Avēsis

A National Vision, Dental and Hearing Company

EYE MEDICAL & ROUTINE EYE CARE PROGRAMS PROVIDER MANUAL - MEDICAID

Property of:
Avesis Third Party Administrators, Inc.

www.avesis.com

Dear Avesis Provider:

Avesis Third Party Administrators, Inc. (Avesis) would like to take this opportunity to welcome you and your staff to our network of preferred Providers. We are pleased that you have chosen to participate with us.

Throughout your relationship with Avesis, this Provider Manual will provide useful information concerning the Avesis Medicaid Eye Care programs.

When communicating with our participating Providers, we make every effort to be clear and concise. Our goal is to answer questions promptly when they arise.

We strive to consistently provide accurate and complete information that will allow you and your staff to understand our programs. This Manual will explain what you can expect from Avesis, how and when to submit requests for prior authorizations, claim submission and other information that you may find necessary when caring for our Members.

If you require assistance or information that is not included within this Manual, please contact our Provider Services Department at the phone numbers located on the front page of this Manual.

Customer Service Department
Monday - Friday 7:00 AM to 7:00 PM (EST)

A Quick Reference Guide is included within this Manual. This easy-to-read reference is intended to give you the most important information in one place. Please place this guide in a convenient location so that it may be used as a reference to answer questions that may arise.

Periodically, your practice may receive updated information directly from Avesis or notification that updates have been placed on the Avesis web site. This information should be inserted in your Manual immediately to remain current. Please visit the Avesis web site at www.avesis.com periodically for the most current information.

Again, we welcome you and your staff to the growing list of satisfied Avesis Providers. We look forward to a successful relationship with you and your practice.

Sincerely,

Avesis Provider Services

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Avesis Contact Information

Avesis Executive Offices
10324 South Dolfield Road
Owings Mills, Maryland 21117
(800) 643-1132

Avesis Corporate Offices
3030 N. Central Avenue
Suite 300
Phoenix, Arizona 85012
(800) 643-1132

Avesis Claims
Avesis Third Party Administrators, Inc.
P.O. Box 7777
Phoenix, Arizona 85011-7777

Avesis makes every effort to maintain the accuracy of information contained in this Provider Manual. If any typographical errors are found please contact Avesis at **(800) 231-0979**. Avesis is not liable for any damages, directly or indirectly, that may occur from a typographical error.

General Information

Avesis Incorporated, the parent company of Avesis Third Party Administrators, Inc., has been providing fully insured eye care programs since 1978. Recognizing that every client is unique, Avesis has built its networks of Providers to support the constantly growing needs of all of our Members. Avesis believes that a successful program is one where the Members receive the best possible care and the Providers are satisfied with the support that they receive.

Avesis prides itself on providing excellent Provider services in order to support you and your staff. To minimize your administrative responsibilities, Avesis maintains a web based processing system allowing for electronic verification of eligibility and claims submission.

For the routine eye care program we have a Vision Advisory Board comprised of Optometrists from around the State; for the eye medical program we have an Eye Medical Advisory Board comprised of Ophthalmologists from around the State. If you would like to speak to an Avesis Advisory Board Member or a Provider Consultant, please contact Provider Services and your information will be forwarded to the appropriate party.

Please take the time to familiarize yourself with this Manual as it contains a great deal of information. If you have any questions please do not hesitate to call for assistance or clarification.

For government programs, only, call the number provided in the applicable State supplement located in the back of this Provider Manual.

Monday – Friday: 7:00 AM to 7:00 PM (EST)

- To assist you with the administration of benefits to Avesis Members, information in this Manual will be periodically updated on the Avesis website. If you have printed the Manual, please be certain to print the updated page(s) and insert them into the printed copy of the Manual.
- If you have received a printed Manual from Avesis and do not have access to the website, please contact Provider Services to have the updated information sent to you.

If you are in doubt as to whether you have the latest revision of the Provider Manual, please check the Avesis website at www.avesis.com for the most current version. You are also able to download individual pages.

Promptly inserting revisions will keep the office copy of your Provider Manual current and accurate.

Statement of Provider's Rights and Responsibilities for Avesis Eye Care Programs

As a Provider, you have the right and responsibility to:

- Communicate openly and freely with Avesis
- Communicate openly and freely with Avesis Member(s)
- Suggest treatment option(s) to Avesis Member(s), when applicable/appropriate
- Recommend non-covered service(s) to Avesis Member(s), when applicable/appropriate
- Obtain information regarding the status of claims
- Provide timely adjudication of all clean claims within State guidelines
- Resubmit a claim with additional information, if applicable
- Maintain patient and record confidentiality in accordance with HIPAA and other rules and regulations regarding patient privacy
- File an appeal with Avesis, if applicable
- Inform a Member of appeal status, if applicable
- Question policies and/or procedures that Avesis has implemented
- Request prior approval as required for Covered Benefits
- Review the results of any audits performed
- Inquire on credentialing/re-credentialing status
- Have an Individual NPI number
- Have a current/active Medicaid ID number
- Ensure that the disclosure form is signed for non-covered service(s) by all parties prior to the rendering service(s)
- Question policies and/or procedures that Avesis has implemented

- Make routine appointments available within twenty-one (21) days and have urgent and emergency appointment times available (NOTE: Urgent appointments must be made available within forty-eight (48) hours of the request). If State or Program guidelines differ, the timeframes required will be in the applicable supplement section at the back of this Provider Manual.

- Make every effort to ensure that Members need not wait in the waiting room for more than forty-five (45) minutes

- Annually train staff with regard to Fraud/Waste and Abuse issues

Statement of Provider's Duties for Avesis Eye Care Programs

- Make every effort to verify Member eligibility prior to each appointment. In cases of medical emergency, it may not always be possible to check eligibility prior to the patient receiving care
- Refer Members, as needed, to specialists participating in the Avesis Eye Medical Program
- Work with Avesis, its Utilization Review staff and consultants, as necessary, with regard to obtaining prior authorization
- Participate in Avesis or Plan Sponsor Quality Assurance programs
- Provide access for Avesis or the Plan Sponsor to review your offices' books and records as they relate to Members covered by Avesis
- Arrange for after hours coverage so that coverage is available to Members 24 hours per day/7 days a week
- Post the hours of operation in a conspicuous place in the office
- Notify Avesis of any changes in demographic information, licensing, certification or malpractice liability

Statement of Members' Rights for All Avesis Programs

Members shall have the right to:

- Communicate openly and freely with Avesis without fear of retribution
- Communicate openly and freely with their Avesis Providers without fear of retribution
- Expect privacy according to HIPAA and other state or federal guidelines
- Be treated with respect, courtesy and dignity
- Be treated the same as all other patients in the practice
- Be informed of their examination findings
- Participate in choosing treatment option(s)
- Know whether treatment is medically necessary
- Know whether the treatment is experimental and give his/her consent
- Refuse any treatment, except as provided by law
- Be provided with a phone number in case of an emergency
- Obtain non-covered service(s) only when a disclosure form is signed by all parties
- Submit a complaint against a Provider, without fear of retribution
- Be informed of any appeals filed on their behalf
- Change Providers at will

Statement of Members' Responsibilities for All Avesis Programs

The Members shall, to the best of their ability:

- Choose Providers who are participating in the Avesis network
- Be honest with the Providers
- Provide accurate information to the Providers
- Provide complete information about past or present complaints/illnesses, hospitalizations, surgical procedures, allergies and medications
- Behave in a respectful manner
- Follow all rules and treatments recommended by his/her physician
- Have Providers explain fees associated with non-covered services
- Understand the procedure(s) being performed and what is expected of him/her
- Have fees associated with non-covered services agreed upon in advance of services being rendered
- Ensure that the financial arrangements made with the Provider are adhered to and fulfilled
- Use best efforts to not miss or be late for appointments
- Cancel appointments in advance, if unable to make scheduled appointments
- Supply the Providers with emergency contact information
- Call their Primary Care Physicians or family physicians in the event of emergencies

Quick Reference Guide

IDENTIFICATION CARD

The Member will present a health plan identification card at the time of the appointment. Samples of the identification cards used by the health plans contracted with Avesis can be located on our website at, www.avesis.com. You do not need to see the Identification Card in order to verify eligibility with Avesis.

ELIGIBILITY VERIFICATION

It is strongly encouraged that you verify eligibility for each Member's appointment the business day prior to rendering services. You will need to obtain the Member's name, Member's ID number or social security number and patient's name. Please note that verification of benefits or eligibility is not a guarantee of payment. Actual payment is based on the terms and conditions of the plan in force once the claim is adjudicated.

Avesis Secure Web Site

- Go to www.avesis.com
- Enter your User Name and Password
- Click "Check Eligibility"
- Enter the Member information

- You will receive a real time response

IVR (Interactive Voice Response System)

- Call the Interactive Voice Response (IVR) at: **(866) 234-4806**
- Enter your Avesis PIN (Provider Identification Number)
- Enter the Member's identification number
- You will receive a real time response

Internet Tutorials

Please follow the tutorials available on the Avesis website at www.avesis.com. To view the tutorials follow these steps:

- Go to www.avesis.com and click Vision Programs
- From the gold bar at the top, click Providers and then Provider Videos
- Then select Videos for servicing Medicaid and Medicare Members

Fax

- Complete the Avesis Eligibility Verification Fax form.
- Securely fax the form, toll free, to: (866) 332-1632.
- Typically, you will receive a response within one business day.

