DavisVision™

2018 Provider Manual

from VersantHealth™

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SECTION I WELCOME TO DAVIS VISION

About The Manual

The policies and procedures in this manual apply to services rendered by Davis Vision network providers to enrollees in benefit plans that are administered by Davis Vision. It is the provider's responsibility to read and understand the policies and procedures in this manual. For questions about this manual, please contact the Davis Vision Provider Call Center at 1-800-773-2847.

The Davis Vision Provider Manual is confidential and should not be shared with parties not contracted with Davis Vision. This version of the Provider Manual supersedes all other prior manuals published by Davis Vision and is subject to change at any time. Davis Vision reserves the right to revise the policies and procedures contained in this provider manual.

All participating providers will be notified of any revisions on the Davis Vision password protected web site prior to implementation. All applicable Federal and state regulations supersede the provisions of the provider manual.

Davis Vision's Provider Relationship Statement

Providers play a crucial role in helping Davis Vision's mission of delivering integrated vision care solutions for the value-seeking customer/patient. Our relationship with practitioners and providers is strengthened through timely communication, joint problem-solving, and mutually beneficial financial arrangements. Relationships are designed to emphasize high-quality, cost-effective patient care.

Regulatory and Compliance

Providers are required to comply with all applicable laws and regulations. In addition, providers are required to comply with certain rules and regulations as contracted providers of Davis Vision. As Davis Vision maintains licenses and certifications with state agencies.

Davis Vision and its designated agents have the right to audit provider files and records with regards to enrollees in benefit plans that are administered by Davis Vision.

Notice About Non-Discrimination

Davis Vision does not discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. In addition, Davis Vision complies with applicable anti-discrimination laws including; Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that receive federal funding, and any other laws and rules that apply for any other reason.

Providers may not discriminate against patients based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin.

A. ABOUT DAVIS VISION

Davis Vision is a wholly owned subsidiary of HVHC Inc., a Highmark company. It has played a major role in providing quality vision care services since 1964. Davis Vision is distinguished from virtually every other vision care plan by its central laboratories, administrative systems, paid-in-full benefits, and a professional quality management program.

Davis Vision provides vision and eye care services including; comprehensive routine eye examinations, eyeglasses, and contact lenses. The plan presently serves more than 21 million funded beneficiaries nationally through managed care organizations (HMOs and PPOs), insurance companies, governmental groups, corporations, union trust funds, and third party administrators.

Corporate headquarters is located in San Antonio, Texas and an Operations Center is located in Latham, New York. Davis Vision uses regionally located optical labs and our wholly owned lab to produce eyewear for Davis Vision participating independent providers. These labs are full service and have the collective capacity to produce over six million pairs of eyewear annually. Each lab holds a Lean/Six Sigma certification, which demonstrates the commitment to continual process improvement of management, procedural compliance, customer service, and holds the International Standards Organization (ISO) 9001:2008 without Design certification. This centralized lab approach allows us to leverage industry expertise, technology, and purchasing power to benefit our providers and provide better quality products.
Davis Vision has over a thousand (1000) employees dedicated to providing quality services to beneficiaries. The data center supporting Davis Vision's proprietary claims processing system is located in the Customer Relationship and Information Technology Center (CRITC) in Latham, New York.

Davis Vision's innovative vision benefit plans and services allow flexibility in the custom design of programs to meet specific client requirements. The broad spectrum of products includes, but is not limited to:

- **Comprehensive Vision Care:** Covers eye examination and materials at the frequency and benefit level chosen by the client.
- **Hybrid Programs:** Provides funded coverage for professional services with preferred pricing discounts on eyewear purchases.
- **Occupational Programs:** Provides specialty eyewear for computer use and OSHA-compliant safety eyewear.

Davis Vision's provider network comprises over twenty thousand (20,000) providers (optometrists, ophthalmologists and retail centers including Visionworks) located in all fifty (50) states, the District of Columbia, and Puerto Rico. The network includes Visionworks, a wholly owned chain of six hundred (600) proprietary vision centers located throughout the United States.

B. CONFIDENTIALITY AND SECURITY OF INFORMATION

Davis Vision established and maintains a Privacy Office. The Privacy Office is under the direction of the Company's designated Chief Privacy Officer for Davis Vision strategic business units, including vision care and proprietary vision centers. The Privacy Office develops, obtains approval for, implements, and monitors compliance with the necessary procedures and protocols that are required to assure full compliance with the Health Insurance Portability and Accountability (HIPAA) and other applicable Federal and State regulations that govern the appropriate use and disclosure of confidential information, including Protected Health Information (PHI).

The Privacy Office also audits compliance, investigates allegations or reports of privacy breaches, coordinates responses as appropriate, and serves as liaison with other privacy offices.

Davis Vision has a moral, legal, and professional obligation to protect the confidentiality of the patient's care record and personal information. Davis Vision's patients are entitled to confidential, fair, and respectful treatment of health information about themselves, and/or family members. Davis Vision abides by all applicable state and federal laws protecting patient confidentiality and the confidentiality of individual medical records. Davis Vision does not and will not release any patient information without proper authorization from the patient and/or as required by law or judicial decree. It is our policy to ensure confidentiality of any health information submitted to, or by Davis Vision, which would identify the patient.

All patient specific information will be considered confidential and therefore, is protected. Patient benefit and/or eligibility status, while confidential, is not considered protected.

Protected Health Information means, any information or data that is created by or received by Davis Vision that would identify an individual and contains information regarding the past, present, or future health status of that individual.

Eligibility information refers to information (written or verbally or electronically communicated) which indicates a patient's eligibility for past, present or future services, as provided under the patient's benefit plan. Eligibility information does not include protected health information.

Davis Vision participating providers agree to keep all protected patient information confidential, and to:

- Prevent unauthorized access to patient records.
- Place all Davis Vision patient records in a secure location that will limit access to authorized personnel only.
- Identify the position and identity of authorized personnel who have access to patient care records.
- Retain patient and financial records in accordance with Davis Vision, state, and federal requirements.

Further, in those instances where Davis Vision needs to obtain patient-specific information from a provider or other healthcare entity it shall abide by its own confidentiality policy:

- Upon calling for patient information the Davis Vision Associate will identify themselves by name, title, and department.
- If further verification is required, Davis Vision will provide the request in writing or the entity may call the Associate back.

Although the records are the property of the provider and/or Davis Vision, patients have the right to examine their records and to copy and/or clarify information contained in them. Accordingly, for the above listed reasons, patients authorize the sharing of medical information about themselves and their dependents with Davis Vision and participating providers. Davis Vision's Confidentiality Policy is available to any patient, provider or group upon request.

1. Disclosure of Information

Davis Vision does not and shall not disclose any health information about a patient received by or collected by Davis Vision unless disclosure is:

- Requested by the patient, legal guardian, or legal representative. Proper identification is required prior to release of information. Written authorization must be dated and signed within the appropriate time frame.
- For the purpose of an audit of Davis Vision's claim processing operations, released information must be relevant to conducting the audit. Any outside agency reviewing information must agree to abide by Davis Vision's confidentiality policies.
- Reasonably necessary for Davis Vision to conduct an audit of utilization by provider.
- To an authorized, regulatory, or accrediting agency conducting a survey and/or audit. The agency must agree to abide by Davis Vision's confidentiality policies.
- To a governmental authority or law enforcement agency while investigating or prosecuting the perpetration of fraud upon Davis Vision or a Davis Vision client.
- Reasonably necessary for the investigation of suspected fraud or abuse by a patient or provider.
- To Davis Vision committees (such as Credentialing, Utilization Management, and Quality Management) that conduct Peer Review audits.
- In response to a court order.
- In response to a governmental authority for the purpose of verifying a patient's eligibility, for which the government is responsible.
- When otherwise authorized or required by contracts with Davis Vision plans, federal, state, and/or local laws.

For the purposes of Treatment, Payment, and Health Care Operations (TPO), Davis Vision will disclose the minimum necessary information to properly report encounter and claims history to a client. Davis Vision will disclose eligibility information when:

- A patient, patient's legal spouse, patient's dependent child/children, patient's legal representative, or participating provider produces proper identification or eligibility documentation. A patient or any listed plan beneficiary accesses the Interactive Voice Response system, speaks with a Patient Service Representative, or logs on to the Davis Vision web site and provides the appropriate patient identification number.

SECTION II RIGHTS AND RESPONSIBILITIES

A. PROFESSIONAL ETHICS

As an administrator of vision care services, Davis Vision promotes the guidelines of ethical behavior established by the American Optometric Association and the American Academy of Ophthalmology. These guidelines highlight Davis Vision's expectations for ethical behavior. All decisions regarding treatment will be determined solely on medical necessity and not on financial cost. The following guidelines are given prominence:

- To hold the physical, emotional, social, health and visual welfare of all Davis Vision patients uppermost at all times.
- To ensure better care and services, and to provide these services with compassion, honesty, integrity, and respect for the patient's dignity.
- To promote and hold in professional confidence all information concerning a patient, to use such information for the benefit of the patient, and, to abide by all federal, state, and local regulatory agencies in maintaining this confidentiality.
- To continually maintain and improve one's competency, which includes technical ability, cognitive knowledge, and ethical concerns for the patient. Competence involves having the most current knowledge and understanding of vision care, enabling providers to make professionally appropriate and acceptable decisions in managing a patient's care.
- To provide care and services appropriate to the degree of education and training.
- To consult with other health care professionals and refer patients, when appropriate.
- To uphold the Davis Vision *Patient's Bill of Rights* (contained in Section D below). To obtain informed consent for all treatment, procedures, and services. To communicate and educate patients and/or appropriate family members.
- To inform Davis Vision of any physical, mental, or emotional impairment that may impede your ability to provide appropriate patient care or to meet contractual obligations with Davis Vision.
- To conduct oneself in an ethical and professional manner as described by the appropriate professional association and to comply with all federal, state, and/or local regulations relating to the practice of one's profession.

- To communicate with each patient at an appropriate level of comprehension and/or in a language understood by the patient, or to refer the patient to Davis Vision for translation services.
- To involve patient and/or family members, when appropriate, in all treatment plans and decisions.
- To resolve all conflicts involving treatment plans or, if unable to do so, to refer the patient to Davis Vision, the patient's applicable Plan, or appropriate state agency for resolution.
- To inform patients of their right to view the policy and procedures for conflict resolution by contacting Davis Vision, their applicable Plan, or appropriate state agency directly.

B. PROVIDER BILL OF RIGHTS

1. Providers have the right to compensation and payment for covered services provided to all Davis Vision patients, within the timeframe specified in the provider agreement specific to the jurisdiction within which they provide covered services.

2. Providers have the right to request prompt payment of all co-payments and/or deductibles from all Davis Vision patients.

3. Providers have the right to request a copy of any document required by a contracting Plan, which has been approved by Davis Vision and requires a provider's signature.

4. Providers have the right to know that composition of the Utilization Review and Quality Management Committees include panel providers whenever appropriate. Providers have the right to provide feedback to Davis Vision on standards of care and clinical practice guidelines utilized by Davis Vision.

5. Providers have the right to voice any grievance on behalf of patients or themselves regarding covered services.

6. Providers have the right to appeal decisions of Davis Vision without fear of reprisal.

7. Providers have the right to confidentiality of all credentialing information, subject to applicable local or state law as per the Participating Provider Agreement. Providers have the right to request access to their credentialing file to review information collected, to correct any erroneous information obtained during the credentialing process and to be informed of their status.

8. Providers have the right to confidentiality of their compensation arrangement with Davis Vision.

9. Providers have the right to discuss all treatment options with a patient or, if applicable, with a have the patient's designee, regardless of restrictions imposed by the vision care plan.

10. Providers have the right to prescribe, refer, and/or manage the care of patients based on their professional experience and judgment.

11. Providers have the right to receive all information needed to understand the benefit plans of patients in their geographic area.

12. Providers have the right to know the qualifications of peers whose recommendations and/or decisions may differ from theirs or may affect their participation on the Davis Vision panel.

13. Providers have the right to make recommendations regarding quality of care, standards of care, or clinical practice guidelines adopted or adapted by Davis Vision.

14. Providers have the right to be treated with respect and dignity regardless of their race, color, religion, gender, age, national origin, disability, or sexual orientation.

*15. Practitioners have the rig*ht to request all information necessary to determine that they are being compensated in accordance with Davis Vision's Participating Provider Agreement. The practitioner may make the request for information by any reasonable and verifiable means. The information provided will include a level of detail sufficient to enable a reasonable person with sufficient training, experience, and competence in claims processing to determine the payment to be made according to the terms of the contract for covered services that are rendered to enrollees. Davis Vision will provide the required information by any reasonable method through which the practitioner can access the information including email, computer disks, paper or access to an electronic database, no later than thirty (30) days after receipt of request.

C. PROVIDER RESPONSIBILITIES

1. *Providers are responsible* to provide all medically appropriate covered services to participants within the scope of their license and to treat, manage, coordinate, and monitor such care to each patient.

2. *Providers are responsible* to maintain a service record and/or treatment record form for each patient and to complete each form in accordance with Davis Vision's policy. Provider will hold such information confidential.

3. Providers may not differentiate or discriminate in the treatment of Davis Vision patients as to the quality of service delivered because of race, sex, marital status, veteran status, age, religion, color, creed, sexual orientation, national origin, disability, place of residence, or health status. Providers will protect the rights of Davis Vision patients (contained in Section D below).

4. *Providers are responsibl*e to be available to provide services to Davis Vision's patients for medically appropriate urgent care and emergent care. Information and instructions regarding emergency care shall be available to patients twenty-four (24) hours per day, seven (7) days per week.

5. *Providers are responsible* to maintain malpractice insurance in the amount of one million dollars ($1,000,000.00) per occurrence and three million dollars ($3,000,000.00) in the annual aggregate to cover any loss or liability, or as otherwise required by state law.

6. *Providers are responsible* to comply with all credentialing, recredentialing, quality assurance, and utilization management requests in a timely manner.

7. *Providers are responsible* to notify Davis Vision immediately if their license has been suspended, restricted, or limited in any way.

8. *Providers are responsible* for notifying Davis Vision timely of changes to their practice, office, and providers.

9. *Providers are responsible* to comply with all applicable federal, state, and/or municipal statutes or ordinances and all applicable rules and regulations and the ethical standards of the appropriate professional society.

10. *Providers are responsible* to comply with all policies and procedures as described in the Provider Manual.

11. *Providers are responsible* to maintain confidentiality of financial information from other providers but may discuss financial arrangements with Davis Vision's patients.

12. *Providers are responsible* to comply with all utilization and quality management programs of Davis Vision and to submit requested documentation in a timely manner.

13. *Providers are responsible* for verifying Davis Vision's patients' eligibility and obtaining authorization prior to the delivery of covered services.

14. In general, providers are responsible for submitting all claims within sixty (60) days of the date services were provided, unless there is a longer time period required by law.

a. For New York Medicaid claims, providers are responsible for submitting all claims within ninety (90) days of the date that services were rendered.

15. *Providers are responsible* to inform Davis Vision's patients of their financial responsibility prior to delivery of services.

16. *Providers are responsible* to inform Davis Vision in writing when their offices will be closed for three (3) months or longer due to vacation, illness, or other circumstances.

17. *Providers are responsible* to adhere to the Davis Vision marketing brand guidelines. These guidelines will be available on the Provider Portal and available upon request.

D. FRAUD, WASTE AND ABUSE (FWA)

1. Special Investigation Unit

The Davis Vision Special Investigation Unit (SIU) is responsible for the prevention, detection, investigation, response, training, and reporting of suspected Fraud, Waste or Abuse (FWA) required by both federal and state regulations.

The SIU takes a dynamic approach to detecting and investigating potential FWA. The SIU reviews all reported allegations of FWA received from Providers and/ or Members. In addition, the SIU's **Payment Integrity Program** performs proactive analytics and audits to ensure providers and member's behavior comport with Davis Vision's established policies, Federal and State regulations, and general accepted practices.

When necessary, the SIU takes internal and/or external corrective action regarding fraudulent activity that affects Davis Vision, its clients, providers, or members. The Payment Integrity Program reports all applicable investigations to our client's Special Investigations Unit, government agencies, and/or law enforcement.

Providers may obtain additional information on Davis Vision's Payment Integrity Program policies and other resources located in the 'Important Links' section of the Davis Vision Provider Portal.

2. Definitions

***Fraud*:** intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person.

Examples:

- Billing for services not rendered
- Billing both medical carrier and Davis Vision for the same service
- Billing for services provided to a non-covered family member
- Misrepresenting the diagnosis or procedure to ensure payment of materials or services
- Soliciting, offering or receiving a kickback, bribe or rebate
- Loaning or using another person's patient identification number (and/or card) to obtain services or materials

***Abuse*:** activities that are inconsistent with sound fiscal, business, or medical practices that result in an unnecessary cost, reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health.

Examples:

- Excessive charges for contact lens materials, services, or supplies
- Billing non-covered or "bundled" services individually
- Misrepresenting services or dates of service
- Charging patient for Davis Vision covered services

***Waste*:** overutilization of services, or other practices that result in unnecessary costs. Generally not considered caused by criminally negligent actions but rather misuse of resources.

3. Statutes

Federal and State laws define expectations on the submission of data, record keeping, access to records, and the privacy of protected health information. Violations of laws may subject you to individual civil or criminal liability.

The False Claims Act

The most common type of fraud and abuse is the filing of false claims. The law does not consider an innocent mistake as a defense for submitting a false claim. Violations could result in multiple penalties to the provider.

This act gives advantage to the Federal government against persons/entities involved in fraudulent activities while dealing with the government and imposes civil penalties. The False Claims Act:

- Prohibits knowingly presenting (or causing to be presented) to the Federal government a false or fraudulent claim for payment or approval.
- Prohibits knowingly making, using or causing to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government
- Applies to claims made to Medicare Advantage Organizations
- Has been interpreted to mean that it is a potential violation of federal law if a provider makes little or no effort to validate the truth and accuracy of his/her statements, representations or claims or otherwise acts in a reckless manner as to the truth

Anti-Kickback Statute

The Federal anti-kickback laws prohibit health care providers from doing the following:

- Knowingly and willfully paying, offering, soliciting, or receiving remuneration (anything of value);
- Inducing a referral of a patient for items or services for which payment may be made, in whole or in part, under a Federal health care program; or
- In return for purchasing, leasing, ordering or arranging for or recommending purchasing, leasing, or ordering any good, facility, service or item for which payment may be made in whole or in part under a Federal health care program

There are certain exceptions specified in so-called “safe harbors” specified by law. Violators are subject to criminal sanctions such as imprisonment, as well as high fines, exclusion from participation on Medicare and Medicaid plans, costly civil penalties, and potential prosecution under state laws.

4. Fraud, Waste, and Abuse and General Compliance Training

The Centers for Medicare and Medicaid Services (CMS) requires Davis Vision’s First Tier, Downstream, and Related Entities (FDRs), including our network providers, to complete General Compliance and Fraud, Waste, and Abuse Training within ninety (90) days of hire and annually thereafter. CMS has developed standardized Fraud, Waste, and Abuse

(FWA) and General Compliance training and education module. The modules are available through the CMS Medicare Learning Network (MLN) at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Waste_Abuse-Training_12_13_11.pdf. First Tier, Downstream, and Related Entities (FDRs) who have met the Fraud, Waste, and Abuse certification requirements through enrollment into the Medicare program (Parts A or B) or accreditation as a Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) are deemed to have met the training and educational requirements for Fraud, Waste, and Abuse. However, General Compliance Training remains a requirement in these instances.

