


Avēsis Medicaid Vision Provider Manual for Parkland Community Health Plan Texas HEALTH*first* & KIDS*first*

CHIP

TEXAS STAR
Your Health Plan ★ Your Choice

Parkland Community Health Plan

avēsis

To learn more, please call 866-563-3591or visit **avesis.com**
Dallas Service Area - Dallas, Collin, Ellis, Hunt, Kaufman, Navarro and Rockwall
TXP-11-11-21 Rev. 9/3/21

Welcome

Dear Provider:

Avēsis welcomes you and your staff to our network of participating optometrists and ophthalmologists. We are pleased that you have chosen to join our network and to provide eye care health services to our members.

With nearly 40 years in the business, we know that serving the Medicaid population isn't always easy. Patients may be just learning how to develop a practice of regularly seeing their eye care provider, and the administrative burden is perceived by many to be high.

While our influence over fees and patients is limited, as your Medicaid vision administrator, we can strive to make the administrative burden a little bit easier by:

- Communicating with you clearly and succinctly about our policies, practices, and resources
- Giving you direct access to eye care health professionals on our team to help answer many of your clinical and procedural questions—on the phone, by email, and in your office
- Keeping our secure web portal up to date with the latest information about which Current Procedural Terminology (CPT®) codes are covered by this plan

Provider Customer Service Number
866-563-3591

This manual outline many of the policies and procedures that govern how we manage this plan. The Contact Information section on page 7 of this manual offers you phone numbers, email addresses, and web tools to help you navigate the plan.

If you require assistance or information that is not included in this document, please contact our Provider Customer Service Department. This office is typically staffed Monday through Friday from 8:00 a.m. – 5:00 p.m. (CST), excluding observed holidays.

Again, we welcome you and your staff to the growing network of participating Avēsis providers, and we look forward to a successful relationship with you and your practice.

Sincerely,

David Worth, O.D.
Vice President, Vision Services

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Contact Information

Avēsis Provider Customer Service Texas Eye Care Providers 866-563-3591 avesis.com	**Parkland Community Health Plan** 888-672-2277 (HEALTH*first*) 888-814-2352 (KIDS*first*) www.parklandhealthplan.com
Claims Avēsis Third Party Administrators, LLC Attention: Eye Care Claims P.O. Box 38300 Phoenix, AZ 85069-8300 Electronic Payer ID 87098	**Corrected Claims** Avēsis Third Party Administrators, LLC Attention: Eye Care Corrected Claims P.O. Box 38300 Phoenix, AZ 85069-8300
Prior Authorization Avēsis Third Party Administrators, LLC Attention: Eye Care Prior Authorization P.O. Box 38300 Phoenix, AZ 85069-8300	**Post Review** Avēsis Third Party Administrators, LLC Attention: Eye Care Post Review P.O. Box 38300 Phoenix, AZ 85069-8300
Avēsis Vice President, Vision Services David Worth, O.D	

We make every effort to maintain the accuracy of information contained in this manual. If you see any typographical errors, please let us know. Call 866-563-3591. Avēsis is not liable for any damages, directly or indirectly, that may occur from the result of a typo.

General Information

Avēsis Third Party Administrators, LLC has been providing dental, vision, and hearing benefits since 1978. Recognizing that every client is unique, we have built a network of general and specialty providers to support the constantly growing needs of our commercial, medical assistance (Medicaid), Medicare Advantage, and underserved member populations. Avēsis 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 they receive.

Avēsis prides itself on providing excellent account management and provider customer service to support our providers and their staff. To reduce administrative responsibilities, we maintain a web portal that allows providers to verify member eligibility and submit claims.

Our vision team includes the Vice President of Vision Services, Medical Director, vision consultants licensed and residing in the state of the program they support, and provider relations representatives. To speak with a member of the Avēsis vision team, call Provider Customer Service at the number listed on page 2 in this manual.

Provider Customer Service operates Monday through Friday, 8:00 a.m. – 5:00 p.m. (CST), excluding the following observed holidays:

- New Year's Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Christmas Day

All offices will be notified 30 days prior to the effective date of any changes or revisions to this manual, unless the change is required by law or regulation. An update/revision will be sent to the office and will be accompanied by a cover sheet to indicate the subject matter being addressed, the page(s) to be replaced or added, and the effective date of the change. To assist providers with the administration of benefits to members, information in this manual will be updated on the Avēsis website at avesis.com It is the responsibility of the provider to stay current with these updates. If they are printed from the Avēsis website, please be sure to discard the older pages and replace them with the revised pages.

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

Provider Rights and Responsibilities

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

- Communicate openly and freely with Avēsis
- Communicate openly and freely with members
- Suggest eye care treatment options to members
- Recommend non-covered services to members
- Manage the ocular healthcare needs of members to ensure that all necessary services are made available in a timely manner
- Maintain the confidentiality of members' personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality, privacy, and security
- Obtain written parental or guardian consent for treatment to be rendered to members who have not yet reached the age of majority or who have been determined to require guardianship, in accordance with state vision board rules or AOA guidelines
- Ensure disclosure form is signed for non-covered services by all parties prior to rendering service
- Obtain information regarding the status of claims
- Receive prompt payments from Avēsis for clean claims
- Resubmit a claim with additional information
- Make a complaint or file an appeal with Avēsis on behalf of a member with the member's consent
- Inform a member of appeal status
- Question policies and/or procedures that Avēsis has implemented
- Request a prior authorization for services identified as requiring authorization
- Refer members to participating specialists for treatment that is outside your normal scope of practice
- Inquire about re-credentialing
- Update credentialing materials, including state licensure, DEA, and professional liability insurance
- Abide by the rules and regulations set forth under applicable provisions of state or federal law
- Inform Avēsis in writing within 24 hours of any revocation, suspension, and/or limitation of your practice, certification(s), and/or DEA license by any licensing or certification authority

As a member of the Avēsis provider network, you further understand that you and your vision office team are prohibited from:

- Discriminating against members based on race, color, creed, gender, national origin, ancestry, language, disability, age, religion, marital status, sexual orientation, health status, disease or pre-existing condition, mental or physical handicap, limited English proficiency, or being part of any other protected class. To

this end, you and your staff agree to comply with the Americans with Disabilities Act, the Rehabilitation Act of 1973, and all other applicable laws related to the same (see Title VI Civil Rights Act of 1964).

- Discriminating against qualified individuals with disabilities for employment purposes
- Discriminating against employees based on race, color, religion, sex, or national origin
- Offering or paying or accepting remuneration to or from other providers for the referral of members for services provided under the eye care program
- Referring members directly or indirectly to or soliciting from other providers for financial consideration
- Referring members to an independent laboratory, pharmacy, radiology, or other ancillary service in which you, your office, or your professional corporation has an ownership interest

Advance Directives

While we never expect that a patient will have an event during an office visit, there is always the possibility a medical emergency can occur. To ensure you are informed of your patient's desires, you should ask your patients for a copy of their advance directive during their patient onboarding process. An advance directive can include a living will or durable power of attorney for health care.

- You should retain a copy of the patient's advance directive in their medical record
- You should note in the patient's chart if the member informs you that their moral and/or religious beliefs that would stop them from making an advance directive

Member Rights and Responsibilities

Member Rights:

1. You have the right to respect, dignity, privacy, confidentiality, and nondiscrimination. That includes the right to:
    a. Be treated fairly and with respect.
    b. Know that your medical records and discussions with your providers will be kept private and confidential.
2. You have the right to a reasonable opportunity to choose a health care plan and primary care provider. This is the doctor or health care provider you will see most of the time and who will coordinate your care. You have the right to change to another plan or provider in a reasonably easy manner. That includes the right to:
    a. Be told how to choose and change your health plan and your primary care provider.
    b. Choose any health plan you want that is available in your area and choose your primary care provider from that plan.
    c. Change your primary care provider.
    d. Change your health plan without penalty.
    e. Be told how to change your health plan or your primary care provider.

3. You have the right to ask questions and get answers about anything you do not understand. That includes the right to:
    a. Have your provider explain your health care needs to you and talk to you about the different ways your health care problems can be treated.
    b. Be told why care or services were denied and not given.
4. You have the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:
    a. Work as part of a team with your provider in deciding what health care is best for you.
    b. Say yes or no to the care recommended by your provider.
5. You have the right to use each available complaint and appeal process through the managed care organization and through Medicaid, and get a timely response to complaints, appeals, and fair hearings. That includes the right to:
    a. Make a complaint to your health plan or to the state Medicaid program about your health care, your provider, or your health plan.
    b. Get a timely answer to your complaint.
    c. Use the plan's appeal process and be told how to use it.
    d. Ask for a fair hearing from the state Medicaid program and get information about how that process works.
6. You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:
    a. Have telephone access to a medical professional 24 hours a day, 7 days a week to get any emergency or urgent care you need.
    b. Get medical care in a timely manner.
    c. Be able to get in and out of a health care provider's office. This includes barrier free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act.
    d. Have interpreters, if needed, during appointments with your providers and when talking to your health plan. Interpreters include people who can speak in your native language, help someone with a disability, or help you understand the information.
    e. Be given information you can understand about your health plan rules, including the health care services you can get and how to get them.
7. You have the right to not be restrained or secluded when it is for someone else's convenience or is meant to force you to do something you do not want to do or is to punish you.
8. You have a right to know that doctors, hospitals, and others who care for you can advise you about your health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
9. You have a right to know that you are not responsible for paying for covered services. Doctors, hospitals, and others cannot require you to pay copayments or any other amounts for covered services.

Member Responsibilities:

1. You must learn and understand each right you have under the Medicaid program. That includes the responsibility to:
    a. Learn and understand your rights under the Medicaid program.
    b. Ask questions if you do not understand your rights.
    c. Learn what choices of health plans are available in your area.
2. You must abide by the health plan's and Medicaid's policies and procedures. That includes the responsibility to:
    a. Learn and follow your health plan's rules and Medicaid rules.
    b. Choose your health plan and a primary care provider quickly.
    c. Make any changes in your health plan and primary care provider in the ways established by Medicaid and by the health plan.
    d. Keep your scheduled appointments.
    e. Cancel appointments in advance when you cannot keep them.
    f. Always contact your primary care provider first for your non-emergency medical needs.
    g. Be sure you have approval from your primary care provider before going to a specialist.
    h. Understand when you should and should not go to the emergency room.
3. You must share information about your health with your primary care provider and learn about service and treatment options. That includes the responsibility to:
    a. Tell your primary care provider about your health.
    b. Talk to your providers about your health care needs and ask questions about the different ways your health care problems can be treated.
    c. Help your providers get your medical records.
4. You must be involved in decisions relating to service and treatment options, make personal choices, and take action to maintain your health. That includes the responsibility to:
    a. Work as a team with your provider in deciding what health care is best for you.
    b. Understand how the things you do can affect your health.
    c. Do the best you can to stay healthy.
    d. Treat providers and staff with respect.
    e. Talk to your provider about all of your medications.

CHIP Member Rights and Responsibilities

Member Rights:

1. You have a right to get accurate, easy-to-understand information to help you make good choices about your child's health plan, doctors, hospitals, and other providers.

2. Your health plan must tell you if they use a "limited provider network." This is a group of doctors and other providers who only refer patients to other doctors who are in the same group. “Limited provider network” means you cannot see all the doctors who are in your health plan. If your health plan uses "limited networks," you should check to see that your child's primary care provider and any specialist doctor you might like to see are part of the same "limited network."
3. You have a right to know how your doctors are paid. Some get a fixed payment no matter how often you visit. Others get paid based on the services they give to your child. You have a right to know about what those payments are and how they work.
4. You have a right to know how the health plan decides whether a service is covered or medically necessary. You have the right to know about the people in the health plan who decide those things.
5. You have a right to know the names of the hospitals and other providers in your health plan and their addresses.
6. You have a right to pick from a list of health care providers that is large enough so that your child can get the right kind of care when your child needs it.
7. If a doctor says your child has special health care needs or a disability, you may be able to use a specialist as your child's primary care provider. Ask your health plan about this.
8. Children who are diagnosed with special health care needs or a disability have the right to special care.
9. If your child has special medical problems, and the doctor your child is seeing leaves your health plan, your child may be able to continue seeing that doctor for three months, and the health plan must continue paying for those services. Ask your plan about how this works.
10. Your daughter has the right to see a participating obstetrician/gynecologist (OB/GYN) without a referral from her primary care provider and without first checking with your health plan. Ask your plan how this works. Some plans may make you pick an OB/GYN before seeing that doctor without a referral.
11. Your child has the right to emergency services if you reasonably believe your child's life is in danger, or that your child would be seriously hurt without getting treated right away. Coverage of emergencies is available without first checking with your health plan. You may have to pay a co-payment, depending on your income. Co-payments do not apply to CHIP Perinatal Members.
12. You have the right and responsibility to take part in all the choices about your child's health care.
13. You have the right to speak for your child in all treatment choices.
14. You have the right to get a second opinion from another doctor in your health plan about what kind of treatment your child needs.
15. You have the right to be treated fairly by your health plan, doctors, hospitals, and other providers.
16. You have the right to talk to your child's doctors and other providers in private, and to have your child's medical records kept private. You have the right to look over and copy your child's medical records and to ask for changes to those records.
17. You have the right to a fair and quick process for solving problems with your health plan and the plan's doctors, hospitals and others who provide services to your child. If your health plan says it will not pay for a covered service or benefit that your child's doctor thinks is medically necessary, you have a right to have another group, outside the health plan, tell you if they think your doctor or the health plan was right.

