Provider Manual
Section 19.0
Vision Network

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PASSPORT HEALTH PLAN

19.1 Company Overview and Mission Statement

Superior Vision Benefit Management, Inc. ("Superior Vision Benefit Management," or the "Company"),provide comprehensive administration of vision care programs for healthcare plans. The Company contracts with health maintenance organizations and other managed care entities for the complete coordination of the plan's vision benefits. The Company and its affiliates currently arrange vision benefits for over three million covered lives nationwide. This Provider Manual applies to the health plan programs Superior Vision manages in the state of Kentucky.

We recognize that our contracted providers have the most direct line of contact with the members enrolled through our client healthplan's programs. It is our goal to form a cooperative partnership with each of our providers that will result in a mutually beneficial relationship. We have learned from our extensive experience in the industry how to continually monitor our systems and procedures to maximize the "provider friendliness" of our program. We believe participation on our panel offers eyecare practitioners a number of advantages, and we look forward to proving the strength of our service to you.

MISSION STATEMENT

It is the mission of Superior Vision to provide the Company's clients and their enrollees, as well as participating providers, with the highest quality of vision program administration services available. For our clients, this means providing comprehensive administrative services that alleviate the healthplan of all burdens associated with its vision program. For the healthplan's enrollees, this ensures access to a panel of eyecare professionals whose high-quality services are monitored through the program's application and credentialing process. For our participating providers, this means a plan whose administrative procedures are straightforward and whose prompt payment cycle is timely and efficient. Superior Vision is committed to simultaneously delivering superior administrative services to each of these constituent groups.

19.2 How the Program Works

Superior Vision's program has been carefully designed to provide members and providers alike with easy access to our services. Here's how a typical patient encounter works:

- The healthplan will distribute a list of participating eyecare providers to a new member who enrolls under the plan.

- When the member decides to seek vision care services, they simply call the participating provider of their choice to schedule an appointment. The member does not generally contact either Superior or the plan to request a referral or other type of authorization (a few plans do require a referral; however, these will be noted in the plan-specific section of this Provider Manual).

- When scheduling an appointment, please inquire as to the member's plan coverage. Since Superior Vision is the program administrator and not the actual healthplan with which the member is enrolled, most members will identify themselves by the name of the healthplan and are not familiar with the Superior Vision name. Please be aware of the specific healthplans that Superior provides service to and equate these calls with the Superior Vision program. Some of Superior Vision's client healthplans elect to notify members of Superior Vision's management of their vision benefits, and these members may identify with the Superior Vision name and/or the healthplan name.

- Once the appointment has been scheduled, contact Superior Vision 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 Provider Manual for general instructions. Please also note that each plan-specific section of this Provider 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 Vision Care Services Agreement with the Company and later sections of this Provider Manual. Please refer to the "Member Charges" section of this Provider Manual for details on allowable collections from the patient.

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

- You may electronically submit claims via the Company's website (www.blockvisiononline.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 (version 02/12) for submitting paper claims to Superior Vision. Please refer to the "Claim Submission Requirements" and "Claims Payment Procedures" sections of this Provider Manual for further details on submitting claims, as well as Superior Vision's reimbursement policies.

19.3 Statement of Members' Rights and Responsibilities

Superior Vision is committed to providing members enrolled through its clients with high-quality eye care and administrative service from Superior Vision's participating providers and the Company's administrative staff. Member inquiries regarding this Statement should be directed to Superior Vision's Member Services department at its toll-free telephone number.

The following rights and responsibilities apply to all members:

Members have the right to:

- Receive information about Superior Vision, its services, its participating providers and members' rights and responsibilities;
- Receive accurate benefit information in a timely manner, as well as to receive timely assistance when seeking to utilize their vision coverage;
- Timely access to care that does not have any communication or physical access barriers;
- Be treated with respect and recognition of their dignity and right to privacy (including the right to have your medical records and care kept private) and to receive eye care services in a non-discriminatory manner on the same basis as patients not enrolled through Superior Vision's clients;
- Be free from any form of restraint or seclusion by use or means of coercion, discipline, convenience or retaliation;
- Actively participate with their Superior Vision provider in making decisions about their eye care, including consent for or refusal of treatment;
- A candid discussion of appropriate or medically necessary treatment options for their eye care conditions, regardless of cost or benefit coverage. This includes the right to ask questions and to receive complete information relating to the member's visual and medical condition(s) and treatment options, including specialty care;
- Voice complaints or appeals about Superior Vision, the healthplan through which the member is enrolled, or the care received and to receive access to the grievance process. This includes the right to receive assistance in filing an appeal and to receive a fair hearing from Superior Vision, the healthplan through which the member is enrolled or other applicable regulatory body (i.e., state Medicaid agency such as the Kentucky Department for Medicaid Services);
- Receive eye care services from a different participating provider each time they access covered services within defined benefit frequency intervals;
- A reasonable opportunity to choose a primary care provider (PCP) and to change to another provider in a reasonable manner. (Selection of a PCP and any PCP changes are coordinated with the healthplan through which the member is enrolled.);
- Timely referral and access to medically-indicated specialty care (in accordance with referral protocols established by the healthplan through which the member is enrolled);
- Have access to medical records in accordance with applicable federal and state laws;
- Prepare Advance Medical Directives pursuant to applicable laws; and
- Make recommendations regarding Superior Vision's members' rights and responsibilities policies.

Members have a responsibility to:

- Become informed about their member rights.

- Supply information (to the extent possible) that Superior Vision, a participating provider and/or the healthplan through which the member is enrolled needs in order to arrange for or provide eye care services;

- Abide by the policies and procedures established by Superior Vision, the healthplan through which the member is enrolled and any applicable regulatory body (e.g., state Medicaid agency such as the Kentucky Department for Medicaid Services);

- Become informed about service and treatment options and to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible;

- Follow plans and instructions for care that they have agreed on with their participating provider;

- Actively participate in personal health and care decisions and to practice healthy lifestyles;

- Report suspected instances of fraud, waste and abuse; and

- Keep scheduled appointments or call the provider's office to cancel.

19.4 Eligibility Verification Procedures

Providers may verify member eligibility 24 hours a day, 7 days a week through Superior Vision's website or Voice Response Unit (VRU).

It is important that you verify member eligibility at the time the appointment is 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 *prior* to the appointment. Providers are encouraged to confirm eligibility 24 hours prior to rendering services.

The eligibility verification number furnished to the provider is unique to that patient and date of service and must be entered on the claim form for processing. It is important to notify Superior Vision if there is a change in the date of service for any eligibility verification number obtained. Additionally, when the member is in your office for services, please check the member's health plan ID card and picture identification for identity verification.

I. Internet Website (www.blockvisiononline.com)

Simply log on to Superior Vision's website to obtain benefits information, verify eligibility and obtain an eligibility verification number. There is no limit to the number of eligibility verifications you may obtain during a website visit.

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

- Click on "Provider Log In" in the upper left-hand corner of the screen
- After reading important information about the website click on "Continue to Provider Login Page"
- Select "Provider Login"
- Select "Provider" from dropdown box
- Enter your NPI Number

- Enter the password you selected the first time you accessed the website
- Select the "Eligibility Verification" menu item

Please follow the instructions included in the Provider Web Manual under the section captioned "Eligibility Verification and Obtaining an Authorization." The Provider Web Manual may be viewed on-line or you may download a copy from the Superior Vision website.

Voice Response Unit (VRU)

In order to access Superior Vision's VRU, please call **(866) 819-4298** and follow the prompts, using your telephone keypad, as follows:

- Enter your NPI Number; press the # key when completed. The system will state the participating provider's name linked to the provider number entered. Please verify that the NPI number entered is correct.
- Select option #1 for member benefits and eligibility verification
- If the member's identification number is alpha/numeric, press 2; otherwise, wait to be prompted to enter the member ID
- Enter the member ID number; press the # key when completed
- You may be asked to enter the member's date of birth in the MM DD YYYY format
- Select option # 1 to authorize services and to hear benefits
- You may be prompted to enter your Superior Vision Location Code
- Enter the date of the appointment in MM DD YYYY format
- The VRU will offer each benefit for which the member is eligible; press 1 to include the benefit in your eligibility verification; press 2 to decline the benefit and move to the next benefit

The VRU will transfer you to a Superior Vision representative in the event the system is unable to process the requested eligibility verification.