Health care providers and office staff are required to complete General Compliance and Fraud, Waste, and Abuse Training within ninety (90) days of hire and annually thereafter. Davis Vision offers our network providers convenient online access to General Compliance and Fraud, Waste, and Abuse Training through our Provider Website. Providers may either use the materials provided by Davis Vision or their own training for employees as long as the training meets the minimum requirements defined by CMS in Chapter 21 of the Medicare Managed Care Manual under 42 CFR §422.503(b)(4)(vi)(C) and 42 CFR §423.504(b)(4)(vi)(C). Providers are required to maintain training records for a period of ten (10) years and are required to demonstrate that their employees have fulfilled these training requirements. Examples of proof may include sign-in sheets, employee attestations, and/or electronic certifications.

Upon request, Davis Vision participating providers must immediately provide a signed attestation for completion of the annual FWA training by all appropriate professional staff, office employees, vendors, and ancillary staff.

5. Contact Information

All inquiries and reports are confidential, subject to limitations imposed by law. Individuals may also make an anonymous report. Davis Vision policy prohibits retaliation against individuals who raise questions or concerns in good faith.

Anyone can contact the Anti-Fraud Hotline – Patients, Providers, Groups, Brokers and Davis Vision Associates. For information and inquiries or to report potential misconduct, contact:

The Davis Vision Fraud, Waste and Abuse Unit at:

A. Toll-Free Hotline twenty-four (24) hours a day, seven (7) days a week at 1-800-501-1491

B. Confidential mail through the U.S. Post Office can be addressed to:

Davis Vision
ATTN: Fraud, Waste and Abuse Unit
PO Box 1416
Latham, NY 12110-1416

C. Confidential Fax: 1-866-999-4690

D. Email: antifraud@davisvision.com

E. PATIENT BILL OF RIGHTS

Courtesy, dignity, confidentiality, communication, cultural sensitivity, and privacy are essential to services provided by Davis Vision. Davis Vision strives to ensure that all providers regard and uphold these rights:

1. *Patients have the right* to understand and use these rights. If for any reason patients do not understand the rights or require assistance, Davis Vision's staff will provide assistance. Patients, including the hearing and speech impaired, have the right to receive communications in a language and manner that is understood by the patient.

2. *Patients have the right* to receive treatment without discrimination as to race, color, religion, sex, age, national origin, disability, sexual orientation, or source of payment.

3. *Patients have the right* to receive materials that clearly explain the scope of covered benefits, such as information regarding accessing covered benefits, including requirements for prior authorization, and accessing emergency or out-of-area services; cost-sharing features under the benefits plan and coverage exclusions. Patients are provided with a mechanism to access a directory of participating providers.

4. *Patients have the right* to expect continuity of care and to know in advance what appointment times and services are available and in which locations.

5. *Patients have the right* to choose all plan services and options. When full service benefits are chosen, the provider agrees to accept the plan fees as payment in full. Where copayments are applicable, patients have the right to an explanation of all such charges. Patients have the right to choose non-plan materials with the understanding that they are responsible for all applicable charges.

6. *Patients have the right* to be shown the Davis Vision Plan Collection and choose a frame from the Collection (where applicable).

7. *Patients (and their families when appropriate) have the right* to know all options, therapies, treatments, and services available to them regardless of any restrictions

imposed by the vision care plan. Practitioners should not be deterred or constrained from presenting these options to the patient. The right entitles the patient access to information on services whose scope or frequency may exceed that which is allowed under the plan. Patients shall be informed of all professional fees prior to the provision of such services.

8. Patients have the right to receive considerate and respectful care in a clean and safe environment.

9. Patients have the right to know the name, position, and function of any office staff involved in care, and may refuse their treatment, examination or observation.

10. Patients have the right to know the names, qualifications and licenses of all providers involved with their care. If an optometrist is involved, they have the right to know whether the provider is certified to use diagnostic pharmaceutical agents and/or therapeutic pharmaceutical agents. If an ophthalmologist is providing care, they have the right to know whether the provider is board certified.

11. Patients have the right to receive complete information about their diagnosis, treatment, and prognosis. *Patients have the right* to receive all the information needed to give informed consent for proposed procedure or treatment. This information shall include the possible risks and benefits of the procedure or treatment. Patients are expected to provide all necessary information to providers to facilitate effective treatment. *Patients are responsible* for providing, to the best of their knowledge, accurate, and complete information about their complaints, medical and family history, eye and vision history, and any other pertinent information.

12. Patients have the right to refuse treatment and be told what effect this may have on their health.

13. Patients have the right to privacy while in the office and confidentiality of information and records regarding their care. Patients have the right that safeguards be adopted to protect their privacy and the confidentiality of all patient data gathered by Davis Vision participating providers. The release of protected information will be provided only to authorized agents and appropriate regulatory authorities.

14. Patients have the right to review, comment upon and request correction of health information on their medical record and obtain a copy of the medical record, for which the office may charge a reasonable fee. Patients cannot be denied a copy solely because they cannot afford to pay. The right allows patients to review, comment upon and request correction of health information on their medical record.

15. Patients have the right to receive the Privacy Practices Notice describing how their medical information may be used and disclosed and how they may gain access to this information as dictated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

16. Patients have the right to receive, without charge, a copy of their eyeglass prescription. Patients wearing contact lenses have the right to receive a copy of their contact lens prescription only after the lens fit has been confirmed as stated in the Fairness to Contact Lens Consumers Act. The prescription may contain an expiration date.

17. Patients have the right to receive an itemized bill and an explanation of all direct charges.

18. Patients have the right to be satisfied with the care and treatment provided. Patients or their designated representatives have the right to voice their grievances, objections and dissatisfaction regarding the care and/or the cost of treatment of care received without the fear of reprisal. Patients or their designated representatives have the right to appeal decisions initially unfavorable to their position. Patients have the right to a system that provides for the receipt and resolution of complaints and grievances in a timely manner.

19. Patients have the right to refuse to take part in any research or investigational studies.

20. Patients in certain states have the right to obtain information on types of provider payment arrangements used to compensate providers for health care services rendered to enrollees.

F. PATIENT RESPONSIBILITIES

All patients are expected to provide information requested by practitioners providing their care. Patients will be informed of their responsibilities as described under Patient's Rights Policy.

Patients are responsible for providing, to the best of their knowledge, accurate and complete information regarding the following:

- Present complaints or reason for seeking services.
- Medical history and any other significant events, including surgical history.
- Eye and vision history, social, and family history.

- Current medications.
- Allergies and reactions.
- Any other pertinent Information.

Additionally:

1. *Patients are responsible* for reporting when they lack a clear understanding of a proposed course of action and what may be expected of them.
2. *Patients are responsible* for following treatment recommendations, including using prescribed medications or treatments and reporting any factors that may prevent them from doing so.
3. *Patients are responsible* for respecting the rights of others, including, but not limited to, other patients, staff, and providers.
4. *Patients are responsible* for assuring that the financial obligations associated with their care, including co-payments, deductibles and fees for non-covered services, are met in a timely manner.
5. *Patients are responsible* for notifying providers at the time an appointment is made that they are covered by a Davis Vision Plan.
6. *Patients are responsible* for notifying providers at least twenty four (24) hours in advance when canceling any appointment.
7. *Patients are responsible* to use the benefit in an honest manner.
8. Patients should be aware that providers who care for them are not employees of Davis Vision and that Davis Vision does not control them.
9. Patients are permitted to question providers about all treatment options and the provider's compensation arrangement with Davis Vision.
10. *Patients are responsible* to ensure that their provider has received the proper authorization for services.
11. *Patients are responsible* to report any concerns to Davis Vision at 1-800-999-5431.

SECTION III CONTACTING DAVIS VISION

A. DAVIS VISION'S WEB SITE, www.davisvision.com

As a participating provider in the Davis Vision network, you have instant access to complete information about patient eligibility and benefits, order and claim status, recent shipments, and forms for your practice. You can also authorize, submit and track orders. If you have not yet created a login password, please call 1-800-77DAVIS (1-800-773-2847) and select option 3.

When you access the Provider Portal, the Home page displays a summary of your Practice Account Status including recent shipping history, work in progress, and existing authorizations. It also displays links to important information such as repair/replacement policies, prior authorization request form, formularies, clinical practice guidelines, an electronic copy of the Provider Manual, etc. It also contains links to current and previously published Provider Newsletters.

Listed below are some of the main functions you can perform via the Provider Portal:

1. Verify Member Eligibility

From the Home page, enter the patient's ID# in the Member Accounts section.

Result: Member Account page displays *Get Authorization* if patient is currently eligible for services or *Not Eligible Until xx/xx/xxxx*.

2. View Benefit Plans

From the Member Account page, scroll down to Member *Forms*. For the Vision Plan Benefit Description, click on *View Form*.

Result: Vision Care Plan Benefit Description displays.

3. View Benefit Alerts

New and updated benefits may be viewed by clicking on *View Benefit Alerts*.

Result: All available Benefit Alerts for the timeframe indicated will display. Select the Alert you wish to view. (After one month, alerts are archived.)

4. View or Print Service Record Form

From the Member Account page, click on the patient's open authorization.

Result: Authorization Detail page displays.

Click on *View Service Record Form*. Result: Service Record Form displays.

5. Obtain an Authorization

From the Member Account page, click *Get Authorization*.

Result: Get Authorization page displays current services for which the patient is eligible. Select the type of authorization desired (exam & materials, exam only, materials only) and click *Get Authorization*.

Result: Authorization Detail page displays authorization number, issue date, expiration date, applicable copayment, and the services authorized.

6. Enter an Order

From Authorization page, click *Enter Claim/Order*

Result: Services Provided page displays. Select the services you performed and click *Submit*.

Result: Order is submitted.

7. Track an Order

From Order Tracking page, enter appropriate search parameters and click *Search*.

Result: Orders matching search parameters are displayed.

8. Place an Excel Advantage Order

From the Home page, select the order type (frames, single vision lenses, contact lenses) and click Order Now.

Result: Excel Advantage Order Entry page displays.

9. Select the Collection, Style, Color, Temple Length, and Quantity

Click View Item Summary.

Result: Order Summary page displays and allows you to either edit the item or add to your shopping cart.

B. INTERACTIVE VOICE RESPONSE SYSTEM (IVR)

Providers may contact Davis Vision twenty-four (24) hours a day, seven (7) a week by calling the IVR at **1-800-888-4321.** You will be prompted to enter your provider number to gain access to the following capabilities:

Verify patient eligibility • Place an order

Obtain an authorization • Track an order

Obtain benefit information • Obtain status of a claim

Determine copayments • Speak with a Member Service Representative

Request Service Record Forms

Member Service Representatives are available Monday through Friday 8:00 AM to 11:00 PM ET, Saturday 9:00 AM to 4:00 PM ET, and Sunday 12:00 PM to 4:00 PM ET. Messages may be left after hours and will be returned the next business day.

C. CONTACT INFORMATION

Provider Relations Monday – Friday 8 a.m. – 6 p.m. (EST)	To contact a Provider Recruiting Associate, please call: **1-800-773-2847** or fax: **1-888-553-2847**	Inquire about becoming a provider Verify credentialing application status Update address and office information
Utilization Review Monday – Friday 9 a.m. – 5 p.m. (EST)	To contact Utilization Review, please fax: **1-800-584-2329**	Request prior authorization for services outside regular eligibility cycle Request prior authorization for medically necessary contact lenses
Excel Advantage	Go to www.davisvision.com	Place an Excel Advantage order
Excel Advantage Payments		At time of order: • Select Immediately charge credit card or Net 30 days and follow instructions • Select Bill Account Post Transaction: • Credit card payments: Complete and fax the bottom of the statement to 1-210-524-7674 (secure fax) • Mail Payments to: Davis Vision PO Box 848393 Dallas TX 75284-8393

Provider Web Site	To access our Web site, please go to: www.davisvision.com and enter your provider # and password. If you have not yet created a login password, please call: **1-800-77DAVIS (1-800-773-2847) option 3**	Verify eligibility/benefits Request authorization for services Place an order Place an Excel Advantage order Check order status Check claim status Review recent shipments Review orders in progress View formularies View updates to benefit info Download forms Access important links: Repair & Replacement Policy Warranty Information Clinical Practice Guidelines Provider Bill of Rights Patient's Bill of Rights Provider Manual Provider Newsletters
Provider IVR (Interactive Voice Response) System (Available 24 hours a day)	To access our IVR system, please call: **1-800-888-4321** and enter your provider #	Verify eligibility/benefits Request authorization for services Place an order Place an Excel Advantage order Check order status Check claim status Request forms Speak with a Member Service Representative
Provider Relations	To contact a Provider Relations Associate, please call: **1-800-933-9371**	Place an order Verify group discount information
Claims	To contact a Claims Associate, please call**: 1-800-77DAVIS (1-800-773-2847)** or write: Vision Care Claims Unit P.O. Box 1501 (U.S. Mail) Latham, NY 12110	Request expired voucher information Request billing information Request status of claim payment
Order Entry	To contact Order Entry, please call: **1-800-888-4321** or use the provider website, http://www.davisvision.com	Obtain warranty information Track jobs Advise Davis Vision of shipment received in error

Collections	To contact Collections, please call: **1-800-783-8031 option #3**	Inquire about provider statements Inquire about negative balances Make payment for "negative balance" Obtain explanation of "balance forward"
Complaints and Appeals	Please call: 1-800-77DAVIS (1-800-773-2847) Email: ProviderCA@davisvision.com, Fax: 1-888-778-1008, or write: P.O. Box 791 Latham, New York 12110	Submit a complaint or payment dispute appeal
Web Site Assistance	To obtain assistance with the Davis Vision website, please call: **1-800-943-5738**	

In our ongoing efforts to provide the most prompt, correct information, we ask that you be prepared with your Davis Vision provider ID number when calling us.

SECTION IV THE VISION CARE BENEFIT

NOTE: *Davis Vision provides comprehensive routine vision and eye care services to more than 21 million beneficiaries nationally through managed care organizations (HMOs and PPOs), insurance companies, governmental groups, corporations, union trust funds, and third party administrators. Each group's benefit design is different and it is incumbent upon you to verify the type of benefits for which your patient is eligible.*

For detailed benefit information, please call Davis Vision at **(800-77-DAVIS)** for Provider Services or our Interactive Voice Response System, or visit our web site at **www.davisvision.com.**

A. MANAGED CARE PLANS

Davis Vision contracts with Managed Care Plans to provide basic routine vision care services for their patients.

When rendering or recommending diagnostic or therapeutic medical eye care services not included in the patient's routine eye care benefit administered by Davis Vision, participating providers must follow the protocol of the patient's medical plan, including coordination of care with the PCP when appropriate.

State Medicaid Managed Care Agencies are not liable or responsible for payment for covered services rendered pursuant to the Davis Vision provider contract.

B. PRIMARY ROUTINE VISION CARE PRODUCTS

Comprehensive Vision Plans cover eye examinations and eyewear Each of our plans is tailored to meet our clients' requests for benefit frequency, copayments, and allowance levels.

Generally, patients are limited to one (1) pair of eyeglasses (or contact lenses in lieu of eyeglasses) per benefit cycle. Some plans may allow two (2) pairs of eyeglasses; Some plans require a thirty percent (30%) courtesy discount that our participating providers must extend to patients who place an order for a second pair that is not covered by a patient's funded benefit (within state regulations).

All plan-supplied eyeglasses include an unconditional breakage warranty for one (1) full year. Coverage for lost eyewear is not provided unless otherwise specified in the plan benefit design.

Occupational Plans cover industrial safety and video display terminal (VDT)/computer eyewear. These programs can be offered on a stand-alone basis or in conjunction with the routine eye care benefit.

Eye Health & Wellness Program® provides clients and members access to our vision library and Eye Health & Wellness Web Site.

Discount Programs provide members to receive vision care services and materials at a discount price. The following are the two (2) Discount Programs of Davis Vision:

In-Network Benefits	Discount Plan 1	Discount Plan 2
Eye Examinations	**Member Price**	
Routine Eye Examination	15% off U&C	15% off U&C
Refraction Only (when eye examination is covered by Medicare)	$20	$20
Retinal Imaging	N/A	$39
Eyeglass Benefit - Frames		
Priced up to $70 Retail	$40	35% off U&C
Priced above $70 Retail	$40 plus 10% off the amount over $70	35% off U&C
Eyeglass Benefit - Spectacle Lenses (Uncoated Plastic)[/2]		
Single	$35	$45
Bifocal	$55	$65
Trifocal	$65	$95
Lenticular	$110	$120
Eyeglass Benefit - Lens Options (Add to Lens Prices Above)[/2]		
Tinting of Plastic Lenses (Solid / Gradient)	$10 / $12	$15
Scratch-Resistant Coating	$20	$15
Polycarbonate Lenses	$30	$35
Ultraviolet Coating	$15	$15
Anti-Reflective (AR) Coating (Standard)	$45	$45
Anti-Reflective (AR) Coating (Premium/Ultra)	20% off U&C	20% off U&C
Progressive Lenses (Standard) (add on to Bifocal lens)	$75	$65
Progressive Lenses (Premium/Ultra) (add on to Bifocal	$125 / 20% off U&C	20% off U&C
High-Index Lenses	$55	$65
Polarized Lenses	$75	$75
Plastic Photochromic Lenses	$65	$75
Contact Lens Benefit (in lieu of eyeglasses)		
Contact Lens Evaluation, Fitting & Follow-Up Care	15% off U&C	15% off U&C
Conventional Lenses	20% off U&C	15% off U&C
Disposable/Planned Replacement Lenses	10% off U&C	15% off U&C
Value-Added Features		
Non-prescription Sunglasses	20% off U&C	20% off U&C
Other Ancillary Products/Solutions	10% off U&C	20% off U&C
Additional Pairs	20% off U&C	30% off U&C for complete pairs on same transaction; otherwise 20% off U&C

C. COVERED ITEMS

The patient's detailed Vision Plan Benefit Description is available on the *Member Account* page of the Davis Vision web site (www.davisvision.com). Please consult this Benefit Description to verify covered, non-covered, and optional items. The basic vision care benefit consists of a routine comprehensive eye examination (including dilation) and eyeglasses (lenses and frame) or contact lenses at a frequency chosen by the patient's group, typically once every twelve (12) or twenty-four (24) months.

Davis Vision benefits are considered primary and there is no coordination of benefits (COB) with medical eye care services, unless otherwise specified in Plan Benefit Descriptions. The basic vision care benefit cannot be used for a refraction service only (CPT Code 92015) which is often provided to patients in conjunction with medical eye services. In addition, many groups make the benefit available annually for diabetic patients if the plan frequency is twenty-four (24) months.

