DAVISVISION®
SEE LIFE

Provider Manual 2010

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SECTION I
WELCOME TO DAVIS VISION

About The Manual

The policies and procedures in this manual apply to services rendered by 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 Professional Affairs and Quality Management at 516-733-5365.

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 physicians and providers is strengthened through timely communication, joint problem-solving and mutually beneficial financial arrangements. Relationships are designed to emphasize high-quality and 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 books 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 members 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. In addition to Davis Vision, HVHC Inc. owns New Jersey-based Viva International Group and Texas-based Eye Care Centers of America. Together these companies rank among the nation's largest vision companies. 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 improvement program.

Davis Vision provides vision care and eye care services including routine eye examinations, eyeglasses, contact lenses, value-added discounts and accessories. The plan presently serves more than 55 million 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 Plainview, New York and Provider and Member Services operations are located in both Plainview and Latham, New York. Davis Vision operates three optical laboratories located in Philadelphia, Pennsylvania; Plainview, New York; and Las Vegas, Nevada. 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 800 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.
- **Discount Programs:** Offers significant uniform discounts on both professional and material fees.
- **Eye Health and Wellness Programs®:** Provides clients and members access to our vision library and Eye Health and 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.

Davis Vision's provider network comprises nearly 32,000 providers (optometrists, ophthalmologists and retail centers) located in all fifty states, the District of Columbia, Puerto Rico, Guam, and Saipan. The network includes a wholly owned chain of proprietary vision centers located throughout upstate New York, Long Island, Central Pennsylvania, Massachusetts, New Hampshire and Rhode Island.

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. RESEARCH

Davis Vision, a leader in vision care, continually reviews 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
- Safety eyewear use
- Medical eye care
- Medically necessary contact lenses

Patient and provider surveys are also conducted in order to improve care.

D. FRAUD, WASTE AND ABUSE

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 Waste, Fraud and/or Abuse and may refer the issue, as appropriate, to the Highmark Special Investigations Unit, CMS or law enforcement.

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 he 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 member identification number (and/or card) to obtain services or materials

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

- 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

Prohibits 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.

4. Contact Information

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

The Davis Vision Fraud, Waste and Abuse Unit

Toll-Free Hotline
24 hours a day 7 days a week
1-800-501-1491

Confidential U.S. Post Office Box
Davis Vision
P.O. Box 1416
Latham, NY 12110-1416

Confidential Fax
1-866-999-4640

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 members 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 member or patient. All member/patient specific information will be considered confidential and is therefore protected. Member 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 member's eligibility for past, present or future services, as provided under the member's benefit plan. Eligibility information does not include protected health information.

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

- Prevent unauthorized access to member records.
- Place all Davis Vision member 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 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, members 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 member, patient, provider or group upon request.

1. Disclosure of Information

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

- Requested by the member, 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 member or provider.
- To Davis Vision committees (such as Credentialing, Utilization Management, and Quality Improvement) that conduct peer review audits.
- In response to a court order.
- In response to a governmental authority for the intent purpose of verifying a member's eligibility for which the government is responsible.
- When otherwise authorized or required by federal, state or local laws.
- For the purposes of Treatment, Payment and Health Care Operations, 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 member, member's legal spouse, member's dependent child(ren) or participating provider produces proper identification or eligibility documentation.
- A member or any listed plan beneficiary accesses the Interactive Voice Response system, speaks with a Member Service Representative or logs on to the Davis Vision web site and provides the appropriate member identification number.

SECTION II
RIGHTS AND RESPONSIBILITIES

A. PROFESSIONAL ETHICS

As a provider of vision care, 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:

1. To hold the physical, emotional, social, health and visual welfare of all Davis Vision members uppermost at all times.
2. To ensure better care and services, and to provide these services with compassion, honesty, integrity and respect for the member's dignity.
3. 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.
4. To continually maintain and improve one's competency which includes technical ability, cognitive knowledge and ethical concerns for the member. Competence involves having the most current knowledge and understanding of vision care, enabling providers to make professionally appropriate and acceptable decisions in managing a member's care.
5. To provide care and services appropriate to the degree of education and training.
6. To consult with other health care professionals and refer patients, when appropriate.
7. 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.
8. 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.
9. 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.
10. To communicate with each member at an appropriate level of comprehension and/or in a language understood by the member, or to refer the member to Davis Vision for translation services.

11. To involve member and/or family members, when appropriate, in all treatment plans and decisions.

12. To resolve all conflicts involving treatment plans or, if unable to do so, to refer the member to Davis Vision, the member's applicable Plan or appropriate state agency for resolution.

13. To inform members 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 members 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 members.

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 members 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 member or, if applicable, with a member'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 members 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 in the State of Texas 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 member.

2. Providers are responsible to maintain a service record and/or treatment record form for each member 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 members 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 members (contained in Section D below).

4. Providers are responsible to be available to provide services to Davis Vision's members for medically appropriate urgent care. Information and instructions regarding emergency care shall be available 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 members.
10. Providers are responsible to comply with all utilization and quality improvement programs of Davis Vision and to submit requested documentation in a timely manner.
11. Providers are responsible for verifying Davis Vision's members' eligibility and obtaining authorization.
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 members of their financial responsibility prior to administering 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.

D. PATIENT BILL OF RIGHTS

Courtesy, dignity, confidentiality, communication 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 co-payments 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 Tower 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 Davis Vision 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 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 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 the Commonwealth of Virginia 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 Patients Rights Policy.

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

- Present complaints.
- 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:

- Patients are responsible for reporting when they lack a clear understanding of a proposed course of action and what may be expected of them.
- Patients are responsible for following treatment recommendations, including using prescribed medications or treatments and reporting any factors that may prevent them from doing so.
- Patients are responsible for respecting the rights of others, including, but not limited to, other patients, staff and providers.
- Patients are responsible for assuring that the financial obligations associated with their care, including co-payments and fees for non-covered services, are met in a timely manner.
- Patients are responsible for notifying providers at the time an appointment is made that they are covered by a Davis Vision Plan.
- Patients are responsible for notifying providers at least 24 hours in advance when canceling any appointment.
- Patients are responsible to use the benefit in an honest manner.
- Patients should be aware that providers who care for them are not employees of Davis Vision and that Davis Vision does not control them.
- Patients are permitted to question providers about all treatment options and the provider's compensation arrangement with Davis Vision.
- Patients are responsible to ensure that their provider has received the proper authorization for services.
- Patients are responsible to report any concerns to Davis Vision at 1-800-584-1487.

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/medically necessary services 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 member 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 member 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** by calling the IVR at **1-800-77DAVIS (1-800-773-2847)**. You will be prompted to enter your provider number to gain access to the following capabilities:

- Verify member eligibility
- Obtain an authorization
- Obtain benefit information
- Determine copayments
- Request Service Record Forms
- Process claims for "Examination Only" services
- Place an order
- Track an order
- Obtain status of a claim
- Speak with a Member Service Representative

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

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.

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: o Repair & Replacement Policy o Warranty Information o Clinical Practice Guidelines o Provider Bill of Rights o Patient's Bill of Rights o Provider Manual o Provider Newsletters
Provider IVR (Interactive Voice Response) System (Available 24 hours a day)	To access our IVR system, please call: **1-800-77DAVIS** **(1-800-773-2847)** 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 Representative
Provider Relations	To contact a Provider Relations Associate, please call: **1-800-933-9371**	• Place an order • Verify group discount information (for members with Affinity Discount plan)

Provider Recruiting Monday – Friday 8 a.m. – 6 p.m. (EST)	To contact a Provider Recruiting Associate, please call: **1-800-584-3140** or fax: **1-888-553-2847** or write: 159 Express Street P.O. Box 9104 Plainview, NY 11803	• 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 a Utilization Review Associate, please call: **1-800-328-4728, ext. 6811** or fax: **1-800-584-2329** or write: 159 Express Street P.O. Box 9104 Plainview, NY 11803	• Request prior approval for services outside regular eligibility cycle • Request prior approval for medically necessary contact lenses • Request Verification (Texas only)
Excel Advantage	To contact a Professional Field Consultant about the Excel Advantage Program, please email: **pfcdept@davisvision.com** or fax your request to: **1-888-281-4974**	• Place an Excel Advantage order
Excel Advantage (Billing)	To contact a Finance Associate about Excel Advantage billing, please call: **1-800-328-4728, ext. 6748** or write: 175 Express Street P.O. Box 9104 (U.S. Mail) Plainview, NY 11803	• Request Excel Advantage billing 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**	• 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** or email: providerbilling@davisvision.com	• 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**	

SECTION IV
THE VISION CARE BENEFIT

NOTE: *Davis Vision provides routine vision and eye care services to more than 55 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 members. Some managed care plans (such as HMOs) may require that patients first consult their Primary Care Physician (PCP) to determine whether the patient needs specialty care such as ophthalmologic services. If so, the PCP may need to obtain an authorization for the patient to seek care from a specialist.

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.

B. PRIMARY ROUTINE VISION CARE PRODUCTS

- **Affinity Discount Plans** offer significant discounts off professional services (e.g., eye examinations) and eyewear through a uniform schedule of maximum charges. Under Affinity Discount plans, providers utilize their own inventory, materials and laboratory services.

- **Hybrid Plans** offer funded coverage for professional services coupled with the Affinity Discount schedule on eyewear.

- **Comprehensive Vision Plans** cover eye examinations and eyewear and are typically categorized by one of three levels: Fashion, Designer, and Premier. Each of our plans are 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; Davis Vision requires a 20% courtesy discounts that our participating providers 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.

- **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 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). In addition, many groups make the benefit available annually for children below a specified age.

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 28 or 35 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 Appendix)
- Most plans cover non-cosmetic contact lenses for conditions such as Keratoconus.

Most groups limit coverage to one (1) pair of Plan eyeglasses (lenses and frame) or one pair of contact lenses. Some groups allow two (2) pairs of eyeglasses (Distance Vision and Near Vision) in lieu of bifocals. Others 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 not be included in the patient's Plan are:

- Medical treatment of eye disease or injury
- Visual therapy
- Special lens designs or coatings other than those described in the benefit plan
- Replacement of lost/stolen eyewear
- Non-prescription (Plano) lenses
- Services not performed by licensed personnel
- Low vision aids and services
- Prosthetic devices and services
- Materials and services not specified in the benefit design
- Contact lenses and eyeglasses in the same benefit period
- Insurance of contact lenses

Providers must inform patients of all associated costs of non-covered items.

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.

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
- Progressive Addition Lenses (Standard and Premium) (Plan Formularies contained in Appendix)
- Corning™ Photochromic (PGX) Lenses
- Anti-Reflective Coating (ARC) (Formulary contained in Appendix)
- Hi-Index Lenses
- Polarized Lenses
- Polycarbonate Lenses (included for dependent children and monocular patients)
- Ultraviolet Coating
- Blended Segment Lenses
- Plastic Photosensitive Lenses
- Mirror Coated Lenses

BEST PRACTICE

When a patient disregards your recommendation for polycarbonate 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 the "*Duty to Warn / Patient Rejection and Waiver Form*" found on the Provider Portal at www.davisvision.com (and in the Appendix of this Manual). 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.

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
- Particular job functions
- Specific employees

Occupational Vision Benefits are available only at Davis Vision 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 Benefit**

Patients with a Stand-Alone Occupational 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 including color vision testing, stereopsis and, at the provider's discretion, any additional testing required to determine the best-corrected visual acuity for the patient. VDT eyeglasses are prescribed for the patient specifically for VDT use. The VDT benefit is available in conjunction with a standard vision benefit (i.e., "dress" pair). To be eligible for the VDT eyeglass benefit, the patient's standard eyeglass prescription and the VDT prescription must differ in the following ways:

1. Prescription difference of at least 0.50 diopters
2. Different lens types, e.g. trifocal vs. bifocals
3. 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. 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.

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 collect all copayments at the time of ordering – not at the time of dispensing.

BEST PRACTICE

Record all plan copayments 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. Courtesy Discount

The Plan requires that participating providers extend members 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.

7. Receipts

Patients are entitled to receipts for copayments 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 member has no personal financial responsibility (items included by their vision benefit).

8. Sales Tax

Depending on the state in which your practice is located, sales tax may be collected on:

- 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

*NOTE: Patients who have an Affinity Discount plan will not require an authorization, and therefore will not typically have an enrollment record within the Davis Vision administrative system. However, the group's discount plan information will be sent to you by Davis Vision. In the event this information is not on file, you may call **1-800-933-9371** to speak directly with a Provider Service Representative, who will help you verify the group's discount information.*

Davis Vision patients will be directed to call your office to schedule an appointment. At that time, you should verify the patient's current eligibility and request an authorization for the services being scheduled. After obtaining the patient's name, member 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**. 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 your patient is currently eligible for services, you may obtain an authorization. The system will display an authorization number. If your patient is not currently eligible for services, you will be notified of the reason (e.g., benefits already received within specified benefit cycle), which can be communicated to the patient. This process pertains only to the funded, Comprehensive and Hybrid vision benefits.

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), 1-800-77DAVIS

Providers may access the IVR **24 hours a day**. When accessing the IVR, you will be prompted to enter your provider number. The IVR will then prompt you to enter the member's ID#. Once the member'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 provide as much clinical information as possible to enable Davis Vision to make a determination.

Complete the Prior Approval/Medically Necessary Services Request Form (on the Provider Portal under Important Links and contained in the Appendix to this Manual) 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 three (3) business days (unless a more stringent timeframe is imposed by State guidelines).

4. Service Record/Voucher Program Eligibility

Network providers are not responsible for determining eligibility in a Voucher Program. Only eligible persons receive vision benefit service record/vouchers Plan services should be provided only to the person name on the service record/voucher.

The benefit coverage for each member 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 (member, 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. Members whose service record/voucher has expired are responsible to obtain a current one.

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

1. Only one service code is required on the service record/voucher claim form for each pair of eyeglasses provided by the Plan.

2. If allowed, members 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.

3. 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 member to require continuing services. For these rare instances, Davis Vision may conduct concurrent review during the course of ongoing treatment.

Complete the Prior Approval/Medically Necessary Services Request Form (on the Provider Portal under Important Links and contained in the Appendix to this Manual) 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 of receipt of necessary information.

If the member 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 member at least ten (10) days prior to the effective date of the denial of authorization for continued services.

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 (**1-800-77DAVIS**) 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.**

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 member 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 1-800-77DAVIS

Orders 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.

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

C. PROVIDER-SUPPLIED FRAMES OR PATIENTS' OWN FRAMES

When mailing a patient's own frame or a provider-supplied frame, please complete the Ship Back Form (see Appendix) 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:

- Member'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 sex
- patient's relationship to insured
- a valid Davis Vision provider number, if the benefit is assigned
- diagnosis/condition (including diagnosis code)
- procedures/services or supplies including days or units
- date of service
- itemized charges and total charge
- 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 "unclean."

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. Unclean Claims

Upon receipt of a claim that does not contain all of the previously-defined clean claim data elements, Davis Vision will 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 (1-800-93-EYES-5).

