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Benefit Options

Envolve Vision, Inc. is a subsidiary of Envolve Benefit Options, Inc

www.envolvevision.com/logon



KANSAS PROVIDER MANUAL

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SECTION I: WELCOME LETTER

Welcome to Envolve Vision

Welcome to Envolve Vision. Envolve Vision values your involvement in its health plan network of participating Providers and looks forward to working with Providers to deliver quality vision benefits with a high level of Member satisfaction.

This manual will provide the necessary reference material to answer frequently asked questions and contains information regarding filing claims, as well as an overview of the Envolve Vision website.

Provider Affairs Mission Statement

All programs, policies, and procedures are designed with Envolve Vision's mission statement in mind:

“A company committed to excellence by building and sustaining quality Provider partnerships through innovation, communication and education to support our clients.”

Background

Envolve Vision has provided comprehensive and affordable eye care services since 1986. Our number one objective is keeping the “care” in our eye care program. Through exclusive agreements with national and regional managed care organizations, Envolve Vision Providers deliver all forms of eye care to Members in both Commercial and Government sponsored healthcare programs.

How to Use This Manual

Envolve Vision is committed to working with our Provider community and Members to provide a high level of satisfaction in delivering quality healthcare benefits. We are dedicated to provide comprehensive information through this Provider Manual as it relates to Envolve Vision's operation, benefits, and guidelines to Providers. In doing so, Envolve Vision will make the Provider Manual available to Providers via the Envolve Vision website and upon a Provider's request. Envolve Vision will post changes to the Provider Manual on its website or provide Providers with applicable state required prior written notice of material changes to the Provider Manual. Please contact Envolve Vision if you need further explanation on any of the topics discussed in this manual.

Providers may contact Envolve Vision on-line or by phone as shown in Appendix: Plan Specifics. Envolve Vision's Customer Service standard office hours are from 8:00 a.m. to 8:00 p.m.

Update Your E-Mail Address

Providers can update the e-mail address for their practice by completing a form available on-line www.envolvevision.com/logon.

Welcome to the Envolve Vision network!

SECTION II: GENERAL INFORMATION

Website Overview

The Envolve Vision website can significantly reduce the number of telephone calls Providers need to make. Utilizing the website allows immediate access to current Provider and Member information twenty-four (24) hours a day, seven (7) days a week. The Envolve Vision website is located at www.envolvevision.com/logon.

Access to Eye Health Manager

Participating Providers have access to the secure online portal, Eye Health Manager. User name and password information is included in the Provider Welcome Letter or upon request. The Eye Health Manager is available at www.envolvevision.com/logon. Upon initial login, the Provider will be prompted to assign an e-mail address to the user name before access is allowed to Eye Health Manager tools and resources.

Provider Tools:

- Verify member eligibility and benefits
- File claims
- Review claim status
- Download, research and reprint Explanation of Benefits/Explanation of Payments
- Request/submit secure, HIPAA-compliant Pre-Authorization

Provider Resources:

- Provider Manual
- Plan Specifics
- Policies and Procedures
- Forms
- Educational Webinar Schedule
- Group Benefit Information
- Newsletters
- Announcements

Rights and Responsibilities

Providers

Providers have the right and responsibility to:

- Make a complaint or file an appeal against Envolve Vision and/or a Member.
- File a complaint on behalf of a Member, with the Member's consent.
- Have access to information about Envolve Vision's Quality Improvement program, including program goals, processes, and outcomes that relate to Member care and services.

- Contact Envolve Vision with any questions, comments, or problems.
- Not discriminate against Members on the basis of age, sex, race, color, religion, sexual orientation, and/or national origin, disability, mental or physical disability, or limited English proficiency.
- Provide clear and complete information to Members, in a language they can understand, about the health condition and treatment, regardless of cost or benefit coverage, and allow the Member to participate in the decision-making process.
- Maintain the confidentiality of Member's personal health information, including medical records and histories, and adhere to state and federal laws and regulations regarding confidentiality.
- Give Members a notice that clearly explains their privacy rights and responsibilities as it relates to the Provider's practice/office/facility.
- Provide Members with an accounting of the use and disclosure of their personal health information in accordance with Health Insurance Portability and Accountability Act (HIPAA).
- Allow Members to request restriction on the use and disclosure of their personal health information.
- Provide Members, upon request, access to inspect and receive a copy of their personal health information, including medical records.
- Allow a Member who refuses or requests to stop treatment the right to do so, as long as the Member understands that by refusing or stopping treatment the condition may worsen or be fatal.
- Allow Members to appoint a parent, guardian, family member, or other representative if they cannot fully participate in their own treatment decisions.
- Follow all state and federal laws and regulations related to Member care and Member rights.
- Participate in payor data collection initiatives, such as Healthcare Effectiveness Data and Information Set and other contractual or regulatory programs.
- Review clinical practice guidelines.
- Disclose overpayments or improper payments to Envolve Vision.
- Provide Members, upon request, with information regarding office location, hours of operation, accessibility, and languages spoken, including the ability to communicate with sign language.
- Notify Envolve Vision of any demographic changes.
- Follow Envolve Vision's established policies and procedures as well as those established by the Payors.
- Receive prompt payment for clean claims.
- Resubmit a claim with additional information.
- Obtain information regarding the status of claims.
- Ensure disclosure form is signed for non-covered service(s) by all parties prior to rendering service(s).

- Disclose to Envolve Vision any Provider or professional corporation ownership interest in any independent ancillary facility prior to referring Members.
- Envolve Vision ensures that punitive action will not be taken against a Provider who requests an appeal on the Member's behalf or supports a Member's appeal request.

Members

These Member Rights and Responsibilities are established by Envolve Vision. This list is not all-inclusive. Envolve Vision acknowledges Member Rights and Responsibilities of its Payors and will adhere to Member Rights and Responsibilities, if listed, in the Plan Specifications.

Members have the right to:

- Access all covered services.
- Participate in making decisions regarding vision health, regardless of cost or benefit coverage, including the right to refuse treatment.
- Make a complaint or file an appeal against Envolve Vision and/or a Provider.
- Request and receive a copy of Member's medical record.
- Request that the Member's medical record be corrected.
- Expect that the Member's medical record and care be kept confidential as required by law.
- Exercise these rights without adversely affecting the way Envolve Vision and its network Providers treat the Member.
- Allow or refuse personal information be sent to another party for other uses unless the release of information is required by law.
- Receive timely access to care.
- Receive information on the managed care program and plan enrolled in.
- Be treated with respect and with due consideration for his or her dignity and privacy.
- Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation
- To be furnished health care services.

