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Introduction

Coventry Health Care of Georgia is committed to working with your office staff toward the success of both the provider practices and the plan.

Welcome! The goal of Coventry Health Care of Georgia, Inc. is to develop and sustain strong, mutually-beneficial relationships with our providers and their office staff. We encourage your active participation in the Health Plan and appreciate your comments. By working together, we create a unique team of people working together to deliver the most appropriate health care in the most cost efficient manner. We share a common goal of preserving the quality of care for patients who seek the benefits and preventive care of a managed care plan within traditional physician/patient relationships.

The purpose of this manual is to answer important questions about administering health care services to Coventry Health Care Members. This manual is referenced as part of the Provider Agreement between you and Coventry Health Care. The manual describes administrative policies and procedures, as well as other pertinent information.

From time to time, it will be necessary to update this manual. When this happens, you will receive replacement pages, along with an explanation of the changes. You will also receive periodic fax blast updates, which will provide you with valuable information. Please add those updates to the back of this manual for future reference.
Overview of Coventry Health Care

Coventry Health Care was formed in April 1998 by combing the staff, resources, and expertise of Coventry Corporation and Principal Health Care, Inc. Coventry Health Care is a public, multi-regional managed care company with health plans located throughout the Midwest, Mid-Atlantic, and Southeast. It is headquartered in Bethesda, MD. Coventry is traded on the New York Stock Exchange under the symbol CVH. In 2005, Coventry purchased First Health and CCN which made the company nationwide. In 2013, Coventry was acquired by Aetna.

Traditional HMO Products
Point-of-Service Products
Open Access Products
Preferred Provider Organization (PPO) Products
Leased Networks
Automobile Insurance Managed Care
Workers' Compensation Product
Medicare Advantage
Medicaid Products
Managed Care Provider Networks

This manual is specific to Coventry Health Care of Georgia, Inc. The provider manuals for the other product lines can be found on their respective websites.

Coventry Health Care has extensive experiences in group medical benefits and a proven record of leadership in plan design and administration. Its core management team is composed of individuals who average approximately 20 years of experience in the managed care industry.

Coventry Health Care of Georgia’s service area is comprised of over 90 counties in the state of Georgia. These counties are located in the following major areas:

- Greater Atlanta
- Augusta
- Brunswick
- Columbus
- Macon
- Savannah
- Valdosta
Who to Contact for More Information

<table>
<thead>
<tr>
<th>Company</th>
<th>Website</th>
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<tbody>
<tr>
<td>Coventry Health Care</td>
<td><a href="http://www.coventryhealthcare.com">www.coventryhealthcare.com</a></td>
</tr>
<tr>
<td>Coventry Health Care of Georgia</td>
<td><a href="http://www.chcga.com">www.chcga.com</a></td>
</tr>
<tr>
<td>Coventry Health Care Provider Portal</td>
<td><a href="http://www.directprovider.com">www.directprovider.com</a></td>
</tr>
<tr>
<td>Coventry National Network</td>
<td><a href="http://www.coventrynational.com">www.coventrynational.com</a></td>
</tr>
<tr>
<td>First Health</td>
<td><a href="http://www.firsthealth.com">www.firsthealth.com</a></td>
</tr>
<tr>
<td>Coventry Workers’ Comp Services</td>
<td><a href="http://www.coventrywcs.com">www.coventrywcs.com</a></td>
</tr>
<tr>
<td>Coventry Auto Solutions</td>
<td><a href="http://www.chcautosolutions.coventryhealthcare.com">www.chcautosolutions.coventryhealthcare.com</a></td>
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Coventry Health Care of Georgia  
Contact Information

<table>
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<tr>
<th>Department</th>
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<tr>
<td>Customer Service</td>
<td>(800) 395-2545</td>
<td>Benefits/ Eligibility inquiries</td>
</tr>
<tr>
<td>Group Members</td>
<td>(866) 364-5663</td>
<td>Claims inquiries</td>
</tr>
<tr>
<td>Individual Members</td>
<td>(866) 341-0359</td>
<td>Authorization inquiries</td>
</tr>
<tr>
<td>Health Services</td>
<td>(800) 470-2004</td>
<td>Prior authorization requests</td>
</tr>
<tr>
<td>(678) 202-2100</td>
<td></td>
<td>Concurrent Review</td>
</tr>
<tr>
<td>(866) 599-3720 fax</td>
<td></td>
<td>Discharge planning</td>
</tr>
<tr>
<td>Pharmacy Precertification</td>
<td>(877) 215-4101</td>
<td>Pharmacy authorization</td>
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<tr>
<td>(877) 554-9137 fax</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider Relations</td>
<td>(800) 470-2004</td>
<td>Provider participation questions including</td>
</tr>
<tr>
<td></td>
<td>(678) 202-2100</td>
<td>reimbursement and contracts.</td>
</tr>
<tr>
<td></td>
<td>(866) 341-0359 fax</td>
<td></td>
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Always confirm the mailing address for claims on the back of the Member identification card. Some products may have an alternate address and phone number.

Coventry Health Care of Georgia Inc.

P.O. Box 7711

London, KY 40742

Electronic Payor Number: 25133

Mail appeals to:

Appeals Department

Coventry Health Care of Georgia, Inc.

1100 Circle 75 Parkway

Suite 1400

Atlanta, GA 30339

For updates on the status of an appeal, please contact Customer Service at (800) 395-2545.

Mail all correspondence other than claims to:

Coventry Health Care of Georgia, Inc.

1100 Circle 75 Parkway

Suite 1400

Atlanta, GA 30339
Coventry National & First Health Network

Contact Information

For any questions related to the status of receipt or payment of a claim call the payor-specific billing telephone number listed on the patient's benefit card. For any questions about how the claim was paid according to your contract, please call Coventry National Provider Services at 1-800-937-6824.

Please refer to Member identification card for customer service preauthorization and claims information.

Provider participation and contract questions are handled by Provider Relations out of Coventry Health Care of Georgia office.

(800) 470-2004 extension 2501

(866) 341-0359 fax number
Administrative Procedures

This section details administrative procedures of the Coventry Health Care of Georgia, Inc. health maintenance organization (HMO), point of service (POS) and open access plans.

Participating Providers

Participating providers include those physicians, hospitals, skilled nursing facilities, urgent care centers or other duly licensed institutions or health professionals that have a contract with Coventry Health Care of Georgia. In order for a Member in an HMO plan to be eligible for covered services, participating providers must be utilized unless non-participating providers are specifically authorized by CHC before services are rendered. Point of Service (POS) products allow the Member to receive covered services from non-participating providers usually with higher Member responsibility.

Please be aware that our Directory is subject to change. You should verify the participation status of a provider with Customer Service or via the web before referring a patient. They can be reached at (800) 395-2545 or www.chcga.com.
Member Identification

All Coventry Health Care of Georgia Members, including minor dependent children, receive a CHC identification card shortly after enrollment. Members must present their card to their Provider at the time services are rendered. If the Member is a recent enrollee who has not yet received a card, he/she must present a copy of the enrollment form. The ID card will list the Member’s name, Member number, PCP if required, group name and number, the benefit plan type, as well as copayments or coinsurance for office visits, prescriptions, outpatient and inpatient services. Benefits vary among our different product lines. Therefore, it is important to reference the Member ID card for the correct copayment or coinsurance amount. The ID card will also contain important Customer Service phone numbers for CHC, our Pharmacy Vendor, and our Mental Health Vendor.

To verify a Member’s eligibility:

Check the Member’s ID card, enrollment form, or other identification card. Please note that the last two digits in the ID number indicate whether the Member is a subscriber (01), spouse (02), or dependent (03 – 99). Eligibility can then be confirmed by calling Customer Service or by logging onto www.directprovider.com. For capitated providers, you can refer to your Membership/Capitation Report as well.

How to Read a Coventry Health Care of Georgia Identification Card

When you receive an identification card, there are four key areas to look at to determine what type of benefit plan that the Member has. Those key items are:

Logo(s)- The Logo tells you the network which the Member is accessing.
Look for the Coventry Health Care of Georgia Logo

An identification card does not guarantee that the patient is eligible for services. Therefore, verifying the Member’s eligibility is essential.
The Coventry Health and Life Logo

is used for Coventry’s insured PPO products. When you see this logo, you will also see a corresponding network logo of Coventry National Network

which represents the network contracts that the Member is accessing.

**Plan Type**- The plan type refers to the type of benefit plan that the Member has (HMO, POS, Open Access).

**PCP Name**- The Member’s PCP’s name will be displayed in this field. If the Member’s benefit plan is one of our Open Access Plans, which does not require a PCP, this field will state “Open Access No PCP” or the PCP field will not be on the card.

**Network Type**- The network type refers to network that the Member is accessing. Options that you may see are as follows: “PCP required” meaning that the plan is a HMO plan with a PCP; “Open Access” meaning that the plan is Open Access with no PCP required; “Coventry” meaning that the Member is a Coventry National PPO Member.

**Member Responsibility Section (Copay)**- This section will show the Member’s responsibility at the time of service. You may see different columns representing In-network versus Non-Network levels of benefit. Refer to the ASO section for details on the columns on those cards.
HMO Card

Open Access HMO Card

Open Access POS Card

Coventry Health and Life PPO Card

High Performance Plan Design

Individual Open Access- Coventry One
ASO RELATIONSHIPS

Coventry Health Care of Georgia provides the administration of several self-funded benefit plans. These administrative services only (ASO) accounts access our Coventry Health Care of Georgia HMO/POS network with a few exceptions or steerage guidelines. Please contact Customer Service for coverage and network information. The Members of ASO accounts which access the Coventry Health Care of Georgia HMO/POS network will have the Coventry Health Care of Georgia logo on their card.

The following are sample cards for some of our ASO clients and does not represent all ASO relationships. Please contact the Customer Service number on the back of the card for more information.

Gwinnett Health System
Southern Regional Health System

Government Employee Health Association (GEHA)

Other product lines such as First Health, Auto, and Workers’ Comp will have differing logos and rules surrounding member identification. Refer to directprovider.com or their respective websites and provider manuals for more information.

Copayment/ Deductible/ Coinsurance Collection

Members are responsible for paying copayments to participating providers at the time of service. Each Member’s ID card indicates the amount of the copayment required. The Member is responsible for only one copayment per office visit and you may collect only one copayment per Member per day. When you submit your claim, do not subtract the copayment from the patient’s bill. CHC will subtract this amount from the final bill.

- Coventry Health Care of Georgia applies the Threshold copay logic to claims. This logic means that an office visit copayment should be collected for all visits to the provider’s office if you are billing for those services.
A copayment should not be collected when a Member has a visit for follow-up care that is included in the global fee for a procedure or situation. Prenatal visits only require one initial copayment.

Many benefit plans carry coinsurance and deductible charges along with copayments. When you see patients with these types of benefits, the amounts for which the Member is liable will appear on the remittance advice.

CHC also has benefit plans which include a Health Reimbursement Arrangement (HRA) and/or a Flexible Spending Account (FSA). For these Members, we ask that you verify their participation in these programs by checking their ID card and calling Customer Service. We also ask that you submit the claims directly to us prior to asking the Member for payment. We will process the claim and pay it from the Member’s HRA or FSA as applicable. If the Member owes a balance to you, we will send an Explanation of Benefits notifying you and the Member of the amount owed. We may also send you a payment directly out of the Members account for any Member responsibility. If you have already collected payment from the patient you may need to refund any overpayment. You may also send a bill to the Member with the amount due.

Under no circumstances should you charge the Member more than the copayment/ deductible/ coinsurance amount. CHC will pay you for covered services in accordance with your CHC provider contract. If payment is denied because you did not follow CHC procedures or for incorrect coding, you may not seek payment from the Member regardless of whether a waiver is signed by the Member.

You may bill a Member for non-covered services, if the Member has been notified in advance that CHC may not cover or continue to cover specific services and the Member chooses to receive the service. Nonetheless, you may not bill a Member if you do not follow CHC utilization management requirements. You may bill a Member for the following non-covered services:

- Examinations and immunizations required by a third party. Immunizations for travel.
- Procedures for cosmetic purposes.
- Experimental procedures as determined by CHC.
- Missed appointments that are not canceled in advance, if this type of payment is in accordance with your standard office policies.
• Routine foot care (except when covered for Members with diabetes or as specified in the benefit plan).

• Other services excluded from the Member’s benefit plan.

Changes in Practice Address or Status

Please notify CHC Provider Relations Department in writing within thirty (30) calendar days for any additions, deletions, or changes to the following. Failure to notify us timely could impact claims processing.

• Tax Identification number (submission of W-9 required)

• Office or Billing Address

• Telephone or Fax Number

• Specialty (may require additional credentialing)

• New physician additions to the practice (please allow time for credentialing)

• Licensure (DEA, DPS, state licensure, or malpractice insurance)

• Group Affiliation

• Hospital Privileges

• Adverse actions taken by a hospital, Board of Medical Examiners, Managed Care Organization, or other entity that is responsible to the National Practitioner Data Bank.

If you make any practice changes, written notification should be provided as far in advance as possible to the CHC Provider Relations Department prior to the change. By providing the information prior to the change, the following is ensured:

• The practice address is properly listed in the CHC directory.

• All payments made to the practice are properly reported to the IRS.

• There is no disruption in claims payments and claims are processed correctly according to the provider’s contract.
• CHC Members are notified in a timely manner to change their PCP if they so desire as a result of the change.
Benefit Plan Options

Coventry Health Care of Georgia offers a wide variety of benefit plan options for our Members to choose from. This section will assist you in determining the benefits of our Members.

Types of Benefit Plans

Our group coverage includes HMO, POS, and PPO plans, as well as consumer-directed options. Riders for vision, chiropractic, prescription coverage, and other options are available. Our consumer-directed plans -- Coventry Consumer Choice (C3) -- offer an array of deductible and personal health account (HSA, HRA, and FSA) choices. We also offer individual plans, as well as coverage for Medicare beneficiaries. The benefits provided and premium required depends upon the product and benefit plan selected. The product descriptions listed below are only summaries of benefits, exclusions and limitations. Please contact our Customer Service Department for a complete description of the Member’s benefits.

Coventry Health Care offers HMO options. While these plans are open access plans which do not require a Primary Care Physician (PCP) selection, we encourage Members to select one to assist in coordination of their health care. Members must receive services from Coventry Health Care of Georgia’s HMO/POS network. No out of network benefits are available. This product is subject to the standard CHC Precertification List.

Coventry Health Care offers several Point of Service (POS) benefit plans to its Members. While these plans are open access plans which do not require a Primary Care Physician (PCP) selection, we encourage Members to select one to assist in coordination of their health care. They have both in and out of network coverage within this plan. The in-network level of coverage is
where services are received from a provider in the Coventry Health Care of Georgia HMO/POS network. The out of network level of coverage occurs when the Member seeks services from a nonparticipating provider. These services will be paid according to our Out of Network Rate and subject to an additional deductible as well as coinsurance. Both levels are subject to the standard CHC Precertification List.

Coventry Health Care of Georgia offers a variety of Individual plans which are open access POS products designed for an individual or family. Our current POS offerings are marketed under the names CoventryOne POS and CoventryOne Fusion. The features of these products include a PCP copayment less than that of the Specialist copayment, fixed copayments for services such as urgent care and emergency room, and various levels of coinsurance for facility based services. Coventry also partners with Assurant Health to offer an open access POS product which accesses our Coventry Health Care of Georgia HMO/POS network.

Coventry Health Care of Georgia markets a PPO (preferred provider organization) product in areas outside of our HMO/POS Service Area. These plans are underwritten by Coventry Health and Life Insurance. They access the Coventry National Network. While the benefit structure is a PPO, most plan procedures will work the same way as those of the HMO/POS. Your office must be participating with the network identified on the card to provide in-network benefits.

These types of plans offer financial advantages, including pre-tax payroll deductions and tax-free employer contributions. In some cases, members' accounts can grow when they carry funds over from year to year. Employers may offer one or more of these types of plans: health reimbursement arrangements, flexible spending accounts, and health savings accounts. Each of these plans will have one of the product types described above as the base benefit plan. Members who purchased individual coverage may also choose from some of our C3 products.

Coventry Health Care of Georgia administers several benefit plans funded by employer groups. These ASO (administrative services only) plans have benefits, networks and guidelines that will vary based on the employer's discretion. Under these plans, the employer, not CHC has the ultimate payment responsibility to the provider. To see if you participate in each of these plans, please contact Provider Relations. To get more information about these benefit plans or for specific Member information, please contact Customer Service.
Coventry contracts with several ancillary providers for supplemental benefits such as dental, mental health, pharmacy, chiropractic, and vision.

**Dental**

Our benefit plans exclude coverage for dental care services unless the services are provided under a supplemental benefit rider. The only exception to this exclusion is coverage for emergency services after an accident for a period of twenty-four hours following the accident. Coventry offers dental policies to complement medical coverage to groups and individuals. These policies are also available as separate stand alone benefit options.

**Mental Health/ Substance Abuse Services**

MHNet Behavioral Health administers mental health and substance abuse services for Coventry’s members. If you have questions about these services, call (800) 752-7242. Some mental health and substance abuse services require prior authorization. Not all members have mental health and substance abuse coverage. Members must check their plan documents or call Customer Service to confirm they have mental health and substance abuse benefits.

**Pharmacy Services**

Express Scripts provides the administration of the drug benefit riders. All prescriptions must be filled at a participating pharmacy. Questions regarding general pharmacy benefits should be directed to Customer Service at (800) 395-2545. Questions regarding pharmacy benefits and pharmacy and drug coverage should be directed to Medco Customer Service at (800) 378-7040. All drug prior authorization requests should be directed to (877) 215-4100.