In most cases, the basic materials benefit includes:

- Almost every lens type
- All lens prescriptions
- Either plastic or glass lenses (for single vision, bifocal, or trifocal)
- Oversized lenses
- All types of bifocals; however, the 25 or 28 mm flat-top should be regarded as the standard bifocal whenever it can satisfy the patient's visual needs.
- Aphakic lenses (single vision and bifocal)
- Solid and gradient tinting of plastic lenses
- Contact lenses (in lieu of eyeglasses) (Formulary contained in Section)

Most plans cover non-cosmetic contact lenses for conditions such as Keratoconus, high Ametropia in excess of 8.00 Diopters, and Anisometropia in excess of 3.00 Diopters, when contact lenses improve visual acuity over glasses.

D. NON-COVERED ITEMS

The patient's detailed Vision Plan Benefit Description is available on the *Member Account* page of the Davis Vision web site (www.davisvision.com). Please consult this Benefit Description to verify covered, non-covered, and optional items.

Examples of services and materials which may be excluded from the patient's planare:

1. Medical treatment of eye disease or injury
2. Medically necessary contact lenses and fitting of those lenses
3. Vision Therapy
4. Corneal Refractive Therapy (CRT)
5. Refraction only
6. Special lens designs or coatings, other than those described in the benefit plan
7. Replacement of lost/stolen eyewear
8. Bilateral Non-prescription (Plano) lenses
9. Services not performed by licensed personnel
10. Low Vision aids and services
11. Prosthetic devices and services
12. Materials and services not specified in the benefit design
13. Contact lenses and eyeglasses during the same benefit frequency period
14. Insurance for contact lenses

BEST PRACTICE Complete the Davis Vision supplied Service Record Form, and obtain the patient's signature acknowledging he/she has been informed of all additional items and costs and agreeing to pay for such items. Providers must inform patients of all associated costs of non-covered items. A signed Advanced Beneficiary Notice (ABN) should be obtained when the services provided exceed the benefits of the patient's Davis Vision routine comprehensive eye exam plan and may result in out-of-pocket expenses for the patient.

E. OPTIONAL ITEMS

The patient's detailed Vision Plan Benefit Description is available on the *Member Account* page of the Davis Vision web site (www.davisvision.com). Please consult this Benefit Description to verify covered, non-covered, and optional items. Listed below are examples of services and materials which may be included in a group's benefit plan (with or without copayments):

- Premier Frames
- Occupational Vision Program
- Additional Pairs of Spectacles
- Contact Lenses (Davis Vision formulary at www.davisvision.com)
- Progressive Addition Lenses (Standard or Premium) (Davis Vision formulary at www.davisvision.com)
- Photochromic Lenses
- Anti-Reflective Coating (ARC) (Davis Vision formulary at www.davisvision.com)
- Hi-Index Lenses
- Polarized Lenses
- Polycarbonate or other Impact Resistant Lenses (included for dependent children and monocular patients)
- Ultraviolet Coating
- Blended Segment Lenses
- Plastic Photochromatic Lenses
- Mirror Coated Lenses

BEST PRACTICE When a patient disregards your recommendation for polycarbonate or other impact resistant lenses for visual safety and protection (due to activities that expose them to the risk of injury from flying objects or physical impact), be sure to use a Duty to Warn form which your office may have developed or you may use the Davis Vision "Duty to Warn / Patient Rejection and Waiver Form" found on the Provider Portal at www.davisvision.com. Obtain your patient's signature acknowledging that they understand your recommendation and has decided to utilize an alternative material.

F. NON-PLAN ALLOWANCES

The patient's detailed Vision Plan Benefit Description is available on the *Member Account* page of the Davis Vision web site (www.davisvision.com). Please consult this Benefit Description to verify covered, non-covered, and optional items. Some benefit plans include a non-plan allowance to be used toward a patient's selection of non-plan frames and/or contact lenses. The amount of the non-plan allowance is subtracted from your usual and

customary fee. Typically, the patient is responsible for the remaining balance less any courtesy discount.

When a patient selects a non-plan frame, the provider will receive one-half (1/2) of the standard dispensing fees.

G. RESTRICTIONS RELATED TO SPLITTING BENEFITS

Some groups require members to obtain their eye examination and materials at the same visit (at the same location). Those members must order their eye wear during their visit for an eye examination. If they order their eye wear at a later date, the materials will not be covered. This is referred to as "splitting benefits," and individual group restrictions are clearly indicated on the patient's detailed Vision Plan Benefit Description and on the member's Service Record Form. It is the responsibility of the Davis Vision provider to understand splitting benefits and if this plan requirement is applicable to the member being provided services in your office.

H. OCCUPATIONAL VISION BENEFIT (OPTIONAL COVERAGE)

NOTE: *When available, the Occupational Vision Benefit is restricted to the employee* ***only****.*

The patient's detailed Vision Plan Benefit Description is available on the *Member Account* page of the Davis Vision web site (www.davisvision.com). Please consult this Benefit Description to verify covered, non-covered, and optional items. It is the provider's responsibility to verify eligibility and obtain an authorization, if necessary. Other restrictions may include limiting eligibility to all employees, only specific job functions, or specific employees.

Occupational Vision Benefits are available only at Davis Vision participating provider offices and materials must be ordered through the provider's assigned Davis Vision regional laboratory.

Safety glasses meet ANSI Z.87 requirements. If used, glass lenses will be chemically hardened in accordance with FDA 21 CFR part 801.

Three types of Occupational Benefits are offered:

1. Standard Occupational Safety Benefit

Patients with the standard Occupational Safety Benefit are entitled to a routine eye examination and, at the provider's discretion, any additional testing required to determine the best-corrected visual acuity for the patient. Patients may choose a standard frame and a safety frame. Safety lens tinting is limited to gray or pink with a maximum density of thirty

percent (30%) and may be ordered **only** in plastic. The patient must place the order for the two (2) sets of eyeglasses (dress pair and occupational pair), at the same time. Providers must submit orders to their assigned Davis Vision regional laboratory.

2. Stand-Alone Occupational Safety Benefit

Patients with a Stand-Alone Occupational Safety Benefit are entitled to a routine eye examination and, at the provider's discretion, any additional testing required to determine the best-corrected visual acuity for the patient. Patients may choose only a safety frame. Safety lens tinting is limited to gray or pink with a maximum density of thirty percent (30%) and may be ordered **only** in plastic. Providers must submit orders to their assigned Davis Vision regional laboratory.

3. Video Display Terminal (VDT)

Patients with a Video Display Terminal (VDT) Benefit are entitled to a routine eye examination and at the provider's discretion any additional testing required to determine the best-corrected visual acuity for the patient at their measured working distance. VDT eyeglasses are prescribed for the patient specifically for computer use. The VDT benefit is available in conjunction with a standard vision benefit (i.e., "dress" pair). Most plans require VDT glasses to be ordered on the same date as the order for the basic materials benefit. To be eligible for the VDT eyeglass benefit, the patient's standard eyeglass prescription and the VDT prescription must differ in the following ways:

- Prescription add difference of at least 0.50 Diopter.
- Different lens types, e.g. trifocal vs. bifocals
- Segment height difference of at least 5mm

SECTION V UTILIZATION REVIEW

A. SERVICES REQUIRING PRIOR AUTHORIZATION

These services and options vary by plan benefit design and by state or Federal requirements. Eligibility for the services and options are clearly identified when checking the patient's benefit design through Davis Vision. Providers must follow Prior Authorization policies and procedures **prior** to initiating care for any services requiring Prior Authorization.

Examples of these additional services include, but are not limited to:

- Additional eyeglasses- lenses and frames during the benefit cycle for significant changes in the patient's prescription
- Visually Requires/Medically Necessary contacts lenses
- Lost/Stolen glasses: Additional glasses of the same prescription to replace lost/stolen glasses during the benefit cycle
- Repair/Replace: Additional glasses of the same prescription to repair broken glasses during the benefit cycle
- Additional glasses or contact lenses after cataract surgery
- Additional eye exams for diabetes or other specified conditions
- Low Vision exams and aids
- Vision Training evaluations and training sessions

B. REQUESTING PRIOR AUTHORIZATION

Print the **2018 *Prior Authorization Request Form*** found on the Provider Portal at www.davisvision.com

Prior authorization or prospective review involves services **before they are rendered**. All pre-service reviews are for non-urgent care. Services and materials for urgent/emergency care are not covered under Davis Vision plans. Prior Authorization Representatives are available during normal business hours, Monday through Friday, from 8:00 a.m. until 4:30 p.m. EST.

Complete all applicable fields. It is the provider's responsibility to provide as much clinical information as possible to enable Davis Vision to make a determination, including but not limited to, the following information:

1. Member and/or patient's identification number
2. Patient's name
3. Diagnosis
4. Requested service or procedure
5. Justification

Fax the completed form to Utilization Review at 1-800-584-2329.

Faxed requests for pre-service authorization review are received in a secure location and treated as confidential medical information.

All faxed forms are date and time stamped automatically when the fax is received by Davis Vision.

For administrative or benefit requests a Utilization Review Associate will review the request.

For visually required/medically necessary contact lens requests, a licensed clinician (OD or MD) will review the request to determine medical necessity. Individuals that conduct clinical reviews are available to discuss review determinations with the member's PCP, the attending physician, or the ordering provider. If the original reviewer is not available, another clinician is available within one (1) business day.

Pre-Service Timeliness of Notification: The approval or denial determination will be documented on the Prior Authorization Request Form and faxed back to the provider within three (3) business days following receipt of the request unless a more stringent timeframe is imposed by State or Federal guidelines. The provider's office will also be notified of the determination via telephone.

If the request is incomplete, Davis Vision will request additional information. Davis Vision will allow the member, member's designee and/or provider a designated number of calendar days by line of business (see listed below) to submit the requested additional information. For all standard organization determination requests, reasonable and diligent efforts to obtain missing information include a minimum of three attempts with requests made, when possible, during normal business hours in the provider's time zone. Methods for requesting information can include telephone, fax, and email and/or standard or overnight mail with certified return receipt. The date/time of the postmark or timestamp on e-mails and faxes are considered the date/time of the request to the provider for the

information. Requests made by telephone are documented with the date and time of the call.

If the provider has not responded to the request for additional clinical information required to make a final determination within the appropriate by calendar days, the decision is considered an adverse determination and the notifications will be initiated.

Requests for Additional Information	Additional Information Due in Calendar Days	Determination Completed and Communicated to the Member and Provider in Calendar Days
Medicaid	14	14
Medicare	14	14
Commercial Plans	45	45
FIDA (Dual Eligible in New York, only)	2	2

*Unless a more stringent timeframe is required by state or federal guidelines.

NOTE: A claim must be submitted for all visually required/medically necessary contact lens requests. Authorizations for enhanced contact lens benefits are not a guarantee of payment for services. Final eligibility for services on the date of service will be determined when the claim is processed. Reimbursement is subject to a maximum allowable fee.

Concurrent review involves services that are currently being rendered. The practitioner is requesting that services continue or extend beyond what has already been approved or for additional services. In rare cases, Davis Vision may review certain services on a concurrent basis during the course of ongoing treatment.

All concurrent determinations are rendered within one (1) business day of receipt of necessary information but no later than fifteen (15) calendar days following the request, both verbally and in writing to both the member and the practitioner (unless a more stringent timeframe is posed by State guidelines). The written determination contains the following information:

1. Number of extended services approved
2. New total of approved services

3. Date of onset
4. Next review date
5. Appeal and Grievance Procedures

Retrospective review involves services that have previously been rendered. Davis Vision does not routinely conduct retrospective reviews for services covered under its plans. However, in the unlikely event a retrospective review is required it may be conducted for the following reasons:

- To determine medical necessity when a member or practitioner fails to obtain authorization for services that require prior authorization before services are rendered.
- To determine medical necessity when a practitioner fails to obtain authorization for services that require concurrent review before services continue beyond the approved timeframe.
- To identify and refer potential quality of care/utilization issues

NOTE: A review initiated as the result of a determination, notification, or claim denial is considered an appeal.

If a service has been pre-authorized or approved by a Utilization Review Agent, the Utilization Review Agent shall not, pursuant to retrospective review, revise or modify the specific standards, criteria or procedures used for the utilization or review or procedures, treatments and services delivered to the insured during the same course of treatment

Timeframes for pre-service authorization and concurrent review determinations may be extended for up to 14 days if: The member, the member's designee or the provider request an extension orally or in writing; or Davis Vision demonstrates or substantiates that there is a need for additional information and how the extension is in the member's best interest. In all other cases, within one (1) business day of receipt of necessary information, but no more than fourteen (14) days after receipt of the Prior Authorization request.

Extensions for additional information/insufficient information: If there is insufficient information to make a decision, Davis Vision may, at the request of the member, the member's designee, the health care provider or as determined by Davis Vision, allow for an extension. The member, the member's designee and/or heath care provider will be given a list of the missing information and a designated period of time in which to respond. For pre-service authorization requests, Davis Vision will review the case and a make a determination within three (3) business days after receipt of necessary information.

Davis Vision will send written notice of the extension to the member, where Davis Vision elects to take an extension of timeframes for determinations. Such notice shall include the following: the reason for the extension, an explanation of how the delay is in the best interest of the member, any additional information required from any source to make a determination, the revised date by which Davis Vision will make its determination, the right of the member to file a Complaint regarding the extension, the process for filing a Complaint, the timeframe within which the Complaint must be filed, the timeframe within which a Complaint determination must be made, the right of the member to designate a representative to file a complaint on his/her behalf, the right of the member to contact the state's department of insurance, if appropriate, regarding his/her complaint, a statement that oral interpretation and alternate formats of written material for members with special needs are available and the process for accessing them, if appropriate.

Low Vision Evaluation and Materials: Davis Visions plans may also include Low Vision benefits for members who qualify for Low Vision services. Providers must confirm member's eligibility, and provide services at accepted standards of care. Services may include both a low vision evaluation and low vision aid(s), and are restricted to the allowances specified by the individual plans or Davis Vision's maximum allowable fee. Members may be responsible for all fees over the allowances.

NOTE: Providers must submit all invoices for low vision aids and must complete the Low Vision Request for Additional Information Form available on the provider portal at www.davisvision.com.

Emergency Services: Davis Vision provides routine vision and eye care services including routine eye examinations, eyeglasses, contact lenses, value-added discounts and accessories. Davis Vision does not provide or manufacture life-saving equipment, nor does Davis Vision authorize or provide medical treatment (urgent, emergent or routine). When a member is out of the service area and an emergency arises, if the member believes that an emergency medical condition exists or that a delay in services might compromise their health, they are permitted to seek emergency care from a licensed health care practitioner or provider without obtaining pre-authorization service request to do so from Davis Vision. Because Davis Vision provides routine vision and eye care services, reimbursement for emergency services will be solely dependent upon whether the member is eligible for the benefit.

C. VISUALLY REQUIRED/MEDICALLY NECESSARY CONTACT LENSES

Some plans include enhanced coverage for contact lenses which must be qualified by coverage following the Davis Vision guidelines below.

***Medically Appropriate/Medically Necessary Services* describes vision care service(s) or treatment(s) that a provider, exercising his/her prudent, clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease, or its symptoms and that is in accordance with the "Generally Accepted Standards of Medical Practice"; and is clinically appropriate in terms of type, frequency and duration; and is considered effective for the patient's illness, injury or disease; and is not primarily for the convenience of the patient or the provider; and is not more costly than an alternative service or sequence of services that are at least as likely to produce equivalent therapeutic and/or diagnostic results as to the patient's illness, injury or disease.**

Contact Lenses may be determined to be visually required/medically necessary and appropriate in the treatment of patients affected by certain conditions when the condition meets the established coverage guidelines. In general, contact lenses may be visually required/medically necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, results in an improvement of distance visual acuity of 2 lines or more and/or improved binocular function, including avoidance of diplopia or suppression.

Additional copies of the Davis Vision coverage guidelines are available to providers upon request. Providers can call 1-800-773-2847 to request a copy. The coverage guidelines are also available on the provider portal at www.davisvision.com.

Davis Vision's Enhanced Contact Lens Benefit is not available for Corneal Refractive Therapy (CRT) or orthokeratology treatments or strategies. The established criteria below must stand alone on clinical record documentation for approval. Clinical record documentation cannot include any references, inferences or indications of CRT procedures or strategies.

Davis Vision reviews requests to determine visually required/medical necessity and appropriateness based on the guidelines of the American Optometric Association and the American Academy of Ophthalmology.

Clinical Criteria for Visually Required/Medically Necessary Contact Lenses and the Hierarchy of Decision Making

Medically Necessary Contact Lens Clinical Criteria
Effective January 1, 2018

Medically Necessary/Visually Required Contact Lenses are only available for the diagnoses listed below. A signed statement of medical necessity is required.

Keratoconus (Ectactic corneal dystrophy):
ICD-10: H18.60, H18.601, H18.602, H18.603, H18.61, H18.611, H18.612, H18.613, H18.62, H18.621, H18.622, H18.623, H18.711, H18.712, H18.713

1. Topography, OCT, or corneal mapping (preferred)
2. Keratometry

High Ametropia:
ICD-10: Myopia H52.10, H52.11, H52.12, H52.13
ICD-10: Hyperopia H52.00: H52.01, H52.02, And H52.03
ICD-10: Astigmatism H52.20: H52.201, H52.202, And H52.203
ICD-10: Degenerative Myopia H44.2: H44.20, H44.21, H44.22, And H44.23

1. Eyeglass prescription is ≥ -8.00 or ≥ +8.00 diopters
2. **And**, eyeglass best corrected visual acuity of 20/40 or worse in either eye
3. **And**, visual acuity improvement of 2 lines or more with contact lenses

Anisometropia:
ICD-10: H52.31

1. The difference in prescription between the right and left eyes is ≥ 3.00 diopters in any meridian between the two eyes

Aphakia:
ICD-10: H27.00, H27.01, H27.02, H27.03

1. For Medicare members only, the Local Coverage Determination (**LCD) ID# L33793** supersedes the Davis Vision criteria for Aphakia for services performed on or after 07/01/2016**.**

Aniridia:
ICD-10: Q13.0, Q13.1, Q13.2

1. Underdevelopment or absence of the iris.

Irregular Astigmatism:
ICD-10: H52.211, H52.212, H52.213, H52.21

1. 2.00 diopters of astigmatism in either eye, with principal meridians separated by less than 90 degrees

The Davis Vision Medically Necessary/Visually Required clinical criteria are derived from the American Optometric Association (AOA) Clinical Practice Guidelines & American Academy of Ophthalmology (AAO) Practice Pattern Guidelines, College of Optometrists in Vision Development (COVD).

For Medicare members only, the hierarchy of decision making is as follows:
1. Any applicable National Coverage Determinations (NCD)
2. Any applicable Local Coverage Determinations (LCD)
3. Any Health Plan criteria for routine vision
4. Davis Vision Medically Necessary clinical criteria

For reimbursement purposes, please ensure that the appropriate contact lens fitting code is submitted as per the current American Medical Association CPT definition. All materials prescribed should be described by the appropriate HCPCS Level II code as per the current American Medical Association Healthcare Procedural Coding System definition. All claims for medically necessary services are subject to review and audit.

