VSP® Vision Care Affiliate Provider Reference Manual

Effective October 1, 2016

Version 9.2
October 1, 2016
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Please remember that this program is limited and comes with some restrictions.

- You aren’t a full in-network VSP provider and can’t promote yourself as one under these arrangements.
- You may not advertise or use any name, symbol, or trademark of VSP in any advertising except as otherwise approved by VSP in writing. To the extent use is permitted, you agree to use VSP’s names, logos, trademarks and service marks only in accordance with a separate limited license agreement granted to you by VSP.
- All providers who provide services to a VSP patient in the practice must participate.
SET UP AN ACCOUNT ON 2020SOURCE.COM

2020source.com is a secure, HIPAA-compliant site that enables you to verify eligibility and submit claims for VSP members.

To set up an account:

1. Open your web browser and go to www.2020source.com; click Sign up for an account.
2. Read and accept the Privacy Policy and Terms and Conditions.
3. Enter your email address.
4. Select the appropriate account type from the dropdown:
   - Retail Chain—Full Service Location (your location provides exams, glasses, and contacts)
   - Retail Chain—Dispensary Only (your location provides glasses and contacts only—no exams)
   - Retail Chain—Independent Doctor (your location provides exams and may dispense contacts)
5. Click Submit. You’ll receive an email with a verification code to complete your account setup.
6. Click the link in the email to be connected to the confirmation screen.
7. Create a password and enter it in New Password and Confirm New Password. Click Verify to proceed to the Welcome page.
8. Review and note your account information—you’ll need it for future logins.
9. Click Profile to go to the Account Profile page. You may see an alert message—this appears when the Account Profile information is incomplete.

Questions? 866.773.3260 or apquestions@vsp.com
10. Most of the Account profile information will be pre-populated. Complete any open fields and click Save Changes.

**NOTE:** Enter the office phone number in the Billing Provider Information section. Using the billing location’s phone number here will cause an error that prevents you from proceeding.
CHECK FOR PATIENT ELIGIBILITY

Before providing services, make sure the patient is eligible for benefits. You can do this on 2020source.com or by phone. The eligibility document, called the VSP Patient Eligibility Report, shows you the patient’s eligibility for services, copays, and coverage.

Check eligibility on 2020source.com

1. Log in to 2020source.com and click Eligibility Check. Complete all fields and click Submit. If you’re checking eligibility for a dependent, you’ll need their first name, last name, and date of birth in addition to the member’s information shown below.


   **NOTE:** If you can’t see the report, it could be because your web browser blocks pop-ups. If this is the case, you’ll see a yellow bar at the top of your screen. Move your cursor over the bar, right click, and select "always allow pop-ups from this site." Another box will appear to verify the change—click yes and the report will open in a new window.

3. Print the report—you’ll need the Authorization Number to file the claim.

Check eligibility by phone

1. Call VSP at 866.773.3260 to access the automated system.
2. Enter your office’s phone number and the following information:
   - Member ID or last four digits of the member’s SSN
   - Member first and last name; patient first and last name and date of birth.
3. You’ll receive an Authorization Number to enter into 2020source.com.

Questions? 866.773.3260 or apquestions@vsp.com
IDENTIFY THE PATIENT’S COVERAGE

Use the VSP Patient Eligibility Report to determine the patient’s coverage.

VSP Coverage

The Patient Identification section shows VSP Eligibility and the Authorization Number.

Out of Network Coverage

The Patient Identification section shows Out of Network Eligibility and the Authorization Number. If the patient has Out-of-Network coverage, exam and materials are covered up to the amount(s) listed. You may charge the patient for any amount over what’s listed.

Neither VSP nor Out of Network Coverage

If the patient doesn’t have VSP coverage or Out-of-Network coverage, the Eligibility Check screen will show the following alert message:

Your eligibility check for [PATIENT] was successful. However, he or she is unable to use their VSP benefits at your location. Please handle as a private transaction.
DETERMINE WHAT TO CHARGE THE PATIENT

The VSP Patient Eligibility Report shows what to charge the patient for the eye exam and materials.

**Important!** You’re not required to honor your organization’s coupons or sale prices for VSP members using their benefit. If a VSP patient wants to use your organization’s coupon or sale pricing, they can submit their claim to VSP as Out of Network.

Exam

The Patient Coverage section shows the patient’s eligibility as well as the benefit type and client name.

Eligible patients may choose either spectacles or contact lenses but are not eligible for both.

If the patient is covered for Retinal Screening, it will be listed here with the applicable copay amount.

Retinal screening is offered to VSP clients for purchase as an optional benefit enhancement. This benefit is for routine, retinal, or fundus photography or imaging such as Optos, but not scanning laser procedures such as OCT, HRT, or GDX.

VSP considers fundus photography and optomap\textsuperscript{®} retinal exams to be separate procedures. They are not acceptable as a replacement for performing direct or indirect ophthalmoscopy, and they do not replace dilation for patients with diabetes or other conditions requiring dilation based on standard of care.

**NOTE:** Retinal screening claims must be submitted with an exam claim and must use CPT code 92250 with modifier 52.

<table>
<thead>
<tr>
<th>PATIENT COVERAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eligibility</td>
</tr>
</tbody>
</table>

**Benefit:** VSP Choice Plan\textsuperscript{©}  
**Client Name:** INTEL CORP.

**Retinal Screening:** Covered with $25.00 copay

Patients with Diabetes

The American Diabetes Association, American Optometric Association, and American Academy of Ophthalmology recommend that patients with diabetes receive an annual dilated eye exam. This exam is also a measure of clinical quality designated by the National Committee for Quality Assurance (NCQA).

We require that eye exams for VSP patients with diabetes include dilation. We recognize that at times there are good reasons for not providing a dilated exam. In those cases, documentation of the rationale for not performing dilation is required. Examples include:

- Patient refused.
- Dilated exam was performed within the last 12 months.
- Patient is under the care of an ophthalmologist.
Plan Details

The Plan Details section outlines the patient copays, allowances, and the value added benefits.

<table>
<thead>
<tr>
<th>PLAN DETAILS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Co-payment</td>
</tr>
</tbody>
</table>

**Frame Allowance**

Extra $20 promotion on Altair Eyewear/Marchon frames and any other available frame promotions included below:

- WFA57 $150.00 for Altair Eyewear/Marchon frames. Patient receives 20% savings on frame overage.
- WFA50 $130.00 for non-Altair Eyewear/Marchon frames. Patient receives 20% savings on frame overage.

**Contacts**

Routine eye exam covered.

- CL Exam Services: Charge the lesser of $25 copay or 85% U&C.
- CL Materials: $200.00

*Note:* Contacts are instead of [less, frame]. If contacts chosen, frame will not be available 01/17.

**Value Added Benefits**

- 10% complete additional pair of glasses, including plano sunglasses, from a participating doctor within 12 months of routine exam.
- 15% contact lens exam services from a participating doctor for 12 months on or following date of routine exam.

Frame

Patients who select a frame that exceed their Wholesale Frame Allowance (WFA) and their Retail Frame allowance should receive a 20% savings on the overage.

However, patients selecting a frame with either a wholesale cost less than their wholesale allowance (WFA) or a retail cost less than their retail allowance do not owe any frame overage.

*Note:* Modifier KX must be included with the frame code (V2020 or V2025) when billing for Marchon or Altair frames to receive the increased reimbursement.

Most VSP members (not out-of-network patients) will have an extra $40 on top of their frame allowance to spend on Calvin Klein1 and Cole Haan frames between November 16, 2016 and March 31, 2017. Reimbursement is based on the higher frame allowance. They cannot combine this with the extra $20 on Marchon® and Altair® frames which has also been extended through 2017.

*Note:* Modifier NU must be included with the frame code (V2020 or V2025) when billing for Cole Haan (Altair) or Calvin Klein (Marchon) brand frames to receive the increased reimbursement.

Contact Lens Exam Services (fitting and evaluation)

Patients with a contact lens exam benefit have a not-to-exceed copay that applies for the contact lens exam services (fitting and evaluation).

The CL Exam Services section shows the patient’s copay, and specific coverage amount. If the patient has a copay for the contact lens exam, charge the copay amount or 85% of your U&C for the contact lens exam (fitting and evaluation), whichever is less.
For example: the patient has a copay of up to $60. Your office has a U&C fee of $90 for contact lens exam services (fitting and evaluation). Calculate the patient’s out-of-pocket cost as follows:

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>U&amp;C fee for contact lens exam services (F&amp;E)</td>
<td>$90.00</td>
</tr>
<tr>
<td>Subtract 15%</td>
<td>-$13.50</td>
</tr>
<tr>
<td>Subtotal</td>
<td>$76.50</td>
</tr>
<tr>
<td>Patient pays</td>
<td>$60.00</td>
</tr>
<tr>
<td>VSP reimburses doctor</td>
<td>$16.50</td>
</tr>
</tbody>
</table>

Do not charge the patient more than the copay amount shown on the VSP Patient Eligibility Report.

**NOTE:** If the Contact Lens Exam section doesn’t appear on the Patient Eligibility Report, the contact lens exam (fitting and evaluation) is a private-pay transaction. Charge the patient your U&C fee, less 15%.

If providing contact lens materials you may charge the patient for any amount over the listed allowance for an initial supply of contact lenses.

**Value Added Benefits**

The Value-Added benefits are considered a private transaction between you and the patient. The patient is fully responsible for the payment of any additional items as described.

**Interim Benefits**

Some VSP clients may offer interim benefits, which covers services or materials when there’s a significant prescription change.

