of service, the patient will receive a refund via home office check once the biller receives the insurance payment/EOP. You DO NOT need to refund the patient from the location.



PATIENT COLLECTIONS
Statements

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If the patient **does not pay or pays too little** at the time of service, the patient will receive a statement for the balance owed. Statements are sent the 1st business day of each month by the Medical Billing team.

Top address is the location of the site they visited.

Silver Lake Eye Clinic
10217 19th Avenue SE #102
Everett, WA 98208

For all billing questions, call: (360) 459-2108
Patient Name: Alexandria Logue
Due Date: Upon Receipt

ALEXANDRIA LOGUE
7741 13TH AVE NE
OLYMPIA WA 98516-5752

Payment Coupon

IF PAYING BY VISA, MASTERCARD, DISCOVER OR AMERICAN EXPRESS, FILL OUT BELOW

☐ VISA ☐ MASTERCARD ☐ DISCOVER ☐ AMER.EXP.

CARD NUMBER	EXP.DATE	AMOUNT
SIGNATURE	MUST INCLUDE 3 DIGIT SECURITY CODE FROM BACK OF CARD	

STATEMENT DATE	PAY THIS AMOUNT	ACCOUNT NO.
07/25/2025	$263.00	129602376

CHARGES AND CREDITS MADE AFTER STATEMENT DATE WILL APPEAR ON NEXT STATEMENT.

SHOW AMOUNT PAID HERE $

MAKE CHECKS PAYABLE / REMIT TO:

OLYMPIA VISION CLINIC & CONTACT LENS CENTER
1625 Cooper Point Road SW
Olympia, WA 98502

"Remit to" is the Legal Entity for check payments

There are four ways a patient can pay a statement balance:

MAIL the top portion of their statement (Payment Coupon) with a check or credit card information.

ONLINE using debit or credit card through the "Pay Now" button on each location's website. **This is the most preferred payment method.**

PHONE directly with the location they visiting using debit/credit.

IN PERSON using debit or credit cards or check. Least Preferred

NOTE: Patient statement payments are NEVER entered into Ciao! Optical. All payments are managed through the E.H.R.

MAIL the top portion of their statement (Payment Coupon) with a check or credit card information.

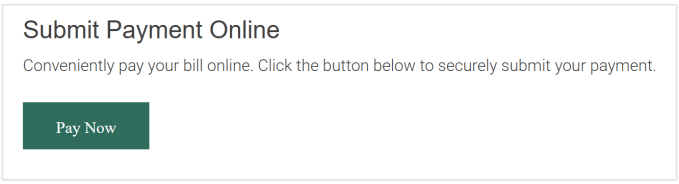
Patient mails in the Payment Coupon from the top of their statement with a check or debit/credit card information. The remittance mailing address is the PRIMARY location for the legal entity.

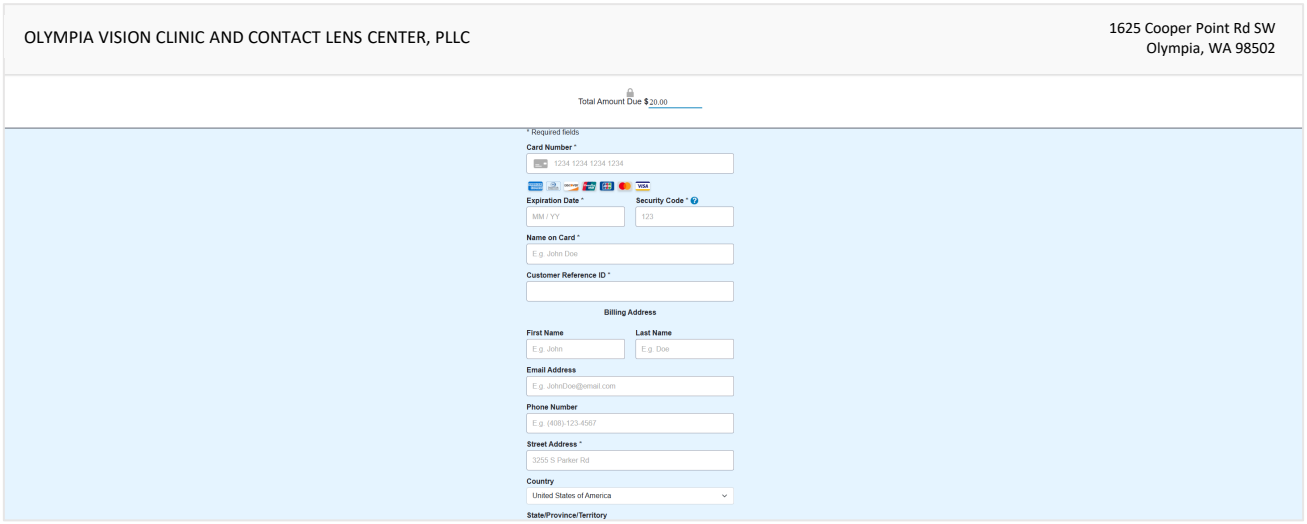
- **Checks**: Medical biller deposits into NCNO insurance account and applies payment in E.H.R.
- **Cards**: Medical biller processes through Transaction Express and applies payment in the E.H.R.

ONLINE using debit or credit card through the "Pay Now" button on each location's website. **This is the most preferred payment method.**

A "Pay Now" button will be added to each location's website for patients to pay directly online

- The LEGAL ENTITY NAME will be displayed when the patient clicks the "Pay Now" button.
- Medical biller reconciles payments and applies them to the patient's account in the E.H.R.
- No action is needed by the site.





PHONE directly with the location they visiting using debit/credit.

Patient calls the location directly to make a statement payment over the phone using a debit or credit card.

- DO NOT process patient statement payments through your in-office credit card device.
- Site processes card through Transaction Express (Online Portal tied to insurance bank accounts)
- Site applies payment in the E.H.R. and emails Medical Biller the patient's name and payment amount for reconciliation purposes.

IN PERSON using debit or credit cards or check. **Least Preferred Payment Method**

Patient pays in person at the site:

- **Cards:** DO NOT process patient statement payments through your in-office credit card device.
  - Site processes card through Transaction Express (Online Portal tied to insurance bank accounts)
  - Site applies payment in the E.H.R. and emails Medical Biller the patient's name and payment amount for reconciliation purposes.
- **Checks:** DO NOT deposit with your regular nightly deposit. Checks must be deposited into the NCNO Insurance Bank account. Each site manages these payments differently depending on bank location and setup. **Confirm the process for your location with your Medical Biller.**
  - Some locations have deposit books and can deposit directly into the NCNO Insurance account.
  - Some locations must mail all checks to the primary location each week for their Medical Biller to process accordingly.
  - Some locations have mobile deposit capability and can take photos to deposit directly into the NCNO account remotely.
- **Cash:** Cash is not accepted on site. Best practice is to guide them to the portal. If they are only able to pay with cash, consult with your Field Leader and Medical Biller for how to handle payment and cash deposit. DO NOT deposit with your regular nightly deposit.

PATIENT COLLECTIONS
Transaction Express

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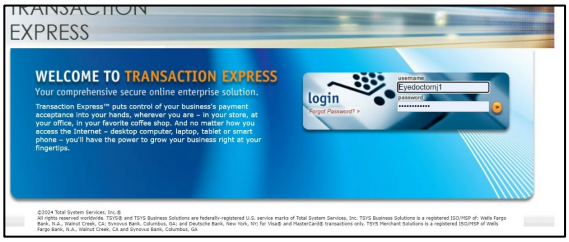
When a patient is using a debit/credit card to pay a statement balance, process via the Ciao! Toolkit or direct link here: Transaction Express. **REMINDER:** If you process a payment through Transaction Express, you must also apply payment to the patient balance in the E.H.R.

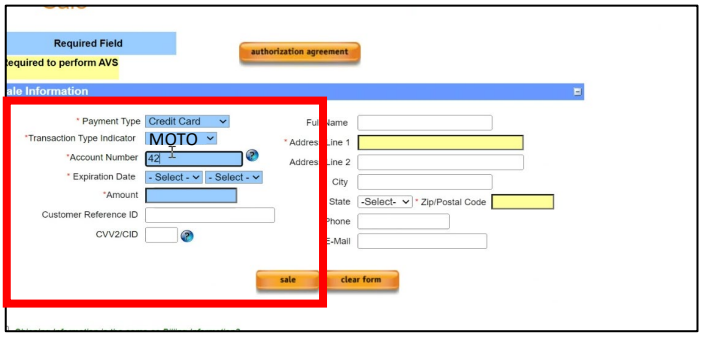
Partner with your Medical Billing team to ensure the correct team members have access to the portal. Medical Billers will manage access for all new hires and terminations. New locations will complete this setup as part of Conversion Week activities.

1. When logging in for the first time, it will ask you to set up **2-Step Authentication.** This will be your own cell phone number (You will receive a code to your cell phone every time you log in)



2. Once logged in, click on **Sale**

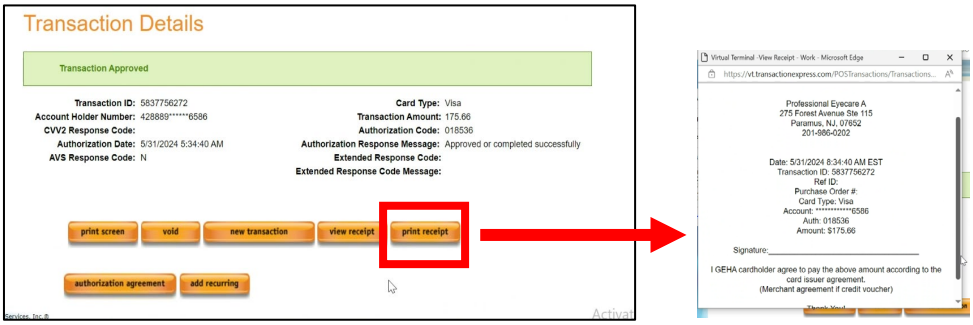
3. **Complete** required drop-down bars then press **Sale** and the transaction will process



- **Payment Type** -Credit Card
- **E Transaction Type Indictor** – MOTO (Mail Order Telephone Order).
- **Account Number** (credit card number) & **Expiration Date**
- **Amount, Name, Address and Zip Code.**

4. After the transaction is complete, you will receive **Approval** confirmation. If card **Declined**, Auth Response Message will be **Declined** or **Insufficient Funds.**

