# Table of Contents: Provider Manual

## CLAIMS

- Submission of Claims ............................................................. 20
- Reimbursement ................................................................. 21
- Claims Editing Information ..................................................... 21
- Electronic Claim Filing ............................................................ 21
- National Provider Identification ............................................... 22
- Claim Inquiries ................................................................. 22
- Appeal Process for Claim Denials ........................................... 22
- Provider Reconsideration Process .......................................... 23
- Provider Reconsideration Workflow ....................................... 24
- Fraudulent Billing ............................................................... 25

## UTILIZATION MANAGEMENT

- Overview ................................................................................. 26
- Prior Authorization ............................................................... 26
- Concurrent Review ............................................................... 27
- Notification of Review ........................................................... 27
- Discharge Planning ............................................................... 28
- Case Management ............................................................... 28
- Disease Management ............................................................ 29
- Denials ................................................................................... 29
- Appeals .................................................................................. 29
- Coordination with Quality Improvement ................................. 29
- Prospective, Concurrent, or Retrospective Reviews ................. 30
- Skilled Nursing Admissions .................................................... 32
- Rehabilitation Admissions ..................................................... 32

## PHARMACY PRESCRIPTION BENEFITS

- Medco ..................................................................................... 33
- Drug Formulary ................................................................. 33
- Generic Drug Policy ............................................................ 34
- Prior Authorization ............................................................... 34
- Step Therapy .......................................................................... 34
- Self-Administered Injectables ................................................ 34
- Non-Formulary Medications ................................................ 35
- Quantity Limits ................................................................. 35
- Diabetic Supplies ............................................................... 35
Table of Contents: Provider Manual

Non-Covered Medications .................................................................36
Pharmacy Network ........................................................................36
Mail Order .....................................................................................36
Appeal Rights ................................................................................36

ANCILLARY ....................................................................................37
Dental ...............................................................................................37
Mental Health/Chemical Dependency ..............................................37
Vision Services ..............................................................................37
PT/OT/ST Benefits ..........................................................................37
Home Health ..................................................................................37
Hospice ...........................................................................................38
Durable Medical Equipment ...........................................................38
Laboratory Services .......................................................................38
Radiology .........................................................................................39
Emergency and Urgent Care .........................................................39
Out of Area Care ............................................................................40
Non-Participating Hospitalization ....................................................40
Introduction

Welcome

At Altius Health Plans our priority is to assure that our members receive the highest quality of healthcare available. Providers must adhere to rigorous credentialing and re-credentialing standards. In addition, our network of physicians, hospital and ancillary providers agree to actively participate in quality improvement and utilization review activities.

The goal of Altius Health Plans is to develop and sustain a strong, mutually beneficial relationships with our providers and their office staff. We appreciate your participation in our networks, and welcome and encourage your comments.

History

Altius Health Plans, a subsidiary of Coventry Health Care, offers HMO, POS, Medicare, and fully insured or self-funded plans to members in Utah, Idaho and Wyoming service areas. Coventry Health Care is a nationally managed health care company based in Bethesda, Maryland and provides a full range of risk and fee-based managed care products in all 50 states as well as the District of Columbia and Puerto Rico. The partnership between Altius Health Plans and Coventry Health Care allows for increased resources and capability to offer a wider range of services. As a result, Altius Health Plans can better respond to the ever changing expectations of our providers, members and employer groups. Additional information can be found at: www.altiushealthplans.com, www.firsthealth.com or www.coventryhealthcare.com.

Vision Statement

We intend to be the premier health plan within our service areas. Our mission is to provide excellent service in a responsible, cost effective and caring manner.

Purpose of this Manual

The purpose of this manual is to answer important questions about administering health care services to Altius Health Plan members. 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. Please check our website for the latest version. Significant changes will be communicated through your provider representative.

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<th>Department</th>
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<td>Paper Claims</td>
<td>Phone: 801-323-6200</td>
<td>Altius Health Plans</td>
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<td>Toll Free: 800-377-4161</td>
<td>P.O. Box 7147</td>
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<td>Electronic Claims - Testing</td>
<td>Contact: Liz Lawrence</td>
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<td>Phone: 800-743-3901 ext 1459</td>
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<td>Contact: Front End Operations Dept.</td>
<td>10421 South Jordan Gateway Suite 400</td>
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<td>South Jordan, Utah 84095</td>
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<td>Phone: 801-323-6200</td>
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<td>Toll Free: 800-879-0234</td>
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<td>Toll Free Fax: 800-434-6250</td>
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<td>Pharmacy Prior Authorization</td>
<td>Phone: 877-215-4100</td>
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<td>Mental Health Network – MHNet</td>
<td>Phone: 800-835-2094</td>
<td>Mental Health Network</td>
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<td>Fax: 801-933-3639</td>
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<td>Austin, Texas 78720</td>
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<td>Coventry National Network and First Health</td>
<td>CSO Provider Service Staff</td>
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<td>Phone: 800-937-6824</td>
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<td>Refunds &amp; Recoveries</td>
<td>Phone: 877-588-0405</td>
<td>Altius Recovery Department</td>
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<td>P.O. Box 951239</td>
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<td>Dallas, TX 75395-1239</td>
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<td>Medicare Advantra</td>
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<td>Network Questions: 800-377-4161</td>
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<td>Benefits/Claims: 866-784-4918</td>
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<td>directprovider.com</td>
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<td>Net Support Team</td>
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<td>Phone: 866-629-3975</td>
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Member Information

Identification

Altius Health Plans will provide an identification card to members listing their name and their assigned 11-digit ID number 9XXXXXXXX-01. The entire ID number must be used for billing and inquiries. Each dependant will receive a card listing their name and the enrollee’s ID number, but with a different suffix.

Although there may be some slight variation in where certain information appears on ID cards, these cards typically include the following:

- Member name, group number and member date of birth
- Summary of key member copay/coinsurance responsibilities
- How to contact Altius Health Plans for eligibility, benefits, precertification and utilization management
- Claims submission information (electronic and postal address)
- Pharmacy and Behavioral Health Services contacts
- Auto and Workers’ Comp clients do not provide ID cards to insured/injured parties. Providers will need to access the Client/Payor list on directprovider.com in order to determine whether they are participating in the Auto or Workers’ Comp network for that member.

Member Eligibility

Altius Health Plans reimburses providers only for medically necessary and covered services rendered to eligible, enrolled members.

To ensure member eligibility, you should check the member ID card. If the patient does not have their member ID card, please contact Altius Health Plans Customer Service at 801-323-6200 or toll free 800-377-4161.

Please note that the member ID card does not guarantee member eligibility. Members may terminate their coverage with Altius Health Plans without surrendering their cards. See the following page for examples of Altius Health Plans member ID cards.

Altius also offers online accessibility to real-time member eligibility/benefit inquiries through the Coventry Health Care owned secure provider portal directprovider.com. For additional information pertaining to directprovider.com, go to the Provider section of this manual under Electronic Solutions.
Member ID Cards

This is not a Medical Insurance Identification Card.

This card provides the holder with all the necessary information to access their Flexible Spending Account information.

Please visit us at: www.altiushealthplans.com
Fax Number: 1-606-330-1377

MAILING ADDRESS FOR FSA REIMBURSEMENT REQUESTS:
Altius Health Care
P.O. Box 7758
London, Kentucky 40742

Altius Health Plans
10681 South Jordan Gateway Suite 450 South Jordan, Utah 84095
Customer Service: (801) 323-6290 or toll free (888) 777-4161
Hours: 8:00 AM to 5:00 PM (MST) Monday through Friday
E-Mail Address: customerservice@altiusplans.com
Website Address: www.altiushealthplans.com
Claims Mailing Address: Altius PO Box 7147, London, KY 40742
Enfocian EDI number: 25132

Altius Health Administrators
18221 South Jordan Gateway Suite 480 South Jordan, Utah 84095
Customer Service: (801) 323-6290 or toll free (888) 777-4161
Hours: 8:00 AM to 3:00 PM (MST) Monday through Friday
E-Mail Address: customerservice@altiusplans.com
Website Address: www.altiushealthplans.com
Claims Mailing Address: Altius PO Box 7147, London, KY 40742
Enfocian EDI number: 25132

Company or other logo here (optional)
Products and Services

Altius Health Plans group product offerings include HMO (Utah & Wyoming Only), PPO, and POS plans, as well as consumer-directed Health Care (CDHC) options. Riders for vision, dental, durable medical equipment, prescription coverage, and other options are also available in connection with our medical plan options. Our CDHC products include a wide range of HSA, FSA and HRA services and configuration options, and are administered in-house by Coventry Consumer Choice (C3). We also offer individual plans, as well as coverage for Medicare beneficiaries.

HMO (Health Maintenance Organization)

With an HMO plan, many health care needs are covered. Services must be medically necessary and provided by participating providers. Coverage includes many preventive health care services to keep members healthy. Members can also change their primary care physician (PCP) as often as once a month.

PPO (Preferred Provider Organization)

A PPO gives members the freedom to choose any doctor, specialist, or hospital to provide their care. The level of member responsibility is determined by whether or not the provider or facility chosen is contracted with Altius. Although the member may choose any provider there are advantages to choosing network providers. These include lower copays and reduced out-of-pocket expenses.