Check your patient’s interim benefits by calling VSP at 866.773.3260 before providing services or materials. Interim Benefits may cover frame and lenses, including elective contact lenses.
**Lens Enhancements**

<table>
<thead>
<tr>
<th>Lens Enhancement Details</th>
<th>Covered with Additional Copay</th>
<th>Covered with Additional Copay, 80% of U&amp;C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rimless Drill</td>
<td>Polycarbonate</td>
<td>High Index</td>
</tr>
<tr>
<td>Solid Tints and Plastic Dyes (Pink I &amp; II)</td>
<td>Progressives</td>
<td>Mirror/Ski Type Coating</td>
</tr>
<tr>
<td>Covered with Additional Copay</td>
<td>Scratch Resistant Coatings</td>
<td>Near Variable Focus</td>
</tr>
<tr>
<td>Anti-Reflective Coatings</td>
<td>UV Protection</td>
<td>Polarized</td>
</tr>
<tr>
<td>Oversize Lenses</td>
<td>Covered with Additional Copay, 80% of U&amp;C</td>
<td>Polycarbonate with Near Variable Focus</td>
</tr>
<tr>
<td>Photochromics</td>
<td>Aspheric (plastic &amp; digital)</td>
<td>Polycarbonate with Polarized</td>
</tr>
</tbody>
</table>

The Lens Enhancement section will detail the coverage for all lens options. If the Patient Coverage section has indicated that the member is NOT eligible for a base lens, the Lens Enhancement Coverages do not apply.

**Covered** – The patient is covered in full for this option. Do not charge the patient anything additional.

**Covered with additional copay** – Go to the Lens Enhancement Chart (match to the correct Benefit type) and charge the patient the indicated patient pay amount.

**Covered with additional copay, 80% U&C** – Charge the patient 80% of your U&C amount.

**Covered with additional copay, apply allowance** – Charge the patient the listed copay for that enhancement.

**Not eligible**—the patient is not eligible for this lens enhancement.

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**NOTE:** You must use the appropriate VSP lens enhancement modifier codes when submitting the claim to ensure proper reimbursement.

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**SUBMIT THE CLAIM**

**NOTE:** You may submit claims on 2020source.com, on paper CMS-1500 forms, or via 837 data transaction. Use the method assigned by your organization.

Using 2020source.com

The 2020source.com claim form uses the same format as the standard CMS-1500 form. If you are unable to submit an electronic claim using 2020source.com, you can submit a paper claim using the CMS-1500 form.

1. Log in to 2020source.com and click Claim Form.
2. Enter the authorization number and click Submit.
3. Enter the patient and insured information. Fields marked with a red asterisk are required.
4. Enter information relating to the services provided.
5. Enter the facility information. If the Service Facility Location and Billing Provider Location are the same, enter “same” under Service Facility Location: Facility Name in box 32.

6. After completing the claim form, click Submit. The next screen will confirm claim submission and give you a claim number. You can return to 2020source.com to view this claim under Claim History.

21—Diagnosis or Nature of Illness: patient's diagnosis/condition. All physician specialties are required to use diagnosis codes and code to the highest level of specificity. Enter up to twelve codes (A-L) in priority order (primary; secondary; etc.). Primary diagnosis should be the patient's chief complaint.

24a—From and To: date of exam—usually the same date in both fields.

24b—POS: the place of service code; for example, the code for a doctor's office is 11.

24c—EMG: emergency services (leave blank).
24d—CPT/HPCS: the appropriate S-code or CPT code for the service(s) provided.
24e—Diagnosis: the alpha character(s) that coincides with the relevant diagnosis code listed in Diagnosis or Nature of Illness.
24f—Charges: your usual and customary amount for the eye exam.
24g—D/Units: this field is most commonly used for multiple visits, units of supplies, anesthesia minutes, or lenses; if only one service is performed, enter the number 1.
24h—EPSDT: indicates whether the patient was referred for further examination due to an Early Periodic Screening Diagnostic Test (EPSDT); enter Y or N.
24j—Rendering NPI: 10 digit Type 1 NPI number of the rendering provider.

25—Federal Tax ID: the Federal Tax ID of the provider receiving payment. Select SSN or EIN.
27—Accept Assignment: check to indicate that the VSP reimbursement for the claim will be accepted as payment in full.
29—Amount Paid: enter the copay amount collected from patient, found on the VSP Patient Eligibility Report.
31—Signature of Physician or Supplier is on file: signature of authorized person in the office.
Using the CMS-1500

The CMS-1500 is the industry-standard paper claim form. Complete all fields neatly in blue or black ink.
Check the box(es) that identifies the type of health insurance coverage(s) applicable.

1a Enter insured’s ID number.

2 Enter patient’s full name.

3 Enter patient’s birthdate (e.g., 05/07/42) and gender.

4 Enter insured’s full name (indicate “Same” if the insured is the patient).

5 Enter patient’s complete current address and telephone number.

6 Indicate the patient’s relationship to the insured.

7 Enter the insured’s address (indicate “Same” if same as patient’s).

8 Reserved for NUCC.

9 If there is any other insurance company or insured party who may be responsible for any part of this bill, enter the insured’s name, then complete 9a and 9d.

10a Check Yes if any of the services described in Box 24 relate to an employment-related accident.

10b Check Yes if any of the services described in Box 24 relate to an auto accident. If Yes, indicate the state where the accident occurred.

10c Check Yes if the services described in Box 24 relate to any other type of accident.

10d Reserved for NUCC.

11 If there is no other eyecare coverage primary to VSP, enter “None.” This box is required to verify that the provider has made a good-faith effort to determine whether VSP is the primary carrier, then complete 11a, 11c, and 11d.

11a Check Yes or No to indicate whether there is another health benefit plan for eyecare. If Yes, complete 9, 9a, and 9d.

12 The patient or authorized representative is required to sign and date this field unless the signature is on file. If the signature is on file, enter “SOF.”

13 The signature in this field authorizes payment of benefits to the provider.

14 If you checked Yes in Box 10a, b or c, enter the date of injury. No qualifier needed.

15 If patient has had the same or similar illness, enter the date of previous onset. No qualifier needed.

16 Enter the dates the patient is unable to work in current occupation. An entry in this field may indicate employment-related insurance coverage.

17 Enter the full name of the referring provider, if applicable.

17a This field is not required—leave blank.

17b Enter the referring/ordering provider’s 10 digit NPI number.

18 Enter hospitalization dates for current condition, if applicable.

19 For VSP claims, this box requires the following information as applicable: For routine eyecare services, indicate “Share of Cost (SOC)” or “Foster Care” and complete Box 29. Indicate “two pairs of glasses in lieu of bifocals.” If you need to indicate multiple items in this box, separate items with a semicolon (e.g., “Share of Cost; two pairs of glasses in lieu of bifocals”).

20 This field is not required—leave blank.

21 Indicate ICD code set. Enter: 9 for ICD-9 or 0 for ICD-10

In ICD Ind box. Enter the patient’s diagnosis/condition. All physician specialties are required to use ICD codes and code to the highest level of specificity. Enter codes in priority order (primary, secondary, etc.). Primary diagnosis codes should be patient’s chief complaint.
22 If this is a resubmission of an unprocessable or denied claim, enter original claim number in Original Ref. No. box.
23 Enter all applicable VSP authorization numbers.
24A Enter the month, day and year for each procedure, service or supply.
24B Enter the appropriate place of service code, as provided by the health insurance entity checked in Box 1. Indicate a place of service code for each item used or service performed.
24C Enter Y (Yes) or N (No) to indicate whether you provided emergency treatment.
24D Identify the procedure, service or supply with the appropriate CPT/HCPCS code and up to four modifiers*.
24E Enter the letter which refers to the primary diagnosis from field 21 for each service billed.
24F Enter your usual and customary billed charge for each service.
24G Enter the number of days or units. This field is most commonly used for multiple visits, units of supplies or lenses. If only one service is performed, enter the number 1.
24H Enter Y (Yes) or N (No) to indicate whether the patient was referred for further exam due to an Early Periodic Screening Diagnostic Test (EPSDT).
24I This field is not required—leave as is.
24J Enter the NPI of the rendering provider in the lower portion of the field.
25 Enter the federal tax ID of the provider/practice receiving payment, and check whether it is an SSN or EIN.
26 Enter the patient account number assigned by the provider’s accounting system. This box is optional and is used to help you with patient identification.
27 Check Yes or No to indicate whether reimbursement for this claim will be accepted as payment in full.
28 Enter total charges for the services (total of all charges in Column 24F).
29 Enter the amount paid by the patient and/or other insurance, if applicable, for the charges represented in Box 28 (i.e., copayment and/or overages). For patients identified as participating in a flexible spending account on the VSP Patient Record Report, enter the total amount paid by the patient including any non-covered services.
30 Reserved for NUCC.
31 Enter signature of provider or representative and the date the form was signed. A stamped or computer-generated signature is acceptable.
32 & 32A Enter the name, physical address, and NPI of the office or facility where services were provided, only if it differs from Box 33 or if Box 33 is a P.O. Box. Indicate “Same” if same address as Box 33 do not leave blank.
33 & 33A Enter the name, billing address, ZIP code, telephone number, and NPI of the billing provider or group. This is a required field.

*Multiple page claims- When reporting line item services on multiple page claims, only the diagnosis code(s) reported on the first page may be used and must be repeated on subsequent pages. If more than 12 diagnoses are required to report the line services, the claim must be split and the services related to the additional diagnoses must be billed as a separate claim.
Send claims submitted on CMS-1500 forms to the appropriate address:

<table>
<thead>
<tr>
<th>VSP network claims</th>
<th>Out-of-network claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retail Chain Provider Program</td>
<td>Retail Chain Provider Program</td>
</tr>
<tr>
<td>Attention: Claim Services</td>
<td>Attention: Claim Services</td>
</tr>
<tr>
<td>PO Box 385020</td>
<td>PO Box 385018</td>
</tr>
<tr>
<td>Birmingham, AL 35238-5020</td>
<td>Birmingham, AL 35238-5018</td>
</tr>
</tbody>
</table>

**NOTE:** If you’re submitting an out-of-network claim on CMS-1500, you must write **AOB/AF1** at the top of the claim form. This ensures the claim is included with your combined payment.
BILLING CODES

Services may be billed using S-codes or CPT codes.

