Avēsis

*A National Vision and Dental Company*

# Vision Provider Manual

## Georgia Medicaid

**The material in this manual is confidential. Contents may not be reproduced or disclosed to anyone other than the intended recipient(s) and their staff. Failure to follow this procedure may result in termination of the contract.**

PROPERTY OF:

**Avesis Third Party Administrators, Inc.**

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

Phone: (800) 231-0979 | Fax: (866) 874-6834 | IVR: (866) 234-4806

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 Medicaid Vision 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 vision team Members to understand which American Medical Association (AMA) Current Procedural Terminology (CPT) codes are covered under the Georgia Medicaid vision plan, which 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) 231-0979**

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 regarding the Avesis Medicaid Vision Program.

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

# Table of Contents

# 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 Southeast Regional Office**
Provider Services
(800) 231-0979

**Avesis Prior Authorization Form**
Avesis Third Party Administrators, Inc.
Attn: Vision Medicaid Prior Authorization
10324 S. Dolfield Road
Owings Mills, MD 21117
(866) 874-6834 – Secure Fax

**Avesis Vision Claims**
Avesis Third Party Administrators, Inc.
Attn: Vision 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) 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 vision services since 1978. Recognizing that every client is unique, Avesis has built a network of providers to support the constantly growing needs of the Medicaid and indigent population. Avesis believes that a successful vision 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.

Avesis has formed the Vision Advisory Board that is comprised of peers from your State who are the liaison between you and Avesis. If you would like to speak to an Avesis Vision Advisory Board Member, 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:

Provider Services: **(800) 231-0979**

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. 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-V-GA refers to Provider Manual – Vision - Georgia 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 vision 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
- Request prior approval as required for Covered Benefits
- Review the results of any audits performed
- Inquire on credentialing/re-credentialing status
- Acquire a separate and unique Georgia Medicaid number for each location where the provider renders services
- Acquire 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 vision examination findings
- Participate in choosing treatment option(s)
- Know whether treatment is medically necessary
- Be provided with a phone number to call the provider 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

## 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 vision appointment. Avesis will update the eligibility files monthly or as the data is provided by the Care Management Organizations (AMERIGROUP and WellCare). 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. If a member is not showing as eligible on the date the claim is submitted but the provider has evidence that the member was eligible on the date eligibility was verified (evidence being a date and time stamped screen shot from the GHP web portal) and such verification occurred within seventy-two (72) hours of filing the claim, Avesis will pay the claim or overturn any denial thereof.

There are four ways to verify eligibility:

## IVR (Interactive Voice Response System)

- Call the IVR at: **(866) 234-4806**
- Enter your Avesis provider PIN number
- Enter the Member's identification number
- Follow the appropriate prompts for verification of eligibility.
- You will receive a real time response

## Internet

- Go to www.avesis.com
- Click "Vision and Dental Medicaid Program"
- Click "Georgia Medicaid Vision"
- You will receive a real time response

## FAX

- Fill out the Avesis Verification Fax Form
- Fax toll free to: **(866) 332-1632**
- Faxes are typically returned within one business day

## Avesis Customer Service

- Representatives are available from 7:00 A.M. to 7:00 P.M. EST Monday through Friday at **(800) 231-0979** except observed holidays.

# Avesis Medicaid Eligibility Verification Fax Form

**Provider Name:** _____ **Provider PIN #:** _____ **Fax Number:** _____

| Member ID Number | Member Last Name | Member First Name | Member DOB | Date of Service | CMO | Member Eligible | | Services Requested | | | Eligibility Reference Number |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | Yes | No | Exam | Frames | Lenses | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |

**Instructions:**

- Complete the appropriate fields indicated above (one line per member) and fax to Avesis' secure fax line at: (866) 332-1632
- Faxes received before 11:00 AM will receive a reply by 12:00 PM
- Faxes received after 11:00 AM will receive a reply by 3:00 PM
- Faxes received after 4:00 PM will be sent a reply by 10:00 AM the following business day

# Annual Eye Examinations and Materials

## Vision Care Program Standards and Requirements

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

### Eye Examination

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

1. Medical history;
2. Visual Acuities;
    - with correction, distance and near
    - without correction, distance and near
3. Cover test at 20 feet and at 16 inches;
4. Versions;
5. External examination;
    - Lids
    - Cornea
    - Conjunctiva
    - Pupillary reaction (neurological integrity)
6. Autorefraction/Refraction;
    - Far point
    - Near point
7. Tonometry/Intraocular Pressure (reasonable attempt or equivalent testing if contraindicated);
8. Retinoscopy;
9. Biomicroscopy/Slit Lamp examination; includes cornea, crystalline lens, vitreous, and Hruby, 78D or 90D (or other fundus lens) of the optic nerve, vessels and macula
10. Indirect ophthalmoscopy of the peripheral retina

## Eyewear Dispensing Standards

Dispensing shall be performed by duly qualified and licensed personnel. The provider performing the dispensing shall be a licensed optician and 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. For providers who have elected to dispense materials, the provider shall maintain the required number of frames within the specified frame allowance.

