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PPO products are underwritten by Coventry Health and Life Insurance Company and administered by Coventry Health Care of Virginia, Inc. “Members” includes members of Coventry Health and Life Insurance Company.
1 About Us

Coventry Health Care of Virginia, Inc. is a Virginia domiciled HMO with offices in Richmond, Charlottesville, and Roanoke, Virginia.* Coventry Health Care of Virginia, Inc. makes available a variety of products to its members including traditional HMO plans, Point-of-Service (POS) products, and a Medicaid product, CoventryCares of Virginia. CoventryCares also participates in Virginia’s FAMIS (Family Access to Medical Insurance Security) program. PPO products are underwritten by an affiliate insurance company, Coventry Health and Life Insurance Company and administered by Coventry Health Care of Virginia, Inc. These PPO products include both local and national provider network products and CoventryOne, a group trust offering health coverage to individuals and families. Throughout this document, Coventry Health Care of Virginia, Inc and Coventry Health and Life Insurance Company are referred to as “Coventry Health Care,” “We,” “Us,” or “Our.”

Coventry Health Care is committed to working with provider practices in an effort to achieve mutual success. We share the common goal of preserving the quality of care for patients who seek benefits from a managed care plan within the traditional physician/patient relationships.

We recognize the important role each provider plays in the administration of the plan. This Provider Manual is designed to serve as a guide for the administrative procedures required by Us and is referenced as part of the Provider Agreement between you and Coventry Health Care. We hope that most of your day-to-day questions are addressed in this manual. We also have a website, www.chcva.com, with updated information, including any revisions or amendments to this manual.

Please call us if you have any questions.

- Coventry Health Care of Virginia, Inc. Customer Service: 800-627-4872, Monday - Friday, 8:00 a.m. - 6:00 p.m. (commercial business)
- CoventryCares Customer Service: 800-279-1878, Monday - Friday, 8:30 a.m. - 5:00 p.m. (Medicaid business)
- For utilization management issues, call Customer Service at 800-627-4872 or fax your questions to 800-586-7015 and your question will be forwarded to a utilization management staff representative, who will call you back to discuss
- Your Provider Relations Representative can also assist you with policies and procedures such as reimbursement, contractual, or participation issues

*This manual is specific to Coventry Health Care of Virginia, Inc. The provider manual for workers’ compensation and auto can be found at http://www.coventrywcs.com/provider-services/document-library/index.htm incorporated herein by reference.
2 Administrative Procedures

2.1 - Participating Providers
Participating providers include those health care providers that have a contract with Coventry Health Care. In order for a member in an HMO plan to be eligible for covered services, Coventry Health Care participating providers must be utilized unless nonparticipating providers are specifically preauthorized by Coventry Health Care before services are rendered or for emergency services. Members may use nonparticipating pharmacies for their prescription drug benefits if the pharmacy has previously notified Coventry Health Care of its agreement to accept as payment in full reimbursement for its services at rates available to a pharmacy that is a participating provider, including any copayment, coinsurance, or deductible consistently imposed by Coventry Health Care. POS and PPO products allow the member to receive covered services from nonparticipating providers usually at a reduced level of coverage.

You should be aware that the Directory of Health Care Providers and the online provider search at www.chcva.com are subject to change. You should verify the participation status of a provider with Customer Service before referring a patient/Coventry Health Care member. Referring members to nonparticipating providers may result in you being charged for any payment made to these providers (see Section 2.13). Please call Customer Service at 800.627.4872 for Coventry Health Care benefit plans.

Primary Care Physicians
Primary Care Physicians (PCPs) are those physicians who accept the responsibility of providing and/or coordinating the health care needs of any Coventry Health Care member who chooses that physician. This applies only to benefit plans that require the member to select a PCP. It is important that all PCPs ensure 24-hour coverage and accessibility for members. Referring patients directly to the Emergency Room for non-emergency services when you are unavailable is not acceptable and is a violation of the Physician Agreement.

Physician may arrange for a physician who is a Participating Provider to furnish coverage on Physician's behalf (a “Covering Physician”) so long as Physician retains primary responsibility for Members’ care. Any participating physician that is listed as a Coventry Health Care PCP may see a member regardless of whom the member has chosen as their PCP. The only exception to this would be certain groups that may require a referral.

Primary Care Physicians fall within the following types of medical specialties:

- Internal Medicine
- Family Practice
- General Practice
OB/GYN Physicians
Coventry Health Care benefit plans which require the selection of a PCP also allow female members, age 13 or older, to select an OB/GYN physician. Even in plans where a member does not select a specific OB/GYN physician, the member may go directly to an OB/GYN physician for covered services.

Specialty Care Physicians
A specialty care physician is a physician who provides care to Coventry Health Care members within the scope of a specific medical specialty.

Hospitals and Ancillary Providers
Coventry Health Care maintains contracts with hospitals and ancillary providers within the service area to fulfill the health care needs of all members. Please note that each participating provider may not be a participating provider for all products or services for which he or she is licensed.

2.2 - Provider/Member Relationships
Coventry Health Care requires all participating providers to discuss treatment options with patients who are our members. This allows a member to make an informed decision about their course of treatment with knowledge of both the possible benefit limitations and treatment options. Information discussed between the physician and the member is to be kept confidential.

2.3 - Credentialing of Providers
Any new provider that is joining your practice/organization must first be credentialed by Coventry Health Care prior to being able to render services to Coventry Health Care members, unless Coventry Health Care determines the provider does not need to complete the credentialing process as described below. If Coventry Health Care receives a claim from a non-credentialed provider in your practice/organization, the claim will be returned to the provider and denied for using a “non-credentialed provider.” The member will not be responsible for the charges.

Please notify Coventry Health Care as far in advance as possible when adding a new provider to your practice. Coventry Health Care will then determine whether the provider must complete the credentialing process. If the provider is required to complete the credentialing process, an application will be provided. Providers may either submit an application through the Council for Affordable Quality Health Care (CAQH) or a standard Coventry Health Care application. Once a clean application and all supporting materials are received by Coventry Health Care, the credentialing process will begin. This process generally takes 60 to 120 days. Please note: A site visit may be required prior to the processing of your application.

Coventry Health Care does not credential the following types of physicians:

- Pediatrics
- Osteopaths
2.4 - Member Number and Identification Cards

Coventry Health Care member numbers are a system-generated unique 11 digit identification number followed by a suffix for each family member. The subscriber’s suffix is 01 and the spouse and dependents’ numbers are 02 through 99. Always verify the member ID and submit it exactly as it appears on the ID card or on the electronic eligibility responses.

The entire number, including the suffix, must be used for billing and inquiries. Each family member receives a card listing their name, their member number, the effective date of the ID card, and the subscriber’s group name and group number. The plan type indicates whether the member is an HMO, POS or PPO member. The effective date on the ID card reflects the most recent benefit change by the member’s group.

If the member has a prescription benefit through Coventry Health Care, the pharmacy Customer Service telephone number will be listed on the back of the identification card. If the member has behavioral health care and substance abuse coverage through Coventry Health Care, the member may self-refer or be referred by their Primary Care Physician for most benefit plans. The telephone number for behavioral health and substance abuse services is on the member’s ID card.

For CoventryCares Members, please refer to Section 14.1.

2.5 - Connection (Provider Newsletter) and Other Provider Communications

Coventry Health Care regularly publishes a provider newsletter entitled Connection. This is the main source of mass communication to participating providers. Connection may include Provider Manual amendments, which are part of the Provider Agreement. Connection is intended to explain amendments and keep participating providers abreast of issues, including but not limited to, Coventry Health Care programs, policy and procedure changes/updates, network changes, changes in the Schedule of Allowances, billing information, and general topics of interest. These notices should be considered part of this manual and kept for further reference. Connection clarifies changes to policies and procedures that amend the provider’s agreement with Coventry Health Care. Connection newsletters are posted on our website at www.chcva.com » Provider Document Library. Be sure to review Connection for important messages.
To ensure proper receipt of Connection, please contact your Provider Relations representative immediately if your address changes.

There are several ways Coventry Health Care communicates updates to its participating providers, including online website postings and broadcast faxes and emails. To receive timely notifications of important updates, please ensure your provider relations representative has an accurate fax number and email address on file.

### 2.6 - Monthly Member Listing

PCP and OB/GYN practices who request a membership report will receive a listing of all members who have designated the physician(s) in that practice as their Primary Care Physician or OB/GYN. Practices may verify eligibility by contacting Customer Service or by utilizing directprovider.com. Please remember that for all plans, members can access any participating PCP, not just the designated PCP.

### 2.7 - On-Call Providers

As a participating physician, you are responsible for providing access for members 24 hours a day, 7 days a week. Referring patients directly to the emergency room for non-emergency services when you are unavailable is not acceptable and is a violation of the Provider Agreement. Physician may arrange for a physician who is a Participating Provider to furnish coverage on Physician’s behalf (a “Covering Physician”) so long as Physician retains primary responsibility for Members’ care. On-call physicians who are not affiliated with your practice but are Coventry Health Care participating providers may bill Us.

On-call nonparticipating physicians may bill Coventry Health Care as well and will be reimbursed at the participating fee schedule for the given product or region. Be sure to inform nonparticipating physicians who are on-call for you that they may not bill patients for any amount other than the applicable copayment. Should the member’s coverage have a deductible and/or coinsurance, the physician can bill the member once the member’s liability is established. In order for Coventry Health Care to reimburse your on-call physician, you must provide Coventry Health Care with information regarding your on-call physician in advance. Otherwise, the claims could be denied or delayed awaiting this information. To facilitate claims processing, please notify your Provider Relations Representative of the current on-call information for your practice.

Please note that sending patients directly to the Emergency Room for non-emergent services solely when you are unavailable is a violation of the Provider Agreement.

*For CoventryCares Members, please refer to Section 14.2.*
2.8 - Copayment/Coinurance/Deductible Collection

The member ID card has information regarding the member's financial responsibility for some types of services; however, for specific benefit information, the member should refer to his/her Schedules of Benefits, which vary among groups. **Therefore, it is important to verify the correct deductible, copayment, and/or coinsurance amount information on the member ID card or Schedule of Benefits by calling Customer Service or through www.directprovider.com.** Copayments should be collected at time of service. For Coinsurance and Deductibles, providers are encouraged to wait until the claim is adjudicated in order to collect the accurate amount. Customer Service is available to provide the most up-to-date coinsurance and/or deductible information.

For CoventryCares members, please refer to Sections 14.3 and 14.4.

2.9 - No-Show Appointments

If your office has an established policy on prior notification of canceled appointments that includes a charge for no-shows, you may charge Coventry Health Care members should they violate this policy. Please note that this must be an established policy communicated to and applied to all patients. Coventry Health Care members may not be charged for a canceled appointment at a rate greater than what would be charged to a non-Coventry Health Care member.

2.10 - Noncovered Services

As stated in your Provider Agreement with Coventry Health Care, you may not bill the member for services that are not covered by Coventry Health Care unless you notify the member before you provide and/or order the service **and** the member indicates in writing their willingness to pay out-of-pocket by signing a form that states that the services are not a covered benefit. The form must clearly identify the specific service that is not covered. A general acknowledgement of liability for non-payment is not an acceptable form. You may be held responsible for the charges associated with the non-covered service if you do not have an executed form indicating that the member understands the service is non-covered and is willing to pay out-of-pocket.

2.11 - Dismissal of Patients From a Practice

It is recommended that your practice have an established policy for dismissing patients from the practice. Coventry Health Care members should be seen and treated in the same manner as other patients you see. Services or appointments cannot be refused in emergency or urgent care situations unless you have provided a member with at least 30 days notice and requested that they select another physician. In the event of a member dismissal from your practice, the member should be notified in writing. It is recommended that the practice submit a copy to Coventry Health Care of the dismissal notification letter sent to the member. If requested, Coventry Health Care can assist the member in selecting a new physician. This policy is to be used for special situations with specific patients only where just cause exists for dismissing the patient.
2.12 - Termination and Restrictions

Participating providers may terminate their participation with Coventry Health Care. Providers wishing to terminate must notify Coventry Health Care in writing. Please refer to your Provider Agreement for detailed requirements about the termination process. Either party may terminate participation in a product listed in Appendix A of the Provider Agreement without terminating the Provider Agreement in its entirety without cause. Such termination requires a ninety (90) day advance notice.