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 in the Appendix. 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. 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 are 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) from the Provider Procedure Codes included in the Appendix.
  - *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 in the Appendix.
  - *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 non-routine medical eye services to be billed to Davis Vision for payment. Davis Vision does not pre-authorize these services. The provider must submit all ancillary medical claims using a HCFA 1550 form to:

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

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 SENSITIVITY

As established by your Participating Provider Agreement, you must provide covered services in a culturally competent manner to all Davis Vision patients, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

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 to the out-of-network claim form at time of submission to Davis Vision.

F. SCHEDULING AN APPOINTMENT

Routine appointments should be made available for members within 7-10 calendar days of request. Appointments for urgent conditions should be made available within 24-48 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 at the time of the examination. 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.

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.
DO NOT SERVICE THE MEMBER WITHOUT AN AUTHORIZATION.

1. Authorizations for Services Requiring Prior Approval

Some plans allow patients to obtain services/options with Davis Vision's prior approval (e.g. additional lenses between eligibility cycles if patient has a qualifying prescription change.) In these cases, Davis Vision has specific criteria against which the patient's request is evaluated. To arrange for prior approval:

i. Print the *Prior Approval/Medically Necessary Services Request Form* 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 three (3) business days (unless a more stringent timeframe is imposed by State guidelines.)

2. Authorizations for Medically Necessary Contact Lenses

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 medically necessary contact lenses. Contact Lenses may be determined to be medically necessary and appropriate in the treatment of patients affected by certain conditions. 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.

When you identify a need for medically necessary contact lenses, please complete the *Prior Approval/Medically Necessary Services 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 attending physician or ordering provider. If the original reviewer is not available, another clinician is available within one business day.

BEST PRACTICE

When completing the *Prior Approval/Medically Necessary Services Request Form*, be sure to include **both** your Professional 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.

Based on clinical practice guidelines of the American Optometric Association (AOA), contact lenses may be determined to be medically necessary and appropriate in the treatment of the following nine (9) conditions:

Keratoconus

- Diagnosis confirmed by keratometric readings and observations, Placido disc or corneal topography
- Best correctable visual acuity with spectacles 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 less 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 less 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 less 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. THE OFFICE VISIT

Patients with appointments should not routinely be made to wait longer than one (1) hour.

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 patient history, examination, discussion of examination results, provision of prescription for corrective eyewear, and dispensing of appropriate eyewear.

BEST PRACTICE

Have the member sign the Service Record Form (available from the member'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 complaints

- 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 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.*
***Davis Vision does not cover refraction-only examinations. The refraction (CPT 92015) is considered part of the eye examination per the Participating Provider Agreement.*

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
- The use of trial lenses if necessary
- 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

3. Provision of Prescription for Corrective Eyewear

In accordance with the rules and regulations of the Federal Trade Commission, a written eyeglass prescription must be issued to the patient upon completion of the examination if an ophthalmic correction is recommended. Patients wearing contact lenses must be provided

with a written contact lens prescription immediately after a contact lens fitting is performed (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.

4. Dispensing Corrective Eyewear

Dispensing 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
- Adjusting eyeglasses for proper fit
- Follow-up adjustments

i. 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, 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 in the Appendix and 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.

ii. 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 (refer to Appendix) 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.

I. MEMBER APPEAL OF DENIED SERVICES

State-specific requirements regarding appeals are included in Sections 11-15.

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. In greater than 99% of all appeals, the member initiates the appeal. 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.

J. REFERRING PATIENTS FOR ADDITIONAL SERVICES

When your patient requires a referral to another practitioner for routine vision services, such referral should be made to a qualified practitioner within the Davis Vision provider 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.

K. 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 (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.

L. 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, reimbursement for emergency services will be solely dependent upon whether the member is eligible for the benefit.

M. REFUSAL OF CARE

Davis Vision's patients who are of legal age have the right to refuse to comply with recommended treatment. The patient should inform 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.

N. INVESTIGATIONAL STUDIES

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

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

- Inform the patient of the purpose of the study
- Inform the patient that he/she has the right to refuse to participate

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

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

O. TRANSFER OF PATIENT RECORDS

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

P. PRIOR APPROVAL

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

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

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

All determinations are rendered within three (3) business days of receipt of a complete request, both verbally and in writing to both the member and the practitioner (unless a more stringent timeframe is imposed by State guidelines). If the request is incomplete, Davis Vision will request additional information within the initial three-business-day time frame. Davis Vision will allow

the member, member's designee and/or provider 45 calendar days to submit the requested additional information. If the requested information is not received within 45 calendar days, Davis Vision will issue a decision within 15 calendar days of the expiration of the 45-day time frame. Written denials based on medical necessity include, but are not limited to, the following information:

- Criteria utilized, including clinical rationale, if any, and documentation supporting the decision.
- Statement that the decision will be final and binding unless the member appeals in writing to the Quality Assurance/Patient Advocate Department within 45 days of the date of the notice of the decision.
- 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.

Q. CONCURRENT REVIEW

Concurrent review involves services that are currently being rendered. The practitioner is requesting that services continue or extend beyond what has already been approved or for additional services. In rare cases, Davis Vision may review certain services on a concurrent basis during the course of ongoing treatment. Practitioners complete the Prior Approval Form and fax it to the Prior Approval Department at (800) 584-2329.

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

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

R. RETROSPECTIVE REVIEW

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

- to determine medical necessity when a member or practitioner fails to obtain approval for services that require prior approval before services are rendered

- to determine medical necessity when a practitioner fails to obtain approval for services that require concurrent review before services continue beyond the approved timeframe
- to identify and refer potential quality of care/utilization issues

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

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

S. MEMBER 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. Please refer to the Section 11-15 for some state 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 can be divided into two categories:

- 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.
- Medical necessity denials – a denial decision based on whether the product or service is medically necessary.

2. Benefit Denials

Routine vision and eye care services are limited to a frequency chosen by the client. Therefore, 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 medically necessary contact lenses. For plans offering enhanced coverage, Davis Vision reviews these requests to determine medical necessity based on the guidelines of the American Optometric Association.

Members have the right to appeal a medical necessity 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 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. Please refer to Sections 11-15 for some state 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 180 days after receipt of the adverse determination. 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**.

SECTION VIII
OPHTHALMIC MATERIALS AND LABORATORIES

A. SAMPLE FRAME COLLECTION

Davis Vision 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 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 member 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 comprehensive 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 reassessment fitting 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.

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 uncuts, 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 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.

PATIENT CHANGES

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

3. 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.

F. 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.

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.*

G. PATIENT SUPPLIED FRAMES OR LENSES

Davis Vision also provides laboratory services for those orders where some portion of the materials are supplied by the patient. **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.

BEST PRACTICE

When shipping a member's existing frame to Davis Vision, be sure to use the **Davis Vision** UPS shipping label which allows your shipment to be tracked.

H. 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.

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.

I. 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.

J. 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.

K. CONTACT LENSES

Contact lenses are covered under the individual manufacturer's warranty. Please contact the appropriate vendor.

L. 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.

M. 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 the office.

1. Laboratory Services

In establishing order procedures, Davis Vision's goals were 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.

N. SHIPPING ERRORS

In the event you receive eyewear for a patient that you did not service, 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.

O. 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.

P. 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

1. 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 are that is readily available and accessible to members.

2. 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 90 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**.

3. 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, Guam, and Saipan. 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 Universal Provider Datasource 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 90 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.

4. 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 Senior Vice President of Professional Affairs and Quality Management for review and guidance.

A designated Credentialing associate receives and monitors monthly notifications from CAQH listing cited practitioners. Because 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 Senior Vice President for Professional Affairs and Quality Management 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.

5. 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 a minimum of once every three years, focusing on information subject to change during the time period since the practitioner was last credentialed.

Ninety (90) 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:

- Supplemental Credentials Warranty or current state-specific Recredentialing Application
- Current State License(s)
- Current Malpractice Insurance Policy

- DEA Certificate (if applicable)
- Controlled Substance Registration (if applicable)
- Blank Patient Exam Form
- Copy of Board Certification (MD/DO Only)
- Hospital Affiliations (MD/DO Only)

The recredentialing process is similar to initial credentialing. In lieu of submitting a complete application, each practitioner must submit a signed Supplemental Credentials Warranty, which warrants that information provided in his/her original Davis Vision Provider Application is still correct and complete, a Universal Provider Datasource (UPD) form, or a state-mandated recredentialing application.

Providers who are registered with CAQH and who maintain a current UPD form are not required to mail updated information to Davis Vision. (However, some information must still be mailed to Davis Vision including, but not limited to, a signed contract.) The Credentialing Associate downloads the provider's application data from CAQH and uses that information to process the application.

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 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, supplemental warranties, 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.

<u>NOTE:</u> 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 from the time it is received in the Credentialing Department, but shall not exceed ninety (90) days.

6. 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 co-payments) 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 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 co-payments apply.

- A courtesy discount of at least 20% off the provider's usual and customary fees (or 10% off for disposable contact lenses) will be extended to Plan beneficiaries for the purchase of materials not covered by the Plan.

- 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 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.

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

7. 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. 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 and possible referral to the Peer Review Committee. Adverse determinations rendered by the Peer Review Committee are communicated to the practitioner or provider in writing including what action is being taken, the reason for the action, and a summary of the appeal rights and process.

> *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.
- Bankruptcy of the provider.

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 Senior Vice President or Assistant Vice President of Professional Affairs. The Assistant Vice President of Professional Affairs 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 Senior Vice President or Assistant Vice President of Professional Affairs. The Assistant Vice President of Professional Affairs 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 Board Certification and TPA licensure.
- Excessive number of panel providers practicing in a geographic area.
- 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 Senior Vice President or Assistant Vice President of Professional Affairs. The Assistant Vice President of Professional Affairs 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 Senior Vice President or the Assistant Vice President of Professional Affairs.

The Senior Vice President or the Assistant Vice President of Professional Affairs 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 Assistant Vice President of Professional Affairs 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 an appeal process for instances in which it chooses to alter the conditions of practitioner participation based on issues of quality of care or service. The appeal process was developed with input from participating providers and is reviewed at least annually. It is available to all participating providers.

> *EXCEPTION: When a provider is terminated based on professional misconduct, or their conduct poses a threat of imminent harm to the health and safety of a member, or when their license limits their ability to fulfill their contractual obligations to Davis Vision, the provider forfeits the right to appeal the decision.*

To challenge 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 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.
Provider Appeals
Professional Affairs and Quality Management
159 Express Street
Plainview, NY 11803

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 one Regional Quality Assurance Representative, who is an active participating

practitioner, and at least two participating practitioners who were not involved in the initial determination. Practitioners are experienced in the peer review process. 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 will present his/her explanation as to why the decision for termination should be modified or reversed. The Director of Professional Services will present Davis Vision's position regarding the termination.

At the conclusion of the hearing, the Provider Appeal Committee will document its findings and recommendation. The Committee will forward their report to the Assistant Vice President of Professional Affairs and Quality Management within thirty (30) days of the hearing. The Assistant Vice President will consider the recommendation of the Provider Appeal Committee and make a final determination within fifteen (15) days. The Assistant Vice President will advise the practitioner of the final determination and will send him/her a copy of the Committee's report containing the specific reasons for the determination.

Decisions resulting in termination of a practitioner will be communicated in writing to the practitioner and will include notification that the termination is effective upon the practitioner's receipt of the notice. This decision involving the practitioner's participation in the Davis Vision network is final.

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. ONSITE OFFICE REVIEW PROGRAM

A key element in assessing practitioner compliance with Davis Vision's requirements, regulatory mandates and accreditation standards is the Onsite Office Review Program. Office and record reviews are conducted by Regional Quality Assurance Representatives (RQARs) who are licensed optometrists or retired optometrists. Offices for review 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 300 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 300 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 quarterly.

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 Assistant Vice President of Professional Affairs. Audit results are communicated to the provider in writing.

For providers who render care to fewer than 300 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 Assistant Vice President of Professional Affairs. Audit results are communicated to the provider in writing.

The audit tool located in the Appendix 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 80% and for medical records is 65%. Providers scoring below 80% for the site visit and/or 65% for the medical record review must submit a written corrective action plan to Davis Vision which must be approved by the Assistant Vice President of Professional Affairs. Providers who score below 50% or whose corrective action plan is not approved by the Assistant Vice President 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 or the period required under applicable State and Federal laws.

ii. Medical Records Documentation

As reflected in the Medical Record Audit Tool contained in the Appendix, Davis Vision requires that the medical records for its members must include the following minimum documentation.

Patient Demographics:

- 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

Case (Medical) History:

- Chief complaint including recent changes in vision
- Relevant past eye, medical, and family history
- Relevant family ocular history
- Current medications
- Allergies to medication

Visual Acuity:

- Monocular
- Binocular
- Habitual
- Corrected
- Distance
- Near

Eye Health:

- External and internal structures of the eye
- Gross Visual Fields
- Pupil
- Intraocular pressure
- Dilated fundus examination, when indicated

Refraction:

- Objective
- Subjective
- Distance
- Near accommodative evaluation

Binocular Function:

- Distance phoria
- Near phoria,

- 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

Other:

- Printed name and signature of the examining doctor
- Exact 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)

Refractive surgeons must include in their documentation appropriate pre- and post-operative clinical notes.

C. 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
- Trial Frame
- Lensometer
- Keratometer
- Biomicroscope
- Field 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.

D. 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, failure of the practitioner to implement or comply with a corrective action plan, or failure of the practitioner to respond to requests for information.

As established in the Participating Provider Agreement, you are required to provide us with copies of medical records for our members within a reasonable time period following our request for the records.

E. MEMBER SATISFACTION

The purpose of Davis Vision's comprehensive member 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 satisfaction rates of over 98%. Those surveyed who indicate less than total satisfaction are contacted individually to ensure 100% satisfaction. If appropriate, participating providers are asked to respond to concerns raised by their patients.

Davis Vision conducts statistical analysis on aggregate results. Semiannually, the RQARs provide comparative statistics to provider offices whose patients completed and returned at least ten (10) surveys. Survey results are shared with the Director of Professional Services, the Quality Improvement Committee and are used during the recredentialing process.

F. 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 members. 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 to the Quality Improvement Committee. The Committee discusses issues and concerns expressed by the providers, focusing on challenging trends or dissatisfaction.

As a result of comments in the Provider Satisfaction Survey, Davis Vision may take action including, but not limited to:

- 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
MARYLAND ADDENDUM

This Addendum is applicable to providers in the State of Maryland with whom Davis Vision has contracted to provide routine vision benefits to members covered through a managed care organization operating in the State of Maryland.

The following requirements and processes supersede those in the Davis Vision Provider Manual.

MARYLAND STATE
MEMBER GRIEVANCE AND COMPLAINT PROCESS

DEFINITIONS

"Adverse Decision" means a utilization review determination that a proposed or delivered health care service which would otherwise be covered under the member's contract is or was not medically necessary, appropriate, or efficient and may result in non-coverage of the health care service. Adverse decision does not include a decision concerning a person's status as a member.

