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9.9 Quantity Limits
9.10 Transition Benefits
9.11 Co-pay Waiver Program
9.12 Formulary Exceptions
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1. GENERAL HEALTH PLAN INFORMATION

1.1 INTRODUCTION

The purpose of this Provider Manual is to give general information to assist HealthAmerica providers and their staff in understanding the managed care products offered or administered by HealthAmerica and its affiliates. Please note the provider manual for the Network Access, Workers’ Compensation and Auto products can be found at http://coventrynational.coventryhealthcare.com/.

This manual is intended as a reference tool only and does not alter the terms of your Participating Provider Agreement with HealthAmerica. Please feel free to contact us at any time should you have any questions.

As of the date of this manual, all provider manuals have been combined and any references in provider contracts to Manuals (facility, physician, provider, etc.) shall refer to this document.

1.2 SCOPE OF COVENTRY PRODUCTS
The Breadth and Depth of Coventry Health Care

A national health care company providing health insurance and administrative services to a broad array of commercial and government accounts.

**Medicare**
Various health plans offer Medicare Advantage coverage. The company offers Advantra Plans as well as Advantra RX and First Health Part D plans through the Medicare Prescription Drug (Part D) Program.

**Commercial**
Both fully-insured and self-insured coverage options are offered through health plans and insurance companies.

**Carrier and TPA**
Through “Network Rental” agreements, our Coventry National Network or First Health Network is made available to third party administrators and other carriers.

**Carrier and TPA**

**Workers’ Compensation**
Coventry Workers’ Comp Services offers a suite of client solutions designed to help drive industry-leading medical outcomes and identify appropriate cost savings at every step of an injured worker’s recovery.

**Auto**
Coventry Auto Solutions offers cost containment solutions to assist with the rising medical costs associated with being injured in an automobile accident.

Coventry National Accounts (formerly known as First Health Group Corp.) provides ASO coverage to national employers, including the Federal Employees Health Benefits (FEHB) Program and Mail Handlers.

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1.3 PENNSYLVANIA REGIONS BY COUNTY

Western Pennsylvania Region – Counties
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1.4 PARTICIPATING HOSPITAL LISTING BY REGION

* The proceeding lists of participating hospitals are subject to change. Please visit our website or call your provider representative for any updates.

**Southeastern Pennsylvania Region – Counties**

- Bucks
- Carbon
- Chester
- Lehigh
- Delaware
- Monroe
- Montgomery
- Northampton
- Philadelphia

**Western Pennsylvania Region - Hospitals**

- Advanced Surgical Hospital
- Allegheny General Hospital
- Allegheny Valley Hospital
- Armstrong County Memorial Hospital
- Bon Secours-Holy Family Hospital (Altoona Regional Health System)
- Butler Memorial Hospital
- Canonsburg General Hospital
- Children’s Home of Pittsburgh
- Children’s Hospital of Pittsburgh of UPMC
- The Children’s Institute of Pittsburgh
- Conemaugh Memorial Medical Center
- Ellwood City Hospital
- Forbes Regional Hospital
- Frick Hospital
- HealthSouth Hamarville Rehabilitation Hospital
- HealthSouth Rehabilitation Hospital of Altoona
- Meyersdale Medical Center
- Miners Medical Center
- Monongahela Valley Hospital
- Nason Hospital
- Ohio Valley General Hospital
- Select Specialty Hospital – Pittsburgh/UPMC
- Select Specialty Hospital – Laurel Highlands
- Select Specialty Hospital – Johnstown
- Select Specialty Hospital – McKeesport
- Somerset Hospital
- Southwest Regional Medical Center
- St. Clair Memorial Hospital
- Transitional Care Center at LifeCare Hospitals of Pittsburgh
- Tyrone Hospital
- Uniontown Hospital
- UPMC Altoona
- UPMC Bedford Memorial
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**Northwestern Pennsylvania Region - Hospitals**

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<td>Central Pennsylvania Region – Hospitals</td>
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1.5 CONTACT INFORMATION - QUICK REFERENCE GUIDES

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<td>HealthAmerica 1-800-752-4165</td>
<td>HealthAmerica Advantra 1-800-290-0190</td>
<td>General Electric Dedicated Unit 1-866-838-9374</td>
<td>Carelink 1-800-348-2922</td>
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## 1.5.2 EPA QUICK REFERENCE GUIDE

### Coventry Health Care Quick Reference Guide

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<td>CHC of Delaware - Refunds PO Box 784328 Philadelphia, PA 19178-4328</td>
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<td>1-800-290-0190 Advantra PO Box 7087 London KY 40742-7087</td>
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**NOTE:** For paper submissions, “Corrected Claim” must be noted on the
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<td>HCFA. Corrected or resubmitted claims can be sent electronically. Use the Claim Frequency Type Code (CLM05-3) value equal to &quot;7&quot; to indicate a replacement claim. The Claim Type Frequency Code (code set 235) may be used for other resubmitted claim types as well.</td>
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2. PRODUCTS AND MEMBER RIGHTS & RESPONSIBILITIES

This section is designed to assist providers and their staff in understanding the various managed health care products administered by HealthAmerica. This guide has been assembled to serve as a comprehensive resource for information. Please feel free to contact us at anytime should you have any questions. Note: Benefits, co-payments, deductibles and coinsurance vary according to individuals' specific coverage.

**Participating Provider** is a health care provider, including, but not limited to a physician, home health agency, laboratory or other professional, facility, supplier, or vendor that has entered into a direct or indirect written agreement with HealthAmerica or a Coventry Health Care entity to provide Covered Services to Members.

**Non Participating Provider** is any health care provider that has not entered into a direct or indirect written agreement with HealthAmerica or a Coventry Health Care entity to provide Covered Services to Members.

2.1 PRODUCT DESCRIPTIONS

**COMMERCIAL INSURED/SELF-INSURED PRODUCT**

The Commercial Insured/Self-Insured Product (ASO) includes health maintenance organization (HMO) products, point-of-service (POS) products, and preferred provider organization (PPO) products offered or administered by HealthAmerica, HealthAssurance, Coventry Health and Life Insurance Company or other Member Company or a Payor.

From time to time Coventry and/or Payors may designate only certain Participating Providers to take part in the provider delivery network for a particular Product benefit plan(s).
MEDICARE ADVANTAGE: Medicare ADVANTRA [HMO] [PPO] [POS] PRODUCT

The Medicare Advantage Product includes the Medicare health benefit plan(s) administered directly by Coventry or a Coventry Company (Health Plan), currently referred to as the “HealthAmerica Advantra Program”.

From time to time HealthAmerica and/or Payors may designate only certain Participating Providers to take part in the provider delivery network for a particular Product benefit plan(s).

Click here to be directed to the HealthAmerica Advantra section of the manual or go to section 3.

2.2 MEMBER RIGHTS AND RESPONSIBILITIES

2.2.1 Commercial Member Rights & Responsibilities

The Plan will provide or administer health care coverage to its Members in a manner, which respects their rights as outlined in this policy, and will educate its Members regarding their responsibilities concerning their health care coverage.

The Plan will provide health care coverage in an environment, which encourages a relationship between the Plan’s Members and their health care team, which is based upon a mutual understanding of each other’s rights and responsibilities.

Members’ Rights

All Plan Members have the right to:

- Respectful and competent treatment regardless of race, color, religion, gender, sexual preference, veteran status, disability, or national origin.

- Know the identity and professional status of all persons providing their health care services.

- Be informed regarding their diagnosis, treatment and prognosis in terms they can understand.

- Participate in decisions concerning their health care after receiving sufficient information to enable them to give informed consent before beginning any procedure and/or treatment. This would include a candid discussion of appropriate or medically necessary treatment options for their condition(s), regardless of cost or benefit coverage.

- Know who is responsible for authorizing and performing procedures and treatment.

- Accept or refuse participation in research and educational projects affecting their care and/or treatment.
• Refuse treatment, drugs or other procedures to the extent permitted by law and to be made aware of the potential medical consequences of refusing treatment.

• Coventry has established standards for member access to primary and specialty care services. Each primary care practitioner (PCP) and specialty care practitioner is required to have appointment availability within the following time frames:
  • PCP Routine Care: within 7 calendar days
  • Specialist Routine Care: within 30 calendar days
  • PCP & Specialist Urgent complaint: same day or within 24 hours
  • In addition, all participating primary care and specialty care physicians 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 the member to the emergency room is not acceptable.

• Reasonable accesses to needed medical care. In an emergency, Members have the right to expect services and treatment without undue delay.

• Be treated in a manner respectful of their privacy and dignity.

• Have access to their medical record.

• Submit an advance directive (e.g. living will, durable power of attorney for healthcare) to their health care practitioner.

• Expect reasonable continuity of care.

• Expect a clean, safe, and accessible environment for receiving health care services.

• Express a complaint, grievance or appeal, as outlined in the Plan’s complaint, grievance and appeal process, and to expect a response to that complaint, grievance or appeal within the time frames required by applicable law.

• Have Member literature and materials written in a manner that truthfully and accurately provides relevant information in a format that is readable and easily understood by the intended audience.

• Have all records pertaining to medical care treated as confidential unless disclosure is necessary to interpret the application of the Member’s contract to medical care or unless disclosure is otherwise provided for by law.

• Be informed of Plan policies and procedures regarding services, benefits, practitioners/providers, and Members’ rights and responsibilities and to be notified of any significant changes in those policies and procedures.

Members’ Responsibilities

All Plan Members will be responsible for:

• Providing, to the extent possible, information that the Plan and its practitioners and providers need to care for them and assisting the Plan in compiling a complete medical record by providing or authorizing the Plan to obtain necessary medical information.
• Being considerate and cooperative in dealing with Plan staff.

• Following treatment plans and instructions for care they have agreed on with their health care practitioner and/or support staff acting on behalf of the practitioner.

• Scheduling appointments and arriving at their practitioner’s office in time for scheduled visits. Members also have the responsibility to notify their practitioner’s office within twenty-four (24) hours if they must cancel or will be late for a scheduled appointment.

• Accepting responsibility for any refusal to comply with their practitioner’s instructions or recommendations.

• Designating an individual to act on their behalf and to authorize treatment in the event of incapacity.

• Getting approval from their Primary Care Physician, if required by the Plan, before seeing a specialist or receiving other services except in emergencies.

• Reading and being aware of materials distributed by the Plan explaining policies and procedures regarding services and benefits.

The Plan will remind all Members of their rights and responsibilities on an annual basis.

The rights and responsibilities detailed above do not modify, negate or diminish any of the terms and conditions of the Member’s group contract.

2.2.2 Medicare Advantage Member Rights & Responsibilities

For information about Medicare Advantage Member Rights and Responsibilities, click here or refer to section 3.2.

2.3 MEMBER CONFIDENTIALITY AND RELEASE OF INFORMATION

As a reminder to all providers, information from Members’ medical records and from physicians or hospitals must be kept confidential in accordance with Federal and State law. HealthAmerica recognizes that Members have the right to have their health and medical information kept confidential, and we are committed to protecting access to our Members’ medical information. HealthAmerica has defined confidential information in our policy as:

• Clinical information communicated to a physician, or other health care provider, in his/her professional capacity, included in the medical record and directly related to a Member’s diagnosis and treatment.

• Data included in the computer or system that is directly related to Member's diagnosis and treatment, such as claims information, information collected in the course of Utilization/Case Management or other processes.
- Member-identifiable secondary health information abstracted from the medical records/computer database for indexes and statistics.

- Member information collected through the enrollment process or generated through Marketing.

A properly completed authorization signed by the Member is required for release of all health information except:
- as required by Federal or State laws, court orders, or subpoenas
- for release to another health care provider currently involved in the care of the Member
- as outline in the Member’s individual or group contract; and
- contractual obligations related to Quality Improvement or Utilization Management analysis.

The following are examples of some of the other situations your office may encounter on a day-to-day basis with some suggestions on how to maintain Member confidentiality in these situations:

- **Telephone inquiries.** Avoid disclosing confidential patient information over the telephone because you have no idea who you are actually speaking with. Anyone can claim to be a physician or the patient’s relative. If you have the patient’s permission to release the information, you should obtain identifying information (e.g. medical record number, address, date of birth, etc.) before giving out any information over the telephone.

- **Phone messages to a patient’s home or place of employment.** Leaving messages containing health information with another person or on an answering machine at the patient’s home or at work may violate the patient’s privacy, unless he/she has authorized you to do so. Leave your name, phone number and place of employment and ask the patient to return your call. If you know that you will need to call the patient back with advice or test results later in the day, ask the patient if you can leave a message on their answering machine or with another Member of their family in the event they are not available. Document they gave you verbal consent to do so.

- **Reporting test results by mail.** All correspondence which contains health information (e.g. test results, appointment reminders) should be mailed to patients in a sealed envelope or post card that can be sealed in some manner.

- **Conversations in social settings.** Be aware of your surroundings. A patient’s neighbor, relative or colleague may be in the elevator with you, sitting next to you at lunch, or following you out the door as you leave the office.

- **Store medical records in a secure manner.** Medical records, test results, consultant reports, etc. should not be left on desks or counters where unauthorized persons may see them. In addition, medical information on computer screens should not be visible to passersby. Always return your computer screen to the main menu or adjust the contrast if you have to leave your work area for any reason.

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

3.1 WHAT IS MEDICARE?

Medicare is a federal health insurance program established in 1965 as an amendment to the Social Security Act. It provides hospital (Part A) and supplemental medical (Part B) coverage for people 65 years of age and older, certain disabled people, and those of any age with End Stage Renal Disease (ESRD).

The Medicare Program is administered by The Center for Medicare and Medicaid Services (CMS), of the U.S. Department of Health and Human Services (DHHS).

3.1.1 What is Advantra HMO?

Advantra HMO is a Medicare Advantage (MA) HMO Program that includes all the benefits of original Medicare coverage plus many extra benefits offered to HMO Members. These benefits may include preventive care, vision exams and pharmacy coverage, depending on the Member's plan.

Advantra Members may pay monthly premiums for their HMO coverage. However, the Advantra Member is required to continue paying their Medicare Part B premium.

HealthAmerica has entered into a Medicare Advantage (MA) HMO Contract with CMS. This contract authorizes HealthAmerica under the Advantra product name to provide comprehensive health services to people who are eligible to receive Medicare benefits and who choose to enroll with Advantra. Advantra assumes full financial risk for the continuing health care of the Medicare Member in return for a prepaid monthly payment from CMS. Because these payments are federal funds, Advantra and its contracted entities are obligated to comply with certain laws applicable to the Medicare Program.

HOW DOES THE PROGRAM WORK?

Advantra HMO Members must choose a Primary Care Physician (PCP) from the Advantra contracted network. The Member's choice of PCP usually determines which delivery system, hospital and specialists he/she will use. A Member may change PCPs monthly and benefit plans once a year during the annual election period.

Advantra HMO Members do not need to have a referral from the PCP to seek specialty care. However, select services may require prior authorization. Members are advised to coordinate all of their health care needs through their PCP to monitor their health care progress.
The Primary Care Physician or Specialist will include the Member in the planning and implementation of their care and will have input in their proposed treatment plan.

Advantra will not pay for services that have not been authorized (if authorization is required) or that have not been provided by an “in-network” provider.

### 3.1.2 What is Advantra PPO?

Advantra PPO is a Medicare Advantage (MA) Preferred Provider Organization (PPO) Program that includes all the benefits of Original Medicare coverage, plus many extra benefits offered to PPO Members, such as preventive care and prescription drug coverage.

Coventry Health and Life Insurance Company D/B/A HealthAmerica has entered into a Medicare Advantage (MA) PPO contract with CMS. This contract authorizes HealthAmerica under the Advantra product name to provide comprehensive health services to people who are eligible for Medicare benefits and who choose to enroll in Advantra’s PPO program. The PPO Program assumes full financial risk for the continuing health care of the Medicare Members in return for a prepaid monthly payment from CMS. Because these payments are federal funds, Advantra and its contracted entities are obligated to comply with certain laws applicable to the Medicare Program.

**HOW DOES THE PROGRAM WORK?**

The Advantra PPO offers more flexibility and choice than the Advantra HMO product. Members are not required to select a Primary Care Physician. They can choose to visit any doctor, any specialist or any hospital at any time. Members can use network physicians and specialists who have agreed to accept our payment to them as payment in full. Members are responsible for co-payments for a doctor or specialist visit. If Members choose Providers outside the network, they are still eligible for benefits, but their cost share will be higher.

Advantra Members may pay monthly premiums for their coverage, must be eligible for Medicare Part A and are required to continue paying their Medicare Part B premium.

### 3.2 Medicare Advantage’s Member Rights & Responsibilities

Medicare Advantage HMO and PPO Members have the right to:

**Timely, Quality Care**

- Choose a Primary Care Provider (PCP). (Note: Contact Customer Service to learn which doctors are accepting new patients.) (HMO only.)

- Go to a women's health specialist without a referral.
• Candid discussion of appropriate or Medically Necessary treatment options for their condition, regardless of cost or benefit coverage. This discussion may also include being told about programs offered to help members manage their medications and use drugs safely.

• Know their treatment options and participate in decisions about their health care including: to know about all their choices, to know about the risks, to have the right to say “no” to recommended treatment, and to receive an explanation if they are denied coverage for care.

• Timely access to Plan Providers and referrals to specialists when Medically Necessary.
  - Routine primary care appointments: within 7 days
  - Urgent care appointments: same day or within 24 hours
  - After hours care: each primary care physician must have a reliable 24 hours a day/7 days a week answering service or machine with a beeper or paging system. A recorded message or answering service that refers members to emergency rooms is not acceptable.

• Get appointments and covered services from the Plan’s network of providers within a reasonable amount of time. This includes the right to get timely services from specialists when they need that type of care.

• Access to Emergency Services without prior authorization when they, as a prudent layperson, acting reasonably, believe that an emergency medical condition existed. Payment would not be withheld in cases where they sought emergency services.

• Receive urgently needed services when traveling outside the Plan’s service area or in the Plan’s service area when unusual or extenuating circumstances prevent them from obtaining care from their Participating Provider.

**Treatment with Fairness and Respect**

• Be treated with respect and fairness at all times, and to have their right to privacy of their medical records and personal health information recognized.

• Exercise their rights regardless of their race, physical or mental disability, ethnicity, gender, sexual orientation, creed, age, religion or national origin, cultural or educational background, economic or health status, English proficiency, reading skills, or source of payment for care. Expect their rights to be upheld by both the Plan and participating Providers.

• Confidential treatment of all communications and records pertaining to Member’s care. Members have the right to access their medical records and personal health information. Access to their records and any information that pertains to the Member must be provided in a timely manner.

• Except as authorized by state or federal law or government agencies, written permission must be obtained from the Member or their authorized representative before medical records can be made available to any person not directly concerned with their care or responsible for making payments for the cost of such care.

• Have the right to know how their health information has been given out and used for non-routine purposes.
• Extend their rights to any person who may have legal responsibility to make decisions on their behalf regarding their medical care.

• Refuse treatment or leave a medical facility, even against the advice of physicians (providing the Member accepts the responsibility and consequences of the decision).

• Stop taking their medication.

• Be involved in decisions to withhold resuscitative services, or to forgo or withdraw life-sustaining treatment.

• Complete an Advance Directive, Living Will, or a Power of Attorney of Health Care and provide a copy(ies) to their Participating Providers.

**Medicare Advantage HMO and PPO Information**

• Be informed of Medicare Advantage policies and procedures regarding services, benefits, Providers, and Member Rights & Responsibilities and to be notified of any significant changes.

• Receive information about Medicare Advantage and Covered Services written in a manner that truthfully and accurately provides information in a format easy to read and understand.

• Know the names and participation status of physicians and health care professionals involved in their medical treatment.

• Receive information about an illness, and all of the treatment options that are recommended for their condition, regardless of the cost or whether the services are covered by our Plan.

• Receive information regarding how medical treatment decisions are made by the Participating Provider, including payment structure.

• Receive information about their medications – what they are, how to take them and possible side effects, as well as how to manage their medications and how to use them safely.

• Receive “Notice of Privacy Practice” which tells about the Member’s privacy rights and explains how Participating Providers and their Plan protect the privacy of their health information.

• To ask Plan to make corrections or additions to their medical records.

• Receive as much information about any proposed treatment or procedure as they may need in order to give an informed consent or to refuse a course of treatment. Except in cases of Emergency Services, this information shall include a description of the procedure or treatment description, the medically significant risks involved, any alternate course of treatment or non-treatment and the risks involved in each.
• Reasonable continuity of care and to know in advance the time and location of an appointment, as well as the physician providing care.

• Get appointments and Covered Services from the Plan’s network of providers within a reasonable amount of time. This includes the right to get timely services from specialists when that care is needed.

• Be advised if any proposed medical care or treatment is part of a research experiment. Member has the right to participate, or refuse to participate, in such research projects or experimental treatment.

• Be informed of continuing health care requirements following discharge from inpatient or outpatient facilities.

• Examine and receive an explanation of any bill for Non-Covered Services, regardless of payment source.

• General coverage and Plan comparison information.

• Plan utilization control procedures.

• Receive summary of statistical data on grievances and appeals that Members have filed against the Medicare Advantage Program and how it compares to other Medicare Advantage health plans.

• Know the financial condition of HealthAmerica.

Timely Problem Resolution

• Make complaints and appeals without discrimination and expect problems to be fairly examined and appropriately addressed.

• Responsiveness to reasonable requests made for services.

• Receive a detailed explanation from HealthAmerica if Member believes that a Plan Provider has denied care that Member believes he/she is entitled to receive. To receive this explanation, Member will need to ask Plan for a coverage decision.

Members of Medicare Advantage Plans have the **responsibility** to:

• Provide their physicians or other care providers the information needed in order to care for them.

• Do their part to improve their own health condition by following treatment plans, instructions and care that they have agreed upon with their physician(s).

• Understand their health problems and participate in developing mutually agreed upon treatment goals to the degree possible.

• Behave in a manner that supports the care provided to other patients and the general functioning of the office or facility.
• Accept the financial responsibility for any co-payment, deductibles or coinsurance associated with covered services received while under the care of a physician or while a patient at a facility.

• Accept the financial responsibility for any premiums associated with membership in Medicare Advantage Plans.

• Review information regarding Covered Services, policies and procedures as stated in their Evidence of Coverage or Member Handbook.

• Ask questions of their Plan Provider or Medicare Advantage. If they have a suggestion, concern, or a payment issue, we recommend they call the Medicare Advantage Member Services Department.

• Pay the full cost of any medical services or medications that are not covered by Plan or by any other insurance Member may have.

3.3 MEMBER IDENTIFICATION

Advantra gives every Advantra Member an identification card shortly after joining the Plan. The identification card contains the following information:

w Member Name
w Member ID Number
w Primary Care Physician's Name and Phone Number (if HMO)
w Primary Care & Specialist Office Visit Co-payments
w Group Number
w Information Specific to Part D (RxBin #, RxPCN, RxGrp)
w Medical Claim Mailing Address
w Customer Service Phone Numbers

3.4 UNIQUE SERVICES

Advantra offers a more comprehensive benefit package for its Members compared to Fee-For-Service Medicare or Medicare Supplement Plans. Examples of these service enhancements are described below. Please note that Advantra services have coverage limitations that are different from the commercial product. In most cases, the coverage limitations follow traditional Medicare Fee-for-Service coverage guidelines.

Note: Members are responsible for the co-payment indicated on their identification card for certain services.
3.4.1 Emergency/Urgent Care/Renal Dialysis Services/Clinical Trials

**Emergency Care**

Emergency services for both inpatient and outpatient services are covered. Emergency care requires no prior authorization.

Emergency medical condition means 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 attention to result in (1) serious jeopardy to the health of the individual (or an unborn child); (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

Medically necessary emergency services are covered no matter where Members are, even if they are provided by a doctor or facility that is not contracted with Advantra.

Post-Stabilization Care is medically necessary, non-emergency services needed to ensure that the enrollee remains stabilized from the time that the treating hospital requests authorization from Advantra until (1) the Member is discharged, (2) a contracted physician arrives and assumes responsibility for the enrollee’s care, or (3) the treating physician and Advantra agree to another arrangement.

Members receiving emergency services are requested to notify their Primary Care Physician for follow-up care by calling the phone number listed on their card within 48 hours, or as soon as possible.

**Coverage for Renal Dialysis Services**

Renal dialysis services are covered from qualified dialysis providers when the Member is temporarily absent from the Plan’s service area. The PCP should coordinate these services; however, no authorization is required for in network services. Authorization is required for out of network services.

**Urgent Care**

If possible, Members are instructed to call their Primary Care Physician before seeking care. However, if this is not an option, Members may seek care from an urgent care facility or hospital emergency room and should inform their Primary Care Physician of urgent services they have received within 48 hours, or as soon as possible.

**Clinical Trials**

Call 1-800-755-1135 if an Advantra Member is participating in an approved clinical trial.
3.5 REFERRALS/PRIOR AUTHORIZATION

Advantra HMO

Advantra Members may self-refer to participating providers. When a Primary Care Physician is coordinating care for an Advantra Member, he/she must refer to an Advantra participating provider. A listing of Providers can be found in the Provider Directory at www.HealthAmerica.cvty.com. No authorization numbers are required for specialists. Physician should always consider member input in the proposed treatment plan. For prior authorization call the Utilization Management Department at: 1-800-669-2202 for WPA/Ohio and NWPA, or 1-800-755-1135 for CPA/SEPA, or contact by fax at 1-800-247-4791.

Advantra PPO

Certain Advantra PPO services require prior authorization. Participating Providers are required to obtain the prior authorization before performing the service. If Members use non participating providers for services, they are responsible for the prior authorization.

Covered services that need prior authorization, either by the network Provider or by the Member who is using non-network providers, may call the Advantra Authorization Department at: 1-800-669-2202 for WPA/Ohio and NWPA, or 1-800-755-1135 for CPA/SEPA, Monday – Friday 8:30 a.m. to 5:00 p.m. If the service is approved, an approval letter is sent to the Advantra Member and the Provider performing the service. If a review is required by a Medical Director, the Provider may also be notified by telephone. Denial notices are sent if the services are not authorized.

3.5.1 Mental Health/Substance Abuse Services Prior Authorizations

MHNet Behavioral Health (MHNet) manages the mental health/substance abuse.

- MHNet is available 24 hours a day, seven (7) days a week for emergencies by calling 1-866-369-8362 or during normal business hours, Monday through Friday, 8:00 AM to 5:00 PM EST, for routine referrals to a Provider.
- The Member or physician must contact MHNet prior to initiating behavioral health services to discuss prior authorization, provider selection and benefit information.
- Physicians may contact MHNet with treatment or referral recommendations.
- The Mental Health Provider (MHP) is responsible for obtaining a release of information from the Member if required by law or regulation, after which the physician will be kept apprised of the Member’s status and progress during treatment.
- MHNet will assist the physician in obtaining consultation regarding behavioral health issues.

MHNet Mailing Address
For Clinical Operations: MHNet Mailing Address
MHNET Behavioral Health For Claims Submissions:
503 Sunport Lane MHNET Behavioral Health
Orlando, FL 32809 PO Box 7802
London, KY 40742
3.6 MEMBER INPUT IN TREATMENT PLAN

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

3.7 ADVANCE DIRECTIVES

An Advance Directive is a written set of instructions expressing a Member’s wishes for medical treatment.

In Pennsylvania, an Advance Directive can take the form of a “Durable Power of Attorney for Health Care,” where a Member names a person to make treatment decisions for him/her, or a “Living Will,” where a Member gives specific directions to his/her health care provider.

In West Virginia, an Advance Directive can take the form of a “Medical Power of Attorney,” where the Member names a person to make treatment decisions for him/her, or a “Living Will,” where the Member gives specific directions to his/her health care provider.

In Ohio, an Advance Directive can take the form of a “Durable Power of Attorney for Health Care,” where the Member names someone to make health care decisions for him/her when he/she cannot speak for himself/herself, or a “Living Will,” where the Member gives specific directions to his/her health care provider.

When an Advantra Member visits your office, we ask that you discuss Advance Directives and document in the medical records whether or not the Member has executed an Advance Directive.

All Advantra Members receive an Advance Directive document as part of their membership materials and then again annually via letter. Extra copies can be obtained through your Provider Relations Representative or click here to see a copy of the form in Chapter 10 Appendix.
3.8 AUTHORIZED REPRESENTATIVES FOR AN ADVANTRA MEMBER

A Member may appoint a representative to become their authorized representative in the event the Member is incapacitated or incompetent. The Authorized Representative should have the appropriate documentation such as Durable Power of Attorney, a health care proxy; appointment of guardianship required by applicable law and regulation or another legally recognized form of appointment to act in this capacity. The Authorized Representative documentation allows a Member’s representative to facilitate care or treatment decisions when the Member is unable to do so because of physical or mental limitations.

3.9 IMPORTANT INFORMATION

If a Provider is informing a Member that a service is not authorized or telling a Member that the service is not covered, the Provider must give the health plan a copy of the Member Request Form located in Chapter 10 the Appendix or click here, and also must inform the Member of the right to appeal as per “Member Grievance or Medicare Appeals Process.” Please direct any Members with questions regarding the Medicare Appeals Process or the Plan’s Internal Grievance Process to Advantra Customer Service Organization.

3.10 PROVIDER APPEALS PROCESS

Advantra is authorized to make benefit determinations in accordance with Medicare guidelines for Medicare-covered services. Advantra is obligated to ensure that services are provided in a culturally competent manner and consistent with professionally recognized standards of health care.

These benefit determinations are never intended to limit, restrict, or interfere with the physician’s judgment or to discriminate against the Member based on health status. In all cases, decisions regarding treatment continuation or termination, treatment alternatives, or the provision of medical services are between the physician and the patient.

However, Advantra is not obligated to pay for unauthorized care (except in cases of emergency). If the Provider does not agree with a medical management determination, and the matter cannot be resolved informally, Advantra maintains a Physician Appeal Process through which all providers (physicians, facility or ancillary) may appeal a medical management issue or benefit determination.

This process also includes provisions for Expedited Provider Appeals. Where there is a clinical necessity for a prompt decision, the Provider can expect a determination within 24 hours of initiating the request.
3.11 MEMBER GRIEVANCE OR MEDICARE APPEALS PROCESS FOR MEDICAL COVERAGE

Advantra has a separate Customer Service Organization with service representatives for Advantra Members.

If a Member has a concern or complaint, Advantra has steps to resolve them.

There are two types of procedures for resolving enrollee complaints:

- the Medicare (CMS) Appeals Process
- the Advantra Internal Complaint/Grievance Process

Members have the right to make a complaint if they have concerns or problems related to their coverage or care. “Appeals” and “grievances” are the two different types of complaints Advantra Members can make.

An “appeal” is a type of complaint made when a Member wants Advantra to reconsider and change a decision Advantra has made about what services are covered or what Advantra will pay for a service. For example, if Advantra refuses to cover or pay for services the Member thinks should be covered, the Member can file an appeal. If Advantra or one of the Plan Providers refuses to give the Member a service they think should be covered, the Member can file an appeal. If Advantra or one of the Plan Providers reduces or cuts back on services the Member has been receiving, the Member can file an appeal. If the Member thinks coverage is stopping too soon, the Member can file an appeal.

A “grievance” is a type of complaint a Member makes if they have any other type of problem with Advantra or one of our Plan Providers. For example, the Member would file a grievance if they have a problem with circumstances such as the quality of care, waiting times for appointments or in the waiting room, the way the doctors or others behave, being able to reach someone by phone to get the information they need, or the cleanliness or condition of the doctor’s office.

Grievance Procedure

Members have the right to file a grievance with Advantra if they are in any way dissatisfied with Advantra or its Participating Providers. The following is a list of examples where the Advantra Grievance Procedure could be used:

- Service complaints including waiting times, provider behavior and any complaint that does not include a liability for payment decision.
- Complaints about the quality of the services received.
A Member is encouraged to resolve the complaint informally by working with their Member Service Representative. A Customer Service Organization representative will review, research and resolve Member complaints in a timely and equitable manner. Members will be informed of the resolution in writing within 30 days. Advantra may extend the time frame by up to 14 days if the Member asks for the extension, or if Advantra justifies a need for additional information and the delay is in the Member’s best interest.

An exception to the 30-day resolution process is the expedited grievance process. If a Member’s grievance is about a decision not to conduct an expedited organizational or coverage determination, reconsideration, or redetermination, the expedited grievance process will be followed. Advantra will respond to a Member’s complaint within 24 hours of his/her contacting Advantra.

If a complaint cannot be informally resolved, Members have the option to file a written complaint for review by Advantra’s Grievance Committee.

Advantra Providers are responsible for forwarding any medical records or necessary information when requested by Advantra Quality Assurance.

**Medicare Appeals Procedure**

Every Advantra Member has the right to appeal any decision made by Advantra or a Provider about medical bills or health care services. Specifically, a Member can use the Medicare Appeals Process whenever he/she thinks Advantra or the Provider:

- w has not paid a bill; for example, bills for urgently needed care outside the service area or a denied claim from a non-plan provider that should have been provided, arranged or paid for by Advantra;
- w has not paid a bill in full;
- w will not approve or deliver care that the Member believes is covered;
- w has reduced or terminated services that the Member believes are medically necessary and are Covered Services.

In addition, a Member may appeal any decision to discharge him/her from the hospital too early. In this case, the Member is given an important message from Medicare that gives him/her the information on how to appeal to a Medical Review (Quality Improvement) Organization. The Member can remain in the hospital while the Quality Improvement Organization reviews the decision.

The Medicare Appeal Procedure has two distinct processes:

- w the 72-hour appeal process
- w the 30-day appeal process
**Expedited 72-Hour or Fast Appeal Process:**

This is the process a Member may use if he/she believes that his/her health, life or ability to regain maximum function may be jeopardized by using the standard 30-day Appeal Process. Members may not use this process to appeal claim payment denials.

Any provider may provide oral or written support for a Member’s request for an Expedited Appeal. Unless the physician makes a request for an Expedited Appeal on behalf of a Member, Advantra makes the determination as to whether the request for a 72-Hour Appeal will be sent through that process or the standard 30-Day Appeal Process.

**30-Day Appeal Procedure:**

This is the standard process that a Member should use when he/she requests that the Plan change any decisions made related to:

- Health services, provided by a non-Advantra contracted Provider, which the Member believes should have been provided, arranged or reimbursed by Advantra.
- Services not yet rendered, but which the Member believes are covered by Advantra and should be provided.
- Claims for services for which no written notice has been issued within 60 days after submission.

This process should be used when the Member believes that the issue he/she is appealing is not time sensitive.

**Appeal Process:**

The Member may file the appeal directly or may appoint a representative to file the appeal on his/her behalf. Please note the Member may appoint any provider, whether contracted or non-contracted with Advantra, as his/her representative. In such cases, the appointment must be submitted to Advantra Customer Service Organization in writing and it must contain:

- the Member’s name and Medicare number
- a short statement appointing the representative
- the Member’s signature and date
- the representative’s signature and date

The Member can also submit an appeal to the Social Security Administration or the Railroad Retirement Board within 60 days of the date of the notice of the initial decision by Advantra.

If Advantra upholds its decision to deny either in whole or in part, the entire file is forwarded to the CMS Appeals contractor for their review.
3.11.1 Notice of Discharge and Medicare Appeal Rights

Hospital Inpatient Discharges

When Members think they are being discharged from the hospital too soon

When a Member is hospitalized, he/she has the right to get all the hospital care covered by Advantra necessary to diagnose and treat his/her illness or injury. The day the Member leaves the hospital (“discharge date”) is based on when the stay in the hospital is no longer medically necessary.

Information Members should receive during their hospital stay

When Advantra Members are admitted to the hospital, someone at the hospital should give him/her a notice called Important Message from Medicare. This notice explains the Member’s rights:

- to get all medically necessary hospital services covered;
- to know about any decisions that the hospital, the doctor, or anyone else makes about the hospital stay and who will pay for it;
- that their doctor or the hospital may arrange for services the Member will need after he/she leaves the hospital;
- to appeal a discharge decision.

Quality Improvement Organizations review of Advantra Members’ hospital discharge

If Advantra Members think they are being discharged from the hospital too soon, they must ask Advantra to give them a notice called the Notice of Discharge & Medicare Appeal Rights (NODMAR). This notice will tell the Member:

- The reason he/she is being discharged.
- The date that Advantra will stop covering the hospital stay (i.e. stop paying its share of the hospital costs).
- What the Member can do if he/she thinks he/she is being discharged too soon.
- Who to contact for help.

The Member (or someone he/she authorizes) may be asked to sign and date this document, to show that the Member received the notice. Signing the notice does not mean the Member agrees that he/she is ready to leave the hospital – it only means the Member received the notice.

Members have the right by law to ask for a review of their discharge date. As explained in the Notice of Discharge & Medicare Appeal Rights, if the Member acts quickly, he/she can ask an outside agency called the Quality Improvement Organization to review whether the discharge is medically necessary.
Skilled Nursing, Home Health, or Comprehensive Outpatient Rehabilitation Facility Discharges

Advantra Members have the right to appeal if they think their coverage for skilled nursing, home health or comprehensive outpatient rehabilitation facility services is ending too soon.

When a patient is in a Skilled Nursing Facility (SNF), home health agency (HHA), or comprehensive outpatient rehabilitation facility (CORF), Members have the right to get all the SNF, HHA or CORF care covered by Advantra medically necessary to diagnose and treat their illness or injury. The day the Provider decides to end their SNF, HHA or CORF coverage is based on when their stay is no longer medically necessary.

Information Members should receive during their SNF, HHA or CORF Stay

If the Provider decides to end the Member’s coverage for SNF, HHA, or CORF services, the Member will get a written notice from the Provider at least 2 calendar days before his/her service ends. The Member (or someone he/she authorizes) will be asked to sign and date this document, to show that he/she received the notice. Signing the notice does not mean that the Member agrees coverage should end – it only means the Member received the notice.

How Members can appeal their coverage to the Quality Improvement Organization

Members have the right by law to ask for an appeal of termination of their coverage. As explained in the notice, Members can ask the Quality Improvement Organization (the “QIO”) to perform an independent review to determine whether terminating the coverage is medically necessary.

If Members want to have the termination of the coverage appealed, they must act quickly to contact the QIO. The written notice the Member receives from the provider gives the name and telephone number of the QIO and tells the Member what he/she must do.

- If Members get the notice 2 days before the coverage ends, the Member must be sure to make his/her request no later than noon of the day after he/she gets the notice from the Provider.
- If Members get the notice and have more than 2 days before the coverage ends, then the Member must make his/her request no later than noon the day before the date that the Medicare coverage ends.

What will happen during the review?

If the QIO reviews the case, the QIO will ask for the Member’s opinion about why he/she believes the services should continue. Members do not have to prepare anything in writing, but may do so if they wish. The QIO will also look at the Member’s medical information, talk to the doctor, and review other information given to the QIO.

After reviewing all the information, the QIO will give an opinion about whether it is medically necessary for the Member’s coverage to be terminated on the date originally set for him/her. The QIO will make this decision within one full day after it receives the information it needs to make a decision.

What happens if the QIO decides in the Member’s favor?

