At Coventry Health Care, we are committed to providing accessible, high quality service to our members, and we appreciate your efforts in helping us to achieve that goal.

In order to ensure that we communicate effectively with you, we have developed this Provider Manual to assist you and your staff. These policies and procedures are designed to guide you through Coventry Health Care’s administrative processes.

We hope you find this manual informative and helpful. We will continue to provide you with updates via letters, the web, and our provider newsletters and through your provider relations representative as changes occur. Should you have any questions regarding our health plan, please contact our Provider Hotline at 800-755-5242.

Update on our integration—what you need to know

As you may know, Coventry and Aetna are now one company. Although we’re one company, we’ll continue to operate separate Coventry and Aetna networks in Illinois and Missouri. In January 2016, Coventry members will begin to transition to Aetna claim systems. As part of this change, we’ll give members new ID cards. See below for a sample.

Your current Coventry participation agreement still applies

The terms in your agreement still apply to members with these new ID cards. This doesn’t impact your participation in the Coventry or Aetna networks.

Direct your patients to in-network providers to save

When needed, direct members to other in-network providers. These providers may vary, depending on which network the member uses. You can find a list of in-network providers at:

- [www.aetna.com](http://www.aetna.com) (Aetna)
- [www.chemissouri.com](http://www.chemissouri.com) (Coventry members with “Accessing the Missouri <Coventry logo>” on the front of their ID card)
- [www.chcillinois.com](http://www.chcillinois.com) (Coventry members with “Accessing the Illinois <Coventry logo>” on the front of their ID card)

We’ll process claims based on Aetna’s policies, not Coventry’s

For Coventry members administered on Aetna claim systems, we’ll process claims based on Aetna clinical and claim payment policies, which may vary from Coventry’s.

Where you should send claims

Please send claims to the address listed on the back of the ID card.

We’re here to help

Just e-mail us at [CHCILMOProviderInformation@aetna.com](mailto:CHCILMOProviderInformation@aetna.com) if you have questions.
<table>
<thead>
<tr>
<th>Important Telephone Numbers</th>
<th>Phone</th>
<th>Toll Free</th>
<th>Fax/Website</th>
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| Coventry Health Care        | 314-506-1700 | 800-743-3901 | 866-874-6403  
|                            |       |           | www.chcmissouri.com  
|                            |       |           | www.coventry-medicare.com  |
| Coventry Health Care Provider Hotline/IVR | N/A | 800-755-5242 | N/A  
| MoDOT/MSHP Provider Hotline | N/A | 800-627-6406 | N/A  
| University of Missouri Provider Hotline Medical Management (Prior Authorizations - All Products) | 314-506-1843 | 800-546-4603 | 866-603-5534  
| • Therapy Providers | | | 866-603-5532  
| • Concurrent Review | | | 866-603-5531  
| • OB | | | 866-769-2407  
| • Custodial Care | | | 866-247-1816  
| • Transplants | | | 724-741-7138  
| • Complex Case Management | | | 866-603-5400  
| • University of Missouri | 866-876-7442 | | 866-603-5536  
| • MoDOT | 877-824-4559 | | 866-603-5536  |
| Medical Management | | |  
| 8:00 a.m.–5:00 p.m. (CST), Monday–Friday | N/A | 800-546-4603 | N/A  
| Medical Management (After Hours On-Call Nurse) | N/A | 877-513-2744 | N/A  
| Provider Hotline | | |  
| 8:00 a.m.–6:00 p.m. (CST), Monday–Friday | N/A | 800-755-5242 | N/A  
| TDD/TTY 711 Relay | | |  
| 8:00 a.m.–8:00 p.m. (CST), Monday–Friday | N/A | 866-784-4916 | N/A  
| Care Management Resources (CMR) | | |  
| Coventry ASO Network (Prior Authorizations) | 314-506-1843 | 800-546-4603 | 866-603-5536  
| Pharmacy Department | N/A | 877-215-4100 | 877-554-9139  
| EyeMed | N/A | 800-521-3605 | N/A  
| Mental Health Network (MHNet) | | |  
| University of Missouri Programs Only | 314-543-5400 | 855-884-8532 |  
| | | 800-735-2966TDD | N/A  
| Mental Health Network (MHNet) | 314-543-5400 | 877-227-3520 | N/A  
| Quest Diagnostic Labs | N/A | 866-697-8378 | N/A  
| Accredo (Express Scripts Specialty Pharmacy) | N/A | 877-881-9047 | N/A  
| Special Groups | | |  
| (Such as BJC Residents, QHDHPs) | N/A | 800-338-4123 | N/A  
| Carpenters’ Claim Issues | 314-644-4802 | 877-232-3863, ext. 1000 | N/A  
| IBEW Local No. 1 | 314-752-2330 | N/A | N/A  
| Local 309 Health and Welfare Fund | 618-344-2002 | N/A | N/A  
| Medicare marketing | N/A | 800-633-4227 | N/A  
| Emdeon | N/A | 877-469-3263 | N/A  
| Express Scripts | N/A | 800-955-1201 | N/A  
| Curascript | N/A | 888-773-7376 | N/A  
| Deaf Interlink | 314-837-7757 | N/A | www.deafinterlink.com  
| NIA | 800-546-4603 (option 6) | www.RadMD.com  
| TRIAD | 888-584-8742 | | 888-229-5680  |
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General Information

Coventry Health Care has many products in our portfolio combined with several networks of providers to service each product’s members, which includes:

• HMO, PPO and Point of Service (POS) products
• CMR
• Coventry ASO Network
• Select
• ASO Select
• Carelink From Coventry
• FocusedCare HPN
• Medicare Advantage
  - Advanta HMO/POS
  - Gold Advantage HMO
  - Advanta PPO
  - Coventry Total Care
• Workers’ Comp
• Auto

For your convenience, frequently called numbers are provided in the front of this manual. The Provider Hotline is your contact point for any questions you may have about claims or member eligibility. When you require an authorization, call the Medical Management number.

When you have questions about or need an authorization for a CMR or Coventry ASO Network member, refer to the number on the back of the Member ID card.

Our Interactive Voice Response (IVR) system is another easy way to check member eligibility, claim status and benefits. Simply call 800-755-5242 and follow the prompts.

You can also access a wide variety of helpful information through www.directprovider.com. Go to www.chcmissouri.com to register.

Coventry Health Care’s Provider Relations Department is ready to serve your office. Provider Relations administers the contracts of in-network providers, ancillary services and hospitals, and trains providers on Coventry Health Care’s policies and procedures. If your office would like a refresher course on our policies and procedures, or if you have questions about your agreement with Coventry Health Care, your provider relations representative will be happy to assist.

Providers are required to furnish covered benefits to Coventry Health Care’s members in accordance with their Coventry Health Care Contract.

Providers are required by the Americans with Disabilities Act of 1990 to provide an interpreter for individuals with hearing impairments who request the service. You can contact an interpreter by calling Deaf Interlink at 314-837-7757. TDD/TTY 711 Relay 866-784-4916.

Appointment Scheduling and Wait Time Guidelines

To assure the best service possible for our members, we ask you to adhere to the following standards for appointment scheduling and waiting time:

Guidelines:

• Obstetrical care appointments during the first or second trimester should be scheduled within one week. Appointments for patients in the third trimester should be scheduled within three days.
• Routine primary care appointments should be scheduled within seven (7) days
• Appointments for urgent care should be scheduled same day or within 24 hours.
• Emergencies must be seen immediately.
• Visits with specialists or consultants should be scheduled within three weeks unless the primary care provider (PCP) requests an earlier time.
• Patients with scheduled appointments should be seen within 30 minutes of their scheduled appointment times.
  For afterhours care each primary care physician must have a reliable 24 hours a day/7 days a week answering service or machine with a beeper or paging system. A recorded message or answering service that refers members to emergency rooms is not acceptable.
  Providers and emergency care facilities are to be available or provide phone coverage 24 hours a day, 7 days a week for emergency care.

Coventry Health Care performs surveys to ensure providers meet the above standards. If the above standards are not met, we send a letter to the provider asking him/her to develop an action plan.

Requirement for Participation

Coventry Health Care and our providers are partners in the health care of Coventry Health Care members. Because of this mutual responsibility, we require our providers to adhere to the following standards for all lines of business:

1. We expect our providers to give the U.S. Department of Health and Human Services (HHS) and U.S. General Accounting Office (GAO), and their authorized designees, the right to audit, evaluate and inspect all books, contracts, medical records, patient care documentation and other records relating to your participation and services furnished to members, for 10 years following termination or expiration of your agreement for
any reason, or until completion of an audit, whichever is later, unless the timeframe is extended.

2. We expect our providers to safeguard the privacy of any information that identifies a particular member in accordance with federal and state laws and to maintain the member records in an accurate and timely manner. We recommend that providers request identification from our members in addition to the Coventry Health Care Member ID card, such as a valid driver’s license.

3. Our providers will not deny, limit or condition the furnishing of covered health care services to members based on health factors including, but not limited to: mental or physical illness, claims experience, receipt of health care, medical history, genetic information, and evidence of insurability or disability.

4. Members are not discriminated against in the delivery of healthcare services based on race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, or source of payment.

5. Our providers will provide covered benefits and health care services to members in a manner consistent with professionally recognized standards of health care. Providers must render or order only medically appropriate services.

6. Our providers will cooperate with Coventry Health Care’s medical management and quality improvement activities and procedures. This includes returning phone calls, answering correspondence, providing medical records and responding to our staff as needed so they can perform their duties.

7. Providers must not require a specialty referral where a product does not permit it.

8. Our providers will cooperate with Coventry Health Care by participating in CMS and HHS quality improvement initiatives.

9. Our providers must obtain authorizations for all hospitalizations as well as the services specified in this manual as requiring prior authorization.

10. We expect our providers to fully comply with the terms of their agreement and maintain an acceptable professional image in the community.

11. We expect our providers to keep their licenses and certifications current and in good standing and to cooperate with our recredentialing program. Coventry Health Care must be notified of any material change in provider qualifications affecting the continued accuracy of the credentialing information submitted to Coventry Health Care.

12. Providers must obtain and maintain professional liability coverage as is deemed acceptable by Coventry Health Care through the credentialing process. Providers must furnish Coventry Health Care with evidence of coverage upon request and must provide the plan with at least 15 days notice prior to the cancellation, loss, termination or transfer of coverage.

13. Providers look solely to Coventry Health Care for payment of services furnished to members, and will not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have claim or recourse against a member, or anyone acting on behalf of a member, under any circumstance unless explicitly approved for reason of coordination of benefits or subrogation. This will not prohibit collection of copays on Coventry Health Care’s behalf made in accordance with the terms of the agreement between Coventry Health Care and the member.

14. Providers will ensure the completeness, truthfulness and accuracy of all claims and encounter data submitted to Coventry Health Care including medical records data required and ensuring that information is submitted on the prescribed form.

15. In the event that the provider or Coventry Health Care seeks to terminate the agreement, it must be done in accordance with the contract.

16. Providers can collect from members charges for services that are not covered services as defined in the agreement between Coventry Health Care and the member provided that the patient has been informed in advance of delivery of services that the services are not covered. Members must agree in writing, in a form substantially similar to the ones found at www.chcmissouri.com. The member must sign the Authorization to Perform Non-Covered Services form and include specific information listing the non-covered services and the date of service specific to the non-covered services. The above-mentioned form cannot be a generic form used upon registration and will not be accepted in lieu of obtaining a prior authorization for covered services. The provider must submit the claim along with any member written acknowledgment to accept responsibility for non-covered services to the plan. Use of this form does not supersede your contract obligations.

17. Providers may not advertise their participation in Coventry Health Care’s Medicare Advantage networks without written consent of Coventry Health Care. Our Medicare contract with CMS stipulates that we must obtain CMS’s approval before releasing any information about our Medicare products. This obligation extends to our contracted providers who wish to publicly announce their Coventry Health Care Medicare Advantage affiliation. Non-compliance with this regulation would place us in violation of our agreement with CMS.

18. If Coventry Health Care’s contract with CMS terminates, expires, or becomes insolvent, providers will continue to provide covered services to Coventry Health Care members who are hospitalized on that date through the date of each member’s discharge or for the remainder of the period the premium has been paid. Continuation of services shall be made in accordance with the terms and conditions of the provider contract.

19. Providers will furnish covered benefits to Coventry Health Care’s Medicare Advantage members consistent with CMS requirements and Coventry Health Care policy.

20. Providers will cooperate with Coventry Health Care in furnishing a health assessment of all new Coventry Health Care Medicare Advantage members within 90 days of the effective date of enrollment.

21. Providers will send in changes to their demographic or payment information 30 days prior to the effective date of change.

22. Notices of termination must be sent within the terms of your agreement. If you fail to notify Coventry Health Care of your desire to terminate
your agreement within the term and timeframe, as outlined in your contract, you must arrange for a Coventry Health Care in-network provider to cover your Coventry Health Care members.

23. Providers will ensure Coventry Health Care Medicare Advantage members have direct access to Pap smears, mammograms, influenza vaccines, pneumococcal vaccines and diabetic retinal eye exams.

24. Providers will be familiar with Coventry Health Care member rights as outlined in the Member Rights and Responsibilities section of this manual. Providers will ensure that they honor all Coventry Health Care member rights, including but not limited to, treatment with dignity and respect, confidential treatment of all communications and records pertaining to their care and to actively participate in decisions regarding health and treatment options. Providers will freely communicate with patients about their treatment, regardless of benefit coverage.

25. Providers will be available to Coventry Health Care members as outlined in the Appointment Scheduling and Waiting Time Guidelines section of this manual. Providers also will arrange 24-hour on-call coverage for his/her patients by providers that participate with Coventry Health Care, as outlined below.

26. Providers will ensure timely and confidential transfer of records between providers as outlined in the Transfer of Information Between Providers section of this manual. Providers may not bill or charge member or Coventry Health Care for the copying or transferring of medical records, x-rays or other information (needed to diagnose and/or treat the member) to another Coventry Health Care in-network provider.

27. Provider will allow the plan access to medical records as needed to process claims, make benefit determination, complete medical management and QA activities.

We encourage our providers to contact their provider relations representative any time they require further details regarding the above. Failure to comply with these standards may result in financial penalties and/or the termination of the contract.

Cultural, Ethnic, Racial and Linguistic Needs of Members

To ensure that Coventry’s health delivery system meets the cultural, ethnic, racial and linguistic needs of its members and providers, Coventry performs, at a minimum, annual assessment of the following to gauge the availability of providers. You can assist us by providing information when a language, other than English, is spoken in your office. Coventry completes:

- Annual review of membership demographics (preferred language, ethnicity, race)
- Local and National geographic population demographics and trends derived from publicly available sources
- Network Assessment
- Health status measures such as those measured by HEDIS as available
- Comparison with selected measures, such as Healthy People 2010
- Evaluation of member satisfaction survey
- Member provider preference

PCP on Call Requirements

You, or the provider on-call for you, must be available and accessible 24 hours a day, 7 days a week. You must arrange coverage when you are unavailable, and the covering provider must be a Coventry Health Care in-network provider.

Coventry Health Care will not pay for services that have been capitated to the member’s PCP. The capitated PCP is financially responsible for the covering provider for his/her practice.

If a fee-for-service PCP arranges for on-call coverage of his/her practice and wants to ensure payment for the on-call provider, the fee-for-service PCP must contact Coventry Health Care Provider Relations to update their on-call coverage record. Coventry Health Care pays the provider for the services provided to the member on a fee-for-service basis.

Taped telephone messages that direct patients to the emergency departments are not acceptable as an alternative to arranging coverage by another provider.

Changes to Tax Identification or Demographics

Please notify Coventry Health Care’s Provider Relations Department in writing with any additions, deletions or changes to the following:

- Tax identification number
• Office or billing address
• Telephone or fax number
• E-mail address
• Specialty
• Board certification information
• New providers added to the practice (please allow time for credentialing)
• Licensure (DEA, DPS, state licensure or malpractice insurance)
• Group affiliation
• Hospital privileges

Adverse actions taken by a hospital, Board of Medical Examiners, managed care organization, or other entity that is responsible for the National Practitioner Data Bank. If a provider leaves a practice or plans to change locations, open new locations, or leave the current practice, written notification should be provided as far in advance as possible to Coventry Health Care’s Provider Relations Department prior to the change. By providing information prior to the change, the following is ensured:

The provider and practice information is properly listed in Coventry Health Care’s Provider Directory. All payments made to the provider practice are properly reported to the IRS.

There is no disruption in claims payments and claims are processed correctly according to the provider’s contract.

**HIPAA**

HIPAA guidelines require that providers be asked certain identifying questions when they are accessing protected health information (PHI). Please have the following information available when contacting Coventry Health Care:

1. Tax identification number
2. Provider ID number
3. Name and address
4. NPI number

**Coventry Health Care’s HMO and PPO Member Rights and Responsibilities:**

**Information**
• Know the names and qualifications of health care professionals involved in your medical treatment.
• Get up-to-date information about the services covered or not covered by your plan, and any limitations or exclusions.
• Know how your plan decides what services are covered.
• Get information about copayments and fees that you must pay.
• Get up-to-date information about the health care professionals, hospitals and other providers that participate in the plan.
• Be told how to file a complaint or appeal with the plan.
• Know how the plan pays network health care professionals for providing services to you.
• Receive information from health care professionals about your medications, including what the medications are, how to take them and possible side effects.
• Receive from health care professionals as much information about any proposed treatment or procedure as you may need in order to consent to or refuse a course of treatment. Except in an emergency, this information should include a description of the proposed procedure or treatment, the potential risks and benefits involved, any alternate course of treatment (even if not covered) or non-treatment and the risks involved in each, and the name of the health care professional who will carry out the procedure or treatment.
• Be informed by participating health care providers about continuing health care requirements after you are discharged from inpatient or outpatient facilities.
• Be informed if a health care professional plans to use an experimental treatment or procedure in your care. You have the right to refuse to participate in research projects.
• Receive an explanation about non-covered services.
• Receive a prompt reply when you ask the plan questions or request information.
• Receive a copy of the plan’s Member Rights and Responsibilities Statement.

**Access to Care**
• Obtain primary and preventive care from the primary care physician you chose from the plan’s network.
• Change your primary care physician to another available primary care physician who participates in the plan.
• Get necessary care from participating network specialists, hospitals and other health care providers.
• Be referred to participating network specialists who are experienced in treating your chronic illness.
• Be told by your health care professionals how to schedule appointments and get health care during and after office hours. This includes continuity of care.
• Be told how to get in touch with your primary care physician or a back-up physician 24 hours a day, every day.
• Call 911 (or any available emergency response service) or go to the nearest emergency facility when you have a medical condition with acute symptoms that are severe enough sufficient so that a prudent layperson, who has average knowledge of health and medicine, could reasonably expect the lack of immediate medical attention to result in serious danger to the person’s health.
• Receive urgently needed medically necessary care.

The Freedom to Make Decisions
• Use these rights regardless of your race, physical or mental disability, ethnicity, gender, sexual orientation, creed, age, religion, national origin, cultural or educational background, economic or health status, English proficiency, reading skills, genetic information, or source of payment for your care.
• Have any person who has legal responsibility to make medical care decisions for you make use of these rights on your behalf.
• Refuse treatment or leave a medical facility, even against the advice of doctors (providing you accept responsibility and the consequences of the decision).
• Complete an Advance Directive, Living Will or other directive and give it to your health care professionals.
• Know that you or your health care professional cannot be punished for filing a complaint or appeal.

Personal Rights
• Be treated with respect for your privacy and dignity.
• Have your medical records kept private, except when permitted by law or with your approval.
• Be involved in deciding on the kind of care you do or do not want.

Input
• Have your health care professional’s help when you have to make decisions about the need for services and if you are involved in the complaint process.
• Suggest changes in the plan’s policies and services, including our Member Rights and Responsibilities policy.

As an Aetna HMO or PPO member, you have a responsibility to: Exercise Your Rights
• Choose a primary care physician from the plan’s network and form an ongoing patient-physician relationship.
• Help your health care professional make decisions about your health care.

Follow Instructions
• Read and understand your plan and benefits. Know your copayments and what services are covered and what services are not covered.
• Follow the directions and advice you and your health care professionals have agreed upon.
• See the specialists your primary care physician refers you to.
• Make sure you have the correct authorization for certain services, including inpatient hospitalization and out-of-network treatment.
• Show your member ID card to health care professionals before getting care from them.
• Pay the copayments required by your plan.
• Promptly follow your plan’s complaint procedures if you believe you need to submit a complaint.
• Treat doctors and all providers, their staff, and the staff of the plan with respect.
• Not be involved in dishonest activity directed to the plan or any health care provider.

Communicate
• Tell your health care professionals if you do not understand the treatment you receive and to ask if you do not understand how to care for your illness.
• Tell your health care professional promptly when you have unexpected problems or symptoms.
• Consult with your primary care physician for referrals to non-emergency covered specialist or hospital care.
• Understand that network doctors and other health care professionals who care for you are not employees of Aetna and that Aetna does not control them.
• Call Aetna’s Member Services department about your plan if you do not understand how to use your benefits.
• Give correct and complete information to doctors and other health care professionals who care for you.
• Tell Aetna about other medical insurance coverage you or your family members may have.
• Ask your treating doctor about all treatment options, and how the doctor is paid by Aetna.

You may have additional rights and responsibilities depending upon any state law applicable to your plan.

Coventry Health Care’s Medicare Advantage Member Rights and Responsibilities
We must support your right to make decisions about your care
• You have the right to know your treatment options and participate in decisions about your health care
• You have the right to participate with practitioners in making decisions about your health care. You have the right to get full information from your doctors and other health care providers when you go for medical care. Your providers must explain your medical condition and your treatment choices in a way that you can understand.

• You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

  − To know about all of your choices. This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.

  − To know about the risks. You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.

  − The right to say “no.” You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.

  − To receive an explanation if you are denied coverage for care. You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 9 of this booklet tells how to ask the plan for a coverage decision.

• We follow specific rules to help us make your health a top concern:
  - Our employees are not compensated based on denials of coverage.
  - Our plan does not encourage denials of coverage. In fact, our utilization review staff is trained to focus on the risks of members not adequately using certain services.
  - You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself. If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

**Member ID Cards**

Sample Member ID cards are located on our website at [www.chechomissouri.com](http://www.chechomissouri.com) in the Providers Document Library. Auto and Workers’ Comp clients do not provide ID cards to insureds/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.

**Coventry Health Care Interactive Voice Response System (IVR)**

The IVR system offers automated information on eligibility, benefits and claim status to our providers 24 hours a day, 7 days a week. You will receive an immediate response to your request, a hard copy fax of information for your records and reduced hold time to acquire information. Simply call 800-755-5242 and follow the prompts to access Coventry Health Care’s IVR system.
## Emdeon

Coventry Health Care partners with Emdeon to give our providers access to helpful information for administration services. The Coventry site allows providers to check eligibility, submit claims, obtain authorizations, check claim status and receive remittance advises and payments through electronic fund transfers for Coventry Health Care members. In addition, there is functionality to allow claims disputes to be processed electronically. This feature allows for a more convenient and timely method of handling disputed claim payments. If you are interested in obtaining a username and password to access this site, please contact your provider relations representative or call Emdeon at 877-469-3263.

## Directprovider.com

Directprovider.com is a one-stop, self-service secure tool offering our providers a direct connection, faster service and lower costs. It is easy-to-use and contains the tools and information providers need to get the job done. By directly connecting to our organizations through the website, providers realize a better response for payments, a simplified work flow process, content and tools that address the needs of all providers, and lower costs.

The website currently offers:

- Claim inquiry
- Claim history, receipt, processing and adjudication of a claim
- Secure messaging
- Claim level rejection, claim editing and resubmission
- Sensitive policy documents and forms
- Eligibility inquiries including benefit information
- EFT and payment inquiry
- Viewable Member ID cards
- Viewable remittances
- Authorization/Referral requests

In addition to the HIPAA-compliant business transactions, the website contains enhanced content and expansive information. Through the security of the website, providers have access to news, industry-standard information about benefit plans, various reports, user guides, prescription tools and resources, downloadable forms, Member ID cards, enhanced reporting for providers, direct connectivity capability and more.

Go to [www.chcmissouri.com](http://www.chcmissouri.com) to register.

## How to find the correct Coventry Plan on directprovider.com

When checking eligibly, authorizations or claims you need to select the appropriate drop down box for your member. Below is a key to the Coventry plans you may need to access:

- **CHC-MO/CMR**..................Coventry of Missouri, Inc. Commercial (HMO, PPO, POS, Select), ASO/CMR and Medicare – name change to ‘Coventry Health Care of Missouri’

- **Coventry Missouri**..................MoDot members – name change to ‘MoDOT and MSHP’

- **Carpenters DC of St. Louis**..................Carpenters members - Carpenter’s is price and pass now isn’t it? If staying on D.P.com, drop down is different ‘Carpenter’s Health and Welfare Trust Fund’
Coventry Health Care Commercial Products

Fully Insured Commercial Products
Coventry Health Care offers a wide variety of products for our members, which include both Group and Individual plans. Coventry Health Care’s HMO, POS, PPO and ASO products are available as Deductible, Coinsurance and Copay benefit plans. For Deductible benefit plan designs, members may be responsible for meeting their in-network and/or out-of-network deductibles before coinsurance or copays are applied by Coventry Health Care when processing the claim. Some of these benefit plans also qualify as high deductible health plans that require member deductibles to be met before Coventry Health Care makes payment, unless such services qualify as a preventive service. Consequently, in-network providers should always collect applicable copays at the point of service and submit claims to Coventry Health Care for adjudication. For benefit plans that have coinsurance established for the service being provided, submit the claim to Coventry Health Care for adjudication prior to collecting funds from the member. In all instances Coventry Health Care’s remittance establishes the contractual allowance and provides direction regarding member liability. You are always allowed to bill members directly for charges determined to be member responsibility.

