DAVIS VISION
EYECARE REFRAMED℠

2015 **PROVIDER MANUAL**

Take A New Look At Eye Care

TABLE OF CONTENTS

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 your 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 because 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, and 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 care and eye care services including comprehensive routine eye examinations, eyeglasses and contact lenses. The plan presently serves more than 18 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 Provider and Patient Services operations are located in Latham, New York. Davis Vision operates five optical laboratories located in Philadelphia, Pennsylvania; Plainview, New York; Syracuse, New York and two in San Antonio, Texas. All laboratories have redundant equipment and systems and have been designed to handle the production from the other laboratories in the event productive capacity is not available at any one of them. Davis Vision has over 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 nearly 18,000 providers (optometrists, ophthalmologists and retail centers including Visionworks) located in all fifty states, the District of Columbia, and Puerto Rico. The network includes Visionworks, a wholly owned chain of 600 proprietary vision centers located throughout the United States.

B. 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.

C. QUALITY IMPROVEMENT

Davis Vision, a leader in vision care, continually reviews data and information that may lead to better vision care and the prevention of eye disease.

Davis Vision collects utilization trend data as an integral aspect of our Quality Improvement program. This data collection can include, but is not limited to:

- Dilated Fundus Examinations
- Pediatric care
- Medical eye care
- Medically necessary contact lenses
- Patient and provider surveys are also conducted in order to improve the quality of vision care services.

D. FRAUD, WASTE AND ABUSE (FWA)

The activities of Davis Vision, its Associates and contracted providers must be carried out in accordance with applicable laws and Davis Vision policies and procedures. 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.

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.

Davis Vision will undertake a reasonable investigation for any credible report of potential Fraud, Waste and/or Abuse (FWA) and may refer the issue, as appropriate, to the Highmark Special Investigations Unit, the client's Special Investigations Unit, CMS or law enforcement. 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 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. Health care providers and office staff are required to complete General Compliance and Fraud, Waste and Abuse Training within 90 days of hire and annually thereafter. Providers may use the materials provided by Davis Vision or may use 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). 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. CMS also has developed and provided a standardized FWA training and education module. The module is available through the CMS Medicare Learning Network (MLN) at http://www.cms.gov/MLNProducts. Providers are required to maintain training records for a period of 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 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.

1. Definitions

Abuse: using wrongly or improperly. Examples:

- Excessive charges for services or supplies

- Billing for “free” services
- Breach of assignment agreements
- Improper billing practices, such as exceeding the limit charge, billing non-covered services as covered
- Misrepresenting services or dates of service.

Conspiracy: an agreement between two or more persons to perform together an illegal, wrongful or subversive act

- *Fraud*: using intentional deception or misrepresentation for unlawful gain or unjust advantage. Examples: Billing for services or supplies that weren’t provided
- Misrepresenting the diagnosis or prescription to ensure payment of materials or services
- Billing the medical carrier and Davis Vision for the same service
- Soliciting, offering or receiving a kickback, bribe or rebate
- An eligible provider billing for the services provided by a non-eligible provider or individual
- Loaning or using another person’s patient identification number (and/or card) to obtain services or materials
- Billing for services provided to a family member

Medical Identity Theft: using another individual’s medical insurance information to obtain medical treatment or services

Waste: using, consuming, spending or expending thoughtlessly or carelessly

2. The False Claims Act

The most common type of fraud and abuse is 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

3. Anti-Kickback Statute

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

- knowingly and willfully paying, offering, soliciting or receiving remuneration (anything of value);
- to induce 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 but 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. Contact Information

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 24 hours a day, 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. CONFIDENTIALITY AND SECURITY OF INFORMATION

Davis Vision has established and maintains a HIPAA Privacy Office, 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 HIPAA Privacy Regulations.

The Privacy Office also audits compliance, investigates allegations or reports of privacy breaches and 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 or family members. Davis Vision will abide by all applicable state and federal laws protecting patient confidentiality and the confidentiality of individual medical records. Davis Vision 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 is therefore 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 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 intent 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 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 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 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 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 responsible 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 and recredentialing 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 to comply with all applicable federal, state or municipal statutes or ordinances and all applicable rules and regulations and the ethical standards of the appropriate professional society.

9. Providers are responsible to comply with all policies and procedures as described in the Provider Manual. Providers are responsible to maintain confidentiality of financial information from other providers but may discuss financial arrangements with Davis Vision's patients.

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

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

12. Providers are responsible for submitting all claims within sixty (60) days of the date services were provided.

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

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

15. 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. 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 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.

E. 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 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 approval 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.

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 **24 hours a day 7 days a week** by calling the IVR at **1-888-800-4321.** 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

Process claims for “Examination Only” services

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 Recruiting 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 approval for services outside regular eligibility cycle • Request prior approval for medically necessary contact lenses
Excel Advantage	Go to www.davisvision.com or fax your request to: **1-888-281-4974**	• Place an Excel Advantage order
Excel Advantage	To contact a Finance Associate	• Request Excel Advantage billing
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) and select 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: **1-888-800-4321** 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 • Process claims for "examination only" services • Speak with a Member Service
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, www.davisvision.com**	• Obtain warranty information • Track jobs • Place "examination only" order • Place other order • 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"
Quality Assurance	To contact a Quality Assurance Associate, please call: **1-888-343-3470** or write: 711 Troy Schenectady Road, Latham, New York 12110	• Submit an appeal • Submit a grievance on behalf of a member
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 18 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 pair of eyeglasses (or contact lenses in lieu of eyeglasses) per benefit cycle. Some plans may allow two pairs of eyeglasses; Some plans require a 20% courtesy discounts 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.

All plan-supplied eyeglasses include an unconditional breakage warranty for one 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. Copies of Sightwire, a newsletter regarding eye care topics released six times a year, are available free of charge for clients to share with employees.

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 12 or 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 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 myopia in excess of 8.00 Diopters, and anisometropia in excess of 4.00 Diopters.

Most groups limit coverage to one (1) pair of Plan eyeglasses (lenses and frame) or one order of contact lenses. Some groups allow two (2) pairs of eyeglasses (Distance Vision and Near Vision) in lieu of bifocals. Only a few plans allow multiple pairs without restriction.