"Company" or "Davis Vision" shall refer to Davis Vision, Incorporated.

"Complaint" means a protest filed with the Maryland Insurance Commissioner involving an adverse decision, grievance decision or an appeal concerning a member.

"Emergency Case" means a case involving an adverse decision for which an expedited review is required if:

a) the adverse decision is rendered for health care services that are proposed but have not been delivered; and
b) the services are necessary to treat a condition or illness that, without immediate medical attention, would seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

"Filing Date" means the earlier of:
a) 5 days after date of mailing; or
b) the date of receipt.

"Grievance" means a written protest filed by a member or a health care provider on behalf of a member through this internal grievance process regarding an adverse decision

concerning the member. A grievance does not include a verbal request for reconsideration of a utilization review determination.

"Grievance Decision" means a final determination that arises from a grievance filed with the Company under its internal grievance process regarding an adverse decision concerning a patient.

"Member" means a person entitled to health care benefits under a policy, plan, or certificate issued or delivered in Maryland that is governed by Title 15, Subtitle 10A of the Insurance Article of the Maryland Annotated Code.

STANDARD GRIEVANCE

The member, or a health care provider acting on the member's behalf, may file a grievance regarding an adverse decision. The member or health care provider acting on the member's behalf must file a grievance within one hundred and eighty (180) days after the member receives the adverse decision.

Grievances must be made in writing to Davis Vision. A written grievance may be made in one of two ways:

- It may be mailed to:
  Davis Vision, Inc.
  P.O. Box 791
  Latham, New York 12110
  Attention: Quality Assurance
- It may be sent via email:
  Log onto our website:
  www.davisvision.com
  Click on "Contact" (at very bottom of screen)
  Click on "To send an email, click here"

Members may call Davis Vision toll free at **1 (800) 999-5431** twenty-four (24) hours a day seven days a week to voice concerns and complaints. A Davis Vision Associate will attempt to resolve verbal complaints or concerns. However, voicing a complaint or concern verbally does not constitute the filing of a formal grievance under this internal grievance process.

Upon receipt of a grievance, a Quality Assurance Associate documents the grievance in the member's file and reviews the grievance to determine whether there is sufficient information to complete the internal grievance process. If not, Davis Vision will provide verbal and/or written notification within five (5) business days to the member or health care provider who filed the grievance on behalf of the member. The notification will include an offer to assist the member and health care provider in gathering the necessary information without delay.

If there is sufficient information to complete the internal grievance process, Davis Vision will provide written acknowledgment of the filing of the Grievance to the member and or the health care provider within 15 days of receipt of the Grievance. The written

acknowledgment includes (1) a statement that the member has the right to designate a representative to participate in the process on his/her behalf, (2) the Associate's name and telephone number, and (3) the timeframe for a Grievance determination.

Standard Grievances are conducted by a clinical peer reviewer other than the clinical peer reviewer who rendered the Initial Adverse Determination and who is not a subordinate of the initial reviewer.

Davis Vision makes Standard Grievance Determinations and provides verbal notification to the member, the member's designee and/or the health care provider as fast as the member's condition requires and within 30 business days of receipt of the request for pre-service requests or within 45 business days of receipt of the request for retrospective requests, unless Davis Vision and the member or health care provider mutually agree that a further extension of the time limit (maximum of 30 business days) would be in the member's best interest. Written notice will be sent to the member, the member's designee and the health care provider within five (5) business days after the decision has been verbally communicated.

A member or a health care provider may file a complaint with the State Insurance Commissioner if the member or health care provider does not receive a Grievance Determination from Davis Vision on or before the 30th business day on which the grievance was filed for pre-service requests or on or before the 45th business day on which the grievance was filed for retrospective requests.

The notice of grievance decision will include:

- Detailed statement in clear, understandable language the specific factual bases for Davis Vision's decision;
- Reference to the specific criteria and standards, including interpretive guidelines, on which the decision was based, without using only generalized terms such as "experimental procedure not covered," "cosmetic procedure not covered," "service included under another procedure," or "not medically necessary;"
- The name, business address, and business telephone number of the designated Davis Vision Associate who has responsibility for the internal grievance process;
- Statement that the member, or provider on behalf of the member, has the right to file a complaint with the State Insurance Commissioner within 30 business days of receipt of the Grievance Determination.
- The Commissioner's address, telephone number, and facsimile number.
- **"THERE IS HELP TO YOU IF YOU WISH TO DISPUTE THE DECISION OF THE PLAN ABOUT PAYMENT FOR HEALTH CARE SERVICES.** You may contact the Health Advocacy Unit of Maryland's Consumer Protection Division Monday-Friday from 9 a.m. to 4:30 p.m. by telephone in Maryland at 1-877-261-8807 or by fax at 410-576-6571 or in writing Office of the Attorney General, Consumer Protection Division, Health Education and Advocacy Unit, 200 St. Paul Place, Baltimore, MD 21202-2021. You may also file your dispute online by accessing the Health Education Advocacy Unit at

http://www.oag.state.md.us/Consumer/HEAUrelform.htm

The Health Advocacy Unit can help you and your health care provider prepare a grievance to file under the carrier's internal grievance procedure. That unit can also attempt to mediate a resolution to your dispute. The Health Advocacy Unit is not available to represent or accompany you during any proceeding of the internal grievance process. Additionally, you may file a complaint with the Maryland Insurance Administration, without having to first file a grievance with the plan, if: (1) the plan has denied authorization for a health care service not yet provided to you, and (2) you or your provider can show a compelling reason to file a complaint, including that a delay in receiving the health care service could result in loss of life, serious impairment to a bodily function, or serious dysfunction of a bodily organ or part. INFORMATION DESCRIBED IN THIS NOTICE MAY ALSO BE FOUND IN YOUR CERTIFICATE OF COVERAGE."

EXPEDITED GRIEVANCE

Davis Vision maintains an Expedited Grievance process for adverse determinations involving a situation where the standard timeframes could result in loss of life, serious impairment to a bodily function or serious dysfunction of a bodily organ. This Expedited Grievance process includes mechanisms that facilitate resolution of the Grievance including, but not limited to, the sharing of information from the member's health care provider and Davis Vision by telephone or fax.

Expedited Grievances are conducted by a clinical peer reviewer other than the clinical peer reviewer who rendered the Initial Adverse Determination and who is not a subordinate of the initial reviewer.

Davis Vision makes Expedited Grievance Determinations and provides notice of determination to the member, the member's designee and the health care provider by telephone as fast as the member's condition requires, but in no event more than 24 hours after receipt of the request. Written notice will be sent to the member, the member's designee and the health care provider within one (1) calendar day after the decision has been verbally communicated. The written Expedited Grievance Determination will contain the same information as the Standard Grievance Determination, described above.

If the Expedited Grievance does not resolve the difference of opinion, the member, the member's designee and/or the health care provider may file a complaint with the State Insurance Commissioner.

A member or a health care provider may file a complaint with the Commissioner if the member or health care provider does not receive an Expedited Grievance Determination from Davis Vision within 24 hours after the grievance was filed.

FILING COMPLAINTS WITH THE INSURANCE COMMISSIONER

The internal grievance process must be exhausted prior to filing a complaint with the Commissioner **unless** the member or health care provider can provide sufficient

information and supporting documentation in the complaint that demonstrates a compelling reason to file with the Commissioner prior to completing the internal procedures. The demonstration of a compelling reason includes a showing that the potential delay in the receipt of a health care service until after the member or health care provider exhausts the internal grievance process and obtains a final decision under the grievance process could result in loss of life, serious impairment to a bodily function, or serious dysfunction of a bodily organ. In a case involving a post-service denial, there is no compelling reason to allow a member or a health care provider on behalf of a member to file a complaint without first exhausting the internal grievance process of the Company.

SECTION XII
NEW JERSEY ADDENDUM

This Addendum is applicable to providers in the State of New Jersey with whom Davis Vision has contracted to provide routine vision benefits to members covered through a managed care organization operating in the State of New Jersey. Depending on the contractual relationship with the New Jersey managed care organization ("NJ-MCO"), Davis Vision may or may not be delegated for member complaints and appeals. Please contact Davis Vision Provider Services at ***1-800-933-9371*** *for specific member and delegation information*

The following requirements and processes supersede those in the Davis Vision Provider Manual.

- NJ FamilyCare/Medicaid members do not pay a fee for vision care. NJ FamilyCare C members pay a $5 personal contribution to care (PCC). NJ FamilyCare D members pay a $5 co-pay for optometrist visits. (I, 3)

- For providers in the State of New Jersey, if Davis Vision terminates the Provider Agreement before the end of the initial term (12 months beginning on the Effective Date on the signature page of the Agreement) or for "cause", the provider can request in writing a hearing within 10 business days following the date of receipt of notice of termination. Davis Vision will hold a hearing within 30 days following receipt of a written request for a hearing by a terminated health care professional before a panel appointed by Davis Vision. (IV, 11)

- For providers in the State of New Jersey, 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 receiving a current course of treatment at least 30 business days prior to the effective date of the termination. (IV, 11)

- Davis Vision will notify the New Jersey managed care organization ("NJ-MCO") upon notification that a provider or subcontractor will be suspended, terminated or voluntarily withdrawn from participation in the Davis Vision network, to allow the NJ-MCO to notify DMAHS at least 45 days prior to the effective date of the action.. If the termination was "for cause," Davis Vision's notice to the **NJ-MCO** will include the reasons for the termination. (IV, 12)

    1. Provider resource consumption patterns will not constitute "cause" unless Davis Vision can demonstrate it has in place a risk-adjustment system that takes into account enrollee health-related differences when comparing across providers.

2. Davis Vision will assure immediate coverage by a provider of the same specialty, expertise, or service provision and will provide the **NJ-MCO** with a copy of the new contract with a replacement provider upon execution, to allow the **NJ-MCO** to submit same to DMAHS 45 days prior to the effective date.

3. Upon request, Davis Vision will provide the **NJ-MCO** with periodic updates and information pertaining to specific potential provider terminations, including status of renegotiation efforts, to allow the **NJ-MC**O to submit same to DMAHS.

- For providers in the State of New Jersey, the Attestation section of the Credentialing Application must indicate whether the applicant has any history of chemical dependency/ substance abuse. (VII, 7)

- For providers in the State of New Jersey, if Davis Vision's Credentialing Committee recommends termination of a provider from the network, the written notification to the provider will include the requirement that the provider must notify those affected members receiving a current course of treatment at least 30 business days prior to the effective date of the termination. (VII, 13)

- At the conclusion of the Provider Appeal Process, if the outcome results in the termination of the provider, the written notification to the provider will include the requirement that the provider must notify those affected members at least 30 business days prior to the effective date of the termination and the provider's termination is effective 45 days from the date of the notification. (VII, 14)

- NJ FamilyCare/Medicaid members should never be charged for copying medical records. (VIII, 3)

- NJ FamilyCare/Medicaid members are not charged for missed appointments. Davis Vision will request that all members notify providers at least 24 hours in advance when canceling any appointment. (VIII, 5)

- **Investigational Studies:**
  NOTE: *Davis Vision provides routine vision and eye care services including routine eye examinations, eyeglasses, contact lenses, value-added discounts and accessories. Davis Vision does not provide or manufacture life-saving equipment, nor does Davis Vision authorize or provide medical treatment (emergency or routine).*
  NJ FamilyCare/Medicaid members who are qualified to participate in an approved clinical trial will not be denied participation in the clinical trial by Davis Vision, will not be denied coverage by Davis Vision of routine costs for items and services furnished in connection with participation in the trial, will not be discriminated against by Davis Vision on the basis of the enrollee's participation in such trial. (Davis Vision will provide payment for routine patient costs as available through the member's benefit design, but is not required to pay for costs of items and services that are reasonably expected to be paid for by the sponsors of an approved clinical trial.) (VIII, 12)

- A "qualified" enrollee means an enrollee under Davis Vision's coverage who meets the following conditions:
    1. The enrollee has a life-threatening or serious illness for which no standard treatment is effective;
    2. The enrollee is eligible to participate in an approved clinical trial with respect to treatment of such illness;
    3. The enrollee and the referring physician conclude that the enrollee's participation in such trial would be appropriate; and
    4. The enrollee's participation in the trial offers potential for significant clinical benefit for the enrollee.

- An "approved clinical trial" means a clinical research study or clinical investigation that meets the following requirements:
    1. The trial is approved and funded by one or more of the following:
        - The National Institutes of Health
        - A cooperative group or center of the National Institutes of Health
        - The Department of Veterans Affairs
        - The Department of Defense
        - The Food and Drug Administration, in the form of an investigational new drug (IND) exemption
    2. The facility and personnel providing the treatment are capable of doing so by virtue of their experience or training.
    3. There is no alternative non-investigational therapy that is clearly superior.
    4. The available clinical or preclinical data provide a reasonable expectation that the protocol treatment will be at least as effective as the non-investigational alternative.

- For providers in the State of New Jersey servicing NJ FamilyCare/Medicaid members, medically necessary services are services or supplies necessary to prevent, evaluate, diagnose, correct, prevent the worsening of, ameliorate, or cure a physical or mental illness or condition; to maintain health; to prevent the onset of an illness, condition or disability; to prevent or treat a condition that endangers life or causes suffering or pain or results in illness or infirmity; to prevent the deterioration of a condition; to promote the development or maintenance of maximal functioning capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities that are appropriate for individuals of the same age; to prevent or treat a condition that threatens to cause or aggravate a handicap or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the enrollee. The services provided, as well as the type of provider and setting, must be reflective of the level of service that can be safely provided, must be consistent with the diagnosis of the condition and appropriate to the specific medical needs of the enrollee and not solely for the convenience of the enrollee or provider of service and in accordance with standards of good medical practice and generally recognized by the medical scientific

community as effective. Course of treatment may include mere observation or, where appropriate, no treatment at all. Experimental services or services generally regarded by the medical profession as unacceptable treatment are not medically necessary for purposes of this manual. (VIII, 14)

- **Appeals:**
  An enrollee, and any provider acting on behalf of the enrollee with the enrollee's consent (enrollee's consent is not required in the case of a deceased patient, or when an enrollee has relocated and cannot be found), may appeal any UM decision resulting in a denial, termination, or other limitation in the coverage and access to health care services. Such enrollees and providers will be provided with a written explanation of the appeal process upon the conclusion of each stage in the appeal process.

  Action means, at a minimum, any of the following:
    - An adverse determination under a utilization review program;
    - Denial of access to specialty and other care;
    - Denial of continuation of care;
    - Denial of a choice of provider;
    - Denial of coverage of routine patient costs in connection with an approved clinical trial;
    - Denial of access to needed drugs;
    - The imposition of arbitrary limitation on medically necessary services;
    - Denial in whole or in part, of payment for a benefit;
    - Denial or limited authorization of a requested service, including the type or level of services;
    - The reduction, suspension, or termination of a previously authorized service;
    - Failure to provide services in a timely manner;
    - Denial of a service based on lack of medical necessity.