POS (Point-of-Service Plan)

With a Point of Service (POS) plan, members choose their level of coverage. Services must be medically necessary and provided by participating providers. Coverage includes many preventive health care services to keep members healthy. Members can also choose their own primary care physician (PCP) from participating providers. No referrals are needed for specialist visits. Under POS plans, members can see participating providers at the lowest level of member responsibility, or go out of network and pay more of the cost themselves. The choice is theirs.

Fully Insured or Self-Funded Options

We offer an extensive variety of products for large, medium and small businesses, including employee health benefit plans and value-added services that can be tailored to meet an organization’s specific needs.

Consumer-Driven Health Plans (CDHP)

CDHPs may be the wave of the future, but traditional high-deductible plans are anything but easy for consumers to manage. That's why Coventry built its own solution: Coventry Consumer Choice (C3). C3 presents a full service suite of options, including FSAs, HRAs, and HSAs, all seamlessly integrated with our medical plans, claims systems and customer service organizations.

Coverage for Medicare Beneficiaries

Altius Health Plans offers 2 types of Medicare Advantage Coordinated Care Plans; Altius Advantra Option 2 HMO, and Altius Advantra Option 1 HMO-POS. Members in our HMO
plans must use plan providers except in emergency or urgent care situations or for out-of-area renal dialysis. Members in our PPO plans can go to doctors, specialists or hospitals in or out-of-network. With the exception of emergency or urgent care. Accessing services from in-network providers can cost less than using services of out-of-network providers.

Altius Extra
Altius Extra is a discount program that is offered at no additional charge to all Altius members. It offers contracted discounts on health related goods and services not covered by their health plan. Members do not need to register in order to receive the discounts, but may register for email updates of special offers on the Altius Extra website www.altiusextra.com/register.html. For additional questions, visit www.altiusextra.com or contact Altius Health Plans Customer Service at 1-800-377-4161.

My Online Services (MOS)
MOS is a secure web portal of tools that makes it easy for members to find, use, and control their personal health and benefits information. It is built around a Personal Health Record with a dashboard view of information and interactive tools. Through My Online Services members can:

- Check claim status
- View current eligibility, benefit, and policy information
- Print an ID card or request a new one
- Change personal information such as address or phone number
- Request wellness reminders (via e-mail) for checkups
- View Recent lab tests
- Review a summary of current drugs & diagnosis
- Locate a participating provider or pharmacy
- Improve their health and wellbeing by using Coventry WellBeing tools such as:
  - Online Health Risk Assessment which creates a personal health report instantly
  - My ePHIT, an online wellness program that helps members set personal goals and keep track of how they are doing. This tool gives members many tips about nutrition, fitness and life habits.
  - KidsHealth where members can find useful information, written at the right reading level for children, teens and parents

My Online Services can be accessed at www.altiusextra.com by clicking on the My Online Services link at the top of the screen and supplying a valid, self established member log in.

Additional products offered through Coventry Healthcare include:

Network Access Product: The Network Access Product includes third party administrators (TPAs), employers, insurance carriers, union trusts, business coalitions or other associations who are interested in securing access to our networks. Coventry has entered into network lease and/or rental agreements with these entities. Subject to the section “Non-Coventry Payors” of your Agreement, Coventry does not assume the financial liability for any claim or fee for health care services provided to Members participating in the Network Access Product. The provider manual for the Network Access product can be located by visiting http://firsthealth.coventryhealthcare.com

Altius Health Plans 2010
Workers’ Compensation Product: The Workers’ Compensation Product includes network access and other services to Payors, including but not limited to workers’ compensation insurance carriers, third party administrators and other entities and corporations for work related injury or illness and subject to state or federal workers’ compensation regulations as required. The provider manual for the Workers’ Compensation Product can be located by visiting: http://www.coventrywcs.com/

Auto Product: The Auto Product includes network access and other services to auto insurance carriers, third party administrators and other entities and corporations for Member injuries resulting from auto accidents for which coverage is provided under relevant Member Contracts. The provider manual for the Auto Product can be located by visiting: http://www.coventrywcs.com/

Although payers may not actively encourage their injured parties to seek treatment through a Coventry Auto Solutions participating provider, injured parties may locate you in a variety of ways: through their group health plan, after being treated by you through Coventry’s network for a prior workers’ comp injury, by locating you through an online provider directory or toll free number, or by recommendation of a trusted associate or family member.

Billing Members

Altius Health Plans members share in the responsibility of their medical expenses, which helps to keep the cost of health care as low as possible. Members share in the cost of health care through copayments, deductibles, and coinsurance.

Member Hold Harmless

The “Member Hold Harmless” clause, outlined in the Provider Agreement, is in accordance with state and federal law. Participating providers may not seek payment directly from members, except for required copayments, annual deductibles, or coinsurance. Providers should collect fees for any non-covered services directly from the member. Providers should not collect for health care services or benefits determined to be not medically necessary, unless the member has agreed in writing prior to the delivery of the service. Providers should not balance bill the member for the difference between the contracted amount and the total billed charges.

Copayments

A copayment is a fixed amount that a member is responsible to pay to the provider at the time of service (i.e. office visits). Some benefit plans have an equal copayment for PCP and Specialists. Open Access plans may have a split copayment where the specialist copayment is higher than the PCP copayment. Copays are generally excluded from the out-of-pocket maximum. The coverage category shows whether the copay is included in the out-of-pocket maximum. Copayments vary according to the member’s particular benefit plan. Refer to the member’s ID card.
Each member’s ID card indicates the amount of copayment the member is required to pay. The member is responsible for only one copayment per office visit, and is responsible for paying the copayment to Altius Health Plans participating providers at the time of service.

**Deductibles**
A deductible is the amount the member must pay out of their own pocket before benefits for a specific service are paid by the plan. Each plan will indicate separate deductible amounts for individual and family deductibles. A family deductible is satisfied when the combined family member’s deductibles meet the amount set for the family deductible. One family member cannot satisfy the family deductible. Deductibles do not apply toward the out-of-pocket maximum. Deductible amounts are identified on the provider’s remittance advice.

**Coinsurance**
Coinsurance is the percentage of eligible medical expense that is payable by the member (1) and Altius Health Plans (2) which will total 100% of the providers contracted amount. Coinsurance applies after the deductible has been met. Coinsurance usually applies to the out-of-pocket maximum.

**Out-of-Pocket Maximum**
An out-of-pocket maximum is the amount of covered expenses which must be paid each calendar year by a member toward the cost of health care. The individual out-of-pocket maximum applies separately to each member. The family out-of-pocket maximum applies collectively to all members in the same family. When two members within the family have met their individual out-of-pocket maximum, the family out-of-pocket maximum is satisfied. Altius Health Plans will pay 100% of the allowable (except for copayments and the charges excluded, including the PPO discount) for any covered family member during the remainder of the year. Some products and services that do not apply toward the annual out-of-pocket maximum include copayments, deductibles, prescription copayments, mental healthcare services, and non-covered services.

Contact Customer Service at 801-323-6200 or toll free 800-377-4161 for specific information regarding the Altius Health Plan member’s copayment, annual deductible, coinsurance, non-covered service or copayment and benefit maximums. For First Health or Coventry National, please refer to the member ID card for the correct customer service phone number.

**Coordination of Benefits**
Coordination of Benefits (COB) applies when a member has health care coverage under more than one plan. When two or more plans pay benefits, the rules for determining the order of payment are as follows:

- The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.
- A plan that does not contain a COB provision that is consistent with this provision is always primary.
- A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.
Altius requires prior authorization on certain medical services even when Altius is considered the second payor. Please see the prior authorization section in this manual for additional information.

**Member Rights and Responsibilities**

Altius Health Plans is committed to establishing and maintaining a mutually respectful relationship with its members that promotes effective health care. The Member Rights and Responsibilities policy also promotes cooperation among Altius Health Plans members and practitioners

**Altius Health Plans members have the following rights:**

- Receive information about Altius Health Plans, its services, its practitioners and providers, and member rights and responsibilities.
- Exercise these rights without regard to race, color, religion, sex, national origin, or cultural, economic or educational background or the source of payment for their care.
- Considerate and respectful care.
- Know the name of the physician who has primary responsibility for coordinating their care and the names and professional relationships of other physicians who will see them.
- Receive information about the illness, the course of treatment and prospects for recovery in terms that they can understand.
- Receive as much information about any proposed treatment or procedure as they may need in order to give an informed consent or to refuse this course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in this treatment, alternate courses of treatment or non-treatment and the risks involved in each, and to know the name of the person who will carry out the procedure or treatment.
- Participate actively in decisions regarding their medical care. To the extent permitted by law, this includes the right to refuse treatment.
- Full consideration of privacy concerning the medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly.
- Be advised as to the reason for the presence of any individual.
- Confidential treatment of all communications and records pertaining to their care. Written permission from them or their authorized representative shall be obtained before the medical records can be made available to any person not directly concerned with their care.
- Reasonable responses to any reasonable request made for services.
- Leave a medical facility, even against the advice of physicians.
- Reasonable continuity of care and to know in advance, the time and location of appointments as well as the physician providing care.
- Be advised that if a provider proposes to engage in or perform human experimentation affecting care or treatment, they have the right to refuse to participate in such research projects.
- Be informed of continuing health care requirements following discharge from inpatient or
outpatient facilities.