S-codes
- Eye exam requirements aren’t defined.
- Provider may bill for services over and above a refractive exam.
- Valid S-codes:
  - **S0620** (S-zero-six-two-zero): routine exam; including refraction; new patient.
  - **S0621** (S-zero-six-two-one): routine exam; including refraction; established patient.
- Don’t bill for refraction separately. It’s included in the definition of the S-codes.
- Don’t balance bill for dilation. This exam code includes dilation if performed.

CPT codes
- Eye exam requirements are defined by the American Medical Association. Please refer to the CPT manual for specific exam requirements.
- Provider may bill for services over and above the requirements listed in the CPT code definition.
- Don’t balance bill for dilation, if performed. This is included with the comprehensive exam.
- Refraction (92015) must be billed separately from the exam or exam payment will be reduced by 20%.
- Retinal screening (92250) must be submitted with an exam claim and use modifier 52.
- Valid CPT exam codes:
  - Comprehensive exam (with dilation)
    - **92004** Ophthalmological services: medical exam and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, one or more visits.
    - **92014** Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, established patient, one or more visits.
  - Intermediate exam (no dilation)
    - **92002** Ophthalmological services: medical exam and evaluation with initiation of diagnostic and treatment program; intermediate, new patient.
    - **92012** Ophthalmological services: medical examination and evaluation with initiation or continuation of diagnostic and treatment program; intermediate, established patient.
  - Contact lens exam (fitting and evaluation)
    - **92310** Prescription of optical and physical characteristic and fitting of contact lens, with medical supervision of adaptation; corneal lens, both eyes, except for aphakia.
    - **92311** Prescription of optical and physical characteristic and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, one eye.
    - **92312** Prescription of optical and physical characteristic and fitting of contact lens,
with medical supervision of adaptation; corneal lens for aphakia, both eyes.

**NOTE:** Exam coverage includes dilation if deemed appropriate. See the Exam section for additional information on patients with diabetes.
EYE EXAMS

Levels of Service

All covered services must be rendered in a VSP qualified office location. VSP follows AMA guidelines for exam requirements, as outlined in CPT. Below, you’ll find guidelines, tests, and processes for each service level.

Comprehensive Exam

This level of service provides evaluation of the complete visual system with or without cycloplegia or mydriasis. A comprehensive level of service is considered to make up a single service. But you are not required to provide all of those services in one session. Where possible, record all tests with quantitative measurements.

Important! Don’t charge your patients for any services included in the exam, as outlined below.

Appropriate evaluation and recording of data in each area outlined below is required. See the Exam Documentation for these requirements.

Case History

● Your patient’s chief complaint or reason for an exam (note: the chief complaint should also be the primary diagnosis on the claim and should determine whether to bill VSP for a routine exam or bill for a medical exam)

● Ocular and visual health history (your patient’s and patient’s family, past and present)

● General health status (e.g., significant illnesses and medical conditions)

● Current medication and medication allergies

● Visual demands for work, school, and recreation

Visual System Health Status Evaluation

● External exam/Biomicroscopy* (anterior segment photos are a separate procedure and are not acceptable as a replacement for biomicroscopy without separate documentation of anterior segment findings)

● Visual field screening

● Tonometry (see guidelines for pediatric patients)

● Internal/Fundus exam including direct and/or indirect ophthalmoscopy, with or without dilation and, at minimum, a numerical notation of cup-to-disc ratio documented for each eye*

Questions? 866.773.3260 or apquestions@vsp.com
*Note: We consider fundus photos and optomap® retinal exams to be separate procedures. They are not acceptable as a replacement for performing direct or indirect ophthalmoscopy, and they do not replace dilation for patients with diabetes or other conditions requiring dilation based on standard of care.

Neurological Integrity

- Pupillary reflexes
- Ocular motility/Versions (versions must be recorded separately from binocular function testing)

Refractive Status Evaluation

- Entering visual acuities (at 20 ft) with habitual Rx or unaided acuity, all recorded monocularly. Document monocular distance acuities for each eye for monovision contact lens patients.
- Subjective refraction with best corrected visual acuities (recorded monocularly). Testing may be delegated to qualified staff under the supervision of a licensed VSP Network Doctor (as permitted by state regulation) and may be done with or without DPAs.
- Accommodative function is based on the doctor's professional judgment and is not an exam requirement for all patients. Any near point accommodation testing should be performed when clinically indicated.

Diagnosis & Treatment Plan

We require ICD-10-CM diagnosis codes and/or related descriptions, plus documentation of the diagnosis in the exam chart notes. V72.0 is not acceptable as the sole diagnosis when there is another more appropriate refractive or medical diagnosis to use.

Documentation of a treatment plan, by the doctor, is required in your patient’s chart notes.

Intermediate Exam

Use this level of service when your patient will not benefit from all services included in a comprehensive exam. Evaluation and data recording in each area outlined below is required to qualify a service as intermediate.

Case History

- Your patient’s chief complaint or reason for an exam
- Ocular and visual health history (your patient’s and family, past and present)
- General health status (e.g., significant illnesses and medical conditions)
- Current medication and medication allergies

Questions? 866.773.3260 or apquestions@vsp.com
Visual demands for work, school and recreation

Visual System Health Status Evaluation

- External exam
- Biomicroscopy (anterior segment photos are a separate procedure and are not acceptable as a replacement for biomicroscopy without separate documentation of anterior segment findings)
- Internal/Fundus exam including direct and/or indirect ophthalmoscopy, with or without dilation and, at a minimum, a numerical notation of cup-to-disc ratio documented for each eye*

*Note: Fundus photos and optomap® retinal exams are separate procedures. They are not acceptable as a replacement for performing direct or indirect ophthalmoscopy, and they do not replace dilation for patients with diabetes or other conditions requiring dilation based on standard of care.

Refractive Status Evaluation

- Best corrected visual acuities through subjective refraction (recorded monocularly).
- Determination of refractive state. Testing may be delegated to qualified staff under the supervision of a licensed VSP Network Doctor (as permitted by state regulation) and may be done with or without DPAs.

Diagnosis & Treatment Plan

We require ICD-10-CM diagnosis codes and/or related descriptions, plus documentation of the diagnosis in the doctor’s handwriting on exam chart notes. V72.0 is not acceptable as the sole diagnosis when there is another more appropriate refractive or medical diagnosis to use.

Documentation of a treatment plan, by the doctor, is required in your patient’s chart notes.

Patient Referrals

In some cases, you may need to refer your patient to another doctor, as appropriate under the circumstances. If you determine that your VSP patient needs care beyond your own scope of practice, please refer your patient to the appropriate doctor as follows:

- In case of a medical emergency, call the primary care doctor if required by your patient’s medical plan, or refer your patient to the appropriate doctor. If the primary doctor and/or the appropriate doctor is/are not available, please refer your patient to a hospital emergency room.
- Provide your findings in writing and follow all referral protocols set by your patient’s health plan. Typically, an HMO requires that patient referrals be coordinated by the primary care physician (PCP). However, a PPO usually allows patients to receive care from any medical provider without a PCP referral.
- Keep a copy of the referral letter in your patient’s records

Questions? 866.773.3260 or apquestions@vsp.com
Evaluation and Management Services

Patients with Diabetes

The American Diabetes Association, American Optometric Association, and American Academy of Ophthalmology recommend that patients with diabetes receive an annual dilated eye exam. This exam is also a measure of clinical quality designated by the National Committee for Quality Assurance (NCQA).

We require that eye exams for VSP patients with diabetes include dilation. We recognize that at times there are good reasons for not providing a dilated exam. In those cases, documentation of the rationale for not performing dilation is required. Examples include:

- Patient refused
- Dilated exam was performed within the last 12 months
- Patient is under the care of an ophthalmologist
- Patient scheduled dilation for a later date

Additionally, communicating exam findings to a patient’s primary care physician (PCP) is critical to ensuring continuity of care for patients with chronic and serious conditions. This communication also establishes you as an important part of the health care continuum and identifies your role in the care of patients with diabetes and other health conditions.

Note: Retinal photography, such as optomap®, doesn’t replace a dilated eye exam as the standard of care for a patient with diabetes.
CLAIM INQUIRIES

To check the status of a claim or for claim corrections, call VSP at 866.773.3260.

Questions? 866.773.3260 or apquestions@vsp.com

To dispute or appeal a claim based on a claim denial or dissatisfaction with a claim payment, you may challenge the claim denial or adjudication by filing a claim dispute or appeal.

Your Responsibility

VSP considers you to be authorized to act on behalf of your patient in pursuing appeals of denied claims. It’s your responsibility to:

- Inform patients of their right to appeal a claim denial.
- Explain the appeal process to your patients.
- Get your patients’ approval to act as their authorized representative in the appeal process. If your patients don’t agree to you representing them in the appeal process, please direct them to contact VSP Member Services at 800.877.7195.

Appeal Process

Submit appeals online, by mail, or by phone. Incomplete appeals will be returned.

A sample Provider Dispute Resolution Request form is provided at the end of this manual. If you prefer to submit a written appeal without using the form, please include the following information with your written appeal:

- Your name and Payment Arrangement ID number
- Your contact information
- Original claim number (listed on the Explanation of Payment)
- Supporting documentation

For most states and plans, appeals must be submitted to us within 180 calendar days from the date of the Explanation of Payment. See state and plan exceptions below for specific timeframes and rules.

Mail: Send appeals to: VSP Claim Appeals, PO Box 2350, Rancho Cordova, CA 95741-2350.