  For your information and to enable you to advise your patients about their appeal rights, please refer to the following description of the NJ Appeals Process. The instructions include the 60-day time limit for members, or providers acting on behalf of members, with the member's written consent, to file an appeal.

  The appeal process for NJ FamilyCare/Medicaid members consists of an informal internal review (Level 1 Appeal), a formal internal review (Level 2 Appeal) and a formal external review (Level 3 Appeal) by an independent utilization review organization under the DOBI and/or the Medicaid Fair Hearing process. Medicaid/NJ FamilyCare A members and certain NJ FamilyCare D members may access the Fair Hearing process. Other NJ FamilyCare members, by federal rule, do not have access to the Medicaid Fair Hearing process.

  1. Level 1 Appeals will be concluded as soon as possible in accordance with the medical exigencies of the case, which in no event will exceed 72 hours in the

case of appeals from determinations regarding urgent or emergency care, and five (5) business days in the case of all other appeals. If the appeal is not resolved to the satisfaction of the member at this level, the **NJ MCO** will provide the member and/or the provider with a written explanation of his or her right to proceed to a Level 2 Appeal, including the applicable time limits, if any, for making the appeal and to whom the appeal should be addressed.

2. Level 2 Appeals are available to any member or any provider acting on behalf of a member with the member's consent, who is dissatisfied with the results of the Level 1 Appeal, will have the opportunity to pursue his or her appeal before a panel of physicians and/or other health care professionals selected by the **NJ MCO** who have not been involved in the utilization management determination at issue. The members of the appeal panel will include practitioners who practice in the same specialty as would typically manage the case at issue or such other licensed health care professional as may be mutually agreed upon by the parties. All Level 2 Appeals are acknowledged by the **NJ MCO** in writing to the member or provider filing the appeal within 10 business days of receipt. All Level 2 Appeals will be concluded as soon as possible after receipt by the **NJ MCO** in accordance with the medical exigencies of the case, which in no event will exceed 72 hours in the case of appeals from determinations regarding urgent or emergent care and, except in the case of a situation in which the **NJ MCO** must extend the timeframe by an additional 14 calendar days, 20 business days in the case of all other appeals. The **NJ MCO** may extend the timeframes by up to 14 calendar if the member requests the extension or the **NJ MCO** shows (to the DMAHS' satisfaction upon its request) that there is need for additional information and how the delay is in the member's interest. If the Level 2 Appeal is denied, the **NJ MCO** will provide the member and/or provider with written notification of the denial and the reasons for the denial together with a written notification of his or her right to proceed to an external Level 3 Appeal. This notification will include specific instructions as to how the member and/or provider may arrange for an external appeal and will include any forms required to initiate such an appeal. In the event the **NJ MCO** fails to comply with any of the previously mentioned timeframes, or if the **NJ MC**O waives its right to an internal review of the appeal, then the member and/or provider will be relieved of his or her obligation to complete the internal review process and may, at his or her option, proceed directly to the external appeals process.

3. The external appeal process (Level 3 Appeal) is available to any member and any provider acting on behalf of a member with the member's written consent who is dissatisfied with the results of the internal appeal process. To initiate an external appeal, the member and/or provider will, within 60 days from receipt of the written determination of the Level 2 Appeal, file a written request with the Department of Banking and Insurance on a form automatically provided to the member.

- **NJ Credentialing Requirements**
  The initial credentialing process obtains and reviews verification of the following information, at a minimum:
    - the practitioner holds a current valid license to practice;
    - valid DEA or CDS certificate, as applicable;
    - graduation from medical school and completion of a residency, or other post-graduate training, as applicable;
    - work history;
    - professional liability claims history;
    - good standing of clinical privileges at the hospital designated by the practitioner as the primary admitting facility; (This requirement may be waived for practices which do not have or do not need access to hospitals.)
    - the practitioners hold current, adequate malpractice insurance according to the plan's policy;
    - any revocation or suspension of a State license or DEA number;
    - any sanctions imposed by Medicare and/or Medicaid for example, suspensions, debarment, or recovery action; and
    - any censure by the State or County Medical Association.

  Davis Vision requests information on the practitioner from the National Practitioner Data Bank and the State Board of Medical Examiners or other appropriate professional licensing board, depending on the provider type.

  The application process includes a statement by the applicant regarding:
    - any physical or mental health problems that may affect current ability to provide health care;
    - any history of chemical dependency/substance abuse;
    - history of loss of license and/or felony convictions;
    - history of loss or limitation of hospital privileges or disciplinary activity; and
    - an attestation to correctness/completeness of the applications.

- **NJ Recredentialing Requirements**
  The recredentialing process is implemented every three years and includes review of data from:
    - member complaints;
    - results of quality reviews;
    - performance indicators;
    - utilization management and;
    - reverifications of hospital privileges and current licensure.

SECTION XIII
PENNSYLVANIA ADDENDUM

This Addendum is applicable to providers in the Commonwealth of Pennsylvania with whom Davis Vision has contracted to provide routine vision benefits to members covered through a managed care organization operating in the Commonwealth of Pennsylvania.

The following requirements and processes supersede those in the Davis Vision Provider Manual.

- Davis Vision makes Prior Approval Review determinations and provides notice of determination to PA HealthChoices/Medicaid members, the members' designee and the health care provider as fast as the member's condition requires and within two (2) business days from receipt of necessary information. A written or electronic confirmation of the decision is given within two (2) business days of communicating the decision.
- If a request for Prior Approval Review does not include sufficient information for Davis Vision to make a determination, Davis Vision will request the required information within 48 hours of the request for service.
- Davis Vision makes Concurrent Review determinations and provides notice of determination to PA HealthChoices/Medicaid members, the members' designee and the health care provider within one (1) business day of receipt of necessary information. A written or electronic confirmation of the decision is given within one (1) business day of communicating the decision.
- Davis Vision recognizes the DPW medical necessity definition as follows:
    - A service or benefit is Medically Necessary if it is compensable under the MA Program and if it meets any one of the following standards:
        - The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability
        - The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability
        - The service or benefit will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age.
- For members under the age of 21 and covered under the MA Program, requests for services that exceed benefit limits will be subjected to additional review for medical necessity. These reviews will be conducted by a licensed clinician and require MD to MD discussion, or documentation of attempts to reach the prescribing physician for discussion.

PENNSYLVANIA MANAGED CARE
MEMBER COMPLAINT AND GRIEVANCE PROCESSES

Davis Vision maintains complaint and grievance processes, each involving two (2) levels of review. A Member or a vision care Provider may contact the Pennsylvania Department of Health ("Department of Health") to complain that Davis Vision's administrative processes or time frames are being applied in such a manner as to discourage or disadvantage the Member or vision care Provider in utilizing the complaint and grievance processes. Referral of the allegations to the Department of Health will not operate to delay the processing of the complaint or grievance review. (Refer to Sections below for the process by which a member may give a provider written consent to file a grievance on his/her behalf.)

At any time during the internal complaint or grievance process, a Member may choose to designate an authorized representative to participate in the complaint or grievance process on his/her behalf. The Member or the Member's authorized representative shall notify Davis Vision, in writing, of the designation. Davis Vision reserves the right to establish reasonable procedures for determining whether an individual has been authorized to act on behalf of a Member.

For purposes of the complaint and grievance processes, Member includes designees, legal representatives and, in the case of a minor, parents of a Member entitled or authorized to act on the Member's behalf.

At any time during the internal complaint or grievance process, at the request of the Member, Davis Vision will appoint a person from its Quality Assurance Department to assist the Member, at no charge, in preparing the complaint or grievance. The Davis Vision employee made available will not have participated in any previous decisions to deny coverage for the issue in dispute.

At any time during the internal complaint or grievance process, a Member may contact the Davis Vision Quality Assurance/Patient Advocate Department at 1-888-343-3470 to inquire about the filing or status of a complaint or grievance.

1. Complaint Process

a. Internal Complaint Process

Davis Vision maintains a complaint process for the resolution of disputes or objections by a Member regarding a Network Provider or the coverage (including contract exclusions and non-covered benefits), operations or management policies of Davis Vision, delivery of services and the breach or termination of the Agreement. A complaint does not include a grievance.

Members have the right to have complaints internally reviewed through the two (2) level process described in this Internal Complaint Process.

Members must exhaust this two (2) level process before seeking further administrative review of a complaint by the Department of Health or Pennsylvania Insurance Department. Except in the case of a Second Level Review involving the denial of a Pre-service Claim, the entire two (2) level process described below is mandatory and must be exhausted before a Member is permitted to institute such action at law or in equity in a court of competent jurisdiction as may be appropriate.

i. Initial Review

1. The Member's initial complaint shall be directed to the Quality Assurance Department. This complaint, which may be oral or in written form, must be submitted within 180 days from the date of the Member's receipt of the notification of an adverse decision or the occurrence of the issue which is the subject of the complaint. Within five (5) business days of receipt of the complaint, Davis Vision will provide written confirmation to the Member and/or the Member's designated representative that the request has been received, and that Davis Vision has classified it as a complaint for purposes of internal review. If a Member disagrees with Davis Vision's classification of a request for an internal review, he/she may directly contact the Department of Health for consideration and intervention with Davis Vision in regards to the classification that has been made.
2. The Member, upon request to Davis Vision, may review all documents, records and other information relevant to the complaint and shall have the right to submit any written comments, documents, records, information, data or other material in support of the complaint. The initial level complaint review will be performed by an Initial Review Committee which shall include one (1) or more employees of Davis Vision. The members of the Committee shall not have been involved or be the subordinate of any individual that was involved in any previous decision to deny the Member's complaint.
3. In rendering a decision on the complaint, the Initial Review Committee will take into account all comments, records and other information submitted by the Member without regard to whether such information was previously submitted to or considered by Davis Vision. The Initial Review Committee will afford no deference to any prior adverse decision on the Claim which is the subject of the complaint.
4. Each complaint will be promptly investigated and a decision rendered within the following time frames:
    a. When the complaint involves a non-urgent care Pre-service Claim, within a reasonable period of time

appropriate to the medical circumstances not to exceed 30 days following receipt of the complaint;

b. When the complaint involves a Post-service Claim, within a reasonable period of time not to exceed 30 days following receipt of the complaint.

5. Davis Vision will provide written notification to the Member and/or the Member's designated representative of its decision within five (5) business days of the decision, not to exceed 30 days from Davis Vision's receipt of the Member's complaint. All notifications shall include, among other items, the specific reason or reasons for the decision, the procedure for appealing the decision, a statement that the member may appeal the decision within 45 days from date of notification and, in the case of a complaint involving the denial of a Pre-service Claim, a statement regarding the right of the Member to pursue legal action.

ii. Second Level Review

1. If the Member is dissatisfied with the decision following the initial review of his/her complaint, including a non-urgent care Pre-service Claim or Post-service Claim complaint, he/she may request to have the decision reviewed by a Second Level Review Committee. The request to have the decision reviewed must be submitted in writing (or communicated orally under special circumstances) within 45 days from the date an adverse decision is received and may include any written information from the Member or any party in interest. Upon receipt of the request for the second level review, Davis Vision will send the Member and the Member's representative an explanation of the procedures to be followed during the second level review, including the Member's right to request the aid of a Davis Vision employee, who did not participate in previous decisions to deny coverage for the issue in dispute, at no charge, in preparing the Member's second level complaint; and notification that the Member and the Member's representative have the right to appear before the Second Level Review Committee and that Davis Vision will provide the Member and the Member's representative with 15 days advance written notice of the time scheduled for that review. The Second Level Review Committee shall be comprised of three (3) individuals who were not involved or the subordinate of any individual that was previously involved in the matter under review. At least one (1) individual of the committee will not be an employee of Davis Vision or of any Davis Vision related subsidiary or affiliate. When arranging the hearing, Davis Vision will notify the member in writing of the hearing procedures and rights at

such hearing, including the right of the member to be present at the review. If a member cannot appear in person at the second level review, Davis Vision shall provide the member the opportunity to communicate with the Committee by telephone or other appropriate means.

2. Attendance at the second level review will be limited to members of the review committee; the Member or the Member's representatives, including any legal representative or attendant necessary for the Member to participate in or understand the proceedings, or both; the Member's provider if the Member consents to the provider being present; applicable witnesses; and appropriate representatives of Davis Vision. Persons attending the second level review and their respective roles at the review will be identified for the enrollee. The second level review will be informal and impartial to avoid intimidating the Member or the Member's representative. The committee members will not discuss the case to be reviewed prior to the second level review meeting. Committee members who are unable to attend the review meeting may vote if they actively participate in the review meeting by telephone or videoconference. If additional information is introduced at the review meeting, it will be provided to committee members participating by telephone or videoconference for review prior to the vote. Depending on the issue under review, Davis Vision may provide an attorney to represent the interests of the committee and to ensure the fundamental fairness of the review and that all disputed issues are adequately addressed. The attorney representing the committee will not argue the Davis Vision's position or represent Davis Vision or its staff. The committee may question the enrollee, the enrollee's representative and Davis Vision employees representing the plan's position. The committee will base its decision solely upon the materials and testimony presented at the review meeting. The proceedings of the second level review committee, including the comments of the Member or the Member's representative, will be recorded electronically and maintained as part of the complaint record.
3. The hearing will be held and a decision will be made within 30 days of Davis Vision's receipt of the Member's request for review. This applies to both the voluntary second level review of a non-urgent care Pre-service Claim complaint and the mandatory second level review of a Post-service Claim complaint.
4. Davis Vision will provide written notification of its decision within five (5) business days of the decision, not to exceed 30 days from Davis Vision's receipt of the Member's request for

review. All notifications shall include, among other items, the specific reason or reasons for the decision, the procedure and timeframes for appealing the decision (including addresses and telephone numbers for the Department of Health and Pennsylvania Insurance Department) and, in the case of a complaint involving the denial of a Post-service Claim, a statement regarding the right of the Member to pursue legal action.

b. Appeal of Complaint

A Member will have fifteen (15) days from the receipt of the notice of the decision of the Second Level Review Committee to appeal the decision to the Department of Health or the Pennsylvania Insurance Department, as appropriate depending on the nature of the dispute. The appeal shall be in writing unless the Member requests to file the appeal in an alternative format.

Appeals may be filed at the following addresses:

Pennsylvania Insurance Department
Bureau of Consumer Services
1321 Strawberry Square
Harrisburg, PA 17120

Department of Health
Bureau of Managed Care
Room 912, Health & Welfare Bldg.
Harrisburg, PA 17120
717-787-5193, Toll Free 888-466-2787
Fax 717-705-0947
PA AT&T relay service 800-654-5984

All records from the initial review and the second level review shall be forwarded to the Department of Health or the Pennsylvania Insurance Department, as appropriate. The Member, the vision care Provider or Davis Vision, may submit additional material related to the complaint. Each shall provide to the other, copies of additional documents provided. The Member may be represented by an attorney or other individual before the appropriate Department.