Providers who wish to restrict their practice in any way also must restrict their practice to all carriers and must give Coventry Health Care written advance notification as stated in your Provider Agreement. The Provider Agreement has provisions regarding the necessary timing.

Provider Agreements will not be terminated by Coventry Health Care to penalize provider in the event Provider: (a) advocates in good faith on behalf of a member; (b) files a complaint against Coventry Health Care; (c) appeals a decision made by Coventry Health Care; (d) treats a substantial number of patients who require expensive or uncompensated care; or (e) requests an expedited appeals resolution or supports an enrollee’s appeal.

2.13 - Use of Nonparticipating Providers

Unless otherwise preauthorized by Coventry Health Care, participating providers must be utilized for services arranged or coordinated by participating providers. Examples of these services are lab procedures, DME supplies, and use of assistant surgeons. If a participating provider sends specimens to a nonparticipating provider for interpretation, provides DME or supplies from a nonparticipating vendor, or uses the services of a nonparticipating assistant surgeon, the participating provider will be held responsible for the nonparticipating provider’s charges. In the event that a nonparticipating provider is recommended, it is the responsibility of the participating provider to obtain a preauthorization for these services. Prior to being held liable, you will receive written notification in the form of a Pay and Educate letter for the first offense. A copy of this letter is sent to Provider Relations for recruitment of the nonparticipating provider. After the initial warning, it will be your responsibility to verify the provider’s participation status.

2.14 - Ancillary Personnel Performing Services

In accordance with Medicare guidelines, certain health care professionals employed by, under contract with, or otherwise supervised by participating providers, must bill claims under their own names and NPI numbers. This applies to the following professionals:

- Nurse Practitioners
- Physician Assistants

For more information, contact your Provider Relations representative.
2.15 - Advanced Directives

Advance directive is a written document or an oral statement in the presence of the attending physician and two (2) witnesses by an adult member who has been diagnosed by his/her attending physician as being in a terminal condition voluntarily executed by an adult member (or by another on behalf of and at the direction of the adult member), and, witnessed by two (2) individuals each of whom is eighteen (18) years of age or older.

Witnesses cannot be a spouse or blood relative of the patient. Employees of health care facilities and physicians’ offices, who act in good faith, may serve as witnesses.

The written or oral statement may also appoint an agent to make health care decisions for the adult member if the adult member is determined to be incapable of making an informed decision.

The adult member is responsible for notifying his/her Coventry Health Care participating provider if an advance directive has been made or if he/she has any moral or religious belief that prohibits the making of an advance directive. Coventry Health Care shall require the adult member’s participating provider to promptly make the advance directive or the objection to an advance directive or a copy of such, if written, or the fact of such if oral, a part of the adult member’s medical records.

Participating Providers shall be required to remind adult members that the directive applies only to care received from that particular participating provider and does not guarantee that it will be implemented by another provider since providers can refuse to implement a directive as a matter of conscience. The participating provider shall be responsible for advising the adult member that it is the adult member’s responsibility to notify other participating providers authorized to treat the adult member of the advance directives or to their objection of an advance directive and to furnish them copies.

Participating providers shall, review the written directive and determine if he/she is willing to honor the request as written or orally presented.

A Coventry Health Care participating provider shall only be expected to implement an advance directive when:

- A written copy of the advance directive has been provided to and accepted by a participating physician. If the adult member is comatose, incapacitated, or otherwise mentally or physically incapable of communication, any other person may notify the participating provider of the existence of the advance directive.
- For any competent adult member who has been diagnosed by his/her attending participating physician as being in a terminal condition, the attending participating physician shall, in the presence of 2 witnesses, receive an oral statement by the adult member authorizing the providing, withholding, or withdrawing of life-prolonging procedures.
or the appointment of an agent to make health care decisions for the adult member under the circumstances stated in the advance directive if the adult member is determined to be incapable of making an informed decision.

Coventry Health Care recognizes that an advance directive can be revoked at any time by the adult member (i) by a signed and dated written revocation from the member or person acting at his/her direction; (ii) by physical cancellation or destruction of the advance directive by the adult member or another in his/her presence and at his/her direction; or (iii) by oral expression of intent to revoke. Any revocation of an advance directive shall be effective when communicated to the participating physician.

For additional documentation regarding advance directives, please see Attachment F.

For more information on advance directives, visit the American Medical Association website at www.ama-assn.org.

2.16 - Translation Services
If a language barrier prevents you from communicating effectively with our members, we have a translation service available to assist. Our language line provides interpreter services at no cost to you. Please contact our Customer Service Department and let the representative know that you need an interpreter and what language is needed. They will make the connection for you.

Our translation service provides interpreters for more than 140 languages and is available during the Customer Service hours of 8:00 a.m. to 6:00 p.m. Eastern. Call Customer Service toll-free at 800-627-4872.
3 Preauthorization

3.1 - Overview
Preauthorization (prior approval) is required for nonemergent inpatient and outpatient hospital admissions; certain medical, surgical or diagnostic procedures; rehabilitative services; durable medical equipment (DME) under specific conditions; and, for HMO members, care by nonparticipating providers. The preauthorization list is periodically updated by Coventry Health Care, and if changes are made you will be notified through our newsletter, Connection, and via fax blast. Please make sure preauthorization for applicable services is issued prior to members receiving the services unless it is an emergency. Preauthorization must be obtained even if Coventry Health Care is not the primary payer. We utilize National Imaging Associates (NIA) on certain Coventry Health Care plans for radiological reviews. Please check the back of the member's card to determine if this applies to your member. If you are unsure about a particular procedure or need more information, contact Health Services at 800.235.2206. Providers may also consult www.directprovider.com to look up codes that require preauthorization.

The provider ordering the care or the provider performing the service must contact Coventry Health Care to obtain preauthorization. Specific medical information is required to determine medical necessity and the availability of benefits. If the service/procedure is suspected of being cosmetic in nature, preauthorization is required regardless of the location performed. If the date of the preauthorized service changes, the provider must contact Coventry Health Care prior to performing the service in order to update the preauthorization. In order to allow sufficient time for the preauthorization process, please contact Coventry Health Care for preauthorization a minimum of 3 working days prior to when the service is needed for elective, scheduled procedures, and diagnostic testing. Procedures on the preauthorization list require preauthorization even when performed in an office setting (e.g., MRIs, sleep studies, cosmetic procedures, etc.).

Even if Coventry Health Care is not the primary carrier, preauthorization must be obtained prior to any nonemergent services (listed as requiring preauthorization), being performed or for services for which someone else may be determined liable and noncovered by Coventry Health Care (i.e., Workers’ Compensation, Medicare primary or other commercial coverage is primary). Coventry Health Care requires that you provide the diagnosis code as well as the CPT code to be performed and/or HCPC codes for durable medical equipment, when requesting preauthorization. The clinical information provided and the plan of treatment will be evaluated and completed by the Preauthorization Nurse within 3 working days of receipt of all necessary information to make a determination for elective procedures or testing for nonurgent requests. For urgent procedures or testing, the determination will be made within 24
hours upon receipt of all clinical information. If the 24-hour deadline falls on a weekend or holiday, preauthorization will be given on the next working day, but in no event more than 72 hours after the request is received. Evaluation using Coventry Health Care approved criteria will be performed and a decision will be made on the requests. For concurrent review, the Concurrent Review Coordinator will review the information the next working day after notification.

Participating providers may be held responsible for the cost of service(s) where preauthorization is required but not obtained. The member may not be billed for the applicable service(s).

The preauthorization number will be given to the ordering provider’s office verbally, thereby creating a paperless preauthorization system. The member will receive written documentation of the approved procedure/service. You may also access www.directprovider.com for the preauthorization function. The preauthorization number should be included on the claim form when submitting the claim to Coventry Health Care. Specialty care providers are expected to forward appropriate reports of consultations or treatments, and/or plans for future evaluation and treatment to the member’s primary care providers.

If a member receives any service on an emergent basis that requires preauthorization or is admitted to the hospital in an emergency, Coventry Health Care must be notified within 24 hours or by the end of the next working day if the 24-hour deadline falls on a weekend or legal holiday. Earlier notification greatly facilitates the utilization review process and allows Coventry Health Care to determine during the stay whether or not the stay meets criteria for coverage. Providers who fail to notify Coventry of inpatient admissions in a timely manner may be subject to a penalty of up to $4,000.00.

Unless the patient has received preauthorization from Coventry Health Care for out-of-network care or is a member of a plan with out-of-network benefits, all nonemergent care must be received within the contracted provider network in order for services to be eligible for coverage. Should the provider refer such a member for care outside of the network without preauthorization, you may be held responsible for the charge(s) of the service(s) rendered and the member may not be billed. Please note that participating providers may not be participating for all products or services. Please call Coventry Health Care to verify participation status.

Coventry Health Care uses InterQual® Clinical Decision Support Criteria and Software, Coventry Tech Assessments, and Coventry Health Care proprietary criteria to determine if the services are medically necessary as defined in the member’s Evidence of Coverage, Certificate of Insurance or Plan Document. Coventry Health Care will ask the provider questions about the member’s symptoms, other indications, and what types of treatment and/or tests have already been utilized. This information will be compared with the criteria’s indications for appropriateness. If the indicators are present, the procedure will be preauthorized as medically necessary. If appropriateness indicators are not
present, the case will be referred to the Medical Director who may discuss this case with the member’s attending physician.

Preauthorization only verifies that the requested service meets the benefit plan’s definition of medical necessity and is not a guarantee of payment. Whether the requested service is covered by Coventry Health Care is subject to all of the terms and conditions of the member’s benefit plan, including but not limited to, member eligibility and benefit coverage at the time the services are provided.

Examples of the procedures where Coventry Health Care utilizes the medical review criteria may include, but are not limited to hysterectomies, cholecystectomies, laminectomies, and septoplasties. When submitting clinical notes for review, please mail them to:

**Coventry Health Care of Virginia, Inc.**  
Attn: Health Services  
9881 Mayland Drive  
Richmond, VA 23233

Notes may also be faxed to 800.586.7015 or 866.715.4720. They may also be submitted through [www.directprovider.com](http://www.directprovider.com), via the authorization function.

**Medical Services Requiring Preauthorization:** For Commercial members, please see Attachment A. For CoventryCares members, please see Attachment B.

### 3.2 - Guidelines for Inpatient Preauthorization

Coventry Health Care must be informed prior to a patient’s nonemergent hospitalization. Before calling Coventry Health Care, please be prepared to provide us with the information contained in the list below which will indicate the severity of illness and/or intensity of service. This information will be used to determine whether or not the care meets Coventry Health Care’s criteria for coverage as an inpatient stay.

- General information such as the member’s name and ID number, the admitting physician, the Primary Care Provider, facility, diagnosis, and procedure code
- Severity of illness including a history of the current illness and the diagnosis(es), description of symptoms (frequency/severity), physical findings and outpatient treatment attempted (if applicable). Coventry Health Care may request lab results (if applicable), x-ray findings, and other significant medical information
- Plan of treatment such as the medications (IV, IM), invasive procedures, tests, monitoring/observation, consultation (If needed during admission, has it been scheduled?), other services (e.g., respiratory treatments, therapies, wound care), activity level (if relevant to treatment plan), and diet (if relevant)
- Anticipated duration of inpatient hospital stay
Please be aware of the services that require preauthorization.

- Alternative treatment available such as IV therapy, skilled nursing, and physical therapy

Hospitalization and the continued stay can be preauthorized only when the severity of the patient's illness and/or the intensity of the required services meet the established criteria for acute inpatient care.

Concurrent review is performed after the initial preauthorization and while the member is still inpatient. If the Concurrent Review Coordinator needs information in addition to that in the patient’s chart, he or she may contact your office. If the member does not appear to meet or continue to meet medical criteria for an inpatient stay, the Concurrent Review Coordinator will discuss alternative care that may be covered. The Medical Director will be involved in the final decision when a coverage denial appears necessary. The hospital and/or attending physician and the member will be notified if medical criteria is not met and benefits are no longer available for coverage of additional inpatient days. Coventry Health Care Concurrent Review Coordinators are available to work with you and the hospital staff to coordinate the care a member may need following discharge from the hospital.