NOTE: A claim must be submitted for all visually required/medically necessary contact lens requests. Authorizations for enhanced contact lens benefits are not a guarantee of payment for services. A claim must be submitted and final eligibility for the date of service will be determined when the claim is processed. Reimbursement is subject to a maximum allowable fee

D. CLINICAL PRACTICE GUIDELINES

Davis Vision has adopted the Clinical Practice Guidelines of the American Optometric Association (AOA) and the American Academy of Ophthalmology (AAO). Providers may find a link to these guidelines on the Provider Portal of Davis Vision's Web site at **www.davisvision.com**. Hard copies of these guidelines are available by contacting the above associations directly

E. CLINICAL STANDARD OF CARE FOR DIABETIC MEMBERS

Davis Vision and its contracted providers share the mission to preserve and protect sight by thorough examinations, clear communications with patients and their other health care providers, and compliance with the highest standards of care.

Davis Vision tracks and trends the outcomes of comprehensive eye exams for people living with diabetes through patient education, provider education, medical record reviews, dilation reports, and claim analysis.

Medicare, Medicaid, and many health plans publically report member compliance rates with preventative health services to include Diabetic Retinal Exams.

The clinical standard of care for the Diabetic Retinal Exam is a retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) annually unless the exam for the previous year was negative for retinopathy.

When treating a member who is diabetic, Davis Vision requires providers to comply with the following:

- Ask the member if they are diabetic during the exam regardless of what the member may or may not have written on the intake form.

- Dilate the eyes of members with diabetes or document one of the following:
  - a dilated fundus exam was performed within the last 12 months and the result was negative for diabetic retinopathy
  - a dilated fundus exam was contraindicated
  - the member declined and was provided educational information about the consequences of diabetic eye disease
  - or there are other reasons why dilation was not performed that are documented in the clinical record.

- Submit all applicable ICD-10 diagnosis codes for members with diabetes.

- ***NOTE: Submit the exam claim using the CPT II code 3072F: Diabetic Retinal Screening- Negative when applicable.***

- Communicate with the member's primary care physician or other specialty provider that you are providing the member with diabetic eye care services

- Call, email, text, or mail reminders to your patients who have diabetes to remind them to return for their annual diabetic retinal exam

- Counsel and educate all diabetic members on the ocular and associated effects of diabetes and the need for a comprehensive, dilated retinal exam in addition to refraction.

For some plans, Davis Vision offers a Diabetic Outreach Program that consists of reminder letters and telephone outreach to diabetic members to remind them of the importance of a diabetic eye exam, even when their vision has not changed.

SECTION VI FEES, ELIGIBILITY & AUTHORIZATION

A. FEES

1. Examination Fees

Examination fees are determined by geographic location and level of service to be provided to beneficiaries and client groups. The examination fees are indicated on the patient's detailed Vision Plan Benefit Description which is available on the *Member Account* page of the Davis Vision web site (www.davisvision.com). Fee information is also included on the patient's Service Record Form.

2. Dispensing Fees

Dispensing fees are determined based on geographic location and client group specifications. The dispensing fees are indicated on the patient's detailed Vision Plan Benefit Description which is available on the *Member Account* page of the Davis Vision web site (www.davisvision.com).

Providers are paid one hundred percent (100%) of the dispensing fee if the patient selects a Plan frame or has new lenses inserted into the patient's own frame. Providers are paid fifty percent (50%) of the dispensing fee if the patient selects a non-Plan frame.

3. Surfees

Surfees are an additional dispensing fee that may be paid to the provider when patients select upgrades or additional options. Only when applicable, such fees will be specified on the Service Record Form for each specific group.

4. Contact Lens Fitting Fees

Contact lens fitting fees are determined by the specific plan. The contact lens fitting fee is indicated on the patient's detailed Vision Plan Benefit Description, which is available on the *Member Account* page of the Davis Vision web site (www.davisvision.com). Fitting fee information is also included on the patient's Service Record Form. Most plans will not cover a contact lens fitting fee without accompanying order of contact lenses using the member's lens benefit.

5. Patient Copayments

Some plans require members to pay a copayment for specific services at the time of ordering. The copayment amounts are indicated on the patient's detailed Vision Plan Benefit Description, which is available on the *Member Account* page of the Davis Vision

web site (www.davisvision.com). Copayment information is also included on the patient's Service Record Form.

It is the provider's responsibility to attempt to collect all copayments and/or deductibles at the time of ordering – not at the time of dispensing. Providers cannot refuse to provide services or materials if the patient cannot pay the applicable copay and/or deductible at the time of service. Arrangements for payments can be made at the time of service to collect the copays and deductibles which apply to the service or material.

BEST PRACTICE: Record all plan copayments or deductibles collected from your patient on the Davis Vision supplied Service Record Form, and obtain the patient's signature acknowledging they have been informed of all additional items and costs and agreeing to pay for such items.

6. Balance Billing

Provider may not bill Members for, or otherwise attempt to recover from Members, the difference between the agreed upon contract allowable fee and the Provider's billed charge(s). This practice is called Balance Billing and is not permitted per Member Billing/Hold Harmless section of your Participating Provider Agreement.

7. Courtesy Discount

Plans may require (within state regulations) that participating providers extend patients a courtesy discount when purchasing items not covered in the basic benefit. The minimum courtesy discount for complete pairs on the same transaction is up to thirty percent (30%) off the provider's usual and customary fees. Otherwise, the minimum courtesy discount is twenty percent (20%) off the provider's usual and customary fees (or ten percent (10%) off for disposable contact lenses). Courtesy discounts apply only to prescription eye wear.

8. Receipts

Patients are entitled to receipts for copayments, deductibles, and the purchase of additional items. They may be needed for tax reports, reimbursement requirements from other health coverage or personal records. Providers do not issue a receipt for the cost of services or materials for which the patient has no personal financial responsibility (specifically, items included by their vision benefit).

9. Sales Tax

Depending on the state in which the provider's practice is located, sales tax may be collected and may be the responsibility of the patient. The sales tax most often applies to materials and not professional services. The provider's office must notify patients of the implication of any sales taxes before the transaction is completed. All sales taxes must be

clearly shown on receipts provided to the Davis Vision patients. Examples of sales taxes that may apply include but are not limited to:

- Eyewear that is dispensed / made by a provider
- Lens option copayments for retail locations
- Lens option copayments made by Davis Vision laboratory

10. Negative Balance

A negative balance is applied when a provider's office has collected copayments which exceed the amount Davis Vision is contracted to pay the office. If the office accumulates a positive balance the following month, that amount will be applied to the negative balance. If the provider has a negative balance two (2) consecutive months, Davis Vision will send the provider a bill for the negative balance. Davis Vision retains the right to seek assistance from various collection agencies and/or to suspend or permanently terminate provider from further participation in Davis Vision Network in accordance with the suspension and termination provisions in the provider agreement.

B. ELIGIBILITY AND AUTHORIZATION

Davis Vision patients will be directed to call the provider's office to schedule an appointment. At that time, the patient's current eligibility should be verified and authorization for the services being scheduled should be requested. After obtaining the patient's name, patient identification number, and the patient's birth date, the provider's office will follow one of the processes described below:

1. Via Web Site, www.davisvision.com

Providers may access the Web site **twenty-four** (**24) hours a day seven (7) days a week**. To access your patient's account on the Web site, from the Home page, enter the patient's ID# in the Member Accounts section. The Member Account page will display either "Get Authorization" if the member is currently eligible for services or "***Not Eligible Until xx/xx/xxxx***."

If the patient is currently eligible for services, the provider may obtain an authorization. The system will display an authorization number. If the patient is not currently eligible for services, the provider will be notified of the reason (e.g., benefits already received within specified benefit cycle), which can be communicated to the patient. The patient must be notified they are not eligible for Davis Vision covered services prior to delivery of the services. Some plans allow patients to obtain additional services between cycles. The can refer to their detailed Benefit Description for additional information.

2. Via Interactive Voice Response System (IVR), 1-800-888-4321

Providers may access the Davis Vision IVR system **twenty-four** (**24) hours a day seven (7) days a week**. When accessing the IVR, the provider will be prompted to enter their provider number. The IVR will then prompt them to enter the patient's ID#. Once the patient's identification has been verified, the IVR will enable the provider to obtain information about eligibility or to request an authorization for services.

3. Service Record/Voucher Program Eligibility

Voucher Programs are not commonly part of the Davis Vision product designs. However, if the provider's office encounters a patient with a Davis Vision voucher product, the office is *not responsible* for determining eligibility for the Voucher Program. Only eligible persons receive vision benefit service record/vouchers and Plan services should be provided only to the person name's name appearing on the service record/voucher.

The benefit coverage for each patient is indicated at the top of the service record/voucher in the Benefit Key section. The coverage varies between groups and sometimes within a group depending on patient type (patient, spouse, child, or retiree).

Provider offices *are responsible* for verifying that service record/vouchers have not expired. The expiration date of the service record/voucher is generally indicated at the top of the service record/ voucher. Patients whose service record/voucher has expired are responsible to obtain a current one.

The major characteristics of the service record/voucher program are:

- Only one (1) service code is required on the service record/voucher claim form for each pair of eyeglasses provided by the Plan.
- If allowed, patients may receive the network (plan-provided) eye examination and still select non-plan frames or contact lenses. The patient pays charges for non-plan items, less any Plan allowance. Specific Plan allowances are found on group-specific service record/ vouchers in the Benefit Key Section.
- Fees and benefit levels may vary somewhat among groups due to contract periods, customary fee levels, and coverage in the region. The Benefit Key at the top of all service record/vouchers contains the most current coverage and benefit information. It is specific to the patient whose name appears on the service record/voucher.

SECTION VII ORDER ENTRY AND CLAIM SUBMISSION

A. OVERVIEW

Orders and/or claims may be submitted to Davis Vision via the Web site at (www.davisvision.com), or mail to Davis Vision. The vast majority of claims received by Davis Vision via Web site and electronic submission are processed immediately upon receipt. Claims received via U.S. Postal Service are typically processed in the order they are received. **Exceptions to this process include claims for states and clients with more stringent processing timeframes such as payment within thirty (30) days following receipt of a clean claim.**

State Medicaid Managed Care Agencies are not liable or responsible for payment for covered services rendered pursuant to the Davis Vision provider agreement.

B. ORDER ENTRY

1. Via www.davisvision.com

Davis Vision's **paperless program** enables order entry and claims processing to occur simultaneously when using the Web site.

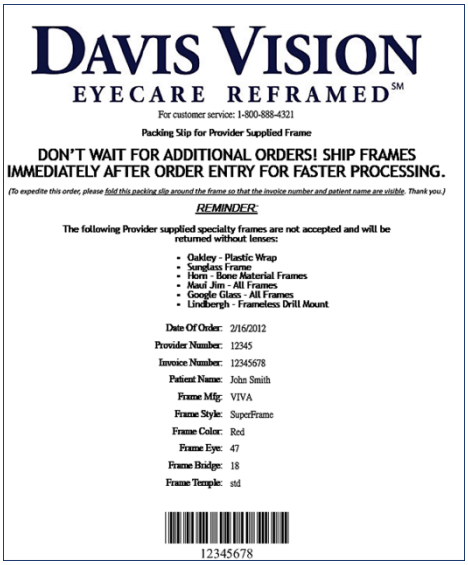
Participating providers confirm patient eligibility and benefit entitlement of the patient prior to delivering services. Once services have been rendered and the eyeglass/lens order needs to be submitted, the provider uses the Authorization Number to generate the order.

On orders for "Lenses Only", you must indicate if the patient's frame is to follow.

C. PROVIDER-SUPPLIED FRAMES OR PATIENTS' OWN FRAMES

When mailing a patient's own frame or a provider-supplied frame, the provider's office will complete the order and print the Davis Vision Packing Slip. The provider's office will wrap the Packing Slip around the provider-supplied frame and secure with tape or rubber band. The provider's office will use the UPS label supplied by Davis Vision to ship the frame. Provider supplied frames must be shipped immediately after order entry to ensure faster processing.

Provider supplied frames not accompanied with Davis Vision Packing Slip will not be processed causing additional delays.



DAVIS VISION
EYECARE REFRAMED℠

For customer service: 1-800-888-4321

Packing Slip for Provider Supplied Frame

DON'T WAIT FOR ADDITIONAL ORDERS! SHIP FRAMES IMMEDIATELY AFTER ORDER ENTRY FOR FASTER PROCESSING.

(To expedite this order, please fold this packing slip around the frame so that the invoice number and patient name are visible. Thank you.)

REMINDER:

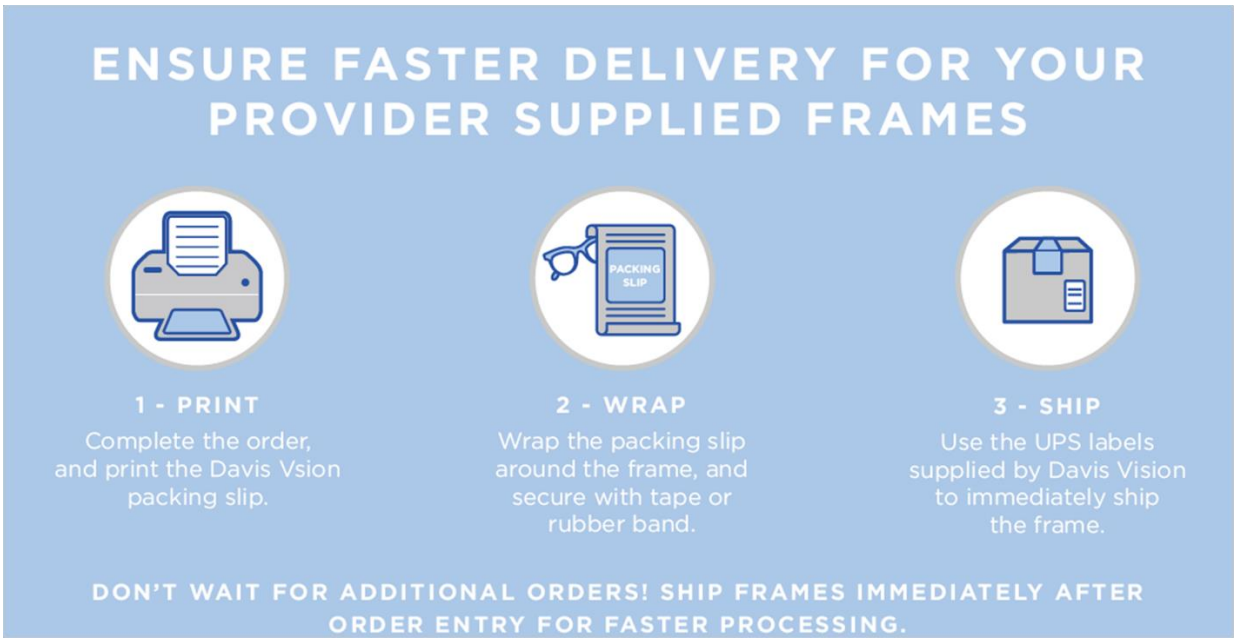
The following Provider supplied specialty frames are not accepted and will be returned without lenses:

- Oakley - Plastic Wrap
- Sunglass Frame
- Horn - Bone Material Frames
- Maui Jim - All Frames
- Google Glass - All Frames
- Lindbergh - Frameless Drill Mount

Date Of Order:	2/16/2012
Provider Number:	12345
Invoice Number:	12345678
Patient Name:	John Smith
Frame Mfg:	VIVA
Frame Style:	SuperFrame
Frame Color:	Red
Frame Eye:	47
Frame Bridge:	18
Frame Temple:	std

12345678

Davis Vision Packing Slip



Davis Vision will not accept responsibility or liability for either frames and/or lenses supplied by the patient, including loss or damage.

Davis Vision will supply doctors with pre-paid, pre-printed shipping labels. Providers should send all returns to the assigned Davis Vision regional laboratory (laboratory addresses and telephone numbers are on the Ship Back Form).

To avoid unnecessary delays, forms should be complete and legible. Ship Back Labels have tracking numbers, which allow Davis Vision to trace all returns. Providers should retain a copy of the label for their records.

BEST PRACTICE: Mail patient-supplied and/or provider-supplied frames to Davis Vision as quickly as possible to avoid delays which negatively impact patient satisfaction.

D. CLAIM SUBMISSION

1. Clean Claim Definition

A clean in-network claim is defined as having the following data elements:

- A valid authorization number, referencing member, and patient information
- A valid Davis Vision-assigned provider number
- The date of service
- The primary diagnosis code
- An indication as to whether or not dilation was performed
- A description of services provided (examination, materials, etc.)
- All necessary prescription eyewear order information (if applicable)
- Itemized charges and total charges are required for paper, EDI, and web submissions

A clean out-of-network claim is defined as having the following data elements:

- Insured's valid ID number
- Insured's name
- Insured's insurance plan or program name
- Patient's name, birth date, and gender
- Patient's relationship to insured
- Diagnosis/condition (including diagnosis code)
- Procedures/services or supplies including days or units
- Date of service

- Itemized charges and total charge
- Information on payment from other carriers for the services such as EOB or office statement
- Signature of the policyholder
- Signature of physician or supplier

If a claim is received with the minimum required data elements as outlined above, the inclusion of additional claim elements cannot render a claim deficient or "non-clean."

Should there be a change in any of the required data elements, Davis Vision will provide at least sixty (60) days' notice to all providers of any such change.

2. Non-clean Claims

Claims that do not contain all of the previously-defined clean claim data elements may be rejected or denied.

3. Request for Additional Information from Participating Provider

If additional information is needed from a participating provider related to a clean claim, Davis Vision will send a written request within thirty (30) days from date of receipt of claim detailing the specific clinical information required. The request will relate only to such information as Davis Vision can demonstrate is specific to the claim or the claim's related episode of care. Davis Vision will process the claim on or before the 15th day from date of receipt of the additional information. If no additional information is received, Davis Vision will process the claim based on the available information.

Davis Vision will not make more than one (1) request for additional information as described above, in connection with a claim.

4. Request for Additional Information from Other Sources

If additional information is needed from someone other than the participating provider who submitted the clean claim, Davis Vision will notify the participating provider within thirty (30) days from date of receipt of claim of the name of the person from whom additional information is being requested. Davis Vision will process the claim on or before the 15th day from date of receipt of the additional information. If no additional information is received, Davis Vision will process the claim based on the available information.

5. In-Network Claims Processing

i. Via www.davisvision.com

Davis Vision's **paperless program** enables order entry and claims processing to occur simultaneously when using the Web site.

Participating providers confirm member eligibility and benefit entitlement of the patient prior to delivering services. During the authorization process, the provider enters the patient's ID number, name, procedure/service/supply, and days/units. Upon successful entry of these elements, an Authorization Number (Eligibility Confirmation Number) is generated.

Once services have been rendered and the eyeglass/lens order needs to be submitted, the provider uses the Authorization Number to generate the claim/order. This significantly abbreviates the claim submission process.

1. Via Mail

Providers who do not have Internet access may submit their claims or vouchers via mail to:

Vision Care Plan Processing
Unit P.O. Box 1525
Latham, New York 12110

Claims should be submitted on CMS 1500 forms. Claims should be filled out accurately and completely including all the data elements outlined in the clean claim section of the manual.

6. Medical Optometry Claims

A limited number of clients allow optometrists providing non-routine medical eye services to bill Davis Vision for payment. Davis Vision does not pre-authorize these services, however they may be subject to retrospective review.