- Examine and receive an explanation of any bills for non-covered services, regardless of source of payment.
- Know which rules and policies apply to their conduct while a member of Altius Health Plans.
- Have rights extended to any person who may have legal responsibility to make decisions regarding medical care on their behalf.
- File an appeal or grievance without discrimination.
- Readily accessible services and ready referral to appropriate medical services, consistent with good professional practice.

Altius Health Plans members have the following responsibilities:

- Give health care providers the information they need in order to care for them.
- Follow the plans and instructions for care that they have agreed upon with their health care provider.
- Behave in a manner supportive of the care provided to other patients and the general functioning of a medical facility.
- Safeguard the confidentiality of their own personal care, as well as that of other patients.
- Accept the fiscal responsibility associated with services they received.
Provider Information

Role of a PCP

PCP Disciplines
Primary Care Providers (PCPs) practice one of the following disciplines: General Practice, Family Medicine, Internal Medicine, Obstetrics/Gynecology or Pediatrics. Although an OB/GYN may choose to be a PCP, many OB/GYN physicians prefer not to provide primary care services and choose to be considered a specialist. The Altius Health Plans Provider Directory designates providers as either a PCP or a Specialist.

PCP Responsibilities
For Altius products which require a member to choose a PCP, a member’s medical care (routine, specialty or hospital) must be rendered or approved by the member’s PCP unless the services have been prior authorized by Altius Health Plans. PCPs are responsible for coordinating a member’s care including issuing referrals to contracted specialists, arranging for medical equipment or home care, and obtaining prior authorization as necessary.

Participating PCPs are expected to provide timely, high quality, medically indicated health care services in a caring manner. Such services should represent the prevailing standard of care. Unproven practices, investigational or experimental treatment, or alternative and complementary medical services are not an Altius Health Plans benefit unless otherwise specified as covered.

Providers are required to provide or coordinate medical services, including emergency services, 24 hours a day, 7 days a week. When Altius Health Plans members are experiencing an urgent medical problem, they are directed to contact their PCP for instructions on how to proceed with their medical care. A participating physician should recommend the use of a hospital emergency room only if medically justified.

Open-Access Plans
Altius Health Plans members can go directly to the following providers without a referral.

OB/GYN
A female enrollee may self-refer to an Altius Health Plans contracted OB/GYN specialist physician.

Optometrist
Contracted Optometrists are available to members without a referral to meet all of their primary eye care needs. The optometrist will refer the member to an ophthalmologist when medically necessary.

Chiropractor
Members can access a contracted chiropractor without a referral. Services beyond the first visit may require prior authorization.
Urgent Care
Members may access a contracted urgent care facility without a referral. Member contribution for urgent care visits vary greatly. Providers are encouraged to call the Customer Service department for benefit information. If customer service is unavailable, the provider may want to collect the member’s PCP copayment at the time of service and then collect additional money, if indicated, by the remittance advice.

Emergency Care
No referral or prior authorization is required to access emergency care when the member or provider determines that the member’s health may be in serious jeopardy if emergency services are not obtained. In general a participating physician should refrain from sending a patient to a hospital emergency room for prescription refills, care for chronic illness, non-emergency x-rays or injections, or other non-emergent care.

Access to and Copying of Records
Provider will not bill the member or Altius Health Plans for expenses related to copying of medical records in the following circumstances:

- Used in order for making a determination regarding whether a service is a covered service for which payment is due.
- Requested by a state or federal agency, including the Centers for Medicare and Medicaid.
- Used in order to assist Altius Health Plans quality improvement, utilization review and risk management programs.

The provider should allow access to all records, books, and papers relating to professional and ancillary care provided to members. This includes financial, accounting, and administrative records. These documents should be available for photocopying during normal business hours.

The provider agrees to maintain all member records for services rendered for at least seven (7) years.

Provider Contracts and Credentialing

Contracts
Altius Health Plans uses standard contracts that outline the obligations of Altius and Providers, as well as governing law and regulatory requirements. Providers should keep a copy of their contract for their reference.

Credentialing
The Altius Health Plans credentialing process is designed to ensure that applicants meet Altius Health Plans requirements prior to acceptance into our network, and continue to meet them prior to renewal of network membership. This credentialing process includes verification of current licensure, hospital privileges, and adequate malpractice coverage. Also taken into consideration, will be data from quality reviews, member complaints, member satisfaction surveys, utilization management, and site reviews.
Participating providers must complete an initial credentialing review and must be approved by Altius Health Plans before providing any covered services to members. Providers are considered participating when they have been contracted and credentialed and will be notified of their participating status through a letter.

Altius Health Plans utilizes the services of Coventry’s Credentials Verification Center (CVC). This arrangement provides centralized and standardized credentialing support. Coventry’s Credentialing Policy has adopted the highest industry standards, plus all applicable state regulations.

To request a provider agreement or to check on the status of your application, please contact your Altius provider service representative or call customer service at 1-800-377-4161 and request Provider Relations. Altius also accepts credentialing applications through CAQH. You can register with CAQH Universal Provider Datasource directly at www.caqh.org.

**Re-credentialing**

Participating providers are re-credentialed at least every three years and will be asked to complete a re-credentialing application or submit through CAQH. Once the credentialing information is received the CVC will conduct a primary source verification of all credentials. The CVC will make the recommendation for a provider’s continued participation. Providers will be notified in writing when the re-credentialing process has been completed.

**Demographic Changes**

The following changes should be faxed to Altius Health Plans at 801-323-6420 or emailed to altiusproviderservice@ahplans.com:

- Provider status change
- Address/phone # change
- Tax ID change (requires an effective date and new W-9 form)
- Not accepting new patients

**Physician Subcontracts**

Physician agrees to not subcontract the performance of services to anyone other than a physician representative without the prior written approval of Altius Health Plans. Physician shall demonstrate and certify to Altius Health Plans that any and all subcontracts comply with the requirements outlined in the provider’s contractual agreement.

Altius Health Plans will conduct an annual audit of all sub-contract agreements or direct employment agreements that may effect the provision of Covered Services by requesting that the provider submit a letter outlining the nature of the sub-contract, including which party is responsible for billing said services, the licensure and/or training of the staff performing the services and the effective date and termination date of the agreement.

**Appointment Availability Standards**

Altius Health Plans maintains policies and procedures to ensure our membership has access to physician care on a 24 hours a day, 7 days a week basis.
Altius Health Plans has established the following standards for appointment availability:

**Specialist**
- Routine Appointments/New patient: 21 days
- Routine Appointments/Established Patient: 21 days
- Urgent/Emergent visit for new or established patient: 24 hours

**PCP**
- Routine Appointments/New patient: 14 days
- Routine Appointments/Established Patient: 14 days
- Urgent/Emergent visit for a new or established patient: 24 hours

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**Quality Improvement, HEDIS**

Altius Health Plans is committed to improving the healthy outcome of our members, expanding the knowledge of our employers, building relationships with our business partners, and increasing the success of our providers.

If there is a “Quality of Care” concern expressed by our members or identified by the provider, please notify Altius Health Plans at 801-323-6200 and we will work with the provider to resolve the issue.

**Health Plan Employer Data and Information Set (HEDIS)**

HEDIS is a set of standardized performance measures that are designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of Altius Health Plans. The HEDIS measures are related to many significant public health issues such as cancer, heart disease, asthma, diabetes and utilization of preventive health guidelines. HEDIS also includes a standardized survey of consumer experiences that evaluate Altius Health Plans performance in areas of customer service, access to care, and claims processing.

HEDIS data is collected by Altius Health Plans each year in the spring. The provider’s office is given a list of Altius Health Plans members who have medical records that need to be reviewed and is asked to pull the charts. The Altius Health Plans Representative will call to schedule a mutually agreeable date and time to review the records. The Altius Health Plans Representative will need a place to sit to conduct the review.

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**Physician Obligations**

**Provision of Covered Services**

Altius Health Plans participating providers will offer covered services to members of products set forth in the member contract in a prompt manner, consistent with professional, clinical and ethical standards of health care. Providers will not discriminate against a member on the basis of age, race, color, creed, religion, gender, sexual preference, national origin, health status, use of covered services, income level, or on the basis that member is enrolled in a managed care organization or is a Medicare or Medicaid beneficiary.
Altius Health Plans participating providers will make covered services available and accessible to members on a 24 hours a day, 7 days a week basis as outlined in the appointment availability standard. In the event that the physician can not provide such coverage, the physician may arrange for a “Covering Physician” who is an Altius Health Plans participating provider to furnish coverage on the physician’s behalf so long as the physician retains primary responsibility for the member’s care.

**Continuity of Care**

In the event the provider’s contract is terminated, the provider should continue to provide care up to 90 days (or as long as may be required to transfer the member’s care). Examples of this circumstance include pregnancy, life threatening illness, and disability.

**Standard of Care**

Physician agrees to provide or arrange for the provision of Covered Services in conformity with generally accepted medical and surgical practices in effect at the time of service. Physician also agrees to implement peer review and credentialing of physicians, nurse practitioners, physician assistants and other ancillary personnel who provide Covered Services to members on behalf of physician.

**Programs & Procedures**

Our providers agree to comply with all Altius Health Plans policies and procedures. Physician agrees to comply with Altius Health Plans Provider Manual, quality improvement, utilization review, peer review, policies and procedures, appeals and grievance procedures, credentialing and re-credentialing procedures, coordination of benefit procedures, and any other policies that Altius Health Plans may implement. Altius Health Plans shall notify physician of any material modifications to such policies 30 days in advance of their applicability.