Policies and Procedures

Under the Provider Participation Agreement, Providers have agreed to follow policies and procedures established by Envolve Vision as well as the guidelines outlined in this Provider Manual. Pertinent Envolve Vision policies are posted at www.envolvevision.com/logon. The Provider may request copies of Envolve Vision's policies by calling Customer Service at the number listed in Appendix: Plan Specifics.

Provider Performance Standards

Providers are expected to maintain high standards of Member/Patient care, well-documented and legible records, and a state-of-the-art facility. Providers should ensure Member satisfaction and avoid generating complaints, over-utilization, unbundling, or up-coding of procedures.

Provider performance is continually monitored through ongoing quality assessment, trending analysis, and utilization review.

Providers failing to meet established quality standards of care or service may be placed on review status, sanctioned, or terminated, depending on the significance of the deviation. If Envolve Vision determines that there is a possibility of a health risk to a Member, Envolve Vision has the undisputed right to place the participation privileges of the Provider's office involved on a temporary suspension pending review. Quality of care issues are referred to the Peer Review Committee.

Access to Care

The following access to care standards have been established for optometrists and ophthalmologists by Envolve Vision's Quality Improvement Committee:

Appointment Wait Time

Routine Eye Examination	Within two (2) weeks
Sub-Acute Problem	Within two (2) weeks
Chronic Problem	Within four (4) weeks
Urgent (Not life-threatening, but a problem needing care within twenty-four (24) hours)	Within the same office day

Time in Waiting Room

Scheduled	After thirty (30) minutes, patient must be given an update on waiting time with an option of waiting or rescheduling appointment; maximum waiting time is sixty (60) minutes
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Work-ins ¹	After forty-five (45) minutes, patient must be given an update on waiting time with an option of waiting or rescheduling; maximum waiting time is ninety (90) minutes
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¹ Called that day prior to going to the Provider Office

Response Time Returning Calls after Hours

Urgent	Twenty (20) minutes
Other	One (1) hour or next working day based on circumstances

Availability

Office Hours	Posted business hours
After Hours	Twenty-four (24) hours/day coverage for medical/surgical eye care

Acceptance of New Members

Providers accepting new Members may not discriminate based on coverage. Provider must supply thirty (30) days written notice to Envolve Vision before no longer accepting new Members.

Specialty Care

Members requiring specialty care should be directed to a participating Provider.

Medical Office Space

Provider agrees that the medical office space will be maintained in accordance with Envolve Vision's policies and procedures, as well as with applicable federal and state laws. Envolve Vision's policy is available via the Eye Health Manager www.envolvevision.com/logon.

Verification of Member Eligibility

Providers should verify Member eligibility prior to delivering service at each visit. Members should present a Member ID card to receive covered services. Presentation of a Member ID card does not guarantee eligibility.

Envolve Vision offers two (2) ways to verify eligibility twenty-four (24) hours per day/seven (7) days per week via the Eye Health Manager www.envolvevision.com/logon or Interactive Voice Response System (refer to Customer Service phone number listed in Appendix: Plan Specifics).

Medical Records

Recordkeeping Requirements

Envolve Vision requires all Providers to maintain sound medical record keeping practices that are consistent with industry standards and the Provider Participation Agreement. Records must be legible, current, detailed, organized, and comprehensive to ensure effective patient care and quality review. Medical records need to be identifiable by the Member or family name and accessible to the Provider as services are rendered.

Envolve Vision does not require the Provider to use specific forms for medical record documentation. Various professional organizations have created templates that can improve documentation processes. Envolve Vision encourages use of standardized forms for documentation as a method to improve continuity and coordination of care for Members.

Audits

Envolve Vision may audit record keeping practices and individual Member records in conjunction with on-going quality improvement activities or as a result of Member complaints.

Envolve Vision encourages Providers to request medical records that document care previously provided to Members who are new to the Provider's practice. This will assist in ensuring the Member receives continuous care, as well as help determine the most appropriate course of treatment.

Confidentiality

Providers should maintain confidentiality of medical records and treatment information in accordance with state and federal laws including the Health Insurance Portability and Accountability Act (HIPAA). Medical records should be kept in a secure location, accessible only by authorized personnel. Providers must periodically train their staff about Member information confidentiality.

Health Insurance Portability and Accountability Act (HIPAA)

To improve the efficiency and effectiveness of the healthcare system, HIPAA, Public Law 104-191, includes Administrative Simplification provisions that require the United States Health and Human Services Department to adopt national standards for electronic healthcare transactions, code sets, unique health identifiers, and security. Envolve Vision has the responsibility to protect the privacy of personally identifiable health information by adhering to all federal and state laws, industry standards, and professional ethics.

Notice of Privacy Practices

Envolve Vision follows privacy practices established by HIPAA and other state and federal guidelines.

Envolve Vision's Notice of Privacy Practices is available on the Envolve Vision website www.envolvevision.com/logon.

National Provider Identifier (NPI)

The NPI is mandated by HIPAA. It is a unique identification number used by healthcare Providers when submitting claims for reimbursement. Providers, Payors, and healthcare clearinghouses are required to use the NPI numbers in the administrative and financial transactions specified by HIPAA. The NPI contains information about the healthcare Provider, such as the type of health care provided or the state where the healthcare Provider is located; and does not include embedded identifiers. The NPI must be used in connection with the electronic transactions identified in HIPAA. The NPI does not:

- Replace state-issued licenses and certifications verifying a Provider's licensing or qualifications.
- Replace Social Security Number, Individual Tax ID number, or Employer ID for tax purposes.

The NPI number can be accessed by visiting the Center for Medicare & Medicaid Services' website and typing in "National Provider Identifier" into the search option. This will bring up options to apply for a NPI number.

Member Liability

Providers are responsible for collecting all copayments, coinsurance, or deductibles applicable to covered services provided to Members according to Appendix: Plan Specifics from members.

Providers may also collect fees associated with non-covered services from the Member, if applicable, based on the Member's benefit program. The Member must be advised of and acknowledge in writing any non-covered vision services rendered by the Provider. The generic (not state specific) Non-Covered Services Liability Acknowledgement form is located on the Envolve Vision website www.envolvevision.com/logon. Please note that some states require a state specific Non-Covered Services Liability Acknowledgement Form. This form must be maintained in the Member's medical record.

Prescriptions

Drugs

If applicable, Providers have the responsibility to abide by the prescription formulary or preferred drug list designated by the Payor when prescribing medications for Members.

Corrective Lenses

Providers are required to release written prescriptions for corrective lenses unless this requirement contradicts state law.