For HMO members, preauthorization to nonparticipating providers for nonemergent services are approved only when medically necessary and when Coventry Health Care does not have a participating provider who can provide the needed service. Coventry Health Care has the right to determine where the covered services can be provided when a participating provider cannot provide the service for in-network coverage. Only those visits made after approval is given will be covered.

Coventry Health Care must be notified of an emergency admission within 24 hours or by the end of the next working day if the 24-hour deadline falls on a weekend or legal holiday. However, earlier notification greatly facilitates the utilization review process and allows Coventry Health Care to determine during the stay whether or not medical criteria for coverage is met.

If you are unsure regarding the necessity for preauthorization, please call Health Services at 800.235.2206.

For weekend or after-hours admissions, you can call Health Services on the next working day at 800.235.2206. For urgent/emergent issues after hours, call 800.235.2206 and you will be directed to an on-call nurse that can assist you. You may also fax to 866.715.4720.

3.3 - Definition of Preauthorization Types

Inpatient

Approval of coverage of an inpatient stay will be contingent upon each day meeting medical necessity criteria based on InterQual® Clinical Decision Support Criteria and Software and Coventry Health Care established guidelines. Inpatient stays require preauthorization.
Outpatient
A procedure (for example, vasectomy) or a service/test (for example, cystogram) that requires less than 6 hours of post-procedure observation is considered outpatient. The requirement for preauthorization depends upon the type of procedure or service rendered. Please call Customer Service or Health Services to determine if preauthorization is required. If the observation period extends beyond 6 hours, contact Health Services for preauthorization (See below for definition for Observation).

Observation
Observation is defined as an admission to an acute care hospital where the length of stay is greater than 6 hours and up to 48 hours. Observation does not include an admission to an intensive care unit, an extended stay in the Emergency Department, or routine observation following an outpatient procedure, service, or that is less than 6 hours. Observation stays require preauthorization.

3.4 - Emergency Room (ER) Visits
Preauthorization is NOT required for a member to be treated for an emergency condition; however, patients are instructed to contact their Primary Care Provider for medical advice prior to seeking care, if possible. Follow-up visits to the emergency room are not covered under most circumstances. If you take a call from a member after hours and advise them to go to the ER, please contact Health Services at 800.235.2206 on the next working day to inform us of your action.

3.5 - Maternity Notification Forms
The Maternity Notification Form can be found as Attachment C. Use of the Maternity Notification Form is recommended as it assists in determining potential high-risk maternity cases. Please notify Coventry Health Care of any potential high risk maternity cases after the initial visit confirming the pregnancy. Notifications should be faxed to Health Services at 804.935.0265 or 800.586.7015. You may also utilize www.directprovider.com to complete and submit the Maternity Notification Form. When using the form, please complete all pertinent information. A copy should be kept in the patient’s file for your records. If you need additional Maternity Notification Forms, you can print the form from our website, www.chcva.com » Providers » Document Library » Maternity Notification Form. You also may contact your Provider Relations Representative.

For pregnant individuals seeking non-maternity care, preauthorization should be obtained by calling Health Services at 800.235.2206. The preauthorization number will be given to the specialty care office verbally, an approval letter will also be mailed to the patient.
3.6 - Preauthorization For Out-of-Network Services To Be Considered As In-Network

For HMO members and certain self-funded plans that do not have out-of-network benefits, Coventry Health Care will preauthorize services rendered by nonparticipating providers or facilities only when the member's medical needs require specialized or unique services which Coventry Health Care considers unavailable within the existing network. For POS or PPO members and certain self-funded plans that do have out-of-network benefits, Coventry Health Care will preauthorize as in-network certain services rendered by nonparticipating providers or facilities only when the member's medical needs require specialized or unique services which Coventry Health Care considers unavailable within the existing network.

While final treatment decisions remain the responsibility of the provider and patient, when discussing treatment options with your patients, your cooperation in fully explaining this process is appreciated.

Coventry Health Care must be notified by phone, fax or www.directprovider.com and preauthorization obtained before care is rendered, except in emergency cases. Please allow 3 working days after all requested information has been received for the evaluation of the preauthorization request.

You and the member will be notified of the approval or denial of care at the in-network level of benefits. Preauthorization for out-of-network services to be considered at the in-network level of benefits will be given for a designated level of service for a specified length of time. Open-ended preauthorizations will not be granted. Subsequent care by the out-of-network provider will require separate preauthorization for coverage at the in-network level of benefits.

If an HMO member sees a nonparticipating provider or is admitted to a nonparticipating hospital in an emergency situation, Coventry Health Care will work with the attending provider to have the member's care transferred to participating providers as soon as medically possible.

In the course of an out-of-network evaluation, any services, tests, or procedures which can be provided within the network must be performed by participating providers in order to obtain coverage as described above. The referring provider is asked to monitor the care of out-of-network providers and assist in case management by helping coordinate lab, x-ray, etc., through participating facilities.

3.7 - OB/GYN Treatment

Most of our benefit plans which require the selection of a Primary Care Provider also allow female members to choose an OB/GYN physician in addition to her Primary Care Provider. Female members, age 13 or older, whether or not they are in a plan where they choose an OB/GYN provider, may receive obstetrical/gynecological care directly from a participating provider. OB/GYNs performing annual exams should bill with the appropriate preventive medicine CPT code.
3.8 - Injectables
All therapeutic office-based injectables covered under the member’s medical benefit require preauthorization before the service is rendered. You may call Health Services at 800.235.2206 to obtain preauthorization for these types of injectables. Injectables are reimbursed according to national rates negotiated by Coventry Health Care with various national vendors. These rates are updated quarterly and notification is done through the provider newsletter. Examples of injectables covered under the member’s medical benefit include (but are not limited to):

- Remicade
- Aranesp
- Neulasta
- Natalizumab Q4079
- Unlisted or miscellaneous drug codes such as (but are not limited to) J9999, J3490, J3590

When self-administered injectable drugs are covered by Coventry Health Care, they may be covered under the member’s pharmacy benefit. These drugs require preauthorization before the service is rendered. You may call Pharmacy Services at 877.215.4100 to obtain preauthorization for these types of injectables. These self-administered injectables are obtained through Coventry Health Care contracted providers, such as Express Scripts. Pharmacy injectable forms and criteria are available on our website by going to our website at www.chcva.com » Providers » Document Library » “Injectable Drug Request Form.”

Examples of self-administered injectable drugs covered under the member’s pharmacy benefit include (but are not limited to):

- Avonex
- Procrit
- Neupogen
- Enbrel

Insulin does not require preauthorization.

Certain self-funded benefit plans where Coventry Health Care administers the benefits may require that self-administered injectables be obtained through the member’s pharmacy benefit. Communication will occur with providers notifying them of these certain plans.

3.9 - Advanced Technologies
Please be advised of the following guidelines for these specific advanced technologies:

- Robotics: Reimbursement for charges related to Robotics assistance during surgery will be based solely on the base standard procedure. There will be no additional reimbursement for the use of robotics. Members shall not be held responsible.
- When a claim is submitted for 3-D Imaging, Coventry Health...
Care does not issue additional reimbursement for the Advanced Technology rendering component. Such a component is incidental and reimbursement will be based solely on the base standard imaging study/procedure. Members shall not be held responsible.

3.10 - Utilization Management (UM) Decisions
UM decision making is based on appropriateness of care, service, and existence of coverage. We do not specifically reward practitioners or other individuals for issuing denials. Financial incentives for UM decisions do not encourage decisions that result in underutilization.
4 Reimbursement & Claims

4.1 - Compensation
Allowances are set up based on practice types and contracts. Typically, physician allowances are set by CPT Code. Facility allowances are contractually set up using such methodologies as per diems, case rates, DRGs, etc. Ancillary allowances are contractually set up using such methodologies as per diems, case rates, fee for service, etc.

Please include any applicable modifiers to ensure proper payment. Payment may be reduced depending on the modifier billed.

4.2 - Immunizations and Injectables
Coventry Health Care reimburses immunizations and injectables based on a list of rates developed by Coventry and adopted by Coventry Health Care. These rates are updated quarterly and will be posted on www.directprovider.com in the News section.


Rabies Vaccinations
Rabies vaccinations are a covered benefit for Coventry Health Care members. A PCP or specialist who elects to provide this service in their office can contact Health Services for assistance in obtaining the vaccine, or forward the injectable request form to our preferred pharmacy vendor. The vaccine will be sent directly to the provider's office. There is NO COST to the provider for the vaccine and the provider should not bill Coventry Health Care for the vaccine. Providers who need assistance with this form may contact Health Services.

Members may also receive the Rabies vaccine at the pharmacy by a vaccinating pharmacist. The member is required to have a prescription from their Doctor to present at the pharmacy. The pharmacy vendor will bill Coventry Health Care directly. Members may also be directed to the nearest participating hospital emergency room or the local Health Department for the vaccine. Claims will pay in accordance to the member's benefit and the corresponding place and/or provider of service.

For CoventryCares members, please refer to Section 14.20.

4.3 - Claims Filing Procedures
Physician
Submit charges on a CMS 1500 Health Insurance Claim form (or UB92 or UB04 if applicable) or its successor directly to the Claims Department.
In January 2014, Coventry Health Care of Virginia, Inc. and other Coventry plans began accepting a new professional claim form, which was approved by the Centers for Medicare and Medicaid Services and was revised primarily to accommodate the change from ICD-9 to ICD-10 diagnosis codes.

- Use a separate claim form for each provider.
- Use a separate claim form for each member.
- Please submit one claim for all services provided in the same day and same place of service. Coventry Health Care reserves the right to retract claims paid where split billing (using two claim forms for the same date of service) is used.
- Submit original form to Coventry Health Care; keep a copy for your files.
- Submit a complete and correct claim form.
- When applicable, include other insurance information on the claim form. When Coventry Health Care is secondary, please attach the primary carrier's Explanation of Benefits (EOB) to the claim (if filing electronically, please see Electronic Claims Submission Process).
- Include all pertinent diagnosis information.
- Include the complete provider TAX ID, National Provider Identifier (NPI), and member number including the two-digit suffix.
- When applicable, include the valid ICD-9 or ICD-10 diagnosis code up to the fourth or fifth digit.

Please note any special circumstances, and/or include office notes with claims submitted for services that require special consideration.

Remember to include:

- Preauthorization number for hospitalization, outpatient hospital services, and other services or procedures requiring preauthorization as stated in this manual
- CPT Procedure Codes - unlisted codes must be accompanied by description of service, test, or procedure before payment will be considered.
- Valid Place of Service code.

Facility
Submit charges on a UB92 or UB04 claim form or its successor directly to the Claims Department.

- Use a separate claim form for each member.
- Please submit one claim for all services provided in the same day/same admission and same place of service. Coventry Health Care reserves the right to retract claims paid where split billing (using two claim forms for the same date of service) is used.
- Submit original form to Coventry Health Care; keep a copy for your files.
- Submit a complete and correct claim form.
- When applicable, include other insurance information on the claim form.
form. When Coventry Health Care is secondary, please attach the primary carrier’s Explanation of Benefits (EOB) to the claim.

- Include all pertinent diagnosis information.
- Include the complete provider number, National Provider Identifier (NPI), and member number including the two-digit suffix.
- Include the valid ICD-9 or ICD-10 diagnosis code up to the fourth or fifth digit.

Please note any special circumstances, and/or include medical records with claims submitted for services that require special consideration.

Remember to include:

- Preauthorization number for hospitalization, outpatient hospital services, and other services or procedures requiring preauthorization as stated in this manual.
- CPT Procedure Codes - unlisted codes must be accompanied by description of service, test, or procedure before payment will be considered.
- Valid Place of Service code.

Submission of Claims
Claims for Coventry Health Care HMO and POS products, PPO products underwritten by CHLIC, and self-funded products should be sent to:

Coventry Health Care of Virginia, Inc.
Attn: Claims Department
P.O. Box 7704
London, KY 40742

For CoventryCares members, please refer to Section 14.21.