If a Member ID card does not list Express Scripts, then Coventry Health Care does not provide pharmacy benefits for the group. Coventry Health Care maintains one drug formulary for all HMO, POS and PPO members and separate formularies for all the Medicare Advantage plan options. These formularies are developed in conjunction with the Coventry Health Care Pharmacy and Therapeutics (P&T) Committee to assist providers in prescribing cost-effective, quality drug therapy. The appropriate Coventry Health Care formulary shall be used for Coventry Health Care member’s prescriptions. The formularies contain convenient cost comparison guides for several drugs within therapeutic categories. When writing a prescription for a Coventry Health Care member, please consider those medications that are covered under the appropriate formulary. Products are accessible in a tiered copay arrangement. Copays may vary depending on the product tier. Coventry Health Care’s formularies can be found at www.chcga.com, or you may contact your provider relations representative for a copy.
Generic Drug Policy

Generic substitution is mandatory if the FDA has determined the generic to be therapeutically equivalent to the brand product. These medications are noted in the formulary. These drugs are covered at a generic reimbursement level and maximum allowable cost (MAC) limits of reimbursement have been defined. If a provider indicates Dispense as Written or if a member insists on the brand-name for a medication listed on the MAC list, the member may incur the cost difference between the brand-name products and the MAC amount in addition to their copay. For medications that have a very narrow therapeutic window, generic substitution is not required. Examples include anticonvulsants (Dilantin® and Tegretol®), Coumadin®, Lanoxin®, Procanbid® and theophylline sustained-release products.

Prior Authorization

To promote appropriate utilization, selected high-risk or high-cost medications may require prior authorization to be eligible for coverage under the member's prescription benefit. These drugs are designated in the formulary by prior authorization required. Prior authorization criteria have been established by the Coventry P&T Committee. In order for a member to receive coverage for a medication requiring prior authorization, the provider or pharmacist can call the Pharmacy Department at 877-215-4100. In addition, you may fax your request to 877-554-9137 on one of the Prior Authorization Request forms. Forms can be found on Coventry Health Care's website (www.chcgca.com). If your request does not have a specific form, please use the form that states Non-Formulary General and fill in the medication that you are requesting. These forms may be duplicated as often as needed.

Quantity Limits

Quantity limits on medications are established for various reasons. Some medications have either a maximum limit recommended by the FDA or a maximum dose suggested by the medical literature. Many commonly used once daily drugs have limits since these drugs are proven to be safe and effective when taken once daily. Secondly, taking two pills daily instead of one pill of equal strength may double the cost of therapy without necessarily improving the benefit. Other drugs are on the list as a safeguard to make sure that members do not receive a prescription for a quantity that exceeds recommended dosage limits.

Vision Services
Coverage and network for routine eye exams is determined by a Member’s benefit plan.

Providers contracted directly with Coventry (optometrists or ophthalmologists) cannot perform routine vision services unless they are part of the members vision network. These providers can only provide services for disease or injury to the eye.

**Chiropractic Coverage**

Member may have chiropractic coverage and should consult their plan documents or call Customer Service to verify. Annual visit limits apply. These services should be provided by our contracted chiropractic vendor, ActivHealthCare. To determine providers who are participating with ActivHealthCare, please refer to their website at www.activhealthcare.com.
Primary Care Physicians

This section details the responsibilities of the primary care physicians, and explains how Members are transferred, as well as the procedure for closing and reopening patient panels.

Primary care physicians are defined as physicians who specialize in Family Practice, Internal Medicine, Pediatrics, or General Practice. The primary care physician (PCP) provides or coordinates all aspects of the Member’s health care. Primary care physicians must never discriminate or differentiate in the delivery of healthcare services based on race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, or source of payment.

Responsibilities

The responsibilities of primary care physicians include:

- Providing primary care services to Members
- Maintaining medical records for Members
- Coordinating all aspects of Members’ health care
• Obtaining precertification through the CHC Health Services Department for certain health care services as specified in the Precertification/Authorization Section of this manual

• Using designated participating laboratory, hospital and other ancillary providers and pharmacy services

• Submitting general medical information required by HEDIS (Health Plan Employer Data Information Set) upon request of the plan

• Ensuring the Member has the opportunity to fully participate in all treatment decisions related to their health care

• Providing 24-hour coverage so that health care services are available to Members in the primary care physician’s absence

• Meeting the credentialing/recredentialing requirements of Coventry Health Care of Georgia, Inc.

• Following Utilization Management/Quality Management guidelines and adhering to Coventry Health Care policy and procedure

• Notifying Coventry Health Care of changes in address, licenses, liability insurance, or any other issue which could affect his or her ability to effectively render medical care.

• You must keep our members’ information confidential and stored securely. You must also ensure your staff members receive periodic training on member information confidentiality. Only authorized personnel should have access to medical records.

• We use practitioner/provider performance data to improve the quality of service and clinical care our members receive. Accrediting agencies require that you let us use your performance data for this purpose.

• Coventry established medical record criteria to provide a guideline for fundamental elements of organization, documentation of diagnostic procedures and treatment, communication and storage of medical records. These criteria are applicable to all benefits plans. Performance goals are established to assess the quality of medical record-keeping practices, and audits are conducted no less than every two years. Coventry’s performance goal is 85 percent compliance.
Coventry Health Care establishes office site standards for its practitioners. Coventry assesses the adequacy of the office site to include, but is not limited to, access and availability, safety, infection control, medical record keeping practices, and compliance with selected state requirements. Network Management follows up with sites which are not compliant with standards to ensure identified issues have been corrected. Here is a partial listing. For a complete listing of Coventry's office site standards please call your provider representative.

**Facility**

- The facility interior and exterior should be accessible with handicapped accessibility, clean, well-lit waiting room, adequate seating, posted office hours, safe environment, ensures privacy and appropriateness and availability of equipment

**Safety/Risk Management**

- The facility must have a plan and be prepared for office emergencies.

- If Medication is kept in the office, it must be stored under the appropriate conditions, stock updated regularly and has not expired, and all medications are kept in secure storage.

**Administration/Medical Recordkeeping**

- Medical records are HIPAA compliant, treated as confidential and kept in a secure/protected/confidential filing system with legible file markers if not electronic.

Coventry Health Care has developed standards for accessibility and availability of primary care physicians for Members.

Although there may be exceptional circumstances, every effort must be made to adhere to these standards.

- Minimum of 20 hours each week of regularly scheduled office hours for treatment of patients for a one-physician practice and minimum of 30 hours for a two or more physician practice

- Response time to urgent calls no greater than 30 minutes after notification
• Ability to accept a minimum of 250 new Members at the time of application

• No more than an average of five patients scheduled and seen each hour for routine office visits for adult medicine, and six for pediatrics

• Member waiting time for urgent care visits - same day or within 24 hours.

• Member waiting time for non-urgent/non-emergency, but symptomatic office visit- within 7 days.

• Member waiting time for a routine non-symptomatic office visit- within 7 days.

• Average office waiting time should be no more than thirty (30) minutes from the appointed time before medical personnel see the patient.

• After hours care: each primary care physician must have a reliable 24 hours a day/7 days a week answering service or machine with a beeper or paging system. A recorded message or answering service that refers members to emergency rooms is not acceptable.

CHC performs surveys to ensure providers meet the above standards. If the above standards are not met, we send a letter to the provider asking for a corrective action plan.

Primary care physicians must be available to Members 24 hours a day, 7 days a week. When the primary care physician is unavailable, coverage should be arranged through a Coventry Health Care physician. A taped telephone message directing patients to the emergency room is not acceptable as an alternative to arranging for coverage by another physician.

The covering physician should report calls and services to the Member’s primary care physician in the usual manner.

Covering physicians, whether participating or not, must adhere to all administrative requirements and agree to not bill the Member for services other than copay. When arrangements are made with non-participating covering physicians, the primary care physician is responsible for securing a signed Covering Physician Agreement.
When a covering physician sends a claim to CHC, covered services will be reimbursed at the rate contracted with the primary care physician at the time services were rendered.

Physicians should always consider Member input in the proposed treatment plan. It is the right of enrollees to be represented by parents, guardians, family Members or other conservators for those who are unable to fully participate in their treatment decisions. Physicians are expected to educate Members regarding their health needs, share findings of history and physician examinations, discuss potential options (without regard to plan coverage), side effects of treatment and management of symptoms; and recognize the Member has the final course of action among clinically accepted choices.

Primary care physicians are responsible for billing the following claims procedures:

- Collecting applicable copayments, coinsurance, and deductibles from Members, and ensuring Members are not balanced billed for covered services.

- Submitting claims or encounter data using HCFA 1500 forms with current CPT-4, HCPCS, and ICD-9 codes or their successors. Claims submitted more than 90 days following the date of service will be denied, unless the claim was returned for further information.

Patient encounter reports from primary care physicians provide CHC with valuable information about the HMO's quality of care and utilization of services. This aggregate information is used to track data according to HEDIS methodology and continuously improves service and quality of care to Members. Primary care physicians are required to submit patient encounter information for all services.

Coordination of care between the Primary Care Physician (PCP) and the Behavioral Health Care Practitioners (BHP) is critical to the well being of the patient.

Coventry Health Care, Inc. uses a variety of mechanisms to monitor continuity and coordination of care between behavioral health and medical care. Coventry works collaboratively with MHNet for the administration, management and monitoring the quality of behavioral health services for members.
Some of the indicators that Coventry may look at on an annual basis are the exchange of information between behavioral healthcare and primary care physicians; the appropriate diagnosis, treatment and referral of behavioral healthcare disorders commonly seen in primary care; the appropriate use of psychopharmacological medications; management of treatment access and follow-up for members with coexisting medical and behavioral disorders; and primary or secondary preventive behavioral healthcare program implementation.

At CHC, we encourage members to receive preventive care services. The Affordable Care Act (ACA) provides for specific preventive services and specific drugs when provided by participating providers to be covered at 100 percent of your contracted rate.

**Coverage for Preventive Services**

Here are some examples of the preventive services that will be covered with no copay, coinsurance or deductible when billed with the appropriate preventive diagnosis codes.

<table>
<thead>
<tr>
<th>Child Preventive</th>
<th>Adult Preventive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exams: Preventive office visits including well child care</td>
<td>Exams: Preventive office visits including well woman exam</td>
</tr>
<tr>
<td>Immunizations:</td>
<td>Immunizations:</td>
</tr>
<tr>
<td>Influenza (flu)</td>
<td>Influenza (flu)</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>Pneumonia</td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>Hepatitis A</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>Hepatitis B</td>
</tr>
<tr>
<td>Diptheria, Tetanus, Pertussis</td>
<td>Diptheria, Tetanus, Pertussis</td>
</tr>
<tr>
<td>Varicella (chicken pox)</td>
<td>Varicella (chicken pox)</td>
</tr>
<tr>
<td>Measles, Mumps, Rubella (MMR)</td>
<td>Measles, Mumps, Rubella (MMR)</td>
</tr>
<tr>
<td>Polio</td>
<td>Polio</td>
</tr>
<tr>
<td>Rotavirus</td>
<td>Rotavirus</td>
</tr>
<tr>
<td>Meningococcal</td>
<td>Meningococcal</td>
</tr>
<tr>
<td>Human Papillomavirus (HPV)</td>
<td></td>
</tr>
<tr>
<td><strong>Screening Tests:</strong> Hearing screening, Eye chart screening, PKU screening (newborns), Sickle cell screening (newborns)</td>
<td><strong>Screening Tests:</strong> Breast cancer screening, Cervical cancer screening, Colorectal cancer screening, Prostate cancer screening, Bone density, Lipid panels, Abdominal aneurysm aortic screening, Screening for sexually transmitted diseases, HIV test, General and immunological labs, Routine blood and urine screenings</td>
</tr>
<tr>
<td><strong>Newborn Preventive Treatment:</strong> Gonorrhea treatment</td>
<td></td>
</tr>
</tbody>
</table>
The list is subject to change as federal guidance is issued.

**Coverage for Specific Drugs**

Here are the specific drugs that will be covered with no copay, coinsurance or deductible. Only the drugs on this list are covered at 100%. Members will need a prescription from their doctor to receive the 100% benefit. Members can fill the prescription at their pharmacy. The pharmacist should submit the claims directly to us.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Aspirin (over-the-counter)</strong></td>
<td>Dose 81 mg and 325 mg, men age 45 to 79 and women age 55 to 79.</td>
</tr>
<tr>
<td><strong>Iron (over-the-counter)</strong></td>
<td>Children up to age one, drops only.</td>
</tr>
<tr>
<td><strong>Folic Acid (over-the-counter)</strong></td>
<td>Dose: 400 mg and 800 mg, women.</td>
</tr>
<tr>
<td><strong>Flouride</strong></td>
<td>Children under the age of six, drops and chewable tablets only.</td>
</tr>
</tbody>
</table>

**Talking with Your Patients about Preventive Care**

We process claims based on your clinical assessment of the office visit. If a preventive item or service is billed separately, member cost-sharing may apply to the patient’s office visit. If the primary reason for your patient’s visit is seeking treatment for an illness or condition, and preventive care is administered during the same visit, member cost-sharing may apply. You may ask a member to pay the appropriate health plan copay, deductible or coinsurance.

Certain screening services, such as a colonoscopy or mammogram, may identify health conditions that require further testing or treatment. If a condition is identified through a preventive screening, any subsequent testing, diagnosis, analysis or treatment are not considered preventive services and are subject to the appropriate cost-sharing.

Coventry adopts evidence-based clinical practice guidelines from nationally-recognized sources. These guidelines have been adopted to promote consistent application of evidence-based treatment methodologies and made available to practitioners to facilitate improvement of health care and reduce unnecessary variations in care. Coventry reviews the CPG’s every two years or more frequently if national guidelines change within the two-year period. You will be advised of updates in the provider newsletter. To request a copy of the Clinical Practice Guidelines, please contact Coventry or go to [CLINICAL PRACTICE GUIDELINES](#)

The CPGs are provided for informational purposes only and are not intended to direct individual treatment decisions. All patient care and related decisions are the sole responsibility of providers. These guidelines do not dictate or control a provider's clinical judgment regarding the appropriate treatment of a patient in any given case.

Preventive Health Guidelines

A review of the medical literature is performed to establish the scientific basis for the preventive health guidelines. The guidelines are reviewed every two years or as new information becomes available. It is important to realize that these recommendations are intended to establish an acceptable level of preventive care. A full list of the most current screening recommendations can be found on the U.S. Preventive Services Task Force (USPSTF) website at http://www.ahrq.gov/clinic/uspstf.htm. Vaccine schedules change often. The most current recommendations for vaccines can be found on the Centers for Disease Control and Prevention (CDC) website at http://www.cdc.gov/vaccines. A catch-up vaccine schedule is also available at the CDC website for children who have fallen behind or started late. Providers must use their own judgment in the care of individual members. These guidelines are available on the Coventry Health Care website at www.chcga.com > Services and Support > Providers > Document Library > Preventive Health Guidelines.

Member lists are available upon request for capitated providers. Contact Provider Relations at (678) 202-2100, ext 2501 or (800) 470-2004, ext. 2501.

Patient Panel

The size of your Member panel is limited only by your ability to provide services in accordance with CHC guidelines, appointment availability, and office accessibility. You must give the Provider Relations Department at least ninety (90) days prior written notice if you do not want to accept additional CHC Members on your panel. Once a panel is closed, any Member who is not already an established patient cannot select that physician as his or her primary care physician. Physicians will not be able to close their panel to CHC Members as long as their panel is open to other health plans.

A PCP can reopen a closed panel by submitting a request in writing to the Provider Relations Department. The change will be made on the first day of the month following submission of the request.
Specialist Physicians

Unlike a primary care physician, a specialist is usually not the first provider from whom the Member seeks care. This section discusses the responsibilities of the specialist and provides specific information for some specialties.

Specialists provide covered services to Members that have been referred from their primary care physician or via self referral. Contact with the PCP is encouraged throughout the specialist’s treatment of the Member.

Responsibilities

The responsibilities of the Specialist physician include:

- Providing the requested specialty services
- Working closely with the PCP to enhance continuity of medical care and providing written recommendations on the appropriate treatment program
- Obtaining precertification through the CHC Health Services Department for certain health care services as specified in the Precertification/Authorization Section of this manual
- Complying with CHC Quality Improvement Program policies and procedures
- Using designated participating laboratory, hospital and other ancillary providers and pharmacy services
- Complying with all of CHC policies and procedures

- Submitting general medical information required by HEDIS (Health Plan Employer Data Information Set) upon request of the plan

- Ensuring the Member has the opportunity to fully participate in all treatment decisions related to their health care

- Meet all of the CHC credentialing and recredentialing requirements

- You must keep our members' information confidential and stored securely. You must also ensure your staff members receive periodic training on member information confidentiality. Only authorized personnel should have access to medical records.

- We use practitioner/provider performance data to improve the quality of service and clinical care our members receive. Accrediting agencies require that you let us use your performance data for this purpose.

Coventry Health Care establishes office site standards for its practitioners. Coventry assesses the adequacy of the office site to include, but is not limited to, access and availability, safety, infection control, medical record keeping practices, and compliance with selected state requirements. Network Management follows up with sites which are not compliant with standards to ensure identified issues have been corrected. Here is a partial listing. For a complete listing of Coventry’s office site standards please call your provider representative.

### Facility

- The facility interior and exterior should be accessible with handicapped accessibility, clean, well-lit waiting room, adequate seating, posted office hours, safe environment, ensures privacy and appropriateness and availability of equipment

### Safety/ Risk Management

- The facility must have a plan and be prepared for office emergencies.

- If Medication is kept in the office, it must be stored under the appropriate conditions, stock updated regularly and has not expired, and all medications are kept in secure storage.
Administration/ Medical Recordkeeping

- Medical records are HIPAA compliant, treated as confidential and kept in a secure/protected/confidential filing system with legible file markers if not electronic.

The specialist’s appointment availability for Members should comply with the following standards, as appropriate for the presenting complaint/condition:

- Minimum of 20 hours each week of regularly scheduled office hours for treatment of patients for a one-physician practice and minimum of 30 hours for a two or more physician practice

- Response time to urgent calls no greater than 30 minutes after notification

- No more than an average of five patients scheduled and seen each hour for routine office visits for adult medicine, and six for pediatrics

- Member waiting time for urgent care visits - same day

- Member waiting time for non-urgent/ non-emergency, but symptomatic office visit - not more than one week

- Member waiting time for a routine non-symptomatic office visit - not more than one month

- Must be available and accessible twenty-four (24) hours/day, seven (7) days/week. Coverage must be arranged if you are not available and the covering physician should be a CHC participating provider. A taped telephone message directing patients to the emergency room is not acceptable as an alternative to arranging for coverage by another physician.