Phone: Call VSP at 866.773.3260.

We’ll review your appeal and send a written response within 30 calendar days for most states and plans. Should the initial denial be upheld, you have the right to pursue a second-level appeal. Second-level appeals must be received within 60 calendar days from the date of the letter stating that the appeal has been denied. Follow the process listed above to submit second-level appeals.
HMO members only: Mail appeals for health plan members may be submitted to us within 365 calendar days from the date of the denial. We'll review your appeal and send a written response within 45 calendar days.

New Jersey
Appeals submitted from providers in New Jersey must be received within 90 calendar days. We'll review your appeal and send a written response within 10 business days from the date of receipt of all information needed to process the appeal.

Our internal second-level appeal is optional for New Jersey doctors. Following state law, New Jersey doctors have the right to use an external second-level appeal after participating in our first-level appeal process.

If you choose this option, we'll share the cost of the arbitration equally. To initiate this process, submit the appeal in writing to an independent arbitrator listed with the American Arbitration Association at: 1633 Broadway, 10th Floor, New York, New York 10019, (Customer Service: 800.778.7879, 212.716.5800, Fax: 212.716.5905; adr.org or websitemail@adr.org) and send a copy to us at: VSP Claim Appeals, PO Box 2350, Rancho Cordova, CA 95741-2350.

**Employee Retirement Income Security Act (ERISA) Patient Rights**

ERISA is a federal law that sets minimum standards for most voluntarily established pension and health plans in private industry to provide protection for people covered under these plans. If your patient’s employer pays for all or part of the patient’s benefits, the patient has additional appeal rights mandated by ERISA. Under this law, patients can get copies of all documents, records, and other information relevant to their appeal free of charge.

Once all mandatory appeals have been completed, ERISA patients may have other voluntary alternative dispute resolution options, such as mediation. Your patients may refer to their Evidence of Coverage (EOC) or Standard Plan Description (SPD), contact their local U.S. Department of Labor Office or their State Insurance regulatory agency to find out what’s available.

ERISA patients have the right to contest the decision of the appeal process. Under ERISA Section 502(a)(1)(B), patients have the right to bring civil actions. This right can be exercised when all required reviews of their claims (including the appeal process) have been completed, the claim wasn’t approved (in whole or in part), and a patient disagrees with the outcome.
CLIENT DETAILS: METLIFE VISION

VSP is the third-party administrator for MetLife Vision. Patients identify their coverage as MetLife Vision, and ID cards are not required. You'll check eligibility and submit claims just as you would for any other VSP patient.

NOTE: Please don’t mention VSP or distribute materials with a VSP logo to these patients.

Most MetLife employees with MetLife Vision are listed by employee ID, not Social Security Number. When a patient identifies themselves as a MetLife employee, check eligibility by entering the employee ID number preceded by zeroes to total nine numbers (e.g., 001234567).

Use the Patient Eligibility Report to determine the patient’s copay and coverage amounts. If you have questions about MetLife Vision coverage, call 866.773.3260. If a MetLife Vision patient has questions about coverage, they can call 855.METEYE1 (855.638.3931).

Patient Eligibility Report

<table>
<thead>
<tr>
<th>Patient Identification</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name Intelxx Testxxx</td>
<td>Auth# 10640886</td>
</tr>
<tr>
<td>Relationship Member</td>
<td></td>
</tr>
<tr>
<td>Member ID XXXX3011</td>
<td></td>
</tr>
<tr>
<td>Member Name Intelxxx Testxxx</td>
<td>Birth Date 01/01/1990</td>
</tr>
</tbody>
</table>

MetLife VisionAccess Program

MetLife also offers MetLife VisionAccess, a discount-only program for eyecare and eyewear.

Patients with this coverage may reference MetLife VisionAccess Program code MET2020 or display a MetLife VisionAccess Program wallet card.

The MetLife VisionAccess program does not include VSP coverage; handle these members as private-pay patients. Members can visit metlife.com or call 800.ASK.4MET (800.275.4638) for additional program details or to find a participating provider.

Questions? 866.773.3260 or apquestions@vsp.com
COMPLAINTS AND GRIEVANCES

While VSP makes every attempt to resolve patient concerns quickly and to the patient’s satisfaction, each Affiliate provider is responsible for ensuring office staff is aware of the VSP complaint process and provides a copy of the VSP Member Complaint/Grievance Form to patients when they ask. The VSP Member Complaint/Grievance Form is available in additional languages by request. Please call 866.773.3260 to request copies.

NOTE: For California residents there is a unique form.

The role of our Quality Assurance (QA) program is to make sure our doctors comply with our patient-care standards. These standards reflect requirements set by state and federal regulations and several entities, including government agencies (e.g., Centers for Medicare and Medicaid Services), medical/employer groups, and accreditation agencies (e.g., NCQA, or the National Committee for Quality Assurance).

Our QA program includes a clinical review of potential quality-of-care grievances. We require you to give a written explanation and relevant documentation if potential quality-of-care concerns are identified. A VSP clinical reviewer evaluates the complaint and informs you of the outcome by mail.

QA evaluates all potential quality-of-care complaints/grievances for individual doctor trends. Our reviewer can use information from past complaints during the review. The frequency and outcome of previous quality of care complaints/grievances may lead to improvement action up to and including termination from the VSP network.
When you’re not happy, we’re not either. We’d love the opportunity to hear from you, and the chance to make it right. If you’d rather call or send an e-mail, call us at 800.877.7195 or visit vsp.com.

Your Information

Name ________________________________________________________________

Member ID# ____________________________

Phone number ____________________________ E-mail address __________________

Address ____________________________________________________________

City ____________________________ State _______ Zip code __________________

Client name, employer, or HMO __________________________________________

Patient name _______________________________________________________

Your relationship to the patient: ☐ Self ☐ Spouse ☐ Child ☐ Other ______________

Doctor Information

Doctor name ______________________________________________ Date of service __________________

Office address _______________________________________________________

City ____________________________ State _______ Zip code __________________

Regarding: ☐ Doctor ☐ Lab ☐ VSP ☐ Client ☐ Other ______________

What’s on your mind? _________________________________________________

____________________________________________________________________

____________________________________________________________________

How can we help? _____________________________________________________

____________________________________________________________________

____________________________________________________________________

May we use your name if we need to contact those referenced above about your comments? ☐ Yes ☐ No

Send this to: VSP, Attn: Complaint & Grievance Unit, PO Box 997100, Sacramento, CA 95899-7100
Once we receive this form, you’ll hear back from us within 30 calendar days.
The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at 800.877.7195 and use your health plan’s grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (1.888.HMO.2219) and a TDD line (1.877.688.9891) for the hearing and speech impaired. The department’s Internet Web site at http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online.

If you are a Medi-Cal patient: You may request a DHS Fair Hearing by contacting the Department of Social Services (DSS) at 800.952.5253 within 90 days after the order or action complained of. A Fair Hearing is an administrative procedure at which you can present your concern directly to the State of California. If you decide to request a Fair Hearing you may represent yourself at the hearing or you may be represented by another person such as an attorney, friend, advocate, relative or any person you choose. DSS can help you obtain a Legal Aid lawyer, free of charge, to help you with your Fair Hearing.
When you're not happy, we're not either. We'd love the opportunity to hear from you, and the chance to make it right. If you'd rather call or send an e-mail, call us at 800.877.7195 or visit vsp.com.

**Your Information**

Name ____________________________________________________________

Member ID# _______________________________________________________

Phone number ____________________________ E-mail address ____________

Address __________________________________________________________

City ____________________________ State ______ Zip code _____________

Client name, employer, or HMO _______________________________________

Patient name _____________________________________________________

Your relationship to the patient:  ☐ Self  ☐ Spouse  ☐ Child  ☐ Other ____________

**Doctor Information**

Doctor name _____________________________________________________ Date of service _____________

Office address _____________________________________________________

City ____________________________ State ______ Zip code _____________

Regarding:  ☐ Doctor  ☐ Lab  ☐ VSP  ☐ Client  ☐ Other _______________

What's on your mind? _______________________________________________

____________________________________________________________________

How can we help? ________________________________________________

____________________________________________________________________

May we use your name if we need to contact those referenced above about your comments?  ☐ Yes  ☐ No

Send this to: VSP, Attn: Complaint & Grievance Unit, PO Box 997100, Sacramento, CA 95899-7100
Once we receive this form, you'll hear back from us within 30 calendar days.
INSURANCE, LICENSURE AND CERTIFICATION

Insurance Requirement
All Affiliate providers must maintain individual malpractice insurance coverage in an amount of not less than $1,000,000 per occurrence and $3,000,000 annual aggregate. However, if a provider participates in an active state patient compensation fund or excess liability program and meets that particular state’s fund/program requirements, that provider will be exempt from maintaining VSP’s individual malpractice insurance coverage requirements. All other Affiliate providers shall maintain the requisite individual coverage, not shared with another individual or entity. Providers must notify us within 10 days of any lapse in professional or general liability insurance coverage and indemnify us against damage or claims stemming from a lack of insurance coverage. Insurance verification is done during the credentialing and recredentialing processes.

Licensure and Certification
Affiliate providers must be licensed and in good standing as optometrists or ophthalmologists in the state(s) where they practice. We verify state licenses; state-controlled substance licenses (CDS) and federally controlled substance certificates (DEA) during the credentialing and recredentialing processes.

U.S. DRUG ENFORCEMENT ADMINISTRATION REQUIREMENTS
Ophthalmologists must maintain current authorization to prescribe medication following federal DEA and state requirements in each state where they see patients. In some states, optometrists must have current DEA licenses to get or maintain TPA certification and prescribe medicine to the fullest extent of that certification.