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 Plan are:

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 him/her 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 he/she understands 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 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 your 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 30% and may be ordered **only** in plastic. The patient must place the order for the two 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 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 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 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 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 members 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 your responsibility to attempt to collect all copayments 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 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 he/she has 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

A few Plans in some states require that participating providers extend patients a courtesy discount when purchasing items not covered in the basic benefit. The minimum courtesy discount is 20% off the provider's usual and customary fees (or 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. 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 your 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. Your 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

9. 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 consecutive months, Davis Vision will send the provider a bill for the negative balance.

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, follow one of the processes described below:

1. Via Web Site, www.davisvision.com

Providers may access the Web site **24 hours a day 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. Please refer to the patient's 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 **24 hours a day, 7 days a week**. When accessing the IVR, you will be prompted to enter your provider number. The IVR will then prompt you to enter the patient's ID#. Once the patient's identification has been verified, the IVR will enable you to obtain information about eligibility or to request an authorization for services.

3. Prior Approval Process

Some plans allow patients to obtain additional services between cycles with prior approval. In these cases, Davis Vision has specific criteria against which the patient's request is evaluated. It is your responsibility to complete in full the Davis Vision Prior Approval Form and provide as much clinical information as possible to enable Davis Vision to make a determination.

Complete the Prior Approval Request Form (on the Provider Portal under Important Links) and fax it to Davis Vision Utilization Review Department at **1-800-584-2329**. A Utilization Review Associate will review your request and will fax the determination back to you. Typically, Prior Approval

requests are completed and faxed back to the provider within two (2) business days after the date of receipt of the fax.

4. Service Record/Voucher Program Eligibility

Voucher Programs are not commonly part of the Davis Vision product designs. However, if your office encounters a patient with a Davis Vision voucher product your 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, 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 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.

5. Concurrent Review Process

Because Davis Vision administers routine eye care services, it is unusual for a patient to require continuing services. For these rare instances, Davis Vision may conduct concurrent review during the course of ongoing treatment.

Complete the Prior Approval Request Form (on the Provider Portal under Important Links) and fax it to Davis Vision Utilization Review Department at **1-800-584-2329**. A Utilization Review Associate will review your request and will fax the determination back to you. Typically, Davis Vision makes Concurrent Review determinations and provides notice of determination to the member, the

member's designee and the health care provider by telephone and in writing within one (1) business day following receipt of necessary information.

If the patient is currently receiving a requested service and Davis Vision denies the request for continued services, Davis Vision will mail the written notice of denial to the patient at least ten (10) days prior to the effective date of the denial of authorization for continued services.

BEST PRACTICE 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 your office should develop policies and procedures to positively identify each Davis Vision patient seen in your office. If the identity of any patient your office provided services is challenged subsequent to service, your office will be required to supply the positive identification used prior to delivery of services or risk having all fees paid to your office for that patient's service recovered by Davis Vision.

SECTION VI ORDER ENTRY AND CLAIM SUBMISSION

A. OVERVIEW

All orders and/or claims must be telephoned, mailed or e-mailed to Davis Vision. The vast majority of claims received by Davis Vision via Web site (www.davisvision.com), IVR and phone (**1-800-888-4321**) are processed immediately upon receipt. Claims received via other methods such as fax and mailed paper claims are typically processed in the order they are received. This means that the oldest claims on hand at any given time are processed prior to more newly received claims. **Exceptions to this process include claims for states and clients with more stringent processing timeframes such as payment within 30 days following receipt of a clean claim.** Davis Vision uses its best efforts to meet or exceed all Federal, state or local requirements for timely processing and payment of claims for services or materials.

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 that the patient's frame is to follow.

2. Via IVR System 1-800-888-4321

Exam Only orders may be processed through the IVR system by calling 1-800-888-4321 **. The IVR will prompt you through the appropriate steps. Material orders and job status questions will be routed to a Customer Service Representative for handling.**

C. PROVIDER-SUPPLIED FRAMES OR PATIENTS' OWN FRAMES

When mailing a patient's own frame or a provider-supplied frame, please complete the Ship Back Form with the invoice number generated when the lens order was placed. This will facilitate matching your order with the patient's frame when it is received. Be certain to enclose one copy of the Ship Back Form with the Frame. Include the following information:

- Patient's name and identification number
- Invoice number that was generated when the order was

placed Special instructions or explanation

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. Please retain a copy of the label for your 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
- description of services provided (examination, materials, etc.)
- all necessary prescription eyewear order information (if applicable)

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 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 60 days' notice to all providers of any such change.

2. Non-clean Claims

Upon receipt of a claim that does not contain all of the previously-defined clean claim data elements, Davis Vision may suspend the claim and request further information from the provider and/or member. Upon receipt of the requested information, the suspended claim is processed/paid. If no response is received within 60 calendar days from date of request, the claim is automatically denied because of failure to submit all required clean claim data elements.

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 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 was received, Davis Vision will process the claim based on the available information.

Davis Vision will not make more than one 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 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 was 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.

ii. Via IVR System 1-800-77DAVIS

Claims for **examination only** services (no materials) may be processed through the IVR system by calling **1-800-77DAVIS (1-800-773-2847)**. The IVR will prompt you through the appropriate steps.

iii. Via Fax 1-800-933-9375

Providers who do not have Internet access may fax claims to 1-800-933-9375 (1800-93-EYES-5).

In the unlikely event Vouchers are required to be submitted, providers submitting Vouchers may not send them via fax. Vouchers must be submitted via mail.

iv. Via Mail

Providers who do not have Internet access and submitting claims or Vouchers may mail them to:

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

A copy of the Voucher/Claim Form is included at www.davisvision.com. You should submit the Voucher/Claim Form after the examination has been provided and the eyeglasses have been ordered. No other correspondence should be submitted with the service record/vouchers. Please **do not mail** laboratory orders with the service record/vouchers.

It is essential that the form be filled out accurately and completely as described below:

- **Header:** The voucher number, member ID, patient name, date of birth, relationship to member, voucher issue date and expiration date are auto-generated when issued by the group. Vouchers are not transferrable to other family members and cannot be changed. Be sure that the patient name on the voucher matches your patient's name and you have positively identified the patient presenting for services. You are responsible for ensuring that the voucher has not expired. (If your patient has an expired voucher, instruct the member to request an extension by calling Member Services at 1-800-999-5431.)

Benefits for which the member is eligible and the applicable copayments or non-plan allowances are clearly indicated. Special coverage and limitations are noted in the fields designated as *OTHER* and *PLEASE NOTE*.

