Utilization management information

Authorizations for services requiring prior approval

Some plans allow patients to obtain services/options with Davis Vision's prior approval.

These services and options vary by plan benefit design and by state or Federal requirements. Eligibility for the services and options will be clearly identified by checking the patient's benefit design through Davis Vision. ECPs must follow Prior Authorization policies and procedures prior to initiating care for any services requiring Prior Approval. Examples of these additional services include but are not limited to:

- Additional lenses during the benefit cycle for significant changes in the patient's prescription
- Additional glasses for lost/stolen or broken glasses during the benefit cycle
- Additional glasses or contact lenses after cataract surgery
- Additional eye exams for diabetes or other specified conditions
- Low Vision exams and materials

To arrange for prior approval

- Print the Prior Approval Request Form found on the ECP Portal at davisvision.com.
- Complete all applicable fields. (It is your responsibility to provide as much clinical information as possible to enable Davis Vision to make a determination.)
- Fax the completed form to Utilization Review at 1 (800) 584-2329.

A Utilization Review Associate will review the request, document the determination on the request form and fax the request form back to you. Typically, Prior Approval requests are completed and faxed back to the ECP within three (3) business days following receipt of the Prior Approval request.

Note: A claim must be submitted for all services requiring prior approval. Authorizations are not a guarantee of payment for services. A claim must be submitted and final eligibility of the patient for services on the date of service will be determined when the claim for services is processed.

Authorizations for the enhanced contact lens benefits

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

Some plans include enhanced coverage for contact lenses which qualify by established criteria developed by Davis Vision. Contact Lenses may be determined to be medically necessary and

appropriate in the treatment of patients affected by certain conditions when the condition meets the established criteria. In general, contact lenses may be medically necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual acuity and/or improved binocular function, including avoidance of diplopia or suppression.

Davis Vision reviews these requests to determine if the request meets established Davis Vision criteria. Based on clinical practice guidelines of the American Optometric Association (AOA) and the practice pattern guidelines of the American Academy of Ophthalmology, contact lenses may be determined to meet established criteria and appropriate in the treatment of the following nine (9) conditions:

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

Additional copies of the Davis Vision criteria are available to ECPs upon request. Please call 1 (800) 773-2847 to request additional copies.

To arrange for medically necessary contact lenses

When you identify a need for medically necessary contact lenses, please complete the Prior Approval Request Form and fax the form to Utilization Review at 1 (800) 584-2329. It is your responsibility to provide as much clinical information as possible to enable Davis Vision to make a determination.

Your request will be reviewed by a licensed clinician to determine medical necessity. Individuals that conduct clinical reviews are available to discuss review determinations with the member's PCP, the attending physician or the ordering ECP. If the original reviewer is not available, another clinician is available within one business day.

Note: A claim must be submitted for all medically necessary contact lens requests. Authorizations for enhanced contact lens benefits are not a guarantee of payment for services. A claim must be submitted and final eligibility of the patient for services on the date of service will be determined when the claim for services is processed

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

Concurrent review

Note: In rare cases, Davis Vision may review certain services on a concurrent basis during a course of ongoing treatment.

Concurrent review involves extension of services that are currently being rendered. Practitioners complete the Prior Approval Form and fax it to the Utilization Review Department at 1 (800) 584-2329.

Retrospective review

Retrospective review involves services that have previously been rendered. In rare instances, a retrospective review may be conducted:

- to determine eligibility for enhanced benefits when a member or practitioner fails to obtain approval for services that require pre-authorization approval before services are rendered
- to determine eligibility using established criteria when a practitioner fails to obtain approval for services that require concurrent review before services continue beyond the approved timeframe
- to identify and refer potential quality of care/utilization issues
- to be completed within 30 calendar days of the receipt of all necessary information unless otherwise required by plan contract or legislative or compliance directive.

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

Hours of operation

The Utilization Review department receives and processes all UR requests and is available from 8:30 a.m. to 5:00 p.m. (Eastern Time) Monday through Friday on regular business days at 1 (800) 584-1487 (or Professional Relations at 1 (800) 933-9371). Alternately, members with questions may call Member Services at 1 (800) 999-5431* Monday through Friday from 8 AM to 11 PM (Eastern Time), Saturday from 9 AM to 4 PM (Eastern Time) and Sunday from 12 noon to 4 PM (Eastern Time). For the hearing or speech impaired members, call TTY at 1 (800) 523-2847, Monday through Friday, 8:30 a.m. to 5:00 p.m.

After normal business hours, callers may utilize the Davis Vision IVR, at the same toll free numbers, which can be reached Monday through Sunday and legal holidays and is capable of accepting or recording incoming requests. All calls will be returned within one (1) business day of the date the call was received. Urgent care and expedited appeals are generally not applicable to the benefits offered by Davis Vision.