18. You have a right to know that doctors, hospitals, and others who care for your child can advise you about your child's health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
19. You have a right to know that you are only responsible for paying allowable co-payments for covered services. Doctors, hospitals, and others cannot require you to pay any other amounts for covered services.

Member Responsibilities:

You and your health plan both have an interest in seeing your child's health improve. You can help by assuming these responsibilities.

1. You must try to follow healthy habits. Encourage your child to stay away from tobacco and to eat a healthy diet.
2. You must become involved in the doctor's decisions about your child's treatments.
3. You must work together with your health plan's doctors and other providers to pick treatments for your child that you have all agreed upon.
4. If you have a disagreement with your health plan, you must try first to resolve it using the health plan's complaint process.
5. You must learn about what your health plan does and does not cover. Read your Member Handbook to understand how the rules work.
6. If you make an appointment for your child, you must try to get to the doctor's office on time. If you cannot keep the appointment, be sure to call and cancel it.
7. If your child has CHIP, you are responsible for paying your doctor and other providers co-payments that you owe them. If your child is getting CHIP Perinatal services, you will not have any co-payments for that child.
8. You must report misuse of CHIP or CHIP Perinatal services by health care providers, other members, or health plans.
9. Talk to your child's provider about all of your child's medications.

Standards of Participation

Avēsis requires that all providers participating in our programs meet any applicable state and federal laws and regulations. The following specifications must be met by all providers for participation in the Texas Medicaid routine and eye medical/surgical program:

- Current licensure by the appropriate licensing board for your specialty
- Contracting and credentialing with Avēsis
- NPI number issued through the CMS National Plan and National Plan and Provider Enumeration System (NPPES)
- Active Texas Medicaid Identification Number

Standards of Care

Avēsis abides by the American Academy of Ophthalmology Preferred Practice Patterns and/or the American Optometric Association Clinical Practice Guidelines. There is an expectation that our providers use all relevant training, knowledge, and expertise to provide the best care for each member.

Each Avēsis provider is expected to practice within the state-mandated standard of care for his/her specialty. Providers are required to practice within the scope of their licenses as established by the governing agency. Providers are expected to be aware of any applicable state and federal laws that impact their position as an employer, a business owner, and a healthcare professional.

Standards for Member Medical Records

Each member must have an individual record that is maintained at the eye care office. The record should meet the requirements defined in the Recordkeeping section of this manual. The records must be available for review by an Avēsis staff member during any facility review. If computerized, the records shall be non-changeable; however, the system shall permit adding to the original record. All files must be properly backed up for protection, in accordance with any applicable HIPAA requirements. The provider shall confirm that all records conform to applicable industry standards.

All services, tests, and procedures billed to Avēsis must be substantiated in the member's medical record. Services that are not documented or where the documentation is incomplete are not reimbursable. When those services, tests, and procedures are identified post-payment, the payment will be reversed.

Recordkeeping

Your office shall maintain confidential and complete member medical records and personal information as required by applicable state and federal laws and regulations. Avēsis requires that member records be maintained for at least 10 years.

Your records must be written in standard English, legible, and maintained in a current, comprehensive, and organized manner. Information that must be a part of the patient record includes:

- Administration documentation
  - Patient's identification number on all pages
  - Signed HIPAA confidentiality statement
  - Signed consent to permit Avēsis to access medical records upon request
  - Claims and billing records
  - The name and telephone number of the member's PCP
- Medical documentation
  - The original handwritten personal signature, initials, or electronic signature of practitioner performing the service, and initialed by the eye care provider, if s/he did not perform the service
  - Current health history
  - Complete medical history
  - Current prescription and non-prescription medications, including quantities and dosages

- Medication allergies and sensitivities, or reference “No Known Allergies” (NKA) to medications prominently on the record
- Any disorders and/or diseases
- Initial examination data
- Tobacco, alcohol, and substance use history for patients aged 14 and older
- A physical assessment, including member’s current complaint, if relevant
- Diagnosis that is reasonably based on the history and/or examination
- Documentation that problems from previous visits were addressed
- Treatment plan consistent with the diagnosis, signed by the provider and adult member or parent/guardian of minor member
- Progress notes
- Date for return or follow-up visit
- Copies of all authorizations or referrals
- Copies or notations regarding any drugs prescribed

In addition, the following significant conditions must be prominently noted in the chart:

- A health problem that requires pre-medication prior to treatment
- Current medications being taken that may contraindicate the use of other medications
- Infectious diseases that may endanger others

Amendments to protected health information shall be governed by the applicable HIPAA provisions of 45 CFR 164.

Confidentiality of Records

The confidentiality of member medical and billing records and personal information shall be maintained in accordance with all applicable federal and state law. You and your office shall not use any information received while providing services to members except as necessary for the proper discharge of your obligations as an Avēsis network provider. You and your office agree to comply with all the applicable federal requirements for privacy and security of health information as set forth in HIPAA and the American Recovery and Reinvestment Act of 2009.

Records Audit

You may be required to disclose member records as required by state law.

Avēsis has the right to request copies of a member’s complete record during the term of your provider agreement and up to 10 years after you leave the Avēsis provider network. In addition, member medical and billing records shall be subject to inspection, audit, or copying by the plan, the state Medicaid agency, the U.S. Department of Health and Human Services, CMS, and any other duly authorized representative of the state or federal government during normal business hours at your place of business.

Your office must provide a copy of the medical record to Avēsis at no charge to us.

Members have the right to request a copy of their records and amend or correct information contained therein.

Standards for Member Contact Information and Outreach

Each office shall maintain accurate contact information for each member 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 dictated by the state and/or the specific health plan. Emergency coverage shall be in keeping with the requirements established in the Avēsis Provider Agreement, by the member's specific vision plan, and as described within this manual. No charges shall be permitted for late or broken appointments.

Standards for Member Appointments

Each new member must have a thorough medical and eye health history documented in the chart. If, in the provider's professional judgment, treatment is required, the member must have a written treatment plan in the chart that clearly explains all necessary treatment. Parental consent must be received prior to the treatment of minors.

Missed Appointments

CMS does not allow a provider to bill for failed appointments. Doing so constitutes potential fraud.

Communication with your patients if they miss an appointment is a useful tool for building trust. We encourage providers to develop an office policy that applies to all patients equally—government-supported, commercial, and private pay—regarding (a) outreach following a missed appointment and (b) termination of a member following multiple missed appointments. Dismissal of a Medicaid patient from your practice may require the approval of the member's medical managed care plan or state Medicaid agency. We encourage providers to follow up with members who miss an appointment.

Standards for Infection Control

The eye care office shall follow all appropriate federal and state guidelines, including any from OSHA and the CDC that impact clinical practice. The office shall perform appropriate sterilization procedures on all instruments and hand pieces.

Appropriate disinfection procedures for all surfaces in the treatment areas shall be performed following each patient visit. Protective eyewear should be available for all healthcare personnel and patients. Members shall always be protected from all chemical and biological hazards.

Failure to use appropriate infection control procedures may result in the immediate suspension of the provider. The suspension shall remain in place from the time of notice of suspension until the provider has satisfactorily demonstrated compliance with infection control procedures.

Standards for Treatment Planning

All treatment plans must be recorded and presented to the member and, if the member is a minor, to the parent. The member must be given the opportunity to accept or reject the treatment recommendations, and the member's response must be recorded in the member's record.

Avēsis Provider Network

Avēsis seeks to support a geographically diverse, high-quality eye care network made up of vision health providers who:

- Are fully and actively licensed and certified
- Are appropriately insured
- Provide excellent care to all members

To accomplish these objectives, the Credentialing Committee is responsible for the development and implementation of a thorough and objective credentialing process. Providers accepted into the Avēsis network must undergo a thorough investigation to establish that they have the necessary skills and capabilities to deliver quality care. Avēsis also believes that it is important to periodically reconfirm that these providers continue to possess these capabilities through a re-credentialing process.

Support for the Avēsis provider network is provided by our clinical staff, including the Vice President of Vision Services, Medical Director, and vision consultants.

Quality

To ensure that the highest quality services are consistently provided to our members and that providers continue to perform only those services that are necessary for the welfare of the members, Avēsis maintains an approach to quality that includes three components:

- Quality standards
- Quality assurance
- Utilization review

We welcome participation from you and other network providers who seek to review and/or contribute to either of these efforts.

Participating network providers are expected to agree, respond to, and/or otherwise comply with Avēsis' Quality Improvement Program as it relates to quality assurance, utilization review, and member grievances. Network providers may also be subject to the quality assurance, utilization review, and grievance programs of the health plan for which Avēsis provides benefit administration.

Avēsis conducts quarterly Provider Satisfaction Surveys. The results from the surveys are important to Avēsis, as this is our primary method used to identify improvement areas pertaining to the Avēsis Provider Network. Participating providers that receive a survey by email, postcard or portal alert, are expected to complete and return all surveys.

Quality Assurance Program

Avēsis' primary quality assurance goals are to provide enrollees access to high-quality eye care services that meet industry standards of care and to perform all necessary administrative services associated with the vision programs. Avēsis operates a Quality Assurance Program (QAP) to facilitate these goals as they pertain to quality-related issues.

The Avēsis QAP includes the following components to monitor the quality of care rendered through our eye care programs:

- New provider credentialing
- Provider re-credentialing
- Ongoing monitoring
- Provider site reviews
- Maintenance of the collection of provider credentialing documents that comply with NCQA credentialing standards

- Member complaint resolution
- Member satisfaction surveys
- Provider complaint resolution
- Provider satisfaction surveys
- Provider corrective action
- Service delivery studies (i.e., office reviews, performance report cards, etc.)
- Utilization review/utilization management
- Review of staff/internal corrective action plans (CAPs)
- QAP Evaluation

These efforts are complemented by the development of quality initiative programs and plans to constantly increase and improve the quality of our services.

Avēsis has also established indicators regarding the clinical aspects of care delivered by our participating network providers. These include:

- Quality of care
- Access and availability
- Utilization management
- Complaints, appeals, and grievances statistics
- Customer/member services

The QAP is reviewed and updated annually by the Avēsis Quality Oversight Committee. The Committee is composed of senior staff of Avēsis and clinical staff, including the Vice President of Vision Services and Medical Director. Members of each state's Optometric/Ophthalmologic Advisory Board are also permitted to participate.

Avēsis Optometric/Ophthalmologic Advisory Board

Avēsis welcomes involvement from the eye care professionals who participate in our network. To provide opportunities for feedback from the local eye care communities, Avēsis has established Optometric/Ophthalmologic Advisory Boards for the states and markets where we arrange for services.

The Optometric/Ophthalmologic Advisory Board is composed of volunteer providers from the specific state or market and the Vice President of Vision Services and other Avēsis clinical staff. Board responsibilities include:

- Establishing lines of communication between Avēsis and the provider stakeholder communities
- Facilitating access to the local provider network for Avēsis' recruitment staff
- Educating Avēsis on market specific considerations
- Elevating care delivery and/or operating issues that are affecting the local provider community
- Understanding, providing feedback and/or recommending network related policy or procedural changes
- Incorporating plan feedback into network provider relations.

Avēsis values feedback from local providers in informing the customization of materials and policies to meet the eye care needs of the community. The Board may also be provided copies of provider communications for review and comment prior to distribution to the provider communication at-large. Meetings are typically held quarterly but frequency may vary as dictated by the needs of the state/market.

Office Accessibility

Services shall be provided to members in a timely manner and in accordance with your facility's routine practice pattern, with reasonable wait times for appointments for routine care, urgent care, and emergency care. In lieu of submitting quarterly reports stating average wait times for members, we will randomly telephone your facility to inquire about wait times; these calls may be anonymous.

After-hours Accessibility

On weekends, after hours, or during holidays, you and your office must have a means of being contacted by members or their authorized representatives (like a parent/guardian). This contact may be an answering service, phone machine, or voice mail directing the member to contact a cell or other phone or another method of reaching a person. Whichever means you choose, it must be checked regularly by your or your designee during hours when your office is closed, to ensure members have access to you or your office in the event of an emergency.

Emergency Care

Providers are responsible for facilitating emergency treatment, as needed. An eye medical emergency is a situation where the member has or believes there is a current, acute crisis involving the eye(s) that could be detrimental to his/her health if not treated promptly.

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

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

Waiver of Prior Authorization for Emergencies

Avēsis shall permit treatment of all eye care services necessary to address an eye emergency for a member without prior authorization. When a request is submitted for a post review and the services have already been provided, providers can submit a retrospective review for a medical necessity. Providers have 60 days from the date of service to submit a retrospective review. Retrospective reviews are accepted in any of the following three formats:

- Avēsis secure web portal
  avesis.com

- Fax to Utilization Management
  1-443-738-9686

- Avēsis Prior Authorization Form via first class mail
  Avēsis Third Party Administrators, LLC
  Attention: Vision UM
  P.O. Box 38300
  Phoenix, AZ 85069-8300

Referrals

There may be times when a member's care may be better served by another eye care provider. This typically happens when specialist care is needed or when timeliness is a factor.

Should you require assistance identifying a participating eye care specialist or sub-specialist for a referral, please call the Avēsis Member Services Department at 866-563-3591 for HEALTH*first* members or KIDS*first* members. Member Services are available from 8:00 a.m. to 5:00 p.m. (CST), Monday-Friday.

