# PHP Provider Manual

## USER GUIDE

June 1, 2023

Physicians Health Plan of Northern Indiana, Inc.

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phpni.com

# Content

# Introduction To PHP

## About Us

Founded in 1983, Physicians Health Plan of Northern Indiana, Inc., is a physician-sponsored not-for-profit health insurance company whose focus has always been on providing our customers with quality, affordable health care customized to meet the specific needs of Indiana residents. More than 30 years later, PHP remains locally sponsored and governed by area doctors and business representatives who are committed to supporting patient/physician relationships and health care options for better health outcomes and healthier communities.

## Indiana Grown, Growing Indiana

Did you know PHP is the only not-for-profit health insurance company in Indiana? With this, comes a true commitment to improving the quality of life in the communities we serve. A core value at PHP is community. And we put our money where our mouth is. In 2019 alone, PHP gave more than $1 million across 150 different charitable organizations!
Our staff also contributes by giving of their time and talent. Through board and committee service, volunteer hours, and supply and collection drives, PHP employees are impacting our community for the better.

Positioned in Indiana, PHP has a unique view of health and wellness, as well as the opportunity to engage members and families through our insurance products. Living and working in the same region as our members allows us to connect on a personal level, making sure health care decisions positively impact the communities we serve in. More so than ever, we are uniquely qualified and prepared to advance the health and well-being of Indiana as a trusted, local resource

## The PHP Foundation

The PHP Foundation is dedicated to building healthier communities by addressing the health and wellness needs of low-income, high risk individuals in the neighborhoods we serve.
Through the PHP Foundation, we offer grants to tax-exempt, private agencies and/or public charities in 46 northern Indiana counties. These grants, totaling more than $10 million in the past 15 years, have helped fill voids in community needs.

PHP charitable contributions have offered broad social benefits to organizations including Matthew 25, Neighborhood Health Clinics, Super Shot, Inc., Maple City Health Care Center, and others. In addition, more than a million lives have been improved through improved access to medical and dental education, treatment, medications, and more; most often reaching low income, disadvantaged, medically and emotionally challenged individuals.

## Academic Scholarships

For 40 years, PHP has awarded academic scholarships to high school seniors in our service area pursuing careers in health-related fields. Nearly 100 students have received a total of more than $150,000 for educational expenses at a college, university, or technical school.

## Introduction and Guide to Manual

This provider manual presents an overview of information regarding key administrative areas; including but not limited to, claims submission, utilization management program, quality standards for Provider and Facility participation, reimbursement, clinical and administration policies and provider appeals.

Physicians Health Plan ("PHP") is committed to providing Providers and Facilities with an accurate and up to date manual; however, there may be instances where new procedures or processes are not immediately reflected in the manual. In such cases, PHP will make every effort to provide updated documentation in the next manual update. In those instances where PHP determines that information in the manual conflicts with the Agreement, the Agreement will take precedence over the manual.

This Manual is intended to support all entities and individuals that have contracted with PHP. The use of "Provider" within this manual refers to entities and individuals contracted with PHP that bill on a CMS 1500. They may also be referred to as Professional Providers in some instances. The use of "Facility" with this manual refers to entities contracted with PHP that bill on a UB04, such as Acute General Hospitals and Ambulatory Surgery Centers. General references to "Provider Inquiry", "Provider Website", apply to both Providers and Facilities.

Capitalized terminology in this document is defined in your PHP Facility Agreement or PHP Provider Participation Agreement otherwise referred to in this manual as "Agreement". The provisions of the provider manual apply unless otherwise provided for in your Agreement.

## Updates and Changes

In order to keep you updated we request that you provide us with your email address. We will use this email address to contact you with important information and updates to items like clinical policies, procedures, and our provider newsletter. Similarly, we will update this manual at least annually.

## Compliance

The information, policies and protocols stated in this manual should align with the terms of your agreement.

You're responsible to comply with all application federal and state laws and regulations. We many issue notifications regarding legal requirements by law and/or regulatory changes, however, you're responsible for compliance regardless of whether we issue a notification.

## Information Sources

**PHP at a Glance** - This guide contains key contact information.

**PHP Provider Administrative Manual** – This manual contains information on PHP process, protocols, precertification and claim submission requirements.

**PHP Website** — An internet site available to PHP Providers and Facilities at www.phpni.com. You must register to use the website. Provider Updates

PHP offers an array of online tools through the Secure Provider Portal.

## How to get started

To register for access to PHP, go to **www.phpni.com**; click the Login Link on the top right screen; under **First Time** User select **Provider** Registration; Select **Provider Registration Form**; an Provider Website User Set-Up Form will appear. Print out this form and fax to PHP, please note that the Tax ID # will need to be filled-in.

If you need further assistance getting registered, please contact PHP Customer Services Department at 1-800-982-6257.

**Provider Portal Training**
Once you log into portal, you'll have access to many resources to help assist in navigation including on-demand training, frequently asked questions, comprehensive help topics and other resources.

**Engage and obtain the information you need instantly with the following tools:**

- **Claim Status Inquiry -** See details and payment information including Claim line-level details/processing.
- **Secure On-Line Provider Authorization -** online provider authorization, referral and inquiry tool for many PHP members.
- **Member Eligibility and Benefits Inquiry -** Get real-time patient eligibility, benefits, and accumulative data, including current and historical coverage information, plus detailed co-insurance, co-payment and deductible information for ALL members.

**Secure Messaging -** Send a question to clarify the status of a claim or to get additional information on claims
Facility and Professional Reimbursement Policies
- Clinical Policies and UM Guidelines
- Joining PHP Networks

**Provider Update** — A periodic newsletter publication designed to educate physicians and facilities and their appropriate staff on administrative issues.

### PHP Provider Web Site

### www.phpni.com

**www.phpni.com** is the unsecured section of the web portal. The public provider website holds timely and important information to assist providers when working with PHP. Some items that can be located from the **Provider Home Page include:**

- Self Service and Support
- Medical Policies and Clinical UM Guidelines
- Electronic Data Interchange (EDI)
- Electronic Self-Service Options
- Precertification Guidelines
- Provider Maintenance Form
- Health and Wellness
- Communications & Updates
- Health Care Reform and Notifications
- ICD-10
- Provider Update
- Important Updates
- Contact Us

## Meet our Team

In order to meet the service needs of our participating provider network we have an experienced staff consisting of Provider Contracting and Provider Services Representative available to assist you.

**Provider Services** generally serves as a liaison and are responsible for implementation, demographic changes, on-site orientation, ongoing training and policy/procedure consultation. They will assist you with administrative policy and procedure problem resolution and service needs.

**Provider Contracting** generally serves as the primary contacts for network contracting.

Providers and Facilities can contact PHP's Provider Team at 260-432-6690 or 1-800-982-6257 in order to identify the appropriate Provider Services and Provider Contracting, please refer to the team below.

**Susan Werner**
Dir. Provider Implementation & Services
**swerner@phpni.com**
**260-421-4528**

**Christy Dimovski**
Provider Network Dev. Manager
**cdimovski@phpni.com**
**(260) 421-4486**

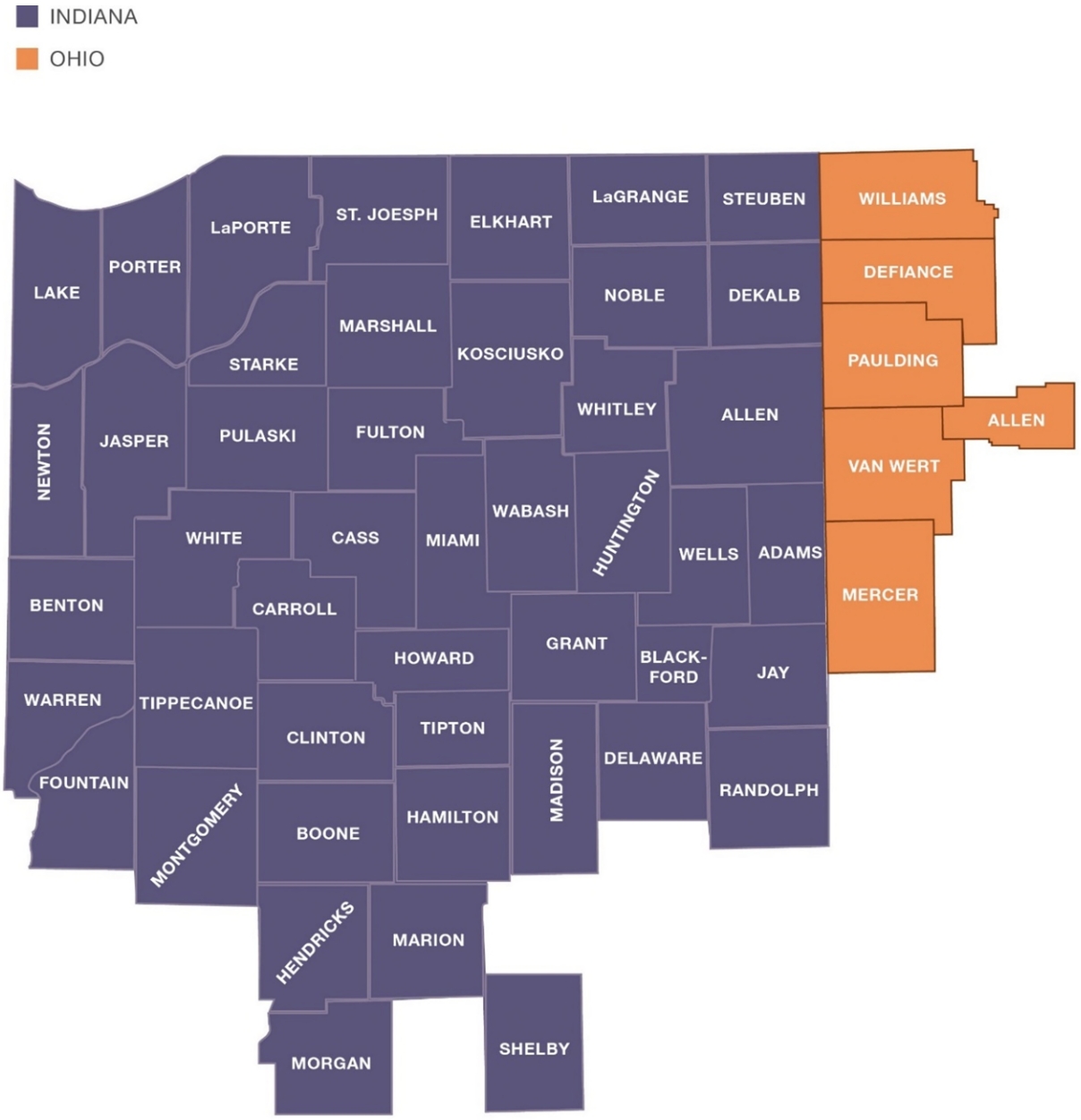
**Dawn Dager**
Provider Contracting Supervisor
**ddager@phpni.com**
**260-421-4304**

**Randy Goins**
Provider Contract Servicing
**rgoings@phpni.com**
**260-421-4527**

**Toni Simmons**
Credentialing Coordinator
**tsimmons@phpni.com**
**260-421-4319**

## Service Area

The service area for PHP in Indiana contains the following counties:




PHP Service Area

# Provider Demographic and Directory Accuracy

## Provider Directories

The provider directory is available on our website at **www.phpni.com**. If you do not have internet access contact the PHP Customer Services Department for assistance in identifying Participating Providers and Facilities. Providers using the directory for referrals to in-network providers should note that not all providers are contracted for all PHP networks. Please note that non-credentialed providers are not found on the online Provider Directory,

Federal provider directory regulations and the No Surprise Act require PHP and providers to maintain accurate provider directory information.

It is required by law that you and PHP keep your information current and to confirm its accuracy every ninety (90) days. From time to time PHP may require confirmation upon request as well.

### Finding Care

Information contained in our directories is used by patient to help find care. Inclusion in our directory allows new patients to find if you are accepting new patient's, your practice location and contact information,

To maintain the most accurate information, please remember to notify PHP of your data changes in accordance with contractual requirements, along with state and federal laws. Failure to do so will result in the removal of your practice from PHP's Provider Directory in accordance with the applicable laws.

## Online Provider Directories and Demographic Information

Providers and Facilities are able to confirm their Network participation status by using the Provider Directory tool. You are able to search by a specific provider name, or view a list of local in-network Providers and Facilities using search features such as provider specialty, zip code, and plan type.

Providers and Facilities who have questions on their participation status are encouraged to contact PHP Contracting Service Rep at: 1-260-421-4472.

## Updating your Demographic Data with PHP

It is critical that your patients receive accurate and current data related to provider availability. Please notify PHP of any changes to your Provider and Facility information. Contractual terms may supersede effective date request.

**Notes:**

- **Tax ID changes must be accompanied by a W-9 to be valid.**
- **For notices of termination from our network, refer to the termination clause in your Agreement for specific notification requirements. Please allow the number of days' notice of termination from our network as required by your Agreement (e.g. 90 days, 120 days, etc.).**
- **PHP does not perform recredentialing for providers who simply have demographic changes or change employment**

Types of demographic data updates can include, but are not limited to:

- Accepting New Patients
- Address - Additions, Terminations, Updates (including physical and billing locations)
- Email Address
- Hospital Affiliation and Admitting Privileges
- Languages Spoken
- Name change (Provider/Organization or Practice)

- National Provider Identifier (NPI)
- Network Participation
- Office Hours/Days of Operation
- Patient Age/Gender Preference
- Phone/Fax Number
- Provider Leaving Group, Retiring, or Joining another Practice*
- Specialty
- Tax Identification Number (TIN)
- Termination of Provider Participation Agreement

Please send us this information online to: www.providerservices@phpni.com or by fax at 260-969-2421 or by using **Provider > Tab > Provider Demographic Form.**

*** Note: To request participation for a new provider or facility, even if joining an existing practice, providers or facility must first begin the Application process.**

Go to **www.phpni.com >Landing Page> Providers>Become a PHP Provider> Provider Credentialing Form> Healthcare Organizational Facility Credentialing/Recredentialing Form.**

## Join the network

### How to apply

Whether you're with a facility that's new to PHP or you're a health care professional who's joining an existing group, it's easy to apply for participation in our network.

## Credentialing/Recredentialing

## Participation

### Standards of Participation

Providers that require full credentialing are identified in the Credentialing Plan. PHP contracts for many types of health services provided by individuals or organizations that do not fit the categories as described in the Credentialing Plan. PHP requires a form of credentialing for these providers, known as "Standards of Participation". The Credentials Committee, with input from Provider Services Department, the Medical Director, and other sources as they deem appropriate, develop a list of providers that are credentialed under Standards of Participation. At least annually, and more frequently if required, the Credentials Committee will evaluate the list and make changes to meet the needs of PHP. PHP and the Credentials Committee retain the right to exclude types or categories of practitioner or facility providers, if they do not meet the needs of PHP.

## Credentialing

In order to initiate participation in our network you be credentialed first. To continue participation, you must be recredentialed every three years.

PHP accesses credentialing verification data through the Council for Affordable Quality Healthcare (CAQH), provider source. In order for PHP to access your information you must designate PHP as an authorized health plan.

### Criteria

The credentialing summary, criteria, standards, and requirements set forth herein are not intended to limit PHP's discretion in any way to amend, change or suspend any aspect of its credentialing program nor is it intended to create rights on the part of practitioners who seek to provide healthcare services to our Members. PHP further retains the right to approve, suspend, or terminate individual physicians and health care professional, and sites in those instances where it has delegated credentialing decision making.

### Credentialing Scope

PHP credentials the following licensed/state certified independent health care practitioners:

- Medical Doctors (MD)
- Doctors of Osteopathic Medicine (DO)
- Doctors of Podiatry (DPM)
- Chiropractor
- Optometrists providing Health Services covered under the Health Benefit Ran
- Doctors of dentistry including oral and maxillofacial surgeons
- Psychologists who have doctoral or master's level training
- Clinical social workers who have master's level training
- Psychiatric or behavioral health nurse practitioners who have master's level training

- Telemedicine practitioners who provide treatment services under the Health Benefit Ran
- Therapists (e.g., physical therapists, speech therapists, and occupational therapists)
- Genetic Counselors
- Audiologists
- Certified nurse midwives
- Registered Dieticians
- Certified Registered Nurse Anesthetists
- Certified Behavioral Analysts
- Certified Addiction Counselors
- Substance Abuse Practitioners

PHP credentials the following Health Care Organizations ("HCOs"):

- Hospitals
- Home Health Agencies
- Skilled Nursing Facilities (Nursing Homes)
- Ambulatory Surgical Centers
- Behavioral Health Facilities providing mental health and/or substance abuse treatment in inpatient, residential or ambulatory settings
- Birthing Centers
- Home Infusion Therapy
- Dialysis Facilities
- Hospice
- Convenience Clinic
- Urgent Care Centers
- Laboratory
- Cardiac Diagnostic Facilities
- Radiology Diagnostic Facilities
- Durable Medical Equipment Suppliers (DME)
- Pharmacy
- Sleep Centers

The decision to accept, retain, deny or terminate a practitioner's participation in the PHP network is conducted by a peer review body, known as PHP's Credentials Committee ("CC').

**Please note:** This is only a representative listing of provider types that require formal credentialing. If you have questions about whether you are subject to the formal credentialing process or the applicable standards of participation for your provider type, please call PHP's Credentialing Team.

## Initial Credentialing

Each practitioner or HCO must complete a standard application form deemed acceptable by PHP when applying for initial participation. For practitioners, the Council for Affordable Quality Healthcare ("CAQH") Cactus system is utilized. To learn more about CAQH, visit their web site at www.caqh.org.

PHP will verify those elements related to an applicants' legal authority to practice, relevant training, experience and competency from the primary source, where applicable, during the credentialing process. All verifications must be current and verified within the one hundred eighty (180) calendar day period prior to the CC making its credentialing recommendation or as otherwise required by applicable accreditation standards.

During the credentialing process, PHP will review among other things, verification of the credentialing data as described in the following tables unless otherwise required by regulatory or accrediting bodies. These tables represent minimum requirements.

**Eligibility Criteria - Health care practitioners:**

**New Applicants (Credentialing)**

The application process includes the following steps:

A. Credentialing/Recredentialing Criteria

1. Maintain current Indiana license to practice, with acceptable disciplinary history.
2. Maintain a valid DEA certificate.
3. Graduate of an acceptable school as defined by the Indiana Health Professions Bureau. (Schooling is verified only at the time of credentialing unless changes are identified at recredentialing.)
4. Malpractice insurance for licensed practitioners as prescribed by State law or set by PHP in states without regulations.
5. Professional liability claims history that does not reflect a negative trend or pattern.
6. Provide a minimum of a ten-year work history, if applicable. Recredentialing applicants are not required to submit the ten-year work history.
7. History of sanctions. Re-credentialing will be from appointment period forward.
8. History of loss or limitation of privileges or disciplinary activity, Recredentialing will be from the appointment period forward.
9. National Practitioner Data Bank (NPDB) report, providing a minimum of a five-year medical malpractice and previous sanction activity by Medicare and Medicaid Program, if applicable. An NPDB report shall be rechecked at the time of reapplications.
10. Meet standards of state law and ethical conduct governing the practice of medicine.
11. Board Certification, or evidence of appropriate training, or evidence of experience in area of specialization.

**Eligibility Criteria - HCO Eligibility Criteria**

New HCO applicants will submit a standardized application to PHP. If the candidate meets PHP screening criteria, the credentialing process will commence. To assess whether Network HCOs, within the scope of the Credentialing Program, meet appropriate standards of professional conduct and competence, they are subject to credentialing and recredentialing programs. In addition to the licensure and other eligibility criteria for HCOs, as described in detail in PHP Credentialing Plan, all participating HCOs are required to maintain accreditation by an appropriate, recognized accrediting body or, in the absence of such accreditation, PHP may evaluate the most recent site survey by Medicare, the appropriate state oversight agency, or a site survey performed by a designated independent external entity within the past 36 months for that HCO.

All HCOs must be accredited by an appropriate, recognized accrediting body or in the absence of such accreditation, PHP may evaluate the most recent site survey by Medicare, the appropriate state oversight agency, or site survey performed by a designated independent external entity within the past 36 months. If a HCO has satellite facilities that follow the same policy and procedures, HCOs are recredentialed at least every three (3) years to assess the HCO's continued compliance with PHP standards.

A. HCOs are defined as hospitals, home health agencies, ambulatory surgical centers, (inpatient and outpatient), physician operatory, behavioral health facilities, and long-term care facilities (Transitional Care Units).

B. Approval of each HCO will be determined by the PHP Medical Director or Credentials Committee according to the guidelines set forth in the PHP Credentialing Plan.

C. Credentialing/Recredentialing criteria is approved by the Credentials Committee. The criteria for HCOs are specified in this document.

**Criteria for affiliation of Health Care Organizations**

1. State Licensure where applicable (determined by individual State regulations, verification and PHP.)
    a. PHP will not require state licensure for Physician Operators.

2. A Quality Improvement (QI) program which includes the following:

a. a defined structure
b. outcome monitoring/quality studies

**The above will be verified by:**

a. copy of the HCO's QI plan and submitted; or
b. by a copy of the federal and/or state survey report for State Licensure and/or CMS certification, or
c. a copy of a post survey letter or certificate of accreditation from an acceptable accrediting agency.