Avesis Customer Service

Representatives are available from 7 AM to 7 PM EST, Monday through Friday.

Observed Holidays

Avesis observes the following holidays: New Year's Day, Presidents Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, the day after Thanksgiving, and Christmas Day (may vary when holiday falls on a weekend)

Provider Services

Please see the applicable State section of this Manual for the correct number to call for the following services:

- Check Application, Credentialing or Re-credentialing Status
- Request Provider PIN number
- Ask General Questions
- Fax (866) 874-6834 (secure fax)

Claims

Electronic claims may be submitted to Avesis:

- Through your practice management software using a clearinghouse
- On our web site at: www.avesis.com

- You may also submit paper claims using the current CMS1500 claim form to:

  Avesis Third Party Administrators, Inc.
  Attn: Eye Care Claims
  PO Box 7777
  Phoenix, Arizona 85011-7777

To prevent any delays with the processing of your paper claims, be certain to complete all information including your NPI. For all Medicaid claims be certain to include your state-issued Medicaid Identification Number.

For more details please refer to the Claims section.

Quick Reference Guide (cont.)

To Correct Information

You have the right to correct information submitted incorrectly within a specified number of days from the date of service, depending upon the type of program in which the Member participates. Please see the appropriate section of this Manual for specific filing instructions.

When submitting a correction to a claim, please identify the claim, at the top as: **CORRECTED CLAIM** and include a copy of the Remittance Advice. Change(s) must be made in writing within the timeframes specified in the State supplement at the back of this Provider Manual and submitted to:

Avesis Third Party Administrators, Inc.
Attention: CORRECTED CLAIMS
PO Box 7777
Phoenix, Arizona 85011-7777

Claims Appeals

If payment for services is denied in whole or in part, you may appeal the decision by requesting a review in writing. All claim reviews are handled in accordance with the applicable Avesis Complaint, Appeal and Grievance (CAG) policies and procedures. All appeals must be submitted in accordance with the rules and specifics of the program in which the Member participates. For more details please refer to the Appeals Process section in this Manual.

Payment

As an Avesis Provider, you are eligible to receive payments via electronic funds transfer (EFT) thereby enabling your practice to maintain a positive cash flow. To receive payment through EFT, you must complete and return an EFT election form to Avesis. The EFT form has been provided in the Forms Section at the end of this Provider Manual.

Avesis adheres to all federal and state prompt pay requirements.

Emergency Care

Should you encounter a Member in need of urgent or emergent care that falls outside of the scope of your licensure, you are required to direct the Member back to his/her health plan or to the Primary Care Physician for care.

Eligibility and Confirmation

The confirmation of eligibility is an important step for every appointment. Avesis updates the eligibility files monthly or as the data is provided by the health plans. Verification of benefits or eligibility is not a guarantee of payment. Actual payment is based on the terms and conditions of the plan in force once the claim is adjudicated. There are three ways to verify eligibility:

Internet

Please follow the tutorials available on the Avesis website at www.avesis.com. To view the tutorials follow these steps:

- Go to www.avesis.com and click Vision Programs
- From the gold bar at the top, click Providers and then Provider Videos
- Then select Videos for servicing Medicaid and Medicare Members

Avesis Secure Web Site

- Go to www.avesis.com
- Enter your User Name and Password
- Click “Check Eligibility”
- Enter the Member information
- You will receive a real time response

Fax

- Complete the Avesis Eligibility Verification Fax form
- Securely fax the form, toll free, to: **(866) 332-1632**
- You will receive a response within one business day

Avesis Customer Service

Representatives are available from 7 AM to 7 PM EST, Monday through Friday.

Covered Services Under the Plan

For specifics regarding the covered benefits for which the Member is eligible, please review the appropriate section of this Manual.

Please note that it is the responsibility of the Provider to determine whether services rendered are medically necessary or appropriate within the scope of your license, as required by the State and are included in the Member's Covered Benefits. Avesis compiles utilization information on a quarterly basis to determine outliers (over-utilization and/or under utilization). Avesis may perform chart audits to determine appropriateness of care and appropriate billing. Avesis will provide all collected data and analysis to the Provider upon request. This data may be reviewed and analyzed by Avesis Peer Reviewers. If it is found that a Provider is functioning outside of local and/or national standards of care, Avesis may move to recover any funds determined to have been paid as a result and/or make other recommendations pertaining to Provider's participation in the program, including Provider suspension or termination.

Avesis expects that Providers licensed in their appropriate states will practice up to the full scope of their licensures within the parameters of the services outlined in this Manual. Claims for all services should be submitted to Avesis for adjudication in accordance with the procedures detailed herein.

Claims that contain medical in conjunction with routine services, and either the procedures or diagnoses are not outlined in this Manual, are subject to pre-payment or retrospective review. These claims must be submitted on a paper (CMS 1500) claim form with clinical documentation in support of the diagnoses or procedure codes submitted on the claim. A determination will be made as to whether the services are covered under the Member's plan.

The goal of the Avesis Eye Care programs is for the Provider to administer necessary and appropriate care within the limits of the Provider's scope of license and within the benefit coverage available. As the Provider, you and/or your staff are responsible for understanding the Member's benefit coverage and for abiding by the authorization and referral processes required by Avesis. If questions arise regarding these processes, please contact Provider Services at the appropriate number for guidance. When the Member requires services that are beyond the scope of those outlined in this Manual, the Member should be referred to his/her Primary Care Physician or to the Member's health plan.

Prior Authorization Information

As with any Programs, certain services that will be provided for Members will require prior authorization from Avesis in order to be considered for payment. This section of the Manual explains the general processes to obtain approval. Processes and procedures requiring prior authorization specific to the Medicaid Program administered by Avesis will be found in the applicable section of this Manual.

Prior authorization requests will be approved or denied on the basis of whether the request meets program guidelines and requirements for coverage as well as the Member's individual circumstances.

Emergency Care

All Avesis Provider offices shall be responsible for the effective response to and treatment of eye medical emergencies, as appropriate and permitted within the scope of your license.

Eye Medical Emergency - a situation where the Member has or believes there is a current, acute crisis involving the eye(s) that could be detrimental to his/her health if not treated promptly.

To confirm whether the situation is a true emergency, you must speak with the Member or the Member's authorized representative to determine the Member's problem and take the necessary actions. If it is determined by you and the Member that it is a true eye care emergency (that is: a situation that cannot be treated simply by medication and, that left untreated, could affect the Member's eye health) then you may either: A) render services in the office to treat the emergency, if appropriate, or B) assist the patient in obtaining proper care from another Avesis participating Provider, outpatient urgent care facility, or hospital emergency room, if the condition warrants emergency room treatment. If the emergency is considered life threatening, the Member should contact 911, or the nearest local emergency services unit.

Once treatment has been rendered, please contact or instruct the Member to contact his/her primary care physician or family physician immediately.

Avesis requires that you provide sufficient access during regular business hours and after hours in an effort to treat patients in Provider offices instead of urgent care centers or hospital emergency rooms, whenever appropriate.

Sentinel Events and Adverse Incidents – If a sentinel event occurs (an unexpected, non-traumatic occurrence that causes a Member's death) or an adverse incident (serious incident, therapeutic misadventure, iatrogenic injuries or other adverse occurrences directly associated with care or service provided) you must report this to Avesis immediately using the Provider Services number provided herein.

CLAIMS

Claims Process

All clean claims submitted will be processed and adjudicated according to the Avesis Provider Fee Schedule. Claims must be submitted within the time period set forth in the supplement section of this Provider Manual. Avesis follows the most current American Medical Association (AMA) Current Procedural Terminology (CPT) guidelines. Each claim must include the appropriate line item with your usual and customary fee, current CPT Code and ICD-9-CM.

Claims must be received within the time limits set forth herein and may be submitted in one of the following three formats:

- Avesis secure web portal at www.avesis.com
- Through your practice management software using a clearinghouse
- CMS1500 claim form via first class mail to:

  Avesis Third Party Administrators, Inc.
  Attn: Eye Care Claims
  PO Box 7777
  Phoenix, Arizona 85011

Electronic Claims Submission via Emdeon Services

You may submit claims using Emdeon, a clearinghouse that can convert paper claims into a HIPAA Compliant Electronic Data Interchange (EDI) format. The Avesis EMC payer identification number you will need to submit claims to Avesis through Emdeon is 86098. If you have any questions regarding Emdeon, please contact your software vendor.

Acceptable Codes for Claims Submission

Please see the appropriate section at the end of this Manual for the acceptable codes for services/materials for your State's program.

Claim Follow-Up

You have a right to correct information that you may have submitted incorrectly. Changes must be made in writing using the current CMS-1500 claim form and directed to the Avesis "CORRECTED CLAIMS" unit within the time frame specified in the state-specific supplement at the end of this Provider Manual.