Locum Tenens

Locum tenens arrangements are made when one provider temporarily replaces another for a period not to exceed 60 continuous days in any 12-month period. During this time, the Avēsis participating provider can submit claims to receive payment for the covered services provided by the locum tenens provider. A completed Locum Tenens form must be submitted in advance to Avēsis whenever possible. Please visit **avesis.com** for a copy.

IMPORTANT: Providers should make their best effort to complete and submit the Locum Tenens form to Avēsis prior to the locum tenens provider rendering services to Avēsis members.

Indiscriminate billing under one provider's name or provider number is strictly prohibited and will be grounds for immediate termination and recoupment of all funds paid for services rendered under the incorrect provider number. 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.

Note: If a locum tenens is used due to the incapacitation or death of a participating provider, then the letter must be signed by the executor of the estate. At no time is a locum tenens allowed to be used for a non-credentialed provider that will be practicing at the office for more than 60 continuous days.

Clinical Coordination

Eye health is an essential component of overall health. In many cases, the provision of good eye health may require coordination between eyecare providers and their patient's primary care physicians or facilities. It is important that your members' medical records include any detail about health conditions that may impact their eye health, along with the names and contact information for your members' primary physician and/or facility. This information will help you communicate with your members' treatment teams in the event of a medical issue that impacts their eye health. You might also have occasion to reach out to a member's primary care team if your care identifies potential medical concerns that might be better addressed outside of the eyecare office.

Patient Outreach

The CMS comprehensive and preventive child health program for individuals under the age of 21 is called Early and Periodic Screening, Diagnostic, and Treatment (EPSDT). EPSDT requires that every Avēsis network provider has documented member outreach policy and procedures to help ensure that members receive eye health services on a regular schedule. CMS specifically requires the following:

- For members of record (under age 21): Providers must attempt to make contact at least two times per year.
- For adult members of record (age 21 and over): Providers must attempt to make contact at least one time per year.

The outreach attempts must be documented in the member's medical record. Avēsis may request to see a record of the attempts during site visits.

Pregnant Women

Under CMS rules, women who are pregnant and lack insurance coverage, may be eligible for limited coverage

under Medicaid. This coverage typically begins on the date pregnancy is verified and ends the date of delivery. Coverage typically includes routine eye care benefits for their age category (under 21 or over 21).

Patients with Special Needs

Certain patients with special needs require additional consideration for treatment. Some patients with special needs may be able to be treated in an eye care office, while others may not. If you have a member with special needs who cannot be treated in your office, please reach out to a pediatric eye care provider or an eye care provider who routinely treats patients with special needs to discuss potential transfer of care.

If your office can treat patients with special needs, please be sure to document the names and contact information for people who are authorized to give permission for treatment for the member, if relevant.

EPSDT (Early and Periodic Screening, Diagnostic, and Treatment)

EPSDT is medical assistance's comprehensive and preventive child health program for individuals under the age of 21. EPSDT was defined by law as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA '89) legislation and includes periodic screening, vision, dental, and hearing services. In addition, Section 1905(r)(5) of the Social Security Act (the Act) requires that any medically necessary healthcare service listed at Section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the state's plan to the rest of the medical assistance population. The EPSDT program consists of two mutually supportive, operational components:

- Assuring the availability and accessibility of required healthcare resources
- Helping medical assistance recipients and their parents or guardians effectively use these resources

These components enable medical assistance agencies to:

- Manage a comprehensive child health program of prevention and treatment
- Seek out eligible patients and inform them of the benefits of prevention and the health services and assistance available and to help them and their families use health resources, including their own talents and knowledge, effectively and efficiently
- Assess the child's health needs through initial and periodic examinations and evaluations
- Assure that the health problems found are diagnosed and treated early, before they become more complex and their treatment costlier

If a provider is unable to conduct the necessary EPSDT screens for members under age 21, they are responsible for making a referral. All relevant medical information, including the results of the EPSDT screens, is to be incorporated into the member's primary medical record.

Sentinel Events and Adverse Incidents

If a sentinel event (an unexpected, non-traumatic occurrence that causes a member's death) or an adverse incident (serious incident, therapeutic misadventure, iatrogenic injuries, or other adverse occurrences directly associated with care or service provided) occurs, you must report this to Avēsis immediately using the Provider Customer Service number provided herein.

Enrollment in Medicaid Programs

No eligible member shall be refused enrollment or re-enrollment, have enrollment terminated, or be discriminated against in any way because of health status or pre-existing physical or mental condition—including pregnancy, hospitalization, or the need for frequent or high-cost care.

Eligibility Verification and Eligibility Effective Date

The Texas Department of State Health Services determines eligibility for the Medicaid Programs. Payment for services rendered is based on eligibility and benefit entitlement. The contractual agreement between providers and Avēsis places the responsibility for eligibility verification on the provider of services.

Providers should verify enrollment with Avēsis. Eligibility can be verified 24 hours a day, 7 days a week for any member by calling our IVR or checking on the secure Avēsis website at avesis.com Possession of a Medicaid ID Card does not guarantee eligibility. A provider should verify a recipient's eligibility each time the recipient receives services. Members are reminded in their member handbooks to carry ID cards with them when requesting medical, vision, or pharmacy services. It is important that the provider verify eligibility prior to rendering services to any member. Unless an emergency condition exists, providers may not refuse service if the member cannot produce the proper identification and eligibility cards.

Each person approved for Medicaid benefits gets a Your Texas Benefits Medicaid card. However, having a card does not always mean the patient has current Medicaid coverage. Providers should verify the patient's eligibility for the date of service prior to services being rendered. There are two ways to do this:

- Use TexMedConnect on the TMHP website at **www.tmhp.com**
- Call Provider Customer Service at the patient's medical plan

Important: Members can request a new card by calling Parkland Community Health Plan Call Center at 888-672-2277 for HEALTH*first* or 888-814-2352 for KIDS*first*. Members also can go online to order new cards or print temporary cards at **www.YourTexasBenefits.com** and see their benefit and case information, view Texas Health Steps Alerts, and more.

Important: Providers should request and keep hard copies of any Medicaid Eligibility Verification (Form H1027) submitted by clients. A copy is required during the appeal process if the client's eligibility becomes an issue.

To apply to become a provider for Texas Medicaid, register and create a login on the Texas Department of State Health Services website.

Credentialing and Re-Credentialing

All providers participating in the Avēsis provider network must have met basic eligibility criteria established by Avēsis and in accordance with National Committee for Quality Assurance (NCQA) guidelines. Prior to receiving the countersigned agreements and your provider identification numbers, the applications and credentials were approved by the Avēsis Credentialing Committee. To maintain participation in the Avēsis provider network, all providers are required to re-credential at least every 36 months.

Note: Providers may not service any Avēsis members until notification of approval is received. Included with the notice will be the provider PIN, which is used to create a username to log into the provider portal. Once a provider has received the written notice, members can be seen, and claims can be submitted online at **avesis.com**.

Credentialing Requirements

Eye care providers are enrolled in our provider network if they:

- Continuously meet the Avēsis credentialing standards based upon the National Committee for Quality Assurance (NCQA) guidelines, as applicable

- Agree to adhere to the administrative procedures of both Avēsis and its partners (e.g., Health Maintenance Organizations [HMO] and insurance companies)

Credentialing Details

Avēsis requires that all providers who apply for participation meet basic credentialing and contracting standards. At a minimum, these include, but are not limited to, the following:

- Signed Provider Agreement and any plan-specific Addendum
- Completed, signed, and dated W-9
- CAQH Number, State-mandated application, if applicable, or an Avēsis provider application with a current signature, attestation, and consent release signed within the most recent 90 days
- Copy of all professional state licenses
- Copy of the active DEA/CDS registration certificate, if applicable
- Current professional liability Insurance coverage with limits of a minimum of $1M/$3M National Provider Identification (NPI-1) number
- Evidence of Board Certification, if applicable
- Complete professional work history for the past five years at a minimum, with all gaps in employment explained in writing

Upon receipt of an initial network application, the Avēsis Credentialing Department will mail the provider a letter confirming receipt of the application.

In the submission, all gaps must be explained, all attestation questions must be completed, a Credentials Release of Verification must be included, and all affirmative responses must include a written explanation.

Avēsis performs primary source verification using NCQA-approved sources. We complete a credentialing checklist for each provider. For each element, this includes:

- Source used
- Date of verification
- Signature or initials of the person who verified the information
- Report date, if applicable

After the primary source verifications are completed, the provider's credentialing file is presented to the Avēsis Credentialing Committee for review. Avēsis will provide written notification to the provider within 60 calendar days of the Committee's decision.

Both the credentialing and re-credentialing processes include the review of the exclusions list produced by the Office of Inspector General (OIG), Government Services Administration, and other state and federal bodies. Providers appearing on one of these lists MAY NOT participate in any government program (i.e., Medicaid and Medicare).

If a provider is excluded from our network, a copy of the report will be placed in the provider's file.

Incomplete Submissions

Within five business days of receipt of an incomplete application, we will contact your office by phone, fax, or email to discuss and request the missing information. This request will include the name and contact information

for the Avēsis Credentialing Specialist making the request. It will also specify that the missing information be supplied within five business days.

Review of the application is suspended until all information is received.

Correcting Information in Your Network Enrollment Package

If the information is received from the Credentials Verification Organization (CVO) or through other source verification that is materially different from that supplied by the provider in the application, the provider will be notified within five business days and given an opportunity to review and modify the information. We will continuously attempt to secure the requested information. On credentialing applications, we will typically halt work if we cannot secure the requested materials by day 30. On re-credentialing applications, we will halt work if we cannot secure requested materials within 90 days of the initial request.

Re-Credentialing Details

Providers must show they:

- Satisfy the Avēsis credentialing requirements met during the time of initial credentialing (Avēsis confirms this by completing primary source verification on each application element except verification of education)
- Are not listed in any claim or utilization files indicating a pattern of inappropriate billing or utilization
- Are free of any substantiated member complaints regarding quality of care or quality of service issues
- Remain in good standing with federal and state regulatory bodies

If a provider does not satisfy one or more of these criteria, our Credentialing team flags the provider for a detailed review. The Credentialing Committee will determine if the issues rise to a level of concern that disqualifies the provider from treating Avēsis members and vote to terminate the provider from the network.

Credentialing Timelines

Applications for credentialing and re-credentialing must be processed and either approved or denied within the timeframe specified by the state authority from the date of receipt of all required information. Providers who are accepted into the Avēsis network during initial credentialing will receive confirmation letters within 15 business days from their acceptance date.

Credentialing Denials

If a provider's application for credentialing or re-credentialing is denied, the Credentialing Committee will notify the provider in writing within 15 business days from the date of the committee meeting. Included in the letter shall be the reason for the denial along with information on how the provider may appeal the Credentialing Committee's decision.

A provider may be denied acceptance into the network for two reasons:

- Provider has not supplied all the required information and signatures
- Provider has not met established criteria

The provider's denial letter will note the specific reasons for the denial and the criteria Avēsis used. In addition, providers with multiple disciplinary actions, with National Practitioner Data Base (NPDB) reports, or whose licenses are on probation may be denied at the discretion of the Committee and upon recommendation by the Vice President of Vision Services or Medical Director.

Credentialing Denial Appeals Process

When a denial of an application for credentialing or re-credentialing is sent to a provider, it will include notification that the provider may appeal the denial by sending a letter to the Vice President of Vision Services or Medical Director.

The written appeal must contain an explanation of why the provider meets the requirement or, if the provider doesn't meet the requirement, what steps they have taken to address meeting the requirement. If the provider does not meet the requirement, s/he must demonstrate how quality of care will still be ensured.

The provider has the right to review any information submitted in support of the credentialing information except for information that is protected by peer review or law. All requests to review information must be made in writing and directed to the Credentialing Department. The provider will be notified of this right in the denial or termination letter. Copies of the information will be sent within 30 days of a written request signed by the provider. The provider has the right to correct erroneous information with the primary source from which it was obtained. The provider must notify Avēsis in writing that the erroneous information has been corrected within 30 days of receipt of the denial or termination letter and may request that their appeal be suspended until the corrected information is received. The provider shall be notified of this right in the denial or termination letter. The primary source may require the provider to work with them directly to correct the misinformation.

A response to the provider must be sent within 30 days of receiving the appeal. It may request additional information, uphold the denial, or grant an exception. Any action on the appeal and the date are noted on the file. Any decision to accept the provider must be made within the credentialing time frames established, or the provider must resubmit the application.

Delegated Credentialing

Typically, Avēsis performs the primary credentialing functions, but on occasion, we delegate all or portions of credentialing to another group or entity. At a minimum, a delegated entity must meet the requirements for credentialing and re-credentialing outlined in the full Avēsis credentialing policies and procedures in addition to the relevant requirements of NCQA and our health plan partners. Avēsis retains the right to deny or terminate network participation to any provider covered by a delegated credentialing arrangement.

