Suzanne Corbitt, OD
Extended testimony RE: S.215.

I am supportive of S.215. I am an optometrist at Ophthalmic Consultants of Vermont (OCV) in South Burlington with Dr. Greg McCormick, who specializes in cornea and cataract surgeries, and Dr. Kate Lane, who is a specialist in oculoplastic and orbital reconstructive surgeries.

After optometry school, I completed an ocular disease residency through the VA hospital system. I work in a multidisciplinary office setting where I practice primarily medical optometry and perform a disproportionate amount of medical eye exams compared to routine vision exams. I also participate in medical triage during office hours within my scope of practice when my office is "on call". My office provides no optical wear, and we do not accept vision insurance plans.

Experience with Cigna:
In May 2014, the billing department at OCV submitted my medical insurance credentialing application (app) and all necessary information to Cigna. On June 11, 2014, the billing department at OCV notified Cigna that I would be participating as a provider with their medical insurance and inquired about the status of my app. OCV was told by Cigna that my app was still being processed but I should be set for a July 1, 2014 effective start date. My employment at OCV started July 1, 2014. From July 2014 lasting into fall 2014, OCV got numerous different answers from different Cigna employees. OCV confirmed with the Vermont Optometric Association (VOA) that Act 182 required Cigna to comply with the law and credential me. On April 10, 2015, Cigna informed OCV that I would potentially be able to see/bill Cigna patients in June 2015. On April 23, 2015, Cigna told OCV that my credentialing app was "inactive" due to "non-use" and that OCV needs to redo and resubmit credentialing app and info. On May 12, 2015, the VOA gave OCV the "green light" to start scheduling Cigna patients with me, so I saw a few Cigna patients as a "test" over the course of about 6 weeks as OCV tracked the success of my Cigna processed submissions and reimbursement. OCV then formally opened my schedule to Cigna patients on July 1, 2015. It was roughly 1 full year from my OCV start date until I was able to see/bill Cigna patients despite Act 182 being passed which meant Cigna was not complying with the Jan 1, 2015 deadline when I should have been credentialed and able to see/bill Cigna patients.

By not being able to see Cigna patients, it limited patient care and the office reputation was jeopardized. Over the course of the year, from July 2014 to June 2015, patients who were originally scheduled with me and had Cigna insurance ended up being shuffled or rescheduled to other providers at OCV when their schedule allowed. It led to an overall poor patient experience, and it was temporarily debilitating to the office for that year.

In addition, by not being able to bill Cigna, it led to inefficient use of office staff time in the numerous hours spent on the phone and emailing to try to understand and resolve the issue with Cigna.

This bill is important because it attempts to assign jurisdiction so that in the future these

problems will not exist for other ODs. The Vermont Optometric Association has continually asked that a state agency enforce this law which is why S.215 was introduced. The inclusion of the "private right of action" is part of federal legislation introduced by the American Optometric Association. We, however, are asking that if the "private right of action" is not included that you require enforcement, either DFR or GMCB.

The provisions of the bill that were passed last year are important, and even though it took a long time to get them into place, it improved our practice setting.

Thank you for your time.

For your reference:

A “routine” eye exam is one where a refraction is usually performed for a spectacle Rx (and possibly a contact lens Rx), and after a full dilated eye exam and ocular health assessment, the diagnosis is routine or one pertaining to a “refractive error” or “accommodative/focusing issue” only. There is no ocular and/or systemic medical diagnosis or further testing/referral necessary. Refractions and “routine” exams are billed to vision plans such as Vision Service Plan (VSP) and Medicaid.

A “medical” eye exam is one where a refraction may or may not be performed, but the exam is focused more on ocular health by performing a dilated eye exam and further testing when applicable due to:

- an initial visit scheduled by the patient to establish care
- a known personal or family systemic condition that may have ocular sequelae as requested by the PCP and/or the patient
- a known personal or family ocular condition as requested by the PCP and/or the patient
- a previously diagnosed, treated, or monitored ocular condition, etc.

The exam may be a previously scheduled exam to diagnose, treat, or monitor a certain condition that the doctor may/may not be treating with oral and/or ophthalmic meds, or the exam may be an “emergency” or same day walk-in if new symptoms encourage the patient to call in to schedule an emergent appointment. The diagnosis is always medical, whether a systemic and/or ocular medical diagnosis, so it is billed to medical insurances such as Cigna, BCBS, MVP, Medicare, Medicaid, etc.

“Routine” diagnoses/exams cannot be billed to medical insurances and “medical” diagnoses/exams should not and most of the time cannot be billed to vision insurances or vision plans.