Referrals

Primary Care Physician Referrals

Envolve Vision does not require Primary Care Physician referrals for in-network eye care, with the exception of lock-in members. **Referrals are required for medical & surgical procedures only for lock-in members only; they are not required for routine eye exams.**

Lock-In members are restricted to specific providers for a period of two years. A written referral is required from the member's lock-in physician before any other physician or specialist can be paid for services rendered. The written referral must be retained in the referred provider's office, and must be furnished on request. The referral must be dated and is only valid for one month immediately following its issue. The following claim submission guidelines apply for lock-in members:

- The name of the PCP making the referral must be submitted in Item# 17 and the PCP's NPI number must be submitted in Item# 17b of the CMS 1500 form or applicable 837 field.
- When submitting a claim through the Envolve Vision website, enter the PCP's NPI number in Block 19 of the web claim form.

Reporting to Primary Care Physicians

When applicable, the Provider should partner with the Primary Care Physician to deliver specialty care to Members. A key component of the Provider's responsibility is to maintain ongoing communication with the Member's Primary Care Physician.

Providers should supply a complete written report of findings to the Member's Primary Care Physician within one (1) week following examination and treatment. If urgent or emergent follow up is required, the Provider shall provide a verbal report to the Member's Primary Care Physician within twenty-four (24) hours.

Provider Practice/Office Information Changes

Providers should notify Envolve Vision when a change occurs in the Provider's practice/office by using the Provider Update Form. This form allows Envolve Vision to maintain accurate information about the Provider's practice. Envolve Vision uses this data when processing Provider claims and updating its Payors for the purposes of developing and maintaining their Provider directories.

Examples of changes include:

- Moving office location(s)
- Opening an additional office
- Changing the business name and/or Tax ID number
- Removing Providers from an office location only*

*Please refer to the **Voluntary Termination from the Network** section of this manual for information related to removing providers from Envolve Vision's provider panel.

The Provider Update Form is available on the Envolve Vision website at www.envolvevision.com/logon. Envolve Vision must receive all applicable changes thirty (30) days in advance of the effective date.

When adding a Provider to an existing practice, please contact Network Management at the phone number listed in Appendix: Plan Specifics.

Marketing — Name, Symbol, Service Mark

If prior written approval is obtained, Provider, Envolve Vision and the Payors have the right to use each other's name, symbol, and service mark for the use of Provider directories or for marketing purposes.

Non-Disparaging Language

Providers must refrain from making false, misleading, or inaccurate statements relating to Envolve Vision or its Payors. Disputes are to be handled between Envolve Vision and the Provider. Providers may reference the Quality Improvement Program for more details on the complaint process.

Provider Credentialing/Re-Credentialing

Credentialing

Providers who want to join Envolve Vision's Provider Network must meet the following criteria for eligibility:

- The optometrist or ophthalmologist must be currently licensed to practice his/her profession in the state and within the service area of the plan, if applicable. Optometrists and ophthalmologists must hold a therapeutic pharmaceutical agent certification and DEA/DPS/BNDD Certification, if applicable in that state, to be considered for medical/surgical panels.
- The Provider must agree to meet the standards of care and service as specified by the appropriate quality committees within Envolve Vision. At the time of re-credentialing the Provider profile (report card) information must meet or exceed the Envolve Vision Quality Assurance requirements. The following items are reviewed: adverse events, Member complaints, unprofessional behavior, utilization patterns, and quality of care issues.
- The optometrist or ophthalmologist must maintain professional liability coverage in the amounts required by Envolve Vision. The minimum

requirement is \$1 million per occurrence and \$3 million aggregate or as required by state law. Providers must not have a history of denial of liability coverage.

- Ophthalmologists must be board eligible with the American Board of Ophthalmology, at a minimum, for initial credentialing. Ophthalmologists must be board certified at the time of re-credentialing. A provider who is registered to sit for the boards will be given a 2 year grace period to complete and pass the oral and written exam. The provider must notify Envolve Vision in writing within one month of the pass or fail of each exam. Should the provider fail an exam and not become board certified within the 2 years grace period, Envolve Vision will term the provider upon receiving notification.
- Optometrists and ophthalmologists must have no unresolved disciplinary reviews or restrictions relating to his/her license. The Credentialing Committee will assess resolved disciplinary reviews.
- Ophthalmologists must have clinical privileges that are in good standing at the hospital designated as the primary admitting facility, if applicable. They must have admitting privileges at a participating facility. Surgery centers are not acceptable.
- Providers must not have greater than six (6) months of unaccounted time gaps in work history.
- Ophthalmologists must have graduated from an accredited medical school and have completed an accredited residency. Optometrists must have graduated from an accredited optometry school.
- Providers should not have significant sanctions reported through Medicaid, Medicare, or appear on the Office of Inspector General's List of Excluded Individuals and Entities.
- Providers must not have a history of criminal conviction or indictment.
- Providers must not be engaged in the use of illegal drugs or in treatment for substance abuse.

Envolve Vision does not discriminate against Providers who serve high-risk populations or who specialize in the treatment of costly conditions. Envolve Vision does not discriminate against Providers based on age, sex, race, religion, sexual orientation, and/or national origin. To avoid any possible discriminatory actions, Credentialing Committee Members are provided the minimal information required for making a decision.

Re-credentialing

All Providers are re-credentialed every thirty-six (36) months unless otherwise required by the Payor. Reminder notices are distributed three (3) months and one (1) month prior to the expiration of the Provider's credentials.

Voluntary Termination from the Network

Providers may voluntarily terminate from the Envolve Vision network according to the Provider Participation Agreement. For a termination request to be approved, a written notice of intent to end participation must be mailed to Envolve Vision 30 days prior to the effective date of the termination. For your convenience, providers may fill out and submit the *Provider Termination from Panel Request* form on our website at www.envolvevision.com/logon. Additionally, Providers are obligated to make available, upon request, Member records in order to facilitate the transfer of care.

Providers must continue to provide service to Members until the termination effective date and until such time as Envolve Vision is able to transfer Members to another participating Provider.

Please refer to Envolve Vision's Participating Provider Agreement for written notification timeframes.

SECTION III: CLAIMS

Envolve Vision is committed to equipping Providers with the best tools possible to support their administrative needs for filing, processing, and claims.

Filing Claims

Providers can file claims online via the Eye Health Manager www.envolvevision.com/logon, electronically via Change Healthcare (formerly Emdeon), or by mail.