   To print the receipt, click **Print Receipt**



PATIENT COLLECTIONS
Receiving Payment in RevEHR

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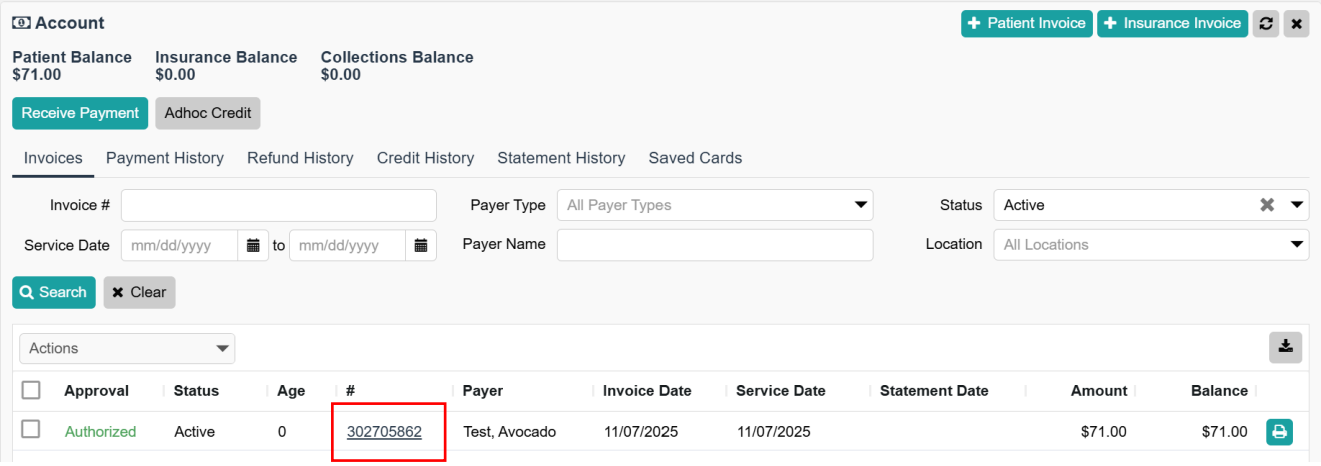
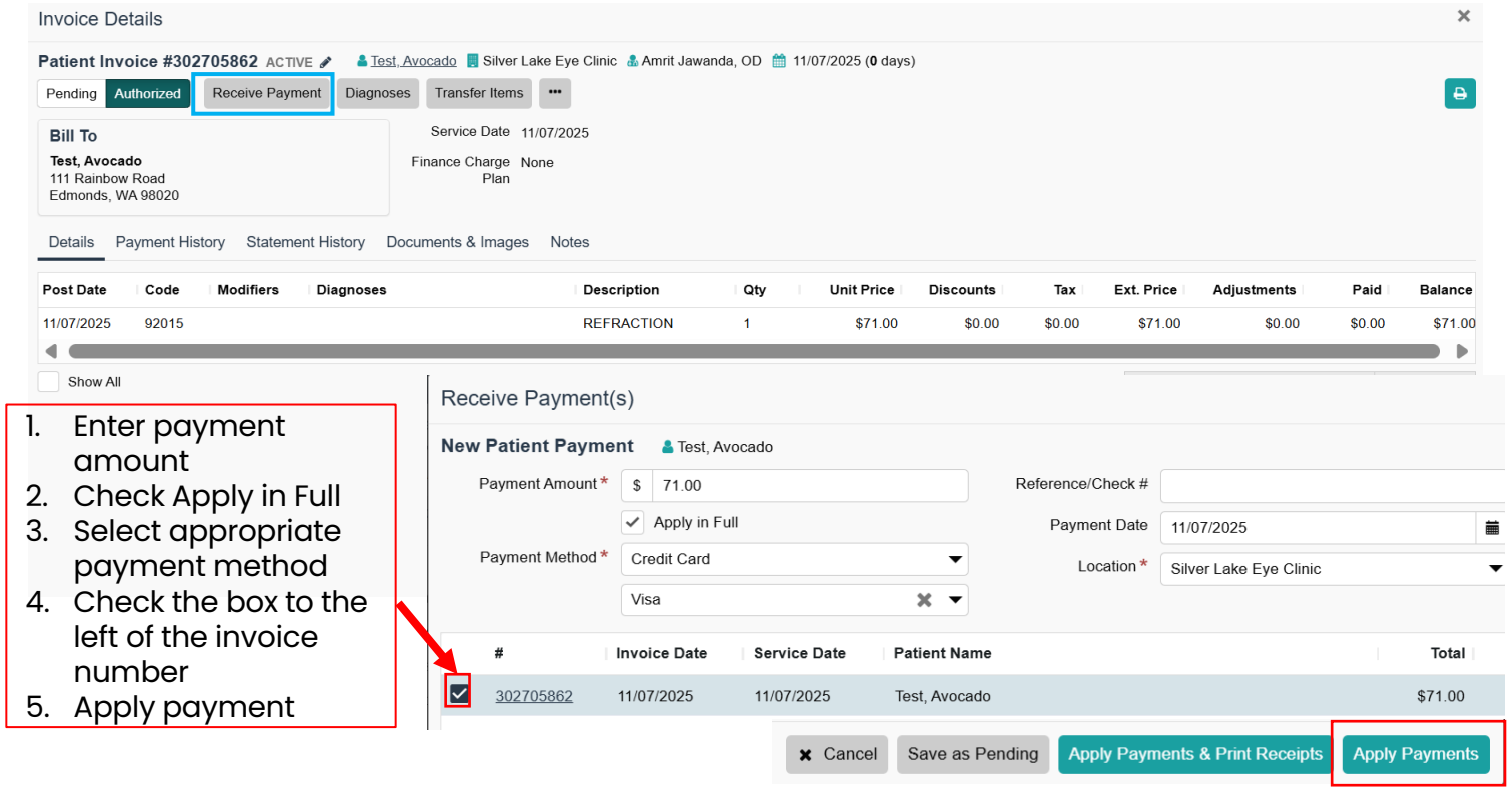
1 Open the patient's "Account" section from their profile and find the active invoice that matches the patient statement. Click the hyperlinked invoice # to open the invoice.



2 Receive payment and enter the amount the patient paid, then apply payments.



1. Enter payment amount
2. Check Apply in Full
3. Select appropriate payment method
4. Check the box to the left of the invoice number
5. Apply payment

3 If you processed a patient payment via Transaction Express, email your Medical Biller the patient's name and payment details for reconciliation.

PATIENT COLLECTIONS
Team Member Roles

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Position	Tasks
PCC	• Verify patient co-pays and deductibles BEFORE the appointment • Enter complete and accurate insurance information in the EHR and scan ins. cards • Collect correct copays, deductibles, and coinsurance at time of service -NO EXCEPTIONS • Do NOT bill 100% to insurance to avoid collecting patient responsibility. • Make weekly phone calls to patients with past due balances (one a week – weeks 3 to 8) • Record all collection attempts and conversations in the EHR
PM	• Verify PCCs are collecting the correct amounts at time of service • Verify there are no "open" or "pending" invoices in the EHR each day • Ensure PCCs are making collection calls in weeks 3 to 8 • Make final collection calls in weeks 9 to 12 • Record all collection attempts and conversations in the EHR • Submit monthly list of balances to be written off by the 10th bus. day of each month • Minimum of 4 statements & 6 weekly phone calls documented • Patients should be notified when scheduling next appointment there is a balance due, and it must be paid before next appointment.
MM	• Review monthly list for collections from each PM for compliance • Submit approved write-offs to respective biller by 15th bus. day of each month
Biller	• Process patient statements on 1st business day of each month. • Communicate with the PM once statements have been sent. • Post all insurance EOBs in EHR within 5 business days of receipt • Transfer appropriate balances to patient and adjust any partial balances <= $25.00 to over/short (partial pay only) • Post all patient payments received via online payment in EHR within 5 business days of receipt • Write off balances as approved by MM by 20th bus. day of each month • Balances >= $100.00 should go to a collection agency • Flag chart once sent to collections or balance written off so it can be collected when the patient returns.

Tips & Tricks:

- Proactively communicate to patients that co-pays and deductibles are due at time of service
- Notify patients through appointment center, electronic reminders & counter signage
- Enforce collection of any past due balances while patient is in office
- **The total patient A/R is not to exceed 3% of the total monthly revenue**
- Work with your biller and Field Leader if you need help working the **aging report**

Scripts	Sample Script
Courtesy Call Week 3	"Hi, my name is <First Name Only>, and I am calling from ____ to inform you that we received notification from your insurance that you are responsible for $__ from your visit on ___. We mailed you a statement on the 1st of the month and I wanted to follow up to see if you have any questions"
Collection Call Weeks 4-8	"Hi, my name is <First Name Only>, and I am calling from ____ to review the balance due from your visit on ___. Do you have any questions regarding this balance, and could we go ahead and take care of this today?"
Collection Call Weeks 9-12	"Hi, my name is <First Name Only>, and I am the Practice Manager calling from ____ to review the balance due from your visit on ___. If payment is not received by the end of the month, your account will be turned over to collections."

PATIENT COLLECTIONS
Insurance Refunds

RETURN TO TABLE OF CONTENTS

If the patient pays too much at time of service, the patient will receive a refund via home office check once the biller receives the insurance payment/EOP. You DO NOT need to refund the patient from the location.

Visibility of tasks, processes, timing and responsibilities for refunds. Checks will reference the site as the Payor but may also reference Luxottica. Note this process can take up to 8 weeks!

Medical Biller
- Email refund requests to Mason Office
- Add requests to refund tracker (spreadsheet)
- Follow up on payments on behalf of the practice

Mason Refund Team
- Monitor refund requests from Billers
- Submit weekly requests to Accounts Payable Team
- Add submission ticket number to refund tracker
- Add check #, amount and mail date to refund cash tracker
- Follow up on status requests from Medical Billers
- Confirm checks are printed and mailed by the Accounts Payable Team

Refund timing overview
- Wednesday – Mason COE submits refund request to AP team
- Accounts Payable timing:
  - Friday – processes refunds
  - Monday – obtain approval
  - Wednesday – print refund checks
  - Thursday – mail refunds and letter

Practice Manager
- Monitor refund progress (Assignment Refund Tracker)
  - *Tracker available 24/7*
- Monitor refund submission ticket number
  - *If not available after 7 days, reach out to Medical Biller for status*
- Inform patients of 30-day window for refund to be mailed

AUDITS

Site Level Audits

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UNASSIGNED ITEMS REPORT

RevolutionEHR

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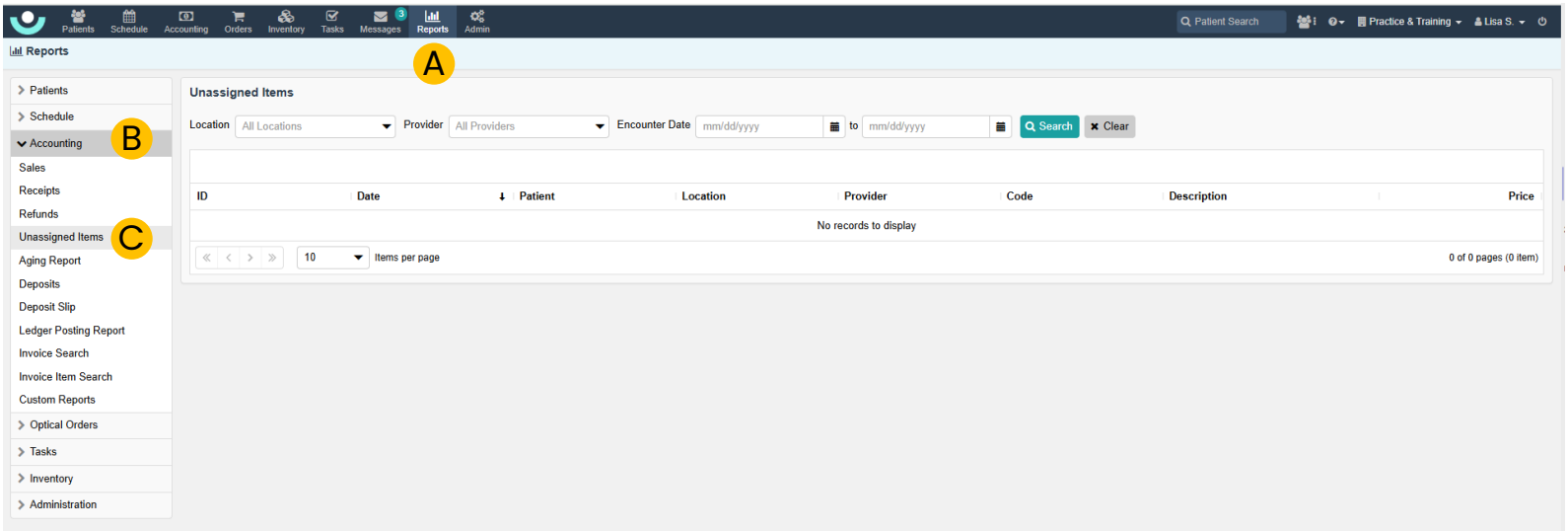
Run your **Unassigned Items Report daily** and act if needed.

