In accordance with the New Jersey Department of Banking and Insurance "Health Claims Authorization, Processing and Payment Act (HCAPP)," Davis Vision is providing the following information concerning its utilization management program. Should any portion of this program or its administration change, Davis Vision will publish the change(s), no less than 30 calendar days before the information or policies or any changes in the information or policies take effect. Please note that the information provided below does not constitute a promise to pay or approve any or all claims submitted under the terms of this Davis Vision program. Should you have any questions regarding this program or the information below please contact Davis Vision's Professional Relations Department at 1-800-933-9371.

UTILIZATION MANAGEMENT

Davis Vision provides routine vision and eye care services including routine eye examinations, contact lenses, value-added discounts and accessories. Davis Vision allows flexibility in the custom design of programs to meet specific client requirements. Some plans include enhanced coverage for medically necessary contact lenses. For plans offering enhanced coverage, Davis Vision reviews these requests to determine medical necessity. Davis Vision does not offer reimbursement, bonuses or incentives to staff or health care providers based directly on consumer utilization of health care services.

MEDICAL NECESSITY

Utilization review to determine medical necessity is based on clinical criteria specific to the condition or service under review. Consideration is given to the individual's needs including, but not limited to status, co-morbidities, psychosocial, environmental, special needs, response to treatment, and prior use of diagnostic services, if applicable. Utilization review is conducted by trained health care professionals. All cases that do not meet clinical criteria for medical necessity are referred to a clinical peer for review and determination.

Davis Vision uses nationally recognized clinical criteria as guidelines for all utilization review determinations. The clinical criteria are reviewed and updated annually. Optometric providers are required to follow the clinical practice guidelines of the American Optometric Association (AOA). Ophthalmologists are required to follow the clinical practice guidelines of the American Academy of Ophthalmology (AAO).

MEDICALLY NECESSARY CONTACT LENSES

For plans that include enhanced coverage for medically necessary contact lenses, contact lenses may be determined to be medically necessary and appropriate in the treatment of patients affected by certain conditions. Although each group plan varies in benefit design, contact lenses may be determined to be medically necessary in the treatment of the following nine (9) conditions:

- Keratoconus
- Aphakia
- Anisometropia
- Aniseikonia
- Pathological Myopia
- Aniridia
- Corneal Disorders
- Post-Traumatic Disorders
- Irregular Astigmatism

PRIOR APPROVAL

Prior approval or prospective review involves services that have not yet been rendered. All pre-service reviews are for non-urgent care as services and materials for urgent/emergency care are not covered under Davis Vision plans. Prior Approval Representatives are available during normal business hours, Monday through Friday, from 8:00 a.m. until 4:30 p.m. EST. Practitioners requesting prior approval of services complete a Prior Approval Form including, but not limited to, the following information:

- Member's and/or patient's identification number
- Patient's name
- Requested service or procedure
- Diagnosis
- Justification

The practitioner faxes the completed form to Davis Vision's Prior Approval Department at (800) 584-2329. A Prior Approval Representative reviews the request for completeness and for medical necessity based on utilization review clinical criteria. The Prior Approval Representative refers all cases that do not meet clinical criteria for medical necessity to a clinical peer for review and determination. As part of the review, the practitioner may be contacted to discuss the case. Individuals that conduct peer clinical review are available to discuss review determinations with the attending physician or ordering provider. If the original peer reviewer is not available, another clinical peer is available within one business day.

All determinations are rendered within three (3) business days of receipt of a complete request, both verbally and in writing to both the member and the practitioner. If the request is incomplete, Davis Vision will request additional information within the initial three-business-day time frame. Davis Vision will allow the member, member's designee and/or provider 45 calendar days to submit the requested additional information. If the requested information is not received within 45 calendar days, Davis Vision will issue a decision within 15 calendar days of the expiration of the 45-day time frame. Written denials based on medical necessity include, but are not limited to, the following information:

- Criteria utilized, including clinical rationale, if any, and documentation supporting the decision
- Statement that the decision will be final and binding unless the member appeals in writing to the Quality Assurance/Patient Advocate Department within 45 days of the date of the notice of the decision
- Appeal and Grievance Procedures
- Name, position, phone number and department of person(s) responsible for the outcome

In cases where a client, plan or regulatory agency mandates a specific appeal process, Davis Vision will abide by that appeal process. In all other cases, Davis Vision's Member Appeals or Member Grievance Process will apply.

CONCURRENT REVIEW

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. Practitioners complete the Prior Approval Form and fax it to the Prior Approval Department at (800) 584-2329.

All determinations are rendered within one (1) business day of receipt of necessary information but no later than 15 calendar days following the request, both verbally and in writing to both the member and the practitioner. The written determination contains the following information:

- Number of extended services approved
- New total of approved services
- Date of onset
- Next review date
- Appeal and Grievance Procedures

RETROSPECTIVE REVIEW

Retrospective review involves services that have been rendered previously. Davis Vision does not conduct retrospective reviews for services covered under its plans. In rare instances, a retrospective review may be conducted:

- To determine medical necessity when a member or practitioner fails to obtain approval for services that require prior approval before services are rendered
- To determine medical necessity when a practitioner fails to obtain approval 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 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 of procedures, treatments and services delivered to the insured during the same course of treatment.