2. Grievance Process

a. Internal Grievance Process

Davis Vision maintains an internal grievance process by which a Member, the Member's designated representative or a vision care Provider, with the written consent of the Member, shall be able to file a grievance regarding the denial of payment for a vision care service on the basis of Medical Necessity and Appropriateness.

A grievance may be filed regarding a decision that:

(a) Disapproves full or partial payment for a requested vision care service;

(b) Approves the provision of a requested vision care service for a lesser scope or duration than requested; or
(c) Disapproves payment for the provision of a requested vision care service but approves payment for the provision of an alternative vision care service. A grievance does not include a complaint.

Members have the right to have grievances internally reviewed through the two (2) level process described in this Internal Grievance Process.

Members must exhaust this two (2) level appeal process before seeking further review of a grievance by an independent external review organization assigned by the Department of Health. Except in the case of a Second Level Review involving the denial of a Pre-service Claim, the entire two (2) level process described below is mandatory and must be exhausted before a Member is permitted to institute such action at law or in equity in a court of competent jurisdiction as may be appropriate.

Vision Care Provider Initiated Grievances

A vision care Provider may, with the written consent of an enrollee or the enrollee's legal representative, file a written grievance. This consent may be obtained by the Provider at the time of treatment. However, the Provider may not require this consent as a condition of providing a health care service. Written consent must include:

- Name and address of the Member and the Policy Holder, if they are different, the Member's date of birth and identification number.
- If the Member is a minor or is legally incompetent, the name, address and relationship to the Member of the person who signs the consent for the Member.
- The Provider's name, address and provider I.D. number as assigned by Davis Vision.
- Davis Vision's name and address, as the plan to which the grievance will be submitted.
- An explanation of the specific service for which coverage was provided or denied to the enrollee for which the consent will apply.
- The following statements:
    - The Member or the Member's representative may not submit a grievance concerning the services listed in this consent form unless the Member or the Member's legal representative rescinds this consent in writing. The Member or the Member's legal representative has the right to rescind consent at any time during the grievance process.
    - The consent of the Member or the Member's legal representative shall be automatically rescinded if the Provider fails to file a

grievance or fails to continue to prosecute the grievance through the second level review process.

- The Member or the Member's legal representative, if the Member is a minor or is legally incompetent, has read, or has been read, this consent form and has had it explained to his/her satisfaction. The Member or the Member's legal representative understands the information in the consent form.

- The dated signature of the Member or the Member's legal representative and the dated signature of a witness.

The Member or the Member's legal representative may rescind consent to a vision care Provider to file a grievance on behalf of the Member at any time during the grievance process. If the Member or the Member's legal representative rescinds consent, the Member or the Member's legal representative may continue with the grievance at the point at which consent was rescinded. The Member or the Member's legal representative may not file a separate grievance. A Member or the Member's legal representative who has filed a grievance may, at any time during the grievance process, choose to provide consent to a vision care Provider to continue with the grievance instead of the Member or the Member's legal representative.

The Provider having obtained consent from the Member or the Member's legal representative to file a grievance, shall have ten (10) days from receipt of the initial, standard written adverse determination and any decision notification letter from a first, second or external review upholding Davis Vision's decision to notify the Member or the Member's legal representative of its intention not to pursue a grievance.

Once the Provider has assumed responsibility for filing a grievance, he/she may not bill the Member or the Member's representative for services provided that are the subject of the grievance until the external grievance review has been completed or the Member or the Member's legal representative rescinds consent for the Provider to pursue the grievance. If the Provider chooses never to bill the Member or the Member's representative for the services provided that are the subject of the grievance, the Provider may withdraw the grievance with notice to the Member and the Member's representative. If the Provider elects to appeal the adverse decision of an external review agent to a court of competent jurisdiction, he/she may not may not bill the Member or the Member's representative for services provided that are the subject of the grievance until a final decision is rendered or the Provider withdraws the appeal.

i. Initial Review

NOTE: Davis Vision will provide an expedited review if written certification is received from the Member's physician.

The Member's initial grievance must be submitted in writing (or communicated orally under special circumstances) within one hundred-eighty (180) days from the Member's receipt of the notification of an adverse decision or occurrence of the issue which is the subject of the grievance and shall be directed to the Quality Assurance Department.

Within five (5) business days of receipt of the grievance, Davis Vision will provide written confirmation to the Member, the Member's designated representative and the vision care Provider including, but not limited to, the following information:

- That the request has been received
- That Davis Vision has classified it as a grievance for purposes of internal review. If the Member disagrees with Davis Vision's classification of a request for an internal review, he/she may directly contact the Department of Health for consideration and intervention with Davis Vision in regards to the classification that has been made.
- That the Member, the Member's designated representative or the vision care Provider may request the aid of a Davis Vision employee, at no charge, in preparing the grievance
- That the Member, the Member's designated representative or vision care Provider, upon request to Davis Vision, may review documents, records and other information relevant to the grievance and shall have the right to submit any written comments, documents, records, information, data or other material in support of the grievance.

The initial level grievance review will be performed by an Initial Review Committee which shall include one (1) or more individuals selected by Davis Vision at least one (1) of whom is a licensed Physician in the same or similar specialty as that which would typically manage or consult on the health care service in question. The members of the Committee shall not have been involved or be the subordinate of any individual that was involved in any previous decision relating to the Member's grievance. The Member or the vision care Provider may specify the remedy or corrective action being sought.

In rendering a decision on the grievance, the Initial Review Committee will take into account all comments, records and other information submitted by the Member without regard to whether such information was previously submitted to or considered by Davis Vision. The Initial Review Committee will afford no deference to any prior adverse decision on the Claim which is the subject of the grievance.

Each grievance will be promptly evaluated and a decision rendered within the following time frames:

When the grievance involves a non-urgent care Pre-service Claim, within a reasonable period of time appropriate to the medical circumstances not to exceed thirty (30) days following receipt of the grievance; or
When the grievance involves a Post-service Claim, within a reasonable period of time not to exceed thirty (30) days following receipt of the grievance.

Davis Vision will provide written notification to the Member, the Member's designated representative and/or the health care provider of its decision (upheld or overturned) within five (5) business days of the decision, not to exceed thirty (30) days from Davis Vision's receipt of the Member's grievance. All notifications shall include, among other items, the specific reason or reasons for the decision including clinical rationale, the procedure for appealing the decision, a statement that the member may appeal the decision within 45 days from date of notification and, in the case of a grievance involving the denial of a Pre-service Claim, a statement regarding the right of the Member to pursue legal action.

ii. Second Level Review

If the Member is dissatisfied with the decision (upheld or overturned) following the initial review of his/her grievance, including a non-urgent care Pre-service Claim or Post-service Claim grievance, he/she may request to have the decision reviewed by a Second Level Review Committee. The request to have the decision reviewed by the Second Level Review Committee must be submitted in writing (or communicated orally under special circumstances) within forty-five (45) days from the date an adverse decision is received and may include any written information from the Member or healthcare Provider.

Within five (5) business days of receipt of the request for second level review, Davis Vision will provide written confirmation to the Member, the Member's designated representative and/or the vision care Provider including, but not limited to, the following information:

- That the request has been received
- An explanation of the second level review process
- That the Member, the Member's designated representative or the vision care Provider may request the aid of a Davis Vision employee, who did not participate in the previous decisions to

deny coverage for the issue in dispute, at no charge, in preparing the Member's second level complaint

- That the Member, the Member's designated representative or vision care Provider, upon request to Davis Vision, may review documents, records and other information relevant to the grievance and shall have the right to submit any written comments, documents, records, information, data or other material in support of the grievance.
- That the Member and the Member's designated representative have the right to appear before the Second Level Review Committee and that Davis Vision will provide the Member and the Member's representative with 15 days advance written notice of the time scheduled for that review.

The Second Level Review Committee shall be comprised of three (3) individuals who were not involved or the subordinate of any individual that was previously involved in the matter under review. At least one (1) individual of the committee will not be an employee of Davis Vision or of any Davis Vision related subsidiary or affiliate. The Committee will include a licensed Physician in the same or similar specialty as that which would typically manage or consult on the health care service in question. When arranging the hearing, Davis Vision will notify the Member, the Member's designated representative and/or the health care provider in writing of the hearing procedures and rights at such hearing, including the right of the member to be present at the review. If a member cannot appear in person at the second level review, Davis Vision shall provide the member the opportunity to communicate with the Committee by telephone or other appropriate means.

Attendance at the second level review will be limited to members of the review committee; the Member or the Member's representatives, including any legal representative or attendant necessary for the Member to participate in or understand the proceedings, or both; the Member's provider if the Member consents to the provider being present; applicable witnesses; and appropriate representatives of Davis Vision. Persons attending the second level review and their respective roles at the review will be identified for the enrollee. The second level review will be informal and impartial to avoid intimidating the Member or the Member's representative. The committee members will not discuss the case to be reviewed prior to the second level review meeting. Committee members who are unable to attend the review meeting may vote if they actively participate in the review meeting by telephone or videoconference. If additional information is introduced at the review meeting, it will be provided to committee members participating by telephone or videoconference for review prior to the

vote. Depending on the issue under review, Davis Vision may provide an attorney to represent the interests of the committee and to ensure the fundamental fairness of the review and that all disputed issues are adequately addressed. The attorney representing the committee will not argue the Davis Vision's position or represent Davis Vision or its staff. The committee may question the enrollee, the enrollee's representative and Davis Vision employees representing the plan's position. The committee will base its decision solely upon the materials and testimony presented at the review meeting. The committee will not base its decision upon any document obtained on behalf of Davis Vision which sets out medical policies, standards or opinions or specifies opinions supporting Davis Vision's decision unless the plan also makes available for questioning by the review committee and/or the Member an individual, selected by Davis Vision, who is familiar with the policies, standards and opinions contained in the document. The proceedings of the second level review committee, including the comments of the Member or the Member's representative, will be recorded electronically and maintained as part of the complaint record.

The hearing will be held and a decision will be made within thirty (30) days of Davis Vision's receipt of the Member's request for review. This applies to both the voluntary second level review of a non-urgent care Pre-service Claim grievance and the mandatory second level review of a Post-service Claim grievance.

Davis Vision will provide written notification to the Member, the Member's designated representative and/or the health care provider of its decision (upheld or overturned) within five (5) business days of the decision, not to exceed thirty (30) days from Davis Vision's receipt of the Member's request for review. All notifications shall include, among other items, the specific reason or reasons for the decision including clinical rationale, the procedure and timeframes for requesting an external grievance review and, in the case of a grievance involving the denial of a Post-service Claim, a statement regarding the right of the Member to pursue legal action.

iii. External Grievance Process

A Member, the Member's designated representative or a vision care Provider, with the written consent of the Member, may request an external review of a denial of a second level grievance within fifteen (15) days from the receipt of the notification of the decision of the Second Level Review Committee. The appeal can be filed by submitting a request for an external grievance to Davis Vision. The Member should include any material justification and all reasonably

necessary supporting information as part of the external grievance filing.

Within five (5) business days of receiving the external grievance, Davis Vision will notify the Department of Health, the Member, the Member's designated representative or the healthcare Provider, as appropriate, that a request for an external grievance review has been filed. Davis Vision's notification to the Department of Health shall include a request for assignment of a Certified Utilization Review Entity (CRE). Davis Vision shall forward copies of all written documentation regarding the denial, including the decision, all reasonably necessary supporting information, a summary of applicable issues and the basis and clinical rationale for the decision to the CRE conducting the external grievance within fifteen (15) days of the receipt of notice that the external grievance was filed. Within this same period, Davis Vision shall provide the Member, the Member's designated representative or the vision care Provider with a list of documents forwarded to the CRE for the external review. The Member, the Member's designated representative or the vision care Provider may supply additional written information, with copies to Davis Vision, to the CRE for consideration on the external review within fifteen (15) days of receipt of notice that the external grievance was filed.

The external grievance process will be conducted by a CRE selected by the Department of Health. The Department of Health will notify the Member or the vision care Provider, and Davis Vision of the name, address and telephone number of the CRE assigned within two (2) business days following receipt of the request for assignment. If the Department of Health fails to select a CRE within two (2) business days of receiving the request, Davis Vision has the right to designate and notify a CRE to conduct the external review. Each party has seven (7) business days from the date on the notice of assignment of the CRE to object orally or in writing to the Department based on conflict of interest. The objecting party may request the assignment of another CRE. Again, each party has seven (7) business days from the date on the notice of assignment of the CRT to object orally or in writing to the Department based on conflict of interest. The objecting party may request the assignment of another CRE. If either party objects to the second CRE assigned, the 60-day time period allowed for the CRE's review will be calculated from the date on which the CRE is accepted by both parties. The CRE conducting the external grievance shall review all the information considered in reaching any prior decisions to deny payment for the vision care service and any other written submission by the Member or the vision care Provider.

Within sixty (60) days of the filing of the external grievance, the CRE conducting the external grievance shall issue a written notification of the decision to the Department, Davis Vision, the Member, the Member's representative or the vision care Provider, including the basis and clinical rationale for the decision.

The external grievance decision may be appealed to a court of competent jurisdiction within sixty (60) days of receipt of the notification of the external grievance decision. Davis Vision shall authorize any vision care service or pay a claim determined to be Medically Necessary and Appropriate based on the decision of the CRE regardless of whether an appeal to a court of competent jurisdiction has been filed.

iv. Expedited Review Process

Davis Vision maintains an Expedited Review Process that is available to Members if the Member's life, health or ability to regain maximum function would be placed in jeopardy by delay occasioned by the Standard Review Process.

The Member, the member's representative or a vision care Provider, with the written consent of the Member, may request an Expedited Review at any stage of the review process by providing Davis Vision with written certification from the Member's physician that the Member's life, health or ability to regain maximum function would be placed in jeopardy by delay occasioned by the Standard Review Process. The certification shall include a clinical rationale and facts to support the physician's opinion. Davis Vision will accept the physician's certification and provide an Expedited Review.

Upon receipt of the request for an Expedited Review accompanied by written certification from the Member's physician, Davis Vision will contact the member by telephone within 12 hours to:

- Acknowledge receipt of the request for an Expedited Review
- Advise the Member of his/her right to participate in the Expedited Review
- Determine whether the Member wishes to participate in the Expedited Review by telephone conference call
- Advise the Member of the proposed time and date of the review. (Adjustments in the time and date of the review may be made to reasonably accommodate the member's participation.)