- If patients are listed on the report, it means the OD has coded the exam, but you have NOT bulk assigned and created invoices.
- Complete all invoices and assign to patient or insurance carrier (in some cases both).
- Confirm services transferred and paid in Ciao! Optical. If not- contact patient for payment.



INSURANCE AUDIT
Game Plan

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Team Goals, Objectives, Focuses:

Actions & Timelines:
Prepping For Patient Arrival:
RevolutionEHR & Check In:
Check Out:
Ciao! Optical:

SELF REVIEW | VSP

Questions	Yes	No (Notes)
Eyefinity:		
Are separate authorizations for exams and materials being pulled?		
Are all patient benefits being printed & Auto-calc plan ID's being documented?		
Ciao! Optical:		
Can all needed team members locate and demonstrate understanding of the Site Insurance guide in the Toolkit?		
Can all team members effectively utilize the google document & Auto-Calculations Guide?		
Can all needed team members correctly enter Patient and Insurance details into Ciao! Optical (Authorizations, Member ID, Address, etc.)?		
Can all needed team members effectively utilize Auto-Calculation Plans for Exams? • Routine Eye Exam • CL Fittings		
Can all needed team members effectively utilize Auto-Calculation Plans for Contacts? • Soft Contact Lenses • Specialty Contact Lenses		
Can all needed team members correctly navigate the VSP Enhancement Charts and Patient Benefit Summary to identify the correct patient copays to enter into Ciao!?		
Can all needed team members effectively enter Bill Actual Plans for Contacts?		
Can all needed team members effectively demonstrate how to enter Bill Actual plans for Eyeglasses using these examples?		
Can all needed team members effectively utilize Bill Actual Plans for Exams?		
Billing:		
Do all team members understand the billing process after Tender?		

SELF REVIEW | Other Routine Carriers

Questions	Yes	No (Notes)
Carrier Websites:		
Are all needed team members able to navigate the websites?		
Are copays/deductibles being determined and documented ahead of the appointment?		
RevolutionEHR:		
Are all insurances being entered and fee schedules selected prior to patient arrival?		
Check In:		
Are insurance cards scanned and documented?		
Are expected fees communicated/reviewed with the patient?		
Are all patient HIPAA, financial forms, and any practice required documents signed, acknowledged, and scanned into RevolutionEHR?		
Check Out:		
Are all copays and patient fees being collected at the time of service?		
Are RevolutionEHR invoices correctly processed?		
Ciao! Optical:		
Are team members able to search for the correct plan in Ciao! Optical?		
Are all services being entered into Ciao! Optical? • All invoices with Insurance applied (regardless of the patient copay) • All patient responsibility		
Review three transactions in Rev & Ciao! Were they entered correctly?		

SELF REVIEW | Medical Carriers

Questions	Yes	No (Notes)
Trizetto/Availity/Insurance Portals:		
Are all needed team members able to navigate the website?		
Are medical copays/deductibles being determined and documented ahead of the appointment?		
RevolutionEHR:		
Are all insurances being entered and fee schedules selected prior to patient arrival?		
Check In:		
Are insurance cards scanned and documented?		
Are expected fees communicated/reviewed with the patient?		
Are all patient HIPAA, financial forms, and any practice required documents signed, acknowledged, and scanned into RevolutionEHR?		
Check Out:		
Are all medical copays, deductibles, and patient fees being collected at the time of service?		
Are RevolutionEHR Invoices correctly processed?		
Ciao! Optical:		
Are team members selecting the medical plan via the Medical Pulldown in Ciao!?		
Are ALL medical services being entered into Ciao! Optical? • All invoices with Insurance applied (regardless of the patient copay) • All patient responsibility		
Review three transactions in Rev & Ciao! Were they entered correctly?		

COMMON BILLING ERRORS

RevolutionEHR

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BILLING ERROR
Example 1

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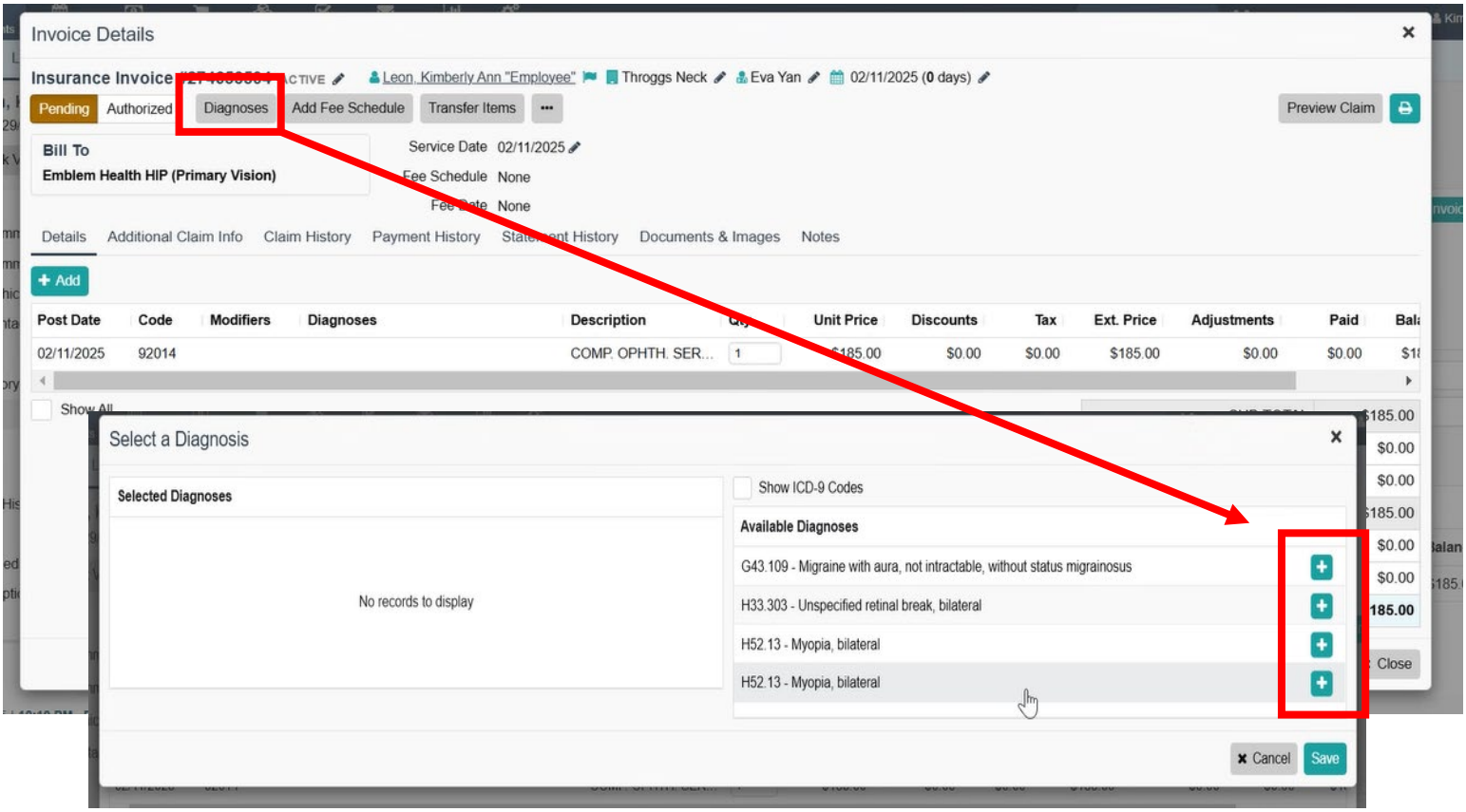
Mistake: Missing diagnosis code

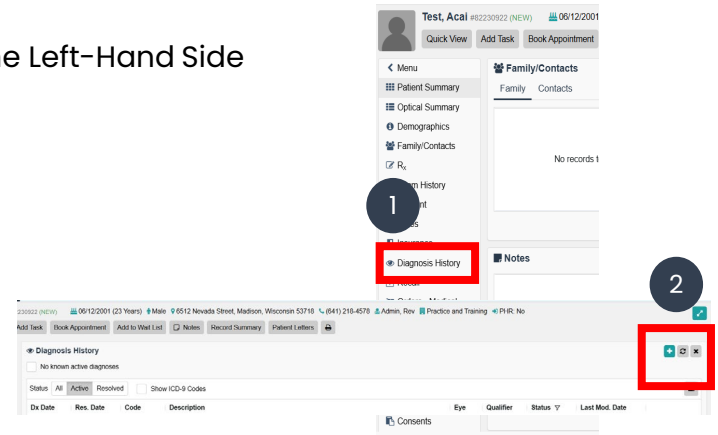
All medical invoices must include a diagnosis. In some cases, based on data from the exam encounter, various Diagnosis will be available for you to manually enter.

- Click diagnosis to add from listing
- Select from the list



For outside Rx's you will have to manually add the Diagnosis and will not be pre-populated.

- After Searching & Selecting Desired Patient:
  - Select 'Diagnosis History' In Column List On The Left-Hand Side
  - Click The '+' Sign within the Diagnosis Box
  - Type In Diagnosis Code & Select
  - Dx Date: 2 Options
    - Date On Outside Rx
    - Date Pt Came Into The Office For Services
  - Click 'Save'