Some of our clients require optometrists to have DEA certificates. We support any such requirement.
OFFICE STANDARDS

Participation Requirements
1. Use laboratories, as required by the Network Affiliate Agreement.
2. Meet the minimum purchasing standards for Marchon frames as outlined in the Network Affiliate Agreement.
3. Provide contact lens care to VSP patients.
4. Provide 24-hour access to VSP patients, as well as have 24-hour access to instrumentation and materials. The 24-hour access to patients must include one or more of the following options: (a) answering service, (b) on-call service, (c) pager/mobile phone or (d) answering machine message providing the patient with instructions on how and where to obtain services from a VSP provider. All of these options must allow a patient to leave a message for a returned call back. All messages are required to be returned by a doctor or qualified office personnel within one hour.
5. Provide service to patients who have the VSP Choice Plan (except, that this shall not apply to providers who practice in states with laws that specifically prohibit a health plan such as VSP from requiring the provision of such services).
6. VSP’s primary method of communication is e-mail. At least one valid e-mail address is required for each approved location. It is the provider’s responsibility to maintain an up-to-date e-mail address to ensure receipt of important updates and critical information from VSP.

General Office Standards
1. Provide access to a clean, properly working restroom, and have a sink with hot and cold running water available in or near the exam room.
2. Have reasonable access to public transportation.
3. Provide access for handicapped patients, including doors wide enough for wheelchairs (minimum 32 inches), restrooms with handrails, and a handicapped parking space. The facility or office must be free of barriers that may prevent a handicapped/disabled person from receiving eye care services.
4. Maintain a pet-free environment, except as required by law.
5. Meet applicable local health and safety codes, including fire hazards, electrical wiring, and office floors that are clean and free of any hazardous obstacles.
6. Have convenient access to records of all patients seen within the last three years.
7. Maintain medical records and member information in a confidential, secured location not accessible to the public.
8. Maintain all VSP patient records and information according to the state law.
9. Efficiently process incoming telephone calls during business hours. A patient should be able to reach the provider’s office by phone within 30 seconds on the first attempt.
10. Efficiently process incoming telephone calls after business hours. A patient should be able to leave a message with an answering service within 45 seconds.

11. Make every effort to see the patient at his/her scheduled appointment time. The patient’s waiting time should not exceed 30 minutes from that time.

12. Make appointment for services available depending on the patient’s condition as follows:

**Routine Preventive Care:** Non-symptomatic, routine preventive eye exam within 30 calendar days.

**Medical Care:** Routine eyecare within seven days.

**Urgent Care:** If call is received during office hours, and the provider determines the need of the member to be urgent, member should be seen within 24 hours.

**Emergency Care:** When emergency treatment is necessary (as determined by the VSP Affiliate provider to be serious or life threatening), the patient is to be directed to the most appropriate emergency facility.

**Unscheduled Appointments:** Evaluated (triaged) by a doctor to determine the severity of the condition and disposition of the patient. Patients who need to be seen immediately are to be accommodated.

**Specialty Referral:** Within 14 calendar days from the time the primary care provider requests the referral.

13. Have online access to Manuals located on 2020source.com.

14. Have VSP complaint/grievance policy and patient resolution forms available to patients upon request.

### Clinical Office Standards

1. Have the minimum instrumentation necessary to provide routine and therapeutic services at the comprehensive level.

2. Maintain diagnostic and/or therapeutic pharmaceutical agents and an inventory of supporting contact lens solutions and care products that are not outdated or expired.

3. Keep all equipment and instruments in proper working order, including (but not limited to):

| • Biomicroscope (Slit Lamp) | • Threshold Visual Fields Device, or Visual Field Testing Device (Minimum of a Tangent Screen) |
| • Foreign Body Removal Instruments | • Blood Pressure Measuring Device |
| • Keratometer | • Gonioprism |
| • Lensometer | • Lacrimal Dilators, Irrigators, Punctal Plugs |
| • Phoropter | • Ophthalmoscope |

Questions? 866.773.3260 or apquestions@vsp.com
4. Maintain hygienically clean instruments and testing devices.
5. Keep antiseptic solutions, such as alcohol, on hand for cleaning faceguards and other areas of instrumentation that come into contact with patients.
6. Maintain good personal hygiene and professional demeanor.
7. Have diagnostic contact lenses available. These can’t be expired.

**Office Standards for Infection Control and Safety**

Infection control measures are to be used for decreasing the risk of transmission of microorganisms in patient care settings. VSP has adopted the recommendations/guidelines of the Centers for Disease Control (CDC) and the Association for Practitioners in Infection Control (APIC) as part of its provider office standards. A fundamental component of infection control is the concept of Universal Precautions, which involve the use of protective methods when taking care of patients.

The following measures make up the fundamentals of infection control:

**Hand washing and Gloving**

Wash hands promptly and thoroughly between patient contacts and after contact with blood, body fluids, secretions, excretions, and equipment or articles used in the patient exam/care setting is one of the most effective measures to reduce the risk of transmitting organisms from one person to another, or from one site to another. Hand washing facilities is defined by OSHA as an adequate supply of clean (potable) running water, soap and single use towels (paper towels, roller towels, or hot air hand dryer acceptable).

Gloves are to be worn when appropriate, to provide barrier protection for the patient and doctor, and to reduce opportunities for the transmission of microorganisms between patients, doctors, and other office personnel. The failure to change gloves between patient contacts is an infection control hazard.

Wearing gloves does not replace the need for hand washing; hands should be washed immediately or as soon as feasible, after removal of gloves or other protective equipment.

**Cleaning, Disinfection and Sterilization of Patient Care Equipment**

Disinfect all instrument surfaces that come into contact with patients by using standard methods such as the recommendations of the CDC (www.cdc.gov) and the APIC (www.apic.org).

**Contact Lens Disinfection**

Use an approved method of disinfecting diagnostic gas permeable contact lenses. Heating at 70 to 80 degrees centigrade for 10 minutes is also an acceptable method of disinfection. Soft trial contact lenses should be disinfected with hydrogen peroxide.

Questions? 866.773.3260 or apquestions@vsp.com
Infectious Waste Disposal
All infectious waste must be placed in appropriately labeled containers (a lined wastebasket with a lid or a sharps container where appropriate) and disposed of according to Federal, state, and local regulations. Infectious waste includes, but is not limited to:

- disposable gloves and gowns
- all sharp disposable instruments
- products used in patient care (e.g., tissue, gauze, etc.)

Occupational Safety and Health Administration (OSHA) Blood Borne Pathogens Standard
Most optometry offices will not be exposed to blood borne pathogens; however, a copy of the OSHA Exposure to Blood Borne Pathogen Standard (29 CFR 1910.1030) can be obtained from the OSHA Publications Office, 200 Constitution Avenue, N.W., Washington, DC 20210, or at the Web site of the Labor Department’s Occupational Safety and Health Administration (www.osha-slc.gov).

Instrument Maintenance
Instruments should be calibrated and maintained according to the manufacturers’ directions. Keep a log of calibration, cleaning, and maintenance for each instrument.

Facility Safety
The office should be safe and accessible for all patients. Safety considerations include ensuring that all areas are free from physical hazards. Minimum standards include proper equipment and patient care material storage, clearly defined exit signs, and clear exit areas. The office is required to have an operational smoke detector and a fire extinguisher. Proper lighting in and around the office, including stairways and parking lots, is also an important safety consideration.

Offices are required to meet the Americans with Disabilities Act Accessibility Guidelines (ADAAG), which are available from the Department of Justice at (800) USA-ABLE, or from the Access Board’s Web site (www.access-board.gov).

Questions? 866.773.3260 or apquestions@vsp.com
PATIENTS’ RIGHTS AND RESPONSIBILITIES

We’re committed to mutually respectful relationships between patients and doctors. We expect these relationships will lead to effective healthcare while recognizing people are individuals who all have different needs. We explain our expectations and set up guidelines for cooperation between patients, doctors, and clients. Patients can find this information at vsp.com.

Our patients have the right to be treated with consideration, dignity, respect and to have VSP doctors:

- Provide complete information about their eyecare and any proposed procedures and alternatives regardless of cost or benefit coverage.
- Allow patients to control decisions about their eyecare treatment.
- Provide 24-hour access for ocular emergencies.
- Maintain privacy and confidentiality regarding their care.
- Make appropriate preventive health services available.
- Give prompt and reasonable responses to questions and requests.
- Provide information regarding their services and qualifications.
- Provide the VSP grievance procedures if there is dissatisfaction with services.
- Obtain input regarding services and assist them with any problems.

Our patients have the responsibility to follow preventative eyecare guidelines, and:

- Check the health care benefits and exclusions of their coverage.
- Establish and maintain a relationship with their primary eyecare provider.
- Give eyecare providers complete and accurate information needed in order to care for them.
- Notify eyecare provider if they are going to be late or need to reschedule an appointment.
- Know the cost (co-payment, deductible, co-insurance) of their care.
- Carry out the treatment plan agreed upon with their eyecare provider or primary care physician.
- Know how to access urgent, emergency and out-of-area medical eyecare services.

American Sign Language (ASL) Interpreter Requests

Under the Americans with Disabilities Act of 1990, eye doctors and other health care providers are required under this federal law to provide American Sign Language (ASL)
interpreter services, at no cost to the patient, to patients who need and request ASL interpreter services.

If you or a member of your staff are ASL-fluent, you may, of course, communicate with hearing-impaired patients in that manner. If neither you nor a member of your staff have fluency in ASL, you should make arrangements for an ASL interpreter to assist at no cost to the patient. If you need help finding an ASL interpreter, you may contact the national Registry of Interpreters for the Deaf (RID) by calling 703.838.0030 or by visiting their website at rid.org.