- Average office waiting time should be no more than thirty (30) minutes from the appointed time before medical personnel see the patient.

CHC performs surveys to ensure providers meet the above standards. If the above standards are not met, we send a letter to the provider asking for a corrective action plan.
CHC has adopted the policy of open access to specialists. This means that the Member's PCP may direct the Member to see a certain specialist but no prior notification to the Plan is required or the Member may self refer to any participating specialist. Therefore, referral numbers are not given nor required. If the services requested require precertification, an authorization number will still be needed and should be obtained through Health Services.

In accordance with State regulations, Coventry Health Care does not require its Members to obtain a referral from their primary care physician as a condition of coverage for services rendered from a participating OB/GYN, Ophthalmologist or Dermatologist. To ensure compliance with this law, we request that primary care physicians do not place any barriers to their patients requesting access to these providers.

Physicians should always consider Member input in the proposed treatment plan. It is the right of enrollees to be represented by parents, guardians, family Members or other conservators for those who are unable to fully participate in their treatment decisions. Physician is expected to educate Members regarding their health needs, share findings of history and physician examinations, discuss potential options (without regard to plan coverage), side effects of treatment and management of symptoms; and recognize the Member has the final course of action among clinically accepted choices.

Specialists are responsible for the following billing and claims procedures:

- Collecting only applicable copayments, coinsurance, and deductibles from Members, and ensuring Members are not balance billed for covered services.

- Submitting claims or encounter data using HCFA 1500 forms with current CPT-4, HCPCS, and ICD-9 codes or their successors. Any claim submitted more than ninety (90) days following date of service will be denied, unless the claim was returned for further information.

Specialists are responsible for submitting a Consultation Report to the referring primary care physician. The report must include the following:

- Description of Services
- Clinical Impressions
- Recommended treatment
Specialists may initially give this report to the referring primary care physician verbally. However, we request that a written report also be sent to the referring primary care physician.

Specialist must never discriminate or differentiate in the delivery of healthcare services based on race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, or source of payment.

The Obstetrician (OB) does not need to notify Coventry Health Care at the time of the pregnant Member’s initial office visit.

**Billing and Reimbursement for Maternity Claims**

The OB should not submit any claims until after the delivery of the newborn, or the care is transferred to another OB. The OB should submit all prenatal services, ancillary services, delivery of newborn, and other services on a HCFA 1500 form. CHC will reimburse the physician under a global OB fee. The global fee reimburses the physician for all provided professional services beginning from the initial office visit, to prenatal and postnatal phases of the pregnancy. Most benefit plans contain an initial copayment to be paid to the provider. For all additional maternity visits, no copayment will be due from the Member.

The standard global OB fee includes the following and is therefore not reimbursed separately:

- Initial Office visit, physical and prenatal profile
- Prenatal visits for obstetrical related problems and routine care
- Labs including venipuncture and specimen handling
- Labor and delivery charges
- Monitoring
- Induction of labor
- Local and regional anesthesia
- Hospital visits for “checks”
- Episiotomy and repair
- Forceps at delivery
- In-hospital care for mother
• Post-partum care following discharge up to 6 weeks, excluding surgical complications
• All Ultrasounds
• All Stress and Non-stress Tests
• Alpha-feto protein

The following are reimbursed outside of the global fee:
• Rhogam (Injection charge is included in global fee)
• Amniocentesis
• Cordocentesis
• Chorionic villus sampling
• Hysterectomy after C-section delivery
• Tubal Ligation following delivery

In the cases involving one of the following diagnoses, all ultrasounds and stress tests are also reimbursed in addition to the global fee:

• Multiple gestation
• Preterm labor
• Excessive vomiting
• Hypertension
• Hemorrhage
• Patients with certain co-morbidities
• Problems associated with amniotic cavity and membranes
• Problems associated with placenta

OB Patient Transfers

For Members who switch OB’s during the course of a pregnancy, CHC follows the CPT code guidelines so each OB should bill according to the services that they provide. Reimbursement will not exceed the global OB case rate.
Amniocentesis

Coventry Health Care will provide coverage for medically necessary amniocentesis. Test performed purely for gender determination is not a covered procedure.

Home Uterine Monitoring

Home Uterine Monitoring is a covered benefit when authorized by the Health Service Department and approved by the Medical Director.

Reproductive Endocrinology Services

Coventry only covers infertility services subject to the terms and conditions of each Member’s benefit package.

Postpartum Check Up

Coventry strongly encourages you to make sure that all postpartum checkups are scheduled within 21 to 56 days after delivery. We request that you bill for the services rendered to capture the encounter data for HEDIS reporting and to prevent medical records requests.

Well Woman Exams

Female Members are encouraged to undergo a well-woman examination (GYN) once a year by a participating gynecologist or primary care physician.

The Well Woman Exam consists of the following:

- History and Physical examination
- Pelvic and Breast examination
- Pap Smear and interpretation
- UA/ Hemoglobin Test
- Mammogram (done at a participating facility)

Well woman exams should be billed using appropriate CPT codes and diagnosis codes.

Breast Cancer Screening
The effectiveness of clinical examination of the breast and mammography screening in the detection of breast cancer in women has been convincingly demonstrated. Coventry Health Care encourages Members to adhere to the breast cancer screening recommendations which follow:

<table>
<thead>
<tr>
<th>Age of Member</th>
<th>Clinical Exam of Breast</th>
<th>Mammography</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ages 35-40</td>
<td>Every 1-3 years</td>
<td>Baseline</td>
</tr>
<tr>
<td>Ages 40-49+</td>
<td>Annual</td>
<td>Every 1-2 Years</td>
</tr>
</tbody>
</table>

Cervical Cancer Screening

Early detection of cervical cancer, through the use of routine Pap Smear testing and treatment, can lower mortality. CHC recommends that all women who are, or who have been sexually active or have reached age 18, should have an annual Pap test and pelvic examination. After a woman has had three or more consecutive satisfactory normal examinations, the Pap test may be performed less frequently at the discretion of her physician. CHC covers the standard Pap smear or the Thin Prep but both must be sent to our participating laboratory for processing.

The Clinical Practice Guidelines listed below are evidence-based processes, procedures, and methodologies determined to be the most currently recognized practices to follow in treating and managing patients with specific diseases and illnesses. Published by professional specialty groups, these guidelines have been researched, reviewed, and recommended to our participating provider network by CHC. The guidelines are meant to assist you in the evaluation and treatment of your patients’ health, but are not intended to replace clinical judgment or create a mandatory course of action for all patients who experience a similar condition.

CHC promotes the U.S. Preventive Services Task Force (USPTF) evidence-based recommendations for clinical preventive services. The guidelines serve as recommendations for individuals at “normal risk”. Providers and members should work together to make decisions about which preventive services are most appropriate for individual members. These preventive health guidelines do not reflect reimbursement or payment practices. The clinical practice guidelines and preventive health guidelines can be found on our website www.chcga.com. A hard copy of the guidelines is available to providers upon request. A provider can request a copy by contacting our Provider Relations department.
Facilities and Ancillary Providers

This section discusses the responsibilities of the facility or ancillary.

Facilities and Ancillaries are an important part of the CHC Provider Network which provides a wide variety of services including but not limited to Hospitals, Ambulatory Surgery Centers, Free Standing Imaging Centers, Home Health Agencies, Durable Medical Equipment Vendors, Dialysis Centers, and Therapy Providers.

Responsibilities

The responsibilities of the facility/ancillary include:

- Providing the requested specialty services
- Working closely with the ordering physician to enhance continuity of medical care
- Obtaining prior authorization through the CHC Health Services Department for certain health care services as specified in the Prior Authorization Section of this manual
- Notify CHC of an emergency hospital admission within twenty four (24) hours or next business day
- Complying with CHC Quality Improvement Program policies and procedures
• Complying with all of CHC policies and procedures

• Ensuring the Member has the opportunity to fully participate in all treatment decisions related to their health care

• Meet all of the CHC credentialing and recredentialing requirements

• Notify CHC of any changes in the following:
  o State Licensure
  o Accreditation Status
  o Ownership
  o Insurance coverage
  o Intent to add, limit or delete any facility or service

• You must keep our members' information confidential and stored securely. You must also ensure your staff members receive periodic training on member information confidentiality. Only authorized personnel should have access to medical records.

• We use practitioner/provider performance data to improve the quality of service and clinical care our members receive. Accrediting agencies require that you let us use your performance data for this purpose.

Facilities and Ancillaries should strongly encourage all hospital based providers such as radiologists, pathologists, anesthesiologist, emergency medicine, and hospitalists to contract with CHC to provide services to our Members. If a new hospital based group is joining your facility, notify CHC as soon as possible to allow CHC to contract with the group.

Providers should always consider Member input in the proposed treatment plan. It is the right of enrollees to be represented by parents, guardians, family Members or other conservators for those who are unable to fully participate in their treatment decisions. Provider is expected to educate Members regarding their health needs, share findings of history and physician examinations, discuss potential options (without regard to plan coverage), side effects of treatment and management of symptoms; and recognize the Member has the final course of action among clinically accepted choices.
Facilities and Ancillaries are responsible for the following billing and claims procedures:

- Collecting only applicable copayments, coinsurance, and deductibles from Members, and ensuring Members are not balance billed for covered services.

- Submitting claims or encounter data using UB 04 or HCFA 1500 forms with current Revenue, CPT-4, HCPCS, and ICD-9 codes or their successors.

- When billing on a UB, submit CPT codes along with revenue codes for radiology, pathology, surgery and any other services which are paid based on CPT according to the terms of your contract.

- When billing for DME, please include the appropriate modifiers to indicate rental (RR), used (UE), or purchase (NU).

- Interim bill is required for hospitalizations when member is hospitalized for greater than or equal to sixty (60) days.

- Payment methodology and rates which are in place on admission will be used to process claim.

To ensure appropriate payment for all services and address surgical procedures that did not get categorized in the final 2007 CMS ASC grouper crosswalk, Coventry has implemented a Coventry Enhanced Grouper (CEG) methodology that utilize an ASC 1-9 grouper payment arrangement.

To develop the first CEG release, Coventry’s clinical team used the current CMS APC relative weights to crosswalk new and previously unmapped surgical procedures to a grouper category. All services mapped in the final 2007 CMS grouper crosswalk remain in their final CMS designated category. The complete CEG crosswalk is available by logging on to www.directprovider.com.

Each year, Coventry’s clinical team will review all surgical procedures and evaluate their payment categories based on the amount and type of resources used and the current CMS APC relative weights. Annual updates will reflect additions, deletions and changes to the CPT/HCPCS codes.

Procedure codes which CMS does not classify as a surgery are not included in the CHC Enhanced Grouper logic including but not limited to certain...
pain management codes (64425, 64450) for example. These codes will be considered outpatient services and processed accordingly.
Coventry Health Care requires prior authorization for certain services. This section will outline those requirements.

Authorizations are required for all inpatient and some outpatient hospital admissions, certain medical, surgical, or diagnostic procedures and care by nonparticipating providers. The prior authorization list is updated periodically by Coventry Health Care. Please make sure an authorization for applicable services is issued prior to Members receiving the services unless it is an emergency. If you are unsure about a particular procedure or for more information, contact Customer Service or log onto www.directprovider.com for a code specific look up tool.

The physician ordering the care must contact CHC to obtain authorization prior to services being rendered. Specific medical information is required to determine medical necessity and the availability of benefits. The initial service authorized must be provided within 90 days from the date the authorization is given. In order to allow sufficient time for the authorization process, please contact CHC a minimum of five (5) working days prior to when the service is needed for elective, scheduled procedures and diagnostic testing. Failure to request an authorization prior to services rendered may result in claims being denied and Members can not be held liable for services denied for lack of authorization. Retro authorizations will not be approved.

Authorization request can be accepted through several methods including:

- Via phone call to our Health Services Department at (800) 470-2004
- Via faxed authorization form to Health Service Department (866) 599-3720
Health Services requires the caller to furnish the following information:

- Referring provider name and phone number
- Patient’s name and ID number
- Reason for referral and diagnosis
- Requested provider or facility (to whom the referral is being made)
- Date of referral appointment or procedure
- Specific services requested
- Clinical support for requested service

Please note additional clinical information may be required to be faxed in as required for review.

The clinical information provided and the plan of treatment will be evaluated and completed by the Preauthorization Nurse on average within three (3) working days of receipt of all necessary information to make a determination for elective procedures or testing. For urgent or emergent procedures or testing (life or limb threatening), the determination will be made within twenty-four (24) hours upon receipt of all clinical information. Evaluation using CHC approved criteria will be performed and a decision will be made on the requests. Please note that cases submitted via directprovider.com with all clinical information will be reviewed and completed on average in less than two (2) days.

Unless the patient has received prior authorization from CHC for out-of-network care, or is a Member of a plan with out-of-network benefits, all care must be received within the contracted provider network in order for services to be eligible for coverage. Should you refer a Member for care outside of the network without an authorization, you may be held responsible for the charges of the services rendered. Please call CHC to verify participation status of providers. Members who have out-of-network benefits may receive care from non-participating providers without an authorization at reduced levels of coverage. It is the Member’s responsibility to ensure an authorization is obtained for procedures that require prior authorization when obtaining them from out-of-network providers unless they are referred by a participating provider.
Coventry has adopted an open access model where Members can self refer to specialists. Coventry Health Care of Georgia still encourages primary care physicians to coordinate all aspects of a Member’s health care. Primary Care Physicians are encouraged to examine patients prior to referring them to a participating specialist. When referring a patient to a specialist, please follow these guidelines:

- A referral to a specialist can be given without notification to CHC. A note should be placed in the patient’s file and the specialist should indicate the referring physician when filing the claim.

- Should a telephonic referral be issued without the Member being seen, no fee may be charged by the physician.

- The HMO/POS Provider Directory, CHC of Georgia Website or Customer Service Department should be used when identifying specialists for referral within the network.

- Referrals do not guarantee payment. Reimbursement for services is subject to Member eligibility and benefit coverage at the time services are provided.

**Prior Authorization List**

Prior authorization is the approval of services by Coventry Health Care as medically necessary before the services are actually rendered. Prior authorization are required for the payment of claims for certain services.

Providers may be held responsible for the cost of services when prior authorization is required but not obtained. The Member may not be billed for the applicable services. Retroauthorizations are not covered.
Please note that authorization is not a guarantee of payment. This list is a
guide of what requires authorization for the business managed by CHC
and is not all-inclusive. For code-specific verification, log on to
www.directprovider.com. Please call the number on the back of the ID card if
you have questions regarding a member’s benefit plan coverage.

<table>
<thead>
<tr>
<th>Category</th>
<th>Details</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Care: All Admissions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Admissions</td>
<td>Acute hospital</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Acute rehab/facilities</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Skilled nursing facilities</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Transplants</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Maternity</td>
<td>Notification only</td>
</tr>
<tr>
<td><strong>Outpatient Care and Other Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advanced Radiology Services</td>
<td>Cardiac nuclear stress</td>
<td>ASO reviewed by Health Plan; all others refer to NIA*</td>
</tr>
<tr>
<td></td>
<td>Cardiac nuclear scans</td>
<td>ASO reviewed by Health Plan; all others refer to NIA*</td>
</tr>
<tr>
<td></td>
<td>Cardiac imaging studies</td>
<td>ASO reviewed by Health Plan; all others refer to NIA*</td>
</tr>
<tr>
<td></td>
<td>MRI/MRA</td>
<td>ASO reviewed by Health Plan; all others refer to NIA*</td>
</tr>
<tr>
<td></td>
<td>PET scans</td>
<td>ASO reviewed by Health Plan; all others refer to NIA*</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment</strong></td>
<td>All rental items</td>
<td>No auth required for oxygen</td>
</tr>
<tr>
<td></td>
<td>Individual purchase items over $1,000</td>
<td></td>
</tr>
<tr>
<td><strong>Prosthetic Devices</strong></td>
<td>Individual purchase items over $1,000</td>
<td></td>
</tr>
<tr>
<td>Medical Supplies</td>
<td>Individual purchase items over $1,000</td>
<td></td>
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<tr>
<td>------------------</td>
<td>-------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Plastic/Cosmetic Surgery</td>
<td>All plastic/cosmetic surgeries, such as but not limited to:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Abdominoplasty</td>
<td></td>
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<td>Blepharoplasty</td>
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<td>Breast procedures</td>
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<td>Ligation/sclerotherapy</td>
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<td>Other Services</td>
<td>Certain surgical procedures</td>
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<td>Chemotherapy Drugs</td>
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<td></td>
<td>Clinical trials</td>
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<td></td>
<td>Endoscopy – Camera</td>
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<td></td>
<td>Excision of lesion removal in non-office setting</td>
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<td>Experimental and investigational procedures</td>
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<td>Gastric bypass</td>
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<td></td>
<td>Genetic testing</td>
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<td>Home health</td>
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<td>Hospice</td>
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<td>Hyperbaric</td>
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<td>Injectable medications</td>
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<td>Molecular diagnostic testing</td>
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<td>New technology (T codes)</td>
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<td>Pain management procedures</td>
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<td>Pulmonary rehab</td>
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<td>Radiation therapy</td>
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<td>Sleep studies</td>
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<td>Spinal surgeries</td>
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<td></td>
<td>TMJ/oral maxillofacial procedures</td>
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</tbody>
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*See Triad box on following page for all non-ASO lines of business*

<table>
<thead>
<tr>
<th>HMO, POS, ASO, PPO</th>
<th>Medicare Advantra</th>
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<tbody>
<tr>
<td><a href="http://www.chcga.com">www.chcga.com</a></td>
<td><a href="http://www.ga.chcadvantra.com">www.ga.chcadvantra.com</a></td>
</tr>
<tr>
<td>MHNET</td>
<td>Coventry Pharmacy</td>
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<tr>
<td>Prior Authorization: 800-752-7242</td>
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<tr>
<td>Mental health/substance abuse inpatient and outpatient services</td>
<td></td>
</tr>
</tbody>
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<thead>
<tr>
<th>National Imaging Associates (NIA)</th>
<th>Triad Health Care</th>
</tr>
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<tbody>
<tr>
<td>Effective 9/1/12</td>
<td>Effective 11/1/12</td>
</tr>
<tr>
<td><a href="http://www.RadMD.com">www.RadMD.com</a></td>
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<tr>
<td>Outpatient Advanced Imaging Program</td>
<td>Interventional Pain Management Program</td>
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<tr>
<td>Authorization Required for:</td>
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</tr>
<tr>
<td>• CT/CTA</td>
<td>• Pain Management Injections</td>
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<tr>
<td>• CCTA</td>
<td>• Destruction of Neurolytic Agents</td>
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<tr>
<td>• MRI/MRA</td>
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<tr>
<td>• PET</td>
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<td>• Nuclear Cardiology/Nuclear Stress/MPI</td>
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<tr>
<td>• Stress Echo</td>
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<tr>
<td>Please refer to website for a complete listing of codes.</td>
<td>Please refer to website for a complete listing of codes.</td>
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</tbody>
</table>
Listed below are common injectable medications/infusions that require prior authorization. Please check coverage and authorization requirements on any new or not widely used medications.