If the QIO agrees with the Member, then coverage will continue for the SNF, HHA or CORF services for as long as medically necessary.
What happens if the QIO denies the Member’s request?
If the QIO decides that the decision to terminate coverage was medically necessary, the Member will be responsible for paying the SNF, HHA or CORF charges after the termination date on the original advance notice given to the Member. Neither traditional Medicare nor Advantra will pay for these services. If the Member stops receiving services on or before the date given on the notice, he/she can avoid any financial liability.

3.12 QUALITY IMPROVEMENT ORGANIZATION REVIEW

The Quality Improvement Organization (QIO), an independent agency, has contracted with the Secretary of the Department of Health and Human Services (DHHS) to review records of medical care provided to Advantra Members when they register complaints concerning the quality of or access to care.

Members also have the right to an Immediate Review by the QIO if the Member believes that he/she is being discharged from the hospital too soon. When Advantra issues a Member a notice of discharge, the notice is subject to QIO Review.

Advantra will contact a Provider’s office to obtain medical records upon the Quality Improvement Organization’s request. All re-reviews will be performed by a board-certified physician of like specialty who was not involved in the original determination and has no relationship to Advantra.

Please direct any questions regarding the Quality Improvement Organization and the Review Process to your Provider Relations Representative.

Pennsylvania:
Livanta
BFCC – QIO Program
9090 Junction Drive Suite 10
Annapolis Junction, MD 20701
Toll Free: 866-815-5440
TTY: 1-866-868-2289
Fax (Appeals): 855-236-2423
Fax (All Other Reviews): 844-420-6671

Ohio:
KEPRO
5201 W. Kennedy Blvd., Suite 900
Tampa, FL 33609
Toll Free: 855-408-8557
Fax: 844-834-7130

West Virginia:
KEPRO
5201 W. Kennedy Blvd., Suite 900
Tampa, FL 33609
Toll Free: 844-455-8708
Fax: 844-834-7129


3.13 CLAIMS AND ENCOUNTER SUBMISSION

It is recommended that CMS 1500 Form or UB 04 Form be submitted within 60 days from the date of service for all claims. Advantra has adopted standard billing guidelines so that completion of the CMS 1500 Form or UB 04 Form is consistent with Medicare Guidelines.

The NPI number must be included on each CMS 1500 Form submitted.

The mailing address for Advantra claims is:

Advantra Claims Department
P.O. Box 7087
London, KY 40742-7087

Submission of all Encounter information is required for all physician, inpatient, outpatient hospital, skilled nursing facility and home health services.

3.14 MEDICARE ADVANTAGE (MA) RISK ADJUSTMENT

The Balanced Budget Act of 1997 specifically required implementation of a Risk Adjustment Method Payment Methodology to Medicare Advantage Organizations. Risk Adjustment Payment Methodology improves the capitated payments made by Centers for Medicare and Medicaid Services (CMS) to MA Organizations by adjusting monthly payment amounts based on the health status of each enrolled Medicare beneficiary in the Advantra Program.

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

All Providers who participate in the Advantra program are required to submit complete and accurate claims data and maintain clean, concise and complete medical record documentation practices.

The following paragraphs outline steps that will assist Providers in the compliance of regulatory requirements when submitting encounter information and in the maintenance of medical record documentation.

1. Use the appropriate ICD-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: There is an 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 the patient’s care should be documented in the medical record and coded according to official coding guidelines.

2. Submit all diagnoses that impacts 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 it is accurate, complete and truthful and is supported by the patient medical record or other relevant documentation.

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

   Physician should sign and date each entry in the medical record.

It is important for physicians and their office staff to be aware of risk adjustment data validation activities because they may be requested to provide medical record documentation to Advantra.

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-CM (or most current version) coding guidelines.

Advantra will monitor the data being submitted from a Provider’s office for accuracy, thus ensuring correct payment from CMS to Advantra. If an error or missing data is identified, Advantra may request from a Provider coding specificity to correct erroneous data and/or the reporting of missing data.

Providers who submit risk adjustment diagnostic data to Advantra for CMS payment purposes do not violate Health Insurance Portability and Accountability (HIPAA) privacy regulations. Therefore, a patient’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.

**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 patient and is an important element contributing to high quality care.
**Educational Quick Facts**

**ICD-CM Overview**

**ICD-CM Coding Process - Physician and Hospital Outpatient**

**Medical Record Documentation Tips**

**Tips for Documentation: The Problem Oriented Medical Record (POMR) Problem List**

**Medical Record Progress Notes - SOAP Notes**

**Resources Section**

**Web Links:**

ICD-CM Public Use Files
- [http://www.cdc.gov/nchs/icd.htm](http://www.cdc.gov/nchs/icd.htm)

ICD Coding Guidelines
- [http://www.cdc.gov/nchs/icd.htm](http://www.cdc.gov/nchs/icd.htm)

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**QUICK FACTS**

**ICD-CM**

*(International Classification of Diseases Clinical Modification)*

**OVERVIEW**

This ICD-CM (International Classification of Diseases Clinical Modification) QUICK FACTS serves as an easy reference to explain ICD-CM coding guidelines. Since diagnostic information is critical for risk adjusted payment, ICD-CM codes must be reported accurately.

**USE CURRENT VERSION OF ICD-CM**

- All hospitals/physicians must use current valid International Classification of Disease Clinical Modification (ICD-CM) codes.
- ICD-CM codes are updated annually on October 1.
- If hospitals/physicians use the Diagnostic Statistical Manual of Mental disorders, 4th edition (DSM IV) for coding, they will need to convert the information to the official ICD-CM codes.

**RELATE DIAGNOSIS TO SERVICE PERFORMED & DOCUMENT**
The medical record must support the diagnosis.

The diagnosis reported must match the coding submitted by the hospital/physician as documented in the medical record.

Report all secondary diagnoses that impact clinical evaluation, management and/or treatment.

Report all relevant V-codes and E-codes pertinent to the care provided.

The medical record must be retrievable to validate the diagnosis reported.

**CODE TO THE HIGHEST LEVEL OF SPECIFICITY**

Basic Coding guidelines prescribe the use of the most specific code (the highest level of specificity). ICD-CM is composed of codes with either 3, 4, or 5 digits. Codes with 3 digits are included in ICD-CM as the heading of a category of codes that may be further subdivided by the use of 4th and/or 5th digits, which provides greater specificity.

- Assign three-digit codes only if there are no four-digit codes within that code category.
- Assign four-digit codes only if there is no fifth-digit sub-classification for that subcategory.
- Assign the fifth-digit sub-classification code for those subcategories where it exists.

Coding guidelines recommend that an unspecified code should not be used if the medical record provides adequate documentation for assignment of a more specific code.

**Resources:** Go to ICD-10 - Centers for Medicare & Medicaid Services for a computer-based training course on the ICD-CM. Additional resources for ICD-CM coding are located on www.cms.hhs.gov (do a site search for ICD-CM) and the CSSC web site at www.mcoservice.com.

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**QUICK FACTS**

**ICD-CM Coding Process-Physician and Hospital Outpatient**

*(International Classification of Diseases Clinical Modification)*

- Review the medical record to identify the reason for the visit.

- Review the medical record for other conditions and confirmed diagnoses that are related to the reason for the visit. Do not code conditions described as “rule out,” “possible,” or “suspected.”

- Look up the main terms of these conditions in the ICD-CM index. Main terms may be followed by other descriptors in parentheses. These terms are called “non-essential modifiers.” The presence or absence of these terms does not affect the coding of the main terms.

- Search the indented terms under each main term to find the closest description of the condition documented. The index may refer to another main term. More than one main term may be required to fully describe the condition.

- Look up the codes selected in the Tabular Index.
Read all definitions and follow all cross reference notes, inclusion notes and exclusion notes found at the beginning of each code category in the Tabular Index.

Code to the highest specificity possible. If there is a fourth and fifth digit to select, use the most appropriate one. If the index refers to a code with the fourth digit of .8 (NEC-not elsewhere classified) or .9 (NOS-not otherwise specified) refer back to the medical record to see if other more specific listings in the code category may apply.

Determine if any of the conditions can be combined or are symptoms of another condition and, therefore, not to be coded.

First, list the diagnosis code chiefly responsible for the service(s) provided. Then, list codes for all other conditions documented.

Code only those conditions supported by clinical medical record documentation on the corresponding date(s) of service.

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**QUICK FACTS**

**Medical Record Documentation Tips**

In accordance with the provider contract with Coventry and applicable laws and regulations, participating physicians and other health care professionals are required to treat personal health information (PHI) as confidential. PHI includes: identity of the individual; the relationship of the individual with Coventry; physical or behavioral health status or condition; and payment information for the provision of health care.

Coventry established medical record criteria to provide a guideline for fundamental elements of organization, documentation of diagnostic procedures and treatment, communication and storage of medical records. These criteria are applicable to all benefits plans. Performance goals are established to assess the quality of medical record-keeping practices, and audits are conducted no less than every two years. Coventry’s performance goal is 85 percent compliance.

In the provider agreements with Coventry, participating physicians and other health care professionals agree to maintain medical records in a current, detailed, organized and comprehensive manner in accordance with customary medical practice, applicable laws and accreditation standards. This requirement survives the termination of the contract, regardless of the cause for termination. You must keep our members’ information confidential and stored securely. You must also ensure your staff members receive periodic training on member information confidentiality. Only authorized personnel should have access to medical records.

Coventry has the right to access confidential medical records of Coventry members, for the purpose of claims payment, assessing quality of care, including medical evaluations and audits, and performing utilization management functions. Medical records may be requested as a part of Coventry’s participation in HEDIS. HIPAA Privacy regulations allow for sharing of personal health information (PHI) for purposes of making decisions around treatment, payment, or health plan operations.
• Medical records should be organized in a systematic format for communication and retrievability.

• Notes on scraps of paper, sticky notes, index cards, etc. are not acceptable.

• Only persons authorized to do so may document the medical record, and each person must be identified.

• Entries must be made at the time of treatment and dated.

• Avoid non-clinical remarks within the body of the record that mention any financial issues or unprofessional remarks about patients or other healthcare team Members.

• Use only standard abbreviations and keep them to a minimum.

• Each page of the medical record should identify the patient.

• The medical record must contain sufficient information to identify the patient, justify the treatment (and level of care), support the diagnosis, document the patient’s progress and the results of treatment, and promote continuity of care among healthcare providers.

Medical Records Must Include Documentation of:

• Admission diagnosis/initial impression.

• Reason for admission, visit, treatment, and/or consultation requests. Many of these reasons will be part of a list of final diagnoses.

• All operative and non-operative procedures, test results and consultations including the rationale for the procedure/treatment/test and evidence that the results or consultation were noted by the physician.

• Patient’s response to care including any complications or conditions (diagnoses) that impact or extend the inpatient length of stay.

• Medications ordered, dispensed and any adverse reactions.

• Conclusions, instructions for follow-up and a summary of care including outcome, disposition, and final diagnoses.

QUICK FACTS

SOAP Notes

One common method of documenting medical record progress notes (for all provider types) that contain all the necessary elements is called the Problem Oriented Medical Record (POMR). POMR includes a problem list and SOAP notes. Each letter in SOAP stands for a section of the progress notes as follows:
SUBJECT

How the patient describes what brings them to the facility/office for care, what medications they have taken, and any other relevant observations by the patient about their condition. This includes chief complaints and associated symptoms.

OBJECTIVE

Data obtained by the current problem focused exam, lab results, vital signs, and other observations made directly by the physician. A full history and physical is a separate document typically generated during the initial patient visit.

ASSESSMENT

Listing and description of a patient's current diagnosis or symptom and status of all chronic conditions. This includes how the objective data relates to each of the patient's problems. Conditions are listed by problem number, referring back to the problem list.

PLAN

The plan includes four elements:

- Diagnostic plan: further diagnostic test or consultation/referrals
- Therapeutic plan: medications and treatments such as physical therapy
- Patient education: instructions for care at home, expected outcomes, potential complications, side effects of medication, etc.
- Follow-up: next scheduled appointment or conditions for return visit or phone call.

QUICK FACTS

Tips for Documentation:

The Problem Oriented Medical Record (POMR) Problem List

- The problem list is a numbered index of the patient’s problems from identification to resolution.
- The list should be kept in the front of the physician office record, clinic record, or hospital progress note section.
- The problems should include acute or chronic diagnoses, symptoms not related to an established diagnosis, social issues, or any other condition that may impact the patient’s care and treatment.
- The problems are numbered and dated so they can be identified in ongoing SOAP notes (see above). The date the problem is resolved can be entered in a separate column.

Example Problem List
Patient Identification: Allergies: None known

Problem #1 10/4/02 Asthma, COPD
Problem #2 10/4/02 History of smoking, quit 2 years ago
Problem #3 12/30/02 Wife expired, no one to render care at home
Problem #4 1/7/03 Broken toe *resolved 3/3/03*
Problem #5 3/3/03 Depression, continued grief reaction

Three of the most commonly used formats of the POMR SOAP notes include:

1) “Pure” POMR notes address each numbered problem with separate SOAP breakdown.

<table>
<thead>
<tr>
<th>Problem #1</th>
<th>Problem #4</th>
</tr>
</thead>
<tbody>
<tr>
<td>S</td>
<td>S</td>
</tr>
<tr>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>A</td>
<td>A</td>
</tr>
<tr>
<td>P</td>
<td>P</td>
</tr>
</tbody>
</table>

2) “Hybrid” POMR notes list SOAP one time and identify the applicable numbered problems under each note.

<table>
<thead>
<tr>
<th>S</th>
<th>Problem #1</th>
</tr>
</thead>
<tbody>
<tr>
<td>O</td>
<td>Problem #1</td>
</tr>
<tr>
<td>A</td>
<td>Problem #1</td>
</tr>
<tr>
<td>P</td>
<td>Problem #1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>S</th>
<th>Problem #4</th>
</tr>
</thead>
<tbody>
<tr>
<td>O</td>
<td>Problem #4</td>
</tr>
<tr>
<td>A</td>
<td>Problem #4</td>
</tr>
<tr>
<td>P</td>
<td>Problem #4</td>
</tr>
</tbody>
</table>

3) Untitled SOAP notes do not use a numbered problem list but document the current pertinent symptoms and diagnoses in the SOAP format.

   Date of visit: 1/7/03

<table>
<thead>
<tr>
<th>S</th>
<th>Patient tripped at home and has pain and swelling of left great toe.</th>
</tr>
</thead>
<tbody>
<tr>
<td>O</td>
<td>X-ray - Fractured left toe, COPD and asthma-stable with home oxygen as needed.</td>
</tr>
<tr>
<td>A</td>
<td>Fractured toe, COPD</td>
</tr>
<tr>
<td>P</td>
<td>Splint toe, instructions to elevate foot, OTC pain reliever per label instructions. Phone numbers given for meals on wheels, follow up in office in 2 weeks. Call office if pain or swelling increases or 911 if experiencing trouble breathing.</td>
</tr>
</tbody>
</table>
3.15 SPECIAL STATUS MEDICARE MEMBERS

CMS reimburses contractors at different rates for each Member based on age, sex, county of residence, and also on the classification into one of five special Status Categories.

The Special Status Categories include:
- Institutional Status
- End Stage Renal Disease
- Medicare/Medicaid Dual Eligible
- Hospice
- Working Aged

It is important that a Provider understand the different Special Status Categories and take the actions defined below when a Member is identified as meeting the Special Status definition.

**End Stage Renal Disease (ESRD)** is defined by CMS as the state of renal impairment that appears to be irreversible and permanent, and requires a regular course of dialysis or kidney transplantation to maintain life.

If 36 months or more has elapsed since a kidney transplant, the person is no longer considered to have ESRD status.

It is very important that a Provider inform its Advantra Medical Management contact of any enrolled Members who meet the ESRD definition. Advantra receives a higher reimbursement from CMS for Members who are ESRD. ESRD status is reported to CMS through the ESRD Network Organization located in 18 geographic areas in the United States. The Provider, usually a contracted nephrologist or renal dialysis facility, needs to submit a completed CMS 2728-U4, “Medical Evidence Report Form,” to the applicable ESRD Network Organization.

The ESRD Network Organization reviews the form and transmits the data to CMS electronically. CMS will notify Advantra of Members who are ESRD and will pay Advantra at a higher rate. *(NOTE: Advantra may be secondary payor for individuals who have both Medicare coverage and Employer Group Health Plan coverage.)*

**Medicare/Medicaid Dual Eligible** is an individual who is covered under both the Medicare and Medicaid programs.

For a qualified Medicare beneficiary (QMB), the state Medicaid program pays for the annual Medicare Part A deductible, Medicare Part A coinsurance, monthly Medicare Part B premium, annual Part B deductible and Medicare Part B coinsurance.

**Hospice** is a Member who has selected Medicare certified Hospice coverage. Prospective Members are entitled to enroll in Advantra if they are receiving Hospice coverage.

An Advantra Member becomes Medicare certified Hospice when he/she completes a Hospice Election Form. This form is usually provided by a Medicare certified Home Health or Hospice Provider. The Provider then submits the form along with the provider bills to the fiscal intermediary. The fiscal intermediary pays the Hospice claims, not Advantra. Advantra receives
a lower reimbursement rate from CMS for Members that are Medicare certified Hospice since the fiscal intermediary is paying the claims.

*Working Aged* is defined as the CMS Medicare Advantage risk payment category for an individual who is defined as eligible for Medicare and (1) is either working for an employer with more than 20 employees or (2) has a spouse with coverage under an Employer Group Health Plan which covers the Advantra Member.

Advantra receives a lower payment rate from CMS for these Members. If a Provider identifies a Member with Employer Group Health Plan coverage in addition to their Advantra coverage, Advantra Member Services needs to be informed. If a Member is Working Aged, a Provider should bill the Employer Group Health Plan as primary and Advantra as the secondary payor.

### 3.16 PRIVACY OF MEDICAL RECORDS

Providers should safeguard the privacy of the Member’s medical record. Original medical records should be released only in accordance with Federal or State laws, court orders or subpoenas. Providers must maintain accurate confidential medical records and maintained for 10 years. All Member information should be available to be transferred upon request by the Member, or authorized representative, to any organization with which the Member may subsequently enroll, or to a provider to ensure continuity of care.

Providers need to ensure timely access by a Member to pertinent records, and information, upon request. Members can be charged a reasonable fee for copies of records.

The Provider must abide by all Federal and State laws regarding confidentiality, documentation on whether or not a Member has executed an Advance Directive and disclosure for mental health records and medical records and provide staff with periodic training in member information confidentiality.

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.

As it applies to this policy, management and employees are required to maintain physical, electronic and procedural safeguards to protect member health information against inappropriate and unauthorized use or disclosure and must limit the information used or disclosed to the “minimum amount necessary” to accomplish the relevant purpose; abide by restrictions to access member health information and will limit to only those employees who need it to provide products or services to our member.
Medical Record Documentation: Standards and Criteria

Our participation agreements require you to treat personal health information (PHI) as confidential. PHI includes: identity of the individual; the relationship of the individual with HealthAmerica physical or behavioral health status or condition; and payment information for the provision of health care.

HealthAmerica established medical record criteria to provide a guideline for fundamental elements of organization, documentation of diagnostic procedures and treatment, communication and storage of medical records. These criteria are applicable to all benefits plans. Performance goals are established to assess the quality of medical record-keeping practices, and audits are conducted no less than every two years. HealthAmerica performance goal is 85 percent compliance.

Our participation agreements require you to maintain medical records in a current, detailed, organized and comprehensive manner in accordance with customary medical practice, applicable laws and accreditation standards. This requirement survives the termination of the contract, regardless of the cause for termination. You must keep our members’ information confidential and stored securely. You must also ensure your staff members receive periodic training on member information confidentiality. Only authorized personnel should have access to medical records.

HealthAmerica has the right to access confidential medical records of HealthAmerica 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 HealthAmerica participation in the Healthcare Effectiveness Data and Information Set (HEDIS). HIPAA privacy regulations allow for sharing of PHI for purposes of making decisions around treatment, payment or health plan operations.

The Managed Care Plan shall ensure maintenance of medical/case records for each enrollee. Medical/case records shall include the quality, quantity, appropriateness and timeliness of services performed under the contract. All records should be kept confidential and maintained for seven (7) years. All Member information should be available to be transferred upon request by the Member, or authorized representative, to any organization with which the Member may subsequently enroll, or to a Provider to ensure continuity of care. We use practitioner/provider performance data to improve the quality of service and clinical care our members receive. Accrediting agencies require that providers let us use your performance data for this purpose.

Participating Practitioner Medical Record Criteria

Organization

- Each page has member’s name and date of birth on it. The member’s name and date of birth should be recorded on each page of the medical record (e.g., all notes, lab reports and consult reports). (1 point)
- Member’s personal data (gender, date of birth, address, occupation, home/work phone numbers, marital status) is documented.
  - Each record must contain appropriate biographical/personal data including age, sex, race, address, employer, home and work telephone numbers, ICE contact and marital status.
  - All members must have their own chart — no family charts. (1 point)
  - A centralized medical record for the provision of prenatal care and all other services must be maintained (prenatal only). (1 point)
• All entries in the record contain author’s signature or initials or electronic identifier (stamped signatures are not acceptable).
  • The provider of service for face-to-face encounters must be appropriately identified on medical records via their signature and physician specialty credentials (e.g., MD, DO, DPM, etc.). Examples of acceptable physician signatures are: handwritten signature or initials; electronic signature with authentication by the respective provider; or facsimiles of original written or electronic signatures. This means that the credentials for the provider of services must be somewhere on the medical record — either next to the provider’s signature or preprinted with the provider’s name on the group practice’s stationery. If the provider of services is not listed on the stationery, then the credentials must be part of the signature for that provider. (1 point)
• All entries are dated. (1 point)
• All entries are legible to someone other than the writer.
  • The medical record should be complete and legible. Illegible medical record entries can lead to misunderstanding and serious patient injury. (1 point)
• Medications noted, including dosages and dated status of prescription (active or discontinued) or date of initial or refill prescription.
  • Evidence of prescribed medications, including dosages and dates of initial or refill prescriptions must be present in the record. This list should be updated each visit. (1 point)
• Medication allergy and adverse reactions or lack thereof prominently noted.
  • Allergies and adverse reactions to medications are prominently noted in chart or the lack thereof is noted as NKA (no known allergies) or NKDA (no known drug allergies). (1 point)
• Up-to-date problem list is completed including significant illnesses and medical and psychological conditions.
  • A problem list recorded with notations must be present and include any significant illness or medical and/or psychological condition found in the history or in previous encounters. The problem list must be comprehensive and show evaluation and treatment for each condition that relates to a diagnosis code on the date of service.
  • A problem list should be either a classical separate listing problems or an updated summary of problems in the progress note section (usually a periodic health exam). The latter type list should be updated at least annually and should include health maintenance. A repetitive listing of problems within progress notes is acceptable. A blank problem list receives a score of 0. (1 point)
• Past medical history is completed (for members seen three or more times) and is easily identified and includes dates of serious accidents, operations and illnesses. For children and adolescents (18 years and younger), past medical history relates to dates of prenatal care, birth, operations and childhood illnesses.
  • Past history including experiences with illnesses, operations, injuries and treatments must be documented. Family history including a review of medical event, diseases and hereditary conditions that may place the member at risk must be documented. (1 point)
• History and Physical (H&P) documents have subjective/objective information for presenting problem.
  • Past medical history including physical examinations, necessary treatments and possible risk factors for the member relevant to the particular treatment are noted. (1 point)
• For members 14 years and older, there is appropriate notation concerning the use of cigarettes, alcohol and substances (for members seen three or more times, query substance abuse history).
  • For members 14 years and older, a score of 1 requires a response to an inquiry concerning alcohol, smoking and/or substance abuse history as part of risk screening in
support of preventative health. For members under the age of 14 years, the score will be N/A. (1 point)

- Note regarding follow-up care, calls and visits. Specific time of return is noted in weeks, months or as needed.
  - 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 (i.e., PRN). (1 point)
- An immunization record has been initiated for children and history for adults.
  - An immunization record (for children) which includes the name of the vaccine and date of administration or disease (e.g., chickenpox) is up to date or an appropriate history has been made in the medical record (for adults). Member reported data is acceptable. (1 point)
- Preventive screenings and services offered according to Coventry guidelines.
  - There is evidence that preventive screenings and services are offered in accordance with the organization’s practice guidelines. Preventive screenings specific to member age/gender/illness (e.g., mammography, immunizations, Pap/HPV tests, BMI value for adults, BMI percentiles for ages 15 and under, colorectal cancer screening, diabetic eye exams) are documented. Documentation should include screening date and result. (1 point)
  - For children and adolescents there should be documentation of counseling for nutrition and physical activity.
- Documentation about advance directives (whether executed or not) is in a prominent place in the member’s record (except for under age 18).
  - There is evidence of advance directives noted in a prominent place in the record (1 point) and whether or not the advance directive has been executed in the chart for members over 18 years of age. (1 point)
- Treatment Plan is documented.
  - There is documentation of clinical findings and evaluation for each visit (presenting complaints, pain management, Diagnosis and Treatment Plan, prescription, referral authorization, studies, instructions). (1 point)
- Working diagnoses are consistent with findings.
  - There is a documented reason for the visit. The progress note contains appropriate subjective and objective information pertinent to the member’s presenting complaints for each visit. (1 point)
- No evidence member is at inappropriate risk. Possible risk factors for member relevant to particular treatment are noted.
  - There is no evidence that the member is placed at inappropriate risk by a diagnostic or therapeutic procedure. Diagnostic and therapeutic procedures are appropriate for the member’s diagnosis and risk factors. Examples: a) Member has complaint of right hip pain and an X-ray of the right hip is ordered. b) Abnormal lab and imaging study results do not have an explicit note regarding follow-up plans. (1 point)

**Examination**
- Blood pressure, weight, height, BMI value or BMI percentile measured and recorded at least annually, if member accesses care. (1 point)

**Studies**
- Lab and other studies are ordered, as appropriate.
  - If a diagnostic service (test or procedure) is ordered, planned, scheduled, or performed at the time of the E/M encounter, the type of service, for example, lab or X-ray should be documented. (1 point)
• Evidence that physician has reviewed lab, X-ray or biopsy results (signed or initialed reports) and member has been notified of results before filing in the record.
  • There is evidence of physician review of lab, X-ray, or biopsy results or other studies by either signing or initialing reports or documentation of the results in the progress notes. Abnormal lab and imaging study results have an explicit note regarding follow-up plans. (1 point)

Communication
• Documentation of communications contact with referred specialist.
  • The PCP or managing practitioner coordinates and manages the care of the member. If a consultation/referral is made to a specialist, there is documentation of communication between the specialist and the PCP with notation that physician has seen it. And there is evidence of discharge summaries from hospitals, HHAs and SNFs, if applicable. If there is no evidence of referral or other facility services, mark N/A. (1 point). Providers must respond and submit requested medical records to Grievance and Appeals and/or Quality Improvement departments promptly to enable The Plan to comply with federal and Florida laws governing grievances and appeals and complaint investigation. Only those records for the time period designated on the request should be sent. A copy of the request letter should be submitted with the copy of the record. The submission should include test results, office notes, referrals, telephone logs and consultation reports.

Medical Record Alteration or Falsification
Alteration or falsification of medical records is unethical conduct for any medical professional. Any incident relating to unethical behavior regarding medical record documentation is subject to the following process:
1. All incidents of possible medical record falsification are reported to The Plan’s Peer Review Committee and the Special Investigation Unit (SIU).
2. The Peer Review Committee reviews the records in question and allows the Provider to explain the circumstances.
3. The Peer Review Committee makes the final decision regarding the allegations of unethical conduct and takes appropriate actions.
4. Health professionals not subject to the peer review process (nurse, lab personnel, etc.) may be reported to the appropriate agency and/or governing body.

3.17 CMS REQUIREMENTS

Please be advised that all communication to Advantra Members requires prior approval by CMS.

Advantra has various CMS-approved materials that can be made available to Providers to announce participation with the Advantra program. Please contact the Advantra Marketing Department if there is an interest in pursuing any communication to Advantra Members regarding the Advantra program.

Advantra Personal Health Profiles
All new Advantra Members are sent an Advantra Personal Health Questionnaire within the first 90 days of enrollment. The questionnaire is to be completed by the Member and is then sent back to Advantra.
The form asks the Member a number of questions specific to the Member’s medical history, as well as questions about lifestyle. The form is also used to educate Members about the use of Advantra contracted Providers and to transition Members into receiving services from contracted Providers.

Advantra requests the Member discuss his/her Personal Health Questionnaire with his/her PCP. The information from the Personal Health Questionnaire will assist the PCP or Specialist in providing direction regarding the Member's health needs and potential treatment options. This exchange will allow the Member to participate in the development of their own treatment plan. Advantra will also assist in the coordination of care for complex or serious disease cases with the PCP or Specialist, will inform Members of any follow-up care, and provide training in self-care through the Case Management or Disease Management Program.

**Laws and Regulations**

All Advantra Providers must comply with applicable Medicare laws and regulations, including but not limited to, Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, the Rehabilitation Act of 1973, and other laws applicable to recipients of Federal funds.

Providers should provide services to Advantra Members without regard to 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, source of payment, or any other classification prohibited by Law.

Advantra’s policy, as well as Federal Law, states that no form of discrimination prohibited by Law will be permitted on the basis of sex, race, color, disability, age, religion or ethnic origin, and that all Members will have access to their medical services at all contracted provider facilities.

**Member Access to Care and Information from Advantra Providers**

Advantra Members have the right to get timely access to Advantra Providers and to all services covered by Advantra. “Timely access” means that Members get appointments and services within a reasonable period of time. Members have the right to get full information from their doctors when they get medical care. Members have the right to participate fully in decisions about their health care, which includes the right to refuse care.

If HMO/POS Members need to talk with their PCP or get medical care when their PCP’s office is closed, and it is not a medical emergency, the Member should call the PCP number listed on their HMO/POS Advantra Membership card. There will always be a doctor on call 24 hours a day, 7 days a week, to help them.

**Disclosure of Information**

At the request of Advantra or CMS, the Provider shall disclose all information necessary to (1) administer and evaluate the program, to include quality performance indicators and information regarding Members’ satisfaction and health outcomes; and (2) establish and facilitate a process for current and prospective beneficiaries to exercise their right to choose Medicare services.
Continuation of Benefits
Provider shall continue to provide covered services to Advantra Members who are hospitalized on the date the CMS contract terminates or expires, or if HealthAmerica becomes insolvent, through the date of each Advantra Member’s discharge or for the remainder of the period for which the Member’s Medicare premium has been paid.

External Review
Provider agrees to cooperate with all independent quality review and improvement organization activities required by CMS and/or Advantra pertaining to the provision of services for Advantra Members.

Plan Provider Termination Notices
The MA Organization must make a good faith effort to notify Members of the termination of a Provider’s contract 30 days before the termination is effective. Providers must follow the termination provision as defined in their contracts to ensure timely notification.

Advantra will notify Providers in writing of the reason(s) for any denial, suspension or termination of the Provider’s participation in the provider network.

When contracted Providers choose to opt out of Medicare or sanctions are taken against that Provider, Advantra will take immediate steps to terminate that Provider’s contract with Advantra.

Compliance with Medical Management
Providers must agree to comply with the Advantra’s Medical policies, QI and Medical Management Programs, and adhere to appeals/grievance procedures.

3.18 MEDICARE PART D

What Drugs are Covered by Medicare Drug Plans?
Advantra drug plans must make sure the members can get medically-necessary drugs to treat their conditions. Advantra prescription drug coverage uses an approved drug list also known as our Formulary. This formulary covers both generic and brand name prescription drugs that must be approved by the FDA (Food and Drug Administration) as safe and effective.

The Formulary includes a range of drugs in the prescribed categories and classes. This range makes sure that people with different medical conditions get the treatment they need. To have lower costs, Advantra plans place drugs into different “tiers,” which cost different amounts.

Prior Authorization (PA)*
Advantra requires Providers to get prior authorization for certain drugs listed on our Formulary. This means a Provider will need to get approval from Advantra before prescriptions can be filled for Advantra Members. If an approval is not obtained, the drug may not be covered.
Quantity Limits
For certain drugs, Advantra limits the drug units covered per prescription or for a defined period of time. For example, Advantra will provide up to 4 units per prescription for FOSAMAX per 30 days. If the medication is listed on the Quantity Level Limitations (QLL) Lists, then no action is needed. Medications on the QLL are identified as once daily.

Step Therapy (ST)*
In some cases, Advantra requires Members to first try certain drugs to treat medical conditions before it will cover another drug for that condition. For example, if Drug A and Drug B both treat a certain medical condition, Advantra may require the Provider to prescribe Drug A first. If Drug A does not work for the patient, Advantra will then cover Drug B. Additional requirements or limits on certain drugs can be found on the Advantra Formulary, which can be obtained from your Provider Services Representative.

*For those medications listed on the Prior Authorization (PA) and Stepped Therapy (ST) Lists, the pharmacy system will automatically allow a “first fill” without action needed by the Provider. An automatic temporary “first fill” of 30 days will be dispensed so the Member will be stabilized during the transition and will allow the Member time to contact the prescribing Provider (prescriber) to request approval if treatment is necessary beyond the “first fill” supply. After the 30-day first fill, the Member and the Provider will be required to follow the normal process for requesting prior authorizations and medical necessity review, step therapy, or exception processing. Decisions on transitions will appropriately address situations involving the Member’s need to be stabilized on drugs not on Advantra’s formulary and that have known risks associated with any changes in the prescribed regimen.

To request Prior Authorization or to place a Member in Step Therapy, the prescribing Provider should:

1. Call 1-800-290-0190 between 7 a.m. – 6 p.m., Monday – Friday, and provide the following Information:
   • Member’s full name
   • Member’s Advantra Member ID number
   • Requested Drug
   • Reason for the request
2. After hours, the prescribing Provider should call Express Scripts, Advantra’s pharmacy benefits manager (PBM) at 1-866-823-5178. Depending on the situation, Express Scripts will either grant a 72 hours fill or contact the on-call pharmacist.

Exception – Medicare Prescription Drug Coverage Determination
Under the Medicare Advantage Part D (MA-PD) prescription drug benefit program for both Advantra RX and First Health RX Part D, a Member or Provider can ask Advantra to make an exception to restrictions or limits. There are several types of exceptions:

• Cover a drug even if it is not on the Formulary
• Waive coverage restrictions or limits on drugs
• Provide a higher level of coverage for the drug
Please contact Advantra to ask for an initial coverage decision for a formulary, tiering or utilization restriction exception. Providers should submit a statement supporting this request. Generally, Advantra must make their decision within 72 hours of getting the prescribing Provider’s supporting statement. An expedited exception is an option if the patient or the Provider believes the patient’s health can be seriously harmed by waiting up to 72 hours for a decision. If a request for an expedited review is granted, Advantra must provide a decision no later than 24 hours after getting the prescribing Provider’s supporting statement.

A Provider Request Form can be found on the www.chcadvantra.com website & choose the “Provider” tab.

A request for a standard coverage determination must be made in writing & mailed to:

    Advantra
    Pharmacy Department
    3721 TecPort Drive
    Harrisburg, PA  17106

    Or may be faxed to: 1-866-738-9682

To request an exception, the prescribing Provider may either call 1-877-215-4100 or fax the request to 1-717-541-5909. Advantra’s hours of operation are 7:00 a.m. to 6:00 p.m. (EST), Monday through Friday.

After hours, Provider may call Express Scripts, Advantra’s pharmacy benefits manager, (PBM) at 1-866-290-6660. The Express Scripts agent will notify the Provider that if the situation is an emergency, the pharmacy provider may enter an override code which will cover a 72 hour supply for the Member. The prescribing Provider may then call the clinical call center once it re-opens to request a long term exception.

If the prescribing Provider requires an immediate response, Express Scripts will contact the Advantra on-call pharmacist, who will respond to the prescriber as quickly as possible. To request an exception, the prescribing Provider needs to provide the following information:

- Member’s full name
- Member’s Advantra Member ID number
- Requested drug
- Reason for the exception

Once an exception request is approved, it is valid for the remainder of the plan year or the length of the therapy authorized, so long as the Provider continues to prescribe the drug, and it continues to be safe and effective for treating the Member’s condition.

Please contact your Provider Services Representative for a copy of the Advantra Formulary or if you need additional information on any of the topics discussed above. Or you can visit our website at www.chcadvantra.com and choose the “Provider” tab.
Part D Appeals Rights

Standard (7 days) – Members can request a standard appeal for a case that involves coverage or payment. The independent reviewer must give the Member a decision no later than 7 days after receiving the appeal.

Expedited (72 hours) – Members can request an expedited appeal for cases that involve coverage if the Member, or the Provider, believes that the Member’s health could be seriously harmed by waiting up to 7 days for a decision. If the Member’s request to expedite is granted, the independent reviewer must make a decision no later than 72 hours after receiving the Member’s appeal.

- If the Provider who prescribed the drug(s) asks for an expedited appeal for the Member, or supports the Member in asking for one, and the Provider indicates that waiting for 7 days could seriously harm the Member’s health, the independent reviewer will automatically expedite the appeal.
- If the Member asks for an expedited appeal without support from a Provider, the independent reviewer will decide if the Member’s health requires an expedited appeal. If the Member does not get an expedited appeal, the appeal will be decided within 7 days.

How do Members request an Appeal?

For an Expedited Appeal: The Member or their appointed representative should contact us by telephone or fax:
Phone: 1-800-290-0190 (TDD 1-800-207-1262)
Fax: 717-526-2789

For a Standard Appeal: The Member or their appointed representative should mail the written appeal to the address below:

Medicare Appeals
Advantra
Attn: Appeals & Grievance Coordinator
3721 TecPort Drive
Harrisburg, PA 17106

What do Members include with their Appeal?
The Member’s name, address, Advantra Member ID number, the reasons for appealing and any evidence they wish to attach. If the appeal relates to a decision not to cover a drug not on the Advantra formulary, the prescribing Provider must indicate that all of the drugs on any tier of the formulary would not be as effective to treat the Member’s condition as the requested off-formulary drug, or that the formulary drugs could be harmful to the Member’s health.

What Happens Next?
When the Member appeals, the independent reviewer will review Advantra’s initial decision. If any of the prescription drugs the Member or Provider requested are still denied, the Member or appointed representative can appeal to an administrative law judge (ALJ) if the value of the
Member’s appeal meets a minimum dollar amount. If the appointed representative or the Member disagrees with the ALJ decision, the Member has the right to further appeal.

3.19 MEDICARE PROVIDER TRAINING AND EDUCATION

We’re pleased to announce that Aetna’s acquisition of Coventry Health Care, Inc. (“Coventry”) is now complete. Aetna and Coventry, as a combined organization, share a commitment to creating mutually beneficial relationships with our First Tier, Downstream, and Related Entities (FDRs). If you are contracted with us to provide administrative and/or health care services for our MA plans, you are considered a “First Tier Entity”. CMS requires that Aetna’s First Tier, Downstream and Related Entities (FDRs) fulfill Medicare Compliance Program Requirements.