Before accepting a group for delegated credentialing, we perform a pre-delegation review to ensure that group complies with Avēsis credentialing criteria. The review includes:

- A complete Delegated Credentialing Intake Form
- Verification that the group does not sub-delegate any credentialing or re-credentialing functions
- Proof that the group's credentialing policies are reviewed annually and updated as necessary
- Proof of the group's NCQA, URAC, or Joint Commission Credentials Verification Organization Accreditation or Certification
- Successful completion of a pre-delegation audit by Avēsis

Once approved by the Avēsis Credentialing Committee, the delegated credentialing group can perform the following credentialing activities for Avēsis:

- Collection of the applicable provider application, including original signature and attestation
- Completion of primary source verification of the following data elements:
    - Unrestricted state licensure, including all states provider holds a valid license
    - Valid anesthesia permit, if applicable

- Current DEA or CDS certificate
- Education and training
- Work history, all gaps explained
- Valid malpractice insurance
- Clean malpractice history for past 10 years
- No record of appearing on the social security death master file
- Confirmation national practitioner identifier (NPI-1) and taxonomy code are compatible
- No federal and state sanctions or exclusions

The group that has been accepted as a credentialing delegate performs no other credentialing activities for Avēsis outside of this list.

Post-Credentialing

Participating providers agree to bill Avēsis for only those services rendered by them personally, or under their direct supervision by salaried employees or assistants duly certified pursuant to state law. 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 that the enrolled provider must be present in the same room; however, the enrolled provider must be present at the site where services are rendered, at the time they are performed (e.g., office suite, hospital, or clinic).

Note: Under no circumstances may a provider bill for services rendered by another provider. Services performed by non-credentialed providers in a group practice are not covered. Services performed by locum tenens will be covered when Avēsis is notified by the provider of the locum tenens situation.

Provider Data Maintenance

Upon acceptance into the network, authorized data entry personnel enter all your application and relevant practice information into the appropriate system(s). Documents associated with the application will be maintained in your file with the most current information on top; this data shall be retained securely. In lieu of retaining your paperwork, scanned images may be saved to your folder on the secure, internal Avēsis network. All records shall be retained for a minimum of 10 years following termination of the provider from the network.

Documentation stored on file includes:

- Completed Provider Agreement
- Completed provider application
- Credentialing Committee approval form
- CVO report form, if applicable
- Verification documents
- Copies of provider's credentials and certificate(s)
- Certificate of Insurance and any reports regarding claims against the provider
- Information regarding any sanctions or suits against the provider
- Disclosure of ownership form, if applicable

Updating Information

Participating providers agree to notify Avēsis in writing and in advance, whenever possible, of any changes in participation status or practice information, including but not limited to: new address, new contact information, new phone number, additional practice location, provider retirement, or change in payee.

Any change to the Taxpayer Identification Number (TIN) or payee information must be submitted on a new, signed and dated W-9. Providers should make every effort to notify Avēsis of any change in participation status by reporting to the Avēsis Network Provider Information Department a minimum of 10 business days in advance of the effective date of the change. Please visit **avesis.com** for a copy of the update form.

Verifying Eligibility

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

Avēsis Secure Website

- Go to **avesis.com**
- Enter your username and password to log into the secure provider portal
- Click “Eligibility Search” from the home screen or select “Member Search” within the Eligibility tab on the blue navigation bar
- Enter any of the following information:
    - Member’s ID in the Member Number field
    - Member’s first name, last name, and date of birth into the First Name, Last Name, and Date of Birth fields
    - Member’s Social Security Number (SSN) and date of birth into the SSN and Date of Birth fields
- Receive a real-time response

Avēsis Provider Customer Service

- Call Avēsis Provider Customer Service using the phone number listed in the Quick Reference Guide
- Member eligibility along with other benefit information is available through the Interactive Voice Response (IVR)
- Member identification number and date of birth and provider NPI is needed; if unable to validate NPI, Taxpayer Identification Number (TIN) can be used

Provider and Practice Support Tools

The strength of our service depends on the strength of the support we provide to you and your office. The two primary ways we support your office are:

- Delivering a secure web portal for managing administrative tasks and sharing important information
- Providing educational resources and programming to you and your office staff

Provider Portal

The Avēsis provider portal is a secure tool for information entry and retrieval allowing for communication between your office and internal Avēsis operations departments. With the portal, you and your staff can:

- Communicate through alerts/announcements, archived messages, and electronic mail
- Search member eligibility
- Submit, modify, and void claims electronically
- Search remittance advice and explanation of benefits information
- Browse our comprehensive knowledge center
- Access all documents associated with Avēsis business

Forms available through the portal include:

- Locum Tenens
- EFT
- Avēsis Provider Update Form
- Non-Disclosure Form
- Eligibility Fax

Provider Educational Programming

The goals of the Avēsis provider education program are to furnish program information to contracted providers to support member access to eye care services, and to support the Avēsis Quality Assurance Program.

Our provider educational programming starts with the welcome call and welcome visit we conduct with each new provider office. During our welcome visit, we orient the providers and their office staff to the use of the secure portal, offer education on key processes like claims submission and eligibility verification, and help the office bookmark the location of important forms. We might also walk through the office facility to identify resources the office may need to effectively service our members.

We also regularly deliver education and information on topics such as utilization management and utilization review protocols, understanding the covered benefits available to members through their health plan, preventing or mitigating claims submission issues, quality data and quality processes, revisions to company policies and procedures, cultural competency, and preventing and reporting fraud, waste, and abuse.

Educational programming may be delivered in myriad ways, including:

- Provider newsletter
- Online education programming through the secure provider portal on the Avēsis website
- Regional provider education meetings, as necessary in the office or over the phone

Claims, Billing and Payment

Eligibility verification is not a guarantee of payment. Benefits are determined at the time that the claim is processed.

Clean Claims

A clean claim contains the following:

- Subscriber's/patient's plan ID number
- Patient's name, date of birth, and gender
- Subscriber's name
- Patient's address (street or P.O. Box, City, ZIP)
- Patient's relationship to subscriber
- Subscriber's address (street or P.O. Box, City, ZIP)
- Subscriber's policy number
- ubscriber's birthdate and gender
- Health plan name
- Disclosure of any other health benefit plans
- Patient's or authorized person's signature or notation that the signature is on file with the provider
- Subscriber's or authorized person's signature or notation that the signature is on file with the provider
- Date of current illness, injury, or pregnancy
- First date of previous, same, or similar illness
- Name of Referring provider, if applicable
- Referring provider NPI Number, if applicable
- (All applicable) Diagnosis codes or nature of illness or injury
- Date(s) of service
- Place of service codes
- Procedure/modifier code
- Diagnosis by specific service
- Charge for each listed service
- Number of days or units
- Rendering provider's NPI number
- Provider's federal TIN
- Total charge(s)
- Signature of provider who rendered service, including indication of professional license (e.g., MD, LCSW, etc.)
- Name and address of office or facility where services were rendered
- The service facility Type 2 NPI

- Provider's billing name and address
- Billing Type 2 NPI number

The claim must be accompanied by all necessary documentation.

Note: Missing or incorrect information will cause either a delay or non-payment of a claim.

Note: Claims being investigated for fraud, waste, and abuse or pending medical necessity review are not considered clean claims.

Timely Filing Deadlines

Timely filing guidelines will be strictly adhered to. Claims received after the filing deadline will be denied. There are no exceptions. The following deadlines will be adhered to unless specified per state/federal guidelines:

Action	Timeline to File Claim
Provider to file a claim	95 calendar days from the date of service
Provider to appeal a claim	120 calendar days from the explanation of benefits
Provider to correct a claim	120 calendar days from the explanation of benefits
Coordination of Benefits	95 calendar days from the primary payer's remittance advice

Claim Submission

All clean claims submitted will be processed and, when appropriate, paid according to the Avēsis Texas Medicaid and CHIP Fee Schedules. Each claim must include the appropriate line item with your charges and applicable codes.

Claims must be received within 95 calendar days from the date of service. Submit a clean claim form or file electronically after services and materials have been provided. Missing or incorrect information will cause delays in the processing of your claim. Any and all applicable member co-payments will be deducted from billed amounts.

Claims may be submitted in one of the following three formats:

- Avēsis secure web portal
  avesis.com
- Through your practice management software using a clearinghouse
  - Change Healthcare
    Payer ID 87098
    www.changehealthcare.com
    866-371-9066
  - TriZetto
    Payer ID 87098
    www.trizettoprovider.com
    800-556-2231
- CMS-1500 form via first class mail to:
  Avēsis Third Party Administrators, LLC
  Attn: Eye Care Claims

P.O. Box 38300
Phoenix, AZ 85069-8300

Eye Medical/Surgical Procedures and Services

Eye medical/surgical procedures are covered when medically necessary and rendered by a Provider duly licensed to practice his/her profession in Texas and eligible to participate in the Texas Medicaid Program.

Claim Status

Providers may check status of a submitted claim at avesis.com Providers are encouraged to follow up on claims submissions within 30 calendar days after claim submission. If the claim has not been received, providers should contact Avēsis. Claims being investigated for possible fraud, waste,
or abuse or those pending medical necessity review are not clean claims.

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

Claims Payment

Avēsis is committed to processing all clean claims within 30 days as defined by state or federal regulations. Providers shall use the appropriate procedure codes for services provided to the member when billing Avēsis. Eye care services provided to members are reimbursed per the Avēsis Medicaid fee schedule. The allowable amount is indicated within the fee schedule as:

- The provider's actual cost (including discounts) from the provider's supplier
- The maximum allowable dollar amount
- The reasonable charge for the procedure as determined by Avēsis

Providers are encouraged to visit **avesis.com** to access the current fee schedule.

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

Lesser of Billed Charges or Fee Schedule

Avēsis pays a provider the lesser of the provider’s billed charge or the amount on the appropriate fee schedule.

Corrected or Voided Claims

Providers have a right to correct claim information that may have been submitted incorrectly. A corrected claim must be resubmitted within 120 calendar days from date of the explanation of benefits. Corrected claims may be submitted via the secure provider portal on our website or by mail. If filing by mail, the following needs to be added to the claim to ensure proper handling within the Claims Department:

- Mark CORRECTED CLAIM at the top of the CMS-1500 form
- The original claim number must be included within the remarks section of the CMS 1500 form

Corrected claims must be submitted to Avēsis by first class mail to:

Avēsis Third Party Administrators, LLC
Attn: Corrected Vision Claims
P.O. Box 38300
Phoenix, AZ 85069-8300

IMPORTANT: Avēsis reserves the right to deny payment of a claim if the provider fails to apply third-party payments, to file necessary claims, or to cooperate in matters necessary to secure payment by the third party.

Receiving Payment

Avēsis providers are eligible to receive payments from Avēsis via paper check, Electronic Funds Transfer (EFT) or Zelis® payments. Using electronic options allows your office to have complete control of your electronic payment, which eliminates the possibility of misplaced checks and aids in maintaining positive cash flow.

Electronic Funds Transfer (EFT)

EFT payments are deposited into an account designated by you. This account is funded once weekly based on services rendered. The remittance advice will be mailed to the address of record in your file weekly and can be viewed on our website. If you wish to elect to have funds electronically deposited, a completed EFT form must be faxed to Avēsis. A voided check must accompany this request.

Please see the Forms and Documents section of this manual or visit **avesis.com** to find a copy of the Avēsis EFT form.

Zelis® Payments

Zelis® payments are deposited into an account designated by your office. Zelis® payments allows secure ePayment options, as a replacement for mailed hard copy checks and explanation of payments. To update payment and remittance delivery methods, or notification options, please call Zelis® Payments Client Service at 877-828-8770 or visit ZelisPayments.com.

Explanation of Payment (EOP)

An EOP is issued with every check/EFT/Zelis® payment. Each EOP includes all the processed claims associated with the payment being made. It will also include any claim that has previously been submitted and where an adjustment has been made, if applicable. Providers have the option to receive electronic payments and remittances through EDI 835. In addition, the EOP can be viewed within one business day of payment on the secure provider portal at avesis.com

Overpayment

There may be times when you or your practice are overpaid for a service provided to a member. There are two ways to return overpayment to Avēsis:

- Sending a check or money order: If you elect to send a check or money order, you must do so within 45 calendar days of receiving notification of the overpayment. The check must be made out to Avēsis and mailed to P.O. Box 38300, Phoenix, AZ 85069-8300. The check or money order must be accompanied by all COB documentation.
- Recoupment: Recoupment refers to the withholding of all or a portion of a future payment until an overpayment refund obligation is met. If no check or money order is received within 45 calendar days of notification of an overpayment, Avēsis will initiate the recoupment process with your practice. You will be notified in writing.

Member Billing

A member shall not be billed for covered benefits denied by Avēsis except where the denial is for covered benefits, the denial was based upon our finding that the services are not medically necessary, and the member still desires to receive the services. In these cases, there must be a Non-Covered Services Disclosure form on file, indicating the member understands that the service or procedure will not be covered by this insurance and that s/he will be

liable for payment.

Any charges to members shall not exceed your office's usual and customary fee for that product or service.

If the member will be subject to collection action upon failure to make the required payment, the terms of said action must be kept in the member's record.

Failure to comply with this procedure will subject you or your office to sanctions up to and including termination from the Avēsis network.

Coordination of Benefits

Avēsis follows guidelines established by the National Association of Insurance Commissioners (NAIC) for determining primary and secondary coverage. These guidelines state that Medicaid should always be the payer of last resort.

If a member seen in your office has additional insurance coverage, all claims must be filed with the other insurance company prior to filing any claim to Avēsis.

If the primary payer pays less than the fee listed on the applicable fee schedule for a procedure, a secondary claim can be sent to Avēsis for the balance. The EOB from the primary payer must be included with the secondary claim submission. If the EOB is not received with the claim, the claim will be denied.

If the claim is considered clean, the remaining charges will be reimbursed up to the maximum allowed for that procedure as noted on the fee schedule.