<table>
<thead>
<tr>
<th>Common Medication/Infusion</th>
<th>Prior Authorization Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abatacept (Orencia)</td>
<td>Infliximab (Remicade)</td>
</tr>
<tr>
<td>Abobotulinumtoxina (Dysport, Botox)</td>
<td>Interferon Beta-1a (Avonex, Avonex Prefilled Syringe, Rebif)</td>
</tr>
<tr>
<td>Afibercept</td>
<td>Interferon, Alfa-N3 (Human Leukocyte Derived)</td>
</tr>
<tr>
<td>Agalsidase (Fabrazyme)</td>
<td>Ipilimumab</td>
</tr>
<tr>
<td>Alefacept (Amevive)</td>
<td>IVIG</td>
</tr>
<tr>
<td>Alglucosidase Alfa (Lumizyme, Myozyme)</td>
<td>Ixabepilone</td>
</tr>
<tr>
<td>Alpha 1-Proteinase Inhibitor-Human, 10mg (use for Prolastin, Zemira)</td>
<td>Leuprolide Acetate (Eligard, Lupron, Lupron Depot, Lupron Depot-Gyn, Lupron Depot-Ped, Viadur)</td>
</tr>
<tr>
<td>Antihemophilic Factors</td>
<td>Menotropins (Menopur, Repronex, Pergonal, Humegon)</td>
</tr>
<tr>
<td>Anti-Inhibitor</td>
<td>Naltrexone (ReVia)</td>
</tr>
<tr>
<td>Antithrombin III (Human), Recombinant</td>
<td>Natalizumab (Tysabri)</td>
</tr>
<tr>
<td>Autologous Cultured Chondrocytes (Carticel)</td>
<td>Octreotide (Sandostatin LAR)</td>
</tr>
<tr>
<td>Azacitidine (Vidaza)</td>
<td>Olanzapine (ZyPREXA, ZyPREXA Zydis)</td>
</tr>
<tr>
<td>Belatacept (Nulojix)</td>
<td>Omalizumab (Xolair)</td>
</tr>
<tr>
<td>Belimumab (Benlysta)</td>
<td>Oprelvekin (Neumega)</td>
</tr>
<tr>
<td>Bevacizumab (Avastin)</td>
<td>Paclitaxel Protein-Bound Particles</td>
</tr>
<tr>
<td>Botulinum Toxin Type B (Myobloc)</td>
<td>Paliperidone Palmitate Extended Release (Invega, Invega Sustenna)</td>
</tr>
<tr>
<td>C-1 Esterase Inhibitor (Human), Berinert</td>
<td>Palonosetron (Aloxi)</td>
</tr>
<tr>
<td>Canakinumab (Ilaris)</td>
<td>Pamidronate Disodium (Aredia)</td>
</tr>
<tr>
<td>Certolizumab Pegol (Cimzia)</td>
<td>Panitumamab</td>
</tr>
<tr>
<td>Cetuximab</td>
<td>Pegaptanib Sodium (Mucagen)</td>
</tr>
<tr>
<td>Chorionic Gonadotropin (Novarel and Pregnyl ...).</td>
<td>Pegfilgrastim (Neulasta)</td>
</tr>
<tr>
<td>Collagenase, Clostridium Histolyticum, Injection (Xiaflex)</td>
<td>Pegloticase (Krystexxa)</td>
</tr>
<tr>
<td>Corticotropin (H.P.Acthar)</td>
<td>Pemetrexed</td>
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<tr>
<td>Decitabine</td>
<td>Protein C Concentrate</td>
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<tr>
<td>Denosumab (Xgeva)</td>
<td>Ranizumab (Lucentis)</td>
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<tr>
<td>Ecallantide, 1 Mg (Kalbitor)</td>
<td>Rituximab (Rituxan)</td>
</tr>
<tr>
<td>Eculizumab (Soliris)</td>
<td>Sodium Hyaluranate (Hyalgan, Supartz)</td>
</tr>
<tr>
<td>Epoetin Alfa (For Non-Esrd Use) (Epogen/Procrit).</td>
<td>Temsirolimus</td>
</tr>
</tbody>
</table>
• Epoprostenol (Flolan, Veletri)  • Thyrotropin Alfa (Thyrogen)
• Eribulin Mesylate  • Tocilizumab (Actemra)
• Filgrastim (Neupogen)*  • Topotecan
• Galsulfase (Naglazyme)  • Trastuzumab
• Goserein Acetate Implant  • Treprostinil (Remodulin)
• Histrelin Implant (Supprelin LA)  • Triptorelin Pamoate (Trelstar Depot, Trelstar Depot Mixject, Trelstar LA, Trelstar LA Mixject)
• Hydroxyprogesterone Caproate, 1 Mg (Makena, Prodrox, Hylutin, Delta-Lutin, Duralutin, Hyprogesterone)  • Unclassified Biologics
• Hyaluronan (Orthovisc)  • Urofollitropin (Metrodin)
• Ibandronate Sodium (Boniva)  • Ustekinumab (Stelara, Stelara PFS)
• Idursulfase (Elaprase)  • Velaglucerase Alfa (VPRIV)
• Imiglucerase (Cerecyme)  • Verteporfin (Visudyne)
• IncobotulinumtoxinA (XEOMIN)  • Von Willebrand Factor Complex (Human)
• * No auth required if given in MD office  • Ziconotide (Prialt)
• Zoledronic Acid (Zometa, Reclast)

All admissions, outpatient surgeries and other services requiring preauthorization are authorized based on standard medical necessity criteria. Policies and procedures guide the Utilization Management Department in evaluating medical necessity and in approving medical services for benefit coverage. The policies and procedures of the Utilization Department are reviewed and updated as needed, on at least an annual basis, through the UMQMC. National criteria sets such as but not limited to InterQual or Milliman are updated annually by licensed contract, informational system updates, and any materials associated with the national vendor are distributed to the staff as the annual updates are received.

The guideline criteria, policies and procedures of the Health Services Department include:
   a. Nationally recognized criteria sets such as but not limited to InterQual or Milliman
   b. Local Medical Guidelines
   c. Utilization Management Department Policy and Procedure Manual
   d. Coventry Health Care Technology Assessments
   e. Certificate/ Evidence of Coverage/ Certificate of Insurance/ Summary Plan Descriptions (COC/ COI/ EOC/ SPD) for Benefit Determination
   f. Coventry Corporate Medical Management and Pharmacy Coverage Policies
   g. Medicare National Coverage Determination Manual
h. Regional Carrier
i. Crosswalk of Coventry Technology Assessments to CMS coverage

CHC must be informed prior to a patient’s non-emergency hospital admission. Failure to notify CHC prior to admission may result in denial of services. Late notification may also result in denial of the days prior to notification. If services are denied for no authorization, the Member can not be held liable. When calling CHC, please be prepared to provide us with the information contained in the list below which will reveal the severity of the illness and/or intensity of service. This information will be used to determine whether or not the care meets CHC criteria for coverage as an inpatient stay.

- General information such as the Member’s name and ID number, the admitting physician and the PCP.
- Severity of illness including a history of current illness and diagnosis(es), description of symptoms (frequency/severity), physical findings and outpatient treatment attempted (if applicable). CHC may request lab results, X-ray findings and other significant medical information.
- Plan of treatment such as the medications (IV, IM), invasive procedures, tests monitoring/observation, consultation (if needed during admission, has it been scheduled?), other services (i.e. respiratory treatments, therapies, wound care), activity level (if relevant to treatment plan) and diet (if relevant).
- Anticipated duration of inpatient hospital stay.
- Alternative treatment available such as IV therapy, skilled nursing, physical therapy, home traction.

Hospitalization and the continued stay can be authorized only when the severity of the patient’s illness and/or the intensity of the required services meet the established criteria for acute inpatient care. For inpatient stays, CHC reviews each patient’s chart on a regular basis either onsite or via phone and coordinates the length of stay with the admitting physician. CHC nurse reviewers are available to work with you and the hospital staff to coordinate the care a Member may need following discharge from the hospital.

Concurrent review is performed prior to the expiration of the assigned length of stay. If the nurse reviewer needs information in addition to that in
the patient's chart, he or she will contact your office. If the Member does not appear to meet medical criteria for an inpatient stay, the nurse will discuss alternative care that can be arranged. The Medical Director will be involved in the final decision when a denial appears necessary. You and the Member will be notified if medical criteria is not met and benefits are no longer available for coverage of additional inpatient days. If services are denied as not medically appropriate, the claims will be denied and the Member can not be held responsible for these denials.

CHC must be notified of an emergency admission within twenty-four (24) hours or the next business day. However, earlier notification greatly facilitates the utilization review process, and allows CHC to determine during the stay whether or not medical criteria for coverage is met. Failure to notify CHC of an admission may result in denial of services. If services are denied for no authorization, the Member can not be held responsible.

You can contact our Health Service Department at 1-800-470-2004 or log onto directprovider.com to notify us of an admission and provide clinical information. Please note that this number can be used twenty-four (24) hours a day for notification.

Coventry Health Care's medical directors are available to you to discuss adverse determinations made on requested services. Practitioners may contact our health services department to schedule a peer-to-peer discussion. Our Health Services staff will arrange a suitable time for the practitioner as well as the health plan reviewer to discuss the case. Peer-to-peer discussions should occur within one business day of the adverse decision. After normal business hours, callers may leave a recorded message and all inquiries are responded to the next business day.

There may be instances when a patient must be evaluated before a plan of care is established. These instances may include stabilization, evaluation, treatment and/or diagnostic work-up to determine a diagnosis. To that end, an observation admission not to exceed one 24-hour period is permitted.

Benefits are payable for additional observation days only if the patient's condition meets CHC's clinical criteria and the service is pre-certified.

CHC providers are required to obtain prior authorization for Members for all rental and purchased durable medical equipment over $1000 per item. Equipment must be obtained from a participating provider unless the Member's benefit plan allows out-of-network coverage. CHC Members may
have a benefit limits for DME and limited coverage for orthotics and other medical appliances. Please consult Customer Service to verify the Member’s benefits at 1-800-395-2545.

Short-term rehabilitative therapy including physical, speech, and occupational therapy does not require authorization. Therapy provided on an inpatient or outpatient basis is covered for a limited period of treatment, per condition, if improvement can be expected within this time period. Contact Customer Service to verify benefits as limits may apply.

Unless specifically outlined in your Provider Contract, physical therapy can not be performed in a physician’s office and will be denied.

In accordance with federal and state laws, all CHC commercial Members have access to mental health benefits. Access to these benefits may need to be coordinated by our Mental Health Vendor and provided by one of their participating providers. Please consult the back of Member’s ID card for information on the mental health vendor.

In the Member documents, a medical emergency is defined as the following:

"...a condition manifesting itself by acute symptoms of sufficient severity (including pain). This condition may be as result of an injury, sickness, or mental illness which occurs suddenly, and is such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. serious jeopardy to the health of the individual (or unborn child);
2. serious impairment to bodily functions; and
3. serious dysfunction of any bodily organ or part.

Emergency services are covered when they are inpatient and outpatient services that are:

1. furnished by a provider qualified to furnish emergency services; and
2. needed to evaluate or stabilize an emergency medical condition.
When the nature of the illness is a medical emergency and care cannot be properly rendered in the physician's office, referrals to an emergency room are appropriate.

An authorization is not required for a Member to be treated in an emergency room for an emergency condition. However, patients are instructed to contact their physician for medical advice prior to seeking care, if possible. Follow-up visits to the emergency room are not covered under any circumstances.

**Emergency/ Urgent Services - In Area**

As with all medical services, Members should contact their physician when an unexpected illness or injury occurs. The physician evaluates the situation and directs the patient to the following, as appropriate:

- Visit the physician’s office
- Visit a participating specialist
- Go to a participating convenience care clinic
- Go to an emergency room of a participating hospital
- Go to a participating urgent care facility

In life-threatening emergencies (such as cerebrovascular accidents, myocardial infarctions, poisoning, or respiratory failure), Members should seek care at the nearest medical facility.

**Emergency Services- Out of Area**

Life-threatening emergencies (such as cerebrovascular accidents, myocardial infarctions, poisoning, respiratory failure, seizures, and compound fractures) that occur while the Member is outside of the service area should be treated at the nearest medical facility. Medically necessary services that require follow-up emergency services outside of the service area must be approved by CHC.

Hospital admissions that occur as a result of an out-of-area emergency are evaluated on the basis of medical necessity by CHC. The Member may be transferred to a participating facility for treatment once the medical condition is stabilized.

Coventry Health Care reviews emergency services claims for medical necessity. If a claim is denied, the Member is responsible for the costs of the emergency services rendered and all associated costs incurred as a result of the emergency room visit.
Coventry Health Care also provides coverage for urgent care and convenience care visits outside of the service area.

All self-injectables require prior authorization before the services are rendered and are covered under the Member’s pharmacy benefit. Depending on their benefit plan, most Members will be subject a 10% coinsurance. You may call Health Services at 800-470-2004 to obtain authorization for injectables. The injectables should be obtained from one of our National Vendors. Regardless of who provides the service, the injectables are reimbursed according to national rates negotiated by Coventry Health Care Inc., with various national vendors.

Coventry Health Care evaluates benefit coverage for new medical technologies or new applications of existing technologies on an ongoing basis. These technologies may include medical procedures, drugs and devices. The following factors are considered when evaluating the proposed technology:

- Input from appropriate regulatory bodies.
- Scientific evidence that supports the technology’s positive effect on health outcomes.
- The technology’s effect on net health outcomes as it compares to current technology.

The evaluation process includes a review of the most current information obtained from a variety of authoritative sources including medical and scientific journals, medical databases and publications from specialty medical societies and the government. Contact your Provider Relations representative if you have any questions.
Reimbursement &
Claims

Providers are reimbursed either through capitation payments or on a fee for service basis. This section outlines the procedures for claims submission.

Provider reimbursement under CHC can be either through capitation payments or on a fee for service basis. Please consult your provider contract to determine your method of reimbursement.

Some physician services are reimbursed on a capitated basis. Capitation is a fixed amount paid to a physician on a monthly basis based on a total number of Members either assigned to the physician or in the products covered by the capitation contract. CHC bases its capitation payments on the type of plan and the age and sex of the CHC Members. PCP's are paid capitation each month for Members enrolled on his/her panel as of the 15th day of the month. PCP's are not paid additional capitation for Members newly enrolled on or after the 16th nor deducted capitation for Members losing eligibility on or after the 16th.

If a PCP's compensation is on a capitated basis and a service is rendered to a Member that is within the scope of the physician's license and expertise, the service is considered a capitated service, even if the service is typically rendered by a specialist. However, CHC has defined some services as non-capitated. Please refer to your provider contract for those items which are payable outside of capitation.
Coventry will furnish a monthly capitation report along with each monthly payment. This report verifies the eligibility of each Member on the provider’s panel, as well as the capitation paid for each Member. The report also provides the Member’s identification numbers, enrollment dates, and benefit plans.

Fee for service reimbursement compensates the provider only for services rendered based on the CPT codes submitted. Physician allowances are set by CPT codes. When submitting claims, please include all applicable modifiers to ensure proper payment. Claims submitted to Coventry should include your usual fee for services rendered by CPT code. Proper coding remains the responsibility of the billing provider. Fee charged for services provided to CHC Members should be the same as those charged to non-Coventry Members for the same services.

Coventry recognizes all valid American Medical Association (AMA) CPT codes ranging from 10000 to 99999 with the exception of unlisted procedures codes such as 69979 or 99199. Unlisted codes may require submission of medical records for processing. Deleted codes are not considered valid for dates of services after the codes have been deleted. In addition, all modifiers listed in the AMA CPT manual are recognized and reimbursed according to industry standards. CHC also recognizes HCFA Common Procedure Coding System (HCPCS) and will reimburse them in accordance to the Coventry fee schedule.

Anesthesia services should be billed with base units for surgical anesthetics in accordance with the current editions of the American Society of Anesthesiologists Relative Value Guide (ASARVG) and Crosswalk. Services billed with CPT codes will be denied until submission with ASARVG codes. Anesthesia claims also require that the proper modifiers are billed to indicate who is providing the service.

**Claims Filing Procedures**

Providers should submit charges on an HCFA 1500 Health Insurance Claim form (or UB92 if applicable) directly to the Claims Address listed on the Member’s Identification Card. Claims should be submitted within ninety (90) days from the date of service unless your contract states otherwise. Coventry will not consider claims for payment submitted more than ninety (90) days after the date of service.

Exceptions will be made for claims involving Coordination of Benefits (COB). Coordination of Benefits is the process of coordinating the payable benefits when the Member is covered by two or more group benefit plans.
COB claims must be submitted within ninety (90) days of the primary insurer's Explanation of Benefit (EOB) date and a copy of EOB must be attached to the claim.

The claim should be submitted with the following information included on the claim:

- Member Name and CHC ID Number
- Name of Referring Physician
- Dates of Service
- ICD-9 diagnosis codes or successors
- CPT-4 procedure code with valid modifiers as applicable
- COB information
- Operative report as applicable
- Provider's tax ID number, name, signature, credentials and NPI

Coventry Health Care of Georgia processes clean claims to providers within fifteen (15) days in accordance with state laws.

Additional information requested via a claim's denial such as but not limited to medical records, invoice, or itemized billing should be submitted to CHC within ninety (90) days of request for such information. Information submitted after ninety (90) days will denied as untimely.