CMS rules explain that these arrangements continue down to the level of ultimate provider of both health care and administrative services. So, providers that deliver healthcare services to our Medicare members are considered FDRs. If you subcontract health care or administrative services, those subcontractors are considered Downstream Entities.

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

1. **What requirements apply to FDRs?**

   CMS requires that Aetna’s FDRs fulfill specific Medicare Compliance Program Requirements. We describe those requirements in our *First Tier, Downstream, and Related Entities (“FDR”) Medicare Compliance Program Guide* (FDR Guide). Review the FDR Guide and ensure you have internal processes in place to support your compliance with the requirements. You can find the FDR Guide on www.aetnaeducation.com. Some of the requirements are described below but you should review the FDR Guide and ensure you have process in place to support your compliance with all the requirements. Additionally, you should communicate the Medicare Compliance Program requirements to your Downstream Entities.

2. **General Compliance and Fraud, Waste and Abuse (“FWA”) Training**

   FDRs must provide CMS’ FWA training to employees within 90 days of hiring or contracting, and annually thereafter. CMS’ training is available on the Medicare Learning Network. You can also download it here. You may be exempted from completing training, but only if you are “deemed”. You are considered deemed if you participate in traditional fee-for-service Medicare OR are accredited as a durable medical equipment, equipment, prosthetics, orthotics and supplies.

   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 within 90 days of hiring or contracting 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.
3. General Compliance Training
   Effective 1/1/2016, FDRs must provide CMS’ General Compliance training to employees within 90 days of hiring or contracting, and annually thereafter. CMS’ training is available on the Medicare Learning Network.

4. Code of Conduct/Compliance Policies
   FDRs must distribute a code of conduct and/or compliance policies to employees within 90 days of hire or contracting, when updates are made, and annually thereafter. You can provide either Aetna’s Code of Conduct and Compliance Policies, or your own comparable code of conduct or compliance policies, to your employees and Downstream Entities that support Aetna’s Medicare Plans.

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

6. 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). Prior to hire or contracting, and monthly thereafter, FDRs must screen their employees and downstream entities against these lists.

7. 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.

8. 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.

9. Make sure you maintain documentation
   You are required to maintain evidence of your compliance with the Medicare compliance program requirements for no less than 10 years. This evidence may be in the form of attestations, training logs, or other means determined by you to best represent fulfillment of your obligations. Aetna or CMS may request that you provide documentation of your compliance with these requirements.

10. Annual Attestation
    Each year on behalf of your organization, an authorized representative is required to complete the Aetna Medicare Compliance Attestation. In addition to completing an attestation, Aetna and/or CMS may request you provide evidence of your compliance with these Medicare Compliance Program requirements.

11. Aetna and Coventry (dually contracted) providers:
    If you’re contracted with both Aetna and Coventry, and have never used NaviNet, we suggest you log in or register today by visiting https://connect.navinet.net/. Once you log in, go to the Aetna Plan Central. On the left, hover over “Compliance Reporting” and then click on “Medicare Attestation.” Submitting an attestation on NaviNet meets both
Aetna and Coventry requirements.

12. **For Coventry-only providers:**
   If you are a Coventry-only provider you need to register and take the annual attestation by:
   
   - Visiting [www.aetnaeducation.com](http://www.aetnaeducation.com).
   - Typing “attestation” in the search box and click “GO.”

   To complete your attestation, log in or register on NaviNet at [https://connect.navinet.net/](https://connect.navinet.net/).
   Once you log in, go to Aetna Plan Central. On the left, hover over “Compliance Reporting” then click on “Medicare Attestation.”

13. **Report concerns or questions**
   If you identify noncompliance or FWA, you can report it to Aetna by using the reporting mechanisms outlined in our Code of Conduct. We prohibit retaliation for good faith reporting of concerns.

   If you have questions about the requirements which apply to FDRs, or if you have difficulty finding our FDR Guide, contact the Provider Service Center. The number for MA plans is 1-800-624-0757. You can also email us at MedicareFDR@aetna.com.

14. **Failure to meet these requirements may lead to:**
   
   - Development of a corrective action plan
   - Retraining
   - Termination of your contract and relationship with Aetna

   Our actions in response to non-compliance will depend on the severity of the compliance issue. If an FDR identifies areas of non-compliance (e.g., refusal of an employee to complete the required FWA training), they must take prompt action to fix the issue and prevent it from happening again.

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.

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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.

4. COMMUNICATIONS AND ELECTRONIC SERVICES

4.1 DIRECTPROVIDER.COM

Directprovider.com is the secure provider portal available to providers to access relevant information for your practice or facility that cannot be obtained through the public HealthAmerica website. There are multiple functionalities available to the provider after website registration is completed, many of which are listed below.

Training dates and times for this website are available at www.healthamerica.cvty.com > Providers > Electronic Solutions/User Support and Training. Training is available by sending an email with “Directprovider.com Training” in the subject line. In the email, indicate which of the available training dates you wish to attend to the following address: TrainingNetworkManagement@cvty.com. All training is conducted on-line via Microsoft Live Meeting.

Additional training on this website is available upon request with your applicable Provider Relations Representative.

**Key Features**
- Claim Payment
- Claim History
- Member Eligibility
- Member Benefits
- Member Primary Care Physician History
- Remittance Advices (PDF format)
- Authorization Requirements (InterQual® Smart Sheets)
- Member ID Cards (PDF Format)
- Secure Messaging

**Online Claims Adjustment Requests**
- Authorization Lookup
- Authorization Submission

4.1.1 How Do I Customize My Favorite Provider List?

The Provider Drop-Down Box contains your “Favorites List” of providers—the providers that you use most frequently according to what you set-up when you first logged-in to directprovider.com. You have the ability to customize—add or remove—providers from your Favorite Provider List at any time by clicking the Edit button next to the health plan drop-down box (click here for example screen print in this section below.)
Adding Providers to Your Favorites List

1. In Step 1, select the appropriate healthplan product from the drop-down box.
2. The list of providers that appears in Step 2 contains all of the providers that are participating providers for that product. A provider may be listed more than once if that provider has ended participation with Coventry and then begun participation again. The Start and End dates will indicate which provider entry is the most current. Place a check mark in the boxes in the far right column to indicate which providers you work with. If you work with all of the providers in your group, you can click Select All and a check mark will be placed next to each provider.
3. Click the Add button. The providers that you have indicated with check marks have now moved to your Favorites list in Step 3.

Removing Providers From Your Favorites List

To remove providers from your Favorites list, review your provider list in Step 3, check the boxes for the providers that you want to remove, and then click the Remove button.

Returning To The Home Page

Once you are satisfied with the providers that appear on your list, click the Done button. You will be taken to the home page and can begin using directprovider.com. You can always return to your Favorite Provider List set-up screen by clicking the Edit button that appears next to the health plan drop-down box on all of the screens in directprovider.com.
**Favorite Provider List**

Modify your existing Favorites List(s) by adding or removing providers.

**Note:** Providers that are new to your practice will not be available for selection until a health plan has assigned them an identification number.

On September 18, 2006 everything corporate will be labeled the Coventry National Network. However, the Coventry National Network is not currently on directprovider.com nor do we anticipate integrating that component until 2008.

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**Step 1: Select A Tax ID**

Your favorites list is different for each tax identification number. Please select a tax identification number for this list:

**Tax ID:**

251838458

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**Step 2: Select A Health Plan**

Your favorites list is different for each health plan. Please select a health plan for this list:

**Health Plan:**

Advantra Freedom

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**Step 3: Add Providers**

There are 456 providers available for Advantra Freedom. To add providers to your Favorites list, check the boxes for the providers you want to add, and then click the Add button.

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Provider Number</th>
<th>Start Date</th>
<th>End Date</th>
<th>Select All</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGH ELECTROPHYSIOLOGY</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. AGH ELECTROPHYSIOLOGY</td>
<td>223071</td>
<td>04/01/2002</td>
<td>04/01/2002</td>
<td></td>
</tr>
<tr>
<td>2. ACEVEDO MD, CELSO</td>
<td>249256</td>
<td>08/13/2003</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AGH CARDIOLOGY</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. AGH CARDIOLOGY</td>
<td>223055</td>
<td>04/01/2002</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. ACHOI MD, SAMFR</td>
<td>261695</td>
<td>01/01/2000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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**Step 4: Review Your Favorites List**

Your favorites list for tax ID number 251838458 and Advantra Freedom contains 2 providers. To remove providers from the list, check the boxes for the providers you want to remove, and then click the Remove button.

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>Provider Number</th>
<th>Start Date</th>
<th>End Date</th>
<th>Select All</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGH ELECTROPHYSIOLOGY</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. BONNET MD, CHRISTOPHER A</td>
<td>236968</td>
<td>04/01/2002</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. CHENARIDES MD, JOHN</td>
<td>236984</td>
<td>04/01/2002</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4.1.2 Online Authorization Requests

The Authorization Online Submission functionality allows providers to submit a new authorization by entering Member information, provider information, diagnosis and procedure codes, detailed comments, as well as attaching documents to support the authorization request. The submitter also has the opportunity to review the authorization prior to submitting.

Check with your directprovider.com account administrator to gain access to the Authorization Submission function. If you do not have an account administrator, you can register your facility at www.directprovider.com

(Click on the Online Help Button to access the directprovider user guide)
4.1.3 Attaching Files in Directprovider.com Secure Messaging

Within directprovider.com, providers can send files along with their messages to Coventry through Secure Messaging. Some of the most popular reasons to send an attachment are as follows:

- Claim Adjustment Request
- Authorization Update
- Authorization Reconsideration

Providers can submit up to 4 files as long as the combined size does not exceed 5 MB, and submitting files through directprovider.com is secure so you can send personal health information (PHI) directly to our customer service representatives. There is no longer any need to fax many of these documents or send them in the mail.

**Claim Adjustment Request**
This function allows users to request that a denied claim be reviewed and re-processed for reasons such as proof of timely filing, EOB, or medical records needed. Users simply click “Request Adjustment” on the claim detail screen and securely attach any records or files needed. The “Request Adjustment” should not be used if a claim needs to be re-filed due to a correction such as a change in CPT codes or diagnosis codes. These claims should be resubmitted.

**Authorization Update or Reconsideration**
For authorizations that have been denied or are pending for additional information, providers have the ability to attach medical notes and additional information that will support their need for a change in the authorization status. Authorization Reconsiderations should always be used prior to requesting an appeal since, in many instances additional information is all that is needed to change the status of an authorization.

For additional information visit [www.directprovider.com](http://www.directprovider.com). You will find a complete user’s guide, Computer Based Training (CBT), an extensive help section, and our Net Support phone number. You can also visit [www.healthamerica.cvty.com](http://www.healthamerica.cvty.com) click the Provider section and click the directprovider.com logo to get updates on our free monthly webcast training sessions, or call your Provider Relations Representative for more information.
Coventry Consumer Choice (C3) is Coventry Health Care’s full suite of consumer-directed health plan options. To better serve you and our Members, HealthAmerica has added the C3 benefit information on the eligibility screen in directprovider.com.

This new feature will demonstrate:

- C3 deductible accumulator information
- Available balances
4.1.5 Mail Handlers Benefit Plan Information is Available on Directprovider.com

Directprovider.com users can select ‘Mail Handlers Benefit Plan’ from the payer drop-down menu and will gain the same access to everyday healthcare transactions they have experienced with the other Coventry payers including:

Eligibility & Benefits
Member ID cards
Claims History & Status
Authorization (Inquiries Only)
Online Remittance Advices ...and more

NOTE:

1) Member ID cards are issued with 11 digit numeric Member numbers. Directprovider.com users will need to utilize the 11digit ID number for Eligibility searches or choose another available search option.

2) Claim History is available for MHBP claims submitted after 8/28/08. History/Status information is available to view for claims submitted after 6/1/2008.

3) Online Remittance Advice is available for MHBP claims finalized after 9/15/2008.

Directprovider.com is our one-stop website available for all Coventry plans, with functionality that also includes Secure Messaging capability into our Customer Service Organization (CSO), a News Section for important Coventry communications, and access to Coventry health plan specific documentation through its Resource Library.

Directprovider.com users have automatic access to MHBP eligibility but will have to add/set up their providers to access MHBP claims or online remittance advice through the ‘Edit’ function on the ‘Home’ page, as they do when adding other Coventry payers.

If you have any questions about accessing Mail Handlers information call the directprovider.com Helpdesk @ 1-866.629.3975.
4.1.6 Medical Criteria Search Functionality Through the Resource Library on Directprovider.com

The Medical Criteria section within the Resource Library is available through our FREE secure provider portal, directprovider.com. Medical criteria documents are used by Coventry Utilization Management to determine what conditions must be met for certain procedures to be considered medically necessary, which may require prior authorization, dependent on the Member benefits.

When users select the Transparency link within the Medical Criteria tab of the Resource Library, a new browser window opens and establishes a 'Single Sign On' directly into the McKesson CERMe (Care Enhanced Review Manager Enterprise) web application, in a read-only access, book view format. Users will no longer see the individual InterQual/SmartSheets/Medical Criteria PDFs, or have to worry if the document is the most current available. On CERMe, Users will have real-time access to search for all applicable InterQual products, along with the specific Categories for each, as well as perform either Keyword(s) and/or Medical Code(s) searches within the chosen criteria. With this new application, Users can be confident they are reviewing the most current explanations and instructions that apply and still be able to access the individual InterQual/SmartSheets if/when needed.

Upon selecting the link from the Medical Criteria tab, the User follows 4 simple steps for search:

1) Select an InterQual Product
2) Select a Category
3) Click on the link for 'Subset Description'
4) To start over, click the 'Select a Different Subset' button in the upper left hand corner of screen/site.

NOTE: Existing Users will be required to 'Accept' the disclaimer from Coventry and McKesson upon selecting the Medical Criteria tab for utilization purposes the first time using the application.

4.1.7 Change Healthcare/Emdeon

Change Healthcare/Emdeon

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

**Services available through Change Healthcare/Emdeon:**
By logging onto Change Healthcare/Emdeon and selecting the Coventry HealthCare – Health America/Health Assurance of Pennsylvania plan, you can perform the following:

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

**Other Electronic Solutions**
HealthAmerica also provides other electronic solutions to our providers.

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

The 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.
4.2 PROVIDER LITERATURE AND PUBLICATIONS

**Facility Connections**
HealthAmerica Provider Relations provides notices and policy updates which are sent via email to facility-type providers.

**Friday Fax**
This Provider Relations communication provides notices and policy updates which are sent via email or fax to physician and practitioner offices.

**Newsletters**
This is a periodic HealthAmerica communication which keeps all providers current on updates in all areas such as policies, procedures, and claims submission information.

If you would like to receive one or more of these publications by email or fax, please contact your Provider Relations representative directly or call 1-800-735-2202 to provide your current contact information.

4.3 MEMBER LITERATURE AND PUBLICATIONS

**Member Guide**
HealthAmerica Member Guides are written and designed for our Members in a Member-friendly format to take the Member through the process of accessing benefits. Major emphasis is placed on readability and understanding of benefits.

**Member Newsletters**
HealthAmerica has Member publications, *Living Well* for commercial Members and *Good Times* for Medicare Members. These publications follow a magazine format and emphasize wellness and early intervention. Our Plan customizes the specific pages and related topics in addition to Plan updates and policies.

Upon enrolling in HealthAmerica, all Members receive a copy of their product specific Member Guide and applicable legal documents outlining benefits. Identification cards are mailed separately. The Member newsletters are mailed directly to the policyholder’s home.

**Surveys**
… Routine surveys are mailed to Members periodically throughout the year.

… A Member satisfaction survey is conducted annually.

… PCP-specific Member satisfaction surveys are conducted
5. GENERAL PROVIDER INFORMATION

5.1 INFORMATION FOR ALL PROVIDER TYPES

Start the application process today

You’re joining a large national network of doctors and hospitals. Our goal is to help you give your patients the highest quality, safest and most cost-efficient care.

Here’s what we have for you:

- Experience to understand your needs
- Online tools to reduce administrative tasks for you and your staff
- Convenient, 24/7 access to your secure provider website

Understand 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.

Thank you for choosing HealthAmerica/Aetna.

Apply to join the network
Read our join the network FAQs

5.2 HOSPITALS

Hospital Employed Physicians:
Facility-based providers who practice exclusively within a network facility and who provide care for Members only as a result of Members being directed to that facility do not require credentialing, but will be required to provide the information on the Facility Information Form. Types of facilities where these providers provide care to Members as covered by this policy include: inpatient facilities; freestanding mammography centers; freestanding urgent care centers; freestanding surgi-centers; and freestanding ambulatory behavioral health centers.

Facility-based providers who maintain a separate practice outside of the facility or who are solely hospital-based but provide direct patient services based on referrals to them individually require full credentialing.

Claims Reconsideration:

Click here for link to timely filing grid or refer to section 8.15.2.

Hospital Facility Hierarchy of Service Policy
Surgical episodes are primary if reported on the same claim as observation or emergency room. Observation services are primary if reported on the same claim as emergency room. Emergency room reimbursement terms are applied when the outpatient encounter is for emergency room services only. Reimbursement is not made separately for each type of service.

The hierarchy of services for hospital outpatient claims where more than one of these service types are billed on the same claim is as follows:

1) Surgery
2) Observation
3) Emergency Room

By way of example:

**Example A:**

Patient presents to the hospital's emergency room with a head injury and is admitted to observation for monitoring over the next 12 hours.

In this example, the primary service is observation. The claim is determined to be an outpatient observation claim. Observation reimbursement terms in the Hospital Agreement are applied. Emergency Room reimbursement terms are not applied.

**Example B:**

Patient presents to the hospital’s emergency room with severe stomach pain. The clinical decision is that an emergency appendectomy is required and the patient is admitted for outpatient surgery.

In this example, the primary service is surgery. The claim is determined to be an outpatient surgery claim. Outpatient surgery reimbursement terms in the Hospital Agreement are applied. Emergency room reimbursement terms are not applied.

**Example C:**

Patient presents to the emergency room with wrist and arm pain due to a fall. The patient receives required clinical work up in the emergency room and the final diagnosis is that the patient has suffered a fractured wrist. The patient is provided with self care at home information and follow up instructions, etc., and is discharged home from the emergency room.

In this example, the primary service is emergency room. The claim is determined to be an outpatient emergency room encounter. Assuming that care has met the emergency service requirement under the plan and/or prudent layperson standards, the emergency room reimbursement terms in the Hospital Agreement are applied.

**NOTE:** Policy does not supersede contract language

[Click here](#) for link to Medical Management Policies or refer to Chapter 7.
Click here for link to UB billing policies and practices or refer to section 8.3. For most current Prior Authorization List, click on the following link:

5.3 PHYSICIANS

5.3.1 Office Visits - HMO, PPO, POS, and Advantra:

Occasionally a new Member will request a medical service prior to receiving their HealthAmerica identification card. Under this circumstance, the Member may present the (yellow) copy of their HealthAmerica enrollment application as temporary identification until their new identification card is received in the mail. Final determination of eligibility will occur at the time of claim adjudication.

- Ask to see the Member’s identification card.

  If they do not have the card with them:

  Verify eligibility via directprovider.com
  or
  Verify eligibility via Emdeon Office
  or
  Call the Customer Service Organization (CSO) at 1-800-735-4404 to verify eligibility
  or
  Encourage Member to visit HealthAmerica website to obtain a printable version of their ID card.

- If applicable, collect the Member’s office visit co-payment at the time of service.
  Co-payment information can be obtained from the identification card or via directprovider.com  Office visit co-pays vary.

Co-payment may apply to:
- Physician visit for illness/injury
- Consult and diagnosis
- Periodic health exams
- Routine check-up
- Pediatric health exam
- Gynecological care
- Chiropractic care
- Initial prenatal visit
- Emergency care in office
- Family planning consult
- Nurse visits (if billing 99211) – does not apply to immunizations, blood pressure checks, allergy injections, blood draws and when billed in conjunction with chemotherapy administration.
Additional co-payments may apply to the following based on the Members benefit:

- Diaphragm fitting
- Vasectomy
- Tubal ligation
- Infertility services

5.3.2 After Hours Emergency Care

HealthAmerica HMO and POS

- Members are directed to call their Primary Care Physician before seeking care after hours, except in an emergency. An emergency is defined as a medical condition that manifests itself by acute symptoms of sufficient severity or severe pain, such that a prudent layperson who possesses average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention might seriously jeopardize the health of the Member (including the health of an unborn child in case of pregnant woman); cause serious impairment to bodily functions; or serious dysfunction of any bodily organ or part of the Member. **When a Member calls after hours, the on-call physician should respond in one of the following ways:**

  Medically advise the patient over the phone and ask that they call your office in the morning for an appointment.

  Arrange to meet the Member in your office or at the hospital.

  Advise the Member to seek care at an urgent care center or participating hospital emergency department if the condition requires urgent or emergent care.

- **If you receive a call after hours from a Member who has an emergent condition and is out of the area:**

  If warranted, advise the Member to visit an urgent care center or hospital emergency department; or

  If non-emergent or follow-up care, advise the Member that routine care is not covered out of the area.

HealthAmerica (PPO)

- Members are not required to call a Primary Care Physician prior to seeking treatment in an emergency department. If a PPO Member does contact you, please provide them with appropriate medical advice.

5.3.3 Physician Request to Transfer Member Policy

The physician – patient relationship is a personal one and occasionally may deteriorate to the point of being unacceptable to either party. Examples may include patients who have repeatedly missed appointments, demonstrating non-compliance with recommended treatment plans, verbal abuse or physical threats directed at staff or physicians, and refusal to pay required co-
payments or other outstanding balances. In those instances, when it is determined to be in the best interest of the Primary Care Physician and the patient, the physician can request that the patient be transferred to another participating physician.

We ask that the basis used for requesting transfer of a HealthAmerica patient remain consistent with that used for any other patient in your practice. HealthAmerica will support current written office policies as much as possible but offers the following guidelines to use when requesting a Member and/or family be transferred:

1. The physician should send a letter or call the Member at the first onset of the problem. A letter should review the nature of the problem and recommend a course of action to encourage patient/provider rapport. A verbal discussion may also be appropriate and should be documented in the patient’s chart. The physician’s records should clearly document all incidents and efforts to educate the Member and encourage rapport.

2. If the Member continues to present a problem, the physician may request that the Member be transferred out of the practice. A written request sent certified mail for transfer should be directed to the Member and copied to your HealthAmerica Provider Relations Representative. Please include copies of previous correspondence and/or chart notes as documented in Step 1.

- Physicians cannot request patient transfers because of cost or type of medical services required by the patient, poor utilization or physical condition of the patient.
- Transfers must be in accordance with state and federal requirements.
- The current provider must provide urgent or emergency care until the transfer effective date (usually 30 days)

3. Please Note: Members choosing to select a new PCP and therefore requesting transfer of medical records, may be charged the state maximum prices.

5.3.4 Members with Disabilities

HealthAmerica will ensure that no one with a disability is excluded from enrollment, denied services, segregated or otherwise treated differently than anyone else because of the absence of auxiliary aids or services (unless such actions would constitute an ‘undue burden’).

1. HealthAmerica will evaluate and access the population served and will provide readable and easily understood Member information in the language(s) of the major population groups served and as needed in alternative formats for the visually impaired.

2. HealthAmerica will make the following services available to Members who are physically disabled or have sensory disabilities (please see next page entitled “Special Needs Members”):

- Qualified interpreters (i.e. formal arrangements with interpreters who can accurately and fluently express and receive in sign language);
• Assistive listening devices;
• Supplemental hearing devices/telephone handset amplifiers;
• Notetakers;
• Written materials for persons with hearing impairments/flash cards;
• Telecommunications devices for deaf persons (TDD);
• Videotext displays;
• Qualified readers;
• Taped texts;
• Braille or large print materials for persons with visual impairment;
• Member information available at a fifth grade level.

3. HealthAmerica will modify standard letters issued to Members who are known to have disabilities or who are scheduled to attend our offices (e.g., complaint or grievance hearings) to advise them that accommodations will be made for their physical or sensory disability:
• If a Member requires accommodation (without undue burden, which will most likely need to be evaluated on a case-by-case basis with the assistance of counsel), the Business Manager should contact local resources for the sensory disabled to ensure services are available;
• HealthAmerica will periodically advise Members of our procedures for accommodation through Member publications such as the Health Journal/Good Times.

“Special Needs Members”

1. Documents for the blind Members can be ordered from Pittsburgh Vision in Braille. Sample of documents:

• ID Card
• Advance Directive
• Rx and Drug Riders
• Member Summary of Benefits
• Member Co-payment Schedule

2. Cassette tapes can be ordered from Radio Information Services. They produce master tapes, dub master cassettes and ship. Sample of documents:

• Evidence of Coverage
• Membership Handbook

3. TDD line available for the deaf: 1-800-207-1262.
5.3.5 Public Accommodations and Services at Participating Primary Care Physician Offices for Members with Disabilities

HealthAmerica requires participating Primary Care Physician offices to comply with Title III of the Americans with Disabilities Act of 1990 and the Rehabilitation Act of 1973 (Acts) when it is readily achievable (i.e. meaning that barriers can be removed without much difficulty or expense).

1. HealthAmerica provider contracts specify that all providers must be in compliance with applicable state and federal laws.

2. HealthAmerica will verify that participating Primary Care Physician offices that receive an on-site review are compliant with the Acts as part of that process. This will include verification that architectural and communication barriers have been removed and that auxiliary aids and service are provided for Members as needed.

3. If a participating Primary Care Physician’s office has architectural/communication barriers that would significantly impede Member access/effective communication, HealthAmerica will inform the provider of the concern and provide specific recommendations that must be met prior to their next on-site audit for participation/continued participation with the plan.

4. Participating Primary Care Physicians who indicate that they are unable to comply with the recommendations because they are not “readily achievable” will be asked to provide HealthAmerica with a written response supporting this statement.

5. If a participating Primary Care Physician’s office continues to be non-compliant with the Acts and is unable to support their position that this is not “readily achievable”, the provider’s file will be sent to the Credentials Committee for further direction.

6. HealthAmerica will educate all participating providers regarding the requirements under the Acts, as well as the contents of this policy, on an annual basis.

5.3.6 Locum Tenens

Occasionally a medical practice will need to use a Locum Tenens (temporary replacement) physician to meet their day-to-day patient needs.

Here is what you need to know when this situation occurs in your practice:

1. Notify your HealthAmerica Provider Relations Representative in writing, outlining the name of the replacement physician and the dates he/she will be caring for HealthAmerica Members. You may mail your notification to:

   **WPA:**
   Coventry HealthAmerica
   11 Stanwix St.
   Suite 1400
   Pittsburgh, PA 15222

   **NWPA:**
   Coventry HealthAmerica
   11 Stanwix St.
   Suite 1400
   Pittsburgh, PA 15222
2. HealthAmerica Members seen by your Locum Tenens physicians: please bill with the “Q6” modifier.

### 5.3.7 Outpatient Lab Policies

These policies are region specific. Please click on the appropriate link below for the appropriate lab policy.

- **WPA Region (including Lawrence and Mercer counties)** or refer to section 5.4.8.
- **NWPA Region (except Lawrence and Mercer counties)** or refer to section 5.4.8.
- **EPA Region** or refer to section 5.4.8.

### 5.3.8 Radiology Services

Please click on the link below to be directed to the NIA Radiology policy and related information for HealthAmerica:

- **NIA Radiology Policy** or **Cardiology Checklist**, both located in section 5.5.4.

### 5.3.9 ICORE - Provider Administered Drug Program

Please click on the link below to be directed to the ICORE Program information and Quick Reference Guide.

- **ICORE Program** or refer to section 5.5.5.

### 5.4 ANCILLARY PROVIDERS

#### 5.4.1 Chiropractic Services

Chiropractors are licensed practitioners that treat bodily disorders by the manipulation of the spine and other areas of the body.

**Authorization Requirements:** No prior authorization is required for chiropractic services.
General Billing Requirements: Chiropractors should bill using a 1500 form. For more billing information click here to be directed to that portion of the manual or refer to section 8.2.

Please refer to your Provider contract for specific coding/billing guidelines.

Advantra coverage is limited to Chiropractic Manipulative Treatment using CPT codes 98940, 98941, and 98942.

Please contact the Customer Service Organization to confirm Member’s benefits. Members may self-refer to Chiropractors.

5.4.2 Physical Therapy

Authorization Requirements: Providers should contact the Pre-authorization number on members’ ID cards to determine authorization requirements for each member.

General Billing Requirements: Physical Therapists should bill using a 1500 form. For more billing information click here to be directed to that portion of the manual or refer to section 8.2.

Please refer to your Provider Contract for coding/billing guidelines

5.4.3 Facility Based Providers

Facility-based providers practice exclusively within a network facility and provide care for HealthAmerica Members only as a result of Members being directed to that facility. This would include: radiologist, anesthesiologist, pathologists, hospitalists and emergency medicine physicians. Types of facilities where these providers may provide care include: inpatient facilities, freestanding radiology centers, urgent care centers, surgery centers.

Claims should be submitted on the CMS 1500 form under the group name.

5.4.4 Outpatient Laboratory Policy

The Outpatient Laboratory Policy varies by region. Be sure to refer to the policy applicable to your region

Northwestern PA - HEALTHAMERICA/ADVANTRA Outpatient Laboratory Policy

Providers may refer Members or send samples to any participating laboratory provider in Northwestern PA with the exception of providers in Mercer and Lawrence counties. (See the following paragraphs for the WPA Lab Policy for Mercer Counties.)

For the list of Northwestern PA counties click here or refer to Section 1.3.
Western PA - HEALTHAMERICA/ADVANTRA Outpatient Laboratory Policy (Also applies to Mercer County in NWPA)

1. **Laboratory Corporation of America (LABCORP) SHOULD BE USED FOR ALL OUTPATIENT LABORATORY SERVICES.** The few exceptions to this policy are noted below in sections 6 & 7.

2. Routine laboratory analysis performed at LabCorp does NOT require prior authorization however there are some Molecular Diagnostic and Cytogenic Studies that require prior authorization. When ordering tests that fall under either category, please contact HealthAmerica’s Utilization Management to confirm and obtain preauthorization at 1-800-669-2202.

3. Most outpatient laboratory analysis performed at a hospital requires prior authorization, with exceptions as noted below in item numbers 8 & 9.

4. To ensure that patient results are reported to you in a timely manner, a completed LabCorp Request Form **MUST** accompany every patient or specimen that is referred to one of the LabCorp patient service centers. To request account specific requisitions, or other related lab supplies, please contact the LabCorp Customer Inquiry Line at **1-800-331-6981**.

5 If you collect laboratory specimens in your office, these samples should be directed to LabCorp for analysis. To set up an account with LabCorp and to obtain courier services, call **1-800-331-6981**.

1. The following STAT laboratory tests when performed in the physician’s office will be reimbursed for instances in which a stat result is of critical importance. Theses services require that the claim is submitted using a modifier “22”, meet medically necessity criteria, and are billed, coded or bundled in accordance with industry standards.

<table>
<thead>
<tr>
<th>Test</th>
<th>CPT Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBC*</td>
<td>85025</td>
</tr>
<tr>
<td>Hematocrit</td>
<td>85013, 85014</td>
</tr>
<tr>
<td>Hemoglobin</td>
<td>85018</td>
</tr>
<tr>
<td>Glucose</td>
<td>82947, 82948, 82962</td>
</tr>
<tr>
<td>Prothrombin Time</td>
<td>85610</td>
</tr>
<tr>
<td>Urinalysis</td>
<td>81000-81003, 81015</td>
</tr>
<tr>
<td>Urine Pregnancy</td>
<td>81025</td>
</tr>
<tr>
<td>Serum Pregnancy, qualitative</td>
<td>84703</td>
</tr>
<tr>
<td>Blood, occult; feces</td>
<td>82270, 82272, 82274</td>
</tr>
<tr>
<td>Rapid Strep</td>
<td>87880</td>
</tr>
<tr>
<td>Rapid Influenza</td>
<td>87804</td>
</tr>
</tbody>
</table>
Additional Blood Count tests when performed in the physician’s office that will be reimbursed for instances in which a stat result is of critical importance include: 85007, 85008, 85014, 85018, 85027, 85032, 85049.

7. Additional tests that may be reimbursed when performed in the physician office as necessary:

<table>
<thead>
<tr>
<th>Test</th>
<th>CPT Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Metabolic Panel</td>
<td>80048</td>
</tr>
<tr>
<td>Complete Metabolic Panel</td>
<td>80053</td>
</tr>
<tr>
<td>Blood Gases – with O2 Saturation</td>
<td>82805</td>
</tr>
<tr>
<td>Hemoglobin Glycosyated</td>
<td>83036</td>
</tr>
<tr>
<td>Iron Binding Capacity</td>
<td>83550</td>
</tr>
<tr>
<td>Tear Osmolarity</td>
<td>83861</td>
</tr>
<tr>
<td>Assay Body Fluid Acidity</td>
<td>83986</td>
</tr>
<tr>
<td>Blood Smear, peripheral, interpretation by physician</td>
<td>85060</td>
</tr>
<tr>
<td>Bone Marrow smear, interpretation only</td>
<td>85097</td>
</tr>
<tr>
<td>Fibrinolysins or coagulopathy screen</td>
<td>85390</td>
</tr>
<tr>
<td>Platelet, aggregation</td>
<td>85576</td>
</tr>
<tr>
<td>Immunoelectrophoresis</td>
<td>86320</td>
</tr>
<tr>
<td>Skin Test; tuberculosis</td>
<td>86580</td>
</tr>
<tr>
<td>Gram Stain</td>
<td>87205</td>
</tr>
<tr>
<td>Wet Prep</td>
<td>87210</td>
</tr>
<tr>
<td>KOH Test</td>
<td>87220</td>
</tr>
<tr>
<td>Semen Analysis</td>
<td>89300</td>
</tr>
<tr>
<td>Sperm Evaluation</td>
<td>89330</td>
</tr>
</tbody>
</table>

8. The following tests may be performed at the hospital, and do not require a separate prior authorization: Blood banking, glucose tolerance testing, RH Factors, Semen analysis, Sperm evaluation, Fine needle aspiration, rapid influenza, rapid RSV, pediatric bilirubin and L/S Ratio.

9. Pre and Post-Op testing should continue to be performed at the hospital facility where the procedure will take place, and does not require prior authorization.

10. LabCorp offers a secure electronic result delivery service entitled “e-Results”. This web-based application is available free of charge and allows providers quick and easy access to preliminary and final patient results. For more information on e-results, please refer one of the following methods:

   • Contact your local LabCorp representative at 1-800-331-6981.
   • Submit an on-line request form by visiting the Healthcare Providers Section on www.labcorp.com. Select the “Connectivity” link and scroll down the web-based solutions page to find the e-results on-line form.

11. Additional questions regarding this policy should be directed to your Provider Relations Representative.

To locate LabCorp patient service centers, please refer to one of the following methods:
A lab locator can be found on LabCorp's website, www.labcorp.com/locator, electronic appointment scheduling is offered where available.
Phone toll free at 1-888-LABCORP (522-2677)

Remind Members to always confirm locations through LabCorp and present their HealthAmerica card when seeking services.

Quest
Outpatient Laboratory Network

HealthAmerica POS, HealthAmerica PPO and Advantra PPO Members can access LabCorp and Quest Diagnostics for outpatient laboratory services.

HealthAmerica HMO and Advantra HMO Members are required to utilize LabCorp exclusively.

Central and Southeast Pennsylvania
HEALTHAMERICA/ADVANTRA Outpatient Laboratory Policy

1. If you collect laboratory specimens in your office, these samples should be directed to a participating laboratory for analysis. Quest Diagnostics, LabCorp or HealthNetwork must be utilized for all laboratory services.

2. HealthAmerica expanded the number of lab tests for which physicians will be reimbursed when performed in the provider’s office to include all current CLIA-waived codes. Please reference the attached list of codes. If your contract with HealthAmerica does not include reimbursement for the CLIA-waived codes on the following list, please contact your HealthAmerica representative to discuss adding these codes to your HealthAmerica contract.

3. Reimbursement will not be made for any lab test performed in a physician’s office which is not listed on the attached table and the member must be held harmless in accordance with existing provider contracts. Instead, the physician should continue to use the currently contracted HealthAmerica laboratory providers for all other labs.

4. Pre- and post-operative testing should be performed at the hospital facility where the procedure will take place and does not require pre-authorization.