19.5 Access and Service Delivery Standards

While the exact schedule of covered services and benefit allowances will vary from plan to plan, Superior Vision maintains a series of access and service delivery standards which must be followed for all of the Company's contracted plans. Participating providers are required to comply with all of the following:

1. The provider must maintain normal office hours of at least 32 hours per week.

2. Members must be offered an appointment within two weeks of the date of request. Compliance with this standard is measured based upon the provider'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 provider 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 providers are required to accept new patients. Provider shall not differentiate or discriminate in the provision of services to members in any way.

3. In order to participate on Superior Vision's provider panel, a practitioner's facility must include the following instrumentation:

a. Projector/Acuity Charts (far/near)
b. Keratometer
c. Direct Ophthalmoscope
d. Binocular Indirect Ophthalmoscope (with appropriate auxiliary lenses) or Slit Lamp Biomicroscope (with appropriate auxiliary lenses)
e. Retinoscope or Autorefractor
f. Phoropter/Refractor
g. Tonometer
h. Color Vision Test
i. Lensometer

4. All examinations covered under the program are to be comprehensive in nature, must comply with applicable state mandates regarding examination standards and, at a minimum, shall include the following:

Comprehensive Eye Examination Requirements

A comprehensive eye examination shall be performed in accordance with state guidelines and shall include, at a minimum, the following:

a.	Case History:	Chief complaint/reason for seeking service Patient medical and eye history Current medications Allergies Present prescription (if any)
b.	Visual Acuities:	Unaided - distance and near Habitual - distance and near
c.	Ocular Health:	External - biomicroscopy of structures Internal – ophthalmoscopy (including dilation when clinically indicated or required under state law) Tonometry - pressures, instrument used, time of day (Note: A reasonable attempt at obtaining IOP's shall be made unless, in the provider's professional opinion, it is contraindicated.)
d.	Preliminaries:	Confrontation visual fields Pupillary responses - direct, consensual, proximal Cover test - far and near Ocular motility testing - rotations, versions, saccades
e.	Refraction:	Objective testing - far and near Subjective testing - far and near
f.	Binocular Coordination Testing:	Gross convergence testing Amplitude of accommodation

Phorias and fusional vergences - far and near

g. Diagnosis/Prognosis/Patient Instructions

NOTE:
1. All findings should be recorded in positive terms.
2. The handwriting on the clinical record must be clear enough so that another clinician could understand the test results and other notations and arrive at the same diagnosis.

At least 30 minutes shall be allocated per complete examination. More time may be needed for contact lens patients and for the elderly 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.

5. When the member's benefit coverage includes contact lenses, the following additional tests/procedures are required for the fitting and assessment of contact lenses:

Contact Lens Examination/Fitting Standards

A contact lens examination and fitting shall include, at a minimum, the following: Keratometry or ophthalmometry;

a. History relating to lens wear (previous wear, allergies, etc.);
b. Fitting or assessment of fit with slitlamp;
c. 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;
d. Follow-up care as appropriate.

Contact Lens Standards

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.

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

Eyewear Dispensing Standards

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

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;
g Verification of eyewear after fabrication (compliance with ANSI standards--Z80)

Advice should be offered to the patient on eyewear selection. The provider 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.

7. Coverage Determinations for Non-Standard Services/Eyewear (Note: applicable regulatory coverage guidelines may supersede these recommendations)

1. Non-Standard Eye Examination

a. Definition – additional routine eye examinations beyond the standard benefit coverage frequency. Provider must submit documentation supporting the clinical appropriateness of all Non-Standard eye examinations to the Company for a coverage determination prior to rendering the Non-Standard eye examinations.

b. Coverage Criteria – additional routine eye examinations are covered: (i) when recommended by the school nurse, teacher or due to other school reasons; and (ii) due to presence of diabetic retinopathy, glaucoma, cataracts, following cataract surgery or when otherwise clinically indicated.