You may call the Customer Service Department to check the status of claims. Our Customer Service Department is available to answer any claim inquiries Monday through Friday between 7 am to 6pm. The phone number is (800)395-2545. You can also check your claims via our interactive voice response system or online with directprovider.com.

It is the responsibility of the Provider to maintain an updated record of their account receivables. CHC recommends that you check your account receivables monthly to determine if there are any outstanding claims. In the event that there are, Provider should contact Customer Service to determine if the claim was received. CHC will not be responsible for claims that were never received and the date of service exceeds the timely filing limit.
For Providers who submit claims electronically, reports are provided to Provider after each submission detailing the claims that were sent and received. It is the Provider's responsibility to track this list to ensure that claims were received by CHC. Coventry will not be responsible for claims that were never received when the date of service exceeds the timely filing limit and an EDI report showing acceptance of the claim is not present.

Coventry Health Care of Georgia strictly enforces its timely filing clause in the provider contracts. Claims must be filed within ninety (90) days or within time frames specified in your contract.

Coventry Health Care will make every effort to work with physician's office having a billing problem. We suggest you contact us as soon as possible should this be a concern or problem.

A process is available for reconsideration of claims denied for failure to file within the deadline. To file a reconsideration, submit proof of timely filing and confirmation of receipt from Coventry. For electronic submissions, submit electronic confirmation report from Vendor/Clearinghouse. For paper claims, please send screen prints showing the dates filed along with a complete key of the payor codes. In situations where the member failed to provide correct insurance information, submit documentation such as screen prints, EOB, copies of member ID cards along with attempts to obtain the information from member. The request should be sent to:

Coventry Health Care of Georgia

P.O. Box 7711

London, KY 40742

It is your responsibility to verify Remittances. If you wish to appeal a payment, you must contact CHC within ninety (90) days of the check date or within the time frame specified in your contract. If you do not notify CHC within time frame specified, payment is considered final. Unless otherwise agreed upon, a claim shall be considered final one year after the date of service and neither you nor CHC can request a review of the claim.

The following is an explanation of the remittance advice you will receive for medical services rendered.
How to Read your Remittance Advice

Here are detailed explanations of the fields on the remittance advice to aid you in reading your remittance advice.

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim Detail</td>
<td></td>
</tr>
<tr>
<td>Patient Name</td>
<td>The name of the Member receiving the services.</td>
</tr>
<tr>
<td>Account #</td>
<td>Patient account number taken from your claim submission.</td>
</tr>
<tr>
<td>Place of Service</td>
<td>Identifies the type of facility where the services were provided, e.g., OUTPT HOSPITAL, OFFICE, etc.</td>
</tr>
<tr>
<td>Member #</td>
<td>Our identification number for the Member receiving services.</td>
</tr>
<tr>
<td>Date Received</td>
<td>The date the claim was received by Coventry Health Care, Inc.</td>
</tr>
<tr>
<td>Processed Date</td>
<td>The date the claim was processed in our system.</td>
</tr>
</tbody>
</table>

Questions concerning claims status, benefits and appeals should be directed to Customer Service at 1-800-340-3300.
Claim # -- A unique number that we assign during the claim imaging process. Please provide this number when making claim inquiries as it will speed specific claim retrieval.

Auth # -- The number that we assign to our referral that is associated with claim, if applicable.

Claim Provider – Identifies the name of the provider in the HIPAA compliant format, who performed and billed the service.

Carrier – The information in this field may vary by product and account. It indicates the entity responsible for funding the claim, including the employer group if a self-funded arrangement is applicable.

Network/ Division – Division of referring physician, if a referral is applicable. May also signify network accessed.

Product- Indicates which one of our products defines coverage for the Member, e.g., HMO-Commercial, PPO, etc.

Service Dates – Dates of service corresponding to each procedure code. From first date the Member received the service from the provider (from date) through the last date the Member received the service from the provider (to date).

Procedure Code – Code pertaining to the procedure performed and billed by the provider on the corresponding service date(s).

Mod Cd – Indicates the modifier for the procedure code and procedure description, if applicable.

DRG/ APC- Reflects the specific DRG or APC used to process the claim, if applicable.

Procedure Description – Describes the procedure performed for the procedure code indicated.

CAP Y =yes, Indicates the claim line was adjudicated as a result of a capitated agreement. N =No, indicates the claim line was adjudicated as a result of a fee for service agreement.

Total Charges – The amount billed fro the procedure(s) performed on the corresponding service dates(s).

Allowed Amount – Amount of billed charges less any ineligible amounts;

Ineligible Amount – Amount that is not covered or is in excess of the provider’s contracted rate and for which the Member or provider is responsible.
Inelig DC - Disposition Code assigned to indicate the reason for ineligible amount; applicable disposition codes descriptions are noted at the bottom of the last page of this report.

COB DC - Disposition code assigned to indicate ineligible amount(s) after Coordination of Benefits; applicable disposition codes descriptions are noted at the bottom of the last page of the remittance advice.

Deductible Amount - Amount of deductible specified under the Member's Certificate of Coverage.

Copay Amount - Amount the Member is responsible for paying to the provider at the time services are received, as defined by their Certificate of Coverage.

Mbr Coins- Amount coinsurance applied as defined by Member's Certificate of Coverage.

Mbr Respons - Total dollars that is Member responsibility (as displayed in columns 17, 18 and 19) in addition to any Member responsible ineligible amount dollars (as displayed in column 14).

MBR DC - Disposition code assigned to indicate the reason for Member responsibility; applicable disposition code descriptions are noted at the bottom of the last page of the remittance advice.

ADJ DC - Disposition code assigned to indicate the reason for claim reconsiderations; applicable disposition code descriptions are noted at the bottom of the last page of the remittance advice.

Paid Amount - The amount being paid to the provider, calculated for each service minus Member responsibility, if applicable.

Interest Calculations - Interest paid as a result of claim processing that extends beyond the defined number of days allowed by State or Federal regulatory requirements, if applicable.

Check # - The number of the reimbursement check.

Claim Totals - Totals columns

Withhold Amount - Indicates Contractual Withhold; the total dollars withheld for the claim in accordance with the terms and conditions of the provider contractual agreement.

Back-Out & Replacement - If a claim is backed out and replaced by another claim, the claim number of the backed out claim and applicable
(negative) dollar amount is listed, as well as the number of the replacement claim.

**Back-Out & Refund** -- Message indicates specific claim that was backed out as well as the vendor's refunded dollar amount, check number and check date. The refund represents positive dollars.

**Distribution:** Payments are processed one to two times per week, depending on the specific Health Plan schedule. Checks and Remittance Advice Summary reports are printed and mailed to you. You may receive more than one check/remittance advice summary in one envelope, since we have individual bank accounts for our various product lines. Electronic Funds Transfers are also processed according to this schedule. Please note that remittance advices are not printed for EFT providers. To access the Remittance Advice, you must log onto directprovider.com or sign up for electronic remittance advices (ERA).

If you discover an underpayment in your claim, please notify our Customer Service Department within ninety (90) days of the check date or within the timeframe specified in your contract. Customer Service will review the claim. If a correction is needed, they will fix the claim and additional payment will be sent to you on a future remittance/check. If you do not notify CHC within time frame specified, payment is considered final. Unless otherwise agreed upon, a claim shall be considered final one year after the date of service and neither you nor CHC can request a review of the claim.

If we have overpaid you, CHC will notify you in writing of the overpayment giving you the opportunity to send the overpayment back to us. If overpayment is not received, CHC will correct the error by subtracting the overpayment from a future remittance/check and reissue the correct payment. Please notify us so that we can make the appropriate adjustments. Please do not return a check to CHC unless it is specifically requested. If a returned check is requested, please mail it to the following address:

Coventry Health Care of Georgia
Recoveries Department
120 East Kensinger Drive
Cranberry Twp, PA 16066

To send in a refund check, please send it to the following address:
Coding Edits Affecting Claims Payment

Coventry utilizes The Centers for Medicare & Medicaid Services (CMS) editing guidelines; and the American Medical Association’s guidelines that state the code(s) selected “accurately identifies the service performed”. Coventry is also in compliance with the HIPAA standardized code sets and thus only considers valid and current ICD-9, CPT-4, and HCPCS codes with their appropriate modifiers, for reimbursement. We also agree with AMA’s statement in their introduction to the CPT-4 manual, that, “inclusion or exclusion of a procedure does not imply any health insurance coverage or entitlement to reimbursement. Coventry also uses Health Plan policy in editing.

Vendors, Software packages and other types of auditing

Coventry utilizes a combination of vendors, software packages, manual medical review, and internal post-payment data analysis to audit the claims received by the above policy with contractual agreements.

1. IDX is our claim adjudication system. It has the following auditing capabilities:
   • IDX reviews the ICD-9, CPT-4 and HCPCS codes billed. It will deny lines billed with codes not found in the HIPAA standardize code sets, deleted codes, or ICD-9 codes not billed with the required 5th digit.
   • It will audit claims for duplicate services performed on the same date and same patient and will deny lines and entire claims as duplicate.
   • IDX has for each surgical CPT code, the associated “global days” as designated in CMS’s National Physician Fee Schedule. It will review claims
submitted and deny office visits as "included in surgical global" those office visits not identified as outside the surgical service performed.

- Those codes deemed by Coventry as cosmetic or experimental/investigational are loaded and denied by IDX. Documents submitted to prove medical necessity are reviewed by the Health Plan.

2. Coventry provides auditing capability for current claims received as well as historical claims for the same patient, same date of service, same provider. The following are some of the edits used by this software:

- Medical Visit
- Duplicate
- Pre-operative
- Post-operative
- Incidental
- Mutual Exclusive
- Assistant Surgeon
- Re bundling
- New Visit
- Multiple Surgical Reduction
- Invalid modifier/procedural code combination

3. Manual review of certain types of claims is performed by RN’s and certified coding staff that are trained in each Health Plan’s specific contracts as well as coding and claim review.

4. Claims are additionally analyzed post-payment by internal and external recovery specialists for the same types of edits listed above

**Definition of edits utilized**

All edits are based on the assumption of same time, same location, same patient, same provider, unless otherwise noted by use of modifiers. Following are some examples of edit types— not all inclusive:
<table>
<thead>
<tr>
<th>Edit</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Global Surgery/Surgery</td>
<td>The global surgery package includes all necessary services normally furnished by the surgeon before, during and after a surgical procedure. The global surgical package applies only to surgical procedures that have a post operative period of 0, 10 or 90 days as defined by CMS.</td>
</tr>
<tr>
<td>Multiple Units</td>
<td>Identifies claims with an excessive number of units submitted either on the same line or on separate lines of the same claim. When used appropriately, certain modifiers can override a multiple unit edits.</td>
</tr>
<tr>
<td>Duplicates</td>
<td>Logic detects where duplicate submissions of a service were submitted on separate claims. The analytics examine codes that, by definition, cannot be billed more than once on the same date of service, within a defined date range, or over the lifetime of the patient.</td>
</tr>
<tr>
<td>CCI</td>
<td>The National Correct Coding Initiative is a compilation of CMS bundling edits that are comprised of two categories: 1) comprehensive and component procedures; and 2) mutually exclusive procedures.</td>
</tr>
<tr>
<td>Global Surgery-E/M</td>
<td>CMS has defined specific time periods during which the Evaluation and Management (E/M) services related to a surgical procedure, furnished by the physician who performed the surgery, are to be included in the payment of the surgical procedure code. This is referred to as the Global Surgical Package. E/M services billed on the same day as the procedure or during the defined global period for the procedure will be denied. All of these edits audit office visits against surgical procedures performed within the global days designated in CMS's National Physician Fee Schedule. Minor surgical procedures have a 0-day pre-operative and 0 or 10 day post-operative span of time where office visits, unless designated by a modifier showing a separate identifiable service was performed, are denied. Major surgical procedures have a 1 day pre-operative and a 90 day post-operative span of time wherein office visits are audited.</td>
</tr>
<tr>
<td>New Visit</td>
<td>The AMA and CPT-4 defines a new patient as one “who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice within 3 years.” The term “professional services” applies to any face-to-face visit with a provider. This includes procedures as well as E/M visits.</td>
</tr>
<tr>
<td>Category</td>
<td>Description</td>
</tr>
<tr>
<td>-------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Multiple Surgeon</td>
<td>The American College of Surgeons and CMS both evaluate the need for an assistant surgeon, co-surgeons and team surgeons for all surgical procedures, defining procedures for which an assistant surgeon, co-surgeon, or team surgeon is not allowed and procedures for which an assistant surgeon, co-surgeon, or team surgeon may be allowed.</td>
</tr>
<tr>
<td>Incidentals</td>
<td>CMS has established services and procedures that are considered incidental to other services or procedures provided on the same date of service. These are status B,P,T,N codes.</td>
</tr>
<tr>
<td>Lab NCD</td>
<td>CMS sets national coverage policy for diagnostic laboratory tests, and the determination of medical necessity for those tests, through national coverage determinations (NCDs). Coventry evaluates the diagnosis submitted and the testing performed to determine whether the diagnosis codes supports the necessity of the test in accordance with the CMS policy.</td>
</tr>
<tr>
<td>Lab Panels</td>
<td>If all of the component codes are submitted for a panel, Coventry will deny all of the component codes and replace them with the appropriate panel code.</td>
</tr>
<tr>
<td>E/M</td>
<td>Correct coding of E/M services stipulates only one E/M code may be reported per day for the same patient/provider. However, the 25 modifier “significant separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service,” can override an E/M edit where appropriate.</td>
</tr>
<tr>
<td>Add-On</td>
<td>Add-on codes are designated in the CPT-4 book with a “+” symbol and frequently contain descriptions such as “each additional” or “list separately in addition to primary procedure.”</td>
</tr>
<tr>
<td>Multiple Procedure Reduction</td>
<td>Multiple Procedure Reduction (MPR), that identifies when more than one surgical or medical procedure is performed on the same patient on the same day and ranks all eligible procedures based on the RVU amount, billed amount, or allowed amount for each procedure. Coventry reimburses multiple procedures at 100/50/25 methodology.</td>
</tr>
<tr>
<td>Invalid Modifier to Procedure</td>
<td>Correct coding based on AMA, CMS guidance to allow identified modifiers with certain procedures.</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>---------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Advanced Technology including but not limited to 3-D imaging and Robotics</td>
<td>Coventry based policy that bundles Advanced Technology codes into Radiological and Surgical procedures. Many of these bundling rules are captured in CCI, and these CMS sourced CCI edits will fire first and have a CCI defense. Coventry specific bundling rules will fire when there is no existing CCI rule.</td>
</tr>
</tbody>
</table>

**Manual review of Claims**

Manual review of claims is performed by Medical Payment staff

1. When a claim is submitted with a –22 modifier indicating a desire for additional reimbursement, the procedure is reimbursed per the fee schedule without documentation. Documentation for manual review is required for consideration of additional reimbursement.

2. Unlisted codes both HCPCS and CPT all require documentation for review for consideration of reimbursement.

Additional edits that require manual review may include bilateral, multiple edits and documentation attached.

**Health Plan Policy**

Each Health Plan may set up editing based on Federal and State Regulations as well as contractual agreements.

For specific questions about coding edits, please contact Customer Service or Provider Relations.

**Reimbursement Determinations**

Whereas the previous sections provides a description of coding edits affecting claims payment, this section is designed to provide some specific information additional rules applied to claims billed by providers to Coventry Health Care.
The CHC schedule of allowances represents the maximum reimbursement amount for each covered service that corresponds to any given medical service code. The basis of determining valid medical service codes are from Current Procedural Terminology (CPT), HCFA Common Procedural Coding System (HCPCS), or National Drug Codes (NDC). For covered services represented by a single code, the maximum reimbursement amount is the allowance amount determined by CHC or the provider’s usual charge for the service, whichever is less. In many cases, CHC allowances are based upon measures of relative value such as Average Wholesale Price (AWP), the Federal Resource Based Relative Value Scale (RBRVS), American Society of Anesthesiologists (ASA) units and Medicare laboratory and Durable Medical Equipment (DME) rates. Your contract will outline the specific fee schedule methodology used to determine your rates.

**Experimental/ Investigational Services/ Supplies/ Drugs**

A health product service, supply or drug is deemed experimental/investigational by CHC according to the following criteria:

- Any drug not approved for use by the Food and Drug Administration (FDA); any drug that is classified as IND (investigational new drug) by the FDA; any drug requiring pre-authorization that is proposed for off-label prescribing.

- Any health product or service that is subject to Investigational Report Board (TRB) review or approval.

- Any health product or service that is the subject of a clinical trial that meets criteria for Phase I, II, or III as set forth by FDA regulations.

- Any health product or service that is considered not to have demonstrated value based on clinical evidence reported by peer-review medical literature and by generally recognized academic experts.

A drug, device, procedure, or other service will be experimental or investigational if CHC makes such a determination based upon criteria noted, unless otherwise noted in the Certificate of Coverage documents. Experimental or investigational services are not covered.
Medical Necessity

Medical necessity is defined by Coventry as the use of services or supplies as provided by a hospital, skilled nursing facility, physician, or other provider required to identify or treat a Member's illness or injury and which, as determined by CHC, are: (1) consistent with the symptoms or diagnosis and treatment of the Member's condition, disease, ailment or injury; (2) appropriate with regard to standards of good medical practice; (3) not solely for the convenience of the Member, his/her participating physician, hospital, or other health care provider; and (4) the most appropriate supply or level of service which can safely be provided to the Member. When specifically applied to an inpatient admission, it further means that the Member's medical symptoms or condition requires that the diagnosis or treatment cannot be safely provided to the Member in an outpatient setting. Services listed in the schedule of benefits are covered only if they are medically necessary.

Medical Record Request

There are certain claim scenarios where CHC may request additional information or medical records in order to process the claim. These claims will be denied requesting this information. Please send the only medical records to the claims address. There is no need to resubmit the claim. Once the information is received, the claim will be processed. Failure to submit requested information in a timely manner may result in denial of the claim. A few examples of instances where medical records may be required are as follows:

- Claims for services subject to pre-existing condition review, emergency services review, experimental/investigational review or high dollar claim review
- Claims involving certain modifiers or unlisted codes
- Claims that are believed to possibly involve inappropriate or fraudulent billing

Billing for Electronic Communication

CHC does not allow billing of charges associated with telephone, e-mail, or other electronic communications or consultations unless mandated by law. These charges are not billable to CHC and are also not billable to the patient.