Part 1: In this section, please place a check mark next to the services provided and enter the amount paid rounded to the nearest dollar.

Part 2: In this section, please enter information related to the Examiner and Dispenser (if different from the Examiner). Be sure to have the Examiner and Dispenser sign on the *Signature* line.

Part 3: Please have the member or eligible dependent (or guardian for dependent children) sign and date the voucher before it is submitted for payment.

- **For Panel Doctors and Claims Processing Unit Use Only Section:** Please enter the provider's name and the provider number assigned by Davis Vision to you at the location where services were rendered. Enter the appropriate service code(s).

  - *Example:* Use Code **002** for Exam, Plan Single Vision Lenses, Plan Frame

- *Example:* Use Code **N05** for Plan Bifocal Lenses, Plan Frame

• For option codes, enter the appropriate code(s) from the Option Codes included at www.davisvision.com.

- *Example:* Use Code **002-P** for Exam, Plan SV Lenses, Plan Frame, Photogrey (PGX)

- *Example:* Use Code **005-A** for Exam, Plan BV Lenses Plan Frame, Polycarbonate Lenses

• If an occupational examination is provided (in conjunction with standard vision care benefit), and no need exists for occupational eyeglasses, enter the appropriate service code with prefix OE.

- *Example:* Use Code OE-001 for Occupational Exam only.

- *Example*: Use Code OE-005 for Occupational Exam, Plan BV Lenses, Plan Frame

• If an occupational examination is provided (in conjunction with standard vision care benefit) and reveals the need for occupational eyeglasses, enter two service codes.

- Conventional eyeglasses: enter appropriate service code with OG prefix (e.g. OG-002).

- Occupational eyeglasses: enter appropriate service code for lenses and frames with no exam (e.g. N05).

- Typical billing would be OG-005, N02 or OG-002, N02.

Also enter the date of service. The provider who performed the examination must sign the form.

6. Ancillary Medical 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. The provider must submit all ancillary medical claims using a CMS 1500 form to:

Vision Care Plan Processing Unit
P.O. Box 1525
Latham, New York 12110
Or you may Fax: 1-800-993-9375

7. ICD-10 Initiative

The International Classification of Diseases, 10th Revision, (ICD-10) will be the accepted nomenclature for diseases and disorders universally used in managed care and insurance claims. The Department of Health and Human Services (HHS) directive is to be ICD-10 compliant by October 2014.

ICd-10 is an advanced coding and classification system which has been developed to accommodate the ever-changing needs of the health care industry, incorporating changes in medical science, clinical terminology and technology. As a result, it includes exponentially more specific data granularity.

Entities covered under HIPAA are required to use the ICD-10 diagnostic and procedure codes. This change affects all insurers, third party administrators and any computer-based system Davis Vision uses. This change affects all Davis Vision systems used for claims submission, processing, adjudication and reporting. Training, communication and business forms are also included.

Davis Vision will be ICD-10 compliant on October 1, 2014 and the ICD-10 mandated changes will be in effect for all dates of service October 1, 2104 and after. Providers may still submit claims for services with ICD-9 coding for dates of service prior to October 1, 2014 after the launch date of ICD-10 and Davis Vision will adjudicate the claim using ICD-9 codes. Any claim submitted with a date of service of October 1, 2014 and later and displaying ICD-9 codes will be denied as an incomplete claim.

The ICD-10 will require correlations between the two classification systems requiring some decision making because there will be more than one code alternative in the new code set. The correlation is not straightforward between the former and new classification system and caution must be exercised when using the new information. The provider delivering the services must determine the best decision-making process when selecting the best code alternatives based upon the documentation and ultimate use of the data.

For example, one of the most common ICD-9 Codes used in the submission of routine vision care eye exam claims is **367.1**, **Myopia.** Effective October 1, 2014 the Davis Vision provider submitting a claim for a routine vision care eye exam for a patient with myopia and a date of service October 1, 2014 or later must determine which of the four new ICD-10 Codes would apply when submitting the claim for payment:

H52.10 – Myopia, unspecified

eye **H52.11** – Myopia, right eye

H52.12 – Myopia, left eye

H52.13 – Myopia, bilateral

Due to the exponential increase in the number of ICD-10 Codes that may apply to the patient for the covered comprehensive eye exam benefit, Davis Vision will be expanding the number of diagnosis code entry positions on claim submissions to 12 diagnosis locations.

Davis Vision will be announcing additional information in Q3 2014 about the new ICD-10 initiative and it is important all Davis Vision participating providers review the Davis Vision provider web site for more information about the ICD-10 initiative and ensure all office staff is familiar with the new information and coding requirements.

SECTION VII 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 your Participating Provider Agreement, you 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 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 languages available at the participating Davis Vision office. Please contact Davis Vision provider services at 1-800-77DAVIS at least seven 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 does not discourage practitioners from engaging 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. BENEFIT ABUSE

If you suspect that a patient is misusing a plan benefit, please report your suspicions to Davis Vision at **1-800-77DAVIS**.

E. 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, please 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, please 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.

F. SCHEDULING AN APPOINTMENT

Routine appointments must be made available for members within 10 calendar days of a request for an appointment. Appointments for urgent conditions should be made available within 48 hours of request.

Davis Vision's members will contact your office directly to schedule an appointment. At that time you 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 you should verify the patient's current eligibility via www.davisvision.com or the IVR at 1-800-77DAVIS. If your patient is not currently eligible for services, you should inform him/her of the next date of eligibility.

BEST PRACTICE Remind patients to notify your 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 your office should develop policies and procedures to positively identify each Davis Vision member seen in your office. If the identity of any patient your office provided services is challenged subsequent to service, your office may be required to supply the positive identification used prior to delivery of services or risk having all fees paid to your office for that patient's service recovered by Davis Vision.

G. OBTAINING AN AUTHORIZATION

During the scheduling process or before the patient's appointment, verify the patient's current eligibility for services and request an authorization for services via www.davisvision.com or the IVR

at 1-800-77DAVIS. While confirming patient eligibility, obtain an authorization for services. Once an authorization is obtained, print the Service Record Form (from the authorization) containing details of covered and non-covered services/options and place it in the patient's file. At the time of the patient's appointment, you should have him/her sign the Service Record Form to confirm his/her understanding of covered and non-covered services/options.