When calling or writing Avesis to follow up on a claim(s) please be certain to submit or have the following information available:

- Patient's Name
- Date of Service
- Patient's Date of Birth
- Member's Name
- Member's ID Number
- Member's Group Number
- CPT Codes and/or HCPCS codes
- Claim Number, if the claim has been paid

Claim Status

You may check status of a submitted claim on the Avesis website by logging in under your Provider identification number. Do not wait more than thirty (30) calendar days after claim submission before notifying Avesis of a claim that has not been adjudicated.

Claims being investigated for fraud or abuse or pending medical necessity review are not Clean Claims.

Note: Members cannot be balance billed for any charges or penalties incurred as a result of late or incorrect submissions.

To Resubmit Claims

Resubmitted claims **must** include the original claim number and be resubmitted within ninety (90) days of the original submission or as stated in the state-supplement section at the end of this Provider Manual. At the top of the new claim form please write **"RESUBMITTED CLAIM"** to ensure proper handling of the claim in the Processing Department. Please include the claim number of the original claim in the remarks section of the CMS 1500 form. You may also resubmit claims on the Avesis website at www.avesis.com.

Summary of Claim

A summarization of the claim payment will be included with your claim check or remittance advice. A summarization of previously submitted claims for underpayments and/or overpayments may also be included. Summarizations of claim payments also are available immediately after submission of a claim on the Avesis website. In addition, providers may review remittance advices within one business day of payment on the website at www.avesis.com.

Coordination of Benefits

Primary vs. Secondary Insurance

Medicaid is the payer of last resort. All claims must be filed with commercial insurance companies or third party payers prior to filing claims with Avesis for Medicaid reimbursement. If Avesis is **not** the primary payer you must bill the primary payer first. If the claim is initially filed with Avesis**,** the claim will be denied. If the primary payer pays less than the Medicaid fee, you may bill Avesis for the balance. You must enclose the Remittance Advice from the primary payer. Avesis must receive the claim within ninety (90) days of the date of the primary payer's Remittance Advice. Remaining charges will be reimbursed up to the maximum allowed amount had Avesis paid as the primary payer. Since the Medicaid program is an individual program, each Member has a unique Member identification number.

Appeal Process

Avesis confirms that you have the right to appeal a claim that has been denied in whole or in part. The following processes may vary by state. If so, the appeal process for your state will appear in the state-specific section in the back of this Provider Manual.

Level One - Complaint:

Submit a written request for the claim to be reviewed, including the justification for the service to be reimbursed.

All requests must be submitted within the time frame specified in the state-specific supplement at the end of this Provider Manual.

The Claims Manager or qualified designee will review the complaint and if, based upon the information provided, it is determined that the service or material should be reimbursed, the claim will be paid.

If the Claims Manager determines that the claim should not be paid, the claim will be referred for peer level review for final determination.

All reviews will be completed within the time frames specified in the state-specific supplement at the back of this Provider Manual.

Level Two - Appeal:

You may file an appeal to Avesis in writing or verbally.

An appeal is any disagreement you may have with respect to payment for services and/or materials. Examples are:

- Reduction of a claim payment
- Benefits that are considered covered or non-covered
- Denial of eligibility

Level Three - Grievance:

You may file a formal grievance.

The grievance must be submitted in writing to Avesis.

The grievance will be investigated and if it is determined that the grievance is administrative in nature, the Claims Appeals Committee will review and resolve. If the grievance is clinical in nature, the Vision Advisory Board will review and resolve.

You will be notified in writing of the determination.

Provider Complaints

Providers are permitted to dispute Avesis Policies and Procedures, as they relate to the Provider and/or his practice. Avesis has designated personnel for the eye care programs who shall be available to received phone calls, emails or in-person questions from Providers. Providers are permitted to consolidate their complaints or appeals of multiple claims involving the same or similar payment or coverage issues, regardless of the number of individual patients or payment claims included in the bundled complaint or appeal.

In the event of a complaint by a Provider, all of the specifics surrounding the complaint are to be thoroughly investigated and documented. Investigation and resolution of the complaint shall be made using applicable statutory, regulatory and contractual provisions.

If, on appeal or as a result of resolution of a provider complaint, a clean claim that was initially denied is determined to be eligible for payment, and as required by state regulations, Avesis will pay interest at the state-required rate calculated from the end of the prompt payment period through the date the claim was paid.

If a Provider has exhausted the Avesis appeals process with regard to denied or partially denied claims, the provider is entitled to pursue the administrative review process or select binding arbitration, as set forth in the Provider Agreement. Information regarding the ways that providers can appeal adverse determinations shall be included with the EOB sent to the Provider.

Complaints may be made to Avesis Provider Services Representatives in the following manner:

In Writing	By Phone	Online
P.O. Box 7777 Phoenix, AZ 85011-7777 ATTN: PROVIDER COMPLAINTS	(800) 231-0979	CONTACT US www.avesis.com

Payment

Avesis is committed to the processing of all clean claims within fifteen (15) business days of receipt or as defined by state or federal regulations. Submit a clean claim form or file electronically after services and materials have been provided.

A “CLEAN” claim contains, at a minimum, the following:

- Member’s Name
- Member’s Date of Birth
- Member’s Identification Number
- Acceptable CPT and/or HCPCS code
- All applicable ICD-9 codes
- Charge amounts for all services
- Approval Number, if applicable
- Provider information, including NPI number and Medicaid ID number
- Provider’s signature

Missing or incorrect information will cause delays in the processing of your claim. Any and all applicable Member co-payments will be deducted from billed amounts.

If payment is not received in a timely manner, it may be due to:

- Avesis not having received the claim
- Eligibility verification
- The claim was missing required information

Should your clean claim not be processed within fifteen (15) business days of receipt, Avesis will pay interest at the state-mandated interest rate.

Providers are encouraged to check the status of their claims via the Avesis web site at www.avesis.com for any claims not adjudicated within thirty (30) calendar days of the date the claim was filed. The timely filing guideline will be strictly adhered to. Claims received after the filing guideline will be denied. There will be no exceptions.

Note: Avesis Members cannot be balance billed for any charges or penalties incurred as a result of late or incorrect submissions or for administrative denials by Avesis of covered services.

Payment Forms

Avesis Providers have the option to receive payment for services rendered in two ways.

Paper Check

Paper checks are cut and mailed via US Postal service along with a copy of the remittance advice once weekly.

Electronic Funds Transfer

Electronic payments are deposited into an account designated by you. This account is funded based upon services rendered, once weekly. The remittance advice will be mailed to the address of record in your file once weekly and can be viewed on our website. If you wish to elect to have funds electronically deposited, a completed EFT agreement must be submitted to:

Avesis
P.O. Box 782
Owings Mills, MD 21117
ATTN: FINANCE DEPARTMENT

A voided check must accompany this request.

Standards of Care for Provider Offices:

Avesis has established standards that we expect our Providers to fulfill. The following are the summaries of those standards:

Professional Standard of Care

Each Avesis Provider is expected to practice within the state mandated standard of care for his/her specialty. You are required to practice within the scope of your license as established by the American Board of Ophthalmology, State Board of Optometry, American Optometric Association or other governing agency. You are expected to be aware of any applicable state and federal laws that impact your position as an employer, a business owner and a healthcare professional.

Parameters of Care

You should be aware of the American Academy of Ophthalmology (ABO) Preferred Practice Patterns and/or the American Optometric Association (AOA) Clinical Practice Guidelines that can be found on the Internet at: http://www.abop.org or http://www.aoa.org, respectively. While only guidelines, Avesis will look to these guidelines as indicative of the appropriate care for the situations described. For the actual treatment that occurs, you are expected to use all of your relevant training, knowledge and expertise to provide the best care for the Member.

Standards for Member Records

Each Member shall have an individual record and an individual file kept at the office where services are rendered. The record shall include at a minimum: a current health history and listing of any prescription or non-prescription drugs taken; the Member's primary care physician's name; a summary of all services provided by the office; a copy of all authorizations or referrals for the Member; and copies or notations regarding any drugs prescribed for the Member. A complete listing of requirements for a Member Record has been provided in this Manual. The records shall be carefully maintained at your office in accordance with all applicable HIPAA and/or other Federal or State guidelines and available for review by Avesis staff, Plan Sponsor, Department of Insurance or Government agency during any facility review. Records shall be maintained for a period of ten (10) years or longer as required by State or Federal guidelines. If computerized, the records shall be non-changeable and properly backed-up for protection in accordance with any applicable state board guidelines. Failure to adhere to these record standards may result in Avesis recouping monies paid for services which are not documented according to these guidelines.

Approved Therapeutic Drug Standards for Doctors of Optometry

Providers practicing in states that have approved the administration of certain therapeutic drugs by optometrists may do so within the scope of their licenses. Any drug

not on this list may not be administered to Avesis Members by a Doctor of Optometry. A provider who administers drugs outside the scope of his/her licensure will have engaged in unprofessional conduct and may be reported to the appropriate agency.