**Licensure**

Provider agrees to maintain in good standing all licenses, accreditations, and certifications required by law and Altius Health Plans credentialing requirements for so long as the agreement is in effect.

**Liability Insurance**

Providers must obtain and maintain professional liability coverage as is deemed acceptable through the Altius Health Plans credentialing process and as is outlined in the provider’s contractual agreement.

**Marketing**

Provider consents to include physician’s name in Altius Health Plans marketing materials and listing physician in the participating provider directory that Altius Health Plans routinely distributes to members, participating providers and employer groups.

**Compliance with Government Requirements**

Physician agrees to comply with all applicable requirements, laws, rules and regulations of CMS, any other federal agencies and any state agencies of the state(s) in which physician practices.
Site Evaluations
Our providers agree to permit Altius Health Plans to conduct periodic site evaluations of physician's facilities, offices and records. Altius Health Plans may perform a scheduled office evaluation. The evaluation includes but is not limited to the following:

- Facility
- Equipment and supplies
- Medications
- Safety and risk management, including review of prescription pads
- Medical record keeping and patient information
- Infection control and adherence to OSHA regulations related to blood-borne pathogens
- Provider access and availability
- Patient health promotion
- Patient outreach

Duty to Notify Altius Health Plans
Physician will immediately notify Altius Health Plans, in writing of the following:

- any change in their licensure accreditation or certification status
- loss or substantial decrease in the limits or change of their medical malpractice policy
- any judgments or settlements decreed or entered into on behalf of the physician
- any complaints they receive from members regarding physician, Altius Health Plans or Altius Health Plans Participating Providers.
- any other situation that may materially interfere with the physician's duties and obligations under the Agreement.

Altius Health Plans will notify the physician of any complaints it receives from members regarding the physician. The physician and Altius Health Plans agree to cooperate fully in the investigation and resolution of any such member complaint.

Role of Provider Relations
An Altius Health Plans Provider Relations Representative will act as an internal advocate for the provider to ensure that the provider’s concerns are addressed and resolved.

An Altius Health Plans Provider Relations Representative will regularly visit provider offices in order to assess operational and contract issues, and to keep the provider informed of current policies and procedures.

Role of Customer Service
Altius Health Plans Customer Service Representatives are available from Monday – Friday, 8:00am - 6:00pm, and are able to answer provider concerns regarding: eligibility/benefit issues, remittance advice/check issues and claims status/retraction issues.
The Altius Health Plans Customer Service Department may be reached through the following:
Phone: 801-323-6200;
Toll Free: 800-377-4161;
Fax: 801-933-3639;
Email: Customer.Service@ahplans.com

Coventry National Network and First Health Customer Service can be reached by calling 800-937-6824.
Electronic Solutions

Provider Services

The Altius Health Plans Electronic Solutions Team is always working for ways to improve the tools it makes available and create a compelling user experience by providing an outstanding level of service for our providers, members and clients. To support that effort, Altius Health Plans has multiple options for obtaining the information you need to maximize every patient visit.

The following section contains information on some of the solutions that we have available for our providers.

DirectProvider.com

Altius Health Plans supports a free online provider portal, www.directprovider.com, designed and maintained to the highest standards, which allows providers to securely access critical information for their Altius patient membership.

We have recently enhanced and expanded our existing portal to improve usability and provide additional features and functionality to increase usage and further reduce costs. This innovative and secure tool provides access for all Coventry and Coventry National plans and returns information pulled directly from the payer data management for up-to-date information on a variety of healthcare related transactions and needs including:

- Eligibility & Benefits
- Member ID Cards
- Claims Inquiry / Online Claim Reconsideration
- Remittance Advices
- Authorization Submissions / Inquiry / Update / Reconsiderations
- Resource Library
- Secure Messaging
- Fee Schedules for PPO Products
- Provider News…and much more

If your organization has not yet signed up, simply identify who will be the account administrator and go to: www.directprovider.com. After completing steps 1-5 you will be provided a registration number for future reference, along with a user name and password. Once your organization has registered, simply contact your account/site administrator to have additional users added to the account to begin managing all of your Altius Health Plan needs at our secure, one-stop, multi-functional provider portal.

For directprovider.com functional issues, please call Net Support at 1-866-629-3975.
EDI Documentation

Emdeon, a recognized leading clearinghouse in the healthcare Electronic Data Interchange (EDI) industry, provides EDI claim services, Electronic Remittance Advice/ERA delivery, and real-time connectivity for all the Coventry National Payer IDs. Emdeon supports connections into the most comprehensive list of Practice Management System (PMS) and Hospital Information System (HIS) vendors, as well as other EDI clearinghouses, and provides the largest network of Channel Partners from which to receive our EDI services.

EDI claim submitters should review the EDI Exclusion List and Electronic Claim Submission Requirements. Altius Health Plans uses the ANSI X12N 837 v4010 and v4010A1 implementation guides that have been established as the standard claim transactions for HIPAA. The official implementation guides for claim transactions are available electronically from the Washington Publishing Company website at http://www.wpc-edi.com

At Altius Health Plans, we value the providers who take care of our members. Our improved website offers you new tools as well as some electronic tools to assist in claims administration: http://coventrynational.coventryhealthcare.com/providers/electronic-solutions/electronic-solutions-documents/index.htm

Electronic Remittance Advices (ERAs)

Altius Health Plans uses the ASC X12 Health Care Claim Payment/Advice (835) transaction version 4010A1 mandated by HIPAA for the transfer of Electronic Remittance Advice (ERA) information to health care providers.


Currently Altius Health Plans utilizes Emdeon to route 835 transactions to Practice Management System (PMS), Hospital Information System (HIS) vendors or other EDI clearinghouses. Emdeon distributes 835s to providers who are enrolled with Emdeon, or through other vendors and/or clearinghouses, to obtain Coventry National transactions. For more information contact your PMS/HIS vendor or EDI clearinghouse.

ERA enrollment forms are available through your Provider Relations Representative, or on our provider portal www.directprovider.com.

Electronic payments are made separately via Electronic Funds Transfer (EFT).

NOTE: Providers can view a PDF copy of the paper remittance advice via the Remittance Advice section of www.directprovider.com
Electronic Funds Transfer (EFT)

Electronic Fund Transfer (EFT) is a service offered by Altius Health Plans that allows for the immediate transfer of funds to a Provider’s bank account. It is the same concept as your direct deposit for your paycheck. This service is available for most claims and capitation payments.

Benefits:
- Improved cash flow/immediate deposit of funds
- Decrease in accounts receivable and days in A/R
- Fewer lost or misplaced checks
- Decreased costs associated with check handling

How To Enroll
The provider must complete the Electronic Fund Transfer Authorization Form, which is available through your Provider Relations Representative, or on our provider portal www.directprovider.com and return it to:

Coventry Health Care, Inc.
Attn: PC&I-EST
P.O. Box 67103
Harrisburg, PA 17106-7103

Providers must also enclose a voided check or deposit slip for the depositing account. It typically takes about 45 days before the first deposit is made. The Provider will continue to receive paper checks until that time. There are no costs associated with EFTs with the exception of minimal banking fees (the Provider must check with his/her banking institution regarding EFT fees).

Effective 9/1/2009: Coventry and Altius Health Plans are Going Green and have announced a new Paperless Policy associated with all new EFT enrollees. Providers who submit an EFT Authorization form on or after 9/1/09 also agree to go paperless and will no longer receive the paper copy of the RA. Existing EFT providers who receive the paper copy of the RA sent via U.S. Mail are not affected by this new policy. Existing EFT providers may contact their provider representative if they wish to no longer receive the paper copy of the RA

Provider Inquiries

For provider support questions, please refer to the following contact and support information available below:

- For directprovider.com issues, please call Net Support at 1-866-629-3975
- For problems with Altius Health Plans electronic claims transactions, contact Front-End Operations (FEO) at 302-283-6570 or email EDIclaims@cvty.com
- For questions regarding EFT enrollment, email CoventryEFTrequest@cvty.com
- Questions regarding ERAs can be emailed to: ERAquestions@cvty.com
- For claim issues through Emdeon products, call Batch Help Desk at 1-800-845-6592
Claims

Submission of Claims

Claims and encounter data must be submitted to Altius Health Plans on a UB92 Form or Centers for Medicare and Medicaid Services (“CMS”) 1500 forms with current CMS coding, current International Classification of Diseases, Ninth Revision (“ICD9”) and Current Procedural Terminology Fourth Edition (“CPT4”) coding in accordance with the then current Medicare guidelines. The provider is responsible for ensuring that the data being submitted is accurate and complete.

All services performed on the same day should be submitted together as one claim. Physician may not bill Altius Health Plans for inpatient Covered Services prior to the date of discharge and shall not separate bills for covered services for purposes of additional payments under the provider agreement, except when hospitalizations of the member are greater than or equal to sixty days, in which case interim billing is required.

Paper claims for covered services should be submitted to:
Altius Health Plans
P.O. Box 7147
London, KY 40742

Also include the following information:
- Patient name (exactly as it reads on the ID card)
- Patient identification number and 2 digit suffix
- Provider name
- Provider federal tax identification number
- Provider National Provider identification number
- Procedures and diagnosis using CPT-4, HCPCS, and ICD9 codes
- Prior authorization number in Box 23 and the referring physician’s name in Box 17 on the claim form.