4.4 - Electronic Claims
If submitting electronically, the commercial payor ID number is 25133. The regulations promulgated pursuant to the Health Insurance Portability and Accountability Act (HIPAA) require that Coventry Health Care 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, Coventry Health Care encourages physicians and medical providers to submit claims electronically. Electronic claims submission can have significant, positive impact on the productivity and cash flow of your practice because:

- EDI reduces the paperwork and costs associated with printing and mailing paper claims.
- EDI reduces the time it normally takes for Coventry Health Care 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.
• 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 Coventry Health Care is easy to establish. Providers can submit directly to Emdeon. Electronic claim submissions will be routed through Emdeon who will review and validate the claims for HIPAA compliance and forward them directly to Coventry Health Care. Please contact Emdeon directly and Emdeon can provide the electronic requirements and set-up instructions. Providers should call 800.215.4730 for information on direct submission to Emdeon or for problems with EDI filing.

Free through our website and as a result of an expanded partnership with Emdeon, providers may now enter claim data directly online or upload a HIPAA-compliant 837 EDI File from a billing system or vendor of their choice. To get started, users should log in to directprovider.com and click on the “Claims Submission” link. EDI claim submitters should review Coventry Health Care’s EDI Exclusion List and Electronic Claim Submission Requirements. Coventry Health Care uses the ANSI X12N 837 v4010 or V5010 and V4010A1 or V5010A1 implementation guides that have been established as the standard claim transactions for HIPAA. The official implementation guides for claim transactions are available electronically from the Washington Publishing Company website: www.wpc-edi.com.

Coventry Health Care encourages and recommends regular review of all EDI Acknowledgement and Reject Reports returned to you to ensure timely filing of resubmissions or claim adjustment requests when necessary.

For CoventryCares members, please refer to Section 14.22.

4.5 - Request for Notes/Invoices
Certain procedures may require the submission of additional documentation before payment is made. In cases of this nature, the claim will be closed, and we will request notes or an invoice. Providers must then submit notes or an invoice in order for the claim to be reviewed. These must be submitted within 1) 90 days of the date of the request or, 2) the original timely filing period applicable to the claim as described in Section 4.6; otherwise the claim will be denied for timely filing.

4.6 - Timely Filing Policy
Coventry Health Care strictly enforces its timely filing clause in the provider contracts. Claims must be filed within 365 days of the date of service. COB claims and/or adjustment requests in which Coventry Health Care is the secondary carrier should be filed with the Explanation of Benefits (EOB) within 365 days of the receipt of the primary carrier’s remittance voucher.

Global charges must be submitted within 365 days of the date of the primary
service (i.e., charges for pregnancy should be submitted within one year of the delivery). Any charges outside of the global charges must also be billed within the 365-day deadline.

**Proof of Timely Filing**
Providers must submit proof of timely filing within 90 days after the timely filing limit or the claim will remain denied. Providers requesting reconsideration of claims denied for timely filing should submit an acceptable form proving timely filing to the Coventry Health Care adjustment request address. Some acceptable forms of proof of timely filing are:

- A copy of the EDI report from Emdeon showing that the electronic carrier accepted the claim within the timely filing limits.
- If the claim was submitted to another insurance carrier, the other carrier’s EOB must be submitted. If there is no EOB, supporting documentation must include claims information from the other insurance carrier.
- Substantiated documentation of follow up contacts with the Customer Service Organization’s (CSO) representatives regarding the claim submission. This documentation should include the dates of all contacts within the timely filing limit, and the CSO representative’s name.

Coventry Health Care will make every effort to work with a physician’s office having a billing problem. We suggest you contact Customer Service at 800.627.4872 as soon as possible should this be a concern or problem.

**Please also refer to Section 10 for Post-Service Claim Review.**

**4.7 - Adjustment Requests**
When filing an adjustment or a corrected claim, please use the address listed at the bottom of this section. Adjustment requests must be received by Coventry Health Care within 365 days of the date of service of the claim.

**Information and Adjustments**
A Claim Inquiry/Adjustment Request Form should be used whenever resubmitting a claim. The form allows you to put in writing your inquiry about a claim. Attaching this form to resubmitted claims helps us process and/or review requests in a timely manner. Please see Attachment D for a Claim Inquiry/Adjustment Request Form.

**Corrected Claims**
All corrected claims should be marked “Corrected Claim.” When submitting a Corrected Claim on a UB92 (or UB04, if applicable) form, the claim should be submitted using a billing type that ends in 7. Handwritten changes on your claim form will only be accepted if written in ink, initialed, dated and accompanied by a Claim/Inquiry Adjustment Request Form. In instances where a provider wishes to appeal, the provider should follow the process defined in Section 10 of this manual.
To send your corrected or replacement claims to Coventry Health Care electronically, use the Claim Frequency Type Code (CLM05-3) value equal to “7” to indicate a corrected or replacement claim for professional claims. For institutional claims use the loop and segment CLM05 value equal to “7” to indicate a corrected or replacement claim. For more information on electronic claim submission to Coventry Health Care, please use the following links from your health plan’s website: Provider/EDI Document/EDI Claims.

**Late Charges**
When submitting a claim for additional or late charges, you should submit the entire claim again with the additional charges included and use a billing type that ends in 5. Any submission of claims of this nature must occur within the 365 days from the date of service of the claim. These claims should be sent to the address below.

All requests listed in this section should be mailed to:

Coventry Health Care of Virginia, Inc.
Attn: Claims Department
P.O. Box 7704
London, KY 40742-7135

For CoventryCares members, please refer to Section 14.23.

**4.8 - Remittance**
Providers may receive remittances electronically. For information and requirements, please contact your Provider Relations Representative. It is the responsibility of the provider to verify remittances. If the provider wishes to dispute a payment, the provider must contact Coventry Health Care within 365 days from the date of service of the claim. If the provider does not notify Coventry Health Care within one year after the date of service on the claim, payment is considered final.

Providers who receive Electronic Remittance Advices (ERAs/835s) are no longer being mailed paper RAs. PDFs of RAs associated with provider checks are available on Coventry’s free provider portal, directprovider.com. To search for RAs, search by the provider’s ID and payment date found on the check page. When searching for RAs by the payment-date feature, the actual check copy is displayed under the check number. The RA for the check will have a link but no check number in the field. A directprovider.com enhancement will soon include the check number as an RA look-up option. (Reminder: providers who enroll for electronic funds transfers can request email notices to let them know when RAs are available.) For assistance with this or any other directprovider.com function, users may call the portal’s dedicated customer service line at 866.213.0805 or 866.629.3975.

**Schedule of Payment**
Checks are scheduled to run on a weekly basis. Checks are usually received by provider offices within 10 working days after a check run.
Method of Payment
For participating providers, payments are made to the provider. The check sum includes payment for all services processed for that practice during the payment cycle. Should a remittance include denied charges or payments requiring adjustment, an explanation of the denial or adjustment code will be given on the remit.

Out-of-Pocket Maximums
Most copayments, deductibles, and coinsurance are applied to the member’s benefit year out-of-pocket maximum. The actual amount of the maximum varies among benefit plans. When a member meets their out-of-pocket maximum, they are instructed to present their letter from Coventry Health Care stating that they have reached the out-of-pocket maximum on all subsequent provider visits for the remainder of the benefit year.

For CoventryCares members, please refer to Section 14.24.

4.9 - Status of Claims
You may call Customer Service to check the status of claims. Customer Service representatives are available to answer any claim inquiries Monday through Friday between 8:00 a.m. and 6:00 p.m. The number is 800.627.4872. You can also check the status of claims online by using www.directprovider.com or Emdeon, including multiple claim submissions at one time. If you do not have access to www.directprovider.com or Emdeon and you need to verify the status of numerous claims, please fax your inquiries to 302.283.6785, Attention: Claims.

Coventry Health Care recommends that claims status inquiries not be made unless it has been at least 45 days since the date of submission.

It is the responsibility of the provider to maintain an updated record of their account receivables. Coventry Health Care recommends that you check your account receivables monthly to determine if there are any outstanding claims. In the event that there are, the provider should contact Customer Service or access www.directprovider.com to determine if the claim was received. Coventry Health Care will not be responsible for claims that were never received and the date of service exceeds the timely filing limit.

For providers who submit claims electronically, reports are provided to the provider after each submission detailing the claims that were sent and received. It is the provider’s responsibility to track this list to ensure that claims were received by Coventry Health Care. Coventry Health Care will not be responsible for claims that were never received when the date of service exceeds the timely filing limit and an EDI report showing acceptance of the claim is not provided.

For CoventryCares members, please refer to Section 14.7 and 14.22.
4.10 - Coordination of Benefits (COB)
The coordination of benefits (“COB”) provision applies when a member has health care coverage under more than one payor.

Until a coordination of benefits determination is made, the member shall not be held liable for the cost of covered services provided. Coventry Health Care will close any claim where other insurance is confirmed. Coventry Health Care will re-open claims for payment once all required information is received.

Coordination of Benefits when Coventry Health Care is Secondary
1. If the primary insurance requires an authorization and authorization is obtained, and the services is covered by the primary insurance and Coventry Health Care (Coventry), we will honor the EOB and coordinate benefits.
2. If the primary insurance does not require an authorization, and the service is a covered service by the primary insurance and by Coventry we will honor the EOB and coordinate benefits.
3. If we receive an EOB with a covered service denied for no authorization and this service requires preauthorization with Coventry, that authorization will be required to coordinate the claim.
4. If we receive an EOB with a covered service denied for no authorization, and the service does not require an authorization for Coventry, we will process as primary.
5. If we receive an EOB for non-covered services from the primary payer, and it is a covered service that requires an authorization from Coventry, we will only pay the claims with an Coventry authorization in place.
6. If we receive an EOB for non-covered services from the primary insurance, and it is non-covered with Coventry, it will be denied.
7. If we receive an EOB for an HMO member and the provider is Non-Participating, authorization will be required even if Coventry Health Care is secondary.

<table>
<thead>
<tr>
<th>Scenario Number</th>
<th>Preauthorization Required</th>
<th>Preauthorization Obtained</th>
<th>Covered Service</th>
<th>Coordinate Benefits</th>
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<td>Y</td>
<td>Y</td>
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<tr>
<td>Coventry Secondary</td>
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<td>Y</td>
<td>Y</td>
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<tr>
<td>Primary Carrier</td>
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<td>Coventry Secondary</td>
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Coordination of Benefits with Commercial Carriers
The charts on the following pages show when Commercial Carriers are primary or secondary.
The provider is prohibited from balance billing as long as:

1. the combined payment from Coventry Health Care and the primary payor equals Coventry Health Care’s allowed amount under our provider contract; or
2. the member had no liability after the primary payor paid, or if the member had liability, Coventry Health Care paid the member responsibility.

If our allowed amount (amount Coventry Health Care would have paid as the primary carrier), is LESS THAN the other carrier’s paid amount, Coventry Health Care will pay nothing. If Coventry Health Care’s allowed amount is more than the primary carrier’s paid amount, Coventry Health Care will pay the difference from our allowed amount and the other carrier’s paid amount for covered services.

**Allowed Amount** is the fee that a participating provider has agreed to accept as payment in full, or in the absence of a fee schedule, the default amount upon which Coventry Health Care will base payment. It is this amount that Coventry Health Care would pay before taking out any member responsibility. This is the same calculation used when Coventry Health Care is the primary carrier.

**Coordination of Benefits with Medicare**

The charts on the following pages show when Medicare is primary or secondary.

Coventry Health Care will always use Medicare’s allowable charges for processing.

If a member is eligible for Medicare as the primary coverage and that member does not elect Medicare Part B coverage, Coventry Health Care will process the claim as if the member had Medicare Part B coverage and will reduce the amount it pays by the amount of the Medicare Part B coverage had it existed. The provider may balance bill members for the difference.

For CoventryCares members, please refer to Section 14.28.