Eye Health Manager

Providers are allowed direct data entry into Envolve Vision's claim system. This method of filing provides immediate confirmation of claim receipt. Access to the site is restricted and password-protected. Contracted providers may obtain a username and password. To become contracted, please contact Network Management at (800) 531-2818; choose option 4

Change Healthcare (formerly Emdeon)

Providers may submit claims electronically through Change Healthcare using payor ID number 56190, listed as Envolve Vision. The payor ID# should be placed in 2010BB Loop/NM109 segment. Use "PI" as the ID Code Qualifier in NM108. Place the rendering Provider ID in 2310B Loop/REF02 segment. Use "N5" as the Reference Number Qualifier in REF01. To set up an account to submit claims electronically, call Change Healthcare at (800) 845-6592.

Mail

All claims submitted to Envolve Vision by mail for payment must be filed on an original CMS 1500 form. Forms must be completed and legible for payment processing.

Mailing Address:

Envolve Vision
[Insert Payor Name]
PO Box 7548
Rocky Mount, NC 27804

Faxing Claims

Envolve Vision does not accept faxed claims unless mandated by state-specific legislation.

General Filing Guidelines

Envolve Vision follows all CMS claims submission guidelines and HIPAA coding standards. The following guidelines must be followed when submitting a claim to Envolve Vision.

- All claims should be submitted within 180 calendar days of the date of service. No reimbursement will be made for claims received beyond this date. Claims received after the 180-calendar day filing deadline will be considered a provider liability and members may not be billed for services.
- All services provided must be included on the CMS 1500 claim form. Billed amounts should be consistent with the provider's usual and customary charges.
- File claims with the correct subscriber ID number, including the correct alpha prefix or suffix, if applicable.
- File claims under the subscriber's name on the ID card, not his or her nickname.
- Claims must include Tax ID number in Item 25 of the CMS 1500 form or the equivalent electronic and Eye Health Manager field. This number should be the Tax ID number or Social Security number reported to Envolve Vision on the Provider's W-9.
- Claims must have the Provider's name (typed or stamped) and signature on file in Item 31 of the CMS 1500 form or the equivalent electronic field. Envolve Vision will return the claim if we are unable to read the Provider's signature. Do not submit a facility or practice name in the signature field.
- Claims must have the address or physical location where services were rendered in Item 32 of the CMS 1500 form or the equivalent electronic field if different from Provider billing address as listed in Item 33.
- Providers must submit their NPI number in Item 24J of the CMS 1500 form or the equivalent electronic field.
- Claims should be filed using current, valid, and appropriate diagnosis codes, and should be coded to the highest level of specificity available.
- Proper sequencing order of the diagnoses codes must be etiology followed by manifestation in Item 21 of the CMS 1500 form or equivalent electronic field. The diagnosis pointer in Item 24E must reference the primary reason for performing the service in the first position.
- When a Member presents for a routine eye examination with no complaints, regardless of the final diagnosis, the Provider must file the

visit as a routine eye examination. Subsequent services to treat the medical diagnosis may be filed as medical visits. The coverage of services rendered by a Provider is dependent on the purpose of the examination rather than on the final diagnosis.

- Providers must submit medical records and a dictated letter signed by the servicing provider detailing the reason for performing the service when billing modifier 59 to bypass National Correct Coding Initiative Edits.
- Use current valid CPT/HCPCS service codes. If there is no suitable CPT/HCPCS service code or if the CPT/HCPCS service code is unlisted, give a complete description in Item 19 or the equivalent electronic field.
- Use current valid CPT/HCPCS modifiers when necessary.
 - When multiple modifiers are billed on a single service line on a claim, use modifier 99 in Item 24D and place the additional modifiers directly after modifier 99.
 - When using modifier 50 to indicate a bilateral service was performed, submit 1 billed unit in Item 24G or the equivalent electronic field.
- Indicate how many times each service was performed and make sure the units are consistent with the CPT/HCPCS service code.
- Claims must contain a pre-certification or referral number if applicable in Item 23 of the CMS 1500 form or the equivalent electronic field.
- When submitting an accident diagnosis, include the date that the accident occurred in Item 14 of the CMS 1500 form or equivalent electronic field.
- When documenting significant changes in vision and/or requesting replacement eyewear (if applicable for Payor) indicate the previous and current prescriptions in Item 19 of the CMS 1500 form or equivalent electronic field.
- When filing for Coordination of Benefits, submit the primary insurance information in Items 9a – d of the CMS form or the equivalent electronic field. A copy of the primary Explanation of Benefit/Payment should accompany the CMS 1500 form when filing for Coordination of Benefits.

- Paper claims must be filed using the following guidelines or the claim may be returned for corrections:
 - Use only an original red-ink-on-white-paper CMS 1500 claim form. Faxed and/or copied claims are not accepted as a claim submission.
 - Submit typed or computer-printed forms.
 - Do not print, handwrite, or stamp additional information on the form.
 - Do not staple, clip, or tape anything to the claim form.
 - Do not use liquid white-off. Use only lift-off correction tape when making corrections.
 - Do not use highlights, Post-it notes, labels, or stickers.
 - Claims forms must be clear and legible.
 - Include the Payor name in Item 11c on the claim form.
 - **Handwritten claims are not accepted. If your office is unable to meet this standard, contact Customer Service and/or Network Management at the phone numbers listed in Appendix: Plan Specifics.**

- Claims (initial filings, resubmissions, and/or appeals) may require additional information that must accompany the CMS 1500 form for the claim to be considered a “clean claim”. The following is a listing of attachment/description requirements:
 - A description on a full sheet of paper or write a description in Item 19 of CMS 1500 form for 92499, V2599, or any other unlisted procedure.
 - Referral forms do not need to be submitted with the claim, unless indicated in Appendix: Plan Specifics.
 - An invoice for consideration of wastage for botox injections, if applicable.
 - A copy of the optical lab invoice and prescription when billing for non-standard eyewear (frames and lenses) and/or additional lens features (i.e. high-powered index lenses, polycarbonate lenses, etc.), if applicable.
 - Office notes/medical records/operative notes signed by the rendering Provider for changes in diagnosis, procedure codes, or rendering Provider.

Place of Service Codes

The Provider must use the standard place of service codes as defined by Centers for Medicare & Medicaid Services when requesting authorizations and filing claims for payment. A current list of the valid place of service codes may be viewed on the Centers for Medicare & Medicaid Services’ website.

Modifiers

The Provider must use the standard modifier codes; CPT codes as defined by the American Medical Association and the HCPCS codes as maintained by the Centers for Medicare & Medicaid Services when requesting authorizations and filing claims for payment. A current list of the valid modifier codes may be viewed on the Centers for Medicare & Medicaid Services' website.