Via: www.davisvision.com

Effective in 2016, Davis Vision has enhanced the Davis Vision website to allow submission of medical optometry claims for all clients. Participating providers may submit via the website for quicker resolution.

Providers who do not have internet access may submit medical optometry claims via mail using a CMS 1500 form to:

Vision Care Plan Processing
Unit P.O. Box 1620
Latham, New York 12110

7. ICD-10

Davis Vision is compliant with ICD-10 nomenclature for all claims with the DOS on or after October 1, 2015. Providers should submit an ICD-10 diagnosis code when available.

SECTION VIII DOCTOR-PATIENT RELATIONS

A. NON-DISCRIMINATION

There should be no discrimination in making appointments. Plan participants should have the same hours available to them as private patients. Additionally, practitioners must not differentiate or discriminate as to the quality of service(s) delivered to patients because of a patient's race, gender, marital status, veteran status, age, religion, color, creed, sexual orientation, national origin, disability, place of residence, health status, need for services, or method of payment.

B. CULTURAL COMPETENCY AND SENSITIVITY

As established by the Participating Provider Agreement, providers must provide covered services in a culturally competent and sensitive manner to all Davis Vision patients, including those with limited English proficiency and diverse cultural and ethnic backgrounds. Providers will only be able to provide culturally competent services if cultural knowledge and sensitivity is incorporated into the office policies, procedures and service manuals.

The U.S. Department of Health and Human Services, Office of Minority Health has established fifteen (15) standards to advance health equity, improve quality, and eliminate health care disparities. These standards may be reviewed by going to www.minorityhealth.hhs.gov and reviewing the Office of Minority Health's Cultural Competency information.

Translation services at no cost to the patient during the provision of services are available through Davis Vision for members requiring communication in a language other than the languages available at the participating Davis Vision office. As a best practice, Providers should contact Davis Vision provider services at 1-800-77DAVIS at least seven (7) business days prior to the patient's appointment to request translation services. The patient's language preference should be documented in the patient's clinical files. Refusal by a patient to accept access to language assistance through Davis Vision at no cost to the member should also be documented in the clinical files.

C. OPEN CLINICAL DIALOGUE

Davis Vision encourages practitioners to engage in open clinical dialogue with their patients including, but not limited to, the discussion of all possible and applicable treatments, whether those treatments are covered services under the patient's benefit plan. Providers are not restricted from filing a complaint or making a report to an appropriate governmental body regarding policies and practices the provider believes may negatively impact the

quality of or access to patient care, nor does Davis Vision prohibit or restrict a provider from advocating on behalf of the member for approval or coverage of a course of treatment.

D. CONFIDENTIALITY FOR ABUSE,NEGLECT, AND DOMESTIC VIOLENCE VICTIMS

Abuse can occur to anyone of any age and gender and from any walk of life. It can take the form of physical battery, emotional bullying, sexual abuse, or neglect.

Most state laws require that any person suspecting that a person (child, adult, or elder person) has been abused or neglected must immediately make a report. If there is an emergency, please contact 911 and then contact your State Abuse Hotline. You are not expected to prove that abuse has definitely occurred.

Davis Vision maintains confidentiality protocols to protect certain personal information of a victim of domestic violence. A victim of domestic violence, the legal representative of the victim or, if a child is the covered person, the child's parent or guardian may request to receive policy and treatment information at an alternate address, telephone number or other method of contact. Please refer to Davis Vision's notice titled Confidentiality for Domestic Violence Victims in the Privacy and Legal section of the Davis Vision website for additional information on this topic. All Providers are encouraged to post a copy of this notice within their office. Davis Vision providers are required ensure compliance with applicable Federal and State Domestic Violence protection laws by implementing protocols to ensure confidentiality for domestic violence victims and educating staff accordingly.

E. BENEFIT ABUSE

If the provider suspects that a patient is misusing a plan benefit, these suspicions should bereported to Davis Vision at **1-800-77DAVIS**.

F. COORDINATION OF BENEFITS

In general, Davis Vision does not coordinate benefits with other insurance companies for in-network services. Since there are a few exceptions, providers should contact Member Services (through the IVR) at **1-800-77DAVIS** if the patient indicates he/she wants to coordinate benefits. If the patient is using his/her out-of-network benefits and has already submitted to the primary carrier, providers should ask the patient to attach the statement or explanation of benefits (EOB) to the out-of-network claim form at time of submission to Davis Vision.

G. SCHEDULING AN APPOINTMENT

Routine appointments must be made available for members within ten (10) calendar days of a request for an appointment. Appointments for urgent conditions should be made available

within forty-eight (48) hours of request. Appointment scheduling requirements are applicable to new and existing patients.

Davis Vision's members will contact the provider's office directly to schedule an appointment. At that time the provider should obtain the member's name, identification number, patient's name (if different from member), date of birth, and relationship to the member. At that time, the patient's current eligibility should be verified via www.davisvision.com or the IVR at 1-800-77DAVIS. If the patient is not currently eligible for services, you should inform him/her of the next date of eligibility.

BEST PRACTICE: The provider should remind patients to notify the office if they are unable to keep an appointment.

Patients should be reminded to bring identification with them at the time of the appointment. Providers are not obligated to provide non-emergent services for members who fail to produce proper identification or members who are not eligible for services. Davis Vision providers should exercise due caution in positively identifying the patient seeking services is the same patient covered by the plan benefits which have been authorized**. Identity theft can be common in health care** and providers should develop policies and procedures to positively identify each Davis Vision member seen in their offices. If the identity of any patient your office provided services is challenged subsequent to service, the provider's office may be required to supply the positive identification used prior to delivery of services or risk having all fees paid to them for that patient's service, recovered by Davis Vision.

Providers may charge "administrative fees" to Members for missed appointments, provided such fees apply uniformly to all Medicare and non-Medicare (Commercial) patients. Providers may not require Members to create a fund or 'escrow account' to ensure payment of missed appointment fees. Such a practice creates a barrier to access to care and violates CMS anti-discrimination regulations.

BEST PRACTICE: Providers are encouraged to have Members to sign a form accepting financial liability for missed appointments.

Medicaid members may not be billed for missed appointments and Providers may not ask Medicaid Members to sign forms accepting financial liability for missed appointments

H. THE OFFICE VISIT

Patients with appointments should not wait longer in the office than one (1) hour after their appointment time before initiation of services.

By contractual agreement, Davis Vision's providers must comply with standards of care based on the guidelines of the American Academy of Ophthalmology and the American Optometric Association.

The office visit must include reason for the visit, patient history, subjective and objective examination, discussion of examination results with the patient, provision of prescription for corrective eyewear, and dispensing of appropriate eyewear.

BEST PRACTICE: To have the patient sign the Service Record Form (available from the patient's authorization on www.davisvision.com) and place the signed copy in their file at EVERY visit.

1. Patient History

Patients are responsible for providing, to the best of their knowledge, accurate and complete information regarding:

- Present complaint or reason for the visit
- Medical history and any other significant events, including surgical history
- Eye and vision history, social and family history
- Current medications
- Allergies and reactions
- Any other pertinent information

2. Examination

A comprehensive ocular assessment to evaluate the physiologic function and anatomic structure of the eye must be performed for all patients. All eye examinations must meet all existing state regulations. The general eye assessment should include, but is not limited to, the following:

- Assessment of current entrance acuity, distance and near, using the member's present corrective lenses, if applicable
- External ocular evaluation including slit lamp examination
- Internal ocular examination*
- Tonometry
- Refraction – objective and subjective**
- Binocular coordination and ocular motility evaluation
- Evaluation of pupillary function
- Biomicroscopy

- Gross visual fields

∗ A Dilated Fundus Examination must be included whenever professionally indicated for people with diabetes. Pupillary dilation is considered part of a comprehensive eye exam benefit and cannot be billed separately from the eye exam or billed separately to the patient even when provided at a later date of service at the request of the patient. Davis Vision's reimbursement for the comprehensive eye exam includes payment for dilation even when provided at a later date of service at the request of the patient.

***Davis Vision does not cover refraction-only services. The refraction (CPT 92015) is considered to be a part of the comprehensive eye examination per the Participating Provider Agreement. This procedure cannot be billed separately to the patient when receiving reimbursement from Davis Vision for a comprehensive eye exam.*

Contact Lens Examinations and Fittings

Contact lens examinations and fittings are not part of a conventional or routine eye examination. Contact lenses require additional tests and measurements which are not part of a routine examination, and for which additional fees and visits may be required. In addition to an eye examination, additional tests for a contact lens fitting may include:

- Measurement of corneal curvatures
- Tear chemistry
- Lid position and tightness
- Slit lamp examination of cornea and contact lens in place
- The use of trial lenses if necessary to determine optimal lens specifications
- One-on-one, hands-on instruction for insertion and removal of contact lenses
- Written instructions, upon delivery, for insertion and removal of contact lenses at home
- Evaluation of patient dexterity
- Custom lens ordering and trial lens evaluations
- Follow-up visits necessary to check lens fit and corneal integrity and arrive at a final lens specification

3. Provision of Prescription for Corrective Eyewear

In accordance with the rules and regulations of the Federal Trade Commission (FTC), a written eyeglass prescription must be issued to the patient upon completion of the examination if an ophthalmic correction is recommended and at no additional cost. Patients cannot be required to purchase ophthalmic materials from the prescribing doctor and there cannot be certain disclaimers or waivers of liability on prescriptions provided to a patient.

Patients wearing contact lenses must be provided with a written contact lens prescription immediately after a contact lens fitting is completed (Federal Trade Commission's *Fairness to Contact Lens Consumers Act*). The contact lens prescription may contain an expiration date according to specific state law, but not less than one (1) year after the issue date of the prescription unless fully documented for medical reasons in the patient's clinical records and clearly explained to the patient. The explanation must be documented as well.

4. Dispensing Corrective Eyewear

Dispensing corrective eyewear must be performed by duly certified and licensed personnel (if required by state regulation) and includes the following services:

- Frame selection - all appropriate plan frames will be shown and advice offered
- Fitting measurements - frame size, seg heights, etc.
- Ordering from central laboratories
- Verification of eyeglasses from laboratory for accuracy prior to dispensing
- Adjusting eyeglasses for proper fit
- Follow-up adjustments, when needed.

A. **Glass Lenses for Children Under the Age of Eighteen (18):** Davis Vision does **NOT** fabricate glass lenses for children under the age of eighteen (18). Providers are strongly encouraged to supply Polycarbonate Lenses or comparable impact resistant lenses, which are provided at no cost for children under the age of eighteen (18). When a patient disregards the provider's recommendation for polycarbonate lenses for children under age eighteen (18), the provider should obtain the patient's signature on the "*Duty to Warn / Patient Rejection and Waiver Form*" found on the Provider Portal at www.davisvision.com.

The Davis Vision lab will hold all orders for glass lenses for children under the age of eighteen (18) until the signed *Duty to Warn Form* is faxed to **1-800-240-4413 Attn:**

Lab Verification. The provider should retain a copy of the signed form in the patient's medical record.

B. Frame Size Challenge: If Davis Vision is unable to fit a patient's frame size from the "Exclusive Collection" of frames, the patient may choose a frame from an Approved Frame Manufacturer (go to www.davisvision.com) with a maximum $40.00 wholesale cost. However, if Davis Vision is able to fit a patient's frame size, but the patient decides not to choose from the "Exclusive Collection" of frames, the frame will be considered a non-plan option if available through the patient's benefit design.

The provider should call the Order Entry Team at **1-800-888-4321** to place their order. The name of the frame manufacturer, model number, color, and size should be included. The Order Entry Team will order the frame directly from the manufacturer and the eyeglasses will be fabricated in a Davis Vision lab. The provider's fee remains the same as if this were a plan frame being dispensed.

I. MEMBER APPEAL OF DENIED SERVICES

Typically, appeals are acknowledged within fifteen (15) calendar days from the date the appeal was received and a determination made and issued in writing within thirty (30) calendar days unless a client agreement, State, or Federal regulation imposes a more stringent timeframe. All notifications issued during the appeal process are communicated to the patient, member, provider, or the member's authorized representative as applicable.

J. REFERRING PATIENTS FOR ADDITIONAL SERVICES

When the patient requires a referral to another vision practitioner for additional vision services, such referral should be made to a qualified practitioner within the Davis Vision provider network, if at all possible, or to a practitioner on the member's health plan network. The provider must explain to the patient the reason for the referral and stress the importance of follow-up care, as well as possible consequences of failure to comply. Members have the right to refuse treatment.

If the provider's recommendations exceed the limitations of the patient's benefit through Davis Vision, please instruct the patient to contact his/her medical carrier for further guidance. you're the provider should make sure the patient has enough information about the reason for the referral so he/she can provide sufficient information to the medical carrier.

BEST PRACTICE: Although not required, it is helpful to give the patient written instructions about consulting another practitioner including possible additional tests to be conducted.

K. ARRANGEMENTS FOR PROLONGED ABSENCE/OFFICE CLOSING

If the provider's office will be closed for three (3) months or longer due to vacation, illness or, other circumstances, then provider should advise Davis Vision's Provider Recruiting Department by calling 1-800-584-3140. If possible, the provider should make arrangements with a colleague (currently credentialed in the Davis Vision network) to provide services for the patients during their absence.

If the provider's office is closing permanently, the provider should advise Davis Vision as soon as possible by calling Provider Recruiting at 1-800-584-3140. Under the terms of the Participating Provider Agreement, it is the provider's responsibility to notify Davis Vision patients prior to the effective date of their discontinuance from the Davis Vision network. Under these circumstances, if the patients ask for copies of their records, the provider must provide them prior to the effective date of their discontinuance from the Davis Vision network.

L. EMERGENCY CARE PROVISIONS

As established in your Participating Provider Agreement, the provider must make after hours emergency care provisions for members twenty-four (24) hours a day, seven (7) days per week. Each method of communication must contain information about the provider's office hours and contain pre-recorded instructions with respect to the handling of an emergency. Patients must also have an opportunity to leave a message regarding a non-emergent concern.

When a Davis Vision member is out of the service area and an emergency arises, if the member believes that an emergency medical condition exists or that a delay in services might compromise his/her health, the member is permitted to seek emergency care from a licensed health care practitioner or provider without obtaining prior approval from Davis Vision. Because Davis Vision provides routine vision care benefits only, reimbursement for emergency services will be solely dependent upon whether the member is eligible for the benefit.

M. REFUSAL OF CARE

Davis Vision's patients who are of legal age have the right to refuse to comply with recommended treatment. The patient should inform the provider of his/her decision. It is the provider's responsibility to inform the member of any potential consequences.

When a patient refuses the recommended course of treatment, the provider should document the patient record. Documentation should include the provider's treatment recommendations, the patient's reasons for refusal, and potential consequences of non-compliance.

N. INVESTIGATIONAL STUDIES

Definition: *Investigational or experimental treatment is described by Davis Vision as an unapproved ocular diagnostic procedure warranted by the ocular health of the member and the subsequent diagnostic findings could alter the member's treatment plan. The risk of a negative outcome utilizing the approved treatment would be no greater than utilizing an alternative treatment.*

Although Davis Vision does not participate in investigational studies, it does not prevent independent providers from participating in such studies. Services and care associated with investigational studies are funded separately by the sponsored research program. It is Davis Vision's policy that all participating providers who do participate in and conduct independent studies will:

- Inform the patient of the purpose of the study
- Inform the patient that he/she has the right to refuse to participate
- Inform the patient how collected data will be utilized
- Inform the patient of all associated risks and/or benefits
- Inform the patient of all associated costs
- Obtain written consent from the patient
- Ensure that all information will be kept confidential
- Provide patients with a written description of the study in a language and level understood by the member

Services performed, as part of an investigational study may not be billed under a Davis Vision program. It is the policy of Davis Vision that members have the right to refuse to participate in research and/or investigational studies.

O. TRANSFER OF PATIENT RECORDS

If a member requests that a provider transfer his/her patient care records to another provider, the provider is required to complete the transfer in a timely manner.

P. PATIENT COMPLAINTS, GRIEVANCES, AND APPEALS

Davis Vision provides routine vision care services to beneficiaries located in all fifty states, the District of Columbia, Puerto Rico, and Guam. The generic complaint, grievance, and appeal processes described below may not include state-specific requirements. For more complete information and guidance, call Davis Vision's Complaints and Appeals Department at ***1-888-343-3470****.*

If Davis Vision denies a request for services, a written adverse determination will be issued explaining the reason(s) for the denial along with the appeal rights. If the patient asks that an appeal should be initiated on his or her behalf, the provider should contact Davis Vision immediately to obtain details on timeframes and requirements for appeal submission.

1. Initial Adverse Determination

Adverse determinations or denials of services are divided into two categories:

A. Benefit denials – a denial decision based on whether the member has a benefit for the service or product at the time the service or product is received. Routine vision and eye care services are limited to a frequency chosen by a client. Therefore, administrative adverse determinations are based solely on whether or not the member has an available benefit. No clinical review is conducted to determine medical necessity.

B. Medical necessity denials – an adverse determination based on whether the product or service meets established medical necessity criteria. Plans include enhanced coverage for contact lenses. For plans offering enhanced coverage, Davis Vision reviews these requests to determine visually required/medical necessity and appropriateness based on the guidelines of the American Optometric Association and the American Academy of Ophthalmology.

2. Appeals of Adverse Determinations

Davis Vision allows a member, a member's designee or healthcare provider one hundred and eighty (180) calendar days to appeal an initial adverse determination.

All appeal requests are processed by Davis Vision's Complaints and Appeals (C&A) department and a C&A associate will document the substance of the appeal request as well as any actions taken in the course of the appeal process. During the discovery period of the appeal process, full investigation of the substance of the appeal, including any aspects of clinical care are developed. Review of the facts will be conducted without deference to the initial denial decision.

Written acknowledgement of the filing of the appeal after initial receipt of the appeal request is provided, at which time the member, member's designee or healthcare provider is informed of the ability to submit written comments, documents or other information relating to the appeal. The acknowledgement notice will also provide direction as to how the member can designate a representative to act on their behalf. In the event of a medical necessity appeal request, the affected individuals will also be provided information regarding an external review process if Davis Vision does not complete its appeal review within specified timeframes.

Appeal review and determination is conducted by an associate that was not involved in the prior adverse determination or a subordinate of such person. With respect to medically necessary appeals, a clinical peer reviewer, other than the reviewer who made the initial determination, will review the appeal. At no instance will the healthcare professional providing healthcare services to the member be permitted to serve as the clinical peer reviewer for such member in connection with the health services being provided to the member.

Davis Vision ensures that all appeals requiring review for clinical issues involving denials pertaining to any aspect of investigational, experimental or medically necessary or appropriate care will be reviewed by a healthcare professional who is appropriately trained in Davis Vision's principles, procedures, and standards and has similar credentials and licensure as those who would typically treat the condition or health problem in question in the appeal. This same-or-similar expertise review will be applied in the event of both a first and second level appeal.

In regard to an appeal of an adverse concurrent care decision, Davis Vision will allow for continued coverage pending the outcome of the appeal.

Appeal determinations will be made in writing or via electronic notification within the following time frames:

- Pre-service Appeals – 30 calendar days from the initial receipt of the request by Davis Vision
- Post-service Appeals – 60 calendar days from the initial receipt of the request by Davis Vision

Extension of the above time frames can only be extended if the member voluntarily agrees to extend the appeal time frame.