Attendance at the expedited review will be limited to members of the review committee; the Member or the Member's representatives, including any legal representative or attendant necessary for the

Member to participate in or understand the proceedings, or both; the Member's provider if the Member consents to the provider being present; applicable witnesses; and appropriate representatives of Davis Vision. Persons attending the expedited review and their respective roles at the review will be identified for the enrollee. The expedited review will be informal and impartial to avoid intimidating the Member or the Member's representative. The committee members will not discuss the case to be reviewed prior to the expedited review meeting. If additional information is introduced at the review meeting, it will be provided to committee members participating by telephone for review prior to the vote. Depending on the issue under review, Davis Vision may provide an attorney to represent the interests of the committee and to ensure the fundamental fairness of the review and that all disputed issues are adequately addressed. The attorney representing the committee will not argue the Davis Vision's position or represent Davis Vision or its staff. The committee may question the enrollee, the enrollee's representative and Davis Vision employees representing the plan's position. The committee will base its decision solely upon the materials and testimony presented at the review meeting. The committee will not base its decision upon any document obtained on behalf of Davis Vision which sets out medical policies, standards or opinions or specifies opinions supporting Davis Vision's decision unless the plan also makes available for questioning by the review committee and/or the Member an individual, selected by Davis Vision, who is familiar with the policies, standards and opinions contained in the document. The proceedings of the expedited review committee, including the comments of the Member or the Member's representative, will be recorded electronically and maintained as part of the complaint record.

The hearing will be held and a decision will be issued within 48 hours of receipt of the Member's request for an Expedited Review accompanied by written certification from the Member's physician. Notification to the Member shall state the basis for the decision, including any clinical rationale and the procedure for obtaining an Expedited External Review. Within 24 hours of receipt of a Member's request for an Expedited External Review, Davis Vision shall submit a request for an Expedited External Review to the Department by fax and telephone.

When the Department has assigned a CRE, Davis Vision will transfer a copy of the case file to the CRE for receipt on the next business day and the CRE shall have 2 business days to issue a decision.

SECTION XIV
TEXAS ADDENDUM

*This Addendum is applicable to providers in the State of Texas with whom Davis Vision has contracted to provide routine vision benefits to members covered through a managed care organization operating in the State of Texas. Depending on the contractual relationship with the Texas managed care organization, Davis Vision may or may not be delegated for member complaints and appeals. Please contact Davis Vision Provider Services at **1-800-933-9371** for specific member and delegation information*

The following requirements and processes supersede those in the Davis Vision Provider Manual.

- Claims must be filed not later than the 95th day after services are rendered for both contracted and out-of-network providers. The provider forfeits the right to payment if the claim is not filed in 95 days, unless failure to comply is the result of a catastrophic event.
- A physician or provider may not submit a duplicate claim before the 46th day for paper-filed claims or before the 31st day for electronically-filed claims after the original submission.
- Providers must notify Davis Vision of a claim underpayment within 270 days of the date of partial payment.
- In accordance with Title 28 of the Texas Administrative Code Section 19.1724, Davis Vision is required to offer Davis Vision contracted providers in Texas the option to submit a "verification" as defined as follows: "A guarantee that an HMO (or HMO's delegate) or preferred provider carrier will pay for proposed medical care or health care services rendered within the required timeframe to the patient for whom the services are proposed."

  Please call the Davis Vision Interactive Voice Response (IVR) System at **1-800-77DAVIS** and follow the prompts to reach the Verification prompt. Provide the following data elements for all verifications:
  - Patient name
  - Member ID number
  - Patient date of birth
  - Name of member
  - Patient's relationship to the member
  - Diagnosis code
  - Proposed procedures or materials
  - Place of service
  - Proposed date of service
  - Group code (Davis Vision group code or prefix code)
  - Other carrier information – if available

- Provider name and Davis Vision Provider Number

SECTION XV
VIRGINIA ADDENDUM

This Addendum is applicable to providers in the State of Virginia with whom Davis Vision has contracted to provide routine vision benefits to members covered through a managed care organization operating in the State of Virginia.

The following requirements and processes supersede those in the Davis Vision Provider Manual.

VIRGINIA MANAGED CARE
MEMBER COMPLAINT AND APPEALS PROCESS

DEFINITIONS (per Code of Virginia §32.1-137.7 and 12VAC5-408.10)

"Adverse Decision" means a utilization review determination by the utilization review entity that a health service rendered, or proposed to be rendered, was or is not *medically necessary*, when such determination may result in non-coverage of the health service or health services.

"Appeal" means a formal request by a *covered person* or a provider on behalf of a covered person or reconsideration of a decision, such as a final *adverse decision*, a benefit payment, a denial of coverage, or a reimbursement for service.

"Commission" means the Virginia State Corporation Commission.

"Complaint" means a written communication from a *covered person* primarily expressing a grievance. A complaint may pertain to the availability, delivery, or quality of health care services including claims payments, the handling or reimbursement for such services, or any other matter pertaining to the *covered person's* contractual relationship with the managed care health insurance plan

"Covered Person" means a subscriber, policyholder, member, enrollee or dependent, as the case may be, under a policy or contract issued or issued for delivery in Virginia by a managed care health insurance plan licensee, insurer, health services plan, or preferred provider organization.

"Emergency Medical Condition" is defined as the sudden and, at the time, unexpected onset of a health condition or illness that requires immediate medical attention, the absence of which would result in a serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the *covered person's* health in serious jeopardy. It also involves a health condition or illness that, if not treated within

the time frame allotted for a standard review, would result in a serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the covered person's health in serious jeopardy.

"Final Adverse Decision" means a *utilization review* determination made by a physician advisor or peer of the *treating health care provider* in reconsideration of an *adverse decision*, and upon which a provider or patient may base an *appeal*.

"Medical necessity" or "medically necessary" means appropriate and necessary health care services which are rendered for any condition which, according to generally accepted principles of good medical practice, requires the diagnosis or direct care and treatment of an illness, injury, or pregnancy-related condition, and are not provided only as a convenience.

"Treating Health Care Provider" or "Provider" means a licensed health care provider who renders or proposes to render health care services to a *covered person*.

"Utilization Review" means a system for reviewing the necessity, appropriateness and efficiency of hospital, medical or other health care services rendered or proposed to be rendered to a patient or group of patients for the purpose of determining whether such services should be covered or provided by an insurer, health services plan, managed care health insurance plan licensee, or other entity or person.

"Utilization Review Entity" or "Entity" means a person or entity performing utilization review.

MEDICAL NECESSITY DETERMINATION

Davis Vision contracted providers who identify a need for services requiring a medical necessity determination complete and fax a Prior Approval Form to Davis Vision including, but not limited to, the patient's identification number, the patient's name, diagnosis, requested service or procedure and justification. A Utilization Review Associate reviews the request for completeness. If additional information is required to make the determination, the Utilization Review Associate notifies the provider verbally and/or in writing.

A licensed clinician reviews the request and all supporting documentation. With the exception of retrospective reviews, Davis Vision makes a reasonable attempt to communicate an initial adverse recommendation to the health care provider prior to the issuance of an adverse decision. Davis Vision shall accept additional information from the health care provider by telephone, fax machine or otherwise, prior to the issuance of an adverse determination.

A licensed clinician makes a determination no later than two (2) business days after receipt of all information necessary to complete the review. Davis Vision provides notice of determination to the member, the member's representative and the health care provider

by telephone and in writing as fast as the member's condition requires and within two (2) business days from receipt of necessary information. Notification of adverse determinations includes instructions for the health care provider to seek reconsideration of the adverse determination including the name, address and phone number of the person responsible for making the adverse determination. Notification also includes the criteria relied upon for the decision, the clinical reason for the adverse decision, a statement advising the covered person of his/her right to pursue an appeal and a description of the appeal process including, but not limited to, time limits, addresses and telephone and fax numbers.

INFORMAL RECONSIDERATION

Reconsideration of any adverse decision may be requested by the provider on behalf of the covered person. A decision on reconsideration shall be made by a licensed clinician. Davis Vision shall notify the treating provider on behalf of the covered person of the reconsideration determination in writing within ten (10) business days of receipt of the request for reconsideration. Notification of the final adverse determination shall include, but is not limited to, the criteria used, the clinical reason for the adverse decision and the opportunity for an appeal.

EXPEDITED APPEAL

If the treating provider determines that the regular appeals process would delay the rendering of health care in a manner that would be detrimental to the health of the patient, Davis Vision shall handle the appeal on an expedited basis. An expedited appeal decision may be further appealed through the standard appeal process unless all material information and documentation were reasonably available to the provider and Davis Vision at the time of the expedited appeal and the reviewer was a peer of the patient's provider.

Expedited appeals are conducted by a clinical peer reviewer other than the clinical peer reviewer who rendered the initial adverse determination. The decision on an expedited appeal shall be made no later than one (1) business day after receipt of all necessary information.

If the review of an expedited appeal results in an adverse determination, Davis Vision shall take the following actions immediately:

- Notify the member, the member's representative and the provider of the decision by telephone, facsimile or electronic mail
- Notify the member that he/she has the right to file a request for an expedited appeal with the Bureau of Insurance.
- Follow-up the above notification within 24 hours with a written notice to the member and the treating provider informing them of the right to appeal the decision to the Bureau of Insurance and providing them with the appropriate forms for filing the appeal.

APPEAL OF FINAL ADVERSE DETERMINATION

Davis Vision maintains an appeals process, including a process for expedited appeals, to review any final adverse decision. The covered person, the covered person's representative or a health care provider acting on the covered person's behalf may request an appeal within 180 calendar days after receipt by the covered person of the initial adverse determination.

Appeals may be made in writing, or by telephone, to Davis Vision as follows:

Davis Vision, Inc.
Quality Assurance Department
P.O. Box 791
Latham, NY 12110
Telephone: 1-888-377-0914
TTY/TDD: 1-800-523-2847
Fax: 1-888-343-3475
Email: www.davisvision.com

Davis Vision provides written acknowledgment of the filing of the appeal to the covered person, the covered person's representative and/or the health care provider within fifteen (15) business days after receipt of the appeal.

Appeals are conducted by a clinical peer reviewer other than the clinical peer reviewer who rendered the initial adverse determination. Davis Vision makes appeal determinations and provides written notification to the covered person, the covered person's representative and/or the health care provider as fast as the member's condition requires and within 60 calendar days of receipt of required documentation.

The written decision includes the criteria used and the clinical reason for the decision. If the appeal process results in an adverse determination, the notification includes a clear and understandable description of the covered person's right to appeal final adverse decisions to the Bureau of Insurance, procedures for making such an appeal, and the binding nature and effect of such an appeal.

No covered person who exercises the right to file an appeal shall be subject to disenrollment or otherwise penalized due to the filing of an appeal.

REGISTERING A COMPLAINT OR GRIEVANCE

Davis Vision maintains a system for the resolution of complaints brought by covered persons, or by providers acting on behalf of a covered person and with the covered person's consent, including complaints regarding availability, delivery or quality of

health care services, or any other matter pertaining to the covered person's contractual relationship with the managed care health insurance plan licensee.

Complaints may be made in writing, or by telephone, to Davis Vision as follows:

Davis Vision, Inc.
Quality Assurance Department
P.O. Box 791
Latham, NY 12110
Toll free Telephone: 1-800-584-1487
TTY/TDD: 1-800-523-2847
Fax: 1-888-343-3475
Email: www.davisvision.com

Davis Vision's toll free number, **1-800-584-1487**, is available 24 hours a day, 7 days a week, for covered persons or providers to voice complaints and concerns. A Davis Vision Associate will attempt to resolve verbal complaints or concerns at time of the initial telephone call. Unresolved complaints or concerns are referred to the Quality Assurance Department where they are documented. At any time, a complainant may request that a formal complaint be registered.

Timelines for responding to complaints shall accommodate clinical urgency and shall not exceed 30 calendar days from receipt of the complaint. Resolution of complaints shall not exceed 60 calendar days from date of receipt of the complaint.

No covered person who exercises the right to file a complaint shall be subject to disenrollment or otherwise penalized due to the filing of a complaint.

ASSISTANCE WITH APPEALS AND COMPLAINTS

Covered persons may contact the Office of the Managed Care Ombudsman at the following address and telephone number to help with appeals and complaints:

Office of the Managed Care Ombudsman
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218
Toll free Telephone: 1-877-310-6560
Richmond Metropolitan Area: 804-371-9032
TDD/Voice: 804-371-9206
Fax: 804-371-9944
E-mail: ombudsman@scc.virginia.gov

EXTERNAL APPEALS - The Virginia Bureau of Insurance

The Virginia Bureau of Insurance maintains an External Appeal process to review final adverse determinations made on the basis of medical necessity or

experimental/investigational procedures. A covered person or a provider acting on behalf of a covered person ("appellant") may appeal to the Bureau of Insurance ("Bureau") for review of any final adverse decision which meets the following criteria:

- The covered person must be covered by an eligible insurance plan, which disqualifies self-funded ERISA plans, Medicare and Medicaid. Also, persons covered by federal employee health plans are not eligible to file appeals for External Review with the Bureau.
- The covered person must have exhausted all internal appeals available through the managed care health insurance plan.
- The covered person must have been denied coverage because it was determined the care was not medically necessary or involved experimental or investigative procedures.
- The covered person must file for an External Review within 30 days of the final decision to deny coverage.
- The covered person's claim must exceed $300.00. There is a $50.00 filing fee with any appeal. This fee may be waived based on financial hardship.

An appellant may request an Expedited External Review for situations involving an emergency medical condition. The Bureau shall make a determination as to whether an expedited review is warranted. If an expedited review is denied, the appellant shall be advised to use the managed care health insurance plan's internal appeal process.

If the External Appeal is accepted, the Bureau shall ask an independent healthcare review organization that is not affiliated with the covered person's managed care health insurance plan to conduct a review of the appeal. The review organization shall obtain medical information pertinent to the appeal from the covered person, the health care provider and the managed care health insurance plan. The review organization shall make a written recommendation to the Commissioner of Insurance who shall review the recommendation to ensure that it is not arbitrary or capricious. The Commissioner shall then issue a written ruling that will uphold, reverse or modify the decision made by the managed care health insurance plan. That ruling is binding and cannot be appealed.

SECTION XVI
APPENDIX

Anti Reflective Coating Formulary

Approved Frame Manufacturers

Contact Lens Collection

Duty to Warn/Patient Rejection and Waiver Form

Lab Shipback Forms

Medical Record Review Tool

Prior Approval/Medically Necessary Services Request Form

Progressive Addition (PAL) and Intermediate Lens Formulary

Proivder Claim Payment Appeal Policy

Provider Office Review Tool

Provider Procedure and Option Codes

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Anti-Reflective Coating (ARC)

The 3 categories are Standard, Premium, and Ultra. Standard being the lowest copayment, Premium next, then Ultra being at the highest copayment. The patient charge, provider reimbursement, or additional dispensing fee (surfee) for any of the category differs and is indicated on the group specified Service Record Form or Personalized Service Record Form, and the plan outline.

The table below indicates the various AR coatings included in each category. *Please note: Not all AR coatings are available on all lens style / material combinations".*

STANDARD ARC

Standard AEGIS
Carl Zeiss BLUE (Super) ET®
Carl Zeiss GOLD ET®
Essilor REFLECTION FREE®

PREMIUM ARC

Essilor CRIZAL™
Carl Zeiss CARAT BLUE®
Carl Zeiss CARAT GOLD®

ULTRA ARC

Essilor CRIZAL SUN™
Crizal AVANCE™ with Scotchgard™
Carl Zeiss CARAT ADVANTAGE BLUE®
Carl Zeiss CARAT ADVANTAGE GOLD®
Carl Zeiss TEFLON®

These Formularies are subject to change at any time. Please visit the Davis Vision website at www.davisvision.com for the current Formularies.