VSP Members Language Assistance Program

VSP provides an online resource for providers to access information on diversity, cultural awareness, and health literacy. The Health Literacy App on the VSP Provider Facebook page offers several resources addressing topics of interpretation services, better communication, health literacy and census information that the provider can drill down to their practice location. To access the Health Literacy App, visit www.facebook.com/VSPProviders.

California health plans regulated by the Department of Managed Health Care (DMHC) are required to implement a Language Assistance Program (LAP) to provide linguistic services to California enrollees who prefer to conduct their affairs in a language other than English.

We have identified that our California Language Assistance Program threshold languages for written document support are Spanish and Chinese.

DOCUMENT TRANSLATION

Members who prefer their VSP member materials in a language other than English can receive free translation of VSP member documents. A notice of VSP’s language assistance services is provided in each California member mailing. This notice is written in VSP’s threshold languages of English, Spanish, and Chinese and provides information on translation services and how to access materials in other languages.

VSP also has a member website available in Spanish. You can direct members who prefer to read VSP’s website in Spanish to es.vsp.com to view all member information, including finding a doctor.

INTERPRETATION

VSP provides telephone interpretation services to any VSP member who prefers to communicate with VSP about their benefits in a language other than English, including TTY/TDD for those who are hearing impaired. In addition to our threshold languages of Spanish and Chinese, VSP provides telephone interpretation for almost all other languages as well.

VSP members who want to discuss their benefits in another language or want to request a translated VSP document can call VSP at 800.877.7195 and indicate their language need. Members can also visit vsp.com to see a list of VSP practices where language(s) other than English are spoken.

Questions? 866.773.3260 or apquestions@vsp.com
You are required to keep your office(s) language capabilities current so members know where they can receive services in languages other than English. Practices must keep in mind that family, friends, and minor children are considered untrained interpreters. Using family, friends, and minor children poses a problem with patient privacy. In addition, family may impose their view of the patient and their health that can lead to not providing the highest quality care as desired.

**Note:** If a patient insists that the provider or staff communicate with bilingual family or friends, document in the member patient record that the VSP member refuses interpreter services and/or uses friend or family to interpret.

**DOCUMENTATION**
The following items should be documented in the patient’s medical record and/or patient history form:

- Patient’s preferred written and spoken language
- Refusal of interpreter (if applicable)
- Use of interpreter and who (family member, minor, friend, doctor, office staff, or trained professional interpreter)

It is suggested to also document the patient’s race and ethnicity with an option for the patient not to disclose this information.

**COMPLAINTS AND GRIEVANCES**
We make every attempt to resolve patient concerns quickly and to their satisfaction. Doctors are responsible for making sure their staff knows our complaint process and gives our complaint/grievance form to patients when they ask. The **VSP Member Complaint/Grievance Form** is available in additional languages by request. Please call 866.773.3260 to request copies.

**New York Confidentiality Protocols for Victims of Domestic Violence and Endangered Individuals**

Individuals experiencing actual or threatened violence frequently establish new addresses and phone numbers to protect their health and safety.

Insurance Regulation 168 (11NYCRR 244) pursuant to New York State Insurance Code, Section 2612, requires VSP® Vision Service Plan to provide Confidentiality Protocols for Victims of Domestic Violence and Endangered Individuals. VSP will accommodate a reasonable request to provide communications of claims-related information by alternative means or at alternative locations in accordance with this regulation for the state of New York.

We recommend you post the full description of VSP’s protocol in your office.

Questions? 866.773.3260 or apquestions@vsp.com
CLAIM APPEALS

To check the status of a claim, call VSP at 866.773.3260.

For claim corrections, such as a diagnosis code, billed amount or service code, call VSP at 866.773.3260.

To dispute or appeal a claim based on a claim denial or dissatisfaction with a claim payment, you may challenge the claim denial or adjudication by filing a claim dispute or appeal.

For other disputes, including disputes related to Doctor Adverse Actions, please contact VSP at 866.773.3260. Copies of the VSP Peer Review Plan and Fair Hearing Policy are available upon request.

Your Responsibility

VSP considers you to be authorized to act on behalf of your patient in pursuing appeals of denied claims. It’s your responsibility to:

- Inform patients of their right to appeal a claim denial.
- Explain the appeal process to your patients.
- Get your patients’ approval to act as their authorized representative in the appeal process. If your patients don’t agree to you representing them in the appeal process, please direct them to contact VSP Member Services at 800.877.7195.

Appeal Process

Submit appeals by mail, or by phone. Incomplete appeals will be returned.

A sample Provider Dispute Resolution Request form is provided at the end of this manual. If you prefer to submit a written appeal without using the form, please include the following information with your written appeal:

- Your name and Payment Arrangement ID number
- Your contact information
- Original claim number (listed on the Explanation of Payment)
- Supporting documentation

You can appeal multiple “like” denials (i.e., numerous claims denied for untimely filing) at the same time by using the Multiple Provider Dispute Resolution Form with the Provider Dispute Resolution Request.

For most states and plans, appeals must be submitted to us within 180 calendar days from the date of the Explanation of Payment. See state and plan exceptions for specific timeframes and rules.

Questions? 866.773.3260 or apquestions@vsp.com
• **Mail:** Send appeals to: VSP Claim Appeals, PO Box 2350, Rancho Cordova, CA 95741-2350.

• **Phone:** Call VSP at 800.615.1883

We’ll review your appeal and send a written response within 30 calendar days for most states and plans. Should the initial denial be upheld, you have the right to pursue a second-level appeal. Second-level appeals must be received within **60 calendar days** from the date of the letter stating that the appeal has been denied. Follow the same process listed above to submit second-level appeals.

Appeal rights for Medicaid patients also include state-specific, fair-hearing processes. Appeal timelines may vary by state. Please check your state’s specific instructions for these processes.

**CALIFORNIA**

**Important!** The following appeal information applies to HMO plan members only.

Appeals for health plan members may be submitted to us within 365 calendar days from the date of the denial. We’ll review your appeal and send a written response within 45 calendar days.

**NEW JERSEY**

Appeals submitted from providers in New Jersey must be received within 90 calendar days of original receipt of claim denial. We’ll review your appeal and send a written response within 10 business days from the date of receipt of all information needed to process the appeal.

Our internal second-level appeal is optional for New Jersey doctors. Following state law, New Jersey doctors have the right to use an external second-level appeal after participating in our first-level appeal process.

If you choose this option, we’ll share the cost of the arbitration equally. To initiate this process, submit the appeal in writing to an independent arbitrator listed with the American Arbitration Association and send a copy to us at: VSP Claim Appeals, PO Box 2350, Rancho Cordova, CA 95741-2350.

Here is additional contact information if you need additional information:

**American Arbitration Association**
Customer Service: **800.778.7879**, 212.484.4181
Web site: [adr.org](http://adr.org)
NJ E-mail: casefiling@adr.org

Questions? 866.773.3260 or apquestions@vsp.com
SERVICES SUBJECT TO REVIEW/AUDIT

All of an Affiliate provider's performance data, services and materials provided to VSP Patients, and claims submitted to VSP, are subject to review and audit. Upon request, and at their own expense, an Affiliate provider will timely furnish patient records to VSP of any or all Enrollees for whom claims have been submitted to VSP for payment. Affiliate provider shall fully cooperate with any VSP review or audit activity, including, without limitation, in-office audits and inspections, business audits, special investigation audits, medical record reviews and all similar VSP investigative or quality assurance efforts. For quality and authentication purposes, Affiliate provider understands and agrees that some audits may be unannounced. Affiliate provider shall not refuse to permit an audit because an audit was not announced in advance, may be disruptive or for any other reason. Should Affiliate provider refuse to permit an audit for any reason, Affiliate provider may be subject to termination for failure to comply with the Network Participation Agreement and/or restitution in an amount to be determined by VSP. Affiliate Provider agrees to cooperate with, abide by, and adhere to, all rulings of any VSP quality assurance or peer review committee. Copies of the VSP Peer Review Plan and Fair Hearing Policy are available upon request by calling VSP at 866.773.3260. All records, data and information acquired by or prepared for any VSP quality assurance or peer review committee shall be held in confidence, except to the extent necessary to carry out the purposes of such review activities, and shall not be subject to subpoena or discovery, except as may be required by law or as otherwise required in the Agreement.

The confidentiality requirements set forth above, shall survive the expiration or termination of the Network Participation Agreement. Affiliate Provider further agrees that upon request, Affiliate Provider will timely furnish case records to VSP of any or all Enrollees for whom claims have been submitted, and that VSP may use any information so obtained for statistical, actuarial, scientific, peer review or other reasonable purposes, including applicable state and federal law requirements, provided that no professional confidence shall be breached thereby. Affiliate Provider also agrees that utilization and claims information may be released to MCOs and peer review groups. The confidentiality of VSP Patient medical information shall not be compromised. Affiliate Provider shall reimburse VSP in a timely manner for its reasonable out-of-pocket expenses and costs incurred in audit(s)/inspection(s) resulting in restitution due to improper billing. These costs shall include the reasonable market value of the time spent by Special Investigative Unit auditors for travel to and from the practice being audited, for recovery of necessary records, to conduct the audit, and the reasonable market value of the time spent to review and finalize the audit results.

FINANCIAL Records

In accordance with VSP policy, all financial records must be itemized.

Questions? 866.773.3260 or apquestions@vsp.com
CONTACT LENSES
Itemized, financial records must be kept for all VSP patients and must include the following for visually necessary, covered and elective contact lenses:

- Patient name
- Date of service
- CL brand
- Type
- Quantity and date dispensed
- U&C cost for services (fitting and evaluation)
- U&C cost for materials
- Amount billed to insurance
- Amount paid by the patient
- Method of payment

Under the Visually Necessary Contact Lens plan benefit, the patient is only charged the appropriate copayment, but you must still keep itemized records as noted above.