HMO and POS Products
Members of Coventry Health Care’s Commercial primary care provider (PCP) products enjoy comprehensive HMO and POS coverage. Some of Coventry Health Care’s HMO and POS benefit plans require the member to select a PCP. The difference between HMO and POS is an out-of-network benefit, or POS option, that is available to POS members.

HMO and POS members use the HMO/POS network. If a PCP is required, HMO/POS members may choose any internist, general practitioner, family practitioner or pediatrician listed in the HMO/POS Provider Directory as their PCP, given the PCP of choice has an open panel or he/she does not have age restrictions for patients.

The PCP is the gatekeeper of the HMO member’s health care. Whenever a PCP wishes to refer an HMO or POS member to a specialist, he/she must refer the member to a provider that participates in the HMO/POS network. POS members have the option to see out-of-network providers however, certain services still require prior authorization. As an in-network provider, you are required to call Coventry Health Care’s Medical Management Department to obtain prior authorization for services as necessary on behalf of Open Access HMO and Open Access POS members.

Some HMO and POS members are not required to select a PCP, but are urged to establish and maintain a professional relationship with a PCP. Like our traditional PCP product, Coventry Health Care offers a POS benefit plan option. The difference between HMO and POS is the out-of-network benefit, (POS option) which is only available to POS members.

POS members receive in-network HMO benefits as long as they stay within the HMO/POS network. If POS members use out of network providers, they receive benefits according to the POS (out-of-network) benefit plan option. Coventry Health Care pays its portion of member coinsurance after members meet their deductibles, with the members assuming financial responsibility for billed charges above Coventry Health Care’s out-of-network allowable, and for the coinsurance percentage of the out-of-network allowable as designated in their benefit design. Please encourage members to utilize in-network providers whenever possible in order to improve your ability to coordinate the delivery of quality health care and to limit their out-of-pocket expenses.

PPO
PPO members utilize the PPO network. PPO members have a strong financial incentive through lower copays, deductibles and coinsurance to utilize PPO in-network providers. Members may choose to utilize out-of-network providers but they’ll face higher out-of-pocket costs. Therefore, Coventry Health Care asks all in-network PPO providers to refer PPO patients to other PPO in-network providers.

PPO in-network providers are responsible to obtain prior authorization for certain services as presented in the Medical Management section of this Provider Manual. Failure to obtain prior authorization will result in holding the member harmless for the service. Providers are required to call Coventry Health Care’s Medical Management Department to obtain prior authorization for services on behalf of PPO members.

Please refer to the Carelink from Coventry and the FocusedCare HPN sections for information specific to these products.

Select
The network utilized by Select members is smaller than the PPO network. Select members have a strong financial incentive through lower copays, deductibles and coinsurance to utilize Select in-network providers. Members may choose to utilize out-of-network providers but they face higher out-of-pocket costs. Therefore, Coventry Health Care asks all network Select providers to refer Select members to other Select in-network providers.

Select in-network providers are responsible to obtain prior authorization for certain services as presented in the Medical Management section of this Provider Manual. Failure to obtain prior authorization will result in holding the member harmless for the service. Providers are required to call Coventry Health Care’s Medical Management Department to obtain prior authorization for services on behalf of Select members.

Qualified High Deductible Health Plans (QHDHP)
Members enrolled in Qualified High Deductible Health Plans (QHDHPs) are usually responsible for meeting deductible requirements before coinsurance and copays apply. However, preventive care is excluded from the deductible requirement and only copays apply.

Members may present a debit-type card to pay for their portion of the service. However, we encourage members not to use these cards at provider offices or contracted facilities. They work best when used at pharmacies or when members reimburse themselves for the copays, coinsurance and deductibles they have paid.

Please note: Based on feedback from the provider community we have made the decision to allow up front collections on QHDHP’s. Deductibles and coinsurance may be collected at the time of service if you are comfortable estimating the contractual allowable for the service being provided.
If you chose to collect at the time of service, you are not permitted to turn members away for being unable to pay at that time. Upon receiving a remittance advice (RA) and payment from Coventry Health Care, all payments in excess of the allowable under the terms of your agreement must be reimbursed to the member. It is important to note, collecting deductibles and coinsurance at the point of service is not permitted under Coventry Health Care’s standard benefit plan designs (non-QHDHP’s). Coventry Health Care Member ID cards clearly identify those enrolled in QHDHPs.

### Coventry Marketplace/Exchange Products

Coventry’s Marketplace (Exchange) products are available to individuals selecting coverage through the Illinois and Missouri Federal Marketplace. Coventry offers its broad traditional CoventryOne PPO network throughout eastern and central Missouri and select counties in southern Illinois. All providers currently participating in Coventry’s PPO are participating in the CoventryOne PPO that is available on the Marketplace (Exchange). For more information on participating providers please visit [www.choomissouri.com](http://www.choomissouri.com). Coventry also offers Carelink From Coventry and FocusedCare HPN on the exchange. For more information on these products, see the Carelink/FocusedCare section on page 16.

### Self-funded/ASO Products

Coventry Health Care acts as the third party administrator for Self-Funded/Administrative Services Only (ASO) products for employers. Care Management Resources (CMR) is Coventry Health Care’s third party administrator division for Coventry Health Care’s partial service ASO accounts that provides a variety of services including, but not limited to, utilization management, case management and claims adjudication services for self-funded union and employer groups. However, Coventry Health Care also administers Self-Funded/ASO products directly for full-service ASO accounts, which is known as Coventry ASO Network. All Self-Funded/ASO products are administered on a fee-for-service basis; whereby, all claims are processed using your underlying fee-for-service contracted fee schedule.

#### Care Management Resources (CMR)

The CMR benefits are unique to each participating group benefit plan. Some plans have a design that is similar to a gatekeeper PCP model with copays, while others have an open-access POS-style with deductibles and coinsurance. Self-funded plans have the flexibility of varying benefit designs to suit the needs of their individual group.

**CMR Member ID Card**

CMR Member ID cards are customized based on the employer group’s specification. CMR-administered benefit plans can be identified by the presence of CMR designation on the front or back of the Member ID card. In some cases only the claim submission address will indicate CMR.

**CMR Network**

CMR subscribers utilize the CMR network. The CMR network encompasses the majority of Coventry Health Care’s HMO/POS network providers, hospitals and ancillary providers. CMR network providers are responsible to obtain prior authorization for certain services as presented in the Medical Management section of this Provider Manual. Failure to obtain prior authorization will result in holding CMR subscribers and members harmless for the service.

**General Referral Information—CMR**

CMR administers the benefit plans for most of the groups it services. Each plan design is unique therefore, the need for and method of referrals to specialists, the requirement to designate a PCP and coverage for out-of-network care are different for each group. If this information is not noted on the Member ID card, call the number on the back of the Member ID card to verify the group’s requirements.

If a particular plan requires that a member designate a PCP, then the PCP should refer the member to a CMR in-network provider for any necessary specialty care. If you send your CMR members to out-of-network providers, the member may incur additional out-of-pocket expenses or, in some cases, receive no coverage at all.

When providing a CMR member with specialty care, list the referring provider’s name on the submitted claim form to indicate that the visit has been authorized by the member’s PCP. In a case where PCP referral is required, the member who schedules the appointment with a specialist without the PCP’s authorization is responsible for the full cost of the specialist’s services and the visit is not covered by CMR.

*If you are ever in doubt about the need for or method of referrals to specialists for CMR member, please call the number on the back of the Member ID card for information about the requirements.*

#### ASO/Self-funded Contact List

CMR groups contract with Coventry of Missouri to use our network and our medical management services. We do not pay claims for these groups and they have their own customer service departments to pay/process all of their claims. Below is a list of Coventry’s CMR groups and their Customer Service phone numbers. For information regarding how claims were paid/processed or for benefit information, please contact the groups Member Service Department.

- **IBEW Local 1** - Member Service Phone 314-752-2330 or 877-281-2430
- **IBEW Local 309** - Member Service Phone 618-344-2002
- **Construction Laborers** – 314-644-2777/1-800-489-0228
Operating Engineers Local 520 - Member Service Phone 1-800-775-3540
Plumbers & Pipefitters Local 562 – Member Service Phone 314-355-1000
Cement Masons 90 (Administered by JW Terrill Benefit Administrators) - Member Service Phone 800-467-5982
Plumbers & Pipefitters Local 101 –(Administered by JW Terrill Benefit Administrators) - Member Service Phone 800-467-5982
Steamfitters Local 439 - (Administered by JW Terrill Benefit Administrators) - Member Service Phone 800-467-5982
Plumbers Local 360 - –(Administered by JW Terrill Benefit Administrators) - Member Service Phone 800-467-5982
UFCW Local 655 - Member Service Phone - 314-835-2700 or 866-565-2700
Sheet Metal Workers Local 36 - Member Service Phone Number 314-652-8175
Carpenters – Member Service Phone – 314-644-4802 or 877-232-3863

Missouri Department of Transportation and Missouri State Highway Patrol (MoDOT/MSHP)
The Missouri Department of Transportation and Missouri State Highway Patrol (MoDOT/MSHP) is administered by Coventry Health Care. As with all Self-funded/ASO programs, MoDOT/MSHP is operated on a fee-for-service basis; whereby all claims are processed using your underlying fee-for-service contracted fee schedule.

Benefit Design
Self-funded benefit plans have the flexibility of varying benefits designs to suit the needs of their individual group. The MoDOT/MSHP has chosen a program with a strong financial incentive to utilize in-network providers, through lower copays, coinsurance and deductibles. Members may choose to utilize out-of-network providers at higher out-of-pocket costs. Therefore, Coventry Health Care asks that all in-network providers refer these members to other in-network providers.

In-network providers are responsible to obtain prior authorization for certain services, as outlined below in the MoDOT/MSHP Prior Authorization list.

Network
This unique plan utilizes a combination of three existing Coventry provider networks. The combined provider network includes the Coventry Health Care PPO network in central and eastern Missouri and southern Illinois, and the Coventry Health Care of Kansas network in western Missouri and Kansas. In addition, providers who do not participate in either the Coventry Health Care PPO or Coventry of Kansas networks, but are contracted through the Coventry Health Care National Network (Coventry National Network), also will be treated as in-network providers by the MoDot/MSHP. Members may visit providers in all three networks on an in-network basis. If a provider is contracted with all three entities, Coventry Health Care’s PPO contracted rates always supersede since we are the administrator of the MoDot/MSHP program. If a provider is contracted with Coventry Health Care of Kansas as well as Coventry National Network, Coventry Health Care of Kansas contracted rates will apply. Coventry National Network rates will only be accessed if a provider does not have a Coventry Health Care or Coventry Health Care of Kansas PPO contract.

You will have the ability to research provider participation on the MoDot/MSHP customized website (www.modot-mshp-cvty.com).

Contact Information
Provider Hotline 800-627-6406 (Claims, benefits, operational questions)
Medical Management 877-824-4559 (Prior authorization, case or disease management)

*Every provider is assigned a Coventry Health Care provider relations representative. If the Provider Hotline is unable to assist, contact the provider relations representative. The provider relations representatives are out of the office several days per week, so the first line of contact should be the Provider Hotline.

Member ID Card
For sample ID cards, go to www.chcmissouri.com.

Claims Submission Address
MoDOT/MSHP—Claims P.O. Box 7401London, KY 40742
*Claims should be submitted using the NPI number and tax ID number.

**Electronic Payor ID—25133

Provider Appeals Address
MoDot/MSHP—Appeals P.O. Box 7798London, KY 40742

Electronic Fund Transfers (EFT)
If a provider currently receives claim payments via an electronic fund transfer, future payments for MoDOT/HSHP members will be delivered via the same method. Providers not already receiving EFTs can enroll by returning the completed form found on our website (www.chcmissouri.com).

Websites
www.modot-mshp-cvty.com
www.directprovider.com
To access MoDot/MSHP members on www.directprovider.com or Emdeon, utilize the dropdown box and add Coventry Missouri. Prior Authorization List
For prior auth lists, go to www.modot-mshp-cvtv.com or www.chcmissouri.com.

Pharmacy
Beginning January 1, 2015 pharmacy benefits are administered by MedImpact. Refer to the back of the Member ID card for additional information. The MedImpact customer service number for non-Medicare members is 844-513-6005 and for Medicare members it is 844-513-6006 or www.mp.medimpact.com.

Self-Administered Injectables (SAIs)
This is administered by Bioservices. Their contact number is 888-518-7246.

Behavioral Health
Behavioral health and chemical dependency benefits are managed by MHNet which also treats Coventry National Network providers who do not participate with MHNet as in-network providers for MoDOT/MSHP members. Refer to the back of the Member ID card for contact information. MHNet number is 866-313-2284.

Lab Services
MoDOT/MSHP members may utilize any in-network provider for lab services.

Carelink and FocusedCare
Both Carelink and FocusedCare are health plans that coordinate a patient centric model of care powered by a high-performance network (HPN)

Carelink From Coventry (PPO) is offered on the Healthcare Exchange (Marketplace) as well as off exchange and is available to members located in the following Missouri counties: Franklin, Jefferson, St. Charles, St. Louis City, St. Louis County and the following Illinois counties: Madison, Monroe and St. Clair. The network is the result of an expanded relationship between Coventry Health Care and Mercy, SSM Health, St. Elizabeth’s in Belleville, IL and Saint Anthony's Health Center in Alton, IL. The network that supports Carelink From Coventry (PPO) is comprised of the systems and their affiliated providers named above, and therefore, by the nature of the HPN concept will not support inclusion of all Coventry Health Care contracted providers.

FocusedCare HPN (PPO) is the result of an expanded relationship between Coventry Health Care and BJC. FocusedCare HPN is offered on the Healthcare Exchange (Marketplace) as well as off exchange and is available to individuals located in the following Missouri counties: Boone, St. Charles, Ste. Genevieve, St. Louis City, St. Louis County & Washington and the following Illinois counties: Madison, Monroe and St. Clair. The network consists of BJC HealthCare (all facilities), St. Elizabeth’s Hospital (HSHS) in Belleville, IL, St. Anthony’s Medical Center in St. Louis, MO, the affiliated/employed physicians of these hospital facilities and other designated independent providers, and therefore, by the nature of the HPN concept will not support inclusion of all Coventry Health Care contracted providers.

Verifying Participation in Network
To verify if you are participating in the Carelink or FocusedCare network go to www.chcmissouri.com. Click on “Find a Doctor” at the top of the page, click on “Enter Provider Search”, and then select Carelink From Coventry Network or FocusedCare HPN Network.

Carelink and FocusedCare HPN for Missouri residents
- Members are encouraged to choose a PCP
- HPN members who live in Missouri do not need a referral
- Carelink Specialist claims will NOT deny without a referral
- Prior authorization rules apply

Carelink and FocusedCare HPN for Illinois residents
- Members must choose a PCP
- Members need a referral from their PCP to see a specialist
- Carelink Specialist claims will deny without a referral
- Referrals are not needed for OB/GYN, PT, or chiropractic care
- Prior authorization rules apply

Carelink and FocusedCare are PPO plans that include out-of-network benefits. Members have a deductible and coinsurance and services are subject to usual and customary charges.

Directprovider.com
To access Carelink From Coventry or FocusedCare on directprovider.com or WebMD, use the dropdown box “Coventry Health Care of Missouri”.

Lab
Carelink From Coventry members may utilize Quest, Mercy or SSM affiliated providers for lab services.
FocusedCare HPN members may utilize Quest for lab services.

Provider Hotline
855-297-1911, 8:00 a.m. - 5:00 p.m., M-F
Membership Cards
For sample ID cards, go to www.chcmisouri.com.

Claims Submission Address	Appeals Address
P.O. Box 7374	P.O. Box 7111
London, KY 40742-7374	London, KY 40742-7111

Prior-Authorization List
Coventry Health Care of Missouri, Inc. standard prior authorization list - For list, go to www.chcmisouri.com.

Electronic Payer ID
25133

E-Visits, Telemedicine & Wellness Coaching
E-visit, telemedicine and wellness coaching are covered under the member’s benefits to take a copay. The QHDHP plans will apply deductible before copay and the non-QHDHP plans will just be copay with no deductible or coinsurance. E-Visit is limited to PCP only. Wellness coaching has a limit of 4 visits.

NOTE: Participating providers shall not provide less than Medically Necessary services to our members and shall not induce any other provider to provide less than Medically Necessary services. For all PPO plans, our members must be allowed to receive services from a non-participating provider and utilize their Out-of-Network benefit without interference by a participating provider, if they so choose. In no instance does Coventry encourage or induce participating providers to provide less than Medically Necessary services to our members. Failure to direct medically appropriate care upon request by a Missouri member and failure to provide services to a Missouri member, due to the absence of a referral, violate the provisions of your contract and could result in financial penalties and/or termination of the contract. Provider acknowledges that solely Coventry Health Care shall determine the amount of any financial penalty imposed.

State of Illinois Medicare Retirees
Aetna, Inc. offers health care benefits through Coventry Health Care of Illinois, Inc. to State of Illinois (SOI) Medicare retirees (State Medicare Retirees, CIP Medicare Retirees or TRIP Medicare Retirees).

SOI offers Coventry Advantra HMO, a Medicare Advantage plan that provides both medical and prescription drug coverage. This option is available for Medicare-eligible retirees and their Medicare-eligible spouses, survivors and dependents. As a Coventry Medicare Advantage participating provider you are included in the Advantra HMO network.

Members who enroll in the Coventry Advantra HMO plan must choose a primary care physician (PCP) from the Advantra HMO network of providers. If a member asks for your provider or PCP number to enter on their application, it is your NPI number. Referrals are required from a PCP when specialty care is needed. The PCP is responsible for specialty care referrals within the Coventry Advantra HMO network. The Coventry standard Prior Authorization list applies. Prior authorization requests can be initiated through www.directprovider.com, or by calling our Pre-Authorization department at 866-557-8748 or by faxing to 800-224-2009.

SOI Members who choose the Coventry Advantra HMO will have a unique customer service number: 855-223-4807. Plan documents are available at: www.aetna-coventryretiree.com/soi. For questions, please contact your Provider Relations representative.

Coventry Health Care’s Medicare Products
Coventry Health Care’s Medicare Advantage plans are Advantra (HMO/POS) and Gold Advantage (HMO), Advantra (PPO) and Coventry Total Care (HMO-POS).

Coventry Health Care’s Medicare Advantage products include all the standard benefits of Medicare coverage plus many extras that Medicare alone does not cover. This coverage is provided under the following distinct networks:

- Plans available in central Illinois:
  o Advantra (PPO) - Crawford, Fayette, Jasper, and Montgomery counties
  o Advantra Connect Plus (PPO) - previously called Advantra Select Plus (PPO)
  o Advantra Value (PPO) - Crawford, Fayette, Jasper, and Montgomery counties
  o Coventry Total Care (HMO): A UnityPoint Health-Methodist Proctor Partnership
- Plans available in central/eastern Missouri and metro East St. Louis, Illinois:
  o Advantra Option 1 (HMO-POS)
  o Advantra Option 2 (HMO)
  o Advantra (PPO)
  o Coventry Total Care (HMO-POS)
  o Gold Advantage (HMO) - and limiting service area to Crawford, Franklin, Jefferson, St. Charles, St. Louis, St. Louis City and Warren counties in Missouri and Madison, Monroe and St. Clair counties in Illinois

The Medicare service area for most Coventry Health Care’s Advantage products include the Missouri counties of Audrain, Boone, Callaway, Cole,
Cooper, Crawford, Fayette, Franklin, Gasconade, Howard, Jasper, Jefferson, Knox, Lincoln, Maries, Miller, Moniteau, Montgomery, Osage, Perry, Pike, Randolph, Shelby, St. Charles, Ste. Genevieve, St. Louis, Warren, and Washington and Illinois counties of Bond, Calhoun, Clinton, Greene, Jersey, Madison, Monroe, Randolph, St. Clair, and Washington. (The service area for Coventry Total Care include; the Missouri counties of St. Louis City, St. Louis, Franklin, Jefferson and St. Charles.)

Advantra PPO, Advantra HMO-POS and Coventry Total Care (HMO-POS) members have the option to see out of network providers at a higher cost.

Coventry Health Care’s Medicare Advantage members may choose an internist, general practitioner, family practitioner or geriatrician as their PCP. Illinois residents also may designate an OB/Gyn as their Woman’s Principal Health Care Provider and may self-refer for any woman’s health issues.

Advantra HMO Plans
Advantra Option 1 (HMO-POS), Advantra Option 2 (HMO) and Advantra Dual Eligible SNP (HMO-SNP) members utilize the Advantra HMO Network. The PCP is the gatekeeper of the Advantra HMO member’s health care. Whenever a PCP wishes to refer an Advantra HMO member to a specialist, he/she must refer the member to an Advantra HMO Network provider in order for the member to receive covered benefits.

Please note that the PCP’s office has the responsibility of calling the specialist’s office to follow-up on the member’s visit with the specialist.

POS members have the option to see out-of-network providers for Medicare-covered services at a higher cost.

Gold Advantage (HMO)
Gold Advantage members utilize the Gold Advantage network. The PCP is the gatekeeper of the Gold Advantage member’s health care. Whenever a PCP wishes to refer a Gold Advantage member to a specialist, he/she must refer the member to a Gold Advantage network provider in order for the member to receive covered benefits.

Coventry Total Care (HMO-POS)
Coventry Total Care is a High Performance Network product with a limited network. The PCP is the gatekeeper of the Coventry Total Care member’s health care. Whenever a PCP wishes to refer a Coventry Total Care member to a specialist, he/she must refer the member to an in-network Coventry Total Care provider in order for the member to receive covered benefits. Coventry Total Care is available to individuals located in the following Missouri counties: Franklin, Jefferson, St. Charles, St. Louis City, and St. Louis County. The network is a result of an expanded relationship between Coventry Health Care and Mercy, SSM Health, Saint Anthony’s Health Center in Alton, IL, St. Anthony’s Medical Center in MO, and St. Luke’s Hospital. The network that supports Coventry Total Care (HMO/POS) is comprised of the systems and their affiliated providers named above, and therefore, by the nature of the HPN concept will not support inclusion of all Coventry Health Care contracted providers.

Advantra Dual Eligible SNP HMO
Advantra Dual Eligible SNP (HMO SNP) is a full-benefit Dual Eligible Special Needs Plan (SNP) program. This plan is only available to individuals who qualify for both Medicare (Part A and Part B) and for some Missouri Medicaid categories of aid. With the assistance of Medicaid, some dual-eligible individuals do not have to pay certain Medicare costs. Below is some information on how this plan is structured.

Advantra Dual Eligible SNP (HMO SNP) is available to individuals in the following Medicaid eligibility categories:

Full Benefit Dual Eligible (FBDE) is a person who:
- has Medicare (Part A and Part B);
- does not receive QMB or SLMB assistance; and
- meets state of Missouri’s requirements for full Medicaid benefits.

Medicaid provides full Medicaid benefits. Medicaid does not pay for Medicare Part A premium, Medicare Part B premium, Medicare deductible, coinsurance or copayments. Medicaid does not pay for costs related to Medicare Part D prescription drug coverage.

Qualified Medicare Beneficiary-Plus (QMB-Plus) (QMB+) is a person who:
- has Medicare Part A
- has income that is not more than 100% of the federal poverty level
- does not have financial resources that exceed the state of Missouri’s limit
- meets state of Missouri’s requirements for full Medicaid benefits.


Specified Low Income Medicare Beneficiary-Plus (SLMB-Plus) (SLMB+) is a person who:
- has Medicare Part A
- has income that is more than 100% but is less than 120% of the federal poverty level (FPL)
- does not have resources above the SLMB social security income (SSI) limit
- meets state of Missouri’s requirements for full Medicaid benefits.

Medicaid provides full Medicaid benefits. Medicaid pays Medicare Part B premium. Medicaid does not pay for Medicare Part A premium, Medicare
Coventry Health Care’s Medicare Provisions

The following provisions apply to each of Coventry Health Care’s Medicare products.

Treatment for Serious or Complex Medical Conditions
The Balanced Budget Act of 1997 requires Coventry Health Care to identify all of Coventry Health Care’s Medicare members with complex or serious medical conditions, establish assessment of the condition, monitor each case on an ongoing basis and establish and implement treatment plans appropriate to the condition.

Health Risk Appraisals
Health risk appraisals (HRA) are sent to each member upon confirmation of effective date from CMS. HRAs are analyzed in order to determine if those members have complex or serious medical conditions.

Post-Stabilization Care
Coventry Health Care provides coverage for members requiring medically necessary, post-emergency services that are needed to ensure stabilization from the time that an in-network or out-of-network provider or facility requests authorization from Coventry Health Care until one of the following occurs:

• The patient is discharged.
• An in-network provider arrives and assumes responsibility for care.
• An out-of-network provider and Coventry Health Care agree to other arrangements.

Organizational Determination
NOTE: Coventry Health Care’s Medicare Advantage Evidence of Coverage documents outline the member appeal process in greater detail. To obtain a copy of this policy, contact your Provider Relations representative.

The first step of the member appeal process is the organization determination. An organization determination is any determination made by a provider or Coventry Health Care regarding the receipt of treatment or payment of services. A member must receive this determination, whether favorable or a denial, within 14 days of a service request, or 60 days of a claims payment request, unless an expedited determination is necessary. Other levels of the member’s appeal process are addressed in the Evidences of Coverage.

For your convenience, Coventry Health Care has developed an Organization Determination form to be used when a provider denies any treatment or referrals to receive treatment. This form must be given to the Coventry Health Care member upon any denial, along with a copy of the form being sent to Coventry Health Care’s Member Appeal Unit at 550 Maryville Centre Drive, Suite 300, Saint Louis, MO 63141. Please retain a copy in the member’s medical records. This form outlines the member’s appeal rights and allows Coventry Health Care to establish a timeframe of denial and maintain compliance with CMS regulations and can be found on our website (www.chcmissouri.com).

Examples of denials are:

1. The member requests a referral to Dr. A. The PCP wants to refer to Dr. B. Even though the member may agree with seeing Dr. B, a denial has still occurred because the member was not given a referral to Dr. A as requested. Thus, an Organization Determination form must be issued.