2. Non-Standard Eyewear

a. Definition – eyewear beyond the standard benefit coverage. Except as set forth in d. below, provider must submit documentation supporting the clinical appropriateness of all Non-Standard eyewear to the Company for a coverage determination prior to 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; and (ii) tinted lenses are covered when the member is diagnosed with albinism, diseases of the retina or when otherwise clinically indicated.

c. Coverage Criteria for Non-Standard Contact Lenses – when contact lenses are beyond the standard benefit coverage, the contact lenses will be covered when: (i) required for treatment of keratoconus; (ii) due to severe myopia, greater than 10 diopters; (iii) due to aphakia in children; and (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 provider; and (iii) polycarbonate lenses when determined to be clinically appropriate by the provider for children enrolled through Medicaid/CHIP programs.

8. The following services/materials are generally excluded from coverage. Any exceptions will be noted in the plan-specific section of this Provider 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), oversize lenses over 75mm, lamination of a lens or lenses, facets or other cosmetic grinds or polishes
- Special mountings (other than standard zyl, 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 eyecare services and diagnostic procedures
- Any examination or corrective eye wear required by an employer as a condition of employment
- Conditions covered by Worker's Compensation

19.6 Eyewear Policies

Superior Vision does not own, manage or maintain any financial interest in the supply of eyewear through its managed care program.

- Provider has the option of using the optical laboratory of his/her choice, subject to all applicable state and/or federal laws concerning self-referral.

- Eyeglass frames are to be dispensed from the provider's usual stock of frames available to all patients. The provider is not required to purchase a frame kit or maintain a collection of Superior-designated frames. However, the provider *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 Provider 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 of Superior's contracted programs provide coverage for "standard" lens types, as defined below:

Single Vision	7 x 25 Trifocal
FT-25 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, will be charged to the member at the provider's usual and customary fees, less any applicable discount as outlined in the plan-specific section of the Provider Manual.

- Lens types other than those listed above (e.g., progressive multifocals, high-index, polycarbonates) 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 provider's usual and customary charge for the lenses. The amount of this allowance is specified in the plan-specific section of the Provider Manual.

  The following specialty lens types are covered for Medicaid and CHIP members (or related public assistance programs, e.g. Family Health Plus in accordance with applicable state guidelines:

  - For members age 21 and over, polycarbonate lenses (or at the provider's discretion mid-index lenses) for lens prescriptions greater than or equal to $\pm$6.00 diopters sphere and/or greater than or equal to $\pm$3.00 diopters cylinder. In order to ensure proper reimbursement, provider must indicate on the claim submission that high- index lenses were dispensed and send a copy of the lab invoice to Superior Vision.

  - For members under age 21, polycarbonate lenses dispensed for protective purposes for all lens prescriptions up to or greater than or equal to $\pm$6.00 diopters sphere and up to or greater than or equal to $\pm$3.00 diopters cylinder. In order to ensure proper reimbursement, provider must indicate on the claim submission that polycarbonate lenses were dispensed and send a copy of the lab invoice to Superior Vision.

19.7 Utilization Management

Substantially all of the programs administered by Superior Vision provide coverage for wellness 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, Superior Vision has the right to review the request prior to authorizing such services/materials.

Additionally, when a member's benefit coverage includes medical eye care services and/or diagnostic procedures, Superior Vision has the right to review the medical appropriateness of such services, at any time, as a condition of issuing payment. In such circumstances, Superior Vision utilizes established Clinical Protocols to review the medical appropriateness of the requested services or materials. These Clinical Protocols have been developed by Superior Vision 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 Superior Vision's Provider Relations Department at (800)-243- 1401.

To request coverage for non-standard services or materials, provider should contact Superior Vision's Member Services staff at ((800)-243-1401) to discuss the nature of the request and supporting clinical information regarding the member's condition. Provider may also fax his/her request to Superior Vision at (410)-752-9184. Provider should submit all supporting documentation

and/or clinical information necessary for Superior Vision to process the request at the time of the request.