Contact Lens Law

If you dispense or intend to dispense or prescribe contact lenses, you must be aware of any applicable state laws regarding the dispensing of contact lens and/or the provision of the Member's contact lens prescription set forth in the 2004 Fairness to Contact Lens Consumers Act. (For the complete text of the Act go to http://www.ftc.gov/os/2004/06/040629contactlensrulefrn.pdf.) You are responsible for knowing and understanding the appropriate Federal and/or state law and how it applies to you.

Standard for Member Contact Information

Your office shall obtain accurate and updated contact information for each Member at the time of each appointment and shall have appropriate contact number for parent(s) or legal guardian, if the Member is under the age of majority. Members shall be offered appointments within the period of time dictated by the state Medicaid administration. No charges shall be permitted for late or broken appointments as required by the state Medicaid program.

Standard for Member Appointments

Each new patient must have a thorough medical and eye health history documented in the chart. If in your professional judgment, treatment is required, the Member must have a written treatment plan in the chart that clearly explains all necessary treatment(s). Parental consent must be received prior to the treatment of minors. Medicaid Members shall be offered appointments within the same time period as your private office patients. Emergency coverage shall be in keeping with the requirements established in your Avesis Provider Agreement, Medicaid Addendum, or as described within this Provider Manual. No charges shall be permitted to Avesis or the Member for late or broken appointments.

Standard for Non-Covered Services

Your office should be aware of those services that are not covered under the Member's Medicaid program. If the Member is willing to have you provide any non-covered services or materials and is willing and able to pay directly for those services, you may provide the requested materials or services based upon the agreed upon discount arrangements. You **must** complete the Avesis Non-Covered Services Disclosure Form included herein and have the Member sign the form prior to rendering services. This form should be maintained in the Member's medical record.

Standards for Submitting

Whenever possible, claims should be submitted to Avesis for all services within seventy-two (72) hours of the Member's appointment being attentive to Avesis' timely filing guidelines as noted herein. Claims and requests for authorization shall be submitted promptly following the Member's appointment and include all of the necessary documentation for Avesis' review.

Medical Records

You may be required to disclose Member records as required by state law. The records:

- Are to be maintained in a current, comprehensive and organized manner;
- Are to be legible;
- Must include the patient's identification number on all pages;
- Must include current health history;
- Must include documented past history;
- Must include current medications;
- Must include initial examination data;
- Must have all entries signed or initialed;
- Must have all entries dated;
- Must include medication allergies and sensitivities, or reference "No Known Allergies" (NKA) to medications prominently on the record;
- Must include a physical assessment (problem directed) that has been documented and reviewed;
- Must include a date for return or follow up visit, if applicable;
- Must include documentation that problems from previous visits, if any were addressed;
- Signed HIPAA Confidentiality Statement;
- Original handwritten personal signature, initials, or electronic signature of practitioner performing the service;
- Must be written in Standard English.

The following significant conditions must be prominently noted in the chart:

- Current medications being taken that may contraindicate the use of other medications.
- Current medications being taken that may contraindicate treatment.
- Infectious diseases that may endanger others.

Medical Records

Review:

An Avesis representative may visit your office to review the medical records of Avesis Members. Generally, you will receive notice at least two (2) weeks in advance of this visit unless the situation is deemed to be emergent. Upon arrival at the office, the reviewer will present the list of the charts being reviewed. The Member's record must:

Include a signed consent to permit Avesis access to medical records upon request.
Be retained by you for all covered services rendered for the greater of ten (10) years or as required by your state law.

The Provider further agrees to furnish at no charge to Avesis, its authorized representatives or contractual agents, such information as it may request from time to time regarding services and materials provided to Members.

Access:

You are required to comply with Avesis' rules for reasonable access to medical records during the Agreement term and upon termination allowing:

The following parties to have access to the Member's medical records:

- Avesis representatives or their delegates;
- Member's subsequent Provider(s); or
- Any authorized third party.

For a maintenance period of ten (10) years from the last Date of Service

Copies:

Avesis has the right to request copies of the Member's complete record. Avesis will reimburse the practice for any requested records. When medical records are required by Avesis due to a claims appeal initiated by you, you may not charge a fee for copying the medical records. When medical records are required by Avesis due to a claims appeal initiated by a Member, you may not charge a fee for copying the medical records.

Credentialing

Avesis is required to confirm the professional qualifications of the Avesis Providers who treat our Members.

Credentialing Process

Prior to your contract with Avesis being approved, you had completed the credentialing process. This process must be completed for *any new Providers* joining your practice *prior* to the new Provider being able to see Avesis Members.

Requirements for credentialing include the specific background information necessary to perform a complete National Committee for Quality Assurance (NCQA) credentialing process. This includes information regarding your education, training, hospital privileges, licensure and other qualifications. Avesis either directly or through a contract with a NCQA certified credentialing verification organization (CVO) performs primary source verification of the required information. The details of the credentialing process are focused upon the specific elements within the NCQA process noted below:

- License to Practice – State license
- Hospital Privileges, if applicable
- DEA/CDS Registration – Drug license(s) if applicable
- Board Certification / Residency Completion / Medical School, if applicable
- Professional Liability Insurance Coverage Limits
- Application Processing – Professional questions and Attestation
- NPDB/ HIPDB – National Practitioner Data Bank information for professional liability claims history including lawsuits and other reported history
- Medicare/Medicaid Sanctions (Office of the Inspector General – OIG)
- Sanctions Against Licensure – State license limitations

Upon completion of the credentialing process, the completed application will be reviewed by the Avesis Credentialing Committee. The Credentialing Committee confirms the receipt of all of the required information and either approves or denies the Provider, based upon the information received. If issues are found during the credentialing process that may negatively impact our review of the Provider, the Provider is given an opportunity to further explain the circumstances concerning the issue found.

Post-Credentialing

Once the credentialing process has been completed and you are approved for participation in the Avesis network, you will receive a welcome packet that includes your Provider number(s) and Service Location Number(s), for each location. As an Avesis Provider, you agree to bill Avesis for only those services rendered by you personally, or under your direct supervision by employees duly certified pursuant to state law, if applicable. Direct supervision includes, at a minimum, periodic review of the patient's records and your immediate availability to confer with the employee performing the service regarding a Member's condition. This does not mean that you must be present in the same room; however, you must be available at the time they are performed.

Note: **Under no circumstances may a Provider bill for services rendered by another individual practitioner who is enrolled or eligible to enroll as a Provider of services in the Avesis Provider network and who is not duly licensed in the State.**

Group Practice

In a group practice, each Provider must complete the credentialing process and be approved by Avesis. Each Provider in the practice must enroll separately and bill for services he/she provided under his/her own Provider number.

A group practice is defined as a partnership, a corporation, or an assemblage of Providers in a space-sharing arrangement in which the Providers each maintain offices and the majority of their treatment facilities in a contiguous space. Services performed by non-enrolled Providers in a group practice are not covered, unless as locum tenens.

Indiscriminate billing under one Provider's name or Provider number without regard to the specific circumstances of rendition of the services is specifically prohibited and will be grounds of disallowing reimbursement, suspension or termination from the network.

The common practice of one Provider covering for another will not be construed as a violation of this Section when the covering Provider is on call and provides emergency or unscheduled services for a period of time not to exceed sixty (60) continuous days during a twelve month period.

Updating Information

You agree to notify Avesis in writing should any changes(s) in participation status occur such as: new address and/or telephone number, additional practice/ office location(s) TIN or change in payee. Any change to the tax identification number or payee information must be submitted on a new, signed and dated W-9. Each change in participation status must be reported to the Avesis Credentialing or Provider Services Department in writing as soon as possible.

Re-credentialing

Avesis will initiate the re-credentialing process thirty to thirty-three (30-33) months of your initial credentialing date and every thirty to thirty-three (30-33) months thereafter. Our process is to send you a re-credentialing information request sixty to ninety (60-90) days prior to your anniversary date. That information must be completed and returned to Avesis promptly in order for us to approve your continued participation in the Avesis network. Failure to promptly complete the recredentialing process within the prescribed time may result in the suspension of payment for claims submitted until recredentialing has been completed.

Our Credentialing Committee will review the completed re-credentialing information. If there are any significant issues revealed, they will be reviewed by the Chief Eye Care Officer, Chief Eye Medical Officer or designee from the Vision Advisory Board.

IMPORTANT

The credentialing and re-credentialing process is necessary in order to confirm that the Providers participating with Avesis are properly licensed and have no sanctions or license limitations that would adversely impact their ability to treat Members. Failure to complete the process may result in Providers not being included in the network or not being permitted to continue seeing Avesis Members.

IMPORTANT

Continuous Credentialing

It is your responsibility and obligation to submit required materials to the Avesis Credentialing Department upon renewal of such documents to ensure continued participation. This is required between the credentialing and recredentialing periods.

Documents include but are not limited to: current license, evidence of current professional liability insurance and DEA certificate, as applicable.

Furthermore, if the Provider's license is reprimanded, placed on probation, suspended or revoked you are required to notify Avesis immediately.