CLIA-Waived and Current HealthAmerica Stat Lab Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0107</td>
<td>CA screen; fecal blood test</td>
</tr>
<tr>
<td>80051</td>
<td>Electrolyte panel</td>
</tr>
<tr>
<td>80061</td>
<td>Lipid panel</td>
</tr>
<tr>
<td>80101</td>
<td>Drug screen, single</td>
</tr>
<tr>
<td>80178</td>
<td>Assay of lithium</td>
</tr>
<tr>
<td>81000</td>
<td>Urinalysis, nonauto w/scope</td>
</tr>
<tr>
<td>81001</td>
<td>Urinalysis, auto w/scope</td>
</tr>
<tr>
<td>81002</td>
<td>Urinalysis nonauto w/o scope</td>
</tr>
<tr>
<td>81003</td>
<td>Urinalysis, auto, w/o scope</td>
</tr>
<tr>
<td>81007</td>
<td>Urine screen for bacteria</td>
</tr>
<tr>
<td>81015</td>
<td>Microscopic exam of urine</td>
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<tr>
<td>81025</td>
<td>Urine pregnancy test</td>
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<tr>
<td>82010</td>
<td>Acetone assay</td>
</tr>
<tr>
<td>82044</td>
<td>Microalbumin, semiquant</td>
</tr>
<tr>
<td>82055</td>
<td>Assay of ethanol</td>
</tr>
<tr>
<td>82270</td>
<td>Occult blood, other sources</td>
</tr>
<tr>
<td>82271</td>
<td>Occult blood, feces, single</td>
</tr>
<tr>
<td>82272</td>
<td>Blood occult peroxidase</td>
</tr>
<tr>
<td>82274</td>
<td>Assay test for blood, fecal</td>
</tr>
<tr>
<td>82465</td>
<td>Assay, bid/serum cholesterol</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>82523</td>
<td>Collagen crosslinks</td>
</tr>
<tr>
<td>82565</td>
<td>Assay of creatinine</td>
</tr>
<tr>
<td>82570</td>
<td>Assay of urine creatinine</td>
</tr>
<tr>
<td>82679</td>
<td>Assay of estrone</td>
</tr>
<tr>
<td>82947</td>
<td>Assay, glucose, blood quant</td>
</tr>
<tr>
<td>82948</td>
<td>Reagent strip/blood glucose</td>
</tr>
<tr>
<td>82950</td>
<td>Glucose test</td>
</tr>
<tr>
<td>82951</td>
<td>Glucose tolerance test (GTT)</td>
</tr>
<tr>
<td>82952</td>
<td>GTT-added samples</td>
</tr>
<tr>
<td>82962</td>
<td>Glucose blood test</td>
</tr>
<tr>
<td>82985</td>
<td>Glycated protein</td>
</tr>
<tr>
<td>83001</td>
<td>Gonadotropin (FSH)</td>
</tr>
<tr>
<td>83002</td>
<td>Gonadotropin (LH)</td>
</tr>
<tr>
<td>83013</td>
<td>Helicobacter pylori breath test</td>
</tr>
<tr>
<td>83014</td>
<td>Helicobacter pylori drug test</td>
</tr>
<tr>
<td>83026</td>
<td>Hemoglobin, copper sulfate</td>
</tr>
<tr>
<td>83036</td>
<td>Glycosylated hemoglobin test</td>
</tr>
<tr>
<td>83037</td>
<td>Glycosylated hb, home device</td>
</tr>
<tr>
<td>83518</td>
<td>Immunoassay, dipstick</td>
</tr>
<tr>
<td>83605</td>
<td>Assay of lactic acid</td>
</tr>
<tr>
<td>83718</td>
<td>Assay of lipoprotein</td>
</tr>
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<td>83721</td>
<td>Assay of blood lipoprotein</td>
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<tr>
<td>83880</td>
<td>Natriuretic peptide</td>
</tr>
<tr>
<td>83986</td>
<td>Assay of body fluid acidity</td>
</tr>
<tr>
<td>84443</td>
<td>Assay thyroid stim hormone</td>
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<tr>
<td>84450</td>
<td>Transferase (AST) (SGOT)</td>
</tr>
<tr>
<td>84460</td>
<td>Alanine amino (ALT) (SGPT)</td>
</tr>
<tr>
<td>84478</td>
<td>Assay of triglycerides</td>
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<tr>
<td>84520</td>
<td>Assay of urea nitrogen</td>
</tr>
<tr>
<td>84703</td>
<td>Chorionic gonadotropin assay</td>
</tr>
<tr>
<td>84830</td>
<td>Ovulation tests</td>
</tr>
<tr>
<td>85004</td>
<td>Automated diff wbc count</td>
</tr>
<tr>
<td>85007</td>
<td>BI smear w/diff wbc count</td>
</tr>
<tr>
<td>85013</td>
<td>Spun microhematocrit</td>
</tr>
<tr>
<td>85014</td>
<td>Hematocrit</td>
</tr>
<tr>
<td>85018</td>
<td>Hemoglobin</td>
</tr>
<tr>
<td>85025</td>
<td>Complete cbc w/auto diff wbc</td>
</tr>
<tr>
<td>85027</td>
<td>Complete cbc, automated</td>
</tr>
<tr>
<td>85032</td>
<td>Manual cell count, each</td>
</tr>
<tr>
<td>85060</td>
<td>Blood smear, peripheral, interpretation</td>
</tr>
<tr>
<td>85097</td>
<td>Bone Marrow, smear interpretation</td>
</tr>
<tr>
<td>85311</td>
<td>Blood platelet aggregation</td>
</tr>
<tr>
<td>85576</td>
<td>Prothrombin time</td>
</tr>
<tr>
<td>85610</td>
<td>Prothrombin time, sub, plasma fractions</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td>85651</td>
<td>Rbc sed rate, nonautomated</td>
</tr>
<tr>
<td>85730</td>
<td>Thromboplastin time, partial</td>
</tr>
<tr>
<td>86294</td>
<td>Immunoassay, tumor, qual</td>
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<tr>
<td>86308</td>
<td>Heterophile antibodies</td>
</tr>
<tr>
<td>86318</td>
<td>Immunoassay, infectious agent</td>
</tr>
<tr>
<td>86403</td>
<td>Particle agglutination test</td>
</tr>
<tr>
<td>86580</td>
<td>Skin test, tuberculosis, intradermal</td>
</tr>
<tr>
<td>86618</td>
<td>Lyme disease antibody</td>
</tr>
<tr>
<td>86701</td>
<td>HIV-1</td>
</tr>
<tr>
<td>86703</td>
<td>HIV-1/HIV-2, single assay</td>
</tr>
<tr>
<td>86707</td>
<td>Culture aerobic identify</td>
</tr>
<tr>
<td>87081</td>
<td>Culture screen only</td>
</tr>
<tr>
<td>87205</td>
<td>Smear, gram stain</td>
</tr>
<tr>
<td>87210</td>
<td>Smear, wet mount, saline/ink</td>
</tr>
<tr>
<td>87220</td>
<td>Tissue exam for fungi</td>
</tr>
<tr>
<td>87430</td>
<td>Strep a ag, eia</td>
</tr>
<tr>
<td>87449</td>
<td>Ag detect nos, eia, mult</td>
</tr>
<tr>
<td>87480</td>
<td>Candida, dna, dir probe</td>
</tr>
<tr>
<td>87510</td>
<td>Garnerella vaginalis, amplified probe</td>
</tr>
<tr>
<td>87797</td>
<td>Infectious agent detection by DNA RNA</td>
</tr>
<tr>
<td>87804</td>
<td>Influenza assay w/optic</td>
</tr>
<tr>
<td>87807</td>
<td>Rsv assay w/optic</td>
</tr>
<tr>
<td>87880</td>
<td>Strep a assay w/optic</td>
</tr>
<tr>
<td>88172</td>
<td>Cytopathology, evaluation of fin needle aspirate</td>
</tr>
<tr>
<td>88173</td>
<td>Cytopathology, evaluation of fin needle aspirate interpretation</td>
</tr>
<tr>
<td>89261</td>
<td>Complex prep</td>
</tr>
<tr>
<td>89300</td>
<td>Semen analysis w/huhner</td>
</tr>
<tr>
<td>89330</td>
<td>Evaluation, cervical mucus</td>
</tr>
</tbody>
</table>

Codes listed in bold font are lab procedures which can be performed in your office according to current lab policy. All remaining codes are the CLIA-waived codes. Please refer to number two above.

### 5.4.5 Durable Medical Equipment (DME) & Home Health Services

**Western PA & Northwestern PA** – Both WPA and NWPA utilize a network manager to contract and maintain DME and Home Health providers. Refer to the RX Healthcare description in the Network Administrators and Health Plan Programs section of this chapter in section 5.5.3 or [click here](#) to go to that section.

For the list of Western PA and Northwestern PA counties [click here](#) or refer to Section 1.3.
5.4.6 Free Standing Radiology

HealthAmerica partners with National Imaging Associates (NIA), an affiliate of Magellan Health Services, to manage and preauthorize non-emergent, high-tech, outpatient radiology services. Click here for the link to the NIA policy for these radiology services or refer to section 5.5.4.

Prior authorization will be required for the following outpatient radiology procedures:

- CT / CTA
- MRI / MRA
- CCTA
- Nuclear Cardiology
- PET Scan
- Nuclear Stress (MPI)
- Echo Stress
- Diagnostic Nuclear Medicine

No retro authorizations will be issued.

Ordering physician can give the Member a script to order all diagnostic imaging. Include authorization number when appropriate. Please provide the following information when calling for prior authorization as follows:

- Ordering physician
- Patient Name
- Patient ID number
- Subscriber’s ID number
- Requested imaging procedure

Prior Authorization guidelines will be posted under the “Prior Authorization Requirements” section of our website and at www.RadMd.com. Key Provisions:

- Emergency room, observation and inpatient imaging procedures do not require authorization.
- The ordering physician must obtain authorization.
- Failure to verify that affected services have been preauthorized may result in non-payment of your claim.

If an emergency clinical situation exists, other than in a hospital emergency room, requiring CT, MRI or MRA studies, you should proceed with the examination and contact HealthAmerica the next business day.

The toll free prior authorization phone number is 1-800-669-2202.
The toll free prior authorization fax number is 1-888-247-4791.

If you are a participating provider that has had a change in your business such as a change in address, additional service locations, or change in services provided, please click the Ancillary Facility Information Form link to complete an updated Provider Information Form, also located in Chapter 10 Appendix, and fax it to the appropriate Network Development as follows:

WPA/NWPA: fax # 1-866-341-8017
EPA: fax #1-866-341-8014
5.4.7 Dialysis

**Authorizations:** Dialysis procedures do not require prior authorization when performed at a participating network facility. However, prior authorization is required for all dialysis services performed at an out-of-network facility.

**Reimbursement**

Items and services related to the treatment of ESRD at an outpatient dialysis facility are reimbursed at a composite rate for all modes of in-facility dialysis, hemofiltration and home dialysis. Under the composite rate, a dialysis facility must furnish all the necessary dialysis services, equipment, and supplies and as such, the cost of all items and services are included under the composite rate unless specifically excluded. **Please refer to your individual facility contract or your Provider Relations Representative for further details regarding the services included in your facility composite rate.**

Refer to Chapter 8 for the Billing and Reimbursement section of the manual for UB/HCFA billing information or [click here.](#)

If you are a participating provider that has had a change in your business such as a change in address, additional service locations, or change in services provided, please click the [Ancillary Facility Information Form](#) link to complete an updated Provider Information Form, also located in Chapter 10 Appendix, and fax it to the appropriate Network Development as follows:

- WPA/NWPA: fax # 1-866-341-8017
- EPA: fax #1-866-341-8014

5.4.8 Ambulatory Surgery Centers (ASCs)

**Authorization:** Services provided in an ambulatory surgery center may or may not require prior authorization. Please contact Medical Management at 1-800-669-2202 to verify if prior authorization is required. Benefit verification may be obtained by contacting the Customer Service Organization or logging onto [www.directprovider.com](http://www.directprovider.com). The prior authorization list is available on the HealthAmerica website at: [http://healthamerica.coventryhealthcare.com/health-care-solutions/network-coverage/pre-authorization-requirements/index.htm](http://healthamerica.coventryhealthcare.com/health-care-solutions/network-coverage/pre-authorization-requirements/index.htm)

If you are a participating provider that has had a change in your business such as a change in address, additional service locations, or change in services provided, please click the [Ancillary Facility Information Form](#) link to complete an updated Provider Information Form, also located in Chapter 10 Appendix, and fax it to the appropriate Network Development as follows:

- WPA/NWPA: fax # 1-866-341-8017.
- EPA: fax #1-866-341-8014
5.4.9 Medical Transportation Providers

The following types of medically necessary transports are generally considered as a covered benefit:

- Ground Ambulance/Advanced Life Support (ALS)
- Ground Ambulance/Basic Life Support (BLS)
- Wheel Chair Van
- Air Ambulance/fixed wing
- Air Ambulance/rotary wing

**Authorization:** Call the pre-certification number on the Member’s ID card to obtain any necessary authorizations for non-emergent transportations.

All ambulance or wheel chair van trips must be medically necessary and be a covered benefit.

**General Billing Requirements:** Medical Transportation providers should bill on a HCFA 1500 unless hospital owned, then they may be billed on a UB 04.

**Transportation/Ambulance providers should always refer to their Provider Agreement to determine if any specific circumstances, coding or billing requirements apply.** For general HCFA billing information [click here](#) to be directed to that section of the manual or refer to Chapter 8.2.

If you are a participating provider that has had a change in your business such as a change in address, additional service locations, or change in services provided, please click the [Ancillary Facility Information Form](#) link to complete an updated Provider Information Form, also located in Chapter 10 Appendix, and fax it to the appropriate Network Development as follows:
- WPA/NWPA: fax # 1-866-341-8017
- EPA: fax #1-866-341-8014

5.4.10 Skilled Nursing Facilities

**Authorization:** Inpatient confinements require authorization. Outpatient services may require authorization. Call the prior authorization number on the Member’s ID card to obtain necessary authorizations.

**General Billing Requirements:** All inpatient and outpatient SNF claims must be submitted on a UB 04 and coded in accordance with the Uniform Billing Expert as published by Ingenix.

**Inpatient:** Room and Board revenue codes are required for all inpatient stays. However, revenue code 0022 that is used primarily by CMS for payment under the CMS prospective payment system may also be required. All inpatient Skilled Nursing Facility care must be prior authorized by HealthAmerica.

**Inpatient Interim Billing:** Interim billing is acceptable for inpatient stays of 30 days or more. SNFs should bill interim claims on a monthly basis, i.e., every 30 days. The appropriate
Type of Bill Code that indicates that the claim is an interim bill is required for all Interim claim submissions.

**Outpatient (also called Part B services)**: Revenue codes must be utilized. CPT/HCPC codes must also be utilized when it is required for them to be billed as indicated within the *Uniform Billing Expert*. Example: Revenue Code 420 requires that a valid physical therapy CPT code be reported as well.

*Helpful Hints for Outpatient Physical Therapy, Occupational Therapy and Speech Therapy Claims that are payable on a Per Visit basis as defined within the Facility Agreement***:

Most HealthAmerica Facility Agreements are paid on a Per Visit basis for Physical Therapy (PT), Occupational Therapy (OT) and Speech Therapy (ST). In order for the Per Visit rate to be paid, PT claims require CPT code 97799 or 97001, OT claims require CPT codes 97139 or 97003 and ST claims require CPT codes 92506 or 92507.

*Skilled Nursing Facility representatives should always refer to their individual Facility Agreement to determine the inpatient and outpatient payment methodology and verify if any specific circumstances, specific coding or specific billing requirements apply.

For additional general UB billing information click here to be directed to that section of the manual or refer to section 8.3.

If you are a participating provider that has had a change in your business such as a change in address, additional service locations, or change in services provided, please click the Ancillary Facility Information Form link to complete an updated Provider Information Form, also located in Chapter 10 Appendix, and fax it to the appropriate Network Development as follows:

**WPA/NWPA**: fax # 1-866-341-8017.

**EPA**: fax #1-866-341-8014

### 5.4.11 Urgent Care Centers

An Urgent Care Center is defined as a location distinct from a hospital, emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

Examples of urgent medical conditions include, but are not limited to:

- Abdominal Pain
- Controlled bleeding
- Flu
- Lacerations (cut or torn skin; wounds)
- Minor fractures
- Objects in the eyes, ears and nose
- Severe headaches
- Sore throat
- Sprain
Referrals are not required for Urgent Care services. Co-payments apply when billed with an E/M service. The Member co-payment is usually less for an Urgent Care visit than if Member would utilize an Emergency Room for services.

**Credentialing Requirements:** HealthAmerica requires the facility to be credentialed but individual physicians do not need to be. Credentialing is based on the facility license, so if the facility has different locations and operate under different license, then each facility would need to complete a facility credentialing application.

**General Billing Requirements:** Urgent Care providers should bill on a HCFA 1500 indicating POS 20 to indicate services were preformed in an Urgent Care facility. The facility NPI should also be indicated on the claim form in box 33.

For general HCFA billing information [click here](#) to be directed to that section of the manual or refer to section 8.2.

If you are a participating provider that has had a change in your business such as a change in address, additional service locations, or change in services provided, please click the **Ancillary Facility Information Form** link to complete an updated Provider Information Form, also located in Chapter 10 Appendix, and fax it to the appropriate Network Development as follows:

- WPA/NWPA: fax # 1-866-341-8017.
- EPA: fax # 1-866-341-8014

## 5.5 NETWORK ADMINISTRATORS AND HEALTH PLAN PROGRAMS

### 5.5.1 Vision Programs

EyeMed Vision Care was selected by HealthAmerica to administer our vision care benefits and can be reached by calling 1-866-723-0514. Website: [www.eyemedvisioncare.com](http://www.eyemedvisioncare.com)

Below is a description of our vision programs:

**HealthAmerica HMO Optometry Rider**

These Members may have a co-payment for an annual routine eye exam and also may have an allowance towards the purchase of eyewear. Members must use a HealthAmerica participating provider.

**HealthAmerica PPO and POS Optometry Rider**

Members with this rider may have a co-payment for their annual exam and may have an allowance towards the purchase of eyewear. In order to utilize the full benefit the Members must see a participating provider. We recognize that PPO and POS Members might choose to use out-of-network benefits for examinations and/or corrective materials. These Members will
pay more for using out-of-network providers. To obtain out-of-network benefits, eligible Members will need to submit an itemized bill with the non-par claim form to the address listed on the claim form: The claim form can be obtained by visiting our website, at www.healthamerica.cvty.com and using the link. 
http://www.healthamerica.cvty.com/framesetdef.asp?Community=Member

If you have any questions regarding the routine vision benefits for HealthAmerica Members, please call the Customer Service Organization.

Please remember any vision problems, which are medical in nature (i.e. cataracts) are handled as medical referrals.

EyeMed’s One Eyecare Program® is a value-added service that is offered to all Members of HealthAmerica for no additional charge.

Members are able to receive a discount on vision services if the services are rendered by a participating EyeMed provider. EyeMed’s One Eyecare Program® offers immediate savings on eye care needs – including discounts on frames, lenses, conventional contacts, and even LASIK surgery – at participating providers through the EyeMed network.

The EyeMed Vision Care network includes Sears Optical, participating Pearle Vision locations, LensCrafters (effective 1/1/08) Target Optical, JCPenney Optical, and many independent doctors of optometry.

Members don’t need an EyeMed Discount ID card to receive the benefit but, if they would like a copy please refer them to the EyeMed website to print one out. All that a Member needs to do to receive the program discount is to show his/her HealthAmerica ID card to the participating EyeMed provider.

Refer to the Advantra Section for Vision Guidelines for Advantra Members.

5.5.2 Behavioral Health Services / Mental Health / Substance Abuse

MHNet Behavioral Health (MHNet) manages the mental health / substance abuse benefits for all products.

- Have the Member contact MHNet prior to initiating behavioral health services to discuss prior authorization, provider selection and benefit information.
- Physicians may contact MHNet with treatment or referral recommendations.
- The Mental Health Provider (MHP) is responsible for obtaining a release of information from the Member, after which, the physician will be kept apprised of the Member’s status and progress during treatment.
- MHNet will assist the physician in obtaining consultation regarding behavioral health issues.
- MHNet is available 24 hours a day, seven (7) days a week for emergencies by calling 1-866-369-8362 or during normal business hours, Monday through Friday, 8:00 AM to 5:00 PM EST, for routine referrals to a provider.
5.5.3 RX Health Care (Home Care Providers including DME)

HealthAmerica – WPA / NWPA utilizes a network manager called RX Health Care, a Walgreens Company for managing home care services, including Respiratory Therapy, Durable Medical Equipment, Orthotics and Prosthetics, Home Skilled Nursing, Home Infusion Therapy, Hospice and Ostomy / Medical Supplies.

RX Health Care, a Walgreens Company is responsible for contracting and credentialing the providers in these specialties. HealthAmerica accesses the RX Health Care network through its agreement with RX Health Care.

HealthAmerica maintains the responsibility for processing all claims on a fee for service basis. RX Health Care works as the intermediary between the provider and HealthAmerica to resolve any claim payment issues.

The ordering physician should contact HealthAmerica at 1-800-755-1135 (WPA), 1-800-669-2202 (NWPA) or 1-800-755-1135 (EPA) to preauthorize services.

5.5.4 Radiology Benefit Management Program (NIA)

To ensure our radiology program continues to reinforce quality practice standards and manage costs in a fair and consistent manner, HealthAmerica has entered into an agreement with National Imaging Associates, Inc. (NIA), an affiliate of Magellan Health Services. Under the agreement between HealthAmerica and NIA, HealthAmerica is responsible for claims adjudication and medical protocols. NIA manages the prior authorization of non-emergent, high-tech, outpatient radiology services.

The agreement with NIA is consistent with industry-wide efforts to coordinate the increasing utilization of these services and to ensure quality care for our Members. NIA is NCQA and URAC accredited and offers our participating providers a program that supports standard protocols and offers the expertise of peer radiologists.

Prior authorization will be required for the following outpatient radiology procedures:

- CT / CTA
- MRI / MRA
- CCTA
- Nuclear Cardiology
- PET Scan
- Nuclear Stress (MPI)
- Echo Stress
- Diagnostic Nuclear Medicine
Prior Authorization guidelines will be posted under the “Pre-Authorization Requirements” section of our website and at www.RadMd.com. Key Provisions:

- Emergency room, observation and inpatient imaging procedures do not require authorization.
- The ordering physician must obtain authorization.
- Failure to verify that affected services have been preauthorized may result in non-payment of your claim.

All other procedures requiring authorizations will be managed by HealthAmerica’s Prior Authorization Department.

Providers have three options for requesting authorizations.

**Phone:**
The toll free prior authorization phone number is 1-800-669-2202, Option 5. If the authorization request is for a procedure managed by NIA, your call will be transferred to NIA.

**Online requests:**
If the procedure you are requesting is one of the procedures listed above as managed by NIA you should send your requests through www.RadMD.com

If the procedure you are requesting is not managed by NIA, you should send your requests through www.Directprovider.com.

**Faxes:**
If the procedure you are requesting is one of the procedures listed above as managed by NIA, you cannot fax your request. NIA does not accept faxes.

If the procedure you are requesting is not managed by NIA you may fax your request to HealthAmerica at the following fax number.
The toll free prior authorization fax number is 1-888-247-4791.

**NIA Privileging**

Providers who perform the following services in their office, must submit a Coventry Privileging Application so they can be authorized and be reimbursed for the services.

<table>
<thead>
<tr>
<th>CT / CTA</th>
<th>PET Scan</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRI / MRA</td>
<td>Nuclear Stress (MPI)</td>
</tr>
<tr>
<td>CCTA</td>
<td>Echo Stress</td>
</tr>
<tr>
<td>Nuclear Cardiology</td>
<td>Diagnostic Nuclear Medicine</td>
</tr>
</tbody>
</table>

To access the online application:

- Direct your web browser to www.RadMD.com
- Click on the link for Coventry Privileging Application (located under Online Tools)
- Enter your login and click login.
NIA will manage the prior authorization of non-emergent, high-tech, outpatient radiology services.

The Claim Matrix on the following pages lists all procedure codes managed by NIA.

HealthAmerica Cardiac Cath
Claim Resolution Matrix 2015

The matrix below contains all of the CPT-4 codes for which NIA Magellan authorizes on behalf of HealthAmerica. This matrix is designed to assist in the resolution of claims adjudication and claims questions related to those services authorized by NIA Magellan. If an exam is billed under any one of the given codes for that grouping and a valid authorization number has been issued within the date of service validity period, the charge for any of the codes should be allowed.

If a family of CPT codes is not listed in this matrix, an exact match is required between the authorized CPT code and the billed CPT code. If the exact match does not occur, the charge should be adjudicated accordingly.

*Please note: Services rendered in an Emergency Room, Observation Room, Surgery Center, or Hospital Inpatient settings are not managed by NIA Magellan.

<table>
<thead>
<tr>
<th>Authorized CPT Code</th>
<th>Description</th>
<th>Allowable Billed Groupings</th>
</tr>
</thead>
<tbody>
<tr>
<td>93452 1</td>
<td>Heart Catheterization</td>
<td>93452, 93453, 93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461, +93462, +93463, +93464, +93565, +93566, +93567, +93568</td>
</tr>
<tr>
<td>70336</td>
<td>MRI Temporomandibular Joint</td>
<td>70336</td>
</tr>
<tr>
<td>70450</td>
<td>CT Head/Brain</td>
<td>70450, 70460, 70470</td>
</tr>
<tr>
<td>70480</td>
<td>CT Orbit</td>
<td>70480, 70481, 70482</td>
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<tr>
<td>70486</td>
<td>CT Maxillofacial/Sinus</td>
<td>70486, 70487, 70488, 76380</td>
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<tr>
<td>70490</td>
<td>CT Soft Tissue Neck</td>
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<tr>
<td>70496</td>
<td>CT Angiography, Head</td>
<td>70496</td>
</tr>
<tr>
<td>70498</td>
<td>CT Angiography, Neck</td>
<td>70498</td>
</tr>
<tr>
<td>70540</td>
<td>MRI Orbit, Face, and/or Neck</td>
<td>70540, 70542, 70543</td>
</tr>
<tr>
<td>70551</td>
<td>MRI Internal Auditory Canal</td>
<td>70551, 70552, 70553, 70540, 70542, 70543</td>
</tr>
<tr>
<td>70544</td>
<td>MRA Head</td>
<td>70544, 70545, 70546</td>
</tr>
<tr>
<td>70547</td>
<td>MRA Neck</td>
<td>70547, 70548, 70549</td>
</tr>
<tr>
<td>Code</td>
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<td>71275</td>
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<td>71550</td>
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<td>72125</td>
<td>CT Cervical Spine</td>
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<td>72128</td>
<td>CT Thoracic Spine</td>
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<td>72131</td>
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<td>MRI Cervical Spine</td>
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<td>MRI Thoracic Spine</td>
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<td>72148</td>
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<td>72191</td>
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<td>MRI Abdomen</td>
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<td>74185</td>
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<td>Diagnostic CT Colonoscopy (Virtual Colonoscopy, CT Colonography)</td>
<td>74261, 74262</td>
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<td>75557</td>
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S8037  MR Cholangiopancreatography  S8037, 74181, 74182, 74183.
S8042  MRI low field  S8042
CARDIOLOGY CHECKLIST
For HealthAmerica

Please be prepared to provide the following information when requesting prior authorization for a cardiology imaging test:

1. **Member height, weight, and BMI**
2. **Family history of heart problems**
   - Relationship to Member
   - Age at diagnosis
   - Event - MI (myocardial infarction), CABG (coronary artery bypass graft), stent, other
3. **Medical history**
   - Diabetes
   - Hypertension
   - Stroke
   - Arrhythmia
   - Other
4. **Cardiac risk factors**
5. **Previous cardiac surgery**
   - CABG (coronary artery bypass graft), PTCA (percutaneous transluminal coronary angioplasty), stent
   - Heart valve surgery
   - Other
6. **Physical examination results related to cardiac conditions**
7. **Medications**
8. **ECG results**
9. **Pacemaker** – if yes, paced rhythm?
10. **Previous cardiac testing and findings**
    - Exercise stress test
    - Echo – transthoracic or transesophageal
    - Stress echo
    - Stress MPI
    - Coronary angiography and left ventriculogram
11. **Problems with Exercise capacity?**
    - Orthopedic, pulmonary, or peripheral vascular disease
    - Distance, heart rate

To initiate an authorization request,
visit [www.RadMD.com](http://www.RadMD.com)
or call: 1-800-755-1135
HealthAmerica has contracted with ICORE Healthcare, LLC (ICORE), an affiliate of Magellan Health Services, to manage a provider-administered injectable drug program. The program is designed to maximize Member care in the most appropriate and affordable manner based on clinically accepted standards.

The following provider-administered injectable drugs will require prior authorization from ICORE. These drugs must be authorized before being administered in the office:

- Aloxi
- Herceptin
- Aranesp
- Leukine
- Avastin
- Neupogen
- Epogen/Procrit
- Neulasta

The program will determine if the proposed service meets the definition of medical necessity under a Member’s benefit plan.

**Drugs Requiring Prior Authorization by HealthAmerica**

For drugs other than those listed above, prior authorization requirements and processes will not change. Call HealthAmerica at 1-800-755-1135 for all telephone requests for prior authorization. Your call will be routed to ICORE if you are requesting prior authorization for one of the drugs listed above.

**Prior Authorization Process and Information Needed by ICORE**

1. To expedite the prior authorization process, have the following information ready:

   - Name and office phone number of the in-office physician
   - Member name and ID number
   - Requested medical pharmacy drug(s)
   - Anticipated start date of treatment (if known)
   - Member weight and/or body surface area
   - Dosing information and frequency
   - Diagnosis
   - Past therapeutic failures (if applicable)

2. If requested, be prepared to fax the following documents:

   - Clinical notes
   - Pathology reports
   - Relevant lab test results

3. To verify Member benefits call HealthAmerica’s Customer Service Organization (CSO) at 1-800-788-8445 or visit directprovider.com.
To contact ICORE Healthcare:

1. Visit ICORE’s secure website at www.icorehealthcare.com and click on the physician tab, or
2. For initial calls for prior authorization, call HealthAmerica at 1-800-755-1135. Your call will be routed to ICORE.

For information on existing ICORE authorizations or reauthorizations:

1. Call ICORE directly at 1-800-424-1719 (Monday – Friday, 9 a.m. to 6 p.m. Eastern Time), or
2. Visit ICORE’s website at www.icorehealthcare.com and click on the physician tab.

Timeframes for Requests for Prior Authorization to ICORE

Urgent requests:

1. Go to ICORE’s website at www.icorehealthcare.com and click on the physician tab, or
2. Call HealthAmerica and you will be routed to the ICORE Call Center.

Urgent requests will be completed within 24 hours from receipt of the request. Non-urgent requests will be completed within 48 hours from receipt of the request. In most cases, ICORE can review and determine prior authorization during the initial phone call if all information needed to process a request is provided. The review and determination process can take longer if Member or provider eligibility verification is required or if the request requires additional clinical review.

ICORE Web Site and Telephone Access

The physician administering a drug in this provider-administered injectable drug program is required to obtain a prior authorization by accessing ICORE’s website or by calling HealthAmerica at 1-800-755-1135.

- **Website Access**
  - Access ICORE’s provider self-service at www.icorehealthcare.com and click on the physician tab.
  - You will receive a separate communication prior to the implementation start date with a unique user name and password for your organization’s administrator. The letter will indicate the temporary password algorithm that is used to create temporary passwords.
  - Your administrator will then be able to set up a user name for each individual site user in your office.
− If a prior authorization request is pended, you will receive a tracking number that you can use to check on the authorization status.
− The ICORE website cannot be used for retrospective or expedited authorization requests. Those must be processed directly through the ICORE Call Center.

• Telephone Access
− Contact HealthAmerica at 1-800-755-1135, and your call will be routed to ICORE. For information related to existing ICORE authorizations or for reauthorizations, contact ICORE directly at 1-800-424-1719.
− ICORE can accept multiple requests during one phone call.

5.5.6 MedSolutions - Radiation Oncology

HealthAmerica Quick Reference Guide for Radiation/Oncology

HealthAmerica will expand their outpatient radiation oncology management program to require prior authorization for a course of radiation therapy treatment. MedSolutions, Inc. (MedSolutions) will manage the authorization process for outpatient radiation oncology services for HealthAmerica’s commercial and Medicare members. Prior authorization is required (except for the initial consultation) when any one of the following modalities are utilized:

• 2D and 3D conformal
• SRS/SBRT
• Brachytherapy
• Proton Beam Therapy
• IMRT
• Neutron Beam Therapy

Requests for prior authorization will receive a response within two business days once complete clinical information is received, or as required by Federal or State regulations.

When radiation oncology services are required in less than 48 hours due to a medically urgent condition, please call for authorization. MedSolutions will expedite the review process. Please indicate clearly that the authorization is for medically urgent care.

The physician ordering the treatment is responsible for obtaining prior authorization for radiation oncology services. The rendering facility must ensure that prior authorization is obtained. We recommend that the ordering physician develop a process to ensure that the appropriate authorization number(s) is obtained. Payment to the treating physician and rendering facility will be denied for procedures performed without necessary authorization; the member cannot be balance-billed for such procedures.

Prior Authorization Process
There are three ways to obtain prior authorization for an imaging procedure from MedSolutions:

1. Web Portal - complete the internet-based submission form by logging on to the secure website at www.medsolutionsonline.com. MedSolutions (need to be consistent is using
MSI versus MedSolutions) strongly recommends use of the web portal as a time efficient tool to enable prompt review of your request. The MSI website cannot be used for retrospective or expedited registration requests. Those requests must be processed by calling.

2. **Call** - to request authorization call toll-free, at 800-755-1135 for Radiation Oncology.
3. **Fax** - complete the appropriate fax form and include the office notes, etc. for the patient and fax your request to 1-877-791-4110.

When requesting prior authorization for radiation oncology services, please have the following information available:

- Patient demographic information, including member ID and date of birth
- Cancer or condition being treated (including the diagnosis code)
- Procedure codes expecting to be billed (including CPT codes and total units for each)
- Dates and results of biopsies and/or procedures
- Anatomic site(s) to be treated
- Intent of the treatment
- Approximate size of the anticipated target volume
- Patient’s prior history
- Number of fractions planned


**Authorizations**

Your request for prior authorization will be processed and communicated within two business days after the receipt of all required clinical information, or as required by Federal and State regulations. MedSolutions will communicate authorization decisions, including an approved CPT code set for the course of treatment, via fax to the requesting facility and to the ordering physician. Authorizations contain a MedSolutions authorization number and CPT codes specific to the studies authorized. Should the performing physician believe requested radiation therapy is different from what is authorized; the physician must contact MedSolutions for review and modification of authorization prior to claim submission.

**Denials**

If a request for prior authorization results in a denial or an alternative recommendation, the ordering physician will receive notification of the determination. The determination will be faxed to the requesting physician and mailed to the member. The written notification will include information about appeal rights.

**Peer Review**

Referring physicians may request a peer review discussion of a denial or an alternative recommendation with one of MedSolutions’ radiation oncologist reviewers. To request a peer review, call MedSolutions at 1-888-693-3211 during normal business hours of 8:00 am – 9:00 pm ET, Monday through Friday.

**MedSolutions Web-Based Services**

You may access MedSolutions on-line for day-to-day transactions and services. To reach MedSolutions on-line services please go to the website, [www.medsolutionsonline.com](http://www.medsolutionsonline.com), select your professional group and follow the online instructions. Here you may sign up for access to a variety of MedSolutions services, including prior authorization guidelines. Please be sure to
watch the website for news of future online initiatives. You can contact the Web Portal Queue at any time for further assistance at 1-800-575-4594 or online@medsolutions.com.

**Fax Forms**

Copies of the fax form can be printed by logging into the MedSolutions Secure website at www.medsolutions.com/documents or by calling the MedSolutions Intake Department toll-free at 1-888-693-3211 option # 1.

**5.5.7 Triad**

**ABOUT TRIAD**

Triad is a leading musculoskeletal health services company focused on the healthcare needs of patients with painful spine and joint conditions. We work with providers, patients, health plans, government agencies and employers to help ensure that patients with musculoskeletal pain complaints receive care that is safe, evidence-based and likely to produce a favorable outcome.

**COVENTRY / TRIAD PROGRAM**

Triad's role in this relationship is:

1. To work with you and your staff to efficiently receive your prior authorization requests and any medical records necessary to perform a review of medical necessity and ensure that these reviews are performed correctly and that you receive a response from Triad in a timely manner.

2. To provide actively practicing physicians who will review compliance between requested procedures and evidenced-based medical policies, using current clinical standards of care, on a case-by-case basis.

3. To make physician and surgeon reviewers available to you to discuss prior authorization determinations to:
   a. Clarify and explain clinical rationale, clinical logic and the medical evidence used in the determinations.
   b. Discuss unique needs of an individual patient or clinical scenario.
   c. Collaborate on clinical best approaches when multiple evidence based treatments are identified.

**SPINE AND SELECT JOINT SURGERY PROGRAM**

Triad will begin processing prior authorization requests for spine and select joint surgery procedures for dates of service on or after June 1, 2014.

Triad will manage the prior authorization process for these musculoskeletal services for the following members:

- Coventry HealthCare of Delaware, Inc. - Commercial
- Coventry HealthAmerica - Commercial
- Coventry HealthAmerica - Medicaid (CoventryCares)
PROCEDURE CODES: Effective June 1, 2014 the following procedure codes require prior authorization. Click here for a list of procedure codes.

PAIN MANAGEMENT PROGRAM

Triad has partnered with Coventry to administer its prior authorization program for Pain Management procedures for Commercial Fully Insured, Medicare and Medicaid members.

You should have received notice from Coventry that this program will begin on 9/1/2012. You can view Coventry’s plan specific notices and Coventry’s plan specific implementation schedule. Coventry's members included in this program are health plan/state specific and can also be accessed here: Plan specific implementation schedule.

PROCEDURE CODES: Effective 9/1/12, the following procedure codes require prior authorization. Click here for a list of procedure codes.

Coventry requires prior authorization be obtained before the services are delivered. If the services do not meet medical necessity as defined in the medical policy, the claim will be denied.

PRIOR AUTHORIZATION: Musculoskeletal Services Authorization fax form can be accessed by clicking here

The Musculoskeletal Services Authorization fax form instructional guide can be accessed by clicking here

SUBMISSION PROCESS: Prior authorization requests, along with the patient medical records, may be submitted beginning 9/1/2012 using Triad’s secure provider portal or via fax at (888) 229-5680. Triad’s secure provider portal is an easy and efficient way for you to manage your prior authorizations.

MEDICAL POLICIES: Triad’s medical policies are posted online here.

GENERAL INFORMATION:
Provider Service Center telephone numbers are specific to your health plan. Hours of Operation are Monday through Friday 8 a.m. - 6 p.m. EST. This information is available within the Plan Specific Implementation Schedule
6. 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 reassess a provider’s qualifications, practice and performance history every three years, depending on state and federal regulations and accrediting agency standards. This process is seamless to providers who are due for recredentialing and whose applications are complete within CAQH. We’ll send providers (whose applications aren’t complete within CAQH) three reminder letters. The letters will ask them to update their recredentialing data. If they don’t respond to the letters, we’ll call them. How can I check the status of my recredentialing application? Call our Credentialing Customer Service department at 1-800-353-1232. Adding a new provider to your group: Go to the Join the Network section of our website to start the application process.

7. MEDICAL MANAGEMENT

7.1 UTILIZATION REVIEW

The purpose of utilization review is to ensure the delivery of services in a medically necessary manner.

The purpose of utilization review is to ensure the delivery of services in a medically necessary manner. The Medical Management Department is composed of a team of professional nurses, supported by clerical staff, who work under the direction of physician Medical Directors. We use evidence-based clinical guidelines from nationally recognized authorities in conjunction with the terms of the member’s benefits plan to guide UM decisions involving precertification, concurrent review, discharge planning, and retrospective review.

Medical management staff consult guidelines from the following sources:
• Clinical Policy Bulletins (CPBs);
• Pharmacy Clinical Criteria;
• MCG® Guidelines (Seattle, WA: MCG Health, LLC);
• InterQual® criteria;
• Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs):
• Other Coventry recognized criteria; and
• Applicable state and federal guidelines.

The relevant guidelines used in making coverage decisions are available, upon request, to Coventry members and their treating practitioners by contacting the Customer Service Representative at the number listed on the member’s ID card. Clinical Policy Bulletins can be accessed on the Coventry website at directprovider.com.
The specific goals of the Medical Management Department are:

1. To assure the effective and efficient utilization of hospitals, physician providers, facilities, case management services, ancillary services and social services.
2. To continually assess and improve as necessary, Member access to care as well as quality of care available to Members.
3. To educate all Members regarding utilization review concepts and medical care trends.
4. To maintain compliance with all applicable state, federal and accreditation requirements, including the National Committee for Quality Assurance (NCQA) and Centers for Medicare and Medicare Services (CMS).
5. To help insure quality care by reporting egregious complications or adverse events identified through the utilization processes to the Quality Improvement Department for investigation and action as necessary.
6. To coordinate and transition the care of the Members with chronic conditions enrolled in case management programs who are stable and discharged from the program but who may benefit from ongoing support and education through disease management.

These goals are primarily accomplished through the functions of prospective, concurrent, retrospective medical care review and case management. In essence, these are aggressive and comprehensive health care planning tasks aimed at the delivery of quality health services in the most appropriate and cost effective setting.

**Ensuring Appropriate Service and Coverage**

Our utilization management program helps our members get medically necessary health care services in the most cost-effective setting under their benefit package. We work with members and physicians to evaluate services for medical appropriateness, timeliness and cost.

- 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.