Billing Error
Example 2

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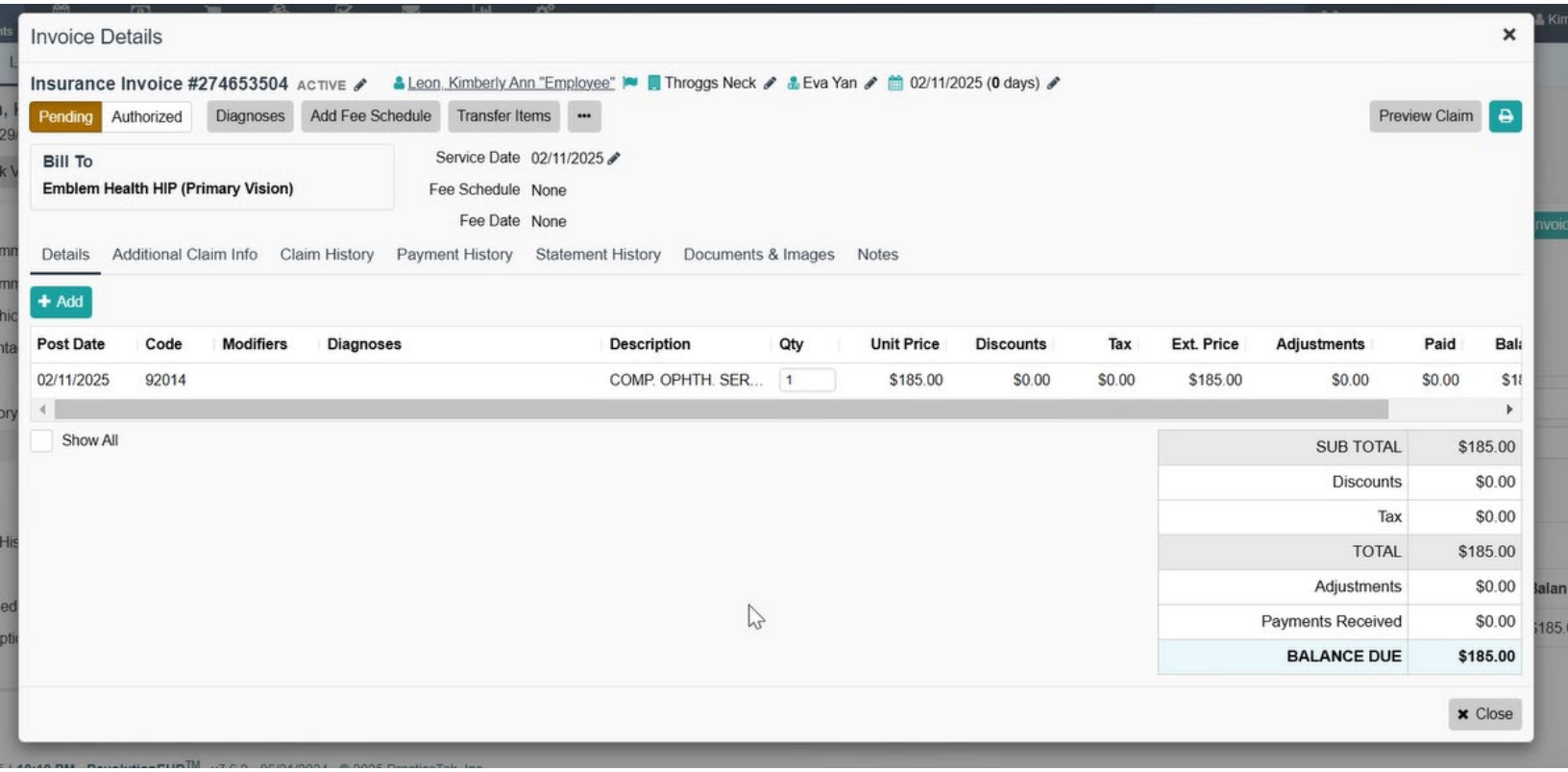
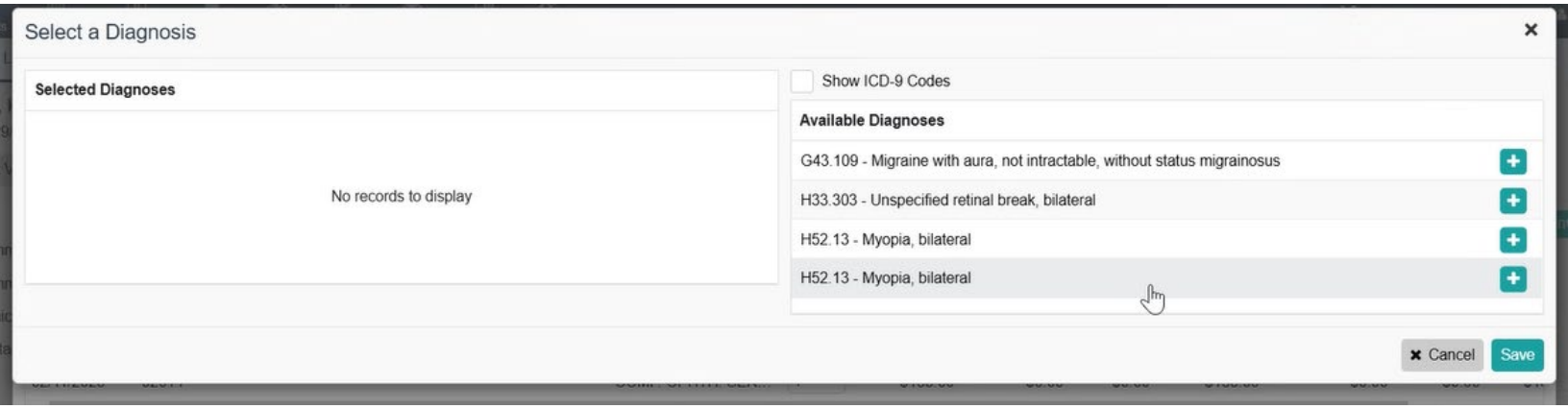
Mistake: Missing fee schedule





BILLING ERROR
Example 3

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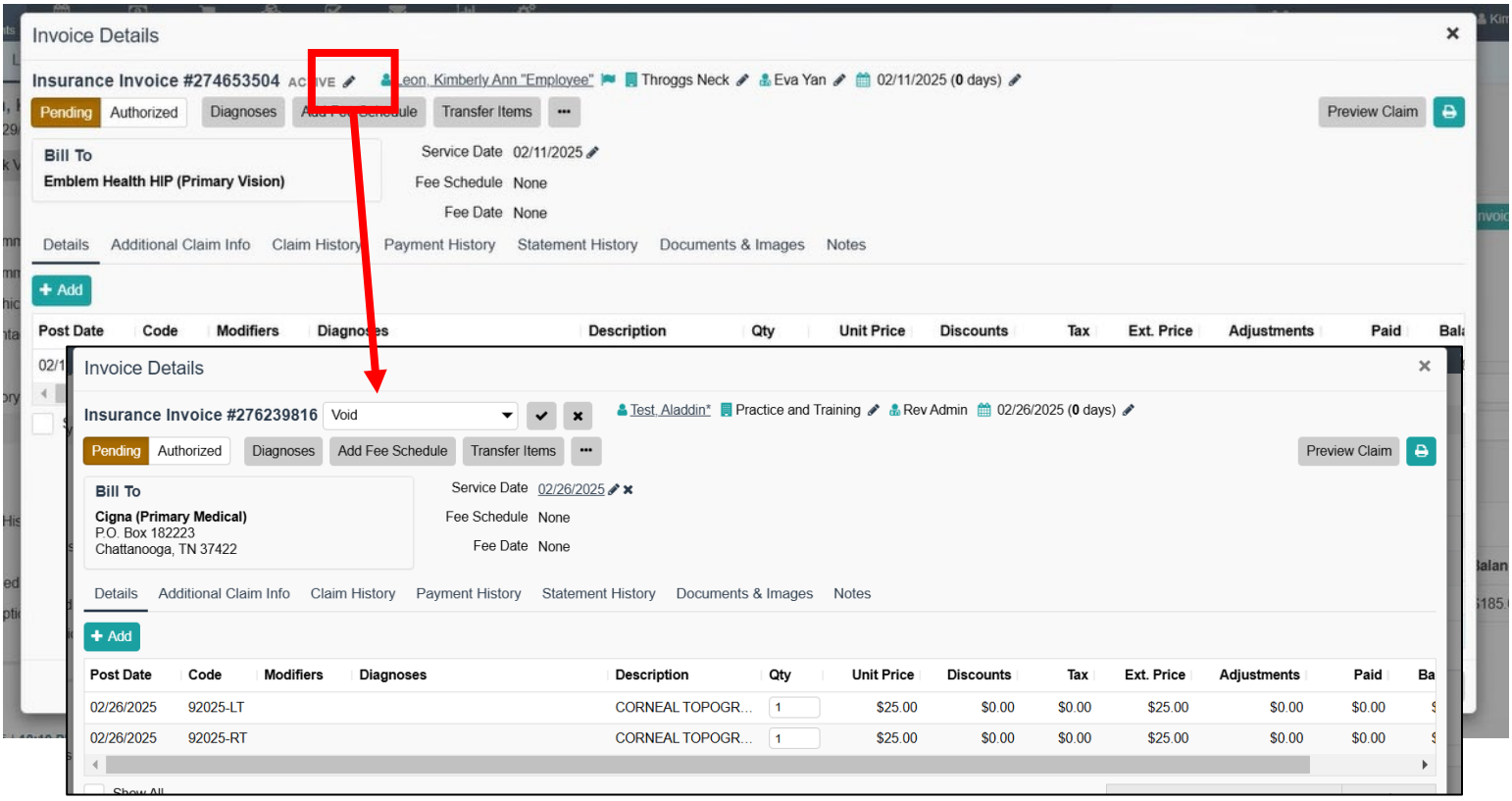
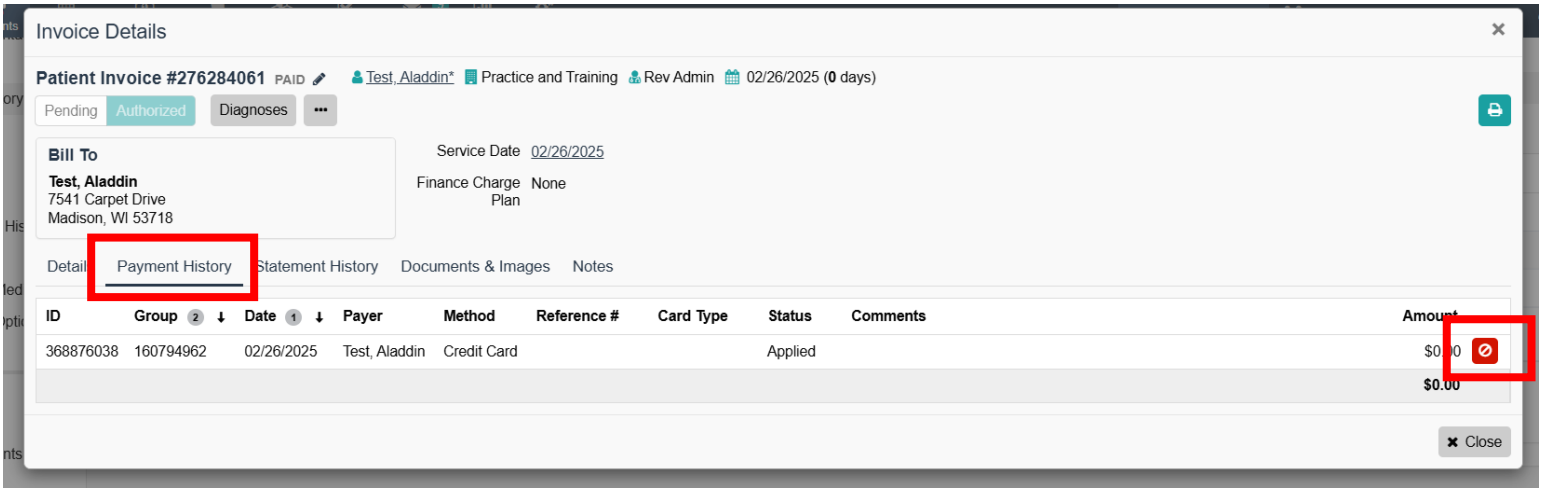
Void an Invoice: This may be used if you need to correct an invoice for various reasons.

- Click the Pencil
- Select Void off the pulldown bar
- Click the Check Mark to Save



Void a Payment: In some instances, to void an invoice you must void the payment.

- Click Payment History
- Select the No-Delete logo



Medical Insurance

- I have general questions about insurance.
- I'd like to learn more about insurance terminology.
- When is there a balance left in the E.H.R- routine or vision insurance?
- Is there an overview of medical insurance billing?
- What does the Medical Biller do?
- How do I know what my patient's copay is?
- What do I need to know about Medicare?

Trizetto

- How do I navigate Trizetto?

RevolutionEHR:

- How do I enter insurance into the patient profile?
- How do I complete a medical invoice?

ECLiPS:

- How do I enter insurance into the patient profile?
- How do I complete a medical invoice?

Routine Vision

- Billing overview- Do I bill it or will it auto file?
- Why are my claims being denied?

Auto Calculation Plans

- How can I find my plan ID's for the auto calculation plans?
- How do I select the correct plan?
- VSP: How do I enter the exam/contacts in Ciao! Optical?
- I have a Spectera plan that is not listed on my google doc, what plan can I use?

Bill Actual Plans

- How do I enter bill actual plans in Ciao! Optical?
- How do I know what VSP will reimburse for an exam?
- How do I bill a contact lens evaluation with VSP?
- How do I know what the Wholesale Frame Allowance is for VSP Insurance?
- How much will VSP reimburse for lenses?
- What do I do if I'm selling Eyezen Lenses in Ciao! Optical?
- What do I charge for Varilux lenses?
- How do I enter proprietary frame and lenses?

General

- What do I do if I'm missing an insurance plan post integration?
- How do I know if my team is processing things correctly?

SELECTING THE CORRECT AUTO CALCULATION PLAN

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Eye care, together.

