SuperiorVision™

# 2023 eye care professional manual

from VersantHealth™

# Table of contents


## Section I: Welcome to the Superior Vision Network ..... 6

A. **About Superior Vision** ..... 7

B. **Confidentiality and security of information** ..... 7

1. Disclosure of Information ..... 9

## Section II: Rights and responsibilities ..... 11

A. **Professional ethics** ..... 11

B. **Eye care professional bill of rights** ..... 12

C. **Eye care professional responsibilities** ..... 14

D. **Fraud, Waste, and Abuse (FWA)** ..... 16

1. Special Investigations Unit ..... 16
2. Definitions ..... 16
3. Statutes ..... 17
4. Fraud, Waste, and Abuse and General Compliance Training ..... 18
5. Contact Information ..... 19

E. **Member statement of rights and responsibilities** ..... 20

F. **Trademark license letter agreement** ..... 21

## Section III: Contacting Superior Vision ..... 22

A. **Superior Vision's website, superiorvision.com** ..... 22

B. **Interactive Voice Response system (IVR)** ..... 22

C. **Contact information** ..... 23

## Section IV: The vision care benefit ..... 26

A. **How a typical patient encounter works** ..... 26

B. **Eyewear dispensing standards** ..... 28

C. **Coverage determinations for nonstandard services and eyewear** ..... 28

D. **Plan Benefit/Compensation Schedule Coverage (PBCS)** ..... 31

E. **Exclusion and limitations** ..... 31

F. **Eyewear policies** ..... 31

Section V: Utilization review ..... 32

Section VI: Eligibility and authorization ..... 34

A. **Superior Vision's website, superiorvision.com** ..... 34

B. **Interactive Voice Response system (IVR)** ..... 34

Section VII: Claim submission ..... 35

A. **Superior Vision's website, superiorvision.com** ..... 35

B. **Healthcare clearinghouse claims submissions** ..... 36

C. **ASC X12N 837 HIPAA standard format** ..... 36

D. **Paper claims – CMS 15OO claim form** ..... 36

E. **Claim payment procedures and Electronic Funds Transfer (EFT)** ..... 37

F. **Members charges** ..... 38

Section VIII: Doctor-patient relations ..... 39

A. **Non-discrimination** ..... 39

B. **Cultural competency and sensitivity** ..... 39

C. **Open clinical dialogue** ..... 40

D. **Confidentiality for domestic violence victims** ..... 40

E. **Benefit abuse** ..... 41

F. **Coordination of benefits** ..... 41

G. **Scheduling an appointment** ..... 41

H. **The office visit** ..... 42

1. Patient History ..... 42
2. Examination ..... 43
3. Contact Lens examinations and fittings ..... 43
4. Provision of prescription for corrective eyewear ..... 44
5. Dispensing corrective eyewear ..... 44
6. Referring patients for additional services ..... 45

I. **Members with special needs** ..... 45

J. **Arrangements for prolonged absence/office closing** ..... 46

K. **Emergency care provisions** ..... 46

L. **Refusal of care** ..... 47

M. **Investigational studies** ..... 47

N. **Transfer of patient records** ..... 48

O. **Member or eye care professional claims dispute/complaint process, Member grievance/appeal process** ..... 48

## Section IX: Ophthalmic materials and laboratories ..... 53

A. **New eyewear dispensing program** ..... 53

B. **Lab errors redos** ..... 54

C. **Essilor lens warranty redos** ..... 54

D. **Eye care professional lens redos** ..... 56

1. First-time redos ..... 56

E. **Patient redos** ..... 57

F. **Cancellations** ..... 57

G. **Upgrades** ..... 57

H. **Repair and replace benefit** ..... 57

I. **Uncut lenses** ..... 58

J. **Eye care professional-supplied frames** ..... 58

K. **Patient-supplied frames or lenses** ..... 58

L. **Sales tax** ..... 58

## Section X: Network management and participation ..... 59

1. **Overview** ..... 59

2. **Council for Affordable Quality Healthcare (CAQH)** ..... 59

3. **Initial credentialing process** ..... 60

4. **Ongoing monitoring of credentials** ..... 61

5. **Recredentialing process** ..... 62

6. **Participating eye care professional agreement** ..... 63

7. **Eye care professional and office and demographic changes** ..... 65

8. **Access and service delivery standards** ..... 66

9. **Security requirements** ..... 67

10. **Patient safety, adverse events, sentinel events, and quality issues** ..... 68

11. **Miscellaneous** ..... 68

12. **Eye care professional corrective action plans. Peer review, and appeal processes** ..... 69
1. Administrative Disputes ..... 70
2. Credentialing Disputes ..... 71
i. Termination with Cause ..... 71
ii. Suspension with Cause ..... 73
iii. Termination without Cause ..... 73
iv. Appeal Processes ..... 74
3. First-Level Appeal Process ..... 74
4. Second-Level Appeal Process ..... 75
5. Reporting to Appropriate Authorities ..... 77

## Section XI: Quality management ..... 78

A. **Overview** ..... 78

B. **Medical records and office site review program** ..... 78
1. Eye care professional Site and Medical Records Review Elements ..... 78
2. Instrumentation and Equipment ..... 79
3. Medical Records Documentation ..... 80
4. Site Visit and Record Review Trigger Methodology ..... 82
a. General Complaint Threshold Monitoring ..... 82
b. Quality of Care/Adverse Event Threshold Monitoring ..... 83
c. Site Visit and Medical Record Review Process ..... 83
d. Corrective Action and Continuous Monitoring ..... 84
e. Eye care professional Failing to Comply with Admin. Requests Outside of Oversight Process ..... 85
5. Interactions with Health Plans QA Programs ..... 85

C. **Member satisfaction** ..... 88
1. Tracking complaints and grievances ..... 89
2. Member satisfactions surveys ..... 90

D. **Practitioner satisfaction** ..... 90

## Section XII: COVID-19 Pandemic ..... 92
Healthcare Facilities: Managing Operations during the COVID-19 Pandemic

## Section XIII: Revision history ..... 93

## About the manual

The policies and procedures in this manual apply to services rendered by Superior Vision network eye care professionals to enrollees in benefit plans that are administered by Versant Health. It is the eye care professional's responsibility to read and understand the policies and procedures in this manual. For questions about this manual, please contact the Superior Vision Provider Call Center at **1 (800) 507-3800**.

The Superior Vision eye care professional manual is confidential and should not be shared with parties not contracted with the Superior Vision network. This version of the eye care professional manual supersedes all other prior manuals published for the Superior Vision network and is subject to change at any time. Versant Health reserves the right to revise the policies and procedures contained in this eye care professional manual.

All participating eye care professionals will be notified of any revisions on the Superior Vision eye care professional manual via the password protected web site prior to implementation. All applicable Federal and state regulations supersede the provisions of the eye care professional manual.

## Versant Health's eye care professional relationship statement

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

## Regulatory and compliance

Eye care professionals are required to comply with all applicable laws and regulations. In addition, eye care professionals are required to comply with certain rules and regulations as contracted eye care professionals of the Superior Vision network, as the Superior Vision network maintains licenses and certifications with state and regulatory agencies.

Versant Health and its designated agents have the right to audit eye care professional files and records with regards to enrollees in benefit plans that are administered by Versant Health.

## Notice about non-discrimination

Versant Health does not discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. In addition, Versant Health 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.

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

## A. About Superior Vision

Superior Vision Benefit Management, Inc. and its affiliates that provide services to health plans, including Superior Vision of New Jersey, Inc. and UVC Independent Practice Association, Inc. (collectively, "the "Company") provide comprehensive administration of routine and medical vision care programs for healthcare plans. The Company contracts with health maintenance organizations and other managed care entities for the coordination of the plan's vision benefits.

Corporate headquarters is located in Baltimore, Maryland and Operations Center are located in Rancho Cordova, California and San Antonio, Texas.

Our vision is to become the most trusted managed eye health and vision care plan for members, clients, brokers, and eye care professionals in the industry.

## B. Confidentiality and security of information

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

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

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

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

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

The Superior Vision network participating eye care professionals agree to keep all protected patient information confidential, and to:

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

Further, in those instances where Versant Health needs to obtain patient-specific information from an eye care professional or other healthcare entity it shall abide by its own confidentiality policy:

- Upon calling for member information the Versant Health Associate will identify themselves by name, title, and department.

- If further verification is required, Versant Health will provide the request in writing or the entity may call the Associate back.

Although the records are the property of the eye care professional and/or Versant Health, members 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 Versant Health and participating eye care professionals. Versant Health's Confidentiality Policy is available to any patient, eye care professional or group upon request.

## 1. Disclosure of information

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

- Requested by the patient, legal guardian, or legal representative. Proper identification is required prior to release of information. Written authorization must be dated and signed within the appropriate time frame.

- For the purpose of an audit of Versant Health's claim processing operations, released information must be relevant to conducting the audit. Any outside agency reviewing information must agree to abide by Versant Health's confidentiality policies.

- Reasonably necessary for Versant Health to conduct an audit of utilization by eye care professional.

- To an authorized, regulatory, or accrediting agency conducting a survey and/or audit. The agency must agree to abide by Versant Health's confidentiality policies.

- To a governmental authority or law enforcement agency while investigating or prosecuting the perpetration of fraud upon Versant Health or a Versant Health client.

- Reasonably necessary for the investigation of suspected fraud or abuse by a patient or eye care professional.

- To Versant Health committees (such as Credentialing, Utilization Management, and Quality Management) that conduct Peer Review audits.

- In response to a court order.
- In response to a governmental authority for the purpose of verifying a patient's eligibility, for which the government is responsible.
- When otherwise authorized or required by contracts with Versant Health plans, federal, state, and/or local laws.

For the purposes of Treatment, Payment, and Health Care Operations (TPO), Superior Vision will disclose the minimum necessary information to properly report encounter and claims history to a client. Versant Health will disclose eligibility information when: A patient, patient's legal spouse, patient's dependent child/children, patient's legal representative, or participating eye care professional produces proper identification or eligibility documentation. A patient or any listed plan beneficiary accesses the Interactive Voice Response system, speaks with a Patient Service Representative, or logs on to the Superior Vision web site and provides the appropriate patient identification number.

# Section II
# Rights and responsibilities

## A. Professional ethics

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

- To hold the physical, emotional, social, health and visual welfare of all Versant Health patients uppermost at all times.
- To ensure better care and services, and to provide these services with compassion, honesty, integrity, and respect for the patient's dignity.
- To promote and hold in professional confidence all information concerning a patient, to use such information for the benefit of the patient, and, to abide by all federal, state, and local regulatory agencies in maintaining this confidentiality.
- To continually maintain and improve one's competency, which includes technical ability, cognitive knowledge, and ethical concerns for the patient. Competence involves having the most current knowledge and understanding of vision care, enabling eye care professionals to make professionally appropriate and acceptable decisions in managing a patient's care.
- To provide care and services appropriate to the degree of education and training.
- To consult with other health care professionals and refer patients, when appropriate.
- To uphold the Versant Health Member's Statement of Rights and Responsibilities (contained in Section E below). To obtain informed consent for all treatment, procedures, and services. To communicate and educate patients and/or appropriate family members.

- To inform Versant Health of any physical, mental, or emotional impairment that may impede your ability to provide appropriate patient care or to meet contractual obligations with Versant Health.

- To conduct oneself in an ethical and professional manner as described by the appropriate professional association and to comply with all federal, state, and/or local regulations relating to the practice of one's profession.

- To communicate with each patient at an appropriate level of comprehension and/or in a language understood by the patient, or to refer the patient to Versant Health for translation services.

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

- To resolve all conflicts involving treatment plans or, if unable to do so, to refer the patient to Versant Health, the patient's applicable Plan, or appropriate state agency for resolution.

- To inform patients of their right to view the policy and procedures for conflict resolution by contacting Versant Health, their applicable Plan, or appropriate state agency directly.

## B. Eye care professional bill of rights

1. Eye care professionals have the right to compensation and payment for covered services provided to all Versant Health members, within the timeframe specified in the eye care professional agreement specific to the jurisdiction within which they provide covered services.

2. Eye care professionals have the right to request prompt payment of all co-payments and/or deductibles from all Versant Health members.

3. Eye care professionals have the right to request a copy of any document required by a contracting Plan, which has been approved by Versant Health and requires an eye care professional's signature.

4. Eye care professionals have the right to know that composition of the Utilization Review and Quality Management Committees include panel eye care professionals whenever appropriate. Eye care professionals have the right to

provide feedback to Versant Health on standards of care and clinical practice guidelines utilized by Versant Health.