If it is later determined that a member has other insurance coverage and a claim was processed without the primary EOB, the office will receive an overpayment request letter. This letter will require that the overpayment is satisfied by check or Avēsis will recoup the overpayment from a future claim payment.

Note: You must enclose the remittance advice from the primary payer. Avēsis must receive the claim within 95 calendar days of the date of the primary payer's remittance advice.

Utilization Management (UM)

The goals and objectives of the Avēsis UM program include:

- Analysis, review, and integration of national, state, and HMO/health plan client goals and initiatives
- Provision of proactive and superior service to all customers
- Provision of information to providers, health plan clients, and members regarding their benefits
- Review of methodologies to streamline the authorization process
- Assurance of adherence to existing health plan standards and existing HIPAA, HITECH, and other rules and guidelines

The UM program is reviewed annually by the Quality Oversight Committee. This process sets and/or affirms the standards and benchmarks for reviewing the utilization patterns of our participating network providers.

The UM Committee reviews claims submission patterns, requests for prior authorization, medical records, and utilization patterns. If potential aberrant billing practices are detected or if other potentially negative processes are uncovered, Avēsis' personnel will speak or meet with a provider to address the problem and help develop a program to resolve the issue. Corrective action plans (CAPs) may be developed for individual provider offices, as required. When the results indicate a potentially negative situation such as up-coding on a routine basis, an audit

process may be initiated. The process may include chart audits and could result in: a) the provider receiving the necessary education to adjust the practice pattern to be within acceptable norms; b) placement of the provider(s) on post-service, prepayment review to confirm appropriate billing; c) placement of the provider(s) on a pre-authorization corrective action plan to ensure proposed services are appropriate; and/or d) recoupment of the overpayment related to the aberrant billing practice(s).

Wait Time Review

In lieu of requiring providers to submit an average wait time report, Avēsis will perform random and anonymous surveys of practices to inquire whether scheduling wait times are excessive.

Providers found to have excessive wait times will be notified that they did not meet wait time standards. Their office will be randomly tested during the next survey cycle. If they do not meet wait time standards the second time, they will receive a call from Provider Relations. During this call, the Provider Relations Representative will work with the office to try to understand the root cause of the wait time issues so they can be addressed. If the provider's office fails a third wait time review survey, a Provider Relations Representative will visit the office to provide one-on-one education about the wait time standards and to try additional ideas for addressing the issue. At this time, Avēsis will need to contact the health plan sponsor or state Medicaid agency.

If a member complains that wait times in a provider's office were excessive, Avēsis is required to notify the provider about the complaint. Typically, this comes through our complaints and grievances process. Our provider relations team may be engaged to do one-on-one education with the provider officer.

Site Reviews

Site reviews will be performed by Avēsis staff to confirm that providers are following mandated practices as established by OSHA, HIPAA, and any relevant state or federal agencies that has rules and/or regulations that impact a provider's office. The key areas that are reviewed during an office review include:

- Office signs and visibility
- Handicapped patient access
- Cleanliness of office
- Appointments and accessibility
- Accessibility of medical emergency kit
- Members' records
- Patient privacy practices
- Infection control practices (e.g., spore testing)
- Equipment inspection
- Staff lists and credentials

A formal site review form is used to help ensure the consistency of the office review process. Offices are evaluated based on the results of the site review and will have the results communicated to them in writing within 30 business days of the review.

If the office fails to earn a satisfactory score, the review will be repeated in 90 to 120 business days or as otherwise designated from the initial review. Consequences for not achieving a satisfactory site review include being placed on a CAP, being placed on probation, or being terminated from the network in accordance with the termination clause in the Provider Agreement.

Inter-Rater Reliability

Avēsis conducts inter-rater reliability (IRR) studies to help ensure the vision consultants who perform our prior authorization and post-treatment review requests are consistently applying relevant clinical criteria to their decision-making.

Facilitated by the Vice President of Vision Services and Medical Director, this process involves the review of clinical prior authorization requests from the previous quarter.

Each vision consultant is sent the cases and asked to make a determination. Their results are compared to one another to determine whether each consultant came to the same conclusion, and the results are presented at a team meeting.

If there is not 90 percent agreement among the vision consultants in the disposition of the case, the vision consultants will review it at a team meeting. When inappropriate or extreme discrepancies exist between the determinations made in the actual clinical case and the recommendations made by the reviewers during the IRR activity, further interventions will be determined by the Vice President of Vision Services. For example, Avēsis may decide to update clinical guideline criteria or provide additional training to the vision consultants or UR processors. In certain instances, auditing of a case may be necessary.

After each IRR session, the Vice President of Vision Services or a designee will report the outcomes of the IRR to the Quality Management Committee.

Covered Services

Avēsis will cover services within the program guidelines when the treatment has appropriate diagnoses and when medically necessary. Coverage limitations and reimbursement guidelines specific to this plan are outlined in the Plan Sheet and Fee Schedule located on the provider portal.

Diabetic Eye Exams

When billing for a member who has received his or her first diabetic retinal exam for the benefit period, which is based on a calendar year, providers are reminded to include the appropriate category II CPT® service codes (2022F, 2024F, 2026F, and 3072F) in addition to the routine eye examination CPT® codes (S0620 and S0621) when submitting claims for members diagnosed as diabetic.

Clinical Protocols

Avēsis relies upon approved clinical protocols in the decision-making process to determine medical necessity. These protocols are developed in consideration of the Local Coverage Determination for Texas, the American Academy of Ophthalmology Preferred Practice Patterns, and/or the American Optometric Association Clinical Practice Guidelines. Avēsis Clinical Protocols are available online at **avesis.com** inside the provider login. Providers are encouraged to visit the website often to ensure they have the most current information.

Prior Authorization

Prior authorization for specific covered services is used to ensure medical necessity of the procedure. Avēsis uses prior authorization to:

- Guard against unnecessary or inappropriate care and services and excessive payments
- Assess the quality and timeliness of service
- Determine if less expensive alternative care, services, or supplies could be used
- Promote the most effective and appropriate use of available services and facilities

- Eliminate improper practices that may be used by providers or members

Consideration of authorization is limited to covered services requested for eligible members. Prior Authorizations can be submitted via the Provider Portal, accompanied by all required documentation by visiting: https://avesis.veriben.net/portal/Framework3/Login.aspx

- Select Claims, under Step 4 find "Claim Type"
- Select Predetermination/Preauthorization.

If internet access is limited, you may also submit your request via fax or postal mail. A completed Avēsis Vision Authorization Form, accompanied by the enrollee's medical record, most current RX and/or any other required documentation can be faxed or mailed to the Avēsis Utilization Management Department prior to rendering the service. Please fax 1-433-738-9686 Or VIA MAIL addressed to: Avesis Third Party Administrators, LLC, Attention: Eye Care Prior Authorization, PO Box 38300, Phoenix, AZ 85069-8300

The Avēsis Utilization Management Department has 3 business days from the received date to make a determination regarding medical necessity. Please ensure your requests are submitted with all required items. If Avēsis identifies information is missing and/or something additional is required per our clinician, we may contact your practice to obtain those additional items. Providers will be notified if additional clinical information is needed to make the determination or if the clinical reviewer has determined that the services requested are necessary. If Avēsis is unable to make a determination with the documentation received, a standard request may be extended up to 7 additional business days. If a member becomes ineligible during the authorization period, the authorization is invalid.

Once all the necessary paperwork is received, licensed eye care consultants review all requests to determine if:

- The service is medically necessary
- A less expensive service would meet the member's needs
- The service conforms to commonly accepted standards in the eye care community

If requested services are determined to be medically necessary, provider notification will be mailed the following business day. That notification will include but not be limited to: member details, services requested/approved, denial rationale and contact information if questions arise. If quicker notification is required, you may access this via the Avēsis portal, or by contacting our Provider Service Center and/or Provider Relations Representative.

Once the determination has been communicated, providers are responsible for advising the member of the review decision. Specific timeframes for determinations are dictated by the program in which the member participates.

Non-emergency treatment begun prior to the granting of authorization will be performed at the financial risk of the eye care office. If authorization is denied, the eye care office or treating provider may not bill the member, the health plan, or Avēsis.

Medically Necessary Services are those healthcare services and supplies that are medically appropriate and:

- Necessary to meet the basic health needs of the member
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the covered service
- Consistent in type, frequency, and duration of treatment with scientifically based guidelines of national medical, research, or healthcare coverage organizations or governmental agencies
- Consistent with the diagnosis of the condition
- Required for means other than convenience of the member or his/her physician
- No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency

- Of demonstrated value
- Of no more intense level of service than can be safely provided

Note: Prior authorization is not transferable to other members or other providers.

Retrospective Review

Retrospective review is made available to providers who are unable to get the services reviewed and approved prior to performing the services.

The retrospective review process shall not deny coverage for services when authorization has been given, unless the approval was based on fraudulent, materially inaccurate, or misrepresented information submitted by the provider, member, or member's authorized representative.

Routine Eye Exams

The following program standards and requirements shall apply to the routine benefit to be reimbursed for the eye exam portion of the benefit available to Covered Persons.

An eye examination shall be performed in accordance with all current and future state board of optometry and professional standards. All findings and test results shall be recorded, both normal and abnormal, in a clear, legible fashion. An eye examination shall include, at a minimum, the following, whenever possible:

- Medical/Eye History
  - Chief complaint
  - Age
  - Medications
  - Family history
  - Significant visual changes
- Visual Acuities
  - Entering, with or without correction, distance and near
  - Best corrected with final Subjective RX, distance and near
- Cover Test – Findings must be recorded at 20 feet and 16 inches
- Versions/Motility Assessment
- Pupils and Pupillary Reactions
- Screening Visual Fields – Record all findings including test or instrument used
- Refraction – To include objective refraction and subjective refraction.
- External Examination/Biomicroscopy
  - Lid
  - Conjunctiva

    - Cornea
    - Crystalline lens
    - Anterior Chamber Angle Quantification
    - Media Clarity
- Tonometry/Intraocular Pressure—To include method of obtaining pressures and the time of day
- Ophthalmoscopy – Direct/Indirect
    - A dilated examination of the retina and the peripheral retina to be performed whenever professionally indicated
    - Document all findings in the vitreous, macula, optic nerve, including numerical C/D ratio, retinal vessels, and grounds
- Diagnosis and Treatment Plan

Standards for Routine Eye (Program-Specific)

All members ages 20 and younger have benefits for an annual eye health examination to evaluate a member's ocular health and determine refractive status, once per every state fiscal year (September 1 through August 31). Limitation of eye examinations for CHIP members can exceed the above when a school nurse or teacher requests the eye exam, when determined to be medically necessary or there is a significant change in vision, and documentation supports a diopter (d) change of 0.5d or greater in the sphere, cylinder, prism measurements, or axis changes; requires prior authorization. Eye examinations are recommended beginning at age three. This annual exam should be conducted in compliance with the Avēsis Eye Examination Standards and Requirements. Coverage includes the examination and the biennial dispensing of non-prosthetic eyewear required to correct visual acuity one time every other state fiscal year (September 1 through August 31).

Adult members (ages 21 and over) have coverage for biennial comprehensive eye examination every 24 months from the date of service (September 1 through August 31). Limitation of eye examinations for refractive error can exceed the above for clients who are 21 years of age and older when there is a significant change in vision, and documentation supports a diopter change of 0.5d or more in the sphere, cylinder, prism measurements, or axis changes; requires prior authorization. This biennial exam should be conducted in compliance with the Avēsis Eye Examination Standards and Requirements. Coverage includes the examination and the biennial dispensing of non-prosthetic eyewear required to correct visual acuity one time every other state fiscal year (September 1 through August 31).

If, in your professional judgment, it is medically necessary for a patient to receive additional eye evaluations and/or replacement materials, you must complete a prior approval form and fax it along with all pertinent clinical data to our secure fax at 1-443-738-9686.

These requests will be reviewed by our Utilization Management department and will be referred to a peer reviewer for all adverse determinations. You will be notified of the decision in writing from Avēsis within 14 calendar days of receipt of all required documentation. If a decision cannot be rendered by then, you will receive written notification of the need for an extension.

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

- S0620: routine ophthalmological examination, including refraction; new patient
- S0621: routine ophthalmological examination, including refraction; established patient

Please note: These services include dilation and determination of refractive state. The provider may not bill separately for dilation or refraction performed on the same date of service.

Eyeglasses

Frame Requirement

Each frame dispensed must carry a minimum of a one-year manufacturer's warranty. If a member selects frames outside the covered frame allowance, the member will be responsible for the balance over the allowance for frame upgrade. In this case, members must complete the Non-Covered Services Disclosure Form found at the end of this manual. Please refer to the Plan Sheet for specific billing instructions. Minor adjustments are to be provided for one year at no additional charge.

Eyeglass Lens Requirement

Fabrication of eyeglasses shall conform to the current American National Standards Institute (ANSI) prescription requirements, and all lenses, frames, and frame parts must be guaranteed against defects in manufacture and assembly.

Polycarbonate lenses: Polycarbonate lenses may be reimbursed when the client meets the following criteria:

- Lens power in at least one meridian of -5.25/+4.00 diopters or more and the eyeglasses are not functional in regular standard glass or plastic lens materials due to weight, thickness or aberration
- Monocular vision with functional vision in one eye
- Retinal detachment or risk for retinal detachment (e.g., lattice degeneration, history of retinal detachment in the family, posterior vitreous detachment)

Contact Lenses

Medically Necessary Contact Lenses

Medically necessary contact lenses are covered for all members; this benefit is in lieu of eyeglasses and subject to prior authorization.