Written determinations and appeals are provided in a culturally and linguistically appropriate manner and include, but not be limited to, the following information:

- Specific reasons for the appeal decision, in easy-to-understand language.
- A reference to the benefit provision, guideline, protocol or criterion on which the appeal was based.
- Notification that the member can obtain a copy free of charge, upon request, of the benefit provision, guideline, protocol or criterion on which the appeal was based. (Pre-Service only)

- Notification that the member can obtain a copy free of charge, upon request, of the benefit provision, guideline, protocol or criterion on which the appeal was based with any new or additional information (Post-Service only)
- Notification that the member can obtain, upon request and at no additional charge, reasonable access to and copies of all documents relevant to the appeal including new or additional evidence.
- The title of each reviewer for benefit appeals and the title and qualifications and specialty for medical necessity appeals, specifically stating that the applicable individual participated in the appeal review.
- A description of the next level of appeal along with relevant procedures
- Medical Necessity second level adverse determinations only of the external review process that includes available appeal rights, clear direction on how to use the external appeal process and how members can obtain additional information about these rights.

If a decision is overturned upon appeal, the notification will state that decision and the date.

Davis Vision provides and expedited appeal process for pre-service appeal requests when a member, the member's representative or a healthcare provider acting on the member's behalf indicates that a delay in the appeal process would seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function.

In the event of an expedited appeal, Davis Vision will make a decision and notify members and providers as expeditiously as the medical condition requires, but no later than 72 hours after the request for an expedited appeal. Oral notification will be made within 72 hours, followed by written notification to both the member and provider with 3 calendar days of the initial oral notification of determination.

Davis Vision offers a second level of appeal to a member, the member's representative or a healthcare provider on the member's behalf if such appeal is requested within one hundred and eighty (180) calendars of the first level appeal determination. Second level determination timeframes will follow the same timeframes outlined in the first level appeal process.

A member, member's representative or healthcare provider may request for an external review within one hundred and eighty (180) days after a final internal adverse determination for medically necessity has been made; however, with the member's

permission, Davis Vision reserves the right to refer an appeal, regardless of level, directly to an independent review organization (IRO) without conducting an internal review. Davis Vision will comply with state or federal requirements as applicable.

SECTION IX OPHTHALMIC MATERIALS AND LABORATORIES

A. SAMPLE FRAME COLLECTION

A Davis Vision plan benefit popular with its clients for reducing patient total out-of-pocket expenses features a standardized Plan Collection of frames at select dispensing locations based upon geographic disbursement of membership. Davis Vision supplies a modern, stylish, and compact frame display that contains samples of plan frames.

All Frames have color-coded tags which allow you to easily determine the appropriate frames to which the member is entitled. It is important to keep the color-coded tags on the frames as they indicate the frame collection level. The frame collection is tagged as follows:

Benefit Level	Color Code
Fashion	Yellow Tag
Designer	Red Tag
Premier	Blue Tag
Safety	Yellow, Red or Blue Tag

The cost of the sample frame collection and display is assumed by Davis Vision and remains the property of Davis Vision. Sample frames from the collection are not to be sold, but can be purchased through our Excel Advantage Program. Davis Vision retains the right to take possession of the Collection when a provider ceases to participate with the Plan and, with reasonable notice, at any other time. Providers assume full responsibility for the cost of any missing frames and will be required to reimburse Davis Vision for missing and unaccounted frames.

Frames supplied meet all standards outlined under the American National Standards Institute ANSI Z80.5-2010.

B. LENSES

Only first quality lenses are supplied under the plans. All lenses are provided and workmanship performed in accordance with the American National Standards Institute ANSI Z80.5-2010. Glass ophthalmic lenses are chemically strengthened to achieve impact resistance in accordance with FDA Regulations 21CFR, Sub Part H, Section 801.410. All finished materials are quality assured prior to shipping.

Polycarbonate lenses or similar impact resistant lenses are provided ***at no extra*** *cost* to all eligible dependent children (as defined by the Plan), patients with amblyopia, beneficiaries who are sighted in only one eye (i.e., monocular patients) and patients with prescriptions greater than + or (-) 6 Diopters without additional dispensing fee to the provider. This policy is intended to provide maximum impact resistance and prevention of eye injuries for all eligible children and monocular patients requiring prescription eyewear.

C. CONTACT LENSES

To ensure maximum value for members, distinction may be made between new and existing contact lens wearers. This differentiation may affect the quantity of lenses supplied by the Plan and the professional fitting fee.

A New Wearer is defined as a patient meeting one of the following criteria: (1) a patient who has never worn/been fitted for contact lenses in the past; (2) a patient who is new to the provider's office (whether a new wearer or an existing wearer); and (3) a patient who has previously been fit with contact lenses in the provider's office, but is now being fit with a significantly different type of contact lens.

New wearers will receive a contact lens fitting and lenses according to Plan protocol. The provider will receive a first time fitting fee including any co-payment, if applicable, which includes payment for the additional steps required to determine the optimal lens type that provides maximum comfort and visual acuity for the patient.

An Existing Wearer is defined as a patient previously fit with contact lenses in the provider's office who is now being fit with the same or similar type of contact lens.

Existing wearers will receive a contact lens evaluation and lenses, according to Plan protocol. The provider will receive a fitting fee including any co-payment, if applicable, for this service.

Davis Vision's contact lens formulary makes various types of contact lenses available. Contact lenses listed on the formulary will incur no cost to the patient for fitting or materials according to their benefit design. Non-formulary contact lenses will be covered for fitting fees and materials only to the benefit allowance. All overage costs for non-formulary contact lenses are the responsibility of the patient.

NOTE: This formulary is not always applicable to all groups. The provider should refer to the group-specific plan highlight sheet for complete contact lens information.

D. WARRANTY AND MATERIALS REPLACEMENT

Davis Vision is committed to providing quality service and 100% customer satisfaction. All materials that are supplied by Davis Vision's wholly owned ophthalmic laboratories are covered under the following repair and replacement policies.

Coverage periods are based on the dates associated with the initial dispensing of eyewear. Any replacement materials that may be supplied will be covered for the remainder of the original coverage period.

Davis Vision may request the return of the original pair of eyeglasses, frames or lenses, including uncut lenses, prior to the processing of the redo order. In the event return of the original eyeglasses is not requested, providers must retain the original eyeglasses for a period of one hundred and eighty (180) days.

1. Breakage Warranty for Plan-Supplied Frames and/or Lenses

All eyeglasses provided by Davis Vision laboratories are warranted against breakage for one (1) year from the original date of dispensing. The warranty is limited to one replacement during one (1) year coverage period. This applies to all spectacle lenses and Davis Vision Collection frames. If the provider's materials should break within the warranty period, Davis Vision will supply replacement materials identical to those originally ordered. The prescription and frames (when available) must match the original order. Providers must document the occurrence of the breakage in the patient record to include the date the materials were identified, a description of the breakage, and the date the patient was fitted for the replacement. Providers may be held responsible for the cost of replacements when appropriate documentation is not maintained

2. Allergic Reaction to Plan-Supplied Frames

If the patient experiences an allergic reaction to plan-supplied frames within the first ninety (90) calendar days from the original date of dispensing, Davis Vision will provide a new complete pair of eyeglasses in an alternative frame at no charge.

3. Scratch Protection Plan

Davis Vision will replace, within one (1) year from original dispensing date*, spectacle lenses that have become scratched under normal usage, **only** if the Scratch Resistance option was selected and paid by the patient at the time of the original order or if the option is covered in full within the group's vision care plan. This policy applies to **ALL** lens types and materials.

Whenever the Scratch Resistance option is selected and the applicable charge collected on any lens type or material at the time of the original order, your office will receive the corresponding additional dispensing fee (surfee) from Davis Vision. No surfee will apply if the Scratch Resistance option is covered in full under the group's benefit design.

BEST PRACTICE: If any of the provider's Davis Vision patients have a history of mishandling their eyeglasses or if they are concerned about the possibility of developing scratches on the surfaces of their lenses, the provider should inform them of the potential benefit of selecting the Scratch Protection Plan.

4. Anti-Reflective Coatings

For a period of one (1) year from the original date of dispensing, all lenses that have had an anti-reflective (AR) coating applied and which is peeling or crazing, will be replaced with new AR coated or uncoated lenses (member choice) of the same material, style and prescription, at no charge. **NOTE: This ARC replacement policy does not cover scratches.**

Davis Vision's ARC replacement policies/coverage periods may differ from other retail or manufacturers' policies. Davis Vision's adherence to the one (1) year period is based on the normal benefit coverage period, which would entitle a member to another exam and a whole new pair of eyewear each year, as opposed to the replacement of just the lenses.

Scratched, AR coated lenses will be replaced, only if the scratch protection copay was paid or covered in full by the group's benefit plan design at the time of original order.

5. Repair and Replace Benefit

A number of government programs managed by Davis Vision, provide coverage for the repair or replacement of damaged, lost, or stolen eyeglasses. Coverage for these items must meet the terms and conditions outlined in the member's benefit plan. Providers must retain documentation of the event in the member record which should include all supporting documentation (to include proof of loss such as a police or fire report). Providers are required to provide this documentation in the event of an audit. The provider should contact Customer Service to determine if this benefit is provided for a specific patient.

E. PATIENT REQUESTED RETURNS

***NOTE:* Dispensing date is assumed to be ten (10) days after the date shipped from the Davis Vision laboratory.**

1. Frame Style, Lens Style and/or Lens Material

For a period of thirty (30) calendar days from the original date of dispensing, the patient may return to the provider any pair of eyeglasses for changes to the Davis Vision Collection frame and/or lenses selected.

***NOTE:* Dispensing date is assumed to be ten (10) days after the date shipped from the Davis Vision laboratory**

F. PROVIDER CHANGES

1. Change of Prescription

To ensure that patients attain the best possible vision, Davis Vision providers may make any prescription changes necessary for a period of either ninety (90) calendar days for eyeglasses or thirty (30) calendar days for contact lenses from the original date of dispensing.

***NOTE:* Dispensing date is assumed to be ten (10) days after the date shipped from the Davis Vision laboratory**

2. Non-Adaptation to Progressive Addition (No-Line Bifocal) Lenses

For a period of sixty (60) calendar days from the original date of dispensing, progressive lenses may be returned for replacement with conventional single vision, bifocal, or trifocal lenses.

***NOTE:* Dispensing date is assumed to be ten (10) days after the date shipped from the Davis Vision laboratory**

NOTE: Any member copayments associated with selection of the original progressive additional lenses will not be returned.

G. PATIENT SUPPLIED FRAMES OR LENSES

Davis Vision also provides laboratory services for those orders where some portion of the materials are supplied by the patient. **Davis Vision will not accept responsibility or liability for either frames and/or lenses supplied by the patient, including loss or damage.**

Davis Vision will make every effort to provide new lenses to a member's existing frame. However, should the member's existing frame break, it will be the member's

responsibility to select another frame (either from the Davis Vision collection at prevailing copays, if applicable, or from the provider's selection) at the member's own expense.

When mailing a patient's own frame, the provider should complete the Ship Back Form (See form on www.davisvision.com) with the invoice number generated when the Rx lens order was placed. This will facilitate matching the provider's order with the patient's frame when it is received at the manufacturing lab. Be certain to enclose one (1) copy of the Ship Back Form with the Frame. The following information should be included:

- Member's name and identification number
- Invoice number that was generated when the order was placed
- Special instructions or explanation

To avoid unnecessary delays, forms should be complete and legible. Ship Back Labels have tracking numbers, which allow Davis Vision to trace all returns. The provider should retain a copy of the label for their records.

BEST PRACTICE: *Mail patient-supplied frames to Davis Vision as quickly as the same day the Rx order is place (if possible) to avoid delays which negatively impact patient satisfaction.*

DID YOU KNOW? The manufacturing labs are open and producing work seven (7) days per week. Providers should enter all of their weekend jobs "real time" and all jobs can be started right away.

H. PROVIDER SUPPLIED FRAMES

In the event Davis Vision damages or loses a new, provider-supplied frame, they will make every attempt to provide a replacement at no cost, without involvement of the provider's office. If the frame cannot be replaced, Davis Vision will reimburse the provider's office for the cost of the replacement frame, as originally invoiced to their office by the frame manufacturer or distributor. Davis Vision will not reimburse the retail price for the frame.

When mailing a provider-supplied frame, the provider should complete the Ship Back Form (see form on www.davisvision.com) with the invoice number generated when the Rx lens order was placed. This will facilitate matching the provider's order when it is received at the manufacturing lab. The provider should be certain to enclose one copy of the Ship Back Form with the Frame and include the following information:

- Patient's name and identification number
- Invoice number that was generated when the order was placed
- Special instructions or explanation

To avoid unnecessary delays, forms should be **complete and legible**. Ship Back Labels have tracking numbers, which allow Davis Vision to trace all returns. The providers should retain a copy of the label for their records.

Davis Vision will supply doctors with pre-paid, pre-printed shipping labels. Providers should send all returns to the assigned Davis Vision regional laboratory (laboratory addresses and telephone numbers are on the Ship Back Form).

The provider should fax or email a copy of the invoice to Davis Vision for reimbursement. If the invoice is not available, Davis Vision's maximum reimbursement to the provider will be the Manufacturer's suggested wholesale price.

BEST PRACTICE: *The provider should mail provider-supplied frames to Davis Vision as quickly as the same day the Rx order is placed (if possible) to avoid delays which negatively impact patient satisfaction.*

DID YOU KNOW? *The manufacturing labs are open and producing work seven (7) days per week. Providers should enter all of their weekend jobs "real time" and jobs can be started right away.*

I. UNCUT LENS POLICIES

A one-time remake of uncuts, due to provider finishing errors, will be honored at no charge. All subsequent provider remakes on uncut orders will be billed through our Excel Advantage program. If not already on file, the provider should provide their credit card information to the Excel Advantage Department in order to process the uncut remakes. If additional uncuts are to be supplied, Davis Vision will charge a fixed fee for each pair.

J. CONTACT LENSES

Contact lenses may be covered under the individual manufacturer's warranty. The provider should contact the appropriate vendor. Any provider contact lens warranty fees, if applicable, or contact lens insurance fees are not covered as part of the Davis Vision contact lens benefit. Office warranty fees and/or insurance fees are the patient's responsibility.

K. LABORATORIES

Davis Vision maintains its own regional laboratories for the Plan vision care benefit. These laboratories have earned a commendable reputation in servicing third party plans. Each provider is assigned to a regional laboratory, depending upon geographic location of their office. The manufacturing labs are open and producing work seven (7) days per week. Providers should enter all of their weekend jobs “real time” and jobs can be started right away.

1. Laboratory Services

In establishing order procedures, Davis Vision’s goals are to assure:

a. Maximum convenience for providers.

b. Uniform format requirements of the order processing data system.

c. Accuracy and speed in processing orders.

d. Prompt reimbursement for services rendered.

L. SHIPPING ERRORS

In the event the provider receives eyewear for a patient that they did not provide service for, they should call Davis Vision at **1-800-888-4321** immediately.

Davis Vision will make arrangements with an appropriate carrier to pick up the package from the provider’s office the following day.

M. RECEIVING YOUR ORDER

All eyewear shipped from a Davis Vision laboratory to the provider’s office should meet the following criteria upon receipt:

- Eyeglasses will have been cleaned, bench aligned and polished to be ready for dispensing upon receipt.
- Each patient’s eyeglasses will be protected in an appropriate case.
- A copy of the original laboratory invoice will be included with the finished eyeglasses (wrapped around the case). Davis Vision suggests that the provider retain this copy. If jobs are returned for changes, it is important that that the provider enclose a copy of this form.

SECTION X NETWORK MANAGEMENT AND PARTICIPATION

A. Overview

The purpose of Network Management is to provide structure and formal processes within which the organization evaluates the adequacy of the Davis Vision network, initiates recruiting efforts, and affords all applicants fair process in compliance with the Health Care Quality Improvement Act of 1986. Davis Vision is responsible for maintaining a network of participating practitioners to deliver high quality patient care that is readily available and accessible to members.

B. Council For Affordable Quality Healthcare (CAQH)

Davis Vision is a member of the Council for Affordable Quality Healthcare (CAQH) and, as such, utilizes the CAQH ProView Application for gathering credentialing data for all the health care professionals.

CAQH is a not-for-profit alliance of more than 100 national, regional and local health plans and networks. CAQH's ProView employs many features that make a difference and improve the quality of health care professional data submitted via CAQH, such as:

- Automatic check for errors
- Only asks questions relative to the practice
- Allows physicians and other health care professionals to save a partially completed application and return later
- Enables common data on multiple health care professionals to be entered only once
- Assists in quickly locating contact information for colleges, medical schools and facilities

The CAQH process is available to health care professionals at no charge. Additionally, the process creates cost efficiencies by eliminating the time necessary to complete redundant credentialing applications for multiple health plans, reduces the need for costly credentialing software, and minimizes paperwork by allowing health care professionals to make updates online. (Every four (4) months, the provider will receive a request from CAQH to re-attest that all information in their application is current.)

We encourage physicians and other health care professionals to familiarize themselves with the CAQH ProView application prior to requesting consideration for inclusion in the Davis Vision Network.

C. INITIAL CREDENTIALING PROCESS

NOTE: Davis Vision's provider network is comprised of optometrists, ophthalmologists, and opticians located in all fifty (50) states, the District of Columbia, Puerto Rico, and Guam. The generic credentialing process described below may not include state-specific requirements.

The purpose of Davis Vision's Credentialing Program is to provide the framework and formal processes within which the organization evaluates potential providers and practitioners and reevaluates participating providers and practitioners. Davis Vision is responsible for recruiting high quality practitioners and for ensuring that each one is qualified by training and experience to deliver high quality patient care that is readily available and accessible to members.

During the credentialing process, practitioners submit an application (Davis Vision, state-mandated or CAQH Form). A Data Entry associate reviews the application for completeness, accuracy, and conflicting information. The associate transfers complete applications to Credentialing where an associate conducts primary source verification of education, licensure, and board certification (if applicable) and queries the National Practitioner Data Bank-Healthcare Integrity and Protection Data Base, State Licensing Boards, the U.S. Treasury Office of Foreign Assets Control (OFAC), the Excluded parties List System (EPLS), and other appropriate databases when indicated. The associate queries the Federation of State Medical Boards (FSMB) regarding practitioners (ophthalmologists and MDs) at credentialing and recredentialing for all MDs. The associate confirms that the practitioner has submitted a copy of his/her DEA registration for every state in which the practitioner is licensed, where applicable. The associate reviews Medicare Opt-Out Reports supplied by part B carriers to determine if an applicant has declined remuneration from Medicare or Medicaid programs, thus preventing Davis Vision from including the applicant on any of Davis Vision's Medicare or Medicaid network panels.

NOTE: During the verification process, if credentialing information obtained from primary or secondary sources varies substantially from submitted information, the applicant is contacted by phone within thirty (30) days of discovery and extended an opportunity to correct erroneous information via fax to a Credentialing

associate within ten (10) business days with an explanation and supportive documentation.