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

6. Eye care professionals have the right to appeal decisions of Versant Health without fear of reprisal.

7. Eye care professionals have the right to confidentiality of all credentialing information, subject to applicable local or state law as per the Participating Eye care professional Agreement. Eye care professionals 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. Eye care professionals have the right to confidentiality of their compensation arrangement with Versant Health.

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

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

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

12. Eye care professionals 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 Superior Vision network panel.

13. Eye care professionals have the right to make recommendations regarding quality of care, standards of care, or clinical practice guidelines adopted or adapted by Versant Health.

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

15. Practitioners have the right to request all information necessary to determine that they are being compensated in accordance with the Superior Vision Participating Eye care professional 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. Versant Health will provide the required information by any reasonable method through which the practitioner can access the information including email, computer disks, paper or access to an electronic database, no later than thirty (30) days after receipt of request.

## C. Eye care professional responsibilities

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

2. Eye care professionals are responsible to maintain a service record and/or treatment record form for each patient and to complete each form in accordance with Versant Health's policy. Eye care professional will hold such information confidential.

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

4. Eye care professionals are responsible to be available to provide services to Versant Health's members for medically appropriate urgent care and emergent care. Information and instructions regarding emergency care shall be available to patients twenty-four (24) hours per day, seven (7) days per week.

5. Eye care professionals 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. Eye care professionals are responsible to comply with all credentialing, recredentialing, quality assurance, and utilization management requests in a timely manner.

7. Eye care professionals are responsible to notify Versant Health immediately if their license has been suspended, restricted, or limited in any way.

8. Eye care professionals are responsible for notifying Versant Health timely of changes to their practice, office, and eye care professionals.

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

10. Eye care professionals are responsible to comply with all policies and procedures as described in the eye care professional Manual.

11. Eye care professionals are responsible to maintain confidentiality of financial information from other eye care professionals but may discuss financial arrangements with Versant Health's members.

12. Eye care professionals are responsible to comply with all utilization and quality management programs of Versant Health and to submit requested documentation in a timely manner.

13. Eye care professionals are responsible for verifying Versant Health's members eligibility and obtaining authorization prior to the delivery of covered services.

14. In general, eye care professionals are responsible for submitting all claims within ninety (90) days of the date services were provided, unless there is a longer time period required by law.

15. Eye care professionals are responsible to inform Versant Health's members of their financial responsibility prior to delivery of services.

16. Eye care professionals are responsible to inform Versant Health in writing when their offices will be closed for three (3) months or longer due to vacation, illness, or other circumstances.

17. Eye care professionals are responsible to adhere to the Versant Health marketing brand guidelines. These guidelines will be available on the eye care professional Portal and available upon request.

## D. Fraud, Waste and Abuse (FWA)

### 1. Special Investigation Unit

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

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

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

Eye care professionals may obtain additional information on Versant Health's Payment Integrity Program policies and other resources located in the 'Important Links' section of the Superior Vision Network eye care professional Portal.

### 2. Definitions

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

Examples:

- Billing for services not rendered
- Billing both medical carrier and Versant Health for the same service
- Billing for services provided to a non-covered family member

- Misrepresenting the diagnosis or procedure to ensure payment of materials or services
- Soliciting, offering or receiving a kickback, bribe or rebate
- Loaning or using another person's patient identification number (and/or card) to obtain services or materials

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

Examples:

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

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

## 3. Statutes

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

## The False Claims Act

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

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

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

## Anti-kickback statute

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

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

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

## 4. Fraud, Waste, and Abuse and general compliance training

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

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

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

Upon request, Versant Health participating eye care professionals must immediately provide a signed attestation for completion of the annual FWA training by all appropriate professional staff, office employees, vendors, and ancillary staff.

## 5. Contact information

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

Anyone can contact the Anti-Fraud Hotline – Patients, eye care professionals, Groups, Brokers and Versant Health Associates. For information and inquiries or to report potential misconduct, contact:

**The Versant Health Fraud, Waste, and Abuse Unit at:**

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

B. Confidential mail through the U.S. Post Office can be addressed to:
**Versant Health**
**ATTN: Fraud, Waste and Abuse Unit**
**PO Box 1416**
**Latham, NY 12110-1416**

C. Confidential Fax: (866) 999-4690

D. Email: antifraud@versanthealth.com

## E. Member statement of rights and responsibilities

Our Company adheres to certain rules of accrediting and regulatory agencies concerning member rights. Members have certain rights and responsibilities when being treated by the Company's contracted eye care professionals. The rights and responsibilities statement below, though not intended to be exhaustive, reminds members and eye care professionals of their complementary roles in maintaining a productive relationship.

1. Members have the right to receive information about the Company, its services, its network eye care professionals along with information about their member rights and responsibilities.
2. Members have the right to participate with their eye care professionals in making decisions about their vision care, including consent for or refusal of treatment and, upon request, receive a copy of their vision care medical records.
3. Members have the right to a candid discussion of appropriate or medically necessary treatment options for their vision health conditions, regardless of cost or benefit coverage.
4. Members have the right to voice complaints and appeals about any aspect of the Company's services and benefits or the care of network eye care professionals without fear of retaliation and receive a response from the Company within a reasonable timeframe.
5. Members have the right to timely referral and access to medically-indicated specialty care (in accordance with referral protocols established by the health plan through which the member is enrolled).
6. Members have the right to timely access to care that does not have any communication or physical access barriers.
7. Members have the right to make recommendations regarding the Company's member rights and responsibility policy.

8. Members have the right to receive eye care services from a different participating eye care professional each time they access covered services within defined benefit frequency intervals
9. Members have the responsibility to supply information (to the extent possible) to the Company and its eye care professionals in order to provide appropriate vision care.
10. Members have the responsibility to follow plans and instructions for vision care that they agreed to with their eye care professionals.
11. Members have the responsibility to understand their vision health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
12. Members have the responsibility to read and be aware of their vision care benefits.
13. Members have the responsibility to express opinions, concerns or complaints in a constructive manner, while being considerate and cooperative in dealing with the Company's contracted eye care professionals and respecting the rights of fellow members.
14. Members have the responsibility to report suspected instances of fraud, waste, and abuse without fear of retaliation.

## F. Trademark license letter agreement

The Trademark License Letter Agreement is a supplement to the Superior Vision Participating eye care professional Agreement and governs an eye care professional's right to use the Superior Vision logo (Licensed Mark). The Trademark License Letter Agreement is a unilateral agreement and does not require an eye care professional's signature. By participating in the Superior Vision network, eye care professionals are agreeing to abide by the terms and conditions of the Trademark License Letter Agreement.

Eye care professionals are subject to the terms and conditions of the Letter Agreement and shall comply strictly with the directions of Versant Health regarding the form and manner of use of the Superior Vision logo in connection with advertising, promoting, and providing Services and shall ensure that the "TM" appears in accordance with Versant Health's instructions.

The full Trademark License Letter Agreement can be located on the Superior Vision eye care professional Portal.

# Section III
# Contacting Versant Health

## Superior Vision's web site: superiorvision.com

### A. Internet website

Simply log on to the Company's website (superiorvision.com) to obtain benefits information or verify eligibility.

Please follow the instructions set forth below to access the website:

- Click on "eye care professionals" at the top of the page next to "member"
- Click on "eye care professional log in"
- Enter your username and password
- If there is more than one office, enter the ZIP code of the location
- Select the eye care professional serving the member
- Enter the member's ID number, last name, and first name
- Click "Submit"
- You can also do an advance search by selecting "advance search" and entering the last 4 digits of the member's Social Security number and date of birth
- Select "Check Eligibility" in the upper left-hand corner of the screen

### B. Voice Response Unit (VRU)

In order to access the Company's VRU, please call 1 (800) 507-3800 and follow the prompts, using your telephone keypad, as follows:

Enter your NPI Number and press the # key when completed. The system will state the participating eye care professional name linked to the eye care professional number entered. Please verify that NPI number entered is correct by pressing 1 for "yes" 2 for "no."

- Select option #1 for member benefits and eligibility verification
- If the member's ID number is alpha/numeric, press 2; otherwise, wait to enter the member's ID number
- Enter the member's ID number and press the # key when completed
- You may be asked to enter the member's date of birth in the MM DD YYYY format
- Enter the date of the appointment in the MM DD YYYY format
- The VRU will offer each benefit for which the member is eligible

The VRU will transfer you to a Company representative in the event the system is unable to process the requested eligibility verification. After hours calls are routed to Customer Service voice messaging and return calls are performed the next business day.

Eye care professionals may verify member eligibility 24 hours a day, 7 days a week through the Company's website or Voice Response Unit (VRU).

## C. Contact information

The Company's staff is available during regular business hours (9:00 am through 6:00 pm EST Monday through Friday, excluding holidays) and can be reached at the telephone numbers listed below. After hours callers to the Company's customer services department (both members and eye care professionals) have the opportunity to leave a recorded voicemail message for a return call the next business day. In order to access the customer services department night message system, please call (877) 235-5317.

Additionally, eye care professionals may access the Voice Response Unit (VRU) 24 hours a day, seven days a week to verify member eligibility and benefits coverage and to obtain an eligibility verification number.

Eye care professionals may also access the Company's website, superiorvision.com, 24 hours a day, seven days a week for information regarding eligibility verification, benefits coverage, claim status, and to submit claims.

| | | |
|---|---|---|
| **Provider Relations**<br>Monday – Friday<br>8 a.m. – 6 p.m. (EST) | To contact a Provider Recruiting Associate, please call: **(844) 585-2020**<br>Email: prsupport@superiorvision.com | • Inquire about becoming a provider<br>• Verify credentialing application status<br>• Update address and office information |
| **Utilization Review**<br>Monday – Friday<br>9 a.m. – 5 p.m. (EST) | To contact Utilization Review, please fax: **(855) 313-3106** | • Request prior authorization for services outside regular eligibility cycle<br>• Request prior authorization |

| | | |
|---|---|---|
| **Provider website** | To access our website, please go to **superiorvision.com** and enter your provider number and password.<br><br>If you have not yet created a login password, please call **1 (800) 243-1401** | • Verify eligibility/benefits<br>• Request authorization for services<br>• Check claim status<br>• View formularies<br>• View updates to benefit info Download forms<br>• Access important links:<br>• Clinical Practice Guidelines<br>• Eye care professional Bill of Rights<br>• Patient's Bill of Rights<br>• Eye care professional Manual Provider Newsletters |
| **Provider IVR (Interactive Voice Response) System** (Available 24 hours a day) | To access our IVR system, please call **1 (800) 507-3800** | • Verify eligibility/benefits<br>• Request authorization for services |
| **Customer Service and Eligibility** | To contact a Customer Service, please call **1 (800) 507-3800** | • Verify eligibility/benefits |

| | | |
|---|---|---|
| **Claims** | To contact a Claims Associate, please call **(866) 819-4298**<br><br>write: **Superior Vision Claims Unit**<br>**PO Box 967**<br>**Rancho Cordova, CA 95741-0967** | • Request billing information<br>• Request status of claim payment |
| **Complaints and Appeals** | Email: **ProviderCA@versanthealth.com**<br><br>Phone: **(888) 343-3470**<br>Fax: **(888) 778-2008**<br>Or write:<br>**Versant Health Complaints and Appeals Department**<br>**PO Box 791**<br>**Latham, NY 12110** | • Submit a complaint or payment dispute appeal |
| **Website assistance** | To obtain assistance with the Superior Vision website, please call **1 (800) 507-3800** | |

# Section IV
# The vision care benefit

**Note**: Versant Health provides comprehensive routine vision and eye care services to more than 33 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 Versant Health at **(844) 585-2020** or email to **prsupport@superiorvision.com** for Provider Relations or our Interactive Voice Response System, or visit our web site at **superiorvision.com.**

The Company's program has been carefully designed to provide members and eye care professionals alike with easy access to our services.

## Here's how a typical patient encounter works

- The Company or the health plan will distribute a list of participating eye care professionals to a new member who enrolls under the plan.
- When the member decides to seek vision care services, they simply call the participating eye care professional of their choice to schedule an appointment. The member does not generally contact either the Company or the plan to request a referral or other type of authorization.
- When scheduling an appointment, please inquire as to the member's plan coverage. Since the Company is the program administrator, and not the actual health plan with which the member is enrolled, most members will identify themselves by the name of the health plan and are not familiar with the Company's name. Please be aware of the specific health plans that the Company provides service to and connect these calls with the Company program. Some of the Company's client health plans elect to notify members of the Company's management of their vision benefits, and these members may identify with the Company's name and/or the health plan's name.
- Once the appointment has been scheduled, contact the Company through its website or automated telephone Voice Response Unit (VRU) to verify the member's eligibility and receive an eligibility verification number.