When utilization management decisions are made by Superior Vision, Superior Vision makes the decision and notifies the requesting provider of the decision on the same day that the decision was made in accordance with the following timeframes, unless a shorter timeframe is required by applicable law:

- Decisions regarding requests for authorization for non-urgent care are made within two business days of Superior Vision's receipt of the request.
- Decisions regarding requests for authorization for urgent care are made within one day of Superior Vision's receipt of the request.
- Decisions regarding requests for concurrent review are made within one day of Superior Vision's receipt of the request.
- Decisions regarding retrospective review are made within thirty days of Superior Vision's receipt of the request (unless a shorter timeframe is required by applicable law).

All coverage determinations will be communicated in writing. Any provider wishing to discuss a coverage denial with the individual who reviewed the request on behalf of Superior Vision may do so by contacting Superior Vision's Utilization Management Department at (800)-243-1401 to arrange for such discussion.

Coverage denials may be appealed by the member or the provider acting on behalf of the member. Management of the appeals process is generally retained by Superior Vision's clients and is not delegated to Superior Vision. Superior Vision'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. To appeal a coverage denial, contact Superior Vision's Utilization Management Department at (800)-243-1401 or by mail to 939 Elkridge Landing Rd, Suite 200, Linthicum, Maryland 21090.

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.

19.8 Claim Submission Requirements

Providers may submit claims to Superior Vision electronically, either through Superior Vision's internet website or through its contracted healthcare clearinghouse, or via paper claims through the mail or facsimile.

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

All claim submissions by provider shall be deemed to be provider'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 provider's wholesale cost, "wholesale cost" means the provider'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.

Provider shall submit a separate claim for each encounter and each claim must include the eligibility verification number issued by Superior Vision for that encounter. Provider should include all services rendered during the encounter on a single claim. If, however, due to provider's organizational structure, professional services and eyewear are billed separately, a separate eligibility verification number should be obtained for the professional services and for the eyewear and the corresponding eligibility verification number for the professional services and the eyewear should be included on each claim.

I. Internet Website (www.blockvisiononline.com)

Providers are encouraged to submit claims for all covered services through Superior Vision's website.

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

- Click on "Provider Log In" in the upper left-hand corner of the screen
- After reading important information about the website click on "Continue to Provider Login Page"
- Select "Provider Login"
- Select "Provider" from dropdown box
- Enter your NPI Number
- Enter the password you selected the first time you accessed the website
- Select the "Enter Claims" menu option

Please follow the instructions included in the Provider Web Manual under the section captioned "Entering a Claim" for all direct data entry claim submissions made through the Superior Vision website. The Provider Web Manual may be viewed on-line or you may download a copy from the Superior Vision website.

The website may also be used to check the status of a previously submitted claim (see section of Provider Web Manual captioned "Claims Status").

II. Healthcare Clearinghouse Claim Submissions

Superior Vision's contracted healthcare clearinghouse is Practice Insight. The **Payer ID** to utilize when submitting electronic claims to Superior Vision through Practice Insight is **BV001.** Please call Superior Vision's EDI Department at (800) 243-1401 to facilitate this connection.

III. ASC X12N 837 HIPAA Standard Format - Direct

Any provider wishing to submit claims in the ASC X12N 837 format directly to Superior Vision should contact Superior Vision's EDI Department at (800) 243-1401.

IV. CMS 1500 Claim Form

Superior Vision accepts the CMS 1500 claim form (version 02/12) for claims processing purposes for all services covered under the program. 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 provider for completion prior to processing**. This is required because Superior Vision must report to its healthplan clients on the number of members seeking services, as well as the type(s) of services rendered.

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

Claims Department
Superior Vision
939 Elkridge Landing Rd, Suite 200
Linthicum, Maryland 21090

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

- In order for a claim to be considered "clean," 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 Superior Vision in Section 23 of the claim form.

- The name of the healthplan through which the member is enrolled must appear in Section 11c. Please note that Superior Vision is **not** the insurance plan name or program name for government programs (e.g. Medicaid, CHIP, Medicare).
- Section 24. may include *either* the Superior Vision contracted exam and eyewear (where applicable) reimbursement rates *or* your 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 Benefits/Compensation Schedule, regardless of billing methodology.

- Your NPI number must be included in Box 33a and the Superior Vision location number (the location number assigned to you by Superior Vision) must be included in Box 33b of the paper claim form.

- The rendering/billing provider taxonomy code should be included in Box 19[1].