Annual dilations are to be performed on all diabetic, glaucoma or patients who may have glaucoma, hypertensive, and cataract patients. 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.

## Eye Exam Exceptions

A school nurse, pediatrician, or teacher may request an additional eye examination for a Member regardless of whether the Member received one during the current eligibility period. This request must be made in writing and forwarded to Avesis along with a completed Prior Approval Form. 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. If it is deemed medically necessary, a Member may receive an additional eye exam regardless of whether they received one during the current annual period.

### Materials

The Member is eligible to receive, at no cost, one pair of spectacle lenses, from specific frames, once every 365 days when medically indicated. The benefit period begins with the month that the spectacles are first dispensed. The lens material will be CR-39, standard plastic lenses, unless the patient is eligible for polycarbonate due to medical necessity. Polycarbonate lenses require prior authorization unless the member is both under 21 and meets the standards as detailed in the Addendum Section at the end of the Manual.

### Additional Exams and Materials

If in your professional judgment, it is medically necessary for a patient to receive additional eye evaluations and/or materials over and above the Member's annual benefits, you will be required to 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 Member of the Vision Advisory Board or the Chief Vision Officer for all adverse determinations. You will be notified of the decision in writing from Avesis within five (5) business days of receipt of all required documentation. If a decision cannot be rendered within the five (5) business days, you will receive written notification of the need for an extension.

# Covered Services under the Vision 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 Medicaid Covered Benefits. 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 to the Vision Advisory Board.

Under this program vision providers licensed in the State of Georgia 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.

**Please note:** When these services are rendered outside of the provider's office, they will be subject to a Site of Service (SOS) differential and the reimbursement will reflect this adjustment.

The procedure codes and diagnosis listed in Appendix A are for the exclusive billing of refractive services for AMERIGROUP Members under their routine vision plan.

The procedure codes and diagnosis listed in Appendix B are for the exclusive billing of refractive services for WellCare Members under their routine vision plan.

These are the only codes reimbursable to an ophthalmologist or optometrist for refractive or medical services or to opticians for dispensing devices under the Avesis Georgia Medicaid program. Provider coding of diagnosis and procedures is required on all claims submitted for payment.

Procedure code(s) and diagnosis that are covered under the Member's routine vision 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 routine vision plan may be covered under their medical benefit. Please contact the appropriate health plan to inquire about such services.

## Covered Services under the Vision Plan (cont.)

Claims that contain medical billed in conjunction with routine services, and/or procedures or diagnoses 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.

The goal of the Avesis Medicaid vision plan is for the vision provider to provide necessary and appropriate care within the limits of the Medicaid vision coverage available. As the vision provider, you are responsible for understanding the coverage in this specific Medicaid program and for abiding by the authorization and referral processes mandated by Avesis. If questions arise regarding these processes, please contact Provider Services at **(800) 231-0979** for guidance. When the Member requires services that are beyond the scope of those outlined in this Manual, the Member must be referred to his/her Primary Care Physician or to the Member's CMO.

# Eyewear Dispensing Options

You have three dispensing options available to you for dispensation of materials. You may choose one (1) option. You must notify Avesis in writing of your choice. The options are as follows:

1. **Provider Frames** – When selecting this option you can sell frames from your current frame inventory and use the lab of your choice. You must supply and maintain a minimum of thirty-five (35) frames including twenty (20) children's frames, five (5) unisex frames, five (5) men's frames, and five (5) women's frames. Frames must carry a minimum one (1) year warranty against manufacturer defect. These frames, together with CR-39 or polycarbonate (should medical necessity be determined due to refractive error) will be billed to Avesis and be reimbursed a total of forty dollars ($40). Please be advised that while you are required to dispense polycarbonate lenses for members under the age of 21 who meet the requirement for medical necessity, you will receive no additional payment for these lenses.

2. **Georgia Department of Correction (GCI)** – When selecting this option you will receive a "covered frame" kit from GCI on consignment and you must place all spectacle orders with GCI. You will bill Avesis and be reimbursed a fifteen dollars ($15) dispensing fee.