2. When a provider requests a referral to a specific type of specialist, (i.e. a chiropractor), and the PCP feels he/she can perform the services in his/her office, so a referral is not given to the member, a denial has occurred. As a result, an Organization Determination form must be issued to the member.

This section was written for providers caring for Coventry Health Care’s Medicare members. Providing services for younger, disabled Advanta or Gold Advantage members may require special direction or assistance.

NOTE: Providers may not advertise their participation in the Coventry Health Care’s Medicare networks without the written consent of Coventry Health Care. Our Medicare Advantage contract with CMS stipulates that we must obtain CMS’s approval before releasing any information about our Medicare Advantage products. This obligation extends to our in-network providers who wish to publicly announce their network affiliation. Non-
compliance with this regulation would place us in violation of our agreement with CMS.

**Missouri HealthNet Coordination with Part C**

On May 5, 2008, the Missouri Department of Social Services announced that MO HealthNet would immediately begin coordinating with Medicare Advantage plans for Medicare/Medicaid Dual Eligibles who enroll in these plans.

“For dates of service beginning October 1, 2007, MO HealthNet Division (MHD) will pay 100 percent of the Medicare Advantage/Part C cost sharing for MO HealthNet participants who are Qualified Medicare Beneficiary (QMB Only) and Qualified Medicare Beneficiary Plus (QMB Plus) participants.” –MO HealthNet provider bulletin

The provider bulletin also gave information about how to bill copays and other cost sharing that may be covered by MO HealthNet for Dual Eligibles enrolled in Medicare Advantage plans. The announcement can be viewed under the May 5, 2008 issue date at: http://www.dss.mo.gov/mhd/providers/pages/bulletins.htm.

This is a significant benefit for many Dual Eligible members of Coventry Health Care’s Medicare Advantage Programs: Advantra, Gold Advantage, Advantra PPO and Coventry Total Care. It means that qualifying members can enjoy the additional benefits of Coventry Health Care membership and retain the full benefit of the MO HealthNet program.

Coventry Health Care advises members who may be eligible for MO HealthNet that they should always present both their Coventry Health Care Member ID card and their MO HealthNet ID card every time they see a provider. We also advise Dual members that they must use providers who participate with both Coventry Health Care and MO HealthNet to get the benefits of both programs. We advise members to check with their providers to verify if the provider participates with MO HealthNet.

MO HealthNet publishes a list of MO HealthNet in-network providers at: https://dssapp.dss.mo.gov/ProviderList/sprovider.asp. Please review your listing on the state of Missouri website. Contact MO HealthNet if there are inaccuracies.

**Prescription Drugs**

Coventry Health Care’s Medicare products have their own drug formularies. There are several different Medicare products that offer pharmacy benefits: Advantra Options 1 and 2, Advantra PPO, Coventry Total Care and Gold Advantage Option 1 and 2. Each one of these plans has a corresponding formulary. Please visit our website (www.chemissouri.com) for printable versions of these formularies. Each Medicare member receives a copy of their formulary.

**Medicare’s Prescription Drug Coverage—Medicare Part D**

*What is Medicare Part D?*

- Medicare Part D is federally-sponsored prescription drug coverage for Medicare beneficiaries.
- The program is voluntary, but beneficiaries must enroll by specific dates if not covered by a qualified employer plan or pay a premium penalty.
- Private companies, like Coventry Health Care, underwrite and administer the Part D benefit plan.
- Medicare Advantage plans such as Coventry Health Care’s Advantra, Coventry Total Care and Gold Advantage also include Part D benefits.
- Part D benefit plans vary with respect to cost sharing and formulary, but all must meet minimum standards.
- Coverage is a good value for most people. The benefit, subsidized by Medicare, is worth more than the member premium on average.
- Many people qualify for additional help paying for Part D premiums and prescription costs because of low income or assets.
- Dual eligible beneficiaries with both Medicare and Medicaid are enrolled automatically and assigned to a Part D plan if they don’t make a choice.

*What Do Your Medicare Members Need to Know?*

- If they already have prescription drug coverage through an employer or union, they should check with that plan sponsor to see if their coverage is creditable toward their Medicare Part D eligibility. Employers are required to inform Medicare employees and retirees if this is the case.
- If the Medicare member already has prescription drug coverage through a Medicare Advantage plan, they are automatically enrolled for Medicare Part D with that plan. The Medicare member should contact their Medicare Advantage plan to verify their Part D coverage.
- If the Medicare member does not have Medicaid, or a creditable plan from an employer, or prescription coverage through a Medicare Advantage plan, they must enroll in a Medicare prescription drug plan in order to get the Medicare Part D drug coverage.

*Where Can Medicare Patients Get More Information?*

- Guidance from Coventry Health Care: Prospective Coventry Health Care members should call 866-557-8753. Current Coventry Health Care members should call 800-533-0367.
- Guidance from Medicare: Call Medicare at 800-633-4227 (TTY 877-486-2048) or go to its website (www.medicare.gov).
- Guidance from Social Security: Call Social Security at 800-772-1213 or go to its website (www.socialsecurity.gov).

**Medicare Part D Reconsideration Requests**

Medicare Part D rules have been revised to allow prescribing physicians and other prescribers, upon providing notice to the enrollee, to request a standard redetermination of the enrollee’s behalf without having been appointed as the enrollee’s representative. CMS defines other prescribers as health care professionals other than physicians who have the requisite authority under State law or other applicable law to write prescriptions for Medicare beneficiaries. A member may request an appeal by submitting in writing an appeal request to the Coventry Health Care Member Appeal Department.
Confidentiality and Accuracy of Enrollee Records
For any medical records or other health and enrollment information it maintains with respect to enrollees, a Medicare Advantage Organization (MAO) must establish procedures to:

- Abide by all Federal and state laws regarding confidentiality and disclosure of medical records or other health and enrollment information. The MAO must safeguard the privacy of any information that identifies a particular enrollee and have procedures that specify:
  - For what purposes the information will be used within the organization; and
  - To whom and for what purposes it will disclose the information outside the organization;
- Ensure that medical information is released only in accordance with applicable Federal or state law or pursuant to court orders or subpoenas;
- Maintain the records and information in an accurate and timely manner; and
- Ensure timely access by enrollees to the records and information that pertain to them.

Providing Medical Records
For purposes of CMS audits of risk adjustment data, upon which health status adjustments to CMS capitation payments to health plans are based, and for the purposes set forth below, network providers should be required under their contracts to provide medical records as requested by the health plans or their designees.

Purposes for which medical records from providers are used by Coventry Health Care include:

- Advance determinations of coverage;
- Plan coverage;
- Medical necessity;
- Proper billing;
- Quality reporting;
- Fraud and abuse investigations; and
- Plan initiated internal risk adjustment validation.

To encourage providers to submit member medical records to the plan our organization, at its discretion and in compliance with a provider’s contract, may send staff to assist in the record collection or reimburse providers for the costs associated with furnishing the records. Coventry Health Care is prohibited from using medical record reviews to delay payments to providers. Both required and voluntary provision of medical records must be consistent with HIPAA privacy law.

Balance Billing
An important protection for beneficiaries when they obtain plan-covered services in an HMO or, PPO plan, is that they do not pay more than plan-allowed cost-sharing. In situations where providers ordinarily are permitted to balance bill, they must obtain this balance billing from the health plan. The rules for balance billing are listed below by type of provider.

- Contracted provider. There is no balance billing paid by either the plan or the enrollee;
- Non-contracting participating provider. There is no balance billing paid by either the plan or the enrollee;
- Non-contracting, Medicare non-participating provider. The health plan pays permitted balance billing consistent with Medicare the allowance. The enrollee, only pays plan-allowed cost sharing.

A Medicare participating provider is a provider that signs an agreement with Medicare to always accept assignment. The MACs post lists of participating providers. Participating providers may never balance bill because they have agreed to always accept the Medicare allowed amount as payment in full. A non-participating provider may accept assignment on a case-by-case basis and indicates this by checking affirmatively field 27 on the CMS 1500 claims form; in such a case, no balance billing is permitted.

Emergency Care
An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency services are covered inpatient and outpatient services that are:

- Furnished by a provider qualified to furnish emergency services; and
- Needed to evaluate or stabilize an emergency medical condition.

Urgently-needed services are covered services provided within the United States that:

- Are not emergency services as defined in this section;
- Are provided when an enrollee is temporarily absent from the MA plan’s service (or, if applicable, continuation) area, or the plan network is
otherwise not available; and
- Are medically necessary and immediately required, meaning that:
  - The urgently needed services are a result of an unforeseen illness, injury, or condition; and
  - Given the circumstances, it was not reasonable to obtain the services through the MA plan’s participating provider network.

Note that under unusual and extraordinary circumstances, services may be considered urgently-needed services when the enrollee is in the service or continuation area, but the organization’s provider network is temporarily unavailable or inaccessible.

**Medicare Provider Training and Education**

Coventry Health Care, Inc. (“Coventry”) is pleased to have the opportunity to work with you as a provider or provider organization in delivering high value services to our members. Our association, particularly in relation to our Medicare product lines, relies on a contracted relationship that establishes your entity as a first tier or related entity. As a first tier or related entity, there are several requirements imposed upon you, some by federal law, some by federal regulations as promulgated by the Centers for Medicare & Medicaid Services (CMS), and other requirements in light of your contracted relationship with Coventry. As a result, you, your entity, any downstream entities and/or related entities under your direction, and in several cases your individual employees who are assigned to work on Coventry’s Medicare business, must complete a number of requirements.

The requirements are summarized below and are applicable to your organization, as well as any of your downstream and/or related entity arrangements.

1. **General Compliance and Fraud, Waste and Abuse (FWA) Training**
   You and/or your organization must complete general compliance training. In addition, you must complete the FWA portion of the training unless you are deemed to have met the FWA certification requirements through enrollment into Parts A or B of the Medicare program or through accreditation as a supplier of DMEPOS.
   You must provide general compliance training to all of your employees, downstream, and related entity arrangements who are assigned to work on Coventry Medicare business initially upon hire and annually thereafter. You must also provide FWA training, initially upon hire and annually thereafter, to all your employees, downstream, and related entity arrangements who are assigned to work on Coventry Medicare business unless these individuals are deemed to have met FWA certification requirements as described above. In addition, your organization must provide either Coventry’s Code of Conduct (COC) or your own equivalent COC to all of your employees, downstream, and related entities who are assigned to work on Coventry Medicare business initially upon hire or contract commencement and annually thereafter.

2. **Reporting Mechanisms**
   You and/or your organization must report compliance concerns and suspected or actual misconduct to Coventry.

3. **Exclusion/Debarment**
   You and/or your organization must ensure that none of its employees or downstream and/or related entities that service Coventry Medicare business are on any of the following excluded persons, sanction and debarment lists: HHS Office of Inspector General (OIG); General Services Administration (GSA).

4. **Downstream and Related Entity Oversight**
   You and/or your organization must ensure that compliance is maintained by you and/or your organization as well as any of your contracted downstream and/or related entities that service Coventry Medicare business.

5. **Offshore Operations**
   You and/or your organization must ensure that you do not engage in offshore operations for Coventry-related Medicare business without the express consent of an authorized Coventry representative. Offshore operations are usually contractually prohibited by Coventry. Any Coventry-approved offshore arrangements are subject to reporting requirements to alert CMS of these activities and therefore must be reported to Coventry before utilization.

You must access the training and compliance materials mentioned above, along with additional information concerning these requirements, available for you on the Coventry Medicare FDR Training and Education Portal under Provider and Provider Group FDRs. This portal can be accessed through the following URL link: www.CoventryMedicareFDRs.com.

Further, if you and/or your organization utilizes downstream and/or related entities to perform Coventry Medicare work or serve Coventry Medicare members, that entity is also responsible for satisfaction of all of the above requirements. Due to the unique nature of the relationship between you and your downstream and/or related entities, Coventry expects that you ensure that they receive these requirements.

You and/or your organization are responsible to ensure that evidence of the effectuation for all of the requirements is developed and maintained. This evidence may be in the form of attestations, training logs, or other means determined by you to best represent fulfillment of your obligations. Please be reminded that Coventry and CMS require records to be retained for a period of ten (10) years, and that your records must be available to Coventry and/or CMS upon request.

Coventry takes these responsibilities very seriously. If you have any questions or concerns regarding this requirement or if you have difficulty accessing the Coventry Medicare FDR Training and Education Portal, please contact Coventry’s FDR Governance personnel at corpcompliance@cvty.com.

1. A first tier entity is defined as any party that enters into a written arrangement acceptable to CMS with a Sponsor (i.e., Coventry) to provide administrative or health care services for a Medicare eligible individual under Part C or Part D.
2. A related entity is defined as any entity that is related to the Sponsor by common ownership or control and a) performs some of the Sponsor’s management functions under contract or delegation; b) furnishes services to Medicare enrollees under an oral or written agreement, or c) leases real property or sells materials to the Sponsor at a cost of more than $2500 during a contract period. 42 CFR 423.501

3. A downstream entity is defined as any party that enters into a written arrangement, acceptable to CMS, below the level of the arrangement between the Sponsor and the first tier entity. These written arrangements continue down to the level of provider of both health and administrative services.

**Coventry Health Care National Network**

Coventry Health Care, Inc., Coventry Health Care’s parent company, acquired First Health Corp, which offers one of the largest national provider networks in the country. Coventry Health Care has transitioned out-of-area care from the PHCS network to the Coventry Health Care National Network (Coventry National Network), formerly the First Health Network, the nation’s largest network of directly contracted, credentialed health care professionals. The First Health Network has a presence in all 50 states, the District of Columbia, and Puerto Rico.

**Billing and Reimbursement Arrangement**

Providers understand and agree that services billed to payors by any other provider in services to members utilizing a federal tax ID number (FTIN) that is designated to or used by an in-network provider will be subject to the rates and terms of the Provider Participation Agreement. In addition, in the case of in-network Provider practices in multiple locations which are subject to different rates of reimbursement under the terms of separate agreements for lines of business but using the same FTIN, the lowest of the different rates of reimbursement shall apply.

**Coventry National Network Provider Appeal Information**

Provider appeals are handled by business segment, and/or National Account group.

For Coventry National Accounts, send to the claims P.O. Box 8400 in London, KY, found on the back of the Member ID cards.

For TPA/Carrier use the fax number 813-630-3103.

For Workers’ Compensation, provider appeals go directly to the client via an address and telephone number on the bottom of the claim if the client pays their own claims. If First Health Workers’ Comp division pays the claims, mail it to: 3611 Queen Palm Drive, Suite 200, Tampa, FL 33610.

If you are unsure which one applies, contact the Provider Services Line at 800-937-6824.

**Coventry National / First Health / Workers’ Compensation/Auto Provider Manual Announcement**

We are pleased to announce the Provider Manual is now available online. It can be found in the Provider sections of the following websites:

- [www.coventrynational.com](http://www.coventrynational.com) (See Related Information)
- [www.firsthealth.com](http://www.firsthealth.com) (See the Document Library)
- [www.coventrywcs.com](http://www.coventrywcs.com) (See Provider Education)

The following pages contain information on the Coventry Health Care National Network.
Quick Reference Guide

CONTACT LIST

Coventry National Network
Provider Services
800-937-6824
Monday–Friday 7:00 a.m.–7:00 p.m. (CST)
*Member benefits
*Eligibility
*Payor phone numbers
*Update provider information
*Claims submission addresses
*Claims resolution
*Workers compensation
*Group health
Claims Submission: Send claims to the address listed on the back of Member ID card.

Mail Handlers
Claims information
For questions regarding claims submission, call 800-410-7778
Claims address:
Mail Handlers
P.O. Box 8402
London, KY 40742

Website
www.coventrynational.com

First Health
Claim Submission
800-937-6824
Monday–Friday 7:00 a.m.–7:00 p.m. (CST)
*Balance billing issues
*Provider disputing repricing
*Payor phone numbers
*Claim status
*Workers compensation
*Group health

Provider Services and Provider Appeals
Send claims to the address listed on the back of the Member ID card. Confirm the claims submission EDI number or mailing address when verifying eligibility and benefits.

Provider Appeals for Network discounts and adjustment requests
Fax to 813-630-3103
Attention: Claims Resolution

Website
www.firsthealth.com
Workers’ Compensation

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 Comp Services is www.coventrywcs.com.

Coventry 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 website for Coventry Auto Solutions is www.coventryautosolutions.com

Although payers may not actively encourage their injured parties to seek treatment though 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
• by recommendation of a trusted associate or family member

Prior Authorization

Medical Management
When contacting Coventry Health Care to prior authorize or verify an authorization for services, the Pre-Authorization staff may ask for the tax identification number to identify the provider and office location. This procedure is to assure the authorization entry for the correct provider and also for HIPAA compliance regarding protected health information (PHI).

Please remember that failure to comply with our authorization process may impose financial liability on the provider as outlined in Coventry Health Care’s Provider Sanctions policy in this manual. In this case, the member must be held harmless.

Prior authorization is the process for authorizing the non-emergency use of facilities, diagnostic testing and other services before care is provided.

Coventry Health Care’s Medical Management staff authorizes medical services. If the health service has not been performed within the specified timeframe, a new authorization is required before services can be rendered.

What do you do if you do not agree with a Coventry Health Care decision (Peer-to-Peer Review/Reconsideration)

If a provider does not agree with a decision of one of Coventry Health Care’s Medical Directors, he/she has the opportunity to speak with the Medical Director who made the decision at 314-506-1708. Peer-to-peer discussions should occur within one business day of the adverse decision.

How to decrease call time to Pre-Authorization Department

Please have the following information available to reduce your call and hold time:

• Your name, office you are calling from and call back number
• Member name
• Member ID number
• Diagnosis (ICD-9 code) if available
• Anticipated date of service
• Findings on physical exam
• Results of previous testing done: pertinent labs, x-rays, standard treadmill, etc.
• Current medications related to this request (including failed medication therapy as appropriate)
• Medical/surgical history related to this request
• Type of member (Commercial, Medicare, ASO)
• Results of physical therapy (if applicable)
• Place of service
• Patient complaints, signs, symptoms
• Results from the use of assistive devices (if applicable)
• Test or procedure requested (CPT code) if available

Providing this information on your initial call decreases office time by reducing the Lack of Information denials and allowing our staff to review your request quickly and efficiently.

If you have questions regarding the prior authorization requirements, please check the Prior Authorization list for the member’s particular product. For authorization requirements for a specific code or service, please refer to the Coventry Health Care website. The List of Authorization Requirements by Code provides information for various places of service.

Please keep in mind that Coventry Health Care’s decision regarding an authorization is simply a benefit coverage determination. Coventry Health Care’s decision is never intended to limit, restrict or interfere with a provider’s medical judgement. In all cases, decisions regarding treatment continuation or termination, treatment alternatives or the provision of medical services are between the provider and member.

CMR and Coventry ASO Network products are self-funded by employers. They have the right to stipulate what health care services require prior authorization. Therefore, the list of services requiring prior authorization will vary from employer to employer. Please be aware that other employers may not be as restrictive and may not require prior authorization for some of the services.

Clinical Trials
If you have a Coventry Health Care member that you intend to enter in a clinical trial, please notify Coventry Health Care’s Medical Management Department for approval prior to enrolling the member or providing services related to the clinical trial.

**Prior Authorization Lists**
Prior authorization lists are located on our website at [www.chmmissouri.com](http://www.chmmissouri.com).

### New peer-to-peer discussion timeframe

Providers have 14 calendar days from the date a Commercial denial is issued to ask for a peer-to-peer discussion with a Coventry medical director. This discussion is optional.

The new timeframe is for pre-service and concurrent denials. And it only applies to members enrolled in our commercial plans. The denial letter will have the information you need to reach the right medical director for a peer-to-peer discussion.

For our Medicare Advantage members, we offer an opportunity for a peer-to-peer discussion before a denial is issued. You’ll receive the right medical director’s information when we call about the intended denial. The review may be requested up to 48 hours after the adverse determination is communicated to the office.

### Specialty Referrals

**HMO/POS**
Members may see in-network providers at any time without a referral. (See Services Requiring Prior Authorization section of this manual for a list of services requiring prior authorization). Coventry providers should refer HMO members to specialists within the appropriate network. If POS members use out of network providers, they receive benefits according to the POS (out-of-network) benefit plan option.

**Select and Advantra PPO**
PPO members do not require a referral to see specialists. (See Services Requiring Prior Authorization section of this manual for a list of services requiring prior authorization). PPO members have a strong financial incentive through lower copays, deductibles and coinsurance to utilize PPO in-network providers. Members may choose to utilize out-of-network providers but they’ll face higher out-of-pocket costs. Therefore, Coventry asks all in-network PPO providers to refer PPO patients to other PPO in-network providers.

**Gold Advantage® and Advantra**
PCPs must refer Gold Advantage and Advantra members to specialists within the respective networks. A referral number is required. Specialists are responsible for confirming they have a referral before seeing these members. Coventry will not retroactively authorize referrals to specialists. NOTE: Please remember that the member is never responsible for obtaining a referral or for hand-carrying a referral number to the specialist’s office.

**Coventry Total Care/Carelink from Coventry/FocusedCare**
See Coventry Total Care/Carelink From Coventry/FocusedCare sections for referral information’

Illinois Carelink and FocusedCare members still need a referral for specialty care. In all cases, specialists are required to report a preliminary diagnosis and treatment plan to the member’s PCP within two weeks from the date of the first office visit. Two weeks after treatment or evaluation is complete, the specialist is required to provide the PCP with a detailed member summary. Each intermediate encounter should also engender written communication within two weeks.

### In Office and Outpatient Procedures

For your convenience a list of CPT codes and procedure descriptions are listed on the Coventry Health Care website ([www.chmmissouri.com](http://www.chmmissouri.com)) along with the prior authorization requirements for the particular code. A single list includes codes that require and do not require prior authorization. The list includes prior authorization requirements for office (place of service 11) and outpatient facilities (place of service 22 and 24). Please note some procedures are considered office-based, therefore prior authorization is required if performed in an outpatient facility. It is important to review the list periodically for changes. In addition to the terms No auth required and Auth required you will also see the following terms:

- **Ineligible**—Services classified as ineligible are generally not considered a covered benefit or the service may be deemed experimental/investigational. If the provider believes the service to be medically necessary, you should call the Pre-Authorization Department.

- **Cosmetic**—Services classified as cosmetic are generally performed to improve the appearance or diminish an undesired appearance of any portion of the body. These services do not promote or improve functions of the body. If the provider believes the service to be medically necessary, the provider may:
  1. Submit clinical notes on office-based procedures, along with the claim. The records will be reviewed for medical necessity, however claim payment is not guaranteed. The provider should inform the member the potential for financial liability prior to performing the procedure.
  2. Contact Pre-Authorization for a clinical review prior to the services being rendered.
OB/GYN Care

Missouri and Illinois mandated benefits do not apply to CMR or Coventry ASO Network.

Members may self refer to their OB/Gyn in the same manner as any other specialty. For HMO/POS, CMR, Coventry ASO Network and PPO members, the OB/Gyn should collect the same PCP copay, rather than the specialty copay. For Coventry Health Care’s Medicare members, the OB/Gyn should collect the specialty copay.

In cases other than well woman exams, we ask that the OB/Gyn maintain a professional contact with the member’s PCP regarding the care the member is receiving.

Well Woman Exams
Members may self-refer for a well woman exam. No authorization is required for this visit, but this benefit should be used only when the member believes she is well.

The yearly well woman exam benefit should never be used when a member makes an appointment for a suspected problem. When a member phones your office with a problem, this visit must be handled the same way all specialist visits are handled.

Claims for well woman exams should be billed under CPT codes 99384-99387 or 99394-99397 and ICD-9 code V72.31 or V72.32.

Mammograms
Coventry Health Care recommends a yearly screening mammogram for women aged 40 and over. No authorization is required for this procedure, but please refer the member to the radiology provider within her network. To determine the correct radiology provider for each patient, please see the Coventry Health Care Network Grid in the Ancillary Section of this Provider Manual.

Pregnancy
Coventry Health Care members may self-refer for the initial pregnancy visit and test without prior authorization from Coventry Health Care. This initial visit is paid fee-for-service and is not included in the Global rate. The claim for this visit must be billed using ICD-9 code V72.4 and a current evaluation and management code and submitted within 90 days from the date of service.

When pregnancy is confirmed, please call our Medical Management Department. If the pregnancy is or becomes high risk, please notify us immediately. We will note this in our records so you are reimbursed appropriately. Claims for Global OB care must be submitted within 90 days from the date of delivery using the following codes: CPT code 59400, 59510, and the appropriate ICD-9 code (640 through 648 and 651 through 676).

Claims for ultrasounds must be submitted within 90 days from the date of service.

Dependent of a Dependent Coverage
Coventry Health Care may not provide coverage for the child of a pregnant dependent. A dependent is the child of the subscriber and can easily be identified since their member numbers end with 03, 04, 05, etc. If you provide care for a pregnant dependent, call the Provider Hotline or the member’s employer group for benefit information.


Ambulance
Ambulance service for transportation to the hospital is a covered benefit in emergencies. Some members have a copay/coinsurance for ambulance services. If this service is authorized in advance, Coventry Health Care may cover transferring a member between facilities. Ambulance service for a patient’s return home is not a covered benefit unless it is medically necessary and authorized in advance. Additional information, such as trip reports, may be requested in order to process the claim.

Durable Medical Equipment (DME)
Durable medical equipment (DME) is covered in the following instances:

- When it is a covered benefit
- When it is medically necessary

DME is defined as equipment that:

- Can withstand repeated use
- Is primarily and customarily used to serve a medical purpose
- Generally is not useful to a person in the absence of an illness or injury
- Is appropriate for use in the home

Prior authorization is required for:

- All rental equipment (Includes but is not limited to: CPAP, BiPAP, hospital beds and wheelchairs)
- All custom equipment

Some ASO groups may have a different authorization requirement. Please check the group specific authorization list on www.chcmissouri.com.
Orthotics Prosthetics and Foot Orthotics/Therapeutic Shoes

Orthotics are defined as appliances used to support, align, prevent or correct deformities, or to improve function of moveable parts of the body.