Claims Processing

Coordination of Benefits

When a Member is covered by more than one Payor, Envolve Vision will coordinate benefits with other plans to reduce the Member's out-of-pocket expenses. Envolve Vision adheres to the coordination of benefits regulations set forth by the National Association of Insurance Commissioners as adopted by the state where the service is rendered.

When Envolve Vision is the Secondary Payor, the Primary Payor information is required for calculation of the secondary payment. When submitting claims electronically or through the website, the appropriate coordination of benefit field(s) should be completed. Provider may also submit a clean CMS 1500 form and a copy of the Explanation of Benefits from the Primary Payor.

Providers may visit the Envolve Vision website to reference the policy titled "Coordination of Benefits Payment Methodology" for more information.

Global Surgical Period

Envolve Vision follows Centers for Medicare & Medicaid Services global period guidelines for all surgical services. The global periods are indicated in the National Physician Fee Schedule, available on the Centers for Medicare & Medicaid Services' website. Reimbursement for surgical procedures includes:

- Pre- and Postoperative visits
- Patient's history and physical
- Any inpatient visits
- Complications following surgery
- Local and topical anesthesia administered by the physician
- Intra-operative services
- Supplies

Major surgeries have a one-day preoperative period and a ninety (90)-day postoperative period. Minor surgeries have either a zero (0) or a ten (10)-day postoperative period. Providers in the same group practice are covered under a single global fee for pre- and postoperative services.

Co-Management of Care

When a Provider, other than the surgeon, is providing the pre/postoperative care, it must be documented at the time of the pre-certification request and billed accordingly using the guidelines below.

Co-management of care requires the following:

- Co-management services must be indicated at the time of the pre-certification request, including the co-managing Provider.
- The surgeon should bill for the surgery only using modifier 54.

Providers should bill the preoperative portion of the global period using the following guidelines:

- Date of service must be the date the surgery was performed.
- The claim must include the surgical procedure code, including modifier 56.

Providers should bill the postoperative portion of the global period using the following guidelines:

- Date of service must be the date the surgery was performed.
- The claim must include the surgical procedure code, including modifier 55.
- Indicate assumed and relinquished dates in Item 19 of the CMS 1500 form or electronic equivalent.

Non-Covered Services

Non-covered services vary by Payor; refer to the Appendix: Plan Specifics for details.

After-Hours Office Visit

Envolve Vision does not reimburse Providers for this service, because it is considered by the Centers for Medicare & Medicaid Services to be a “bundled” service. Bundled services are not payable, nor should they be reported, even when performed incidental to or in combination with another service.

Telephone Consultations

Billing for telephone consultations is not covered.

Billing for Missed Appointments

Envolve Vision does not cover charges for missed appointments. Commercial and Medicare Members may be billed for missed appointments only if this is the standard office procedure, the Member has previously received a written statement of this procedure, or it is posted in a prominent location in the office.

Medicaid Members may not be billed for missed appointments.

Verifying Claim Status

Claim status can be obtained via the Eye Health Manager www.envolvevision.com/logon.

Correcting Claims

A corrected claim is defined as a claim that is being re-filed with necessary, additional information that enables the proper adjudication of the claim. In most instances, the original claim was initially submitted without all of the proper elements necessary to process the claim, resulting in a denial for additional information.

Corrected claims must include all services rendered on the date of service. Include the appropriate Resubmission Code and original claim number in Item 22 of the CMS 1500 claim form or equivalent electronic field or indicate CORRECTED CLAIM and the original claim number on web.

Payment of Claims

Providers have the following two (2) options to receive payments:

Mail

Providers will receive checks by mail with or without the Explanation of Benefit/Explanation of Payment Statement depending upon their specified preference.

Electronic Funds Transfer

Envolve Vision has partnered with PaySpan Health to deliver Electronic Funds Transfers (EFTs), Electronic Remittance Advice (ERAs). PaySpan Health is a free solution to enable online presentment of remittance/vouchers, straightforward reconciliation of payments to empower our providers to reduce costs, speed secondary billings, improve cash flow, and help the environment by reducing paper usage. Instructions to register for PaySpan Health are below.

How to Register for PaySpan

- Call 1-877-331-7154 Option 1 for your unique registration code.
- Go to www.payspanhealth.com and click the **Register Now** button.
- Enter your Registration Code and click **Submit**.

Payment Methodologies

Envolve Vision complies with all applicable prompt payment laws regarding the processing and payment of clean claims. Covered procedures are subject to Envolve Vision's payment methodologies for both commercial and government sponsored programs based on: Medicare Physicians Fee Schedule, The National Correct Coding Policy Manual for part B Medicare Carriers, and local Medicare Carrier Policies in addition to Envolve Vision's coding guidelines. These

guidelines are intended to incorporate and, in specific instances, include the requirements of the Centers for Medicare & Medicaid Services guidelines. Additional resources for payment methodologies administered by Envolve Vision may include, but are not limited to:

- American Medical Association's CPT Manual
- American Academy of Ophthalmology Preferred Practice Patterns
- State Medicaid Guidelines
- Input from board-certified doctors of ophthalmology
- Current medical literature

Payment Discrepancies

The Provider should call the Customer Service number listed in the plan specifications when a payment discrepancy is discovered.

When Envolve Vision notices that an overpayment has been made, a written request for reimbursement will be sent to the Provider. Adjustment(s) on future Explanation of Benefits/Explanation of Payments will be made if reimbursement is not received within 45 days from the date of the request and funds are available for retraction.

Incorrect payments made on governmental programs (Medicaid and Medicare) may be retracted without prior written notification.

Claim Appeal Process

Providers may appeal a claim that has been denied in whole or in part for disputes relating to claim payments.

- The provider has the right to submit a request for reconsideration within 120 calendar days of the date of the Notice of Action, plus 3 calendar days is allowed for mailing time.
- Providers have the opportunity to include testimony, in addition to evidence and legal and factual arguments, when submitting reconsiderations.
- Plan will resolve within 30 calendar days from the date received.
- Provider will be sent a revised/unrevised EOP for same claim number within 1 business day of resolution.
- Provider can discontinue a reconsideration and proceed to appeal within 63 calendar days of the date of the original EOP or Notice of Action.

A claim appeal is a written communication regarding a disagreement in the way a claim was processed, and does not require a claim to be corrected. The appeal must be submitted within 63 calendar days of the original EOP OR within 63 calendar days of an EOP resulting from a reconsideration. Providers wishing to appeal a claim must complete the Claim Appeal Form. The Claim Appeal Form

can be obtained at www.envolvevision.com/logon by clicking on *Claims Appeal Request Form for KanCare Members*.