Upon receipt of a clean claim (a claim containing all the elements necessary to process as required by the law of the State or in accordance with the requirements outlined under the Claim Submission portion of the contract), Altius Health Plans shall make payments to the participating Provider in accordance to the terms of the provider agreement. When an incomplete claim is received, the claim will be denied and the remittance advice will state what information is needed in order to reconsider the claim.

Altius Health Plans requires appropriate documentation and coding to support payment for covered services. The provider will have the opportunity to correct any billing or coding error within 30 days of the denial related to any such claim submission. Altius Health Plans will have the right to recover payment or retain portions of future payments in the event that Altius Health Plans determines that an individual was not an eligible member at the time of services, or in the
event of duplicate payment, overpayment, payment for non-covered services, or fraud. When Altius Health Plans is not the Payor, Altius Health Plans will have no obligation and liability with respect to any claim or fee for health care services rendered.

Provider understands and agrees that failure to submit claims in accordance with the requirements of this section may result in the denial of such claims.

**Reimbursement**

Altius Health Plans reimburses providers for medically necessary covered services in accordance with their provider agreements. Altius Health Plans applies business rules when claims are adjudicated. These rules encompass the industry standard practices for claims processing. The business rules are applied when claims are submitted with modifiers, multiple procedures or other separately identifiable coding aspects of a claim.

**Claims Editing Information**

Altius Health Plans accepts the American Medical Association’s (AMA) guidelines that state the code(s) reported/billed “accurately identifies the service performed”. Altius also requires 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.” Consistent with today’s industry standards, Altius Health Plans edits including but are not limited to those that are defined under the CMS Correct Coding Initiative Guidelines (CCI).

**Electronic Claim Filing**

Altius Health Plans encourage physicians and medical providers to submit claims electronically. Electronic claims submission can have significant, positive impact on the productivity and cash flow for your practice.

- Reduce paperwork and costs associated with printing and mailing paper claims.
- Reduce time for Altius Health Plans to receive a claim by eliminating mailing time.
- Reduce delays due to incorrect claim information by returning errors directly to you through the same electronic channel. These claims can be corrected and re-submitted electronically.
- Improve accuracy by decreasing the chance for transcriptions errors and missing/incorrect data.
- Track and monitor claims through claim status reports received electronically.

Electronic Claim Submission to Altius Health Plans is easy to establish. Contact your practice management system vendor or clearinghouse to initiate the process. You can also go to the Provider section of this manual under Electronic Solutions to view EDI and other pertinent information and options that are available to you.
National Provider Identifier (NPI)

An NPI is the 10 digit numeric unique identification number to be used by all health care providers as specified by HIPAA.

Altius Health Plans accepts NPI only and NPI dual (with legacy) identifiers for claims transactions throughout our systems. All providers are required to report and use NPI’s on all claim submissions. Failure to do so could interfere with the accurate and timely processing of claim payments.

Claim Inquiries

Customer Service
Provider inquiries regarding claims payment should be directed to Altius Health Plans Customer Service at 801-323-6200 or toll free 800-377-4161. Please be prepared to provide the following information to the Customer Service Representative:

- Patient’s name and ID number
- Patient’s date of birth or age
- Date of service
- Description of service
- Billed amount

Inquiries regarding claims for Coventry National Network and First Health should be directed to the CSO Provider Service at 800-937-6824

Real-Time Claim Inquiries and Adjustment Requests
Claims inquiries and adjustment requests can be performed online at your convenience through the Coventry Health Care owned secure provider portal directprovider.com.

The User Guide for directprovider.com explains how to perform an Online Claim Adjustment Request through the Altius Health Plans provider portal. You can download, view, and print the document(s) using Adobe Acrobat Reader.

For additional information pertaining to directprovider.com, go to the Provider section of this manual under Electronic Solutions.

Appeal Process for Claims Editing Denials

All disputes, except in the case of a credentialing decision, that may arise between a physician, other professional health-care provider or a health-care facility and Altius Health Plans, will be addressed using the Provider Claim Reconsideration Policy and Procedure outlined below:
Provider calls Altius Health Plans Customer Service to initiate the following:

1. **Level I Review**
   a. Medical records may be required for all claim edits or coding issues. A Medical Records Coversheet (See Attachment 1) must be utilized when records are required for additional review. Medical records and/or corrected claims may be emailed, faxed or mailed to the Customer Service Dept. at following address: Altius Health Plans  
      PO Box 7147  
      London, KY 40742  
      ATTN: Customer Service Dept.
b. A determination will be made by a Medical Claims Review Nurse (MCRN) to either approve or deny the reconsideration. Altius Health Plans will then issue a new Remittance Advice indicating the reconsideration determination.
c. For reconsiderations regarding pre-service clinical denials, refer to the Pre-Service Clinical Appeals Policy.
d. Reconsiderations regarding Timely Filing or Fee Schedule disputes are forwarded to the provider Relations Dept.
e. All reconsideration requests must be made within 365 calendar days of the date of notification of the denial unless the provider contract stipulates a different timeframe. If the provider or designated representative has not requested review within the specified timeframe, the provider has waived the right to reconsideration.
f. All Level I Reconsiderations will be processed within thirty (30) days of receipt of reconsideration.
g. All mental health provider disputes will be forwarded to the contracted mental health vendor for review.

2. **Level II Review**
   a. Once a Level I determination has been made and the provider still disagrees with the health plan's decision, the provider may request a Level II review. All Level II reconsideration requests can be emailed, faxed or mailed to the address below:  
      Altius Health Plans  
      10421 S Jordan Gateway Ste 400  
      South Jordan, UT 84095  
      ATTN: Provider Relations Dept.
b. Requests must contain a detailed explanation of the dispute, including any documentation that had not been previously submitted through the Level I review.
c. The respective Provider Relations Representative will review all of the information provided including information from the Level I review. The Provider Relations Representative may consult the Chief Medical Office, Medical Claims Review Nurses or any other applicable business unit to assure that a fair and impartial review has occurred.
d. The Provider Relations Representative will record the decision both in the IDX system and in the STARS database.
e. All Level II Reconsiderations will be processed within thirty (30) days of receipt of reconsideration.
f. Written communication of the decision will be mailed to the provider within five (5) business days of the final determination. Written notification will include the reason for approving or denying the requests.

3. **Reporting**
   a. Reports will be generated from the STARS database on a monthly basis and results will be provided to the Quality Improvement Committee (QIC). The report will include the total number of reconsiderations processed during the month, total number that were overturned or upheld, turnaround times and the reason for the reconsideration.
b. The intent of the report is to track and trend the volume of reconsiderations submitted and to identify billing/payment trends that are a direct result of systematic or operation issues. It also serves as a provider educational tool to outline and reiterate company policies and procedures.

See below for a detailed work flow of this policy and procedure.
Provider/Facility Reconsideration Workflow
(Contract Disputes, Claim Edits, Reduction in Services)

**Level 1**

Provider sends Medical records/corrected claim with Reconsideration Request & Coversheet

Information mailed to Altius:
P.O. Box 7147
London, KY 40742

Medical records/corrected claim reviewed by Informal Review MCRN

If approved, claim is reprocessed

Provider/Facility gets new RA with payment

If provider/facility disagrees with decision, request can be sent in for Formal Review

See Level II Review Process

If denied, claim is re-denied

Provider/Facility gets new RA with denial

**Level II**

Provider/Facility disagrees with Level I decision, request for Level II review sent to Altius/Provider Relations Dept

Information mailed to Altius:
10421 S Jordan Gateway Ste 400
South Jordan, UT 84095

Request reviewed by Provider Relations Representative

Request reviewed by Formal Review MCRN

If approved, claim is reprocessed & new RA is sent

If denied, Reconsideration Exhausted letter is sent
Fraudulent Billing

It is essential for the provider to understand the coding and billing process. According to CMS, each year the health care industry loses more than $100 billion to health care fraud and abuse. CMS and Coventry Health Care/Altius Health Plans define fraud, abuse and billing error as follows:

- Fraud is the knowing and willful deception, misrepresentation or reckless disregard of the facts with the intent to receive an unauthorized payment.

- Abuse is a practice that, although not considered a fraudulent act, may directly or indirectly cause financial loss. Abuse usually does not involve a willful intent to deceive.

- Billing error is the incorrect submission of services rendered due to factors such as an uneducated office staff, coding illiteracy, staff turnover, etc.

Anti-fraud detection is a preventive measure. The Coventry Health Care Special Investigation Unit (SIU) proactively reviews provider claims to identify and investigate unusual or inappropriate billing patterns. This could lead to some claims being denied for supporting medical documentation. The SIU may also request supporting documentation or schedule an on-site audit to investigate previously paid claims. The investigation does not mean that a provider is practicing fraud. In many cases, the SIU finds the provider billing practice was in error. In all cases, the SIU will work with the appropriate Provider Relations representative to communicate what is believed to be an inappropriate billing practice.
Utilization Management

Overview

Altius Health Plans performs the management of medical services through the personnel and processes of the Health Services Department. The purpose of managing medical services is to ensure the delivery of services in a quality oriented, timely, medically appropriate, and cost efficient manner for the Altius Health Plans membership. Altius Health Plans’ intent is to provide its members with a comprehensive, preventive and therapeutic health care delivery system.