3. An on-site review to determine compliance with PHP standards, performed within the previous three years, confirmed by one of the following:
    a. Satisfactory site visit by a PHP Quality Management representative, utilizing an appropriate standards and review tool.
    b. ISDOH site visit (verified by a copy of the state survey report with summary statement of any deficiencies).
    c. CMS certification (verified by a copy of the federal survey report with summary statement of any deficiencies, if the survey occurred within the previous three years).
    d. Accreditation by an acceptable accrediting agency (verified by a copy of the accreditation award letter or accreditation certificate).

4. The designated acceptable accrediting agencies as noted in sections 2 and 3 above are
    a. The Joint Commission (TCJ) formerly JCAHO (Joint Commission on Accreditation of Healthcare Organizations),
    b. CARF Commission on Accreditation of Rehabilitation Facilities),
    c. AAAHC (Accreditation Association for Ambulatory Health Care),
    d. AAAASF (American Association for Accreditation of Ambulatory Surgical Facilities),
    e. CCAC (Continuing Care Accreditation Commission), and
    f. HFAP (Healthcare Facilities Accreditation Program). The acceptability of other accrediting agencies for this purpose will be determined, as necessary, by the Credentials Committee.
    g. CABC (Commission for Accreditation of Birthing Centers); and
    h. ACHC (Accreditation Commission for Health Care)
    i. CHAP (Community Health Accreditation Program)

5. Malpractice Liability Insurance as prescribed by individual State regulations. (Verified by a copy of the insurance policy cover page stating the coverage amount, or by phone or written confirmation by the insurance carrier).
    a) The State of Indiana requires the following minimum coverage levels:
        1) Hospitals with 100 beds or less require $250,000 per occurrence and $5,000,000 in the annual aggregate.
        2) Hospitals with more than 100 beds require $250,000 per occurrence and $7,500,000 in the annual aggregate.
        3) Other health facilities* with 100 beds or less require $250,000 per occurrence and $750,000 in the annual aggregate.
        4) Other health facilities* with more than 100 beds require $250,000 per occurrence and $1,250,000 in the annual aggregate.
        5) All other providers require $ 250,000 per occurrence and $750,000 in the annual aggregate.

    The Indiana Code under which the HCO is licensed determines the designation of an HCO as a hospital, or other health facility.

    b) The State of Ohio and Michigan do not require healthcare organizations to carry malpractice liability insurance. PHP minimum requirements are:
        1) Hospitals and other facilities with 150 beds or less require $1 million per occurrence and $3 million in the aggregate.
        2) Hospitals over 150 beds will require a minimum of $1 million per occurrence and $5 million in the aggregate.
        3) Hospitals over 500 beds or University Hospitals would require a minimum of $1 million per occurrence and $9 million in the aggregate.

| INDIVIDUAL/ORGANIZATION BY CATEGORY | STANDARDS OF PARTICIPATION DOCUMENTS TO BE SUBMITTED |
|---|---|
| Cardiac Diagnostic Center or Facility | State, Medicare and/or Medicaid Certification |
| Cardiac Diagnostic Services | Joint Communication (JC), CHAP, or ACHC Certification<br>Medicare Provider Letter<br>Product Liability Insurance (if providing DME Services) |
| Dialysis Center | Medicare Certification or Provider Letter<br>Indiana Facilities – State of Indiana End Stage Renal Disease Facility Certification |
| Dieticians, Registered (independent) | State License or Certification |
| Durable Medical Equipment | Joint Communication (JC)or CHAP, or ACHC Certification<br>or<br>Medicare Provider Letter<br>Product Liability Insurance |
| Home or Ambulatory Infusion providers | Joint Communication (JC) or CHAP or ACHC<br>State & Pharmacy Licensure |
| Orthotics & Prosthetics | American Board for Certification in Orthotics, Prosthetics & Pedorthics – copy for each provider |
| Sleep Study Lab | American Academy of Sleep Medicine Certification<br>Medicare Provider Letter |
| Walk In/Urgent Care Center<br><br>*If affiliated with a hospital, JCAHO, or CHAP certification. | Physician Medical Director/Supervision<br>Extended Hours<br>American Board of Urgent Care Medicine (ABUCM)<br>Staffed by MD or DO<br>Certification from Urgent Care Centers of America (UCAOA) or<br>Urgent Care Center Accreditation (UCCA)<br>CLIA Certification if Applicable |
| Convenience Clinics | Services offered through extended hours<br>Staffing with at least a Nurse Practitioner on all shifts<br>CLIA Certification or CLIA Waiver, if applicable. |
| Clinical Laboratory (other than inside Hospital or Ambulatory Care Center) | CLIA Certification<br>Medicare Certification |
| Outpatient Therapy Group/Office/Clinic (PT, OT, SP) | Medicare and/or Medicaid Provider Letter<br>If or as applicable under Indiana Regulations Certification as a:<br>Other Rehabilitation Facility (ORF)<br>Out Patient Physical Therapy (OPT)<br>Comprehensive Outpatient Rehabilitation Facility (CORF) |
| Occupational Medicine Clinic | Physician Medical Director<br>Unrestricted State License for Medical Director<br>Accept all PHP Plans<br>Staffed by MD or DO |
| Vision / Optical Suppliers | Registered Retail Merchant Certificate<br>Commercial / General / Professional Liability Insurance Certificate |
| Radiology Diagnostic Center of Facility | State, Medicare and/or Medicaid Certification |

## Recredential - Practitioners

The recredentialing process incorporates re-verification and the identification of changes in the practitioner's or HCO's licensure, sanctions, certification, health status and/or performance information (including, but not limited to, malpractice experience, hospital privilege or other actions) that may reflect on the practitioner's or HCO's professional conduct and competence. This information is reviewed in order to assess whether practitioners and HCO's continue to meet PHP credentialing standards.

All applicable practitioners and HCO's in the Network within the scope of PHP Credentialing Program are recredentialed every three (3) years unless otherwise required by contract or state regulations

**NOTE**: PHP does not perform recredentialing for providers who simply have demographic changes or change employment

## Recredentialing - Health Care Organizations

Recredentialing of HCOs occurs every three (3) years. Each HCO applying for continuing participation must submit a new application and attestation and submit all required supporting documentation.

On request, HCO's will be provided with the status of their credentialing application. PHP may request, and will accept, additional information from the HCO to correct incomplete, inaccurate, or conflicting credentialing information. The CC will review this information and the rationale behind it, as presented by the HCO, and determine if a material omission has occurred or if other credentialing criteria are met.

## Nondiscrimination Policy

PHP will not discriminate against any applicant for participation in our provider network(s) on the basis of race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran, or marital status or any unlawful basis not specifically mentioned herein. Additionally, Other than gender and language capabilities which are provided to the members to meet their needs and preferences, this information is not required in the credentialing and re-credentialing process. Determinations as to which practitioners and providers require additional individual review by the Credentials Committee are made according to predetermined criteria related to professional conduct and competence. CC decisions are based on issues of professional conduct and competence as reported and verified through the credentialing process.

PHP will monitor credentialing files (in-process, denied and approved) to ensure that practitioners are not discriminated against, if a discriminatory practice is identified through audit or through other means, PHP will take appropriate action(s) to track and eliminate those practices.

## Ongoing Sanction Monitoring

To support certain credentialing standards between the recredentialing cycles, PHP has established an ongoing monitoring program. This monitoring is performed to ensure continued compliance with credentialing standards and to assess for occurrences that may reflect issues of substandard professional conduct and competence. To achieve this, the credentialing department will review periodic listings/reports within thirty (30) calendar days of the time they are made available from the various sources including, but not limited to, the following:

1. Office of the Inspector General ("0IG")
2. Federal Medicare/Medicaid Reports
3. National Practitioner Databank (NPDB)
4. Office of Personnel Management ("OPM")
5. State licensing Boards/Agencies (Indiana, Ohio and Michigan)
6. Customer Services Departments
7. Utilization Review and Quality Improvement (including data regarding complaints of both a clinical and non-clinical nature, reports of adverse clinical events and outcomes, and satisfaction data, as available)
8. Other internal PHP Departments
9. Any other information received from sources deemed reliable by PHP.

When a practitioner or HCO within the scope of credentialing has been identified by these sources, criteria will be used to assess the appropriate response.

## Appeals Process

PHP has established policies for monitoring and re-credentialing practitioners and HCO's who seek continued participation with PHP. Information reviewed during this activity may indicate that the professional conduct and competence standards are no longer being met, and PHP may wish to terminate practitioners or HCOs. PHP also seeks to treat Network practitioners and HCO's, as well as those applying for participation, fairly and thus provides practitioners and HCO's with a process to appeal determinations terminating/denying participation in PHP's Networks for professional competence and conduct reasons. PHP will permit practitioners and HCO's who have

been refused initial participation the opportunity to correct any errors or omissions which may have led to such denial (informal/reconsideration only).

Immediate terminations may be imposed due to the practitioner's or HCO's license suspension, probation or revocation, or if a practitioner or HCO has been sanctioned, debarred or excluded from the Medicare, Medicaid or FEHB programs, or has a criminal conviction, or PHP determines that the practitioner's or HCO's continued participation poses an imminent risk of harm to our Members. Participating practitioners and HCO's whose network participation have been terminated due to the practitioner's suspension or loss of licensure or due to criminal conviction are not eligible for reconsideration through the Appeal Process. Participating practitioners and HCOs whose network participation have been terminated due to sanction, debarment or exclusion from the Medicare, Medicaid or FEHB are not eligible for reconsideration under the Appeal Process as they no longer meet the standards of PHP Credentialing Plan.

## Reporting Requirements

When PHP takes a professional review action with respect to a practitioner's or HCO's participation in one of our Networks, PHP may have an obligation to report such to the NPDB, state licensing board and legally designated agencies. In the event that the procedures set forth for reporting reportable adverse actions conflict with the process set forth in the current NPDB Guidebook, the process set forth in the NPDB Guidebook will govern.

# Accessibility Standards

PHP uses the following standards to assess the access of services for our commercial members. Offices are to make best efforts to provide access in accordance with the member's needs and expectations for their medical and behavioral health circumstances.

**Open Practice Reminder: Keep PHP updated of status changes for our online directory.**

| **OFFICE APPOINTMENT ACCESSIBIILITY**<br>**Assessment of appointment timeliness to meet members needs** | |
|---|---|
| ***MEDICAL APPOINTMENT ACCESS*** | ***COMPLIANCE*** |
| ***Emergency*** | **Immediate access 24/7/365** or refer to 911 or ER. |
| ***Urgent/ Acute Care*** | **Within 24 hours -**<br>• Patient can be seen in the office by their doctor, another participating practitioner in the practice or a covering practitioner within the timeframe. |
| ***Non-Urgent***<br>*(Symptomatic or chronic)* | **Within 72 hours -**<br>• Patient can be seen in the office by their doctor, another participating practitioner in the practice or a covering practitioner with in the timeframe. |
| ***Routine/ Check-up*** | **Within 10 business days -**<br>• Patient can be seen in the office by their doctor, another participating practitioner in the practice or a covering practitioner with in the timeframe. |
| ***Preventive Care*** | **Within 30 calendar days -**<br>• Patient can be seen in the office by their doctor, another participating practitioner in the practice or a covering practitioner within the timeframe. |
| ***Office Wait Time*** | Recommended not to exceed 30 minutes or less before taken to the exam room. |
| ***After Hours Urgent Care***<br>*(Required arrangements)* | **24/7/365 phone access -**<br>All Members shall have phone access to urgent medical help or instructions after regular business hours through their primary care physician via:<br>• Live person connects the caller to their available doctor or on-call doctor.<br>• Recording or live person directs the patient to Urgent Care, 911 or ER, as appropriate.<br><br>In addition to, but not in place of the above criteria, the caller may be directed to contact a live health care practitioner (via cell or transfer system) or get a call back for urgent instructions.<br><br>***Having no provision is non-compliant*** |
| ***BEHAVIORAL HEALTH APPOINTMENT ACCESS*** | ***COMPLIANCE*** |
| ***Emergency*** | **Immediate access 24/7/365** or refer to 911, ER or crisis center. |

| OFFICE APPOINTMENT ACCESSIBIILITY<br>Assessment of appointment timeliness to meet members needs | |
|---|---|
| ***Discharge Follow-up BH Appointment*** | **Within 7 days -**<br>• *New or existing* patient can be seen in the office by designated BH practitioner within the timeframe after discharge from an inpatient psychiatric hospitalization. |
| *Emergent - Non-Life Threatening* | **Within 6 hours -**<br>• Patient can be seen in the office by their BH practitioner, another participating practitioner in the practice or a covering practitioner within the timeframe.<br>• Patient is directed to 911, ER or 24-hour crisis services, as appropriate. |
| *Urgent Care* | **Within 48 hours -**<br>• Patient can be seen in the office by their BH practitioner, another participating practitioner in the practice or a covering practitioner within the timeframe.<br>• Patient is directed to 911, ER or 24-hour crisis services, as appropriate. |
| *Routine- Initial Appointment* | **Within 10 business days -**<br>• *New* patient can be seen in the office by a designated BH practitioner or another appropriate participating practitioner within the timeframe. (After the intake assessment or referral.) |
| *Routine- Follow-up Appointment* | **Within 30 calendar days -**<br>• *New or existing* patient can be seen in the office by their BH practitioner, another participating practitioner in the practice or a covering practitioner within the timeframe. |
| *After Hours Urgent Care (Required arrangements)* | **24/7/365 phone access -**<br>All Members shall have phone access to emergent/urgent instructions/consultation after regular business hours through their BH practitioner via:<br>• Recording or live person directs patient to 24-hour crisis services. 911 or ER, as appropriate.<br>• Caller is directed to contact a BH Practitioner (via cell or transfer system) or get a call back for instructions or consultation.<br><br>***Having no provision is non-compliant*** |
| *Out of Office Coverage* Assessment | Arrangement for coverage when the practitioner is unavailable (vacation, illness, holiday, etc.) via:<br>• Cell phone after hours messaging, etc.<br>• Patient is directed to another BH practitioner in the practice, on call or covering practitioner.<br>• Prior arrangement with patients. |

# Verifying member eligibility and benefits

**Member identification and verification of eligibility**

The following are ways to identify whether a patient is a PHP member.

**ID Cards**

PHP provides each member with their own unique identification number and card. Below are examples of the ID cards that PHP members will present.

**Digital ID cards**

Members can access and view their digital ID cards on the PHP member website, PHP.com. Members can print a new or replacement card from the PHP member portal. Digital ID cards are identical to the plastic ID cards.

**No ID card?**

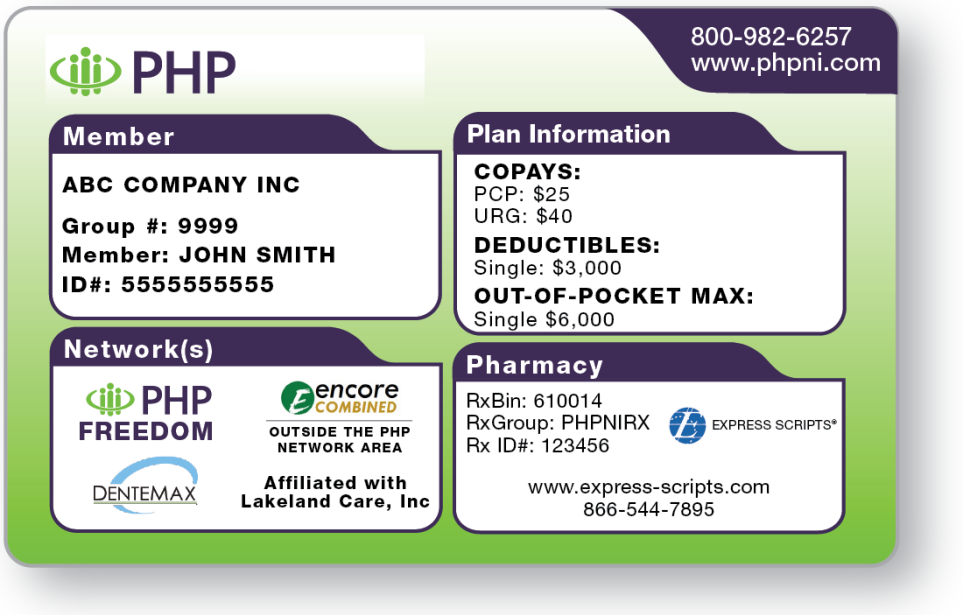
Use the eligibility and benefits inquiry transaction on the provider web portal at www.phpni.com. you can enter the patient's full or partial name and date of birth to find patient eligibility and coverage information.

**Verifying benefits**

Use the Eligibility and Benefits Inquiry transaction to obtain member-specific plan details. Check eligibility prior to a patient's visit since coverage could have expired or been suspended. Depending on plan details, transaction fields may include: •

- ✓ Copay, deductible and coinsurance
- ✓ Exclusions and limitations
- ✓ Visits used and visits remaining
- ✓ Referral and precertification requirements

Here are some tips to help you complete a transaction. • Search using the patient's full first and last names and date of birth if you don't have the member ID number.



# Precertification

## Clinical Policies and Utilization Review ("UR") Guidelines

The principal component of the process is the review for development of Medical Necessity and/or investigational policy position statements or clinical indications that are objective and based on clinical evidence for certain new medical services and/or procedures or for new uses of existing services and/or procedures. The services consisting of medical, surgical, and behavioral health treatments include, but are not limited to devices, biologics and specialty pharmaceuticals, and professional health services.

The Medical Advisory/Pharmacy and Therapeutic Committee ("MAC') is a multiple disciplinary group including physicians from various medical and clinical practice environments and geographic areas. Voting membership may include external physicians in clinical practices and participating in the network, external physicians in academic practices and participating in the network, internal medical directors and Chair of MAC Subcommittee. Non-voting members may include internal legal counsel and internal medical directors.

### Clinical Policy and Utilization Review ("UR') Guidelines Distinction

Clinical Policy and clinical UR guidelines differ in the type of determination being made. Both set forth position statements or clinical indications regarding the medical necessity of individual services and/or procedures. In general, Clinical Policy may be developed to address experimental or investigational technologies (including a novel application of an existing technology) and services where there is a significant concern regarding Member safety. Clinical UR guidelines address Medical Necessity criteria for technologies or services where sufficient clinical evidence exists to evaluate the clinical appropriateness of the request, goal length of stay (GLOS), place of service and level of care. In addition, Medical Policies are implemented by all PHP Plans while clinical UR guidelines are adopted and implemented by PHP.

Clinical Policies and Clinical UR Guidelines are posted online at www.phpni.com

All PHP Clinical Policies are available on our website, which provides transparency for Providers and Facilities, Members and the public in general.

To locate Clinical Policy online: www.phpni.com > Providers > Resources for Providers > Utilization

# Utilization Review

### Utilization Review Program

Providers and Facilities agree to abide by the following Utilization Review ("UR') Program requirements in accordance with the terms of the Agreement and the Member's Health Benefit Plan. Providers and Facilities agree to cooperate with PHP in the development and implementation of action plans arising under these programs. Provider or Facility shall comply with all requests for medical information required to complete **VÃLENZ Care** UR review. Providers and Facilities agree to adhere to the following provisions and provide the information as outlined within this section. All requests for prior authorization, case management, and disease management should be submitted to **VÃLENZ Care** using the following email, fax or webportal.

Vãlenz
https://www.valenzhealth.com/login/
FAX**:** 863-333-4417
PHONE**:** 877-608-2200 press 1 for precert, press 2 for CM/DM

## UR Definitions

**Pre-admission Certification:** The purpose of this element of PHP's Utilization Review and Quality Improvement Plan is to limit inpatient services to those that are believed to be necessary and effective. It will be accomplished by pre-certifying services such as:

- All scheduled hospital admissions;
- All scheduled admissions to alternate care facilities; e.g., Rehab;
- All skilled nursing facility admissions;
- Emergency admissions (within 48 hours of admission);
- Selected outpatient procedures as determined by the QIC.

PHP's utilization review activities will focus on determining whether admissions and lengths of stay are necessary and appropriate according to generally accepted standards of medical practice, required for the care of the Covered Person.

**Concurrent Review:** This activity is designed to encourage, as medically necessary, the timely discharge of hospitalized Covered Persons, and to permit a concurrent assessment of the appropriateness of diagnostic tests and treatment performed in conjunction with inpatient stays. Further, concurrent review should provide for proactive assessment for discharge planning and home health care arrangements.

**Services that require prior authorization:** List of procedures that require Pre-service approval include the items below/ but not inclusive contact Medical Management for additional listing of prior authorization services. Providers > Prior Authorization Search Tool >

Review, the provider submits the pertinent information, as referenced below, as soon as possible to **VÃLENZ Care** prior to service delivery.

- Place of Service (ex, Inpatient, Outpatient)
- Type of Service (ex. Medical, Surgical, Behavioral Health)
- Date of Service
- Member Identification Number (with 2-character suffix)
- Member Name and Member's Date of Birth
- Level of Service (ex. Elective, Urgent, Emergent)
- Diagnosis
- HCPCS or CPT Codes for scheduled Procedure
- Name and address of Provider and NPI
- Name and address of Facility and NPI
- Clinical information to support the request

**Business Day** Monday through Friday, excluding designated company holidays.

**Notification:** The telephonic and/or written/electronic communication to the applicable Providers, Facility and the Member documenting the determination, and informing the Member, Providers, and Facility of their rights if they disagree with the determination.

**Adverse Determination:** means a denial, reduction or failure to make payment (in whole or in part) for a benefit based on a determination that a benefit is experimental, investigational, or not medically necessary or appropriate as defined in the applicable health benefit plan. This may apply to prospective, continued stay, and retrospective reviews.