3. **Essilor** – You will receive a "covered frame" kit (on consignment) from Essilor at no charge. All spectacle orders will be placed with an assigned Essilor laboratory. Avesis should be billed for the eye glasses as well as the fifteen dollar ($15) dispensing fee. If you select this option you will be billed by Essilor the Avesis contracted rate for this program and will be responsible for payment directly to Essilor.

Dispensing of spectacles must be performed by a licensed dispensing optician or optometrist. The dispensing notes in the Member's record must include the following:

- Frame Size
- Lens material
- Pupillary distance
- Base curve of lens, when indicated
- Verification of eyewear after fabrication
  (compliance with American National Standards Institute (ANSI) standards Z80)

Advice on frame selection should be offered to the patient at the time of eyewear selection.

# Prior Approval Information

As with any vision benefit program, certain services that will be provided for Members under the Avesis Medicaid vision plan will require prior approval from Avesis in order to be considered for payment. This section of the Manual explains the processes to get those authorizations approved.

If a Member is in need of a service that requires prior authorization, once coverage is verified, Avesis Medicaid providers should render the following services:

1. Diagnosis and treatment of abnormal refraction
2. Dispensing of optical devices to compensate for refractive errors

Upon completion of the above listed services, if it is determined that additional services requiring prior authorization are necessary; please fax the Avesis prior approval form along with all pertinent clinical information to: **(866) 874-6834**.

Non-emergency treatment started prior to the determination of coverage will be performed at the financial risk of the provider. In the event that approval is not granted, the treating provider may not bill the Member, the sponsor, or Avesis.

When appropriate, you will receive an authorization code within five (5) business days of receipt of a completed Prior Authorization Form and all pertinent clinical data by Avesis. Adverse decisions will be reserved for peer reviewers. Authorization requests received with missing or incomplete documentation will be refused and will be returned.

## Services Requiring Prior Authorization

The following procedures require the Avesis Vision Prior Approval form be completed by you and submitted to Avesis with all pertinent clinical data, including but not limited to the chart notes for the Member's encounter:

1. Refractive examination, or replacement of eyewear within 365 days of having received services or materials (replacement of temporary lenses does not require prior authorization)
2. Ultraviolet tint for prosthetic lenses and/or goggles
3. Trifocal lenses with add power less than +2.50.
4. Adult enhanced materials benefit for WellCare eligible members (Only spectacle **materials** that have a minimum refractive error of +/- 1.00 will be approved.)
5. Gonioscopy
6. Visual fields
7. Medically necessary contact lenses
8. Fundus photography
9. Punctal occlusion

**Please Note:** Polycarbonate lenses must be dispensed for medical necessity to children for refractive errors in excess of -5.25/+4.00 diopters in any of the four meridians. No prior authorization is required for children meeting this refractive error standard.

## Emergency Care

The Members' health plan shall be responsible for all emergency care for eligible Members. Please contact the appropriate health plan for guidance in an emergency situation or immediately refer the member to their CMO Primary Care Physician.

**Vision Emergency** - a situation where the Member has or believes there is a current, acute vision crisis that could be detrimental to their health if not treated promptly.

## Non-Covered Items or Services

Non-covered services include investigational items and experimental drugs or procedures not recognized by the United States Food and Drug Administration, the United States Public Health Service, Medicare, and Avesis as universally accepted treatment. It may also refer to elective tests or procedures not included in the routine eye exam or supported by the patient's clinical diagnosis, including but not limited to, positron emission tomography, dual photon absorptiometry, etc.

# Non-Covered Services Disclosure Form

## To be completed by Avesis Medicaid Provider rendering Care

_____ has chosen to receive materials
*Name and Medicaid Member Number*
that are above and beyond the benefit covered by Medicaid. I have applied my entire annual benefit for frames/lenses (circle one or both) to the purchase price of the materials.

| QUANTITY | DESCRIPTION | RETAIL COST |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

The total amount of the frame is $_____ (minus $20) = _____.
The total amount of the lenses is $_____ (minus $20) = _____.

*Doctor's Signature* *Date*

## To be completed by Member

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

| Read the question and check either YES **or** NO | YES | NO |
|---|---|---|
| I understand this purchase uses my **entire $20 annual lens** benefit. | | |
| I understand this purchase uses my **entire $20 annual frame** benefit. | | |
| I have chosen to receive these materials **not** covered by Medicaid. | | |
| I am aware that **I am financially responsible** for paying for these services. | | |
| I am aware that Medicaid is **not** paying for these services beyond my annual total benefit limit of $40. | | |

*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 Medicaid fee, current CPT Code, 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: Vision Claims
P.O. 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. If you have any questions regarding Emdeon, please contact your software vendor.

