

Avēsis

**Hearing Provider Manual
Medicare Advantage Hearing Program**

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PROPERTY OF:
Avesis Third Party Administrators, Inc.

P.O. Box 782
Owings Mills, MD 21117-0782

Phone: (800) 952-6674 | Fax: (866) 332-1631

www.avesis.com

Dear Avesis Provider:

Avesis Third Party Administrators, Inc. (Avesis) would like to take this opportunity to welcome you and your staff as Members of 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 Medicare Advantage Hearing Program.

When communicating with our network providers, we make every effort to be clear and concise. Our goal is to answer questions promptly when they arise. We want to provide accurate and effective information that will allow you and your office staff to understand which American Medical Association (AMA) Current Procedural Terminology (CPT), Health Care Service Procedures Coding System (HCSPCS) codes are covered under the Medicare Advantage hearing plan, International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) to use, and what to expect from Avesis.

If you require assistance or information that is not included within this Manual, please contact our Provider Services Department at the following number:

Provider Services: (800) 952-6674

Monday - Friday: 8:00 AM to 5:00 PM (CST)

Specific details regarding the program can be found throughout this Manual. Periodically, your practice may receive updated information from Avesis. This information should be inserted in your Manual immediately to remain current. Please visit the Avesis website at www.avesis.com periodically for the most current information.

Again, we welcome you and your staff to the growing list of 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 S. Dolfield Road
Owings Mills, Maryland 21117
(410) 581-8700
(800) 643-1132

Avesis Corporate Offices

3724 N. 3rd Street Suite 300
Phoenix, Arizona 85012
(800) 522-0258

Avesis Provider Services

Provider Services
(800) 952-6674

Avesis Hearing Claims

Avesis Third Party Administrators, Inc.
Attn: Hearing Claims
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) 952-6674**. 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 vision, dental, and hearing services since 1978. Recognizing that every client is unique, Avesis has built a network of providers to support the constantly growing needs of the Medicare population. Avesis believes that a successful hearing program is one where the Members receive the best possible care and the network 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.

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:

Provider Services: **(800) 952-6674**

Monday - Friday: 8:00 AM to 5:00 PM (CST)

To assist you with the administration of benefits to Avesis Members, information in this Manual will be periodically updated. It is your responsibility to:

- Remove the older pages from the binder
- Replace with the revised pages

Please note the document numbers at the bottom left of the page. PM-H-MOL refers to Provider Manual – Hearing - Molina and the “v” stands for version which refers to the date. If you are in doubt as to whether you have the latest revision, please check the Avesis website at www.avesis.com for the most current version of a form. You will be able to download individual pages.

Promptly inserting revisions will keep your Provider Manual current and accurate.

Statement of Providers' Rights and Responsibilities

Providers shall have the right and responsibility to:

- Communicate openly and freely with Avesis
- Communicate openly and freely with Avesis Member(s)
- Suggest hearing treatment option(s) to Avesis Member(s)
- Recommend non-covered service(s) to Avesis Member(s)
- Ensure that the disclosure form is signed for non-covered service(s) by all parties prior to the rendering service(s)
- Obtain information regarding the status of claims
- Adjudication of all clean claims within fifteen (15) business days of receipt
- Resubmit a claim with additional information
- File an appeal with Avesis
- Inform a Member of appeal status
- Question policies and/or procedures that Avesis has implemented
- Review the results of any audits performed
- Inquire on credentialing/re-credentialing status
- Obtain a NPI number

Statement of Members' Rights

Members shall have the right to:

- Communicate openly and freely with Avesis without retribution
- Communicate openly and freely with their Avesis providers without retribution
- Expect privacy according to HIPAA and other state or federal guidelines
- Be treated with respect and dignity
- Be treated the same as all other patients
- Be informed of their hearing examination findings
- Participate in choosing treatment option(s)
- Know whether treatment is medically necessary
- 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

Statement of Members' Responsibilities

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
- Behave in a respectful manner
- Have providers explain fees associated with non-covered services
- Have fees associated with non-covered services agreed upon in advance of services being rendered
- 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 in the event of emergencies

Eligibility and Confirmation

The confirmation of eligibility is an important step for every hearing appointment. Avesis will update the eligibility files monthly or as the data is provided by the Health Plan. 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 received.

There are three ways to verify eligibility:

Internet

- Go to www.avesis.com
- Click “Medicaid/Medicare Programs”
- Click “Provider Login”
- Enter your Avesis Provider username and password
- Click “Verify Eligibility/Submit a Claim”
- Enter the Member’s identification number
- You will receive a real time response

FAX

- Fill out the Avesis Verification Fax Form
- Fax toll free to: **(866) 332-1631**
- Faxes are typically returned within one business day

Avesis Customer Service

- Representatives are available from 8:00 A.M. to 5:00 P.M. CST Monday through Friday at **(800) 952-6674** except observed holidays.