**7.2 PROSPECTIVE REVIEW/ PRIOR AUTHORIZATION**

The prospective review process may be defined as the review of and the medical necessity of designated, non-emergent outpatient surgeries and procedures, including but not limited to, the level of service prior to resource expenditure.

Prior Authorization (sometimes referred to as prospective review or pre-certification), is mandatory for:

- Selected elective Outpatient Surgeries
• Elective Inpatient Admissions
• Complex Diagnostic Testing; e.g., MRI, CAT scans, and PET scans and Cardiac Nuclear Imaging.
• Ancillary services including, but not limited to, home care, infusion, DME, Orthotics & Prosthetics and hospice.

To see the specific procedures requiring prior authorization, refer to HealthAmerica’s website at: http://healthamerica.coventryhealthcare.com/health-care-solutions/network-coverage/pre-authorization-requirements/index.htm

1. In the prior authorization/prospective review process, the following areas are considered, and evaluated against established criteria and/or policy:
   - Eligibility of the Member;
   - Medical appropriateness of the Procedure;
   - Network participation of the Provider;
   - Place of service of the proposed treatment modality;
   - Benefit coverage by the individual's health insurance coverage;
   - Proposed length of stay;
   - Age of the Member;
   - Co-morbidities and complications;
   - Proposed treatment plan;
   - Psychosocial situation;
   - Characteristics of the local delivery system, i.e. availability of services nearby to support the needs of the Member;
   - Other necessary factors needed to address a complicated Member’s needs;
   - Previous/current medical/surgical treatment(s) Member has received to date and the response to treatment(s).
   - Inpatient admissions for the purpose of pre-operative diagnostic testing require medical Director approval. To facilitate the review process, providers should submit all clinical documentation regarding the reason for admission.

2. Prior authorization of coverage for services does not guarantee claim payment, which is subject to a number of conditions, including but not limited to retroactive enrollment terminations and specific contract clauses and benefit limitations.

3. Coventry may require a minimum of two (2) business days from receipt of all information in order to process requests for prior authorization for coverage of elective services. However, this notice may be waived should medically necessary services be required prior to the two (2) business days. Emergency services do not require prior authorization. (Emergency Services are defined as the sudden onset of acute symptoms of sufficient severity (including pain) which would cause the prudent layperson, with an average knowledge of health and medicine, to reasonably expect that the absence of immediate medical attention would result in serious jeopardy to the health of the individual, or in the case of a pregnant woman, jeopardy to her unborn child, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.)

The provider/facility of services will be notified either orally or electronically of admissions/procedures approved for coverage. The ordering physician and Member will be prospectively notified of any adverse reimbursement decisions as well as their rights to appeal such decisions. Facilities/providers may also access Coventry web based sites (Emdeon or directprovider.com) to verify authorization statuses. (Facilities/providers may contact their
4. The Primary Care Physician or Specialty Care Physician should contact Coventry at 1-800-669-2202 (WPA/Ohio and NWPA) or 1-800-755-1135 (EPA) with elective health service requests. Provider requests are accepted through telephone, fax, or directprovider.com. section of this manual or refer to section 4.1.

5. If the treating physician would like to discuss a case with the physician reviewer (this must be a treating or consulting physician only), please call the Medical Management Department. Callers may also access the Medical Management Department via the Customer Service Organization as the call may be direct transferred from the representative into the Medical Management Department. After normal business hours, callers may leave a recorded message and all inquiries are responded to the next business day.

6. Only a Medical Director (physician) has the authority to decide that a requested service does not meet medical necessity standards. Coventry Medical Directors consult with specialists from a Medical Advisory Panel when appropriate. Coventry includes all applicable Member and appeal rights in any denial of coverage (some times referred to as a pre-service adverse determination notification).

7. Effective July 15, 2015, providers will have 14 calendar days from the date a 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 appropriate 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 will receive the appropriate medical director’s information when we call about the intended denial.

7.3 CONCURRENT REVIEW

The concurrent review process involves the screening of all inpatient hospital admissions for medical necessity, and timeliness of the plan of care, from time of admission through acute care, skilled care or rehabilitation facility or discharge. Registered Nurse Concurrent Review Coordinators are assigned to all acute care participating hospitals.

Concurrent Review Coordinators conduct reviews during all inpatient admissions. The review may be conducted either on-site or telephonically based on the facility’s geographical location and/or census count of the HealthAmerica Membership in a given region.

1. The Concurrent Review Coordinator utilizes InterQual® Adult Acute/Pediatrics Criteria, or MCG Care Guidelines in the review process and works closely with the facility during the review process to ensure that medically necessary services are rendered in the most timely and cost-effective manner possible. The Criteria pertinent to a specific Member is available to the provider upon request. Concurrent Review Coordinators adhere to facilities policies regarding appropriate access at a facility, use of a facility contact person, and identify our Coordinator as an outside reviewer.
2. The Concurrent Review Coordinator performs an initial review. The review encompasses an assessment of the admission appropriateness to include prior authorization, level of care, timeliness, benefit package review, and necessity of service ordered/rendered. Concurrent Review Coordinators are dependent upon the hospital’s admission/utilization review office for notification of all elective/emergent admissions to ensure timely review.

3. Subsequent reviews may be conducted every one to three days throughout the entire hospital stay to ensure appropriateness of continued stay and to identify opportunities to transition the Member to alternative levels of care. Alternative levels of care may include long term acute care, rehabilitation, skilled, sub-acute nursing, outpatient services or home care.

4. Concurrent Review Coordinators may assist with coordination of discharge planning with the appropriate staff at the facility. The Concurrent Review Coordinator assists the facility discharge planner in identifying participating providers for all discharge needs. Such services may include, home health care, home infusion, skilled nursing facility care, inpatient or outpatient rehabilitation care and procurement of durable medical equipment. Should a Member require transfer to another facility, the Coordinator will assist the hospital in all medically necessary transfers by identifying participating ground and air transportation providers. The attending physician is responsible for communication and coordination of the transfer with the receiving facility.

5. If utilization issues are identified, the Concurrent Review Coordinator will notify the facility’s UM Department of the problem within 24 hours. This notification gives the facility the opportunity to supply additional information to support continued stay or arrange for transfer or discharge of the Member as well as the opportunity for the physician to discuss any concerns with the HealthAmerica Medical Director.

6. The Concurrent Review Coordinator discusses all admissions that do not meet medical necessity criteria for coverage of an admission or continued stay with a Medical Director. All decisions relative to continued approval are the responsibility of the HealthAmerica Medical Directors. The facility may assume a stay is approved unless notified that coverage of a continued stay is in question. If a day is not covered, HealthAmerica will notify the provider of the adverse coverage decision and explain the right to provider reconsideration. If the treating physician wishes to discuss a case with the physician reviewer, they may call the Medical Management Department at 1-800-669-2202 (WPA/Ohio and NWPA) or 1-800-755-1135 (EPA).

7. In the event HealthAmerica finds it necessary to deny coverage for days or reduce payment to a facility, the hospital will be notified in writing of the final decision. This notification will include the appropriate appeal information.

8. Effective July 15, 2015, providers will have 14 calendar days from the date a 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. The denial letter will have the information you need to reach the appropriate medical director for a peer-to-peer discussion.
7.4 RETROSPECTIVE REVIEW

Retrospective review is a review of the medical record for medical necessity for services rendered and not previously reviewed through the prospective review process.

In the event a Member is discharged prior to completion of concurrent review or if HealthAmerica is unaware of a Member’s admission to a facility, HealthAmerica will conduct a retrospective review of the medical records.

The same criteria will be utilized to measure the medical necessity of a service or hospital stay and the applicable provider will be notified in writing of all adverse coverage decisions. Retrospective review decisions will be made within thirty (30) days of obtaining all of the necessary information to decide coverage of services. You are required to submit information to HealthAmerica within specified time frames in order to expedite retrospective review coverage determinations.

7.5 MEMBER/PATIENT FACILITY DENIALS

In the event a Member receives a service that is not a covered benefit, for example, cosmetic surgery, or physical therapy beyond paid benefit limits, a provider may bill the Member if the Member has received written notification prospectively that they will be financially responsible for the services. As a participating provider you may not balance bill the Member if the Member has not been notified of their financial obligation prior to receipt of service.

Fee schedule issues, coding issues or late payment concerns between the provider and HealthAmerica, are not considered non-covered benefits but provider/payor issues, and are not the responsibility of the Member. In the event a hospital and attending physician attempt to discharge the Member and the Member refuses discharge, the facility may bill the Member once the Member has received written notification that they will be financially responsible for continued hospital stay. The hospital is responsible for providing written notification to the Member of their financial responsibility; for Advantra Members, the hospital is responsible for adhering to all CMS requirements regarding notice of non-coverage. Refer to Section 3. Advantra for more information on the requirements for that product.

7.6 COORDINATION OF BENEFITS

The Concurrent Review Coordinator assists in discharge planning in order to allow the Member to maximize their benefit plan and allow optimal Member choice for the highest level of coverage.
7.7 MEDICAL/CLINICAL CRITERIA

Nationally recognized criteria utilization is based on the facility’s contract language.

InterQual® criteria are one of the most widely used, nationally recognized, tools for utilization and management of healthcare resources. The criteria sets used by HealthAmerica include:

- Procedures
- Imaging
- DME
- Level of Care Acute-Adult
- Level of Care Acute -Pediatric
- Level of Care Subacute /SNF
- Level of Care Inpatient Rehab
- Level of Care Home Care

The guidelines are objective and include comprehensive detail on clinical findings corresponding medical and professional interventions and clinical indicators reflecting readiness for discharge. Each criteria set is developed by clinicians recognized for expertise in their respective fields.

MCG Care Guidelines
MCG is a nationally recognized criteria set that is updated annually. MCG is evidence-based clinical guidelines that span the continuum of care from surgical care, ambulatory care, recovery facility care, and home care. The MCG criteria sets used by HealthAmerica include:

- Inpatient and Surgical Care
- General Recovery Guidelines
- Recovery Facility Care
- Home Care

Medicare
Medicare (CMS) criteria are the standard applied to requests pertaining to the Advantra Membership. Please feel free to contact the Medical Management Department in Western Pennsylvania at 1-866-559-4017 to request a copy of the criteria set used for a case decision in question.

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. You will be advised of updates in the provider newsletter. To request a copy of the Clinical Practice Guidelines, please contact Coventry or go to www.healthamerica.cvty.com > Services and Support > Providers > Document Library > Preventive and Clinical Practice Guidelines.

The CPGs are provided for informational purposes only and are not intended to direct individual treatment decisions. All patient care and related decisions are the sole responsibility of providers. These guidelines do not dictate or control a provider’s clinical judgment regarding the appropriate treatment of a patient in any given case.
Preventive Health Guidelines
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.healthamerica.coventryhealthcare.com. Once on the site, go to Services and Support > Providers > Document Library > Preventive Health Guidelines.

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

Aetna Clinical Policy Bulletins
Aetna Clinical Policy Bulletins (CPBs) explain the medical, dental and pharmacy services we may or may not cover. These criteria are based on objective, credible sources, such as the scientific literature, guidelines, consensus statements and expert opinions. CPBs are accessible via Aetna.com.

Medical Clinical Policy Bulletins (CPBs) detail the services and procedures we consider medically necessary, cosmetic, or experimental and unproven. They help us decide what we will and will not cover. CPBs are based on:

- Peer-reviewed, published medical journals
- A review of available studies on a particular topic
- Evidence-based consensus statements
- Expert opinions of health care professionals
- Guidelines from nationally recognized health care organizations

7.8 COMPLEX CASE MANAGEMENT

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, education and available resources to promote quality, cost-effective outcomes. Case Management Services are provided to members who have suffered a traumatic injury or illness or have a significant medical condition necessitating ongoing medical follow-up and treatment. Case Managers follow members' cases where continuity of extensive services is needed for acute interventions or chronic conditions.

Case Management promotes quality care and cost-effective outcomes that enhance physical, psychosocial, and vocational health of individuals. It includes assessing, planning, implementing, coordinating, and evaluating health-related service options. Case managers work in conjunction with the member's primary or specialist physician, other health care professional(s), and the plan Medical Director as deemed appropriate to coordinate services according to member's benefits as deemed appropriate. Referrals for case management may be received from a variety of sources such as the Primary Care Physician, Specialist Physician, Utilization Management team members, Medical Director, member/family, internal departments, employer group, etc. Once a member is assessed to benefit from case management and the
member or caregiver agrees to participate in the program, an individualized care plan is
developed. 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.

7.8.1 DISEASE MANAGEMENT

Our disease management programs are designed to help your patients work with their doctors to
effectively manage ongoing health conditions and improve outcomes. Disease Management
programs are available for the following conditions:

- 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. The member is identified by various
methods including, but not limited to, claims, pharmacy, health risk assessment, physician
referral, caregiver referral, or self-referral. Providers may refer a member to a disease
management program by calling the Disease Management Call Center at 1-800-579-5755.

Quality Improvement Programs for Medicare Advantage members
Annual Chronic Care Improvement Programs (CCIPs) and Quality Improvement Projects (QIPs)
are implemented and maintained for 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 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 members and will focus on a significant aspect of clinical and non-
clinical care and health disparities to help 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.
A referral is the mechanism used by a PCP to refer a Member to a specialty provider which enables the PCP to continue to coordinate and manage the Member’s care. An “authorization referral number” is the process utilized by HealthAmerica to direct claims payment for services requiring precertification.

An office visit referral from a Primary Care Physician to a participating specialist for consultative visits and office based services does not require an authorization number.


A PCP is responsible for managing a Member’s care and refer appropriately. HMO, POS and Advantra Members are not required to have referrals, however HealthAmerica strongly encourages their Members to coordinate their care with their PCP.

**Medical Continuity and Coordination of Care**
To facilitate continuous and appropriate care for members, and to strengthen continuity and coordination of care among medical practitioners and providers, Coventry Health Care monitors the coordination and continuity of care across health care network settings and transitions in those settings. Examples of information that is monitored are as follows:

- Medical Record Reviews/HEDIS Medical Record Reviews
- Member Complaints
- Notification and movement of members from a terminated practitioner
- Presence of medical consultant reports
- Home Health continuing care plans
- Presence of behavioral health consultant reports following primary care referral to behavioral health
- Discharge summaries post-hospitalization for behavioral health admissions

HealthAmerica in their ongoing efforts to assure quality to its Members encourages communication and coordination between PCP and the Specialty Care Providers (SCP). Refer to Chapter 10 Appendix for an example of a Member Information Form for your use. In place of this form you may chose to send to the PCP office the Member’s medical record.

**Please Note: Authorization does not guarantee claim payment. Payment is based on eligibility and specific benefits available to the Member on the date medical services are rendered.**

Authorization numbers and pre-certifications are obtained by contacting Medical Management either by telephone, fax, Emdeon, or directprovider.com. A copy of the Authorization Request
Telephone:  1-800-669-2202 WPA/Ohio and NWPA  
1-800-755-1135 EPA  
Fax:  1-888-247-4791  

**Advantra (Medicare Advantage HMO/PPO):** Go to the Advantra section for guidelines or refer to section 3.5.

**Prior Authorization**

The following health care services require precertification for medical necessity review. Precertification is obtained by contacting Medical Management either by telephone, fax, Emdeon or directprovider.com. **REMEMBER, THE ORDERING PHYSICIAN MUST OBTAIN THE AUTHORIZATION FOR A PROCEDURE OR TEST.**

HealthAmerica HMO, Advantra HMO, Advantra PPO, HealthAmerica POS, HealthAmerica PPO, and HealthAmerica ONE require prior authorization through the Medical Management Department for the following services:

- Durable Medical Equipment (includes orthotics and prosthetics)
- All inpatient hospital admissions (acute, skilled, sub-acute, observation or rehabilitation)
- Outpatient surgeries (hospital or free standing surgical centers)
- Prenatal care
- Home health/Hospice care
- Out of Network Referral Requests including hospital admissions
- Experimental Investigational Care Needs
- Transplant Requests
- Pain Management
- Complex Diagnostic Testing (excludes routine radiology and lab – includes MRI, MRA, CAT, Pet scans, and cardiac nuclear studies).
- Injectable Medication Requests
- All cosmetic or plastic surgery requests
- Chronic Care Requests (out of network dialysis and all chemotherapy)
- Rehabilitation service including physical, speech, occupational, cardiac and pulmonary
- Infertility Treatment (including genetic counseling)
- Radiation Oncology Requests

Medical Directors are available by telephone to discuss Medical Management determinations and application of medical necessity criteria.

*Psychiatric/Psychology/Mental Health/Chemical Dependency services including home health care continue to require medical necessity prior authorization.* For more information regarding Behavioral Health Services, refer to Section 5.5.2
To obtain a list of participating Providers, please go to www.healthamerica.cvty.com and click on Locate a Provider.

7.10 GLOBAL NOTIFICATION FOR PRENATAL CARE

HealthAmerica requests completion of a Pregnancy Assessment Form if the Member is considered high-risk for complications. (To obtain this form click on the link to the form located on the HealthAmerica website at http://healthamerica.coventryhealthcare.com/services-and-support/providers/document-library/index.htm

On the left side of the page, under Providers, click Provider Manual. Then go to Section 11 and the additional Section 7 under Supplementing Documentation. Or contact your Provider Relations Representative. This form allows our Members to be screened for entry into our High Risk Obstetrical Program. It also initiates a series of mailings to help ensure a Member’s healthy pregnancy. HealthAmerica utilizes a global methodology for coverage of prenatal care, using a select list of CPT codes in Chapter 10 Appendix. A provider does not need to call to seek authorization for, or to perform the procedures listed. Any procedure not under the global authorization will need to be authorized.

Pregnancy Assessment Forms must be completed for high risk Members and faxed or mailed to:

Mail: HealthAmerica Utilization Department 3721 TecPort Drive Harrisburg PA 17106-7103
Attn: Prior Authorization Request

Fax: 1-888-247-4791 All regions
Voice: 1-800-669-2202 WPA/Ohio & NWPA

Pregnancy Assessment Form
Please make sure the items below have been completed or checked before sending the Pregnancy Assessment Form. This will prevent us from having to call your office for information.

Please Note: The Member needs to complete the pregnancy assessment form with the medical provider validating the medical information requested.

1. Correct spelling of Member’s name and Member ID number as listed on their insurance card.
2. All blank spaces including EDC, pregnancy and medical history should be completed. All current medication sections should be completed.
3. HEDIS requires a provider’s signature to verify the first prenatal exam. Please have physician, midwife, or nurse practitioner sign and date the provider’s signature box. Stamp signatures are valid.
4. The Member’s signature is also required on the assessment form.
5. If the Member is changing OB providers at anytime during their pregnancy, a Pregnancy Assessment Form needs to be completed.

Lab Services (covered under Global Authorizations)

Quest Diagnostics and LabCorp are contracted to provide lab services. Refer to section 5.4.8 for a complete overview of HealthAmerica’s lab policy. With questions regarding any high risk testing, please contact the High Risk Pregnancy Case Manager for clarification at 1-412-553-
Post Partum Visit Encounter Form (covered under Global Authorization)
Based on your contractual agreement with HealthAmerica, we are requesting that all OB providers submit a CMS 1500 Encounter Form to the HealthAmerica Claims Department for post partum visits. NCQA has required Health Plans to report the percentage of women who have seen their OB provider by the 42nd day after delivery. Because of global coding, this encounter information is the only means we have of capturing this visit date. We anticipate that the provision of this encounter information will mean less disruption to your busy office than an on-site audit for this specific HEDIS measure.

Questions
If you have any clinical questions, please feel free to contact the High Risk Pregnancy Case Manager at and 1-800-788-6445 x 5927

7.11 GYNECOLOGICAL SERVICES (All Products)

Members may access all Obstetrical and Gynecological services from participating providers, including medically necessary follow-up care and diagnostic testing related to maternity and gynecological care, without prior approval from PCP in accordance with the Pennsylvania Quality Health Care Accountability and Protection Act (Act 68).

Advantra Guidelines for Gynecological Visits
Advantra Members are entitled to one office visit per year for a routine annual exam including a pap smear without a referral from the PCP when using an Advantra contracted gynecologist. A co-payment may apply.

8. Billing and Reimbursement

8.1 CLAIM SUBMISSION

Correct claim submission increases cash flow to the provider organization and prevents costly follow-up time on the part of the provider’s office/billing staff. HealthAmerica’s guidelines comply with HIPAA, Medicare, CHAMPUS Claim Form rules and applicable state law “clean claim” definition.

Please submit claims electronically to HealthAmerica whenever possible. Electronic submission is the most cost effective solution for claim submission. Electronic Claim Submission/EDI is covered in detail in section 8.1.1.

For the Timely Filing Grid refer to section 8.15.2.
The Health Insurance Portability and Accountability Act (HIPAA) requires Coventry Health Care and all other covered entities to comply with Electronic Data Interchange (EDI) standards for health care as established by the Secretary of Health and Human Services. In support of HIPAA and its goal of Administrative Simplification, HealthAmerica encourages providers to submit claims electronically. Electronic claims submission can have a significant, positive impact on the productivity and cash flow for your organization:

- EDI reduces the paperwork and costs associated with printing and mailing paper claims.
- EDI reduces the time it normally takes for the Health Plan to receive a claim by eliminating mailing time.
- EDI reduces the delays due to incorrect claim information by returning these errors directly to you through the same electronic channel. These claims can be corrected and re-submitted electronically.
- Electronic claim submission improves claim accuracy by decreasing the chance for transcription errors and missing/incorrect data.
- EDI claims can be tracked and monitored through claim status reports received electronically.

Electronic claim submission to the Health Plan is easy to establish. Contact your practice management system vendor or clearinghouse to initiate the process. Electronic claim submissions will be routed through Change Healthcare/Emdeon who will review and validate the claims for HIPAA compliance and forward them directly to Coventry.

Providers can also submit directly to Change Healthcare/Emdeon. Change Healthcare/Emdeon will provide the electronic requirements and set-up instructions. Providers should call 1-877-363-3666 or go to www.changehealthcare.com for information on direct submission to Change Healthcare/Emdeon.

EDI claim submitters should review HealthAmerica’s EDI Exclusion List and Electronic Claim Submission Requirements. All Coventry health plans use the ANSI X12N 837 v5010 implementation guide that has been established as the standard claim transactions for HIPAA. The official implementation guides for claim transactions are available electronically from the Washington Publishing Company website: http://www.wpc-edi.com.

Coventry Health Care encourages and recommends regular review of all EDI Acknowledgement and Reject Reports returned to you. Coventry Health Care, Inc. has staff available to assist you with EDI claim filing. For more detail on each of these topics please click here or refer to section 8.4.

**EDI Submission Requirements**
- For Professional Claim EDI Submission Requirements, click here or go to section 8.2.
- For Institutional Claim EDI Submission Requirements, click here or go to section 8.3.

**EDI Specifications**
- For EDI Specifications refer to the following section 8.1.2.
8.1.2 EDI Specifications


This Coventry document contains clarifications and payer specific requirements related to data usage and content with submitting an EDI claims to Coventry. Please note that this document is intended to list only those elements where payer specific requirements or clarifications apply.

The loop, segment and data element references below in italics relate to the 5010 format. If you submit your electronic claims using a different format, you should check with your software vendor or clearinghouse to ensure that your data is mapped to the proper data elements.

8.1.3 Coventry Specific Payer Edits at Change Healthcare/Emdeon

All EDI claims submitted through Change Healthcare/Emdeon will be subject to these Coventry specific payer edits (unless indicated for one transaction only) that are in place at Change Healthcare/Emdeon. Submitters will receive these types of rejections on their level 1 payer rejection reports.

- The patient and/or subscriber id must be at least two characters in length or the claim will reject.
- To allow zero dollar line charges and zero dollar claim charges.
- The billing provider id may not contain a value of 999999999 or the claim will reject.
- If the procedure code begins with 0, then Anesthesia Minutes are required or the claim will reject (Prof Only). Excluding procedure code 01953, 01995, 01996 or 0199. For these codes service units are required and the Anesthesia Minutes should contain 00 or the claim will reject. If the procedure code begins with a 0 and ends with a T, then service units are required and the Anesthesia Minutes should contain 00 or the claim will reject (Prof Only).
- If the procedure code does not begin with a 0, then service units are required and the Anesthesia Minutes should contain 00 or the claim will reject (Prof Only).
- The discharge hour must contain a numeric value of 00-23 or 99 for inpatient submissions where the statement period from date is equal to the statement period thru date (Inst only).
NOTE:
Submissions to First Health Networks (Payer ID 73159) and Coventry Dental (Payer id CX036) are not included with this guide.

8.1.4 Paper Claim

For professional claim services submit the claim by using the updated Health Insurance Claim Form, known as the CMS 1500 form. This form is recognized as the universal Claim Form throughout the industry, and has been approved by the American Medical Association (AMA) Council on Medical Services.

Refer to the CMS 1500 requirements in the Clean Claim section for the required fields or refer to section 8.8.

For facility and/or ancillary claim services submit the claim by using the updated Health Insurance Claim Form, known as the CMS 1450 form (i.e. UB 04). This form is recognized as the universal Claim Form throughout the industry, and has been approved by the American Medical Association (AMA) Council on Medical Services.

Refer to the CMS 1450 (UB 04) requirements in the Clean Claim section for the required fields. Click here to go to that section of the manual or refer to section 8.8.

Providers have a designated number of days to submit a new claim (timely filing). Claims need to be submitted based on the terms of the provider agreement. Any claims received after the designated time frame outlined in the provider agreement will automatically be denied for untimely filing. Providers may still collect for Member responsibilities such as supplemental charges, non-covered Services, and co-pays.

Please Note: It is the provider’s responsibility to check with the Plan periodically on all claim submissions. It is suggested your organization contact the Plan within 30 days from the date of original submission to determine if the Plan has received the claim.

Providers can also use Directprovider.com within 7 days from the date of submission to determine if the plan received the claim. If the Plan has no record of the claim, the provider should re-submit the claim within the timely filing limits as defined in the provider agreement. If the timely filing time period has passed, and the Plan has no record of the claim in its system, the provider will need to submit proof of timely filing of the claim in order for the Plan to review the claim for processing.

Refer to 8.15.1 Claims Addresses, the appropriate region’s Quick Reference Guide in section 1.5 Contact Information – Quick Reference Guides, or the Member’s ID card for claims mailing addresses.
8.2 PROFESSIONAL/DENTAL EDI CLAIM SUBMISSION
INFORMATION

Key Information required by HIPAA/Coventry or clarified as to Coventry’s use of the data:

8.2.1 Provider Information

Billing Provider (2010AA & 2000A)

- **Federal Tax ID (TIN) of Billing Provider** (9 digit number).
- **National Provider ID (NPI) is required** Coventry is expecting that this NPI is typically a Type 2 (organizational provider) NPI. Individuals with a Type 1 NPI are only allowed to be sent as the Billing Provider when services were performed by non-incorporated, independent, individuals.

Billing Provider’s Last Name (NM103) and Provider’s First Name (NM104) are both required if the provider entity type qualifier indicates “person”. Provider first name should be submitted completely and not just a first initial. However, as stated in the NPI bullet, Coventry expects this data to reflect an organizational provider (entity type 1) and only be submitted with the NM103 in most cases.

**Billing Address** must be a street address and cannot contain PO Box or rural route address information. PO Box types of address must be submitted in the Pay To Address loop (see below).

**Billing Zip Code** must be a full 9 digit zip code.

**Taxonomy** (PRV) – strongly recommended on all claims and required for claim submission to Medicaid plans.

- **Rendering Provider 2310B**
  - **National Provider ID (NPI) is required** for the rendering provider when a rendering provider is submitted.
  - **Rendering Provider Name** (Loop 2310B) is required when different than the billing provider (2010AA). Provider first name should be submitted completely and not just a first initial.

  - If your organization submits rendering provider information at the claim header level (Loop 2310B), do not also submit service line level (Loop 2420A) rendering provider information. Although, Coventry accepts provider data at the claim level, Coventry will read and file the claim using the provider at the claim header level only.
  - **Taxonomy** (PRV) – strongly recommended on all claims and required for claim submission to Medicaid plans.

*Note: In 5010, when the Rendering Provider is an organizational provider, it must be a separate and external entity to the Billing Provider. The NPI is used to identify the external provider entity, e.g. a clinical reference laboratory, in this loop. There is no change to the Rendering Provider when the Billing Provider is a group of practitioners. The individual practitioner who rendered the service continues to be sent in the Rendering Provider loop and their Type 1 NPI is used to identify them.*
Pay To Address (2010AB)

- **Pay-To Address** *(Loop 2010AB)* is used to identify a payment address when that address is different from the Billing Provider’s street address.
- No additional provider identifiers can be included in this loop.

Claim Header Information:

- **Referring Provider Loop 2310A** always include when known. If the referring provider is a person, both the first name (NM104) and last name (NM103) are required.
  - Referring Provider NPI is preferred.
  - Coventry will use referring provider data at the claim header level only *(Loop 2310A)*.

Service Facility Location *(Loop 2310C)* is required when the service location is different than the location in the billing provider loop *(2010AA)* and is a separate external entity from the billing provider.

  - Service facility location name *(NM1)* is required in 5010. When the place of service is the patient’s home, use a default name such as “Patient Home” when no name is available.
  - Service Facility NPI is preferred and should be included when the NPI is a separate and distinct NPI from the billing provider NPI. Do not include a Service Facility NPI when there is no separate NPI for the Service Facility Location. NPI is only reported in the Billing Provider Loop in this case.
  - Service Facility Zip code must be a full 9 digit zip code.
  - When reporting ambulance services, do not use this loop. Use Loop ID-2310E–Ambulance Pick-up Location and Loop ID-2310F – Ambulance Drop-off Location.

- **Admission Date** *(Ref02 where REF0=435)* is required per HIPAA guides for inpatient medical visits and ambulance claims when the patient was admitted to the hospital.
- **Ambulance Pick Up and Drop off Location** *(2310E/F)* is required when billing for ambulance or non-emergency transportation services. PW qualifier is used for pick up location and 45 is used for the drop off location.
- **Compliant Medical Code Sets** such as HCPCS, ICD, and CPT-4 are required on both electronic and paper claims.
- **ICD** codes should be submitted with the highest level of specificity (the correct number of digits) for proper adjudication.

8.2.2 Patient Information

- All Coventry members have a unique ID number so information must be sent at the subscriber level *(2010BA)* in 5010 transactions. All subscriber data elements must be populated as required (e.g., Date of Birth *(DMG02 where DMG01=D8)* and Gender Code *(DMG03)*).
• **Member ID Number** as shown on the patient's ID card should be submitted as the Subscriber ID. Newborns are assigned a Coventry ID number at the point they are enrolled by the subscriber. However, providers may need to submit claims prior to obtaining this number. When this occurs, providers should submit the subscriber information in the 2010BA NM1IL loop and the newborn information in the 2010CA NM1QC loop because the newborn patient cannot be uniquely identified to Coventry when using the subscriber's ID.

### 8.2.3 Special Data Items

- **Anesthesia EDI Claims.** Coventry requires the submission of time-based CPT codes (formally called ASA codes) for all anesthesia services. Anesthesia claims submitted with surgical CPT codes will be denied during processing.
  - Total Anesthesia Minutes are required on all time-based CPT codes, with the exception of 01995 and 01996. Total Minutes should be entered in the SV104. The qualifier MJ should be entered in the SV103.
  - All non time-based services (01996 included) require units of service. Units should be entered in the SV104, with a Qualifier of UN in the SV103.
  - Obstetrical Anesthesia minutes can be submitted, but are not used in processing at this time.

- **Billed Amounts** -- Coventry requires applicable total charged amounts to be submitted for all encounter/capitated submissions at both the claim header (2300 CLM02) and line level (2400 SV102). *Note: Coventry accepts zero dollar billed amounts for appropriate no charge situations.*

- **Claims with Attachments.** Coventry is able to receive and use in processing the EDI Claim Supplemental Information paperwork segment as defined in the Health Care Claim 837 Implementation Guide. This segment contains paperwork codes to indicate documents available to the payer if needed.

  4010 Specifications for 2300 Loop - PWK Segment
  - PWK01 - Report Type Code (see applicable codes below)
  - PWK02 - Report Transmission Code must be 'AA' for available on request at provider site.
  - PWK06 - Attachment Control number (if applicable).
  - PWK07 - Description (optional)(UB claims only).

Coventry’s business practices support the following paperwork codes (PWK01), which will be considered during adjudication:
  - (03) Report Justifying Treatment beyond Guidelines
  - (04) Radiology Reports
  - (05) Treatment Diagnosis
  - (06) Initial Assessment
  - (08) Plan of Treatment
  - (09) Progress Report
  - (11) Chemical Analysis
  - (13) Certified Analysis
  - (15) Justification for Admission
  - (AM) Ambulance Certification
  - (AS) Admission Summary
  - (B2) Prescription
  - (B3) Physician Order
Please note for claims with attachments:

- The PWK segment and attachments should only be used when supplemental information is necessary for the claim to be accurately and completely adjudicated according to established policies.
- If the documentation is needed for adjudication, Coventry will contact you and request a faxed copy. This copy must be received within 72 hours of the request or the claim will be denied.
- The specific paperwork codes in the PWK segment will trigger processors to consider the contents of the supplemental information obtained via fax. Therefore, use of these codes incorrectly may delay the processing of the claim as compared to a like claim without a PWK.
- Coventry will continue to accept paper claims with attachments.

- Secondary COB Claims - secondary claims may be submitted electronically.
  - Send the secondary claim electronically using Loops 2320 for claim header data and Loops 2420 and 2430 for claim service line data.
  - All COB secondary claims must contain information regarding the other payer approved and allowed amounts. Additionally, we need to receive the applicable
claim adjustment reason codes at the header or line level for other payer amounts.
  o Payer Responsibility Sequence Number Code (SBR01) should indicate the correct level of responsibility on the claim for Coventry.
  o All COB claims should send these AMT amounts, as applicable:
    Other Payer Paid Amount 2320|AMT02 – D
    Total Noncovered Amount 2320|AMT02 – A8
    Other Payer Remaining Patient Responsibility 2320|AMT02 - EAF
  o Coventry does not require secondary COB claims to be submitted electronically. Providers may continue to submit COB claims on paper and attach a copy of the paper EOB.

NOTE: Coventry receives Medicare Part A & B primary claims automatically through the cross over process for secondary payment. To eliminate duplicate claim submissions, refer to the EOB/RA from Medicare (look for code "MA-18" on your Medicare Remittance Advice) before submitting secondary claims directly to Coventry. If you do not receive Medicare remits with MA18 codes, please contact customer service to validate your claim has crossed over prior to submitting. We do not receive crossover for any Coventry Medicaid plans with the exception of Kentucky. The Commonwealth of Kentucky obtains these crossover claims and submits them to Coventry daily.

Resubmitted Claims – Corrected, replacement or voided claims may be submitted electronically. Use the Claim Frequency Type Code (CLM05-3) value equal to “5”, “7” or “8” to indicate the type of resubmitted claim. These claims must also contain a 2300 REF F8 indicating the original Coventry claim number if available or other identification number.
  • Pharmaceutical Claims - May be submitted electronically. These drug claims should not be for retail pharmacy claims nor can they be in an NCPDP format. If you are submitting a claim for pharmaceutical services, the HCPCS J codes or other applicable codes are required to identify the drug. NDC code to be submitted in the LIN segment in the 2410 loop with a qualifier of N4, and the associated data of the NDC code submitted in the CTP segment in the 2410 loop. The associated data for the NDC consists of the Quantity (National Drug Unit Count) and the Unit of Measure which can be one of 5 qualifiers: F2 – International Unit, GR – Gram, ML Milliliter, ME Milligram, or UN Unit.
  • Claim Notes – Although Coventry can accept notes submitted at both the header level (2300) and line level (2400), the 5010 implementation guide discourages the use of narrative information in the 837 file. If the narrative is required, then submit the narrative at either the header level, 2300 NTE segment with qualifier of ADD or at the line level, 2400 NTE segment with qualifier of ADD.
  • The SV101-7 at the line level in the 2400 loop to indicate non-specific procedure codes. Do not use the NTE segment to describe a non-specific procedure code. If an NDC code is reported in Loop 2410, do not use this segment for a description of the procedure code. The NDC in loop 2410 will provide the description.
8.3 INSTITUTIONAL EDI CLAIM SUBMISSION INFORMATION

Key Information required by HIPAA/Coventry or clarified as to Coventry’s use of the data:

8.3.1 Provider
Billing Provider (2010AA)

- **Federal Tax ID (TIN) of Billing Provider** (9 digit number).
- **National Provider ID (NPI) is required** - Coventry is expecting that this NPI is typically a Type 2 (organizational provider) NPI. Individuals with a Type 1 NPI are only allowed to be sent as the Billing Provider when services were performed by non-incorporated, independent, individuals.
- **Billing Provider’s Last Name (NM103) and Provider’s First Name (NM104)** are both required if the provider entity type qualifier indicates "person". Provider first name should be submitted completely and not just a first initial. However, as stated in the NPI bullet, Coventry expects this data to reflect an organizational provider (entity type 1) and only be submitted with the NM103 in most cases.
- **Billing Address** must be a street address and cannot contain PO Box or rural route address information. This type of address must be submitted in the Pay To Address loop (see below).
- **Billing Zip Code** must be a full 9 digit zip code.
- **Taxonomy** (PRV) – strongly recommended on all claims and required for claim submission to Medicaid plans.

Pay To Address (2010AB)

- **Pay-To Address (Loop 2010AB)** is used to identify a payment address when that address is different from the Billing Provider’s street address.
- No additional provider identifiers can be included in this loop.

*NOTE: Providers should notify Coventry in advance of any changes in pay to address so our system and inbound claims data will be in sync.*

Other Providers

- **Referring Provider** (Loop 2310F) always include when known. If the referring provider is a person, both the first name (NM104) and last name (NM103) are required.
  - Referring Provider NPI is preferred.
  - Coventry will use referring provider data at the claim header level only (Loop 2310F).
- **Service Facility Location** (Loop 2310E) is required when the service location is different than the location in the billing provider loop (2010AA).
  - Service facility location name (NM1) is required in 5010, when the place of service is the patient's home, use a default name such as "Patient Home" when no name is available.
  - Service Facility NPI is required and must be a separate external entity from the billing provider.
  - Service Facility Zip code must be a full 9 digit zip code.
• **Attending Provider Name** (*Loop 2310A*) is recommended on all institutional claims.
  - If the attending provider is a person, both the first name and the last name are required.
  - Attending NPI is preferred.
• **Institutional Rendering** (*2310D*) - data is accepted but not used in Coventry claims processing.