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

- Examination
- Fitting
- Training
- Follow-up visits for a minimum of 60 days after completion of fitting

The following criteria are used when reviewing written prior authorization requests:

- Monocular Aphakia, when visual acuity of the two eyes is equalized within two lines (H27.00, H27.01, H27.02, H27.03)
- Anisometropia, when the difference between the two eyes exceeds 4.00 diopters and visual acuity of the two eyes is equalized within two lines (H52.31)

- Keratoconus (H18.601-H18.629)/Corneal Dyscrasias (H18.40, H18.501-H18.559, H18.711-H18.719)
    - When there is a clear evidence that best spectacle correction will not suffice

Contact Lens Standards

Members do not have an elective contact lens benefit.

Replacements

Members aged 0-20 years of age may obtain replacement non-prosthetic eyeglasses if the first pair is lost or destroyed. There are no limitations on the number of replacements that a member who is 0-20 years of age may receive. Prior authorization is required to replace frames. If the lenses alone need replacing, the provider must use existing frames. Please refer to the Plan Sheet for specific billing instructions.

- A change of 0.50 diopters or more in any corresponding meridian.
- A cylinder axis change of at least 20 degrees for a cylinder power of 0.50-0.62 diopters
- A cylinder axis change of at least 15 degrees for a cylinder power of 0.75-0.87 diopters
- A cylinder axis change of at least 10 degrees for a cylinder power of 1.00-1.87 diopters
- A cylinder axis change of at least 5 degrees for a cylinder power of 2.00 diopters or greater
- One repair of glasses every 12 months including replacement of the broken component(s) only, billed using V2799 if cost is greater than $2

Non-Covered Services

Avēsis will not cover lenses that are non-covered. Members can purchase lenses and pay the balance after the plan maximum has been reached. Additional exclusions:

1. Replacement or repair of prosthetic devices and durable medical equipment (exception – aphakic eyewear), such as eyeglasses, due to misuse, abuse or loss when confirmed by the member or the vendor
2. Plano sunglasses
3. Optional eyeglass features that are requested by the client but that do not increase visual acuity (e.g., lens tint, industrial hardening, and decorative accessories or lettering)
4. Low vision aids, such as magnifying glasses
5. Elective surgery to correct vision
6. Cosmetic surgery/services solely for cosmetic purposes.

Should a member ask you or your office to render services that are not covered benefits, the member must consent in writing to the services and the cost of the services. The consent must be in writing and include:

- The member's willingness to accept non-covered procedures or treatments
- The member's acknowledgement that they received notice that the procedure is not a covered benefit
- The member's acknowledgement that they have been informed of the cost of the non-covered procedure or treatment

- Assurance that there are no covered benefits available to the member

If the member elects to receive any non-covered service, the member is financially responsible and should be billed the usual and customary fee as payment in full for the agreed upon procedure or treatment. If the member becomes subject to collection action upon failure to make the required payment, the terms of the action must be kept with the member's record.

Failure to comply with this procedure may subject you and your office to sanctions that may include termination.

Please visit **avesis.com** to find a copy of the Avēsis Non-Covered Services Disclosure form.

Fraud, Waste, and Abuse

The Centers for Medicare & Medicaid Services (CMS) defines fraud as: "an intentional representation that an individual knows to be false or does not believe to be true and makes, knowing that the representation could result in some unauthorized benefit to himself or some other person." Both Avēsis and the Parkland Community Health Plan view fraud, waste, and abuse as a serious matter. Identifying and reporting fraud, waste, and abuse is everyone's responsibility—from doctors to employees to members.

Acceptance of improper payments is a form of Fraud, Waste, and Abuse. This includes payments that should not have been made or were made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative or other legally applicable requirements. It includes payment to an ineligible recipient, payments for an ineligible good or service, duplicate payments, payments for a good or service not received (except for such payments where authorized by law) and payments that do not account for credit for applicable discounts (Improper Payments Elimination and Recovery Act [IPERA]).

Examples of Member Fraud, Waste, and/or Abuse:

- Inappropriately using services such as selling prescribed narcotics, or seeking controlled substances from multiple providers or multiple pharmacies
- Altering or forging prescriptions
- Sharing ID cards
- Non-disclosed other health insurance coverage
- Alteration of prescription forms
- Obtaining unnecessary equipment and supplies
- Members receiving services or picking up prescriptions through identify theft
- Providing inaccurate symptoms and other information to providers to get treatment, drugs, etc.

Examples of Provider Fraud, Waste, and/or Abuse:

- Prescribing drugs, equipment, or services that are not medically necessary
- Failing to provide patients with medically necessary services due to lower reimbursement rates
- Billing for tests or services not provided
- Intentionally using improper medical/eye coding to receive a higher reimbursement

- Purchasing drugs from outside the United States
- Prescribing high quantities of controlled substances without medical necessity
- Unbundling services to obtain higher reimbursement
- Not verifying Member ID resulting in claims submission for non-covered persons
- Scheduling more frequent return visits than are needed
- Billing for services outside of your medical/optometric qualification
- Using enrollee lists for the purpose for submitting fraudulent claims
- Drugs billed for inpatients as if they were outpatients
- Payments stemming from kickbacks or Stark Violations
- Retaining overpayments made in error by Parkland Community Health Plan and/or Avēsis
- Preventing Members from accessing covered services resulting in underutilization of services offered

Avēsis is committed to preventing, detecting, and reporting possible fraud, waste, and abuse. We expect that all our staff and providers understand and adhere to the Avēsis Anti-Fraud Program. Compliance is everyone's responsibility.

Reporting Suspected Fraud, Waste, and Abuse

Avēsis and its staff are committed to preventing, detecting, and reporting possible fraud, waste, and abuse, adhering to the Avēsis Anti-Fraud Program. All Avēsis personnel receive annual training regarding the detecting of fraud, waste, and abuse, and staff involved with claims processing, claims payment, and utilization review receive more in-depth training. All our providers and their office staff are also expected to be alert to possible fraud, waste, and abuse and report any suspicious activity to Avēsis. The Avēsis fraud hotline number is 855-704-0435. You may leave a message on the hotline's voice mail anonymously, as the hotline is not answered in real time. Or you may leave your contact information so that we may provide you with updates on the investigation. Upon receipt of a report of suspected fraud, waste, or abuse, Avēsis will work with relevant plan fraud units and the applicable state/federal fraud, waste, and abuse authorities to investigate.

Let us know if you think a doctor, dentist, pharmacist at a drug store, other health care providers, or a person getting benefits is doing something wrong. Doing something wrong could be waste, abuse, or fraud, which is against the law. For example, tell us if you think someone is:

- Getting paid for services that weren't given or necessary.
- Not telling the truth about a medical condition to get medical treatment.
- Letting someone else use their Medicaid or CHIP ID.
- Using someone else's Medicaid or CHIP ID.
- Not telling the truth about the amount of money or resources he or she has to get benefits.

To report waste, abuse or fraud, choose one of the following:

- Call the OIG Hotline at 1-800-436-6184
- Visit **https://oig.hhsc.state.tx.us/** Under the box labeled "I WANT TO" click "Report Waste, Abuse, and Fraud" to complete the online form

- Directly to your health plan:
  - MCO's name
  - MCO's office/director address
  - MCO's toll free phone number
- Avēsis Compliance Department
  - Mail a report to: Chief Compliance Officer, Avēsis, 10400 N 25th Ave, Ste 200 Phoenix, AZ 85021
- EthicsPoint, an independent third party that will obtain anonymous reports
  - Call 866-ETHICSP (866-384-4277) or visit the website (**www.ethicspoint.com** and click on "File a Report")

To report waste, abuse or fraud, gather as much information as possible.

- When reporting about a provider (a doctor, dentist, counselor, etc.) include:
  - Name, address, and phone number of provider
  - Name and address of the facility (hospital, nursing home, home health agency, etc.)
  - Medicaid number of the provider and facility, if you have it
  - Type of provider (doctor, dentist, therapist, pharmacist, etc.)
  - Names and phone numbers of other witnesses who can help in the investigation
  - Dates of events
  - Summary of what happened
- When reporting about someone who gets benefits, include:
  - The person's name
  - The person's date of birth, Social Security number, or case number if you have it
  - The city where the person lives
  - Specific details about the waste, abuse, or fraud

Federal Laws and Statutes Affecting Providers

The Federal False Claims Act allows everyday people to bring "whistleblower" lawsuits on behalf of the government-knows as "qui tam" suits-against businesses or other individuals that defraud the government through programs, agencies, or contracts. Using the False Claims Act, you can help reduce fraud against the federal government. The False Claims Act, also called the "Lincoln Law" imposes liability on persons and companies who defraud governmental programs.

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

CMS requires that Avēsis and providers who treat medical assistance and/or Medicare Advantage members check two federal exclusions databases and a state database for the state in which the provider is rendering service prior to the start of an employee or consultant's employment and monthly thereafter. The federal databases are Office

of the Inspector General (OIG), List of Excluded Individuals and Entities (LEIE), the Government Services Administration, and System for Award Management (SAM).

Most states maintain exclusions that must also be screened prior to employment and monthly thereafter.

As a participating network provider, you are required to ensure that no staff providing services to medical assistance or Medicare Advantage members appears on any of these lists. If you identify yourself or a staff member on one of these lists, you must report the event to the Chief Compliance Officer at Avēsis within two days by calling 855-704-0435 or emailing **compliance@avesis.com**.

Anti-Fraud Training

All Avēsis personnel receive annual training about detecting fraud, waste, and abuse; however, staff involved with claims processing and payment and utilization review receive more in-depth training on this topic.

The Centers for Medicare & Medicaid Services (CMS) requires that annual fraud, waste, and abuse training is completed by all employees (providers and staff) in a practice that treats Medicaid and/or Medicare Advantage members. Additionally, any non-employee providers (independent contractors) associated with the practice must complete the training. For your convenience, Avēsis has placed a link to the fraud and compliance training available from the CMS Medicare Learning Network (MLN) in the secure provider portal of our website. Avēsis does not require that training is completed through us if similar training has been completed through another source. Once training has been completed, either through the Avēsis portal or through another venue, read and attest to the following statement:

The employees in my practice and I have completed the annual Fraud, Waste, and Abuse training during this current year. I understand that non-employee providers must complete the training and attestation separately.

If you complete this training through our secure provider portal, please fill out the online attestation indicating fulfillment of this annual requirement. Your NPI number must be included as part of your attestation. If we do not have this on record, it could result in:

- Contract termination
- Criminal penalties
- Exclusion from participation in all federal healthcare programs
- Civil monetary penalties

Reporting Abuse, Neglect or Exploitation (ANE)

Report suspected Abuse, Neglect, and Exploitation:

MCOs and providers must report any allegation or suspicion of ANE that occurs within the delivery of long-term services and supports to the appropriate entity. The managed care contracts include MCO and provider responsibilities related to identification and reporting of ANE. Additional state laws related to MCO and provider requirements continue to apply. Providers must provide the MCO with a copy of the abuse, neglect, and exploitation report findings within one Business Day of receipt of the findings from the Department of Family and Protective Services (DFPS).

Report to the Department of Aging and Disability Services (DADS) if the victim is an adult or child who resides in or receives services from:

- Nursing facilities;
- Assisted living facilities;
- Home and Community Support Services Agencies (HCSSAs) – Providers are required to report allegations of ANE to both DFPS and DADS;
- Adult day care centers; or
- Licensed adult foster care providers

Contact DADS at 1-800-647-7418.

Report to the Department of Family and Protective Services (DFPS) if the victim is one of the following:

- An adult who is elderly or has a disability, receiving services from:
  - Home and Community Support Services Agencies (HCSSAs) – also required to report any HCSSA allegation to DADS;
  - Unlicensed adult foster care provider with three or fewer beds
- An adult with a disability or child residing in or receiving services from one of the following providers or their contractors:
  - Local Intellectual and Developmental Disability Authority (LIDDA), Local mental health authority (LMHAs), Community center, or Mental health facility operated by the Department of State Health Services;
  - a person who contracts with a Medicaid managed care organization to provide behavioral health services;
  - a managed care organization;
  - an officer, employee, agent, contractor, or subcontractor of a person or entity listed above; and
- An adult with a disability receiving services through the Consumer Directed Services option

Contact DFPS at 1-800-252-5400 or, in non-emergency situations, online at **www.txabusehotline.org**

Report to Local Law Enforcement:

- If a provider is unable to identify state agency jurisdiction but an instance of ANE appears to have occurred, report to a local law enforcement agency and DFPS.

Failure to Report or False Reporting:

- It is a criminal offense if a person fails to report suspected ANE of a person to DFPS, DADS, or a law enforcement agency (See: Texas Human Resources Code, Section 48.052; Texas Health & Safety Code, Section 260A.012; and Texas Family Code, Section 261.109).
- It is a criminal offense to knowingly or intentionally report false information to DFPS, DADS, or a law enforcement agency regarding ANE (See: Texas Human Resources Code, Sec. 48.052; Texas Health & Safety Code, Section 260A.013; and Texas Family Code, Section 261.107).

- Everyone has an obligation to report suspected ANE against a child, an adult that is elderly, or an adult with a disability to DFPS. This includes ANE committed by a family member, DFPS licensed foster parent or accredited child placing agency foster home, DFPS licensed general residential operation, or at a childcare center.