The Credentialing associate verifies that no information will be more than one hundred and eighty (180) days old at the time of the Credentialing Committee review. The associate verifies that the practitioner's license and DEA registration will be in effect at the time of the credentialing decision, if applicable.

Davis Vision completes its review of the application and notifies the applicant in writing of the outcome or status within one hundred and eighty (180) days (unless more stringent timeframe is a state mandate) of

receiving the complete application. Denial notifications advise an applicant the reason for the denial and afford the applicant an opportunity to correct erroneous information and appeal the decision based upon the erroneous information.

D. ONGOING MONITORING OF CREDENTIALS

Davis Vision monitors information related to its participating providers on an ongoing basis. Complaints involving potential quality of care issues are immediately forwarded to the Chief Medical Officer (CMO) for review and guidance.

A designated Credentialing associate receives and monitors monthly notifications from CAQH listing cited practitioners. Being that CAQH does not monitor Medicare Opt-Out or Office of Foreign Assets Control (OFAC) reports, or Excluded Parties Listing System (EPLS), Davis Vision monitors these sources monthly to ensure that Davis Vision participating providers are not among those providers cited. Although CAQH monitors the Office of Inspector General (OIG), Davis Vision additionally monitors this source monthly to ensure participating providers have not been excluded from Medicare/Medicaid programs.

If a Davis Vision provider is included in the CAQH citation notifications received during the month, the associate primary source verifies the information through NPDB-HIPDB or the entity that issued the license and documents all pertinent information. This information is reviewed by the Credentialing Committee at the next scheduled meeting. Potential actions taken by the Credentialing Committee might include, but are not limited to: continued follow up, site visit, medical record review, etc. However, if a serious incident is involved, the case is referred to the CMO for immediate review and action.

All practitioners and providers are required to notify Davis Vision within thirty (30) calendar days of any licensure sanctions (including probations or limitations, suspensions or terminations) by any other panel or third party program, all malpractice actions and any sanctions or changes in participation within the Medicare and Medicaid programs.

E. RECREDENTIALING PROCESS

NOTE: Davis Vision's provider network is comprised of optometrists, ophthalmologists, and opticians located in all fifty (50) states, the District of Columbia, Puerto Rico, and Guam.. The generic credentialing process described below may not include state-specific requirements.

Davis Vision's participating practitioners are recredentialed at a minimum of once every three (3) years, focusing on information subject to change during the time period since the practitioner was last credentialed. The recredentialing process is similar to initial credentialing. One hundred twenty (120) days before the recredentialing date, the Credentialing Department receives a report of all practitioners due for recredentialing. A notification letter is sent to each practitioner containing a list of documents to be submitted. Documents include:

- A current state-specific Recredentialing Application
- Current State License(s)
- Current Medicaid number and confirmation letter, if applicable
- Current Medicare number and confirmation letter, if applicable
- Current Malpractice Insurance Policy
- DEA Certificate (if applicable)
- Controlled Substance Registration (if applicable)

Thirty (30) days from the date of the initial notification letter, a second request is sent to any practitioners who have not yet submitted the recredentialing documentation. Thirty(30) days from the date of the second request, a third request is sent to any practitioners who have not yet submitted the recredentialing documentation. Thirty (30) days from the date of the third request, a final request is sent to any practitioners who have not yet submitted the recredentialing documentation advising them that their participation with Davis Vision will be suspended on the last day of the month if documentation is not received.

Credentialing Department associates verify through primary or secondary source verification the information contained in all supporting documentation. (Refer to ***Overview of Initial Credentialing Process*** for information about verification sources.)

Davis Vision's recredentialing process includes a review of the practitioner's performance since initial credentialing. Performance indicators may include, but are not limited to, results of site visits and medical record review, member complaints, and member satisfaction surveys.

The Credentialing Department associate verifies that no information (applications, signatures, or primary or secondary source verification information) will be more than one hundred and eighty (180) days old at the time of the Credentialing Committee review. Questionable items or items that do not meet the screening criteria are documented and presented to the Credentialing Committee for discussion and/or individual consideration.

Completed recredentialing files are forwarded to the Credentialing Committee for review and final determination of network status. Practitioners/providers are notified of the results of the Credentialing Committee's determination.

Practitioners who fail to return the recredentialing package are suspended in accordance with the notification in the "final request" letter. If these practitioners wish to appeal their suspension, they must submit a new credentialing application.

NOTE: If additional information is required, the practitioner is contacted in writing within ten (10) business days of the Credentialing Committee's request and extended an opportunity to provide the additional information within 10 business days. (If the requested information is not received *within ten (10) business days, the Committee will consider the application voluntarily withdrawn.) If the Credentialing Committee has approved* ***or*** *denied the application, the practitioner will be notified in writing within sixty (60) calendar days of the decision. Denial notification advises the practitioner that he/ she may correct erroneous information and may appeal the decision based upon the erroneous information. Upon request, Davis Vision will make available to the practitioner any information obtained during the credentialing process.*

The average time required for completion of a recredentialing application per practitioner is thirty (30) days but shall not exceed ninety (90) days.

F. PARTICIPATING PROVIDER AGREEMENT

As part of the Network Development and Recruitment processes, providers sign a Davis Vision Participating Provider Agreement. As part of the Retail Strategy & Development processes, providers join Davis Vision through a subcontract arrangement of a Group or Retailer Agreement. Providers that are subcontracted by a group entity that is contracted with Davis Vision, must be subject to, and abide by, the same provisions in the Davis Vision Participating Provider Agreement for professional services.

Regardless of the way an individual provider has joined Davis Vision, the signed Agreement obligates all providers to comply with numerous requirements including, but not limited to, the following:

Provider agreed to be bound by all the provisions of the rules and regulations of Davis Vision as well as all applicable laws and administrative requirements of regulatory agencies.

Provider agreed to abide by all Federal and State laws regarding confidentiality, including unauthorized uses or disclosures of patient information and personal health information.

Provider agreed to provide an eye examination including, but not limited to, visual acuities, internal and external ocular examinations (including dilation where professionally indicated), refraction, binocular function testing, tonometry, neurological integrity, biomicroscopy, keratometry, diagnosis and treatment plan and (when authorized by state law and covered by a Plan) medical eye care, diagnosis, treatment and eye care management services, and ordering and dispensing plan eyeglasses or contact lenses according to Plan protocols.

Provider agreed to ensure that members will have access to an answering service, a pager number and/or an answering machine twenty four (24) hours a day, seven (7) days per week.

Provider agreed to comply with Davis Vision's eligibility system requirements and to obtain a valid confirmation of eligibility number prior to rendering services to any member.

Provider agrees to observe the standards of care, quality improvement and grievance resolution protocols as set forth in this Provider Manual.

Provider agreed to prepare and maintain patient records consistent with generally accepted standards and the requirements of Davis Vision. Copies of the Service

Record Form will be completed for each individual to whom services are rendered, signed by both the doctor and the patient, and retained for a period of not less than ten (10) years (or per statutory/federal requirement, whichever is greater).

Provider agreed to notify members in writing in advance of costs for which member is financially responsible before services are rendered.

Provider agreed to accept the Plan's fees as payment in full (except for applicable plan copayments) for the eye examination and dispensing of lenses and frames or contact lenses provided by the central laboratory. The client-specific fees will be applied for all billing, laboratory orders and allowances for non-plan items. The provider agreed not to assert any patient charge for covered items except for applicable co-payments or allowable amounts.

Professional liability insurance will be maintained at a level equal to $1 million per occurrence/$3 million annual aggregate or the community standard.

Provider agreed, if applicable, to maintain the Collection of Plan frames in accordance with the specifications in the Provider Agreement. Beneficiaries will be shown all suitable frame styles. The Collection, display, and other Plan materials will be returned to Davis Vision upon request.

No claim for compensation for any covered services will be made against any participant. The vision care plan fee, as designated in the Plan outline, will be accepted as payment in full for the eye examination and dispensing of Plan lenses and frames, except when Plan copayments apply.

Provider agreed to indemnify and hold Davis Vision and its clients harmless from any damages or legal action arising out of the services provided under the terms and conditions of the Provider Agreement.

Provider agrees to submit and maintain on file with Davis Vision a current and completed application, copies of their current state and CDS/DEA licenses, board certification and current malpractice policies, among other items as applicable.

Provider will maintain in good standing all licenses required by law and must notify Davis Vision immediately of any action, which may adversely affect continuation of any applicable licenses. The provider must also notify Davis Vision of any pending malpractice claims or settlements made against them.

Provider agreed to allow Davis Vision to conduct on-site office visitations and patient record reviews and to cooperate fully with those peer review programs.

Provider agreed to abide by the protocols and standards detailed in this manual.

G. PROVIDER AND OFFICE DEMOGRAPHIC CHANGES

Providers have an obligation to promptly notify Davis Vision of all changes. Changes shall be submitted in writing and the Davis Vision Provider Addition, Change, and Termination Forms can be located and downloaded from the Provider Portal. The forms may also be requested from the Provider Recruiting Team.

The following time frames should be followed:

- Changes in license status, board actions, address or name changes, DBA, or Tax ID require Immediate notification

- Removal of a participating provider requires a thirty (30) days prior notice.

- A thirty (30) day notice is required if provider and/or participating provider: (a) is unavailable to provide Covered Services to Members; (b) moves his/her/its office location; (c) changes his/her/its place of employment; (d) changes his/her/its employer; or (e) reduces capacity at an office location.

- Addition of a new provider to the office:

    - Already credentialed Davis Vision provider requires thirty (30) days prior notice
    - Non-credentialing providers require one-hundred twenty (120) days prior notice

- Termination of network participation – a ninety (90) days prior notice required to allow for continuity of care coordination

H. PROVIDER DISPUTE RESOLUTION PROCESSES

Davis Vision provides routine vision care services to beneficiaries located in all fifty states, the District of Columbia, Puerto Rico, and Guam. The generic provider dispute processes described below may not include state-specific requirements. For more complete information and guidance, the provider should call Davis Vision's Complaints and Appeals Department at 1-888-343-3470.

The Provider Dispute Resolution Processes are at a minimum reviewed annually by the Credentialing Committee to determine if any updates or changes are needed. The Credentialing Committee is comprised of participating practitioners, non-participating

practitioners, and Davis Vision personnel involved in the administration of the Credentialing Program.

The dispute process requires direct communication between the provider and Davis Vision and does not require any action by an enrollee. A written dispute is considered a formal request for review.

Davis Vision will not retaliate or take any discriminatory action against any provider as a result of filing a dispute.

The Provider Disputes Resolution Processes applies:

1. Payment Disputes – disputes regarding adverse claim determinations, payment disputes, timely filing, systemic or operational problems.
2. Administrative Disputes – disputes involving administrative matters not related to quality of care.
3. Credentialing Disputes – disputes concerning a provider's professional competence or conduct and terminations for professional competency and/or conduct, or quality-of-care issues.

1. Payment Disputes

Davis Vision provides for one level of review of which the determination will be final; however, additional levels of appeal may apply in accordance with any contractual state or Federal regulation where applicable.

A provider must file a dispute in writing within sixty (60) calendar days following receipt of the initial claim determination to:

Davis Vision
Complaints and Appeals Department
PO Box 791
Latham, NY 12110
Email: ProviderCA@davisvision.com
Fax: 1-888-778-2008

Providers should provide, at a minimum, the following information with their dispute request:

- Provider number
- Provider name
- Provider address
- Provider telephone number
- Patient ID number

- Member name
- Patient name (if different from member)
- Date of service
- Billed amount
- Authorization number
- Clear description of reason for appeal

An acknowledgement letter will be sent to the provider within five (5) calendar days of receipt summarizing the challenge and providing clear direction regarding how a provider can submit additional information for review. Upon receipt of all necessary information, a Davis Vision associate, qualified to render a decision and who was not involved in the initial determination, will review the dispute and renders a determination.

Davis Vision will complete its review, make a determination and provide written Notice of Determination to the provider within thirty (30) calendar days from receipt of the initial dispute.

2. Administrative Disputes

Davis Vision has established an administrative dispute resolution process to address issues initiated by a provider concerning administrative matters. An administrative dispute is different from a dispute related to professional competence and/or conduct, or quality of care. These matters may arise when a contracted provider challenges Davis Vision's decision that a provider has breached the provider's contractual obligations or violated a Davis Vision policy. Examples of administrative disputes include, but are not limited to:

- Non-compliance with administrative terms in the participation agreement or Provider Manual.
- Billing a member improperly.
- Failure to submit requested medical records.

Davis Vision will send out a notice of breach letter to advise the provider of the objectionable conduct and request that the provider comply. If the provider fails to cure the breach within the stated timeframe (typically 30 calendar days), Davis Vision will initiate the administrative dispute process.

Administrative Dispute Process

1. To begin the process, Davis Vision will send a termination letter notifying the provider that the contract is terminated, and providing information about the consideration rights.

2. The provider may request reconsideration in writing, no later than 60 calendar days after receipt of the notice from Davis Vision.

3. An acknowledgement letter will be sent to the provider within five (5) calendar days of receipt summarizing the reconsideration and providing clear direction regarding how a provider can submit additional information for review.

4. After the provider's reconsideration request is received, an authorized representative of the organization, not involved in the initial decision on the subject of the dispute, will review the written reconsideration and make a decision.

5. The authorized representative's decision is final and will be communicated to the provider in writing within 30 calendar days from the receipt of the provider's written reconsideration request.

Providers must file administrative disputes in writing within sixty (60) calendar days to:

Davis Vision
Complaints and Appeals Department
PO Box 791
Latham, NY 12110
Email:ProviderCA@davisvision.com
Fax: 1-888-778-2008

3. Credentialing Disputes

Davis Vision's Provider Agreements and the Provider Manual contain requirements for continued participation in the Davis Vision network. These requirements were developed to protect member health and welfare and to promote the highest quality of care. Practitioners or providers who fail to comply with these requirements may be subject to a professional review that affects their network status. Practitioners considered for a professional review (termination or suspension) are referred to the Credentialing Committee. Adverse determinations rendered by the Credentialing Committee are communicated to the practitioner or provider in writing, including what action is being taken, the reason for the action, and a summary of the appeal rights and process.

i. Termination with Cause

Davis Vision may terminate the Provider Agreement immediately for cause. "Cause" means:

- A suspension, revocation, or conditioning of provider's license to operate or practice his/her profession.
- A suspension or a history of suspension from Medicare or Medicaid or any other third party plan.
- Conduct by provider, that in Davis Vision's sole discretion endangers the health, safety, or welfare of members.
- Any other material breach of any obligation of the provider as detailed in the terms of the Provider Agreement.
- Conviction of a felony.
- The bankruptcy of a provider.
- Loss or suspension of a Drug Enforcement Administration (DEA) identification number.
- Voluntary surrender of the provider's license to practice in any state in which the practitioner serves as a Davis Vision provider while an investigation into the provider's competency to practice is taking place by that state's licensing authority.
- A failure by provider to maintain malpractice insurance coverage as required by the Provider Agreement
- A failure by provider to comply with applicable laws, rules, regulations, and ethical standards as required by the Provider Agreement
- A failure by provider to comply with Davis Vision rules and regulations as required by the Provider Agreement
- A failure by provider to comply with the utilization review, quality management, and special investigation (FWA) procedures as required by the Provider Agreement
- A violation by provider of the non-solicitation covenant contained in the Provider Agreement whereby the provider agrees not to directly or indirectly engage in the practice of solicitation of members, plans or any employer of members without Davis Vision's prior written consent.
- Failure to comply with the recredentialing process.
- Egregious billing practices

- Excessive number of member complaints

ii. Suspension for Cause

Davis Vision may suspend the Provider Agreement for cause. “Cause” means:

- A failure by provider to comply with applicable laws, rules, regulations, and ethical standards as required by the Provider Agreement
- A failure by provider to comply with Davis Vision rules and regulations as required by the Provider Agreement
- A failure by provider to comply with the utilization review and quality management procedures as required by the Provider Agreement
- A violation by provider of the non-solicitation covenant contained in the Provider Agreement whereby the provider agrees not to directly or indirectly engage in the practice of solicitation of members, plans or any employer of members without Davis Vision’s prior written consent.
- Failure to comply with on-site reviews, record reviews, and/or corrective action plans
- Davis Vision reserves the right to immediately suspend the Provider Agreement, pending investigation, of any participating practitioner who, in the opinion of the senior clinician, is engaged in behavior or who is practicing in a manner that appears to pose a significant risk to the health, welfare, or safety of members. Davis Vision will investigate these instances on an expedited basis.

iii. Termination Without Cause

In addition to Practitioners being considered for professional review (termination or suspension) the Provider Agreement may be terminated by either Davis Vision or the participating practitioner/provider without cause, after the initial twelve (12) month term has ended and upon ninety (90) days prior, written notice.

iv. Appeal Processes

A first-level and second-level Appeal Process are available to all participating providers that have an adverse determination rendered by the Credentialing Committee and have been terminated or suspended from the Davis Vision Network. The appeal processes were developed with input from participating providers and are reviewed at least annually.

First-Level Appeal Process

To appeal a termination decision, a practitioner must send a written request to Davis Vision (at the address in the notice of action) for a hearing to modify or reverse a decision to terminate or suspend. The practitioner's request must be sent by certified mail, return receipt requested and postmarked no later than thirty (30) days following receipt of the notice of action by the practitioner. This request serves as notification to Davis Vision that the practitioner wants to use the appeal process.

The request for a first-level appeal must include all of the following information in order for Davis Vision to examine and consider the appeal:

- Name, office address and telephone number of the participating provider
- National Provider Identifier number of the participating provider
- A letter or other written communicating requesting a Participating Provider Request for Appeal Determination which includes a description of the issue to be examined and considered
- The specific basis or rationale for the Request for Appeal
- Copies of all relevant documentation in support of the Request for Appeal
- The specific remedy or relief sought
- The written Request for Appeal must be mailed via certified, return receipt mail, or insured overnight delivery to the following address:

  Davis Vision, Inc.
  Network Operations
  175 E. Houston Street
  San Antonio, Texas 78205

Within sixty (60) days of receipt of the practitioner's request for a hearing, a Provider Appeal Committee will convene to hear the appeal. A first-level Provider Appeal Committee is composed of at least three (3) individuals, who did not participate in the original decision, with at least one participating Network Practitioner who is a clinical peer of the practitioner that filed the first level appeal, who is not involved in the day to day operations of the Davis Vision, and who does not participate on other Davis Vision committees. None of these individuals may have been involved in the initial termination.

Notice of the hearing will be sent at least ten (10) days before the scheduled hearing date and will advise of the practitioner of his/her right to be represented by an attorney or other person of his/her choice. This notice serves as notification to the practitioner that Davis Vision agrees to hear the practitioner's appeal. Failure to appear at the hearing will be deemed a waiver of the practitioner's right to appeal.

The practitioner may request additional time or may ask that the hearing be rescheduled. The request must be made in writing, sent by certified mail, return receipt requested, and must be received at Davis Vision at least ten (10) days before the scheduled hearing before the first-level Provider Appeal Committee.

At the hearing, the practitioner, their attorney and witnesses if applicable, will present his/her explanation as to why the decision for termination should be modified or reversed. The CMO will present Davis Vision's position regarding the termination.