See the subsequent two pages for Coventry Health Care Coordination of Benefits (COB).
### Which Plan pays First? Order of Benefit Determination Rules

<table>
<thead>
<tr>
<th>When a Member is covered by 2 group plans, and</th>
<th>Then</th>
<th>We are Primary</th>
<th>We are Secondary</th>
</tr>
</thead>
<tbody>
<tr>
<td>If one plan does not contain a COB provision</td>
<td>The plan without COB provision is</td>
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<td>The plan with COB provision is</td>
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<tr>
<td>The Member is the subscriber under one plan and dependent under the other</td>
<td>The plan covering the Member as the subscriber is</td>
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<tr>
<td></td>
<td>The plan covering the person as a dependent is</td>
<td></td>
<td></td>
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<tr>
<td>The Member is the subscriber under a retiree plan and dependent under an active plan</td>
<td>The plan covering the Member as the subscriber is</td>
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<tr>
<td></td>
<td>The plan covering the person as a dependent is</td>
<td></td>
<td></td>
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<tr>
<td>The Member is a subscriber in two active group plans</td>
<td>The plan that has been in effect longer is</td>
<td>0</td>
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<tr>
<td></td>
<td>The plan that has been in effect the shorter amount of time is</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Member is a subscriber under both an active employee plan and a retiree plan</td>
<td>The plan which the subscriber is an active employee is</td>
<td>0</td>
<td>Ö</td>
</tr>
<tr>
<td></td>
<td>The retiree plan is</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Member is an active employee on one plan and enrolled as a COBRA subscriber</td>
<td>The plan which the subscriber is an active employee is</td>
<td>0</td>
<td>Ö</td>
</tr>
<tr>
<td></td>
<td>The COBRA plan is</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Member is covered as a dependent child under both plans</td>
<td>The plan of the parent whose birthday occurs earlier in the calendar year (known as the birthday rule) is</td>
<td>0</td>
<td>Ö</td>
</tr>
<tr>
<td></td>
<td>The plan of the parent whose birthday is later in the calendar year is</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>NOTE:</strong> If the parents have the same birthday (MM/DD), the plan that has been in effect longer is primary</td>
<td>The Group Plan is</td>
<td>0</td>
<td>Ö</td>
</tr>
<tr>
<td></td>
<td>Medicaid is</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Member is covered as a dependent child and coverage is specified in a court decree</td>
<td>The plan of the parent primarily responsible for health coverage under the court decree is</td>
<td>0</td>
<td>Ö</td>
</tr>
<tr>
<td></td>
<td>The plan of the other parent is</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Member is covered as a dependent child and coverage is not specified in a court decree</td>
<td>The custodial parent or spouse of custodial parent’s plan is</td>
<td>0</td>
<td>Ö</td>
</tr>
<tr>
<td></td>
<td>The non-custodial parent’s plan is</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>NOTE:</strong> If the parents have the same birthday (MM/DD), the plan that has been in effect longer is primary</td>
<td>The plan of the parent whose birthday occurs earlier in the calendar year is</td>
<td>0</td>
<td>Ö</td>
</tr>
<tr>
<td></td>
<td>The plan of the parent whose birthday is later in the calendar year is</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Coordination of Benefits with Medicare for Members under 65 with a Disability or ESRD

<table>
<thead>
<tr>
<th>When a Member is covered by Medicare and a group plan, and</th>
<th>Then</th>
<th>We are Primary</th>
<th>Medicare is Primary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is a Member who is qualified for Medicare coverage due solely to End Stage Renal Disease (ESRD)</td>
<td>For the first 30-months after Medicare becomes effective&lt;br&gt;Upon completion of the 30-months after Medicare becomes effective</td>
<td>Ø</td>
<td>Ø</td>
</tr>
<tr>
<td>Is a disabled Subscriber who is an active employee</td>
<td>If the employer employs 100 employees or more&lt;br&gt;If the employer employs fewer than 100 employees</td>
<td>Ø</td>
<td>Ø</td>
</tr>
<tr>
<td>Is the disabled spouse or dependent child of an active full-time Subscriber</td>
<td>If the employer employs 100 employees or more&lt;br&gt;If the employer employs fewer than 100 employees</td>
<td>Ø</td>
<td>Ø</td>
</tr>
<tr>
<td>Is a person who becomes qualified for Medicare Coverage due to ESRD after already being enrolled in Medicare due to disability</td>
<td>If Medicare had been secondary to the group plan before ESRD entitlement, then for the first 30 months following ESRD entitlement&lt;br&gt;If Medicare had been primary to the group plan before ESRD entitlement</td>
<td>Ø</td>
<td>Ø</td>
</tr>
<tr>
<td>Disabled and Subscriber not actively employed by the employer group</td>
<td></td>
<td></td>
<td>Ø</td>
</tr>
</tbody>
</table>

### Coordination of Benefits with Medicare for Members over 65

<table>
<thead>
<tr>
<th>When a Member is covered by Medicare and a group plan, and</th>
<th>Then</th>
<th>We are Primary</th>
<th>Medicare is Primary*</th>
</tr>
</thead>
<tbody>
<tr>
<td>The member is age 65 or over, and is the Subscriber or the Subscriber’s spouse, and the Subscriber is actively working for employer group</td>
<td>If the employer group has less than 20 employees&lt;br&gt;If the employer group has 20 or more employees</td>
<td>Ø</td>
<td>Ø</td>
</tr>
<tr>
<td>Is a person who becomes qualified for Medicare Coverage due to ESRD after already being enrolled in Medicare due to age.</td>
<td>If Medicare had been secondary to the group plan before ESRD entitlement, then for the first 30 months following ESRD entitlement&lt;br&gt;If Medicare had been primary to the group plan before ESRD entitlement</td>
<td>Ø</td>
<td>Ø</td>
</tr>
<tr>
<td>The member is age 65 or over, is the Subscriber or the Subscriber’s spouse and the Subscriber is not actively working for the group</td>
<td></td>
<td></td>
<td>Ø</td>
</tr>
</tbody>
</table>
4.11 - Systems Affecting Preauthorization and Claims Payment

The systems noted below contain licensed or copyrighted material. Due to the licensing agreements and copyright law, Coventry Health Care cannot distribute the detailed logarithms, policies, or rules used in these systems to its providers. However, pursuant to Virginia Code Section 38.2-3407.15 B 4 (b), Coventry Health Care shall reply to any provider’s specific inquiry about a rule or policy affecting the provider within ten (10) working days of receipt of a written request. Requests should involve specifics of the preauthorization or claims payment issue for which information is needed. To ensure proper handling of requests for system or policy information, please send requests to the address below and reference the ten-day response time requirement.

Coventry Health Care of Virginia, Inc.
Provider Relations Department
Attention: Policy Information Requests
9881 Mayland Drive
Richmond VA 23233

Utilization Management Guidelines

Coventry Health Care primarily utilizes InterQual® Clinical Decision Support Criteria and Software to determine medical necessity of inpatient stays, outpatient surgeries, home health, DME, outpatient therapies, and diagnostic services that require preauthorization. The InterQual® Clinical Decision Support Criteria and Software is nationally recognized and was approved for use by Coventry Health Care by the Utilization Management Committee which is comprised of participating providers within the Coventry Health Care network. The criteria consist of objective, measurable, clinical indicators.

InterQual® Clinical Decision Support Criteria and Software also indicate diagnostic and therapeutic services reflecting the need for such services. Also included are parameters of patient stability indicating readiness for discharge from the hospital and options for alternative settings. It addresses appropriateness of admission to and continued stay in and discharge from general and special units within the hospital. Any InterQual® Clinical Decision Support Criteria and Software guideline is available upon request. Coventry Health Care will provide the medical criteria used in the decision making process upon receipt of a written, faxed, or telephone request by the provider. Criteria may be reviewed on site at the Coventry Health Care office, read to the provider over the phone, or viewed on Directprovider.com. Health Services will provide the information within ten (10) days of the request. A provider may call Customer Service or the Preauthorization Department to initiate request.

Although InterQual® Clinical Decision Support Criteria and Software guidelines are used for most procedures, Coventry Health Care supplements its policies with proprietary utilization management guidelines. These guidelines are traditionally developed with the involvement of providers in the affected specialty and often are formally approved by the Coventry Health Care Utilization Management Committee before use.
Medically Necessary/Medical Necessity
Those services, supplies, equipment, and facility charges that have been determined by Coventry Health Care to be: (i) medically appropriate, which means that the expected health benefits (such as, but not limited to, increased life expectancy, improved functional capacity, prevention of complications, relief of pain) exceed the expected health risks by a sufficiently wide margin; (ii) necessary to meet the basic health needs of the member as a minimum requirement; (iii) rendered in the most cost-efficient manner and setting appropriate for the delivery of the health service; (iv) consistent in type, frequency, and duration of treatment with scientifically based guidelines of national medical research, professional medical specialty organizations, or governmental agencies that are accepted by Coventry Health Care; (v) consistent with the diagnosis of the condition; (vi) required for reasons other than the comfort or convenience of the member or his or her physician; and (vii) of demonstrated value based on clinical evidence reported by Peer Reviewed Medical Literature and by generally recognized academic medical experts; this is, it is not Experimental or Investigational or unproven. Coventry Health Care has an appropriate practitioner available to discuss any UM denial decision, and they can be reached by calling the Preauthorization Department numbers found on the back of the member’s ID card.

Preauthorization
Some services may be noncovered or only partially covered if they are not preauthorized through Coventry Health Care’s Health Services Department. You may contact the Health Services Department at 804.270.9200 or 800.235.2206 if outside the Richmond area.

4.12 - Subrogation/Recovery
Coventry Health Care, along with its affiliates, have contracted with third party vendors (the “Recovery Vendor”) to recover monies paid to providers that should not have been paid to such providers (Ineligible Payments). Ineligible Payments may occur for numerous reasons, including, but not limited to, late notice to Coventry Health Care of an ineligible member; a member failing to provide correct coordination of benefits information to Coventry Health Care or its self-funded clients; or a provider failing to disclose all information related to the service or item requested for payment by Coventry Health Care. The recovery parameter is twelve (12) months from the last paid date of the claim(s).

Coventry Health Care shall identify Ineligible Payments and litigation matters that are appropriate to refer to the appropriate Vendors. A recovery letter is then generated requesting the overpayment and the provider is given 30 days (unless otherwise specified in the provider contact) to refund the overpayment. After 30 days, if the refund has not been received, the claim will be adjusted to recover the overpayment.

Coventry Health Care, along with its affiliates, also has contracted with one or more third party vendors (Subrogation Vendors) to supervise some of its self-funded clients’ interests in litigation with third parties that may lead to a
subrogation payment to these self-funded clients. (The Recovery Vendor and Subrogation Vendor are hereinafter collectively referred to as the Vendors and individually as a Vendor.)

**NOTE:** Pursuant to Virginia Code Section 38.2-3405, health insurers and HMOs cannot subrogate the rights of an insured to recoveries from a third party for accidental injuries. In addition, Coventry Health Care does not pursue subrogation for its self-funded clients if indicated in their Summary Plan Description (SPD).

If you believe you received a refund letter in error or have any pertinent information that may not have been considered in making the determination, please contact our Customer Service Department at 1-800-627-4872, Monday through Friday 8:00 a.m. to 6:00 p.m. EST.

All refunds should be mailed to:

**Coventry Health Care of Virginia, Inc.**  
Recovery – Refund  
PO Box 8500-53843  
Philadelphia, PA 19178-3843

All return checks should be mailed to:

**Coventry Health Care**  
The Recovery Dept  
120 East Kensinger Dr.  
Cranberry Twp, PA 16066

**4.13 - Payment Policy Program**

Coventry Health Care utilizes software packages to improve business processes. This software is used in auditing pre-payment claims submitted to Coventry Health Care. The program aligns our payment policies and claims adjudication system with nationally accepted coding standards and guidelines of the Centers for Medicare and Medicaid Services (CMS) and the American Medical Association (AMA). These software packages provide auditing capability for current claims received as well as historical claims for the same patient, same date of service, and same provider. The following are some of the edits utilized by these software packages:

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

In addition to these software packages, Coventry Health Care supplements its claims policies with proprietary claims payment guidelines. These guidelines are generally developed on a national level by the medical management staff at Coventry’s corporate headquarters and then approved at the local Coventry Health Care level prior to use. Examples of areas of care where proprietary claims payment guidelines exist include, but are not limited to, spinal manipulation and payment of supplies.

History Edits
These edits apply to once-in-a-lifetime procedures, such as an appendectomy. These edits also apply to items such as drugs or supplies that may have monthly limits. History edits may also apply to certain codes, which denote services for a specified time period such as weekly or monthly radiology or renal dialysis.