**Claim Header Information**

• **Admission Date and Time** is required for all inpatient claims. *DTP03* should be in this format: *CCYYMMDDHHMM* where *DTP01=435* and *DTP02=DT*.
• **Billed Amounts** – Coventry required applicable total charged amounts to be submitted for all encounter/capitated submissions at both the claim header (*2300 CLM02*) and line level (*2400 SV102*). *Note: Coventry accepts zero dollar billed amounts for appropriate no charge situations.*
• **Service Line Date** is required on outpatient claims. *DTP03 where DTP01=472 in Loop 2400.*
• **Unit or Basis for Measurement Code** *SV204 in Loop 2400* (days, units, international unit or dosage) is required at the service line level.
• **Compliant Medical Code Sets** such as HCPCS, ICD, and CPT-4 are required on both electronic and paper claims.
• **ICD** codes should be submitted with the highest level of specificity (the correct number of digits) for proper adjudication. These codes should be submitted without the decimal point on electronic claims.
  - ICD PX codes are expected on all outpatient surgery claims.
• **Occurrence Codes** (*2300 HI BH*) Coventry accepts all submitted on EDI claim, however only use the first four in adjudication. Please submit in priority order.

**8.3.2 Patient**

All Coventry members have a unique ID number so information must be sent at the subscriber level (*2010BA*) in 5010 transactions. All subscriber data elements must be populated as required (e.g. *Date of Birth* (*DMG02 where DMG01=D8*) and *Gender Code* (*DMG03*)

• **Member ID Number** (10-11 digit number) as shown on the patient’s ID card should be submitted as the Subscriber ID.
• Newborns are assigned Coventry ID number at the point they are enrolled by the subscriber. However, provider may need to submit claims prior to obtaining this number. When this occurs, providers should submit the subscriber information in the *2010BA NM1IL* loop and the newborn information in the *2010CA NM1QC* loop because the newborn patient cannot be uniquely identified to Coventry when using the subscriber’s ID number. All Coventry members have a unique ID number so information must be sent as the subscriber level in 5010.

**8.3.3 Recommended Information**

• **Claims with Attachments.** Coventry is able to receive and use in processing the EDI Claim Supplemental Information paperwork segment as defined in the Health Care
Claim 837 Implementation Guide.

4010 Specifications for 2300 Loop - PWK Segment
- PWK01 - Report Type Code (see applicable codes below)
- PWK02 - Report Transmission Code must be ‘AA’ for available on request at provider site.
- PWK06 - Attachment Control number (not used now, but will be implemented in the future).
- PWK07 - Description (optional)(UB claims only).

Coventry’s business practices support the following paperwork codes (PWK01), which will be considered during adjudication:
- (03) Report Justifying Treatment beyond Guidelines
- (04) Drugs Administered
- (05) Treatment Diagnosis
- (06) Initial Assessment
- (08) Plan of Treatment
- (09) Progress Report
- (11) Chemical Analysis
- (13) Certified Test Report
- (15) Justification for Admission
- (AM) Ambulance Certification
- (AS) Admission Summary
- (B2) Prescription
- (B3) Physician Order
- (CT) Certification
- (D2) Drug Profile Document
- (DA) Dental Models
- (DB) Durable Medical Equipment RX
- (DG) Diagnostic Report
- (DJ) Discharge Monitoring Report
- (DS) Discharge Summary
- (EB) Explanation of Benefits
- (HR) Health Clinical Record
- (LA) Laboratory Results
- (M1) Medical Record Attachment
- (NN) Nurse Notes
- (OB) Operative Report
- (OD) Orders and Treatments Document
- (OE) Objective Physical Examination Document
- (OX) Oxygen Therapy Certification
- (P4) Pathology Report
- (P5) Patient Medical History Document
- (P6) Periodontal Charts
- (PN) Physical Therapy Notes
- (PO) Prosthetics or Orthotic Certification
- (PQ) Paramedical Results
- (PY) Physician’s Report
- (PZ) Physical Therapy Certification
Please note for claims with attachments:

- The PWK segment and attachments should only be used when supplemental information is necessary for the claim to be accurately and completely adjudicated according to established policies.
- The specific paperwork codes in the PWK segment will trigger processors to consider the contents of the supplemental information obtained via fax. Therefore, use of these codes incorrectly may delay the processing of the claim as compared to a like claim without a PWK.
- If the documentation is needed for adjudication, Coventry will contact you and request a faxed copy. This copy must be received within 72 hours of the request or the claim will be denied.
- Coventry will continue to accept paper claims with attachments.

**Secondary COB Claims** - secondary claims may be submitted electronically:

- Send the secondary claim electronically using the 837 4010A1 using *Loops 2320 and 2330* for claim header data and *Loop 2430* for claim service line data.
- All COB secondary claims must contain information regarding the other payer approved and allowed amounts. Additionally, we need to receive the applicable claim adjustment reason codes at the header or line level for other payer amounts.
- Payer Responsibility Sequence Number Code (SBR01) should indicate the correct level of responsibility on the claim for Coventry.
- Coventry does not require secondary COB claims to be submitted electronically. Providers may continue to submit COB claims on paper and attach a copy of the paper EOB.

**NOTE:** Coventry receives Medicare Part A & B primary claims automatically through the cross over process for secondary payment. To eliminate duplicate claim submissions, refer to the EOB/RA from Medicare (look for code "MA-18" on your Medicare Remittance Advice) before submitting secondary claims directly to Coventry. If you do not receive Medicare remits with MA18 codes, please contact customer service to validate your Medicare primary claim has crossed over prior to
submitting directly to Coventry. We do not receive crossover claims for any Coventry Medicaid plans with the exception of Kentucky. The Commonwealth of Kentucky obtains these crossover claims and submits them to Coventry.

- **Resubmitted Claims** – Corrected or replacement claims may be submitted electronically. Use the Claim Frequency Type Code (CLM05-3) value equal to “7” to indicate a replacement claim. These claims must also contain a 2300 REF F8 indicating the original Coventry claim number if available or other identification number.

- **Pharmaceutical Claims** - May be submitted electronically using an 837. These drug claims should not be for retail pharmacy claims nor can they be in an NCPDP format. If you are submitting a claim for pharmaceutical services, the HCPCS J codes are required to identify the drug. The NDC code to be submitted in the LIN segment in the 2410 loop with a qualifier of N4, and the associated data of the NDC code submitted in the CTP segment in the 2410 loop. The associated data for NDC consists of the **Quantity** (National drug Unit Count) and the **Unit of Measure** which can be one of 5 qualifiers: F2 – International Unit, GR – Gram, ML – Milliliter, ME – Milligram, or UN – Unit.

- **Claim Notes** – Although Coventry can accept notes submitted at the header level (2300), the 5010 implementation guide discourages the use of narrative information in the 837 file. If narrative is required, then submit the information at the header level, 2300 NTE segment with the qualifier of ADD.

- **Supervising Provider Information** – Please contact the EDI support number below if your submissions require provider matching based on data in this loop. The Coventry standard is to use the rendering or billing provider information for all claims (2310D/E). However, supervising data can be used as appropriate.

### 8.3.4 EDI Data Not Used - Professional Institutional and Dental

Although Coventry accepts the following data, it is not used in claim adjudication.

- **All Providers loops and segments at the claim line level (Loop 2420 A-H).**
- **Supervising Provider Information** – Please contact the EDI support number below if your submissions require provider matching based on data in this loop. The Coventry standard is to use the rendering or billing provider information for all claims (2310D/E). However, supervising data can be used as appropriate.

- **Currency.** Information in the CUR segment will not be considered in processing. All electronic transactions will be with trading partners in the United States. (Loop 2000A).

- **Responsible Party Information** *(Loop 2010BC)* information submitted on appropriate legal documentation and maintained in internal files will be used.

- **Participation Indicator** (Loop 2300 CLM16) and **Contract Information** (Loop 2300 and 2400) – We will use information in our internal provider files.

- **Service Authorization Exception Code** in Loop 2300 REF.

- **Ambulatory Patient Group** in Loop 2300 REF.

- **Demonstration Project Identifier** in Loop 2300 REF.

- **Mammography Certification Number** in Loops 2300 and 2400 REF.

- **File Information** in *Loop 2300 K3 segment*. This is not needed as no usage for this segment has been defined.
• **Peer Review Organization (PRO) Approval Number** in Loop 2300 REF.
• **Medicare PPS Assessment Date** *(Loop 2400 DTP)*.
• **Explanation of Benefits Indicator** *(CLM18)*. Information from our internal files will be used.
• **Treatment Code Information** - in *Loop 2300 HI*.
• **DMERC CMN Indicator** in Loop 2400 PW.
• **Hospice Employee Indicator** in Loop 2400 CRC.
• **Credit/Debit Card Account Holder Name** *(Loop 2010BD)* Credit/Debit Card Maximum Amount *(Loop 2300 AMT segment)* Sales Tax *(Loop 2400 AMT)*, **Postage** *(Loop 2400 AMT)*
• **Ambulance Pick up and Drop off** at the line level in Loops 2420 G & H.
• **Obstetric Anesthesia** Additional Units in Loop 2400 QTY.
• **Immunication Batch Number** in Loop 2400 REF.
• **Property and Casualty Claim Number** *(REF segments in Loops 2010BA and 2010CA)*
• **Select Patient Information Segment** including **date of death** *(PAT06)*, **Weight** *(PAT08)*, and **Pregnancy Indicator** *(PAT09)*.

  The following claim header **DTP Date segments** *(Loop 2300)* are not referenced from the inbound claim: Initial Treatment Date, Last Seen Date, Acute Manifestation, Last Menstrual Period, Last X-ray Date, Hearing and Vision Prescription Date, Disability Dates, Last Worked, Authorized Return to Work, Assumed and Relinquished Care Dates, Property and Casualty Date of First Contact, and Repricer Received Date.

  The following claim line **DTP Date segments** *(Loop 2400)* are not referenced from the inbound claim: Prescription Date, Certification Revision/Recertification Date, Begin Therapy Date, Last Certification Date, Last Seen Date, Test Date, Shipped Date, Last X-ray Date, and Initial Treatment Date.

### 8.4 EDI ACKNOWLEDGEMENT AND REJECT REPORTS

For every claim filed electronically, the provider should monitor whether or not that claim has been rejected by reviewing EDI Acknowledgement and Reject reports on a regular basis. The following reports should be monitored regularly:

- **Initial Reject Report** *(Change Healthcare/Emdeon report Rpt 05 or equivalent vendor report)* - This is a report that shows claims rejected by Change Healthcare/Emdeon and were not forwarded to Coventry. These claims should be corrected and resubmitted electronically as applicable.
- **Initial Accept Report** *(Change Healthcare/Emdeon Envoy Report Rpt 04 or equivalent vendor report)* - This report shows Change Healthcare/Emdeon accepted the EDI claims that are forwarded to Coventry for processing.
- **Payer Reject Report** *(Change Healthcare/Emdeon Report Rpt 11 or equivalent vendor report)* - This report states why the Coventry health plan rejected the claim. These claims should be corrected and re-submitted electronically as soon as possible.

**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. Due to the size of this report a file summary report might be more appropriate to monitor the number of accepted claims.

- 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 payers will appear on the Payer Reject Report. Any claims appearing on this report should be corrected and re-submitted electronically as soon as possible to avoid timely filing issues.

**Timely Filing**
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 payer reports on a regular basis, please contact your clearinghouse or vendor. A provider can avoid timely filing issues by understanding and regular monitoring of EDI Reports. This process will help to ensure all rejected claims are re-filed timely and electronically.

**8.5 COMMON REJECTION REASONS**

Review the following tips for assistance with resolving the most common rejections received by providers.

The most common claim reject reason for Coventry is “Member not found.” Use the Coventry Health Care secure provider portal, directprovider.com, Change Healthcare/Emdeon, or an integrated solution through your vendor or clearinghouse to verify/validate Member’s eligibility prior to submitting claims.

1. **Patient Date Of Birth**
   Submit a correct date of birth for the patient.
   - Do not send “00” for the month or date.
   - Do not send dummy dates such as “17760704”
   - Do not send a date of birth greater than the date of service.
   A claim will be rejected if a valid date of birth does not match the date of birth on file in the Coventry system. If this is the case, please verify the patient date of birth with the patient or policyholder.

2. **Member Identification Number**
   Submit the 10 or 11-digit number as displayed on the patient’s ID card.

3. **Date Format**
   Submit all dates in the following format: CCYYMMDD unless otherwise specified.
   - Submit valid dates of service.
   - Do not submit future dates of service.

4. **Monetary Amount Format**
   Include the decimal point in all monetary amounts unless otherwise specified.
   - Do not submit negative dollar amounts.
5. Coding Detail
Consider the following when verifying service codes and/or modifiers that have been rejected:
- Submit service codes and modifiers appropriate to the age and gender of patient.
- Submit service codes and modifiers appropriate to the date of service.
- Submit service codes to their greatest level of specificity.

8.6 EDI ASSISTANCE

Clearinghouse – Typically, the first point of contact for resolving an EDI issue is the provider’s specific clearinghouse.

Change Healthcare/Emdeon - The customer service center can track all EDI submissions received and maintain all status messages returned from healthy plans. This information is readily available for 45 days after the submission and older upon request. ON24/7 is a web-based system that allows Change Healthcare/Emdeon customers to submit service requests and check on the status of those requests 24 hours a day, 7 days a week. To register or learn more about ON24/7 call 1-888-363-3361. Coventry staff is available to assist you with electronic filing concerns as they relate to our submission requirements or status messages. Please contact us at 302-283-6570 or via e-mail at EDIclaims@cvty.com

8.7 ELECTRONIC FUND TRANSFER (EFT)

Coventry Health Care, Inc. offers providers the ability to receive payments electronically through an EFT transaction.
- All participating providers who submit claims to HealthAmerica are eligible to participate in the electronic funds transfer.
- Providers will receive claim payments more quickly. The payments will be directly deposited into a provider’s bank account electronically.
- The provider should check with its banking institution to verify it will be able to receive Automated Clearing House (ACH) transactions and if there are fees associated with this service.
- When enrolling in EFT, the provider also agrees to no longer receive paper remittance advices by mail. Instead the provider will obtain remittance advices on Coventry’s provider portal: www.directprovider.com
- A deposit transaction will appear on the monthly bank statement for each separate transaction.

How To Enroll - The provider must complete the Electronic Fund Transfer Authorization Form, indicating “New Provider” and return it to:

Coventry Health Care, Inc.
Atten: PC & I - EST
PO Box 67103
The Coventry EFT Authorization Form is available to providers by contacting HealthAmerica Provider Relations or by going to www.directprovider.com to access the current form.

The provider must enclose an original voided check or deposit slip for the depositing account. A letter from the provider’s bank is also accepted. When properly executed, the EFT will become effective approximately 30 days after receipt by HealthAmerica.

**Banking Changes**

The provider must give 30 days written notice to HealthAmerica describing any changes to their EFT Service. The provider needs to complete a new EFT Authorization Form with the revised banking information indicating “Update to Existing Provider Information”. Providers that were enrolled with EFT prior to September 1, 2009, will continue to receive paper Remittance Advises with any updates.

The following is a list of Coventry Health Care Plans that will be included in your EFT Authorization:

- Health America, Inc.
- Carelink Health Services, Inc.
- Southern Health Services, Inc.
- Coventry Health Care of Delaware, Inc.
- Coventry Health Care of Florida, Inc.
- Coventry Health Care of Georgia, Inc.
- Wellpath
- Coventry Health Care of Louisiana, Inc.
- Coventry Health Care of Illinois, Inc.
- Coventry Health Care of Iowa, Inc.
- Coventry Health Care of Missouri, Inc.
- Coventry Health Care of Nebraska, Inc.
- CoventryCares of Nebraska
- CoventryCares of Kentucky
- Altius Health Plans, Inc.
- Coventry Health Care of Kansas, Inc.
- Group Health Plan
- Personal Care
- Vista Health Plans (Eff 4/1/2010)
- Coventry National Health Plans
- Mail Handlers Benefit Plan
- Rural Carriers Health Plan
- Association Benefit Plan
- American Foreign Services Benefit Plan
- Carenet
- Omnicare
- HealthCareUSA
- CHC Cares
- Carelink Medicaid
- Diamond Health Plan
- Coventry Health Plan
- Coventry Consumer Choice
- MHNet
Health plan staff are available to assist your organization with any questions. Please contact your Provider Relations Representative or send an email to CoventryEFTrequest@cvty.com.

8.8 CLEAN CLAIMS

A clean claim is defined as a claim that has no “defect” or impropriety, including lack of required substantiating documentation or particular circumstances requiring special treatment that prevents timely payment from being made. Please note any claim requiring HealthAmerica to obtain information from an external source for correct processing makes the claim “non-clean”.

The submission of the required claim data elements will help to ensure the prompt and accurate payment of claims. For further information regarding claims’ submission, please contact HealthAmerica Customer Service for WPA, NWPA and Ohio at 1-800-735-4404, for EPA/SEPA at 1-800-788-8445, or Advantra Customer Service at 1-800-290-0190.

Providers are required to submit all claims in a timely manner in accordance with their provider agreement.

Pennsylvania Claims

Pennsylvania Act 68 specifies that all “clean” claims submitted by a provider for fully insured business must be paid within 45 days of receipt or an interest penalty of 10% annually must be paid to the provider of service – regardless of participating status (par or non-par).

It is HealthAmerica’s intent to pay clean claims for authorized covered services within 45 days of receipt, as is required by Pennsylvania state law. Clean claims not paid within this time period are subject to interest charges, in accordance with Pennsylvania state law. However, please be aware there are certain valid conditions, such as coordination of benefits or subrogation, which legitimately may delay the payment of a claim that otherwise meets the clean claim requirements.

Ohio Claims

Ohio law specifies that all “clean” claims submitted by a provider for fully insured business must be paid within 30 days of receipt (Ohio Revised Code section 3901.381) or an interest penalty of 18% annually must be paid to the provider of services – regardless of participating status (par or non-par) (Ohio Revised Code section 3901.389).

It is HealthAmerica’s intent to pay clean claims for authorized covered services within 30 days of receipt, as is required by Ohio State law. Clean claims not paid within this time period are subject to interest charges, in accordance with Ohio State law. However, please be aware that there are certain valid conditions, such as coordination of benefits or subrogation, which legitimately may delay the payment of a claim that otherwise meets the clean claim requirements.
Ohio legislation has been passed that addresses the protection of patient rights. Part of that legislation also addresses the prompt payment of “Clean Claims” to health care providers by payors. In order to address the requirements of that legislation the following bullets outline HealthAmerica’s definition of a “Clean Claim”.

1. A clean claim includes accurate and complete information in all applicable fields on the CMS 1500 (HCFA) or CMS 1450 (UB 04) form. (Click on the respective name to see the forms and accompanying legends for the CMS 1500 and CMS 1450 forms that outlines each box requirement or refer to the following sections 8.9 for HCFA and 8.10 for UB 04.)
2. A clean claim has all necessary documentation attached, which substantiates and supports any special treatment and/or complex procedure(s), including operative reports or the use of an assistant surgeon.
3. A clean claim includes current Revenue, DRG codes, CPT codes or Level II HCPC codes (with appropriate modifiers) that accurately and best describe the services provided.
4. A clean claim has all appropriate ICD diagnosis code(s), carried to the highest level of specificity.
5. A clean claim has alphanumeric Level II HCPC J codes if billing for covered injectables.

The 1500 Health Insurance Claim Form (version 08/05) requires the reporting of the National Provider Identifier (NPI).

Please note:

- NPI and proprietary PIN for all physician/provider boxes – referring physician (box 17), rendering physician (box 31), facility where serves were indeed rendered (box 32) and billing (box 33).
- In addition, six claim detail lines have been divided horizontally to accommodate submission of NPI and proprietary identifiers. Additionally, the divided lines will also support the submission of supplemental information to support billed services (such as NDC for drug codes or anesthesia time).

### 8.9 SUBMITTING NPI AND COVENTRY PROPRIETARY NUMBERS (PIN/UPIN)

All providers must include their NPI provider identification numbers on all claim submissions. Coventry has made all internal changes necessary to accept, transmit and store NPI numbers. Providers may continue to use their legacy identifiers (UPIN and Coventry’s proprietary number) in addition to their NPI.

Please refer to the following guideline for submitting NPI and legacy provider ID numbers on the CMS 1500 Claim Form:
- Rendering Provider (Box 31) proprietary ID number should be submitted in Box 24J on the shaded part of the first claim line. The accompanying qualifier in Box 24I is not used, so any value may be included. (Note: Coventry will only read one rendering provider ID per claim - not different provider ids on separate claim lines)
- Rendering Provider (Box 31) NPI number should be submitted in Box 24J on the lower, non-shaded section of the first claim line. (Note: Coventry will only read one rendering provider ID per claim - not different provider ids on separate claim lines)
- The NPI # for the Facility where services are rendered (Box 32) should be submitted in box 32A on the new form.
- The Billing Provider (Box 33) NPI should be submitted in Box 33A.
- The Billing Provider (Box 33) proprietary number (if applicable) should be submitted in Box 33B.
8.10 OTHER REQUIREMENTS (UB 04 FIELD REQUIREMENTS)

Coventry does not have any special requirements in addition to the national instructions for the fields on the UB 04 form. Providers should refer to the Uniform Billing Expert as published by Ingenix for information on the proper submission of UB 04 (CMS 1450) claims.

Some of the more significant changes and data capture instructions for the UB 04 are listed below. Click here for a sample of the UB 04 or look to the end of this section.

Box 1 - Facility Name, Address and Telephone number
Used for the actual location address. Will only be captured if Box 2 is blank

Box 2 - Facility Pay-to Name and Address
Name and Address where payment should be sent. PO Box addresses are to be sent in this box.

Box 3a - Patient Control # (patient account #) no change
3b - Med. Rec. # (UB 04 Box 23)

Box 8a - Patient ID
This is the patient’s unique ID which will be captured for claims’ adjudication. If it is blank, the data will be captured from the old Box 60, which is insured ID on the UB 04

Box 8b - Patient Name (UB 04 Box 12)

Box 9a,b - Patient Address, City, State, Zip Code. (UB 04 Box 13)
c,d

Box 29 - Accident State (new field)
Not data captured

Box 39-41 - Value Codes
UB 04 boxes 8, 9, and 10 were deleted. Data will now need to be sent as value codes. All value codes will now be captured.

Box 42 - Revenue Code and line level details
Line 23 now consists of a Page number field, (# of # pages), a Creation Date Field, and a Total Charge field. The Total Charge field eliminates the need for Rev code 001.

Box 56 - NPI
Facility NPI should be submitted in this field.

Box 66 - DX Qualifier
Not currently used, but will distinguish between ICD and ICD coding.

Box 67 - Diagnosis
There is now a place for 18 codes, only first 4 are captured on First Claim. First 6 for IDX.
**Box 69 - Admit Diagnosis**
Should be used by provider on all inpatient claims

**Box 70 - Patient Reason For Visit**
For outpatient claims, this field contains the diagnosis code that indicates the reason for the visit. It should be used instead of an Admit Diagnosis field. This field will be keyed when the admit diagnosis field is blank and will populate in the Admit DX field in all systems.

**Box 71 - PPS CODE**
This is where the DRG code should be placed.

**Box 72 - External Cause of Injury**
Now up to three “E” diagnosis codes can be submitted for accidents. Only one will be captured.

**Box 74a-e - Principal Procedure code**
Key the same as today. First Claim – the first two are captured. IDX captures all.

**Box 81 - Code to Code Field**
This field is used to communicate any additional information not defined in a specific field. The main data element Coventry will be using from this field is the taxonomy code. A provider can submit a taxonomy (national specialty coding) to assist in the provider selection logic for facilities with separate sub-parts that share the same NPI number.
8.11 PENDED CLAIMS

HealthAmerica may pend the consideration of a claim for several reasons. The majority of pended claims result from the investigation of a claim’s authorization, fraud investigation, or the potential liability of another insurance company for payment of the claims (Coordination of Benefits or COB). A claim that has been pended for investigation will be addressed as either a payment or a denial on a future remittance advice. The number of pended claims can be reduced by ensuring only the services specifically authorized by HealthAmerica for payment are performed. If a provider decides at the time of service additional services will be necessary, please contact Medical Management at 1-800-669-2202 for WPA, NWPA and Ohio and 1-800-788-8445 for EPA/SEPA.

8.12 DENIED CLAIMS

HealthAmerica may deny payment of a claim for several reasons. It is important to remember if a provider disagrees with the denial reason of a claim, the provider should submit, within 60 days, a request for reconsideration to the Customer Service Organization. Please refer to “Claims Inquiry” (Click here or go to section 8.13) for further instruction. Resubmission of a denied claim will result in a “duplicate” denial. For some denial codes providers are permitted to bill the Member. For others, a provider is prohibited from billing the Member as a result of the provider’s contractual participation with HealthAmerica.

Editing Software

The editing software is a claim processing tool used to expedite and ensure the accuracy of claims’ payment. This software is used to review correct coding combinations based on the following criteria:

- CPT-4, HCPCS and ICD-CM coding definitions
- AMA and CMS guidelines and industry standards
- Medical policy and literature research
- Input from academic affiliations

The Editing Software also affords HealthAmerica the ability to customize the product to ensure consistency with Coventry Health Care, Inc.’s Medical Management policies and provider agreements. It is an integral part of our claims’ payment policy.

Clarification of Proper Coding

HealthAmerica uses software and clinical nurse reviewers to review correct coding combinations based on the following criteria:

Claims with one or more CPT 4 or HCPCS codes are audited. The relationship between the codes submitted is examined to ensure the correct application of procedural coding rules. The inappropriate CPT 4 procedure code is either denied or attached to a more comprehensive procedure code. This audit may result in a claim edit which may deny, reduce or adjust payment for covered services not billed or coded in accordance with the above mentioned standards. MCO may recover from provider’s amounts for services determined to have been improperly coded for up to eighteen (18) months from the submission of such bills.
HealthAmerica updates its medical claims’ review process continuously to ensure quality, consistency and integrity. These updates include a review of annual CPT 4 updates, changes in CMS/Medicare guidelines and specialty society guidelines.

Common terms seen with software editing:

“Incidental”- means the procedure is performed at the same time as a more comprehensive procedure and is, therefore, not reimbursable as the primary service

e.g. 94760 - Noninvasive ear or pulse oximetry for oxygen saturation; single determination
- is incidental to a more comprehensive procedure

“Mutually exclusive”- means two or more procedures not usually performed during the same encounter or on the same date of service

e.g. – Total Abdominal Hysterectomy and vaginal hysterectomy are not generally performed during the same encounter

“Duplicate edit”- Based on procedural definition, there are 4 types of duplicate edits:

1. "Bilateral" - procedure can be performed only once on a single date of service
2. "Unilateral/bilateral" - procedure can be performed only once on a single date of service
3. “Unilateral” billed twice when there is a bilateral code with the same definition
4. Maximum clinical possibilities; 47600 - cholecystectomy (only 1 allowed) or 29126 - application of short arm splint (only 2 allowed)

“Rebundle”- means two or more codes are being billed when there is a more comprehensive code for the services

e.g. - 82947 (glucose) and 84295 (sodium) are rebundled into 80048 (basic metabolic panel) when done on the same date of service

“Multiple Surgery Reductions”- The Editing Software will identify the primary procedure as the one with the highest RVU (relative value unit) and then add, if not on the claim, the -51 modifier to the rest of the surgical procedures billed. Physician reimbursement for Multiple Surgical Reductions are determined by the RVU Medicare assigns each procedure.

“Invalid code combination”- means an improper modifier was used with a CPT code

e.g. - using a 25 modifier with a surgical code

“Assistant Surgeon Denial”- this term may appear if an assistant surgeon is generally not indicated for the procedure billed. If there is an unusual procedure or circumstance, please submit notes with the claim. American College of Surgeons (ACS) is the primary source for determining assistant surgeon designations. Editing Software uses ACS designations based on the fact that ACS determines these designations using clinical guidelines versus statistical measures.

“Included in the Surgical Global package”- use appropriate modifiers if procedure is outside the surgical global package. Submit notes with appeal. Consider using CPT code 99024 for post-op visit.
Reconsideration of an editing software denial:

If there is a disagreement with the Editing Software denial, your organization can call the Customer Service Organization (CSO) at 1-800-735-4404 to initiate a reconsideration request, or the provider can mail the request to the claim re-submission address. Please be prepared to submit office notes, operative reports or any other additional supporting documentation. This process involves a review of the submitted information and the software auditing logic. The Medical Claim Review nurse will review the notes submitted and make a determination on whether or not to override the coding denial. Providers will be notified via the Remittance Advice as to the outcome of the code review request.

If the edit is upheld by the Medical Claims Review Nurse Department, the provider can request another reconsideration of the edit from the Medical Director by sending the claim and a letter from the physician stating why they disagree with the edit. The letter along with notes and documentation should be sent to: HealthAmerica, P.O. Box 7108, London KY, 40742-7108, for Commercial claims or to HealthAmerica Advantra, P.O. Box 7087, London, KY 40742-7087, for Advantra claims. All letters should be sent to: Attn: Medical Director, Editing Software Reconsideration.

Helpful Resources:

- ICD Manual
- CPT(current year) manual
- HCPCS (current year) manual
- AMA Corrective Coding Initiative
- Modifiers Made Easy
- CPT Assistant monthly newsletter
- Federal Register- copies are obtainable through the AMA
- St. Anthony’s Medicare Correct Coding Payment Manual
- HealthAmerica/HealthAssurance: Home
- www.Emdeon.com
- www.hgsa.com
- CPT® Network

Modifiers

HealthAmerica’s editing software is set up to recognize correct coding, including the appropriate use of modifiers.

It is important the appropriate modifier(s) be used on the original submission of the claim.

For Example:

- If a procedure is a staged procedure, the appropriate modifier should be appended to the procedure code on the original submission.

- If a procedure is an unrelated procedure or service by the same physician during the postoperative period, the appropriate modifier should be appended to the procedure code on the original submission.
• If the procedure is a distinct procedural service, the appropriate modifier should be appended to the procedure code on original submission.

• If the procedure is a significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service, the appropriate modifier should be appended to the procedure code on the original submission.

Medical records must support the use of the modifier. HealthAmerica has the right to ask for supporting documentation on a claim, including requesting the medical record. If a claim is resubmitted and a modifier is applied with the resubmission, the Medical Review staff and Medical Directors will request documentation to support the use of the modifier. If the medical records/notes do not support or justify the use of the modifier, the denial will be upheld.

Non-Covered Services

Provider shall not seek compensation from a Covered Individual for performance of non-Covered Services, including, without limitation, those services for which Provider sought payment from Coventry or a Payor, unless the Covered Individual so requested in writing Facility to render such services and Provider advised the Covered Individual of his/her payment responsibility prior to rendering any such services.

8.13 CLAIMS INQUIRY

If there are questions regarding claim status, several resources are available. Claim status can be verified via directprovider.com (click here to be directed to information in this manual about directprovider.com, go to www.directprovider.com to access the website, or refer to section 4.1.); or the provider can call the automated response system (My Voice Services) 1-800-735-4404. Use Option 2, then #2. For security purposes the provider must be prepared to enter the organization’s Tax Identification Number (TIN). At any time a provider may request an associate by using the appropriate prompt.

8.13.1 My Voice Services

My Voice Services uses state-of-the-art technology to give providers and members direct access to information by phone. Providers no longer need to press menu options and get stuck in “voicemail limbo.” Callers can use their own voice to interact with the telephone system and obtain some of the most commonly requested information quickly and privately. With My Voice Services, information that previously required speaking with a Member Services representative is available 24 hours a day, 7 days a week.

Providers are able to access the following information through My Voice Services:

• Claim Status summary and details regarding paid, denied, and pending claims.
• Authorization status information regarding authorizations issued by HealthAmerica.
  (Information will be faxed, not spoken).
• Eligibility information regarding Member coverage status and PCP information.
• Benefit Information such as co-pay and deductible information for the most common benefits

Members are also able to access claim, authorization, and benefit information as well as request ID cards via **My Voice Services.**

**My Voice Services** is easy to use. A caller should utilize the same toll-free number used to access the Customer Service Organization. The person will be guided through the available options. If the call is received during normal business hours, Monday to Friday from 7 am – 6 pm and Saturday from 9 am – 1 pm EST/EDT, the caller can easily transfer to Member Services if additional assistance is needed. The caller will also be given information on how to access help if there is any difficulty with the **My Voice Services** feature. Callers can also use the phone touch-tone keypad, rather than voice interaction, if it is preferred.

[Click here](#) for an outline of the Menu Options or [here](#) for helpful hints when using **My Voice Services** or refer to sections 8.13.2 and 8.13.3.

### 8.13.2 My Voice Services Features and Functions of Menus Options

<table>
<thead>
<tr>
<th>HealthAmerica @ 1-800-735-4404</th>
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</thead>
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<tr>
<td>Advantra @ 1-800-290-0190</td>
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</table>

<table>
<thead>
<tr>
<th>Menu Selection</th>
<th>Options</th>
<th>Result</th>
<th>Required Entry</th>
<th>Information Provided</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Main Menu</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Member</td>
<td>Claim Status</td>
<td>Remain in IVR, 10 claim maximum</td>
<td>Date of Service</td>
<td>Provider Name</td>
</tr>
<tr>
<td><strong>Must enter Member ID and DOB to proceed to Menu Selections</strong></td>
<td></td>
<td></td>
<td></td>
<td>Mbr Responsibility</td>
</tr>
<tr>
<td>Benefit Information</td>
<td>Remain in IVR</td>
<td>Select from list of available options</td>
<td></td>
<td>Most popular benefit categories offered for selection (i.e. physician office visit)</td>
</tr>
<tr>
<td>Authorization Information</td>
<td>Remain in IVR</td>
<td>Date of Service</td>
<td>Referral Number</td>
<td>Referred By</td>
</tr>
<tr>
<td>ID Card Request</td>
<td>Remain in IVR</td>
<td></td>
<td>From and To Dates</td>
<td>Type of Referral</td>
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<tr>
<td>None of these</td>
<td>Go to Plan Specific Menu and Prompts</td>
<td></td>
<td>Total Days</td>
<td></td>
</tr>
<tr>
<td>Provider</td>
<td>Claim Status</td>
<td>Remain in IVR</td>
<td>Member ID</td>
<td>Same as Member Claim Status</td>
</tr>
<tr>
<td><strong>Must enter Tax ID to proceed to Menu Selections</strong></td>
<td></td>
<td></td>
<td>Date of Service</td>
<td></td>
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</tbody>
</table>
### 8.13.3 My Voice Services Helpful Hints

**HealthAmerica @ 1-800-735-4404**

**Advantra @ 1-800-290-0190**

- “Short Cuts” - the caller does not have to wait for the IVR to indicate the options. Once the caller has learned the menu prompts the caller can always “short cut” the system and immediately state the desired menu options. For example, if the call is for claim status information, using the guide on the previous page, the caller can immediately state: “Provider, Claim Status” and then follow the prompts to enter Member data.
- Ask for “Help” as necessary
- Say “Repeat” if the a prompt is missed or a prompt is not understood
- To skip something, say “next”
- To return to the beginning, say “Main Menu”
- To end the call, say “Exit”
- Have any necessary account information handy
- When entering the 11 digit Member ID number, please be sure to include the Member’s suffix as part of the number, the 9 digits without the suffix will not be recognized.
- When entering information such as ID numbers or dates of service, the caller will be given 3 attempts to enter valid information in the correct format. After three failed attempts, the caller will be transferred to an agent queue.
• When callers are transferred by the system (on errors, etc.) the caller will hear a message explaining why they are being transferred.

Callers can easily obtain personal assistance by saying “agent,” or pressing “0” on your keypad.

Please note:

For Pennsylvania products, HealthAmerica requires that all claim issues be fully resolved within 18 months of the date of original payment and will not consider claims older that that time frame.

For Ohio products, HealthAmerica requires that all claim issues be fully resolved within 24 months of the date of original payment and will not consider claims older that that time frame.

To contest the payment or denial of a claim, 1) contact the Customer Service Organization, or 2) submit the appeal in writing to:

HealthAmerica
PO Box 7089
London KY, 40742-7089
Attn: Claims' Appeals
(Detail the appeal reason and attach documentation as appropriate)

Advantra (Medicare Advantage): Click here to go to the Advantra section for guidelines or refer to Chapter 3.

8.14 RESUBMISSION GUIDELINES

• Any additional documentation (e.g. other payor remittance advices, operative reports, etc.) requested by HealthAmerica for review on the first claim submission should be affixed to the resubmitted claim.

• Other identifiers such as a colored face sheet, or “Second Submission” stamped on the resubmitted claim must be used in order for the resubmitted claims to be processed appropriately.

Note: For this process to be effective, it is imperative these post office boxes only be used for re-submissions. Any “new” (initial) claims submitted to these post office boxes will be forwarded to the appropriate post office box, thus delaying the payment process.

The established post office boxes for resubmission claims only, are as follows:

| WPA & NWPA resubmission is the same as the original submission address: | Advantra resubmission is the same as the original submission address. |
| P.O. Box 7129 | Advantra Claims: |
| London, KY 40742-7129 | Advantra |
| | P.O. Box 7087 |
| | London, KY 40742-7087 |

| EPA/SEPA resubmission is the same as the original submission | |
Examples of appropriate claims’ resubmissions are as follows:

- Claim denied for additional information (Please attach the requested information with the resubmitted claim)
- Claim paid incorrectly according to contracted rates
- Miscoded Claims
- Inquiries for resubmitted claims can be directed to:
  - HealthAmerica: 1-800-735-4404
  - Advantra: 1-800-290-0190

Resubmissions Helpful Hints:

- For UB 04 submissions, please note it is a resubmission and list the original claim number in Box 84.

- Clearly note the reason for the resubmission on the claim. The following are some examples:
  
  … For a claim where additional information was requested, attach the requested medical records and note the claim number by attaching a highlighted copy of the remittance advice for the original claim.
  … For a claim denied for miscoding, attach a highlighted copy of the remittance advice for the original claim and note the correction.
  … For a claim HealthAmerica has no record of receiving, include a screen print or other documentation of the date of original submission.

- As the resubmission is prepared, please check to see if this is the second or third time that the claim has been resubmitted. If the claim has been submitted more than twice, it may indicate a problem with the billing process. Please call the Customer Service department to check on the status of the claim before submitting the claim again.
8.15 CLAIM SUBMISSION HELPFUL HINTS

• Submit same-day charges on one claim. For example, if an office visit and lab services occur on the same date, billed charges for both services should be submitted on the same claim.

• Physical therapy, chemotherapy or radiation therapy claims should all be itemized, rather than date spanned.

• The name of the Primary Care Physician that acquired the authorization and the authorization number should be identified.

• Coordination of Benefit (COB) information is critical to the processing of any claim by HealthAmerica. BOX 9A THROUGH 11D MUST BE COMPLETED. Indicate “NONE” if no other coverage. Other insurance information should be provided. If another insurance carrier has been billed, please attach a copy of the primary carrier’s Explanation of Benefits.

• Always use current CPT 4, ICD and HCPCS codes. Utilize current CPT or Level II HCPC codes with appropriate modifiers when itemizing procedures. (Procedure Terminology Manual (PTM) codes are inappropriate for third-party payors). Claims submitted with invalid procedure codes or missing codes will be processed and denied due to lack of supporting documentation.

• Appropriate ICD diagnosis code(s) must appear on the claim form and should be carried out to the highest level of specificity.

• If a claim is submitted with a procedure code followed by a 22 modifier, supporting documentation (i.e., operative report/office notes) must accompany the claim. This excludes lab tests referenced in the HealthAmerica WPA lab policy (click here to be directed to the WPA lab policy or refer to section 5.4.4.)