PLAN ID's

RETURN TO TABLE OF CONTENTS

Use the Quick Links below to locate **Plan ID's** for the available auto-calculation plans for your practice group.

As a part of prepping for patient arrival, it is a best practice to document the Exam & Material Plan ID's ahead of time to streamline Ciao! Optical entry with the patient present.

Advanced Family Eyecare (T035)

Basden Eyecare (AL)

Coventry

Cooper, Metro

Dalton, Dixon (GA)

DiNapoli, LIVC, Park Professionals Eyecare

Golden Group (CA)

Highline

Lake & Williams (MO)

Lake Havasu/Daynes (AZ)

Rainbow

River Valley Eye Professionals

Rosin Optical

Saferstein/Ross

Tosland/Hall

True Eye Experts

TVO North Carolina

TVO South Carolina

Vinciguerra

SELECTING THE CORRECT PLAN

RETURN TO TABLE OF CONTENTS

Selecting the correct auto-calculation plan is one of the main ways to avoid denied claims.

In addition to selecting the correct plan, you will want to make sure the details entered into Ciao! Optical are correct.

Notes:

- **VSP Advantage plans-** if your patient has an advantage plan, enter as VSP Choice with the same copay
    - i.e., Patient has VSP Advantage $10 copay, in Ciao! Optical select the VSP Choice Exam $10 copay plan
- If you come across a plan with a unique copay, use bill actual or select the same type of plan (i.e. choice or signature) and edit the patient copay
- The claim will submit on the 837 file the way you enter it into Ciao! Optical
    - i.e., if you select a CL allowance of $150 but your patient actually has a $173 benefit, you can edit the auto-calculation plan and it will file the way you edited it in Ciao! Optical
- If your patient is receiving the 15% off contact lens evaluation discount, please complete a second transaction in Ciao! (enter as private pay and tender with the exam services and other materials)

The following pages will guide you through how to select the correct plan in Ciao! Optical.

SELECTING THE CORRECT PLAN

RETURN TO TABLE OF CONTENTS

In Ciao! Optical:

For eye exams and eyeglasses, each VSP plan will be listed by the VSP plan type (Choice, Signature, Advantage) and service/product. If your patient will be charged $60 for the Contact Lens Fitting, then select the appropriate Auto-Calculation Plan.

VSP CHOICE EXAM $10 $60 FIT-

If they will be receiving 15% off the contact lens evaluation, then complete as a cash pay transaction and tender together with your routine eye exam.

For contact lenses, you will search via carrier and product, adding allowance amount will reduce the number of plans that will pull up in Ciao!

VSP CONTACTS $100

You can NOT use Auto-Calculation plans for Medically necessary or CL materials over $1000.

For eyeglasses, the wholesale frame allowance (WFA) will also be listed:

VSP CHOICE COMP PR WFA100

If you add in the copay following the WFA, then it will limit the number of plans provided in Ciao! and it will make selecting the correct plan easier.

In addition, if **polycarbonate is a covered in full item**, we must select the plan that indicates poly is covered.

VSP CHOICE COMP PR WFA100 0 CPY COV ROS → Covered

VSP CHOICE COMP PR WFA100 0 CPY NC ROS → Not-Covered

In general, the more information you type into Ciao! the more you will reduce the number of plans that pull up and will help your team select the correct plan.

The product icon selected in Ciao! Optical must match the VSP plan you select, or your claim will be rejected!

 Exams  Contact Lens  Complete Pairs  Lens only

Note- not all practice groups will have eyeglass auto-calculations plans available. Your group will be notified during your auto-calculation training.

Click To View A Video Of How To Search For VSP Auto-calculation Plans

Click Here To Watch A Video Of The New VSP Process In Action!

SELECTING THE CORRECT PLAN

RETURN TO TABLE OF CONTENTS

Use the chart below to help guide you in which plans to use:

Exams & Contact Lenses

Patient Benefits	Select this plan
Contact lenses over $1000	Bill Actual
Medically necessary contact lenses	Bill Actual
Combine CL allowance/fit plans	Bill Actual
Copay not found in Ciao!	Auto-Calculation and edit patient copay line
VSP Advantage plan not in Ciao!	Use VSP Choice plan with SAME copay
All Other Plans	**Auto Calculation Plans**
15% off CL Fitting	**Process as Cash Pay**

Eyeglasses and/or Lens only

Patient Benefits	Select this plan
Covered in full items other than poly (AR, Progressives, etc.)	Bill Actual or edit line item
Copay is different from the VSP ENH chart	Bill Actual or edit line item
Easy options plan	Bill Actual
Patient allowed to choose an upgrade	Bill Actual or edit line item
Plans not programmed	Bill Actual
ALL OTHER PLANS	**AUTO CALCULATION PLANS**

Covered in Full Items:

Ciao! Optical will not know that the patient has other covered in full items (AR Coating, Progressives, Transitions, etc.) and does not communicate with VSP when pricing exams and materials on the pricing worksheet in Ciao!

- For other covered in full items, you can use a generic (bill actual) plan OR use an auto-calculation plan and edit the line item that is covered
- See VSP Enhancement Charts for plan pay amounts if editing the claim
- This would be true for all plans that have unique copays (a copay different than the VSP Enhancement chart) or Easy Options plans.

Note- Generic plans can be found in Ciao! Optical by searching "VSP-" under Plan Name dropdown or found on the Auto-Calculations Plan ID listing.

EYEMED

Ciao! Optical Entry and Auto-filing

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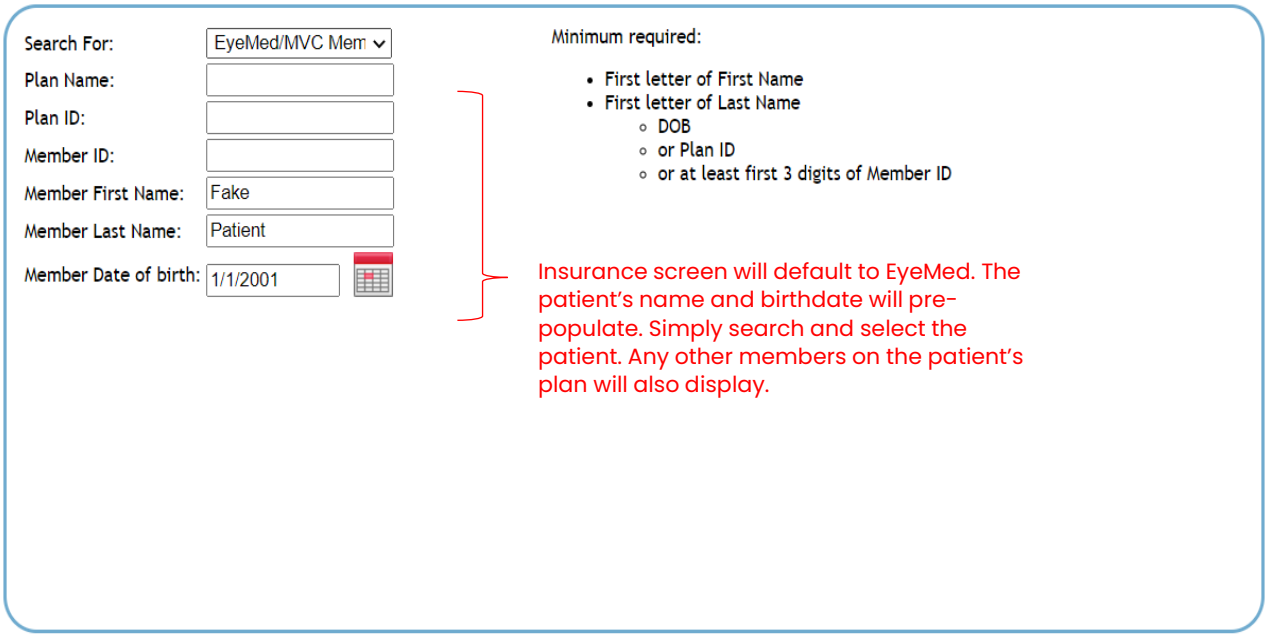
Most locations will accept EyeMed Insurance. Click HERE for a high-level overview of EyeMed Claim Filing.

- EyeMed is integrated with Ciao! Optical.
- You can find member and check eligibility directly in Ciao! Optical using Name/DOB OR you can check on the EyeMed website.
- Ciao! Optical will automatically calculate and submit claims; no additional action required.
- If you need to re-enter an order in Ciao (i.e., grey pencil on Staged screen) and the benefits are showing used, call EyeMed to cancel authorization.

In Ciao! Optical:



TYPE:	**Routine Vision Professional Services & Materials**
PLAN ID:	*In Ciao! Optical – varies by member*
PLAN NAME:	*In Ciao! Optical – varies by member*

LAB: RxO

BILLING: Ciao! Optical

ITEM	ACTION & NOTES
Exam	Routine exams and contact lens fittings are covered – member's responsibility is based on charges and plan coverage.
Frame	All frames available – member's responsibility is based on charges and plan coverage.
Lenses	All frames available – member's responsibility is based on charges and plan coverage.
Manufacturing	Order is placed with RxO (Rx Operations – Luxottica Lab Network).
Lab Processing Application (LPA)	Order as uncut, product to come, or complete.
Claims	Submit at Ready status – no additional action needed.

VSP AUTO-CALCULATION PLANS

Ciao! Optical Entry

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CIAO! ENTRY

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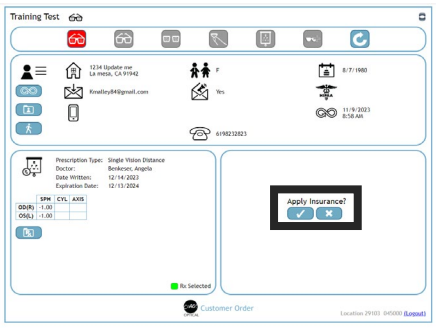
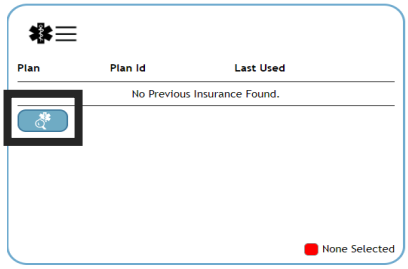
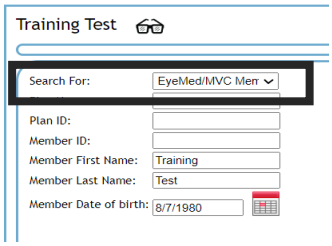
1. Click the Checkmark to indicate you'd like to apply insurance



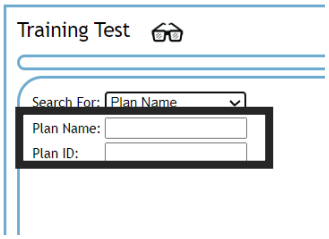
2. Click the blue the Search button



3. On the Search For pulldown bar, change it to Plan Name



4.
- Fill in the Plan Name or Plan ID from your Google Doc
- Click the Search button (Magnifier)



Tip: When searching by Plan Name on your Google Doc reduce the number of plans by typing in **key words**.

Refer to your google doc for naming conventions- each practice group could be different.