Services rendered to Self or Family Members
CHC does not allow providers to bill or be reimbursed for services rendered to themselves or a member of their family.

**Facility Clinic Reimbursement**

Coventry Health Care of Georgia defines a facility clinic visit as a service provided to an ambulatory patient in an outpatient setting, whether in a free standing or an attached facility center that is either owned, operated, leased or controlled by the facility. CHC reimburses professional providers for covered services provided in a facility clinic setting when reported on a professional CMS 1500 form with a place of service office. This reimbursement includes both the professional services and the associated overhead. Therefore, we will not separately reimburse a facility for facility clinic visits and services billed on a UB-04 when reported with revenue codes 510-525, 527-529 and any successor codes, unless there is a specific contractual arrangement which allows for payment. The technical and overhead component of the facility clinic visit is included in the maximum allowable benefit paid to the professional provider for professional services (reported on the CMS-1500 form with a place of service office), which encompasses but is not limited to E&M services in a clinic setting. The facility may not seek reimbursement for any technical or overhead component of the clinic charge from CHC or the member. The member is held harmless for these clinic overhead charges.

**Additional Review of Claims Payment**

Coventry Health Care of Georgia uses a variety of vendors and internal departments to perform recovery activities for us. Each of the vendors has signed Business Associate Agreements with CHC and are working on our behalf. They may contact you directly in regards to their claims review. The following list outlines the types of recovery activities that they perform. Please note that this list is not all inclusive and is subject to change.

<table>
<thead>
<tr>
<th>Recovery Activity</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collections</td>
<td>Coventry has contracted with a vendor to pursue retro-terminated pharmacy recoveries and open payable provider collections.</td>
</tr>
<tr>
<td><strong>COB</strong></td>
<td>A coordination of benefits (COB) recovery occurs when the vendor identifies other primary insurance that was not identified during the claim payment process and recovers overpayments made to providers or individuals. Sources of recovery include other commercial insurance, Medicare, End Stage Renal Disease, working aged and the disabled.</td>
</tr>
<tr>
<td><strong>Credit Balance</strong></td>
<td>A credit balance is a positive balance in a patient’s account, created when a payer remits more than the final billed amount or contractually agreed upon amount. Credit balances exist on the provider account as a recorded liability.</td>
</tr>
<tr>
<td><strong>Data Mining</strong></td>
<td>Data mining is the systematic retrospective review of paid medical and pharmacy claims using proprietary algorithms to identify overpaid claims. The use of data mining vendors acts to supplement Coventry’s internal data mining efforts.</td>
</tr>
<tr>
<td><strong>DRG Audit Services</strong></td>
<td>A DRG audit is a comprehensive medical record review that involves a review of the medical record documentation to validate the assignment of the principal and secondary diagnosis as well as the principal procedure code or CPT assignment. As part of this audit a coding validation is conducted to confirmation of the diagnosis code recorded by the provider and its relevance to the billed procedure code(s). These audit processes determine if the correct DRG was assigned.</td>
</tr>
<tr>
<td><strong>Provider Bill Audit</strong></td>
<td>A Provider Bill Audit is an audit to determine whether all medical/clinical items or services appear on the provider’s bill and whether the provider’s medical/clinical documentation substantiate or support the bill.</td>
</tr>
<tr>
<td><strong>TPL</strong></td>
<td>Third Party Liability exists for accident</td>
</tr>
</tbody>
</table>
related medical care when another party is liable through Home Owner Insurance, Workers Compensation and Motor Vehicle Accident situations.

**Special Investigations Unit (SIU)**

SIU provides comprehensive fraud and abuse detection services for CHC. These services include training claims staff on fraud detection and reporting, the prospective investigation of claims for potential abuse, and the ongoing monitoring of claims paid data to identify claims paid to “suspect” providers. Identification of “suspect” providers and other services are based on the SIU proprietary review protocol. Services include the validation of the tax identification number and licensures of providers from zip code areas where prior billing abuse has been widespread.
Specialty Services

Coventry Health Care of Georgia contracts with ancillary providers for specialty services such as laboratory, radiology, and home health care. This section explains how these services are accessed by HMO/POS Members.

Laboratory and Pathology services must be performed by a Coventry Health Care of Georgia participating laboratory. CHC maintains a contract with Quest Diagnostics, Inc. to provide outpatient lab services for Members. Quest Diagnostics labs provide the following:

- All necessary supplies
- Request forms
- Specimen pick-up
- Accurate, prompt test results

The telephone number for Quest Diagnostics, Inc. is (770)934-9200 or (866) 709-0772.

Laboratory and Pathology services provided by an outside or reference lab that is not the applicable contracted laboratory provider (Quest Diagnostics) will not be reimbursed to the provider of service by CHC. Laboratory and Pathology services include but are not limited to clinical labs, nonclinical labs, pathology, and dermatopathology. If services are performed in office, the provider may not bill the Member/patient or CHC for the laboratory/pathology services.
Although CHC maintains a contract with Quest to provide lab and path services, we recognize the need for urgent lab work to make a diagnosis, or to treat the patient while in the provider’s office. When this situation occurs, some lab procedures listed below can be billed to CHC and the provider will be reimbursed according to the fee schedule.

**In office Lab/ Path List**

<table>
<thead>
<tr>
<th>Code 1</th>
<th>Code 2</th>
<th>Code 3</th>
<th>Code 4</th>
<th>Code 5</th>
<th>Code 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>80104</td>
<td>81025</td>
<td>82948</td>
<td>85027</td>
<td>87205</td>
<td>89320</td>
</tr>
<tr>
<td>81000</td>
<td>82270</td>
<td>82962</td>
<td>85610</td>
<td>87210</td>
<td></td>
</tr>
<tr>
<td>81001</td>
<td>82272</td>
<td>85013</td>
<td>85611</td>
<td>87220</td>
<td></td>
</tr>
<tr>
<td>81002</td>
<td>82274</td>
<td>85018</td>
<td>86403</td>
<td>87804</td>
<td></td>
</tr>
<tr>
<td>81003</td>
<td>82947</td>
<td>85025</td>
<td>86580</td>
<td>87880</td>
<td></td>
</tr>
</tbody>
</table>

36410, 36415 are reimbursed in office as well. Specimen Handling 99000 is not a reimbursable item.

85002, 85007, 85008 is allowed in office for Hematology/Oncology providers only.

Reproductive Endocrinologist can perform all labs in their office but member infertility benefits will apply.

**Services rendered by a Contracted Pathologist**

The plan pays for surgical pathology CPT codes 88300-88399. If the same provider bills for both technical and professional components, no modifier should be used and payment is based on a global fee. For all other codes, the plan follows the federal RVU database from the federal register to identify procedures that are 100 percent technical, with no professional component (not allowed with -26 modifier). Denials will be sent for inappropriate use of modifier -26. The health plan does not recognize a professional component for any clinical laboratory codes not listed in the federal RVU database.

All preadmission laboratory testing must be performed by a CHC contracted lab. For Members schedule for elective admission, all preadmission diagnostic work-ups including lab, radiology, and supporting specialty consultations, must be referred to free-standing contracted providers.

**Radiology**

Routine X-rays must be performed by a contracted provider, free standing imaging center or outpatient hospital facility. Please consult the Provider.
Directory for a listing of providers in your area. Use of a free standing imaging center may result in lower member responsibility.

For a listing of the radiology procedures that require pre-authorization, please refer to the PreAuthorization Listing in this manual.

**Home Health Care**

All home health services must be performed by a Coventry Health Care participating agency, and require pre-authorization from the Health Service Department.

Coventry Health Care of Georgia maintains a contract to provide home health services for Members. Home Health services provide the following:

- Home Infusion Therapies
- Respiratory Care Services
- Women’s Health Services
- Home Sleep Diagnostic Program
- Respiratory Medications
- Home Medical Equipment

**Durable Medical Equipment and Supplies**

All DME and supplies should provided by a participating provider. Certain DME and supplies must be preauthorized. Please refer to Preauthorization for the listing.

**Injectable Medications**

Coventry Health Care has contracted with preferred vendors for the supply of expensive injectable medications. These medications require preauthorization by our Health Service Department. Our Health Service Department will assist in you in making arrangements for the delivery of the medications to your office or the patient’s home. The authorization request can be faxed to our Health Service Department using the corresponding form.
Utilization and Quality Improvement

Utilization management tracks health care costs while assuring the quality of and access to health care, while quality management assures that all health care services provided to Members meet the highest standards of quality. This section details the processes of utilization and quality management at Coventry Health Care of Georgia.

Utilization management occurs by reviewing how health care resources are utilized by Members and identifies and evaluates appropriateness, timeliness, medical necessity, utilization patterns and clinical outcomes.

Utilization management at Coventry Health Care consists of the following functions:

- Prior authorization of hospital admissions and outpatient services to determine medical necessity.
- Concurrent review of inpatient care to ensure appropriate treatment and length of hospital stay.
- Retrospective review of health care costs
- Use of alternative resources and settings
- Case management
- Disease management programs
- Oversight of delegated utilization management functions

Coventry's Utilization Management staff is available eight hours a day, via a toll free number during normal business hours to assist you with questions you may have about Coventry's Utilization Management process. Members can access the Utilization Management Department via the Customer Service Organization by calling the number on the member's ID card. The call may be direct transferred from the customer service representative into the utilization management department where a staff member will identify themselves by name and title.

After normal business hours, callers will hear a recorded message with instructions on how they can reach somebody immediately, or will have the option to leave a message which will be responded to the next business day.

Coventry offers TDD/TYY services for deaf, hard of hearing and speech impaired members. Language assistance via the language line is also available for members to discuss UM issues.

Coventry Health Care, Inc. (Coventry) employees make clinical decisions regarding health care based on the most appropriate care and service available. Coventry does not reward practitioners or other employees for any denials of service. Coventry does not encourage nor reward clinical decisions that result in decreased services.

Coventry does not use incentives to encourage barriers to care and service. Furthermore, Coventry prohibits any employee or representative of Coventry from making decisions regarding hiring, promotions, or terminations of practitioners or other individuals based upon the likelihood or perceived likelihood that the individual or group will support or tend to support the denial of benefits.

Clinical Criteria for UM Decisions

The medical criteria used in the decision making process will be provided upon receipt of a written, faxed, or telephone request by the provider. Criteria may be reviewed on site at the Coventry Health Care office, read to the provider over the phone, or viewed on Directprovider.com.
New Technology

Because technology advances over time, we review new medical technologies and new applications of established technologies regularly to determine whether and how such technologies will be considered medically necessary and/or not experimental/investigational under our benefits plans. Our process of assessing technologies begins with a comprehensive review of the peer-reviewed medical literature and other recognized references concerning the safety and effectiveness of the medical technology. This evaluation involves analyzing the results of studies published in peer-reviewed medical journals. We consider the position statements and clinical practice guidelines of medical associations and government agencies, including the Agency for Healthcare Research and Quality (AHRQ). When applicable, we consider the regulatory status of a drug or device, including review by the U.S. Food and Drug Administration (FDA) and Centers for Medicare & Medicaid Services (CMS) coverage policies.

Telephonic or onsite concurrent inpatient reviews include the following:

- Reviewing that continued inpatient care is medically necessary and based on assessments of documentation present in the medical record, on observation of the Member, and in consultation with the treating physician, Medical Director, and ancillary providers as needed using approved criteria.

- Reviewing that care is provided efficiently and effectively in the appropriate setting and at the appropriate level of care

- Facilitating timely and comprehensive discharge planning that includes assessment, planning and follow-up to ensure continuity of care

- Decreasing risk and improving quality through identifying and monitoring risk-related guidelines in accordance with CHC Quality Management Plan

- Intervening at the direction of the Plan Medical Director when medical necessity is not met, care does not meet acceptable standards, or resources are not utilized appropriately

Initial concurrent review assessment occurs within one working day of admission or notification. Days are approved prospectively when medical necessity and length of stay criteria is met. If upon review days are denied for delay of treatment, facility and treating physician charges associated with those days will be denied. Failure to provide requested clinical information
may also result in denial of days. Member can not be held liable for these charges.

Out of network admissions and out of area emergency admissions are reviewed as soon after notification as possible. The facility is notified that coverage will cease when the patient is stable enough to be transferred or discharged.

Coventry Health Care members have access to case management—a collaborative process between Coventry Health Care, the member and the provider. Our case management programs are designed to assess, plan, implement and evaluate services and resources required to meet the member’s health care needs. The process aims to efficiently produce the highest quality outcomes and manage health care costs. The program is staffed by registered nurses to advocate for the member in the case management process. Coventry Health Care nurses are educated in health care management and service delivery and help our members smoothly navigate their health care by connecting them with resources and support within their respective communities. Our health plan nurses embrace cultural diversity and are well suited to assist members of any background. We require that Coventry Health Care nurses continue to expand their expertise through professional development including certification, seminars and classes for continuing education and case management credits. You can refer a member for Case Management by calling our Health Services Department.

All inpatients are evaluated for discharge planning needs to monitor cost-effective follow-up. Discharge planning includes, but is not limited to:

- Determining the resources of the family and/or significant others, and including them appropriately in the discharge planning process
- Determining the level of post-discharge care
- Determining if, when, and at what level post-discharge facility care is needed
- Initiating appropriate patient and family education regarding post-discharge care
- Coordinating key contacts to arrange for home care or equipment needs, (e.g., ancillary providers for durable medical equipment (DME), home care services, supplies, etc.)
Our disease management programs are designed to help your patients work with their doctors to effectively manage ongoing health conditions and improve outcomes. Disease Management programs are available for the following conditions:

- Diabetes
- Chronic Kidney Disease
- Heart Failure
- Asthma (Commercial members only)
- CAD (Medicare members only)

Our aim is to proactively reach out to members and engage them in managing their health, by emphasizing prevention through education, supporting the physician-patient relationship and reinforcing compliance with their physicians' care plan. Members are identified by various methods including, but not limited to, claims, pharmacy, health risk assessment, physician referral, caregiver referral, or self-referral. Providers may refer a member to a disease management program by calling the Disease Management Call Center at 1-800-579-5755. The Clinical Practice Guidelines that support each of our disease management programs are found on our website at www.chcga.com - Providers - Document Library. CHCGA implements a population-based approach to specific chronic diseases or conditions. All members with the identified condition are sent educational material to promote better Member understanding of the disease or condition affecting them. Information also addresses self-care, appropriate medical care and testing which are supported by evidence-based practices and tools.

Members identified as having significant "gaps" in their care and/or disease/condition education, and who are motivated to commit to condition-modifying changes are assigned to a Case Manager to facilitate the Members' opportunities for improved self-care, lifestyle modifications and health resource access.

**Quality Improvement**

Our QI Program provides a structure for promoting and achieving excellence in all areas through continuous improvement. It provides the framework for Coventry to continually monitor, evaluate and improve the quality of care, safety and services provided to all members, employers, practitioners/providers and external/internal customers. The program provides an ongoing evaluation process that lends itself to improving identified opportunities for under/over utilization of services. Core values of the program include maintaining respect and diversity for members, providers and employees.
Medical Records

In accordance with the provider contract with Coventry and applicable laws and regulations, participating physicians and other health care professionals are required to treat personal health information (PHI) as confidential. PHI includes: identity of the individual; the relationship of the individual with Coventry; physical or behavioral health status or condition; and payment information for the provision of health care. Coventry established medical record criteria to provide a guideline for fundamental elements of organization, documentation of diagnostic procedures and treatment, communication and storage of medical records. These criteria are applicable to all benefits plans. Performance goals are established to assess the quality of medical record-keeping practices, and audits are conducted no less than every two years. Coventry's performance goal is 85 percent compliance.

In the provider agreements with Coventry, participating physicians and other health care professionals agree to maintain medical records in a current, detailed, organized and comprehensive manner in accordance with customary medical practice, applicable laws and accreditation standards. This requirement survives the termination of the contract, regardless of the cause for termination. You must keep our members' information confidential and stored securely. You must also ensure your staff members receive periodic training on member information confidentiality. Only authorized personnel should have access to medical records. Coventry has the right to access confidential medical records of Coventry members, for the purpose of claims payment, assessing quality of care, including medical evaluations and audits, and performing utilization management functions. Medical records may be requested as a part of Coventry's participation in HEDIS. HIPAA Privacy regulations allow for sharing of personal health information (PHI) for purposes of making decisions around treatment, payment, or health plan operations.

HEDIS

The Healthcare Effectiveness Data and Information Set (HEDIS) results are used to measure the effectiveness of many of these QI initiatives. HEDIS is a set of standardized performance measures designed to ensure that the public has the information it needs to reliably compare performance of managed health care plans. HEDIS results are based on statistically valid random samples of members. The HEDIS results are subjected to a rigorous review by certified HEDIS auditors.

HEDIS measures can be generated using three different data collection methodologies:
• Administrative (uses claims and encounter data)

• Hybrid (uses medical record review along with claims and encounter data)

• Survey

Medical record review is an important part of the HEDIS data collection process. The medical record contains information such as lab values and results of tests that may not be available in the administrative data. QI staff call a provider’s office to schedule an appointment for the chart review. If there are only a few charts to be reviewed, the office may choose to fax or mail the specific information to Coventry Health Care. The HIPAA Privacy Rule permits a provider to disclose protected health information to a health plan for the quality-related health care operations of the health plan, provided that the health plan has or had a relationship with the individual who is the subject of the information, and the protected health information requested pertains to the relationship. See 45 CFR 164.506(c)(4). Thus, a provider may disclose protected health information to a health plan for the plan’s HEDIS purposes, so long as the period for which information is needed overlaps with the period for which the individual is or was enrolled in the health plan.

CAHPS

Coventry Health Care uses a certified survey firm to administer the Consumer Assessment of Healthcare Providers and Systems (CAHPS) member satisfaction survey to a sample of our adult commercial and Medicare members. The CAHPS survey provides information on the experiences of members while they are members of a health plan and gives a general indication of how well the plan meets member expectations. Coventry Health Care has a quality improvement initiative to improve member satisfaction with the health plan.