  Please refer to the "Eligibility Verification Procedures" section of this eye care professional manual for general instructions. Please also note that each plan-specific

section of this eye care professional manual provides details on the format of the member I.D. numbers and any specific instructions necessary for verifying member eligibility or receiving prior authorization for those services for which prior services authorization is required under the plan.

**It is important that you verify member eligibility at the time the appointment is initially scheduled. In the event the member's eligibility status must be researched, this will allow sufficient time for the necessary research and follow-up with your office.**

- On the day of the appointment, your services should be delivered in accordance with the Member's benefit coverage and the service standards set forth in your participating eye care professional agreement with the Company and this eye care professional manual. Please refer to the "Member Charges" section of this eye care professional manual for details on allowable collections from the member.

- Each eye care professional has the option of using the optical laboratory of his/her choice, subject to all applicable state and/or federal laws concerning self-referral. The eye care professional's choice of optical laboratory does not affect coverage determinations and reimbursements.

- You may electronically submit claims via the Company's website (www.superiorvision.com) or in the ASC X12N 837 HIPAA standard format, either directly to the Company or through its clearinghouse. You may also utilize the CMS 1500 form for submitting paper claims to the Company. Please refer to the "Claim Submission Requirements" section of this eye care professional manual for further details on submitting claims, as well as the Company's reimbursement policies.

Contact Lens Examination/Fitting Standards: When the member's benefit coverage includes contact lenses, the following additional tests/procedures are required for the fitting and assessment of contact lenses:

A contact lens examination and fitting shall include, at a minimum, the following:

a. Keratometry or ophthalmometry;
b. History relating to lens wear (previous wear, allergies, etc.);
c. Fitting or assessment of fit with slit lamp; and
d. Visual acuities with lenses in place.

The patient must also receive the following:

a. Instruction on insertion and removal of lenses;
b. Appropriate care (disinfecting) system and its use;

c. Wearing instructions; and
d. Follow-up care as appropriate.

The following standards are recommended for contact lens patients:

a. Patient shall receive a diagnostic evaluation prior to the time of dispensing.
b. A sixty-day clinical adaptation period should be used for all patients who are newly fitted for contact lenses.
c. A thorough evaluation should be made of all contact lens users at each follow-up visit.
d. All contact lens patients should have written instructions that advise them of proper wear, hygiene, and maintenance of their lenses.

## Eyewear Dispensing Standards

When the member's benefit coverage includes eyewear, the following additional standards are required:

Dispensing shall be performed by duly certified and licensed personnel. The eye care professional performing the dispensing of eyewear should note the following on the record:

a. Frame size;
b. Appropriate lens material;
c. Appropriate tints, when indicated;
d. Pupillary distance;
e. Base curve of lens, when indicated;
f. Follow-up adjustments for a period of six months; and
g. Verification of eyewear after fabrication (compliance with American National Standards Institute [ANSI] standards Z80).

Advice should be offered to the patient on eyewear selection. The eye care professional is required to maintain the proper number of frames within the specified frame allowance covered by the plan. All eyewear must be made available to the member as soon as received from the laboratory; eyewear turnaround time must be no more than five business days.

## Coverage Determinations for Non-Standard Services and Eyewear

**Note: applicable regulatory coverage guidelines may supersede these requirements**

1. Non-Standard Eye Examination

a. Definition – A "Non-Standard Eye Examination" means any additional routine eye examination beyond the standard benefit coverage frequency.

The eye care professional must submit documentation supporting the clinical appropriateness of all Non-Standard Eye Examinations to the Company for a coverage determination before rendering a Non-Standard Eye Examination.

b. Coverage Criteria – Non-Standard Eye Examinations may be covered. Please refer to our Coverage Policy 13.16.00 – Eye Exams for Specific Criteria located in the eye care professional portal.

2. Non-Standard Eyewear

a. Definition – “Non-Standard Eyewear” means eyewear (including both eyeglass lens and contact lenses) beyond the standard benefit coverage. Except as set forth below, the eye care professional must submit documentation supporting the clinical appropriateness of all Non-Standard Eyewear to the Company for a coverage determination before dispensing the Non-Standard Eyewear.

b. Coverage Criteria for Non-Standard Eyeglass Lens Types – non-standard eyeglass lens types are covered as follows: (i) plano (non-prescription) lenses are covered when required for protective purposes when the member is limited to vision in only one eye; (ii) tinted lenses are covered when the member is diagnosed with albinism, diseases of the retina, or (iii) when otherwise clinically indicated.

c. Coverage Criteria for Non-Standard Contact Lenses –Non-Standard Contact Lenses are covered when: (i) required for treatment of keratoconus; (ii) due to severe myopia, greater than 10 diopters; (iii) due to aphakia in children; or (iv) otherwise clinically indicated.

d. Non-Standard Eyewear Not Requiring Coverage Determination – the following Non-Standard Eyewear does not require a coverage determination: (i) high index lenses for lens prescriptions greater than +6.00 diopters sphere and/or + 3.00 diopters cylinder; (ii) lenses with prism when determined to be clinically appropriate by the eye care professional; or (iii) polycarbonate lenses when determined to be clinically appropriate by the eye care professional for children enrolled through Medicaid/CHIP programs.

## Plan Benefits/Compensation Schedule (PBCS)

A Plan Benefits/Compensation Schedule (PBCS) is a group specific document outlining the Member's benefit information, covered services, provider reimbursements and other group specific information. PBCS documents are available to all providers electronically on the eye care professional portal.

## Exclusion and limitations

The following services and materials are generally excluded from coverage. Any exceptions to these exclusions and limitations will be noted in the plan-specific section of this eye care professional manual as applicable.

- Safety lenses and frames
- Two pairs of frames and lenses in lieu of bifocals
- Replacement of lost or damaged frames or lenses
- Tinted lenses and photo-chromatic lenses
- Aniseikonic lenses, blended or progressive bifocals, sunglasses, special occupational lenses, special coatings (e.g., hard, anti-reflective, etc.), oversize lenses over 75mm, lamination of a lens or lenses, facets, or other cosmetic grinds or polishes
- Special mountings (other than standard zyl (zylonite), standard metal or standard half-eyes)
- Orthoptics, vision training, low vision aids, or any supplemental training
- Non-prescription (plano) eyewear or eyewear with a prescription of less than +0.50 diopters
- Medical eye care services and diagnostic procedures
    - Any examination or corrective eye wear required by an employer as a condition of employment
    - Conditions covered by Workers' Compensation

## Eyewear policies

- Each eye care professional has the option of using the optical laboratory of his/her choice, subject to all applicable state and/or federal laws concerning self-referrals.

- Eyeglass frames are to be dispensed from the eye care professional's usual stock of frames available to all patients. The eye care professional is not required to purchase a frame kit or maintain a collection of Company-designated frames. However, the eye care professional is required to maintain a minimum number of in-stock frames within the plan's stated benefit allowances. Unless otherwise stated in the plan-specific section of this eye care professional manual, this in-stock selection shall include at least 30 frames (10 each for men, women, and children) within the plan's benefit allowances.

- Most benefit plans administered by the Company provide coverage for "standard" lens types, as defined below:

| | |
|---|---|
| Single Vision | |
| Bifocal | 7 x 28 Trifocal |
| FT-28 Bifocal | Aspheric-Lenticular/Single Vision |
| Round Bifocal | Aspheric-Lenticular/Round Bifocal |

Such lenses will be provided in glass or plastic. Tinted lenses are covered only for aphakia and pseudo-aphakia.

- Lenses must contain a total refractive value of at least +0.50 diopter in at least one eye in order to qualify for eyewear coverage.

- All lens add-ons, such as tints and coatings, must be charged to the member at the eye care professional's usual and customary fees, less any applicable discount as outlined in the plan-specific section of this eye care professional manual.

- Lens types other than those listed above (e.g., progressive multifocals, high-index, polycarbonates, etc.) are considered to be specialty lenses, which are generally not covered under commercial or Medicare benefit plans. However, the commercial or Medicare member is generally entitled to an allowance toward the eye care professional's usual and customary charge for these lenses. The amount of this allowance is stated in the plan-specific section of this eye care professional manual.

# Section V
# Utilization review

Substantially all of the programs administered by the Company provide coverage for routine vision benefits which are available on demand, subject to the member's eligibility for such benefits, and a review of the medical appropriateness of such services is not necessary. However, if a request is made for coverage of non-standard services or materials, the Company has the right to review the request prior to authorizing such services or materials.

Additionally, when a member's benefit coverage includes medical eye care services and/or diagnostic procedures, the Company has the right to review the medical appropriateness of such services, at any time, as a condition of issuing payment. In such circumstances, the Company utilizes established Clinical Protocols to review the medical appropriateness of the requested services or materials. These Clinical Protocols have been developed by the Company based upon the American Academy of Ophthalmology's Preferred Practice Patterns and the American Optometric Association's Optometric Clinical Practice Guidelines. A copy of the Clinical Protocols is available upon request by contacting the Company's Provider Relations Department at 844-585-2020.

To request coverage for non-standard services or materials, the eye care professional should contact the Company's customer services department at 1 (800) 507-3800 to discuss the nature of the request and supporting clinical information regarding the member's condition. The eye care professional may also fax his/her request to the Company at (855) 313-3106. The eye care professional should submit all supporting documentation and/or clinical information necessary for the Company to process the request at the time of the request.

When utilization management decisions are made by the Company, the Company makes the decision and notifies the requesting eye care professional of the decision/coverage determination in the manner required by applicable law on the same day that the decision/coverage determination was made.

Such decisions for Medicare plans are made in accordance with the following timeframes, unless a shorter timeframe is required by applicable law:

- Decisions regarding requests for authorization for Medicare standard organization determinations (non-urgent care) are made within 14 calendar days of the Company's receipt of the request.

- Decisions regarding requests for Medicare expedited organization determinations are made within 72 hours of the Company's receipt of the request. Members or eye care professionals (on the member's behalf) can request expedited organization determinations when the member or the member's eye care professional believes that waiting for a decision under the standard timeframe could place the Member's life, health, or ability to regain maximum function in serious jeopardy.

State required timeframes for the Company to render standard, expedited, concurrent, and/or retrospective utilization management decisions vary according to states laws and regulations. The Company will abide by all applicable state and/or federal laws and rules on utilization management decision timeframes and notice requirements.

Any eye care professional wishing to discuss a coverage denial with the individual who reviewed the request on behalf of the Company may do so by contacting the Company's utilization management department at 1 (800) 243-1401 to arrange for such discussion.

Coverage denials may be appealed by the member or the eye care professional acting on the member's behalf. Management of the appeals process is generally retained by the Company's clients and is not delegated to the Company. The Company's notification of the coverage denial will include the procedure for submission of an appeal, including the timeframe for submitting the appeal and the address to which the appeal should be sent.

Individuals making utilization management decisions on behalf of the Company do not receive financial incentives in connection with the utilization management decision making process. Therefore, there are no financial incentives for individuals making utilization management decisions on behalf of the Company that encourage decisions that result in underutilization. The Company does not specifically reward practitioners or other individuals for issuing denials of coverage or service care.

# Section VI
# Eligibility and authorization

Eye care professionals may verify member eligibility 24 hours a day, 7 days a week through the Company's website or Voice Response Unit (VRU).

### A. Internet Website

Simply Log on to the Company's website (superiorvision.com) to obtain benefits information or verify eligibility.

Please follow the instructions set forth below to access the website:

- Click on "eye care professionals" at the top of the page next to "member"
- Click on "eye care professionals log in"
- Enter your username and password
- If there is more than one office, enter the ZIP code of the location
- Select the provider serving the member
- Enter the member's ID number, last name, and first name
- Click "Submit"
- You can also do an advance search by selecting "advance search" and entering the last 4 digits of the member's Social Security number and date of birth
- Select "Check Eligibility" in the upper left-hand corner of the screen

### B. Voice Response Unit (VRU)

In order to access the Company's VRU, please call 1 (800) 507-3800 and follow the prompts, using your telephone keypad, as follows:

Enter your NPI Number and press the # key when completed. The system will state the participating eye care professional name linked to the eye care professional number entered. Please verify that NPI number entered is correct by pressing 1 for "yes" 2 for "no."