Prosthetics are defined as an artificial substitute for a missing body part, such as an arm, leg, hand or foot.

Orthotics and prosthetic devices are covered benefits when medically-necessary and authorized in advance by Coventry Health Care. This does not include foot orthotics/therapeutic shoes and over-the-counter items. All prosthetic devices over $10,000 require prior authorization.

All foot orthotics and therapeutic shoes require prior authorization as they are often excluded from the benefit plans.

Home Health Services

Medically necessary home health services such as those rendered by a registered nurse, licensed practical nurse, physical therapist, respiratory therapist or speech therapist are covered benefits and may need prior authorization.

CMS requires that Medicare Advantage members receive a Notice of Medicare Non-Coverage prior to the termination of home health care services. Please refer to the Appendix Forms section of this Provider Manual for a copy. The notice may be given on the first visit if the service has been authorized for only one visit. If a series of visits has been authorized, the form may be given on the first visit, the second to last visit or two days prior to the end of services. The home health care agency needs to determine the last day of service. If services are continued beyond the original termination date, an updated notice should be given. Please note that the following are required by CMS to consider the notice valid:

- Coventry Health Care name
- CMS form approval
- Member name and ID number
- Type of service terminating
- Date the service terminates
- Signature
- Date of signature

If the member refuses to sign the notice, a note should be documented on the form regarding the refusal to sign, the date and a witness signature. The member may be informed of the termination of services and appeal rights by telephone if necessary. There must be two witnesses to the call. The form should indicate that the consent was provided by phone with the signature of two witnesses and date of the call. The telephone call must be followed by a mailed form to the member or member’s representative. The plan must receive all of the complete signed forms. The forms must be faxed to the Medical Management Department at 866-603-5531.

Hospital Services for Medicare Members

CMS requires hospitals to provide all Medicare beneficiaries, including Medicare Advantage members, with the Important Message (IM) for Medicare upon admission to the hospital. The IM provides the beneficiaries with their appeal rights if they disagree with discharge from the hospital. The IM must be re-issued by the hospital according to the CMS requirements.

When notified by the QIO that the member has chosen to appeal a hospital discharge, the hospital is responsible for sending the medical record and signed IM to the QIO and Coventry Health Care is responsible for preparing the Detailed Notice of Discharge to be given to the member and sent to the QIO. The hospital may be asked to assist with the preparation of the Detailed Notice and/or the delivery of the notice to the member.

Podiatry Care

Advanta, Coventry Total Care and Gold Advantage: Nail trimming and the removal of corns and calluses by a podiatrist are covered when performed by an in-network Advanta/Gold Advantage/Coventry Total Care provider. Routine care is limited; contact the Provider Hotline for specific benefit information.

HMO, POS, Select and PPO: Routine foot care is not a covered benefit unless authorized in advance by Coventry Health Care.

CMR/Coventry ASO Network: Routine foot care benefits vary by employer for CMR/Coventry ASO Network members. Contact CMR/Coventry ASO Network for specific benefit information.

Non-Emergency Patient Transportation

Advanta, Coventry Total Care and Gold Advantage members have an annual benefit of 24 one-way trips to and from scheduled appointments for covered services with in-network providers. Transportation is provided through Access 2 Care. The member calls Access 2 Care with 48-hours notice to schedule a transportation appointment. The member may fill a prescription on a return trip without an additional charge against the trip benefit.

Skilled Nursing Facility

Coventry Health Care covers medically necessary services including semi-private room and board, rehabilitation services, medical social services, drugs, nursing services and medical supplies when provided at a Coventry Health Care in-network skilled nursing facility. Advanta, Coventry Total Care or Gold Advantage members must comply with applicable Medicare law and regulations. Care at a skilled nursing facility for Advanta or Gold Advantage members is a limited benefit and must have prior authorization by Coventry Health Care. Some CMR and Coventry ASO Network groups limit skilled nursing benefits. Please call the employer group or the Provider Hotline for specific benefit information.
CMS requires that Medicare Advantage members receive a Notice of Medicare Non-Coverage two days prior to the termination of services at a skilled nursing facility. Please note that the following are required for CMS to consider the notice valid:

- Coventry Health Care name
- CMS form approval
- Member name and ID number
- Type of service terminating
- Date the service terminates
- Signature
- Date of signature

The Coventry Health Care concurrent review coordinator faxes a completed form to the skilled nursing facility on or before the day before the date the letter is due to be signed. The skilled nursing facility must get the member’s consent no later than two days before the termination of services. If a member refuses to sign the notice, documentation should be made on the form noting the member’s refusal to sign, along with the date and two witnesses. The entire signed document must be faxed to the Medical Management Department at 866-603-5531.

Over-the-Counter (OTC) Items
Over-the-counter (OTC) items are splints and braces that can be readily found in a retail drug store and/or other non-medical store (sports equipment, discount department store). OTC items are not a covered benefit for most of Coventry Health Care’s benefit plans.

Samples of OTC Item—This is not an all-inclusive list.
- foam collar, pre-fabricated
- rib belt
- ankle brace elastic/neoprene, pre-fabricated
- ankle brace, lace up type, pre-fabricated
- ankle brace, multiligamentus support, rigid, pre-fabricated
- elbow brace, elastic with stays, pre-fabricated (not rigid)
- elbow brace, elastic/neoprene pre-fabricated (strap)
- wrist/hand brace, cock up splint, lace up style, pre-fabricated
- wrist brace, elastic/neoprene, pre-fabricated
- wrist/hand/finger elastic/neoprene brace, pre-fabricated (soft thumb/hand splint)
- ankle brace, stirrup style, any type interface (gel, air, etc.) pre-fabricated

Nutritional Counseling
Some Coventry ASO Network accounts do not cover nutritional counseling or have benefit limitations on visits for nutritional counseling:

For all other nutritional counseling codes will auto pay (no prior authorization needed) when billed with one of the following diagnoses:
- Diabetes
- Gestational diabetes • Hyperlipidemia
- Morbid obesity*
  - Essential hypertension, hypertensive heart disease • Hypertensive renal disease, hypertensive heart and renal disease, secondary hypertension
  - Congestive heart failure, left heart failure
  - Chronic renal failure

*Definition of morbid obesity: The term morbid obesity refers to patients who are 50–100 percent or 100 pounds above their ideal body weight. Alternatively, a body mass index (BMI) value greater than 39 may be used to diagnose morbid obesity. (Source: National Institute of Health).

**Other Medical Management Processes**

Concurrent Review
Concurrent review is a method for reviewing inpatient medical care at the time the care is being rendered and is conducted through onsite review of the medical record or via telephone with the hospital case managers. Hospitals are responsible for notifying the Coventry Health Care Pre-Authorization Department by telephone, fax or Emdeon Office of all admissions and observation stays within one business day. Member demographics are collected and entered into the computer system. The Coventry Health Care concurrent review coordinator reviews medical records of members admitted to an onsite hospital. The hospital case manager is responsible for providing clinical reviews to the Coventry Health Care concurrent review coordinators via phone on those hospitals with telephonic review.
The main objectives of the Concurrent Review are:

- Continuously monitor the medical necessity, level of care and quality of care
- Ensure the efficient management of inpatient days
- Develop discharge plans in conjunction with the provider, member, member’s family and/or hospital discharge planner

Coventry Health Care uses nationally recognized criteria in the review process. Cases that meet criteria are approved by the concurrent review coordinator. An authorization number is provided with the level of care approved. At onsite hospitals, this information is provided via the hospital UR log. Telephonically reviewed hospitals receive this information via the telephone.

When a concurrent review coordinator identifies an inpatient stay that does not meet Coventry Health Care criteria for the level of care being provided, the case is referred to the Medical Director for a determination. In some cases, the Medical Director may consult with a physician advisor within the appropriate specialty. If requested, the Medical Director is available to the attending provider for a peer-to-peer discussion. Refer to the Prior Authorization section for addition information.

Concurrent Review – Determinations are usually made within one business day of the review. Change to Determinations and notifications are usually made within 24 hours of receipt of a completed request. are provided verbally and in writing via the hospital UR log within one working day. Adverse determinations are provided verbally within one day of the determination and in writing via the UR log and/or a letter of non-coverage within one day of the verbal notification.

**Skilled Nursing Admissions**

Skilled nursing facility (SNF) admissions require prior authorization. The concurrent review coordinator, as part of the discharge planning process, usually performs prior authorization of SNF admissions. Following the admission, the concurrent review coordinator reviews the medical records of members admitted to the SNF unit at onsite hospitals. Admissions to facilities other than the onsite hospitals are reviewed via the telephone.

**Rehabilitation Admissions**

Admissions to rehabilitation facilities require prior authorization, which the concurrent review coordinator performs as a part of discharge planning. Concurrent review is performed either by telephone or onsite. For catastrophic cases, a complex case manager is assigned to review the case and coordinate discharge plans.

**Discharge Planning**

The concurrent review coordinator begins the discharge planning process at the time of admission. The concurrent review coordinator collaborates with the hospital discharge planner and the member’s provider to ensure the member receives all medically necessary services available within the member’s benefit at the time of discharge. The concurrent review coordinator may be available to attend discharge planning conferences. A complex case manager is assigned to coordinate the care of members with significant medical issues or with catastrophic illnesses.

**On-Call Nurse**

A registered nurse is available by pager after business hours Monday – Friday and on weekends and holidays by calling 314-941-8219. The registered nurse is available to answer questions regarding medical necessity, network providers, initiate urgent or expedited appeals, etc. Discharge planning is also available through the on-call registered nurse who arranges for home care and durable medical equipment, as needed. The on-call registered nurse has access to Coventry Health Care’s Medical Director if a medical determination is needed.

**Access to Medical Records**

According to your contract with Coventry Health Care and Coventry Health Care’s participation in the Medicare Advantage program, Coventry Health Care is required to perform medical record reviews for various programs such as HEDIS and other quality improvement projects. This includes programs designed by the Centers for Medicare and Medicaid (CMS) such as the Quality Improvement Project (QIP) (see 42 C.F.R. 422.152).

Coventry Health Care is authorized to access our members’ medical records and make copies as necessary. Coventry Health Care will request, access and if applicable, copy only that section or sections of the medical record that is minimally necessary to make a coverage determination, pay claims or otherwise administer plan programs.

**Readmission Policy**

Plan reserves the right to enforce CMS guidelines regarding Hospital In-Patient Readmissions based upon 31 day Readmission Reviews*. All admissions that qualify for Readmission Review * under this policy will be evaluated according to Plan guidelines using diagnosis detail present on claims and corresponding medical records for the admissions under review. Plan retains the right to deny claims which qualify as Readmissions either retrospectively through the Readmission Review process or concurrently as part of the Concurrent Review process.

* Readmission Reviews

(Rev. 264; Issued: 08-07-08; Effective Date: 08-01-08; Implementation Date: 08-15-08)

Readmission review involves admissions to an acute, general, short-term hospital occurring less than 31 calendar days from the date of discharge from the same or another acute, general, short-term hospital (see §1154(a)(13) and 42 CFR 476.71(a)(8)(ii)). Neither the day of discharge nor the day of admission is counted when determining whether a readmission has occurred.
Clinical Practice Guidelines
Coventry adopts evidence-based clinical practice guidelines from nationally-recognized sources. These guidelines have been adopted to promote consistent application of evidence-based treatment methodologies and made available to practitioners to facilitate improvement of health care and reduce unnecessary variations in care. Coventry reviews the CPGs every two years or more frequently if national guidelines change within the two-year period. CPGs that have been formally adopted can be found on the Coventry Health Care website at www.chcmissouri.coventryhealthcare.com. Once on the site, go to Providers > Document Library > Clinical Practice Guidelines.

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

Medical Appeals Process
Appeals must be submitted in writing (unless expedited) within 180 days of the adverse benefit determination and must contain the following information: * Member name * Member identification number * Member date of birth * Provider name, address, phone number and fax number * Service being appealed * Expected date(s) of service, or if service has already been provided, date(s) of service received * Clear indication of the remedy or corrective action being sought and an explanation why the plan should reverse the adverse benefit determination Copy of documentation to support the reversal of decision (e.g., emergency details, date, time, symptoms, etc.) In cases where the member’s authorized representative is appealing on behalf of the member, a completed member designated release of information form.

Member Appeals department fax: 855-426-6155.

Utilization Management Criteria
Coventry uses the following protocols based on national criteria and reviewed by the National Quality Advisory committees:

- Coventry Health Care policies including, but not limited to, new technology assessments and medical review policies
- Nationally recognized HealthCare Management guidelines medical management criteria
- American College of Obstetrics and Gynecology criteria
- Specialty society and internally developed guidelines and policies
- Medicare coverage issues
- National Comprehensive Cancer Network guidelines

Utilization Management Criteria: The medical criteria used in the decision making process will be provided upon request by contacting the Customer Service Representative number listed on the back of the member’s ID card. Criteria may be viewed on Directprovider.com or a hard copy may be requested.

Current versions of our prior authorization requirements and related schedules are available on our website at www.chcmissouri.com. The following materials are modified throughout the year: the medical injectable prior authorization list, the prior authorization list for prescription drugs and the self-administered injectable medications list. All new injectable drugs require prior authorization unless you are otherwise notified. Contact your Provider Relations representative at 800-755-5242 if you have any questions or would like paper copies of our schedules.

Evaluation of New Technology
Coventry Health Care evaluates benefit coverage for new medical technologies or new applications of existing technologies on an ongoing basis. These technologies may include medical procedures, drugs and devices.

The following factors are considered when evaluating the proposed technology:

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

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

Complex Case Management
Coventry Health Care members have access to unrivaled complex case management—a collaborative process between Coventry Health Care, the member and the provider. Case management is “a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet an individual’s and a family’s comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes.” Our complex case management programs are designed to assess, plan, implement and evaluate services and resources required to meet the member’s health care needs. The process aims to efficiently produce the highest quality outcomes and manage health care costs. The program is staffed by registered nurses to advocate for the member in the case management process. Coventry Health Care nurses are educated in health care management and service delivery and help our members smoothly navigate their health care by connecting them with resources and support within their respective communities. Our health plan nurses embrace cultural diversity and are well suited to assist members of any background. We require that Coventry Health Care nurses continue to expand their expertise through professional development including certification, seminars and classes for continuing education and case management credits.
Members who may benefit from Complex Case Management services are identified through Coventry Health Care’s utilization review process and utilization flags. In addition, members are referred for Complex Case Management evaluations from other Coventry Health Care departments such as Disease Management and Customer Service. Members also may be referred for an evaluation by their employer group, Coventry Health Care providers or by self-referral. We welcome referrals from treating physicians to our case management program. You can submit a referral through the toll-free phone number on the member ID card. Once we decide that a member is right for case management and the member or caregiver agrees to it, we make an individualized plan. We work with the member, the member’s family, physician(s), and other health care professional(s).

**Ancillary Services**

**Lab Services**

Coventry Health Care has an agreement with Quest Diagnostics for the provision of lab services. You have the option of drawing specimens in your office and sending the specimen to Quest, or sending patients to a Quest draw site for this service. For the locations of the Quest draw sites, please see the list of Quest Diagnostics Patient Service Centers later in this section. If you draw specimens in your office, you may bill Coventry Health Care for phlebotomy.

Lab specimens for Commercial and Coventry Medicare Advantage members should be sent to Quest Diagnostics in the St. Louis Metro area, or one of the approved outpatient labs for those outside of the metro area. The metro area is defined as:

- In Missouri: Franklin, Jefferson, Lincoln, St. Charles, St. Francois, St. Genevieve, St. Louis City, St. Louis, Warren, Washington counties
- In Illinois: Madison, Monroe, St. Clair counties

NOTE: Quest is not the capitated lab provider for all Coventry Health Care members. For detailed information about where to send Coventry Health Care members for lab services, please refer to the Coventry Health Care Network Grid at the end of this section.

**Provider in-office lab policy**

Coventry Health Care reimburses in-network providers for the following procedures when they are performed in office on a STAT basis only.

<table>
<thead>
<tr>
<th>Procedure Description</th>
<th>Reference Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>10021 Fine needle, aspiration with or without prep of smears</td>
<td>83986 Assay body fluid acidity</td>
</tr>
<tr>
<td>38220 Bone marrow, aspiration only</td>
<td>85007 Blood smear, microscopic examination</td>
</tr>
<tr>
<td>38221 Bone marrow biopsy, needle or trocar</td>
<td>85013 Hematocrit</td>
</tr>
<tr>
<td>81000 Urinalysis</td>
<td>85018* Hemoglobin</td>
</tr>
<tr>
<td>81001 Urinalysis, automated, with microscopy</td>
<td>85025 CBC</td>
</tr>
<tr>
<td>81002 Urinalysis, non automated, without microscopy</td>
<td>85027 Hemogram and platlet count, automated</td>
</tr>
<tr>
<td>81003 Urinalysis, automated, without microscopy</td>
<td>85048 WBC</td>
</tr>
<tr>
<td>81025 Pregnancy test</td>
<td>85610 Prothrombin time</td>
</tr>
<tr>
<td>82044 Albumin; urine, microalbumin, semiquantitative</td>
<td>85651 Sedimentation rate, erythrocyte, non-automated</td>
</tr>
<tr>
<td>82270* Fecal occult blood</td>
<td>86308 Heterophile antibodies; screening</td>
</tr>
<tr>
<td>G0107 Fecal occult (colorectal cancer)</td>
<td>86403 Mono test</td>
</tr>
<tr>
<td>82272* Blood, occult, by peroxidase activity</td>
<td>86580 Tuberculosis, intradermal</td>
</tr>
<tr>
<td>82274* Blood, occult, by fecal hemoglobin</td>
<td>87205 Gram stain</td>
</tr>
<tr>
<td>82375 Carbon monoxide, (carbonoxymhemoglobin) quantitative</td>
<td>87210 Wet prep</td>
</tr>
<tr>
<td>82731 Fetal fibronectin</td>
<td>87220 KOH test</td>
</tr>
<tr>
<td>82805 Gases, blood, any combination of pH, pCO2, pO2, CO2, HCO3 with O2 saturation, by direct measurement, except pulse oximetry</td>
<td>87430 Streptococcus, group A</td>
</tr>
<tr>
<td>82947 Glucose</td>
<td>87880 Streptococcus, group A</td>
</tr>
<tr>
<td>82948* Glucose</td>
<td>88720 Bilirubin total transcutaneous</td>
</tr>
<tr>
<td>82962 Glucose</td>
<td>Q0111 Wet mounts</td>
</tr>
<tr>
<td>83655 Lead screen</td>
<td>Q0112 Potassium Hydroxide (KOH) preps</td>
</tr>
<tr>
<td></td>
<td>Q0115 Post coital</td>
</tr>
</tbody>
</table>

*Tests are included in monthly capitation payments. Capitated PCPs do not receive additional payment for these tests.

Request for special or unique lab services, requires approval from Coventry Health Care’s Medical Director. Contact Coventry Health Care’s Medical Management Department at 800-546-4603 for prior authorization.

**Hospital Lab Policy**
Preadmission Lab Services

Coventry Health Care members who anticipate inpatient stays or outpatient services at a hospital or outpatient surgery center must have lab services performed at the facility within 24 hours of the event. Any lab service required prior to the 24-hours must be performed as described above.

Primary Procedure Dependent Lab Services

Lab services necessary to perform a procedure on the same day may be considered reimbursable, if the primary procedure is dependent upon a lab result. (Note: Reimbursement for such lab work shall ultimately be determined by the payment methodology associated with the primary service being performed as outlined within the Provider’s Participation Agreement. For instance, payment methodologies defined as Case Rate, Per Procedure, Per Visit or Per Diem establishes such lab services as inclusive to the primary service being performed and therefore shall not be reimbursed in addition to the primary service.)

CLIA Certification

Office labs must hold either a CLIA certificate or a CLIA waiver to perform lab tests for Coventry Health Care members.

Quest Diagnostics

Please remember to fill out the insurance information completely on the Quest Requisition forms. Incorrect or incomplete information are the major reasons our members receive bills. Please verify the information you send to Quest so our members are not billed.

NOTE: Quest is now taking appointments. Please have members call 800-669-7525, prompt 7. They also take walk-in appointments.

Direct Billing Requirement

All lab services billed by a provider office must be performed onsite within the provider’s office/facility. All lab services must be billed by the provider performing the service.

Prior Authorization

Certain lab codes may require prior authorization, such as genetic testing codes. Visit our website (www.chcmissouri.com) for the List of Authorization Requirements by Code.

Lab Tests for Genetic Testing

Lab tests for the purpose of genetic testing must be authorized in advance and performed at a participating lab vendor.

NOTE: Member may have a copay or coinsurance for lab work in an outpatient hospital setting. Quest Diagnostics provides courier service to providers throughout the entire Coventry Health Care service area. Providers may call Quest at 866-697-8378 to schedule service.

Outpatient Imaging Program

Coventry Health Care has an agreement with National Imaging Associates, Inc. (NIA)® for advanced outpatient imaging management services. Under terms of the agreement, Coventry Health Care retains ultimate responsibility and control over claims adjudication and all medical policies and procedures. The enhanced outpatient imaging program is managed under the terms of your Coventry Health Care Participation Agreement. Please go to www.chcmissouri.com to review the Outpatient Imaging Program Quick Reference Guide and specific program instructions.

The outpatient imaging program applies to Coventry Health Care Commercial members as well as members of our Coventry Medicare Advantage products. At this time, members accessing care through the following networks are excluded from this program: Coventry ASO Network, CMR, Coventry National Network, Coventry Total Care, Carelink from Coventry, FocusedCare HPN and First Health Network. Prior authorization is required for the following advanced outpatient radiology procedures:

- CT / CTA• PET scan
- MRI/MRA• Nuclear stress (MPI)dm
- CCTA• Echo stress
- Nuclear cardiology• Diagnostic nuclear medicine

NOTE:

- It is the ordering physician’s responsibility to obtain authorization.
- Providers rendering the above services should verify the necessary authorization is obtained. Failure to do so may result in non-payment of your claim.
- Coventry Health Care members with Medicare primary coverage are excluded from the NIA agreement.

NIA maintains protocols as part of the outpatient imaging program to ensure that all advanced imaging providers meet minimum standards required to adequately perform the technical and professional components of these services. Compliance with Coventry Health Care’s medical management program and administrative procedures, including our outpatient imaging program standards for the technical and professional components of these services is are requirements under the terms and conditions of your Coventry Health Care Participation Agreement.

While the outpatient imaging program is part of Coventry Health Care’s procedures, our radiology management vendor, National Imaging Associates, Inc. (NIA)®, administers the process and in this capacity, to review all Coventry Health Care contracted providers performing advanced diagnostic imaging services. If you perform any diagnostic imaging services, you are required to complete a Coventry Health
Care Privileging application. Please contact your provider relations representative for more information on the privileging process.

NIA Multiple Procedure Discount Policy

NIA considers a single session to be one encounter where a member could receive one or more radiological studies. If more than one of the imaging services in a single code family is provided to the member during one encounter, this constitutes a single session and the charge for the lower-priced procedure(s) should be reduced by 25 percent. If a member has a separate encounter on the same day for a medically necessary reason and receives a second imaging service from the same code family, these are considered multiple studies in the same code family on the same day to be provided in separate sessions. The provider should use modifier -59 to indicate multiple sessions, and therefore the multiple procedure discount does not apply.

*The multiple procedure discount does not apply to imaging services billed with the -26 modifier, which denotes the professional component. The multiple procedure discount will be applied to the technical component (services with the -TC modifier) and to the full amount on services contracted as global that have no modifier.

**Outpatient cardiac catheterizations**

Effective August 1, 2015, National Imaging Associates (NIA) will manage the authorization process for outpatient cardiac catheterizations for Coventry Health Care of Missouri and Coventry Health Care of Illinois members. Coventry requires prior authorization for non-emergent, outpatient cardiac catheterizations. This includes CPT codes 93452 through 93461. The health plan will still manage authorizations for Coventry Health Care of Missouri and Coventry Health Care of Illinois members. Coventry requires prior authorization for non-emergent, outpatient cardiac catheterizations. This includes CPT codes 93452 through 93461. The health plan will still manage authorizations for inpatient and emergency procedures.**Note:** This only applies to fully insured commercial and Medicare members.

**Key points to know**

- The ordering physician is responsible for getting prior authorization. To do so, go to www.RadMD.com. Or, call 1-800-642-7835 for CHC of Illinois members and 1-800-642-7339 for CHC of Missouri members.
- The facility must ensure that the physician got prior authorization. We recommend that the facility develops a process to ensure that this happens.
- We may deny payment to the physician and facility for procedures done without authorization.
- The member can’t be balance-billed for these procedures.

Used correctly, cardiac catheterization is useful for diagnosing cardiovascular problems. But it’s an invasive procedure and has risks. So, it’s

**Triad-Outpatient Pain Management Services**

At Coventry Health Care of Missouri, Inc. (“Coventry Health Care”), we have a prior authorization process for procedures related to elective outpatient pain management services and large joint (hip and knee) inpatient and outpatient services. This process is designed to promote and ensure appropriateness of care.

Coventry Health Care engaged Triad Healthcare, Inc. (“Triad”) to manage the prior authorization process for these services. Triad is NCQA- and URAC-accredited and offers our participating providers a program that supports standard protocols and offers the expertise of peer interventional pain management physicians.

**Please note:** The new prior authorization process applies to services for Coventry Health Care members with coverage under both fully insured and Medicare products. It does not include self-funded products, Carelink, Total Care or FocusedCare.