**Post Service (Retrospective) review:** means a utilization review that is conducted after the health care service (or supply) has been provided to the Member.

**Urgent Care Review:** means review of health care services which in the opinion of the treating Provider or any health care provider with knowledge of the Member's medical condition or based on a prudent layperson's judgment which, in the absence of urgent care review time frames could:

- Would seriously jeopardize the life, health or ability to reach and maintain maximum function or;
- In the opinion of physician familiar with patient, would subject them to severe pain that cannot be adequately managed unless we approve the service.

## Program Overview

Utilization Review (UR) may be required for Pre-certification/Pre-authorization, Pre-service (Prospective) Review, Continued Stay Review, or Post-service (Retrospective) Review.

The determination that services are medically necessary is based on the information provided, and is not a guarantee that benefits will be paid. Payments are based on the Member's coverage at the time of service.

These terms typically include certain exclusions, limitations and other conditions. Benefit payment could be limited, for example, when:

- The information submitted with the claim, or on the medical record, differs from that given by telephone, fax or electronic communication.
- The service is excluded from coverage.
- The Member is not eligible for coverage when the service is provided.

- The review may consider such factors as the Medical Necessity of services provided, and whether the service involves cosmetic or experimental/investigative procedures.
- UR may be conducted via multiple communication paths.
- Inpatient medical admissions require UR review. UR for inpatient medical services may include but is not limited to: acute hospitalizations, units described as "sub-acute," "step-down" and "skilled nursing facility;" designated skilled nursing beds/units; comprehensive outpatient rehabilitation facilities; rehabilitation units; inpatient hospice; and sub-acute rehabilitation facilities or transitional living centers. These services are subject to admission review for determination of Medical Necessity and appropriateness, site of service and level of care.
- Non-inpatient medical services may require Pre-Service Review.
- The list of Pre-certification/Pre-authorization Requirements can be accessed online at www.phpni.com. [link to site]
- UR for behavioral health inpatient and non-inpatient services, including but not limited to Residential, Partial Hospitalization and intensive outpatient services, require Pre-Service Review or Continued Stay Review.

## Pre-service Review & Continued Stay Review

A. Provider or Facility shall ensure both requirements (1) and (2) are met:

(1) that non-emergency admissions and outpatient procedures that require Pre-certification/Pre-authorization as specified by PHP are submitted for review and have a decision rendered before the service occurs. Information provided to **VÃLENZ Care** shall include demographic and clinical information including, but not limited to, see listing below

- Diagnosis.
- Appropriateness of level of care in relation to the treatment plan, patient acuity and other related factors
- Appropriateness of procedure for the prescribed plan of treatment
- Anticipation length of stay
- Timeliness of admission [e.g., when a surgery is scheduled?]; and
- Eligibility of certain procedure for coverage [e.g., cosmetic procedures, oral surgery, etc.]

(2) For non-emergency admissions, Provider or Facility shall also provide confirmation to **VÃLENZ Care** the necessary demographic information and primary diagnosis within twenty-four (24) hours or next Business Day following the Member's admission.

B. If an Emergency admission has occurred, Provider or Facility shall notify **VÃLENZ Care** within forty-eight (48) hours or the first Business Day following admission. If the forty-eight (48) hours expires on a day that is not a Business Day the timeframe will be extended to include the next Business Day. Information provided to **VÃLENZ Care** shall include demographic and clinical information including, but not limited to, primary diagnosis.

C. Provider or Facility shall comply with all requests for medical information required to complete **VÃLENZ Care** review up to and including discharge planning coordination. To facilitate the review process, Provider or Facility shall make best efforts to supply requested information within twenty-four (24) hours of request.

D. PHP specific Pre-certification/Pre-authorization Requirements may be confirmed on the **VÃLENZ Care** web site or by contacting customer service.

E. When the review is completed, the physician, hospital, facility, or other health care professional(s) and the Member receive notification of the UR determination.

UR Review Timeframes follow State, Federal and accreditation requirements as may be applicable to the review.

## Medical Policies and Clinical UM Guidelines

Please refer to the Clinical Policies and Utilization Management (UM) Guidelines section of this manual for additional information about Medical Policy and Clinical UM Guidelines.

## On-Site

If PHP maintains an on-site Initial Request/Continued Stay Review program, the Facility's UR program staff is responsible for following the Member's stay and documenting the prescribed plan of treatment, promoting the efficient use of services and resources, and facilitating available alternative outpatient treatment options. Facility agrees to cooperate with PHP and provide PHP with access to Members medical records, as well as, access to the Members in performing on-site Initial Request/Continued Stay Review and discharge planning related to, but not limited to, the following:

- Emergency and/or maternity admissions
- Ambulatory surgery
- Case management
- Pre-admission testing ("PAT')
- Inpatient Services, including Neonatal Intensive Care Unit ("NICU")
- Focused procedure review

Certain services may be excluded from on-site review including but not limited to Transplant.

## Discharge Planning

Discharge planning includes the coordination of medical services and supplies, medical personnel and family to facilitate the Member's timely discharge to a more appropriate level of care following an inpatient admission.

## Observation Bed Policy

Please refer to the "Observation Services Policy" located in the Billing and Reimbursement Guidelines section of the Manual.

## Retrospective Utilization Review

PHP doesn’t preform retrospect utilization review, services will be denied for lack of prior authorization in accordance to provider contract. Failure of the Provider to comply with PHP's UR/QI Plan may result in a reduction or total loss of reimbursement to the Provider. Provider shall promptly review changes to the UR/QI Plan.

## Utilization Statistics Information

On occasion, PHP may request utilization statistics for disease management purposes using Coded Services Identifiers. These may include, but are not limited to:

- Member name
- Member identification number
- Date of service or date specimen collected
- Physician name and/or identification number

- Value of test requested or any other pertinent information PHP deems necessary

This information will be provided by Provider or Facility to PHP at no charge to PHP.

## Clinical Appeals

Clinical appeals refer to a situation in which an authorization or Claim for a service was denied as not medically necessary or experimental/investigational. Medical necessity appeals/prior authorization appeals are different than Claim Payment Disputes and should be submitted in accordance with the Clinical appeal process.

For questions regarding non-clinical decisions, please refer to the Claim Payment Dispute section. Examples of non-clinical items that fall under Claim Payment Disputes include:

- Contractual payment issues
- Disagreements over reduced or zero-paid Claims
- Claim code editing issues
- Duplicate Claim issues
- Retro-eligibility issues
- Claim data issues
- Claims that are denied for no authorization when an authorization was obtained, a claim dispute may be submitted as long as the authorized services match the claim details.
- Timely filing issues

### Clinical Appeals

Clinical Appeals can be used if Providers or Facilities disagree with a clinical decision. Clinical Appeals are requests to change decisions based on whether services or supplies are Medically Necessary or experimental/ investigative. UM program Clinical Appeals involve certification decisions, Claims, or predetermination decisions evaluated on these bases. Clinical Appeals can be made verbally, in writing, or by using Interactive Care Reviewer for appeals regarding prior authorization adverse decision.

PHP Members may designate a representative to exercise their complaint and appeal rights. When a Provider or Facility is acting on behalf of a Member as the designated representative, the complaint or appeal may be directed to Provider Customer Service, using the phone number on the back of the Member ID card. These types of issues are reviewed according to PHP's Member Complaint and Appeal Procedures, for each applicable state. Provider Customer Service will help Providers and Facilities determine what action must be taken and if a Designate of Representative ("DOR") form is needed.

#### Guidelines and Timeframes for Submitting Clinical Appeals

- Providers and Facilities have one hundred and eighty (180) calendar days to file a clinical appeal from the date they receive notice of PHP's initial decision.
- All standard post-service clinical appeals will be resolved within a reasonable period of time appropriate to the medical circumstances, but not later than sixty (60) calendar days from the receipt of the appeal request by PHP.
- For clinical appeals, there are two (2) types of review: expedited and standard.

  ✓ **Expedited Appeal:** PHP offers an expedited appeal for decisions meeting the expedited criteria. Please note: Requests to handle a review as "expedited" are always handled as a Member appeal. Both standard and expedited appeals are reviewed by a person who did not make the initial decision. Unless the Member, on his or her own behalf, or another Provider or Facility has already filed an expedited appeal on the service at issue in the appeal, a Provider or Facility that requests an expedited appeal will be deemed to be the Member's designated representative for the limited purpose of filing the expedited appeal. As a result, the expedited appeal will be handled pursuant to the PHP Member Appeal Procedures exclusively.

- ✓ **Standard Appeal:** A standard appeal is available following the reconsideration, or initially, if it is formally requested.

- UM decisions are communicated in writing to the Provider or Facility and Member. These letters provide details on appeal rights and the address to use when sending additional information.

**Please note:** Requests for appeal of Pre-Service requests will always be handled as a Member appeal. An expedited appeal is available for cases meeting the expedited criteria. Please see the instructions detailed in the UM decision letter.

Appeals should be submitted to PHP, along with a copy of our response to the original complaint. Send the appeal request to:

**PHP**
**Attention: Grievances and Appeals**
**1700 Magnavox Way Suite 201**
**Fort Wayne IN 46804**

# Off Plan Referrals

## Referring to Non-Participating Providers

PHP's mission is to provide affordable quality health care benefits to its Members. In order for Members to maximize their highest level of health care benefits and assure quality of care, it is imperative for them to obtain services from Network/Participating Providers and Facilities. Providers and Facilities put Members at risk of higher out of pocket expenses when they refer to non-participating providers. To help manage cost, PHP has in place a referral process by which participating providers can submit prior authorization request to PHP.

In order for non-emergency health services provided by non-participating providers to be considered for coverage the following criteria must be satisfied.

- PHP Participating Providers must submit a Referral Request.
- the Health Services requested cannot be provided by or through Par Providers;
- the Health Services are Medically Necessary;
- a Par Doctor Referred the patient to the non-Par Provider;
- the Health Services are specified as Covered by the health benefit plan;
- the Health Services are rendered in the United States and its Territories; and
- we have approved the Referral in writing before services are receive.

Providers are reminded that per their Agreement with PHP they are generally required to refer Members to Network/Participating Providers. Providers and Facilities who establish a pattern of referring Members to non-participating providers are subject to disciplinary action, up to and including termination from the Network. We understand that there may be instances in which a Network/Participating Provider must refer to a nonparticipating provider. For additional information on the non-participating provider Claims payment policy please refer to the reimbursement policy section of this manual.

A referral to a non-participating specialty doctor may be obtained if a uniquely specialized procedure is medically necessary and not performed by any participating doctors. This process must be requested by the participating doctor and approved by PHP, in writing, prior to receiving the services. It is the member's responsibility to notify us of the initial appointment date, or a change to the date they were given by the physician.

If the visit results in a recommendation for further treatment such as therapy, durable medical equipment, additional testing or surgery, the member must notify us prior to receiving these services. After the visit, the non-participating specialty doctor should send the treatment plan summary to:

Vãlenz
https://www.valenzhealth.com/login/
FAX**:** 863-333-4417
PHONE**:** 877-608-2200 press 1 for precert, press 2 for CM/DM

## Transplant

Since 2013, PHP has utilized OptumHealth Care Solutions, Inc. to manage all transplant cases. PHP utilizes a narrow network strategy center around Optum's Regional Centers of Excellence (COE) Network which consists of 18 COE facilities within 220 miles of Fort Wayne. Optum Medical Directors ensure transplantation listing is appropriate and the member receives the appropriate care. Optum case managers work to ensure that each member referred for transplantation select the appropriate COE and provide both education and support to the patient and family during the pre-transplant, transplant, and post-transplant.

# Claims Submission

To eliminate processing delays and unnecessary correspondence follow these Claim filing tips:

Please utilize the address below to submit RED HCFA 1500/UB04 claims:

**PHP Claims Department**
**PO Box 2359**
**Ft. Wayne, IN 46801**

PHP's Electronic Payor ID: **12399**

## CPT Coding

The most current version of the CPT® Professional Edition manual is considered by PHP as the industry standard for accurate CPT and modifier coding.

## ICD-10-CM Codes

CMS requires that physicians use the ICD-10 CM Codes (ICD-10 Codes) or successor codes and coding practices for all services submitted to PHP. In all cases, the medical record documentation must support the ICD-10 Codes or successor codes selected and substantiate that proper coding guidelines were followed by the Provider or Facility. For example, in accordance with the guidelines, it is important for Providers and Facilities to code all conditions that co-exist at the time of an encounter and that require or affect patient care, treatment or management. In addition, coding guidelines require that the Provider or Facility code to the highest level of specificity which includes fully documenting the patient's diagnosis.

## Electronic Data Exchange (EDI) Overview

PHP recommends using Electronic Data Interchange ("EDI") for Claims submission. Electronic Claims submissions can help reduce administrative and operating costs, expedite the Claim process, and reduce errors. Providers and Facilities who use EDI can electronically submit Claims and receive acknowledgements 24 hours a day, 7 days a week.

PHP uses Change Health as our exclusive EDI vendor. Submitting via EDI may require additional hardware and software needed to automate other tasks in your office. No matter what method you choose to submit your transactions (on paper or through a clearinghouse/billing company), PHP does not charge a fee to submit electronically. Providers and Facilities engaging in electronic transactions should familiarize themselves with the HIPAA transaction requirements.

## Paper Claims Submissions

If Providers or Facilities must file Claims on paper, PHP requires that they are submitted on the most current red CMS-1500 (Form 1500 (02-12)) or (UB04) failure to do so can cause Claims to be rejected and/or returned to the Provider or Facility

More information and the most current forms can be found at https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS1500.pdf.

- Submit all paper Claims using the current standard **RED CMS Form 1500** for professional Claims and the **UB04)** for Facility Claims.
- If Providers or Facilities are submitting a multiple page Claim, the word "continued" should be noted in the total charge field, with the total charge submitted on the last page of the Claim.
- When submitting a multiple page document, do not staple over pertinent information.
- Complete all mandatory fields.
- Do not highlight any fields. Check the printing of Claims from time to time to help ensure proper alignment and that characters are legible. Ensure all characters are inside the appropriate fields and do not overlap.
- Change the printer cartridge regularly.

- Submit a valid member identification number as found on the member PHP ID card on all pages.
- Claims must be submitted with complete provider information, including referring, rendering and billing NPI, tax identification number, name, and servicing and billing addresses on all pages.

## Submitting Paper HCFA 1500 Health Care Claims

### Recommended Fields for Paper Form 1500 Claims

If these are not completed, Claims may be delayed or returned to the Provider

| FIELD | DESCRIPTION |
|---|---|
| **Field Ia:** | Insured's ID Number — from Member ID card, including any prefix |
| **Field 2:** | Patient's Name — do not use nicknames or middle names |
| **Field 3:** | Patient's Birth Date — date of birth should be 8-digit (MMIDDIYYYY) format and Sex |
| **Field 4:** | Insured's Name — "same" is acceptable if the insured is the patient |
| **Field 5:** | Patient's Address — submitted when the patient's address is different than the insured's address. If it's the same, this field does not need to be populated. |
| **Field 6:** | Patient Relationship to Insured |
| **Field 7:** | Insured's Address |
| **Field 10:** | Is Patient's Condition Related to:<br>**Field 10A:** Employment?<br>**Field 10B:** Auto Accident?<br>**Field 10C:** Other Accident? |
| **Field 12:** | Patient Authorization Signature — If patient signature is on file, "Signature on file" is acceptable. |
| **Important information about Fields 14 and 15:**<br>**CMS Form 1500 (02-12) gives Providers and Facilities two fields (14 and 15) to enter a date with a "Qualifier" that tells payers what the date is for. Field 14 is titled "Date of Current Illness, Injury, or Pregnancy" and field 15 is titled "Other Date". If the visit is due to an accident, Qualifier "439" must be entered in field 15 along with the appropriate date. This information is consistent with the form instruction manual available on the NUCC website. For more guidance, please see information available on the NUCC website at www.nucc.org.** | |
| **Field 14:** | Date of Current Illness, Injury or Pregnancy (LMP) (if applicable) —<br>Enter the 8-digit **(MMIDDIYYYY)** date of the present illness, injury, or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date.<br>Enter the applicable qualifier to identify which date is being reported:<br>• 431 — Onset of current symptoms or illness<br>• 484 — Last Menstrual Period |
| **Field 15:** | Other Date — Enter another date related to the patient's condition or treatment.<br>Enter the date in the 8-digit (MMIDDIYYYY) format.<br>Enter the applicable qualifier to identify which date is being reported:<br>• 454 — Initial treatment<br>• 304 — Latest visit or consultation<br>• 453 — Acute manifestation or a chronic condition<br>• 439 — Accident<br>• 455 — Last X-ray<br>• 471 — Prescription<br>• 090 — Report start (assumed care date)<br>• 091 — Report end (relinquished care date)<br>• 444 — First visit or consultation |
| **Field 16:** | Dates Patient Unable to Work in Current Occupation — This is the time span a patient is or was unable to work |
| **Field 17:** | Referring physician name — Enter the name of the referring or ordering provider.<br>Enter the applicable qualifier to the left of the vertical, dotted line:<br>• DN — Referring provider<br>• DK — Ordering provider<br>• DQ — Supervising provider |
| **Field 17b:** | Referring physician NPI |

| FIELD | DESCRIPTION |
|---|---|
| **Field 21:** | Diagnosis or Nature of Illness or Injury — enter the appropriate diagnosis code/nomenclature —Relate A-L to Field 24E |
| **Field 21:** | ICD Ind - ICD Indicator must be submitted between the vertical, dotted lines in the upper right-hand portion of the field or Claim may be rejected. Enter "9" for Code Set ICD-9-CM diagnosis for dates of service prior to 10/01/2015 or "0" for Code Set ICD-10 diagnosis for dates of service 10/01/2015 and later. |
| **Field 22:** | Resubmission and/or Original Reference Number — **This field is not intended for original Claim submissions.** When resubmitting a Claim, enter the original PHP Claim number and the appropriate bill frequency code (7=Replacement of prior Claim; 8=Void/Cancel of prior Claim) left justified in the left-hand side of the field. |
| **Field 23:** | **Prior Authorization Number** |
| **Field 24:** | NDC - When submitting an NDC the NDC should be submitted in the shaded area and should be preceded with the qualifier N4, followed immediately by the 11-digit NDC code. The NDC quantity should be submitted in positions 17-24 of the same line. The Quantity should be preceded by the appropriate Qualifier. UN (units), F2 (international units), GR (gram), MG (milligram) or ML (milliliter) number. The total dosage administered in mgs or mis can be reported in box 24 (the shaded section) and should not be reported in the Units field. The Units field on the CMS-Form 1500 (02-12) box 24G represents the number of units based on the NDC number. |
| **Field 24A:** | Date(s) of Service |
| **Field 24B:** | Place of Service |
| **Field 24D:** | Procedures, Services or Supplies — Enter the appropriate CPT, HCPCS code/nomenclature; include a narrative description for Non-Specific (NOC) codes. Do not use NOC codes when a specific CPT code is available. **PHP must have a clear description of the item/service billed with a NOC code to review.** Descriptions should be included in the shaded area for item 24 on professional Claim forms. Please indicate appropriate modifier when applicable. |
| **Field 24E:** | Diagnosis Pointer — refer to field 21 - Be sure to enter the diagnosis code reference (pointer) from Field 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference number for each service should be listed first, other applicable services should follow. The references w ere changed from numeric to alpha characters on the updated 02/12 form version.<br>**Be sure to use alpha characters (A-L) and not numeric in this field**. |
| **Field 24F:** | $ Charges — line item charge. |
| **Field 24G:** | Days or Units — When providing anesthesia submit time in minutes. When providing pain management, drugs, etc. it should be submitted in units. |
| **Field 24J:** | Lower: National Provider Identification number (NPI) |
| **Field 25:** | Federal Tax ID Number (9-digit) |
| **Field 28:** | Total Charge — total of line item charges |
| **Field 31:** | Full name and title of Physician or Supplier — actual signature or typed/printed designation is acceptable. |
| **Field 32:** | Service Facility Location Information — Address where services were rendered<br><br>**Attention Ambulance Providers:** Consistent with guidance from the Centers for Medicare and Medicaid Services (CMS), please include the zip code for the point of pick up. Providers or Facilities can report the physical pick up and drop off addresses in field 32 |
| **Field 32a:** | Service Facility's National Provider Identification number (NPI) — Service location NPI |
| **Field 33:** | Billing Provider Information and Phone # — Complete name, address, city, state and zip code Reminder: If submitting Claims electronic, this field must hold a physical address and should not contain any of the following: "Post Office Box", "P.O. Box", "PO Box", "Lock Box", "Lock Bin", "PO Box" |
| **Field 33a** | Billing Provider's National Provider Identification number (NPI) — Billing Provider NPI<br><br>**Note:** To help improve payment accuracy and timeliness, please remember that when filing Claims, the Tax Identification Number (TIN) and National Provider Identifier (NPI) numbers are required. Additionally, bill Claims using the taxonomy codes as applicable. |

## Submitting Paper UB-04 Institutional Health Care Claims

### Recommended Fields for Paper Form UB-04 Claims

If these fields are not completed, Claims may be delayed or returned to the Provider or Facility for additional information.