Utilization Management is a team effort requiring expertise in medical management, clinical care, care management systems, provider relations, network development, and quality improvement.

The Altius Health Plans Utilization Management staff are not compensated based on the outcome of individual certification decisions or based on the number or type of non-certification decisions rendered. In addition, the Utilization Management staff will not be influenced by conflicts of interest as defined in the Conflict of Interest policy.

Prior Authorization

Altius Health Plans requires prior-authorization for referrals to selected specialists, hospital admissions, selected outpatient surgeries, selected ancillary services, selected procedures, or equipment that are of high cost, or frequently inappropriately utilized. Altius requires prior authorization on these services even when Altius is the secondary payor in a Coordination of Benefits (COB) situation. A current list of Altius Health Plans Prior Authorization requirements can be found at www.directprovider.com

Prior Authorization review includes the evaluation of:

- the medical appropriateness of the recommended procedure/service
- the level of service recommended
- the date of service requested
- the proposed length of stay, if applicable
- the appropriateness of the providers

Requests are evaluated clinically, utilizing the specific clinical guidelines. Benefit quotation is performed by the Altius Health Plans Customer Service department.

When contacting Altius Health Plans to prior authorize or verify an authorization for services, please have the following information available to reduce the incidence of lack of information denials and achieve review of your request quickly and efficiently:

- Your name and office you are calling from and call back number
- Member Name/ID number
- Diagnosis (ICD-9 code) and procedure codes if available
• Anticipated date of service
• Date of admission for hospitalizations and anticipated length of stay
• Finding on physical exam
• Results of previous testing done: pertinent labs, X-rays, EKG, etc
• Results of physical therapy if applicable
• Test or Procedure request (CPT code if available)
• Place of service
• Patient symptoms and findings

The prior authorization phone numbers are 801-323-6200 or 1-800-377-4161. Pre-certification can also be obtained via fax at 801-323-6160 or 1-800-434-6250.

**Real-Time Authorizations Submissions/Inquiries**

Authorizations can be submitted and verified online at your convenience through the Coventry Health Care owned secure provider portal directprovider.com. Many authorizations can be approved in the time it would take you to dial Altius Health Plans. For additional information pertaining to directprovider.com, go to the Provider section of this manual under Electronic Solutions.

**Concurrent Review**

Concurrent review is the active review of ongoing care with regard to medical necessity, appropriateness, timeliness, quality issues, and potential case management candidates. This review extends from the time of admission until discharge and applies to all admissions to acute care, skilled care, or rehabilitative care. Concurrent reviews involve screening medical records for the medical necessity, appropriateness, and timeliness of the delivery of medical care. The intent is to facilitate the treating physician’s plan of care in an efficient manner, as well as to anticipate treatment and patient needs as the patient moves towards discharge. The Prior Authorization Coordinators additionally confer with the patient’s attending physician, PCP, hospital social services or discharge planners as required by the individual patient needs.

The initial review for medical cases is conducted within one business day of the admission after notification of the admission is received. For prior authorized surgeries, the initial review is conducted if the stay exceeds established length of stay guidelines. Subsequent concurrent reviews are conducted at varying intervals as the particular case warrants. Patients requiring special coordination because of the complexity of their illness, home situation, or frequent emergency room or hospital admissions will be referred to a Case Manager. The Case Manager coordinates both ambulatory and inpatient care needs, and maintains frequent contact with the patient.

Any identified concerns are referred to the Quality Improvement department for further research and appropriate measures in accordance with the Plan’s policies and procedures.

**Notification of Review**

The Utilization Management department will provide verbal notification of review determinations to the requesting provider, and written notification of certification to the member.
If the approved health service has not been performed within the specified timeframe, an updated authorization will be required before services can be rendered.

Written notification of non-certification (denial) will be sent to the member, relevant facility or provider and will include the following information:

- The principal reason for the determination to not certify the service
- A statement that the clinical rationale used in making the determination will be provided, in writing, upon request
- Instructions for initiating an appeal of the non-certification and for requesting a clinical rationale for the non-certification

### Discharge Planning

The goal of discharge planning is to assist a patient through inpatient hospitalization and to return the member to a state of wellness as quickly as possible. Discharge planning is the process by which Utilization Management staff assess the patient's needs prior to and during an inpatient hospitalization to anticipate care needs when the patient is discharged from the hospital. Using all the previously identified information sources, the staff can intervene and work in conjunction with the primary care provider, hospital social services and/or specialist to assist in the coordination of services for the patient in the home setting.

Examples of medical care that can be arranged in the discharge planning phase include home health care, physical therapy, speech therapy, and occupational therapy; skilled nursing facility placement; rehabilitation therapy facility placement; home infusion therapy; and durable medical equipment.

### Case Management

Case Management services are provided to members who have suffered a traumatic injury or illness or have a significant medical condition necessitating ongoing medical follow-up and treatment. Proper medical management of a catastrophic case is intended to assure the continuity of high quality care in a cost-effective manner. Case Managers follow patient care cases where extensive services are needed for chronic conditions. Case Management is a collaborative process that promotes quality care and cost effective outcomes that enhance physical, psychosocial, and vocational health of individuals. It includes assessing, planning, implementing, coordinating, and evaluating health related service options.

Each case manager works in conjunction with a member's primary or specialist physician as appropriate and coordinates their work activities with the Chief Medical Officer/Medical Director as deemed appropriate.

Referrals for case management may be received from a variety of sources such as the Primary Care Physician, Specialist Physician, Utilization Management team members, Chief Medical Officer, Medical Director, member/family, internal departments, employer group, etc.
Disease Management

Disease Management is an information based process focused on a specific population involving the continuous improvement of value in all aspects of care. Disease Management programs focus on the entire spectrum of health care delivery; from prevention through treatment and ongoing management. Disease Management is a coordinated, disease specific approach to patient care that seeks the best-measured outcome at the lowest possible cost. Disease Management programs may be conducted within the Quality Management department or the Utilization Management department.

Denials

If criteria for a Utilization Management determination are not met, or are questionable, efforts are made to obtain all pertinent clinical information to allow a licensed medical professional to review the case. The Chief Medical Officer/Medical Director will utilize guidelines, current medical knowledge and/or outside expert opinion to determine if approval or denial of coverage is appropriate.

Case reviews forwarded to the Chief Medical Officer/Medical Director will be handled according to the Utilization Management Clinical Peer Review Policy. If the requested service is denied, written notification will be provided in accordance with the Utilization Management Notification of Determination Policy.

Appeals

Mechanisms for appeal of a denial decision are outlined in the denial letter, the Member Handbook, the Altius Health Plans web site, and the Group Coverage document. All provider and member appeals are directed to the Appeals Dept, who maintain a log and database of appeals and process the appeal as specified in the Altius Health Plans Appeal Policy.

Coordination with Quality Improvement

If quality or risk issues related to the practices of Utilization Management are identified by the Quality Improvement personnel, these are taken immediately to the Chief Medical Officer or Medical Director for corrective action. Resolution or corrective action of these issues becomes the responsibility of the Quality Improvement department.

Provider Satisfaction surveys are done on a regular basis. Included in these surveys are issues related to Utilization Management. These are reported to the Chief Medical Officer, Health Service Director and Senior Management to see if goals and objectives are being met. In addition, protocols and guidelines are re-evaluated against current medical knowledge and updated on an annual basis.
Prospective, Concurrent, or Retrospective Reviews

The retrospective review process involves the review of medical claims for medical necessity issues related to care needs not previously screened through the prior authorization process. The same clinical guidelines and criteria sets utilized in the prior authorization process are utilized during a retrospective review.

Contracted providers and members of Altius Health Plans must request prior-authorization of certain services in order for payment to be rendered, as outlined in the Provider Manual, Group Service Agreement, and the Member Handbook. Responding to this request, Altius Health Plans will evaluate the request for medical necessity (as appropriate) and determine if the services are a covered benefit. Failure to obtain prior authorization may result in non-payment as outlined in the Provider Manual/Member Handbook.

Prospective and concurrent reviews are based solely on the medical information obtained by Altius Health Plans staff at the time of the review determination. Retrospective reviews are based solely on the medical information available to the attending physician or ordering provider at the time the medical care was provided. Altius Health Plans will not reverse a certification decision determination unless it receives new information that is relevant to the certification and that was not available at the time of the original certification (reconsideration).

For routine prospective, concurrent, or retrospective reviews, Altius Health Plans will:
1. Accept information from any reasonable reliable source that will assist in the certification process. If the source of the information, such as the member, cannot provide all the necessary information, staff in the Utilization Management Department will make the necessary additional contacts to obtain all information.
2. Collect only the information necessary to certify the admission, procedure or treatment, length of stay, or frequency or duration of services.
3. Not routinely require hospitals, physicians, and other providers to numerically code diagnoses or procedures to be considered for certification, but may request such codes, if available.
4. Not routinely request copies of all medical records on all patients reviewed.
5. Accept needed clinical information over the phone, by fax, or other electronic means and not routinely require that a letter of medical necessity be sent.
6. When the medical record is deemed critical, require only the section(s) of the medical record necessary in that specific case to certify medical necessity or appropriateness of the admission or extension of stay, frequency or duration of service, or length of anticipated inability to return to work.
7. Pay reasonable medical record copying costs for records requested from providers that are not contracted with Altius Health Plans. The contracts of contracted providers may preclude such charging.
8. Avoid duplicate requests for information from members or providers by scanning medical records or entering the relevant clinical and demographic information into Altius Health Plans Systems so that various departments within Altius Health Plans and Coventry Health Care with a need to know and the appropriate access rights can view the information.