Four global rating questions reflect overall satisfaction:

• Health plan overall

• Health care overall

• Personal provider overall

• Specialist overall
Medical Continuity and Coordination of Care

To facilitate continuous and appropriate care for members, and to strengthen continuity and coordination of care among medical practitioners and providers, we monitor the coordination and continuity of care across health care network settings and transitions in those settings. Examples of information that is monitored are as follows:

• Medical Record Reviews/ HEDIS Medical Record Reviews

• Member Complaints

• Notification and movement of members from a terminated practitioner

• Presence of medical consultant reports • Home Health continuing care plans

• Presence of behavioral health consultant reports following primary care referral to behavioral health

• Discharge summaries post-hospitalization for behavioral health admission

Coventry Health Care has developed a reimbursement policy for “Never Events” and Hospital-Acquired Conditions (HAC’s) to define these conditions and their handling from a coverage perspective. The goal of this policy is to align Coventry’s practices with those of Centers for Medicare & Medicaid (CMS).

“Never Events”

The National Quality Forum (NQF) defines “Never Events” as “errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, and that indicate a real problem in the safety and credibility of a health care facility”. In order to be included in the NQF list of “Never Events”, the following criteria must be met:

• “Unambiguous - clearly identifiable and measurable, and thus feasible to include in a reporting system;
• Usually preventable - recognizing that some events are not always avoidable, given the complexity of health care;
• Serious - resulting in the death or loss of a body part, disability, or more than transient loss of a body function, and
• Any of the following:
  • Adverse and/ or
• Indicative of a problem in the health care facility's safety systems and/or, important for public credibility or public accountability."

Procedures performed on the wrong side, wrong body part, wrong procedure or wrong person are referred to in this policy as “Never Events”. CMS has adopted a national payment policy that all Wrong Site/Procedure/Person procedures (E876.5) are never reimbursed to facilities. CMS prohibits providers from passing these charges on to patients. Consistent with CMS policy, Coventry will not reimburse providers for “Never Events” listed below. In addition, Coventry prohibits passing these charges on to patients.

Hospital Acquired Conditions (HACs)
HACs are preventable conditions that are not present when patients are admitted to a hospital, but become present during the course of the patient’s stay. These preventable medical conditions were identified by CMS in response to the Deficit Reduction Act of 2005 and meet the following criteria: (a) the conditions are high cost or high volume or both, (b) result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence based guidelines.

Effective October 1, 2008, CMS will end payment for the extra care resulting from HACs. CMS also prohibits passing these charges on to patients. Consistent with CMS policy, Coventry will not reimburse providers for the extra care resulting from HACs listed below. In addition, Coventry prohibits passing these charges on to patients.

Coventry will review admissions with identifiable “Never Events” and HACs that are listed below. “Never Event” or HAC can be identified from various sources, including, but not limited to, medical director review of cases, concurrent review, member complaints, and administrative claim reports as well as from hospitals, pharmacies, and providers. Once a “Never Event” or HAC is identified, the case is investigated and presented to the Medical Director for review. If it is determined there were additional hospital inpatient days at a participating provider facility which directly and exclusively resulted from an HAC (not present on admission), reimbursement for such additional inpatient days must be denied. If the “Never Event” or HAC is confirmed subsequent to the claim submission and claim payment, the Medical Director will determine, in consultation with the facility or provider, what will and will not be denied for payment.
# NEVER EVENTS & HOSPITAL-ACQUIRED CONDITIONS (HACs)

<table>
<thead>
<tr>
<th></th>
<th>NQF NE or CMS HAC</th>
<th>CONDITION/EVENT</th>
<th>CC/MCC ICD-9-CM Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>NE</td>
<td>Artificial insemination with the wrong donor sperm/egg</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>NE &amp; HAC</td>
<td>Unintended retention of a foreign object in a patient after surgery or other procedure</td>
<td>998.4 998.7</td>
</tr>
<tr>
<td>3</td>
<td>NE</td>
<td>Death/serious disability associated with patient elopement (disappearance)</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>NE</td>
<td>Death/serious disability associated with a medication error (e.g., errors involving the wrong drug, wrong patient, wrong time, wrong rate, wrong preparation or wrong route of administration)</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>NE &amp; HAC</td>
<td>Incompatible Blood/Death or serious disability associated with a hemolytic reaction related to incompatible blood/blood products</td>
<td>999.6</td>
</tr>
<tr>
<td>7</td>
<td>NE &amp; HAC</td>
<td>Death/serious disability associated with a fall while being cared for in a healthcare facility [CMS HACs: Fractures, Dislocations, Intracranial Injuries, Crushing Injuries, and Burns resulting from Falls/Trauma in the hospital]</td>
<td>800 – 829 830 – 839 850 – 854 925 – 929 940 – 949 991 – 994</td>
</tr>
<tr>
<td>8</td>
<td>NE &amp; HAC</td>
<td>Death/serious disability associated with the use of restraints or bedrails while being cared for in a healthcare facility. [CMS HACs: Fractures, Dislocations, Intracranial Injuries, Crushing Injuries, and Burns resulting from Falls/Trauma in the hospital]</td>
<td>800 – 829 830 – 839 850 – 854 925 – 929 940 – 949 991 – 994</td>
</tr>
<tr>
<td>10</td>
<td>NE¹²</td>
<td>Surgery performed on the wrong body part</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>NE¹³</td>
<td>Surgery performed on the wrong patient</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td><strong>NQF NE or CMS HAC</strong></td>
<td><strong>CONDITION/EVENT</strong></td>
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<td>-----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>23</td>
<td>NE</td>
<td>Patient death/serious disability due to spinal manipulative therapy</td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>NE</td>
<td>Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances</td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>NE</td>
<td>Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider</td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>NE</td>
<td>Abduction of a patient of any age</td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>NE</td>
<td>Sexual assault on a patient within or on the grounds of the healthcare facility</td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>NE</td>
<td>Death/significant injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of the healthcare facility</td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>HAC</td>
<td>Catheter Associated Urinary Tract Infection</td>
<td>996.64</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The following must be excluded from acting as CC/MCC:</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>112.2 (CC); 590.10 (CC); 590.11 (MCC); 590.2 (MCC); 590.3 (CC); 590.80 (CC); 590.81 (CC); 595.0 (CC); 597.00 (CC); 599.0 (CC)</td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>HAC</td>
<td>Deep Vein Thrombosis (DVT)/Pulmonary Embolism Procedure Codes:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total Knee Replacement: 81.54</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Hip Replacement: 00.85, 00.86, 00.87, 81.51, 81.52</td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>HAC</td>
<td>Surgical Site Infection</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. Surgical Site Infection Following Mediastinitis After Coronary Artery Bypass Graft Procedure Codes: 36.10 – 36.19</td>
<td>519.2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. Surgical Site Infection Following Certain Orthopedic Procedures Procedure Codes: 81.01 – 81.08; 81.23 – 81.24; 81.31 – 81.38; 81.83; 81.85</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>c. Infection and inflammatory reaction due to other orthopedic device and implant graft</td>
<td>996.67</td>
</tr>
<tr>
<td></td>
<td></td>
<td>d. Other postoperative infection</td>
<td>998.59</td>
</tr>
<tr>
<td>NQF NE or CMS HAC</td>
<td>CONDITION/EVENT</td>
<td>CC/MCC ICD-9-CM Code</td>
<td></td>
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<tr>
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<tr>
<td>12</td>
<td>Wrong surgical procedure performed on a patient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Intraoperative or immediately post-operative death in an ASA Class I patient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Death/serious disability associated with the use of contaminated drugs, devices, or biologics</td>
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<tr>
<td>15</td>
<td>Death/serious disability associated with the use or function of a device used other than as intended</td>
<td></td>
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<tr>
<td>16</td>
<td>Air Embolism/Death or serious disability associated with intravascular air embolism</td>
<td>991.1</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Infant discharged to the wrong person</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Patient suicide, or attempted suicide resulting in serious disability</td>
<td></td>
<td></td>
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<tr>
<td>19</td>
<td>Maternal death/serious disability associated with labor or delivery in a low-risk pregnancy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Death/serious disability associated with hyperglycemia/hypoglycemia</td>
<td>See Below.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>a. Diabetic ketoacidosis</td>
<td>250.00 - 250.13</td>
<td></td>
</tr>
<tr>
<td></td>
<td>b. Nonketonic Hyperosmolar Coma</td>
<td>250.20 - 250.23</td>
<td></td>
</tr>
<tr>
<td></td>
<td>c. Hypoglycemic Coma</td>
<td>251.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>d. Secondary Diabetes with Ketoacidosis</td>
<td>249.10 or 249.11</td>
<td></td>
</tr>
<tr>
<td></td>
<td>e. Secondary Diabetes with Hyperosmolarity</td>
<td>249.20 or 249.21</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Death/serious disability (kernicterus) associated with failure to identify and treat hyperbilirubinemia in neonates</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>Pressure Ulcers</td>
<td>See Below.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>a. Stage III pressure ulcers acquired after admission to a healthcare facility</td>
<td>707.23</td>
<td></td>
</tr>
<tr>
<td></td>
<td>b. Stage IV pressure ulcers acquired after admission to a healthcare facility</td>
<td>707.24</td>
<td></td>
</tr>
</tbody>
</table>
Coventry is committed to encouraging quality health care of our members. One way that we measure quality is through HEDIS. HEDIS is a quality measurement data system established by the National Committee for Quality Assurance (NCQA), to ensure that all HMOs measure performance in an identical manner, so that purchasers and consumers can make comparisons between plans. The focus of HEDIS is on measuring Plan performance, rather than the performance of individual providers.

HEDIS has a variety of measurements which are tracked via your claim submission and through medical record review. CHC may contract with an outside vendor to complete medical record reviews. Your office will be notified via a faxblast from us of the name of the company. The company and its employees will have signed confidentially agreements with us; therefore, we ask that you cooperate with them and release medical records as requested. Please note that all of our members have authorized the release of medical information for quality assurance activities when they accepted our coverage. Proper coding of the claims will eliminate the need for medical record requests. Therefore, we have developed the following HEDIS reference tool to assist you in proper coding of these claims.

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>HAC</td>
<td>e. Surgical Site Infection Following Bariatric Surgery for Obesity</td>
<td>998.59</td>
</tr>
<tr>
<td></td>
<td>Procedure Codes: 44.38, 44.39, 44.95 AND 278.01 for Morbid Obesity</td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>HAC</td>
<td>999.31</td>
</tr>
<tr>
<td></td>
<td>Vascular Catheter Associated Infection</td>
<td></td>
</tr>
</tbody>
</table>
### HEDIS® Measures - Helpful tips for Providers

<table>
<thead>
<tr>
<th>Measure Definitions</th>
<th>What You Can Do</th>
<th>Coding Tips</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ABA</strong>&lt;br&gt;Adult BMI Assessment&lt;br&gt;Members 18-74 years of age with their body mass index (BMI) and weight documented annually.</td>
<td>Perform and document criteria of Ht / Wt / BMI calculation at each visit. <em>Pregnant members are excluded from this measure</em>&lt;br&gt;Use correct diagnosis and procedure codes and submit claims timely.</td>
<td>Diagnostic Codes: V8500-V855&lt;br&gt;Procedure Codes: 99201-99235, 99236, 99211-99215, 99341-99345, 99346, 99347-99350, 99351-99357, 99358-99361, 99401-99404, 99411-99413, 99420, 99428, 99455-99458 *V69-70, V72, V23, V28</td>
</tr>
<tr>
<td><strong>AWC</strong>&lt;br&gt;Adolescent Well Care Visits&lt;br&gt;Members 12-21 years of age with at least one comprehensive well care visit with a primary care practitioner or an OB/GYN practitioner annually.&lt;br&gt;Minimum of 1 Required</td>
<td>Documentation MUST include ALL three criteria:&lt;br&gt;Health education / anticipatory guidance&lt;br&gt;Physical exam&lt;br&gt;Health and developmental history (physical and mental).&lt;br&gt;<em>This may be done during a sick visit or well child exam.</em></td>
<td>Diagnostic Codes: V6900, V6905, V6910, V703, V705, V706&lt;br&gt;CPT Codes: 99384, 99385, 99394, 99905&lt;br&gt;HPCPCS: G0043, G0049</td>
</tr>
<tr>
<td><strong>BCS</strong>&lt;br&gt;Breast Cancer Screening&lt;br&gt;Women 50-74 years of age with one or more mammograms within last 2 years.</td>
<td>Documentation of member education on the benefits of early detection of breast cancer.&lt;br&gt;Encourage mammography to all women who are within risk group.</td>
<td>Procedure Codes: 77055-77057, G0020, G0024, G0026</td>
</tr>
<tr>
<td><strong>COL</strong>&lt;br&gt;Colorectal Cancer Screening&lt;br&gt;Adults 50-75 years of age with an appropriate screening for colorectal cancer.</td>
<td>Educate members on importance of early detection.&lt;br&gt;Order colonoscopy or flexible sigmoidoscopy as needed.&lt;br&gt;Perform Flex or Colonoscopy Test in house.&lt;br&gt;Proper documentation in medical record, correct diagnosis code and timely submission of data is requested.</td>
<td>Diagnostic Codes: V7132, V7142&lt;br&gt;Procedure Codes: B3140, B3141, B3142, B3143, B3144, B3145, B3146, B3147, B3148, B3150, B3152, B3154, B3164, B3167, B3171, B3174, B3175</td>
</tr>
<tr>
<td><strong>CCS</strong>&lt;br&gt;Cervical Cancer Screening&lt;br&gt;Women 21-64 years of age with one or more Pap tests within the last 3 years.</td>
<td>Woman who has had a total hysterectomy with no residual cervix are excluded. This must be documented in history or problem list.&lt;br&gt;Notation of Pap test located in progress notes MUST include the lab results in order to meet NCQA® requirements.</td>
<td>Diagnostic Codes: 401</td>
</tr>
<tr>
<td><strong>CBP</strong>&lt;br&gt;Controlling High Blood Pressure&lt;br&gt;Members 18-65 years of age with a diagnosis of hypertension (HTN) and whose BP is adequately controlled (&lt;140/90).&lt;br&gt;Patients with systolic blood pressure &gt;160 mmHg need to be re-evaluated within 3 months.</td>
<td>If BP elevated (140/90 or greater) at initial visit sign assessment, allocate potential factors that might cause temporary elevation and recheck BP during exam.&lt;br&gt;If elevation persists, treat as necessary and recheck BP.&lt;br&gt;Document all measurements and efforts to obtain BP control.&lt;br&gt;Schedule follow-up visits to monitor effectiveness of BP medication.</td>
<td>Diagnostic Codes: 77100, 77200, 77300, 77400, 77490, 77491, 77492, 77810</td>
</tr>
<tr>
<td><strong>CHL</strong>&lt;br&gt;Chlamydia Screening in Women&lt;br&gt;Women 15-24 years of age who are identified as sexually active with a Chlamydia test annually.</td>
<td>Assist with member education of STD.&lt;br&gt;Perform routine test for Chlamydia, document and submit timely.</td>
<td>Procedure Codes: 80061, 83700, 83701, 83702, 83704, 83721</td>
</tr>
<tr>
<td><strong>CMC</strong>&lt;br&gt;Cholesterol Management for Patients With Cardiovascular Conditions&lt;br&gt;Members 18-75 years of age who have had a myocardial infarction, ischemic vascular disease, coronary artery bypass graft (CABG) or percutaneous coronary intervention (PCI) and have had a LDL-C test.</td>
<td>Documentation must include the date on which the LDL-C test was performed and of the result of the LDL-C test. This information can be on a lab report or within progress notes.&lt;br&gt;Use of correct diagnosis and procedure codes&lt;br&gt;Timely submission of claims and encounters data&lt;br&gt;Ensure proper documentation of date and test results</td>
<td>CPT Codes: 80061, 83700, 83701, 83702, 83704, 83721</td>
</tr>
<tr>
<td>HEDIS® Measures</td>
<td>What You Can Do</td>
<td>Coding Tips</td>
</tr>
<tr>
<td>-----------------</td>
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</tbody>
</table>
| **CDC**
Comprehensive Diabetes Care
Members 18-75 years of age with diabetes should have each of the following annually: HbA1C, Eye Exam, LDL-C, Blood Pressure Control, and attention for Nephropathy.
| Document results of HbA1C, LDL-C, and Microalbumin exams annually or more often as needed.
Refer member to Optometrist for Dilated Retinal Eye Exam annually.
Work with member closely to achieve blood pressure control. (~140/90)
| **Diagnosis Codes:**
250, 357.2, 362.0, 366.41, 648.0.

**Procedure Codes:**
67028, 67038, 67039-67042, 67105, 67107-67108, 67113, 67141, 67228, 81000-81005, 83036, 83037, 80061, 83700, 83701, 83704, 83721, 83042, 82043, 82044, 84156, 92002-92004, 92011, 92014, 92114, 92225, 92226, 92235, 92239, 99203-99205, 99213-99215, 99242-99245 |
| **CIS**
Childhood Immunization Status
Children who received recommended vaccinations prior to second birthday.

*Document parental refusal.*
| Educate office staff to schedule appointments PRIOR to 2nd birthday. Perform Outreach to members to obtain appointment.
Immunizations recommended: 4 DTaP/DT, 3 IPV, 1 MMR, 3 Hib, 3 Hep B, 1 VZV, 4 PCV, 1 Hep A, 2 or 3 Rotavirus and 2 Influenza vaccines.
Documentation in medical record if member has evidence of the disease for which immunization is intended or contraindication due to anaphylactic reaction.
| **CPT Codes:**
90688, 90700, 90711, 90713, 90723, 90707, 90710, 90708, 90709, 90704, 90706, 90645, 90648, 90748, 90740, 90744, 90747, 90716, 90669, 90670, 90653, 90658, 90680, 90655, 90657, 90461, 90463, 90748, 90710 |
| **IMA**
Immunizations in Adolescents
Members 10-13 years of age who received:
1 Meningococcal (ages 11-13) and 1 Tdap vaccine or 1 TD booster (ages 10-13).