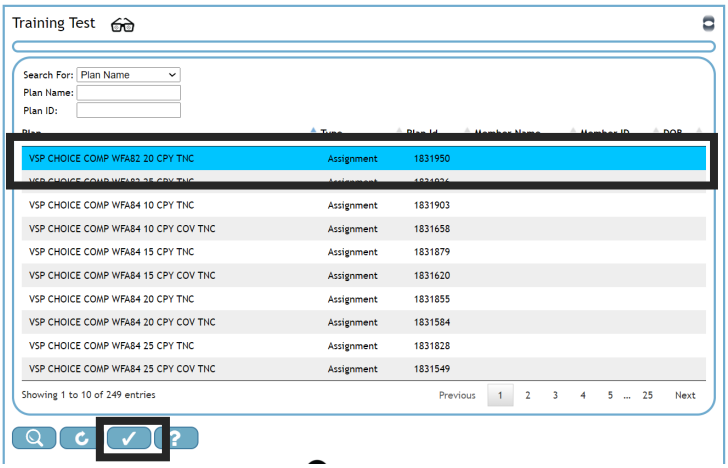
- VSP Contacts $___(cl allowance)
- VSP Sig Complete WFA_ _ _ (e.g.: 60, 107)
- VSP Sig Lens Only _ _ (patient copay)
- VSP Signature Exam $_ _ (patient copay)
- VSP Choice Complete WFA _ _ _ (WFA allowance)
- VSP Choice Lens Only $_ _ (patient copay)
- VSP Choice Exam $_ _ (patient copay)

For eyeglasses, indicate if Poly is covered or not by selecting the correct plan

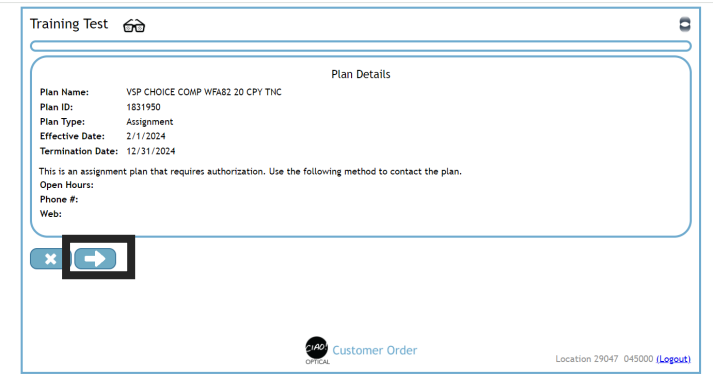
VSP CHOICE COMP PR WFA100 0 CPY COV ROS → Covered

VSP CHOICE COMP PR WFA100 0 CPY NC ROS → Not-Covered

5. Select the plan from the listing and click the Checkmark



6. Review you've selected the correct plan and click the Checkmark



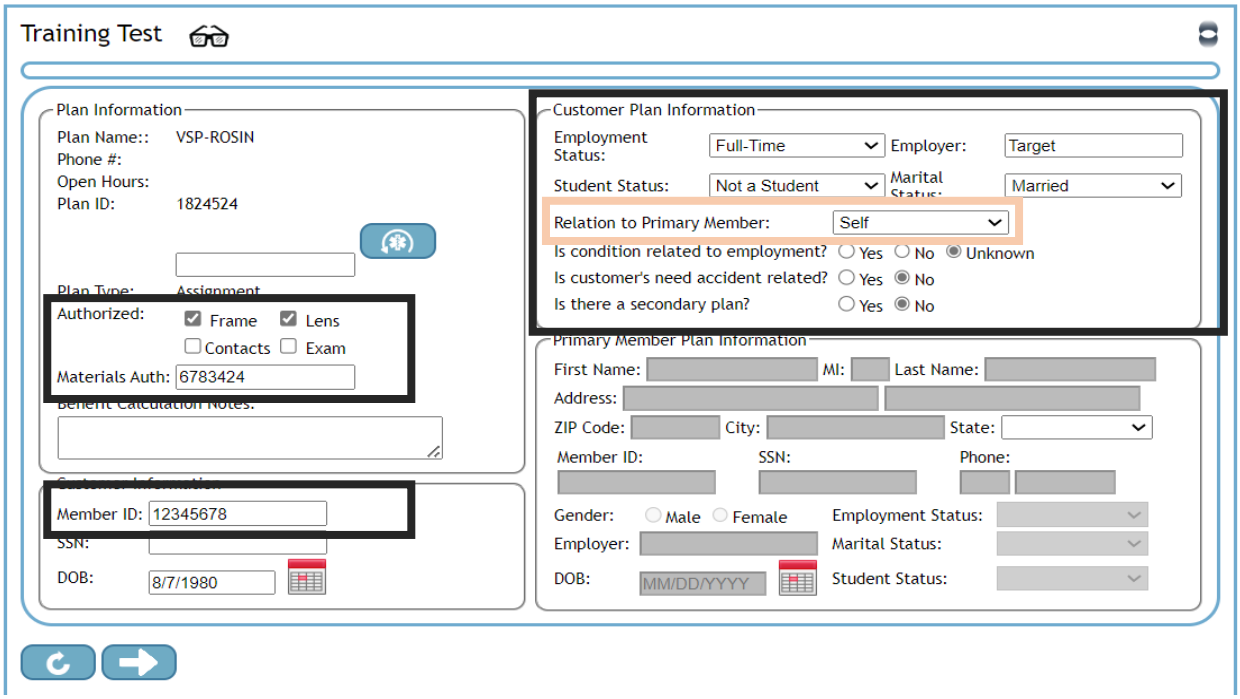
7 Complete the Insurance Demographics Screen

A. Checkmark the service you are currently entering and enter Material Authorization number
- If carrier (Spectera) does not issue authorizations, enter 1234

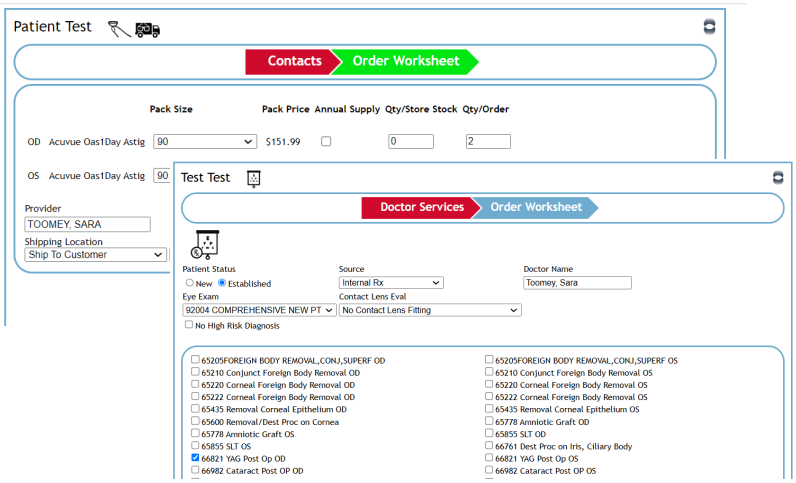
B. Enter the Member ID number

C. Complete all fields for Customer Plan Information
- For Primary Member indicate Self
- For Dependents, complete the Primary Member Plan Information for your billing team

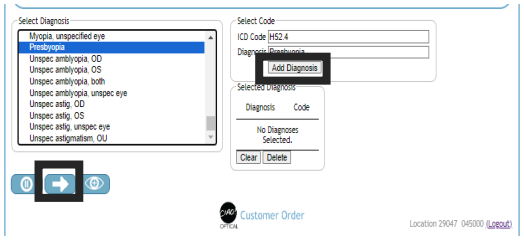
Reminder- Exam and Contact Lens Materials must have separate auth entered into Ciao!



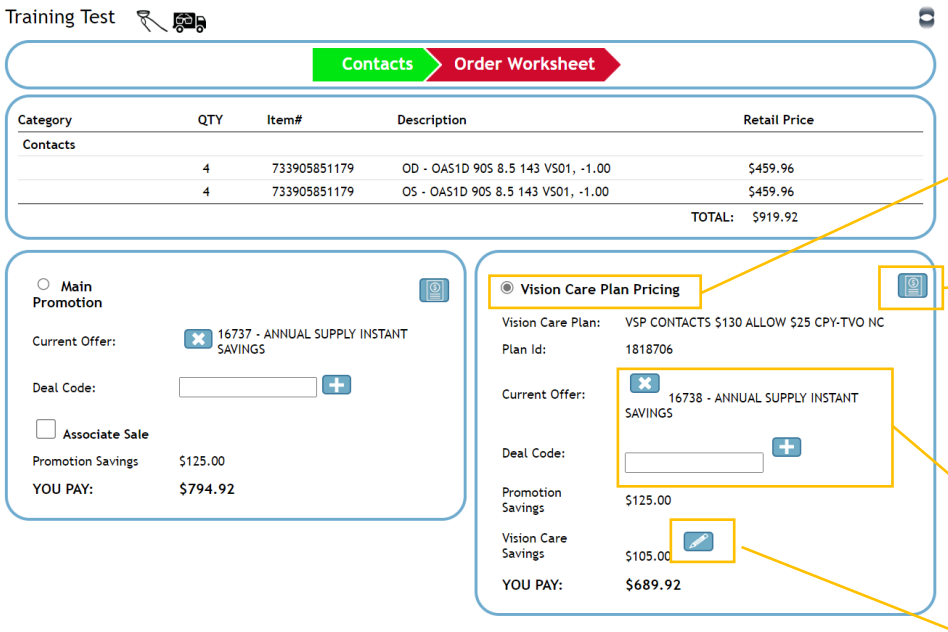
8 Enter needed services



Note: For all eye exams a medical diagnosis must be entered

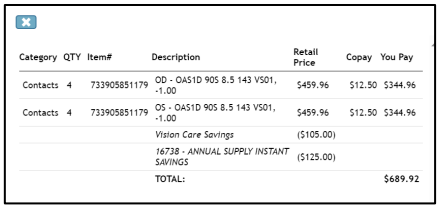


9 Ciao! will calculate the patient out of pocket expenses. Select the Radio Button and continue



Radio button will select insurance pricing

Review insurance details and other savings



Apply contact lens instant savings

Edit the claim

Note: Patients find insurance confusing, so a best practice is to Celebrate The Total Savings and share the out-of-pocket costs, but If a patient requests to see how it was broken out by line item, click the dollar bill for fees

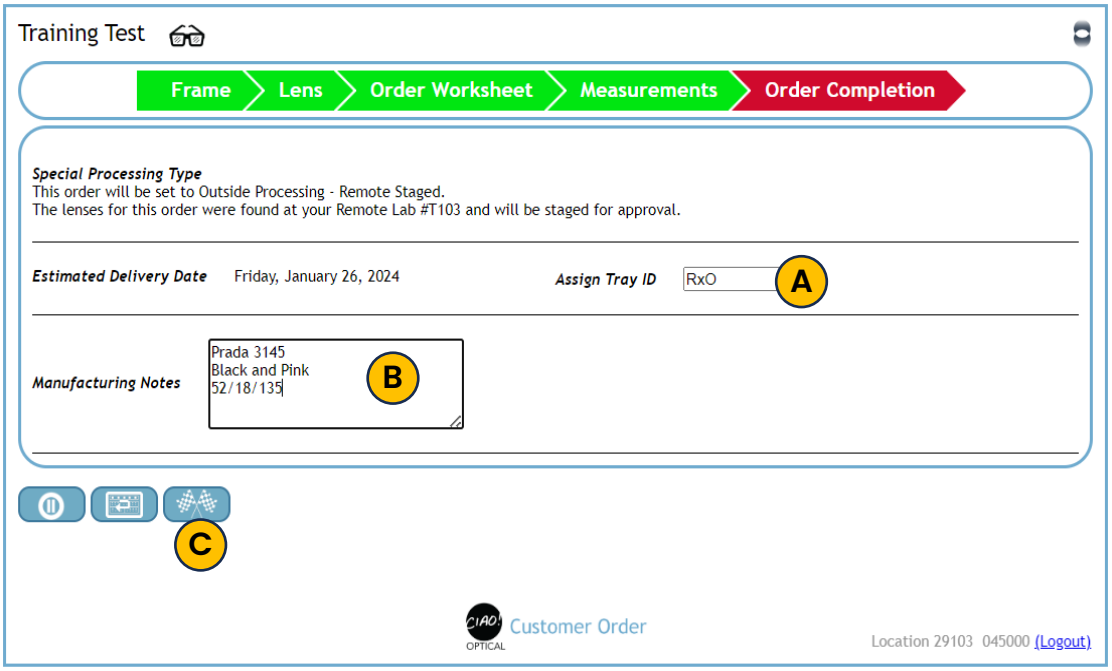
14 For glasses only, fill out the Order Completion screen.