Review requests will be handled in a systematic manner utilizing the appropriate team member at
specific phases of the process. The phases include a non-clinical pre-review screening, an initial clinical review, and as indicated, a peer clinical review and/or clinical peer review by an appropriate specialist. Initial clinical reviews are the responsibility of licensed health professionals. Peer clinical reviews are the responsibility of licensed physicians. The Health Services Department is under the direct supervision of at least one full-time, on-site Medical Director. To ensure appropriate, quality services to Altius Health Plans members, review requests shall be processed within an established time frame.

<table>
<thead>
<tr>
<th>Review Process</th>
<th>Timeframe for Decision*</th>
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<tbody>
<tr>
<td>Prospective – Urgent</td>
<td>As soon as possible but no later than 72 hours</td>
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<tr>
<td>Prospective - Non Urgent</td>
<td>Within 15 calendar days</td>
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<td></td>
<td>This period may be extended one time for up to 15 calendar days provided that it is</td>
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<td></td>
<td>determined that an extension is necessary because of matters beyond our control and</td>
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<td>the patient is notified prior to the expiration of the initial 15 calendar day period</td>
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<td>of the circumstances requiring the extension and the date when a decision can be</td>
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<td></td>
<td>expected. If a patient fails to submit the necessary information to decide the case,</td>
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<td></td>
<td>the notice of extension must specifically describe the required information, and the</td>
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<td></td>
<td>patient must be given at least 45 days from receipt of notice to respond to the plan</td>
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<td></td>
<td>request for more information.</td>
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<tr>
<td>Concurrent - Reductions or termination in a previously approved course of treatment</td>
<td>Early enough to allow the patient to request a review and receive a review decision</td>
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<td></td>
<td>before the reduction or termination occurs; and for requests to extend a current course of treatment, the organization issues the determination within:</td>
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<td></td>
<td>• 24 hours of the request for a utilization management determination, if it is a case</td>
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<td></td>
<td>involving urgent care and the request for extension was received at least 24 hours</td>
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<td></td>
<td>before the expiration of the currently certified period or treatments; or</td>
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<td></td>
<td>• 72 hours of the request for a utilization management determination, if it is a case</td>
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<td></td>
<td>involving urgent care and the request for extension was received less than 24 hours</td>
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<td></td>
<td>before the expiration of the currently certified period or treatments.</td>
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<tr>
<td>Retrospective</td>
<td>Within 30 calendar days from the receipt of request for a Utilization Management</td>
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<td></td>
<td>determination.</td>
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<td></td>
<td>This period may be extended one time for up to 15 calendar days if an extension is</td>
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<td>necessary because of matters beyond our control and the patient is notified prior to</td>
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<td>the expiration of the initial 30 calendar days of the circumstances requiring the</td>
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<td>extension and the date when a decision is expected.</td>
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<td>If the patient fails to submit necessary information to decide the case, the notice of</td>
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<td>extension must specifically describe the required information, and the patient must</td>
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<td>be given at least 45 calendar days from receipt of notice to respond to the request</td>
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<td>for more information.</td>
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<tr>
<td>Idaho Members per ID Statute 41-3930 (2)</td>
<td>A managed care organization shall respond to member or provider requests for prior</td>
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<td>authorization of a non emergency service within two (2) business days after complete</td>
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<td>member medical information is provided to the managed care organization unless</td>
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<td>exceptional circumstances warrant a longer period to evaluate a request.</td>
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</table>

*Time begins when the request is received
Skilled Nursing Admissions

Skilled Nursing Facility (SNF) admissions require pre-authorization. The Concurrent Review Coordinator, as part of the discharge planning process, usually performs pre-authorization of SNF admissions. Following the admission, the Concurrent Review Coordinator will review the stay via telephone with the facility Case Manager (or designated facility review staff).

Rehabilitation Admissions

Admissions to rehabilitation facilities require prior authorization, which is often performed by the Concurrent Review Coordinator as a part of discharge planning. Concurrent review is performed by telephone. For catastrophic cases, a Complex Case Manager may be assigned to review the case and coordinate discharge plans.
Pharmacy Prescription Benefits

Medco

For the majority of our employer groups, Altius Health Plans has contracted with Medco for the administration of drug benefits. All prescriptions must be written by a participating provider and filled at a participating pharmacy.

Drug Formulary

The Drug Formulary is the foundation of drug therapy quality improvement and cost containment efforts in managed care organizations. Its purpose is to optimize patient care through rational selection and use of drugs and to ensure quality plus cost-effective prescribing. The drugs included in this formulary support that goal. There are three key elements that are important for establishing a formulary:

- A collaborative relationship among health care professionals
- A defined medical staff or physician-provider network
- An interdisciplinary Pharmacy and Therapeutics (P&T) Committee

The Drug Formulary was developed by the Coventry Health Care P&T Committee in conjunction with the respective P&T Committees of Altius Health Plans. These committees are composed of pharmacists and physicians from various specialties. They have reviewed medications in each therapeutic class for efficacy, adverse events, and cost of treatment, and have selected agents in each category. The maintenance of the formulary is a dynamic process, and new medications and information concerning existing medications are continually reviewed by the P&T Committees.

Physicians are encouraged to review the formulary and utilize it when prescribing for our members. This is extremely important since a member’s prescription benefit is based on medications being prescribed from the Drug Formulary. Under some circumstances formulary drugs may be excluded from a member’s benefit (for example, oral contraceptives). The formulary is in no way meant to interfere with your exercise of independent medical judgment based on the patient-physician relationship.

The formulary applies only to outpatient prescription medications dispensed by participating pharmacies. It does not apply to inpatient medications or the medications obtained from and/or administered by a physician. The formulary can be obtained at www.altiushealthplans.com, in the provider section under Prescription Documents. A physician may request a formulary change by completing a written request for drug addition to include the following:

- advantages and disadvantages of the drug compared to current formulary alternatives
- indications for use, efficacy, and review of side effects (this request should be submitted to the Altius Health Plan’s P&T Committee).

Comments and suggestions to the formulary are welcomed and should be directed to the Altius Regional Pharmacy Director.
Generic Drug Policy

For certain medications, generic substitution is mandatory if the FDA has determined the generic to be equivalent to the brand product. These drugs are covered at a generic reimbursement level and Maximum Allowable Cost (MAC) limits of reimbursement have been defined. If a physician indicates “Dispense as Written” or if a member insists on the brand name for a medication listed on the MAC list, the member will be responsible for a higher out-of-pocket amount based on their benefit design. If a physician determines that a generic equivalent is not medically appropriate, authorization for the brand name product must be obtained from the Plan for it to be covered (and is subject to benefit limitations.) Requests for exceptions to the generic policy must clearly document specific reasons for medical necessity and appropriateness.

Prior Authorization

To promote appropriate utilization, selected high-risk or high-cost medications may require prior authorization by Altius Health Plans to be eligible for coverage under the member’s prescription benefit. These drugs are designated in the formulary by “Prior Authorization Required” next to the generic name. Altius Health Plans Prior authorization criteria have been established by the P&T Committee.

A list of medications that require authorization and a prior authorization criteria and forms that are specific to each drug are available on the Altius Health Plans website www.altiushealthplans.com.

In order for a member’s prescription to be considered for coverage, the physician or pharmacist must call the Member Services number on the member ID card to request prior authorization. Or, fax a completed prior auth form to the number listed on the form. The request will be reviewed against approval criteria. The physician and member will be notified of the coverage decision.

Step Therapy

Step Therapy is an automated form of Prior Authorization based on previous pharmaceutical treatment. Drugs designated as stepped therapy will require prior authorization if the condition is not met when the pharmacist would attempt to transmit a prescription claim. Drugs that could require Step Therapy or Prior Authorization are identified in the Altius Health Plan Health Care formulary by (ST or PA) next to the name.

Self-Administered Injectables

Injectable drugs defined as self administered are covered under the prescription benefit for most of the Altius Health Plans. Members should refer to their plan-specific documents for coverage information. For a list of the drugs that fall into this category, please see the last page of the printed formularies or the self-administered injectable formulary on the website. As noted, this coverage applies to commercially insured members only. All of these medications require prior authorization except for emergency or urgent situations these drugs are dispensed from Altius.
Health Plan’s contracted Specialty Pharmacy Providers once coverage has been determined. Supplies will be limited to up to a one month supply per prescription. Insulin, Glucagon and Bee Sting Kits will continue to be provided as part of the traditional pharmacy program and are not part of the self administered injectable program. Please contact your local Provider Relations Representative if you have questions about this coverage.

**Non-Formulary Medications**

Depending on a member’s prescription drug benefit (example: closed formulary) a physician may request an override of the formulary for a specific member. The request for coverage will be reviewed by the Plan. The physician and the member will be notified of the coverage decision. Pharmacies may bill automatically for overrides that have been approved. A member’s prescription will be approved for a specific drug, and different non-formulary drugs will require prior authorization when needed.