BEST PRACTICE If you have a problem obtaining an authorization, call Davis Vision at 1-800-77DAVIS. DAVIS VISION DOES NOT RECOMMEND PROVIDING SERVICES TO THE MEMBER WITHOUT AN AUTHORIZATION.

Authorizations are not guarantee of payment for services. Final eligibility of the patient for services on the date of service will be determined when the claim for services is processed.

1. Authorizations for Services Requiring Prior Approval

Some plans allow patients to obtain services/options with Davis Vision's prior approval. In these cases, Davis Vision has specific criteria against which the patient's request is evaluated.

These services and options vary by plan benefit design and by state or Federal requirements. Eligibility for the services and options will be clearly identified by 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 Approval. Examples of these additional services include but are not limited to:

- Additional lenses during the benefit cycle for significant changes in the patient's prescription
- Additional glasses for lost/stolen or 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 materials
- Vision Training evaluations and training sessions

To arrange for prior approval:

i. Print the *Prior Approval Request Form* found on the Provider Portal at www.davisvision.com.

ii. Complete all applicable fields. (It is your responsibility to provide as much clinical information as possible to enable Davis Vision to make a determination.)

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

A Utilization Review Associate will review the request, document the determination on the request form and fax the request form back to you. Typically, Prior Approval requests are completed and faxed back to the provider within two (2) business days following receipt of the Prior Approval request

2. Authorizations for the Enhanced Contact Lens Benefits

Definition: *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 extent site 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.*

Some plans include enhanced coverage for contact lenses which qualify by established criteria developed by Davis Vision. Contact Lenses may be determined to be medically necessary and appropriate in the treatment of patients affected by certain conditions when the condition meets the established criteria. In general, contact lenses may be medically necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual acuity and/or improved binocular function, including avoidance of diplopia or suppression.

Additional copies of the Davis Vision criteria are available to providers upon request. Please call 1-800-773-2847 to request additional copies of the criteria listed below.

When you identify a need for medically necessary contact lenses, please complete the *Prior Approval Request Form* and fax the form to Utilization Review at **1-800-584-2329**. It is your responsibility to provide as much clinical information as possible to enable Davis Vision to make a determination. Your request will be reviewed by a licensed clinician 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 business day.

BEST PRACTICE When completing the *Prior Approval Request Form*, be sure to include **both** your Professional Fitting Fees and Material Fees. Do not include routine exam fees.

If your request for medically necessary contact lenses is approved, Davis Vision will fax the authorization to your office utilizing the Request Form. This faxed authorization is your confirmation. The reviewer will send a copy of the authorization to Claims for manual processing.

Davis Vision's Enhanced Contact Lens Benefit is not available for Corneal Refractive Therapy CRT) 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.

Based on clinical care guidelines of the American Optometric Association (AOA) and the practice pattern guidelines of the American Academy of Ophthalmology, contact lenses may be determined to be medically necessary and appropriate in the treatment of the following nine (9) conditions when meeting or exceeding the established Davis Vision criteria for:

Keratoconus

- Diagnosis confirmed by keratometric readings and observations, Placido disc or corneal topography
- Best correctable visual acuity with spectacle lenses or subjective refraction of 20/40 or less in either eye
- At least two lines improvement in best correctable visual acuity (as measured with standard Snellen chart) with rigid contact lenses
- Intact corneal epithelium
- Absence of corneal hydrops

Aphakia

- Aphakia in one or both eyes of congenital, surgical or traumatic etiology without implantation of an intraocular lens
- No corneal or vitreous opacities along the visual axis
- Intact macula
- Best correctable acuity of 20/100 or better
- Intact corneal epithelium

Anisometropia

- ≥ 4.00 diopters difference in prescription (spherical equivalent) between right and left eyes
- Best correctable acuity of 20/40 or better in the better eye

- Intact corneal epithelium

Aniseikonia

- Unequal image size between right and left eye resulting in intermittent or constant diplopia, suppression or binocular rivalry, or less than 100° steropsis
- Intact corneal epithelium

Pathological Myopia

- Myopia >8.00 diopters in one or both eyes
- Intact corneal epithelium

Aniridia

- Aniridia of congenital, surgical or traumatic etiology in one or both eyes
- Intact corneal epithelium

Corneal Disorders

- Any condition of congenital, pathological or surgical etiology causing compromised integrity of the corneal curvature or media resulting in best correctable acuity of 20/70 or worse with spectacles in one or both eyes
- Corneal opacification
- Intact corneal epithelium

Post-Traumatic Disorders

- Any condition of traumatic etiology causing compromised integrity of the corneal curvature or media resulting in best correctable acuity of 20/70 or worse with spectacles in one or both eyes
- Corneal opacification
- Intact corneal epithelium

Irregular Astigmatism

- ≥ 2.00 diopters of astigmatism in either eye where the principal meridians are separated by less than 90°, resulting in best correctable acuity of 20/70 or worse in the affected eye with spectacles

- At least two lines improvement in best correctable visual acuity (as measured with standard Snellen chart) with rigid contact lenses

H. PRIOR AUTHORIZATIONS FOR LOW VISION BENEFITS

Davis Vision plans may also include benefits for patients who qualify for Low Vision services. Providers must confirm the eligibility for any Davis Vision patients who meet the criteria for low vision services and provide those services to meet the commonly accepted standards of care.

These services may include both a low vision evaluation and low vision aids and are usually restricted to a specific allowance. Davis Vision providers will be reimbursed a full usual and customary fee up to the patient's allowance amount which can vary by plan. Patients are responsible for all fees over the allowance determined by the vision plan.

Davis Vision criteria for Low Vision benefits are:

- Best corrected acuity in the better eye is 20/100 or less with conventional spectacles or contact lenses; or

- Constriction of the peripheral fields in the better eye to 10 degrees or less from the fixation point; or

- The widest diameter of vision subtends an angle less than 20 degrees in the better eye.

To obtain prior authorization for Low Vision services, the Davis Vision Prior Authorization Request form must be completed and faxed to the Utilization Review department at **1-800-584-2329**

I. 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 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 and on diabetic patients. 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.*

In addition to those procedures performed as part of the conventional eye examination, contact lens fitting should include:

- Measurement of corneal curvatures
- 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
- 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 18: Davis Vision does **NOT** fabricate glass lenses for children under the age of 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 18. When a patient disregards your recommendation for polycarbonate lenses for children under age 18, 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 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.