Triad’s medical policies, a list of CPT codes designated as pain management services requiring prior authorization and managed by Triad, along with authorization forms, are available at triadhealthcareinc.com or by contacting Triad at 888-584-8742. You may also obtain the list of CPT codes and authorization form on the Providers section of our website at chemissouri.com, by clicking on the Prior Authorization link on the left side of the screen or through http://www.triadhealthcareinc.com/cvt/pt.aspx

Prior authorization requests and your patient’s medical records must be submitted using any of the following methods:

- Web: triadhealthcare.com/cvt
- Fax: 888-229-5680
- Phone: 888-584-8742

**MedSolutions Radiation Oncology Services (eviCore healthcare)**

MedSolutions, Inc (MedSolutions) manages the prior authorization process for radiation oncology service. This applies to all Coventry Health Care of Illinois and Coventry Health Care of Missouri commercial and Medicare Advantage members. Please note: the prior authorization process applies to service for Coventry Health Care members with coverage under both fully insured and Medicare products. It does not include ASO/CMR self-funded products or Carelink/Total Care/FocusedCare.

Prior authorization is required for radiation therapy using any of the following modalities:

- 2D and 3D Conformal
- SRS/SBRT
- Brachytherapy

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Coventry will continue to manage the prior authorization for inpatient radiation oncology treatment. **The ordering physician is responsible for obtaining prior authorization for outpatient radiation oncology services.** The rendering facility must ensure that prior authorization is obtained. Payment to the treating physician and rendering facility will be denied for any procedures performed without the required authorization, as well as for units or fractions exceeding the authorized treatment plan. The member cannot be balance-billed for such procedures. The Radiation/Oncology Clinical Guidelines are posted at [http://www.medsolutions.com/documents/guidelines](http://www.medsolutions.com/documents/guidelines). This program is designed to work directly with radiation therapy providers to develop a treatment plan which is consistent with the standards developed and accepted by the American society for Radiation Oncology (ASTRO), the American college of Radiology (ACR), and other nationally recognized cancer networks.

To request a prior authorization, you may use the 24/7 Web Portal ([www.medsolutionsonline.com](http://www.medsolutionsonline.com)), call (888) 693-3211, or fax a MedSolutions request form (available on Web Portal) to (877) 791-4110.

### Behavioral Health/Chemical Dependency

**Commercial and Medicare Advantage**

Coventry Health Care members may self-refer for behavioral health/chemical dependency services. These services must be provided through the appropriate behavioral health/substance abuse provider. Coventry Health Care has a multidisciplinary team of behavioral health professionals available 24-hours a day, 7 days a week to care for our members. Members can contact MHNet toll free at 877-227-3520.

PCPs are requested to ask members who see a behavioral health provider to sign a release of information so they can be kept up-to-date on their progress.

### Oncology Drug Program

**Oncology Pathway Solutions Program**

The Oncology Pathway Solutions program is managed by New Century Health (“NCH”). The Oncology Pathway Solutions program utilizes clinical guidelines based on nationally recognized, evidence-based criteria for determining medical necessity in cancer care. It streamlines the complex administrative process associated with chemotherapy pre-authorizations. It also allows us to work closely with you and your staff to develop a team approach in delivering quality patient care. The program will allow for peer-to-peer discussions with medical oncologists who have the understanding and background to discuss treatment regimens. The administrative benefits of the program will expedite the authorization review process.

Key features offered by NCH:
- Provider web portal available 24/7/365, offering:
  - Real-time authorizations when selecting evidence-based NCH treatment care pathways
  - Reduced documentation requirements
  - Real-time status of authorization requests
  - Eligibility verification
- Fax authorization requests can utilize one submission form for all regimens
- Supportive telephonic authorization staff available at 877-624-8601, option 5, available Monday through Friday, 8 a.m. - 8 p.m. EST
- Quick turnaround on authorization requests submitted via fax or phone
- Peer-to-peer consultations by medical oncologists
- An NCH provider representative is available to provide support as needed

**Prior Authorization Process**

Chemotherapeutic drugs and supporting agents will require pre-authorization by NCH if administered in a physician’s office, elective inpatient, outpatient or ambulatory setting. This will apply to all Coventry Medicare and Commercial members ages 18 and older. These drugs must be authorized prior to administration. The requesting physician must complete the NCH Chemotherapy Request Form (CTR). To access and submit the CTR:

- Login onto NCH’s provider web portal at [my.newcenturyhealth.com](http://my.newcenturyhealth.com), or
- Fax to NCH at 877-624-8602, or
- Call NCH’s Utilization Management Intake department at 877-624-8601, option 5 (Monday through Friday, 8 a.m. - 8 p.m. EST).

Please note: The new prior authorization process applies to services for Coventry members with coverage under both fully insured and Medicare products. It does not include ASO/CMR self-funded, Carelink or FocusedCare products.

**Timeframe for Prior Authorization Requests**

Selection of evidence-based regimens or NCH treatment care pathways will grant instant authorization. All other requests will be processed within 72 hours from receipt of a complete CTR. This process may take longer if the request requires verification or additional
Pharmacy Prescription Benefits

Pharmacy Drug Formulary
If a Member ID card does not list Express Scripts, then Coventry Health Care does not provide pharmacy benefits for the group.

Coventry Health Care maintains one drug formulary for all Commercial HMO, POS and PPO members and separate formularies for all the Medicare Advantage plan options and the Individual Marketplace plan options. These formularies are developed in conjunction with the Coventry Health Care Pharmacy and Therapeutics (P&T) Committee to assist providers in prescribing cost-effective, quality drug therapy. The appropriate Coventry Health Care formulary shall be used for Coventry Health Care member’s prescriptions. The formularies contain convenient cost comparison guides for several drugs within therapeutic categories. When writing a prescription for a Coventry Health Care member, please consider those medications that are covered under the appropriate formulary. Products are accessible in a tiered copay arrangement. Copays may vary depending on the product tier.

Coventry Health Care’s formularies can be found at www.chemissouri.com, or you may contact your provider relations representative for a copy. Additionally, the formulary is available electronically through Epocrates and can be downloaded onto a Personal Digital Assistant, PalmPilot, etc.

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

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Prior Authorization
To promote appropriate utilization, selected high-risk or high-cost medications may require prior authorization to be eligible for coverage under the member’s prescription benefit. These drugs are designated in the formulary by prior authorization required. Prior authorization criteria have been established by the Coventry P&T Committee. In order for a member to receive coverage for a medication requiring prior authorization, the provider or pharmacist can call the Pharmacy Department at 800-546-4603, option 2, and then option 3 to request authorization. In addition, you may fax your request to 877-554-9139 on one of the Prior Authorization Request forms. Forms can be found on Coventry Health Care’s website (www.chemissouri.com). If your request does not have a specific form, please use the form that states Non-Formulary General and fill in the medication that you are requesting. These forms may be duplicated as often as needed.

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

Diabetic Supplies
Diabetic blood glucose test strips are covered if the employer purchases this benefit. For those members, only LifeScan OneTouch® Ultra®, OneTouch® FastTake®, OneTouch® SureStep® and OneTouch® Test Strips are available on the formulary. Insulin is a covered benefit.

Self-Administered Injectables/Specialty Drugs
Self-administered injectable (SAI) and specialty drug coverage is a pharmacy benefit. This applies to all Coventry Health Care Commercial members, which includes Coventry Health Care’s HMO, POS, PPO, ASO and CMR plans. SAI/SAIs/specialty drugs require prior authorization and are limited to up to one month’s supply per fill. Members should purchase SAI/ Specialty drugs through Coventry Health Care’s Specialty Pharmacy Provider using their Coventry Health Care pharmacy benefit. Copays are assessed at that time.

A small number of Coventry Health Care’s members receive their pharmacy benefits through a carve out vendor other than Coventry Health Care Pharmacy. For these groups, the appropriate pharmacy vendor will dispense the SAI/specialty drugs.

In addition, the prior authorization process for SAI/specialty drugs goes through the Pharmacy Department rather than the Coventry Health Care Pre-Authorization Department. To request authorization for SAI/specialty drugs, providers may download the forms from our website (www.chemissouri.com). Oral and Self Administered Specialty Drugs are generally defined as drug that:

• are used to treat rare or complex diseases;
• require close clinical monitoring and management;
• frequently require special handling;
• may have limited access or distribution

Non-Covered Medications
1. Injectables, other than insulin, glucagon, Immitrex®, bee sting kits and self-administered injectables are not covered under the pharmacy prescription benefit. Other injectables may be covered under the medical benefit.
2. Medications that can be obtained over the counter or have a nonprescription alternative are not covered, with a few exceptions as determined by Coventry Health Care. If possible, providers and pharmacists should refer members to an equivalent OTC product. If the member or provider insists on the prescription product, the member must pay the entire cost of the prescription. Prilosec OTC, Prevacid OTC, Claritin/D OTC, Zyrtec/D OTC, Miralax and Zaditor OTC are covered with a provider’s written prescription.
3. Medications for cosmetic use (e.g., Rogaine®, Propecia®, Renova®, etc.)
4. Weight management agents
5. Smoking cessation agents
6. Experimental and investigational uses of medications
7. Vitamins and minerals (both OTC and legend), except generic legend prenatal vitamins for pregnant/nursing females, liquid or chewable legend pediatric vitamins for children
8. Drugs for infertility (Illinois members may be covered)
9. Exclusions contained in the respective health plan rider

Coverage of Oncology/Transplant Drugs
All antineoplastics and immunosuppressants are covered for FDA-approved indications and may require prior authorization. Coverage for Advantra, Coventry Total Care and Gold Advantage may be limited to medications covered under the Medicare Part B drug list. Drugs prescribed for experimental or non-FDA approved indications are not covered unless a specific indication is listed in American Hospital Formulary Service-Drug Information (AHFS-DI), NCCN Drugs and Biologics Compendium (Oncology), Thomson Micromedex DrugDex, or Clinical Pharmacology. If it is not mentioned in any of the above compendia, but the drug is recommended for that particular type of cancer in formal studies, the results of which have been published in at least two peer-reviewed professional American medical journals, then Coventry Health Care will also cover the medication. Some member benefits may have a separate copay/co-insurance for these medications and prescriptions should be obtained from the contracted Specialty Pharmacy Provider.

Coverage of AIDS Drugs
Please refer to the Coventry Health Care formulary. Most drugs are covered; however, some combination products may be non-formulary. Some member benefits may have a separate copay/co-insurance for these medications and prescriptions should be obtained from the contracted Specialty Pharmacy Provider.

Pharmacy Network
Coventry Health Care members who have Coventry Health Care’s prescription benefit may have their prescriptions filled through the Coventry Health Care in-network pharmacies. Please refer your Coventry Health Care members to their Provider Directory for a comprehensive list of in-network pharmacies or the online provider search (www.chcmisouri.com).

Express Scripts
Coventry Health Care provides the convenience of a mail order pharmacy through Express Scripts for members who are on long-term, maintenance medications. Coventry Health Care members can purchase a 90-day supply of medication for generally two to three copays, 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 by the mail order pharmacy program. The list of medications which are excluded from the mail order program are indicated on the formulary which is posted on our website (www.chcmisouri.com).

Maintenance Drug Program
In addition to Express Scripts’ mail order service, Coventry Health Care members may obtain maintenance medications through pharmacies that are specifically contracted with Coventry Health Care to provide 90-day supply services. 50 percent copay applies if a member obtains more than a 31-day supply of maintenance drugs from any other in-network pharmacy.

Appeal Rights
The fact that Coventry Health Care in-network providers may prescribe, recommend or order a medication does not of itself make such a medicine a covered benefit.

Medical Appeals Process
Appeals must be submitted in writing (unless expedited) within 180 days of the adverse benefit determination and must contain the following information:

   Member name
   Member identification number
   Member date of birth
   Provider name, address, phone number and fax number
Service being appealed  
Expected date(s) of service, or if service has already been provided, date(s) of service received
Clear indication of the remedy or corrective action being sought and an explanation why the plan should reverse the adverse benefit determination
Copy of documentation to support the reversal of decision (e.g., emergency details, date, time, symptoms, etc.)

In cases where the member’s authorized representative is appealing on behalf of the member, a completed member designated release of information form.

**Member Appeals department fax: 855-426-6155.**

How to Use the Online Searchable Formulary
On Coventry Health Care’s website under the pharmacy section, you may reach the formulary for pharmaceutical products using several different methods.

- Searches can be conducted by simply clicking on the appropriate first letter of the drug name under the Alphabetical Search section.
- A search can be made by drug name using the Brand & Generic Name Search option where products are listed by both brand (trade) and generic (chemical) names. Click in the entry box, type the first few letters (e.g., Zoe) or the entire drug name (e.g., Zocor), and click Go.
- Click on the appropriate drug class (e.g., Anti-infective agents) under the Therapeutic Class Search section.

Please be aware that some medications require pre-authorization and are noted on the formulary listing with a “∗PA”

Pre-authorization should speak with their provider about covered alternatives or for assistance with the submission to the plan.
Forms that members submit cannot be accepted since requests for pre-authorization generally involve questions of medical necessity. Forms are to be used by prescribing providers and require the provider's signature. These forms can be viewed and downloaded.

**Network Grid**

<table>
<thead>
<tr>
<th>Network</th>
<th>Lab*</th>
<th>Radiology*</th>
<th>Routine Eye Care</th>
<th>Specialty Eye Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>HMO</td>
<td>Quest Diagnostic or approved hospital lab</td>
<td>HMO In-Network provider</td>
<td>EyeMed</td>
<td>HMO In-Network provider</td>
</tr>
<tr>
<td>Advantra</td>
<td>Quest Diagnostic or approved hospital lab</td>
<td>Advantra In-Network provider</td>
<td>EyeMed</td>
<td>HMO In-Network provider</td>
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<tr>
<td>Gold Advantage</td>
<td>Quest Diagnostic or approved hospital lab</td>
<td>Gold Advantage In-Network provider</td>
<td>EyeMed</td>
<td>Gold Advantage In-Network provider</td>
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<tr>
<td>Care Management Resources (CMR)</td>
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<td>CMR In-network provider</td>
<td>EyeMed</td>
<td>CMR In-network provider</td>
</tr>
<tr>
<td>Coventry ASO Network (includes Choice Health and MoDOT/MBHP)</td>
<td>Coventry ASO Network In-network provider</td>
<td>Coventry ASO Network In-network provider</td>
<td>EyeMed</td>
<td>Coventry ASO Network In-network provider</td>
</tr>
<tr>
<td>POS</td>
<td>Quest Diagnostic or approved hospital lab</td>
<td>POS In-Network provider</td>
<td>EyeMed</td>
<td>POS In-Network provider</td>
</tr>
<tr>
<td>Barnes-Jewish and St. Louis Childrens Residents</td>
<td>Quest Diagnostic or BJC facility</td>
<td>POS In-Network provider</td>
<td>EyeMed</td>
<td>POS In-Network provider</td>
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<tr>
<td>PPO</td>
<td>Quest Diagnostic or approved hospital lab</td>
<td>PPO In-Network provider</td>
<td>EyeMed</td>
<td>PPO In-Network provider</td>
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<tr>
<td>Select</td>
<td>Quest Diagnostic or approved hospital lab</td>
<td>Select In-Network provider</td>
<td>EyeMed</td>
<td>Select In-Network provider</td>
</tr>
<tr>
<td>Coventry Total Care</td>
<td>Quest Diagnostic or Mercy/SSM affiliated provider</td>
<td>Coventry Total Care In-Network provider</td>
<td>EyeMed</td>
<td>Coventry Total Care In-Network provider</td>
</tr>
<tr>
<td>Carelink from Coventry</td>
<td>Quest Diagnostic or Mercy/SSM affiliated provider</td>
<td>Carelink from Coventry In-Network provider</td>
<td>EyeMed</td>
<td>Carelink from Coventry In-Network provider</td>
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<tr>
<td>Focused Care</td>
<td>Quest Diagnostic</td>
<td>FocusedCare In-Network provider</td>
<td>EyeMed</td>
<td>FocusedCare In-Network provider</td>
</tr>
</tbody>
</table>
* Members may also use Boyce & Bynum, LabCorp and Jefferson City Medical Group. Southeast Missouri members may use Gamma Healthcare
* Certain Radiology services must be authorized through NIA. Refer to page 34 for specifics

## Coventry Health Care Approved Lab Sites

**OP Hospital Lab Sites***

<table>
<thead>
<tr>
<th>Missouri</th>
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<tbody>
<tr>
<td>AUDRAIN COUNTY</td>
<td>Audrain Medical Center</td>
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<tr>
<td>CALLAWAY COUNTY</td>
<td>Callaway Community Hospital</td>
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<tr>
<td>CAMDEN COUNTY</td>
<td>Lake Regional Health System</td>
<td></td>
<td></td>
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<tr>
<td>CAPE GIRARDEAU COUNTY</td>
<td>St. Francis Medical Center</td>
<td></td>
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<tr>
<td>GASCONDE COUNTY</td>
<td>Herman Area District Hospital</td>
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<td></td>
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<tr>
<td>MADISON COUNTY</td>
<td>Madison Medical Center</td>
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<td></td>
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<tr>
<td>PIKE COUNTY</td>
<td>Pike County Memorial Hospital</td>
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<td></td>
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<tr>
<td>WASHINGTON COUNTY</td>
<td>Washington County Memorial Hospital</td>
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<td></td>
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<tr>
<td>Illinois</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>BOND COUNTY</td>
<td>Greenville Regional Hospital</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| CHRISTIAN COUNTY | Pana Community Hospital |          |          |
| CALLAWAY COUNTY | Taylorville Memorial Hospital |          |          |
| CLINTON COUNTY | St. Joseph Hospital-Breese |          |          |
| FAYETTE COUNTY | Fayette County Hospital |          |          |
| FRANKLIN COUNTY | Franklin Hospital |          |          |
| GREENE COUNTY | Boyd Memorial Hospital |          |          |
| JACKSON COUNTY | Memorial Hospital of Carbondale |          |          |
| JEFFERSON COUNTY | Crossroads Community Hospital |          |          |
| JERSEY COUNTY | Jersey Community Hospital |          |          |
| LOGAN COUNTY | Abraham Lincoln Hospital |          |          |
| MAOUPIN COUNTY | Carlinville Area Hospital |          |          |
| MADISON COUNTY | St. Joseph’s Hospital-Highland |          |          |
| MARION COUNTY | Salem Township Hospital |          |          |
| MORGAN COUNTY | Passavant Area Hospital |          |          |
| MONTGOMERY COUNTY | St. Francis Hospital |          |          |
| RANDOLPH COUNTY | Marshall Browning Hospital |          |          |
| SALINE COUNTY | Ferrell Hospital |          |          |
| SANGAMON COUNTY | Memorial Medical Center |          |          |
| SHELBY COUNTY | Shelby Memorial Hospital |          |          |
| WILLIAMSON COUNTY | Heartland Regional Medical Center |          |          |
| Herrin Hospital |          |          |          |
| Illinois |          |          |          |
| BOND COUNTY | Sparta Community Hospital |          |          |
| HARDIN COUNTY | Hardin County General Hospital |          |          |

CMR/ASO/PPO Only

**OP Hospital Lab Sites**
Emergency Care

Coventry Health Care advises members to go to the nearest hospital emergency department 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: (1) serious jeopardy to the health of the individual (or unborn child); (2) serious impairment to body function; or (3) serious dysfunction to any bodily organ or part. If you instruct a member to visit the emergency room, or if you admit a 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 Coventry Health Care of an emergency department 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, members should call 911 or another local emergency number.

Urgent Care Situations
For urgent care situations that arise during regular business hours, members are instructed to call their PCPs. For urgent care situations that arise after hours, members should contact their PCP or call the urgent care phone number listed on their Member ID card, if applicable.

Out-of-Area Care
Emergency care for Coventry Health Care members is covered whether the need arises in or out of Coventry Health Care’s service area, in the United States or abroad. Services will be authorized to prevent further deterioration of the member’s health before he/she can return to the service area.

NOTE: Out-of-area coverage for CMR and Coventry ASO Network members may vary according to each group’s individual schedule of benefits.

Out-of-Network Hospitalization
Whenever we are advised a Coventry Health Care member is hospitalized due to an emergency in an out-of-network facility, we notify the member’s PCP. The member may be transferred to a Coventry Health Care in-network facility when the member’s condition has stabilized. These services require prior authorization and may be authorized by contacting the Medical Management Department.

Claims Information

Claims/Encounter Submission Data
Claims and encounter data (for capitated providers) must be submitted to Coventry Health Care within 90 days from the date of service on CMS-1500 and UB-92 forms. The provider is responsible for ensuring data being submitted is accurate and complete.

The term clean claim means it has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payments from being made. A clean claim requires no outside request for additional information.

New Online Claim Submission and Remittance Advice Features
We’re pleased to announce you now have the option to upload HIPAA compliant EDI claim files, direct data enter claims for Coventry, and view remittance advice files online through our expanded partnership with Emdeon®. These new online capabilities have similar functionality to what is available today through other clearinghouse vendors such as Emdeon’s Office product. What’s best is we have made these features available to you at no cost*

The following online features are intended to offer you a choice and help make doing business with Coventry simple and convenient! If your provider practice currently uses a successful EDI claim submission or automated remittance solution, please continue that process.

Online Claim Submission
Submitting paper claims is no longer necessary with the new Web-interface available through directprovider.com and Emdeon. You can use a direct data entry method for online claim submission or you can upload a HIPAA compliant 837 EDI file from a billing system or vendor of your choice.

To get started, simply log in to directprovider.com, select the “Claim Submission” link on the left navigation, and click the link to go to the new site. Proceed by completing the necessary registration steps on the Emdeon & Coventry Health Care site by selecting "enroll new user”.

When using this online feature, it is essential that you are able to manage the full cycle of EDI claim submission by monitoring accept/reject status messages through the new Emdeon web connect site. Timely review and resubmission of any claims that are rejected for the reasons indicated online is key.
Remittance Advises
If you do not currently have an automated remittance advice process in place for retrieving and viewing HIPAA compliant 835 files, consider using our solution. To get started, select the “Remittance Advises” link on the left navigation and then “HIPAA 835 Remittances”. Proceed by completing the necessary registration steps.

About directprovider.com
If you are not currently registered, please consider the advantage of using directprovider.com to:

- View member eligibility and ID card details
- Check claim status, history and payment information
- Submit authorization and referral requests
- Download and print remittance advices
- Submit claim adjustment requests
- And more!

These functions of the directprovider.com website may be limited by plan. If you have any questions, please contact your Coventry representative. For Emdeon support, call 877-667-1512.

* By choosing to use these online features, you will be required to agree to Emdeon’s End User Agreement. Although Emdeon’s End User Agreement contains information about fees, these online features are available to you as a registered user at no cost. You will be required to maintain a separate username and password from your directprovider.com account. After initial registration, Emdeon’s setup process could take up to 30-45 days before claims can be submitted online or remittance advices are available to view or download. For more information about Emdeon’s registration guidelines, select the “Resource Library” link on directprovider.com.

Electronic Claims
Electronic claims require the same information as paper. Coventry Health Care accepts the submission of claims with attachments. Coventry Health Care accepts all claims submissions electronically through Gateway EDI or Emdeon. For more information, contact your provider relations representative.

Claims filed electronically are NOT considered received unless they have passed our system edits and have been accepted into our system. For every claim filed electronically the provider should receive:

1. A report that the clearinghouse accepted the claim.
2. A file stating the action taken by Coventry Health Care (Second Level Acceptance report).

If you do not receive both reports, please check with your clearinghouse. It is important to review rejection reports and ensure all rejected claims are re-filed timely. A claim must be received by Coventry Health Care within 90 days of the date of service or it will be denied for untimely filing. A claim that is filed and rejected is not considered received.

Monitoring Your EDI Reports
Please note that claims appearing on the Initial Reject Report have not met the initial clearinghouse criteria approved by Coventry and have not been sent to Coventry for adjudication. Any claims appearing on this report must be corrected and should be re-submitted electronically as soon as possible to avoid timely filing issues.

Claims displayed on the Initial Accept Report have passed the clearinghouse edits and have been forwarded to Coventry for additional payer editing. It is also important to note that a claim can pass the clearinghouse edits and be displayed on the Initial Accept Report, but still be rejected by Coventry. Claims rejected by Coventry will appear on the Payor Reject Report. Any claims appearing on this report should be corrected and re-submitted electronically as soon as possible to avoid timely filing issues.

Coventry must accept a claim within its timely filing limit or it will be denied for untimely filing. If you are not receiving the described clearinghouse and payor reports on a regular basis, please contact your clearinghouse or Emdeon Business Services. A provider can avoid timely filing issues through understanding and regular monitoring of EDI reports. This process will help to ensure all rejected claims are refiled timely and electronically.

The payor ID for electronic claim filing is 25133.

Submitting Corrected Claims Electronically
Submitting corrected claims electronically is more efficient and cost effective than dropping claims to paper. Did you know you Coventry Health Care accepts corrected claims for both UBs and HCFA electronically? Submitting a corrected UB claim is done by using the type of bill field. Claims with a type of bill ending in a 5 (late charge), 7 (replacement of prior claim), or 8 (void/cancel of prior claim) are indicative of a corrected claim submission. To resubmit a corrected HCFA claim simply enter a 5 (late charge), 7 (replacement of prior claim), or 8 (void/cancel of prior claim) in the EDI field called Claim Frequency Type Code. Claims submitted in this fashion allows Coventry Health Care’s claim unit to identify your electronic claim as a resubmission and process it accordingly.

Duplicate/Tracer Claims Filing
It is not necessary to submit a duplicate or tracer Claim to inquire about the status of a Claim. Please allow thirty (30) days from the Claim submission date before inquiring on the status. Duplicate or tracer Claims submitted less than thirty (30) days from the Claim’s submission date delay processing. Duplicate Claims are rejected by the Claims system regardless of the format received, electronic or paper. When Claims are handled multiple times, there is always an opportunity for increased error. Providers are encouraged to check
Medical Records

Medical records, whether paper or electronic, may be required to determine Medical Necessity, to make a Claim determination or to process an appeal. Providers must provide copies of records at no charge, even if using an external vendor to process medical records requests. In addition to the medical record, Providers may be required to furnish a list of names of individuals that have documented in the medical record. Providers must keep our members’ information confidential and stored securely. They must also ensure staff members receive periodic training on member information confidentiality. Only authorized personnel should have access to medical records.