- Select option #1 for member benefits and eligibility verification
- If the member's ID number is alpha/numeric, press 2; otherwise, wait to enter the member's ID number
- Enter the member's ID number and press the # key when completed
- You may be asked to enter the member's date of birth in the MM DD YYYY format
- Enter the date of the appointment in the MM DD YYYY format
- The VRU will offer each benefit for which the member is eligible

The VRU will transfer you to a Company representative in the event the system is unable to process the requested eligibility verification. After-hours calls are routed to Customer Service voice messaging and return calls are performed the next business day.

# Section VII
# Claim submission

Eye care professionals may submit claims to the Company electronically, either through the Company's internet website or through its contracted healthcare clearinghouse, or via paper claims through the mail or facsimile. When submitting paper claims, an eye care professional should use the CMS 1500 form.

**All claims must be submitted to the Company within 90 days of the date of service, or as otherwise required by applicable law. The Company may not honor any claims submitted after 90 days, or such longer period of time required by applicable law.**

All claim submissions by eye care professionals shall be deemed to be the eye care professional's certification as to the completeness and truthfulness of all encounter data and other information included on the claim, regardless of the means by which the claim is submitted.

When submitting claims for frame reimbursement based on the eye care professional's wholesale cost, "wholesale cost" means the eye care professional's actual cost of purchasing the frame. Cost data shall be compared against the manufacturer's published price data, exclusive of any buying group discounts or bulk quantity pricing incentives.

The eye care professional must submit a separate claim for each encounter. The eye care professional should include all services rendered during the encounter on a single claim.

## A. Internet website (superiorvision.com)

Eye care professionals are encouraged to submit claims for all covered services through the Company's website.

Please follow the instructions set forth below to access the website:

- Click on "eye care professionals" at the top of the page next to "member"
- Click on "eye care professionals log in"
- Enter your username and password
- If there is more than one office, enter the ZIP code of the applicable location
- Select the eye care professional servicing the member

- Enter the member's ID number, last name, and first name
- Select "Submit a Claim"
- Enter the diagnoses, date of service, procedure codes, and modifiers (if applicable)
- Enter the charges in the field provided
- Click on "Save Service". Once a service is saved, you may select the pencil icon to edit or modify your entry or select "X" to remove the service.
- Select "Submit Claim" when you have completed entering all of the claim information.
- You can choose "print confirmation" from the next page to print a copy for your records.

How to view claims:

- From the member information page, enter the primary member information in the fields provided.
- Click on View Claims.
- Claims history for processed claims on this member will be displayed. This does not include claims currently in process.

## B. Healthcare Clearinghouse Claim Submissions

The Company's contracted healthcare clearinghouse is RelayHealth. The ChangeHealth Payer ID is 41352. Eye care professionals must use this ID number when submitting electronic claims to the Company through RelayHealth. Please call the Company at 1 (800) 243-1401 to register for use of RelayHealth.

## C. ASC X12N 837 HIPAA Standard Format – Direct

Any eye care professional wishing to submit claims in the ASC X12N 837 format directly to the Company should contact the Company at 1 (800) 243-1401.

## D. IV. Paper Claims – CMS 1500 Claim Form

The Company accepts the CMS 1500 (version 02/12) claim form for claims processing purposes for all covered services. It is crucial that all areas of the claim form be correctly completed and the claim submission include any required attachments or other data necessary to process the claim, as incomplete claim forms will be returned to the eye care professional for completion prior to processing. This is required because the Company must report to its health plan clients on the number of members seeking services, as well as the types of services rendered.

All paper claims must be submitted to the Company at the following address:

Versant Health
Claims Department

PO Box 967
Rancho Cordova, CA 95741

When completing the CMS 1500 claim form, please note the following:

- In order for a claim to be considered a "clean claim," the following sections of the claim form must be completed: 1a, 2–7, 11.c, 12– 14, 21, 23– 33. Please include the eligibility verification number issued by the Company in Section 23 of the claim form.

- The name of the health plan through which the member is enrolled must appear in Section 11c. Please note that the Company is not the insurance plan name or program name for government programs (e.g., Medicaid, CHIP, Medicare, etc.).

- Section 24 may include either the Company's contracted fee schedule for exams and eyewear (as applicable) or the eye care professional's usual and customary fees for services and eyewear rendered. Claims will be processed in accordance with the contracted fee schedule and/or the applicable plan-specific compensation rates, regardless of billing methodology.

- The eye care professional's NPI number must be included in Box 33a and the company location number (the location number assigned to you by the Company) must be included in Box 33b of the paper claim form.

- All claim forms must be signed by the patient at the time the services are rendered (Section 12) as a means of verifying receipt of services, unless the patient's signature is on file with the eye care professional's office, and the eye care professional indicates that on the claim form.

## E. Claim payment procedures and Electronic Funds Transfer (EFT)

The Company adjudicates all claims for covered services in accordance with applicable state prompt pay laws and/or applicable Medicaid or Medicare regulations. Superior Vision offers eye care professionals payment through Electronic Funds Transfer (EFT) direct deposit, which includes electronic remittance advice (ERA). Eye care professionals may enroll in the program by visiting www.instamed.com/eraeft. Eye care professionals who are not enrolled in EFT will receive paper checks.

If the Company does not adjudicate a Clean Claim within the timeframe required under applicable law or program requirements, the eye care professional shall be entitled to receive interest calculated and paid in accordance with the applicable state or federal prompt pay

law. The Company reserves the right to audit any claim in accordance with applicable state or federal laws or regulations.
Eye care professionals are encouraged to use the Company's website to obtain the status of a claim. If the claim is marked as "paid" and more than 20 days from the date of the check has passed and the eye care professional has not received the check, the eye care professional may contact the Company to trace the check. The Company will research any lost check for up to one year from the date of issue.
Unless otherwise required by applicable law, all claim payments are deemed final within 60 days of the date of payment unless the eye care professional notifies the Company within such 60 day period that the eye care professional disputes the amount paid. Any claim dispute must be submitted by the eye care professional to the Company, in writing by mail to the address noted above for submission of paper claims. Such correspondence must specify the amount disputed and include all supporting documentation.

## F. Member charges

The eye care professional is responsible for collecting from the member all co-payments, charges for non-covered services/items, and/or services/items which exceed the benefit allowances. Payment is due at the time services are rendered, unless other arrangements have been established between the eye care professional and the member.
Please remember the following policies, which must be adhered to at all times:

- Eye care professionals are not permitted to bill the member for any amounts due from the Company. Eye care professionals are also not permitted to balance bill members for the difference between the eye care professional's usual and customary charges for covered services/items and the reimbursement amount agreed to between the Company and the eye care professional.

- Members must be informed and acknowledge in writing their agreement to pay for all requested non-covered services/items or services/items whose retail cost exceeds the plan's benefit allowances. Such notification and acknowledgment of charges must be coordinated in advance of the provision of such services/items and must include the amount the member will be required to pay. Failure to give the required notice and obtain the acknowledgment will result in the member's non-liability for such charges. The Company bears no financial responsibility for these charges.

# Section VIII
# Doctor-patient relations

## A. Non-discrimination

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

## B. Cultural competency and sensitivity

As established by the Participating eye care professional Agreement, eye care professionals must provide covered services in a culturally competent and sensitive manner to all Versant Health members, including those with limited English proficiency and diverse cultural and ethnic backgrounds. Eye care professionals will only be able to provide culturally competent services if cultural knowledge and sensitivity is incorporated into the office policies, procedures and service manuals.

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

Translation services at no cost to the patient during the provision of services are available through Versant Health for members requiring communication in a language other than the languages available at the participating Versant Health office. As a best practice, eye care professionals should contact eye care professional services 844-585-2020 at least seven (7) business days prior to the patient's appointment to request translation services. The patient's language preference must be documented in the patient's clinical files. Refusal by a patient to accept access to language assistance through the Company at no cost to the member should also be documented in the clinical files.

The Company's client health plans, through which a member may be enrolled, are required by law to give the member written information concerning health care advance directives. If a member is not competent to make health care decisions due to a physical or mental change or condition as determined under applicable state law and gives the eye care professional an advance directive regarding the member's health care, the eye care professional is required to document the member's medical record with respect to the existence of the advance directive in compliance with the Patient Self-Determination Act (Section 4751 of the Omnibus Reconciliation Act of 1990), as amended, and other applicable law. The advance directive will serve as the member's instructions, as applicable, regarding the provision or withholding of eye care services or the designation of another individual to make treatment decisions on the member's behalf if the member is or becomes unable to make his/her own decisions.

## C. Open clinical dialogue

Versant Health encourages practitioners to engage in open clinical dialogue with their patients including, but not limited to, the discussion of all possible and applicable treatments, whether those treatments are covered services under the patient's benefit plan. Eye care professionals are not restricted from filing a complaint or making a report to an appropriate governmental body regarding policies and practices the eye care professional believes may negatively impact the quality of or access to patient care, nor does Versant Health prohibit or restrict an eye care professional from advocating on behalf of the member for approval or coverage of a course of treatment.

## D. Confidentiality for abuse, neglect, and domestic violence victims

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

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

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

laws by implementing protocols to ensure confidentiality for domestic violence victims and educating staff accordingly.

## E. Benefit abuse

If the eye care professional suspects that a patient is misusing a plan benefit, these suspicions should be reported to Versant Health's Special Investigation Unit (SIU) at **1 (800) 501-1491**.

## F. Coordination of benefits

In general, Versant Health does not coordinate benefits with other insurance companies for in-network services. Since there are a few exceptions, eye care professionals should contact Customer Service at 1 (800) 507-3800 if the patient indicates they want to coordinate benefits. If the patient is using his/her out-of-network benefits and has already submitted to the primary carrier, eye care professionals should ask the patient to attach the statement or explanation of benefits (EOB) to the out-of-network claim form at time of submission to Versant Health.

## G. Scheduling an appointment

Routine appointments must be made available for members within ten (10) calendar days of a request for an appointment. Appointments for urgent conditions should be made available within forty-eight (48) hours of request. Appointment scheduling requirements are applicable to new and existing patients.

Versant Health's members will contact the eye care professional's office directly to schedule an appointment. At that time the eye care professional should obtain the member's name, identification number, patient's name (if different from member), date of birth, and relationship to the member. At that time, the patient's current eligibility should be verified via superiorvision.com or the IVR at 1 (800) 507-3800. If the patient is not currently eligible for services, you should inform him/her of the next date of eligibility.

**Best practice:** The eye care professional should remind patients to notify the office if they are unable to keep an appointment.

Patients should be reminded to bring identification with them at the time of the appointment. Eye care professionals are not obligated to provide non-emergent services for members who fail to produce proper identification or members who are not eligible for services. Superior Vision network eye care professionals should exercise due caution in positively identifying the patient seeking services is the same patient covered by the plan benefits which have been authorized**. Identity theft can be common in health care** and eye care professionals should develop policies and procedures to positively identify each

Versant Health member seen in their offices. If the identity of any patient your office provided services is challenged subsequent to service, the eye care professional's office may be required to supply the positive identification used prior to delivery of services or risk having all fees paid to them for that patient's service, recovered by Versant Health.

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

**Best practice:** Eye care professionals are encouraged to have Members to sign a form accepting financial liability for missed appointments.

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

## H. The office visit

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

By contractual agreement, Superior Vision network eye care professionals must comply with standards of care based on the guidelines of the American Academy of Ophthalmology and the American Optometric Association.

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

**Best practice:** To have the patient sign the Service Record Form (available from the patient's authorization on superiorvision.com) and place the signed copy in their file at **every** visit.

### 1. Patient history

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

- Present complaint or reason for the visit
- Medical history and any other significant events, including surgical history
- Eye and vision history, social and family history

- Current medications
- Allergies and reactions
- Any other pertinent information

## 2. Examination

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

- Medical History, including chief compliant
- History of present illness
- General medical observation
- Review of systems
- Assessment of current entrance, acuity, distance and near, using the member's present corrective lenses, if applicable
- External ocular evaluation including slit lamp examination
- Internal ocular examination*
- Tonometry
- Refraction – objective and subjective**
- Binocular coordination and ocular motility evaluation
- Evaluation of pupillary function
- Biomicroscopy
- Gross visual fields

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

** Versant Health may not cover refraction-only services. The refraction (CPT 92015) is considered to be a part of the comprehensive eye examination per the Participating Eye care professional Agreement. This procedure cannot be billed separately to the patient when receiving reimbursement from Versant Health for a comprehensive eye exam.

## 3. Contact lens examinations and fittings

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

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

## 4. Provision of prescription for corrective eyewear

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

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

### 5. Dispensing corrective eyewear

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

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

### 6. Referring patients for additional services

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

If the eye care professional's recommendations exceed the limitations of the patient's benefit through Versant Health, please instruct the patient to contact his/her medical carrier for further guidance. you're the eye care professional should make sure the patient has enough information about the reason for the referral so they can provide sufficient information to the medical carrier.