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Approved Frame Manufacturers

(Please select up to a $49.00 Wholesale cost)
(Special fit circumstances up to $40.00 Wholesale cost)

A & A Optical	**I Deal Optics**	**Safilo**
Artcarft	**Kenmark**	**Signature Eyewear**
Aspex	**L'Amy**	**Silhouette**
Avalon	**Liberty**	**Silver Dollar**
B. Robinson/Magazine	**Lido West**	**Smilen**
Britalia	**Limited Edition**	**TMS Titmus (Sperian)**
Cadillac Eyewear	**Luxottica**	**Tura**
Capri	**Marchon**	**Value Eyewear**
Charmont	**Marcolin**	**Viva**
Clear Vision	**Mcgee Group**	**Windson Eye**
Colors in Optics	**Modern Optical**	**Zimco**
Contienental	**Neo Style**	**Zyloware**
Eastern States	**New Millenium**	
Europa	**Nouveau**	
Eyedeals	**On-Guard Safety**	
Eyewear Designs	**Optimate**	
Eye Q Eyewear	**Optio vision**	
Hart Specialties	**REM Eyewear**	
Hilico	**Revolution**	

Davis Vision can special order any of the above frame selections.

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CONTACT LENS COLLECTION

Type	Lens	Manufacturer
D	Soflens 38 (6 Pk)	Bausch & Lomb®
D	Clear Site (1-Day 30 Pack)	Cooper/OSI
D	Focus Dailies - 30 Pk	CIBA Vision®
D	O2 Optix	CIBA Vision®
D	Cooper Clear FW	Cooper/OSI
D	Biomedics XC (Silicon Hydrogel)	Cooper/OSI
D	Encore Premium	Cooper/OSI
D	Acuvue	Johnson & Johnson
D	Acuvue 2	Johnson & Johnson
D	Acuvue Advance	Johnson & Johnson
D	1-Day Acuvue	Johnson & Johnson
D	Biomedics 38	Cooper/OSI
D	Biomedics 55	Cooper/OSI
D	Freshlook LT	CIBA Vision®
PR	Purevision (Silicon Hydrogel)	Bausch & Lomb®
PR	Proclear Compatibles	Cooper/OSI
PR	Frequency 38	Cooper/OSI
PR	Frequency 55	Cooper/OSI

The above list may be updated from time to time without prior notice. Please check your plan materials (provider outline and service record form) for specific benefit and copayment information (as certain contact lenses may be available with a copayment and that copayment may vary by lens type based on plan design) and for the dispensing amount.

KEY: D - Disposable PR - Planned Replacement

These Collections are subject to change at any time. Please visit the Davis Vision website at www.davisvision.com for the current Formularies.

Duty to Warn / Patient Rejection and Waiver Form

Proper selection and use of eyewear is critical to your eye safety. If your occupational, sports, or other activities expose you to the risk of flying objects or physical impact, you eye safety may require the use of special spectacle lens materials. For tasks which require impact protection, polycarbonate lenses should be used. Of all materials that spectacle lenses may be fabricated from, polycarbonate lenses are the most impact resistant.

I understand that my doctor / dispenser has recommended polycarbonate lenses for my visual safety and protection. I hereby acknowledge that I have voluntarily, and with full knowledge of the possible consequences of my selection, decided to utilize an alternative material for my eyewear. I am ordering lenses made of

[ ] CR39 Plastic
[ ] Glass
[ ] High Index Plastic

Polycarbonate lenses were recommended by doctor / dispenser for the following reason(s):

_____

_____

_____

_____

_____ _____

Patient Signature *Date*

_____

Signature of Parent/Guardian (if applicable)

_____

Signature of Witness

Fax completed form to:
Davis Vision Lab Research / Redo Team
Fax Number: 1-800-240-4413

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SHIP-BACK INFORMATION
TO ACCOMPANY ITEMS SENT TO LABORATORY

520 AIRPORT ROAD
SUITE A-5
ALBUQUERQUE, NM 87121
(FAX) 1-505-833-3520

170 EXPRESS STREET
PLAINVIEW NY 11803
1-800-888-4321
(FAX) 1-800-933-9375

3805 WEST CHESTER PIKE
BUILDING D, SUITE 150
NEWTOWN SQUARE, PA
19073
1-800-836-2082
(FAX) 215-937-0649

5555 BADURA AVE STE. 160
LAS VEGAS, NV 89118
1-800-393-7919
(FAX) 1-702-270-7805

Todays Date:			
From:			
Patient:			

FOR NON-PLAN FRAME ORDERS

From:	MANUFACTURER	STYLE	SIZE
Reference:	DATE OF ORDER	INVOICE#	COLOR

FOR EYEGLASS RETURNS

ORIGINAL ORDER DATE:	DATE OF ORDER	INVOICE#	
TYPE RETURNED (check one)	UNDISPENSED	DISPENSED	WARRANTY

DETAILS: PLEASE DESCRIBE REASONS FOR RETURN OF EYEWEAR BELOW:

(FOR LABORATORY USE ONLY)

LSF20101215

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SHIP-BACK INFORMATION
TO ACCOMPANY ITEMS SENT TO LABORATORY

520 AIRPORT ROAD
SUITE A-5
ALBUQUERQUE, NM 87121
(FAX) 1-505-833-3520

170 EXPRESS STREET
PLAINVIEW NY 11803
1-800-888-4321
(FAX) 1-800-933-9375

3805 WEST CHESTER PIKE
BUILDING D, SUITE 150
NEWTOWN SQUARE, PA
19073
1-800-836-2082
(FAX) 215-937-0649

5555 BADURA AVE STE. 160
LAS VEGAS, NV 89118
1-800-393-7919
(FAX) 1-702-270-7805

Todays Date:
From:
Patient:
FOR NON-PLAN FRAME ORDERS
From: MANUFACTURER STYLE SIZE
Reference: DATE OF ORDER INVOICE# COLOR
FOR EYEGLASS RETURNS
ORIGINAL ORDER DATE: DATE OF ORDER INVOICE#
TYPE RETURNED (check one) UNDISPENSED DISPENSED WARRANTY
DETAILS: PLEASE DESCRIBE REASONS FOR RETURN OF EYEWEAR BELOW:
(FOR LABORATORY USE ONLY)
LSF20101215

Provider Name: **Provider Number:** **DATE**

RQAR:

PRINT NAME

	I Demographics (8)			II Case History (14)				III Habitual VA (4)		IV Eye Health (30)						V Refraction (20)					VI Binoc Function (8)				VII Assessment / Mgt (10)		VIII Other (6)		
Chart Identification	**Adult/Child/Special**	**Form (4)**	**Demographics (4)**	**CC (4)**	**EH (4)**	**MH (4)**	**FH (2)**	**Distance (2)**	**Near (2)**	**External (8)**	**Internal (8)**	**Visual Field (2)**	**Pupil (3)**	**Tonometry (4)**	**Dilation (5)**	**Objective (4)**	**Subjective (8)**	**Distance VA (2)**	**Near Refraction (4)**	**Near VA (2)**	**Ocular Motility (2)**	**NPC (2)**	**Near Phorias (2)**	**Distance Phorias (2)**	**Diagnosis/Assessment (5)**	**Education / Plan (5)**	**Dr. Signature (3)**	**Legibility (3)**	**TOTALS**
1.																													
2.																													
3.																													
4.																													
5.																													
6.																													
7.																													
8.																													
9.																													
10.																													
Numerical Totals	**X**																												**XXXXX**
Numerical average	**X**																												

Observations & Comments:

ADD SEPARATE SHEET FOR ADDITIONAL COMMENTS:

For Office Use Only:

Site Visit **I** **II** **III**

Record Review **I** **II** **III**

Auditors Signature

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Progressive Addition (PAL) and Intermediate Lens Formulary

In order to best support each practitioner's professional judgment in providing the ideal PAL design for an individual patient's needs, Davis Vision has implemented a 2-tier progressive lens formulary for most groups. Under this formulary, members may receive either Standard or Premium progressive lens designs. The patient charge for either category may differ and is indicated on the group specified Service Record Form or Personalized Service Record Form. A listing of all progressive lens designs in each category is represented in the following table:

STANDARD PROGRESSIVE STYLES

Short Corridor:

AO Compact
AO Compact Ultra
Armorlite Navigator Short
Vision Ease Outlook
Vision Ease Tegra Outlook

Traditional Corridor:

Armorlite Navigator
Essilor Adaptar
Essilor Natural
Hoya GPWide
Sola Instinctive
KbCo Fusion II
Sola VIP / VIP Gold
X-Cel Freedom ID
Younger Image

PREMIUM PROGRESSIVE STYLES

Short Corridor:

Armorlite Kodak Concise
Armorlite Kodak - Precise Short
Essilor Smallfit
Hoya Summit CD
Seiko Proceed III
Varilux Ellipse
Varilux Physio Short
Zeiss GT2 Short

Traditional Corridor:

AO Easy
Armorlite Kodak Precise
Essilor Accolade
Essilor Ovation
Hoya Summit ECP
Seiko Proceed II
Sola SolaMax
Sola SolaOne
Varilux Comfort (New Design)
Varilux Physio
Vision Ease Illumina
Zeiss GT2

INTERMEDIATE LENS STYLES

For task specific uses such as computer vision

AO Sola Access
Hoya Tact
Zeiss Gradal RD
Zeiss Business

Please note: If your patient cannot successfully adapt to progressive lenses within 60 days, standard bifocals will be remade without any cost to the member. However, co-payments or patient charges (if any) will not be refunded to the patient.

These formularies are subject to change at any time.

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Received by Davis Vision

PRIOR APPROVAL / MEDICALLY NECESSARY SERVICES REQUEST FORM

Submit To: Toll Free Fax 1-800-584-2329 Questions? Call: 1-800-328-4728 x6811

IMPORTANT: PLEASE VERIFY MEMBER BENEFIT PRIOR TO SUBMITTING REQUEST.

Patient Information

Patient Name (Please Print)		Member/Patient ID Number
Patient Date of Birth	New Patient Yes ☐ No ☐	Group/Employer Name

Provider Information

Provider Name (Please Print)	Provider Panel Number	Today's Date
Provider Telephone Number	Provider Fax Number	

Services Requested

Exam Only ☐	Contact Lens Evaluation ☐	Keratoconus ☐	Progressive Myopia ☐
Exam & Eyeglasses ☐	Contact Lenses ☐	Aphakia/Post Cataract ☐	Pathological Myopia ☐
Eyeglasses Only ☐	Low Vision Evaluation ☐	Anisometropia ☐	Diabetes ☐
Repair/Replace ☐	Low Vision Aids ☐		Other _____
	Additional Exam ☐		

Diagnosis/Reason for Services

Provider Comments **Supporting Documents Attached** ☐

Prescription Information **Fees (Information Required)**

Rx Eyeglasses	OD OS	VA OD VA OS	Professional Fee $_____
Contact Lenses	OD OS	VA OD VA OS	Material Fee $_____ Contact Lenses ☐ Low Vision Aids ☐ Eyeglasses ☐

BOTH OLD AND NEW PRESCRIPTION MUST BE COMPLETED BELOW FOR REQUESTS RELATED TO SIGNIFICANT CHANGES IN RX.

Old Rx	OD OS	**New Rx**	OD OS

FOR DAVIS VISION USE ONLY – DO NOT WRITE BELOW THIS AREA

Approved Date	Auth No./Benefit	Denied Date	Reviewed By: Signature
Comments:			
Additional Information Required		Date Requested	Date Received

PROVIDER CLAIM PAYMENT APPEAL POLICY

Davis Vision affords providers the opportunity to a written appeals process for disputes related to payment of claims, other than those based upon utilization management determinations. The appeals process requires direct communication between any provider and Davis Vision and does not require any action by the enrollee.

Providers have the right to file an appeal to any claim decision at any time. Davis Vision will not retaliate or take any discriminatory action against any provider as a result of filing a complaint, grievance or appeal.

The appeal process is intended to:

- provide a mechanism for all providers to dispute billing or payment concerns and to have those concerns addressed in a satisfying and timely manner.
- be easily accessible to providers
- provide prompt, fair and full investigation and resolution of appeals
- meet the criteria/requirements set forth by regulatory and accrediting bodies.

A written appeal from a participating or non-participating provider is considered a formal request for a review related to any adverse payment or billing determination rendered by Davis Vision.

An appeal can arise from and includes, but is not limited to, the dispute of claim issues such as reimbursement, timeliness and resubmission. In addition, providers may file an appeal regarding:

- obtaining a prompt authorization
- dissatisfaction with Davis Vision's policies and procedures
- lost of incomplete claim forms or electronic submissions
- requests for additional explanation as to services or treatment
- inappropriate or unapproved referrals initiated by any provider
- or any other reason for a billing dispute.

All claim appeals must be submitted in writing and received within 90 calendar days following receipt of the initial claim determination.

To file a claim appeal, a provider should mail all of the above-mentioned information to:

Davis Vision
Provider Appeals – Quality Assurance
P.O. Box 791
Latham, NY 12110

Appeal determinations, including written notification, shall be completed within thirty (30) calendar days from receipt of the request.

Providers Practicing in the State of New Jersey

A provider should submit all of the following information when filing an initial claim appeal and *must submit the appeal request on the appropriate appeal form created by the New Jersey Department of Banking and Insurance:*

- name and address of the Provider
- Professional Provider's Tax Payer Identification Number or an Institutional Provider's Medicaid Provider Number, as applicable
- the Member/Covered Person/s name
- the date(s) of service for the specific claim in question
- a letter or other writing, clearly denoted as a Provider Claim Determination Appeal, which includes a description regarding the claim in question
- a copy of any and all prior Explanation of Benefits forms or correspondence issued by Davis Vision supporting its Claims Payment Determination

- a copy of any and all documentation demonstrating proof of a claim submission
- the specific basis or rationale for the claim appeal
- the specific remedy or relief sought and if the amount due on the claim is questioned, the specific amount the provider believes is due and the basis, rationale and supporting documentation for such view.

Other documentation that supports the rationale for the claim appeal, if necessary, include:

- payment vouchers
- claim records
- prior correspondence
- print outs of electronic claims systems transactions
- any other documentation necessary to adequately support the rationale for the Claim Appeal

To file a claim appeal, a provider should mail all of the above-mentioned information to the address listed below.

Davis Vision
Provider Appeals – Quality Assurance
P.O. Box 791
Latham, NY 12110

Appeal determinations, including the written notification, shall be completed within thirty (30) calendar days from the receipt of the request.