**Quantity Limits**

Quantity limits are set on medications for different reasons. Many commonly used once daily drugs have limits since these drugs are proven to be safe and effective when taken once daily. Secondly, the different strengths of many of these drugs cost the same amount of money. Because of these two facts, taking two pills daily instead of one doubles 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 limits or maximum doses as recommended by the FDA.

Quantity limits are reviewed and determined by clinical staff, pharmacy directors, and/or the Pharmacy & Therapeutics Committee. The quantity limits are based on FDA approved dosing schedules and the medical literature related to the particular drug. A link for our prescription quantity limit list can be found at [www.altiushealthplans.com](http://www.altiushealthplans.com).

If an exception is requested, the physician’s office can contact Altius Health Plans, where the pharmacy department and/or medical staff review the medical information provided by the physician to determine if an exception is appropriate. The Altius Health Plans Pharmacy Department then puts an authorization into the pharmacy system if the request is approved.

**Diabetic Supplies**

Diabetic blood glucose test strips are covered under the prescription drug benefit, as offered by the employer. Covered brands of strips are Lifescan products which are:

- One Touch Ultra®
- One Touch Basic®
- One Touch Sure Step®
- One Touch Fast Take® (monitors are no longer available)
Non-Covered Medications

1. Medications, except insulin, that can be obtained over-the-counter (OTC) or that have a non prescription alternative
2. Medications for cosmetic use (e.g. Rogaine®)
3. Weight loss agents
4. Smoking Cessation Agents
5. Experimental or Investigational medications
6. Vitamins and Minerals, both OTC and Legend (specific formulations intended to cover extreme nutritional deficiencies) except prenatal vitamins for pregnant/nursing females, liquid or chewable legend pediatric vitamins for children
7. Drugs for infertility
8. Any other specific exclusion contained in the respective Altius Health Plans Drug Rider or benefit document

Pharmacy Network

Your patients may have their prescriptions filled through the wide network of Altius Health Plans participating pharmacies. Please refer your patients to their provider directory for a comprehensive list of participating pharmacies.

Mail Order

Altius Health Plans provides the convenience of a mail order pharmacy through Medco for members who are on long-term, maintenance medications. Altius Health Plans members can purchase a 90-day supply of medication, depending on their pharmacy benefit. Prescription drugs that require close monitoring or drugs that are considered controlled substances by federal or state law are excluded from the mail order pharmacy program. The list of medications which are excluded from the mail order program can be found at www.altiushealthplans.com.

Appeal Rights

The fact that Altius Health Plans contracted physicians or health care providers may prescribe, recommend or order a medication, does not of itself make such a medicine a covered benefit. Whether or not a member obtains a medication that is not covered is a decision between you and your patient. A request for coverage of a medication that has been denied only indicates that Altius Health Plans will not be responsible for charges incurred.

With the consent of the member, you may request reconsideration of a decision on behalf of the member if you believe this decision was made in error. All requests should be made by calling Customer Service at 801-323-6200 or toll free 800-377-4161. You may also submit a letter of medical necessity to the following address:

Altius Health Plans
ATTN: Appeals Department
10421 South Jordan Gateway, Suite 400
South Jordan, UT 84095
Ancillary

Dental

The Evidence of Coverage (EOC) excludes coverage for dental care services unless the services are provided under a supplemental benefit rider. Please contact the Altius Health Plans Customer Service Organization (CSO) for detailed information on dental benefits provided through Altius Health Plans.

Mental Health/Chemical Dependency

In general, services that are complex or exceed the normal skill level for medical care providers are expected to be referred for specialty care to appropriate mental health providers. Such care may include major depression, psychosis, bipolar disease, autism, substance abuse, dissociative disorders, sexual disorders, serious eating disorders, or serious personality disorders. Patients requiring high dose psychopharmacologic therapy or therapy with multiple agents are generally to be referred for psychiatric care and oversight.

Coverage for mental health and substance abuse is administered by a Coventry Health Care wholly-owned subsidiary, MHNet Behavioral Health. MHNet is a nationally recognized behavioral health leader. They emphasize evidence-based, consumer-focused behavioral health review. This helps us improve the health and well-being of our members. MHNet contact information is as follows: Mental Health Network

P.O. Box 209010
Austin, Texas 78720
Phone: 800-835-2094 / Fax: 801-933-3639

Vision Services

Services for routine eye exams may or may not be covered under the member’s benefit plan. Please contact Customer Service at 801-323-6200 or toll free 800-377-4161 at 866-765-7747 for detailed information on vision benefits provided through Altius Health Plans.

PT/OT/ST Benefits

Altius Health Plans will cover short term outpatient physical therapy, occupational therapy, and speech therapy for plan members subject to clinical criteria and benefit visit limitations. The continuation of any type of therapy will be determined depending on evidence of objective progress, medical necessity and the condition being treated, and is subject to the limits of the patient’s Altius Health Plans benefits.

Home Health

Home Health services require prior authorization. Home Health services must be provided under a physician prescribed plan of care that is updated regularly by the physician. The Altius Health
Plans Home Health benefit covers part time, intermittent or fulltime medically necessary home health skilled nursing services. A prior auth nurse or case manager will assess the ability of the family and other caregivers to be trained and assume responsibility for the care. Home Health Services will not be covered when the service can be safely and adequately provided by the member, a relative or willing friend or the member is not home bound.

**Hospice**

Hospice care will be covered on a per diem basis for members of Altius Health Plans who have a terminal illness and a life expectancy of 6 months or less determined by a physician, and who choose to participate with a participating hospice program instead of standard acute aggressive medical care for their illness.

The hospice benefit is a total package of care for all medical needs associated with the patient’s terminal illness. When a member elects hospice coverage, they must complete and sign a Hospice Election Statement that includes identification of the hospice program and documents the member’s understanding of the hospice care. By signing this statement, the member waives their right to coverage relating to the curative treatment of their illness.

A member may choose to discontinue hospice at any time by signing a Revocation Statement. Once the member revokes their hospice election, the member immediately resumes prior curative treatment coverage through Altius Health Plans.

**Durable Medical Equipment**

The rental or purchase of Durable Medical Equipment DME must be used in the patient’s home in order to be covered.

Coverage is subject to the requirement that the equipment be necessary and reasonable for the treatment of an illness or injury, or to improve the functioning of a malformed body member. In most cases a physician's prescription for the equipment and other medical information available will be sufficient to establish that the equipment serves this purpose, however, specific criteria must be met for some items. Even though an item of durable medical equipment may serve a useful medical purpose, it must be determined as to what extent, if any, it would be reasonable for coverage of the item prescribed.

The Period of Medical Necessity will be determined by the requesting physician and/or Utilization Medical Director or Utilization Management Committee based upon the length of time that the equipment is medically necessary.

**Laboratory Services**

If you collect laboratory specimens in your office, these samples should be directed to an Altius Health Plans participating laboratory for analysis.
There are certain laboratory services for which physicians will be reimbursed when performed in the provider office. All lab services billed by a physician office must be performed onsite within the physician’s office/facility that is CLIA certified. All lab services must be billed by the provider performing the service.

Reimbursement will not be made for any lab specimen that is directed to a non-participating lab or any test performed in a physician’s office which is not approved by Altius Health Plans. In this instance, the provider may not bill Altius Health Plans for the laboratory services and the member must be held harmless, in accordance with provider contracts.

**Radiology**

Please refer your Altius Health Plans patients to the appropriate provider in their network for radiology services. To determine where to send your patients for radiology services, please refer to Altius Health Plans Provider Directory. For a list of Radiology and other services that require prior authorization, please refer to the Medical Management section of this manual.

**Emergency and Urgent Care**

Altius Health Plans defines medical emergencies as situations that place a person’s life in jeopardy or threaten permanent impairment to body functions.

An Urgent health problem is a situation resulting from an unforeseen illness or injury that requires medical attention to prevent serious deterioration of a person’s health. Severe headaches, sudden joint swelling or pain, lacerations, severe human or animal bites, and puncture wounds are just a few examples.

Altius Health Plans advises their members to go to the nearest hospital emergency room if a medical condition exists that manifests itself by acute symptoms of sufficient severity (including severe pain), such that a prudent lay person with average knowledge of health and medicine could reasonably expect that absence of immediate medical attention would result in the following:

- serious jeopardy to the health of the individual (or unborn child)
- serious impairment to body function
- serious dysfunction to any bodily organ or part

If you instruct a member to visit the emergency room, or if you admit the member to the hospital in an emergency situation, please call Medical Management within 24 hours or by the next business day. Please remember that failure to notify Altius Health Plans of an emergency room visit or emergency hospital admission may result in financial penalties and/or a reduction in benefits to the member.

Ambulance service for transportation to the hospital is a covered benefit for members in emergencies only. In such an emergency, 911 or another local emergency number should be called.
Out of Area Care

Emergency care for Altius Health Plans members is covered whether the need arises inside or outside of Altius Health Plans service area, in the United States or abroad. Emergent and Urgent Care Services will be authorized to prevent further deterioration of the member’s health before he or she can return to the service area. Altius Health Plans members are urged to contact their primary care provider for follow-up care.

Non-Participation Hospitalization

Whenever we are advised that a Altius Health Plans member has been hospitalized on an emergency basis in a non-participating facility, the patient may be transferred to an Altius Health Plans participating facility when the patient’s condition has stabilized. These services require authorization and may be authorized by contacting the Medical Management Department.