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

## I. Members with special needs

The Company is committed to making arrangements to accommodate member's with special needs to ensure that such members have access to administrative and clinical services within the scope of the Company's program on the same basis as do members without special needs. Eye care professionals must notify the Company of members with special needs so that appropriate accommodation can be made for such members. Due to

varying individual needs, the Company may determine the nature of the accommodation on a case-by case basis pursuant to the special need identified.

For those members that are non-English speaking, the Company employs bilingual (English and Spanish) customer services representatives and utilizes the services of LLE Link for translation assistance in processing calls in more than 150 other languages. The Company utilizes the services of the Maryland Relay Service (1-800-201-7165; or TTY 1-800-735-2258) for communication with individuals who are hearing impaired. The Company will also provide translation services in the eye care professional's office to facilitate access to vision care services.

The health plan through which the member is enrolled is required by law to give the member written information concerning health care advance directives. If a member is not competent to make health care decisions due to a physical or mental change or condition as determined under applicable state law and gives the eye care professional an advance directive regarding the member's health care, the eye care professional is required to document the member's medical record with respect to the existence of the advance directive in compliance with the Patient Self-Determination Act (Section 4751 of the Omnibus Reconciliation Act of 1990), as amended, and other applicable law. The advance directive will serve as the member's instructions, as applicable, regarding the provision or withholding of eye care services or the designation of another individual to make treatment decisions on the member's behalf if the member is or becomes unable to make his/her own decisions.

The Company is also committed to assisting in the coordination of care for members who are minors and require the involvement of a parent, guardian, or other individual in making decisions concerning the minor's eye care.

## J. Arrangements for prolonged absence/office closing

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

If the eye care professional's office is closing permanently, the eye care professional should advise Versant Health as soon as possible by calling Provider Relations at 1 (800) 584-3140. Under the terms of the Participating eye care professional Agreement, it is the eye care professional's responsibility to notify Versant Health members prior to the effective date of their discontinuance from the Superior Vision network. Under these

circumstances, if the patients ask for copies of their records, the eye care professional must provide them prior to the effective date of their discontinuance from the Superior Vision network.

## K. Emergency care provisions

As established in your Superior Vision Participating eye care professional Agreement, the eye care professional must make after hours emergency care provisions for members twenty-four (24) hours a day, seven (7) days per week. Each method of communication must contain information about the eye care professional'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 Versant Health 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 eye care professional without obtaining prior approval from Versant Health . Because Versant Health provides routine vision care benefits only, reimbursement for emergency services will be solely dependent upon whether the member is eligible for the benefit.

## L. Refusal of care

Versant Health's members who are of legal age have the right to refuse to comply with recommended treatment. The patient should inform the eye care professional of his/her decision. It is the eye care professional's responsibility to inform the member of any potential consequences.

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

## M. Investigational studies

**Definition:** Investigational or experimental treatment is described by Versant Health 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 Versant Health does not participate in investigational studies, it does not prevent independent eye care professionals from participating in such studies. Services and care

associated with investigational studies are funded separately by the sponsored research program. It is Versant Health's policy that all participating eye care professionals who do participate in and conduct independent studies will:

- Inform the patient of the purpose of the study
- Inform the patient that they have 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 Versant Health program. It is the policy of Versant Health that members have the right to refuse to participate in research and/or investigational studies.

## N. Transfer of patient records

If a member requests that an eye care professional transfer his/her patient care records to another eye care professional, the eye care professional is required to complete the transfer within fourteen (14) days following the request, or as such other time period required under applicable Regulatory Requirements.

## O. Member or eye care professional claim dispute/complaint process, member grievance/appeal process

The Company provides vision care services to beneficiaries located in all fifty states, the District of Columbia, Puerto Rico, and Guam. The generic processes described below may not be inclusive of all state-specific or federal requirements. For more complete information and guidance, call the Company's Complaints and Appeals Department at **1 (888) 343-3470**.

### Eye care professional Claim Dispute and Complaint Process

Versant Health provides for a two-level dispute and complaint review process of which the determination will be final; however, additional levels of appeal may apply in accordance with any contractual state or federal regulation where applicable.

An eye care professional must file a complaint or dispute in writing within 60 calendar days following the date of notification of the initial claim determination or incident of dissatisfaction to:

**Versant Health**
**Complaints and Appeals Department**
**PO Box 791**
**Latham, NY 12110**
**Email: ProviderCA@versanthealth.com**
**Fax: 1-888-778-2008**

Eye care professionals should provide, at a minimum, the following information with their dispute or complaint request:

- Eye care professional's Superior Vision number
- Eye care professional name
- Eye care professional address
- Eye care professional telephone number
- Patient ID number
- Member name
- Patient name (if different from member)
- Date of service
- Billed amount
- Authorization number
- Clear description of reason for appeal

An acknowledgement letter is sent to the eye care professional within five (5) calendar days of receipt summarizing the challenge and providing clear direction regarding the process for an eye care professional to submit additional information for review. Upon receipt of all necessary information, an associate qualified to render a decision and who was not involved in the initial determination, will review the dispute or complaint and render a determination/resolution.

The Company will complete its review, make a determination and provide a written determination/resolution to the eye care professional within 30 calendar days from receipt of the initial dispute.

The Company does offer a second level appeal process if an eye care professional is dissatisfied with an underlying determination. Initial dispute or complaint notification sent to an eye care professional will include instructions on how to appeal a decision/resolution. an Appeals would need to be initiated in writing within 15 calendar days of the Company's underlying written decision.

**Member complaint / grievance / appeal process**

The Company allows a member, a member's designee or healthcare provider 180 calendar days to appeal an initial adverse determination.

Written acknowledgement of the filing of the appeal is issued, at which time the member, member's designee or healthcare provider is informed of the ability to submit written comments, documents or other information relating to the appeal. The acknowledgement notice will also provide direction as to how the member can designate a representative to act on their behalf. In the event of a medical necessity appeal request, the affected individuals will be given information regarding an external review process if Versant Health does not complete its appeal review the specific state or federal requirement, where applicable.

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

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

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

Appeal determinations are made in writing and/or via electronic notification within the following timeframes:

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

Extension of the above timeframes are made if the member voluntarily agrees to extend the appeal timeframe.

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

- Specific reasons for the appeal decision, in easy-to-understand language.

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

When decisions are overturned upon appeal, the notification will state that decision and the date.

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

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

The Company offers a second level of appeal to a member, the member's representative or a healthcare provider on the member's behalf if such appeal is requested within one 180

calendar days of the first level appeal determination. Second level determination timeframes will follow the same timeframes outlined in the first level appeal process.

Additionally, a member, member's representative, or healthcare provider may request an external review within 4 months after a final internal adverse determination for medically necessity has been made; however, with the member's permission, Versant Health reserves the right to refer an appeal, regardless of level, directly to an independent review organization (IRO) without conducting an internal review. Versant Health will comply with state or federal requirements as applicable.

# Section IX
# Ophthalmic materials and laboratories

## A. New Eyewear Dispensing Program

In October 2019, Versant Health announced its' new eyewear dispensing program and the program will be presented to the network in a phased approach. The program keeps costs stable and provides you and your patients with access to high quality eyewear using advanced technology and broad choice in lens functionality. The program also includes timesaving, simplified administration of orders and claims. Under the new eyewear dispensing program, eye care professionals will dispense orders from a catalogue featuring innovative products from Essilor, using a nationwide network of Essilor labs. Dispensing will take place through an integrated lab ordering process using a brand-new online portal. Portal training will be offered through our Network Development and Provider Relations Teams.

Our new eyewear dispensing program offers your patients who are commercial members a vastly expanded product selection. Eyewear dispensed to your patients in our Medicaid plan will be ordered from the Versant Health lab in Pennsylvania. We will offer our exclusive frame collection for select Medicaid benefit programs and some plans may require the dispensing of collection frames.

We look forward to your continued participation in our network of valued eye care professionals and eyewear dispensing program and we thank you for your continued service to our members. If you have any questions or concerns, please contact an eye care professional representative at 844-585-2020.

## B. Lab error remakes

All lens remakes due to an Essilor Lab error will be processed at no charge with a description of the lab error, copy of the original invoice/ shipping slip and lenses must be returned, up to six (6) months from original Rx delivery.

## C. Essilor lens warranty redos

While under warranty, lenses will be processed at no charge. Eye care professionals are required to return the lenses with a copy of the original invoice/shipping slip as requested by the lab.

- Non-adapts: For a period of sixty (60) calendar days from the original date of dispensing Progressive and Digital Single Vision lenses will be remade with a fitting change one time at no charge in the same design and material (or lesser priced design and material). If the Member still cannot adapt after the no-charge replacement, Essilor will remake the Rx into conventional lenses at full charge and bill the eye care professional.

- Varilux
  - Within 365 days of delivery, if the Member is not satisfied with the progressive addition lenses, Essilor will remake the progressive addition lenses with a fitting change one time at no charge in the same progressive design and material (or lesser priced design or material). If the Member still cannot adapt after the no-charge replacement, Essilor will remake the Rx into conventional lenses at full charge to the eye care professional. OR:
  - Within 365 days of delivery, if the Member is not satisfied or cannot adapt to the original progressive lenses and prefers to go directly from the original progressive Rx to conventional lenses, the original progressive lenses will be credited and the conventional lenses will be billed at full charge to the eye care professional.

- Scratch: All scratch resistant coated lenses are guaranteed for one year from date of order and will be replaced at no charge during that one year in the same prescription and original frame at no additional charge if damaged due to scratching. Lenses must be replaced in identical form. A maximum of one replacement per Rx order is allowed. Front surface scratches through normal use will be covered; however, abuse of the lens will not be covered.

- Anti-reflective: Anti-reflective coatings are warrantied for a one-year, one-time replacement in the same prescription and original frame at no additional charge. Lenses must be replaced in identical form.

- Crizal®: Lenses are guaranteed for two years, two-time replacement. As long as a Member is wearing lenses coated with Crizal, Essilor will stand behind these with a one hundred percent (100%) Patient Satisfaction Guarantee. In the event a Member is dissatisfied for any reason with the performance of his or her Crizal lenses, Essilor will replace them with scratch resistant lenses, without AR, in the same prescription and original frame at no additional charge.

## D. Eye care professional lens redos

First-Time eye care professional Redo

- First-time eye care professional redos for lenses only are at no charge to the eye care professional as long as they meet all of the following criteria:
    - Same Essilor Lab used for original job and redo
    - Requested within six (6) months of ship date
    - Redo for lenses only
    - Not a frame change alone
    - First redo request only (not 2nd or 3rd)
    - Not due to an upgrade request
    - Not due to materials lost, broken or damaged by Member
- Acceptable first-time eye care professional redos require at least one of the following:
    - Power changes (not including changes resulting in plano lenses)
    - Axis changes
    - Segment height/segment style changes due to no adaptation (i.e., FT28 to Executive)
    - Change in lens style (i.e. TF to BF, BF to SV, or any other base lens change, except PAL to non-PAL lens style)
    - Errors in transcription (not including transcription errors involving tints, photochromics, frames or coatings)
    - Change in materials (i.e., glass to plastic, plastic to poly, plastic to high index plastic or glass, etc.)
    - Changes in base curves
    - Lenses within ANSI standards but rejected by eye care professional
- To qualify, eye care professionals are requested to return the lenses with a copy of the original invoice/ shipping slip.
- Frame Changes

- A frame change is not an acceptable First-Time eye care professional Redo if it is due to eye care professional's error or the Member's dissatisfaction with the style, shape, size or fit of the frame. The Eye care professional will be required to submit the redo request and ship the new frame to the Essilor Lab. The Eye care professional will be billed for the redo job at the full private pay pricing.
- Subsequent Doctor Redo
- After the First-time eye care professional Redo policy is applied, eye care professionals will be charged at full private pay pricing for subsequent Doctor redos on the same job.

- Eye care professional Redo and Essilor Lab errors after six (6) months
  - Redo requests submitted to the Essilor Lab six (6) months or more after the original shipped date will be charged to the Eye care professional at the full private pay pricing.

## E. Patient redos

Essilor shall be responsible for the costs associated with the following redos:

- Breakage Warranty for Collection Frames and/or Lenses: All Vision Collection frame and/or lenses are warranted against breakage for one (1) year from the original date of dispensing. Limited to a one-time use, except for Versant's United Automobile Workers Client that has a two (2) year breakage warranty.