Leaving the Network

Both you and Avēsis have the right to terminate your network agreement at any time, provided written notice is supplied within the timelines set by your provider contract.

Voluntary Termination

If you or your office no longer wishes to see our members, you must notify us in writing and agree to comply with the continuity of care policy for the plan for which you provide services. Generally, you may close your practice to our members effective the first of the following month, provided you gave us written notice at least five business days before the end of the month; otherwise, the policy will become effective the first of the following month.

Involuntary Termination

Avēsis may terminate your agreement at any time for immediate cause, which includes, but is not limited to:

- The failure of a provider to maintain or obtain a license to practice medicine in the state where services are provided
- The failure of a provider to obtain and/or maintain hospital privileges at a hospital or contracted ambulatory healthcare facility
- The cancellation of a provider's coverage or insurability under his/her professional liability insurance
- A provider’s conviction of a felony
- Unprofessional conduct by or on behalf of a provider as defined by the laws of the state where services are rendered
- A filing of bankruptcy (whether voluntary or involuntary) by a provider, declaration of insolvency by a provider, or the appointment of a receiver or conservator of a provider’s assets

If conditions arise that cause Avēsis to issue a notice of termination, in most cases the provider shall be given the opportunity to mediate the issue within time frames set forth in the contract. If the provider fails to implement a satisfactory cure within the required time frame, his/her network participation will be terminated.

There may be instances where a provider’s agreement with Avēsis may be terminated immediately. Conditions that may lead to this action include, but are not limited to, situations where:

- A provider breaches a material term of his/her agreement or the provider manual, including, without limitation, the representations and warranties or responsibilities defined in these documents and in such a way that the problem cannot be mediated
- The provider poses an imminent danger to Avēsis members or the public health, safety, and welfare
- The provider is charged with a felony or a crime of moral turpitude
- The provider is convicted of an offense related to Medicare or Medicaid

- The provider fails to satisfy the credentialing or re-credentialing program requirements
- The provider ceases participation in Avēsis network through non-renewal of the credentialing application or denial of approval for participation

Participating providers shall be automatically unenrolled from the Avēsis network upon their death or retirement or if their license expires, lapses, or is inactivated by the applicable state licensing board.

Termination Appeals

Providers terminated for a quality issue have appeal rights. The notice of termination will provide the appeal rights and method and timeframe for requesting an appeal.

Upon receipt of written notification of appeal stating the grounds for the appeal, Avēsis will convene a hearing panel to review the appropriate information. The decision will be either confirmed or overturned. If the original decision is overturned, the contracting entity and/or participating provider will be reinstated. If the original decision is confirmed, the contracting entity and/or participating provider shall continue to have the right to dispute resolution as outlined in their contract.

Providers terminated for a reason other than a quality issue do not have provider rights. A provider may reapply for inclusion in the network. Providers will only be allowed one reapplication to the network each twelve-month period.

Suspension

Avēsis may, in its sole and absolute discretion, suspend a provider and/or eye care office's participation in the network if any of the following were to occur:

- Billing or claims submission issues occurring with such frequency that Avēsis, in its sole and absolute discretion, determines the provider and/or office should be suspended pending further investigation and the resolution of said issues
- Breach of contract by the provider or office, until what caused the breach has been cured
- Other concerns that Avēsis in its sole discretion believes may have a negative impact to member health and safety

Complaints and Appeals

Avēsis has designated personnel who are available to receive phone calls or encrypted emails regarding complaints or appeals. If you make a complaint or appeal, all the specifics surrounding it will be thoroughly investigated and documented. Investigation and resolution shall be made using applicable statutory, regulatory, and contractual provisions. Often issues can be resolved before it rises to the level of a formal complaint or appeal by working with your provider relations representative to understand the concern. Please feel free to contact your provider relations representative or our provider customer service team who are standing by to assist you with any questions or concerns you may have. Of course, you may always file a complaint or appeal. 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. Avēsis stores all the documentation related to Complaints and Appeals in a digital database. This includes retention of fax cover pages, emails to and from Avēsis and maintaining a log of telephone communications.

To fully investigate and resolve an appeal or complaint that you may file, please include all documentation necessary for the conclusion. Necessary documentation may include any of the following:

- Records
- Billing records
- Patient registration records
- Test Results
- Other, any documents necessary to support the appeal/complaint

Inquiries

Calls are classified as an inquiry when the member, authorized representative, state, or others ask a question or describe an issue without overt dissatisfaction.

Complaints

A complaint is an expression of dissatisfaction (verbally or written) that results in either an Appeal or a Grievance. It includes but is not limited to: the quality of care or services provided, failure to respect the member's rights, or a dispute over an extension of time proposed by Parkland Health Community Plan to make an authorized decision.

A provider may file a complaint by calling or writing Avēsis. Should you require assistance, Avēsis' provider customer service departments can assist you. The complaint must include the reason for the issue or concern and any supporting documentation.

Avēsis will review the complaint, and if, based upon the information provided, it is determined that the service or material should be reimbursed, the claim will be paid. If Avēsis determines that the claim should not be paid, the claim will be referred for peer level review for final determination. Complaints can be made in writing to:

Avēsis Third Party Administrators, LLC
Attn: Complaint, Appeal and Grievances
P.O. Box 38300
Phoenix, AZ 85069-8300

Claim Disputes and Reconsideration

All claim dispute reviews are handled in accordance with the Avēsis Complaints, Appeals, and Grievances (CAG) policies and procedures (available at **avesis.com**). All provider claim disputes must be submitted within 120 days of disposition. The provider will be notified by mail of the decision. Submit your verbal or written claim disputes to:

Avēsis Third Party Administrators, LLC
Attn: Complaint Appeal and Grievances
P.O. Box 38300
Phoenix, AZ 85069-8300
AG@avesis.com
844-232-3122

Appeals

An appeal is a request for review of an Action. Upon receipt, we will conduct a thorough investigation of the provider appeal. We will review all information related to your appeal including documentation you submit. If needed, we may request additional information from you. Avēsis will then review all documentation and issue a resolution letter to you.

If we agree with your position, we will either reverse the denied claim or correct the identified issue. We will notify you of the decision and the correction in writing.

If we uphold our initial decision, we will notify you in writing. There are no further appeal levels. However, you may pursue further review by following the dispute resolution process outlined in your provider agreement.

You may consolidate your 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.

Information regarding the ways you can appeal adverse determinations will be included with each EOP.

Prior Authorization Appeals

An appeal can be sent to Avēsis verbally or in writing within 60 calendar days to:

Avēsis Third Party Administrators, LLC
Attention: Utilization Management Appeals
P.O. Box 38300
Phoenix, AZ 85069-8300
PSA@avesis.com
844-232-3122

Note: If the Avēsis appeals process has been exhausted regarding denied or partially denied claims, a provider may pursue the administrative review process or select binding arbitration as set forth in the Provider Agreement. Information regarding how to appeal adverse determinations will be included with the Notice of Action that is sent.

Complaints

A complaint is an expression of dissatisfaction about any matter other than an action, including but not limited to:

- The quality of care or services provided and aspects of interpersonal relationships such as rudeness of a provider or employee
- Failure to respect the enrollee's rights, regardless of whether remedial action is requested
- A dispute over an extension of time proposed by the MCO to make an authorized decision

Complaints and Appeals with Texas Health and Human Services Commission (HHSC)

A provider who believes that they did not receive full due process from Avēsis may file a complaint with HHSC. HHSC is only responsible for management of the complaints. Appeals, hearing or dispute resolutions are the responsibility of Avēsis. Providers must exhaust the complaint/appeal process with Avēsis before filing a complaint with HHSC.

Providers should refer to the Texas Medical Provider Procedure's Manual for specific information on complaint requirements. Complaints should be mailed to the following address:

Texas Health and Human Services Commission
Health Plan Operations, H-320
Resolution Services

P.O. Box 85200
Austin, TX 78708-5200
Email: **HPM_Complaints@hhsc.state.tx.us**

The network provider understands and agrees that HHSC reserves the right and retains the authority to make reasonable inquiries and to conduct investigations into provider complaints.

CHIP Complaints and Appeals

A provider who believes that they did not receive full due process from Avēsis may file a complaint with the Texas Department of Insurance (TDI). Providers must exhaust the complaint/appeal process with Avēsis before filing a complaint with TDI. Providers should refer to the Texas Medical Provider Procedure's Manual for specific information on complaint requirements. Complaints to TDI should be mailed to the following address:

Texas Department of Insurance Consumer Protection (111-1A)
P.O. Box149091
Austin, Texas 78714-9091
Phone: 512-463-6500 or 800-252-3439
Fax: 512-475-1771
Email: **ConsumerProtection@tdi.state.tx.us**

The network provider understands and agrees that TDI reserves the right and retains the authority to make reasonable inquiries and to conduct investigations into provider complaints.

Provider Appeal Process to HHSC (related to claim recoupment due to Member disenrollment)

Provider may appeal claim recoupment by submitting the following information to HHSC:

- A letter indicating that the appeal is related to a managed care disenrollment/recoupment and that the provider is requesting an Exception Request.
- The Explanation of Benefits (EOB) showing the original payment. Note: This is also used when issuing the retro-authorization as HHSC will only authorize the Texas Medicaid and Healthcare Partnership (TMHP) to grant an authorization for the exact items that were approved by the plan.
- The EOB showing the recoupment and/or the plan's "demand" letter for recoupment. If sending the demand letter, it must identify the client name, identification number, DOS, and recoupment amount. The information should match the payment EOB.
- Completed clean claim. All paper claims must include both the valid NPI and TPI number. Note: In cases where issuance of a prior authorization (PA) is needed, the provider will be contacted with the authorization number and the provider will need to submit a corrected claim that contains the valid authorization number.

Mail appeal requests to:

Texas Health and Human Services Commission
HHSC Claims Administrator Contract Management
Mail Code-91X
P.O. Box 204077
Austin, Texas 78720-4077

The network provider understands and agrees that HHSC reserves the right and retains the authority to make reasonable inquiries and to conduct investigations into provider complaints.

Member Inquiries, Complaints, and Appeals

Upon enrollment, the Health Plan informs the members of their right to file complaints or appeals. With written consent from the member or the member's legal representative, a provider may file a complaint on behalf of the member and/or serve as the member's advocate.

If the provider acts in this capacity, he/she should be aware of the member complaint and appeal processes, including the time frames for filing. Complaint procedures must comply with applicable state and/or CMS rules. Please refer to the Parkland Community Health Plan website for the Member Handbook.

Cultural Competency and Language Services

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

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

Cultural competency is more than a philosophy. It is also a legal requirement for the delivery of services. To this end, Avēsis complies with applicable federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. To help facilitate the fair and equal treatment of all members, Avēsis:

- Provides aid and services to people with disabilities to communicate effectively with us and your practice, such as:
    - Qualified sign language interpreters
    - Information written in other formats (Braille, large print, audio, accessible electronic formats, other formats)
- Provides language services to people whose primary language is not English such as:
    - Qualified interpreters
    - Information written in other languages

Avēsis is committed to ensuring that network providers, as well as our policies and infrastructure, meet the diverse needs of all members, especially those who face these challenges. Cultural competency is a key component of Avēsis' continuous quality improvement efforts.

Cultural competency includes:

- Identifying members who may have cultural or linguistic barriers so that alternative communication methods can be made available

- Using culturally sensitive and appropriate educational materials based on the member's race, ethnicity and primary language spoken
- Ensuring that resources are available to overcome the language barriers and communication barriers that exist in the member population
- Recognizing the culturally diverse needs of the population
- Teaching staff to value the diversity of both their co-workers inside the organization and the population served, and to behave accordingly

If a member seen in your practice needs linguistic support, please contact our customer service line to make arrangements. If you are unable to coordinate linguistic support through our customer service team, please reach out to our Chief Compliance Officer:

10400 N 25th Ave, Ste 200
Phoenix, AZ 85021
800-643-1132

Foreign Language Translation Services/Special Needs Assistance

Avēsis also employs customer service representatives who are fluent in Spanish. The representatives may be reached through the Spanish language queue at our toll-free number. Our interactive voice response (IVR) is also available in Spanish. Additionally, Avēsis contracts with a company that provides language assistance services in more than 200 languages for members with limited English proficiency. Avēsis pays all costs for this service.

In compliance with the Affordable Care Act, Section 1557, the Avēsis website has information for members who need language assistance.

Deaf or Hard-of-Hearing Patients

Members who are deaf or hard of hearing may require devices or services to aid them in communicating effectively with their providers.

Avēsis' customer service representatives have the ability to communicate with members who are deaf or hard of hearing using relay devices. When a member calls using a relay service, our team will ask the member if he/she would like a certified interpreter—such as a computer-assisted real-time reporter, oral interpreter, cued speech interpreter, or sign-language interpreter—to be present during the provider visit. Customer Service maintains a list of phone numbers and locations of interpreter services by county.

If the use of an interpreter is not requested by the member, Customer Service will ask the member to specify a preferred type of auxiliary aid or service.

To support the linguistic accessibility of your office to any patient who is deaf or hard of hearing, please consider the following suggestions:

- Provide a quiet background for the patient
- Reduce echoes to enhance sound quality
- Add lights to enhance visibility
- Install flashing lights that work in conjunction with auditory safety alarms
- Clearly identify all buildings, floors, offices, and room numbers

- Include telecommunications relay services (TRS) to communicate by phone with a member with a hearing or speech disability

If the member requires an interpreter onsite during or following the examination, contact the appropriate Health Plan Special Needs Unit to make the necessary arrangements.