Coventry makes every effort to maintain the privacy and security of all individually identifiable health information, including medical records. Providers can assist in this initiative by directing records to the specific person or department that requested the records. When using electronic health or medical records (EHR or EMR), Coventry shall be entitled to access the documents in native file format, including metadata and audit trails. Coventry expects that all Providers comply with state and federal laws pertaining to electronic medical records, including but not limited to HIPAA, the Federal Rules of Civil Procedure, and all State laws.

Providers are expected to know where all of their Member information is housed and establish policies and procedures relative to: retention, destruction, spoliation, legal holds, responding to subpoenas, disaster recovery, and business continuity planning. Providers are strongly encouraged to develop a comprehensive communication and education program to inform all individuals in the office about the existence of the procedures and their responsibilities with respect to electronic discovery. Electronic documentation tools offer exciting new time-saving and validity checking features designed to enhance communication for all health record users. They address traditional, well-known requirements for documentation principles, while supporting expansive new HIM capabilities. However, use of these features without appropriate management and guidelines may cause invalid auto-population of data fields, manufactured documentation to enhance expected reimbursement, and other undesirable outcomes. Providers should be aware of the following areas of concern regarding the EHR environment and the expectation of Coventry with respect to Claims submitted for Members.

Authorship integrity: The following acts are strictly prohibited by Coventry: borrowing record entries from another source or author; representing or displaying past as current documentation; and misrepresenting or inflating the nature and intensity of services provided. Records must be attributable to the individual performing the service so that Coventry may verify the actual Provider of care or the amount of work performed by each person providing services. Providers are required to ensure that all documentation authorship is accurately recorded. Most auto-authentication methods fall short of federal and state authentication requirements, and therefore are inadequate compliance with Coventry policies. Some Providers choose not to enter their own information electronically and use scribes or assistants to type entries into the system for subsequent authorization. Policies, procedures, and checks and balances must be in place to ensure that the physician or legally responsible individual reviews the health record entries and affixes an authorization compliant with existing law. Electronic tools make it easy to copy and paste documentation from one record to another or pull information forward from a previous visit, from someone else’s records, or from other sources, either intentionally or inadvertently. Defaulting clinical information with previous existing documentation from other patient encounters facilitates billing at a higher level of service than was actually provided. It is the Provider’s responsibility to ensure that the record is accurate, free of duplicated, inapplicable, misleading or erroneous documentation, and supports the codes billed.

Auditing integrity: Provider’s should ensure their EHR systems have adequate, enabled auditing functions in order to determine when an entry was modified or borrowed from another source or represented as an original entry by an authorized user. If an EHR lacks adequate audit trail functionality, there may be no way to determine if and when corrections or amendments were made to the documentation, by whom, or the nature of the correction or amendment, critical information to Coventry in determining Claims payment. Coventry must be able to determine whether an original note or amendment includes the correct date and time. Some systems automatically assign the date that the entry was made, while others allow authorized users to revise the date of entry to the date of the visit or service. It is imperative that Coventry be able to identify the date the note or amendment originated and the service date that the note or amendment references. As stated before, auto-authentication, defined as signing multiple documents at one time without opening the documents, falls short of federal and state authentication requirements, and violates the Coventry Provider Agreements and this Manual. Some Providers use scribes or assistants to type entries into the system for subsequent authorization. In some situations, the physician or other Provider gives his or her access codes to assistants to allow direct entry of the notes. The system recognizes the author as the physician or other authorized Provider of care, instead of the assistant. Checks and balances must be in place to ensure that the physician or other legally responsible individual has reviewed the health record entries and authenticated them compliant with existing law.

Documentation integrity: Documentation templates can be very helpful tools in completing patient documentation. Coventry cautions Providers, however, against utilizing default or auto-generated data for common fields. Providers should take the time necessary to review all documented data for changes and remove incorrect information from the record. When it is obvious that some information was automatically entered or copied and pasted, the accuracy of the entire documented entry may be questioned.

Patient identification and demographic accuracy: Demographic and insurance information may be defaulted for a patient’s encounter. It is the Provider’s responsibility that the record accurately reflects current patient information, including the patient care setting. Be aware that patient identity theft is an area of vulnerability for healthcare organizations. In the wrong hands, Claims data coupled with the ability to manufacture supporting documentation creates the risk of false Claims and criminal activity. Coventry expects users of EHR to employ effective, appropriate safeguards to identify fraud and abuse or business arrangements involving data management that may violate patient privacy.

Claims Payment Procedures

Claims Payment Procedure for Providers in Multiple Network
When a Coventry Health Care provider participates in more than one network, we pay according to the following guidelines:

1. If the Coventry Health Care provider is contracted with the same network as the member’s PCP, he/she is paid according to that network’s contract.

2. If the Coventry Health Care provider is not contracted with the same network as the member’s PCP, he/she is reimbursed according to Coventry Health Care’s Maximum Allowable fee schedule.

3. If the Coventry Health Care member has chosen a Coventry Health Care product that does not require selection of a PCP, the provider is reimbursed according to Coventry Health Care’s Maximum Allowable fee schedule.

<table>
<thead>
<tr>
<th>Coventry Commercial</th>
<th>Coventry Medicare</th>
<th>CMR and Coventry ASO</th>
</tr>
</thead>
<tbody>
<tr>
<td>P O Box 7374</td>
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<td>London KY 40742-7817</td>
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**NOTE:** Secondary claims for ASO groups may have a different mailing address. Please check the back of the Member ID card.

### Timely Filing

Claims and encounter data must be submitted to Coventry Health Care within 90 days from the date of service or date of discharge. Coordination of Benefits (COB) claims must be submitted within 90 days from the date of the primary carrier EOB, which must be attached to the claim for consideration. More detailed information on Coventry Health Care’s timely filing guidelines are found in our Timely Filing Guidelines Reconsideration Policy as outlined below.

#### I. Timely Filing Guidelines

- **Claims and encounter data must be submitted to Coventry Health Care within 90 days from the date of service or date of discharge. Providers that do not receive an acknowledgement should contact the provider hotline to verify receipt of the claim. Initial claim submissions received after 90 days from the date of service/discharge are denied untimely, provider responsibility. (Missouri law requires an acknowledgement be sent to the provider within 10 working days of the receipt of a paper claim, and within 24 hours for claims submitted electronically. However, this requirement excludes ERISA qualified plans).**

- **COB claims must be submitted within 90 days from the date of the primary carrier RA, which must be attached to the claim for consideration. COB claims submissions received after 90 days from primary carriers RA are denied untimely, provider responsibility.**

- **Corrected claims must be submitted by provider within 90 days from the date of the original Coventry Health Care provider RA. Corrected claims include: (1) claims where Coventry Health Care has requested additional information to pay the claim or (2) claims resubmitted by provider which contain claims data not available/present on the original claim submission. Corrected claims received after 90 days of Coventry Health Care’s RA are denied untimely, provider responsibility.**

- **In situations where the carrier of record is incorrect based upon the most current information presented by the member, providers generally drop the account to self-pay and begin billing the member directly upon receiving a denial RA or claim rejection from the carrier of record. Upon receiving correct carrier information from the member or Coventry Health Care, the provider has 90 days to submit the claim. Failure to submit the claim within 90 days of the provider receiving correct carrier information will result in the claim denying for failure to meet timely filing, provider responsibility.**

  - If the claim is received within 365 days of the date of service and the provider can document that the member provided the information within the last 90 days, we will process the claim for payment.

  - If it is over 365 days and the provider can document that the member never provided insurance information or provided it beyond the 365 days, we will reprocess the claim to deny untimely, member responsibility.

- **There are also situations where the provider submits the claim to a payor (including Coventry Health Care entities) and receives a denial/rejection of member not found. In these cases, providers generally drop the account to a self-pay and begin billing the member. Upon receiving correct carrier information from the member or Coventry Health Care, the provider has 90 days to re-submit the claim to Coventry Health Care. This often happens with newborns or when dependents are added to the plan late.**

  - If the claim is received within 365 days of the date of service and the provider can document that the member provided updated information within the last 90 days, we will process the claim for payment.

  - If it is over 365 days and the provider can document that the member provided updated information beyond the 365 days, we will reprocess the claim to deny untimely, member responsibility.

  - Notwithstanding the above, if a member not found denial is a result of provider error (such as billing with the wrong Member ID number) the normal claims filing guidelines would apply. Therefore, upon receiving the rejection from Coventry Health Care or payor the provider has 90 days to resubmit a corrected claim.
II. Timely Filing Reconsideration Policy

The provider has 365 days from the date of the original Coventry Health Care provider RA or 365 days from date of service or discharge date where no RA was issued, to submit proof of timely filing and follow up efforts. If the provider is disputing a timely filing denial of a claim, the following proof must be submitted with the claim:

- Electronically: As proof of timely filing, Coventry Health Care accepts the acceptance report form the clearinghouse showing that the claim was accepted by Coventry Health Care. Documentation must support the claim being submitted within 90 days from the date of service. Additional documentation from the practice management system may be submitted to support or clarify the report sent.
- Paper: The provider must submit supporting documentation from his/her practice management system or a UB92, CMS 1500 with the original date billed in order for Coventry Health Care to reconsider the claim. Documentation must support the claim being submitted within 90 days from the date of service or discharge date. A tracer claim is not sufficient supporting documentation. Documentation is required to support Timely Filing Reconsideration requests. Acceptable documentation includes: other carries EOB, notes from provider’s practice management system, face sheets documenting insurance information from the member, copies of billing statements, paper claims with the original billing date, acceptance reports for electronic claims, or other documentation Coventry Health Care determines to be appropriate.

Some provider agreements provide longer timeframes to submit claims and encounter data. It such circumstances, all references to 90 days within this document shall be substituted with the timeframe contained within the applicable agreement.

In all the above scenarios, other processing guidelines, such as prior authorization, must be met in order for PR to have the claim reprocessed. If authorization issues are involved, it must be appealed to Medical Management. Medical records should be attached to the submission for review. Retro-review of medical records to determine medical necessity will only be performed in situations where Coventry Health Care is not determined to be the carrier/payor of record at the time services are rendered.

NOTE: In accordance with Missouri law, an acknowledgement must be sent to the provider within 10 working days of the receipt of the claim. Electronic claims submissions are to be acknowledged within one day. If you have not received an acknowledgement, contact the Provider Hotline to verify receipt of the claim.

How To Follow Up On Your Claim

Prior to sending in a claim resubmission or claim reconsideration you should check the status of the claim. We provide a number of different outlets in order to assist you in your claim follow up process. All of the following resources are available to make your job easier:

- Directprovider.com
- Emdeon
- CSO by telephone (At the number listed on the back of the Member ID card)
- Interactive voice response system (IVR) (Same number as the CSO)

Claims Resubmission

Corrected claims, claims where additional information has been requested and claims having proof of timely filing attached, are considered examples of claims resubmission.

The provider has 90 days from the date of the original Coventry Health Care provider RA to submit a corrected claim or requested additional information in order for the claim to be considered timely. Claims received after 90 days will be denied untimely.

The provider has 365 days from the date of the original Coventry Health Care provider RA or 365 days from date of service or discharge date where no RA was issued, to submit proof of timely filing and follow up efforts. If the provider is disputing a timely filing denial of a claim, and the claim is filed:

- Electronically: The only proof that Coventry Health Care accepts as timely filing is the acceptance report form the clearinghouse showing that the claim was accepted by Coventry Health Care. Documentation must support the claim being submitted within 90 days from the date of service.
- Paper: The provider must submit supporting documentation from his/her practice management system or a UB92, CMS 1500 with the original date billed in order for Coventry Health Care to reconsider the claim. Documentation must support the claim being submitted within 90 days from the date of service or discharge date. A tracer claim is not sufficient supporting documentation.

Claim resubmissions can also be submitted via www.directprovider.com or mailed to:

Corrected claims should be directed to the P.O. Box for initial claims submissions

Claims Disputes

A claims dispute occurs when a claim is not paid according to a provider’s contract, did not pay as authorized, or denied for authorization when the provider has an authorization for the service. Bundling issues can also be considered a claims dispute. The provider has 365 days from the date of the original Coventry Health Care remittance advice to file a claim dispute.

- Claims disputes can be filed electronically using Emdeon Office. The dispute is filed by claim line. Indicate the error on the claim line(s). Send the dispute via email to the appropriate area for a resolution. A claim that has been denied for no authorization and the provider has an authorization; the authorization number should be given in the line description of the dispute. If additional information needs to be provided with the claim, the dispute cannot be filed electronically. It must be submitted on paper via mail.
• Claims disputes can be filed in writing. Please include a description of why you feel the claim has not been processed correctly. Include any supporting documentation. Disputes may be sent to www.directprovider.com or mailed to:

Coventry Health Care Claims Disputes  University of Missouri/MoDOT
Attention: Claims Dispute Coordinator  P.O. Box 7798
P.O. Box 7111  London, KY 40742-7798
London, KY 40742-7111

NOTE: Corrected claims are not considered a claims dispute and must be submitted within 90 days of the date of the original RA to the claims resubmission address. (Late charges are considered a corrected claim).

• Claims Reconsideration via our Website: Online claims adjustment is available at www.chemissouri.com and by logging into www.directprovider.com. Providers can view each claim line detail and request a claim adjustment on a line-by-line basis. You can also attach up to four files with the request. To request an online, adjustment, please submit a reason for the adjustment and your name (contact) field is auto-populated. A comment box (per claim line) is also available to add additional notes. When you submit your request, you will receive a secure message along with an issue number for tracking purposes. Your response is responded to within 48 hours and resolution completed within 30 days. Please note: Online claim adjustments cannot be done on the following: claims that have already been disputed, a claim that has an associated back out or replacement claim, nor can you dispute a rejected claim (an EDI claim that has been rejected on your initial reject report).

Decision for Dispute
A Coventry Health Care/CMR claims dispute coordinator who was not involved in the initial claims determination reviews the case and renders a decision. The decision will be based on the information submitted. Coventry Health Care does not request additional information, but makes the determination based on the documentation provided with the claims dispute request for appeal. Coventry Health Care communicates the review decision in writing or on a RA to the requesting provider within 30 business days or receipt of the request. The review by Coventry Health Care/CMR and its determination are final.

Appeals
An appeal generally deals with some aspect of the authorization process. A provider can appeal a claim denied for no authorization requesting a review of medical records to determine if a retro-authorization is appropriate. Failure to call for a prior authorization is not sufficient reason to request a retro-authorization. A provider may appeal an existing authorization if the authorization does not cover all the services a provider determines is medically necessary. When additional services are required that need prior authorization, the provider is required to contact Medical Management regarding these additional services as soon as possible, preferably before the service is rendered. However, we are aware that this is not always possible.

The member also has a right to appeal this determination. If the member chooses to appeal, they should refer to the instructions in their Certificate of Coverage. If a member has questions regarding the appeals process, they may call the Coventry Health Care Member Services Department number on the back of their Member ID card. If you are planning to appeal a non-urgent pre-service benefit determination at the request of a Coventry Health Care Commercial member, Coventry Health Care requests the provider submit an Authorized Representative form. This form can be found online (www.chemissouri.com). The member may also call Coventry Health Care at the number on the back of their Member ID card to provide verbal authorization for you to act as his/her authorized representative.

If you are planning to appeal an urgent or standard pre-service benefit determination on behalf of a Coventry Health Care Medicare member, please note that Medicare Advantage regulations have been revised to allow a physician providing treatment to an enrollee, upon notice to the enrollee, to request a standard plan reconsideration on the enrollee’s behalf without being appointed as the enrollee’s representative.

Request for review of the adverse determination must be submitted in writing within one-hundred eighty (180) days of the adverse determination, and include the rationale, including clinical grounds, for requesting a review of the adverse determination, and a copy of the adverse determination letter. Review requests should be submitted to the following address for processing:

Coventry Health Care Medical Appeals  University of Missouri/MoDOT
Provider Appeals  P.O. Box 7798
P.O. Box 7111  London, KY 40742
London, KY 40742-7111
Fax: 855-426-6155

Other Disputes
Disputes other than claims or authorizations should be submitted in writing to your Provider Relations representative at:

Coventry Health Care
Provider Relations Department
550 Maryville Centre Drive, Suite 300
St. Louis, MO 63141
**HIPPA**

The HIPAA Transaction and Code Set (HIPPA TCS) regulations are the foundation for the most comprehensive change to the way electronic health care claims are processed. At this time, Coventry’s health plans do not accept electronic claims directly from providers. Coventry Health Care receives electronic claims from its two designated clearinghouses: WebMD and Gateway EDI. Providers can send their electronic claims to the clearinghouse or a practice management system/hospital information system vendor of their choice, which will route the claims to one of Coventry’s designated clearinghouses.

Coventry has partnered with WebMD to deliver real-time transactions to providers. These transactions can be submitted to WebMD, or one of its channel partners and the appropriate response transaction are generated on Coventry’s behalf. Providers may send these transactions through a variety of internet applications, specialty devices, practice and hospital management or true EDI transmissions. WebMD Companion Guides for claims may be found on our website (www.chcmissouri.com) under the Provider icon and the section marked HIPAA FAQs.

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**Remittance Advice**

The following pages contain a sample copy of a Provider RA and an explanation of each field on the form. (Certain CMR or Coventry ASO Network groups may use a different format for their RA.)
**FORM HEADINGS**

1. **Page of —** Identifies the page number and the total number of pages in the statement.
2. **Title**—Identifies the name of the report and the specific Coventry Health Plan/product name.
3. **Provider #: Provider Name**—Unique identifier assigned to all providers for claims processing and provider name.

**CLAIM DETAIL**

4. **Patient Name**—The name of the member receiving the service.
5. **Account #**—Patient account number assigned by provider, billed on claim and reflected back for accounting purposes.
6. **Place of Service**—Identifies the location where services were rendered, e.g., OUTPT HOSPITAL, OFFICE, etc.
7. **Member #**—Unique identifier for the member receiving services.
8. **Date Received**—The date the claim was received by Coventry Health Care, Inc.
9. **Processed Date**—The date the claim was adjudicated.

**Claim #**—A unique number that is assigned during the initial processing stage. Please provide this number when making claim inquiries as it will speed specific claim retrieval.

**Auth. #**—The number that is assigned to each authorization request which applies to the claim being processed, if applicable.

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

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

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

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

**Service Dates**—Dates of service corresponding to each procedure code. From the first date the member received the service from the provider (From Date) through the last date the member received the service from the provider (To Date).

**Proc Code**—Code pertaining to the procedure performed and billed by the provider on the corresponding service date(s).

**Mod Cd**—Indicates the modifier appended to the billed procedure code by the provider, if applicable.

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

**Procedure Description**—Describes the procedure performed for the code indicated.

**CAP**—Y=Yes, indicates the claim line was adjudicated as a result of a captivated agreement. N=No, indicates the claim line was adjudicated as a result of a fee for service agreement.

**Total Charges**—The amount billed for the procedure(s) performed on the corresponding service date(s).

**Allowed Amount**—Amount allowed for the covered service(s) performed.
13 Allowed Amount – Amount allowed for the covered service(s) performed.
14 Ineligible Amount – Amount that is not covered or is in excess of the provider’s contracted rate and for which the member or provider is responsible.
15 Inelig DC – Disposition code assigned to indicate the reason for ineligible amount; applicable disposition codes descriptions are noted at the bottom of the last page of the remittance advice.
16 COB DC – Disposition code assigned to indicate ineligible amount(s) after Coordination of Benefits; applicable disposition codes descriptions are noted at the bottom of the last page of the remittance advice.
17 Deductible Amount – Amount of deductible applied as defined by the member’s Certificate of Insurance.
18 Copay Amount – Amount that the member is required to pay at the time of services, as defined by the member’s Certificate of Insurance.
19 Mbr Coins – Amount of coinsurance applied as defined by the member’s Certificate of Insurance.
20 Mbr Respons – Total dollars that is member responsibility (as displayed in columns 17, 18 and 19) in addition to any member responsible ineligible amount dollars (as displayed in column 14).
21 Mbr DC – Disposition code assigned to indicate the reason for member responsibility; applicable disposition codes descriptions are noted at the bottom of the last page of the remittance advice.
22 ADJ RC – Reason code assigned to indicate the reason for claim reconsiderations; applicable reason code descriptions are noted at the bottom of the last page of the remittance advice.
23 Paid Amt – Amount paid to the provider, calculated for each service line minus member responsibility, if applicable.
24 Interest Calculation – Interest paid as a result of claim processing that extends beyond the defined number of days allowed by State or Federal regulatory requirements, if applicable.
25 Check # – The number assigned to the reimbursement check.

26 Claim Totals – Totals columns 12, 13, 14, 17, 18, 19, 20 and 23.
27 Withhold Amount – Total dollars withheld for the claim and is the difference between the Allowed Amount and the Paid Amount minus any member responsibility.
28 Backed Out & Replacement – Backed out and replacement situations occur when an adjustment has been made to the original claim. An adjustment can be done for the following reasons: Claim payment error, applied refunds, provider billing error, contract updates, etc. The backed out claim (1234567890) is a mirror image of the original claim in a negative form. The original claim number and the replacement claim number will appear. The replacement claim (1234567894) reflects the new payment/adjustment/or applicable denial.
Backed Out & Refund – The message (corresponding refund dollar amount, check number and check date) will display if a claim was backed out as a result of a provider refund. The refund represents positive dollars. In this example, the original claim from a previous statement 1234567890 is backed out by claim 1234567890.

PROVIDER SUMMARY
This section provides report totals for columns 12, 13, 14, 15, 16, 17, 18, 19, 20 and 23, differentiated by Fee for Service and CAP claims when appropriate. Also included is a summary of any provider refunds.

PROVIDER NET REFUND SUMMARY
This section provides refund check number, check date and refund check amount for checks associated with a net refund.

PROVIDER CHECK SUMMARY
Summarizes claim detail.
Check Number – Document control number of paper check or EFT payment.
Check Date – The date the check was generated or transmitted.
Check Amount – Total check amount; equals Total Paid Amount + Total Interest Paid + Provider Refunds, as applicable.
Total Interest Paid – Total amount of interest paid from claim detail, as applicable.
Total Withhold Amount – Sum of total Contractual Withhold amounts from claim detail, if applicable. This amount is already accounted for in Total Paid dollars and does not need to be included to calculate Check Amount.

DISPOSITION CODE SUMMARY
Summary of member and provider ineligible disposition codes, adjustment reason codes and HIPAA compliant remark codes that define any claim adjustments, ineligible amounts, or denials. Also displayed is the website link where Remark Code Descriptions are located: http://www.wpo-edi.com/codes/remittanceadvice

IMPORTANT NOTES
If you have registered your practice at www.directprovider.com, you can view your remittance advice as an exact image of the paper remittance advice that is sent through the mail. It is different than what is available as an electronic remittance advice file (835 file). You will need Adobe Acrobat Reader 7.0 to view Remittance Advices. If you haven’t registered your practice, go to www.directprovider.com and register by entering your assigned provider number, located at the top left hand corner of your remittance advice, and your Tax Identification number. Also available online you will find information regarding eligibility/benefits, claim status, interqual sheets, and medical technology assessments. Visit us today.

COVENTRY
Health Care

CHCH9372
Collection Advice

When a claim is adjusted, putting your office in a negative balance with Coventry Health Care, you will receive a collection advice (formerly referred to as a negative remit). Each time there is activity on your account, the balance of the account is still a negative amount. Each of the remits will repeat all of the claims that have been reversed plus any new claims that are being held against this negative. Since these claims may be received on remits several times and eventually will be paid with a check, you may want to only note their status until they are finally paid.

If your office does not do enough business with Coventry Health Care to clear this negative balance within a month, please refund the overpayments. It is best to remit the sum of the negative claims only. The Collection Advice Summary indicates the amount of refund we are requesting. Once the refund is worked, a check is issued for any positive claims that are being held. Please make your refund check payable to Coventry Health Care and mail to:

Coventry Health Care Finance Department
550 Maryville Centre Drive, Suite 300
St. Louis, MO 63141

If you have any questions about the reversed claims, please contact the Provider Hotline at 800-755-5242.

Payments from HRA, FSA or HAS Plans

Many employer groups are looking for solutions to manage costs. One increasing trend is in the sales of HSA, HRA and FSA plans. Coventry now provides an option for members to have their coinsurance and/or deductible paid directly from their accounts to the provider once the claim has been processed by the plan.

For these types of claims, you will receive payments in the same manner as with your Coventry Health Care claims, via EFT or paper check. However, they will not be on the same checks and remits as your Coventry Health Care claims. You will receive a separate EFT payment or check along with an Explanation of Payment (EOP). The EOP and check will have Coventry Consumer Choice listed on them. Please contact the Provider Hotline at 800-755-5242 if you have questions.

Department Of Labor Guidelines (Does not apply to Medicare Advantage)

Department of Labor
The Department of Labor (DOL) issued claims regulations that apply to claims filed beginning July 1, 2002, or no later than the first day of the benefit year starting after July 1, 2002, through December 31, 2002 (66 FedReg. 35886).

These claims regulations do not supersede any state law that regulates insurance except to the extent that the law prevents the application of requirement in the regulation.

Claims Administration
Coventry Health Care administers claims in accordance with the following:

- Department of Labor claims regulations
- Missouri law as applicable
- Illinois law as applicable

Member Appeal Categories
The DOL regulations separate the appeal process for member appeals:

- Pre-Service Appeals—an appeal for which an adverse benefit determination has been rendered for a service that has not yet been provided and requires prior authorization.
- Post-Service Appeal—an appeal for which an adverse benefit determination has been rendered for a service that has already been provided.
- Urgent Appeals—Services for which a delay in decision could seriously jeopardize the life or health of the member, ability to regain maximum function, or for care that the treating provider determines is urgent, or determines that a delay would subject the member to severe pain that could not be adequately managed without the treatment requested.

Authorized Representative
A provider may act on a member’s behalf as an authorized representative with the member’s expressed consent. No expressed consent is needed for emergency situations. Expressed consent most commonly refers to written consent from the member.