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

19.9 Claim Payment Procedures and Electronic Funds Transfer

Superior Vision adjudicates all claims for covered services in accordance with applicable state prompt pay law, as well as applicable Medicaid and Medicare regulations for claims submitted for covered services rendered to Medicaid or Medicare members. Superior Vision's standard method of provider payment is through Electronic Funds Transfer (EFT) direct deposit, which includes electronic remittance advice (ERA). Providers may enroll in the program by visiting www.instamed.com/eraeft

If Superior Vision does not adjudicate a clean claim within the timeframe required under applicable law, provider shall be entitled to receive interest calculated and paid in accordance with the applicable state or federal prompt pay law. Superior Vision also reserves the right to audit any claim in accordance with the state or federal laws or regulations applicable to such claims audit.

Providers are encouraged to use Superior Vision's website to obtain the status of a claim. If the claim is marked as "paid" and more than twenty days from the date of the check has passed and provider has not received the check, provider may contact Superior Vision to trace the check. Superior Vision 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 sixty days of the date of payment unless provider notifies Superior Vision within such sixty day period that provider disputes the amount paid. Any claim dispute must be submitted by provider to Superior Vision, in writing, either by mail to the address noted above for submission of paper claims, or by fax to 443-451-6012. Such correspondence must specify the amount disputed and include all supporting documentation.

19.10 Member Charges

The provider is responsible for collecting from the member all co-payments and/or charges for non-covered services/items 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 provider and the member.

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[1] The current provider taxonomy codes include: optometrists 152W00000X; ophthalmologists 207W00000X; and opticians 156FX1800X.

Please remember the following policies, which must be adhered to at all times:

- Providers are ***not*** permitted to bill the member for any amounts due from Superior Vision. Providers are also ***not*** permitted to balance bill members for the difference between provider's usual and customary charges for *covered* services/items and the reimbursement amount agreed to between Superior Vision and the provider.

- Members are to 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 said services/items and must include the amount the member will be required to pay. Failure to give such notice and receive such acknowledgment will result in the member's non-liability for such charges. Superior Vision bears no financial responsibility for such situations.

19.11 Quality Assurance Program

Superior Vision maintains a comprehensive Quality Assurance (QA) Program to ensure the delivery of high-quality services to members enrolled under the program. The program is designed to assist providers by establishing program policies and procedures regarding service standards. The program has been designed to comply with standards established by the National Committee for Quality Assurance (NCQA), the most widely accepted policy-making body in the managed healthcare industry. The program's activities are based upon applicable NCQA standards and include the items listed in this section. A copy of the QA Program Manual is available upon request by contacting Superior Vision's Provider Relations Department at (800)-243-1401.

All participating providers are required to cooperate fully with the QA process. Failure to do so may result in termination of the provider's Vision Care Services Agreement. QA program requirements apply to all providers, and periodic QA inquiries to your office should *not* be viewed as a threat to your program participation. Should any finding of the QA program indicate a quality-of-care concern, you will be notified of such concern and, when possible, offered the opportunity to jointly establish with Superior Vision a corrective action plan. In accordance with the Vision Care Services Agreement, a provider's program participation may be terminated immediately if the contracting healthplan requests such action or if the situation presents a reasonable danger to the health and safety of members.

Following is a summary of the QA program elements, as well as information on how you may be asked to participate in the QA process:

- **QA Program Structure**

  The Quality Assurance (QA) Program is executed through the efforts of the Company's QA Committee, full-time QA staff members, including the Company's Clinical Director and QA Director, the Company's Medical Director, and a team of regional optometric consultants.

  Daily program activities are carried out under the supervision of the Company's management staff. These individuals work closely with the Company's Clinical Director to develop quality standards and appropriate means for gauging compliance with these standards, as well as appropriate action to be taken in the event a quality concern is revealed. There is a QA Coordinator who is responsible for carrying out service delivery studies and other non-credentialing activities. The Company's credentialing coordinators are responsible for gathering all credentials for new providers, verifying pertinent information with primary sources and periodic provider recredentialing.

  The QA Committee meets periodically to set policy and to review and act upon findings of the daily QA process. QA subcommittees meet on an as-needed basis to address issues within such subcommittee's purview. Meeting minutes are recorded to document the Committee's and any subcommittee's actions.