Hearing Examination and Instrument

Hearing Care Program Standards and Requirements

The following program standards and requirements shall apply to the hearing benefit for Covered Persons.

Diagnostic Examination

A comprehensive hearing examination shall be performed in accordance with industry guidelines and shall include, at a minimum, the following:

1. Speech audiometry w/ speech recognition
2. Comprehensive audiological evaluation

The audiological evaluation must include any and all procedures necessary for the determination of:

1. Thorough history of hearing loss history
2. A auditory sensitivity (audiometric thresholds)
3. Speech recognition capabilities
4. Type, degree, and configuration of hearing loss
5. Need for referral to a physician
6. Need for referral to other professionals and agencies
7. Need for hearing instrument(s) and other amplification devices.

Routine Examination with Hearing Instrument Dispensing, if applicable

A routine hearing examination shall be performed for the fitting of a hearing instrument in accordance with industry guidelines. The Member must have medical necessity for a hearing instrument with no medical contraindications for using the instrument. The air conduction puretone average in the better ear should be 45 dB or greater. Dispensing shall be performed by duly qualified and licensed personnel with the following noted in the Member record:

1. Hearing Aid exam and selection; monaural
2. Hearing Aid exam and selection; binaural
3. Basic electroacoustics
 - i. Determine electroacoustic characteristics
 - ii. Determine nonelectroacoustic characteristics
4. Hearing Instrument Fit
 - i. Comfort of instrument
 - ii. Ease of placement and removal of instrument
 - iii. Security in ear
 - iv. Microphone(s) location
 - v. Instrument controls functioning properly
5. Probe microphone measures for real-ear electroacoustical performance
6. Thresholds of discomfort using frequency specific stimuli
7. Routine Care – Teach Member:
 - i. How to operate instrument
 - ii. How to change a battery
 - iii. How to place and remove hearing instrument

If hearing acuity is not correctable without feedback using routine measures, the Member should be referred to their Primary Care Physician 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 hearing and to accurately determine the Member's best intervention.

Instrument – 30- Day Trial Period

The Member must be allowed a 30 consecutive day trial period that gives the Member sufficient time to determine satisfaction with a purchased hearing instrument. During the trial period, you may dispense additional hearing instruments as medically necessary until the Member is satisfied or you determine the Member will not benefit from dispensing an additional hearing instrument.

Instrument – Purchased

The Member shall be offered a “new” hearing instrument using the allowance below. Each hearing instrument must be a current model that meets the performance specifications indicated by the manufacturer and the Member's hearing needs. A new hearing instrument is one that has never been used and carries a full 12-month manufacturer's warranty. The manufacturer's warranty must be effective for 12-months after the dispensing date.

If the Member is not satisfied with purchased hearing instrument, they may return it to you within 30 days for a full refund. You may charge the Member a rental fee for the period of time only if you had the Member sign a Non-Covered Services Disclosure Form prior to dispensing the hearing instrument.

The Member is eligible to receive a \$350 allowance toward a hearing instrument annually. The benefit period begins with the month that the instrument is first dispensed. Fitting, dispensing, and post-fitting check are included in the \$350 allowance. You must allow a 30 day trial period to elapse from the dispensing date before completing a 30 day trial period certification statement.

Hearing Dispensing Options

You have multiple dispensing options available to you for dispensation of materials. The analog hearing aid may be completely in the ear (CIC), in the canal (ITC), in the ear (ITE), or behind the ear (BTE). You may choose one (1) option. The digital hearing aid may be CIC, ITC, ITE, or BTE. You may choose one (1) option.

Covered Services under the Hearing Plan

It is the responsibility of the licensed practitioner to determine whether services rendered are medically necessary or appropriate within the scope of license as required by the State and are included in the Member's Covered Benefits.

Under this program audiologists licensed in the State the services are rendered are allowed to practice up to the full scope of their licensure 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.

Procedure code(s) and diagnosis that are covered under the Member's hearing plan must be taken from the list of covered services itemized in the appendices relative to the Member's health plan. Services not included in covered benefits for the Member's hearing plan may be covered under their medical benefit.

Utilization Review

Avesis compiles utilization information on a quarterly basis to determine outliers (over-utilization and/or underutilization). Should the statistics suggest that a provider is rendering excessive services; Avesis may perform chart reviews to determine appropriateness of care, take additional steps to ensure that the provider is rendering appropriate care or may suspend participation in the network. Avesis will provide all collected data and analysis to the provider upon request. This data will be reviewed and analyzed by Avesis peer reviewers. If it is found that the 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 the provider's participation in the program,

Non-Covered Services Disclosure Form

To be completed by Avesis Provider rendering Care

_____ has chosen to receive materials
Name and Member Number
 that are above and beyond the benefit covered. I have applied my entire annual benefit for hearing instrument to the purchase price of the materials.