When billing VSP for contact lenses, you must keep a list of U&C fees and costs for services and materials for reference. This must be shown to any VSP Representative upon request.

GLASSES
Itemized, financial records must be kept for all VSP patients and must include the following for glasses:

- Patient name
- Date of service
- Lens type
- Lens options
- Frame make, model and retail cost
- Date dispensed
- Amount billed to insurance
- Amount paid by the patient
- Method of payment

Failure to keep and provide itemized records may result in the denial of payment for billed services and materials.

Questions? 866.773.3260 or apquestions@vsp.com
QUALITY ASSURANCE PROGRAM

Program Overview
Our Quality Assurance (QA) program partners with you to deliver the highest quality eyecare to VSP patients. The program also educates you and your staff about our QA policies and procedures. This program follows state and federal regulations and guidelines from accrediting organizations like the National Committee for Quality Assurance (NCQA).

Note: Our Quality Assurance department protects patient records, confidentiality and all proprietary information. For more information, refer to VSP’s Privacy Policy and its Privacy Commitment outlined below.

Quality Assurance Medical-Record Review
Medical record reviews involve an internal mail-in review or an on-site office review. QA requests only VSP patient records during these reviews. Electronic-record documentation is acceptable if findings are included. We use clinical peer reviewers trained in our policies and procedures to assess and grade reviews.

Patient medical records are submitted to VSP and reviewed by OD/MD auditors who verify the exam and treatment for each patient follows established criteria and is properly documented.

Review Levels
Medical record reviews have up to three levels and may occur at any time. Each level requires ten, randomly selected VSP patient records. The patient names are chosen from claims billed in your name. A patient record with a different doctor noted as the one who performed the exam will not be reviewed and may impact the result of your review.

A peer reviewer accesses each record based on VSP’s exam and documentation standards and returns the results to the QA administrator who informs you of the review outcome. A QA contact name is provided and you may call at any time for clarification of the review results.

EDUCATIONAL REVIEW (ROUTINE REVIEW)
The first review you’ll receive is a routine educational review. The review is assessed for a pass or non-pass and the results are communicated to you.

If you pass this educational review, no follow up review or financial assessment will occur.

A non-passing outcome will result in a First Formal review in approximately six months. This timeframe allows correction of the initial identified discrepancies.

Questions? 866.773.3260 or apquestions@vsp.com
FIRST FORMAL REVIEW
You will receive a First Formal review, requiring another ten VSP patient medical records, when you do not pass the prior educational review.

If you pass this First Formal, no follow up review or financial assessment will occur.

A non-passing outcome results in a financial assessment for each record with discrepancies at a maximum of $100.00. A Second Formal follow up review will occur in approximately six months. This timeframe allows the doctor to correct identified discrepancies.

SECOND FORMAL REVIEW
You will receive a Second Formal review, requiring another ten VSP patient medical records, when you do not pass the prior First Formal review. This is the last review level to demonstrate you meet VSP’s exam and documentation standards.

A $500.00 fee is assessed and collected at the time of the Second Formal review.

If you pass this Second Formal, no other follow up review or additional financial assessment will occur.

Non-passing outcomes, at a minimum, lead to higher financial assessments for records with discrepancies based on the doctor’s 12-month claim volume and may result in a recommendation for possible contract termination from our network.

VSP'S PRIVACY COMMITMENT

Our Privacy Commitment
All VSP employees, upon employment, get privacy and security training and agree to abide by our “Confidentiality of Information” policy. Our policy explains the importance of protecting the confidentiality of medical records, personal information, insurance claims and other materials. Violating this policy can lead to disciplinary action up to and including termination.

Medical Directors, Optometry Directors, Clinical Consultants, and Clinical Committee Members also get Privacy and Security training. They must sign a Conflict of Interest and Confidentiality Statement.

Any patient specific or Protected Health Information is confidential. This information is shared only with people who have a need to know and authority to get such information, as explained above.

We’ll only use and disclose patient Protected Health Information when needed to coordinate vision care treatment, to disclose information to the patient’s employer/plan sponsor to the extent permitted by law, for payment and healthcare operations, or as required or permitted by law.

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Our legal department reviews any court order or subpoena for disclosure of confidential information to determine the order’s legitimacy, the reason for disclosure, and limitations on information disclosed.

All patient information is stored for the amount of time required by law and company policy in locked files accessible only for the above reasons.

System stored patient information is protected by system security measures block unauthorized access. We’ve also implemented security policies and procedures required by HIPAA. We currently employ industry-standard, system-security measures to protect electronically stored and transmitted information.

Our network doctors’ offices must maintain confidentiality and guard patients’ Protected Health Information against loss, defacement, tampering, or use by unauthorized people. The contracted doctor’s office must maintain a policy of confidentiality for patient medical record information.

If we uncover a confidentiality violation by a network doctor, either through an onsite visit or a complaint/grievance, our Quality Assurance Committee and our staff determine steps needed to restore confidentiality. We consult our Human Resources department if one of our employees was involved in violating confidentiality.

Our Notice of Privacy Practices will be provided to any member, client, or network doctor on request.

**Confidentiality and Security on vsp.com**

We respect the privacy of our website users. We don’t collect personal information from anyone who simply visits our website.

Patients who enter personal information should know all communication between their computers and our Web servers is encrypted using secured server technology (SSL). Our secure server software is the industry standard and among the best software available today for secure transactions.
QUALITY MANAGEMENT PROGRAM

Program Overview
VSP has a comprehensive Quality Management (QM) and Quality Improvement (QI) Program that presents a framework for ensuring quality eye care for members accessing VSP providers. The QM/QI Program Description defines the goals, scope, structure, function and other components for the QM/QI Program at VSP.

Scope

PURPOSE
VSP’s QM/QI Program ensures quality vision and eye health care to members accessing VSP’s doctors. The program is designed to objectively and systematically monitor and evaluate the quality and appropriateness of care and services. We strive to continuously pursue opportunities for improvement and problem resolution.

POLICY
It is the policy of the organization to ensure:

• Compliance with VSP approved policies and procedures for the QM/QI process
• Adherence to guidelines, standards and criteria set by government, accrediting agencies, and other regulatory agencies as appropriate
• The QM/QI Program accommodates the contractual requirements and benefit design of each client/health plan

GOALS
The goals of the QM/QI program include, but are not limited to, the following:

• To develop, implement and coordinate all activities that are designed to improve the processes by which care and services are delivered
• To provide tools, resources and training for staff involved in quality of care processes with clinician oversight and guidance
• To identify inappropriate practice patterns and opportunities to improve patient care
• To evaluate the effectiveness of implemented changes in order to continuously improve the quality of care and service provided by VSP and doctors to VSP customers (members, clients, and health plans)
• To ensure that there are documented mechanisms to evaluate the effects of the QM/QI Programs utilizing member and doctor satisfaction data
• To ensure that QM/QI policies and procedures are reviewed, revised and approved, as needed, by the QM Committee

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• To utilize efficient and appropriate communication channels to deliver QM information to appropriate individuals
• To facilitate documentation, reporting and follow-up of Credentialing and QM/QI activities in order to facilitate excellence in vision care services and outcomes.

Quality Improvement Process

OVERVIEW
The QI process includes documented policies and procedures utilized in monitoring, reviewing and improving care and services provided to VSP members by VSP doctors. VSP may use applicable provider data for quality improvement activities.

POLICY
The QM/QI policy review occurs annually and is revised as needed. Procedural revisions and revisions with clinical impact are reviewed and approved by the QM Committee. The Patient and Provider Committee performs subsequent review and approval of modifications. VSP’s clients and regulatory agencies receive material revisions to the policy or procedures, as required.

PATIENT SAFETY
Patient safety is reviewed and addressed. Interventions are identified and implemented. Patient safety activities include, but are not limited to:

• Potential Quality of Care Complaints/Grievances
• Credentialing/Recredentialing
• QA Doctor Reviews
• Clinical Practice Guidelines / algorithms
• Member Surveys

QI WORK PLAN
QM/QI plans activities each year as documented in the QI Work Plan and approved by the Patient and Provider Committee annually. Quarterly updates to the work plan reflect progress on QM/QI activities and are evaluated annually. The QM Committee reviews the updates and evaluations before forwarding to the Board of Directors.

IMPROVEMENT ACTIVITIES
Development, implementation and review activities include, but are not limited to the following:

Potential Quality of Care Complaints and Grievances
• Doctor Trends

Questions? 866.773.3260 or apquestions@vsp.com
• Complaint type trends
• Credentialing/Recredentialing and Professional Review
• Doctor Improvement Action Plan

Member, Client and VSP Doctor Satisfaction
• QA Report/Evaluations
• QA Doctor Reviews
• Company Satisfaction Survey Results

Risk Management
• Clinical Practice Guidelines and Algorithms
• Assessment of New Technology

Benefit Utilization
• Identification of outlier practice patterns that may identify under or over utilization

VSP’S FRAUD AND ABUSE POLICY

VSP considers insurance fraud and abuse as professionally unacceptable and criminal behavior and takes every precaution to ensure such activities are detected, eliminated, and referred to appropriate governmental authorities. VSP will vigorously pursue all fraudulent and abusive activities and supports all efforts to combat such practices by enforcing the following measures concerning, but not limited to, the health care provider, contract laboratories, VSP employees, clients, agents, and patients.