Global/Incidental Claims Processing
For some medical services, Coventry Health Care will impose global surgery processing rules, wherein some services are incidental to other services when provided within a defined time period and in conjunction with the procedural service.

An incidental procedure is one that is performed at the same time as a more complex primary procedure and it does not require significant, additional physician resources and/or is clinically integral to the performance of the primary procedure. When multiple medical service codes are billed in conjunction, some codes may be considered incidental to other codes and may not be considered toward the total allowance for the aggregation of billed codes. A code which is a subset of another code based on an objective interpretation of CPT verbiage will be considered incidental to the latter code. Coventry Health Care may also consider a code incidental to another if the Relative Value Unit (RVU) of the former is less than one fourth of its usual value when provided in combination with the latter. In many instances, this occurs when the lesser services do not pertain to different routes of access, different organ systems, different pathological processes, or to multiple trauma.

Modifiers
Coventry Health Care accepts most standard modifiers; however, some may require clinical review. The use of a modifier may reduce the payment. If you have a question about the resulting payment from a modifier being applied to a specific medical service code, please use Attachment E. For example, bilateral procedures are usually indicated by physicians billing with a 50 modifier on surgical CPT codes (10040-69990). There are also non-surgical codes that are allowed with a 50 modifier. Payment for bilateral procedures is calculated as 100% of the allowable for one procedure and 50% of the allowable for the second procedure making a total allowable of 150%.

Payment Guidelines for Bilateral Procedure Billed Alone
If the provider charges for a bilateral procedure with no other surgical
procedures performed, the following guidelines are followed.

Procedures billed on a SINGLE line:

- If modifier 50 is billed with one surgical CPT code and one unit, then claim will reimburse 150% of the allowable.
- If modifier 50 is billed with one surgical CPT code and two units, the claim will be split into two lines and one line will be paid with modifier 50, as ONE UNIT with total dollars billed as described immediately above. Line two will deny with the same bilateral procedure, as one unit and zero dollars as included in services performed on the same date of service.

Procedures billed on TWO lines:

- If modifier 50 is NOT billed, our claims review software will review the claim as multiple surgery and automatically apply a 51 modifier to the second line, which will pay a total of 150%.
- If modifier 50 is billed on the second line and each line has one surgical CPT code and one unit, we will pay the line that is billed with modifier 50, as ONE UNIT with the total dollars billed and deny the other line with the same bilateral procedure, one unit and zero dollars as included in services performed on the same date of service.

Payment Guidelines for Non-Surgical Procedures

If charges are received for a non-surgical procedure code billed with a modifier 50, the modifier will not be removed. If our claims edit system determines the procedures are appropriate, the claim will be split into separate lines and the modifier 50 removed. If the claim should pay 150%, one line will indicate 100%, and a modifier 51 will be placed on the second line and payment will be 50%. If our claims edit software indicates the procedures are not appropriate, the non-surgical code will deny as invalid code combination.

If charges are received with multiple lines billed with same CPT code and a modifier 50 on each line:

- The first line will be split into two lines and the modifier 50 removed. The second line will be denied as included in services performed on the same date of service. Our claims edit software will determine if the claim should pay 200% of the allowance amount and, if so, payment will be made.

Multiple Surgeries/Procedures

When two or more different medical service codes are provided to the same patient (usually by the same provider on the same date of service) for covered surgical services provided in a single operative session, reimbursement would be made at 100% of the allowable amount for the surgery with the highest RVU, 50% of the allowable amount for the second surgery, and 50% of the allowable amount for each subsequent procedure.

Re-bundling Claims Processing
Procedure unbundling occurs when two or more procedures are used to describe a service when a single, more comprehensive procedure exists that more accurately describes the complete service performed by the provider. For some combinations of medical service codes, Coventry Health Care will allow the allowance amount for a totally different service code while disallowing the billed medical service codes. Coventry Health Care refers to this as the re-bundling processing. Medical service codes to which billed services are combined are usually a superset of the billed codes. An example would be a set of laboratory codes that are all contained within a single panel or multichannel test. Coventry Health Care will combine billed codes into a code which is not a superset of the billed codes, but does represent the value of the combined medical services billed.

**Reimbursement Regarding Secondary and Subsequent Procedures**
Multiple units of the same medical service code may be subject to limits and/or to partial payments for secondary and subsequent units of service. For some medical service codes which may be provided multiple times to a single patient on a single day, Coventry Health Care allows a partial payment (typically one-half) of the usual allowance amount for secondary and subsequent units of service. For some such medical service codes, Coventry Health Care establishes a maximum total allowance (limit), notwithstanding the number of units provided.

**Payment Policy Program Review**
The Payment Policy Program is used to ensure that claims are paid correctly based on clinical patterns. It also checks for the use of inappropriate CPT codes, modifiers and for duplicate claims. Payment Policy reviews do not follow the appeal process and are not considered to be appealable. To request a Payment Policy review, please complete and mail the form that is attached as Attachment D, and include applicable documentation within 365 days of the date of service. Request should be sent to:

Adjustments Department  
Attn: MCRN Review for Payment Policy  
P.O. Box 7135  
London, KY 40742-7135  

*There is not a fax option for a Payment Policy review request.

To check on the status of a Payment Policy review request please contact Customer Service at 800.627.4872. A Coventry Health Care Medical Claims Review Nurse (MCRN) will review the documentation and consult with the Medical Director to reach a decision. Notice of the decision is provided on the remittance advise. **Decisions are considered to be final and are not able to be appealed.**

**4.14 - Provider Reimbursement Fee Schedule**
Providers are generally notified of any change in fees at least 60 days in advance of any change. Please use the form on Attachment E to request CPT specific
fee information. Coventry Health Care shall reply to written requests from providers for specific allowances within 30 working days of receipt. Requests should be limited to frequently billed services offered by the provider.

4.15 - Noncovered Services

Certain services and supplies are noncovered and/or specifically excluded by Coventry Health Care. Different Coventry Health Care products may have a different list of exclusions. The most common exclusions for the Fully Insured products are listed at the end of this section. This list may be reduced or expanded for self-funded groups. Please contact the Customer Service Department for information about exclusions and any specific benefit plan for which you need information. Both the Medicaid and VASM products have exclusions involving specific state regulations. In addition to those items specifically listed as a noncovered service in the member’s Evidence of Coverage, Certificate of Insurance, or Plan Documents, any service which is not medically necessary will be considered noncovered.

Benefits are described in detail in the member’s Evidence of Coverage, Certificate of Insurance, or Plan Documents which is made available to each subscriber at the time of enrollment. Covered benefits and the member’s payment responsibility may vary among employer groups. Members are advised that their Evidence of Coverage, Certificate of Insurance, or Plan Documents, the member website and the Customer Service Department should be their sources of information regarding coverage status.

If you have questions about the coverage for a certain service, please call our Customer Service Department number located on the back of the member’s ID card. Be sure to have the member’s ID number so you can get accurate information.

If patients come to you with their benefit questions, please instruct them to call the Customer Service Department number located on the back of their ID card.

Fully Insured Non-Covered Services

Coventry Health Care does not cover (i) any service or supply that is not medically necessary; (ii) any service or supply that is not listed as a covered service; or (iii) any service or supply that is a direct result of receiving a non-covered service. Contact Customer Service for information about specific services that are excluded from coverage.
5 Pharmacy Benefits

Overview
Pharmacy coverage is optional and certain Groups may not have drug coverage through Coventry Health Care. Please access www.directprovider.com or contact Customer Service to determine if a member has drug coverage through Coventry Health Care.

The Prescription Drug List is based on the recommendations of the Pharmacy and Therapeutics (P&T) Committee. The criteria used by this committee in formulating the Prescription Drug List include, but are not limited to, the following:

- Safety of the medication
- Comparison to other currently approved medications in regard to the effectiveness of the new medication
- Cost compared to other currently approved medications

As a participating physician, you should prescribe medications that are preferred on the Coventry Health Care Prescription Drug List if medically appropriate for your patient. Changes to the Prescription Drug List are printed in the Connection newsletter after the P&T Committee meetings.

A tiered version of our prescription drug list is posted on our website. Tier 1 includes preferred generic drugs and select OTC drugs. Tier 2 includes preferred brand drugs and Tier 3 includes non-preferred brand and generic medications. Members with a Tier 4 benefit design have coverage for preferred self-administered injectables on Tier 4 level. Tier 5 includes non-preferred specialty medications. Self-administered injectables are listed in the Specialty Medications section of the Prescription Drug List. When you prescribe drugs from preferred tiers 1 and 2, members will have the lowest out of pocket costs.

Subject to the exclusions, deductibles, and copayments and coinsurance described, benefits are available for outpatient prescription drugs when the prescription is written by a provider licensed to prescribe prescription drugs and when the member uses a participating pharmacy. The benefit described includes a mail order option, as well as an option to obtain up to a 90-day supply of maintenance drugs at participating pharmacies. A copayment and/or coinsurance applies to each covered prescription or refill. Most prescription drug benefits include one copayment and/or coinsurance for preferred generic drugs, one copayment and/or coinsurance for preferred brand drugs, and one copayment and/or coinsurance for non-preferred drugs. Some members may have a coinsurance on Tier 4 or Tier 5 for self-administered injectables.

Some plans have a prescription drug deductible; under those plans members must first meet their prescription drug deductible before Coventry Health Care makes any payment for covered prescription drugs. These deductibles apply to each benefit year.
In order to receive this benefit, a member must present his or her Coventry Health Care Member ID card at the time the prescription is filled. Prescriptions filled at participating pharmacies must be submitted through the online claims adjudication process. The pharmacy will then charge the member the lesser of: 1) the applicable copayment, coinsurance, or deductible, 2) the negotiated contract amount for the drug, or 3) cost of the drug. Coventry Health Care will not reimburse members who fail to follow this procedure.

Except as otherwise indicated, the quantity of a prescription dispensed by a retail pharmacy for each prescription or refill is limited to the lesser of the following and will be considered a prescribing unit:

- The amount prescribed in the prescription order or prescription refill.
- A 31-day supply as defined by Coventry Health Care.
- The amount necessary to provide 31-day supply according to the maximum dosage approved by the Food and Drug Administration for the indication for which the drug was prescribed.
- Depending on the form and packaging of the product, the following:
  - 480 ml of oral liquids.
  - A sufficient amount to provide the prescribed dosage for 4 weeks (for drugs prescribed based on the number of doses per week).
  - One inhaler or one commercially prepackaged set of doses (for inhaled drugs).
  - One commercially prepared or packaged tube of topical medications including salves, creams, ointments, suppositories or patches.
  - The number of vials of one type or strength of insulin needed to provide the prescribed dosage for 31 days.
  - One commercially prepackaged set of doses, (i.e. tablets, capsules).

Coverage for certain drugs, established by Coventry Health Care's Pharmacy and Therapeutics Committee, is subject to specific quantity or dosage limits. You can get information about specific quantity limits from the Coventry Health Care website at www.chcva.com or by contacting the Pharmacy Help Desk at 800.378.7040. If a drug is not covered at the dosage or quantity prescribed by the physician and the physician deems that the non-covered dosage or quantity is medically necessary, then the physician may request payment for the non-covered dosage or quantity or to make other exception requests by contacting the Pharmacy Call Center by phone 877.215.4100 or fax 877.554.9137. If Coventry Health Care, after reasonable investigation and consultation with the prescribing physician, approves an exception, the prescription will be covered at the non-preferred drug copayment and/or coinsurance once the member has satisfied any applicable deductibles for the benefit year. Such an exception will be acted on within two working days of Coventry Health Care's receipt of the request.

For a patient with intractable cancer pain, the member's physician may request a dosage that is in excess of the recommended dosage of a pain relieving agent. The physician should provide information to Coventry Health Care to confirm that the drug is for intractable cancer pain and that the drug is FDA approved for that use. A decision will be made within 24 hours of receiving the request.
and communicated by telephone to the requesting physician.