- Allergic Reaction to Vision Collection: If the Member experiences an allergic reaction to plan-supplied frames within the first ninety (90) calendar days from the original date of dispensing, Essilor will provide a new complete pair of frame and lens eyeglasses in an alternative frame at no charge. Limited to a one-time use.

- Patient Requested Returns: For a period of forty (40) calendar days from the date the shipped notification is received from Essilor, the Member may return to the Eye care professional any pair of eyeglasses for changes to the Vision Collection frame and/or lenses selected. Limited to a one-time use.

## F. Cancellations

Jobs are considered in manufacturing process as soon as the order has been submitted to the Lab. At Essilor's sole discretion, a cancellation of a job may result in the job being billed to the Eye care professional at private pay pricing.

## G. Upgrades

If additional options are requested by the Eye care professional, and the Rx job has to be cancelled and restarted, the Eye care professional may be charged, at Essilor's sole discretion, for the original cancelled job and the new upgraded job will be the charged to Versant Health.

## H. Repair & replace benefit

A number of government programs managed by Versant Health provide coverage for the repair or replacement of damaged, lost, or stolen eyeglasses. Coverage for these items must meet the terms and conditions outlined in the member's benefit plan. In the event of a Repair and Replace benefit, Versant will send Essilor a new electronic order through the Eye care professional Portal and Essilor will bill Versant for the order at the prices in the Price List.

## I. Uncut lenses

Any redo request for uncuts, due to Eye care professional finishing errors, will result in the Eye care professional being billed directly at their full private pay amount.

## J. Eye care professional supplied frames

In the event Essilor damages or loses a new, Eye care professional-supplied frame, Essilor will use commercially reasonable efforts to provide a replacement at no cost, without involvement of the Eye care professional's office. If the frame cannot be replaced, Essilor will reimburse the Eye care professional's office for the cost of the replacement frame, as originally invoiced to their office by the frame manufacturer or distributor. Essilor will not reimburse the retail price for the frame.

## K. Patient supplied frames or lenses

Essilor will not accept responsibility or liability for either frames and/or lenses supplied by the Member, including loss or damage. Essilor will make commercially reasonable efforts 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 Vision collection at prevailing copays, if applicable, or from the Eye care professional's selection) at the Member's own expense.

## L. Sales tax

If you are in a state that charges sales tax, please ensure you complete and return a Uniform Sales and Use Tax Certificate to Versant Health. This form is available from the Network Development and Eye care professional Relations Teams and can be signed using DocuSign or by mailing it to us. States that currently charge sales tax include: AL, AR, HI, IL, KY, MI, MS, NE, NM, NV, OH, OK, SC, and UT.

If you are in one of these states and do not return the completed form to Versant Health, you will be charged sales tax on your lab orders.

# Section X
# Network management and participation

## A. Overview

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

## B. Council for Affordable Quality Healthcare (CAQH)

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

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

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

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

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

## C. Initial credentialing process

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

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

**Note: During the verification process, if credentialing information obtained from primary or secondary sources varies substantially from submitted information, the applicant is contacted by phone within thirty (30) days of discovery and extended an opportunity to correct erroneous information via fax to a Credentialing associate within ten (10) business days with an explanation and supportive documentation.**

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

Versant Health completes its review of the application and notifies the applicant in writing of the outcome or status within one hundred and eighty (180) days (unless more stringent timeframe is a state mandate) of receiving the complete application. Denial notifications advise an applicant the reason for the denial and afford the applicant an opportunity to correct erroneous information and appeal the decision based upon the erroneous information.

## D. Ongoing monitoring of credentials

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

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

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

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

## E. Recredentialing process

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

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

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

Thirty (30) days from the date of the initial notification letter, a second request is sent to any practitioners who have not yet submitted the recredentialing documentation. Thirty (30) days from the date of the second request, a third request is sent to any practitioners who have not yet submitted the recredentialing documentation. Thirty (30) days from the date of the third request, a final request is sent to any practitioners who have not yet submitted the recredentialing documentation advising them that their participation with Superior Vision network 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.)

Versant Health's recredentialing process includes a review of the practitioner's performance since initial credentialing. Performance indicators may include, but are not limited to, results

of site visits and medical record review, member complaints, and member satisfaction surveys.

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

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

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

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

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

## F. Participating eye care professional agreement

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

Regardless of the way an individual eye care professional has joined the Superior Vision network, the signed Agreement obligates all eye care professionals to comply with numerous requirements including, but not limited to, the following:

Eye care professional agrees to be bound by all the provisions of the rules and regulations of the Superior Vision network as well as all applicable laws and administrative requirements of regulatory agencies.

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

Eye care professional 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.

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

Eye care professional agrees to comply with Superior Vision network's eligibility system requirements and to obtain a valid confirmation of eligibility number prior to rendering services to any member.

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

Eye care professional agrees to prepare and maintain patient records consistent with generally accepted standards and the requirements of Versant Health.

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

Eye care professional agrees to accept the Plan's fees as payment in full (except for applicable plan copayments) for the eye examination and dispensing of lenses and frames or contact lenses provided by the central laboratory. The client-specific fees will be applied for all billing, laboratory orders and allowances for non-plan items. The eye

care professional agreed not to assert any patient charge for covered items except for applicable co-payments or allowable amounts.

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

Eye care professional agrees, if applicable, to maintain the Collection of Plan frames in accordance with the specifications in the Eye care professional Agreement. Beneficiaries will be shown all suitable frame styles. The Collection, display, and other Plan materials will be returned to Versant Health upon request.

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

Eye care professional agrees to indemnify and hold Versant Health and its members harmless from any damages or legal action arising out of the services provided under the terms and conditions of the Eye care professional Agreement.

Eye care professional agrees to submit and maintain on file with Versant Health a current and completed application, copies of their current state and CDS/DEA licenses, board certification and current malpractice policies, among other items as applicable.

Eye care professional will maintain in good standing all licenses required by law and must notify Versant Health immediately of any action, which may adversely affect continuation of any applicable licenses. The eye care professional must also notify Versant Health of any pending malpractice claims or settlements made against them.

Eye care professional agrees to allow Versant Health to conduct on-site office visitations and patient record reviews and to cooperate fully with those peer review programs.

Eye care professional agrees to abide by the protocols and standards detailed in this manual.

## G. Eye care professional and office demographic changes

Eye care professionals have an obligation to promptly notify Versant Health of all changes. Changes shall be submitted in writing and the Superior Vision Network Eye care professional Addition, Change, and Termination Forms can be located and downloaded from the Eye care professional Portal. The forms may also be requested from the Eye care professional Recruiting Team.

The following time frames should be followed:

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

- Removal of a participating eye care professional requires a thirty (30) days prior notice.

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

- Addition of a new eye care professional to the office:

    - Already credentialed Superior Vision network eye care professional requires thirty (30) days prior notice
    - Non-credentialing eye care professionals require one-hundred twenty (120) days prior notice

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

## H. Access and service delivery standards

While the exact schedule of covered services and benefit allowances will vary from plan to plan, the Company maintains a series of access and service delivery standards which must be followed for all services provided to the Company's client's members. Participating eye care professionals are required to comply with all of the following:

1. Office Hours: The eye care professional must maintain office hours of at least 32 hours per week.

2. Appointment Standards: Members must be offered an appointment within two weeks of the date of request.

Compliance with this standard is measured based upon the eye care professional's first available appointment and not when the appointment is actually scheduled, as we recognize the member may impose certain availability restrictions, for which the eye care professional cannot be accountable.

The standard in-office waiting time for a wellness vision appointment is within 30 minutes of the scheduled appointment, and the standard for in-office waiting time for a medical eye care appointment is within 45 minutes of the scheduled appointment.

All eye care professionals are required to accept new patients. Eye care professional shall not differentiate or discriminate in the provision of services to members or in the quality of services delivered to Members on the basis of race, color, sex, sexual preference, marital status, age, religion, place of residence, health status, handicap, disability, credit history, or source of payment. Eye care professionals must observe, protect, and promote the rights of Members as patients. Eye care professionals must provide care and services to Members on the same basis as they provide care and services to non-Members.

## I. Security requirements

The Company expects that all eye care professionals are familiar with, and eye care professionals have educated their staff regarding, the Health Insurance Portability and Accountability Act's Security regulations set forth in 45 C.F.R. Parts 160, 162, and 164 (the "HIPAA Security Rule") as applicable to an eye care professional who transmits any health information in electronic form in connection with a transaction covered by HIPAA, and regarding standard transactions regulations as set forth in 45 C.F.R. Part 160, 164, subparts A, C, and E and Part 162 (the "Transactions Rule"). All terms used in this section, but not defined in this section, shall have the meaning given to those terms in the HIPAA Security Rule or the Transactions Rule.

The Company expects all eye care professionals covered by the HIPAA Security Rule and/or Transactions Rule to comply with all applicable provisions of the HIPAA Security Rule and/or Transactions Rule, including, without limitation the following:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Electronic Protected Health Information that the eye care professional creates, receives, maintains, or transmits on behalf of the Company or any plan.

2. Report to the Company any Security Incident of which the eye care professional becomes aware.

3. Ensure that any agent, including a subcontractor, to whom the eye care professional discloses Electronic Protected Health Information received from the Company or any plan agrees in writing to implement reasonable and appropriate safeguards to protect such Electronic Protected Health Information

4. If the eye care professional conducts Standard Transactions (as defined in 45 C.F.R Part 162), for or on behalf of the Company or any plan, the eye care professional will comply, and will require each subcontractor or agent involved with the conduct of such Standard Transactions to comply, with all applicable requirements of the Transactions Rule.

## J. Patient safety, adverse events, sentinel events, and quality issues

The Company is committed to promoting an environment that helps eye care professionals improve the safety of their practices. This includes the collection of data regarding eye care professional compliance with universal patient safety standards and making data regarding such findings available to the Company's client health plans and to members enrolled through such clients.
To this end, the Company has adopted an Infection Control Policy which is based upon the "universal precautions" guidelines of the Centers for Disease Control (CDC) and that of the Occupational Safety and Health Administration (OSHA). A copy of the Infection Control Policy is available upon request by contacting the Company's eye care professional relations department at 1 (800) 243-1401.

The Company will include measurement of eye care professional compliance with the Infection Control Policy in the site reviews it conducts of participating eye care professional offices, with findings to be shared with the health plan clients on whose panel the eye care professional participates.

Eye care professionals must promptly report to the Company any adverse events, sentinel events, or quality issues. Adverse events are defined as an injury to a member that occurred when receiving vision care from an eye care professional. Sentinel events are any unanticipated event in a healthcare setting resulting in death or serious physical or psychological injury to a patient, not related to the natural course of the patient's illness. Quality issues are related to the quality of care received. Quality of care refers to the degree to which health services increase the likelihood of desired health outcomes and are consistent with current professional knowledge. Please contact the Company's quality department at 1 (800) 243-1401 to report any adverse events, sentinel events, or quality issues or if there are questions about such issues.

## K. Miscellaneous

Additional policies and procedures not previously addressed include the following:

- Eye care professionals may not highlight the Company's or the health plan's name in their advertising. Eye care professionals may include the health plan's name in a comprehensive list of managed care participation; however, neither the Company nor

its clients may be singled out or treated differently from other health plans or companies in any way. Eye care professionals further agree not to directly solicit known health plan members in any way.

- Eye care professionals must be generally supportive of managed healthcare, the Company, and its client health plans in their communication with members. Eye care professionals must not encourage members to disenroll from the health plans and must not encourage participation in one health plan over another.

- In order for the Company's client health plans to comply with applicable laws regarding notification to members of an eye care professional termination, all participating eye care professionals are required to notify the Company if they elect to terminate their participating eye care professional agreement with the Company in advance of the effective date of such termination within the time period specified in the participating eye care professional agreement. Participating eye care professionals agree that in the event of expiration or termination of a participating eye care professional agreement with the Company, the health plan and/or the Company will notify members seen on a regular basis by the terminating eye care professional of the eye care professional's termination from the Company network.

Unless otherwise stated in the plan-specific sections of this Eye care professional manual, the Company's programs are limited to wellness vision services. When medical eye care and diagnostic procedures are not administered by the Company, the health plan requires eye care professionals to refer the member to the primary care physician in the event such services are determined to be necessary. Any questions regarding the rendering of such services must be directed to the health plan.

## L. Eye care professional corrective action plans, peer review, and appeal processes

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

The Eye care professional Dispute Resolution Processes are at a minimum reviewed annually by the Credentialing Committee to determine if any updates or changes are needed. The Credentialing Committee is comprised of participating practitioners, non-participating practitioners, and Versant Health personnel involved in the administration of the Credentialing Program.