• For any codes in the 10000-60000 surgery code range ending in 99 an operative report must accompany the claim.

• Always submit notes when billing with Unlisted Procedure codes (99 codes).

• If two or more surgical procedures are performed during the same surgical setting, the claim will be subject to clinical code review.

• Alphanumeric HCPCS codes for supplies must be used instead of a generic supply code. A description of the supply is recommended when the HCPC code does not adequately describe the service rendered.

• Claim submissions must include alphanumeric Level II HCPC J codes whenever possible when billing for covered injectable drugs. It is also necessary to include the correct number of units for accurate reimbursement.

• For unlisted drugs classified J3490/J3590/J9999 the Name, Dose, and NDC# is required.
• Multiple Procedures – either the same code or similar codes add the “51” modifier to the second procedure. Note: Due to billing requirements, outpatient facilities are not required to report modifier 51 when submitting surgery claims on a UB 04.

• Bilateral Procedures – use “50” modifier and “1” unit, when the CPT definition of the code does not already specify bilateral procedure. If by CPT definition the code states bilateral, **Do Not add a “50” modifier.**

• Physician Assistants – Acting as Assistant Surgeons – use “AS” Modifier. Bill with Physician Assistant’s name in Box 31.

• MD’s – Acting as Assistant Surgeons – use “80/82” Modifier. **Do Not use “AS” Modifier.** Bill with MD assistant surgeon’s name in box 31.

• Physician Assistants (Office Based) – bill with Physician Assistant’s name in Box 31.

• CRNP (Office Based) – bill with CRNP’s name in Box 31.

• Locum Tenens – bill physicians name in Box 31 and use a “Q6” Modifier.

• **Splitting Charges/Reimbursement** between physician for surgical care and physician for postoperative care –
  - 54-Surgical Care Only
  - 55-Postoperative Management
    • Physician billing for Surgical Care should bill with the “54” modifier. The physician will be reimbursed at 70% of contractual amount.
    • Physician billing for Post-Operative Care should bill the same procedure code with the “55” modifier. The physician will be reimbursed at 30% of contractual amount.
    • Both physicians should bill with the actual date of the procedure in box 24A of the HCFA form.
    • The postoperative physician using “55” modifier should note date of postoperative care in box 19 of the HCFA form.
      (Box 19 does not affect payment or the processing of the claim but will allow this information to be available if needed for review to avoid claim denying as a duplicate)

The above information applies to situations where both physicians are with the same group and also when the physicians are from two separate groups/tax identification numbers.

• Any questionable ER services (e.g. diagnosis is non-trauma related such as headache, pain, fever, etc.) should be submitted with the ER notes to the appropriate P.O. Box.

• If at all possible, submit a completed billing. Submitting late charges on any claim (specifically inpatient or surgery claims) will cause an adjustment that will slow down payment.

• **UB 04 forms.** Always indicate the type of bill in field 4 on the UB 04.

• **UB 04 forms.** Many revenue codes also require the reporting of a supporting CPT or HCPC code. Providers should follow the revenue code/CPT code billing requirements as defined within the *Uniform Billing Expert* published by *Ingenix.*
8.15.1 Claim Addresses

WPA and NWPA

Initial claim submission          Claim resubmission
HealthAmerica                     HealthAmerica
PO Box 7088                        PO Box 7088
London, KY 40742-7088              London, KY 40742-7088

Advantra
PO Box 7087                        PO Box 7087
London KY 40742-7087                London, KY 40742-7087

EPA and SEPA

Initial claim submission          Claim resubmission
HealthAmerica                     HealthAmerica
PO Box 7089                        PO Box 7089
London, KY 40742-7089              London, KY 40742-7089

Advantra
PO Box 7087                        PO Box 7087
London KY 40742-7087                London, KY 40742-7087

Other Addresses for initial claim submission:

Central PA Teamsters             HealthAmerica One                  CHC of West Virginia (formerly Carelink Health Plan)
Health & Welfare Fund             Attn: Claims                      PO Box 7373
PO Box 15224                      P.O. Box 7142                     London KY 40742-7373
Reading PA 19612                  London, KY 40742-7142

Claim status check: Inquiry on a submitted claim may be done by accessing DirectProvider.com or the HealthAmerica Interactive Voice Response (IVR) line: 1.800.735.4404.

Balance billing: Participating providers are contractually bound to accept contracted rates as payment in full for services rendered. The Member is to be held harmless for any contractual adjustment balance.

Claim disposition legend: A single disposition code is printed per claim line. Additional disposition codes may apply to a claim line not reflected on the remittance. Please review each claim thoroughly for any billing correction considerations before submitting a corrected claim.
8.15.2 Timely Filing

- Claims initially denied for timely filing must be contested within the greater of:
  1. 18 months of the timely filing denial for the Commonwealth of Pennsylvania;
  2. 24 months of the timely filing denial for the State of Ohio;
  2. within four (4) months of the date of notice from another carrier denying or limiting the other carrier’s liability;
  3. within four (4) months of receiving a change in insurance information from the Member.

- If the provider is disputing the denial on the basis the original claim was previously filed in a timely fashion, the provider should supply documentation supporting the original filing date, such as a screen print indicating the first transmittal date and documentation of follow-up with Health America.

- Timely filing grid
### CSO Member Appeal, Payment Reconsideration, and Denial Appeal Policy for PAR

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<thead>
<tr>
<th>Situation</th>
<th>Standard Rule</th>
<th>Follow-up Extension</th>
<th>COB/Subrogation Exception</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Timely Filing Denial</strong></td>
<td><strong>PAR Provider</strong>&lt;br&gt;The claim must initially be acknowledged by a denial, documented call, letter, etc. within 9 months of the date of service to be considered for appeal. Appeals must be received within 18 months of the timely denial for Pennsylvania; 24 months of the timely denial for Ohio:</td>
<td><strong>PAR Provider</strong>&lt;br&gt;Appeals may be extended beyond these requirements as long as the initial contact was within 9 months of the date of service and there is evidence of continual follow-up within 4 months of the last contact.</td>
<td><strong>PAR Provider</strong>&lt;br&gt;Appeals may be extended to within 4 months of date of the primary carrier’s EOB.</td>
</tr>
<tr>
<td><strong>Invalid Submission, missing info, improper coding</strong></td>
<td><strong>PAR Provider</strong>&lt;br&gt;Corrected information must be received within 4 months of the request</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Records, Notes, or Additional Information Requested</strong></td>
<td><strong>PAR Provider</strong>&lt;br&gt;Requested documents must be received within 4 months of the request.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Additional Payment Reconsideration</strong></td>
<td><strong>PAR Provider</strong>&lt;br&gt;Appeal must be received within 18 months of the Original Payment Date for Pennsylvania; 24 months of the Original Payment Date for Ohio.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Withhold Appeal</strong></td>
<td><strong>PAR Provider</strong>&lt;br&gt;Appeal must be received within the greater of 12 months from the Date of Service or 60 days from the withhold date.</td>
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</tbody>
</table>

* These guidelines apply to claims submissions only. These guidelines are not in lieu of and do not supersede Member appeal rights or the prior authorization reconsideration process.
8.15.3 Denial Appeal Policy

Unless otherwise noted below, all claims must be submitted timely by the provider and the receipt acknowledged by either a payment, denial or request for additional information from HealthAmerica within nine (9) months of the date of service (“DOS”) in order to request reconsideration of the decision. Notwithstanding the foregoing, all claims will be processed in accordance with the applicable laws then in effect.

The following are some of the most common reasons for claim denials and information the Provider should provide when contesting the denial:

- **Denied Not Medically Necessary/Non-Covered Service**
  A separate detailed policy exists for appeals of denials based on medical necessity. This policy is to be followed for all denials of this nature. In addition, appeals on the grounds that a non-covered benefit may improve the condition of the Member are also subject to this policy. [Click here](#) for the appeals of denials policy or refer to section 7.2.

  This policy does not prohibit the collection of charges for services which are not Covered Services provided that the patient has been informed *in advance of delivery of such services that such services are not covered and patient has agreed in writing to accept responsibility for payment of such services.*

  We advise that an executed waiver be submitted with the medical documentation when providing services that may be denied for medical necessity. [Click here](#) to go to a sample waiver document or refer to Chapter 10 Appendix.

- **“Closed” – Additional Records Requested**
  For claims initially denied or “closed” for additional records, in order for HealthAmerica to determine if 1) a procedure was medically necessary, 2) the conditions met the prudent layperson definition for urgent/emergent claims, or 3) the diagnoses codes match the level of care billed, the provider must supply the additional information requested within four (4) months of the date of such request.

- **Invalid Submission**
  If a claim is initially denied as an invalid submission (missing information, improper coding, the CPT code does not correspond with the eligibility information, etc.), the provider must supply the additional information requested within four (4) months of the date of the request.

- **Denied – Covered Under Capitation**
  If the claims were initially denied as covered under capitation, the provider may appeal the denial within 18 months of the date of the denial for the State of Pennsylvania.

  If the claims were initially denied as covered under capitation, the provider may appeal the denial within 24 months of the date of the denial for the State of Ohio.
• **Denied COB/Subrogation**

Claims denied because it is suspected that another payor is liable may be appealed within the greater of:

1. 18 months of the date of the denial for the State of Pennsylvania;  
   24 months of the date of the denial for the State of Ohio; or

2. four (4) months of the date of notice from another carrier denying or limiting the other carrier’s liability.

• **Denied Upon Review of Initial Decision – Retroactive Termination**

If a claim is initially paid and subsequently denied because the Member’s eligibility was retroactively terminated, the decision to deny the claim will not be reversed solely because another carrier refuses to accept liability for reasons of timely filing.

Should the other carrier deny liability on these grounds, the provider may hold the Member liable after they have properly pursued the claim through the other carrier’s appeal process.

• **ASO Contracts**

Self-funded clients may request a previously denied claim be overturned for any reason.

If a claim that was initially denied is subsequently appealed, and it appears there are legitimate reasons to reverse the original decision:

1. for active groups, the self-funded employer must approve any payment:
   
   a. made more than 12 months from the DOS or;  
   b. in excess of $5,000.

2. for terminated groups, the self-funded employer must approve all payments.

• **For the State of Ohio - payment considered final after two years**

Under Ohio Revised Code section 3901.388 a payment made by a third-party payer to a provider in accordance with the Act is to be considered final two years after the payment is made. After that date, the amount is not subject to adjustment, except in the case of fraud by the provider.
HealthAmerica coordinates benefits with other health insurance companies in accordance with the terms of the member’s coverage and applicable federal and state law, including, but not limited to, the Pennsylvania Motor Vehicle Financial Responsibility Law and Worker’s Compensation.

It is especially important any information regarding all insurers potentially liable for services rendered to our Members is provided. Services involving minors, dependents, accidents or injuries occurring anywhere, need to be specifically addressed.

HealthAmerica periodically requests information from Members regarding other insurance coverage. Claims submitted for Members who have not completed a recent request (COB and/or accident questionnaire), may be pended for COB review.

**Note:** When HealthAmerica is the “secondary” insurer, the obligations of all parties remain the same, except for the requirement to provide additional information needed to coordinate benefits, as outlined in the preceding paragraphs. Pre-certification and authorization are still required, where applicable, for payment of services to occur. Claims must be filed to receive payment for any portion not covered by the primary carrier. Balance billing Members is not permitted. If not specified in the Member Contract, a “benefit less benefit” payment calculation shall be applied so that the combination of the other insurer or third party payment and HealthAmerica’s payment does not exceed the payment obligation.

**Medicare Coordination of Benefits for Electronic Claims Processing**

HealthAmerica and Carelink can accept secondary claims electronically. Electronic claims are received in two ways: 1) directly from Medicare via GHI, Medicare’s COB contractor or 2) from Emdeon via provider submissions. Medicare claims forwarded directly from Medicare for processing are considered “crossover” claims. HealthAmerica does not have a direct connection with any other payer to receive secondary claims. All other COB claims must be sent via the provider-to-payer approach through Emdeon or via paper claims.

Members or employers are required to provide Coordination of Benefits (COB) information to health plans. An eligibility extract is generated from our claims’ system for Members primary with Medicare. It is submitted to GHI (Medicare’s contractor) on a regular basis. GHI will then match claims received from all Medicare intermediaries/contractors with the eligibility data supplied by health plans and determine which claims to submit to participating payers. These claims are submitted to HealthAmerica and other payers daily, Monday through Friday.

A provider can determine if a claim has been sent to HealthAmerica from Medicare/GHI by reviewing the Medicare remittance. On the Medicare remittance/explanation of payment there is a remark code of “MA18” if Medicare has sent the claim to the secondary payer from GHI.

Providers can use [directprovider.com](http://directprovider.com) to validate receipt of the crossover claim. Please only file secondary Medicare claims directly to HealthAmerica when the claim in question is not in directprovider.com and it is at least ten (10) days since the original claim filing.

Medicare’s website provides the official information about this process. Click on the following link to be connected to this information: [Coordination of Benefits - Centers for Medicare & Medicaid Services](http://www.medicaid.gov)
8.15.5 Coventry Consumer Choice (SM) Products

Coventry Consumer Choice (C3) is Coventry Health Care's full suite of consumer-directed health plan options. If a provider renders services to a patient who has a C3 plan, the provider needs to do the following:

1. Check the patient’s ID card and verify participation by calling the number on back of the ID card.
2. Send all claims to the address on the back of the ID card.
3. Allow Coventry to process the claim before requesting payment from the patient. Doing so allows appropriate discounts to be applied and also ensures accurate payment.

C3 uses the Smart Payment feature where the correct party is automatically paid, whether it is the Member or the provider. Coventry is committed to paying claims promptly and correctly.

Providers will only be paid directly for deductible or coinsurance payments (co-payments are sent to the Members). The Explanation of Payment (EOP) identifies the Member and the amount being paid for that Member.

Direct deposit providers (EFT) will receive EOPs 7 to 10 business days after the deposit has been made. These payments can be identified by the issuer’s company name, listed as either HealthEquity or Coventry Health.

Coventry has added the C3 benefit information on the eligibility screen in directprovider.com. The feature demonstrates:

- C3 deductible accumulator information
- Available balances

For questions or further assistance, please contact the number on the back of the Member’s ID card. If the customer service agent is unable to answer the inquiry, the call will be transferred to the dedicated C3 customer service team.

8.15.6 Remittance Advice Information

Remittance Advice Example

Each finalized claim (whether paid or non paid) is reported on a Remittance Advice. The Remittance Advice will be mailed to the provider via USPS unless the provider is enrolled for EFT payments, and/or ERA/835 files. ERA and/or EFT users will not have their paper RAs mailed to them. PDFs of the paper RA are available via our free provider portal www.directprovider.com.
Refer to “How to Read Your Remittance Advice” on the next page.
<table>
<thead>
<tr>
<th>Service Dates</th>
<th>Proc Mod Drg Code</th>
<th>APC</th>
<th>Procedure Description</th>
<th>Cap Total</th>
<th>Changes</th>
<th>Allowed Amount</th>
<th>Ineligible Amount</th>
<th>Inelig DC</th>
<th>COR DC</th>
<th>Deductible Amount</th>
<th>Copay Amount</th>
<th>Mar Coins</th>
<th>Mar Receipts</th>
<th>Nbr DC</th>
<th>RC</th>
<th>ADJ</th>
<th>Paid Amount</th>
</tr>
</thead>
</table>

**Provider Summary:**

| | Total | Changes | Allowed Amount | Ineligible Amount | Deductible Amount | Copay Amount | Mar Coins | Mar Receipts | Nbr DC | ADJ | Paid Amount |
| | | | | | | | | | | | |

| Non-Elective Claims Total: |
| | | | | | | | | | | |

| Provider Claims Total: |
| | | | | | | | | | | |

| PRIMARY CARE PHYSICIAN Claim Total: |
| | | | | | | | | | | |

| Provider Refund Total: |
| | | | | | | | | | | |

**Provider Not Refund Summary:**

| Provider Check Summary: |
| | | | | | | | | | | |

**Remark Code**: can be located at [http://www.wspedi.com/codes/merilliance]|
8.15.7 Posting a Remittance Advice

Post a Remittance Advice

- **Posting “Completely”**: It is important to post the remittance advice amounts and review the entire remittance advice in order to determine if important procedural information has been provided. For example, HealthAmerica may have asked the provider to resubmit the claim with notes, denied the claim as Member ineligible on the date of service, indicated the Member had other, primary insurance, or the billed service was not a covered benefit. All of these examples require an action by the provider. If nothing is done the claim will remain unpaid. If the issue is addressed, then the provider’s accounts receivable will only include outstanding, bona fide claims.

- **Posting of Transactions**: Several providers have indicated a difficulty with posting entries that include adjustments of previous claim overpayments. The following is a sample accounting entry (the account names may vary) to post these transactions to a provider’s accounts:

<table>
<thead>
<tr>
<th><strong>Dr</strong></th>
<th>Cash</th>
<th><strong>$90.00</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Note: The above entry assumes the provider recorded the following entry when the refund check was issued:

Dr.  Accounts Payable – Duplicate Reimbursement $85.00  
Cr.  Cash $85.00

- **Sample Format:** [Click here](#) for a sample Remittance Advice Summary report or refer to section 8.15.6 above. Slight variations may be seen among products.

- **Differentiation of Products:** A product identifier is indicated in field #3. This product identifier indicates what type of benefit(s) applies to the payments reflected on the check/remittance advice summary.

- **Distribution:** Checks and Remittance Advice Summary reports are printed and mailed 1-2 times per week, depending on the check run schedule. Since HealthAmerica has individual bank accounts for various product lines, providers may receive more than one check/remittance advice summary in one envelope.

**Claim Accept/Reject messaging during the Coventry to Aetna Migration Period:**
As Aetna and Coventry continue to integrate and migrate business, it may be difficult separating appropriate Coventry claim submissions from Aetna claim submissions. Aetna has implemented a process to ensure claims are routed to the appropriate adjudication system regardless of how they are submitted.

For claims received by Aetna, which are not identified for an active Aetna member, Aetna will attempt to determine if the member is actually covered under a legacy Coventry plan. This process will be transparent to you and will occur with any method of submission for professional, dental, and facility claims. Similarly, a claim that is originally received by Coventry and the member is not found or not effective on the legacy plan will be electronically sent to Aetna to determine if the member has active Aetna coverage.

If an active member is found, you will receive the adjudication results (EOB/request letters, etc.) from the correct system regardless of where the claim was submitted originally. If an active member is not found under Aetna nor one of the legacy Coventry plan, then the submitter will receive a reject message.

<table>
<thead>
<tr>
<th>Claim Submitted to:</th>
<th>Type</th>
<th>Result</th>
<th>Communication to Submitter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coventry</td>
<td>EDI/Paper</td>
<td>Active Coventry Member</td>
<td>Coventry Remit</td>
</tr>
<tr>
<td>Coventry</td>
<td>EDI/Paper</td>
<td>Active Aetna Member</td>
<td>Aetna Remit</td>
</tr>
<tr>
<td>Coventry</td>
<td>Paper</td>
<td>Not Active Coventry or Aetna</td>
<td>Coventry Reject Letter</td>
</tr>
<tr>
<td>Coventry EDI</td>
<td>Not Active Coventry or Aetna</td>
<td>Coventry Reject Message</td>
<td></td>
</tr>
<tr>
<td>-------------</td>
<td>-----------------------------</td>
<td>-------------------------</td>
<td></td>
</tr>
<tr>
<td>Claim Submitted to:</td>
<td>Type</td>
<td>Result</td>
<td>Communication to Submitter</td>
</tr>
<tr>
<td>Aetna</td>
<td>EDI/Paper</td>
<td>Active Aetna Member</td>
<td>Aetna Remit</td>
</tr>
<tr>
<td>Aetna</td>
<td>EDI/Paper</td>
<td>Active Coventry Member</td>
<td>Coventry Remit</td>
</tr>
<tr>
<td>Aetna</td>
<td>Paper</td>
<td>Not Active Coventry or Aetna</td>
<td>Aetna sends reject Letter</td>
</tr>
<tr>
<td>Aetna</td>
<td>EDI</td>
<td>Not Active Coventry or Aetna</td>
<td>Aetna reject message</td>
</tr>
</tbody>
</table>

### 8.15.8 Collection Advice Summary

HealthAmerica will issue a separate remittance advice indicating when adjusted claims have resulted in overpayment amounts owed to HealthAmerica.

This remittance advice will be titled “Collection Advice Summary.” HealthAmerica will release this remittance advice at the beginning of every month when there is an outstanding overpayment due. Collection Advice Summaries are also available on DirectProvider.com.

This Collection Advice Summary remittance will indicate the specific claims that have been adjusted by HealthAmerica and the remaining overpayment. It is very important not to post the claims that are on the Collection Advice Summary. These claims will remain on the Collection Advice month after month until the overpayment is resolved. Once the overpayment is resolved all claims will be sent to you on a postable Remittance Advice. Please make checks payable to HealthAmerica, Advantra, or Coventry Health and Life as applicable and remit to:

HealthAmerica – Refunds
P.O. Box 784182
Philadelphia, PA 19178-4182.

**Note:** Include a copy of the appropriate Collection Advice Summary remittance so that funds received can be applied to the appropriate accounts.

This remittance does not include a cash payment, but rather indicates amounts are owed to HealthAmerica or Advantra. If a payment is not made, HealthAmerica will continue to deduct the outstanding overpayment amount from future claims. This process is commonly referred to as an “offset” or “withhold” of future claim payments. The claims offset or withheld will be indicated on the provider’s standard remittance advice, as claims are processed against the outstanding overpaid balance. Each month there is an outstanding overpaid balance, HealthAmerica will remit this separate advice, which will indicate the original claim adjustment that created the net amount overpaid, the claims that have been withheld against this outstanding balance, and the new overpayment balance.

If the overpayment is not offset or payment is not received within six (6) months of the initial notice, HealthAmerica will initiate collection via a third-party collection agency.
If there are any questions regarding this process please call your Provider Relations Representative or the Customer Service Organization in your service area.

Advantra Providers: 1-800-290-0190
Central and Southeastern PA Providers: 1-800-788-8445
Northwestern PA Providers: 1-800-752-4404
Western PA and Ohio Providers: 1-800-735-4404

Refer to the next page to see a Collection Advice Summary example.
**Collection Advice Summary Example**

Collection Advice Summary – HealthAmerica Pennsylvania, Inc.

Provider XXXXXX: XXXXXX, XXXXX

<table>
<thead>
<tr>
<th>Service Dates From</th>
<th>To</th>
<th>Proc Code</th>
<th>Mod</th>
<th>DRG</th>
<th>APC</th>
<th>Procedure Description</th>
<th>Cap Charges</th>
<th>Total</th>
<th>Allowed</th>
<th>Ins eligible</th>
<th>Ineligible</th>
<th>Prv DC</th>
<th>Deductible</th>
<th>CoPay</th>
<th>Mbr Ctrns</th>
<th>Mbr Mbr</th>
<th>Mbr Response</th>
<th>Mbr Paid</th>
<th>Paid Amt</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/03/03</td>
<td>01/03/03</td>
<td>99214</td>
<td></td>
<td></td>
<td></td>
<td>OFFICE/OP VISIT, EST 25 MINN</td>
<td>$10.00</td>
<td>$10.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$-10.00</td>
<td>$10.00</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

Check #: 

<table>
<thead>
<tr>
<th>Service Dates From</th>
<th>To</th>
<th>Proc Code</th>
<th>Mod</th>
<th>DRG</th>
<th>APC</th>
<th>Procedure Description</th>
<th>Cap Charges</th>
<th>Total</th>
<th>Allowed</th>
<th>Ins eligible</th>
<th>Ineligible</th>
<th>Prv DC</th>
<th>Deductible</th>
<th>CoPay</th>
<th>Mbr Ctrns</th>
<th>Mbr Mbr</th>
<th>Mbr Response</th>
<th>Mbr Paid</th>
<th>Paid Amt</th>
</tr>
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<tr>
<td>01/03/03</td>
<td>01/03/03</td>
<td>99214</td>
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<td>$10.00</td>
<td>$10.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$-10.00</td>
<td>$10.00</td>
</tr>
</tbody>
</table>

Check #: 

Provider Summary:

Nonstatistical Claims Line Totals:

Provider Claims Totals:

Provider Disposition Codes Description (Prv DC):

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>015X</td>
<td>INELIGIBLE - DOLLAR AMOUNT ABOVE CONTRACTUAL ALLOWANCE</td>
</tr>
</tbody>
</table>

Member Disposition Codes Description (Mbr DC):

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0245</td>
<td>APPROVED - SERVICE APPROVED FOR PAYMENT</td>
</tr>
<tr>
<td>0931</td>
<td>ENROL RETROACTIVE TERMINATION OF MEMBER CONTRACT</td>
</tr>
</tbody>
</table>

Please make your check in the amount of $7.86 payable to:

HealthAmerica PA - Refunds
P.O. Box 9500-54192
Philadelphia PA 19176-4192

Please call your customer service center.
8.15.9 Recoveries Unit

The Recovery Department works with providers on reclaiming funds owed to HealthAmerica for claims incorrectly paid or billed. Examples may include, but are not limited to, adjustments to previously processed claims, duplicate payments, improper benefit interpretations, fee schedule corrections and ineligible Member recoveries.

In the event HealthAmerica has overpaid a claim, the provider should return the funds to our Recovery lock box (a check from provider’s own account). The address is:

HealthAmerica - Refunds
PO Box 784182
Philadelphia, PA 19178-4182

Teamsters
Central Pennsylvania Teamsters
Health and Welfare Fund
P.O. Box 15224
Reading, PA 19612-5224

If HealthAmerica has issued the provider a check in error, the provider should return the original HealthAmerica check to our Recovery team. The address is:

HealthAmerica and Advantra
120 East Kensinger Drive
Cranberry Twp, PA 16066
Attention: RECOVERIES DEPT

Please make checks payable to HealthAmerica, Advantra, Coventry, or American Services Life as applicable. Include with the refund checks any HealthAmerica correspondence or Remittance Advice(s) and an explanation of why these funds are being returned. Doing so will ensure timely deposits of the funds and the proper crediting of these funds to the correct patient accounts. Please do not send claims to the lock box address listed above.

If the Recovery Department identifies overpaid claims, a recovery effort will be initiated. The original claim will be reversed and replaced with a properly adjudicated claim, resulting in a net amount. This net amount will be deducted from a future remittance. This process is more commonly referred to as an “offset” or “withhold” of future claims’ payment.

If you have any questions regarding a recovery appearing on your remittance advice, please contact the Customer Service Organization at 1-800-735-4404.

HealthAmerica has incorporated the following into our policy on recoveries of incorrect payments.

1. A recovery effort by HealthAmerica will begin no later than 18 months after the date of the last payment or claim denial. In accordance with Pennsylvania Act 68, the date of payment is considered to be the date the check is mailed to the provider or the date funds are transferred electronically to the provider. In accordance with Ohio law, the date of payment
is considered to be the date the check is mailed to the provider or the date funds are transferred electronically to the provider.

2. In general, HealthAmerica will recover overpayments by withholding the identified overpaid amount from future claim payments. If the recovery amount is significant, HealthAmerica may initiate alternative recovery arrangements with the provider. Providers should contact their Provider Relations Representative if they need more information or need to discuss a specific recovery situation.

3. Providers may request HealthAmerica to reconsider the payment decision of a previously processed claim up to 18 months after the date of the last payment. **Note:** this request only applies to any previously processed claim, not part of a current recovery effort.

The provisions of the HealthAmerica Recovery Policy do not alter or supersede the timely claim submission requirements in the provider agreements or the HealthAmerica appeals policy. Also, this policy does not apply to cases of suspected fraudulent activity.
9. COMMERCIAL PHARMACY BENEFITS

9.1 GENERAL

Most HealthAmerica members have coverage for prescription drugs that are routinely self-administered. These members are provided covered drugs for a co-payment (and sometimes an ancillary charge) when they use one of our contracted pharmacies (see Locate a Pharmacy on HealthAmerica’s website at www.healthamerica.cvty.com). Co-payments differ by employer group and can range from $0 to 50%. For the co-payment, most members are able to receive up to a 31-day supply or 100 units (whichever is less) from a contracted retail pharmacy. Some drugs have additional quantity limits based on FDA approved dosing or coverage limitations. Members prescribed covered drugs available in commercially prepackaged containers (inhalers, topical creams, eye drops, etc., excluding insulin) are charged one co-pay per container. Many employer groups also offer a mail order option.

Disclaimer: HealthAmerica members’ coverage varies in accordance with their benefits documents. The foregoing paragraph is intended only as an example.

9.2 FORMULARY

HealthAmerica and Coventry National Plans Formulary Link:


HealthAmerica utilizes a formulary. Copies of the formulary are available on our web site www.healthamerica.cvty.com or by clicking on the direct link above. Other important formulary related information can be found at http://healthamerica.coventryhealthcare.com/health-care-solutions/prescription-coverage/prescription-documents/index.htm. The formulary is set by our National Pharmacy & Therapeutics Committee. The criteria used to decide formulary and prior authorization include, but are not limited to, the following:

- Safety of the medication
- Effectiveness of the new medication compared to other currently approved medications
- Cost compared to other currently approved medications
9.3 CO-PAYMENTS/Generic Policy

As noted in the General section above, co-payments can vary. Most members have either a two-tier managed (closed) formulary or three-tier open formulary co-payment plan. Under a two-tier managed formulary plan, Tier One drugs include formulary generic drugs and select brand, including OTC (over the counter) drugs, covered at a lower co-payment; Tier Two drugs include formulary brand drugs and are covered at a higher co-payment. Our benefits are designed to pass on savings to our members when safe, effective and less-costly generic drugs are prescribed for the condition being treated. Typically coverage for non-formulary drugs, under a two-tier managed plan, is only provided through the formulary exception process.

Under a three-tier open formulary design, members pay the co-payment as outlined above for Tier One and Tier Two drugs. In addition, non-formulary drugs are covered at a Tier Three co-pay. Most brand versions of drugs available generically are also subject to an ancillary charge independent of the Tier. Since non-formulary drugs are covered under the three-tier design, coverage or tier exceptions are not granted.

HealthAmerica offers several options to employers for coverage of brand drugs when a generic is available. The most common are Mandatory Generic and Incentive Generic Benefits. For individuals who have prescription coverage under HealthAmerica, coverage is provided for the generic drug when:

1. An FDA approved generic alternative exists
2. The substitution is permissible by law

Exceptions to the generic policy include contraceptives and narrow therapeutic index drugs such as levothyroxine, warfarin, etc.

**Mandatory Generic Benefit and Ancillary Charge**

Under a Mandatory Generic Benefits and Ancillary Charge, if either the physician or member requests a brand name medication and the above criteria are met, the member must pay the appropriate Tier co-pay and the Ancillary Charge or Dispense as Written (DAW) charge. The Ancillary Charge is the difference between the cost of the brand and the cost of the generic medication. This charge is added to the appropriate co-payment.

**Incentive Generic Benefit**

Under an Incentive Generic Benefits design, the member will pay the Tier Three co-pay since the brand drug is considered non-formulary.
9.4 DEDUCTIBLES/BENEFIT MAXIMUMS

Some employers choose a benefit design that incorporates a deductible. Under these designs, the member is responsible for 100% of our discounted cost of the prescription until the deductible is met. Some designs can have individual, family prescription only or combined medical & pharmacy deductible amounts. Benefits can be set up on either a calendar year or contract year basis. The patient is responsible for knowing if his/her benefit has a deductible, how much it is and what period is used to accumulate it. Benefit maximums and maximum out-of-pocket expenses are other features used by different employers. Under a maximum out-of-pocket design, the member who has higher expenses (as defined by the employer), will receive continued coverage at reduced cost to the member once the out of pocket maximum has been met.

9.5 MAIL ORDER

The Mail Order Pharmacy benefit allows members to order certain maintenance medications through the mail. Maintenance medications are drugs needed for long-term or chronic conditions such as high blood pressure, high cholesterol or diabetes.

With the Mail Order Pharmacy benefit, members can order up to a 90-day supply of covered maintenance medications. Instead of paying one co-payment for each 30-day supply, members generally save by paying fewer co-payments. The mail order co-payments for a 90-day mail order supply are selected by the employer and are typically between 2, 2.5 or 3 times the 30-day retail co-pay. Mail order prescriptions must be written for a 90-day supply, rather than one month with refills. Writing prescriptions this way assures the pharmacist filling the prescription that the physician believes the patient will be on this drug and dose for at least 90 days.

HealthAmerica does not provide mail order pharmacy coverage for any controlled substances, or non-maintenance medications, as defined by HealthAmerica. Common mail order excluded drugs are controlled substances and drugs not considered maintenance, e.g., triptans for migraine therapy, erectile dysfunction drugs, etc. Our member formulary notes common drugs which are not covered under the Mail Order option. Members have been given information on where to mail prescriptions. We rely on the physician’s judgment to determine if a 90-day prescription is reasonable for the patient. Ninety (90) day prescriptions should not be written when there is a good chance that therapy will end or change (dose increase or decrease) before the 90 day prescription is used. Our Mail Pharmacy Vendor offers optional physician fax or phone in prescription options for those physicians who prefer to communicate directly with the pharmacy.

9.6 LIFESTYLE DISCOUNT

HealthAmerica offers our members the value of our pharmacy discount on drugs defined as lifestyle when these drugs are excluded from coverage under the member’s contract. If the contract covers one of the below categories, the member will be responsible for the co-pay. If the
drug is excluded from coverage, the member will be able to purchase the drug at 100% of our cost. All of these products require a prescription in order to be covered. Typical lifestyle drugs are:

- non-covered prescription vitamins,
- prescription drugs for sexual dysfunction,
- prescription fertility drugs supplied by our Specialty Pharmacy Provider,
- Prescription cosmetic drugs and
- Prescription weight loss medications.

9.7 PRIOR AUTHORIZATION INCLUDING STEP THERAPY

Some medications are not covered unless HealthAmerica approves the coverage prior to the pharmacist dispensing the drug. Physicians wishing to prescribe one of these medications will need to obtain prior authorization for coverage by contacting the Pharmacy Services Department at the numbers provided in section 9.14 below. The purpose of our prior authorization program is to assure that first line agents are used to their fullest extent before starting a second line or more expensive agent. Prior authorization is also used to assure that the prescribing is consistent with FDA labeling. This list is reviewed regularly as new drugs are marketed and new information is made public. Our prior authorization program covers members who have both a two-tier and three-tier benefit design. When coverage is approved, the member is required to pay the applicable co-pay and/or ancillary charge. A complete, up-to-date list of prior authorization drugs and request forms is available on our web site (www.healthamerica.cvty.com). The most common prior authorization drugs have specific forms that are used to gather all necessary information at one time. Forms are available on our website, via an Interactive Voice Response (IVR) system or by speaking with one of our CSO representatives.

The website also lists those drugs considered Step Therapy drugs. Step Therapy is an automated form of prior authorization where the Step Therapy drug is automatically approved if the member has a record of one or more of the prerequisite drugs in their history with HealthAmerica. If the prerequisite drugs have not been tried or we do not have any record of prior usage of the prerequisite drugs, Step Therapy drugs will require a request for prior authorization.

We will provide a response to the submitting physician within two business days for each request, once we have all the required information. Members are also informed of these decisions and provided their applicable appeal rights, which can be utilized when adverse determinations are made.

9.8 SPECIALTY DRUGS/ SELF ADMINISTERED INJECTABLE DRUGS

Drugs defined as Specialty Drugs by the Plan, including self-administered injectables are covered under the RX benefit for our members. All Specialty Drugs require prior authorization and are limited to up to a one month’s supply per fill. These medications are distributed by Coventry's Specialty Pharmacy Provider.

Contact the Pharmacy Call Center at 1-877-215-4100 or 717-541-5761 to request prior authorization and to be directed to our contracted Specialty Provider, if coverage is approved. A
complete list of Specialty Drugs is posted on our website (www.healthamerica.cvty.com) and is also included in the member formulary. Oral and self-administered specialty drugs are defined as drugs 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

9.9 QUANTITY LIMITS

Some drugs have quantity limits such as many commonly prescribed once daily oral medications where the total dose is available in one tablet or capsule. The list of agents includes, but is not limited to, antihypertensive, cholesterol lowering, and antidepressants, which are FDA-approved for once daily dosing. Other examples of drugs with quantity limits includes but are not limited to the triptans, the 5-HT<sub>3</sub> antiemetics, (Zofran, Kytril, etc.) and certain anti-infectives (Zithromax, etc.). The list of medications with either per day or other quantity limits is posted on our website (www.healthamerica.cvty.com).

9.10 TRANSITION BENEFITS

Changing insurance carriers can be difficult for members on drugs that require prior authorization and are taken once daily (dose optimization) since different carriers have different lists and different criteria. In order to assist new members, we offer to most employer groups a “Transition Rx” benefit which permits a one-time fill within the first 90 days of enrollment for most prior authorization and once daily medications. The member is notified when this fill is dispensed. Alternatives, when applicable, are provided for consideration.

9.11 CO-PAY WAIVER PROGRAM

HealthAmerica initiated a Co-pay Waiver (Tier 0) Program in 2008 that has two primary purposes: 1) encourage the member to speak with their doctor about drugs that cost them the least amount of money (versus the most heavily promoted drugs) and 2) suggest specific alternative drugs that may not have been considered. The program involves target drugs, which generally are Tier Three medications the member has recently filled. A letter offers a three-month co-pay waiver period for the member who wishes to try a similar medication that has been proven to be beneficial in managing the condition for which the target drug was originally prescribed. For example, members who have recently filled a prescription for Livalo are offered a three-month co-pay waiver for a comparable strength of either generic Zocor or Pravachol. If the member, with agreement by the treating doctor, switches to the co-pay-waived drug, the co-pay is a Tier One co-pay after the three-month waived co-pay period, so the member will enjoy the lowest co-pay long term. The program has flexibility to expand from the original classes of drugs, which are cholesterol & triglycerides, PPIs for heartburn, select blood pressure drugs, osteoporosis drugs, diabetes drugs and oral, ophthalmic and nasal allergy agents, NSAIDs and osteoporosis medications. This program is completely voluntary and requires that our member and their doctor agree on the change.
9.12 FORMULARY EXCEPTIONS

Under our managed formulary benefits, exceptions are considered when the formulary agent(s) are not effective in managing or treating the condition, or where the patient has a contraindication to the formulary agent(s), or experiences intolerable side effects from the formulary agent(s) or as required by state or federal law. HealthAmerica will provide a response to the requesting physician within two (2) business days of each request. Members will also be given information on the reason(s) for all denied requests for coverage. This information will also include their appeal rights. Please contact the Pharmacy Call Center (see below) to request a formulary exception for members whose benefits are limited to formulary drugs only.