At the conclusion of the hearing, the first-level Provider Appeal Committee will document its findings and make a recommendation within thirty (30) days of the hearing. The Network Operations Department will send the practitioner a copy of the Committee's determination via certified mail, with the specific reason(s) for the determination, and the practitioner's second-level appeal rights.

Second-Level Appeal Process

To appeal a first-level appeal determination, a practitioner must send a written request to Davis Vision (at the address in the notice of action) for a hearing to modify or reverse a decision to terminate. The request must be sent by certified mail, return receipt requested, and postmarked no later than thirty (30) days following receipt of the notice of action by the practitioner. This request serves as notification to Davis Vision that the practitioner wants to use the second-level appeal process.

The request for a second-level appeal must include all of the following information in order for Davis Vision to examine and consider the appeal:

- Name, office address, and telephone number of the participating provider
- National Provider Identifier number of the participating provider
- A letter or other written communicating requesting a Participating Provider Request for Appeal Determination which includes a description of the issue to be examined and considered
- The specific basis or rationale for the Request for Second-Level Appeal

- Copies of all relevant documentation in support of the Request for Appeal
- The specific remedy or relief sought
- The written Request for Second-Level Appeal must be mailed via certified, return receipt mail, or insured overnight delivery to the following address:

  Davis Vision, Inc.
  Network Operations
  175 E. Houston Street
  San Antonio, Texas 78205

Within sixty (60) days of receipt of the practitioner's second-level appeal, a Provider Appeal Committee will convene to hear the appeal. A second-level Provider Appeal Committee is composed of at least three (3) individuals, who did not participate in the original decision, with at least one participating Network Practitioner who is a clinical peer of the practitioner that filed the first level appeal, who is not involved in the day to day operations of the Davis Vision, and who does not participate on other Davis Vision committees. None of these individuals may have been involved in the initial termination.

Notice of the hearing will be sent at least ten (10) days before the scheduled hearing date and will advise of the practitioner of his/her right to be represented by an attorney or other person of his/her choice. This notice serves as notification to the practitioner that Davis Vision agrees to hear the practitioner's appeal. Failure to appear at the hearing will be deemed a waiver of the practitioner's right to appeal.

At the hearing, the practitioner, their attorney and witnesses if applicable, will present his/her explanation as to why the decision for termination should be modified or reversed. The CMO will present Davis Vision's position regarding the termination.

At the conclusion of the hearing, the second-level Provider Appeal Committee will document its findings and make a recommendation within thirty (30) days of the hearing.

The Network Operations Department will send the practitioner a copy of the Committee's determination via certified mail and the specific reasons for the determination. The second-level decision involving the practitioner's participation in the Davis Vision network is final.

I. Reporting to Appropriate Authorities

All terminations related to professional competence or conduct, adversely affecting clinical privileges for a period longer than thirty (30) days, or related to the practitioner's voluntary

surrender or restriction of clinical privileges while under, or to avoid, investigation are reported within fifteen (15) days of termination to the National Practitioner Data Bank-Healthcare Integrity and Protection Data Bank (NPDB-HIPDB), and the appropriate state licensing board(s). It is the responsibility of the Credentialing Department associates to submit these reports via the IQRS application available through the NPDB website: www.npdb-hipdb.com. IQRS includes a draft report feature allowing for report data input and saving. In addition, the associate mails a copy of the report to the appropriate state licensing board.

Fraud, Waste, and Abuse terminations are reported to State and/or Federal Agencies as required.

SECTION XI QUALITY MANAGEMENT

A. OVERVIEW

The purpose of Davis Vision's Quality Management (QM) Program is to provide the framework and the formal processes within which the organization continually assesses and improves the quality of clinical care, safety, and service provided to members. This includes the ongoing and systematic monitoring, analysis, and evaluation of the accessibility and availability of vision care. This approach enables the organization to focus on opportunities for improving operational performance, health outcomes and member/practitioner/provider satisfaction.

The QM program committee structure includes participation of a participating provider. Annual evaluation of the Davis Vision QM program can be made available to any participating provider upon request.

B. MEDICAL RECORDS and OFFICE SITE REVIEW PROGRAM

Participating providers agree, via the Company's executed provider agreement, to adhere to site and record standards outlined in this provider manual and to cooperate with the Company's efforts in conducting the quality audit program. The information is available to providers upon initial contracting, upon request, and available online at the Company's website provider portal.

The Company has established elements, standards, and performance thresholds that focus and include, but are not limited to:

- Physical accessibility
- Physical appearance
- Adequacy of waiting and examining room space
- Availability of appointments
- Health record documentation standards

1. Provider Site and Medical Record Review Elements

Adherence to the following commonly accepted guidelines is expected of all practitioners with regard to physical site and maintenance of medical records.

a. As reflected in the Medical Record Audit Tool located on the provider portal at www.davisvision.com, provider sites requires adherence to applicable State and Federal laws for the following minimum elements:

I. Reception & Waiting Area
II. Examining Rooms
III. Dispensing Area
IV. Patient Care Exam Rooms
V. Rest Rooms
VI. Safety
VII. Personnel
VIII. Accessibility

b. Each provider in the office must be individually credentialed and have an individual Davis Vision provider number
c. Medical records must be kept for individual patients in a secure area, away from patient access, but readily available to practitioners
d. The office must have policies in place for maintaining patient confidentiality in accordance with State and Federal laws.
e. Practitioners must follow applicable professional and clinical guidelines for documenting care provided to patients.
f. Practitioners must retain patient medical records for the period required under applicable State and Federal laws.

2. Instrumentation and Equipment

Each participating provider office must include the following instrumentation and equipment to administer high quality and comprehensive examinations (see next page for audit tool):

- Examination Chair
- Instrument Stand
- Acuity Chart/Slides/Cards
- Ophthalmoscope
- Retinoscope/Autorefractor
- Phoropter
- Tonometer
- Trial Lens Set
- Lensometer
- Keratometer
- Biomicroscope
- Fields Testing Equipment
- Color Vision Test
- Stereopsis Test

- Binocular Indirect Ophthalmoscope with appropriate lens
- All instrumentation must be well maintained, properly calibrated, and in good working order.
- Infection control measures must be incorporated into the maintenance of all equipment.

3. Medical Records Documentation

As reflected in the Medical Record Audit Tool (at www.davisvision.com) requires that the medical records for its members must include the following minimum documentation.

a. Patient name and date of birth on each page, or patient name and member ID number on each page.

b. Medical records must be legible and organized in a manner that allows for easy identification of patient name, date of birth, significant medical conditions, and allergies

c. Date all entries, and identify the author and their credentials.

d. Clearly label or document subsequent changes to a medical record entry by including the author of the change and date of change. The provider must also maintain a copy of the original entry.

e. Dilated Retinal Exams or appropriate substitute must be performed on diabetic members or documentation must be indicated in the member's medical record why the exam was not performed. In addition, documentation of the presence or absence of diabetic eye disease must be present in the member's medical record, documented by ICD-10 coding

f. Allergies to medication or other severe, potentially life-threatening allergic reactions (e.g., severe food allergies, latex, etc.)

g. Address, phone number, or other identifiers

h. Chief complaint including recent changes in vision or reason for the visit

i. Relevant past eye, medical, and family history

j. Relevant family ocular history

k. Current medications

l. Allergies to medication

m. Entrance visual acuity, with and without correction, distance and near:

n. External and internal evaluation of the structures of the eye

o. Gross Visual Fields

p. Pupil responses

q. Intraocular pressure

r. Dilated fundus examination, when indicated

s. Presence or absence of diabetic retinopathy.

t. Objective and Subjective Refraction:

u. Best corrected acuities, distance and near with refraction

v. Binocular Function:

w. Ocular motility

x. Assessment/Management:

y. Examination results including diagnosis and clinical recommendations, prescription as needed, and any communication directed to the Member's Primary Care Physician.

z. Patient education and recommendation for follow-up care, if appropriate

aa. Referral to specialist or Primary Care Physician, if required

bb. Printed name and signature of the examining doctor

cc. Exact prescription of lenses and frames and/or contact lenses dispensed

dd. Record must be legible

ee. Include the patient's Service Record Form in the medical record when applicable (including patient's agreement to pay for services not covered by the benefit plan)

4. Site Visit and Record Review Trigger Methodology

Davis Vision retains the right to visit any participating provider's office at any time and without prior notice. Reasons for an office visit may include, but are not limited to, member complaints, fraud, waste and abuse investigations, failure of the practitioner to implement or comply with a corrective action plan, failure of the practitioner to respond to requests for clinical records information, support of a client quality improvement initiatives and to comply with federal and state regulation or standards of an accrediting body such as NCQA and URAC.

As established in the Participating Provider Agreement, the provider is required to provide Davis Vision or the clients of Davis Vision with copies of complete eye exam

records including patient intake history forms for our members within a reasonable time period following our request for the records. Davis Vision participating providers will provide the requested records without charge to Davis Vision or to their client groups requesting the same.

a. General Complaint Threshold Monitoring

Quality Management receives and monitors a report of all resolved member complaints involving providers on a quarterly basis with a rolling look-back period of six months from the last date in the reporting quarter.

Example: Last day in Q1 = 3/31/XXXX with six-month look-back beginning 10/1/XXXX

If the report indicates three or more complaints within the reporting look-back period for any particular provider and/or office, the provider/office will be flagged for audit based on the following:

- Complaints involving quality of care, patient safety, physical accessibility, physical appearance or adequacy of waiting and examining room space will warrant site visit review
- Complaints involving quality of service, thoroughness of examination or satisfaction with prescription will warrant medical record review
- If there is a combination of the above, both site and medical record review will be requested

b. Quality of Care/Adverse Event Threshold Monitoring

Singular complaint and/or adverse events that warrant clinical peer review during the complaint investigation process can qualify for site or medical exam review on demand at the Medical Director's discretion or at the request of a client. This process will supersede the need for meeting the complaint threshold monitoring process and/or any current or recently closed site or record review process.

Additionally, the medical director can bypass the site or exam review process and immediately refer a provider challenge to the Credentialing Committee to request peer review for possible termination or suspension of network participation when imminent safety and quality concerns warrant immediate action.

In the event that the Medical Director deems a challenge unsubstantiated and does not request immediate site or record review, the complaint then will then be subject to the general complaint threshold monitoring process

c. Site Visit and Medical Record Review Process

Coordination of the site visit and/or record review process is managed within the Quality Department. For site only or combination site and medical record review requests, a Quality associate will engage a Regional Quality Assurance Reviewer (RQAR) to initiate scheduling the site visit and will also request medical records for a provider, both within 10 calendar days after the last day of the quarter where threshold monitoring triggers were met or from the date in which the medical director or client requested the reviews. Notice to the provider will indicate all necessary due dates in which documentation must be submitted to the Company.

The associate will also advise the RQAR of the timeframe in which the site visit will need to be completed, which shall be no later than 60 calendar days from the last day of the quarter where threshold monitoring triggers were met or from the date in which the medical director or client requested the reviews.

The RQAR is responsible to:

- Make arrangements with the practitioner or provider group to schedule a date and time for the on-site visit
- Provide at least a seven-day notice of an on-site visit
- Complete a fair and thorough review in accordance with established standards
- Conduct site visits using the approved scoring assessment forms
- Review preliminary results with the provider when on-site
- Address any immediate concerns raised by the provider while on site
- Provide immediate on-site training when applicable
- Determine whether additional areas of non-compliance are identified
- Perform a chart review and a check of licensure requirements, if warranted or required
- Submit audit results to the Quality department within 3 business days.

Upon submission from the RQAR, a Quality associate updates the system of record with the completed evaluation results.

When requesting exam records, a Quality associate will document 3 verbal attempts, at different times and days to secure document requests that are more than 30 days from the date of the original request.

If a provider fails to provide documents by the end of the 60-day requirement to complete the audit, case documentation of administrative attempts will be

forwarded to Credentialing for peer review recommendations regarding possible network action.

d. Corrective Action and Continuous Monitoring

The scoring mechanism for both site and medical record review includes weighted scoring elements. The passing threshold for both site and record review is 70%.

Any office scoring below the 70% threshold is subject to corrective action and ongoing monitoring until such point the deficiencies have been remediated.

Audit result letters are issued to providers as follows:

- > 70%, within 30 calendar days of the visit. Notice will provide:
  - Results of audit
  - Advise the audit was satisfactorily closed

- < 70%, within 10 calendar days of the visit. Notice with provide:
  - Results of audit
  - Corrective Action Plan (CAP) template (See Exhibit C)
  - Requirement of 30 calendar days from date of notice to return completed CAP document

Upon receipt of the provider's CAP response, the Company's medical director will approve or revise the CAP and the provider will be notified of the outcome of the 14 days of receipt of the CAP. The provider/office will then be flagged for re-audit after 6 months has elapsed from the date of notice of acceptance of the CAP actions.

If re-audit concludes that remediation was satisfactorily achieved, the audit will be closed and notification to the provider given.

If re-audit indicates that remediation was unsatisfactory, the case will be reviewed by the medical director to recommend either additional education and re-audit or move case to Credentialing Committee for peer review recommendations and possible network action.

If the provider/office meets the complaint threshold for a different standard after completing CAP remediation, the Company will apply the complaint threshold monitoring process as stated previously in this document.

e. Providers Failing to Comply with Administrative Requests Outside of Oversight Process
If a provider does not comply within the timeframe for resolution of a member complaint, the Complaints and Appeals department will forward a recommendation for action to Quality.

Quality will then document the incident and prepare a recommendation to Credentialing Committee regarding possible network action.

C. PATIENT SATISFACTION

The purpose of Davis Vision's comprehensive patient satisfaction program is to:

- Determine overall member perception of the vision care plan.
- Identify aspects of the program in which members would recommend a change.
- Identify practitioners on the panel who are not providing courteous and high quality services to members.
- Identify elements of the system which may be causing delays in the provision of care.
- Provide members with the opportunity to offer both positive and critical feedback
- Offer members the opportunity to ask questions regarding the program.
- Provide feedback to the practitioners on their patients' opinions about their care.
- Provide feedback to the laboratory on the patients' opinions about their services and materials.
- Provide feedback to the program's sponsor group on the assessment of the benefit by their constituents.

Patients' attitudes and perceptions are the fundamental component of quality improvement that is why Davis Vision members have the right to access and express their opinions and concerns. Patients obtaining services have the opportunity to complete a patient satisfaction survey to express their views concerning the quality of services rendered. This survey instrument is designed to elicit the patient's opinion on access to care, treatment by the professional staff and satisfaction with the examination and prescriptive eyewear.

Survey responses are evaluated and, if necessary, follow-up action is taken promptly.

Davis Vision conducts and reports statistical analysis on patient satisfaction aggregate results.

D. PRACTITIONER SATISFACTION

The Provider Satisfaction Survey establishes a platform for open communication and creates a better partnership between Davis Vision and its participating providers. The

opinions, ideas, and suggestions of Davis Vision's participating providers are as important as those of Davis Vision's patients.

At least annually, Davis Vision sends participating providers a Provider Satisfaction Survey that addresses topics such as laboratory services, administrative processes and reimbursement. Responses are scanned and evaluated. Aggregate results are presented annually to the Quality Management Committee. The Committee discusses concerns and trends reported by the providers, focusing on challenging issues or dissatisfaction.

As a result of comments in the Provider Satisfaction Survey, Davis Vision takes appropriate action to address identified issues.

SECTION XII REVISION HISTORY

Version	Effective Date	Revision
2015.1	01/15/2015	Updated the Fraud, Waste, and Abuse (FWA) Section
	01/15/2015	Added Provider adherence language to the Provider Responsibilities section
	01/15/2015	Updated the IVR Phone Number throughout the Manual
	01/15/2015	Added Balance Billing section
	01/15/2015	Updated the Recredentialing Process to begin at one-hundred twenty (120) days
	01/15/2015	Updated the first-level appeal process
	01/15/2015	Added the second-level appeal process
2016.1	04/01/2016	Provider Responsibilities - added Provider are responsible for notifying Davis Vision timely of changes to their practice, office, and providers (page 15)
	04/01/2016	Provider Responsibilities – updated claims submission from 180 days to 60 days; added New York Medicaid claims to be submitted within 90 days (page 15)
	04/01/2016	Courtesy Discount percentage updated from 20% to 30% (page 29,37)
	04/01/2016	Discount Programs schedule added to the Provider Manual (page 30)

	04/01/2016	Non-clean Claims language updated to match existing claims processing practice (page 43)
	04/01/2016	Added “may be subject to retrospective review” to *Medical Optometry Claims* section (page 46)
	04/01/2016	Added *billing members for missed appointment* language to Scheduling an Appointment section (page 48-49)
	04/01/2016	Added language to *Authorizations for the Enhanced Contact Lens Benefits* section: A claim must be submitted for all visually required/medically necessary contact lense requests. Authorizations for enhanced contact lens benefits are not a guarantee of payment for services. A claim must be submitted and final eligibility of the patient for services on the date of service will be determined when the claim for services is processed. Reimbursement is subject to a maximum allowable fee (page 50)
	04/01/2016	Updated language to *Prior Authorizations for Low Vision Benefits*: Davis Visions plans may also include Low Vision benefits for members who qualify for Low Vision services. Providers must confirm member’s eligibility, and provide services at accepted standards of care. Services may include both a low vision evaluation and low vision aid(s), and are restricted to the allowances specified by the individual plans or Davis Vision’s maximum allowable fee. Members are responsible for all

		fees over the allowances; A claim must be submitted for all Low Vision Evaluation and Low Vision Aid requests. Authorizations for Low Vision Evaluation or Aids are not a guarantee of payment for services. A claim must be submitted and final eligibility of the patient for services on the date of service will be determined when the claim for services is processed. Reimbursement subject to a maximum allowable fee (page 51)
	04/01/2016	Added language to *Examination* section regarding Contact Lens Examinations and Fittings (page 53)
	04/01/2016	Added *Provider and Office Demographics* language to Section IX (page 80)
	04/01/2016	Added language to *Medical Records Documentation* section: Each provider in the office must be individually credentialed and have an individual Davis Vision provider number, so that the scores reflected in the audit accurately reflect the documentation of the provider named (page 89-90)
2017.1	07/15/2017	Plainview, New York (laboratory) removed from Section I Welcome to Davis Vision; A. About Davis Vision
	07/15/2017	Created Section V Utilization Review section and pulled in all U.R. language into this section
	07/15/2017	Collection Agency and Suspension language added to Section VI Fees, Eligibility, & Authorization; 10. Negative Balance

	07/15/2017	Section VII Order Entry and Claims Submission updated to accurately represent Davis Vision processes
	07/15/2017	Confidentiality for Domestic Violence Victims language added to Section VIII Doctor- Patient Relations
2018	05/01/2018	*Provider Agreement* language updated to include subcontract relationships (page 79)
	05/01/2018	*Provider Disputes Resolution Processes* updated (page 82)
	05/01/2018	Section V *Utilization Review* was revised and updated to better reflect existing processes (pages 36-44)
	05/01/2018	Section VII. C. *Provider-Supplied Frames or Patients' Own Frames* was revised and updated to better reflect existing processes (pages 49-50)
	05/01/2018	*Section XI Quality Management* was revised and updated to better reflect existing processes (pages 93-100)