The Department of Banking and Insurance has established a binding and non-appealable external ADR mechanism that involves arbitration, and in some cases, mediation, for providers who remain dissatisfied following their pursuit of an appeal through the initial claim appeals process. These mechanisms are described below:

Upon determination of the initial appeal, providers may appeal all adverse determinations through an independent, binding ADR process. Arbitration must be initiated on or before the 90th calendar day following receipt of the determination of an appeal. Disputes must be in the amount of $1000 or more. Providers and healthcare professionals must aggregate claims to reach the $1000 minimum under circumstances in which the same claim issue is involved.

Providers may initiate the above binding and non-appealable external ADR review of an adverse decision of a provider claim appeal after the initial appeal review, by filing a request for external ADR review, with the written findings from the initial appeal determination within ninety (90) calendar days from the date of the written decision to the following address:

Davis Vision
Provider Appeals – Quality Assurance
P.O. Box 791
Latham, NY 12110

All external ADR appeal requests must be submitted on the applicable appeal form created by the Department of Banking and Insurance. The ADR arbitrator is subject to change. Proceedings under such external ADR mechanism, including the method of selecting the mediator or arbitrator that will mediate or arbitrate the case shall be in accordance with the rules followed by the ADR organization.

The arbitrator's decision shall be issued on or before the 30th calendar day from receipt of the appeal form and all necessary documentation for the arbitrator to complete the review.

The decision of the independent arbitrator shall be binding and non-appealable. If the arbitrator results are made against the payer, the claim must be adjudicated with accrued interest at the rate of 12% per annum, on or before the tenth business day following the issuance of the arbitrator's determination.

Provider Office Review

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TOTAL SCORE:

Provider No. **Provider Name:** **Office Manager:** **Phone#:**

Address: **City:** **State:**

Initial Date: **RQAR:** **Follow-up Visit:** **QOC Visit:**

Practice Type: Solo: **Partnership:** **Group:** **Optical:** **Ophthalmology:**

Resources: Facilities/Personnel (35 Points)	Points	Score	Comments
Reception & Waiting Area:			
Adequate Space and Seating	3		
Cleanliness and Ventilation	2		
Handicap Access	1		
Examining Rooms:			
Adequate Space and Seating	3		
Cleanliness and Ventilation	2		
Hand Washing Facilities	1		
Privacy of Examination	2		
Dispensing Area:			
Adequate Space and Seating	3		
Cleanliness	2		
Location Davis Vision Tower	1		
Other Patient Care Exam Rooms:			
Contact Lens/Pre Testing	1		
Visual Fields/Vision Training	1		
Additional Testing/Laboratory	1		
Consultation Room	1		
Rest Rooms:			
Sanitary/Adequately Supplied	3		
Safety:			
Smoke Alarms/Extinguishers	1		
Exit Sign Clearly Visible	1		
Evacuation Plan	1		
Emergency Kit	1		
Personnel:			
Identifying Tag (Licensed Personnel)	1		
Appearances	2		
Licenses Displayed	1		

Provider Office Review

Equipment (40 Points)	Point	Score	Comments
Examination Chair	3		
Instrument Stand	2		
Projector Chart/Slides	2		
Near Point Cards	2		
Direct Ophthalmoscopy	2		
Binocular Indirect Ophthalmoscope	3		
Retinoscope/Auto	3		
Phoropter	2		
Tonometer/Type	2		
Trial Lens Set	2		
Lensometer	2		
Keratometer	2		
Biomicroscope	3		
Contact Lens Kit	2		
Visual Field	3		
Color Vision Test	2		
Imaging Instrumention HRT/GDX	1		
Other	2		
Infection Control (7 Points)			
Alcohol, Gel, Solution, Disinfection	2		
Drugs (Check Expiration dates)	2		
Contact Lens & Solutions (Check Expiration Date)	2		
Medications Adequately Stored	1		
Accessibility (5 Points)			
Wait Time (45 Minutes or Less)	1		
Exam Availability (at Least 12 hours per week)	1		
Patients Obtain Appointment within 2 Weeks	1		
Protocol Missed Appointment (Charts noted, Patient called)	1		
Emergency/After Hours Protocol (e.g. Answering Machine)	1		
Medical Records/Privacy (13 Points)			
Records Stored in a Secure and Confidential Area	2		
Patient Name or ID on Chart Pages	1		
Doctors' Name or ID on Chart Pages	1		
All Entries Dated	1		
Records Legible to Others	1		
Place to Document Allergies	1		
Place to Document Medications	1		
Place to Document Med/Eye History	1		
All Items Secured in Chart	1		
HIPAA Requirments Written Policy use/Disclousure of PHI	1		
Designated Compliance Office	1		
Cooperation of Office Personnel	1		

Davis Vision
Provider Procedure Codes

Procedure Code	Description
CL01	Contact Lens Evaluation
CL02	Contact Lens Evaluation; Fitting (New Patient)
CL03	Contact Lens Evaluation; Re-Fit (Existing Wearer)
CL04	Contact Lens Evaluation; Fitting Toric (New Patient)
CL05	Contact Lens Evaluation; Re-Fit Toric (Existing Wearer)
CL12	Daily Wear Contact Lens Fitting (New Wearer)
CL13	Daily Wear Contact Lens Re-Fitting (Existing Wearer)
CL14	Toric Daily Wear Contact Lens Fitting (New Wearer)
CL15	Toric Daily Wear Contact Lens Re-Fitting (Existing Wearer)
CL16	Disposable Contact Lens Fitting (New Wearer)
CL17	Disposable Contact Lens Re-Fitting (Existing Wearer)
CL18	Toric Disposable Contact Lens Fitting (New Wearer)
CL19	Toric Disposable Contact Lens Re-Fitting (Existing Wearer)
92310	Daily Wear Contact Lens Fitting
S0592	Extended Wear Contact Lens Fitting
001	Examination Only
002	Exam, Plan Single Vision Lenses, Plan Frame
003	Exam, Plan Single Vision Lenses, Practioners Frame
004	Exam, Plan Single Vision Lenses, Own Frame
005	Exam, Plan Bifocal Lenses, Plan Frame
006	Exam, Plan Bifocal Lenses, Practioners Frame
007	Exam, Plan Bifocal Lenses, Own Frame
008	Exam, Plan Trifocal Lenses, Plan Frame
009	Exam, Plan Trifocal Lenses, Practioners Frame
010	Exam, Plan Trifocal Lenses, Own Frame
011	Exam, Practioners Single Vision Lenses, Plan Frame
012	Exam, Practioners Bifocal Lenses, Plan Frame
013	Exam, Practioners Trifocal Lenses, Plan Frame
014	Exam, Practioners Aphakic Single Vision Lenses, Plan Frame
015	Exam, Practioners Aphakic Bifocal Lenses, Plan Frame
016	Exam, Practioners Single Vision Lenses, Practioners Frame
017	Exam, Practioners Bifocal Lenses, Practioners Frame
018	Exam, Practioners Trifocal Lenses, Practioners Frame
019	Exam, Practioners Aphakic Single Vision Lenses, Practioners Frame
020	Exam, Practioners Aphakic Bifocal Lenses, Practioners Frame
021	Exam, Practioners Contact Lenses (no definition of the type)
022	Exam, Practioners Medically Necessary Contacts
023	Exam, Plan Contact Lenses
024	Exam, Plan Frame
025	Exam, Practioners Soft Contact Lenses
026	Exam, Practioners Hard Contact Lenses
027	Exam, Practioners Toric Contact Lenses
028	Exam, Practioners Rigid Gas Permeable Contact Lenses
029	Exam, Practioners Frame
030	Exam, Plan Disposable Contact Lenses

031	Exam, Plan Premium Disposable Contact Lenses
032	Exam, Plan Single Vision Lenses Safety Complete
034	Exam, Plan Single Vision Lenses Safety Lenses
035	Exam, Plan Bifocal Lenses Safety Complete
037	Exam, Plan Bifocal Lenses Safety Lenses
038	Exam, Plan Trifocal Lenses Safety Complete
039	Exam, Plan Trifocal Lenses Safety Lenses
046	Exam, Practioners Bifocal Contact Lenses
N02	Plan Single Vision Lenses, Plan Frame
N03	Plan Single Vision Lenses, Practioners Frame
N04	Plan Single Vision Lenses, Own Frame
N05	Plan Bifocal Lenses, Plan Frame
N06	Plan Bifocal Lenses, Practioners Frame
N07	Plan Bifocal Lenses, Own Frame
N08	Plan Trifocal Lenses, Plan Frame
N09	Plan Trifocal Lenses, Practioners Frame
N10	Plan Trifocal Lenses, Own Frame
N11	Practioners Single Vision Lenses, Plan Frame
N12	Practioners Bifocal Lenses, Plan Frame
N13	Practioners Trifocal Lenses, Plan Frame
N14	Practioners Aphakic Single Vision Lenses, Plan Frame
N15	Practioners Aphakic Bifocal Lenses, Plan Frame
N16	Practioners Single Vision Lenses, Practioners Frame
N17	Practioners Bifocal Lenses, Practioners Frame
N18	Practioners Trifocal Lenses, Practioners Frame
N19	Practioners Aphakic Single Vision Lenses, Practioners Frame
N20	Practioners Aphakic Bifocal Lenses, Practioners Frame
N21	Practioners Contact Lenses
N22	Practioners Medically Necessary Contact Lenses
N23	Plan Contact Lenses
N24	Plan Frame, Member Lenses
N25	Practioners Soft Contact Lenses
N26	Practioners Hard Contact Lenses
N27	Practioners Toric Contact Lenses
N28	Practioners Rigid Gas Permeable Contact Lenses
N29	Practioners Frame
N30	Plan Disposable Contact Lenses
N31	Plan Premium Disposable Contact Lenses
N32	Safety Single Vision Lenses, Safety Frame
N34	Safety Single Vision Lenses, Own Frame
N35	Safety Bifocal Lenses, Safety Frame
N37	Safety Bifocal Lenses, Own Frame
N38	Safety Trifocal Lenses, Safety Frame
N39	Safety Trifocal Lenses, Own Frame
N46	Practioners Bifocal Contact Lenses
MN11	Practioners Single Vision Lenses, Own Frame
MN12	Practioners Bifocal Lenses, Own Frame
MN13	Practioners Trifocal Lenses, Own Frame
MN14	Practioners Aphakic Single Vision Lenses, Own Frame
MN15	Practioners Aphakic Bifocal Lenses, Own Frame
M011	Exam, Practioners Single Vision Lenses, Own Frame

M012	Exam, Practioners Bifocal Lenses, Own Frame
M013	Exam, Practioners Trifocal Lenses, Own Frame
M014	Exam, Practioners Aphakic Single Vision Lenses, Own Frame
M015	Exam, Practioners Aphakic Bifocal Lenses, Own Frame
R01	Refractive Exam Only
R02	Refractive Exam, Plan Single Vision Lenses, Plan Frame
R03	Refractive Exam, Plan Single Vision Lenses, Practioners Frame
R04	Refractive Exam, Plan Single Vision Lenses, Own Frame
R05	Refractive Exam, Plan Bifocal Lenses, Plan Frame
R06	Refractive Exam, Plan Bifocal Lenses, Practioners Frame
R07	Refractive Exam, Plan Bifocal Lenses, Own Frame
R08	Refractive Exam, Plan Trifocal Lenses, Plan Frame
R09	Refractive Exam, Plan Trifocal Lenses, Practioners Frame
R10	Refractive Exam, Plan Trifocal Lenses, Own Frame
R11	Refractive Exam, Practioners Single Vision Lenses, Plan Frame
R12	Refractive Exam, Practioners Bifocal Lenses, Plan Frame
R13	Refractive Exam, Practioners Trifocal Lenses, Plan Frame
R14	Refractive Exam, Practioners Aphakic Single Vision Lenses, Plan Frame
R15	Refractive Exam, Practioners Aphakic Bifocal Lenses, Plan Frame
R16	Refractive Exam, Practioners Single Vision Lenses, Practioners Frame
R17	Refractive Exam, Practioners Bifocal Lenses, Practioners Frame
R18	Refractive Exam, Practioners Trifocal Lenses, Practioners Frame
R19	Refractive Exam, Practioners Aphakic Single Vision Lenses, Practioners Frame
R20	Refractive Exam, Practioners Aphakic Bifocal Lenses, Practioners Frame
R21	Refractive Exam, Practioners Contact Lenses
R22	Refractive Exam, Medically Necessary Contact Lenses
R23	Refractive Exam, Plan Contact Lenses
R24	Refractive Exam, Plan Frame
R29	Refractive Exam, Practioners Frame
R30	Refractive Exam, Plan Disposable Contact Lenses
R31	Refractive Exam, Plan Premium Disposable Contact Lenses
R32	Refractive Exam, Safety Single Vision Lenses, Safety Frame
R34	Refractive Exam, Safety Single Vision Lenses, Own Frame
R35	Refractive Exam, Safety Bifocal Lenses, Safety Frame
R37	Refractive Exam, Safety Bifocal Lenses, Own Frame
R38	Refractive Exam, Safety Trifocal Lenses, Safety Frame
R39	Refractive Exam, Safety Trifocal Lenses, Own Frame
S0500	Exam, Practioners Disposable Contact Lenses
SN500	Practioners Disposable Contact Lenses
E2400	Exam, Practioners Supplied Soft Contact Lenses
N2400	Practioners Supplied Soft Contact Lenses
E2500	Exam, Plan (Practioners Supplied) Hard Contact Lenses
N2500	Plan (Practioners Supplied) Hard Contact Lenses
E2600	Exam, Practioners Supplied Extended Contact Lenses
N2600	Practioners Supplied Extended Contact Lenses
NONS0500	Exam, Practioners, Non Disposable Contact Lenses
NONSN500	Practioners, Non Disposable Contact Lenses

Davis Vision
Option Codes

F	Premier Frame
D	Designer/Metal Frames
L	Fashion Frame
S	Scratch Resistant Coating
P	Photogrey (PGX)
R	Anti Reflective Coating (Standard)
U	Ultraviolet Coating
I	Standard Progressive Lenses
@	Premium Progressive Lenses
A	Polycarbonate Lenses
B	Double Segment Bifocal Lenses
E	Blended Invisible Bifocal Lenses
G	Polarized Lenses
H	High Index Plastic Lenses
T	Tinting (Plastic Gradient)
Q	Plastic Photosensitive Lenses
C	Color Coating
V	Edge Treatment
$	Intermediate Lenses
Y	Blended Myodisc
%	Quadrifocals
J	High Index Glass
M	Mirror Coating
K	Didymium Single Vision Lenses
O	Rose Tint (Plastic)
N	Didymium Multifocal Lenses
W	Premium Anti Reflective Coating
Z	Ultra Anti Reflective Coating
+	Tinting (Plastic Solid)
-	Tinting (Glass)
=	Executive Multifocal
*	Rose Tint (Glass)
#	Colorcoating (Gradient)
<	High Index Plastic (Under 1.6 Center)
(	High Index Glass (Under 1.6 Center)
>	Oversize Lenses