If a physician prescribes a medication in a dose that requires two separate strengths and a pharmacy must dispense two separate prescriptions to accommodate the prescribed dose, the member will be required to pay the required copayment or coinsurance for each pharmacy prescription dispensed. The pharmacy department may require two separate strengths for cost-effectiveness. Any covered medication that has a duration of action extending beyond one month shall require the number of copayments that is equal to the anticipated duration of the medication. For example: Depo-Provera is effective for three months. It is covered and will require three copayments.

Mail Order Benefit
The copayment and/or coinsurance applies to each initial and refill prescription for up to a 90-day supply of maintenance drugs once any applicable deductibles have been satisfied for the benefit year. The member will need to allow at least a 14-day turnaround time to receive their mail order prescription. Only maintenance drugs, as defined by Coventry Health Care, are available through mail order. Controlled substances are not available through the mail order program. Please refer to the Mail Order Exclusion List on our website for additional information.

Retail Maintenance Drug Benefit
In addition to the mail order benefit, the member also has the option to obtain up to a 90-day supply of maintenance drugs from a participating pharmacy. The member will pay one copayment and/or coinsurance for each prescribing unit in a 90 day supply. Only the maintenance drugs defined by Coventry Health Care will be available at the retail maintenance drug benefit. Controlled substances and Tier 4 or Tier 5 medications are not available at the retail maintenance drug benefit.

Specialty Medications
Specialty medications are available through our preferred Specialty Pharmacy Provider. Specialty medications as defined by us are typically high-cost drugs, including but not limited to the oral, topical, inhaled, inserted or implanted, and injected routes of administration. Included characteristics of specialty medications are drugs that:

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

Except in urgent situations, all specialty medications are distributed by a Specialty Pharmacy approved by us and are limited to no more than a 31 day supply per fill. Specialty medications require Prior Authorization, unless specified elsewhere and are subject to quantity limits.

General Information
Most Coventry Health Care plans require mandatory generic substitution. If a brand name prescription drug is dispensed, and an FDA-approved A-rated equivalent generic prescription drug is available, the member shall pay an ancillary charge directly to the pharmacy in addition to the non-preferred brand
name copayment and/or coinsurance once any applicable deductibles have been satisfied for the benefit year. The ancillary charge is the difference between the price of the brand name drug and the generic drug and does not apply to any deductible.

Certain drugs require prior authorization by Coventry Health Care prior to coverage. Participating physicians and Coventry Health Care's Customer Service Department have a current list of these medications. If the member needs to take a drug that requires prior authorization, the prescribing physician must contact Coventry Health Care with the medical indications for prescribing the medication. Prior authorization is determined using criteria developed by Coventry Health Care's Pharmacy and Therapeutics Committee, based on FDA approved uses and laws of the Commonwealth of Virginia. In addition, high dollar claims will be reviewed by Coventry Health Care for efficacy and cost effectiveness in conjunction with FDA standards of care.

Because there may be more than one therapeutically equivalent brand name of a prescription drug, not all therapeutically equivalent brands of prescription drugs (i.e., those produced by different manufacturers) may be included in Coventry Health Care's Prescription Drug List. In some instances, for the same drugs (i.e., drugs with the same active ingredients) made by two different manufacturers, Coventry Health Care may only put one of the drugs on its Prescription Drug List and the other drug will be excluded from coverage.

In certain situations, Coventry Health Care can, upon written notification to the member, give notice that the member's prescription drug benefit is in jeopardy. These situations include, but are not limited to, a member using medications in a manner that contradicts his/her prescription or standard prescribing practices, consistently using multiple pharmacies, or obtaining prescriptions for the same medication from multiple physicians. Continued abuse of this nature can result in termination, upon 31-day written notice to the member, of prescription drug benefits for the member and all covered dependents.

What is covered:

- Medically Necessary drugs:
  - Obtained from a participating pharmacy (including mail order)
  - For which a prescription is required by federal or state law
  - Which are not specifically excluded

- Self-administered injectable drugs.

- Diabetic supplies, including insulin, syringes, blood glucose strips, lancets, and glucose monitors.

- Compounded prescriptions when all of the following apply:
  - No suitable commercially available alternative is available.
  - The main active ingredient is a covered prescription drug.
  - The purpose is solely to prepare a dose form that is medically necessary and is documented by the prescribing doctor.
  - And, when the claim for the prescription is submitted electronically.
Depo-Provera is covered through our pharmacy benefit. Physicians are to write a prescription for the medication and the patient is to obtain the medication from a participating pharmacy. Depo-Provera will not be covered if supplied by the physician’s office.

Coverage for preventive drug products will be provided at 100% of the Allowable Charge/Allowed Amount in a manner consistent with Section 2713 of Federal H.R. 3590. This includes over-the-counter aspirin, folic acid, iron and fluoride tablets. Members will need a written prescription in order for these to be covered.

What is not covered:

- Drugs which are not medically necessary.
- Drugs obtained from nonparticipating pharmacies in a non-emergency situation when such pharmacies have not previously notified Coventry Health Care, by facsimile or otherwise, of their agreement to accept as payment in full reimbursement for their services at rates available to pharmacies that are participating providers, including any copayment, coinsurance and/or deductible consistently imposed by Coventry Health Care.
- Any prescription drug which is to be administered, in whole or in part, while a member is in a hospital, medical office, or other health care facility.
- Travel prophylaxis.
- Growth hormone for adults.
- Any prescription drug that is being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance.
- Drugs which do not require a prescription by federal or state law, with the exception of over-the-counter (OTC) programs sponsored by Coventry Health Care. For example: Legend drugs for which there is a non-prescription drug alternative (such as over-the-counter), over-the-counter drugs (like aspirin, antacids, herbal products, medicated soaps, food, food supplements, food replacements, and bandages) or over-the-counter equivalents, behind-the-counter drugs, nutraceuticals or medical foods.
- Contraceptive implant systems and intrauterine devices (IUDs). Note: IUDs are covered under medical.
- Dietary supplements, appetite suppressants, drugs used to treat obesity or assist in weight reduction or weight gain, and malabsorption agents.
- Drugs and products for smoking cessation, including prescription drugs such as Zyban, with the exception of OTC programs sponsored by Coventry Health Care and those OTC drugs required to be covered by state or federal law.
- Medications prescribed for cosmetic purposes, including but not limited to, tretinoin for aging skin and minoxidil lotion.
- Drugs and products used to treat infertility (unless covered by a rider).
- Injectable medications, except self-administered injectable drugs.
- Medications for treatment of diseases of teeth and gums, except fluoride
tablets or drops.
• Devices or supplies of any type, regardless of having a prescription order, unless specifically listed as covered in the member’s pharmacy rider. These include, but are not limited to tubing for insulin pumps; ostomy supplies, including bags, adhesives, tubing, therapeutic devices, support garments, corrective appliances, non-disposable hypodermic needles, or other devices regardless of their intended use. The member’s prescription drug coverage does not extend to drugs or products that are not FDA approved prescription medications, such as those without an approved FDA application (NDA, ANDA or BLA).
• Allergy supplies, including syringes.
• Experimental and investigational drugs; products not approved by the FDA; drugs with no FDA-approved indications, medications prescribed at dosages in excess of FDA approval; drugs prescribed for purposes other than the FDA approved use, unless a drug is recognized for treatment of the covered indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature. Cancer drugs that are FDA approved for a certain cancer type may be used for treatment of other types of cancer, provided the drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the standard reference compendia. Any drug approved by the FDA for use in the treatment of cancer pain shall not be denied for coverage on the basis that the dosage is in excess of the recommended dosage of the pain relieving agent, if the prescription in excess of the recommended dosage has been prescribed in compliance with Virginia law for a patient with intractable cancer pain.
• Vitamins and minerals (both OTC and legend), except legend prenatal vitamins for pregnant and nursing females, liquid or chewable legend pediatric vitamins for children under age 13, and potassium supplements to prevent/treat low potassium.
• Biological sera and Hemophilia blood factors with the exception of programs sponsored by Coventry Health Care.
• Medications used to enhance athletic performance, including but not limited to, anabolic steroids.
• Medications related to sexual transformation or transgender.
• Medications for a condition or injury related to a Worker’s Compensation claim.

Helpful Prescription Drug Information On Our Website
You can access the following pharmacy information on our website at www.chcva.com » Providers » “Prescription Documents”:
• A list of preferred pharmaceuticals, including any restrictions and/or preferences
• A list of medications which require prior authorization, and applicable coverage criteria
• A list of medications which require step-therapy, including the medications which must be tried/failed prior to coverage
• A list and explanation of medications which have limits or quotas
• Copayment and coinsurance requirements, and the medications or classes to which they apply
• Procedures for step-therapy, prior authorization, generic substitution, preferred-brand interchange, and therapeutic interchange
• Information on the use of pharmaceutical management procedures
• Criteria used during the evaluation of new medications for inclusion on the formulary
• A description of the process for requesting a medication coverage exception
6 Laboratories

6.1 - All Coventry Health Care Areas
Laboratories listed in the Directory of Health Care Providers are the participating outpatient laboratories for Coventry Health Care in your specific geographic area.

It is Coventry Health Care policy that laboratory services should be provided by a participating outpatient laboratory for lab services not provided in the provider’s office. When a participating provider sends a lab to a vendor that Coventry Health Care has not contracted with to perform lab services, the provider is responsible for the charges per Section 2.13.

A provider may bill one handling charge, CPT Code 99000, per patient visit whenever the lab specimens are sent to a participating outpatient laboratory.

Surgical Pathology
Surgical pathology specimens may be sent to any participating Coventry Health Care pathologist or to a participating outpatient laboratory. One handling charge, CPT code 99000, per patient per visit will be paid.

Handling Laboratory Specimens
You may handle laboratory specimens and/or charges in any of the following ways:

1. Physicians should draw the specimen in their office and send it out to a participating lab.

   Exceptions are listed below.
   
   • One handling charge, CPT code 99000, per patient per visit may be billed whenever lab specimens are sent to participating lab.
   • Venipuncture (CPT codes 36410, 36415, 36416 and G0001) is not payable under place of service 11 (office). All other place of service locations will allow payment for venipuncture.

2. You may direct the patient to a participating lab drawing station to have the specimen drawn and tested. You should provide patients with a lab test order form before directing them to a participating lab service center/drawing station.

   Patients should have a test order form from the physician when visiting a patient service center/drawing station.

Lab Slip Procedures
When completing these slips for members, these seven items must be included:

• Date of collection
• Time of collection, if clinically significant
• Patient’s full name
• Patient’s sex and age
• Member number, including suffix, written in the patient ID field
• Ordering physician’s National Provider Identifier (NPI) number, written in the physician ID field
• “Coventry Health Care Services Inc.” written in the billing box under Insurance for HMO and POS members; “Coventry Health and Life Insurance Company” for PPO members

Using the ordering physician’s NPI enables Coventry Health Care to determine that the provider is a participating physician and to identify the utilization of laboratory services. If the provider number is not on the form, the reporting of the test results may be delayed. Please notify your laboratory technician of this requirement.

Nonparticipating laboratories can only be used when preauthorized by Coventry Health Care and when Coventry Health Care does not have a participating laboratory that can provide the specific lab test.

6.2 - Thin Prep Pap Test
Coventry Health Care provides coverage for the thin prep pap test.

Providers may send specimens to the participating outpatient laboratory in your area, or bill Coventry Health Care directly for CPT code 88142. Refer to the prior sections for information on your area’s contracted lab vendor.

Code Q0091 will be reimbursed if the code is billed alone. If the code is billed in conjunction with an office visit code, the code is deemed to be included in the reimbursement for the office visit.

6.3 - Genetic Testing
Some lab procedures may require preauthorization such as Genetic testing. For a complete listing of services requiring preauthorization, see Attachment A.

6.4 - STAT labs
If a provider has a CLIA certified lab and has provided the certificate to Coventry Health Care, you may provide and bill for labs done in your office. The lab reimbursement will be at the Lab Reimbursement Fee Schedule.

Should you have questions regarding the fee schedule or would like to provide your CLIA certificate, please contact your Provider Relations Representative.
7 Plan Options

7.1 - Types of Benefit Plans
Health Maintenance Organization (HMO), Point-of-Service (POS), and Preferred Provider Organization (PPO) products are available to both large and small groups with as few as two employees. The specific benefits provided and premium required depends upon the product and benefit plan selected. The product descriptions are only summaries of benefits, exclusions and limitations and are not contracts. The complete benefits, limitations, exclusions and procedural requirements of a plan can be found in the coverage documents for each product.