Please call the Order Entry Team at **1-800-888-4321** to place your order. Please include the name of the frame manufacturer, model number, color and size. 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.

J. MEMBER APPEAL OF DENIED SERVICES

If Davis Vision denies a request for services, the written adverse determination explains the reason for the denial (e.g. "not a covered benefit") and includes the member's appeal rights. If your patient

requests that you initiate an appeal on his/her behalf, please contact Quality Assurance at **1-888-343-3470** immediately to obtain details on timeframes for appeal submission. Individual groups and states have varying requirements and Quality Assurance will assist you with the appeal process.

Typically, appeals/complaints/grievances are acknowledged within 15 days and resolved within 30 days unless a group or State imposes a more stringent timeframe. The outcome of appeals/complaints/grievances is communicated in writing to the patient/member/provider.

K. REFERRING PATIENTS FOR ADDITIONAL SERVICES

When your 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. You must explain to your 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 your recommendations exceed the limitations of the patient's benefit through Davis Vision, please instruct your patient to contact his/her medical carrier for further guidance. Please be sure that your 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 your patient written instructions about consulting another practitioner including possible additional tests to be conducted.

L. ARRANGEMENTS FOR PROLONGED ABSENCE/OFFICE CLOSING

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

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

M. EMERGENCY CARE PROVISIONS

As established in your Participating Provider Agreement, you must ensure that Davis Vision's patients have access to an answering service, a pager number and/or an answering machine 24 hours a day, 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.

N. 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 you of his/her decision. It is your responsibility to inform the member of any potential consequences.

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

O. 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.

P. TRANSFER OF PATIENT RECORDS

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

Q. PRIOR APPROVAL

Prior approval or prospective review involves services that have not yet been 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 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:

1. Member and/or patient's identification number
2. Patient's name
3. Diagnosis
4. Requested service or procedure
5. 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 Davis Vision established utilization review clinical criteria which have been reviewed and approved by the plan. 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 two (2) business days following receipt of a complete request, usually both verbally and in writing to both the member and the practitioner (unless a more stringent timeframe is imposed by State guidelines). If the request is incomplete, Davis Vision will request additional information.. 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.
- Name, position, phone number and department of person(s) responsible for the outcome.

Appeal and Grievance Procedures

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.

R. 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. The most common concurrent review is in conjunction with Vision Therapy 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 (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

S. RETROSPECTIVE REVIEW

Retrospective review involves services that have previously been rendered. Davis Vision does not conduct retrospective reviews for services covered under its plans. However in the unlikely event a retrospective review is required it 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 or procedures, treatments and services delivered to the insured during the same course of treatment.

T. PATIENT COMPLAINTS AND GRIEVANCES

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/appeal/grievance processes described below may not include state-specific requirements. For more complete information and guidance, call Davis Vision's Quality Assurance Department at ***1-888-343-3470****.*

1. Adverse Determinations/Denials

Adverse determinations or denials of services can be 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.

B. Medical necessity denials – an adverse determination based on whether the product or service meets established medical necessity criteria.

2. Benefit Denials

Routine vision and eye care services are limited to a frequency chosen by the client. Therefore, administrative adverse determinations are based solely on whether or not the member has an available benefit. No review is conducted to determine medical necessity.

Members have the right to voice a *complaint or grievance* about a benefit denial at any time and have the right to designate a representative to file on their behalf. Davis Vision will not retaliate or take any discriminatory action against any member as a result of filing a complaint or grievance. Davis Vision will provide members with a copy of the Grievance Resolution process upon request.

Members who call Customer Service about benefit denials are educated about the frequency with which they can obtain routine vision and eye care services.

3. Medical Necessity Denials

Some plans include enhanced coverage for contact lenses. For plans offering enhanced coverage, Davis Vision reviews these requests to determine medical necessity and appropriateness based on the guidelines of the American Optometric Association and the American Academy of Ophthalmology.

Members have the right to appeal an adverse determination at any time and have the right to designate a representative to file on their behalf. Davis Vision will not retaliate or take any discriminatory action against any member as a result of filing an appeal. Davis Vision will provide members with a copy of the Grievance Resolution process upon request.

4. Appeal of Medical Necessity Denials

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/appeal/grievance processes described below may not include state-specific requirements. For more complete information and guidance, call Davis Vision's Quality Assurance Department at ***1-888-343-3470****.*

i. Appeal Level 1

The member, the member's representative or the health care provider may file an appeal verbally or in writing within 90 days after receipt of the adverse determination unless otherwise specified by Federal, state or plan contract. The claimant may submit written comments, documents, records and other information relevant to the appeal. Within 15 days of receipt of the appeal of a medical necessity denial, Davis Vision will send a written acknowledgment to the member. If only a portion of such information is received, Davis Vision will request the missing information in writing within five (5) business days of receipt of the partial information. Davis Vision makes Standard Appeal determinations as fast as the member's condition requires and within 30 days of receipt of all necessary information. Davis Vision notifies the member, the member's designee and/or the health

care provider in writing of the Appeal Determination within two (2) business days of the rendering of the determination. Davis Vision maintains an Expedited Appeal process for adverse determinations involving continued or extended health care services/procedures/treatments or additional services for a member undergoing a course of continued treatment prescribed by a health care provider, and for adverse determinations in which the health care provider believes an immediate Appeal is warranted.

ii. Appeal Level 2

Davis Vision maintains a single level Appeal process for Adverse Utilization Review Determinations. When requested by a client or required by state regulations, a second level of appeal will be available.

iii. External Review

Most states have developed an External Review Program designed to resolve disputes between health plans and consumers for services that were denied on the basis that they were not medically necessary. This process is regulated by the state in which the member resides.

For additional information about the availability of External Review, please contact Davis Vision's Quality Assurance Department at **1-888-343-3470**.

U. PROVIDER DISPUTE RESOLUTION

*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, call Davis Vision's Quality Assurance Department at 1-888-343-3470.*Disputes with Davis Vision can be divided into two categories:

1. Complaints regarding challenges related to payment of claims other than those based upon utilization review adverse determinations and can include, but is not limited to disputes involving reimbursement, timeliness and resubmission.

2. Complaints involving administrative concerns including, but not limited to contractual obligations, as well as administrative and operational issues involving providers.