# 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 may be made in writing and directed to the Avesis "CORRECTED CLAIMS" unit or made on the Avesis website at www.avesis.com.

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.

## 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. 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. 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 Avesis' website. In addition, providers may view 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.

**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 thirty (30**) 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 a member of the Vision Advisory Board or the External Vision 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.

# Provider Complaints

Providers are permitted to dispute Avesis Policies and Procedures, as they relate to the provider and/or his practice. Avesis has designated one person for the vision program 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 more than fifteen (15) business days have passed since the filing of the clean claim, Avesis will pay interest at the rate of twenty percent (20%) per year calculated from fifteen days after the date the clean claim was submitted.

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 |
|---|---|---|
| PO Box 7777<br>Phoenix, AZ 85011 – 7777<br>ATTN: PROVIDER COMPLAINTS | By phone: (800) 231 – 0979 | Online: Talk to Us on www.avesis.com |

# 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:

1. Member’s Name
2. Member’s Date of Birth
3. Member’s Identification Number
4. Acceptable CPT or HCPCS code
5. All applicable ICD-9 codes
6. Charge amounts for all services
7. Approval Number, if applicable
8. Provider information, including Medicaid and NPI numbers
9. 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

Should your clean claim not be processed within 15 business days of receipt, Avesis will pay interest at the rate of 20% per annum.

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 and providers may access their remittance advice electronically within 24 hours of the payments being deposited. 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 ☐ 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:

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 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 Vision Offices:

Avesis has established for the Medicaid vision panel standards that our provider offices are expected to fulfill. The following are the summaries of those standards:

## Vision Professional Standard of Care

Each Avesis Medicaid 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 vision practice as established by the State Board of Optometry or the American Board of Ophthalmology. 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 AOA parameters of care that can be found on the Internet at: http://www.aoa.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 vision office. 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 vision office; a copy of all Medicaid 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 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.

## Approved Therapeutic Drug Standards

The State of Georgia has an approved list of therapeutic drugs that may be administered by a Doctor of Optometry. Please refer to the following website http://www.sos.state.ga.us/plb/optometry/ for a complete listing of these drugs. Any drug not on this list may not be administered to Avesis Members. The license of any Doctor of Optometry who commits any acts listed on http://rules.sos.state.ga.us/docs/430/10/04.pdf will have engaged in unprofessional conduct and shall be subject to disciplinary sanctions pursuant to O.C.G.A. 41-1-19 and 43-30-19.

## 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 the period of time dictated by the state Medicaid administration. Emergency coverage shall be in keeping with the requirements established in your Avesis Provider Agreement/Addendum, by the state Medicaid administration and as described within this Provider Manual. 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 vision 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.

## Standard for Services not covered under Medicaid

Your office should be aware of those vision services that are not covered under the Medicaid 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 Medicaid vision services within seventy two (72) hours 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 vision treatment.
- Infectious diseases that may endanger others

# Medical Records

## Review:

An Avesis representative may visit your office to review the medical records of Medicaid 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 Medicaid providers who will treat our Members. The process has two parts:  the review of the professional credentials and the physical review of each vision office.

## 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 contracts with a NCQA certified credentialing verification organization (CVO) to complete the collection and 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 vision 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 – Medicaid 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 Medicaid 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 Medicaid patients. Negotiations with practices where the providers are employees of the practice should be undertaken with the practice manager or other person authorized to enter into agreements for the practice.

## Credentialing (Cont.)

The Avesis Provider Agreement is not exclusive and providers are not excluded from participating with other health care providers. Furthermore, providers may not require Avesis to contract with other providers as a condition of their contracting with Avesis.

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 in the Avesis Medicaid program or who is not duly licensed in the State of Georgia. 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 physicians 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 in order for us to work with our CVO to verify the data.

Our Credentialing Committee will review the completed re-credentialing information. Prior to that review, if there are any significant issues, they will be reviewed by the Chief Vision Officer or designee from the Vision Advisory Board. 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.**

# Office Review

## Site Survey 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 vision 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 vision facility. The key areas that will be reviewed during an office audit include:

- Office signs and visibility
- Handicapped patient access
- Cleanliness of office
- Vision information available
- Patient scheduling and recall
- Proper history and records for each patient

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 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.