Variation Between Missouri and Illinois
The appeal structure differs between Missouri and Illinois state laws and also varies according to the type of appeal: Pre-Service or Post Service. The various levels of appeals available to members are explained in all denial letters and in an attachment that is issued with the Explanation of Benefits whenever a denial of service takes place.

Credentialing
- Uses Missouri-Mandated form
- Uses Illinois-Mandated form
Medicare Advantage Risk Adjustment

All hospitals and providers must use current valid International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) Codes; report all relevant diagnoses related to services performed, justified by medical record documentation, and must follow official coding guidelines using the most specific code.

All providers who participate in the Coventry Health Care’s Medicare programs are required to submit complete and accurate claims data and maintain clean, concise and complete medical record documentation practices.

The following procedures have been identified to assist providers in complying with the regulatory requirements of submitting encounter information and maintaining medical record documentation.

1. Use appropriate ICD-9-CM code set for reporting diagnoses and code to the highest level of specificity known for all conditions present or being managed at the time of a visit.
   
   NOTE: Exception to this rule: History codes (V10 through V19) may be used as secondary codes if the historical condition or family has an impact on current care or possibly influences treatment.
   
   Providers are responsible for ensuring that coding adheres to the ethical standards as outlined by the American Health Information Management Association (AHIMA). All diagnoses that impact patient care should be documented in medical records and coded according to official coding guidelines.

2. Submit all diagnoses that impact the patient evaluation, care and treatment:
   
   • Main reason for visit or admission
   • Co-existing acute condition
   • Chronic condition
   • Permanent past conditions

3. Periodically review claim/encounter data submission to ensure that they are accurate, complete and truthful and are supported by the patient medical record or other relevant documentation.

4. Maintain appropriate medical record documentation. This includes recording of conditions and diseases; updating a problem list, if used; and recording of the patient’s name on each page of the medical record. Documentation should be concise, clean, consistent, complete and legible.
   
   Provider should sign and date each entry in the medical record.

5. Medicare requires that records be maintained for a period of at least 10 years.

It is important for providers and their office staff to be aware of risk adjustment data validation activities because Coventry Health Care may request medical record documentation.

The medical record documentation must show that the diagnosis was assigned within the data collection period, may include the entire medical record or only parts of the record and diagnostic data must comply with ICD-9-CM coding guidelines.

Coventry Health Care monitors the data your office submits for accuracy, thus ensuring we receive correct payment from CMS. If an error or missing data is identified, Coventry Health Care may request from your office coding specificity correcting erroneous data and/or reporting of missing data.

Providers who submit risk adjustment diagnostic data to Coventry Health Care for CMS payment purposes do not violate Health Insurance Portability and Accountability (HIPAA) privacy regulations. Therefore, a member’s authorized information release is not required to comply with risk adjustment data submission or to respond to a medical record request from CMS for data validation.

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

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

**Importance of Medical Record Documentation**

- Accurate risk adjusted payment relies on complete medical record documentation and diagnostic coding.
- CMS annually conducts risk adjustment data validation by medical record review.
- The medical record chronologically documents the care of the member and is an important element contributing to high quality care.

**Medicare Guidelines for Risk Adjustment Data Validation**

Risk adjustment data validation is the process of verifying diagnosis codes submitted for payment are supported by medical record documentation. The purpose is to ensure risk adjusted payment integrity and accuracy.

- Medical record documentation must be legible.
- CMS will only consider medical record documentation from a face-to-face encounter (between a patient and physician/provider). [Note: CMS does not accept initials and a date on a lab report as adequate documentation. It also does not accept a copy of a note in the file where lab results were mailed to a patient. The condition or findings must be discussed and notated in the patient face-to-face encounter for CMS to accept as appropriate documentation. Superbills or encounter forms and problem lists are also unacceptable types of medical record documentation to validate an ICD-9 CM code].
  - The physician/provider’s signature and his/her credentials must be included on each patient encounter, the following is acceptable: Mary C. Smith, MD or MCS, MD. [Note: signature or initials without the credentials is not acceptable to CMS].
  - An electronic signature requires authentication by the responsible physician/provider. [For example, but not limited to “Approved by,” “Signed by,” or “Electronically signed by.” They must also be password protected and used exclusively by the individual provider].
  - A signature stamp must comply with state signature stamp authorization regulations.
  - A typed signature is unacceptable unless it is authenticated by the physician/provider.
  - The patient’s name must appear on every page of the medical record and all entries/encounters must be dated.
- Records must be coded in accordance with the ICD-9-CM Guidelines for Coding and Reporting. [Medical record documentation must support the code selected and substantiate the proper coding guidelines were followed].
- All documented conditions that coexist at the time of the visit, and require or affect patient care treatment or management must be coded [Do not code conditions that were previously treated and no longer exist. However, history codes may be used if the historical condition or family history impacts current care or influences treatment. Do not document a diagnosis as “history of” for a condition that is acute or chronic still requiring management or treatment].
- Chronic conditions treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s). [Even if the note states, “doing well with diabetic diet or continues to do home blood sugar monitoring,” CMS considers this notation as meeting its criteria].
- Sign the medical record and make all notations timely. [Note: CMS expects records to be documented at the time of the visit].
- Addendums are only acceptable in certain circumstances such as the following: Patient has a visit for a mole removal. The pathology report is received several days after the office visit and confirms malignant melanoma. The physician/provider reviews the findings, initials the report and documents the results and patient notification in the record. Since mole was removed during the office visit, the new code (172.9) should be submitted with that date of service].
New Patient/Consults — General Multisystem Exam

(Three of the Three KEY components are required — History, Exam, Medical Decision)

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<thead>
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At Least 1 from any system area

- Limited exam system & related area or 6 elements
- Extended exam of system & 2 related area or 12 elements
- Comprehensive system and 2 related systems or 18 elements from 9 areas
- Comprehensive system and 2 related systems or 18 elements

Constitutional:
- Any three of seven vital signs
- General appearance of patient

Eyes:
- Conjugative & lid
- Pupils & Injuries
- Ophthalmoscopic examination of optic discs

ENT:
- External ears & nose
- Exam EACs & TM
- Hearing
- Nasal mucosa, septum & turbinates

Neck:
- Exam of Neck
- Exam of Thyroid

Respiratory:
- Respiratory effort
- Percussion of chest
- Palpation of chest
- Auscultation of lungs

Cardio-Vascular:
- Palpation of heart
- Auscultation of heart
- Carotid arteries
- Abdominal aorta
- Femoral arteries
- Extremities for edema and/or varicosities
- Inspection of breasts
- Palpation of breast & axilla

GI (Alimentary):
- Exam for masses, tenderness
- Liver & Spleen
- Hernia — presence or absence
- Anus, perineum & rectum
- Oscilating blood test

Genitourinary:
- Male:
  - Scrotal contents
  - Penis
  - DRE of prostate gland
- Female:
  - External genitalia
  - Urethra
  - Bladder
  - Cervix
  - Uterus
  - Adnexa/parametria

Lymph:
- Lymph nodes in two or more areas
- Neck
- Axillary
- Groin
- Other

Muscular:
- Exam Gait & Station
- Inspection Digit & nails
- Sensation
- Stability
- Muscle Strength & tone
- Note atrophy or abnormal movements

Skin:
- Inspection of skin & subcutaneous tissue
- Palpation of skin & subcutaneous tissue

Neurology:
- Cranial nerves
- Deep tendon reflexes
- Sensation

Psychiatric:
- Judgment & insight
- Orientation to time, place, people
- Recent & remote memory
- Mood and affect

The following pages contain several guides to assist you in determining the level of care to bill.
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Time: When more than 50% of the face-to-face time with the patient was spent in addressing counseling components, the visit may be coded based on time if the CHART DOCUMENTATION supports the time. The documentation must list the total time of the encounter and that coding was based on counseling regarding ______.

Counseling components: □ Diagnostic results □ Prognosis □ Risks and benefits of treatment options □ Impressions □ Instructions for management □ Importance of compliance with chosen treatment options □ Risk factor reductions □ Patient and family education

Total time of encounter: _______

Date of service: ________ Provider: ________ Patient #: ________

Audit summary: Code originally reported ________

Documentation supports code ________

Additional comments: ________
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**Constitutional:**
- Any three of seven vital signs
- General appearance of patient

**Eyes:**
- Conjunctivitis & lids
- Papils & irises
- Ophthalmoscopic examination of optic discs

**ENT:**
- External ear & nose
- Ears of EACs & TMs
- Hearing
- Nasal mucosa, septum & turbinates

**Neck:**
- Lips, teeth & gums
- Pharynx: oral mucosa, salivary glands, tongue, tonsils and posterior pharynx

**Respiratory:**
- Respiratory effort
- Percussion of chest
- Auscultation

**Cardio/Vascular:**
- Palpation of heart
- Auscultation
- Coroid arteries
- Abdominal aorta
- Femoral arteries
- Femoral pulses

**Chest:**
- Inspectors for edema and/or xerostomies

**GU(Abdomen):**
- Menses, tenderness
- Liver & Spleen
- Hemia
- Arom, perineum & rectum
- Occult blood test

**GU:**
- Male: Seminal contents, Penis, Prostate gland
- Female: External genitalia, Uterus, Bladder, Cervix, Uterus, Adnexa, parametria

**Lymph:**
- Lymph nodes in two or more areas
- Neck
- Axilla
- Groin
- Other

**Muscular:**
- Gait & Station
- Digit & nails—Exam of Joint(s), bone(s), muscles of at least one area: 1) Head, neck
- 2) spine, ribs, pelvic; 3) right upper extremity; 4) left upper extremity; 5) right lower extremity;
- 6) left lower extremity, with exam including:
  - Inspect and palpate
  - ROM
  - Stability
  - Strength and tone

**Skin:**
- Inspection of skin & subcutaneous tissue
- Palpation of skin & subcutaneous tissue

**Neurology:**
- Cranial nerves
- Deep tendon reflexes
- Sensation

**Psychiatry:**
- Judgment & insight
- Orientation to time, place & person
- Memory
- Mood & affect
## Medical Decision Making

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</table>

*Time:* When more than 50% of the face to face time with the patient was spent in addressing counseling components the visit may be coded based on time if the CHART DOCUMENTATION supports the time. The documentation must list the total time of the encounter and that coding was based on counseling regarding…….

**Counseling components:**
- Diagnostic results
- Prognosis
- Risks and benefits of treatment options
- Impressions
- Instructions for management
- Importance of compliance with chosen treatment options
- Risk factor reductions
- Patient and family education

**Total time of encounter:**

**Date of service:**
**Provider:**
**Patient #:**

**Audit summary:** Code originally reported
**Documentation supports code**
**Additional comments:**
Medical Record Review Guidelines

1. Each page in the record contains the patient’s name or ID number.
2. Personal biographical data include the address, employer, home and work telephone numbers and marital status.
3. All entries in the medical record contain the author’s identification. Author identification may be a handwritten signature, unique electronic identifier or initials.
4. All entries are dated.
5. The record is legible to someone other than the writer.
6. Significant illnesses and medical conditions are indicated on the problem list.
7. Medication allergies and adverse reactions are prominently noted in the record. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record.
8. Past medical history (for patients seen three or more times) is easily identified and includes serious accidents, operations and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations and childhood illnesses.
9. For patients 14 years and older, there is appropriate notation concerning the use of cigarettes, alcohol and substances (for patients seen three or more times, query substance abuse history).
10. The history and physical examination identifies appropriate subjective and objective information pertinent to the patient’s presenting complaints.
11. Laboratory and other studies are ordered, as appropriate.
12. Working diagnoses are consistent with findings.
13. Treatment plans are consistent with diagnoses.
14. Encounter forms or notes have a notation, regarding follow-up care, calls or visits, when indicated. The specific time of return is noted in weeks, months or as needed.
15. Unresolved problems from previous office visits are addressed in subsequent visits.
16. There is review for under or overutilization of consultants.
17. If a consultation is requested, there is a note from the consultant in the record.
18. Consultation, laboratory and imaging reports filed in the chart are initiated by the practitioner who ordered them, to signify review. (Review and signature by professionals other than the ordering practitioner do not meet this requirement.) If the reports are presented electronically or by some other method, there is also representation of review by the ordering practitioner. Consultation and abnormal laboratory and imaging study results have an explicit notation in the record of follow-up plans.
19. There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure.
20. An immunization record (for children) is up to date or an appropriate history has been made in the medical record (for adults).
21. There is evidence that preventive screening and services are offered in accordance with the organization’s Disease Management Clinical Practice Guidelines.

Claims/Reimbursement Issues

Copays
Copays apply to office visits billed with E and M codes. They do not apply to blood pressure checks and laboratory services where an E and M codes are not billed. Obstetrical patients are to make one copay at the time of the initial visit and should not be charged additional copays for subsequent visits. It is your responsibility to collect applicable copays from members at the time of service.

Note: The Patient Protection and Affordable Care Act (PPACA) provides for specific preventive services when provided by participating providers to be covered at 100 percent. Our fully insured group health plans already provide coverage for many of those preventive services. Starting on October 1, 2010, for all new plans and for renewing plans that are not grandfathered plans, as of the plan’s effective date/renewal date, member who use our network providers will receive preventive care services paid at 100 percent.

Coinsurance/Deductibles
Coventry Health Care currently offers plans where the member is responsible for a coinsurance and/or deductible rather than a copay. If you see a member with a coinsurance/deductible, it is your responsibility to bill the member for the coinsurance/deductible after Coventry Health Care makes payment on the claim. Some of these benefit plans also qualify as High Deductible Health Plans (HDPHs) that require a member’s deductible is met before Coventry Health Care makes payment, unless such service qualifies as a preventive service. The remittance advice will indicate the member liability to be billed by your office.

NOTE: Based on feedback from the provider community we have made the decision to allow up front collections on QHDHP’s. Deductibles and coinsurance may be collected at the time of service if you are comfortable estimating the contractual allowable for the service being provided. If you chose to collect at the time of service you are not permitted to turn members away for not being able to pay at that time. Upon receiving an RA and payment from Coventry Health Care, all payments in excess of the Allowable under the terms of your agreement must be reimbursed to the member. It is important to note collecting deductibles and coinsurance at the point of service is not permitted under Coventry Health Care’s standard benefit plan designs (non-QHDHP’s). Coventry Health Care Member ID cards clearly identify those enrolled in QHDHP’s.

Collecting Upfront on HRA members
Some patients/members use a Health Reimbursement Arrangement (HRA), Healthcare Savings Account (HSA) and/or Flexible Spending Account (FSA) to pay for qualified health care expenses. An HRA/HSA/FSA is an employer-funded arrangement that encourages members to become active participants in their health care. Coventry Healthcare encourages members to seek appropriate medical care
and to work closely with their providers when receiving medical care.

We also appreciate your need for prompt payment for services. To help ensure timely, accurate payment of claims, we ask that you do the following:

1. Check the patient’s ID card and verify HRA/HSA/FSA participation by calling the number on the ID card or verifying online.
2. Before you ask a patient for payment, submit claims to the address on the back of the ID card.
3. As a contracted provider you are not allowed to turn a member away if they chose to have their liability paid directly from their HRA/HSA/FSA vs. providing payment at the time of service. This includes Deductibles, Coinsurance and Copays.

We will process the claim and pay it from the member’s HRA/HSA/FSA. If the patient/member owes a balance to you, we will send an Explanation of Benefits (EOB) notifying you and the member of the amount owed. We may also send you a payment directly out of the members account for any member responsibility. If you have already collected payment from the patient you may need to refund an overpayment. You may also send a bill to the member with the amount due.

**Out-of-Pocket Maximums**

Coventry Health Care’s out-of-pocket maximum is the amount of covered expenses that a member must pay each benefit year before the payment percentage increases. 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 a family have met their individual out-of-pocket maximum, the family out-of-pocket maximum is satisfied. Coventry Health Care pays 100 percent of the allowable (except for copays and the charges excluded, including the discount) for any covered family member during the remainder of the benefit period. Some services that may be excluded from applying towards the annual out-of-pocket maximum include copays, deductibles, prescription copays, mental health care services, and non-covered services. Please contact the Provider Hotline Service for specific information on copay and benefit maximums.

**Maximum Allowable Fee Schedule (MAFS)**

The maximum allowable fee schedule (MAFS) applies to in-network providers who are contracted to provide covered services to members and reimbursed based upon the Coventry Health Care’s MAFS. The MAFS is the regionally adjusted maximum reimbursement for covered services rendered by in-network providers, as determined by Coventry Health Care and may be modified time-to-time without requiring an amendment to the agreement under which said in-network provider is contracted with Coventry Health Care.

**Multiple Surgeries**

Following are the payment guidelines for multiple surgical procedures when done during the same operative session:

- Primary procedure: lesser of charges or 100 percent of fee schedule minus copays and deductibles, as applicable
- Secondary procedure: lesser of charges or 50 percent of fee schedule minus copays and deductibles, as applicable
- Third through fifth procedure: lesser of charges or 25 percent of fee schedule minus copays and deductibles, as applicable

**Anesthesia Modifiers**

The anesthesiologist or CRNA MUST bill a modifier to indicate who performed the services. This modifier should be entered in the modifier field. If provider fails to bill a modifier, the claim will be denied.

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
<th>Payment Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>AA</td>
<td>Anesthesia services performed personally by anesthesiologists</td>
<td>100% of contracted unit rate</td>
</tr>
<tr>
<td>QZ</td>
<td>CRNA Services: without medical direction by a provider</td>
<td>100% of contracted unit rate</td>
</tr>
<tr>
<td>QK</td>
<td>Medical direction of 2, 3 or 4 concurrent anesthesia procedures</td>
<td>50% of contracted unit rate involving qualified individuals</td>
</tr>
<tr>
<td>AD</td>
<td>Medical supervision: more than 4 concurrent anesthesia services</td>
<td>50% of contracted unit rate</td>
</tr>
<tr>
<td>QX</td>
<td>CRNA Services: with medical direction by a provider</td>
<td>50% of contracted unit rate</td>
</tr>
<tr>
<td>QS</td>
<td>Monitored anesthesia care services</td>
<td>QS is informational only and should not be billed alone</td>
</tr>
<tr>
<td>QY</td>
<td>Medical direction of one CRNA by an anesthesiologist</td>
<td>50% of contracted unit rate</td>
</tr>
</tbody>
</table>

All modifiers billed for anesthesia services must accurately reflect who provided the service as well as the medical direction or supervision of such service as defined by CMS.

**Assistant Surgeons**

Following are the payment guidelines for assistant surgeons (assuming that an assistant surgeon is warranted based upon the surgery performed):

- For MDs, 16 percent of total amount paid to the surgeon minus copays and deductibles, as applicable
- For PA, nurse practitioner and clinical nurse specialist, 14 percent of total amount paid to surgeon minus copays and deductibles, as applicable
- Multiple surgery restrictions apply
Please note: Carpenters claims must have the assistant surgeon rendering the services listed on the claim. If a claim is received with the same provider name and date of service the claim will deny as provider cannot assist himself. Additionally, this information is required to ensure a correct billing for assistant surgeon fees since there are different reimbursement rates if the services are billed with a modifier 80 or AS. Modifier 80 should only be billed if the assistant is a doctor of medicine (M.D. or D.O.). AS modifier should be used when the assistant is not a provider, but a licensed medical professional (nurse practitioner [NP] or clinical nurse specialist).

Coding Edits
Claims are processed consistent with Medicare payment policy but not limited to National Correct Coding Initiative NCCI and HIPAA standards for billing and coding practices, which may include the use of industry accepted software to edit claims to ensure appropriate billing and coding practices. Coventry Health Care reserves the right to require appropriate documentation and coding to support payment for covered services. For additional information regarding these guidelines, please visit the CMS website (http://www.cms.hhs.gov/NationalCorrectCodInitEd).

CPT/HCPCS/Revenue Code Unbundling
Procedural unbundling occurs when two or more procedures are used to bill for a service when a single, more comprehensive procedure exists that more accurately describes the complete service. This practice leads to overpayments. When this occurs the component procedures will be denied and rebundled to pay the comprehensive procedure. If the comprehensive procedure has been submitted along with the component procedures, either on a single claim or on multiple claims, all component codes will be denied and rebundled to the comprehensive code. If only the component codes are billed either on a single claim or on multiple claims, all component codes will be denied and the comprehensive code will be added to the claim for payment.

Provider Appeal Process for Claims Editing Denials
When a provider resubmits a claim for reconsideration of a payment edit, the claim and supporting documentation is sent to the medical criteria review nurse (MCRN) who reviews the submitted documentation and makes a determination whether or not to override the edit. In making the determination, the MCRN considers Coventry’s guidelines, the provider’s contractual agreement, AMA and CPT coding guidelines, clinical knowledge, Medical Director input, and Medicare’s CCI edits and guidelines.

Each claim involved in the reconsideration is adjusted and paid in accordance with the MCRN’s decision, with the lines reconsidered; having specific disposition codes attached indicating the MCRN’s decision. If the provider is dissatisfied with the MCRN’s decision, the provider has the right to resubmit the claim, with any additional documentation, for a final review and determination by the Medical Director. The Medical Director’s decision is communicated in writing to the provider and, if necessary, the claim under review is adjusted and paid in accordance with the Medical Director’s decision.

Non-Covered Services
Coventry Health Care does not reimburse for services billed for administrative services, sales tax, special handling charges or stat charges. These charges are covered in the primary statement and not billable to the member.

Experimental and Investigational Services
Experimental and investigational treatments and services have been on our prior authorization list for some time now. In the past, we often denied these codes up front as member responsibility and did not administer the authorization requirement. However, there is now a requirement for us to establish medical necessity up front before denying these services as experimental or investigational, which is a generally a member liability.

As of January 1, 2009 you must call in for authorization prior to rendering services to the member. When you call for authorization, the request will be reviewed for medical necessity and an authorization will be loaded as approved and payable, or denied as experimental and investigational, which is a member liability. Letters will be mailed to both you and the member informing up front of the determination. If you do not obtain an authorization prior to rendering the service, the claim will be denied as no authorization, which is a provider liability. The list of codes that require prior authorization can be found on our website (www.chcmissouri.com). This will be applicable to all Coventry Health Care members including Commercial and Medicare, ASO groups and CMR groups.

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 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.

If you receive an overpayment, please notify Coventry Health Care through the Provider Hotline. Questions about billing and coding should be directed to the Provider Hotline.

National Coverage Determinations
Please refer to chcmissouri.com to find information on the following coverage determinations:

- Screening and behavioral counseling interventions in primary care to reduce alcohol misuse
- Screening for depression in adults
• Intensive behavioral therapy for cardiovascular disease
• Screening for sexually transmitted infections (STIs) and high-intensity behavioral counseling (HIBC) to prevent (STIs)
• Intensive behavioral therapy for obesity

**Hospital-Acquired Condition (HAC) or Never Events**

Consistent with CMS policy, the health plan will not reimburse providers for the extra care resulting from HAC’s listed on the CMS website found at POA/HAC: http://www.cms.hhs.gov/HospitalAcqCond/. In addition, the health plan prohibits passing these charges on to plan members.

**Coventry Anti-fraud and Abuse Policy**

Coventry Health Care, Inc. (Coventry) will not tolerate health care fraud or abuse in any of its relationships with either internal or external stockholders. Coventry will identify, report, monitor and when appropriate, refer for prosecution, situations in which suspected fraud and abuse occurs.

The anti-fraud and abuse goals of Coventry’s Special Investigation Unit (SIU) include:

• Financial responsibility, accountability and savings
• Civic responsibility
• Customer acquisition and retention
• Regulatory compliance
• Deterrence or Sentinel Effect
• Employee awareness

Anti-fraud detection is a preventive measure. The 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 also may 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 an inappropriate billing practice.

**Policy for Financial Incentives**

At Coventry, we are committed to ensuring appropriate health services for our members. We support open communication between our members and their doctors regarding treatments that may or may not be medically appropriate or necessary. Our decisions are based entirely on appropriateness of care and service and the existence of coverage, using nationally recognized guidelines and resources.

We do not pay or reward practitioners, employees or other individuals for denying coverage or care.

Financial incentives do not encourage our staff to make denials of coverage. In fact, our utilization review staff is trained to focus on the risks of members not adequately using certain services.

We do not encourage utilization decisions that result in underutilization.

**Hold Harmless**

Providers shall accept as payment in full for covered services rendered to members such amounts as are paid by Plan/Payor. In no event, (including non-payment by Plan/Payor for covered services rendered to members by provider for whatever reason, including claim submission delays and/or UM sanctions, insolvency of Plan/Payor, or breach by Plan/Payor of any term or condition of the agreement under which provider participates with plan), shall provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have recourse against any member or a person (other than Plan or Payor) acting on a member’s behalf for covered services eligible for payment, nor shall provider bill a member or a person (other than Plan/Payor) acting on a member’s behalf for the difference between the customary charge and the negotiated rate or the amount provider has agreed to accept as full payment under the agreement or for any amounts Plan may owe provider or for any monies in excess of applicable copays, deductibles or coinsurance, except as otherwise noted below. Provider shall in no event seek payment from any member for any service for which Plan or Payor has denied payment on the grounds that provider has failed to comply with the requirements with respect to such service, including, but not limited to, the failure of provider to obtain required precertification.

Provider shall collect from the member and may retain only copays, deductibles or charges for services which are not covered services under the member’s benefit plan as long as the charges are not charges for non-reimbursable services. In the event a member requests non-covered services, a provider may render non-covered services to a member so long as provider has obtained a request for such non-covered services in writing and member has acknowledged in writing that Plan shall not cover such services. This does not prohibit provider from pursuing available legal remedies including, without limitation, collecting from any insurance carrier providing coverage to an individual.

Failure to comply with these provisions may result in sanctions including, without limitation, loss of reimbursement, payment of any
member’s or Plan/Payar’s costs of defense or collection arising out of such failure, up to and including financial penalties and/or termination of participation.