The dispute process requires direct communication between any provider and Davis Vision and does not require any action by an enrollee. A written dispute from a participating or non-participating provider 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.

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 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 or incident facilitating an unresolved expression of dissatisfaction to:

Davis Vision
Quality Assurance Department
PO Box 791
Latham, NY 12110
Email: RTQA@davisvision.com
Fax: 1-888-343-3475

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 Quality Assurance Associate, who is qualified to render a decision and was not involved in the prior determinations, reviews 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. The written Notice of Determination to the provider includes, but is not limited to:

The detailed reason for the determination, including any provision used in making the determination, when applicable;

- A list of the titles and qualifications of the individuals participating in the review;
- The name, address and phone number of Davis Vision's contact person;
- A statement that the notice is a final determination and that the dispute will not be reviewed again.

2. Administrative Disputes

Davis Vision has established a general dispute resolution process to address issues initiated by the member or provider concerning administrative matters. These provider challenges include, but are not limited to contractual obligations as well as administrative and operational issues involving providers. The primary source of provider issues involves adherence to the terms and obligations of the provider contract. Examples of these may include, but are not limited to:

- Providers balance billing the member

- Providers refusal to file claims
- Willful violation of network requirements
- Reimbursement concerns
- Administrative or service issues can include the following:
- Recognition of member ID cards
- Availability of provider appointments
- Conduct of provider office personnel
- Obtaining a prompt authorization
- Dissatisfaction with Davis Vision's policies and procedures
- Loss of incomplete claim forms or electronic submissions
- Requests for additional explanation as to services or treatment
- Provider issues may also be generated from Davis Vision operational challenges. For instance, the provider or Davis Vision identifies these issues have resulted from incorrect or incomplete information on Davis Vision's provider files, and as a result, the following items may be adversely affected:
- Network participation
- Directory listings
- Claims payment

Providers may also file with an applicable state's Department of Insurance (DOI). When this occurs, the inquiry is forwarded to Davis Vision Quality Assurance for resolution.

Providers must file an administrative dispute in writing within sixty (60) calendar days following the incident facilitating an unresolved expression of dissatisfaction to:

Davis Vision
Quality Assurance Department
PO Box 791
Latham, NY 12110
Email: RTQA@davisvision.com
Fax: 1-888-343-3475

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 Quality Assurance Associate, who is qualified to render a decision, will work with the provider to secure all necessary documents, research the challenge and render a written dispute resolution to the provider.

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 or upon receipt of all necessary information needed to resolve.

The written notice of resolution to the provider includes, but is not limited to:

1. The detailed reason for the resolution, including any provision used in making the resolution, when applicable;

2. A list of the titles and qualifications of the individuals participating in the review;

3. The name, address and phone number of Davis Vision's contact person.

In working to resolve contractual, administrative, service or operational issues Davis Vision may need to request cooperation and action from a provider. In these circumstances, if a provider fails to act on any prescribed actions requested within thirty (30) business days from the initial date of contact by Davis Vision with the provider, the provider's name may be submitted to the Credentialing Committee for involuntary termination for failure to respond to the corrective action request.

SECTION VIII 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. 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 Z.80.5-1979.

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 Z80.1-1979. 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 your office (whether a new wearer or an existing wearer); and (3) a patient who has previously been fit with contact lenses in your 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 your 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. Please refer to the group-specific plan highlight sheet for complete contact lens information.

D. WARRANTY

NOTE: There are no exceptions to Davis Vision's generous warranty policy.

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.

E. LENS COATINGS *NOTE: Dispensing date is assumed to be 10 days after the date shipped from the Davis Vision laboratory.*

1. Scratch Protection Plan

Davis Vision will replace, within one 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 your 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, be sure to inform them of the potential benefit of selecting the Scratch Resistance option.

2. 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.

F. PATIENT CHANGES

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

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

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

G. PROVIDER CHANGES

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

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 90 calendar days for eyeglasses or 30 calendar days for contact lenses from the original date of dispensing.

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

For a period of 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: Any member copayments associated with selection of the original progressive additional lenses will **not** be returned.*

H. 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. **We 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, please 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 your order with the patient's frame when it is received at the manufacturing lab. Be certain to enclose one copy of the Ship Back Form with the Frame. Include the following information:

- 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. Please retain a copy of the label for your 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 7 days per week. So enter all of your weekend jobs "real time" and all jobs can be started right away.

I. PROVIDER SUPPLIED FRAMES

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

When mailing a provider-supplied frame, please 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 your order when it is received at the manufacturing lab. Be certain to enclose one copy of the Ship Back Form with the Frame. 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. Please retain a copy of the label for your 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).

Please 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 you will be the Manufacturer's suggested wholesale price.

BEST PRACTICE - Mail provider-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 7 days per week. So enter all of your weekend jobs "real time" and jobs can be started right away.

J. MATERIALS REPLACEMENT

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

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. This applies to all spectacle lenses and Davis Vision Collection frames. If your materials should break within the warranty period, Davis Vision will supply replacement materials identical to those originally ordered.

2. Allergic Reaction to Plan-Supplied Frames

If your patient experiences an allergic reaction to plan-supplied frames within the first 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.

K. 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, please provide your credit card information to the Excel Advantage Department in order to process your uncut remakes. If additional uncuts are to be supplied, Davis Vision will charge a fixed fee for each pair.

L. CONTACT LENSES

Contact lenses may be covered under the individual manufacturer's warranty. Please 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.

M. WARRANTY CERTIFICATE

A Warranty Certificate will accompany all Plan materials (eyeglasses and lenses) covered under Davis Vision's warranty (according to the rules described herein). Please deliver the warranty certificate to the member whenever dispensing Plan eyeglasses.

N. 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 your office. The manufacturing labs are open and producing work 7 days per week. Enter all of your 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:

1. Maximum convenience for providers.
2. Uniform format requirements of the order processing data system.
3. Accuracy and speed in processing orders.
4. Prompt reimbursement for services rendered.

O. SHIPPING ERRORS

In the event you receive eyewear for a patient that you did not provide service for, please call Davis Vision at **1-800-888-4321** immediately.

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

P. RECEIVING YOUR ORDER

All eyewear shipped from a Davis Vision laboratory to your 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 warranty certificate will be enclosed in each case which is to be presented to the patient with the eyeglasses.