QUANTITY	DESCRIPTION	RETAIL COST

The total amount of the instrument is \$_____ (minus \$350) = _____.

Doctor's Signature *Date*

To be completed by Member

I _____, have requested services
Print Your Name
 and/or material(s) that are above and beyond the material(s) that are covered by Medicare Advantage.

Read the question and check either YES or NO	YES	NO
I understand this purchase uses my entire \$350 annual instrument benefit.		
I am aware that I am financially responsible for paying for these services.		
I am aware that Avesis is not paying for these services beyond my annual total benefit limit of \$350 or services not covered under my benefit plan.		

I am responsible for a rental fee in the amount of \$_____ if I return the hearing instrument within 30 days from the date dispensed. The returned hearing instrument must be in the same condition as when dispensed.

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

Claims

Claims Process

All claims submitted will automatically be processed and paid according to the Avesis Provider Fee Schedule. Avesis follows the most current American Medical Association (AMA) Current Procedural Terminology (CPT) guidelines. Each claim must include the appropriate line item with your fee, current CPT Code, current HCSPCS and ICD-9-CM.

Claims must be received within one hundred eighty (180) days from the date of service and may be submitted in one of the following three formats:

- E-billing 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: Hearing Claims
P.O. Box 7777
Phoenix, Arizona 85011-7777

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 "CORRECTED CLAIMS" unit within one hundred eighty (180) days of the date of the Avesis remittance.

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

1. Patient's Name
2. Date of Service
3. Patient's Date of Birth
4. Member's Name
5. Member's ID Number
6. Member's Group Number
7. CPT Codes
8. 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 and clicking on the "View Claim Status" option along the left hand side of the page.

To Resubmit Claims

Resubmitted claims **must** include the original claim number. At the top of the new claim form please write "CORRECTED CLAIM" to ensure proper handling of the claim in the Processing Department and include the claim number of the original claim in the remarks section of the CMS 1500 form.

Summary of Claim

A summarization of the claim payment will be included with your claim check. A summarization of previously submitted claims for underpayments and/or overpayments may also be included.

Appeal Process

Avesis confirms that you have the right to appeal a claim that has been denied in whole or in part.

Level One:

1. Submit a **written** request for the claim to be reviewed including the justification for the service to be reimbursed.
2. All requests must be submitted within one hundred eighty **(180) days** from the date Avesis denied the service.
3. The Claims Manager or qualified designee will review the appeal and if, based upon the information provided, it is determined that the service or material should be reimbursed, the claim will be paid.
4. If the Claims Manager or qualified designee determines that the claim should not be paid, the claim will be referred for peer level review for final determination.
5. All reviews will be completed within 30 days from the date of receipt of the request for review.

Level Two:

1. You may file an appeal to Avesis either in writing or verbally.
2. 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
3. The appeal will be reviewed by an External Audiology Consultant.

Level Three:

1. You may file a formal grievance.
2. The grievance must be submitted in writing to Avesis.
3. The grievance will be investigated and will involve the Complaint Resolution Committee to review and resolve.
4. You will be notified of the determination.

Payment

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

A "CLEAN" claim contains, at a minimum, the following:

5. Member's Name
6. Member's Date of Birth
7. Member's Identification Number
8. Acceptable CPT or HCPCS code
9. All applicable ICD-9 codes
10. Charge amounts for all services
11. Provider information, including Medicare and/or NPI numbers
12. Provider's signature

Missing or incorrect information will cause delays in the processing of your payment or the claim may be denied. 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:

1. Avesis not having received the claim
2. Eligibility verification
3. The claim was missing required information

Providers are encouraged to follow up on any and all claims not paid within 30 days of the date the claim was filed. The 180 days timely filing guideline will be strictly adhered to. There will be no exceptions. Claims received after the 180 day filing guideline will be denied.

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

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 the provider funds for services rendered once weekly. The remittance advice will still be mailed to the address of record in the provider file once weekly as well. If a provider wishes 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

Note: A voided check must accompany this request.

Electronic Funds Transfer Agreement

ACCOUNT REGISTRATION INFORMATION	
Name	Tax ID Number
Address	
City, State, Zip Code	
BANK INFORMATION	
Bank Name	<input type="checkbox"/> Checking <input type="checkbox"/> Savings <input type="checkbox"/> 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:

1. The origination of electronic credits to my account must comply with the provisions of United States law.
2. Avesis and the Bank will share with each other limited account and contract information as necessary to affect these credits.
3. By signing this document, I agree to accept the terms of the Electronic Funds Transfer.
4. This form must be 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: _____

Standards of Care for Audiology Offices:

Avesis has established hearing standards that our provider offices are expected 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 licensure as established by the State Board of Audiology or the American Speech and Language Association. 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 ASHA parameters of care that can be found on the Internet at: <http://www.asha.org>. 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 audiology office and maintained for a period of ten years. The record shall include 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 audiology office; 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 during any facility review. 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.