**For Inpatient and Outpatient UB-04 Claim Forms – these fields must be completed:**

| FIELD | DESCRIPTION |
|---|---|
| **Field I:** | Provider name and complete address |
| **Field 2:** | Provider's designated billing name and remittance address |
| **Field 4:** | Type of Bill |
| **Field 5:** | Federal Tax Identification Number |
| **Field 6:** | Statement Covers Period (From-Through) |
| **Field 8:** | Patient Name |
| **Field 9:** | Patient Address |
| **Field 10:** | Birth Date (8-digit (MMIDDIYYYY) format) |
| **Field 11:** | Sex |
| **Field 12:** | Admission Date |
| **Field 13:** | Admission Hour |
| **Field 14:** | Admission Type — Priority (Type) of Admission or Visit [Inpatient only] |
| **Field 15:** | Admission SRC — Point of Origin for Admission or Visit [Inpatient only] |
| **Field 16:** | Discharge Hour [Inpatient only] |
| **Field 17:** | Patient Discharge Status [Inpatient only] |
| **Field 31 - 34** | Occurrence Codes and Dates |
| **Field 39-41:** | • Value Code(s) and Amounts<br>• If there is a Combined Deductible + Coinsurance + Copay amount on the EOMB greater than zero, there must be a corresponding Value code of Al, B1, C1, 08, 09, 11, A2, B2, C2 A7, B7 or C7 and amount on the UB04.<br>• If there is a Value Code present and not equal to 02 there must be a Value Code amount.<br>• The Value Codes to be submitted when billing Private Room Revenue codes according to the UB-04 Data Specifications Manual 2014 and CMS Manual Transmittal 1104 are:<br>• "01" (semi-private room facility) must be accompanied by the semi-private room rate when the facility offers semi-private rooms and the patient's stay is in a private room<br>• "02" indicating "private room only" facility with $0.00 when the facility is private room only<br>• Common errors in Fields 39-41:<br>• The following is a quick overview of the most common errors are on fields 39, 40 and 41, when Medicare is primary and PHP is secondary:<br>• Value codes are missing. Value codes Al, B1, C1 are deductibles. Value codes 09, 11, A2, B2 and C2 are coinsurance. Value codes A7, B7 and C7 are copay. Value code 06 is blood deductible.<br>• The member deductible is missing or does not match the EOB (Explanation of Benefits). If there is a deductible amount indicated on the primary payer's remittance advice, the UB04 must include the member deductible (Al, B1 or C1 value code) and amount.<br>• The coinsurance amount is missing. If there is coinsurance on the primary payer's remittance advice, the UB04 must include the coinsurance amount (09, 11, A2, B2 or C2 value code).<br>• The copay amount is missing. If there is copayment on the primary payer's remittance advice, the UB04 must include the copay amount (A7, B7, or C7 value code).<br>• Blood deductible is not noted. If there is blood deductible on the payer's remittance advice, the value code 06 must be on the Claim, along with the amount.<br>• There are errors in listing multiple value codes. If more than one value code is submitted on lines a — d, please fill in fields 39a, 40a or 41a before populating 39b, 40b, or 41b.<br>• The value code and remittance advice amounts are different. In all cases, the value code and remittance advice amounts must match. |

| FIELD | DESCRIPTION |
|---|---|
| **Field 42:** | Revenue Code(s) — When submitting Revenue Code 011X or 11X and/or 014X or 14X, (X = numeric value) a value code of 01 with an amount greater than zero OR a value code of 02 with zero charges or blank must also be submitted |
| **Field 43:** | Description — NDC: When submitting an unlisted drug HCPCS code, please submit the National Drug Code (NDC) in the shaded area above the drug code. Submit qualifier N4 followed immediately by the 11-digit NDC code. The NDC quantity should be submitted in positions 17-24 of the same line. The Quantity should be preceded by the appropriate Qualifier. UN (units), F2 (international units), GR (gram), MG (milligram) or ML (milliliter). The total dosage administered in mgs or mis can be reported in the shaded section and should not be reported in the Units field. The Service Units Field (46) represents the number of units based on the NDC number |
| **Field 44:** | HCPCS/Accommodation Rates/HIPPS Rate Codes |
| **Field 45:** | Service Date |
| **Field 46:** | Service Units |
| **Field 47:** | Total Charges |
| **Field 56:** | Providers National Provider Identification number (NPI) |
| **Field 58:** | Insured's Name |
| **Field 59:** | Patient's Relationship |
| **Field 60:** | Insured Unique ID — from Member ID card, including any prefix/suffix |
| **Field 66:** | Diagnosis and Procedure Code Qualifier (ICD Version Indicator) — The qualifier that denotes the version of International Classification of Diseases (ICD) reported. The following qualifier codes reflect the edition portion of the ICD: 9 -Ninth Revision for dates of service prior to 10/01/2015 or 0 -Tenth Revision for dates of service 10/01/2015 and later. |
| **Field 67:** | Principal Diagnosis Code and Present on Admission (POA) Indicator |
| **Field 67a-q:** | Other Diagnosis Code(s) and Present on Admission (POA) Indicator(s) |
| **Field 74:** | Principal Procedure Code and Date |

# Claim Filing Guidelines

## Ambulatory Surgical Centers

When billing revenue codes, always include the CPT or HCPCS code for the surgery being performed. This code is required to determine the procedure, and including it on the claim helps us ensure the claim is process correctly and more quickly. Ambulatory surgical Claims must be billed on a CMS-1500 or UB04, as indicated in your Agreement.

## Ambulance Claims

- Include the Point of Pickup ZIP Code for all ambulance (including air ambulance) Claims, both institutional outpatient and professional.
- The Point of Pick-up ZIP Code should be submitted as follows:
  - ✓ *Professional Claims* — for CMS-1500 submitters: the PO Box ZIP code is reported in field 23
  - ✓ *Institutional outpatient Claims* — for UB submitters: The Value Code of 'AO' (zero), and the related ZIP Code of the geographic location from which the beneficiary was placed on board the ambulance, should be reported in the Value Code Amount field and billed with the appropriate revenue 54x codes.

## Duplicate or Repeat Services
## Submit services on one claim using the Days/Units field and appropriate modifier

- Be sure to use the correct modifiers on the claim when multiple identical services are performed in order to identify these services as separate services. A denial can result if the same services is submitted on more than one claim or more than one claim line for the same date of service.

## Durable/Home Medical Equipment and Supplies

- Durable/Home Medical Equipment and Supplies (D/HME) are outline in the provider reimbursement exhibit of your participation agreement is determined by the CPT code billed.

## Home Infusion Therapy – Services and Supplies

- All home infusion therapy services and supplies require prior authorization and are reimbursed in accordance to the CPT and/or REV codes as identified in the reimbursement exhibit of your participation agreement.

## Interim Billing

- Interim bills are allowed every 60 days.

## Laboratory Claims

- ✓ At all times participating laboratories should be used for the processing of laboratory and pathology services. A listing of PHP's participating laboratories can be found on our website by accessing the provider directory.
- ✓ Genetic testing services must be rendered by a PHP participating provider laboratory and requires prior authorization.
- ✓ Facilities billing for laboratory services should be billed with the appropriate REV and CPT Code combination for each service.

## Specialty Pharmacy Claims

- Prior authorization is required for specialty pharmacy services.
- PHP maintains a complete listing of specialty pharmacy drugs on our website at www.phpni.com/provider.
- Specialty pharmacy claims are determined by the CPT, dosage and deration of authorized services.

## Duplicate Claims/Tracers

Providers and Facilities should refrain from submitting a claim multiple times to avoid potential duplicate denials. Providers or Facilities can check the status of claims online at www.phpni.com/providers.

## Itemized Bill

Providers and Facilities are required to submit a complete itemized bill for all Inpatient Services with charges over $75,000.

## Late Charges

Late charges for Claims previously filed can be submitted electronically. You must reference the original Claim number in the re-billed electronic Claim.

Late charges for Claims previously filed can be submitted via paper. Type of bill should contain a 5 in the 3rd position of the TOB (ex: 135). A late billing should contain ONLY the additional late charges. The Provider should also advise the original claim to which the late charges should be added.

## Maternity Delivery Claims

Services provided in uncomplicated maternity cases include antepartum care, delivery and postpartum care. Breakout services must be billed when a PHP member:

- Has more than one physician or physician group providing services during her maternity care
- Change in insurance plan during her pregnancy
- Has miscarried

## Zero or Negative Charges

When filing claims for procedures with zero or negative charges, please don't include these lines on the claim. Zero or Negative charges often result in an out-of-balance claim that must be returned to the provider for additional clarification.

## Not Otherwise Classified (NOC) Codes

- When submitting Not Otherwise Classified (NOC) codes please follow these guidelines to avoid possible Claim processing delays. **In order for PHP to consider for payment, we must have a clear description of the item/service billed with a NOC code.**

    - ✓ If the NOC is for a drug, include the drug's name, dosage NDC number and number of units.
    - ✓ If the NOC is not a drug, include a specific description of the procedure, service or item.
    - ✓ If the item is durable medical equipment, include the manufacture's description, model number and purchase price if rental equipment.
    - ✓ If the service is a medical or surgical procedure, include a description on the claim and submit medical record/and the operative report (if surgical) that support the use of a NOC and medical necessity for the procedure.
    - ✓ If the NOC is for a laboratory test, include the specific name of the laboratory test(s) and/or a short descriptor of the test(s)

    *NOTE: NOC codes should only be used if there are no appropriate listed codes available for the item or service. Descriptions should be included in the shaded area for item 24 on professional claim forms, or locator 43 on facility claim forms.*

## Occurrence Dates

When billing facility claims, please make sure the surgery date is within the service from and to dates on the claim. Claims that include a surgical procedure date that falls outside the service from and to dates will be returned to the provider.

## Other Insurance Coverage

When filing claims with other insurance coverage, please ensure the following fields are completed and that a legible copy of the Explanation of Benefits (EOB) from the other insurance coverage is attached to the claim:

**CMS-1500 Fields:**

Field 9: Other insured's name
Field 9a: Other insured's policy or group number
Field 9b: Other insured's date of birth
Field 9c: Employer's name or school name (not required in EDI)
Field 9d: Insurance plan name or program name (not required in EDI)

**UB-04 Fields:**

Field 50a-c: Payer Name
Field 54a-c: Prior payments (if applicable)

Including Explanation of Medicare Benefits (EOMB) or other paver Explanation of Benefits (EOB):

When submitting a CMS Form 1500 (02-12) or CMS-1450 (UB04) Claim form with an Explanation of Medicare Benefits (EOMB) attached, the EOMB should indicate Medicare's Assignment. When submitting a CMS Form 1500 (02-12) or CMS-1450 (UB04) Claim form with an Explanation of Medicare Benefits (EOMB) or other payer Explanation of Benefits (EOB) attached, the EOMB or EOB should match each service line and each service line charge submitted on the CMS Form 1500 (02-12) or CMS-1450 (UB04).

## Preventative Colonoscopy

PHP allows for preventive colonoscopy in accordance with state and federal mandates. Colonoscopies which are undertaken as a SCREENING colonoscopy, during which a polyp/tumor or other procedure due to an abnormality are discovered, should be covered under benefits for Preventive Services. Frequently the Provider or Facility will bill for the CPT code with an ICD-10 diagnosis code corresponding to the pathology found rather than the "Special screening for malignant neoplasms, of the colon", diagnosis code V76.51.

CMS has issued guidance on correct coding for this situation and states that the *ICD-10 diagnosis code Z12.11 **(Encounter for screening for malignant neoplasm of colon)** should be entered as the primary diagnosis* and that the ICD-10 diagnosis code for any discovered pathology should be entered as the secondary diagnosis on all subsequent Claim lines.

## Type of Billing Codes

When billing facility claims, please make sure the type of bill coincides with the revenue code(s) billed on the claim. For example, if billing an outpatient revenue code, the type of bill must be for outpatient services.

### Claim Inquiry/Adjustment Filing Tips

The different types of Claim inquiries should be handled in separate ways depending on what is being requested. Here are some examples:

- **Claim Inquiry:** A question about a Claim or Claim payment is called an inquiry. Claim Inquiries do not result in changes to Claim payments, but the outcome of the Claim Inquiry may result in the initiation of the Claim Payment Dispute. In other words, once the Provider or Facility receives the answer to the Claim Inquiry, the Provider or Facility may opt to begin the Claim Payment Dispute process. Providers and Facilities can call or submit a Secure Message to the Provider Services Department at 260-432-6690 or providerservices@phpni.com.
- **Claim Correspondence:** Claim Correspondence is when PHP requires more information to finalize a Claim. Typically, PHP makes the request for this information through the Provider Remittance Advice ("PRA"). The claim or part of the claim maybe denied, but it is only because more information is required to process the claim. Once the information is received, PHP will use it to finalize the claim.
- **Clinical / Medical Necessity Appeals:** An appeal regarding a clinical decision denial, such as an authorization or Claim that has been denied as not medically necessary, experimental/investigational.

For more information on Clinical / Medical Necessity Appeals, please refer to the *Clinical Appeals* section within the Provider Manual. [Review Contract Language]

- **Claim Payment Disputes:** Please see the *Claim Payment Dispute* section for further details. [Review Contract Language]
- **Precertification Disputes:** Precertification disputes should be handled via the process detailed in the letter received from our precertification department. If Providers or Facilities disagree with a clinical decision, please follow the directions detailed on our letter. Sending precertification/predetermination requests or appeals to the provider correspondence address may delay responses.
- **Corrected Claims:** Submitting corrected claims should only be utilized to update information on the claim form. If the inquiry is about the way the claim processed, please refer to the prior sections. If Providers or Facilities have corrections to be made to the claim, please submit according to the Corrected Claim Guidance below.

For additional information on provider complaints, disputes and appeals, please refer to the *Claim Payment Dispute* and Clinical Appeals sections.

## Corrected Claim Submission

When submitting a correction to a previously submitted claim, submit the entire claim as a replacement claim if Providers or Facilities have omitted charges or changed claim information (i.e., diagnosis codes, procedure codes, dates of service, etc.) including all previous information and any corrected or additional information. To correct a claim that was billed to PHP in error, submit the entire claim as a void/cancel of prior claim.

| TYPE | PROFESSIONAL CLAIM | INSTITUTIONAL CLAIM |
|---|---|---|
| EDI | **To indicate the Claim is a replacement Claim:**<br>• In element CLM05-3 "Claim Frequency Type Code"<br>• Use Claim Frequency Type 7 | **To indicate the Claim is a replacement Claim:**<br>• In element CLM05-3 "Claim Frequency Type Code"<br>• Use Claim Frequency Type 7 |
| | **To confirm the Claim which is being replaced:**<br>• In Segment "REF — Payer Claim Control Number"<br>• Use F8 in REF)! and list the original payer Claim number is REFO2 | **To confirm the Claim which is being replaced:**<br>• In Segment "REF — Payer Claim Control Number"<br>• Use F8 in REF)! and list the original payer Claim number is REF02 |
| | **To indicate the Claim was billed in error (Void/Cancel)**<br>• In element CLM05-3 "Claim Frequency Type Code"<br>• Use Claim Frequency Type 8 | **To indicate the Claim was billed in error (Void/Cancel)**<br>• In element CLM05-3 "Claim Frequency Type Code"<br>• Use Claim Frequency Type 8 |
| | **To confirm the Claim which is being void/cancelled:**<br>• In Segment "REF — Payer Claim Control Number"<br>• Use F8 in REF)!and list the original payer Claim number is REFO2 | **To confirm the Claim which is being void/cancelled:**<br>• In Segment "REF — Payer Claim Control Number"<br>• Use F8 in REF)!and list the original payer Claim number is REFO2 |
| | **To indicate the Claim is a replacement Claim:**<br>• In Item Number 22: "Resubmission and/or Original Reference Number"<br>• Use Claim Frequency Type 7 under "Resubmission Code" | **To indicate the Claim is a replacement Claim:**<br>• In Form Locator 04: "Type of Bill"<br>• Use Claim Frequency Type 7 |
| | **To confirm the Claim which is being replaced:**<br>• In the right-hand side of Item Number 22 under "Original Ref. No." list the original payer Claim number for the resubmitted Claim. | **To confirm the Claim which is being replaced:**<br>• In Form Locator 64: "Document Control Number (DCN)" list the original payer Claim number for the resubmitted Claim. |

If the original claim was filed by paper and/or EDI and you are submitting a paper corrected claim, please complete an Adjustment Request Form and following the coding listed below.

| TYPE | PROFESSIONAL CLAIM | INSTITUTIONAL CLAIM |
|---|---|---|
| PAPER | **To indicate the Claim is a void/cancel of a prior Claim:**<br>• In Item Number 22: "Resubmission and/or Original Reference Number"<br>• Use Claim Frequency Type 8 under "Resubmission Code" | **To indicate the Claim is a void/cancel of a prior Claim:**<br>• In Form Locator 04: "Type of Bill"<br>• Use Claim Frequency Type 8 |
| | **To confirm the Claim which is being void/cancelled:**<br>• In the right-hand side of Item Number 22 under "Original Ref. No." list the original payer Claim number for the void/cancelled Claim. | **To confirm the Claim which is being void/cancelled:**<br>• In Form Locator 64: "Document Control Number (DCN)" list the original payer Claim number for the void/cancelled Claim. |

## Reimbursement Methodologies

If reimbursement methodologies are outlined differently in the Contract Reimbursement Exhibit Schedule they will supersede those that are outlined below.

### Case Rate Methodology

A Per Case Rate is an all-inclusive level of reimbursement for a specific inpatient or outpatient Covered Service, as specified by DRG, CPT/HCPCS/Revenue Code in the reimbursement section of the PHP Agreement. Unless otherwise specified, no additional reimbursement shall be made for any covered service(s) submitted on the same Claim as a covered service reimbursed under Per Case Rate methodology.

### DRG Methodology

DRG means Diagnostic/Diagnosis Related Group as set forth by the CMS.

DRG Rate means the all-inclusive dollar amount applied to the appropriate DRG Weight which results in the PHP Rate, if the reimbursement methodology as shown on the **Provider Reimbursement Exhibit** is on a DRG basis.

DRG Weight means the computed value assigned to each DRG using CMS cost weights.

For inpatient admissions on or after the Agreement effective date for which the total Facility charges for Covered Services is less than or equal to the DRG Outlier amount specified on the Reimbursement section of the Agreement, we will reimburse the DRG Rates specified in effect on the date of inpatient admission and specified on the reimbursement section of the Agreement multiplied by the weight for the assigned DRG in effect on the date of discharge, using the relative weights as established (and amended from time to time) by CMS.

For inpatient admissions on or after the Agreement effective date for which the total of Facility charges for Covered Services is greater than the DRG Outlier amount specified in the reimbursement section of the Agreement, we will reimburse the DRG Outlier Rate percentage as specified in the reimbursement section of the Agreement.

For inpatient admissions for Members who are transferred out of the hospital to another Facility for purposes of providing Inpatient Care Services, please reference your Reimbursement Exhibit.

For those Facilities reimbursed on a methodology other than DRG, for Inpatient Services and Outpatient Services rendered on or after the Agreement effective date, the applicable PHP Rate is pursuant to the reimbursement section of the Agreement.

## Fixed Outpatient Reimbursement Methodology

Fixed Outpatient Reimbursement methodology provides PHP with the ability to reimburse outpatient Facility Claims utilizing the CPT/HCPCS Codes currently being reported on Claims. Revenue Codes will require a companion CPT/HCPCS Code when Facility's Agreement includes Fixed Outpatient Reimbursement.

## Global Period

The global time frame for care begins one day before the procedure or service and includes the day of services plus a global period. Minor or simple procedures may have either a 0-day or 10-day global period. A 0-day global means there is no preoperative or postoperative period. Conversely major procedures are more resource intensive and require a longer recovery for the patient, and have a 90-day global period.

## Modifier Deductions

The following is an outline of PHP's modifier payment adjustments.

| Modifier | Description | Contract Percentage |
|---|---|---|
| 50 | Bilateral Procedure | 150% |
| 51 | Multiple Procedures | 50% |
| 52 | Reduced Procedure | 50% |
| 54 | Surgical Care Only | 75% |
| 55 | Postoperative Management Only | 10% |
| 56 | Preoperative Management Only | 15% |
| 80 | Assistant Surgeon | 20% |
| 81 | Minimum Assistance Surgeon | 10% |
| 85 | Assistant Surgeon (when qualified resident) | 20% |
| AS | PA Assistant at Surgery | 20% |
| PA | Surgery Wrong Body Part | 0% |
| PB | Surgery Wrong Patient | 0% |
| PC | Wrong Surgery on Patient | 0% |
| QK | Medical Direction 2-3-4 Concurrent Anesthesia | 50% |
| QX | CRNA Service w/Medical Direction by a Physician | 50% |
| QY | Medical Direction One CRNA by Anesthesiologist | 50% |

## Outlier Reimbursement

Paid in accordance with the reimbursement section of the Agreement, the Outlier Rate percentage will not apply to services reimbursed as a Per Diem Rate, Per Case Rate, or Percentage Rate, unless specifically identified in the Reimbursement section of the Agreement.

## Outpatient Facility Fee Schedules

The Outpatient Facility Fee Schedule methodology provides PHP with the ability to reimburse specified Outpatient Services based on a fee schedule utilizing the CPT/HCPCS Code.

## Revenue Codes Requiring Additional Coded Services Identifiers

The following is a current listing of services and Revenue Codes that will require a CPT/HCPCS Code when the Facility's reimbursement section of the Agreement includes one or more Outpatient Facility Fee Schedules:

| Services | Revenue Code(s) |
|---|---|
| Drugs | 25X, 63X |
| Implants | 27S |
| Lab | 30X, 31X, 39X |
| Observations | 76X |
| Pathology | 31X |
| PT/OT/Speech | 42X, 43X, 44X |
| Radiology | 32X, 333, 34X, 402 |

Claims that include specified CPT/HCPCS Code(s) will be reimbursed in accordance with the PHP Rate in the reimbursement section of the Agreement unless such Claim includes a service reimbursed under a Case Rate methodology. Outpatient Facility Fee Schedule services provided in conjunction with a service reimbursed under Case Rate methodology are considered incidental to the Case Rate service and are not separately payable.