The form and supporting documentation should be mailed to:

Envolve Vision
Attn: Appeals Department
PO Box 7548
Rocky Mount, NC 27804

To expedite the processing of your appeal, please attach:

- A copy of the EOP(s) with claim(s) to be adjusted clearly circled;
- Documentation supporting the claim (operative reports, medical records, chart notes, etc.)

If no additional documentation is provided, the original disposition will prevail. The original claim number must be referenced in the documentation. The form must also include a detailed description of the reason for the request. Unclear or non-descriptive requests could result in no change in the processing, a delay in the research or delay in the reprocessing of the claim. Envolve Vision shall process, and finalize all corrected claims and claim appeals to a paid or denied status, and notify the provider of the appeal outcome within 30 calendar days of receipt of the corrected claim or appeal.

If a provider is not satisfied with the outcome of an appeal decision, the provider may request a Fair Hearing appeal through the Office of Administrative Hearings. Fair Hearings are allowed under the following circumstances for providers:

1. Provider Right to Appeal Adverse Credentialing Determinations
2. Provider Appeals
3. A Medical Necessity Decision

A provider has the right to appeal and request an administrative fair hearing under the Kansas Administrative Procedures Act, K.S.A 77-501, et seq. and K.A.R. 30-7-68, and after an appeal has been filed with Envolve Vision. A written request for such administrative fair hearing shall be sent to:

Office of Administrative Hearings
1020 South Kansas Avenue
Topeka, KS 66612-1327

The request must specifically request a Fair Hearing. The request must be made 120 + 3 calendar days from the date of notice. The request should describe the decision appealed and the specific reasons for the appeal.

SECTION IV: UTILIZATION MANAGEMENT

Utilization Management

Clinical Criteria

Envolve Vision has established clinical criteria for determining medical necessity. All clinical criteria are evaluated annually by the Medical Directors through a formal process. The Quality Improvement Committee also reviews and approves the clinical criteria annually.

Envolve Vision utilizes the most recent editions of the following references to annually re-evaluate all clinical criteria in addition to input from board certified doctors of ophthalmology, but are not limited to:

- American Academy of Ophthalmology Preferred Practice Patterns
- American Medical Association CPT Manual
- National Correct Coding Initiative Edits
- Medicare Physician Fee Schedule
- Current medical literature

Current policies are published on the Envolve Vision website www.envolvevision.com/logon.

Routine Eye Examination

When performing a preventative (routine) eye examination, the duly licensed eye care provider performs a complete visual system examination, including history, examination, diagnosis, and initiation of management. Included within each part of the evaluation is a series of tests particularly suited for the detection, diagnosis, and initiation of appropriate therapy for eye disorders.

The exam elements listed below are basic areas of evaluation and are not meant to exclude additional exam components that might be appropriate.

- History
- Assessment of relevant aspects of patient's mental and physical status
- Visual fields by confrontation
- Best corrected visual acuity (with refraction¹ when indicated)
- External examination
- Pupillary function
- Ocular alignment and motility
- Slit-lamp biomicroscopy examination
- Intraocular pressure measurement
- Fundus examination (generally requires dilated pupils unless contraindicated, slit-lamp, and diagnostic lenses)

¹Refractions are separately reportable unless specifically included with the description of a service (e.g. S0620 & S0621).

Clinical Decisions

Utilization Management decisions are based on appropriateness of care, service, and existence of coverage. Envolve Vision does not reward individuals conducting utilization reviews for issuing denials of coverage or service. Financial incentives for Utilization Management decision makers do not encourage decisions that result in underutilization.

The Provider, in conjunction with the Member, is responsible for making all clinical decisions regarding the care and treatment of the Member. Envolve Vision's Medical Directors are responsible for making medically necessary decisions in accordance with covered benefits and established criteria. Failure to obtain authorization for services that require approval will result in payment denials.

Authorizations

Authorization requirements vary according to the Payor, please refer to Appendix: Plan Specifics for details.

Envolve Vision accepts authorization requests through the Eye Health Manager www.envolvevision.com/logon, by fax, or by mail. The Pre-Authorization Request form is available on the Envolve Vision website. Changes to previously authorized services require approval and must be submitted by fax with applicable supporting documentation.

Assistant Surgeon

Envolve Vision allows assistant surgeon services for procedures identified by Centers for Medicare and Medicaid Services as potentially requiring an assistant surgeon. Providers must submit a Pre-Authorization Request form for both the primary surgeon and the assistant surgeon for all services that require authorization.

Emergency Care

Envolve Vision defines emergency care as any healthcare service provided in a hospital emergency facility (or comparable facility) in order to evaluate and stabilize medical conditions of recent onset and severity (including severe pain), if such condition would lead a prudent layperson (possessing an average knowledge of medicine and health and acting prudently) to believe that failure to get immediate medical care might result in:

- Placing the person's health in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part
- Serious disfigurement

- In the case of a pregnant woman, serious jeopardy to the health of the fetus

Emergency room/urgent care services do not require preauthorization.

Envolve Vision will follow Payor and/or state required language in reference to emergency care, if it varies from the above definition. Check the Plan Specifics for specific Payor information. If more information is required in reference to policies and procedures, please refer to the Envolve Vision website www.envolvevision.com/logon.

Out-of-Network Eye Care Services and Facilities

Envolve Vision coordinates out-of-network care for Members, when delegated by the Payor. Out-of-Network care may be approved if there are no participating Providers or facilities to provide the necessary care. All requests should be submitted using the Pre-Authorization Request form located on the Envolve Vision website www.envolvevision.com/logon. Requests are considered for the following situations, but are not limited to:

- Prior surgery was performed and continuing care is medically necessary for continuity.
- Interruption in the treatment plan would jeopardize the Member's recovery time.

Providers must use participating facilities. For non-participating facility approval, the Facility Name & Address field of the form should be completed in full by the rendering Provider and faxed to the number provided on the form. If the Payor does not approve the requested facility, Envolve Vision will not approve the requested service.

Pharmaceuticals

Envolve Vision requires pre-authorization for injectables aflibercept (Eylea®), ranibizumab (Lucentis®), pegaptanib (Macugen®), and verteporfin (Visudyne®). The use of bevacizumab (Avastin®) does not require pre-authorization. The Anti-VEGF Pre-Authorization Request Form, along with supporting medical records documenting that the member has met all approval criteria, must be submitted for a pre-authorization request to be considered. This form and information can be found on the Envolve Vision website (www.envolvevision.com/logon).