Office Review

The office reviews will be performed by Avesis staff or designated representative(s) using the Avesis office review form. The intent of this office review is to confirm that the office is following all mandated practices as established by OSHA, HIPAA, and the Department of Health along with any other governmental agency that has rules and/or regulations that impact a Provider's office. The key areas that will be reviewed during an office audit include:

- Office signs and visibility
- Handicapped patient access
- Cleanliness of office
- Eye medical information available
- Patient scheduling and recall
- Proper history and records for each patient, as set forth herein

The office will be informed of the results of the site survey. Each office will be evaluated based upon the results of the site survey. Any issues that are found during the review along with any required corrective action will be documented. If the office fails to earn a satisfactory score, the review will be repeated in ninety to one hundred twenty (90-120) days or as otherwise designated from the initial review. A copy of the review will be made available, if requested.

The office reviews will be repeated at intervals as determined by Avesis. An office that fails to reach a satisfactory score on the second review will be placed on probation and may be terminated according to the termination clause(s) in the Agreement.

Fraud, Waste and Abuse

The Centers for Medicare & Medicaid Services (CMS) defines fraud as: “an intentional representation that an individual knows to be false or does not believe to be true and makes, knowing that the representation could result in some unauthorized benefit to himself or some other person.”

Committed to preventing, detecting and reporting possible fraud, waste and abuse, Avesis, its staff and Providers adhere to the Avesis Anti-Fraud Program. All Avesis personnel receive annual training with regard to the detecting of fraud, waste and abuse and staff involved with claims processing and payment and utilization review receive more in-depth training.

All of our Providers are also expected to be alert to possible fraud, waste and abuse and report any suspicious activity to Avesis. Avesis will then work with the MCO, their fraud unit and the applicable State / Federal Fraud, Waste and Abuse authorities.

Providers should also be aware of the anti-kickback statute (42 U.S.C. Sec. 1320a-7b) and the physician self-referral law (42 U.S.C. Sec. 1395nn). Violations of these rules could result in claims not being paid, monetary penalties, exclusion from participating in Medical Assistance and Medicare Advantage programs or imprisonment.

As a Provider treating Medical Assistance and/or Medicare Advantage Members, you must also be aware of the Office of the Inspector General (OIG) website. The OIG’s List of Excluded Individuals and Entities provides information on individuals and entities excluded from participating in the Medicare Advantage, Medical Assistance or other Federal health care programs.

Prior to your being approved for participation in the Avesis network for these programs, a check of the OIG List was conducted to be certain that your name does not appear. Avesis also checks the OIG List annually and at time of hire for all of its personnel. As a Participating Provider, you are also required to ensure that no staff providing services to Medical Assistance or Medicare Advantage Members appears on the list. The website for the OIG list is: http://exclusions.oig.hhs.gov/.

Reporting Fraud and Abuse to the Centers for Medicare and Medicaid Services
The Centers for Medicare and Medicaid Services has established a hotline to report suspected fraud and abuse committed by any person or entity providing services to Medicare Advantage beneficiaries.

The hotline number is 1-800-HHS-TIPS (800-447-8477), and it is available Monday through Friday from 8:30 AM to 3:30 PM. Callers may remain anonymous and may call after hours and leave a voice mail if they prefer.

Quarterly Statistical Provider Review

At the end of each quarter, Avesis will compile and review total services rendered by all Medicaid providers. The objective of the utilization review process is to provide precise statistical data regarding the demand for routine vision and eye medical services and utilization trends across the entire network. Each code will be analyzed against the number of total number of Medicaid enrollees accessing care. The result will be an average frequency of services per one hundred (100) members treated in the Medicaid program. The following items may formulate the basis of the utilization review:

1. Relative Service Comparison - Certain vision services are typically performed with or after other services. Avesis will review a series of related vision services for appropriate care. An example of such services would be:

   92225 - Ophthalmoscopy, extended, with retinal drawing (e.g., for retinal detachment, melanoma) with interpretation and report; initial followed by a 92226 - Ophthalmoscopy, extended, with retinal drawing (e.g., for retinal detachment, melanoma) with interpretation and report

2. Accurate Claim Submission - This will be accomplished:

   During the on-site office audits a selection of patient records will be reviewed. Each record will be compared with claims submitted to confirm that the services submitted were those actually rendered. Claim submission errors are not considered to be over or under-utilization, but over-reporting of services.

3. Review of Prior Authorizations - Avesis will review all prior authorizations for:

   - Compliance with Avesis process
   - Correct use of emergency authorization

Avesis' goal in the utilization review process is to ensure that the appropriate level of care is delivered to the appropriate Member at the appropriate time to ensure quality care for Medicaid enrollees.

AVESIS MEDICAID PROGRAMS

KENTUCKY MEDICAID PROGRAM

Avesis Customer/Provider Services: **(855) 469-3368**
Fax: (866) 874-6834

For Claims/Billing Information on Fee-for-Service Members, please contact:

HP Enterprise Solutions
(800) 807-1232

Kentucky Department for Medicaid Services
General Information: (800) 807-1232
Ky_Provider_inquiry@eds.com

Statement of Providers' Rights and Responsibilities

Abide by the rules and regulations set forth under applicable provisions of the Kentucky Revised Statutes Chapter 194A, Cabinet for Health Services, Kentucky Revised Statutes Chapter 205, Public Assistance and Medical Assistance and Kentucky Administrative Regulations – Title 907.

Frequently Asked Questions

General Information

With which Managed Care Organization(s) (MCO) is Avesis associated?

Avesis is associated with WellCare of Kentucky.

Will third party liability still be the same?

For Centers of Medicaid and Medicare Services (CMS) programs and CHIP programs, Avesis, on behalf of the MCO is always the payer of last resort. If the Member has other health insurance, claims must be filed with that payer first. Upon receipt of the primary Remittance Advice (RA), you should submit a claim to Avesis with the primary payer's RA within no more than six (6) months of the date on the primary payer's RA.

However, Avesis agrees to pay all Clean Claims for EPSDT services to children. Avesis recognizes that cost avoidance of these Claims is prohibited.

Provider Services

Is there a number to call where you can speak to a representative?

Avesis Provider Services is available to assist you at **(855) 469-3368** Monday through Friday from 7 AM until 7 PM EST, except observed holidays.

For Medicaid Programs only, will we get new Medicaid Provider numbers?

You will keep your current Medicaid Provider number. If you do not have a Medicaid Provider number, you will need to apply for one. You should apply for your Medicaid number through the Commonwealth's website. The application can also be found on the Avesis website at www.avesis.com.

Will we get an Avesis Provider number?

After you are credentialed, you will receive an Avesis PIN number which will be your Avesis identification number.

Will we be able to view the Member's benefits online?

Full benefit information is available on the Avesis website at www.avesis.com.

For Medical Assistance, when are children considered adults under this program?

The first day of the month following their 21st birthday.

How will I obtain eligibility and benefits information?

Your office can:

- Visit the Avesis website anytime at www.avesis.com
- Utilize Avesis IVR anytime at: (866) 234-4806
- Call Avesis Customer Service Center during normal business hours at (855) Monday through Friday 7:00 AM – 7:00 PM EST

Emergency Care

You are responsible for facilitating emergency treatment, as needed.

Members may need to be directed to their medical Provider. Assistance is available for the Health Plan using the phone numbers provided below:

Call the Member Services Department at (877) 247-6272; TTY users should use 711. Member Services is available from 8 AM to 8 PM, seven days a week.

SPECIAL NEEDS
If you have a member with special needs that may require additional assistance, please contact the Health's Plans Special Needs Department at: (877) 247-6272.

URGENT CARE
In accordance with Kentucky Code Section 304-17A-600(17), Urgent Care means health care treatment with respect to which the application of the time periods for making non-urgent determination (a) could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or (b) in the opinion of a physician with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the utilization review.

Samples of WellCare Member Identification Card

Note: Payment will not be issued for services rendered based on the possession of a Member Identification Card. Services will be reimbursed based on member's eligibility at the time the services were rendered.

Claims Process

Kentucky Medicaid rules permit claims to be submitted within three hundred sixty-five (365) days of the date of service.

NOTE: Kentucky Medicaid allows providers up to six (6) months from the date the claim was adjudicated by Medicare or another insurer to submit for Medicaid reimbursement.

Billing of Eyeglass Services

When billling for eyeglasses, you need to submit the actual laboratory costs of the materials. The prescription and laboratory costs of the materials are to be maintained in the Member's medical record. Provider's who perform their own laboratory work, must maintain their laboratory invoice with the breakdown of the lens costs and the frame name and manufacturer's invoice.

Claim Follow - Up

The Provider has a right to correct information submitted by another party or to correct his/her own information submitted incorrectly. Changes must be made in writing and directed to the Avesis Claims Manager within ninety (90) days from the date of the remittance advice.

To Resubmit Claims

Resubmitted claims must be submitted within ninety (90) days of the initial submission and include the original claim number.

Member Inquiries, Complaints, Grievances and Appeals

DEFINITIONS

A ***complaint*** is an issue that a Provider or Member presents to the MCO or Avesis, either verbally or in writing, that is subject to informal resolution within thirty (30) days.

A ***grievance*** is a Member's request for reconsideration of a decision regarding the medical necessity and appropriateness of services. A grievance must be resolved within the 30-day resolution period.

Provider Appeal Process for Denial of Claim(s)

Procedure Levels

Administrative Appeals – Appeals involving adverse determinations for reasons other than medical necessity (e.g. timeliness of filing, no prior authorization, etc.)