*Female Members Only*– 3 doses of HPV (Human Papillomavirus) are suggested.
| Educate staff to schedule PRIOR to 13th birthday.
Document and submit timely with correct code.
Offer HPV Vaccine to females age 9 to age 13. Three doses should be completed prior to age 13.
| **CPT Codes:**
90733, 90734, 90715, 90714, 90710, 90703 |
| **PPC**
Prenatal and Postpartum Care
Pregnant mothers who require prenatal care during 1st trimester and postpartum care between 21-56 days after delivery.
| Educate staff to be aware of measure parameters when scheduling.
Encourage attendance for postpartum visit.
| **Diagnosis Codes:**
V24.1, V24.2, V76.2 |
| **WCC**
Weight Assessment and Counseling for Children
3–17 years of age with Weight Assessment & Counseling for Nutrition & Physical Activity for Children and Adolescents.
| Documentation MUST include ALL three criteria during at least one office visit annually.
BMI percentile
Discussion of nutrition
Discussion of physical activity
| **Diagnosis Codes:**
V65.5, V65.3
**CPT Codes:**
97802-97804 |
| **W15**
Well Child 15 months
Members 0-15 months of age with 6 comprehensive well child visits.

Minimum of 6 required before 15 months
| Documentation MUST include ALL three criteria:
Health education / guidance
Physical exam
Developmental health and history
Never miss an opportunity! Exam requirements can be performed during a sick visit or a well child exam.
| **Diagnosis Codes:**
V20.2, V20.3, V20.31, V20.32, V70.0, V70.3, V70.5, V70.8, V70.9
**CPT Codes:**
99382, 99383, 99391, 99392, 99461
**HCPCS:**
G0438, G0439 |
| **W34**
Well Child 3-6 years
Members 3-6 years of age with at least 1 comprehensive well child visits annually.

Minimum of 1 required.
| Documentation MUST include ALL three criteria:
Health education / guidance
Physical exam
Developmental health and history
Never miss an opportunity! Exam requirements can be performed during a sick visit or a well child exam.
| **Diagnosis Codes:**
V20.2, V70.0, V70.3, V70.5, V70.8, V70.9
**CPT Codes:**
99382, 99383, 99391, 99392, 99461
**HCPCS:**
G0438, G0439 |
Provider Participation Information

Your participation with Coventry Health Care of Georgia comes with some guidelines. This section outlines those guidelines.

A provider must complete an application, sign two (2) Provider Agreements and be fully credentialed in order to be approved for participation and treat any Coventry Health Care of Georgia Members. Once the Agreements have been executed, an original copy will be returned to the provider for his/ her records.

The CHC network is open for application by a particular provider/ provider specialty type if at least one of the following criteria is met:

a. Coventry Health Care of Georgia, Inc. access and availability standards are not being met in that area.
b. There appears to be a need in the market place for a particular specialty due to referral patterns.
c. There is a Member or group demand for a certain provider or a particular specialty even though access and availability standards are being met.
d. A certain provider's participation is in the best interest of the Plan and meets the business needs of the Plan.
e. Adding a certain provider or specialty would positively impact new sales and retention, even though access and availability standards are being met.

Once a determination has been made to add the provider to the network and reimbursement has been mutually agreed upon, the provider must meet
quality of care and quality of service standards as well as CHC’s minimum administrative requirements as follow:

- Has a current and active unrestricted license;
- Has a current DEA certificate, if applicable;
- Has a current states Controlled Drug Substance (CDS) certificate, if applicable;
- If a practitioner, has current malpractice insurance coverage that meets CHC minimum requirements;
- Is not currently excluded from the Medicare or Medicaid program, or any other Federal Health Care Program;
- If a facility, is accredited through one of the recognized accreditation organizations

In order to be listed as a certain specialty, you either need to be Board Certified or Eligible in the specialty or have completed a fellowship in the specialty.

Physicians will be solely responsible for the treatment and medical care provided to a Member, and the maintenance of their relationship with a Member. Coventry will not exercise control or direction over, nor will be liable for, the manner or method by which the physician provides professional services under the Physician Agreement. Physicians can and must freely communicate with Members regarding appropriate treatment alternatives and / or the treatment options available to them regardless of benefit coverage limitations. Coventry is entitled to deny payment for physician services to a Member which it determines are not covered services. A coverage denial does not absolve physicians of his/her professional responsibility to provide appropriate medical care to Members.

Coventry values physician input and views it as an important element of the management structure of Coventry. From time to time, you may be asked to participate in a variety of professional committees. Your participation in these committees will be greatly appreciated.

We use a standard application and a common database called the Council for Affordable Quality Healthcare (CAQH) to gather credentialing information. Our recredentialing process. We reassess a provider’s qualifications, practice and performance history every three years, depending on state and federal regulations and accrediting agency standards. This process is seamless to providers who are due for recredentialing and whose applications are complete within CAQH. We’ll send providers (whose applications aren’t complete within CAQH) three reminder letters. The letters will ask them to update their recredentialing data. If they don’t respond to the letters, we’ll
call them. How can I check the status of my recredentialing application? Call our Credentialing Customer Service department at 1-800-353-1232. Adding a new provider to your group: Go to the Join the Network section of our website to start the application process.

CHC has an ongoing monitoring policy to ensure continued compliance with our credentialing standards. CHC performs ongoing monitoring on a monthly basis. The monitoring includes all federal and state sanctions.

All Coventry providers will be required to sign a written agreement. These agreements can be signed by the individual provider or facility, a group practice, an Independent Physician Association (IPA), or a Provider Hospital Organization (PHO).

The agreements will at least contain the following elements:

- A listing of all individuals or entities that are covered under the agreement
- Conditions for participation
- Obligations and responsibilities of CHC and the provider including any obligations to participate any CHC programs
- Events that may result in the reduction, suspension, or termination of network participation privileges
- Access to medical records
- Health care services to be provided and any restrictions
- Claims submission requirements and restrictions
- Payment methodology
- Mechanisms for provider dispute
- Term of the contract and procedures for terminating the contract
- Confidentiality of patient health information
- Prohibitions regarding discrimination against consumers
Please contact our Provider Relations Department if you do not have a copy of your contract or see that the items above are missing from the contract you have.

Site Visit--Office site visits are made to network practitioners after receiving a member's complaint to evaluate the physical accessibility, physical appearance, adequacy of waiting and exam room space related to the settings in which member care is delivered. Standards are set for office site criteria and medical record keeping practices. If a site visit is required for member complaints to evaluate the physical accessibility, physical appearance, adequacy of waiting and examining room space, the medical record keeping practices are also evaluated to assess methods used to maintain confidentiality of member information and for keeping information in a consistent, organized manner for ready accessibility. No site visit is required for complaints regarding availability or medical records keeping. The Coventry Office Assessment criteria are stated in the practitioner agreements and business criteria of the practitioner agreements. The medical record keeping practice standards are stated in the Coventry Medical Record Criteria that are distributed to practitioners.

Coventry Health Care is committed to treating Members in a manner that respects their rights as Members.

As a member of a Coventry Health Care of Georgia, Inc. (Coventry) Health Plan, you have the right to:

• receive information about the organization, its services, its practitioners and providers and member rights and responsibilities

• to be treated with respect and recognition of their dignity and their right to privacy

• to participate with practitioners in making decisions about their health care

• a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage

• voice complaints or appeals about the organization or the care it provides

• make recommendations regarding the organization's member rights and responsibilities policy
As a member of a Coventry Health Plan, you have the responsibility to:

- supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care
- follow plans and instructions for care that they have agreed to with their practitioners
- understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible
Provider Appeal
Process

Coventry Health Care of Georgia recognizes that providers may occasionally encounter situations in which the operation of CHC does not meet their expectations. When this occurs, the provider is encouraged to call the matter to our attention. This section outlines the process to do so.

Coventry has appeal processes which apply to all providers including but not limited to physicians and facilities. This chapter addresses three types of appeals; Adverse Determinations Appeals, and Claim Payment Appeals. These processes are specific to Provider Appeals and do not replace, and are separate and apart from, Member Appeal policies or Providers acting as the Member’s Authorized Representative. Coventry Health Care recognizes each Member’s right to privacy and holds that all medical information is to be treated with the strictest confidence and only the minimum amount necessary is to be shared with others when it is appropriate for ensuring delivery of health care services, administration of health care benefits or health care payments, or as otherwise required by law.

Adverse Determinations Appeals

An Adverse Determination is defined as a denial of a request for service or a failure to provide or make payment (in whole or in part) for a benefit. An Adverse Benefit Determination also includes any reduction or termination of a benefit. An Adverse Benefit Determination based in whole or in part on a medical judgment, includes the failure to authorize
or cover services because they are determined to be experimental, investigational, cosmetic, out of area referrals, not medically necessary or inappropriate. An Adverse Determination Appeal will be handled in accordance to the following process.

If a Provider is dissatisfied with the Health Plan’s Adverse Determination and contacts a Health Plan Customer Service Representative, the Customer Service Representative should educate the Provider of the right to Appeal and the steps for filing an Appeal. The Provider is advised to send a written request to the Health Plan within ninety (90) calendar days after receipt of the initial notification of Adverse Determination or as specified in his/her contract. If the Provider contacts Health Services or Provider Relations staff regarding the Adverse Determination, the Plan staff will educate the Provider on Appeals and ask the Provider to send the written request to the Plan within ninety (90) calendar days after Provider’s receipt of the initial notification of Adverse Determination or as specified in his/her contract. Requests for Appeals received after such ninety (90) calendar day period or as specified in the provider’s contract, will not be eligible for review under the Health Plan’s internal Appeal process.

The Provider is instructed to include the following in the written Appeal indicating:

- Member name;
- Provider name;
- A description of the service which was denied;
- Date(s) of service;
- Clear indication of the remedy or corrective action being sought and an explanation of why the Health Plan should “reverse” the Adverse Determination; and
- Copy of documentation which the provider believes supports the reversal of the Health Plan’s decision (e.g., emergency details, date, time, symptoms, why the Member did not contact the PCP, etc.), if any.

Once received by the Health Plan, the appeal is reviewed to determine the type of appeal. Those Provider requests that meet the definition of an Adverse Determination Appeal will be reviewed in accordance with the following:

- Provider Administrative Appeals will be reviewed by one (1) manager or senior manager of the Health Plan who will consider the Provider Appeal based upon the plan documents and the information submitted by the provider.
• Provider Medical Necessity Appeals will be reviewed by a like or similar specialty physician not previously involved in the case, who holds an active, unrestricted license to practice medicine and is board certified (if applicable) by the American Board of Medical Specialties or the Advisory Board of Osteopathic Specialists from the major areas of clinical services (doctors or osteopathic medicine).

• Provider appeals will be processed within fifteen (15) calendar days for pre-service appeals, and thirty (30) calendar days for post-service appeals with notification being sent to the provider.

• If the initial denial is reversed, the approval letter should instruct the provider how to obtain the approved services (e.g., contacting Health Services to schedule the procedure); and notification will be sent to the Customer Service Center to overturn the adverse determination, if necessary.

• If the decision is adverse to the provider, the denial letter shall advise the provider of the reason for the decision. The clinical rationale for adverse benefit determinations based in whole or in part on a medical judgment, will be provided in writing, upon request. The provider is notified that this is the final level of Appeal.

The provider requests which do not meet the definition of an Adverse Determination are considered to be either an inquiry or a complaint. An inquiry is any question from a Provider regarding issues received by a Customer Service Representative in the Customer Service Center ("CSO") (e.g., benefits information, claim status, or eligibility). A complaint is any expression of dissatisfaction expressed by a Provider regarding an issue in the Health Plan, which may be resolved by the Customer Service Representative in the CSO. All Provider inquiries/complaints received by the Health Plan should be copied and returned to the Customer Service Representative or appropriate Health Plan staff. The CSO or the appropriate Health Plan staff (i.e. Provider Relations Representative) notifies the Provider of the receipt of the inquiry/complaint within three (3) business days. The inquiry/complaint must be resolved within thirty (30) calendar days.
Claims Payment Appeals

A claims payment appeal is defined as an appeal related to the processing of a claim. An Adverse Determination does not qualify under this appeal policy. The appeal could be administrative or contractual in nature. Administrative appeals deal with policies and procedures surrounding claims and contractual appeals relate to contract interpretation or timeliness of appeal. The following grid outlines how these are handled and the timeframes associated with them.

<table>
<thead>
<tr>
<th>Description of Issue</th>
<th>Submission Timeframe *</th>
<th>Handled by</th>
<th>Resolution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrected claim</td>
<td>Within 90 days of initial claim decision (EOB date)</td>
<td>Submission directly to claims for processing</td>
<td>Corrected claim processed according to standard guidelines</td>
</tr>
<tr>
<td>Untimely filing denials</td>
<td>Within 90 days of initial claim denial (EOB date)</td>
<td>Submission directly to claims with supporting documentation showing initial submission and follow-up</td>
<td>Documentation reviewed by CSO and claim readjudicated reflecting decision</td>
</tr>
<tr>
<td>Claims denied for medical records, invoice, itemized bills</td>
<td>Within 90 days of initial claim denial (EOB date)</td>
<td>Submission directly to claims with requested documents</td>
<td>Requested records reviewed and claim readjudicated according to standard guidelines</td>
</tr>
<tr>
<td>Claims payment reconsideration for coding edits and processing guidelines such as modifier reductions, multiple procedure reduction</td>
<td>Within 90 days of initial claim decision (EOB date)</td>
<td>Submission directly to claims with supporting documentation</td>
<td>Claim and documentation will be reviewed by Medical Claims Review Nurse (MCRN). Claim will be readjudicated reflecting decision</td>
</tr>
<tr>
<td>Contractual Dispute</td>
<td>Within 90 days of initial claim decision (EOB date)</td>
<td>Submission to claims or directly to Provider Relations Representative</td>
<td>Claim and supporting contract will be reviewed to verify terms of the contract. If claim paid correctly, Provider Relations will contact provider to discuss review. If claim not paid in accordance with the contract, Provider Relations will correct the system and have claim reprocessed.</td>
</tr>
</tbody>
</table>

* These timeframes may differ depending upon the terms of your contract. If provider or CHC does not dispute or question the payment of a claim within one year from the date of service, both parties agree that the claim payment is considered to be final.
Electronic Solutions

Coventry Health Care of Georgia has a wide array of electronic solutions to assist you in the management of our Members. This section outlines those solutions.

The world today offers a wide variety of electronic solutions to make your everyday duties quicker and easier.

Coventry has a free provider website www.directprovider.com.

√ A user-friendly secure provider site that gives you the information you need to know to get your claims paid quickly and efficiently.
√ A one-stop shop for the Coventry family of health plans.
√ Information directly from the health plan so the information is accurate and fast.
√ A service that is free to Coventry providers.
Key Features

- Claim Payment
- Claim History
- Member Eligibility
- Member Benefits/Riders
- Member Primary Care Physician History
- Remittance Advices (PDF format)
- Authorization Requirements (InterQual® Smart Sheets)

Features Coming Soon

- Online Claims Adjustment Requests
- Authorization Lookup
- Authorization Update
- Authorization
- Reconsideration/Appeal
- Authorization History
- Secure Messaging
- Authorization Submission
- Direct Claims Submission

Eligibility and Benefits

Eligibility inquiries identify the Member’s coverage history and primary care physician history. Detailed benefits information provides copay information, current deductibles, and approved and remaining visits and days.

Claims Inquiries

Claims can be viewed by status for any 30 day period, and searched by Member, claim number, or date range. Most significant is that claims disposition codes are understandable and Member responsibility on each
claim is clearly displayed. Providers are able to see if there is a pre-existing condition, the authorization number and the line level detail for each claim. By clicking claim history, you can see exactly when we received the claim and how it was transmitted through our system and when.

**Remittance Advices**

Tired of waiting for remittance advices in the mail? directprovider.com has searchable and downloadable remittance advices in .pdf format right on line, without waiting. Remittances can be searched by check or EFT (electronic funds transfer) number, Member name and date of birth, payment date, date of service, claim number, or Member ID.

**Authorization Submission**

You can submit authorizations online for faster processing. A template can be created for your common authorization requests which will be more efficient for your office. Medical records can be electronically attached to the authorization so that you will no longer be required to fax the information to us.

**Resource Library**

The resource library contains critical forms and manuals for the health plan. It also contains the authorization criteria the health plan uses to guide them to a decision on an authorization request. Providers can view technology assessments that review all the latest treatments and devices. All documents can be printed directly from your screen or downloaded to your personal computer.

**How Do I Sign Up?**

If your organization has not yet signed up, simply identify who will be the account administrator, go to directprovider.com and click “Register” then fill out the online form. You will be emailed your temporary password within one business day.

If your organization has already registered, simply contact your site administrator who can immediately set up a temporary password for you.

**Emdeon office**

Coventry Health Care of Georgia has also teamed up with Emdeon Office to provide your office tools to make your day to day activities in the office quicker and easier. Just imagine the ability to get the information you need when you need it. Just one simple click and you have at your fingertips, eligibility and co-pay information, authorizations and claims status. Imagine getting authorization approvals before the patient has left the building. All
of this is possible now through our partnership with Emdeon Office. We are
continually adding and enhancing the services that we provide. The
information provided below is just a sample of the services which are
available. Please visit the Provider Channel of www.chcga.com for more
information

**Services available through Emdeon Office:**

By logging onto Emdeon Office and selecting the Coventry HealthCare of
Georgia plan, you can perform the following:

- Eligibility Inquiry
- Benefits Inquiry
- Claims Status Inquiry
- Authorization Status Inquiry
- Authorization Submission
- Electronic Remittance Advises

**Other Electronic Solutions**

Coventry Health Care of Georgia also provides other electronic solutions to
our providers.

**Electronic Funds Transfers** are available to transfer your claims
payments directly to your bank account. Please contact our Provider
Relations Department for more information and the necessary forms to set
this option up.

**Interactive Voice Response System** is available through our
Customer Service phone number at 1-800-395-2545 which allows you to
check eligibility, claims and authorization status over the phone without
speaking with a Customer Service Representative. You can also choose to
get a faxed confirmation of the information you receive.
Future Communications

 Coventry Health Care of Georgia will from time to time send out communications to your office which will contain important information about the management of our Members. Please use this section to keep future communications in one spot for easy reference.