Program Components
The components of our Anti-Fraud and Abuse Business Plan are:
• The Anti-Fraud and Abuse Policy
• Education
• Prevention and Internal Controls
• Detection
• Investigation
• Sanctions and Disciplinary Action
• Full Cooperation with Law Enforcement and Regulatory Authorities

Questions? 866.773.3260 or apquestions@vsp.com
• Reporting
• Applicable Regulations and Laws

**Education**

VSP recognizes that the best defense against becoming a victim of fraudulent or abusive behavior is an educated work force capable of preventing, detecting and eliminating such activities. VSP is dedicated to providing appropriate education and training in this area. Company-wide training of all employees will cover the following topics:

• VSP’s Fraud and Abuse Policy
• The true costs of insurance fraud and how it directly affects them
• Definition of what constitutes fraud and abuse, including money laundering
• Indicators of fraudulent and abusive activities
• Reporting of suspected fraud and abuse
• Roles and responsibilities of the Special Investigative Unit (SIU)
• Responsibilities of each employee in reporting suspected or known fraudulent or abusive activities

Education and training for providers, contract laboratories, clients, agents, and patients concerning fraud and abuse will consist of:

• Definition of what constitutes fraud and abuse
• Indicators of fraudulent and abusive activities
• Repercussions of fraud and abuse
• Reporting of suspected fraud and abuse

**Prevention and Internal Controls**

VSP will maintain a comprehensive system of internal controls designed to prevent and detect occurrences of fraud and abuse. The system of internal controls will consist of:

• An organizational structure which segregates functions of claims processing, claims recording, and claims payment as well as maintenance of patient and provider membership tables and provider and laboratory fee tables
• Procedures incorporated into the manual work flow to maximize the probability that questionable claims will be identified and investigated
• Mainframe system checks that identify all claims which meet pre-set indicators and criteria that are known to be outside the norm of our industry standards and services
• Provider peer review processes and procedures

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• Internal claim audits of a statistically valid sampling
• A system of supervisor accountability for the review and approval of their unit’s actions

Detection
Well-trained personnel are able to routinely spot indicators of fraud and abuse. VSP’s SIU is the coordinator for all information and investigation regarding the detection and reporting of fraudulent and abusive activities. Detection of fraud or abuse can come from the following areas:

Claims Processors
• All claims processors will be familiar with the indicators of fraud and abuse
• Suspicious claims will be reviewed to determine if any misrepresentation has occurred
• Pertinent information will be documented
• If a claim is VSP internally confirmed to be fraudulent or abusive of the system, the matter will be forwarded to the SIU for appropriate action

Claims Auditors
• The claims auditors will continuously review reimbursement claims received during the normal course of daily audits with the purpose of identifying fraud and abuse
• The claims auditors will be made available to perform special reviews of any situation where fraud or abuse is suspected

Customer Service Representatives
• All customer service representatives will be familiar with the indicators of fraud and abuse
• Calls concerning provider fraud and abuse will be documented and the information forwarded to the SIU.
• All non-provider calls concerning fraud and abuse will be documented and the information forwarded to the SIU.

Quality Management Specialists
• All quality management specialists will be familiar with the indicators of fraud and abuse.
• Any potential fraud or abuse issues that are identified during a quality assurance review will be forwarded directly to the SIU.

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SIU
- The SIU will routinely run reports against our claims systems to identify activities that are uncharacteristic of our industry.
- Abnormal utilization patterns will be researched and appropriate action taken.

Hotline
- An Anti-Fraud Hotline has been made available for all parties (providers, contract laboratories, employees, clients, agents, and patients) to report any suspected fraud or abuse.
- The toll-free number is 800.877.7236.

Investigation
All cases of suspected fraudulent or abusive activities employed/practiced by providers, contract laboratories, VSP employees, agents, clients, or patients will be fully investigated with the involvement of the SIU and VSP Legal Counsel as needed. The following items will be considered to be a part of the investigation:
- Information gathering
- Claim validity
- Scope of the investigation
- Ability to prosecute
- Ability to recover monies owed
- On-site investigations conducted by VSP personnel
- Use of outside investigators and experts

Sanctions and Disciplinary Action
Fraudulent and/or abusive practices could result, without limitation, in the following sanctions and/or disciplinary actions:
- Providers—suspension or removal from the VSP network, assessment and collection of restitution, assessment and collection of reasonable audit costs and expenses, referral to the appropriate state’s governing Board of Optometry, Board of Ophthalmology, or Medical Boards, referral to the appropriate state’s law enforcement or other government agency(ies) and reporting to the National Practitioner Data Bank and/or other appropriate data reporting agency
- Contract Laboratories—suspension or removal from the approved listing of VSP laboratories and restitution collected
- VSP employees—termination and restitution collected

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• Agents—suspension or removal as VSP agent, restitution collected, and referral to the appropriate state’s governing Insurance Department

Upon the expiration or termination of the Network Participation Agreement, a provider will no longer be or be considered a VSP Affiliate Provider. From the date of expiration or termination onward, unless the parties otherwise agree in a separate writing, the doctor, in any capacity, unless prohibited or limited by law, will: (a) no longer directly or indirectly submit any VSP patient claims for reimbursement to VSP for any purpose, (b) directly or indirectly advertise or indicate in any manner or in any way that he/she is a VSP Affiliate Provider, affiliated with or authorized by VSP and/or a VSP out of network provider, or any variation thereof, (c) act as, or hold himself/herself out to the public to be, a VSP Affiliate Provider and/or a VSP out of network provider, or any variation thereof and/or (d) submit any VSP patient claims for reimbursement to VSP as an out of network provider. The doctor will promptly advise all VSP patients that as of the date of expiration or termination, he/she no longer is a participant on the VSP doctor network. The doctor shall not issue/make any disparaging, slanderous and/or libelous remarks regarding/concerning VSP and its business to any VSP client, VSP patient and/or any third party for any reason whatsoever.

Full Cooperation with Law Enforcement and Regulatory Authorities

In cases where sufficient evidence is gathered to indicate that fraudulent activity has in fact occurred, VSP’s Corporate Legal Counsel will coordinate actions with law enforcement agencies as well as be prepared to initiate civil litigation in furtherance of all anti-fraud objectives. VSP will cooperate fully with all law enforcement agencies in the subsequent prosecution of fraudulent activities.

Reporting

The SIU will collect data and maintain documentation of investigations to provide support for Company actions. Cases under review or turned over to law enforcement for prosecution will be documented and reported to the Corporate Compliance Officer quarterly. The Corporate Compliance Officer will report the quarterly results to the Finance Committee of the Board. To meet standards of compliance, the SIU will report to states and requesting clients as required. The Company will also evaluate the effectiveness of its anti-fraud and abuse efforts on an annual basis.

VSP is a member of the National Health Care Anti-Fraud Association. VSP will incorporate any additional fraud detection and investigation measures deemed necessary and pertinent to our operation to comply with the NHCAA standards, and with local, state or federal law, as required.

Applicable Regulations and Laws

VSP helps administer many Federal and State healthcare programs such as Medicare and Medicaid that apply the following laws and regulations:

Questions? 866.773.3260 or apquestions@vsp.com
ANTI-KICKBACK STATUTE
Prohibits anyone from knowingly and willfully soliciting or receiving anything of value in return for referring healthcare goods or services for which payment may be made in whole or in part under a federal health care program. The penalties are severe. If a person or entity is found guilty of violating the statute, a fine of up to $25,000 or imprisonment of up to five years may be imposed.

Certain provider activities are “safe harbors” that are outlined in the law.

In addition to the Federal Anti-Kickback Statute, many states have adopted state anti-kickback statutes. Many of these statutes have the same elements and penalties as the Federal Anti-Kickback Statute.

FEDERAL PHYSICIAN SELF-REFERRAL
Prohibits a physician (or immediate family member) who has a financial relationship with an entity from making a referral to that entity for furnishing a designated health service (DHS) for which Medicare or Medicaid would otherwise pay. Congress provided for a number of exceptions to this prohibition and gave CMS the authority to create additional exceptions.

FEDERAL FALSE CLAIM ACT
Federal False Claim Act prohibits any individual or business from submitting, or causing someone else to submit, to the government a false or fraudulent claim payment. These false claims acts apply to all types of goods, services and government contracting, and have been particularly effective in combating healthcare fraud. The fines for filing a false claim includes up to three times the government damage plus $5,500 to $11,000 per false claim.

In addition to the Federal False Claim Act, many states have adopted state false claim statutes. Many of these statutes have the same elements and penalties as the Federal False Claim Act.

MEDICARE AND MEDICAID
Medicare is health insurance for people 65 or older, under 65 with certain disabilities, and any age with End-Stage Renal Disease (ESRD). ESRD is permanent kidney failure requiring dialysis or a kidney transplant. The different parts of Medicare help cover specific services if you meet certain conditions.

Medicaid is a health care program funded by the U.S. federal and state governments that pays the medical expenses of people who are unable to pay some or all of their own medical expenses.
Submitting this form constitutes an agreement not to bill the patient during the claim appeal resolution process.

Please Print

Doctor name __________________________  Date _____________________
Doctor ID ____________________________  Tax ID ____________________
Address _____________________________  Phone ____________________
City, state, zip __________________________

Claim information

Number of claims appeals  □ Single  □ Multiple (indicate number of claims) ___
Patient name __________________________  Date of birth _____________________
Member ID or last four digits of SSN ______________________________________
Claim number __________________________  Date of service _____________________
Original claim amount billed $__________  Original claim amount paid $__________

Summary of services provided ___________________________________________
_____________________________________________________________________
_____________________________________________________________________

Indicate reason for appeal and a detailed description of circumstances. Please attach any supporting documentation.
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

Contact name __________________________  Title _________________________
Signature ______________________________  Date __________________________
Phone _________________________________

Mail to: VSP Claim Appeals, PO Box 2350, Rancho Cordova, CA 95741-2350
# Master Copy

## Multiple-Provider Dispute Resolution Form

Submit this form with the VSP Provider Dispute Resolution Request.

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<th>Number</th>
<th>Patient name</th>
<th>DOB</th>
<th>Member ID or last four digits of SSN</th>
<th>Claim number</th>
<th>Date of service</th>
<th>Original claim amount billed</th>
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