A **Assign Tray ID:** Each office utilizes this field differently. Connect with your team to determine what should be entered here.

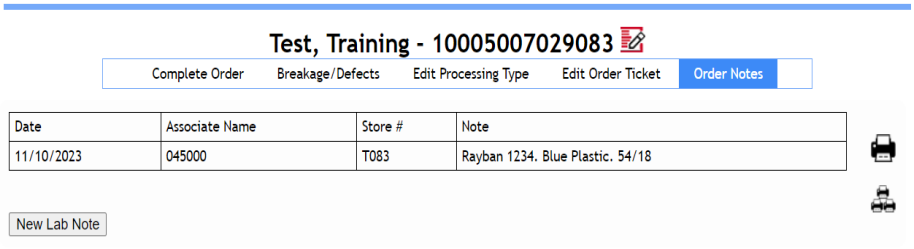
B **Manufacturing Notes:** These notes can only be seen in LPA. Info here may vary depending on insurance and location. For all Blue Tag frames, use the manufacturing notes to document:

- Frame brand
- Model number
- Color
- Eye size, Bridge, Temple Length

C **Checkered Flags** to bring the order to the Active Orders list for tendering.



Manufacturing Notes can be viewed from LPA by searching the order and viewing Order Notes (See Order Management Guide for more details)



Additional Note:

- Auto calculations may distribute copays on a different line item that you are used to.
- You are not expected to review the copays/plan pay amounts (it will look different than a bill actual plan).
- When the correct plan is chosen, Auto Calculations will be correct within $25.
- If you chose the correct plan, and do not edit the claim it will not be sent back to you to re-key unless there are incorrect details.
- If the patient is over charged, there may be specific instances where the Billing Team (or yourself if you are billing) asks the site to process an After The Fact (ATF) discount in Ciao Optical! to refund the patient.
- In other circumstances the Assignment Team will refund the patient.

Product Notes:

Contact lenses:

- **If the retail amount is over $1000, you must use the Generic Plan.**
- Medically necessary contacts must be billed with Generic Plans.

Eyezen:

- The TA, Blue Filter, and Eyezen copay will be on the DST line
  - Eyezen copays/cost will be $70 for Choice (Copay + CM Fee + Blue Light 45/10/15), $65 for signature, and DST $60.
- The Material Copay will be on the base line of lens.

Varilux X Fit and Comfort Max Fit:

- The Material Copay and Custom Measurement fee for Varilux X Fit and Comfort Max Fit have been added to the Progressive Copay.
- For example, this means the Copay will be $160 instead of $150 .

Standard vs. Branded Progressives:

- When billing and entering the claim into Eyefinity, you may choose either Ovation or Accolade as they are both category K lenses.
- Varilux XR Fit & Comfort Max Fit Lenses will provide your patient with a wider field of view and Crizal coatings will be available.
- Varilux XR Track Fit is currently not available with VSP but the patient can use their 20% off other items discount on the lenses.

SPECTERA AUTO-CALCULATION PLANS

Ciao! Optical Entry

TeamVision
Eye care, together.

SPECTERA OVERVIEW

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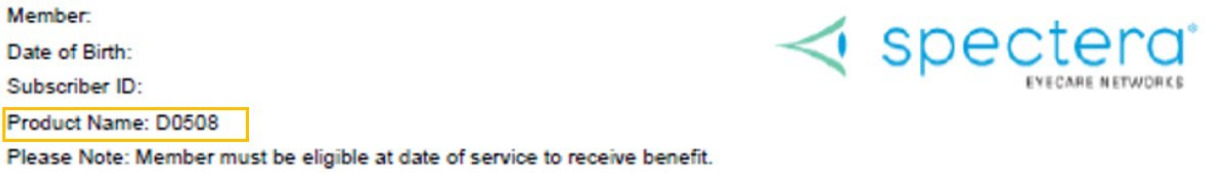
- Most Spectera plans will auto calculate for exams & materials.
- When selecting an auto-calculations plan, it will also auto file to Spectera.
- Similar to VSP, if you do not select the correct plan and enter the correct patient demographics in Ciao! Optical your claim will be denied.
- If you do not see the correct **product name** on your google document, reference the product name on crosswalk on the next page.



- If the auto-calculation plan did not calculate correctly, you can edit the patient copays. The claim will submit with the edits you made.
- Do not use an auto-calculation plan with **Eyezen** lenses, it will not calculate correctly.
- **Contact lens formulary** plans will be Bill Actual plans. You will be provided training during your integration week.
- **Medically necessary contact lenses** will be Bill Actual plans. Click HERE for the medically necessary guide.

ESSENTIAL HEALTH BENEFIT CROSSWALK

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Use the product name on the patient's benefit summary (card) and cross reference your google sheet to see if the Auto-Calculation Plan is already loaded in Ciao! Optical.

If not, use the crosswalk below to guide you in which plan to choose in Ciao! Optical:

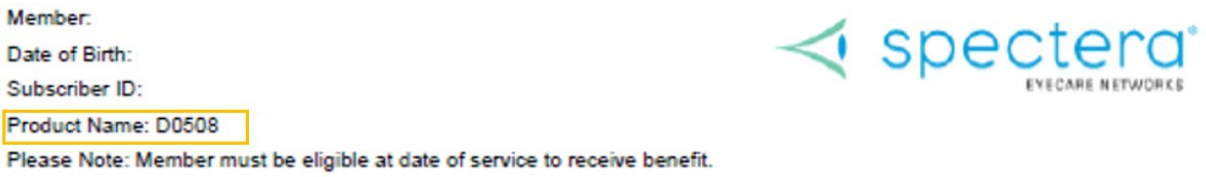
PRODUCT NAME	PLAN CODE
F2977	21
N0008	57
10E2E, KAE3E	USE EXAM PLAN
F3005	112
KAEK1	USE EXAM PLAN
J5286***	141 EHB PLAN
JC528***	283 EHB PLAN
VC00, VC14	2Q
F9004	3X
F9003	3Y
M1427, M1430	3Z
M0929, M0979, M1050, M1371, M1374	4K
D0508	8T
SH002/SH006/SH010/SH018	AF
SH106/SH107/SH402/SH403, TH320	
F3135	AG
L003V, S1074/S1075, V1506, V1826	C1
J8083***	D42 EHB PLAN
F2704	DL
L009C, V1602, T1151, S104C/S104V	E1
S1004/S1008/S1012/S1020	
C0141	E8
D0352, M0036	FK
F3412	LB
S1026/S1037/S1043/S1049	M1
V1781	Q1
SH413/SH414	RH
F2966	U2
M1157, M0917, M0971	WK
M1159	XP
***	USE BILL ACTUAL PLAN

SPECTERA CIAO! ENTRY

RETURN TO TABLE OF CONTENTS

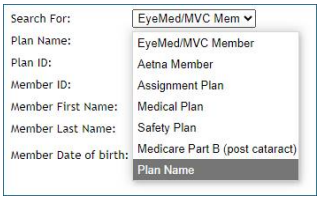
Key Information

1. To identify the plan, review the **Product Name** on the Benefit Summary

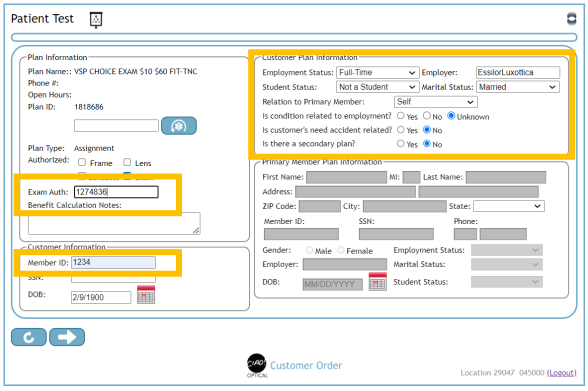


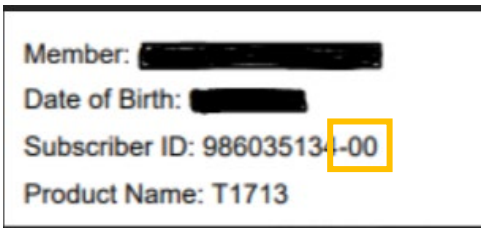
2. Using your practice groups Plan ID listing, select the **Spectera Tab** across the bottom

4. On the keyboard, hit the control button (CTRL) and the letter F to find your plan ID
5. Type in the **Product Name** to find the matching **Plan ID** for Ciao!
6. In Ciao!, search via the Plan ID



7. Enter the correct member demographics, including ID number with the last two digits BUT NOT THE -, which can be found on the member benefit summary. i.e. The example below would be entered as 98603513400 NOT 986035134-00.





Exceptions:

Contact lenses:

- Formulary & medically necessary contact lenses still need to be processed as they currently are

Eyezen:

- Use the **Generic** Spectera Plan and process as you do today

VERSANT AUTO-CALCULATION PLANS

Davis & Superior Ciao! Optical Entry

TeamVision
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VERSANT CIAO! OPTICAL ENTRY

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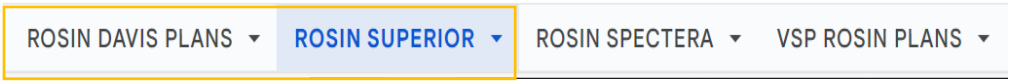
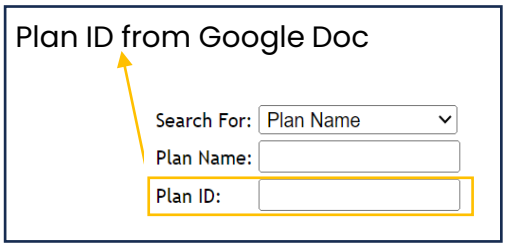
Key Information

1. To identify the plan, review the **Plan Name (Davis) or Copay/Allowances (Superior)** on the Benefit Summary (service record form) or Online Portal

2. Using your practice groups Plan ID listing, select the Davis or Superior Tab across the bottom



3. On the keyboard, hit the control button (CTRL) and the letter F to find your plan ID
4. Type in the **Plan Name (Davis)** or Copay/Allowance (Superior) to find the matching **Plan ID** for Ciao!
5. In Ciao!, search via the Plan ID



4. Enter correct member details in Ciao! Optical

Exceptions:

Contact lenses:

- Medically necessary contact lenses must be billed through a generic plan

Eyezen:

- Use the **Generic** plans and process as you do today

Standard vs. Branded Progressives:

- In Ciao! Optical- if the order is placed with standard lenses, order standard lenses in the Versant Portal
- In Ciao! Optical- if the order is placed with premium lenses, order Premium lenses in the Verstant Portal
- Varilux Lenses will provide your patient with a wider field of view and Crizal coatings will be available

Frame Kits:

- You will have a generic UPC to enter into ciao! for the Davis frame kit
- Davis will provide the frame as complete
- In order for your biller to know what frame to order, in the authorization field enter the frame model, color, and any other details

VBA AUTO-CALCULATION PLANS

Ciao! Optical Entry

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We are very excited to announce that you can accept VBA insurance starting March 3!