- A copy of the original laboratory invoice will be included with the finished eyeglasses (wrapped around the case). We suggest you retain this copy. If jobs are returned for changes, it is important that you enclose a copy of this form.

Q. DELIVERY

Davis Vision will make every effort to promptly fill all Plan supplied ophthalmic material orders. Single vision stock orders will be shipped within one (1) to three (3) business days and multifocals within one (1) to five (5) business days.

SECTION IX 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 Universal Credentialing DataSource (UCD) 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 UCD 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 months, you will receive a request from CAQH to re-attest that all information in your application is current.)

We encourage physicians and other health care professionals to familiarize themselves with the CAQH Universal Credentialing DataSource prior to requesting consideration for inclusion in the

Davis Vision network. Simply access the UCD demo at https://upd/caqh.org/OAS/ and click on **Overview**.

C. INITIAL CREDENTIALING PROCESS

NOTE: Davis Vision's provider network is comprised of optometrists, ophthalmologists and opticians located in all fifty 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 re-evaluates 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 30 days of discovery and extended an opportunity to correct erroneous information via fax to a Credentialing associate within 10 business days with an explanation and supportive documentation.

The Credentialing associate verifies that no information will be more than 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 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 states, the District of Columbia, Puerto Rico, Guam, and Saipan. 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 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 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 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 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 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.

NOTE: If additional information is required, the practitioner is contacted in writing within 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 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 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 Initial Credentialing and Recredentialing processes, you signed Davis Vision's Participating Provider Agreement. By signing this Agreement, you agreed to comply with numerous requirements including, but not limited to, the following:

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

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

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

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

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

G. PROFESSIONAL REVIEW ACTIONS

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 professional review actions that affect network status. Practitioners being considered for a professional review action (termination, suspension, limitation of privileges) are referred to the Credentialing Committee for review. Adverse determinations rendered by Davis Vision 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.

EXCEPTION: Practitioners and providers will not be penalized, terminated or suspended from the network because they acted as an advocate for a member seeking appropriate covered services, or filed a complaint or an appeal, or requested a hearing or review.

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.

1. Termination Without Cause

Provider Agreements are effective for an initial term of twelve (12) months beginning on the Effective Date on the signature page of the agreement. After the initial twelve (12) month term has ended, the Provider Agreement may be terminated by either Davis Vision or the participating practitioner/provider without cause, upon 90 days prior, written notice. If Davis Vision terminates the agreement before the end of the initial term or for "cause", the provider can request a hearing before a panel within 30 days of receipt of the provider's request.

If the provider terminates the Provider Agreement without cause, or if an individual practitioner leaves the provider's practice or otherwise becomes unavailable to the members, the provider will notify those members prior to the effective date of the termination.

2. Termination for 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 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.
- 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.

Upon identification of a practitioner meeting any of the above criteria, his/her file is referred to the Credentialing Committee for immediate review. The Committee will report the outcome of the review to the Chief Medical Officer (CMO). The CMO will send a written notice to the practitioner by certified mail (with return receipt requested). The notice will indicate what action is being taken and the reason for the action. The notice advises the practitioner that he/she can send a written request to Davis Vision within 30 days of receipt of the notice for a hearing to modify or reverse the decision to terminate. Termination becomes effective immediately upon receipt of notice by the practitioner.

3. Suspension for Cause

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

- 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 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.

Upon identification of a practitioner meeting any of the above criteria, his/her file is referred to the Credentialing Committee for review. The Committee will report the outcome of the review to the

Chief Medical Office (CMO). The CMO will send a written notice to the practitioner by certified mail (with return receipt requested). The notice will indicate what action is being taken and the reason for the action and the date upon which the action becomes effective (at least 60 days from the date of the notice). The notice advises the practitioner that he/she can send a written request to Davis Vision within 30 days of receipt of the notice for a hearing to appeal the determination.

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. Davis Vision's appeal process is available to the practitioner(s) involved in the investigation.

4. Right to Terminate or Limit Privileges for Non-Quality Issues

Davis Vision retains the right to terminate or limit the privileges of practitioners or providers based on non-quality issues, which may include, but are not limited to:

- Lack of TPA licensure for optometrists.
- Excessive number of panel providers practicing in a geographic area.
- Excessive number of member complaints
- Failure to comply with the recredentialing process.
- Failure to comply with on-site and/or record reviews.

Upon identification of a practitioner meeting any of the above criteria, his/her file is referred to the Credentialing Committee for review. The Committee will report the outcome of the review to the Chief Medical Officer. The CMO will send a written notice to the practitioner by certified mail (with return receipt requested). The notice will indicate what action is being taken and the reason for the action and the date upon which the action becomes effective (at least 60 days from the date of the notice). The notice advises the practitioner that he/she can send a written request to Davis Vision within 30 days of receipt of the notice for a hearing to appeal the determination.

5. Credentialing Committee Review of Terminations

One or more members of the Credentialing Committee will review the proposed or potential termination of any practitioner or provider appropriately and will consider all applicable and available material (except for practitioners who fail to return the recredentialing package). Committee member(s) may, at his/her/their own discretion, request that the practitioner submit a written explanation of the issues under review or that the practitioner submit written responses to

questions posed by the Committee. The Committee member(s) will report the outcome of the review with recommendations to the Chief Medical Officer

The Chief Medical Officer will determine what action should be taken. Possible actions include, but are not limited to, sending an educational letter or continuing observation with the recommendation that the practitioner's participation in the network be restricted, suspended or terminated. If it is determined that a practitioner or provider should be suspended or terminated, the Chief Medical Officer will send a written notice to the practitioner or provider by certified mail (with return receipt requested). The notice will indicate what action is being taken, the reason for the action and the manner in which the practitioner or provider may appeal the decision and the date upon which the action becomes effective.

6. Practitioner or Provider Appeals

Davis Vision has a first-level and second-level appeal process for instances in which it chooses to alter the conditions of practitioner participation based on participation criteria and on issues of quality of care or service. The appeal processes were developed with input from participating providers and is reviewed at least annually. Both processes are available to all participating providers.

First-Level Appeal

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. 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 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.
  Professional Affairs
  175 E. Houston Street
  San Antonio, Texas 78205

Within thirty (30) days of receipt of the practitioner's request for a hearing, the Provider Appeal Committee will convene to hear the appeal. The Provider Appeal Committee is composed of the Director of Optometric Recruitment and Development, the Director of Regulatory Compliance, an active 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 Provider Appeal Committee.