The dispute process requires direct communication between the eye care professional and Versant Health and does not require any action by an enrollee. A written dispute is considered a formal request for review.

Versant Health will not retaliate or take any discriminatory action against any eye care professional as a result of filing a dispute.

The Eye care professional Disputes Resolution Processes applies:

1. Administrative Action Disputes – disputes involving administrative matters not related to quality of care.

2. Credentialing Disputes – disputes concerning an eye care professional's professional competence or conduct and terminations for professional competency and/or conduct, or quality-of-care issues.

## 1. Administrative disputes

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

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

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

Administrative Action Dispute Process

1. To begin the process, Versant Health will send a termination letter notifying the eye care professional that the contract is terminated and providing information about the reconsideration rights.

2. The eye care professional may request reconsideration in writing, no later than 60 calendar days after receipt of the notice from Versant Health.
3. An acknowledgement letter will be sent to the eye care professional within five (5) calendar days of receipt summarizing the reconsideration and providing clear direction regarding how an eye care professional can submit additional information for review.
4. After the eye care professional's reconsideration request is received, an authorized representative of the organization, not involved in the initial decision on the subject of the dispute, will review the written reconsideration and make a decision.
5. The authorized representative's decision is final and will be communicated to the eye care professional in writing within 30 calendar days from the receipt of the eye care professional's written reconsideration request.

Eye care professionals must file administrative dispute communications in writing within sixty (60) calendar days to:

**Versant Health**
**Network Operations**
**175 E. Houston 5th Floor**
**San Antonio, Texas 78205**

## 2. Credentialing disputes

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

i. Termination with cause

Versant Health may terminate the Superior Vision Eye care professional Agreement immediately for cause. "Cause" means:

- A suspension, revocation, or conditioning of eye care professional'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 eye care professional, that in Versant Health's sole discretion endangers the health, safety, or welfare of members.
- Any other material breach of any obligation of the eye care professional as detailed in the terms of the Eye care professional Agreement.
- Conviction of a felony.
- The bankruptcy of an eye care professional.
- Loss or suspension of a Drug Enforcement Administration (DEA) identification number.
- Voluntary surrender of the eye care professional's license to practice in any state in which the practitioner serves as a Superior Vision network eye care professional while an investigation into the eye care professional's competency to practice is taking place by that state's licensing authority.
- A failure by eye care professional to maintain malpractice insurance coverage as required by the Eye care professional Agreement
- A failure by eye care professional to comply with applicable laws, rules, regulations, and ethical standards as required by the Eye care professional Agreement
- A failure by eye care professional to comply with Versant Health rules and regulations as required by the Eye care professional Agreement
- A failure by eye care professional to comply with the utilization review, quality management, and special investigation (FWA) procedures as required by the Eye care professional Agreement
- A violation by eye care professional of the non-solicitation covenant contained in the Eye care professional agreement whereby the eye care professional agrees not to directly or indirectly engage in the practice of solicitation of members, plans or any employer of members without Versant Health's prior written consent.

- Failure to comply with the recredentialing process.
- Egregious billing practices
- Excessive number of member complaints

ii. Suspension for cause

Versant Health may suspend the Superior Vision Eye care professional agreement for cause. “Cause” means:

- A failure by eye care professional to comply with applicable laws, rules, regulations, and ethical standards as required by the Superior Vision Eye care professional Agreement
- A failure by eye care professional to comply with Versant Health rules and regulations as required by the Superior Vison Network Eye care professional Agreement
- A failure by eye care professional to comply with the utilization review and quality management procedures as required by the Superior Vision Eye care professional Agreement
- A violation by eye care professional of the non-solicitation covenant contained in the Superior Vision Eye care professional Agreement whereby the eye care professional agrees not to directly or indirectly engage in the practice of solicitation of members, plans or any employer of members without Versant Health’s prior written consent.
- Failure to comply with on-site reviews, record reviews, and/or corrective action plans
- Versant Health reserves the right to immediately suspend the Superior Vision Eye care professional 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. Versant Health will investigate these instances on an expedited basis.

iii. Termination without cause

In addition to Practitioners being considered for professional review (termination or suspension) the Superior Vision Eye care professional Agreement may be terminated by either Versant Health or the participating practitioner/eye care

professional without cause, after the initial twelve (12) month term has ended and upon ninety (90) days prior, written notice.

iv. Appeal processes

A first-level and second-level Appeal Process are available to all participating eye care professionals that have an adverse determination rendered by the Versant Health Credentialing Committee and have been terminated or suspended from the Superior Vision Network. The appeal processes were developed with input from participating eye care professionals and are reviewed at least annually. Unless there is a regulatory mandated State Specific appeal process, the Versant Health Appeals process will be utilized.

## 3. First-level appeal process

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

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

- Name, office address and telephone number of the participating eye care professional
- National Eye care professional Identifier number of the participating eye care professional
- A letter or other written communicating requesting a Superior Vision Participating Eye care professional 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:

  **Versant Health**
  **Network Operations**
  **175 E. Houston Street 5th Floor**
  **San Antonio, Texas 78205**

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

Notice of the hearing will be sent at least ten (10) days before the scheduled hearing date and will advise of the practitioner of his/her right to be represented by an attorney or other person of his/her choice. This notice serves as notification to the practitioner that Versant Health 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 Versant Health at least ten (10) days before the scheduled hearing before the first-level Eye care professional Appeal Committee.

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

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

## 4. Second-level appeal process

To appeal a first-level appeal determination, a practitioner must send a written request to Versant Health (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 Versant Health that the practitioner wants to use the second-level appeal process.

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

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

  **Versant Health**
  **Network Operations**
  **175 E. Houston Street 5th Floor**
  **San Antonio, Texas 78205**

Within sixty (60) days of receipt of the practitioner's second-level appeal, an Eye care professional Appeal Committee will convene to hear the appeal. A second-level Eye care professional Appeal Committee is composed of at least three (3) individuals, who did not participate in the original decision, with at least one participating Network Practitioner who is a clinical peer of the practitioner that filed the first level appeal, who is not involved in the day-to-day operations of Versant Health and who does not

participate on other Versant Health committees. None of these individuals may have been involved in the initial termination.

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

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

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

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

## 5. Reporting to appropriate authorities

All terminations related to professional competence or conduct, adversely affecting clinical privileges for a period longer than thirty (30) days or related to the practitioner's voluntary surrender or restriction of clinical privileges while under, or to avoid, investigation are reported within fifteen (15) days of termination to the National Practitioner Data Bank-Healthcare Integrity and Protection Data Bank (NPDB-HIPDB), and the appropriate state licensing board(s). It is the responsibility of the Credentialing Department associates to submit these reports via the IQRS application available through the NPDB website: www.npdb-hipdb.com. IQRS includes a draft report feature allowing for report data input and saving. In addition, the associate mails a copy of the report to the appropriate state licensing board.

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

# Section XI
# Quality management

## A. Overview

The purpose of Versant Health'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/eye care professional satisfaction.

The QM program committee structure includes participation of a participating eye care professional. Annual evaluation of the Versant Health QM program can be made available to any participating eye care professional upon request.

## B. Medical records and office site review program

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

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

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

### 1. Eye care professional site and medical record review elements

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

a. As reflected in the Medical Record Audit Tool located on the eye care professional portal at superiorvision.com, requires adherence to applicable State and Federal laws for the following minimum elements:

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

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

## 2. Instrumentation and equipment

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

- Examination Chair
- Instrument Stand
- Acuity Chart/Slides/Cards
- Ophthalmoscope
- Retinoscope/Autorefractor
- Phoropter
- Tonometer
- Trial Lens Set
- Lensometer

- Keratometer
- Biomicroscope
- Fields Testing Equipment
- Color Vision Test
- Stereopsis Test
- Binocular Indirect Ophthalmoscope with appropriate lens or Slit Lamp Biomicroscope (with appropriate auxiliary lenses)
- All instrumentation must be well maintained, properly calibrated, and in good working order.
- Infection control measures must be incorporated into the maintenance of all equipment.

## 3. Medical records documentation

As reflected in the Medical Record Audit Tool (at superiorvision.com), medical records for its members must include the following minimum documentation.

a. Patient name and date of birth on each page, or patient name and member ID number on each page.
b. Medical records must be legible and organized in a manner that allows for easy identification of patient name, date of birth, significant medical conditions, and allergies
c. Date all entries and identify the author and their credentials.
d. Clearly label or document subsequent changes to a medical record entry by including the author of the change and date of change. The eye care professional must also maintain a copy of the original entry.
e. Dilated Retinal Exams or appropriate substitute must be performed on diabetic members or documentation must be indicated in the member's medical record why the exam was not performed. In addition, documentation of the presence or absence of diabetic eye disease must be present in the member's medical record, documented by ICD-10 coding
f. Allergies to medication or other severe, potentially life-threatening allergic reactions (e.g., severe food allergies, latex, etc.)
g. Address, phone number, or other identifiers

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

i. Relevant past eye, medical, and family history

j. Relevant family ocular history

k. Current medications

l. Allergies to medication

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

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

o. Gross Visual Fields

p. Pupil responses

q. Intraocular pressure

r. Dilated fundus examination, when indicated

s. Presence or absence of diabetic retinopathy.

t. Objective and Subjective Refraction:

u. Best corrected acuities, distance and near with refraction

v. Binocular Function:

w. Ocular motility

x. Assessment/Management:

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

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

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

bb. Printed name and signature of the examining doctor

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

dd. Record must be legible

At least 30 minutes shall be allocated per complete examination. More time may be needed for contact lens patients and for the elderly or disabled or cases with existing pathologies. This amount of time will allow for a complete examination to be done along with all of the necessary patient record documentation.

## A. Site visit and record review trigger methodology

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

As established in the Superior Vision Participating Eye care professional Agreement, the eye care professional is required to provide Versant Health or the clients of Versant Health with copies of complete eye exam records including patient intake history forms for our members within a reasonable time period following our request for the records. Superior Vision participating eye care professionals will provide the requested records without charge to Versant Health or to their client groups requesting the same.

### a. General complaint threshold monitoring

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

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

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

- Complaints involving quality of care, patient safety, physical accessibility, physical appearance or adequacy of waiting and examining room space will warrant site visit review

- Complaints involving quality of service, thoroughness of examination or satisfaction with prescription will warrant medical record review

- If there is a combination of the above, both site and medical record review will be requested

### b. Quality of care/adverse event threshold monitoring

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

Additionally, the Versant Health Medical Director can bypass the site or exam review process and immediately refer an eye care professional challenge to the Versant Health Credentialing Committee to request peer review for possible termination or suspension of network participation when imminent safety and quality concerns warrant immediate action.

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

### c. Site visit and medical record review process

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

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

The RQAR is responsible to:

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

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

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

If an eye care professional fails to provide documents by the end of the 60-day requirement to complete the audit, case documentation of administrative attempts will be forwarded to Credentialing for peer review recommendations regarding possible network action.

**d. Corrective action and continuous monitoring**

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

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

Audit result letters are issued to eye care professionals as follows:

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

- < 70%, within 10 calendar days of the visit. Notice with provide:
    - Results of audit
    - Corrective Action Plan (CAP) template (See Exhibit C)

- Requirement of 30 calendar days from date of notice to return completed CAP document

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

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

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

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

**e. Eye care professionals Failing to Comply with Administrative Requests Outside of Oversight Process**

If an eye care professional does not comply within the timeframe for resolution of a member complaint, the Complaints and Appeals department will forward a recommendation for action to Quality.

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

## B. Interaction with health plan QA programs

The Company works with each health plan for which it administers vision benefits to establish a cooperative and productive QA program that satisfies the standards and protocols of each health plan's quality assurance program.

a. Privacy requirements - HIPAA

Eye care professionals must abide by all applicable provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the federal standards for privacy of individually identifiable health Information issued under

HIPAA at 45 C.F.R. part 160 and part 164, Subparts A and E (the “HIPAA Privacy Rule”), and the Health Information Technology for Economic and Clinical Health Act (“HITECH”). All terms used in this section, but not defined in this section, shall have the meaning given to those terms in the HIPAA Privacy Rule or HITECH.