- **New Provider Credentialing**

All providers first joining Superior's vision panel are required to complete our Provider Enrollment Application listing general practice, academic, licensure and administration information. Providers are also required to submit evidence of professional liability coverage, stating coverage period, coverage amount and the named insured(s).

Information given by the provider in his/her Provider Enrollment Application, either directly or through CreDentals/VerifPoint, an NCQA accredited credentials verification organization is verified. Primary verification is performed with the State licensing body, the National Practitioner Databank, and when the State licensing body does not perform primary verification of graduation/degree from optometry/medical school, with the academic institution the provider graduated from. Superior Vision notifies the provider of any information obtained by Superior Vision during the credentialing process that varies substantially from the information which the provider submitted to Superior Vision, and affords the provider the right to correct any erroneous information. Providers also have the right to review information used by Superior Vision to support the credentialing process and to be informed of the status of their credentialing application upon request. The Company's credentialing application cover letter furnished to new provider applicants includes the procedure to follow to request the status of the application or to review information used in support of the credentialing process.

A copy of Superior Vision's Credentialing Policy is available to providers upon request. The Credentialing Policy provides a complete description of Superior Vision's process and requirements for new provider credentialing.

- **Provider Recredentialing**

  To ensure that Superior Vision maintains current information on all participating providers, recredentialing is performed on two levels, as follows:

  1. Annual license renewal is verified with the State licensing board. The participation of any provider whose license is not renewed will be terminated.

  2. Documentation of professional liability coverage renewal must be submitted annually, immediately upon renewal. Superior Vision tracks the expiration date of professional liability coverage and, shortly before expiration, notifies the provider of the need to submit evidence of renewal. Failure to supply such documentation will result in the provider's inability to obtain member eligibility verification until such time that malpractice coverage renewal documentation is received.

  3. Once every three years, at a minimum, Superior Vision will ask the provider to review and update all information in the Company's provider database. The provider will be supplied with a credentialing application for completion. This level of recredentialing also includes a repeat of the *primary verification process* described in the New Provider Credentialing' Section above. The recredentialing process also includes a review of quality indicators with respect to the provider's panel participation, such as service delivery study findings, as well as member

satisfaction survey results and member complaint history, as applicable.

4. Superior Vision notifies the provider, in writing, of any information obtained by Superior Vision during the recredentialing process that varies substantially from the information which the provider submitted to Superior Vision, and affords the provider the right to correct any erroneous information within thirty (30) days of the Company's notification. Providers also have the right to be informed of the status of their recredentialing application and to review information used by Superior Vision to support the recredentialing process. Each of these requests should be communicated in writing and sent by mail or fax to the Company as follows:

Superior Vision
939 Elkridge Landing Rd, Suite 200
Linthicum, Maryland 21090 Attention:
Quality Management Department
Fax: 410-625-1596

The request should include the following information:

- Provider Last Name, First Name and Classification
- Practice Address(es)
- Phone Number
- Statement that provider is requesting a status of his/her recredentialing application *or, as applicable,* statement that provider is requesting to review information collected in support of his/her recredentialing application
- Signature of requestor and date

A copy of Superior Vision's Recredentialing Policy is available to providers upon request. The Recredentialing Policy provides a complete description of Superior Vision's process and requirements for provider recredentialing.

19.12 Contacting Superior Vision

Superior Vision's staff is available during regular business hours (9:00 am through 6:00 pm ET) and can be reached at the telephone numbers listed below. After hours callers to the Company's Member Services Department (both members and providers) have the opportunity to leave a recorded voice mail message for a return call the next business day. In order to access the Member Services Department night message system, please call (866) 819-4298.

Additionally, providers 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.

Providers may also access the Superior Vision website, www.blockvisiononline.com, 24 hours a day, seven days a week for information regarding eligibility verification, benefits coverage, claim status and to submit claims.

Credentialing/Recredentialing	(800) 243-1401, ext. 2107
Member Services	(866) 819-4298
Provider Relations	(800) 243-1401, ext. 2107
Eligibility Verification Line	(866) 819-4298
Claims Administration	(866) 819-4298