1. You need to submit a written request for the claim to be reviewed including the justification for the service to be reimbursed within thirty (30) calendar days of the adverse determination.
2. The Claims Manager will review the appeal within thirty (30) calendar days of receipt. If based upon the information provided it is determined that the claim should be paid, the initial determination will be reversed and the claim will be paid within ten (10) business days.
3. If the Claims Manager determines that the claim should not be reimbursed, the Provider will be notified of decision and advised that administrative appeals are only reviewed one time.

Medically Necessary Appeals – Appeals involving adverse determinations finding that there was no medically necessary reason to pay the claim.

Level One:

1. Provider sends a written notice of appeal to Avesis within thirty (30) calendar days of receipt of the adverse determination. The appeal should include documentation in support of the appeal not previously provided.
2. The Chief Eye Care Officer or Chief Eye Medical Officer or his/her designee will review the appeal and, if necessary, speak directly with the Provider. The appeal will be reviewed by a Member of the appropriate Avesis Advisory Board who was not involved in the initial determination.
3. Within thirty (30) calendar days of receipt of the appeal a decision will be made to either support or reversal the initial determination and the Provider will be notified of the decision.

Fair Hearing Appeal

A Member may ask for a Fair Hearing Appeal. A Member requests this appeal by sending a letter to Department for Medicaid Services within 30 days from the date of the notice by regarding the denial, decrease in services, or approval of a different service.

Fraud, Waste and Abuse

The Kentucky Cabinet for Health and Family Services has established a toll free fraud hotline operated by the Office of the Inspector General. Use this hotline to report suspected fraud and abuse committed by any person or entity providing services to Medical Assistance recipients.

The hotline number is (800) 372-2970 and operates Monday through Friday from 8:00 AM to 4:30 PM. Callers may remain anonymous and may call after hours and leave a voice mail if they prefer.

Providers may also mail any fraud and abuse issues to: Cabinet for Health and Family Services, Office of the Inspector General, Division of Audits and Investigations, 275 East Main Street, 5 E-D, Frankfort, Kentucky 40621.

Information reported may be done anonymously.

Cultural Competency

As a company dedicated to providing clients with superior service, Avesis fully recognizes the importance of serving Members in a culturally and linguistically appropriate manner. We know from direct experience that:

- Some Members have limited proficiency with the English language including some Members whose native language is English but who are not fully literate.
- Some Members have disabilities and/or cognitive impairments that impede their communicating with us and using health care services.
- Some Members come from other cultures that view health-related behaviors and health care differently than the dominant culture.

Avesis is committed to ensuring that network Providers, as well as its policies and infrastructure, are attuned to meeting the diverse needs of all Members, especially those who face these challenges. Cultural competency is a key component of Avesis' continuous quality improvement efforts.

To be culturally competent, you shall:

- Work with Members so that once Members are identified that may have cultural or linguistic barriers alternative communication methods can be made available.
- Utilize culturally sensitive and appropriate educational materials based on the Member's race, ethnicity and primary language spoken.
- Ensure that resources are available to overcome the language barriers and communication barriers that exist in the Member population.
- Make certain that you recognize the culturally diverse needs of the population.
- Teach staff to value the diversity of both their co-workers inside the organization and the population served, and to behave accordingly.

Foreign Language Translation Services/Special Needs Assistance

Communication with Avesis – There is a Spanish language queue set up in Customer Service that Members can access as they call into Customer Service. Avesis employs customer service representatives who speak Spanish. In addition, Avesis uses Voiance for interpreter services as needed to communicate with Members who have limited English proficiency. Avesis pays all costs for the Voiance interpreting services.

Special Services for Persons with Hearing Impairments – Members who are hearing impaired may require devices or services to aid them in communicating effectively with their Providers. Customer Service Representatives ask Members who are hearing impaired if they would like a certified interpreter—such as a computer assisted real-time reporter, oral interpreter, cued speech interpreter, or sign-language interpreter—to be present during a visit to the Provider. Customer Service maintains a list of phone numbers and locations of interpreter services, by county. If the use of an interpreter is not requested by the Member, Customer Service will offer the Member the chance to specify what other type of auxiliary aid or service they prefer.

Also, Provider Services and Provider Relations staff will educate Providers on what they can do to make facilities more accessible for individuals with hearing impairments, such as the following:

- Ensure a quiet background for the patient
- Reduce echoes to enhance sound quality
- Add lighting to enhance visibility
- Install flashing lights that work in conjunction with auditory safety alarms
- Clearly identify all buildings, floors, offices and room numbers
- Include a TTY (teletypewriter) or TDD (telecommunications devices for deaf persons) in the office

Should the Member require an interpreter on-site during or following the examination, please contact the appropriate Health Plan Special Needs Unit to make the necessary arrangements.

Functional Illiteracy – Often hidden from view is the fact that certain Members who speak English as their native language cannot read at levels that permits them to perform basic tasks such as filling out forms used in everyday transactions. Fearing embarrassment, seldom do such Members identify themselves to staff or to network Providers. Nevertheless, we are committed to making best efforts to help these individuals so that they can get the most out of their health care plan.

We begin by encouraging our staff and Providers' office staffs to look for telltale signs of literacy problems. These personnel then attempt, with sensitivity and discretion, to help the Member with the immediate need, such as completing a form. We will also try to guide the Member to appropriate community resources that can help the Member improve his or her literacy skills.

Website adaptations – Avesis' website has been updated to improve the content and interactive capabilities available to Members and prospective Members.

Annual Eye Examinations and Materials

Standards and Requirements

The following program standards and requirements shall apply in order to be reimbursed for the eye exam portion of the benefit available to eligible Members.

Eye Examination

An eye examination shall be performed in accordance with all current and future American Academy of Ophthalmology (ABO) Preferred Practice Patterns, American Optometric Association (AOA) Clinical Practice Guidelines, State Board of Optometry Practice Standards and local community professional standards. All findings and test results shall be recorded in a clear, legible fashion. The eye examination shall include, at a minimum, the following, whenever possible:

1. Medical / Eye History
   - Chief complaint
   - Age
   - Medications
   - Family history
   - Significant visual changes
2. Visual Acuities
   - Entering, with or without correction, distance and near.
   - Best corrected with final Subjective RX, distance and near.
3. Cover Test – Findings must be recorded at 20 feet and not necessary at near unless the patient complains of problems at near not accounted for by a near glasses prescription
4. Versions/Motility Assessment
5. Pupils and Pupillary Reactions
6. Screening Visual Fields
   - Record all findings including test or instrument used.
7. Refraction
   - To include subjective refraction.
8. External Examination / Biomicroscopy
   - Lids
   - Conjunctiva
   - Cornea
   - Crystalline lens
   - Anterior Chamber Angle Quantification
   - Media Clarity
9. Tonometry / Intraocular Pressure
   - You must include method of obtaining pressures and the time of day.
10. Ophthalmoscopy – Direct / Indirect
    - A dilated examination of the retina and the peripheral retina to be performed whenever professionally indicated.
    - Document all findings in the vitreous, macula, optic nerve, including numerical C/D ratio, retinal vessels and grounds.

11. Diagnosis and Treatment Plan

Standards for Routine Eye (cont)

All members have benefits for an annual eye health examination for the purpose of evaluating a member's ocular health, and determining the refractive status of the member. This annual eye health examination should be conducted in compliance with the Avesis Eye Examination Standards and Requirements. Coverage includes the examination and the annual dispensing of spectacle frames and lens materials required to correct visual acuity one time every 366 days. Adult members (ages 21 and over), have coverage for an annual comprehensive eye examination only.
If in your professional judgment, it is medically necessary for a patient to receive additional eye evaluations and/or replacement materials, you must complete a prior approval form and fax it along with all pertinent clinical data to our secure fax at (866) 874-6834.

These requests will be reviewed by our Prior Authorization Coordinator and will be referred to a peer reviewer for all adverse determinations. You will be notified of the decision in writing from Avesis within fourteen (14) calendar days of receipt of all required documentation. If a decision cannot be rendered within the fourteen (14) calendar days, you will receive written notification of the need for an extension.

Provider should utilize the following CPT codes when billing for the annual comprehensive eye health examination under the routine eye care program:

- 92002 and 92004: comprehensive or intermediate eye examination for new patients
- 92012 and 92014: comprehensive or intermediate eye examination for established patients

Please note: These services include dilation, when professionally indicated. The Provider may not bill separately for dilation performed on the same date of service.

ICD-9 Codes which may be considered for the routine eye examination:

307.81	tension headache
346.0	classical migraine
368.8 and 368.9	blurred vision
379.91	pain in or around eye
784.0	headache

Materials

All Members under age 21 are eligible to receive, at no cost to the Member, one pair of spectacle lenses or medically necessary contact lenses once every 366 days. Members age 21 and over do not have coverage for eyeglasses. For all members the lens material will be polycarbonate with scratch resistant coating.