The Company may use or disclose Protected Health Information without the member’s authorization for Treatment, Payment, and Health Care Operations as permitted under the HIPAA Privacy Rule. This may include the Company using or disclosing Protected Health Information to perform the functions, activities, or services which it is contracted to perform for or on behalf of its clients, including the Company’s arranging for the provision of covered eye care services to members enrolled through its clients, payment for covered eye care services, and administrative and other services. The Company may also use Protected Health Information for the proper management of the Company or to carry out the legal responsibilities of the Company. The Company has implemented reasonably appropriate administrative, technical, and physical safeguards to protect the privacy of Protected Health Information. Other uses and disclosures of Protected Health Information by the Company will only be made with the member’s authorization, or as otherwise permitted under applicable state or federal laws. The Company will give members the right of access to inspect and obtain a copy of their Protected Health Information in a Designated Record Set in accordance with the HIPAA Privacy Rule.

The Company expects that eye care professionals are familiar with, and have educated their staff regarding, the HIPAA Privacy Rule and HITECH. Eye care professionals shall comply with all applicable provisions of the HIPAA Privacy Rule and HITECH, including, without limitation, the following provisions with regard to eye care professional’s use and disclosure of Protected Health Information which the Company and/or any plan has disclosed to eye care professional or which eye care professional holds or has collected for the Company and/or any plan:

1. Eye care professionals are prohibited from using or disclosing Protected Health Information for any purposes other than the purposes stated in this Eye care professional Manual and/or in the eye care professional’s participating eye care professional agreement.

2. Eye care professionals are prohibited from using or disclosing Protected Health Information in a manner that would be prohibited by the HIPAA Privacy Rule if the disclosure was made by the Company and/or any plan, or if either eye care

professional, the Company, and/or any plan is otherwise prohibited from making such disclosure by any present or future state or federal law, regulation, or rule.

3. Eye care professionals agree to maintain appropriate safeguards to ensure that Protected Health Information is not used or disclosed except as provided in this Eye care professional Manual, the eye care professional's participating eye care professional agreement, or as required by state or federal law, regulation, or rule.
4. Eye care professionals agree to immediately report to the Company in writing any unauthorized acquisition, access, use, or disclosure of Protected Health Information that is in violation of the provisions of this Eye care professional Manual or the eye care professional's participating eye care professional agreement, including any Breach, and in no case more than two business days after becoming aware of such violation.
5. Eye care professionals agree to ensure that any subcontractor or agent to whom eye care professionals disclose Protected Health Information received from the Company or any plan will agree to the same restrictions and conditions that apply to eye care professionals with respect to such Protected Health Information. Eye care professionals further agree that, if at any time a eye care professional becomes aware that any subcontractor or agent has violated these restrictions and conditions, the eye care professional will require such subcontractor or agent to immediately take action to mitigate against damage caused by such violation.
6. Eye care professionals agree to notify the Company in writing within three business days of any material alteration of an individual's Protected Health Information made at the individual's request, which the Company and/or any plan has disclosed to an eye care professional or which an eye care professional holds or has collected for the Company and/or any plan. Eye care professionals further agree to provide the Company and/or the plan, as applicable, within three business days and at no charge to the Company or the plan: (1) a copy of the altered Protected Health Information, (2) an explanation of such alteration, and (3) the reason for such alteration. The Company and/or the plan, as applicable, will make the alteration and explanatory documents a part of the individual's Protected Health Information. Eye care professionals shall also make the alteration and explanatory
   documents a part of the individual's Protected Health Information. Eye care professionals are not required to notify the Company of alterations to an individual's Protected Health Information which are made in the ordinary course of routine record keeping conducted by the eye care professional.
7. Eye care professionals agree to incorporate into Protected Health Information any amendments or corrections received from the Company and/or any plan. Eye care professionals further agree to make such amendment or correction in the manner and within the time limits mandated by the HIPAA Privacy Rule.

8. Eye care professionals agree to make available to applicable state and federal agencies, and their agents, such of the eye care professional's internal practices, books, and records as are related to the use and disclosure of Protected Health Information received from or kept for the Company and/or any plan.
9. Eye care professionals agree to grant the Company and/or any plan access at any time during the eye care professional's regular business hours to Protected Health Information received from or held for the Company and/or any plan.
10. Eye care professionals agree to incorporate any amendments, corrections, or additions to Protected Health Information when notified by the Company and/or a plan that the information is inaccurate or incomplete or that other documents are to be added as required by or allowed by the HIPAA Privacy Rule.
11. Any breach of these requirements shall be a breach of the eye care professional's participating eye care professional agreement, and the Company may terminate the participating eye care professional agreement and/or eye care professional's participation on any plan eye care professional panel effective immediately upon advance written notice to the eye care professional, which notice shall set forth the reason for such termination. This provision shall be deemed to amend and supplement the eye care professional's participating eye care professional agreement, and shall be in addition to all other rights of termination which the Company may have under the eye care professional's participating eye care professional agreement.
12. Eye care professionals will make available to their patients (a) their own Protected Health Information for purposes of review or amendment, and (b) information required to provide an accounting to the patient of all disclosures of that patient's Protected Health Information as required under the HIPAA Privacy Rule as modified by HITECH. Eye care professionals will also make available to the Company or any plan information required by the Company or the plan to respond to a request by a patient of an eye care professional for an accounting to such patient of disclosures of that patient's Protected Health Information in accordance with the HIPAA Privacy Rule as modified by HITECH.
13. Upon termination of the eye care professional's participating eye care professional agreement, the eye care professional will return to the Company or destroy as much as possible of the Protected Health Information that the eye care professional has received from the Company or that the eye care professional has created or collected on behalf of the Company, or will provide a written explanation to the Company as to why it is not feasible to return or destroy the Protected Health Information.
14. The terms and conditions contained herein override and control any conflicting term or condition of the participating eye care professional agreement and shall survive termination of the participating eye care professional agreement.

## C. Member satisfaction

The Company monitors member satisfaction in two ways: tracking complaints and grievances and member satisfaction surveys.

### 1. Tracking complaints and grievances

The first form of gathering member feedback is through tracking complaints and grievances filed by members who have utilized their vision benefits and are unhappy with their experiences.

- A “complaint” is an oral or written communication of concern or dissatisfaction with any aspect of the eye care encounter, including dissatisfaction with professional services or eyewear received through the program. A complaint may be filed by a member, a member’s representative, or the eye care professional.

- A “grievance” is an oral or written expression of dissatisfaction about any matter related to administration of the vision benefit, other than a coverage denial issued by the Company through its utilization management program.

Definitions and timeframes to resolve complaints and grievances vary depending on federal and state regulations. The Company will abide by the applicable state and/or federal law or rule.

The Company’s clients frequently delegate to the Company the complaint and/or grievance resolution process. Even in the absence of a formal delegation, it is part of the Company’s standard program management services to record, research, and resolve complaints and grievances and the Company cooperates with the client’s complaint and grievance resolution processes.

Members or eye care professionals who wish to file a complaint or grievance should contact the Company’s customer services department. The Company is committed to responding to all complaints and grievances as expeditiously as the member’s visual health condition requires. Company representatives investigate all complaints thoroughly and objectively, where applicable. Participating eye care professionals are required to cooperate with any request for information related to a complaint or grievance investigation.

It is the Company’s policy to resolve all complaints and grievances within 15 days of receipt of all necessary information, not to exceed 90 days from the date that the Company received the complaint or grievance, or such shorter timeframe as is required by applicable law. A resolution will be reached within 24 hours of receipt when the complaint or grievance is identified as urgent. These timeframes may be extended by up to 14 days in certain circumstances at the member’s request.

The complaint or grievance decision is telephonically communicated to the individual who filed it within one business day of the determination being made, although written confirmation of the determination may also be made, depending upon case circumstances, or as required by applicable law.

For any complaint or grievance that is not resolved in the member's favor, the notification process includes written notification of the member's appeal rights, which either follow the Company's appeals process or the client's appeals process.

Eye care professionals should recognize that the Company may resolve a complaint or grievance in favor of the member for the sake of achieving member satisfaction, and that such an action does not necessarily imply wrongdoing on behalf of the eye care professional.

### 2. Member satisfaction surveys

The second form of gathering member feedback is through Member Satisfaction Surveys. Each quarter, survey forms are provided to randomly selected members who have utilized services requesting their feedback on all aspects of their vision encounter. Survey outcomes are monitored, with low-scoring eye care professionals targeted for a closer review. Total number of surveys returned, source of dissatisfaction, and long-term trended results are all factors considered by the Company in analyzing survey results.

Participating eye care professionals who consistently receive low scores on satisfaction surveys and/or who are the subject of a high number of complaints will be expected to address the situation through implementation of a Corrective Action Plan, as described below, in conjunction with the Company's QA staff.

As directed by the client health plan, the Company sends the results of the member satisfaction surveys to the applicable client health plan, who in turn may send such results to the appropriate state agencies.

## D. Practitioner satisfaction

The Practitioner Satisfaction Survey establishes a platform for open communication and creates a better partnership between Versant Health and its Superior Vision participating network eye care professionals. The opinions, ideas, and suggestions of Superior Vision's participating network eye care professionals are as important as those of Versant Health's members.

At least annually, Versant Health sends participating network eye care professionals an Eye care professional Satisfaction Survey that addresses topics such as laboratory services, administrative processes and reimbursement. Responses are

scanned and evaluated. Aggregate results are presented annually to the Versant Health Quality Management Committee. The Committee discusses concerns and trends reported by the eye care professionals, focusing on challenging issues or dissatisfaction.

As a result of comments in the Eye care professional Satisfaction Survey, Versant Health takes appropriate action to address identified issues.

# Section XI COVID-19

## [1] Healthcare Facilities: Managing Operations during the COVID-19 Pandemic

The coronavirus disease 2019 (COVID-19) pandemic has changed how health care is delivered in the United States and has affected the operations of healthcare facilities. Effects may include increases in patients seeking care for respiratory illness that could be COVID-19, deferring and delaying non-COVID-19 care, disruptions in supply chains, fluctuations in facilities' occupancy, absenteeism among staff because of illness or caregiving responsibilities, and increases in mental health concerns.

Healthcare facilities need to provide care for all patients in the safest way possible for patients and healthcare personnel (HCP) and at the appropriate level, whether patients need home-based care, outpatient care, urgent care, emergency room care, inpatient care, or intensive care. Versant Health recommends Eye Care Professionals consult and stay informed on the CDC's guidance to outline goals and strategies for U.S. healthcare facilities to operate effectively and safely during the COVID-19 pandemic. The CDC provides links to CDC guidance on providing care in different settings and situations.

This guidance offers recommendations for healthcare facilities to

- Operate effectively during the COVID-19 pandemic
- Adjust the way they deliver healthcare services to reduce the need to provide in-person care
- Follow infection prevention and control recommendations tailored to their setting
- Provide necessary in-person clinical services for conditions other than COVID-19 in the safest way possible, minimizing disease transmission to patients, HCP, and others

1 From "Healthcare Facilities: Managing Operations During the COVID-19 Pandemic", Center for Disease Control and Prevention https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-hcf.html

# Section XII Revision History

| Version | Effective Date | Revision |
|---|---|---|
| 2021.1 | 3/30/2021 | Added section on PBCS |
| 2020.1 | 6/01/2020 | Added section on Center for Disease Control (CDC) Healthcare Facilities: Managing Operations **d**uring the COVID-19 Pandemic |
| | 7/15/2020 | Examination services under Doctor-patient relations updated |
| | 7/15/2020 | Provider Relations contact number removed from Contact Information |
| | 7/15/2020 | Appeal process section updated to include “Unless there is a regulatory mandated State Specific appeal process, the Versant Health Appeals process will be utilized.” |
| | 7/15/2020 | Healthcare Clearinghouse updated to ChangeHealth Payer ID is 41352 |
| | 7/15/2020 | Transfer of Patient Records timeliness language updated |
| | 7/15/2020 | Superior Vision Laboratory Model language removed |
| 2019.1 | 9/1/2019 | Superior Vision updated to Versant Health |
| | 9/1/2019 | “Providers” and “Practitioners” updated to “eye care professionals” |
| | 9/1/2019 | Paper claims mailing address updated |
| | 9/1/2019 | Credentialing Department address updated |
| | 9/1/2019 | Fraud, waste, and abuse section updated |

| | |
|---|---|
| 9/1/2019 | Quality Assurance (QA) program section updated |
| 9/1/2019 | Ophthalmic and laboratory section added |
| 9/1/2019 | New Eyewear Dispense Program section added |
| 9/1/2019 | Eye care professional corrective action plans, peer review, and appeal processes section updated |
| 9/1/2019 | Sales Tax section added |
| 9/1/2019 | Trademark License Letter Agreement section added |
| 9/1/2018 | Revision history section added |

SuperiorVision™

from VersantHealth™

superiorvision.com