Standard for Member Contact Information

Your office shall obtain accurate contact information for each Member at the time of their appointment and shall have appropriate contact numbers for parent(s) or legal guardian, if the Member is under the age of majority. Members shall be offered appointments within a reasonable period of time.

Standard for Member Appointments

Each new patient must have a medical history and a thorough hearing 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).

Standard for Services not covered under Medicare Advantage

Your office should be aware of those hearing services that are not covered under their Hearing Program. If the Member is willing to have you provide any non-covered services and is willing and able to pay directly for those services, you **must** complete the Avesis Non-Covered Services Disclosure Form included herein and have the member sign the form prior to rendering services.

Standards for Submitting

Whenever possible, claims should be submitted to Avesis for all hearing services within ten (10) business days of the Member's appointment being attentive to Avesis' one hundred eighty (180) day timely filing guideline. Claims and requests for authorization shall be submitted promptly following the Member's appointment and include all of the necessary materials for Avesis' review.

Member 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 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 hearing treatment.
- Infectious diseases that may endanger others

Medical Records

Review:

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

1. Include a signed consent to permit Avesis access to medical records upon request.
2. 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:

1. The following parties have access to the Member's medical records: Avesis representatives or their delegates, the Member's subsequent provider(s), or any authorized third party.
2. 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. The amount of reimbursement will not exceed \$10 per chart.

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

As a managed care organization, Avesis is required to confirm the professional qualifications of the Avesis providers who will treat our Members.

Credentialing Process

The credentialing process began with the gathering of documentation from you. The Credentialing Checklist is available on the Avesis website at www.avesis.com. Requirements for credentialing included the specific background information necessary to perform a complete National Committee for Quality Assurance (NCQA) based credentialing of your education, licensure and other qualifications. Avesis does primary source verification of each network provider. The details of the credentialing process are focused upon 10 specific elements within the NCQA process. Those elements are as follows:

- License to Practice – State audiology 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
- Professional Liability Claims History including previous lawsuits, if any
- Application Processing – Professional questions and Attestation
- NPDB/ HIPDB – National Practitioner Data Bank information
- Medicare/Medicaid Sanctions – Medicare limitations
- 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 successful completion of the information gathering and admits or denies your participation into the network. If issues are found during the credentialing process, you will be given an opportunity to further explain the circumstances concerning the issue found.

This credentialing process for each Avesis provider practicing in your office will be repeated every three (3) years. Any new providers joining the practice must be credentialed by Avesis prior to their treatment of any Avesis members.

Credentialing (Cont.)

Once fully credentialed, participating providers agree to bill Avesis for **only** those services rendered by them personally, or under their direct supervision by salaried employees such as licensed technicians, or assistants duly certified pursuant to state law guidelines. Direct supervision includes, at a minimum, periodic review of the patient's records and immediate availability of the provider to confer with the salaried employee performing the service regarding a Member's condition. This does not mean the enrolled provider must be present in the same room; however, the enrolled provider must be present at the site of these services, e.g., office suite, hospital, clinic, etc. 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 or who is not duly licensed in the State there are practicing. In a group practice, each provider must enroll separately and bill for services he/she provided under his/her own provider number. For purposes of this policy, 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 a 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 for recoupment of funds for services billed under a provider other than the provider rendering service, or claim denial.

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.

Participating providers 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) or change in payee. Each change in participation status must be reported to the Avesis Credentialing Department as soon as possible.

Re-credentialing

Avesis will initiate the re-credentialing process prior to the third anniversary of your initial credentialing date and every third year 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 should be completed and returned to Avesis promptly.

Our Credentialing Committee will review the completed re-credentialing information. 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.

IMPORTANT

Re-Credentialing

It is the sole responsibility of Avesis providers to submit required materials to the Avesis Credentialing Department upon renewal of such documents to ensure continued participation on the Avesis Preferred Provider Network. Documents include but are not limited to current license, malpractice insurance information and DEA certificate, as applicable. This responsibility also covers the period between credentialing and re-credentialing.

Quarterly Statistical Provider Review

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

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

92556 – Speech audiometry with speech recognition

92557 – Comprehensive audiological evaluation

2. Accurate Claim Submission - This will be accomplished:

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 Members.

Agreement-Amendments-Fee Schedule

Please place any amendments you receive from Avesis in this section.