Functional Illiteracy

A person with functional illiteracy is someone with basic education but whose reading and writing skills are inadequate for everyday needs. Health illiteracy is the degree to which individuals lack the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.[1] This becomes important to a provider when a member is unable to accurately complete registration and medical/eye history forms.

Signs a member seen in your practice may be functionally illiterate or have lower than proficient health literacy include difficulty:

- Circling the date of a medical appointment on a follow-up appointment form
- Completing required forms accurately
- Following basic, printed follow-up or procedure preparation requirements
- Reiterating printed information about personal eye health conditions

Strategies your office might consider implementing to help all patients successfully access the written materials available through your office include:

- Orally reviewing printed medical history or other forms with patients to ensure accuracy and completeness of the information
- Complementing the distribution of printed material with oral explanations of treatment preparation or follow-up instructions
- Offering to complement written appointment reminders with phone call reminders

Cultural Competency Training

CMS guidelines require that all providers servicing Medicaid patients complete a cultural competency training each year. Information about your completion of this training is required by law to be included in our provider directory.

You will be asked to fill out an attestation indicating that this training has been completed.

For your convenience, Avēsis has placed a link to the cultural competency training on the secure provider portal of our website. You do not have to complete this through Avēsis if similar training has been completed through another source.

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[1] U.S. Department of Health and Human Services. 2000. *Healthy People 2010*. Washington, DC: U.S. Government Printing Office. Originally developed for Ratzan SC, Parker RM. 2000. Introduction. In *National Library of Medicine Current Bibliographies in Medicine: Health Literacy*. Selden CR, Zorn M, Ratzan SC, Parker RM, Editors. NLM Pub. No. CBM 2000-1. Bethesda, MD: National Institutes of Health, U.S. Department of Health and Human Services.

Once training has been completed, either through the Avēsis portal or through another venue, read and attest to the following statement:

My employees and I have completed the annual Cultural Competency training during this current year. I understand that non-employee providers who interact with patients must complete the training and attestation separately.

If you complete this training through our secure provider portal, please use the online attestation indicating fulfillment of this annual requirement. Your NPI number must be included as part of your attestation.

If we do not have this on record, it could result in:

- Contract termination
- Criminal penalties
- Exclusion from participation in all federal healthcare programs
- Civil monetary penalties

Cultural Competency Grievances

If you believe Avēsis has failed to adequately provide cultural or linguistic support to a member in your care, you can file a grievance with us. This may be done in person or by phone, mail, fax, or email. If you need help filing a grievance, the Chief Compliance Officer is available to help you. You may reach the Chief Compliance Officer by:

Telephone:	855-704-0435
Fax:	602-638-5976
Mail:	Compliance 10400 N 25th Ave, Ste 200 Phoenix, AZ 85021
Email:	**compliance@avesis.com**

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 800-368–1019 or 800-537–7697 (TDD)

Clinical Criteria

Avēsis Vision Clinical Protocols are available online at http://www.avesis.com. To locate this information, navigate to the “Providers” page then scroll down to the “Resources” section. Providers are encouraged to visit the website frequently to ensure they have the most up-to-date information and to refer to plan benefit grids/fee schedules for covered services and prior and post-authorization requirements. The materials provided to you are guidelines used by the plan to authorize, modify or deny care for person with similar illnesses or conditions. Specific care and treatment may vary depending on individual needs and the benefits covered under your contract. For additional questions, network providers should contact either the Customer Service Department or Provider Relations Department by phone or email, using the Provider Manual or Portal to obtain contact information.

Forms and Documents

Avēsis Locum Tenens Form

Non-Covered Services Disclosure Form

Electronic Funds Transfer Form

Member ID Card

Avēsis Locum Tenens Form

Locum Tenens is a Latin phrase that means: Holding the Place. Locum Tenens arrangements are between providers whereas one provider will temporarily replace another provider for a period of time. After Avēsis receives notification of a Locum Tenens situation, the Participating Provider may submit a claim under his/her name and provider number and receive payment for covered benefits for services provided by the locum tenens provider.

Please complete below:	
Tax Identification Number:	
Provider Name and NPI:	
Locum Tenens Name and NPI:	
Contact Person:	
Contact Phone Number:	
Effective Date for Locum Tenens Relationship:	
Reason for Locum Tenens Relationship:	
Expected Termination Date for Locum Tenens Relationship:	

The following documentation **must** accompany this form:

7. A written notice from the owner of the facility to Avēsis in advance advising of the use of a locum tenens provider. If the use of the locum tenens is due to the incapacitation or death of the Participating Provider, then the letter must be signed by the executor of the estate.
8. Copy of the Locum Tenens provider's license
9. Proof of professional liability of one million dollars per occurrence/three million aggregate minimum

In accordance with the Provider Agreement, the Participating Provider may pay the locum tenens provider for his/her services on a per diem basis or similar fee for time basis.

The locum tenens provider may not provide services to members for a period of time in excess of sixty (60) continuous days within a twelve (12) month period.

Non-Covered Services Disclosure Form

To be completed by Physician Rendering Care

I am recommending that _____ receive services
Member Name and Identification Number

that are **not** covered by the _____ Avēsis Covered Benefits Schedule. I am willing
Health Plan Name
to accept my Usual and Customary Fee as payment in full. The following procedure codes are recommended:

CODE	DESCRIPTION	FEES

The total amount due for service(s) to be rendered is $_____

_____

Doctor's Signature *Date*

To be completed by Member

I _____, have been told that I require
Print Your Name

services or have requested services that are not covered by the _____ Avēsis
Health Plan Name
Covered Benefits Schedule.

Read the question and check either YES or NO	YES	NO
My doctor has assured me that there are no other covered benefits.		
I am willing to receive services not covered by my Health Plan		
I am aware that I am financially responsible for paying for these services.		
I am aware that my Health Plan is not paying for these services.		

I agree to pay $_____ per month. **If I fail to make this payment, I may be subject to collection action.**

_____ _____

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

Electronic Funds Transfer Agreement (EFT)

Account Registration Information	
Business 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 Avēsis to deposit funds into my bank account using EFT. 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 Avēsis Agreement and the appropriate Provider Manual. All funds shall be deposited into my bank account at the banking institution shown above. The bank shall provide to Avēsis 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. Avēsis 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 EFT.
4. This form must processed by Avēsis 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: _____

Please fax this form to: 855-591-3564, Attention: NPID or email to: 18555913564@fax.glic.com.

A voided check must be included with this application.

Member ID Cards


Parkland Community Health Plan STAR | TEXAS Health and Human Services | TEXAS STAR

Always carry this ID card with you and show it when you get care.
Siempre lleve consigo esta tarjeta de identificación y preséntesela a su proveedor siempre que reciba atención.

Member / miembro
Member ID / número de identificación
DOB / fecha de nacimiento
Effective date / fecha de vigencia

PCP
PCP phone / teléfono del PCP
PCP effective date / fecha de vigencia del PCP

Navitus
RxBIN: 610602 | RxPCN: MCD | RxGRP: PCH
Pharmacist use only 1-877-908-6023
TX-16-04-06 Rev 9-19 093MS-ID-01-040116

Attention provider
You must call 1-888-672-2277 for precertification or case management

Parkland Community Health Plan, Dallas Service Area


In case of an emergency, please call 911

En caso de una emergencia, por favor llama al 911

Directions for what to do in an emergency
In case of emergency **call 911** or go to the closest emergency room. After treatment, call your primary care provider (PCP) within 24 hours or as soon as possible.

Instrucciones para lo que debe hacer en caso de una emergencia
En caso de emergencia **llama al 911** ó vaya a la sala de emergencias más cercana. Después de recibir tratamiento, llame a su proveedor de cuidado primario (PCP) dentro de 24 horas ó tan pronto como sea posible.

Member Services & Pharmacy / Servicios al Miembro y Farmacia 24 hours a day, 7 days a week / 24 horas al día, 7 días de la semana	1-888-672-2277
Beacon Behavioral Health 24 hours a day, 7 days a week / 24 horas al día, 7 días de la semana	1-800-945-4644
Nurse Line / Línea de Enfermería 24 hours a day, 7 days a week / 24 horas al día, 7 días de la semana	1-888-667-7890 / 214-266-8773
Avēsis – Vision Services	1-866-678-7113
Relay Texas TT/TDD / Relevo TT/TDD de Texas 24 hours a day, 7 days a week / 24 horas al día, 7 días de la semana	1-800-735-2989 / 711

Mail claims to this address / envie reclamaciones a este domicilio:
Parkland Community Health Plan
Claims Processing Center
PO Box 560327
Dallas, TX 75356
Payer ID: 66917


Parkland Community Health Plan CHIP | TEXAS Health and Human Services | CHIP

No copays for well-child, well-baby or immunization visits.
No aplican copagos para visitas de vacunas de bienestar infantil o de bebés.

Member / miembro
Member ID / número de identificación
DOB / fecha de nacimiento
Effective date / fecha de vigencia

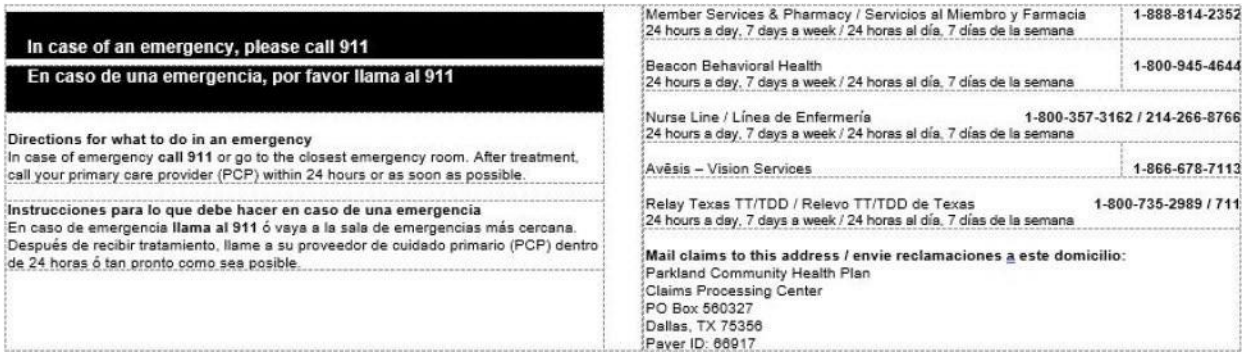
PCP
PCP phone / teléfono del PCP
PCP effective date / fecha de vigencia del PCP

Doctor's office visit / visita al consultorio del doctor:
Emergency room / sala de emergencias:
Hospital inpatient / paciente interno en el hospital:
Prescription generic drugs / medicamentos genéricos de prescripción:
Prescription brand drugs / medicamentos de marca de prescripción:

Navitus
RxBIN: 610602 | RxPCN: MCD | RxGRP: PCH
Pharmacist use only 1-877-908-6023
TX-16-04-07 REV 9-19 009MS-ID-01-040116 TDI

Attention provider
You must call 1-888-814-2352 for precertification or case management

Parkland Community Health Plan, Dallas Service Area


In case of an emergency, please call 911

En caso de una emergencia, por favor llama al 911

Directions for what to do in an emergency
In case of emergency **call 911** or go to the closest emergency room. After treatment, call your primary care provider (PCP) within 24 hours or as soon as possible.

Instrucciones para lo que debe hacer en caso de una emergencia
En caso de emergencia **llama al 911** ó vaya a la sala de emergencias más cercana. Después de recibir tratamiento, llame a su proveedor de cuidado primario (PCP) dentro de 24 horas ó tan pronto como sea posible.

Member Services & Pharmacy / Servicios al Miembro y Farmacia 24 hours a day, 7 days a week / 24 horas al día, 7 días de la semana	1-888-814-2352
Beacon Behavioral Health 24 hours a day, 7 days a week / 24 horas al día, 7 días de la semana	1-800-945-4644
Nurse Line / Línea de Enfermería 24 hours a day, 7 days a week / 24 horas al día, 7 días de la semana	1-800-357-3162 / 214-266-8766
Avēsis – Vision Services	1-866-678-7113
Relay Texas TT/TDD / Relevo TT/TDD de Texas 24 hours a day, 7 days a week / 24 horas al día, 7 días de la semana	1-800-735-2989 / 711

Mail claims to this address / envie reclamaciones a este domicilio:
Parkland Community Health Plan
Claims Processing Center
PO Box 560327
Dallas, TX 75356
Payer ID: 66917

Provider Manual Change Addendum

The Provider Manual Change Addendum is used to track all changes within this manual. Changes made have been vetted through all approval processes and are finalized.

Definitions:

Date of Change:Date the approved change was made to the Provider Manual.

Effective Date: Date the approved change goes into effect. This date may represent a retroactive, current, or future date.

Section: Section/Sub-Section number(s) to which the change(s) was made.

Change Description: Description of the change(s)

Reason: A brief explanation of the change(s) (including rule number(s) if applicable)

Related Communications References any correspondence that relates to the change(s) (ex: Bulletin, Provider Notice, CSR, etc.)

Date of Change	Effective Date	Section	Change Description	Reason	Related Communications
2.4.25	2.4.25	Contact information, throughout	Update emails, update logos, update portal links, CS holiday updates		
12.3.25	12.3.25	Entire Manual	Ways of submission prior to Auth, Clinical Criteria		