The pre-authorization for aflibercept (Eylea®), ranibizumab (Lucentis®), pegaptanib (Macugen®), or verteporfin (Visudyne®) will last for 12 months and will be tied to the rendering physician. Should the patient need to receive one of these injectables for a longer period of time or through a different provider, an additional pre-authorization must be obtained. Retrospective authorization requests following claim denial may not be approved.

Many Payors utilize a drug formulary or designated pharmaceutical vendor. The Payor's website should be referenced prior to writing a prescription.

Utilization Management Appeals

Providers will receive specific instructions within their denial letter on how to file an appeal. Member appeals are immediately submitted to the health plan for timely processing. Expedited appeals may be filed when the time expended in a standard appeal could jeopardize the life and health of the Member. A clinician must decide whether expedited criteria has been met. Additional information is available on the Envolve Vision website www.envolvevision.com/logon under Policies and Procedures.

Standard Appeal Process

Step 1:

Member files appeal by calling Customer Service, or by sending a fax or letter to the Health Plan.

Step 2:

Member may request to have services continue while they are waiting for the Health Plan to make a decision, but this request must be made within 10 calendar days of mailing date on notice of action for non-HCBS services and HCBS services will continue automatically with appeal request.

Step 3:

Health Plan sends a letter within 5 calendar days of the receipt of the appeal to let member know the appeal has been received.

Step 4:

Health Plan will resolve the appeal and send the member a written notice of their decision as expeditiously as member condition warrants and within 30 calendar days of receipt of the appeal. The notice should also include the date the appeal was completed.

Step 5:

If a member is not satisfied with the Health Plan appeal decision, they have the right to request a State Fair Hearing within 123 calendar days from the date the Member Appeal Resolution notice from Health Plan.

Additional information can be found in the Health Plan's Provider Manual.

Utilization Management Committee

The Utilization Management Committee oversees policy and procedural aspects of the Utilization Management Department and performs Utilization Management monitoring processes. The Envolve Vision Utilization Management Committee

contains a subcommittee called the Payment Integrity Team that is responsible for reviewing recommendations presented by the Utilization Management Department, Claims, or System Analysis in response to discoveries of inappropriate provider utilization and/or billing concerns. While education and improvement in billing patterns is the goal, the Payment Integrity Team may be called upon to review and make recommendations in cases where education or other sanctions to change provider billing patterns have proven unsuccessful.

Provider education is initiated through continuous monitoring of trends in Provider billing behaviors to ensure appropriate coding, and to identify inappropriate billing patterns and potential waste, abuse, and fraud. The goal of Provider education is to promote efficient utilization of optometric and ophthalmologic services (both routine and medical) through retrospective review. These activities include, but are not limited to review of required documentation to support medical necessity, benefit exceptions, appropriate levels of care, and appropriate use of diagnostic services. In addition to education, this process allows for continual assessment of Envolve Vision's current claim processes and policies to determine if procedures adhere to current industry standards and Payor/state/federal regulations.

Current policies may be viewed through the Envolve Vision website (www.envolvevision.com/logon). If you do not have access to the internet, please call our Utilization Management Department at (800) 465-6972 for copies of our clinical policies.

Waste, Abuse, and Fraud Prevention

Envolve Vision has a comprehensive program designed to identify, prevent, reduce, and report Waste, Abuse, and Fraud that complies with state and federal laws.

Waste: To spend money or utilize benefits carelessly or uselessly; to allow benefits to be used inefficiently. Waste directly or indirectly results in unnecessary costs to the program due to carelessness or inefficiency.

Abuse: Actions inconsistent with accepted, sound medical, business, or fiscal practices. Abuse directly or indirectly results in unnecessary costs to the program through improper payments for services that are not medically necessary; do not meet professionally recognized standards for healthcare; or do not meet standards required by contract, statute, regulation, or previously sent interpretations to of any items listed.

Fraud: Intentional deception or misrepresentation that someone makes, knowing it is false, that could result in an unauthorized payment. Keep in mind the attempt itself is fraud, regardless of whether it is successful.

Envolve Vision conducts internal utilization management audits to ensure compliance with all applicable regulations. Envolve Vision also uses systems to identify possible Waste, Abuse, and Fraud through analyzing claims. If Waste, Abuse, and/or Fraud are detected through internal utilization management audits, internal systems or if an external referral is received, Envolve Vision's Special Investigation Unit will conduct a review which may result in actions against those who are found to have committed Waste, Abuse, and Fraud. Envolve Vision's actions may include the following:

- Provider education
- More rigorous Utilization Review
- Recover monies previously paid
- Report findings to appropriate Payor and/or regulatory agencies
- Termination from the Envolve Vision Network

Some of the most common Waste, Abuse, and Fraud submissions seen are:

- Unbundling of codes
- Up-coding
- Add-on codes without primary CPT
- Diagnosis and/or procedure code not consistent with Member's age/gender
- Claims for services not rendered

If a Provider suspects another Provider is inappropriately billing Envolve Vision or if a Member is receiving unnecessary services, please contact Envolve Vision's Fraud, Waste and Abuse hotline at (800) 361-9025. Envolve Vision takes all reports of potential Waste, Abuse, and Fraud seriously and investigates all reported issues.

SECTION V: QUALITY IMPROVEMENT PROGRAM

The Quality Improvement Program ensures the coordination, safe delivery and evaluation of the high quality, cost-effective routine and medical eye care required by Payors for their covered Members. Envolve Vision's Quality Improvement Program assures the timely identification, assessment, and resolution of known or suspected deficiencies in the quality of care or services received by Members and to prevent their reoccurrence by continuous monitoring, evaluation, and improvement of the routine and medical eye care services.

Program Scope

Envolve Vision develops performance thresholds and benchmarks, based on current practice standards and scientific studies. The Quality Improvement Department develops, monitors, and conducts internal operational evaluations. Quality deficiencies, individual concerns, and patient safety issues are identified and monitored by the Quality Improvement Department utilizing the following resources:

- Concerns, complaints, and grievances of Members, Providers, and/or Payors
- Delegating Payor input (solicited and unsolicited)
- High-risk care and service evaluation (e.g. diabetic studies)
- High volume care and service evaluation
- Internal audits for Claims, Credentialing, Customer Service, Network Development, and Utilization Management, Enrollment, and Provider Maintenance departments
- Monitoring of established practice guidelines through review of medical records and utilization indicators
- Member satisfaction surveys (as delegated)
- Member access evaluations
- Payor satisfaction surveys
- Provider inquiries
- Provider office procedure review
- Provider satisfaction surveys
- Re-credentialing
- Retrospective chart review
- Site visits (Quality of Service Issues)
- Provider profiling
- Telephone abandonment rates and delay to answer statistics
- Utilization data evaluation

Envolve Vision investigates identified quality issues. Providers in question have the right to see all documents related to the case and the right to respond to all of the issues and have their responses recorded. Providers may appeal decisions

pertaining to their cases, and have their case reviewed by a Peer Review Committee.