The following information must be submitted with the request before an exception can be considered:

- Patient name
- Patient ID #
- Medication requested
- Diagnosis
- Prescriber Name and Contact Information
- Formulary agent(s) tried and outcomes or reasons for contraindications

9.13 WHERE TO CALL FOR INFORMATION AND ASSISTANCE

The Pharmaceutical Services staff is available Monday-Friday, 8:00 a.m. to 6:00 p.m. For medications that need prior authorization and for questions regarding the formulary please call 1-877-215-4100 or 717-541-5761, or FAX 1-866-738-9682 or 717-541-5909. Our staff is available to discuss formulary exceptions, prior authorization criteria, and quantity limit exceptions. For those physicians wishing to mail in this information, our address is:

HealthAmerica
3721 TecPort Drive
P.O. Box 67103
Harrisburg, PA 17106-7103
Attention: Pharmacy Services
10. APPENDIX – Supporting Documents and Links to Respective Information

1. General Health Plan Information
   - Member Companies List
   - PA Regions By County
   - Participating Hospital Listing By Region
   - Coventry Quick Reference Guide

2. Products and Member Information
   - ID Cards
     - HealthAmerica HMO
     - HealthAmerica PPO
     - HealthAmerica POS
     - HealthAmerica SI HMO
     - HealthAmerica SI PPO
     - HealthAmerica Ohio HMO
     - HealthAmerica Ohio PPO
     - HealthAmerica Qualified High Deductible PPO
     - HealthAmerica Qualified High Deductible POS
     - HealthAmerica Ohio Qualified High Deductible Plan
     - HealthAmerica One
     - HealthAmerica One Qualified High Deductible Plan
     - HealthAmerica Advantra HMO
     - HealthAmerica Advantra PPO

3. Advantra
   - Prior Authorization List Link:
   - Advance Directive Form
   - Member Request Form

4. Communications and Electronic Solutions
   - How Do I Customize My Favorite Provider List?
   - Online Authorization Requests
   - Attaching Files in Directprovider.com Secure Messaging

5. General Provider Information
   - How to Become a Participating Provider
   - OP Lab Policies
   - RX Healthcare
   - NIA Policy
   - Cardiology Checklist
   - ICORE Program
Physician Provider Information Form
Ancillary Facility Provider Information Form
Anesthesia Provider Information Form
Hospital Based Group Provider Information Form

6. Credentialing
   How to Become a Participating Provider
   Physician Interested Provider Questionnaire
   Ancillary Interested Provider Questionnaire

7. Medical Management
   Pregnancy Assessment Form Link:
   OB Procedure Codes Included in Global Authorization
   Prior Authorization List Link:
   Case Management Referral Form (CCM Form) Link:
   Authorization Request and Notification Form Link:
   Member Information Form
   Consent to Request a Reconsideration

8. Billing and Reimbursement
   Timely Filing Grid
   Sample HCFA 1500
   Sample UB 04
   HCFA 1500 Submission Requirements
   UB 04 Submission Requirements
   My Voice Services – Features & Functions of Menu Options
   My Voice Services – Helpful Hints
   Sample Waiver Document
   How to Read Your Remittance Advice
   Collection Advice Summary

9. Commercial Pharmacy
   HealthAmerica and Coventry National Formulary Link
ADVANCE DIRECTIVE FORM

I, ________________________________, being of sound mind, willfully and voluntarily make this declaration to be followed if I become incompetent. This declaration reflects my firm and settled commitment to refuse life-sustaining treatment under the circumstances indicated below.

I direct my attending physician to withhold or withdraw life-sustaining treatment that serves only to prolong the process of my dying, if I should be in terminal condition or in a state of permanent unconsciousness.

I direct that treatment be limited to measures to keep me comfortable and to relieve pain, including any pain that might occur by withholding or withdrawing life-sustaining treatment.

In addition, if I am in the condition described above, I feel especially strongly about the following forms of treatment: (please circle your response).

Cardiopulmonary Resuscitation (CPR)
The use of drugs and/or electric shock to start the heart beating and artificial breathing
I want  I do not want

Mechanical Respiration
Breathing by machine
I want  I do not want

Tube Feeding
Artificial, invasive form of food given through a tube in the veins, nose or stomach
I want  I do not want

Artificial Hydration
Artificial, invasive form of liquids given through a tube in the veins, nose or stomach
I want  I do not want

Blood or Blood Products
The use of whole blood or parts of the blood to replace blood lost
I want  I do not want

Surgery
Use of any form of surgery to remove or repair any part of the body
I want  I do not want

Invasive Diagnostic Tests
Tests that help reach a diagnosis by entering the body in some way, i.e., a tube inserted to look at the stomach, etc.
I want  I do not want

Kidney Dialysis
Machine used to cleanse the blood of toxic waste because the kidneys are unable to do so on their own
I want  I do not want

Antibiotics
Medicine given to treat or prevent an infection
I want  I do not want

Other
I want  I do not want
I realize that if I do not specifically indicate my preference regarding any of the forms of treatment listed above (page 1), I may receive that form of treatment.

SURROGATE OPTION (PROXY)

I (do) (do not) want to designate another person as my surrogate to make medical treatment decisions for me if I should be incompetent and in a terminal condition or in a state of permanent unconsciousness.

Surrogate’s Name: ________________________________
Address: ______________________________________
___________________________________________

Substitute Surrogate (if surrogate above is unable to serve):

Name: _______________________________________
Address: _____________________________________
___________________________________________

I made this declaration on the ______ day of ________, ______.

Declarant’s Signature: __________________________
Address: _____________________________________
___________________________________________

The declarant or the person on behalf of and at the direction of the declarant knowingly and voluntarily signed this writing by signature or mark in my presence. The declarant appeared lucid, rational and of sound mind.

Witness’ Signature: ___________________________
Address: _____________________________________
___________________________________________

Witness’ Signature: ___________________________
Address: _____________________________________
MEMBER REQUEST FORM

1. Member Information

Advantra Member Number: __________________

Member Name: ____________________________________________

Last          First          MI

Date of Birth: /       /       Telephone (  ) ___________ - ___________

Member Address:

Number/ APT  Street Name  City  State  Zip

2. Physician Information

Name: ____________________________  Provider Number: ____________

Address:

Number  Street Name  Suite  City  State  Zip

Telephone: (________) ___________ - ___________

3. Member Encounter Information

Date of Encounter  Time of Encounter  Purpose for Encounter

Member Requested Service: (Check all appropriate and add brief description)

___ Referral to _________ type:

___ Imaging Exam  __________________

___ Prescription  __________________

___ Therapy  __________________

___ Laboratory Test  __________________

___ Radiological Exam  __________________

___ Other  __________________

Reason Request Declined:

________________________________________

________________________________________

_______ I have advised Member of the rights to a reconsideration of this decision.

________________________________________

Signed          Date

KEEP A COPY OF THIS FORM AND FORWARD ANOTHER COPY TO:
ADVANTRA MEMBER SERVICES DEPARTMENT

Advantra
Attention: Advantra Member Services
3721 TecPort Drive
P.O. Box 67103
Harrisburg, PA  17106-7103

Advantra Member Services:  1-800-290-0190
TDD for deaf Members only:  1-800-207-1262
Hours of Operation: Monday – Friday, 7:00 a.m. to 6:00 p.m.
Place marker for Physician IPQ form.
Place marker for Ancillary IPQ form.
Placemarker for new PIF document
Ancillary Provider Information Form

I. INSTRUCTIONS

Please complete ALL sections of this form. Print or type information. If you have any questions please call your HealthAmerica contact or the Provider Relations Department. All information is held in strict confidence and used for approval for participation status in the HealthAmerica network.

*Please return this completed form to the attention of your Provider Relations Representative via fax or mail*

<table>
<thead>
<tr>
<th>WPA &amp; NWPA:</th>
<th>EPA:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coventry HealthAmerica</td>
<td>Coventry HealthAmerica</td>
</tr>
<tr>
<td>11 Stanwix St.</td>
<td>3721 TecPort Drive</td>
</tr>
<tr>
<td>Suite 1400</td>
<td>PO Box 67103</td>
</tr>
<tr>
<td>Pittsburgh, PA 15222</td>
<td>Harrisburg, PA 17106-7103</td>
</tr>
<tr>
<td>1.866.804.4860 (toll-free fax)</td>
<td>1.866.341.8014 (toll-free fax)</td>
</tr>
</tbody>
</table>

II. PROVIDER INFORMATION

Provider Name: _____________________________________________________________________________

Provider Location Address: ______________________________________________________________

(Number)                                                                       (Street)

(City)                                                                                    (State)                                                 (Zip)

Main Phone #: __________________________________ Administration Fax #:  _____________

County: ___________________________________ Tax ID #: ______________________

Website address: _________________________________ NPI #: __________________________

IF DIFFERENT THAN ABOVE:

Provider Mailing Address:

(Number)                                                                       (Street)

(City)                                                                                    (State)                                                 (Zip)

Managed Care Contact: _________________________________________________________________________

Managed Care Contact Title: ____________________________ Phone #:  _______________________

E-Mail Address: ____________________________ Contact Fax #: ___________________

CEO: ____________________________ Phone #:  _______________________

Name and phone number of person responsible for completing credentialing form(s):

Name: ___________________________________________ Phone #::_____________________ Date: __________

If more than one location, provide list of appropriate information for each location.
III. BILLING INFORMATION

IF DIFFERENT THAN ABOVE:

Billing Company Name: ________________________________________________________________

Pay to Address: _________________________________________________________________
(Number) (Street)
(City) (State) (Zip)

Pay To Name: _________________________________________________________________

W9 Legal Name: ________________________________________________________________
(Please attach a copy of W9 Form to application)

Billing Company Phone #: __________________________ Fax #: _________________________

Patient Accounts Contact: _______________________________________________________

Patient Accounts Contact Title: __________________________ Phone #: ______________________

E-Mail Address: __________________________ Contact Fax #: ______________________

IV. FACILITY BASED PHYSICIAN GROUPS

Completion of this section is only required if the provider is a Facility, e.g., Ambulatory Surgery Center.

If applicable, please complete this information in ALL cases regardless of the relationship between the facility and the facility based physician group. Indicate if the group is owned, employed, or contracted by the facility.

RADIOLOGY

Tax ID #: __________________________ NPI #: __________________________

Contact Name: __________________________ Phone #: __________________________

E-Mail Address: __________________________ Contact Fax #: __________________________

Billing Address: _____________________________________________________________
(Number) (Street)
(City) (State) (Zip)

Billing Phone #: __________________________ Billing Fax #: __________________________

Is this group: _____ Owned  _____ Employed  _____ Contracted by the facility

Physicians and facility bill separately: _____ Yes  _____ No
PATHOLOGY

Tax ID #: ____________________________________ NPI #: ________________
Contact Name: ________________________________ Phone #: _____________________________
E-Mail Address: ________________________________ Contact Fax #: _____________________________
Billing Address: ____________________________________________
(Number)                                                                       (Street)
____________________________________________________________________
(City)                                                                           (State)                                                                                           (Zip)
Billing Phone #: ___________________________________ Billing Fax #: ______________________
Is this group:             _____  Owned             _____  Employed             _____  Contracted by the facility
Physicians and facility bill separately:           _____  Yes                  _____  No

ANESTHESIOLOGY

Tax ID #: ____________________________________ NPI #: ________________
Contact Name: ________________________________ Phone #: _____________________________
E-Mail Address: ________________________________ Contact Fax #: _____________________________
Billing Address: ____________________________________________
(Number)                                                                       (Street)
____________________________________________________________________
(City)                                                                           (State)                                                                                           (Zip)
Billing Phone #: ___________________________________ Billing Fax #: ______________________
Is this group:          _____  Owned              _____  Employed              _____  Contracted by the facility
Physicians and facility bill separately:          _____  Yes                  _____  No
V. OWNERSHIP AND CONTROL

Provider is Owned by:

Address: __________________________________________

(Number) (Street)

(City) (State) (Zip)

Main Phone #: _______________________________ Administrative Fax #: __________________

Year Opened/Planned Opening Date: __________________________

Please check where appropriate:

Investor-Owned (For Profit): _____ Individual _____ Partnership _____ Corporation

Government (Non-Federal): _____ State _____ County _____ City _____ City/County

Facility District or Authority: ____________________________________________________________

Non-Government (Not for Profit): _____ Church Operated _____ Other

Is the management vested in a Board: _____ Yes _____ No

Board Officers and Members:

<table>
<thead>
<tr>
<th>Name</th>
<th>Business Affiliation</th>
</tr>
</thead>
<tbody>
<tr>
<td>President</td>
<td></td>
</tr>
<tr>
<td>Vice President</td>
<td></td>
</tr>
<tr>
<td>Secretary</td>
<td></td>
</tr>
<tr>
<td>Treasurer</td>
<td></td>
</tr>
</tbody>
</table>

Please attach Board of Directors roster for each entity e.g. Facility, System.

List name and TIN of affiliated organizations/subsidiaries or ownership (25% or more) in other entities:

______________________________________________________________________________________

______________________________________________________________________________________

Does the provider own any: _____ PCP Practices _____ Specialty Practices

_____ # of PCP Practices _____ # of Specialty Practices
VI. AVAILABLE SERVICES

Describe Scope of Services and indicate general facility or provider type below:
________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Please check all that apply to the Provider’s TIN:

_____ Ambulatory Surgery Center*
_____ Ambulatory Care Center
_____ Audiology (Hearing Testing & Treatment)
_____ Birthing Center
_____ Dialysis
    _____ CAPD
    _____ Hemodialysis
    _____ Home Hemodialysis
_____ Dialysis
_____ Occupational Therapy
_____ Physical Therapy
_____ Speech Therapy
_____ Ambulance/Patient Transport
    _____ Specify all types of transport available
_____ Oncology Center
    _____ Specify all types of treatment available
_____ Other (Specify) _________________________
    __________________________

_____ Bone Density
_____ CT Scan
_____ High Capacity
_____ Diagnostic Imaging
_____ Fluoroscopy
_____ Mammograms
_____ Digital Mammograms
_____ MRA
_____ MRI
_____ High capacity
_____ Open MRI
_____ Strength of magnet
_____ Nuclear Medicine
_____ PET Scan
_____ Portable (Mobile) Diagnostic Imaging
_____ Ultrasound
_____ Urgent Care

*List types of surgery performed:
________________________________________________________________________________
__________________________________________________________________________________

Hours of Operation:

Monday    _____ AM to _____ PM
Tuesday    _____ AM to _____ PM
Wednesday    _____ AM to _____ PM
Thursday    _____ AM to _____ PM
Friday      _____ AM to _____ PM
Saturday     _____ AM to _____ PM
Sunday      _____ AM to _____ PM
Holidays     _____ AM to _____ PM

If the provider has a direct patient relationship at a free standing office/facility location, please complete the following:

Is there a waiting room available to accommodate patient/client requirements?  ____ Yes  ____ No
Seating capacity?  __________

Is there handicap access to provider location, including reserved parking and an access ramp for physically impaired?
  ____ Yes  ____ No

Are there special services available for the hearing impaired?  ____ Yes  ____ No.

Are interpreter services available for non-English speaking patients/clients?  ____ Yes  ____ No
VII. LICENSURE

State License Number: ______________________  State:  ______  Exp. Date:  ______
State License Number: ______________________  State:  ______  Exp. Date:  ______

Provide copies of licensure certificate(s).

VIII. ACCREDITATION

____  JCAHO  Date Accredited:  ___________  Status:  _______________________
____  CARF  Date Accredited:  ___________  Status:  _______________________
____  AOA  Date Accredited:  ___________  Status:  _______________________
____  ACR  Date Accredited:  ___________  Status:  _______________________
____  FDA  Date Accredited:  ___________  Status:  _______________________
____  NRC  Date Accredited:  ___________  Status:  _______________________
____  AAAHC  Date Accredited:  ___________  Status:  _______________________
____  COLA  Date Accredited:  ___________  Status:  _______________________
____  CLIA  Date Accredited:  ___________  Status:  _______________________
____  CHAP  Date Accredited:  ___________  Status:  _______________________

OTHER:  ____________________________________________________________________________

____________________________________________________________________________________

Medicare Provider Number:  _________________________  Exp. Date:  _______________________
Date of last CMS site review:  _______________________

If the provider is accredited by any of the organizations listed above, please provide copies of accreditation certificate(s) and accrediting organization’s letter indicating accreditation level.

As applicable, please provide a copy of the latest CMS and/or State site review/survey report and Letter of Compliance.

IX. ADDITIONAL INFORMATION
1. What is the name of your malpractice insurance carrier? ____________________________________________
   - What is its limit of liability? ________________________________________________________________
   - What is the expiration date of the policy? ______________________________________________________

   Provide copy of malpractice insurance policy.

2. Does your facility or provider office have transfer agreements with any nearby facility(s) for immediate transfer of patients?
   _____Yes; Facility(s) ________________________________________________________________
   _____No   ____ N/A

3. Does your facility or provider office have available, for review by HealthAmerica, documented emergency procedures, including procedures addressing treatment, transportation and disaster evacuation plans to provide for safety of our members? _____ Yes _____ No ___ N/A

4. When applicable to provider’s licensing and scope of services, do you maintain on site documentation of equipment indicating: current certification, proper maintenance, calibration and compliance with any applicable industry or regulatory standards (including OSHA standards, federal, state and local laws and regulations)?
   _____ Yes _____ No (If “No”, where is documentation stored?) ________________________________
X. CHECKLIST

Please enclose the following if applicable:

1. Address, phone, and tax identification number of additional locations (see “General Information”, Section II)
2. Board of Directors roster(s) (see “Facility Ownership & Control”, Section IV)
3. Complete list of owned practices by specialty (see “Facility Ownership & Control”, Section IV)
4. List of current licensure certificate(s) (see ‘Licensure’, Section VI)
5. Copy of accreditation certificate(s) and accrediting organization’s letter indicating accreditation level (See “Accreditation”, Section VII)
6. CMS and/or State site review report, if not JCAHO accredited (see “Accreditation”, Section VII)
7. Copy of American College of Radiology Accreditation certificate (if applicable)
8. Copy of NRC license (if applicable)
9. Copy of registration/inspection by the State Department of Environmental Protection Bureau of Radiation Control or other state agency responsible for oversight of radiological facilities (if applicable)
10. Copy / proof of FDA certification (if applicable)
11. Copy of all technicians’ certificates employed by provider
12. Physicist Reports for equipment (if applicable)
13. Current medical staff roster by specialty
14. Form W-9
15. Marketing materials
16. Copy of malpractice insurance policy (see “Additional Information”, section VIII)
ADDITIONAL INFORMATION

1. In the past 5 years has the provider or facility ever had any of the following items involuntarily denied, revoked, suspended, not renewed, placed under probation, subject to disciplinary action or otherwise limited or curtailed; or has the facility voluntarily relinquished any item in anticipation of any of these actions; or are any of these actions pending with respect to any of the following items?

   A. State License  
      □ Yes  □ No  □ N/A

   B. Medicare, or other local, state, and / or government program participation  
      □ Yes  □ No  □ N/A

   C. HMO, PPO, or other health plan participation  
      □ Yes  □ No  □ N/A

   D. Other regulatory agency (OSHA, etc.)  
      □ Yes  □ No  □ N/A

   E. Accreditation organization (CLIA, JCAHO, etc.)  
      □ Yes  □ No  □ N/A

2. In the past 5 years, has the provider or facility ever been placed under temporary government ordered management?  
   □ Yes  □ No  □ N/A

3. In the past 5 years, has the provider or facility ever permitted the appointment of a receiver for its business or its assets?  
   □ Yes  □ No  □ N/A

4. Would the facility or office location be willing, if needed, to sponsor or provide educational programs for members of HealthAmerica?  
   □ Yes  □ No  □ N/A

5. Do you understand that subject to proper confidentiality restrictions and authorization, medical records might be subject to on site review by HealthAmerica representatives for peer review, utilization review, and quality assurance purposes?

Affiliations with other health plans? Please list: ________________________________________________
____________________________________________________________________________________

ATTESTATION

The undersigned hereby certified that the above information and all attachments provided to HealthAmerica is truthful, correct and complete in all respects and the undersigned further understands the intentional submission of false or misleading information or the withholding of relevant information are grounds for termination or disapproval as a participating provider with HealthAmerica.

The undersigned hereby agrees to notify HealthAmerica of any material changes in the above information within 30 days of change.

____________________________________________ _______________________
Signature  Date

____________________________________________ ________________________
Printed name of above person  Title
Anesthesiology Information Form

I. INSTRUCTIONS

Please complete ALL sections of this form. Print or type information. If you have any questions please call your HealthAmerica contact or the Provider Relations Department. All information is held in strict confidence and used for approval for participation status in the HealthAmerica network.

*Please return this completed form to the attention of your Provider Relations Representative via fax or mail*

<table>
<thead>
<tr>
<th>WPA &amp; NWPA:</th>
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<tbody>
<tr>
<td>Coventry HealthAmerica</td>
<td>Coventry HealthAmerica</td>
</tr>
<tr>
<td>11 Stanwix St.</td>
<td>3721 TecPort Drive</td>
</tr>
<tr>
<td>Suite 2300</td>
<td>PO Box 67103</td>
</tr>
<tr>
<td>Pittsburgh, PA 15222</td>
<td>Harrisburg, PA 17106-7103</td>
</tr>
<tr>
<td>1.866.804.4860 (toll-free fax)</td>
<td>1.866.341.8014 (toll-free fax)</td>
</tr>
</tbody>
</table>

II. GENERAL INFORMATION

Group Legal Name (filed with IRS): ________________________________________________

Group D/B/A Name (if different): __________________________________________________

Make Checks Payable To: ________________________________________________________

Tax ID #: _________________ Group NPI #: ___________________

Billing Method: [ ] Paper [ ] Electronic

Does your practice currently employ anesthesiologists? [ ] Yes [ ] No

Does your practice currently employ CRNAs? [ ] Yes [ ] No

MAILING ADDRESS (for correspondence):

Group Mailing Address:___________________________________________________________

(Street) (State) (Zip)

 Managed Care Contact: ________________________________________________________

Managed Care Contact Title: ___________________________ Phone #: __________________

E-Mail Address: ___________________________ Contact Fax #: ____________________

CEO: _________________________________________ Phone #: __________________

Name and phone number of person completing this form:

Name: ___________________________ Phone #: __________________ Date: _____________
At what facility(ies) does the group provide anesthesia services?

Facility Name: _________________________________________________________________

Location Address:  ______________________________________________________________
                   (Number)                                                                       (Street)
                   (City)                                                                                     (State)                                                (Zip)

County: ___________________________________

Facility Name: _________________________________________________________________

Location Address:  ______________________________________________________________
                   (Number)                                                                       (Street)
                   (City)                                                                                     (State)                                                (Zip)

County: ___________________________________

Facility Name: _________________________________________________________________

Location Address:  ______________________________________________________________
                   (Number)                                                                       (Street)
                   (City)                                                                                     (State)                                                (Zip)

County: ___________________________________

Facility Name: _________________________________________________________________

Location Address:  ______________________________________________________________
                   (Number)                                                                       (Street)
                   (City)                                                                                     (State)                                                (Zip)

County: ___________________________________

Facility Name: _________________________________________________________________

Location Address:  ______________________________________________________________
                   (Number)                                                                       (Street)
                   (City)                                                                                     (State)                                                (Zip)

County: ___________________________________

Note: If the group provides services at more physical addresses than spaces available, either duplicate this page as needed, or add a separate sheet of paper with the above requested information.
II. GENERAL INFORMATION (Continued)

IF DIFFERENT THAN MAILING ADDRESS:

Billing Company Name: ____________________________________________________________

Billing Company Address: __________________________________________________________

(Number) (Street)

(City) (State) (Zip)

Remit Address (if different from Billing Co. Address):

(Number) (Street)

(City) (State) (Zip)

Billing Company Phone #: ___________________________ Fax #: ________________________

Patient Accounts Contact: ________________________________

Patient Accounts Contact Title: ___________________________ Phone #: __________________

E-Mail Address: _______________________________ Contact Fax #: ______________________

III. GROUP OWNERSHIP AND CONTROL

Owned by: ____________________________________________________________________
(Please indicate whether this is owned by an outside entity, e.g. hospital, management company, etc.)

Address: ________________________________________________________________

(Number) (Street)

(City) (State) (Zip)

Main Phone #: ________________________________ Administrative Fax #: ______________

Owner’s NPI #: ________________________________

Please check where appropriate:

Investor-Owned (For Profit): _____ Individual _____ Partnership _____ Corporation

Is the management vested in a Board: _____ Yes _____ No
Board Officers and Members:

<table>
<thead>
<tr>
<th>Name</th>
<th>Business Affiliation</th>
</tr>
</thead>
<tbody>
<tr>
<td>President</td>
<td></td>
</tr>
<tr>
<td>Vice President</td>
<td></td>
</tr>
<tr>
<td>Secretary</td>
<td></td>
</tr>
<tr>
<td>Treasurer</td>
<td></td>
</tr>
</tbody>
</table>

Please attach the Board of Directors roster for the group (if applicable).

List name and TIN of affiliated organizations/subsidiaries or ownership (25% or more) in other entities:
________________________________________________________
________________________________________________________

IV. AVAILABLE SERVICES

Identify Scope of Services:

☐ Anesthesia (timed and non-timed services)

☐ Pain Management in an outpatient setting (This does not include any pain management provided post surgery whether in an inpatient or outpatient setting.)

   Does group use a different NPI for pain management? ________
   If so, what is it? __________________

Note: If this group provides outpatient pain management in an office setting, practitioners providing these services must be credentialed.

Who is the credentialing contact person for these practitioners? _____________________________

Other Services Provided: ________________________________________________________________

____________________________________________________________________________________
V. LICENSURE

State License Number: ________________   State: _________   Exp. Date: _________

State License Number: ________________   State: _________   Exp. Date: _________

Provide copies of licensure certificate(s).

VI. ACCREDITATION

Medicare Provider Number: ________________   Exp. Date: ________________

OTHER:
______________________________________________________________________________________
______________________________________________________________________________________

VII. ADDITIONAL INFORMATION

1. What is the name of your malpractice insurance carrier? ________________________________
   - What is its limit of liability? ______________________________________
   - What is the expiration date of the policy? _________________________________

Provide copy of malpractice insurance policy.

VIII. CHECKLIST
Please enclose the following if applicable:

1. Address, phone, and tax identification number of additional locations (see “General Information”, Section II)
2. Board of Directors roster(s) (see “Group Ownership & Control”, Section III)
3. Complete list of owned practices by specialty (see “Group Ownership & Control”, Section III)
4. List of current licensure certificate(s) (see “Licensure”, Section V)
5. Form W-9
6. Marketing materials (if applicable)
7. Copy of malpractice insurance policy (see “Additional Information”, section VII)
8. List of practitioners and individual NPI numbers (see “Individual Practitioners, section IX)

**ADDITIONAL INFORMATION**

1. In the past 5 years has the facility ever had any of the following items involuntarily denied, revoked, suspended, not renewed, placed under probation, subject to disciplinary action or otherwise limited or curtailed; or has the facility voluntarily relinquished any item in anticipation of any of these actions; or are any of these actions pending with respect to any of the following items?
   
   A. State License
   B. Medicare, Medicaid, or other local, state, and / or government program participation
   C. HMO, PPO, or other health plan participation
   D. Other regulatory agency (OSHA, etc.)
   E. Accreditation organization (CLIA, JCAHO, etc.)

   Yes  No  N/A

   Yes  No  N/A

   Yes  No  N/A

   Yes  No  N/A

   Yes  No  N/A

2. Affiliations with other health plans? Please list:

   ______________________________________________________

   ______________________________________________________

   ATTESTATION

The undersigned hereby certified that the above information and all attachments provided to HealthAmerica is truthful, correct and complete in all respects and the undersigned further understands the intentional submission of
false or misleading information or the withholding of relevant information are grounds for termination or disapproval as a participating provider with HealthAmerica.

The undersigned hereby agrees to notify HealthAmerica of any material changes in the above information within 30 days of change.

________________________________________________ ____________________________
Signature Date

________________________________________________ ____________________________
Printed name of above person Title

<table>
<thead>
<tr>
<th>IX. INDIVIDUAL PRACTITIONERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practitioner Name</td>
</tr>
<tr>
<td>Anesthesia (timed and non-timed services)</td>
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<tr>
<td>----------------------------------------</td>
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<tr>
<td>Anesthesia (timed and non-timed services)</td>
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<td>Anesthesia (timed and non-timed services)</td>
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<td>Anesthesia (timed and non-timed services)</td>
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</tbody>
</table>

If there are more practitioners than space needed, please copy this page as needed.

**Hospital Based Physician Group Information Form**
I. INSTRUCTIONS

Please complete ALL sections of this form. Print or type information. If you have any questions please call your HealthAmerica contact or the Provider Relations Department. All information is held in strict confidence and used for approval for participation status in the HealthAmerica network.

*Please return this completed form to the attention of your Provider Relations Representative via fax or mail*

<table>
<thead>
<tr>
<th>WPA &amp; NWPA: Coventry HealthAmerica 11 Stanwix St. Suite 2300 Pittsburgh, PA 15222 1.866.804.4860 (toll-free fax)</th>
<th>EPA: Coventry HealthAmerica 3721 TecPort Drive PO Box 67103 Harrisburg, PA 17106-7103 1.866.341.8014 (toll-free fax)</th>
</tr>
</thead>
</table>

II. GENERAL INFORMATION

Group Legal Name (filed with IRS): ______________________________________________________

Group D/B/A Name (if different): ______________________________________________________

Make Checks Payable To: ____________________________________________________________

Tax ID #: ___________________ Group NPI #: ___________________

Billing Method:  □ Paper  □ Electronic

MAILING ADDRESS (for correspondence):

Group Mailing Address: ____________________________________________________________

______________  ________________  ________________
(Number) (Street) (City) (State) (Zip)

Managed Care Contact: ____________________________________________________________

Managed Care Contact Title: _______________ Phone #: ______________________

E-Mail Address: _______________________________ Contact Fax #: ______________ 

CEO: _______________________________ Phone #: ______________________

Name and phone number of person completing this form:

Name: _______________________________ Phone #: ______________________ Date: _________

At what facility(ies) does the group provide professional services?

Facility Name: ___________________________________________
Note: If the group provides services at more physical addresses than spaces available, either duplicate this page as needed, or add a separate sheet of paper with the above requested information.
II. GENERAL INFORMATION (Continued)

IF DIFFERENT THAN MAILING ADDRESS:

Billing Company Name: _________________________________________________________

Billing Company Address: _______________________________________________________

(Number)                                                                       (Street)

(City)                                                                           (State)                                                                                           (Zip)

Remit Address (if different from Billing Co. Address):

____________________________________________________________________________

(Number)                                                                       (Street)

(City)                                                                           (State)                                                                                           (Zip)

Billing Company Phone #: ___________________________    Fax #: _____________________

Patient Accounts Contact: _______________________________________________________

Patient Accounts Contact Title: _______________________    Phone #: ___________________

E-Mail Address: ___________________________________    Contact Fax #: ______________

III. GROUP OWNERSHIP AND CONTROL

Owned by: ____________________________________________________________________
(Please indicate whether this is owned by an outside entity, e.g. hospital, management company, etc.)

Address:______________________________________________________________________

(Number)                                                                       (Street)

(City)                                                                           (State)                                                                                           (Zip)

Main Phone #: ___________________________      Administrative Fax #: ________________

Owner’s NPI #: ______________________________

Please check where appropriate:

Investor-Owned (For Profit): _____ Individual _____ Partnership _____ Corporation
Is the management vested in a Board:  _____ Yes                             _____ No

**Board Officers and Members:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Business Affiliation</th>
</tr>
</thead>
<tbody>
<tr>
<td>President</td>
<td></td>
</tr>
<tr>
<td>Vice President</td>
<td></td>
</tr>
<tr>
<td>Secretary</td>
<td></td>
</tr>
<tr>
<td>Treasurer</td>
<td></td>
</tr>
</tbody>
</table>

Please attach the Board of Directors roster for the group (if applicable).

List name and TIN of affiliated organizations/subsidiaries or ownership (25% or more) in other entities:
______________________________________________________________________________
_____________________________________________________________________________

**IV. LICENSURE**

State License Number:  ______________  State:  ______  Exp. Date:  ____________
State License Number:  ______________  State:  ______  Exp. Date:  ____________

Provide copies of licensure certificate(s).

**V. ACCREDITATION**
VI. ADDITIONAL INFORMATION

1. What is the name of your malpractice insurance carrier? ____________________________
   - What is its limit of liability? ____________________________
   - What is the expiration date of the policy? ____________________________

   Provide copy of malpractice insurance policy.

VII. CHECKLIST

Please enclose the following if applicable:

1. Address, phone, and tax identification number of additional locations (see “General Information”, Section II)
2. Board of Directors roster(s) (see “Group Ownership & Control”, Section III)
3. Complete list of owned practices by specialty (see “Group Ownership & Control”, Section III)
4. List of current licensure certificate(s) (see “Licensure”, Section V)
5. Form W-9
6. Marketing materials (if applicable)
7. Copy of malpractice insurance policy (see “Additional Information”, section VII)
8. List of practitioners and individual NPI numbers (see “Individual Practitioners, section IX)

ADDITIONAL INFORMATION

1. In the past 5 years has the facility ever had any of the following items involuntarily denied, revoked, suspended, not renewed, placed under probation, subject to disciplinary action or otherwise limited or
curtailed; or has the facility voluntarily relinquished any item in anticipation of any of these actions; or are any of these actions pending with respect to any of the following items?

F. State License

G. Medicare, Medicaid, or other local, state, and / or government program participation

H. HMO, PPO, or other health plan participation

I. Other regulatory agency (OSHA, etc.)

J. Accreditation organization (CLIA, JCAHO, etc.)

2. Affiliations with other health plans? Please list:

___________________________________________________________________________

___________________________________________________________________________

**ATTESTATION**

The undersigned hereby certified that the above information and all attachments provided to HealthAmerica is truthful, correct and complete in all respects and the undersigned further understands the intentional submission of false or misleading information or the withholding of relevant information are grounds for termination or disapproval as a participating provider with HealthAmerica.

The undersigned hereby agrees to notify HealthAmerica of any material changes in the above information within 30 days of change.

_____________________________________________ __________________________
Signature  Date

_____________________________________________ __________________________
Printed name of above person  Title

VIII. INDIVIDUAL PRACTITIONERS
<table>
<thead>
<tr>
<th>Practitioner Name</th>
<th>NPI #</th>
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</tbody>
</table>

If there are more practitioners than spaces available, please copy this page as needed.

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### OB PROCEDURE CODES - NO AUTHORIZATION REQUIRED

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<tr>
<th>CPT CODES</th>
<th>DESCRIPTION</th>
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<tbody>
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<td>Amniocentesis Diagnostic</td>
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<tr>
<td>Code</td>
<td>Description</td>
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<td>--------------------------------------------------</td>
</tr>
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<td>59020</td>
<td>Fetal Contraction Stress Test</td>
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<td>59025</td>
<td>Fetal Non-Stress Test</td>
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<tr>
<td>59412</td>
<td>Antepartum Manipulation</td>
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<td>59420</td>
<td>Antepartum Care</td>
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<td>76700</td>
<td>Echo Exam of Abdomen</td>
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<td>76770</td>
<td>Echo Exam of Abdomen Back Wall</td>
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<td>76775</td>
<td>Echo Exam Back Wall-Limited</td>
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<td>76805</td>
<td>Echo Exam of Pregnant Uterus</td>
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<td>76810</td>
<td>Echography Fetal Materiel Evaluation</td>
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<td>Echo Exam Fetal Age/Growth</td>
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<td>76816</td>
<td>Echo Exam Follow-up or Repeat</td>
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<td>76818</td>
<td>Fetal Biophysical Profile</td>
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<td>Biophysical Profile w/o NST</td>
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<td>76830</td>
<td>Echo Exam - Transvaginal</td>
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<td>76856</td>
<td>Echo Exam of Pelvis</td>
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<td>76942</td>
<td>Echo Guide of Needle Biopsy</td>
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<td>76946</td>
<td>Echo Guide for Amniocentesis</td>
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<td>OB Profile Path-Lab (prenatal labs-routine)</td>
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<td>82105</td>
<td>Alpha-Fetoprotein Serum</td>
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<td>Alpha-Fetoprotein: Amniotic</td>
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<td>Cytopathology Interpretation</td>
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<tr>
<td>U482</td>
<td>Stress Test</td>
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<tr>
<td>U720</td>
<td>Labor Room &amp; Delivery</td>
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<tr>
<td>U732</td>
<td>Telemetry</td>
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<tr>
<td>U760</td>
<td>Treatment Room- greater &gt;23 hours requires auth</td>
</tr>
<tr>
<td>U762</td>
<td>TX/Observation Room Observation- greater &gt;23 hours requires auth</td>
</tr>
<tr>
<td>U923</td>
<td>Pap Smear</td>
</tr>
</tbody>
</table>
MEMBER INFORMATION FORM
(Please type or print clearly)

PCP REPORT

Member Name/ID Number: _________________________________________

Diagnosis/Rule Out:
________________________________________________________________
________________________________________________________________

Referring Physician/Practice Name/Phone Number:
________________________________________________________________________
________________________________________________________________________

Tests/Procedures Completed Prior to Referral:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

************************************************************************

CONSULTANT REPORT

Physician Name/Practice Name/Phone Number:
________________________________________________________________________
________________________________________________________________________

Findings/Recommendations:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

************************************************************************

NOTE: IF INPATIENT CARE IS RECOMMENDED, CONSULTANT OFFICE SHOULD CALL THE HEALTHAMERICA UTILIZATION NURSE AT 1-800-252-5742, OPTION 4, TO PRECERTIFY THE ADMISSION.
Precertification for elective admissions or outpatient surgical procedures must be received seven (7) days prior to admission.
CONSENT TO REQUEST RECONSIDERATION FORM

Member Name

Member Date of Birth

Member HealthAmerica ID number

Name of subscriber (if not the Member listed above)

If Member is a minor or legally incompetent, name, address, and relationship of person giving consent on behalf of the Member

Please briefly describe the service(s), supplies or equipment that you would like HealthAmerica to reconsider for coverage:

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Name of Provider

Phone Number

HealthAmerica Provider ID number

I hereby give my consent for the provider listed above to ask HealthAmerica to reconsider its denial of coverage for the service(s), supplies or equipment listed above

____________________________________________________________________

Member's Signature (or signature of legal representative/parent/guardian) Date

Please return form to HealthAmerica, Attn: Provider Reconsiderations: via fax to 717-541-5764; or via mail to HealthAmerica, PO Box 67103, Harrisburg, Pennsylvania 17106-7103.
Waiver of Liability
Authorization to Perform Non-Covered Services

_____________________________________________________
[Provider/Practice Name]

_____________________________________________________
[Identify Non-Covered Service]

1. I have requested that my physician perform _______________[describe service in detail].

2. I understand that the _______________[service] may not be medically necessary, and therefore, would not be covered by my insurance company. As such, I will be responsible to pay for the _______________[service].

3. The amount I will pay my physician for the _______________[service] is _______[$].

4. My signature below indicates that I agree to accept responsibility for payment for the _______________[service] in the event that the service is not deemed to be medically necessary.

_________________________________   ________________
Signature of Patient      Date

_________________________________
Printed Name of Patient