Provider further agrees that:

- The no balance billing provision shall survive the termination of the participation regardless of the cause giving rise to termination and shall be construed to be for the benefit of members and Plan/Payar;
- This no balance billing provision supersedes any oral or written contrary agreement now existing or hereafter entered between provider and a member or a person acting on his/her behalf; and
- This provision shall be included in any subcontracts between provider and any other provider for the provision of covered services to plan members. Any modification, addition or deletion to the provisions shall become effective on a date no earlier than 60 days after the appropriate state department of insurance or applicable state and federal regulatory agency received written notice of such proposed change and has approved such change.

**Capitation Payments**

If capitation is your primary method of reimbursement, Coventry Health Care remits payment to you on the 15th day of each month. If the 15th day falls on a weekend or holiday, payment is mailed the next workday. The capitation payment is based on the status of your panel as of the first day of that same month. A listing identifying member eligibility and explaining payment accompanies every check. The professional services covered by this payment are identified in your contract with Coventry Health Care.

**Reporting Patient Encounters**

Your agreement with Coventry Health Care stipulates that all patient encounters must be reported, even if the services rendered were covered under capitation. In addition, state regulatory agencies and employer groups require reporting patient encounters. For Coventry Health Care Medicare members, reporting all patient encounters is a CMS requirement.

However, submitting encounter information also benefits the Coventry Health Care provider in two ways:

1. Because we develop our capitation tables based on actual member usage, having accurate encounter information on hand will assist us in establishing tables that are fair and reflect true utilization.
2. Reporting patient encounters relieves the provider of the burden of sorting those encounters that fall under capitation from those that are paid fee-for-service. Submitting all patient encounters to Coventry Health Care allows us to do the sorting for you.

All patient encounters should be submitted to Coventry Health Care monthly by ASCII file on disk or on a claim form using the appropriate format outlined in the claims submission portion of this manual. Send this information to:

Coventry Health Care * Coventry Health Care Medicare Department * P.O. Box 7374 *P.O. Box 8052 * London, KY 40742-7374 * London, KY 40742-8052

Failure to submit encounter information may result in our withholding your capitation payment.

**Medicare Reporting**

CMS uses the following classifications to categorize a Medicare beneficiary’s health status. As a Medicare Advantage contracted plan, Coventry Health Care is required to report if a member becomes eligible or changes a health status category. The categories are:

- Hospice patient
- Patient with end-stage renal disease

If a member becomes eligible to be classified under one of these categories, or if a member’s health status changes, the contracted provider must complete a Medicare Reporting form and return it to Coventry Health Care Medicare. Coventry Health Care will notify CMS of the change.

**Worker Compensation Claims**

If you believe that a Coventry Health Care member requires treatment for a work-related illness or injury, ask the member to contact his/her employer to report that condition in accordance with the State Workers’ Compensation Law. Claims for your treatment of this work-related illness or injury should be billed to the employer or the employer’s workers’ compensation insurer. Coventry Health Care’s Certificate of Coverage specifically excludes work-related illnesses and injuries.

If the member’s employer or the employer’s workers’ compensation insurer denies reimbursement for your services, you should advise the member of that fact. The member may elect to be treated by a provider who the employer or its insurer designates to treat such work-related conditions or to pay for your services on a fee-for-service basis and then seek reimbursement from the employer or insurer. In any case, it is important to follow Coventry Health Care’s authorization procedures so that if the employer successfully contests the issue, you will be reimbursed.

**Motor Vehicle Accidents/Personal Injury Claims**

For motor vehicle or personal injury accident claims, it is important to obtain the proper authorizations for reimbursement. When submitting claims, Box 10 must be completed on the CMS 1500. Do not hold motor vehicle or personal injury accident claims until settled. Please submit claims within 90 days of the date of service as timely filing requirements apply and indicate “Auto Accident or Other Accident” on the claim.
**Coordination of Benefits**

When Coventry Health Care or CMR is the primary carrier, either entity compensates in-network providers in accordance with the terms of their agreements. If the payment does not cover all incurred charges, the provider may submit a claim to a secondary carrier. However, providers may not seek additional compensation for charges from members other than copays, deductibles and coinsurance. When we are the secondary carrier, the provider should first seek payment from the member’s primary carrier. They must submit the claim with a copy of the Explanation of Benefits from the primary carrier along with a claim form with the same services and billed charges that were sent to the primary carrier. (Coventry Health Care does not reduce capitation payment amounts for members that have a primary insurance plan. The capitation payment would cover any primary carrier copay applied; therefore, no additional copay should be collected.)

**Status of a Dependent**

The National Association of Insurance Commissioners’ Coordination of Benefits birthday rule governs whether Coventry Health Care or another insurer is considered primary or secondary for a dependent. This rule mandates that a dependent’s primary health coverage is determined by which parent’s birthday comes first in the calendar year; the birth year is not considered.

In the case of a divorce custody arrangement, however, primary and secondary coverage may vary.

**Coordination of Benefits**

Coventry Health Care will adjust benefits so that the total benefits paid or provided by all plans during a contract year are not more than the total allowable expenses. Coventry Health Care will calculate the amount we would have paid as if we were the primary insurer less any member deductible, copay or coinsurance a member has on his/her Coventry Health Care insurance. The member’s responsibility on the primary plan will be paid up to the amount Coventry Health Care would have paid if Coventry Health Care were the primary insurer. Because of this change, Coventry Health Care recommends that you do not collect for any member liability until the RA is received.

NOTE: ASO/CMR may have different COB guidelines.

**High Dollar Review of Outpatient and Inpatient Claims**

For Coventry Health Care, all claims with approved amounts over $50,000 are reviewed. We must receive itemized bills from the provider before the review process can begin. Items that are generally considered inclusive for facilities are as follows:

- Non-itemized supplies
- IV flushes – 30 cc or less
- Bedside glucose testing by nurse
- Gloves, gowns, syringes
- Bedside commodes
- Injection charges
- Pharmacy charge – profile
- Other identified nursing charges
- IV nursing care
- Lab handling fee
- Equipment charges such as feeding pumps, microscopes, anesthesia machine, suction machine, Video equipment in surgery
- Personal items such as slippers, lotions, powders, deodorant, admission kits (except MD), toothettes, denture care kits, underpads

* The above list is not all inclusive. Edits/denials are applied considering the individual circumstances of each claim.

**Deniable items in an intensive care unit:**

- Cardiac monitoring, BP monitoring, resp. ETCO2 monitoring
- Pulse ox monitoring
- Lab draw, venipuncture
- Equipment charges
- IVAC, IMEDS
- Assessment charges
- Any of the above acute care charges

**Implant and Drug Reviews**

All claims submitted with implants and drug charges exceeding $25,000 per revenue code will be denied for itemization and operative reports upon receipt of the claim if not included. Itemization and medical records will be reviewed by medical management staff to determine medical necessity and experimental and investigation status of the device or drugs. If this information is not provided at time of authorization, the services will be reviewed when the claim is submitted and denials issued to the provider.
Recoveries

Coventry Health Care recovers overpaid claims from providers up to 365 days from the date of payment. Recovered monies are negatively remitted and adjusted off future claim payments or deducted from future capitation payments.

If you identify an overpayment, you can contact the Provider Hotline and request an adjustment be made to take the money off of a future claims payments or you can send a check in the amount of the overpayment with a copy of the remittance advice identifying the claim that was overpaid to:

<table>
<thead>
<tr>
<th>Coventry Health Care</th>
<th>CMR/Coventry ASO Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attention: Finance Department</td>
<td>Attention: Finance Department</td>
</tr>
<tr>
<td>550 Maryville Centre Drive, Suite 300</td>
<td>550 Maryville Centre Drive, Suite 300</td>
</tr>
<tr>
<td>St. Louis, MO 63141</td>
<td>St. Louis, MO 63141</td>
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</tbody>
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*Information in this section does not apply to most CMR members.

Quality Improvement

The goal of the QI program is to facilitate consistent delivery of high quality coordinated member care and service throughout Coventry by assessing and improving care/service processes and outcomes. We use practitioner/provider performance data to improve the quality of service and clinical care our members receive. Accrediting agencies require that you let us use your performance data for this purpose. For comprehensive information describing the QI department and QI program updates, please visit our website at www.chmissouri.com

> Services and Support > Providers > Document Library.

HEDIS

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

HEDIS measures can be generated using three different data collection methodologies:

- Administrative (uses claims and encounter data)
- Hybrid (uses medical record review along with claims and encounter data)
- Survey

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

CAHPS

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

Four global rating questions reflect overall satisfaction:

- Health plan overall
- Health care overall
- Personal provider overall
- Specialist overall

The composite scores summarize the responses in the following six key areas:

- Claims processing
- Shared decision making
- Customer service
- Getting care quickly
- Getting needed care
• How well providers communicate
• Plan information on costs

Provider Satisfaction Surveys
We conduct a survey every two years to assess provider satisfaction with our plan, asking providers to rate Coventry Health Care on several standards of service. Through this survey, we can assess how well we are serving the providers who care for our members and take measures, where indicated, to improve service. We encourage our in-network providers to take part in Coventry Health Care’s satisfaction surveys.

Reviews for Outside Agencies
To ensure compliance with applicable laws, regulations and contractual requirements, various state or federal regulatory agencies may audit Coventry Health Care’s in-network providers. Provider’s medical records may be audited by CMS through the Missouri Quality Improvement Organization (QIO) and accreditation agencies such as NCQA. We would appreciate your cooperation during such audits, as outlined in your agreement with Coventry Health Care.

A copy of the Coventry Health Care Quality Improvement program is available to network providers by calling Coventry Health Care or by visiting the website at www.cheimissouri.com.

Coventry Health Care Disease Management Programs
Our disease management programs are designed to help your patients work with their doctors to effectively manage ongoing health conditions and improve outcomes. Disease Management Programs may be available for the following conditions:
• Asthma
• CAD
• COPD
• Diabetes
• Heart Failure

Our aim is to proactively reach out to members and engage them in managing their health, by emphasizing prevention through education, supporting the physician-patient relationship and reinforcing compliance with their physicians’ care plan. Members are identified by various methods including, but not limited to, claims, pharmacy, health risk assessments, physician referral, caregiver referral, or self-referral. To refer a Commercial member to a disease management program, call the Disease Management Call Center at 1-800-579-5755. To refer a Medicare member, call Customer Service at 1-800-533-0367.

MoDOT/MSHP
Missouri Department of Transportation and Missouri State Highway Patrol (MoDOT/MSHP)
In addition to Coventry Health Care's disease management programs for asthma, CAD, COPD, diabetes, and heart failure, MoDOT/MSHP members may also participate in Coventry Health Care's disease management programs for the following conditions:
• Crohn's disease
• Chronic kidney disease
• Hemophilia
• HIV/AIDS
• Low back pain
• Multiple sclerosis

MoDOT/MSHP members identified with these conditions are automatically enrolled in the program. They are also provided with information on how they can opt out, if they do not want to participate. The exception is the HIV/AIDS program. Members are only enrolled in the HIV/AIDS program upon request.

MoDOT/MSHP members may self refer to any disease management program by contacting the Disease Management Call Center at 1-800-579-5755. Providers may refer MoDOT/MSHP members to any disease management program by contacting the Disease Management Call Center at 1-Management800-579-5755.

Coventry Health Care Complex Case Management Program
Case management is “a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet an individual’s and a family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes. Coventry Health Care’s complex case management program offers special assistance to members with serious and complex, long-term medical needs. Serious and complex medical conditions are defined as persistent and substantially disabling or life-threatening and that require treatment and services across a variety of arenas for care. Long-term medical needs are those that are more chronic than acute and can be expected to require extended use of health care resources. Coventry Health Care’s complex case management staff includes experienced registered nurses and social workers who are trained to educate the member and members of the health care team about health plan benefits, cost factors and community resources so that informed decisions can be made. The complex case manager is frequently the link between the member, providers, the plan, and the community. The complex case managers are coordinators of care, catalysts, problem solvers, facilitators, impartial advocates and educators. They work closely with the member and family as well as the providers to ensure open communication, patient understanding and involvement with the treatment plan. They assist members by getting information and expediting the delivery of services.
Program Referrals
Members are referred to the complex case management program through a variety of ways, including the utilization review process, utilization reports and direct referrals from members and providers. We welcome referrals from treating physicians to our case management program. You can submit a referral through the toll-free phone number on the member ID card or Providers may refer to the program by using the Complex Case/Disease Management Provider Referral form located at www.chemissouri.com or by contacting the Medical Management Department at 800-743-3901, ext. 1853. Once we decide that a member is right for case management and the member or caregiver agrees to it, we make an individualized plan. We work with the member, the member’s family, physician(s), and other health care professional(s).

Quality Improvement Programs
Annual Chronic Care Improvement Programs (CCIPs) and Quality Improvement Projects (QIPs) are implemented and maintained for Medicare Advantage (MA) HMO and PPO members in accordance with CMS requirements. These quality improvement programs are designed and conducted to have a beneficial effect on health outcomes and beneficiary satisfaction.

An annual CCIP is in effect for MA members with chronic conditions to help improve health outcomes and quality of care. Several programs are available to support your patients and to help them make healthy lifestyle choices.

An annual QIP is in effect for MA members and will focus on a significant aspect of clinical and non-clinical care and health disparities to improve health outcomes, improve satisfaction and quality of care. Programs are available to encourage your patients to get the care and preventive services they need.

Preventive Health and Wellness Programs
As a health plan, Coventry Health Care is concerned about our members’ health and wellness. To ensure our members receive the preventive health screening tests and information to assist them in leading a healthier lifestyle, Coventry Health Care has designed numerous programs to educate our members and assist them with managing their own health and wellness.

Most importantly, Coventry Health Care works with our members and their health care providers to ensure continuity of care and assist in caring for our members. We have designed comprehensive programs that range from comprehensive disease management to outreach reminders. Examples of some of our preventive services are flu shots, breast cancer screening exams, cervical cancer screening exams, childhood immunizations and general preventive health guidelines. We also stratify our outreach to members regarding issues that are specific to their sex and/or age group.

Coventry Health Care members receive a copy of our member newsletter LivingWell two times a year. This newsletter contains information on maintaining a healthy lifestyle and other health care topics. LivingWell also is a good source of information on how to use their benefits and gain the most from their Coventry Health Care membership.

Please contact customer service for the most current benefit plan information for the specific member.

Preventive Health Guidelines
Coventry adopts nationally accepted evidence-based preventive services guidelines from the U.S. Preventive Services Task Force (USPSTF) and the Centers for Disease Control and Prevention (CDC). Where there is a lack of sufficient evidence to recommend for or against a service by these sources, or conflicting interpretation of evidence, we may adopt recommendations from other nationally recognized sources. These guidelines are available on the Coventry Health Care website at www.chemissouri.coventryhealthcare.com. Once on the site, go to Providers > Document Library > Preventive Health Guidelines.

We review guidelines every two years unless updates from recognized sources warrant more frequent review.

Provider Communications
Coventry Health Care advocates providers’ freedom to communicate with patients regarding available treatment options, including medication alternatives, regardless of benefit coverage.

Coventry Health Care also maintains a policy for accepting requests from providers to consider new and emerging technologies and criteria. Such requests should be submitted with a letter outlining the medical necessity of the procedure or criteria. Providers also may make a request on behalf of a member.

Coventry Health Care forwards all requests to its parent company, Coventry Health Care, to determine if the new treatment or procedure would be beneficial to Coventry Health Care members. Coventry then gathers extensive medical documentation on the subject and submits the documentation for medical review.

Please note that new and emerging technology must be proven safe and effective and also must be regarded by the medical community as a mainstream method of treatment before it is approved for Coventry Health Care members. Requests and recommendations for coverage of a new or emerging technology should be submitted in writing to:

Coventry Health Care
Medical Management Department
Panel Closings

In-network PCPs must have a minimum panel of 100 PCP patients or a total of 250 combined PCP and Open Access patients before Coventry Health Care consent to closing their panels to new patients. Please remember that if you close your panel to Coventry Health Care members, you must close your panel to all payors/patients. If you find it necessary to close your panel, please make your request in writing, 60 days in advance to your provider relations representative at the following address:

Coventry Health Care Provider Relations Department
550 Maryville Centre Drive, Suite 300
St. Louis, MO 63141

Facility/Provider Authorization Review Procedure

Hospital Clinical Appeals
Facilities providing inpatient/observation services for Coventry Health Care members may request a review of an adverse determination decision through the Hospital Clinical Appeals process as outlined below. An adverse determination is a Coventry Health Care decision concerning admission, availability of care, continued stay or other health care service that has been reviewed and, based upon the information provided, does not meet Coventry Health Care’s requirements for medical necessity, timeliness, appropriateness, health care setting or level of care or effectiveness, and the payment for the requested service is therefore denied, reduced or terminated.

Facility/Provider Authorization Review Procedure

Requests for reviews of adverse determinations must meet the following requirements:

- Submit in writing or electronically via WebMD.
- Include a copy of the Coventry Health Care adverse determination letter.
- Submit within 180 days of the date on the adverse determination notification letter from Coventry Health Care.
- Must include the provider’s rationale for requesting a review of the adverse determination, supported by medical records.

Submit review requests to:

Coventry Health Care/CMR Authorization Review Coordinator
P.O. Box 7111
London, KY 40742-7111

A Coventry Health Care Medical Director not involved in the adverse determination decision reviews the case and render a decision. The decision is based on the information submitted. Coventry Health Care will not request additional information.

Coventry Health Care communicates the review decision in writing to the requesting provider within 30 calendar days of receipt of the request. The review by Coventry Health Care and its determination is final.

Delegated Contracting

Coventry Health Care recognizes delegated contracting entities and they are administered in accordance with URAC/NCQA and CMS standards as well as meet Coventry Health Care contracting requirements. The standards are outlined as follows:

A. Specify those responsibilities delegated to the contractor and those retained by the organization
B. Require that services be performed in accordance with the organization’s requirements and URAC standards
C. Require notification to the organization of any material change in the contractor’s performance of delegated functions
D. Specify that the organization may conduct surveys of the contractor, as needed
E. Require that the contractor submits periodic reports to the organization regarding the performance of its delegated responsibilities
F. Specify recourse and/or sanctions if the contractor does not make corrections to identified problems within a specified period
G. Specify the circumstances under which activities may be further delegated by the contractor, including any requirements for obtaining permission from the organization before any further delegation
H. Specify that, if the contractor further delegates organizational functions, those shall be subject to the terms of the written agreement between the contractor and the organization and in accordance the URAC standards
Request to Terminate Your Relationship with a Member

A request to terminate your relationship with a member must be based on a good faith inability to maintain an effective provider-patient relationship, not the member’s health status or the cost of providing services to that member. If you believe it is necessary to terminate your relationship with a member, please notify the member in writing by stating your reason for desiring the termination and explaining the transition of care. Send a copy of the letter to your Coventry Health Care provider relations representative at:

Coventry Health Care Provider Relations Department
550 Maryville Centre Drive, Suite 300
St. Louis, MO 63141

Your Coventry Health Care provider relations representative will notify Coventry Health Care’s Member Service Department, who will advise the affected member of the need to select a new provider.

We make every effort to accomplish a transfer to a new provider within 30 days of receipt of an approved request to terminate a provider-patient relationship. During the transition period, however, the existing provider is obligated to provide services for the member until the transfer is complete.

Whenever you have a patient who continually abuses benefits, notify your Coventry Health Care provider relations representative so that appropriate action can be taken by Coventry Health Care. Always document no-shows or incidents adversely affecting your relationship with a member and retain any correspondence to/or from such members.

Failure to pay copays/coinsurance and deductibles

If a member has a history of not paying copays, co-insurance and deductible or the provider consistently finds it difficult to collect from the member, the provider should contact the Provider Hotline at 800-755-5242.

If necessary, the member is notified in writing that his/her failure to pay may result in the termination of coverage. If the member pays (or makes payment arrangements) within a 31-day period of this notice, coverage remains in force.

New Provider Orientation

Upon credentialing approval by Coventry Health Care, a welcome letter is sent to the provider within 30 days of the provider’s effective date. Orientations may be conducted in person, by mail or by telephone.

The Coventry Health Care provider relations department furnishes the provider’s office with all of the new provider orientation materials.

You may request an orientation visit by contacting your provider representative.

Transfer of Information Between Providers

During the orientation process, Coventry Health Care’s provider relations representatives educate providers and/or office staff on the following to ensure continuity of care for our members:

- Primary Care Providers:
  When a PCP refers a patient to a specialist, they will forward at no cost to the plan or member, all appropriate notes, x-rays, reports or other medical records to the specialist prior to the patient’s scheduled appointment.
  If a Coventry Health Care member changes their PCP, the previous PCP will forward at no cost to the plan or member, the member’s medical records within 10 days of request to the member’s new PCP.
- Specialists:
  Specialists are required to report preliminary diagnosis and treatment plans to the patient’s PCP within two weeks from the date of the first office visit. Two weeks after treatment or evaluation is complete; the specialist is required to provide the PCP with a detailed patient summary. Each subsequent encounter also should engender written communication within two weeks.

This and other medical record information transferred by Coventry Health Care in-network providers should be done in a confidential, timely and accurate manner consistent with state and federal regulatory agencies. Charges should not be incurred to either the member or the plan.

Provider Selection Standards

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

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

**Advance Directives**

All Coventry Health Care in-network providers are required by law (42 U.S.C. 1395 CC) to document in the patient’s medical record whether or not the member has executed an Advance Directive. Advance Directives document patients’ wishes should they become incapacitated and unable to speak or act for themselves. The following is a brief summary of Missouri and Illinois state law regarding Advance Directives:

**Missouri**

Missouri recognizes the constitutional right of legally competent adults to make decisions regarding medical treatment that they wish to receive or refuse, including the acceptance or refusal of life-sustaining or prolonging treatment such as breathing machines and artificial nutrition and hydration.

However, Missouri does not recognize the right of any relative, including a spouse, child or parent to make these decisions. Furthermore, while Missouri law allows for a court appointed legal guardian to make decisions regarding day-to-day health care choices, this state does not recognize the right of a legal guardian or any other person to make decisions regarding the refusal or withdrawal of certain life-prolonging treatments without clear and convincing evidence that such person is making a decision consistent with the patient’s desires.

So that patients may avoid situations where their wishes cannot be carried out, Missouri provides for two separate ways for patients to communicate their desires:

1. **Living Will**
   This is a declaration directing the withholding or withdrawal of death-prolonging procedures when a provider determines that a patient is suffering from a terminal condition and is unable to make decisions regarding his or her own treatment. While the Missouri Living Will provides for refusal of death-prolonging procedures, withholding the administration of medication or nutrition and hydration to the patient must be specifically addressed in a Living Will. That Will must be witnessed by two adults and notarized.

2. **Durable Power of Attorney for Health Care**
   A Durable Power of Attorney for Health Care allows patients to name someone to make medical decisions for them if they are unable to do so. This power of Attorney becomes effective when two providers have certified, through a written statement in the patient’s medical record, that the patient is incapacitated. This document identifies the person who will make decisions for the patient regarding the withdrawal or withholding of treatment if the patient is incapacitated. However, similar to Living Wills, the withdrawal or withholding of artificially supplied nutrition and hydration must be specifically addressed in the document.

   Before withholding nutrition and hydration, the provider must either:
   - Attempt to explain to the patient the intention to withdraw nutrition and hydration and its consequences, and provide the patient with an opportunity to refuse such withdrawal
   - OR
   - Certify in the patient’s medical record that the patient is comatose or consistently in a condition that makes it impossible for the patient to understand the intention and consequences of the withdrawal.

**Illinois**

Illinois law recognizes the right of any competent adult to make decisions regarding the acceptance or refusal of recommended treatment, including the acceptance or refusal of nutrition and hydration. Unlike Missouri law, Illinois law recognizes the role of a surrogate decision-maker, even in the absence of a written Advance Directive, under certain circumstances; however, because this law has many limitations, it is preferable for the patient to have executed a Living Will or a Durable Power of Attorney for Health Care.

Under Illinois law, other individuals may make decisions regarding the acceptance or refusal of life-sustaining treatment if the patient lacks decisional capacity and suffers from a qualifying condition. Qualifying conditions include the following when certified in writing in a patient’s medical record by the attending provider and one other qualified provider:

1. **Terminal conditions (illness or injury for which there is no reasonable prospect of cure and death is imminent);**
2. **Unconsciousness that is permanent, void of thought, sensation and purposeful action and for which initiating or continuing life-sustaining procedures only provides minimal benefit; and**
3. **Irreversible conditions such as:**
   - Conditions for which there is no reasonable prospect of recovery
   - Conditions that will ultimately cause the patient’s death even if life-sustaining treatment is initiated or continued
• Conditions that pose severe pain or inhumane burden on the patient
• Conditions where life-sustaining treatment only provides minimal medical benefit

Like Missouri, Illinois provides two ways for patients to express their wishes:

1. Living Will
The Illinois Living Will statute is similar to Missouri’s except that it specifically includes artificial nutrition and hydration, so long as the death that would result from the withdrawal or withholding of nutrition and hydration would be caused by the underlying terminal condition rather than solely from dehydration or starvation. Illinois also stipulates that the two witnesses attesting to the Living Will may not be:
• Related to the patient by blood or marriage,
• Entitled to any portion of the patient’s estate, or
• Directly or financially responsible for the patient’s medical care.

2. Health Care Power of Attorney
The Illinois Health Care Power of Attorney is similar to Missouri’s with the following exceptions:
• It does not require notarization.
• Although withholding or withdrawing life-sustaining measures such as artificial nutrition and hydration would probably be recognized, such measures should be specifically addressed in the document.
• The provider is not required to certify in the patient’s medical record that he or she is incapacitated. The Power of Attorney becomes operative when the provider believes that the patient lacks the capacity to provide informed consent on his or her own behalf
• The provider is not required to consult with the patient prior to withholding or withdrawing nutrition or hydration.

Coventry Health Care is supplying you with this information because the obligation to honor an Advance Directive falls on the provider. Whenever the withholding or withdrawal of medical treatment, hydration or nutrition violates a provider’s religious beliefs, the provider has every right to transfer the patient to another provider who is able to carry out the patient’s Advance Directive.