Additional materials exceeding a member's annual benefit and replacement eyeglasses are subject to prior authorization. Replacement eyeglasses must be identical to the initial pair. The Avesis prior authorization form must be completed in its entirety and be submitted with clinical documentation such as chart notes to the Avesis prior authorization department for review. The decision to cover or not cover an additional pair of glasses would be made based on the amount of change in the Member's refractive error.

Eyewear Dispensing Standards (if provided in your office)

Dispensing shall be performed by duly qualified and licensed personnel, where licensing is required by state regulations. The Provider performing the dispensing shall note on the record the following:

1. Frame size;
2. Appropriate lens material;
3. Pupillary distance;
4. Base curve of lens, when indicated;
5. Verification of eyewear after fabrication (compliance with ANSI standards Z80).

Advice shall be offered to the patient on eyewear selection.

Contact Lens Examination/Fitting Standards

Contact lens examination and fittings require prior approval and are only approved for certain medically necessary conditions. When approved as medically necessary, contact lens examination services shall include, at a minimum, the following:

1. Examination;
2. Fitting;
3. Training; and
4. Follow-up visits for a minimum of 60 days after completion of fitting.

Contact Lens Standards

The following standards are recommended for contact lens patients:

1. Patient shall receive a diagnostic evaluation prior to the time of dispensing.
2. A sixty (60) day clinical adaptation period should be used for all patients who are newly fitted for contact lenses.
3. A thorough evaluation should be made of all contact lens users at each follow-up visit.
4. All contact lens patients should have written instructions that advise them of proper wear, hygiene and maintenance of their lenses.

Contact lenses will only be considered medically necessary when any one of the following is met:

1. The corrected acuity in the Member's better eye is 20/50 and shall be improved with the use of contact lenses;
2. The visual prescription of + 8.00 diopter or greater;
3. The Member's diagnosis is 4.00 diopter anisometropia; or
4. Other written justification that this method is Medically Necessary or Medically Indicated.

Other Services

When indicated or required by state regulations, annual dilations are to be performed on all diabetic, glaucoma, hypertensive, or cataract patients. Annual dilation is also to be performed on patients suspected of having glaucoma. If visual acuity is not correctable using routine measures, dilation should be done to rule out possible medical conditions.

Providers are expected to spend the amount of time necessary with each patient to access the health of the patient's eyes and to accurately determine the patient's best corrected acuity. More time may be needed for contact lens patients, elderly patients, or patients with existing pathologies. This block of time will allow for a complete examination along with all of the necessary patient record documentation. Routine dilation should be performed when it is deemed to be medically necessary.

Acceptable Codes for Claims Submission

All valid CPT-4 and HCPCS Codes

Fee Schedules

Reimbursements: Avesis will reimburse eye care services the lesser of the 2011 Kentucky Medicaid Physician Fee Schedule or billed charges.

CPT	Fee
15820	$321.09
15821	$358.36
15822	$285.62
15823	$416.75
65091	$399.41
65093	$424.57
65101	$426.70
65103	$461.78
65105	$511.32
65110	$843.33
65112	$805.70
65114	$877.46
65125	$156.56
65130	$441.96
65135	$357.23
65140	$393.75
65150	$393.71
65155	$544.41
65175	$384.62
65205	$33.30
65210	$37.72
65220	$35.75
65222	$43.31
65235	$366.69
65260	$546.11
65265	$634.98
65270	$87.37
65272	$151.17
65273	$205.62
65275	$166.57
65280	$464.06
65285	$698.27
65286	$285.96
65290	$323.76
65400	$346.39
65410	$88.45
65420	$236.88
65426	$330.96
65430	$40.74
65435	$48.62
65436	$160.06
65450	$182.19

CPT	Fee
65810	$287.57
65815	$265.64
65820	$491.28
65850	$664.97
65855	$310.28
65860	$223.48
65865	$354.88
65870	$338.42
65875	$356.87
65880	$389.03
65900	$540.57
65920	$466.74
65930	$422.24
66020	$101.70
66130	$369.67
66150	$498.06
66155	$488.32
66160	$580.12
66165	$479.40
66170	$673.07
66172	$742.32
66174	$857.76
66175	$972.58
66180	$829.35
66185	$503.94
66220	$382.65
66225	$692.83
66250	$367.55
66500	$234.45
66505	$207.16
66600	$504.94
66605	$696.75
66625	$326.70
66630	$380.71
66635	$387.81
66680	$331.53
66682	$377.79
66710	$299.85
66711	$368.68
66720	$299.12
66740	$299.36
66761	$258.84

CPT	Fee
67015	$377.81
67025	$378.77
67027	$557.54
67028	$164.69
67030	$296.66
67031	$283.53
67036	$788.97
67039	$928.59
67040	$1,077.81
67041	$896.92
67042	$1,027.18
67043	$1,077.91
67101	$463.16
67105	$471.76
67107	$917.62
67108	$1,309.85
67110	$546.74
67112	$937.62
67113	$1,183.24
67115	$305.90
67120	$366.21
67121	$562.99
67141	$323.62
67145	$335.02
67208	$420.10
67210	$531.53
67218	$747.55
67220	$558.15
67221	$179.52
67225	$32.21
67227	$412.32
67228	$691.57
67229	$778.24
67250	$442.52
67255	$555.13
67311	$412.47
67312	$493.52
67314	$467.63
67316	$527.08
67318	$393.19
67320	$542.65
67331	$504.92

CPT	Fee
67515	$33.65
67550	$559.37
67560	$530.65
67570	$579.63
67599	$0.00
67700	$52.02
67710	$57.01
67715	$76.48
67800	$66.04
67801	$93.51
67805	$102.63
67808	$164.46
67810	$66.37
67820	$36.79
67825	$64.38
67830	$109.41
67835	$355.29
67840	$92.82
67850	$71.33
67875	$88.91
67880	$215.44
67882	$312.57
67900	$239.47
67901	$449.83
67902	$455.68
67903	$413.76
67904	$397.06
67906	$350.04
67908	$328.42
67909	$344.27
67911	$345.04
67912	$698.92
67914	$238.76
67915	$126.19
67916	$334.11
67917	$383.41
67921	$204.74
67922	$121.06
67923	$361.03
67924	$369.60
67930	$140.47
67935	$285.60

CPT	Fee
68328	$515.36
68330	$297.00
68335	$448.85
68340	$203.38
68360	$270.53
68362	$428.69
68371	$265.09
68400	$76.40
68420	$94.84
68440	$47.47
68500	$529.57
68505	$549.87
68510	$241.05
68520	$465.10
68525	$234.29
68530	$186.50
68540	$531.41
68550	$693.63
68700	$257.73
68705	$87.55
68720	$507.27
68745	$428.38
68750	$542.71
68760	$74.95
68761	$64.09
68770	$313.57
68801	$36.96
68810	$51.50
68811	$105.43
68815	$138.62
68816	$472.05
68840	$49.67
68850	$38.13
76510	$121.56
76513	$69.95
76514	$9.01
76519	$52.34
76536	$62.77
90901	$19.78
92015	$20.22
92018	$57.64
92019	$51.78

CPT	Fee
92230	$37.09
92235	$68.33
92240	$74.62
92250	$49.01
92260	$29.88
92265	$32.03
92270	$42.95
92275	$54.99
92283	$15.65
92284	$23.41
92285	$13.89
92286	$53.79
92287	$66.48
92311	$56.56
92312	$68.82
92313	$51.33
92352	$33.00
92353	$39.00
92370	$29.00
92371	$16.31
92502	$77.27
92504	$12.74
92531	$6.96
92532	$5.83
92533	$6.69
92534	$2.76
95930	$33.75
95999	$0.00
96111	$49.92
96116	$81.03
97110	$20.90
97112	$21.66
97530	$21.61
99050	$72.00
99201	$29.66
99202	$53.00
99203	$79.04
99204	$112.27
99205	$143.29
99211	$16.98
99212	$31.08
99213	$42.63

65600	$166.11
65710	$640.47
65730	$784.56
65750	$833.29
65755	$834.75
65756	$815.33
65760	$964.08
65765	$992.66
65767	$646.76
65770	$873.59
65771	$367.58
65772	$264.48
65775	$358.46
65778	$1,095.71
65779	$991.27
65780	$560.32
65781	$860.34
65782	$741.13
65800	$104.61
65805	$107.02

66762	$299.21
66770	$321.50
66820	$246.39
66821	$192.76
66825	$432.66
66830	$444.32
66840	$491.25
66850	$568.58
66852	$628.18
66920	$553.04
66930	$580.72
66940	$554.92
66982	$636.91
66983	$567.11
66984	$652.61
66985	$517.73
66986	$688.20
66990	$63.00
67005	$497.73
67010	$488.67

67332	$561.19
67334	$398.83
67335	$187.85
67340	$498.62
67343	$369.31
67345	$151.25
67346	$132.84
67400	$577.65
67405	$488.55
67412	$598.30
67413	$516.94
67414	$531.22
67415	$108.74
67420	$869.07
67430	$674.08
67440	$815.04
67445	$704.41
67450	$806.84
67500	$44.22
67505	$53.41