Vision Office Name: _____ Office #: _____

Address: _____ Phone Number: _____

_____

Reviewer Name: _____ Review Date: _____

**Rating System:**
Satisfactory = **S** Unsatisfactory = **U** Not Applicable = **N**

| **A. Facility:** | **Rating** | | |
|---|---|---|---|
| | **S** | **U** | **N** |
| 1. Exterior is clean, well-maintained and well-lit. | | | |
| 2. Facility has adequate parking and/or access to public transportation. | | | |
| 3. Facility has appropriate handicap access. | | | |
| 4. The reception area and front office are clean, well-maintained, well-lit and have adequate space; and, patient records are stored to maintain appropriate confidentiality.<br>☐ Appearance ☐ Confidentiality ☐ Space | | | |
| 5. Examining rooms are clean, well-maintained, and have adequate space.<br>☐ Appearance ☐ Space | | | |
| 6. Equipment is in good working condition and adequate for the examination, diagnosis and treatment of patients. | | | |
| 7. Emergency exits are accessible and well-marked. | | | |
| 8. A fire extinguisher, periodically inspected for proper operation, is accessible to all areas of the office. | | | |

| **B. Staff:** | | | |
|---|---|---|---|
| 1. Auxiliary personnel have current licensure.<br>Current licensure is available for review: ☐ Opticians | | | |

| **C. Access:** | | | |
|---|---|---|---|
| 1. Initial appointment for new patient is available within _____ weeks.<br>Actual date of next initial appointment: _____ # of weeks: _____ | | | |
| 2. Routine appointment for patient-in-treatment is available within 3 weeks.<br>Actual date of next routine appointment: _____ # of weeks: _____ | | | |
| 3. Emergency appointments are available within 24 hours or on the same day if indicated. | | | |
| 4. During business hours, office is accessible. After-hours telephone system allows for expeditious call-back response from vision professional.<br>Access not acceptable during: ☐ business hours ☐ after-hours | | | |
| 5. After-hours access system includes:<br>☐ answering service ☐ answering machine ☐ pager ☐ other | | | |
| 6. Recall system and follow-up for all patients in active treatment includes:<br>☐ postcard ☐ telephone ☐ computer ☐ other | | | |
| 7. Broken appointment follow-up includes:<br>☐ postcard ☐ telephone ☐ computer ☐ other | | | |

| D. Facility Forms: | Rating | | |
|---|---|---|---|
| | S | U | N |
| 1. Medical and vision history forms requiring “yes” or “no” responses allow for documentation of a comprehensive medical and vision history, updates, medical alerts and signatures of patient (or guardian) and Avesis Medicaid panel. | | | |
| 2. Vision examination forms allow for documentation of: ☐ history ☐ refraction ☐ pressures ☐ diagnosis ☐ diseases | | | |
| 3. Forms allow for documentation of informed consent including treatment alternatives, risks, benefits, financial disclosures, consequences of refusal to treat and signatures of patient (or guardian) and dentist. | | | |

| E. Equipment: | | | |
|---|---|---|---|
| 1. Tonometer | | | |
| 2. Slit Lamp/Biomicroscope | | | |
| 3. Visual Fields Drive | | | |
| 4. Fundus Camera | | | |
| 5. Keratometer | | | |
| 6. Phoropter | | | |
| 7. Ophthalmoscope | | | |
| 8. Retinoscope | | | |
| 9. Projector | | | |
| 10. Autorefractor | | | |

| F. Medical Emergency Preparedness: | | | |
|---|---|---|---|
| 1. An established medical emergency plan includes procedures for obtaining outside medical emergency assistance. | | | |
| 2. Avesis Medicaid panel and appropriate personnel have current CPR certification. | | | |
| 3. Emergency telephone numbers are posted. | | | |
| 4. Operational cold water eyewash station is readily available. | | | |

| G. Restrooms: | | | |
|---|---|---|---|
| 1. Restroom is kept clean and well maintained | | | |

| Please check all specialties applicable to the facility review at this location: | | |
|---|---|---|
| ☐ Optometrist | ☐ Ophthalmologist | ☐ Optician |

Vision Office Name: _____ Phone Number: _____

Reviewer Name: _____ Review Date: _____

1. Summary of positive points:

_____

_____

_____

_____

_____

_____

2. Summary of areas needing improvement including recommendations made to the Avesis Participating Provider:

_____

_____

_____

_____

_____

_____

_____

3. Exit interview conducted with:

_____

4. Avesis staff reviewer's comments:

_____

_____

_____

_____

_____

_____

Provider Signature: _____ Date: _____

☐ Optometrist ☐ Ophthalmologist ☐ Optician

Reviewer's Signature: _____ Date: _____

# 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 vision 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 underutilization, 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.

## Agreement and Amendments

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