Committee Structure

Quality Improvement Program Committee Structure:

The Quality Improvement Program committee structure is comprised of several committees to assist in performing duties, to provide guidance and direction and to promote the goals and objectives of the Quality Improvement Program as a whole.

Audit & Risk Management Steering Committee

The Audit & Risk Management Steering Committee provides high-level oversight of internal and external audit results, internal controls, compliance with laws and regulations, and risk management and emerging risks.

Credentialing Committee

The Credentialing Committee develops comprehensive credentialing standard operating procedures, reviews applications, and makes credentialing decisions.

Grievance/Appeals Committee

The Grievance/Appeals Committee objectively hears grievances or appeals that are not able to be resolved through an informal process.

Peer Review Committee

The Peer Review Committee reviews complaints pertaining to quality of care and service issues.

Utilization Management Committee

The Utilization Management Committee oversees the development, research, and implementation of claim payment policies and other programs as mandated by state or federal legislation, in addition to monitoring quality, quantity, and cost-effectiveness of care.

Healthcare Effectiveness Data and Information Set

Healthcare Effectiveness Data and Information Set (HEDIS) is a set of standardized performance measures developed by the National Committee for Quality Assurance (NCQA) which allows comparison across Payors. HEDIS gives purchasers and consumers the ability to distinguish between Payors based on comparative quality in addition to cost differences. Envolve Vision supports our Payors through data analysis and access to clinical expertise in order to improve HEDIS compliance rates.

The Envolve Vision website www.envolvevision.com/logon contains a full description and a list of requirements related to Envolve Vision's HEDIS participation.

Grievance Procedures

A grievance is any expression of dissatisfaction about any matter, other than an action that would be resolved through the appeals or claim dispute process. Envolve Vision maintains an internal system for receiving and resolving oral and written grievances. The system has a process for acknowledgement and resolution.

Provider must submit grievances to Envolve Vision within 180 calendar days of the date of the incident being grieved. Envolve Vision will resolve 98% of grievances and provide notice within (30) calendars from the date the grievance is received.

Provider Grievance Process

Acknowledgement

When Envolve Vision receives an oral or written grievance from a Provider, it is thoroughly documented and logged for tracking purposes. All grievances will be acknowledged in writing within ten (10) calendar days of receipt. All acknowledgement letters document the date the grievance was received and describe the grievance procedures and timeframes.

Grievance Resolution Time Frame

All Provider grievances should be resolved within five (5) business days from the date of receipt. Health Plan will resolve all grievances and send written resolution within 30 calendar days of receipt.

Depending on the circumstances and the amount of information needed to thoroughly investigate the grievance, the process may take up to thirty (30) calendar days once all necessary information is gathered.

Member Grievance Process

Envolve Vision and the contracted Provider will follow the grievance process as directed by the Payor, which is outlined in the Health Plan's Provider Manual.

Step 1:

Grievance filed by calling Customer Service, or by sending a fax or letter to Health Plan

Step 2:

Health Plan sends a letter within 10 calendar days of receipt of the grievance acknowledging the grievance has been received, unless the grievance is resolved on the same day it is received by the Health Plan.

Step 3:

Health Plan resolves the grievance as expeditiously as the member condition warrants and sends a resolution notice within 30 calendar days of receipt of the grievance. Clinically urgent member grievances will be resolved within 72 hours if they meet the criteria as determined by a clinician.

Cultural Competency

Envolve Vision is committed to providing culturally and linguistically appropriate eye care services in a manner which affirms, values, and respects the worth of the individual Member. These services are to be provided to people of all cultures regardless of race, age, gender, ethnicity, socioeconomic status, sexual orientation, or religion. Envolve Vision promotes superior quality eye care services with culturally competent staff, Providers, and contractors. Envolve Vision supports the development of healthy Provider/Member relationships to foster equitable treatment of all Members and enhance cultural awareness. Envolve Vision has adopted the Culturally and Linguistically Appropriate Services Standards, as developed by the Department of Health and Human Services, Office of Minority Health, and serves as a key resource in providing culturally sensitive services.

Cultural Competency Defined

Cultural competency is a set of behaviors, policies, and attitudes that harmoniously come together in a system, agency, or among healthcare professionals to bolster effectiveness in cross-cultural situations. It is the willingness and ability of a system to value the importance of culture in the delivery of services to all segments of the population.

Provider Responsibilities

Providers are expected to be knowledgeable about the Member's culture and to use this information in treating Members. Providers are also expected to ask questions relating to the way family and cultural values influence healthcare decisions. Providers are encouraged to use the Culturally and Linguistically Appropriate Service Standards to make their practices more culturally and linguistically accessible.

Increase Cultural Diversity

To develop culturally competent and proficient practices, Providers must ensure:

- Medical care is provided with consideration of the Members' race/ethnicity and language and its impact/influence of the Members' health or illness.
- Treatment plans are developed and clinical guidelines are followed with consideration of the Members' race, country of origin, native

language, social class, religion, mental or physical attributes, heritage, acculturation, age, gender, sexual orientation, and other characteristics that may result in a different perspective or decision-making process.

- Members understand that they have access to medical interpreters, signers, and TDD/TTY services to facilitate communication without cost to them. For TDD/TTY services, please call (844) 257-4142.
- Printed and posted materials are available in English, Spanish, and any other languages as required by the state.
- Office staff makes reasonable attempts to collect race and language specific Member information. Staff will also explain race/ethnicity categories to a Member so that the Member is able to identify the race/ethnicity of themselves and their children.
- Office staff that routinely interacts with Members has access to and participate in cultural competency training and development.

Cultural Activities and Resources

Cultural Competency activities include the development of skills through training and use of self-assessment tools for Providers and systems, which are made available via the Envolve Vision website www.envolvevision.com/logon. Envolve Vision encourages its participating Providers to complete the U.S. Department of Health and Human Services Physician Practical Guide to Culturally Competent Care, which equips healthcare professionals with the skills necessary to better treat the diverse populations that they serve. This accredited educational program is available on-line and is free of charge. For registration information, please visit <https://cccm.thinkculturalhealth.hhs.gov>. For additional information and resources related to Cultural Competency, please visit www.envolvevision.com/logon.

APPENDIX: PLAN SPECIFICS