It will be your responsibility to ensure you, and your team are ready to help VBA patients in your office. Use the chart below to learn more about the VBA process:

Topic	
Retail Overview Page- General Info	Getting Authorization
Retail Provider Portal Guide	Member ID/Card Info (bottom of the page)
The plan pay amounts for frames and lenses and patient copays have been added to the Toolkit Documents > Insurance > Insurance Guides > VBA Folder > Retail Plan Rate & Fee Schedules	

Additional notes:

- In your area, there are approx. 5000 members with VBA insurance
- You will always want to pull separate authorizations for exam and materials
- Authorizations are valid for 60 days
- You will use the patient's name/dob or SS to locate the member in the portal (note some school districts will have a unique ID)
- You can transfer an authorization from one office to another if needed
- **Short term:** At the time of launch, you will use a **bill actual plan (Plan ID: 1838461) and will 837 fil, Long term:** These plans will be auto-calc plans and file on the 837 claim (google doc will update)
- The patient will **always have a $50 out of pocket contact lens fitting fee** (they can call VBA to verify if needed)
- With all fittings the patient is entitled to two follow up visits (the third follow up is private pay)
- Similar to VSP, there are some plans that are combined exam and materials plans, and the authorization will clearly indicate this.
- There is a **dispensing fee** of $15 or $17 (will be indicated on the authorization) this goes into your **plan pays** for the base line of the lens

Your login details for pulling authorization:

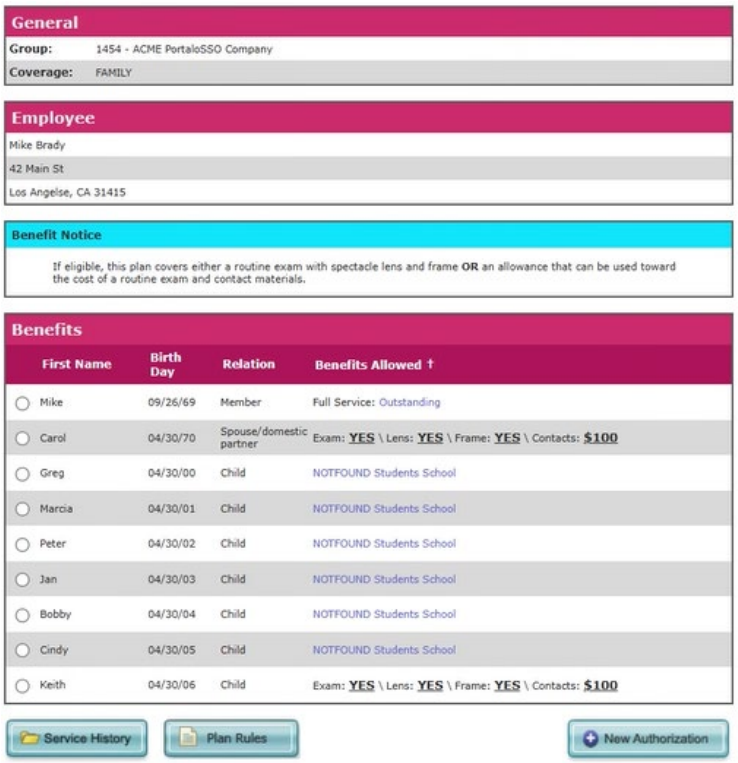
Visit the VBA Website: **www.vbaplans.com**. **The VBA App is on page 3 of the toolkit.** Should you need support within the website there is a chat function, or you can call the main number listed below.

Site Name	Site #	Account #	Password
Triangle Visions Optometry - Asheville	T040	LTVT040	VBALXCole1234
Triangle Visions Optometry - Cary Maynard	T042	LTVT042	VBALXCole1234
Triangle Visions Optometry - Durham	T046	LTVT046	VBALXCole1234
Triangle Visions Optometry - Thomasville	T061	LTVT061	VBALXCole1234
Your Billing Account is LTV9999. Authorizations for all locations can be viewed from the Billing Account.			

Additional Contacts:

Medically Necessary Contacts-Prior Auth Email	MNC@vbaplans.com
VBA Main Phone Number (8:30-6pm M-F)	1 800 432 4955

Below are examples of the coverage & authorization forms.



General

Group:	1454 - ACME PortaloSSO Company
Coverage:	FAMILY

Employee

Mike Brady
42 Main St
Los Angelse, CA 31415

Benefit Notice

If eligible, this plan covers either a routine exam with spectacle lens and frame **OR** an allowance that can be used toward the cost of a routine exam and contact materials.

Benefits

	First Name	Birth Day	Relation	Benefits Allowed †
○	Mike	09/26/69	Member	Full Service: Outstanding
○	Carol	04/30/70	Spouse/domestic partner	Exam: YES \ Lens: YES \ Frame: YES \ Contacts: $100
○	Greg	04/30/00	Child	NOTFOUND Students School
○	Marcia	04/30/01	Child	NOTFOUND Students School
○	Peter	04/30/02	Child	NOTFOUND Students School
○	Jan	04/30/03	Child	NOTFOUND Students School
○	Bobby	04/30/04	Child	NOTFOUND Students School
○	Cindy	04/30/05	Child	NOTFOUND Students School
○	Keith	04/30/06	Child	Exam: YES \ Lens: YES \ Frame: YES \ Contacts: $100

Service History | Plan Rules | New Authorization

Home > Doctor Home

Vision Benefits of America - Coverage & Authorization Print

General

Authorization Number:	5136189228	**Valid for Service between:**	02/20/2025 - 04/20/2025
Doctor:	LTV9999 - CLARK OPTOMETRIC CENTER PA	**Filing Deadline:**	05/04/2025
Group:	1454 - ACME PortaloSSO Company		
Patient:	Barney Rubble	**Relation to Member:**	Member
Address:	124 Main St Bedrock, CO 31415		

Benefits

Exam	Lenses	Frames	- OR -	Contacts[2]
Eligible	None	None		None

Plan Copays & Allowances

Copays:	**Exam:** $0.00	**Lens/Frame:**	$0.00
Retail Frame Allowance:	$112.50		
Cost Contained Fees:	**Contact Eval and/or Fitting Fee:**		$50.00

Dispensing Fees (Paid by VBA)

Lens Dispensing:	$15.00
Frame Dispensing:	$17.00

Fully-Covered Services and Materials

Vision Care Exam	Single Vision Lens	Lined Multifocals
Lenticular Lens	Scratch, Standard	Medical Contacts
Polycarb., 18 & Under		

Partially-Covered Services and Materials (See PRLS to determine member responsibility)

Contacts	Frame [1]	
Progressive, Std	Progressive,Digital	Progressive,Premium

Non-Covered Services and Materials (See PRLS to determine member responsibility)

Digital Retinal Screening	A/R Bluelight	A/R Ultra
A/R, 1 Year	A/R, 2 Year	A/R, Premium

INTEGRATION WEEK

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Eye care, together.

SOFT OPENING

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During your integration week, you will review insurance systems training with your trainer. Your site will be provided a site-specific guide that will include your insurance process details. The guide will include:

- Overview of the billing process for your site
- Insurance Fee Schedules
- Plan ID's for Ciao! Optical
- Insurance required Lab Details

Our Operations teams aim to have RevolutionEHR, Insurance Fee Schedules, and all systems live by your soft opening. Should this not occur, your onsite Ops manager and post support team will provide additional guidance.

We highly encourage the Practice Manager, Assistant Practice Manager, and key Team Members in the building to adjust the site operational process as needed. We can not change the systems but can align on how to make them work for you!

During your soft opening, you should work together as a team to ensure accurate data is entered into the E.H.R and Ciao! Systems. It is critical that over the next 30-60 days you observe the insurance process and double check for correct entry into the E.H.R & Ciao! Use the Insurance Audit in this guide (last 4 pages).

There are occasions where claims are held for various reasons. This is a back-office process and will not impact your ability to service the patient. You will continue to invoice in RevolutionEHR & complete Ciao! Optical entry.

The following page will provide guides for if providers are not loaded into Ciao! Optical and/or payment processing is down.

In all cases below, notify your Onsite Operations Partners & your Field Leader.

Services Not Listed In E.H.R.

- Confirm with OD/PC Holder this is a go-forward service.
- Confirm correct service & pricing in Ciao! Optical- if not, take action.
- Add service AND fee schedule into Rev (if you don't have access partner with your biller or email Help@Revolutionehr.com)

U&C (Price) Incorrect In E.H.R

Integration Sites: notify your onsite Ops partner. **All other sites:** notify their Field Leader.

- Confirm with OD/PC Holder this is a go-forward price.
- Confirm correct pricing & service in Ciao! Optical- if not, take action.
- Adjust price in Rev (if you don't have access partner with your biller or email Help@Revolutionehr.com)

Missing Insurance Carrier in the E.H.R and/or Ciao! Optical

- Hold the patient services & materials until the insurance carrier is loaded into all systems and correct billing can occur.
- The carrier must be loaded into ciao! optical (plan ID creation)
- Email Tracy Martinez (TMartinez2@luxotticaretail.com) to work towards getting the carrier added. Provide:
    1. Carrier name and routine or medical
    2. Fee schedule for medical insurance
    3. Routine, plan pay details must be added to your insurance binder
- Determine billing process (biller or site, etc.)

Missing Fee Schedule In The E.H.R.

1. Gather Fee Schedule from provider (online or call and request fax).
2. Send Fee Schedule to Tracy Martinez (Tmartinez2@luxotticaretail.com).

Services Not Listed In Ciao! Optical

Integration Sites: notify your onsite Ops partner. **All other sites:** notify their Field Leader.

- Confirm with OD/PC Holder this is a go-forward service.
- Confirm these services & prices are listed in RevolutionEHR- if not, take action.
- Add to Ciao! Optical (If a professional service needs to be added it can take up to 7 days).

U&C (Price) Incorrect In Ciao! Optical

Integration sites: notify your onsite Ops partner. **All other sites**: notify their Field Leader.

- Confirm with OD/PC Holder correct pricing.
- Confirm these prices & services are entered & match in RevolutionEHR- if not, take action.
- Ciao! Optical Correction (Can take up to 7 days).
- You may need to make adjustments at the site level to get correct funds in Ciao! Optical. Your onsite support or PM can assist you.

Providers Not In Ciao! Optical

1. Complete invoice in RevolutionEHR.
2. Use insurance benefit summaries & enhancement charts to quote patient and determine out of pocket costs.
3. In Ciao! Optical:
    - Build Ciao! Profile and enter Rx
    - Enter order details WITHOUT insurance and print a quote and document optical measurements as a backup.
    - Once on active orders, move to virtual to save the order.
4. Day of service: Collect patient out of pocket expenses and keep payment reciept with routing slip, quote, and other documents.
5. Designate a secure place in the office to keep the order and payment details.
6. Email Sales Audit to alert them to the closing discrepancy.

Once Tendering Possible:

1. Designate a secure place in the office to place all routing slips & card logs.
2. Identify a key person in the office to enter once payment processer set up.

Can Not Process Payment

1. Complete invoice in RevolutionEHR.
2. Transfer services to Ciao! Optical.
3. Manually document amount patient is paying on routing slip.
4. Take payment:
    - Should credit card devices be down, document card details on Credit Card Log.
    - Click HERE for a printable copy.
    - You may want to record all payments on this log to ensure they are all accounted for during step 4.
5. Email Sales Audit to alert them to the closing discrepancy.

Once Tendering Possible:

1. Designate a secure place in the office to place all routing slips & card logs.
2. Identify a key person in the office to enter once payment processer set up.

Payment	How to process
Cash/Check	• On routing slip, document amount and that the patient has paid • Hold checks/cash in safe with patient name
Credit: Visa, MC, Amex, Discover	• Review with patient the amount to be collected. • Log patient name and payment details on Credit Card Log. • Process physical payment and record once systems up and running
Care Credit	• Review with patient the amount to be collected. • Log patient name and payment details on Credit Card Log. • Process physical payment and record once systems up and running

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