## Other Outpatient Services

PHP will reimburse other Outpatient Services not defined by fee schedule, Per Diem, Per Case, by percent discount at the other Outpatient Services percentage as specified in the reimbursement section of the Agreement.

## Per Diem Rate

Per Diem Rate as specified in the reimbursement section of the PHP Agreement is an all-inclusive fixed payment for each full day of covered services or one (1) outpatient encounter. A full day begins at midnight and ends twenty (24) hours later. The day of admission counts as a full day. The day of discharge, death, or transfer is not counted as a full day. If admission and discharge, death or transfer occurs on the same day, the day is counted as one (1) inpatient full day.

Outpatient surgery reimbursed at a Per Diem Rate will apply multiple surgery logic.

## Per Unit/Visit Rate

Services reimbursed at a Per Unit/Visit Rate include but are not limited to physical therapy, occupational therapy, speech therapy, and respiratory therapy. A Per Unit/Visit Rate means a single date of service. Per Unit/Visit Rates include, but are not limited to: facility use, therapist/professional services, laboratory, radiology, supplies, equipment, pharmaceuticals, and other services incidental to the visit.

## Special Procedure Room Charge

Special procedure room charges are included in the reimbursement of the procedure, defined as, but not limited to:

- Revenue Code 761 (treatment room)
- When billed with procedures such as dialysis or emergency department procedures, the fee for the treatment room (Rev Code 761) is not separately reimbursable.
- When billed in conjunction with a [DEC line insertion.
- When billed in conjunction with a Procedure (CPT) in addition to Cast Room (Revenue Code 761), the Cast Room is not separately reimbursable

- When billed in conjunction with inserting a peripheral IV, the treatment room is not separately reimbursable

## Reimbursement Policies and Procedures

This section includes reimbursement guidelines and policies on how PHP will reimburse Providers and Facilities for certain services. Additional Professional and Facility Reimbursement Policies are published on www.phpni.com be sure to check both places. PHP reserves the right to review and revise policies when necessary.

PHP's public provider website is your source for reimbursement policies. Go to **www.phpni.com >Providers>Coding**

You can also access the policies via the Portal.

## Blood, Blood Products, Processing, Storage and Administration

Blood and blood products such as platelets or plasma are reimbursable. Blood product processing fees (typing, serology and cross-matching and blood storage) are also reimbursable. However, transportation charges are included in the reimbursement for the product itself and are not separately reimbursable. Blood and blood product administration services are reimbursable only on an outpatient basis when billed hourly or as a flat rate with total eligible Charges capped at the average approved semi-private room rate less discount, as submitted to PHP. Blood and blood product administration services are not reimbursable on inpatient claims.

## Changes During Admission

There are elements that could change during an admission. The following table shows the scenarios and the date to be used for the entire Claim:

| CHANGE | EFFECTIVE DATE |
|---|---|
| Member's Insurance Coverage | Admission |
| Facility's Contracted Rate (other than DRG) | Admission |
| DRG Base Rate | Admission |
| DRG Grouper | Discharge |
| DRG Relative Weight | Discharge |

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**DRG Grouper Version / DRG Relative Weight changes can occur any time after October 1st each year.**

## Charge Master Data and Corresponding Rate Changes

In accordance to your provider contract Hospitals will provide appropriate charge master increase information and thirty (30) days prior to the effective date of any charge master rate changes. This includes room rate changes.

PHP will review after analysis calculate of the Hospital's charge master and will escalate reimbursement appropriately. Rate changes will include rounding of price changes to the nearest whole dollar, e.g., $0.01 to $0.49 will be rounded down to the nearest dollar and $0.50 to $0.99 will be rounded up to the nearest dollar.

## Clinic Charges / Treatment Room

### Professional Providers

When a Professional Provider performs a service that is office-based service (e.g., office visit, outpatient consultation, professional interpretation and report), he/she must submit a CMS-1500 claim form or the electronic equivalent 837p for the office-based service. In such cases, the office-based service fee and the office-based overhead (e.g., practice expense) are included in the professional provider health care service PHP Rate.

### Facility and Other Facility

When a Professional Provider performs a service that is considered to be in any setting, including an office-based setting located within a facility, a facility campus, facility affiliate, or facility or facility affiliate-owned site, division, or other location (e.g., clinic, treatment room and courtesy room), services will be reimbursed at a facility location rate.

## Courtesy Room

Facility shall not bill PHP, and/or Members for any charges related to use of a Courtesy Room in the provision of Health Services to a Member. "Courtesy Room" means an area in the Facility where a professional provider is permitted by Facility to provide Health Services to Members, which could otherwise be provided in an office setting.

## Eligibility and Payment

A verification of eligibility is not a guarantee of payment.

## Emergency Room Supply and Service Charges

The Emergency Room level reimbursement includes all monitoring, equipment, supply, time and staff charges. Reimbursement for the use of the Emergency Room includes the use of the room and personnel employed for the examination and treatment of patients. This reimbursement does not typically include the cost of physician services.

## Facility Personnel Charges

Charges for Inpatient Services for Facility personnel are not separately reimbursable and the reimbursement for such is included in the room and board rate. Examples include, but are not limited to, lactation consultants, dietary consultants, overtime charges, transport fees, nursing functions (including IV or PICC line insertion at bedside), professional therapy functions, including Physical, Occupational, and Speech (typically billed in Revenue Codes 976, 977. 978 and 979), call back charges, nursing increments, therapy increments, and bedside respiratory and pulmonary function services (typically billed in Revenue Codes 410-419, 460 and 469). Outpatient Services for Facility personnel are also not separately reimbursable. Reimbursement is included in the reimbursement for the procedure or observation charge.

## Financial Institution/Merchant Fees

Providers and Facilities are responsible for any fees or expenses charged to it by their own financial institution or payment service provider.

## General Industry Standard Language

Per PHP policy and the Agreement, Provider and Facility will follow industry standards related to billing. Examples of general industry standards include, but are not limited to, HCPCS, ICD10/CM, health service codes (also known as Revenue Codes) per the UB-04 Claim billing manual or subsequent forms CPT codes.

## Implants

Implants are objects or materials which are implanted such as a piece of tissue, a tooth, a pellet of medicine, a medical device, a tube, a graft, or an insert placed into a surgically or naturally formed cavity of the human body to continuously assist, restore or replace the function of an organ system or structure of the human body throughout its useful life. Implants include, but are not limited to: stents, artificial joints, shunts, pins, plates, screws, anchors and radioactive seeds, in addition to non-soluble, or solid plastic materials used to augment tissues or to fill in areas traumatically or surgically removed. Instruments that are designed to be removed or discarded during the same operative session during which they are placed in the body are not implants. In addition to meeting the above criteria, implants must also remain in the Member's body upon discharge from the inpatient stay or outpatient procedure for a period of six (6) months or longer. Staples, sutures, clips, as well as temporary drains, tubes, similar temporary medical devices and supplies shall not be considered implants.

Facility shall not bill PHP, and PHP shall not reimburse Facility for implants that are deemed contaminated and/or considered waste and/or were not implanted in the Member. PHP also requires an itemization of all implant kits that contain procedure tools or medical supplies. If an implant is supplied during the inpatient stay or outpatient procedure as part of a kit, then the implant will be the only component of the kit that shall be reimbursed by PHP.

## IOP

Intensive outpatient structured program (e.g., evening care) and partial hospitalization (three to five (3 to 5) hours per day); IOP is the default, unless Partial Hospitalization is approved by utilization management.

## PARTIAL HOSPITALIZATION

This includes partial hospitalization (six to eight (6-8) hours per day), residential care and outpatient electroconvulsive therapy. All Partial Hospitalization care requires Utilization Review approval/certification.

Special billing instructions and requirements:

1. ICD-10 diagnosis codes must be included for each care level.
2. Revenue Codes must be included for each care level. Appropriate Revenue Codes are 0901, 0911 - 0914, 0944 or 0945.
3. Utilization management must approve the level of care for all services. An authorization number is required for each Claim.
4. Each service date must be billed as a separate line item.

## IV Sedation and Local Anesthesia

Administered by the provider performing the procedure, and/or nursing personnel, is not separately reimbursable and is included as part of the OR time/procedure reimbursement.

## Lab Charges

Venipuncture, specimen collection, draw fees, phlebotomy, heel stick, processing fees, handling fees, blood storage and processing, blood administration. These charges are inclusive of the procedure/lab test performed and not separately reimbursable.

## Labor Care Charges

PHP will reimburse appropriately billed room and board or labor charges. Payment will not be made on both charges billed concurrently. Facilities reimbursed under DRG may not bill for Outpatient Services rendered prior to the admission.

## Medical Care Provided to or by Family Members

Services for any type of medical care rendered by a Provider to him/herself or to an immediate family member (as defined below), who is a Member, are not eligible for coverage and should not be billed to PHP. In addition, a Provider may not be selected as a Primary Care Physician (PCP) by his /her immediate family member.

Unless otherwise set forth in a Member's Health Benefit Plan, an immediate family member includes: father, mother, children, spouse, domestic partner, legal guardian, grandparent, grandchild, sibling, step-father, stepmother, step-children, step-grandparent, step-grandchild, and/or step-sibling.

## Non-Participating Provider Claims Payment Policy

PHP has established Maximum Allowed Amounts for services rendered by non-participating providers. Once PHP determines the appropriate Maximum Allowed Amount for services provided by a nonparticipating provider, the payment will be remitted to the Provider in most situations and not the member.

## Observation Services Policy

PHP considers outpatient observation services to mean active, short-term medical and/or nursing services performed by an acute facility on that facility's premises that includes the use of a bed and monitoring by that acute facility's nursing or other staff and are required to observe a patient's condition to determine if the patient requires an inpatient admission to the facility. Observation services include services provided to a patient designated as "observation status", and in general, shall not exceed 72 hours. Observation services may be considered eligible for reimbursement when rendered to patients who meet one or more of the following criteria:

- Active care or further observation is needed following emergency room care to determine if the patient is stabilized.
- The patient has a complication from an outpatient surgical procedure that requires additional recovery time that exceeds the normal recovery time.
- The patient care required is initially at or near the inpatient level; however, such care is expected to last less than a 72-hour time frame.
- The patient requires further diagnostic testing and/or observation to make a diagnosis and establish appropriate treatment protocol.
- The patient requires short term medical intervention of facility staff which requires the direction of a physician.
- The patient requires observation in order to determine if the patient requires admission into the facility.

**Policy**

The payment, if any, for observation services is specified in the Provider Reimbursement Exhibit with the applicable Facility. Nothing in this Policy is intended to modify the terms and conditions of the Facility's agreement with PHP. If the Facility's agreement with PHP does not provide for separate reimbursement for observation services, then this Policy is not intended to and shall not be construed to allow the Facility to separately bill for and seek reimbursement for observation services.

The patient's medical record documentation for observation status must include a written order by the physician or other individual authorized by state licensure law and facility staff bylaws to admit patients to the facility that clearly states "admit to observation". Additionally, such documentation shall demonstrate that observation services are required by stating the specific problem, the treatment and/or frequency of the skilled service expected to be provided,"

The following situations are examples of services that are considered by PHP to be inappropriate use of observation services:

- Physician, patient, and/or family convenience
- Routine preparation and recovery for diagnostic or surgical procedures
- Social issues
- Blood administration
- Cases routinely cared for in the Emergency Room or Outpatient Department
- Routine recovery and post-operative care after outpatient surgery
- Standing orders following outpatient surgery
- Observation following an uncomplicated treatment or procedure

## Operating Room Time and Procedure Charges

The operating room ("O.R.") charge will be based on a time or procedural basis. When time is the basis for the charge, it should be calculated from the time the patient enters the room until the patient leaves the room, as documented on the O.R. nurse's notes. The Operating Room is defined as surgical suites, major and minor, treatment rooms, endoscopy labs, cardiac cath labs, Hybrid Rooms, X-ray, pulmonary and cardiology procedural rooms. The operating room charge will reflect the cost of:

- The use of the operating room.
- The services of qualitied professional and technical personnel
- Linen packs, basic instrument packs/trays/its, basic packs, basic post-op dressing, equipment and routine supplies such as sutures, gloves, dressings, sponges, prep kits, drapes, and surgical attire,

tubing, connectors, trocars, drill bits, clips, catheters, cords, batteries, sheathes, guide/glide wires, balloons, introducers, dilators, needles, pumps, arterial line, irrigation fluids, closure devices, staplers/staples all types, anesthesia supplies (i.e. mask, stylet, ET tubes, blades, oxi-sensor, circuit breathing, circuit adult/peds, gases, oxygen) this list is not all inclusive.

The operating room charge includes any cost of robotic technology and so robotic technology is not eligible for separate reimbursement.

Examples of charges that are not eligible for separate or additional reimbursement are listed below, but not limited to:

- Increased operating room unit cost charges for the use of the robotic technology
- Charges billed under CPT or HCPCS codes that are specific to robotic assisted surgery, including, not limited to S2900
- Supplies billed related to the use of robotic technology

Separate charges are allowed for specialized packs, which are necessitated by the procedure not by physician preference, such as those used for open heart, eye and scope surgeries, packs for extensive plastic repair and complex post-op dressing or specialized equipment such as hip pins, bone nails, bone plates, and tantalum mesh. This includes the cost of preparing, storing and handling such supplies. These charges will be subject to medical review with supporting documentation.

## Other Agreements

If Facility currently maintains a separate Agreement(s) with PHP solely for the provision and payment of home health care services, skilled nursing facility services, ambulatory surgical facility services, or other agreements that PHP designates (hereinafter collectively "Other Agreement(s)"), said Other Agreement(s) will remain in effect and control the provision and payment of Covered Services rendered there under.

## Personal Care Items

Personal care items used for patient convenience are not reimbursable. Examples include but are not limited to: breast pumps, deodorant, dry bath, dry shampoo, lotion, non-medical personnel, mouthwash, pow der, soap, telephone calls, television, tissues, toothbrush and toothpaste. Any Items used for the patient which are needed as a direct or indirect result of a procedure or test are considered part of the room and board or procedure charges and are not separately reimbursable or billable to the patient. Examples include but are not limited to: blood glucose test meter, lancets, alcohol wipes, blood glucose test strips, bedpans, chux, hot water bottles, icepacks, pillows, sitz baths, and urinals.

## Place of Service and Evaluation & Management Facility Reimbursement Policy

This provision describes PHP's policy regarding facility reimbursement for services provided outside of the primary structure on the campus of a hospital or institutional provider and for Evaluation & Management (E&M) services provided within the primary structure on the campus of a hospital or institutional provider.

The primary structure on the campus of a hospital or an institutional provider is the physical site location where there are state licensed inpatient beds and/or a state licensed emergency room or emergency department, as well as provision of 24 hours per day seven days a week on site continuous physician and nursing services for diagnosis and treatment of patients.

E&M services are defined as professional services rendered by a physician or other qualified health care professional for the prevention or diagnosis and treatment of illness or injury and the promotion of optimal health. E&M services typically include development of medical history, physical examination, medical decision making or counseling and coordination of care.

### Policy

- Services that are rendered in an office, professional building, medical office building, clinic or a space owned by a hospital or an institutional provider, other than the primary structure on the campus of the hospital or institutional provider, or rented by a professional from the hospital or an institutional provider, must be billed on a CMS-1500 claim form and are not reimbursable if they are billed on a UB-04 claim form.

- PHP shall not separately reimburse a clinic fee or any other facility fee associated with space used to provide E&M services in the event they are billed on a UB-04 claim form.
- PHP does not reimburse for professional E&M charges billed on a UB-04 claim form regardless of
- where services are rendered; reimbursement for these charges are included in the professional fee allowance.
- All professional services including, but not limited to, those rendered by hospital-based physicians such as emergency room physicians, radiologists, anesthesiologists, hospitalists, independent practitioners, and Certified Registered Nurse Anesthetists (CRNA) must be billed on a CMS-1500 claim form using the appropriate CPT®/HCPCS codes.
- Professional E&M services shall not be billed or reimbursed on a UB-04 Claim form. The Member is not responsible for these charges.

## Portable Charges

Portable charges are included in the reimbursement for the procedure, test or x-ray and are not separately reimbursable.

## Pre-Operative Care or Holding Room Charges

Charges for a pre-operative care or a holding room used prior to a procedure are included in the reimbursement for the procedure, and are not separately reimbursed. In addition, nursing care provided in the pre-operative care area will not be reimbursed separately. Reimbursement for the procedure includes all nursing care provided.

## Preparation (Set-Up) Charges

Charges for set-up, equipment or materials in preparation for procedures or tests are included in the reimbursement for that particular procedure or test.

## Psychiatric Outpatient/Residential Services

The billing requirements for psychiatric outpatient/residential services apply to each approved and medically necessary service date in a licensed psychiatric outpatient/residential program, and include payment for all services rendered during a psychiatric outpatient/residential visit including, but not limited to, facility use (that includes all nursing care), laboratory, radiology, supplies, equipment, pharmaceuticals, and all other services incidental to the outpatient/residential visit. A psychiatric outpatient/residential visit means a single service date.

PHP recognizes the below Levels of Care. These levels differ in terms of the degree of services required, as defined by the combination of ICD-10 or successor diagnosis codes and revenue codes.

## Recovery Room Charges

Reimbursement for recovery room services (time or flat fee) includes all used and or available services, equipment, monitoring, nursing care that is necessary for the patient's welfare and safety during his/her confinement. This includes, but is not limited to EKG monitoring, Dinamap® and/or any other patient monitoring devices), pulse oximeter, injection fees, nursing, nursing time, nursing supervision, equipment and supplies, (whether disposable or reusable), defibrillator, and oxygen. Separate reimbursement for these services will not be made.

## Recovery Room Services related to IV sedation and/or local anesthesia

PHP will not provide reimbursement for a phase I or primary recovery room charged in connection with IV sedation or local anesthesia. Charges will be paid only if billed as a post procedure room or a phase II recovery (step-down) (e.g., arteriograms).

## Stand-by Charges

Standby equipment and consumable items such as oxygen, which are on standby, are not reimbursable. Only actual use is covered. Professional staff on standby is included in the reimbursement for the procedure and also is not separately reimbursable.

## Stat Charges

Stat charges are included in the reimbursement for the procedure, test and or x-ray. These charges are not separately reimbursable.

## Submission of Claim/Encounter Data

Facilities and Providers will submit Claims and encounter data to PHP on a CMS-1500, UB04 or subsequent form, in a manner consistent with industry standards and policies and procedures as approved by PHP. PHP will make best efforts to pay all complete and accurate Claims for Covered Services submitted by Facilities and Providers in accordance with the applicable state statute, exclusive of Claims that have been suspended due to the need for additional information including, but not limited to, information to determine medical necessity, coordination of benefits, subrogation or verification of coverage.

## Supplies and Equipment

Charges for medical equipment, including but not limited to, IV pumps, PCA Pumps, and isolation carts and supplies are not separately reimbursable. Also, oxygen charges, including but not limited to, oxygen per minute, per hour and therapy, when billed with room types ICU/CCU or any Specialty Care area, where equipment is a requirement to be authorized for specialty category, are not separately reimbursable. For additional information, please see the complete policy on line under clinical policies

## Tech Support Charges

Pharmacy Administrative Fees (including mixing medications), any portable fees for a procedure or service, patient transportation fees when taking a patient to an area for a procedure or test are not separately reimbursable. Transporting a patient back to their room following surgery, a procedure, or test, are not separately reimbursable.

## Telemetry

Telemetry charges in emergency room ("ER") and intensive care unit ("ICU") or telemetry unit are included in the reimbursement for the place of service. Additional monitoring charges are not reimbursable.

## Test or Procedures Prior to Admission(s) or Outpatient Services

The following diagnostic services, defined by specific Coded Service Identifier(s), are considered part of pre-admission/pre-surgical/preoperative testing:

| Revenue Code(s) | Services |
|---|---|
| 254 | Drugs incident to other diagnostic services |
| 255 | Drugs incident to radiology |
| 30X | Laboratory |
| 31X | Laboratory pathological |
| 32X | Radiology diagnostic |
| 341 | Nuclear medicine, diagnostic |
| 35X | CT scan |
| 40X | Other imaging services |
| 46X | Pulmonary function |
| 48X | Cardiology |
| 53X | Osteopathic services |
| 61X | MRI |
| 62X | Medical/surgical supplies, incident to radiology or other services |
| 73X | EKG/ECG |

| Revenue Code(s) | Services |
|---|---|
| 74X | EEG |
| 92X | Other diagnostic services |

Non-diagnostic services are also considered part of pre-admission/pre-surgical/preoperative testing if they are furnished in connection with the principal diagnosis that necessitates the outpatient procedure or the Member's admission as an inpatient.

## Time Calculation

- **Operating Room ("O.R.")** — O.R. time should be calculated from the time the patient enters the room until the patient leaves the room, as documented on the O.R. nurse's notes.
- **Anesthesia** — Time charges should be calculated from the start and finish times as documented on the anesthesia record. Anesthesia materials may be charged individually as used or included in a charge based on time. A charge that is based on time will be computed from the induction of the anesthesia until surgery is complete. This charge will include the use of all monitoring equipment. Other types of anesthesia such as local, regional, and I\/ sedation, must be billed at an appropriate rate for the lower level of anesthesia services.
- **Recovery Room** — Time should be calculated from the time the patient enters the recovery room until the patient leaves the recovery room as documented on the post anesthesia care unit record.
- **Post Recovery Room** — Time charges should be calculated from the time the patient leaves the recovery room until discharge. Charges are not to exceed the approved average semi-private room and board rate, less discount, as submitted to PHP.