67938	$52.24
67950	$370.09
67961	$362.93
67966	$422.94
67971	$582.53
67973	$754.71
67974	$767.08
67975	$378.30
68020	$53.14
68040	$37.50
68100	$67.63
68110	$85.43
68115	$122.22
68130	$254.43
68135	$73.35
68200	$29.05
68320	$326.90
68325	$458.28
68326	$441.18

92020	$18.88
92025	$21.74
92060	$41.60
92065	$32.71
92070	$54.18
92081	$36.45
92082	$48.64
92083	$55.27
92100	$33.94
92120	$32.57
92130	$37.40
92132	$31.75
92133	$38.87
92134	$38.87
92136	$21.47
92140	$22.96
92225	$29.58
92226	$25.89
92227	$10.09
92228	$26.11

99214	$67.10
99215	$98.39
99221	$51.66
99222	$85.60
99223	$119.25
99231	$25.89
99232	$42.24
99233	$60.07
99241	$36.55
99242	$67.83
99243	$90.43
99244	$128.22
99245	$166.18
99251	$35.76
99252	$55.73
99253	$74.75
99254	$107.50
99255	$148.20

Avesis Kentucky Medicaid – Eye Care Services

SERVICE	TOTAL FEE (Plan Maximum)	AVESIS PAYS	MEMBER PAYS
EXAMINATION (One examination per member, per provider, per 12 month period)	92002 92004 92012 92014	$51.67 $94.51 $46.92 $69.80	$0.00
Frame – Up to Age 21	Material Allowance Global Choices: Up to $200.00 retail value material allowance maximum per year. Limit of $150.00 retail value maximum per pair of eyeglasses. Up to one replacement eyeglasses per year with Prior Authorization. Family Choices, Comprehensive Choices, Optimum Choices: Up to $400.00 retail value material allowance maximum per year. Limit of $150.00 retail value maximum per pair of eyeglasses. Up to two replacement eyeglasses per year with Prior Authorization. All replacement eyeglasses must be identical to the initial pair.	$50.00	$0.00
Lenses – Up to Age 21 *Polycarbonate with Factory Scratch Resistant Coating*	**Single Vision,** **Bifocal ST25/ST28** **Trifocal 7x25, 7x28** (Minimum refractive error ±0.50 sphere, ±0.50 cylinder, 0.50 diopter of vertical prism or a total of 2 diopter of lateral prism)	$28.00 $43.00 $56.00 *Per lens*	$0.00
Eyeglass Dispensing Fee	92340 (monofocal) 92341 (bifocal) 92352 (fitting of spectacle prosthesis, monofocal) 92353 (fitting of spectacle prosthesis, multifocal) 92370 (Repair & Refitting)	$33.00 $38.00 $33.00 $39.00 $29.00	$0.00
Contact Lenses	Considered if medically indicated only.	Refer to Provider Manual	$0.00 when approved for medical necessity

Frequency			
Member	**Exam**	**Frame**	**Lenses**
Up to Age 21	1 Per Benefit Year	1 Per Benefit Year	1 Per Benefit Year
Age 21 And Over	1 Per Benefit Year	N/A	N/A

NON-STANDARD LENSES: Polycarbonate (CR-39 for members age 21 and above) single vision FT25, FT28, 7 X 25 and 7 X 28; all powers up to ±7.00 spherical with -4.00 cylinder and +3.00 D add. Prescriptive requirements that exceed this standard will be reimbursed invoice plus $20.00 dispensing. Refer to Provider Manual for details.

ASSIGNMENT: The Provider must accept an Assignment of Benefits for all eligible members. The member's signature is required on the Assignment of Benefits clause. The claim form authorizing payment should be completed and forwarded to:

Avesis Third Party Administrators, Inc.
P.O. Box 7777
Phoenix, AZ 85011-7777
Attention: Vision Claims
Or online at www.avesis.com

Avesis Claim Codes:

Service	Acceptable Codes
Comprehensive Eye Health Examination	**92002,92004,92012,92014**
Frame-In Selection	**V2020**
Frame –Out of Selection	**V2025**
Single Lens	**V2100**
Bifocal Lens	**V2200**
Trifocal Lens	**V2300**

Avesis Kentucky Medicaid - Eye Care Services

Reimbursements: Avesis will reimburse eye care services the lesser of the 2011 Kentucky Medicaid Physician Fee Schedule or billed charges.

Prior Authorizations: No prior authorizations are required, except for eyeglass replacements.

Limitations of Services
Providers should submit claims to Avesis in accordance with the Physician's Current Procedural Terminology (CPT). Avesis will not reimburse separately for procedures that are part of a more comprehensive service.

CPT	Description	Limitation
92002	Ophthalmological service, intermediate, new patient	A new patient is one that has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice within the past three years.
92004	Ophthalmological service, comprehensive, new patient	A new patient is one that has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice within the past three years.
92012	Ophthalmological service, intermediate, established patient.	Limit to one member, per provider, per 12 month period
92014	Ophthalmological service, comprehensive, established pt.	Limit to one member, per provider, per 12 month period

92002, 92004, 92012, and 92014 will not be reimbursed if billed with the following procedure codes: 99201, 99202, 99203, 99304, 99205, 99211, 99212, 99213, 99214 and 99215.

92015 Refraction

99201, 99202, 99203, 99204 and 99205 Evaluation and Management new patient office ophthalmological services are limited to one per member, per provider, per three year period.

99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214 and 99215 will not be reimbursed with the following procedure codes: 99241, 99242, 99243, 99244, 99245, 99251, 99252, 99253, 99254 and 99255.

99211 Evaluation and Management ophthalmological service will not be reimbursed unless there is actual physician-patient contact during the visit.

99214 and 99215 Evaluation and Management ophthalmological services are limited to two per member, per year, per diagnosis, per provider.

Visual field examinations (CPT codes 92081, 92082, 92083) are limited to one examination per member, per provider, per date of service.

Ophthalmoscopy examination procedure codes (92230, 92235, 92250, 92260) are limited to one examination per member, per provider, per date of service.

Eyeglasses are covered based on a diagnosed visual condition included in one of the following categories: amblyopia, post surgical eye condition, diminished or subnormal vision or other diagnosis which indicates the need for eyeglasses.

Frame requirement: Each frame dispensed must carry a minimum of a one year manufacturer's warranty, If a member selects frames outside the covered frame allowance, the member will be responsible for the payment of the frames. Avesis will not pay the difference in the costs. Minor adjustments are to be provided for a period of one year at no additional charge.

Lenses: Lenses must be available in a complete range of corrected curves. Lenses must meet the requirements of inspection, tolerance, and testing procedures as outlined in the American Standard Prescription Requirements. All lenses shall meet the current Food and Drug Administration (FDA) standards of impact resistance and must be polycarbonate and scratch coated. The cost of prism(s) when medically indicated are covered in the cost of the lenses and not reimbursed separately.

Tints: Tints will only be reimbursed if the prescription specifically states the diagnosis of photophobia.

Plano safety glasses: Plano safety glasses will only be payable when medically indicated. For example, member is blind in one eye and requires additional protection.

Low-Vision Services: Low-vision services are excluded.

Prescriptive Errors: The Provider is responsible at no additional cost to Avesis or the member for inaccurately ordered and filled prescriptions, defective materials and improperly fitted frames and lenses.

Sample Forms – ALL STATES

Non-Covered Services Disclosure Form

To be completed by Avesis Medicaid Eye Care Provider rendering Care

_____ has chosen to receive services that are
Member Name and Medicaid Number
above and beyond the benefit covered by the Medicaid Program. I have applied my entire benefit for _____ to the purchase price of the materials.

QUANTITY	DESCRIPTION	UCR

If dispensing materials the total amount of the frame is $_____ (minus $10) = _____.
If dispensing the materials the total amount of the lenses is $_____ (minus $10) = _____.

Doctor's Signature _____ Date _____

To be completed by Member

I _____, have requested services that are
Print Your Name
above and beyond the material(s) that are covered by the Medicaid Eye Medical Program.

Patient's Signature if over eighteen (18) or Parent or Guardian _____ Date _____

Electronic Funds Transfer Agreement

ACCOUNT REGISTRATION INFORMATION	
Name	Tax ID Number
Address	
City, State, Zip Code	
BANK INFORMATION	
Bank Name ☐ Checking ☐ Savings ☐ Other _____	
Address	
City, State, Zip Code	
Routing #	Account #

I, _____, as the authorized party, allow Avesis to deposit funds into my Bank Account using Electronic Funds Transfer. A voided check is included with this agreement to facilitate this process. This transfer is for my convenience. All claims filed are in accordance with the terms of the executed Avesis Agreement and the Avesis Provider Manual. All funds shall be deposited into my bank account at the banking institution shown above. The bank shall provide to Avesis your most current address upon request.

I understand that:

The origination of electronic credits to my account must comply with the provisions of United States law.

Avesis and the Bank will share with each other limited account and contract information as necessary to affect these credits.

By signing this document, I agree to accept the terms of the Electronic Funds Transfer.

This form must processed by Avesis before funds will be transferred into my Bank Account.

_____
Printed Name of Account Holder

_____ _____
Signature of Account Holder Date

_____
Printed Name of Joint Account Holder

_____ _____
Signature of Joint Account Holder Date

Telephone Number: _____