Any documentation to be presented by the practitioner at the hearing, including the names, addresses and credentials of any witnesses, if applicable, must be mailed to Davis Vision (at the address in the notice of action) by certified mail, return receipt requested, and must be received at least ten (10) days before the scheduled hearing date At its discretion, the Provider Appeal Committee may or may not accept documentation or testimony of witnesses received after this date.

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 Provider Appeal Committee will document its findings and make a recommendation within thirty (30) days of the hearing. The Credentialing 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

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.
Professional Affairs
175 E. Houston Street
San Antonio, Texas 78205

Within thirty (30) days of receipt of the practitioner's second-level appeal, the Provider Appeal

Committee will convene to hear the appeal. The Provider Appeal Committee is composed of the Vice President of Professional Affairs, the Vice President of Business Compliance, and an active Participating Network Practitioner, who is a clinical peer of the practitioner that filed the second 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 first level appeal determination.

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 Provider Appeal Committee will document its findings and make a recommendation within thirty (30) days of the hearing.

The Credentialing 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

Decisions resulting in termination of a practitioner will be communicated in writing and certified mail to the practitioner and will include notification that the termination is effective upon the practitioner's receipt of the notice.

7. 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.

SECTION X 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.

B. PEER REVIEW PROGRAM

A key element in assessing practitioner compliance with Davis Vision's requirements, regulatory mandates and accreditation standards is the Davis Vision Peer Review Program. Office site visits and clinical record reviews are conducted by Regional Quality Assurance Representatives (RQARs) who are licensed optometrists. Offices for reviews are selected according to the following criteria:

- Combination site visits and record reviews are scheduled once every three years for high-volume providers (e.g., providers who render care to at least 100 Davis Vision members annually).
- Record reviews (without a site visit) are conducted for providers who do not meet the high-volume provider criteria for a full onsite office review (e.g., providers who render care to fewer than 100 Davis Vision members annually).

Audit results are reported to Credentialing for inclusion in the provider's file and are considered by the Credentialing Committee when the provider's recredentialing file is presented for approval. Audit results are presented to the Quality Management Committee annually.

1. Office and Record Reviews

During a site visit, the RQAR reviewer evaluates the physical facilities for overall appearance, safety and cleanliness and evaluates equipment for overall condition and maintenance. Office staff may be interviewed regarding protocols for scheduling, dispensing and compliance with Davis Vision's policies and procedures, including safety and infection control practices. During the site visit, a sample of the provider's medical records is collected and examined. The RQAR reviewer evaluates the audit results and reports the findings to the Vice President Clinical Standards. Audit results are communicated to the provider in writing.

For providers who render care to fewer than 100 Davis Vision members annually, Davis Vision requests from the provider a sample of medical records from the total universe of plan patients.

The medical records submitted are examined by a RQAR reviewer and the results are reported to the Vice President Clinical Standards. Audit results are communicated to the provider in writing.

The audit tool located at www.davisvision.com clearly identifies the components of the site visit and record review audits and the scoring methodology utilized by Davis Vision. The scoring threshold for site visits is 70% and for medical records is 70%. Providers scoring below 70% for the site visit and/or 70% for the medical record review must submit a written corrective action plan to Davis Vision which must be approved by the Vice President Clinical Standards. Providers who score below 70% or whose corrective action plan is not approved are subject to a follow-up review (an additional site visit or a new sample of five records) in six months.

i. Commonly Accepted Guidelines for Medical Records

Adherence to the following commonly accepted guidelines is expected of all practitioners maintaining medical records:

- Medical records must be kept for individual patients in a secure area, away from patient access, but readily available to practitioners.
- 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.
- The office must have policies in place for maintaining patient confidentiality in accordance with State and Federal laws.
- Practitioners must follow applicable professional and clinical guidelines for documenting care provided to patients.
- Date all entries, and identify the author and their credentials when applicable.
- 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.

Practitioners must retain patient medical records for a period of at least 10 years, for pediatric patients for a period of 10 years past the date of maturity or the period required under applicable State and Federal laws.

ii. Medical Records Documentation

- As reflected in the Medical Record Audit Tool (see at www.davisvision.com) requires that the medical records for its members must include the following minimum documentation. Patient name and date of birth on each page, or patient name and member ID number on each page

- Allergies to medication or other severe, potentially life-threatening allergic reactions (e.g., severe food allergies, latex, etc.)
- Address, phone number or other identifiers
- Chief complaint including recent changes in vision or reason for the visit
- Relevant past eye, medical, and family history
- Relevant family ocular history
- Current medications
- Allergies to medication
- Entrance visual acuity, with and without correction, distance and near:
- External and internal evaluation of the structures of the eye
- Gross Visual Fields
- Pupil responses
- Intraocular pressure
- Dilated fundus examination, when indicated
- Objective and Subjective Refraction:
- Best corrected acuities, distance and near with refraction
- Binocular Function:
- Ocular motility
- Assessment/Management:
- Examination results including diagnosis and clinical recommendations and prescription
- Patient education and recommendation for follow-up care, if appropriate
- Referral to specialist or Primary Care Physician, if required
- Printed name and signature of the examining doctor
- Exact prescription of lenses and frames and/or contact lenses dispensed

- Record must be legible
- 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)

2. Instrumentation and Equipment

Each participating provider office must include the following instrumentation and equipment to administer high quality and comprehensive examinations:

- 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. Unscheduled Office Visits

Davis Vision retains the right to visit any participating provider's office at any time and without prior notice. Reasons for an unscheduled 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, or failure of the practitioner to respond to requests for clinical records information.

As established in the Participating Provider Agreement, you are 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 our client groups requesting the same.

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 consistently achieves patient satisfaction rates over 98%. Those patients surveyed who indicate less

than total satisfaction are contacted individually to ensure satisfaction. If appropriate, participating providers are asked to respond to concerns raised by their patients.

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 may take action including, but not limited to

- Referring specific provider surveys to Davis Vision business offices for direct outreach to the office
- Referring a topic to the Peer Review Committee for review and discussion at the annual Peer Review meeting
- Addressing trends to the senior management of Davis Vision
- Referring a topic to the Opportunities Committee, or other appropriate committee
- Referring a survey to a Professional Field Consultant or Regional Quality Assurance Representative for a site visit

SECTION XI 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