## Undocumented or Unsupported Charges

Per PHP policy, PHP will not reimburse charges that are not documented on medical records or supported with reasonable documentation.

## Video Equipment used in Operating Room

Charges for video equipment used in a surgery are included in the reimbursement for the procedure and are not separately reimbursable. Charges such as batteries, covers, film, anti-fogger solution, and tapes are not separately reimbursable. The use of technology to generate visual assistance in the operating room is part of the operation services and not separately reimbursable. Examples of technology used to generate visual assistance in the operating room which are not separately reimbursable would include, but are not limited to, Fluoroscopy, Ultrasound, and Computer Assisted Navigation.

# Hospital Acquired/Never Events

## CMS Hospital Acquired Conditions (HAC)

PHP follows CMS' current and future recognition of HACs. Current and valid Present on Admission ("POA") indicators (as defined by CMS) must be populated on all inpatient acute care Facility Claims.

When a HAC does occur, all inpatient acute care Facilities shall identify the charges and/or days which are the direct result of the HAC. Such charges and/or days shall be removed from the Claim prior to submitting to the Ran for payment. In no event shall the charges or days associated with the HAC be billed to either the Plan or the Member.

Four (4) Major Surgical Never Events

When any of the Preventable Adverse Events ("PAEs") set forth in the grid below occur with respect to a Member, the Provider or Facility shall neither bill, nor seek to collect from, nor accept any payment from the Plan or the Member for such events. If Provider or Facility receives any payment from the Plan or the Member for such events, it shall refund such payment within ten (10) business days of becoming aw are of such receipt. Further, Providers and Facilities shall cooperate with PHP in any PHP initiative designed to help analyze or reduce such PAEs.

Whenever any of the events described in the grid below occur with respect to a Member, Providers and Facilities are encouraged to report the PAE to the appropriate state agency, The Joint Commission ("TJC'), or a patient safety organization ("PSO") certified and listed by the Agency for Healthcare Research and Quality.

| Preventable Adverse Event | Definition / Details |
|---|---|
| 1. Surgery Performed on the Wrong Body Part | Any surgery performed on a body part that is not consistent with the documented informed consent for that patient. Excludes emergent situations that occur in the course of surgery and/or w hose exigency precludes obtaining informed consent. Surgery includes endoscopies and other invasive procedures. |
| 2. Surgery Performed on the Wrong Patient | Any surgery on a patient that is not consistent with the documented informed consent for that patient. Surgery includes endoscopies and other invasive procedures. |
| 3. Wrong surgical procedure performed on a patient | Any procedure performed on a patient that is not consistent with the documented informed consent for that patient. Excludes emergent situations that occur in the course of surgery and/or w hose exigency precludes obtaining informed consent. Surgery includes endoscopies and other invasive procedures. |
| 4. Retention of a foreign object in a patient after surgery or other procedure | Excludes objects intentionally implanted as part of a planned intervention and objects present prior to surgery that were intentionally retained. |

## Reimbursement Guidelines for Disallowed Charges

| MEMBER RESPONSIBILITY | |
|---|---|
| **Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below** | **Description of Excluded Items** |
| 0990 | Patient Convenience Items |
| 0991 | Cafeteria, Guest Tray |
| 0992 | Private Linen Service |
| 0993 | Telephone, Telegraph |
| 0994 | TV, Radio |
| 0995 | Non-Patient Room Rentals |
| 0996 | Late Discharge |
| 0998 | Beauty Shop, Barber |
| 0999 | Other Patient Convenience Items |

## Electronic Funds Transfer ("EFT")/ Electronic Remittance Advice ("ERA")

Providers or facilities seeking to register or manage account changes for ERA/EFT will need to use InstaMed® at **https://register.instamed.com/eraeft** a secure electronic ERA/EFT registration platform. This tool will help eliminate the need for paper registration and reduce administrative time and costs.

### Additional Information

For additional information concerning electronic Claims submission and other electronic transactions, please reference the EDI Section of this manual.

### Overpayments

PHP shall have the right to request a refund within three hundred sixty-five (365) days from payment of a disputed claim to collect overpayment amounts, which shall be promptly made by Provider or to offset against future payments to Provider, any payments for services which are determined by concurrent or post-discharge review, or following an audit of Provider's books and records. In the event Provider receives an excess or mistaken payment from PHP, the Provider shall promptly notify PHP and return payment to PHP within thirty (30) days. For additional information regarding overpayments please reference your participation Agreement.
Some common reasons for overpayment are:

- Paid wrong provider/member
- Coordination of Benefits
- Allowance overpayments
- Late credits
- Billed in error
- Duplicate charges
- Non-covered services
- Claims editing
- Terminated Members
- Total charge overpaid

## Provider and Facility Identified Overpayments

If PHP is due a refund as a result of an overpayment discovered by a Provider or Facility, refunds can be made in one of the following ways:

Submit a refund check with supporting documentation outlined below, or Submit the **Adjustment Request Form** with supporting documentation to have claim adjustment/recoupment done off a future remittance advice.

When voluntarily refunding PHP on a Claim overpayment, please include the following information:

- Adjustment Request Form (see directions below for how to access online))
- All documents supporting the overpayment including EOBs from PHP and other carriers as appropriate
- Member ID number
- Member's name
- Claim number
- Date of service
- Reason for the refund as indicated in the list above of common overpayment reasons

**Important Note:** If a Provider or Facility is refunding PHP due to coordination of benefits and the Provider or Facility believes PHP is the secondary payer, please **refund the full amount paid**. Upon receipt and insurance primacy verification, the Claim will be reprocessed and paid appropriately.

## How to access the Adjustment Request Form on line

To download the Adjustment Request Form: **www.phpni.com > Menu > Providers > Forms & Downloads > General Forms> Adjustment Request Form**. Providers can also reference the Links section of the manual for the direct link information.

**Please utilize the proper address noted in the grid below to return payment:**

Please utilized the address below to return payment:

**PHP Claims Department**
**PO Box 2359**
**Ft. Wayne, IN 46801**

- **Who do I contact with Claims questions?**
  PHP Customer Services Department at 1-800-982-6257, extension 11 or 1-260-432-6690, extension 11.

- **How do I handle calls from Members and others with Claims questions?**
  If Members contact you, tell them to contact PHP, by referring them to back of their ID cards.

- **Where can I find more information?**
  Visit PHP's Web site at www.phpni.com.

## Coordination of Benefits

If a Member or eligible dependent is covered by more than one health benefit plan, the carriers involved work together to prevent duplicate payments for any services. This is called Coordination of Benefits ("COB"), a provision in all of PHP Benefit Plans.

## Coordination of Benefits

In the event a Covered Person is eligible for coverage of Health Services under one or more health benefit plans or other insurance coverage ("Other Coverage"), coverage under the Covered Person's Benefit Contract and the Other Coverage shall be coordinated in accordance with the coordination of benefits provisions of the Covered Person's Benefit Contract and/or applicable Indiana law. In no event will any obligation for payment to Provider hereunder exceed the amounts specified in Exhibit A. Provider shall provide to PHP the explanation of benefits from the Other Coverage in advance of any payment for Health Services. Provider shall notify PHP of any Covered Person who notifies Provider of Other Coverage and shall assist PHP in coordinating benefits with the Other Coverage. Provider shall have six (6) months from the date the Other Coverage's explanation of benefits was issued to submit a claim to PHP.

## Payments Made under COB

A payment made under another Coverage Plan may include an amount that should have been paid under This Plan. If it does, we may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again.

The terms payment made includes providing benefits in the form of services. In that case, payment made means the reasonable cash value of the benefits provided in the form of services.

## Coordination of Benefits/Subrogation

When payment for Covered Services is subject to either coordination of benefits or subrogation between two (2) or more sources of payment and PHP is not the primary source, payment shall be based upon the PHP Rate for the applicable network/program in which the Member participates, reduced by the amount paid for the Covered Services by other source(s). Providers and Facilities agree to accept such amount as payment in full for the Covered Services and shall not balance bill the Member.

To the extent permitted by law, Plan may, under third party liability, third party recovery, or similar provisions of Health benefit plans, service agreements, certificates or other documents setting forth terms and conditions of health coverage, become entitled to refunds of benefit amounts paid by Plan. However, the right of Plan to such a refund will not, in any case, affect or increase the maximum compensation to which Provider or Facility is entitled under the Agreement for any services that are, or in the absence of Plan's right to such refund would be, Covered Services.

## Medicare Eligibility

Member's shall be deemed to be enrolled in Medicare Part B, whether or not the Member actually enrolled in Medicare Part B. The Member shall be deemed to have received the amount they would have received under Medicare Part B as if they were actually enrolled, and benefit under this Policy, as the Secondary Plan, shall be reduced or denied accordingly. This provision shall be administered with the Social Security Act of 1965 and applicable Ohio insurance laws and regulations.

## Right to Recovery under COB

If we paid more than we should have paid under this COB provision, we may recover the excess payments. Such payments include the reasonable cash value of any benefits provided in the form services.

Notwithstanding the foregoing, in no event shall Plan or the Member be required to pay more than they would have paid had the Plan been the primary payor. Providers and Facilities will not collect any amount from the Member if such amount, when added to the amounts collected from the primary and secondary payors, would cause total reimbursement to the Provider or Facility for the Covered Service to exceed the amount allowed for the Covered Service under the Agreement. Provider shall not waive Copayments, Coinsurance or Deductibles due from Covered Persons; provided, however, Provider may waive a Copayment, Coinsurance or Deductible in accordance with an established financial hardship policy, which shall apply the same hardship standards to all Covered Persons. Overpayments by a Covered Person must be returned to the Covered Person by check or electronic payment within thirty (30) days of Provider becoming aware of the overpayment.

# Claim Payment Disputes

## Provider and Facility Claim Payment Dispute Process

If a Provider or Facility disagrees with the outcome of a Claim, the Provider or Facility may begin the PHP Claim Payment Dispute process. The simplest way to define a Claim Payment Dispute is when the Claim is finalized, but a Provider or Facility disagrees with the outcome.

Please be aware there are three common, Claim-related issues that are **not** considered Claim Payment Disputes. To avoid confusion with Claim Payment Disputes, they are defined briefly here:

- **Claim Inquiry:** A question about a Claim or Claim payment is called an inquiry. Claim Inquiries do not result in changes to Claim payments, but the outcome of the Claim Inquiry may result in the initiation of the Claim Payment Dispute. In other words, once the Provider or Facility receives the answer to the Claim Inquiry, the Provider or Facility may opt to begin the Claim Payment Dispute process.
- **Claim Correspondence:** Claim Correspondence is when PHP requires more information to finalize a Claim. Typically, PHP makes the request for this information through the Payment Remittance Advice ("PRA") The Claim or part of the Claim maybe denied, but it is only because more information is required to process the Claim. Once the information is received, PHP will use it to finalize the Claim.
- **Clinical/Medical Necessity Appeals:** An appeal regarding a clinical decision denial, such as an authorization or Claim that has been denied as not medically necessary, experimental/investigational. For more information on Clinical / Medical Necessity Appeals, please refer to the PHP UR/QI Section within this manual.

Please reference the Claims Submission Filing Tips section for additional information.

The PHP Claim Payment Dispute process consists of two steps. Providers and Facilities will not be penalized for filing a Claim Payment Dispute, and no action is required by the Member.

1. **Claim Payment Reconsideration:** The Claim Payment Reconsideration represents the Provider or Facilities initial request for an investigation into the outcome of the Claim. Most issues are resolved at the Claim Payment Reconsideration step.

A Claim Payment Dispute may be submitted for multiple reason(s), including:

- Contractual payment issues
- Disagreements over reduced or zero-paid Claims
- Claim code editing issues
- Duplicate Claim issues
- Retro-eligibility issues
- Claim data issues
- Claims that are denied for no authorization when an authorization was obtained, a Claim Payment Dispute may be submitted as long as the authorized services match the Claim details.
- Timely filing issues*

* PHP will consider reimbursement of a Claim that has been denied due to failure to meet timely filing if the Provider or Facility can: 1) provide documentation the Claim was submitted within the timely filing requirements or 2) demonstrate good cause exists.

## Claim Payment Reconsideration/Dispute

The first step in the PHP Claim Payment Dispute process is called the Claim Payment Reconsideration. It is the Provider or Facilities initial request to investigate the outcome of a finalized Claim. Please note, PHP cannot process a Claim Payment Reconsideration without a finalized Claim on file.

PHP accepts Claim Payment Reconsideration requests in writing, within no less than 180 days (or according to the Agreement) from the date on the EOP (see below for further details on how to submit). Claim Payment

Reconsiderations filed beyond this timeframe will be considered untimely and denied unless good cause can be established.

When submitting Claim Payment Reconsiderations, Providers and Facilities should include as much information as possible to help PHP understand why the Provider or Facility believes the Claim was not paid as expected. If a Claim Payment Reconsideration requires clinical expertise, it will be reviewed by the appropriate PHP clinical professionals.

PHP will make every effort to resolve the Claim Payment Reconsideration within 60 calendar days of receipt.

PHP will send the Provider or Facility the decision in a determination letter, which will include:

- A statement of the Provider or Facility's Reconsideration request.
- A statement of what action PHP intends to take or has taken.
- The reason for the action.
- Support for the action, including applicable statutes, regulations, policies, Claims, codes or Provider Manual references.
- An explanation on how to request a Claim Payment Appeal within 30 calendar days of the date of the Reconsideration determination letter.
- Options and instructions for how to submit a Claim Payment Appeal.

If the decision results in a Claim adjustment, the payment and EOP will be sent separately.

## Required Documentation for Claims Payment Disputes

PHP requires the following information when submitting a Claim Payment Dispute (Claim Payment Reconsideration or Claim Payment Appeal):

- Provider or Facility name, address, phone number, email, and either NPI or TIN
- The Member's name and his or her PHP or Medicaid ID number
- A listing of disputed Claims, which should include the PHP Claim number and the date(s) of service(s)
- All supporting statements and documentation

## How to Submit a Claim Payment Dispute

There are several options to file a Claim Payment Dispute:

- Written (for Claim Payment Reconsiderations and Claim Payment Appeals): Mail all required documentation (see below for more details), including the Adjustment Request Form.
- To download the Adjustment Request Form: **www.phpni.com > Menu > Providers > Forms & Downloads > General Forms> Adjustment Request Form**. Providers can also reference the Links section of the manual for the direct link information.

  Mail all required documentation including the Adjustment Request Form, to:

**PHP Claims Department**
**P O Box 2359**
**Fort Wayne, IN 46801**

## Dispute Resolution and Arbitration

*Please note in the instances where the information in this section conflicts with the Agreement the Agreement will take precedence.*

A. **Disputes.** For the purposes of this Section, "Dispute" means any dispute or claim between PHP and Provider arising out of or related to the interpretation or application of this Agreement or breach thereof. No disputes or grievances concerning medical malpractice shall be adjudicated pursuant to this Section and all such claims shall be handled exclusively pursuant to the provisions of the Indiana Medical Malpractice Act (IC 34-18-1 et seq.).

B. **Negotiation of Disputes.** Resolution of Disputes shall be subject to good faith negotiation between the parties. The complaining party shall notify the other party in writing of such Dispute and the parties shall meet, attempting in good faith to resolve the Dispute within ninety (90) days of the date of such notice, or within such time as is mutually agreed upon by the parties in writing. In the event the Dispute is not resolved within such time period, it may be submitted in writing to arbitration by the originating party within fifteen (15) days of the termination of the negotiations as provided above.

C. **Arbitration of Disputes.** Disputes shall be arbitrated in accordance with the rules of the American Arbitration Association (AAA) and the following provisions:

1. Selection of Arbitrators. Arbitration shall be conducted by three (3) arbitrators with experience in the matter of HMOs, facilities and related contractual issues. One arbitrator shall be appointed by each party within seven (7) days of submission to arbitration. The third shall be selected by the two (2) appointed arbitrators from a list of prospective neutral arbitrators provided by the AAA. The two (2) appointed arbitrators shall have fifteen (15) days from the date of mailing of such list to cross off any names to which they object, number the remaining names, indicating the order of their preference, and return the list to AAA. The appointment shall be made promptly by AAA in accordance with its rules.

2. Location of Arbitration. Any arbitration proceeding under this Agreement shall be conducted in Allen County, Indiana.

3. Judgment upon Arbitration. Judgment rendered by the arbitrators may be entered in any court having jurisdiction thereof. Arbitrators shall have no authority to award any punitive or exemplary damages, or to vary or ignore the terms of this Agreement and shall be bound by controlling law.

**Retroactive Effect of Resolution.** The negotiated agreement or arbitrated ruling shall be effective not more than ninety (90) days prior to the date first written notice was given pursuant to subsection B above unless otherwise mutually agreed to by the parties in writing.

## Member Quality of Care/Quality of Service Investigations Overview

The Grievances and Appeals department develop, maintains and implements policies and procedures for identifying, reporting and evaluating potential quality of care/service concerns or sentinel events involving PHP Members. This includes cases reviewed as the result of a grievance submitted by a Member and potential quality issues reviewed as the result of a referral received from a PHP clinical associate. All PHP associates who may encounter clinical care/service concerns or sentinel events are informed of these policies.

Quality of care grievances are processed by clinical associates and/or the Director Provider Implementation and Service. When deemed necessary medical record and a response from the Provider and/or Facility are requested. Upon completion of the review, a final determination will be documented for tracking and trending purposes. If the case is a Member grievance, the Member is sent a resolution letter within thirty (20) business calendar days of PHP's receipt of the grievance. The Member is informed that peer review statutes do not permit disclosure of the details and outcome of the quality investigation.

Significant quality of care issues may be elevated to the Medical Advisory Committee and/or Peer Review Committee. This may result in a subsequent referral to the appropriate Credentials Committee.

Providers and Facilities have a contractual obligation to actively cooperate with any investigation. When a Member alerts PHP to a quality concern regarding the care they received, PHP has an obligation to thoroughly investigate that allegation by reviewing all relevant materials including any internal investigation and their outcomes done by the impacted Providers and/or Facility. This requirement is in the Provider and Facility Agreements and, as a business associate, PHP has a right to that information.

### Corrective Action Plan

When corrective action is required, the Medical Director or the applicable local Peer Review Committee will determine appropriate follow-up interventions which can include one or more of the following: a corrective action plan from the Provider and/or Facility, chart reviews, on-site audits, tracking and trending, Provider and/or Facility counseling, and/or referral to the appropriate committee.

### Reporting

G&A leadership reports grievance and provider quality of care rates, categories, and trends; to the appropriate Medical Advisory Committee on a quarterly basis or more often as appropriate. Quality improvement or educational opportunities are reported, and corrective measures implemented, as applicable. Results of corrective actions are reported to the Committee. The Medical Advisory Committee and Quality Improvement Committee reviews these trends annually during the process of prioritizing quality improvement activities for the subsequent year.

### Peer to Peer Review Process

Upon the provider's request, from an attending physician or treating provider, PHP provides a clinical peer-to-peer conversation when an adverse medical necessity determination will be made or has been made regarding health care services for Members. The attending physician or treating provider may offer additional information and/or further discuss his/her cases with a physician or other appropriate reviewer. In compliance with accreditation standards, a provider or his/her designee may request the peer-to-peer review. Others such as hospital representatives, employers and vendors are not permitted to do so.

### Quality of Care Incident

Providers and Facilities will notify PHP in the event there is a quality of care incident that involves a Member.

## Audits/Records Requests

At any time, PHP may request on-site, electronic or hard copy medical records, utilization review sheets and/or itemized bills related to Claims for the purposes of conducting audits and reviews to determine Medical Necessity, diagnosis and other coding and documentation of services rendered.

## Case Management

Case Management is a voluntary Member Health benefit plan management program designed to support the use of cost-effective alternatives to inpatient treatment, such as home health or skilled nursing facility care, while maintaining or improving the quality of care delivered. The nurse case manager in PHP's case management program works with the treating physician(s), the Member and/or the Member's Authorized Representative, and appropriate Facility personnel to both identify candidates for case management, and to help coordinate benefits for appropriate alternative treatment settings. The program requires the consent and cooperation of the Member or Member's Authorized Representative, as w ell as collaboration with the treating physicians.

A Member (or Member's Authorized Representative) may self-refer or a Provider or Facility may refer a Member to PHP's Case Management program by calling the Customer Service number on the back of the member's ID card.

## Electronic Data Exchange

Facility will support PHP by providing electronic data exchange including, but not limited to, ADT (Admissions, Discharge and Transfer), daily census, confirmed discharge date and other relevant clinical data plans. Providers can submit requests regardless of how they were sent (phone, fax, **PHP's Web Portal** or other online tool).

- Initiate pre-authorization requests online, eliminates the need to fax.
- Allows detailed text, photo images and attachments to be submitted along with your request.
- Make inquiries on previously submitted requests via phone, fax, **PHP's Web Portal** or other online tool.
- Instant accessibility from almost anywhere including after business hours.
- Update clinical information when the case is still active.
- Update the case with extension of services or discharge information.
- View, download or print all provider letters associated to the case.
- Utilize the dashboard to provide a complete view of all **PHP's Web Portal** submitted UM and behavioral health requests with real time status updates.
- Email notifications if requested using a valid email address to notify activity on the case.

Please visit our **PHP's Web Portal** Help Page on www.phpni.com..

## Misrouted Protected Health Information (PHI)

Providers and Facilities are required to review all Member information received from PHP to ensure no misrouted PHI is included. Misrouted PHI includes information about Members that a Provider or Facility is not currently treating. PHI can be misrouted to Providers and Facilities by mail, fax, email, or electronic remittance. Providers and Facilities are required to immediately destroy any misrouted PHI or safeguard the PHI for as long as it is retained. In no event are Providers or Facilities permitted to misuse or re-disclose misrouted PHI. If Providers or Facilities cannot destroy or safeguard misrouted PHI, Providers and Facilities must contact Provider Services to report receipt of misrouted PHI.

## Privacy Policy Statement

Information regarding PHP's Corporate Privacy Policy Statement that sets forth guidelines regarding a Member's right to access and amend information in PHP's possession is available by selecting the "Privacy Statement" at the bottom of the PHP Website Landing page of our public website. **To access this information, go to www.phpni.com select Provider under "Policies" at the bottom of the page. Click Notice of Privacy Practices https://www.phpni.com/uploads/resources/PHP-B-FI-Notice_of_Privacy_Practices_2019-FINAL_LR.pdf and/or HIPPA** Privacy. https://www.phpni.com/policies/hipaa-privacy [insert hyperlink]

# Quality Improvement Program

## Quality Improvement Program Overview

We believe health care is local and PHP has the strong local presence required to understand and meet Member needs. PHP is well positioned to deliver what Members want: innovative, choice-based products; distinctive service; simplified transactions; and better access to information for quality care. Our local presence and broad expertise create opportunities for collaborative programs with our Providers and Facilities. Providers and Facilities are expected to cooperate with Quality Improvement activities. Our commitment to health improvement and care management provides added value to Members and health care professionals — helping in-prove both health and health care costs. PHP takes a leadership role to improve the health of communities and is helping to address some of health care's most pressing issues. The Quality Improvement ("UR/QI") Program Description defines the quality infrastructure that supports PHP's UR/QI strategies.

- PHP has established a standing committee in accordance with the bylaws of PHP. The Board of Directors has delegated the oversite authority, of the Quality Improvement Committee (QIC), which has the responsibility of the administrating the Utilization Review and Quality Improvement Plan.
- The primary purpose of the Utilization Review and Quality Improvement Plan is to establish procedures based on professional recognized standard to access and monitor the health services deliver to covered persons, including mechanism to implement corrective action, when necessary, and to assess the availability, accessibility, utilization, continuity and satisfaction of care and services.
- To fulfill this purpose, the program is comprehensive, ongoing and includes effective mechanism to identify, continuously monitor, evaluate and resolve issues that impact accessibility, complaints, satisfaction, quality, safety, utilization and continuity of clinical care and services delivered to Covered Persons in all lines of our business by Providers in both inpatient and outpatient settings, with a focus on enhancing the delivery of quality care in a cost-effective manner. The Scope of the quality improvement process includes a wide range of activities including process and outcomes of clinical care, behavioral health, ancillary services, pharmacy services, vendor and delegated services, member services, satisfaction, patient safety, and efficient use of resources. The program shall address the needs of internal and external “customers,” including PHP’s internal departments, clients and members. The program shall include monitoring of clinical and non-clinical services.

**Objectives**

The Program objective support PHP's vision and values, promote continuous improvement in quality care, patient safety for Members and quality of service to Members, Providers and Facilities:

A. To assess effective and efficient utilization of medical facilities and services.

B. To maintain a quality management program that promotes objective and systematic measurement, monitoring and evaluation of services, work processes, and implements quality improvement activities based upon the outcomes.

C. To analyze data collected for appropriate utilization of health care resources and quality services.

D. To identify opportunities to improve the outcomes of medical and behavioral health care utilization and services available to members.

E. To develop, implement and monitor action plans to improve medical and behavioral health care as well as services.

F. To establish, recommend, implement, and evaluate medical policies addressing protocols and criteria.

G. To develop, recommend, implement and evaluate alternative inpatient and outpatient services to enhance the quality and cost-effectiveness of care.

H. To monitor the consistency and application of medical policies and determinations; and to resolve identified issues through continuing education programs, changes in PHP procedures, or changes in medical practices that improve the quality and cost-effectiveness of health care.

I. To recommend corrective actions and monitor the results of corrective actions where deficiencies with an individual, department or organization's performance have been identified to assure that quality of care and/or service has been improved.

J. To monitor the process and resolution of complaints and grievances.

K. To participate in the Professional Review Oversight process.

L. To adhere to the policy governing the protection and confidentiality of clinical and patient protected health information.

## Quality and Safety of Clinical Care

A. Responsibilities of the QIC include, but are not limited to:

1. Monitors and analyzes reports, progress, action plans, follow up and achievement toward goals of QI activities from committees, subcommittees, departments, services, teams and Delegated Vendors.
2. Reviews, provides guidance, prioritizes, and approves Quality Improvement Projects (QIPS).
3. Provides analysis and evaluation of the results of quality improvement, utilization review, case management, and disease management activities (including but not limited to member and provider satisfaction survey results, member complaint and service issues, member and provider communication, member access, network adequacy and individual and/or aggregate utilization data and problem cases identified while performing utilization review.
4. Requires performance reporting, including reporting on performance measures or key process indicators from any source including delegated entities.
5. Recommends institution of needed action as a result of reviews of reports or data analysis.
6. Ensures that follow up to needed action occurs as appropriate.
7. Obtains input and recommendations from the Medical Advisory/Pharmacy & Therapeutics Subcommittee on clinical related policies, procedures, and criteria, including commercial criteria which may be implemented for utilization review purposes.
8. Obtains input and recommendations from the Medical Advisory/Pharmacy & Therapeutics Subcommittee to address reports of individual and/or aggregate utilization data and problem cases identified while performing utilization review or quality improvement.
9. Appoint subcommittees, Ad hoc committees, work groups, or teams to address specific issues, tasks or projects, reporting back to the QIC.
10. Monitors compliance with URAC Accreditation Standards, recommending action as needed.
11. Evaluates the effectiveness of the Utilization Review and Quality Improvement (UR/QI) Plan and Program at least annually.
12. Reports the findings of the annual evaluation, along with recommendation for updates and changes to the Plan and Program to the Board of Directors for approval annually.
13. With the assistance of the Medical Advisory/Pharmacy & Therapeutics Subcommittee, carries out the Peer Review Plan, as described in that Plan.

B. Responsibilities of the Medical Advisory/Pharmacy & Therapeutics Subcommittee include, but are not limited to:

1. Provides input and recommendations on clinical related policies, procedures and criteria, including commercial criteria which may be implemented for utilization review purposes.
2. Provides input and recommendations addressing reports of individual and/or aggregate utilization data and problem cases identified while performing utilization review or quality improvement.
3. Provides assessment, evaluation and recommendations on clinical issues related to quality
4. Improvement and utilization review.
5. Participates in the annual assessment and evaluation for effectiveness of the UR/QI Plan and Program.
6. Evaluate and provide recommendations pertaining to assessment of achievement and setting goals for member access and network adequacy.
7. Acts as the Peer Review Committee as described in the Peer Review Plan.
8. Reviews and provides input pertaining to the annual evaluation of mental health parity.

## Service Quality

PHP annually surveys its Members, using the industry standard CAHPs survey which provides monitoring of the quality of care and service of network providers and strives to provide excellent service to Members, Providers and Facilities. PHP actively analyzes business processes, trends, identifies and acts on opportunities to improve the Member, Provider and Facility experience, recommending appropriate activities to address root causes.

## Patient Safety for Members

The strategic vision is to establish and maintain goals in advancing patient safety for Members. This program is structured to align with the overall mission and national patient safety for Members' strategy. The goals are to work with physicians, hospitals in the network and other health care partners to reduce adverse drug events, health care associated conditions, hospital readmissions and avoidable cost of care, as well as develop innovative programs to accelerate improvements in quality and safety. Priority areas include medication safety, radiation safety, surgical safety, infection control, protection, engagement, care management and payment innovation. Patient safety for member initiatives are managed by various business units within the enterprise, but tracked by a single unit. These member- and provider-facing initiatives/activities are designed to meet regulatory and accreditation requirements and consumer needs. Whenever possible, nationally endorsed clinical metrics are used to evaluate progress.

## Audit

From time to time PHP may conduct claim reviews or audits either on a prepayment or post payment basis. Claim reviews and audits are conducted in order to confirm that healthcare services or supplies were delivered in compliance with the Member's plan of treatment or to confirm that charges were accurately reported in compliance with PHP's policies and procedures as well as general industry standard guidelines and regulations.

In order to conduct these audits, PHP or its designee may request documentation, most commonly in the form of patient medical records. PHP may accept additional documentation from Provider or Facility that typically might not be included in medical records such as other documents substantiating the treatment or health service or delivery of supplies.

This policy documents PHP's guidelines for claims requiring additional documentation and the Provider's or Facility's compliance for the provision of requested documentation.

**Definition:**

The following definitions shall apply to this Audit section only:

- Agreement means the written contract between PHP and Provider or Facility that describes the duties and obligations of PHP and the Provider or Facility, and which contains the terms and conditions upon which PHP will reimburse Provider or Facility for Health Services rendered by Provider or Facility to Member(s).
- Appeal means PHP's or its designee's review of the disputed portions of the Audit Report, conducted at the written request of a Provider or Facility and pursuant to this Policy.
- Appeal Response means PHP's or its designee's written response to the Appeal after reviewing all Supporting Documentation provided by Provider or Facility.
- Audit means a qualitative or quantitative review of Health Services or documents relating to such Health Services rendered by Provider or Facility, and conducted for the purpose of determining whether such Health Services have been appropriately reimbursed under the terms of the Agreement.
- Audit Report and Notice of Overpayment ("Audit Report") means a document that constitutes notice to the Provider or Facility that PHP or its designee believes an overpayment has been made by PHP and identified as the result of an Audit. The Audit Report shall contain administrative data relating to the Audit, including the amount of overpayment and findings of the Audit, that constitute the basis for PHP's or its designee's belief that the overpayment exists. Unless otherwise stated in the Agreement between the Provider or Facility and PHP, Audit Reports shall be sent to Provider or Facility in accordance with the Notice section of the Agreement.
- Business Associate or designee means a third party designated by PHP to perform an Audit or any related Audit function on behalf of PHP pursuant to a written agreement with PHP.
- Provider or Facility means an entity with which PHP has a written Agreement.
- Provider Manual means the proprietary PHP document available to the Provider and Facility, which outlines certain PHP Policies.
- Recoupment means the recovery of an amount paid to Provider or Facility which PHP has determined constitutes an overpayment not supported by an Agreement between the Provider or Facility and PHP. A Recoupment is generally performed against a separate payment PHP makes to the Provider or Facility which is unrelated to the services which were the subject of the overpayment, unless an Agreement expressly states otherwise or is prohibited by law. Recoupments shall be conducted in accordance with applicable laws and regulations.
- Supporting Documentation means the written material contained in a Member's medical records or other Provider or Facility documentation that supports the Provider's or Facility's claim or position that no overpayment has been made by PHP.

**Policy:**

Upon request from PHP or its designee, facilities are required to submit additional documentation for claims identified for pre-payment review or post payment audit. Applicable types of claims include, but are not limited to:

1. Claims being reviewed to validate the correct diagnosis related group (DRG) assignment/payment (DRG validation audits)

2. Claims being reviewed to validate items and services billed are documented in the medical record for hospital bill audits (also known as hospital charge audits)

3. Claims with unlisted or miscellaneous codes

4. Claims for services requiring clinical review

5. Claims for services found to possibly conflict with covered benefits for Members after validity review of the Member's medical records

6. Claims for services found to possibly conflict with Medical Necessity of covered benefits for Members

7. Claims being reviewed for potential fraud, abuse or demonstrated patterns of billing/coding inconsistent with peer benchmarks

8. Claims for services that require an invoice

9. Claims for services that require an itemized bill

10. Claims for beneficiaries where other health insurance is indicated with the claim submission

11. Claims requiring documentation of the receipt of an informed consent form

12. Claims requiring a certificate of Medical Necessity

13. Appealed claims where supporting documentation may be necessary for determination of payment

14. Other documentation required by other entities such as the Centers for Medicare and Medicaid Services (CMS), and state or federal regulation

15. Documentation for such services as the provision of durable medical equipment, prosthetics, orthotics, and supplies, rehabilitation services, and home health care

PHP or its designee will use the following guidelines for records requests and the adjudication of claims identified for prepayment review or post payment audit:

1. Upon confirmation of Provider's or Facility's address, an original letter of request for supporting documentation will be sent.

2. When a response is not received within 30 days of the date of the initial request, a second request letter will be sent.

3. When a response is not received within 15 days of date of the second request, a final request letter will be sent.

4. When a response is not received within 15 days of the date of the final request (60 days total):

   A. PHP or its designee will initiate claim denial for claims identified as pre-payment review claims as Provider or Facility failed to submit the required documentation. The Member shall be held harmless for such payment denials.

   Or

   B. PHP or its designee will initiate claim retractions for claims identified as post payment audit claims as Provider or Facility failed to submit the required documentation. The Member shall be held harmless for such payment retractions.

PHP or its designee will not be liable for interest or penalties when payment is denied or recouped when Provider or Facility fails to submit required or requested documentation for claims identified for prepayment or post payment audit.

[This policy will not supersede any individual Provider or Facility contract provisions or state or federal guidelines.]

**Procedure:**

1. **Review of Documents.** PHP or its designee will request in writing or verbally, final and complete itemized bills and/or complete medical records for all Claims under review. The Provider or Facility will supply the requested documentation in the format requested by PHP or its designee within the time frame outlined above.

2. **Under-billed and Late-billed Claims.** During the scheduling of the Audit, Provider or Facility may identify Claims for which Provider or Facility under-billed or failed to bill for review by PHP during the Audit. Under-billed or late-billed Claims not identified by Provider or Facility before the Audit commences will not be evaluated in the Audit. These Claims may, however, be submitted (or resubmitted for under-billed Claims) to PHP for adjudication.

3. **On-Site and Desk Audits.** PHP or its designee may conduct Audits from its offices or on-site at the Provider's or Facility's location. If PHP or its designee conducts an Audit at a Provider's or Facility's Location, Provider or Facility will make available suitable work space for PHP's or its designee's on-site Audit activities. During the Audit, PHP or its designee will have complete access to the applicable health records including ancillary department records and/or invoice detail without producing a signed Member authorization. When conducting credit balance reviews, Provider or Facility will give PHP or its designee a complete list of credit balances for primary, secondary and tertiary coverage, when applicable. In addition. Explanation of Benefits and insurance information to determine validity of credit balances. If the Provider or Facility refuses to allow PHP or its designee access to the items requested to complete the Audit, PHP or its designee may opt to complete the Audit based on the information available. All Audits (to include medical chart audits and diagnosis related group reviews) shall be conducted free of charge despite any Provider or Facility policy to the contrary.

4. **Completion of Audit**. Upon completion of the Audit, PHP or its designee will generate and give to Provider or Facility a final Audit Report. This Audit Report may be provided on the day the Audit is completed or it may be generated after further research is performed. If further research is needed, the final Audit Report will be generated at any time after the completion of the Audit, but generally within ninety (90) days. Occasionally, the final audit report will be generated at the conclusion of the exit interview which is performed on the last day of the Audit. During the exit interview, PHP or its designee will discuss with Provider or Facility its Audit findings found in the final Audit Report. This Audit Report may list items such as charges unsupported by adequate documentation, under-billed items, late billed items and charges requiring additional supporting documentation. If the Provider or Facility agrees with the Audit findings, and has no further information to provide to PHP or its designee, then Provider or Facility may sign the final Audit Report acknowledging agreement with the findings. At that point, Provider or Facility has thirty (30) calendar days to reimburse PHP the amount indicated in the final Audit Report. Should the Provider or Facility disagree with the final Audit Report, then Provider or Facility may either supply the requested documentation or Appeal the Audit findings.

5. **Provider or Facility Appeals.** See Audit Appeal Policy.

6. **No Appeal.** If the Provider or Facility does not formally Appeal the findings in the final Audit Report and submit supporting documentation within the (thirty) 30 calendar day timeframe, the initial determination will stand and PHP or its designee will process adjustments to recover the amount identified in the final Audit Report.

**Documents Reviewed During an Audit:**

The following is a description of the documents that may be reviewed by PHP or its designee along with a short explanation of the importance of each of the documents in the Audit process. It is important to note that Providers and Facilities must comply with applicable state and federal record keeping requirements.

**A. Confirm that Health Services were delivered by the Provider or Facility in compliance with the plan of treatment.**

Auditors will verify that Provider's or Facility's plan of treatment reflected the Health Services delivered by the Provider or Facility. The services are generally documented in the Member's health or medical records. In situations where such documentation is not found in the Member's medical record, the Provider or Facility may present other documents substantiating the treatment or Health Service, such as established institutional policies, professional licensure standards that reference standards of care, or business practices justifying the Health Service or supply. The Provider or Facility must review, approve and document all such policies and procedures as required by The Joint Commission ("TJC") or other applicable accreditation bodies. Policies shall be made available for review by the auditor.

**B. Confirm that charges were accurately reported on the Claim in compliance with PHP's Policies as well as general industry standard guidelines and regulations.**

The auditor will verify that the billing is free of keystroke errors. Auditors may also review the Member's health record documents. The health record records the clinical data on diagnoses, treatments, and outcomes. A health record generally records pertinent information related to care and in some cases, the health record may lack the documented support for each charge on the Member's Claim. Other appropriate documentation for Health Services provided to the Member may exist within the Provider's or Facility's ancillary departments in the form of department treatment logs, daily charge records, individual service/order tickets, and other documents. PHP or its designee may have to review a number of documents in addition to the health record to determine if documentation exists to support the Charges on the Member's Claim. The Provider or Facility should make these records available for rev and must ensure that Policies exist to specify appropriate documentation for health records and ancillary department records and/or logs.

## Clinical Practice Guidelines

PHP considers clinical practice guidelines to be an important component of health care. PHP adopts nationally recognized clinical practice guidelines, and encourages you to participate in the development and utilization of these guidelines to improve the health of our Members. The guidelines, which PHP uses for quality and disease management programs, are based on reasonable medical evidence. We review the guidelines at least once every year or when changes are made to national guidelines for content accuracy, current primary sources, new technological advances and recent medical research.

Providers can access the up-to-date listing of the medical, preventive and behavioral health guidelines online. To access the guidelines, go to www.phpni.com > Providers > Resources > Clinical Guidelines.

With respect to the issue of coverage, each Member should review his/her Certificate of Coverage and Schedule of Benefits for details concerning benefits, procedures and exclusions prior to receiving treatment. The Certificate of Coverage and/or Schedule of Benefits supersede the clinical practice guidelines.

## Insurance Requirements

A. Providers and Facilities shall, during the term of this Agreement keep in force with insurers the following coverage:

Shall procure and maintain, at Provider/Facility full expense, comprehensive general liability and professional liability insurance and/or umbrella liability insurance in amounts in accordance with prevailing community and professional standards and shall at all times qualify as a "health care provider" under the Indiana Medical Malpractice Act and applicable law. Provider/Facility shall also require that all Ancillary Providers procure and maintain malpractice insurance in an amount necessary to qualify as a health care provider under the Indiana Medical Malpractice Act and applicable law. Coverage shall be either occurrence or claims made with an extended period reporting option under such terms and conditions as may be reasonably required by PHP. Upon request by PHP, Provider shall provide evidence of insurance coverage. Provider shall notify PHP in writing, to the attention of the Vice President, Provider Contracting within fifteen (15) days of any changes in

B. Providers and Facilities shall notify PHP of a reduction in, cancellation of, or lapse in coverage within fifteen (15) days of such a change. A certificate of insurance shall be provided to PHP upon execution of this Agreement and upon request during the Agreement period.

## Open Practice

Providers shall give Plan sixty (60) days prior written notice when Provider no longer accepts new patients.

## Preventative Health Guidelines

PHP considers prevention an important component of health care. PHP develops preventive health guidelines in accordance with recommendations made by nationally recognized organizations and societies such as the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the Advisory Committee on Immunizations Practices (ACIP), the American College of Obstetrics and Gynecology (ACOG) and the United States Preventive Services Task Force (USPSTF). The above organizations make recommendations based on reasonable medical evidence. We review the guidelines annually for content accuracy, current primary sources, new technological advances and recent medical research and make appropriate changes based on this review of the recommendations and/or preventive health mandates. We encourage physicians to utilize these guidelines to improve the health of our Members.

The current guidelines are available on our website. To access the guidelines, go to **www.phpni.com> Menu > Providers Resources > Preventive Health Guidelines**.

With respect to the issue of coverage, each Member should review his/her Certificate of Coverage and Schedule of Benefits for details concerning benefits, procedures and exclusions prior to receiving treatment. The Certificate of Coverage and/or Schedule of Benefits supersede the preventive.

## Provider and Facility Responsibilities

Providers are required to comply with Federal and State Laws. In addition, providers must verify their employees, contractors, subcontractors or agents have not been identified as ineligible persons on the General Services Administration' List of Parties Excluded from Federal Programs and the CMS/OIG list of Excluded Individual/Entities or as otherwise designated by the Federal government.

In Accordance to the Federal No Surprise Act, PHP requires all providers/practices to supply PHP with an Excel File and/or email listing of their current providers that includes all locations for each practitioner and should include indicators to advise if the provider is accepting new patients and if the offer telehealth services.

Providers are responsible for notifying PHP when changes occur within the Provider Organization. Our Provider Agreement requires Providers give PHP at least 10 days prior notice when making changes. All changes must be approved by PHP.

Examples of these changes include, but are not limited to:

- adding a new practitioner to your group
- change in ownership
- change in Tax Identification Number
- making changes to your demographic information or adding new locations
- selling or transferring control to any third party
- acquiring other medical practice or entity
- change in accreditation
- change in affiliation
- change in licensure or eligibility status, or
- change in operations, business or corporation

# Medical Record Documentation Requirements

## Provider and Facility Records

PHP recognizes the importance of medical record documentation in the delivery and coordination of quality care. PHP has medical record standards that require Providers and Facilities to maintain medical records in a manner that is current, organized, and facilitates effective and confidential medical record review for quality purposes.

Provider and Facility shall prepare and maintain all appropriate medical, financial, administrative and other records as may be needed for Members receiving Health Services. All of Provider's and Facility's records on Members shall be maintained in accordance with prudent record keeping procedures and as required by any applicable federal, state or local laws, rules or regulations.

Pursuant Provider's Agreement with PHP, the Provider may not charge PHP or the member for the cost of copies of medical records unless expressly identified in the provider agreement.

Medical records significantly impact risk adjustment because:

- They are a valuable source of diagnosis data;
- They dictate what ICD-10 Code or successor code is assigned; and

Because of this, the Provider and Facility play an extremely important role in ensuring that the best documentation practices are established.

***PHP medical record standards are based on AMA documentation recommendations.***

**The following information is required on a medical record to consider it valid.**

1. Each page of the medical record will include patient identification, either by name or ID number.
2. Personal biographical information will be included on each patient's medical record. Gender and Date of Birth.
3. The medical record will be legible.
4. All entries in the medical record will contain author identification.
5. All entries will be dated.
6. Significant illnesses and medical conditions will be indicated and readily identifiable on a problem list or flow sheet.
7. The documentation must be clear, concise, complete, specific and supportive of diagnosis and service provided.
8. If a definitive diagnosis has not been established by the end of the encounter, it is appropriate to report codes for sign(s) and/or symptom(s) in lieu of a definitive diagnosis.
9. Medication allergies and other adverse reactions will be noted prominently in the medical record. If there are no known allergies, this should also be noted in the record.
10. Past medical history will be easily identifiable. (Includes serious accidents, operations, and illnesses. Includes menstrual and pregnancy history of adolescent and adult females. For children and adolescents, relates to prenatal care, birth, operations, and childhood illnesses.)
    - ✓ Family history will be available.
    - ✓ Social history will include age appropriate assessment. (Includes assessment of alcohol, tobacco, and other substance use/abuse by patients 14 years or older.)

11. Each encounter note will include a reason for encounter (chief complaint), history and physical exam (subjective/objective assessment), a clinical impression or diagnosis, a plan regarding treatment and/or further evaluation, and when indicated, follow-up care.

    - ✓ Unresolved problems from previous visits will be addressed in subsequent visits.
    - ✓ Medication administration/injection will be recorded, including drug name, dosage, and route.

12. Lab, x-rays, and other studies will be ordered appropriately and documented in the encounter note. The reason for the above studies will be documented or easily implied.

13. Consultants will be utilized appropriately.

    - ✓ When consultation has been requested, there will be a report or notation from the consultant in the medical record.

14. Consultation, lab, and imaging reports filed in the chart will be initialed by the primary care physician to signify review, or a notation is made in the medical record acknowledging review of specific diagnostic test results.

    - ✓ Reports presented electronically or by other methods have some representation of physician review. Consultation, abnormal lab and imaging study results have an explicit notation in the record of follow-up plans.

15. Medical records of children and adolescents 0-16 years old will contain documentation of each immunization. When immunizations are not up to date, documentation will indicate reason or plan.

    - ✓ Immunization documentation will contain record of serum, manufacturer, lot number, date, and site of administration for immunizations provided after 1995.
    - ✓ If immunizations are obtained elsewhere, the medical record should note this, and that immunizations are up to date.

16. A valid signature for services provided that is handwritten or electronic. Credentials need to be present. Stamped signatures if you have a physical disability and can prove you are not able to sign due to that disability

17. Examples of a Valid Signature:

    - ✓ Legible full signature
    - ✓ Legible first initial and last name
    - ✓ Illegible signature over a typed or printed name
    - ✓ Illegible signature where the letterhead, addressograph or other information on the page indicates the identity of the signatory.
    - ✓ Illegible signature NOT over a typed/printed name and NOT on letterhead, but the submitted documentation is accompanied by: a signature log, or an attestation statement
    - ✓ Initials over a typed or printed name
    - ✓ Initials NOT over a typed/printed name but accompanied by: a signature log, or an attestation statement

Signature need to be legible or can be validated by comparing to a signature log or attestation statement.

**Signature Log Statement:** Providers will sometimes include a signature log in the documentation they submit that lists the typed or printed name of the author associated with initials or illegible signature. The signature log might be included on the actual page where the initials or illegible signature are used or might be a separate document

**Signature Attestation Statement:** If the signature is missing from any medical documentation PHP shall accept a signature attestation from the author of the medical record. An attestation statement must be signed and dated by the author of the medical record entry and must contain sufficient information to identify the beneficiary. All entries will be dated.

Late entries, addendums, or corrections to a medical record are **legitimate occurrences in documentation of clinical services**. A late entry, an addendum or a correction to the medical record, **bears the current date of that entry and is signed by the person making the addition or change**

**Amendments, Corrections and Delayed Entries in Medical Documentation** All services provided are expected to be documented in the medical record at the time they are rendered. Occasionally, certain entries related to services provided are not properly documented. In this event, the documentation will need to be amended, corrected, or entered after rendering the service.

- Clearly and permanently identify any amendment, correction or delayed entry as such, and
- Clearly indicate the date and author of any amendment, correction or delayed entry, and
- Clearly identify all original content, without deletion.

**Paper Medical Records:** When correcting a paper medical record, these principles are generally accomplished by: Using a single line strike through so the original content is still readable, and the author of the alteration must sign and date the revision. Amendments or delayed entries to paper records must be clearly signed and dated upon entry into the record. Amendments or delayed entries to paper records may be initialed and dated if the medical record contains evidence associating the provider's initials with their name.

**Electronic Health Records (EHR):** Medical record keeping within an EHR deserves special considerations; Distinctly identify any amendment, correction or delayed entry, and Provide a reliable means to clearly identify the original content, the modified content, and the date and authorship of each modification of the record.

## Medical Records Submission (Solicited and Unsolicited)

### Solicited Medical Records Submission

When additional medical records are being submitted in response to PHP's request or to support an appeal, please submit them via mail or fax to the appropriate department as directed in the letter received from PHP to ensure a fast, accurate response. Always include the PHP letter requesting records on the top of the records. A copy of the Claim is not needed. Please do not place copy of Claim on top of the records.

- If Providers or Facilities are submitting X-Rays, pictures or dental molds, remember to include a valid and complete member identification number on page one of the material sent with these items.

### Unsolicited Medical Records Submission

PHP will send a request when medical records are required. However, if a Provider or Facility wishes to send medical records with the Claim submission, below are helpful tips to follow.

To determine what medical records or portion of the medical records may be required, refer to the applicable PHP Medical Policy, PHP Clinical Guideline at **www.phpni.com**. Review the section in the PHP Medical Policies, or Clinical Indications section in the applicable PHP Clinical Guidelines or the appropriate to determine what medical records are needed. Refer the Medical Policies, Clinical Guidelines, sections of the Provider Manual for details on accessing this information.

When submitting medical records that are not requested by PHP, include a clear description of the billed code submitted with the Claim to help ensure prompt processing of the Claim for all miscellaneous, not otherwise classified (NOC), not otherwise specified (NOS), and unlisted HCPCS and CPT codes.

### Types of Medical Records Required

Medical records needed to determine the medical necessity of a billed code include, depending on the service or procedure, some or all of the following examples:

1. History & Physical, Office Notes, Treatment Records & Response
2. Chemotherapy Regimens, Chemotherapy Drugs, and Records
3. Medications List (current and prior)
4. Radiology, Diagnostic Imaging, or Diagnostic Testing Reports
5. Therapy/Rehabilitation Records
6. Laboratory reports, Pathology reports
7. Exact description of NOC/NOS code
8. Operative/Procedure Report

9. Inpatient Admission Summary, Daily Records, Discharge Summary

## PHP May Require Additional Records

Some situations may require additional medical records in addition to what was submitted with the Claim. Although these situations may not have specific rules and guidelines, PHP will make every attempt to make these requests explicit and limited to the minimal requests necessary to render a decision. Examples include, but are not limited to, the following situations:

1. Review and investigation of Claims
2. Medical review and evaluation
3. Medical management review (utilization review) and evaluation
4. Adjustments
5. Appeals
6. Quality management (quality of care concerns)
7. Records documenting prolonged services
8. Provider audits
9. Fraud, waste and abuse
10. HEDIS,RADV, or government audit

## HIPAA Privacy Rule – Minimum Necessary

PHP complies with HIPAA Privacy Rules and will request the minimum necessary information needed to determine benefits and/or coverage associated with Claim processing. Providers and Facilities are also required under the Minimum Necessary rule to submit only those records requested.

# Medical Record Review for Federal Law Audits

## Overview of HEDIS®

HEDIS (Healthcare Effectiveness Data and Information Set) is a set of standardized performance measures used to compare the performance of managed care plans and physicians based on value rather than cost. HEDIS is coordinated and administered by NCQA and is one of the most widely used sets of health care performance measures in the United States. PHP's Quality Department is responsible for collecting clinical information from Provider offices in accordance with HEDIS specifications. Record requests to Provider offices begin in early February and PHP requests that the records be returned within 10 business days to allow time to abstract the records and request additional information from other Providers, if needed. Health plans use HEDIS data to encourage their contracted providers to make improvements in the quality of care and service they provide. Employers and consumers use HEDIS data to help them select the best health plan for their needs.

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

## Risk Adjustments and HEDIS

**Compliance with Federal Laws, Audits and Record Retention Requirements**
Medical records and other health and enrollment information of Members must be handled under established procedures that:

- Safeguard the privacy of any information that identifies a particular Member;
- Maintain such records and information in a manner that is accurate and timely; and
- Identify when and to whom Member, information may be disclosed.

In addition to the obligation to safeguard the privacy of any information that identifies a Member, PHP Providers and Facilities are obligated to abide by all Federal and State laws regarding confidentiality and disclosure for medical health records (including mental health records) and enrollee information.

## Encounter Data for Risk Adjustment Purposes

Commercial Risk Adjustment and Data Submission: Risk adjustment is the process used by Centers for Medicare and Medicaid Services" CMS") to adjust the payment made to health plans under the Affordable Care Act ("ACA") based on the health status of Members who are insured under small group or individual health benefit plans compliant with the ACA (aka "ACA Compliant Plans"). Risk adjustment was implemented to pay health plans more accurately for the predicted health cost expenditures of Members by adjusting payments based on demographics (age and gender) as well as health status. PHP, as a qualifying health plan, is required to submit diagnosis data collected from encounter and claim data to CMS for purposes of risk adjustment. Because CMS requires that health plans submit all ICD10 codes for each beneficiary, PHP also collects diagnosis data from the Members' medical records created and maintained by the Provider or Facility.

Under the CMS risk adjustment model, the health plan is permitted to submit diagnosis data from inpatient hospital, outpatient hospital and physician/qualified non-physician e.g. nurse practitioner encounters only.

Maintaining documentation of Members' visits and of Members' diagnoses and chronic conditions helps PHP fulfill its requirements under the Affordable Care Act. Those requirements relate to the risk adjustment, reinsurance and risk corridor, or "3Rs" provision in the ACA. To ensure that PHP is reporting current and accurate Member diagnoses, Providers and Facilities may be asked to complete an Encounter Facilitation Form (also known as a SOAP note) for Members insured under small group or individual health benefit plans suspected of having unreported or out of date condition information in their records. PHP's goal is to have this information confirmed and/or updated no less than annually. As a condition of the Facility or Provider's Agreement with PHP, the Provider or Facility shall comply with PHP's requests to submit complete and accurate medical records, Encounter Facilitation Forms or other similar encounter or risk adjustment data in a timely manner to PHP, Plan or designee upon request.

In addition to the above ACA related commercial risk adjustment requirements, Providers and Facilities also may be required to produce certain documentation for Members enrolled in Medicare Advantage or Medicaid.

## RADV Audits

As part of the risk adjustment process, CMS will perform a risk adjustment data validation (RADV) audit in order to validate the Members' diagnosis data that was previously submitted by health plans. These audits are typically performed once a year. When PHP is selected by CMS to participate in a RADV audit, PHP, and the Providers or Facilities that treated the Members included in the audit will be required to submit medical records to validate the diagnosis data previously submitted. Please refer to your provider contract for possible reimbursement of medical record copies.

# Member Satisfaction Survey

## Overview of CAHPS

CAHPS® (Consumer Assessment of Healthcare Providers and Systems) surveys represent an effort to accurately and reliably capture key information from PHP's Members about their experiences with PHP's Health Plans in the past year. This includes the Member's access to medical care and the quality of the services provided by PHP's network of Providers. PHP analyzes this feedback to identify issues causing Members dissatisfaction and works to develop effective interventions to address them. PHP takes this survey feedback very seriously.

Health Plans report survey results to National Committee for Quality Assurance ("NCQA"), which uses these survey results for the annual accreditation status determinations and to create National benchmarks for care and service. Health Plans also use CAHPS® survey data for internal quality improvement purposes.

Results of these surveys are shared with Providers annually via our provider newsletter, so they have an opportunity to learn how PHP Members feel about the services provided. PHP encourages Providers to assess their own practice to identify opportunities to improve patients' access to care and improve interpersonal skills to make the patient care experience a more positive one. Our Provider newsletters can be found at: www.phpni.com
® CAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

# Fraud, Waste and Abuse Detection

We are committed to protecting the integrity of our health care programs and the effectiveness of our operations by preventing, detecting and investigating fraud, waste and abuse (FWA). Combating FWA begins with knowledge and awareness.

- **Fraud** — intentionally falsifying information and knowing that deception will result in improper payment and/or unauthorized benefit. This includes, knowingly soliciting, receiving, and/or offering compensation to encourage or reward referrals for items or services and/or making prohibited referrals for certain designated health services

- **Waste** — includes overusing services, or other practices that, directly or indirectly, result in unnecessary costs. Waste is generally not considered to be driven by intentional actions, but rather occurs when resources are misused.
- **Abuse** — when health care providers or suppliers do not follow appropriate medical billing/documentation practices or medical practices resulting in unnecessary or excessive costs, incorrect payment, misuse of codes, or services that are not medically necessary.

## Investigation Process

The Special Investigations Unit ("SIU") investigates suspected incidents of FWA for all types of services. We may take corrective action with a Provider or Facility, which may include, but is not limited to:

- **Written warning and/or education:** We send letters to the Provider or Facility advising the Provider or Facility of the issues and the need for improvement. Letters may include education or requests for repayment, or may advise of further action.
- **Medical record review**: We review medical records to investigate allegations or validate the appropriateness of Claims submissions.
- **Edits:** A certified professional coder or investigator evaluates Claims and places payment or system edits in PHP's Claims processing system. This type of review prevents automatic Claims payments in specific situations.
- **Recoveries:** We recover overpayments directly from the Provider or Facility. Failure of the Provider or Facility to return the overpayment may result in reduced payment for future Claims, termination from our network, or legal action.

## Prepayment Review

One method PHP uses to detect FWA is through prepayment Claim review Through a variety of means, certain Providers or Facilities, or certain Claims submitted by Providers or Facilities, may come to PHP's attention for behavior that might be identified as unusual for coding, documentation and/or billing issues, or Claims activity that indicates the Provider or Facility is an outlier compared to his/her/its peers.

Once a Claim, or a Provider or Facility, is identified as an outlier or has otherwise come to PHP's attention for reasons mentioned above, further investigation is conducted by the SIU to determine the reason(s) for the outlier status or any appropriate explanation for unusual coding, documentation, and/or billing practices. If the investigation results in a determination that the Provider's or Facility's actions may involve FWA, the Provider or Facility is notified and given an opportunity to respond.

Despite the Provider's or Facility's response, PHP continues to believe the Provider's or Facility's actions involve FWA, or some other inappropriate activity, the Provider or Facility may be placed on prepayment review. If that occurs, the Provider or Facility will receive written notice of being placed on prepayment review. This means that the Provider or Facility will be required to submit medical records and any other supporting documentation with each Claim so PHP can review the appropriateness of the services billed, including the accuracy of billing and coding, as well as the sufficiency of the medical records and supporting documentation submitted. Failure to submit medical records and supporting documentation to PHP in accordance with this requirement will result in a denial of the Claim under review. The Provider or Facility will be given the opportunity to request a discussion of his/her/its prepayment review status.

Under the prepayment review program, PHP may review coding, documentation, and other billing issues. In addition, we may use one or more clinical utilization management guidelines in the review of Claims submitted by the Provider or Facility, even if those guidelines are not used for all Providers or Facilities delivering services to Ran Members.

The Provider or Facility will remain subject to the prepayment review process until PHP is satisfied that all inappropriate billing, coding, or documentation activity has been corrected. If the inappropriate activity is not corrected, the Provider or Facility could face corrective measures, up to and including termination from our network.

Finally, Providers and Facilities are prohibited from billing a Member for services we have determined are not payable as a result of the prepayment review process, whether due to RNA, any other coding or billing issue or for failure to submit medical records as set forth above. Providers or Facilities whose claims are determined to be not payable may make appropriate corrections and resubmit such Claims in accordance with the terms of their Provider and Facility Agreement, proper billing procedures and state law. Providers or Facilities also may appeal such a determination in accordance with applicable grievance and appeal procedures.

## Acting on Investigation Findings

In addition to the previously mentioned actions, we may refer suspected criminal activity committed by a Member, Provider or Facility to the appropriate regulatory and/or law enforcement agencies

## Recoupment/Offset/Adjustment for Overpayments

PHP shall be entitled to offset and recoup an amount equal to any overpayments or improper payments made by PHP to Provider or Facility ("Overpayment Amount") against any payments due and payable by PHP or any Affiliate to Provider or Facility with respect to any Health Benefit Plan under this Agreement or under any provider agreement between Provider and an Affiliate regardless of the cause. Provider or Facility shall voluntarily refund the Overpayment Amount regardless of the cause, including, but not limited to, payments for Claims where the Claim was miscoded, non-compliant with industry standards, or otherwise billed in error, whether or not the billing error was fraudulent, abusive or wasteful. Upon determination by PHP that an Overpayment Amount is due from Provider or Facility, Provider or Facility must refund the Overpayment Amount to PHP within thirty (30) calendar days of the date of the overpayment refund notice from PHP to the Provider or Facility. If the Overpayment Amount is not received by PHP within the thirty (30) calendar days following the date of such notice letter, PHP shall be entitled to offset the unpaid portion of the Overpayment Amount against other Claims payments due and payable by PHP or an Affiliate to Provider or Facility under any Health Benefit Plan in accordance with Regulatory Requirements. In such event, Provider or Facility agrees that all future Claim payments, including Affiliate Claim payments, applied to satisfy Provider's or Facility's repayment obligation shall be deemed to have been legally paid to Provider or Facility in full for all purposes, including Affiliates and/or Regulatory Requirements as defined by the Provider or Facility Agreement. Should Provider or Facility disagree with any determination by PHP or a Plan that Provider or Facility has received an overpayment or improper payment, Provider or Facility shall have the right to appeal such determination under PHP's procedures set forth in the Provider Manual, provided that such appeal shall not suspend PHP's right to recoup the Overpayment Amount during the appeal process unless required by Regulatory Requirements. PHP reserves the right to employ a third party collection agency in the event of non-payment.

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# Understanding Pharmacy Benefits

It is important for patients to work with their doctor on how best to maintain good health and how to successfully manage any existing health conditions. To assist with receiving the highest quality of care at the most affordable price, our pharmacy benefit program has been designed to include five Tier of prescription drug coverage. When medicines are needed to treat a health condition, patients should understand how to get the most effective drug treatment while controlling the cost of prescriptions. These five Tier are described below.

## What is a five-tiered copayment pharmacy benefit and how does it work?

A five-tiered copayment benefit means there are five possible copayment levels. A member's copayment is based on the prescription drug being purchased. For example, the first tier represents a preferred generic drug that has the lowest copayment.

## TIER 1 Generic

Covered drugs that are no longer protected by a drug company patent allowing other drug companies to manufacture equivalent versions of the same drug at a reduced cost.

## TIER 1 Non-Preferred Generic

Similar to Tier 1 covered drugs, but available with a higher copayment.

## TIER 3 Brand Formulary

A list of brand-name drugs that PHP participating network doctors are encouraged to prescribe, when appropriate, for treatment of a medical condition.

## TIER 4 Brand Non-Formulary

Covered drugs that are not included in the formulary listing. You may obtain non-formulary brand-name drugs with a higher pharmacy copayment.

## TIER 5 Specialty Drugs

Specialty drugs are generally injectable, high-cost medications, which you may obtain through our specialty pharmacy, unless administered by a PHP network provider.

## Maximize the Pharmacy Benefit

Sometimes it's possible to swap a prescription for an over-the-counter drug, a great way to save dollars. Staying on top of need-to-know prescription information can also save money. But it can also save a life by preventing medical mix-ups. Tips for avoiding serious side effects and overdosing are included with prescription drugs.