HMO Products
Coventry Health Care of Virginia, Inc. offers several HMO options. All HMO plans allow members to select a primary care physician to assist in coordination of their health care. Female members age 13 and older have the option of selecting an OB/GYN in addition to a PCP.

Members receive services from the Coventry Health Care of Virginia, Inc. network of quality health care professionals. Members can access participating specialists directly for covered services without a referral. Participating PCPs as well as participating specialists are able to obtain directly from us any required preauthorization needed. There is a full range of HMO benefit plans available from those that have a low level of member responsibility to those that have a higher level of member responsibility.

POS Products
Coventry Health Care of Virginia, Inc. offers several POS benefit plans to its members. These benefit plans allow a member to select a primary care physician. Female members age 13 and older have the option of selecting an OB/GYN in addition to a PCP. Members have the choice of receiving care from a participating provider (in network) and receiving a higher level of benefit or the member may go to a nonparticipating provider (out-of-network) at a reduced level of benefit.

Referrals from the PCP for office visits to other participating providers are not required. POS members may access any participating specialist directly and receive covered services at the in-network level. Participating and nonparticipating PCPs and specialists are able to obtain directly from us any required preauthorization needed. There is a full range of POS benefit plans available from those that have a low level of member responsibility to those that have a higher level of member responsibility.

PPO Products
Employers have the option to purchase PPO benefit plans that use a local network of PPO providers as well as a national network of providers through Coventry Health Care National Network. Some of these benefit plans may also be coupled with either an FSA (Flexible Spending Account), HRA (Health Reimbursement Arrangement), or HSA (Health Savings Account, or any...
combination thereof. The PPO benefit plans have different Directories of Health Care Providers from the HMO and POS plans.

**CoventryOne**
New for the Health Insurance Marketplace – High Performance Networks

Coventry Health Care of Virginia, Inc. has developed new individual health benefit plans that are being sold in Virginia on the federal Health Insurance Marketplace (also called the Exchange). Effective January 1, 2014, Coventry’s Exchange products will involve new limited High Performance Networks (HPNs) that will support its individual health benefit plans. Coventry is offering two products (HMO and POS) for individuals only at this point. HPN product member ID cards will say Carelink/CoventryOne on them and involve a tiered benefit structure. Also offered on the Exchange is a POS/Non-HPN individual product – which just says CoventryOne.

Note: Effective December 31, 2013, the Coventry Health and Life Insurance Company CoventryOne “PPO” product which was a non-employer group trust licensed out of West Virginia is no longer available. Participation for members will end upon their individual contract renewal date.

HPN Tier 1 providers will be identified in our provider directory and in member documents. Exchange products have a dedicated customer service number. To verify benefits for Coventry Exchange members, please call the number on the back of the member’s ID card.

**Employer Self-Funded Benefit Plans**
Coventry Health Care of Virginia, Inc. arranges the provider network for benefit plans funded by employer groups. These benefit plans are administered by us. In these plans, the employer, not us, has the ultimate payment responsibility to the provider.

**CoventryCares**
Coventry Health Care of Virginia, Inc. offers a Medicaid HMO product, CoventryCares, to eligible Medicaid recipients and to children who qualify for health care coverage through the Family Access to Medical Insurance Security (FAMIS). The physician network and reimbursement methodology for providers may vary from our commercial products. For a CoventryCares fee schedule, please contact your Provider Relations Representative. Please refer to Section 14 for CoventryCares information. For more information about participation in the CoventryCares network, please contact your Provider Relations Representative.

**Product Options**
Coventry Health Care providers have the ability to opt-out of certain networks. In the event a provider wishes to opt-out of a network, notice must be given pursuant to the provider’s agreement.

**To obtain specific benefit information about one of your Coventry Health Care patients, please refer to** [www.directprovider.com](http://www.directprovider.com) **or call Customer Service.**
8 Physician Participation Information

8.1 - General Guidelines
A provider must complete an application, sign two Agreements and be fully credentialed in order to be approved for participation. Once the Agreements have been executed, an original copy will be returned to the provider for his/her records.

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

Committee Activity
Provider input is an important element of the management structure of Coventry Health Care. There are several committees where external professionals are essential. These committees allow our participating providers a voice in the policy and procedure-making process and in the clinical and medical/utilization management studies. If you are interested in joining any of these committees, please contact your Coventry Health Care Provider Relations Representative.

Minimum Initial & Recredentialing Standards
All practitioners applying for initial and continued participation in the Coventry Health Care network must meet the minimum credentials criteria, unless an exception is made by the Credentialing Committee. If the applicant does not meet criteria and an exception is not made, he/she may reapply to the network in six months from the determination.

All practitioners applying for initial and continued participation in the Coventry Health Care Network must meet all applicable criteria as outlined below:

- Have completed an application and a signed attestation statement.
- Have a current, unrestricted state license in the state in which they are applying to provide services.
• Have a current, unrestricted Drug Enforcement Agency (DEA) certificate. An exemption is made for applicants who do not prescribe medications.
• Have current malpractice insurance issued by an insurance carrier domiciled in the U.S. and in accordance with the coverage requirements as stated in Coventry Health Care policies and Section 8.5 of this manual.
• Have no significant liability claims history and fully disclose all judgments, settlements, or pending claims in professional liability cases, imposed and pending sanctions including but not limited to Medicare, Medicaid, or DEA and criminal conviction(s) for the past five years.
• Have no Medicare/Medicaid sanctions.
• The physical and mental health status of the applicant must permit him/her to practice medicine in an unrestricted manner.
• The applicant must be free of impairment due to chemical/substance abuse.
• Have a work history for the five years previous, with no gaps greater than six months, unless gaps can be explained, either verbally or in writing. A gap in work history that exceeds one year must be clarified in writing.
• For PCPs only, office hours availability at least 25 hours a week and perform the functions of a primary care physician by meeting one of the following conditions: a) performs the functions of a primary care physician at least 50% of the time in which he/she engages in the practice of medicine, or b) has limited their practice for at least two years prior to association with Coventry Health Care to general practice, internal medicine, pediatric, or family medicine.
• At the time of recredentialing, PCPs must perform adequately when information pertaining to member complaints, member satisfaction, utilization management, and/or results of quality improvement activities is evaluated.
• State and/or Medicare/Medicaid sanctions or licensure restrictions identified regarding a participating provider shall be reviewed by the Credentialing Committee. Recommendations for action will be communicated to the identified provider by the Credentialing Committee Chairperson. The provider has the right to appeal.

The provider has the right to review and to correct erroneous information. The provider will be notified by Coventry Health Care via phone, fax or letter and will have 15 days to comply with the request, in writing or verbally. Upon receipt of the corrected information, the provider’s file will be amended. The provider will be furnished all necessary policies and procedures pertaining to their right to review and correct erroneous information in the event the credentialing information obtained from other sources varies substantially from that which the provider has supplied in their credentialing application.

Recredentialing is required within three years of initial credentialing.
Additional criteria for Credentialing Midwives:

- The applicant must have an unrestricted license as a Registered Nurse and Nurse-Midwife.
- The applicant must have staff membership in good standing at the network hospital for which he/she is applying. “Staff membership” refers to any designation adopted by the hospital where the Nurse Midwife can provide services permitted by his/her licensure and certification.
- The applicant will have a formal working relationship with a network obstetrician/gynecologist.

8.2 - Coventry Health Care and CoventryCares Access and Availability Standards

Coventry Health Care utilizes accessibility/availability standards based on requirements from NCQA, state and federal regulations. The Access Standards are communicated to physicians and members by newsletters and the Coventry Health Care website and are part of the Provider Manual.

Practitioners that do not meet Coventry Health Care's access standards are provided recommendations for improvements in order to meet the set standard. The Credentialing Committee reviews the information as part of the initial and reappointment process.

PCP Availability

- Routine History, Physical Exam & Preventative Care Appointments: < Six weeks
- Routine Primary Care (non-urgent, symptomatic conditions) Appointments: < One week
- Semi-Urgent Care Appointments (fever): < 48 hours
- Urgent Complaint: Same Day
- Emergency Care Appointments: Immediately

Access to after-hours care by a network PCP is available to members 24 hours a day, 7 days a week. (Emergency Room physicians and Urgent Care Centers are not considered “network physicians for routine call duty.”)

OB/GYN Availability

In addition to the standards above:

- First Trimester: < 14 days
- Second Trimester: < 7 days
- Third Trimester: < 3 days
- High Risk: < 3 days

8.3 - Office Survey and Medical Record Review

To ensure and evaluate the accessibility of services and the quality of care, Coventry Health Care performs on-site reviews of physician offices. There are two aspects of the review: 1) a survey addressing office policies and procedures, and 2) a medical record review. Coventry Health Care may use a third-party
A compliance review of medical record documentation practices is conducted annually. This is an NCQA requirement for accredited health plans. The medical record review will be conducted at the time of the HEDIS data collection. Provider offices are notified of the charts needed for HEDIS review by FAX. These same member/patient records are assessed for medical record documentation standard compliance during the same onsite visit. (Please refer to Quality Improvement Section 12.13 for the Documentation Standards)

The office survey is completed by a Coventry Health Care reviewer and the office manager or physician in the practice. Coventry Health Care surveys the office policies and procedures, such as those to schedule appointments, handle emergencies, and ensure patient confidentiality. The Quality Improvement (QI) Reviewer conducts the medical record review. Prior to the medical record review, a list of names is sent to the practice for medical records to be pulled for the Coventry Health Care QI Reviewer to check for documentation and coding accuracy.

Coventry Health Care considers these reviews educational and works with the office to improve areas in which there is a deficiency. Information, including sample problem lists, is available to those practices that request follow-up. Offices will be revisited as determined by the results of the review. Generally an office may be revisited every one to three years.

More information about the office survey and medical record review, including Coventry Health Care’s required standards, may be obtained by contacting your Provider Relations Representative.

**8.4 - Maternity Guidelines**

The length of stay for a vaginal delivery is 48 hours. The length of stay for a cesarean section is 96 hours. If the physician believes the mother’s medical condition warrants a longer stay, the physician must contact Coventry Health Care for preauthorization of such additional services. Shorter stays shall occur where patient and physician agree. For all expectant Coventry Health Care members, physician is strongly encouraged to complete the Maternity Notification Form listed as *Attachment C* in this Manual. This form assists Coventry Health Care in identifying high risk pregnancies and in providing additional support and services for pregnant members.

Benefits for inpatient care are determined in accordance with applicable federal and state law. The criteria outlined in the most current version of the Guidelines for Perinatal Care prepared by the AAP and ACOG, or the Standards for OB/GYN Services prepared by ACOG. Coventry Health Care is allowed a six-month period to incorporate any changes in these guidelines or standards in its procedures. Each expectant mother is mailed information during her pregnancy that includes a request to notify Coventry Health Care of the baby’s physician. In addition, Coventry Health Care sends mothers-to-be a *Baby Matters* packet
which includes information on the stages of pregnancy, proper nutrition, and a list of community classes and resources.

For CoventryCares members, please refer to Section 14.15.

8.5 - Malpractice
All providers must have the Coventry Health Care required malpractice limits of $1 Million/$1.5 Million. Only the Credentialing Committee has the ability to make exceptions.

8.6 - Members’ Rights and Responsibilities
Coventry Health Care is committed to treating members in a manner that respects their rights as members, including those members with diverse cultural and ethnic backgrounds and those with physical and mental disabilities.

Members of Coventry Health Care have the right to:

- Be provided with accurate information about Coventry Health Care’s services, benefits, their rights and responsibilities, and participating providers
- Participate with their physician in decisions made regarding their health care
- Have access to the Coventry Health Care Customer Service Department
- Discuss appropriate or medically necessary treatment options for medical conditions, regardless of the cost or benefit coverage
- Be treated with respect and recognition of their dignity and need for privacy and confidentiality
- Voice complaints and appeals about this organization or the care provided by participating providers and to have a clear, documented method for addressing any complaints and appeals
- Request a description of all types of payment arrangements that Coventry Health Care uses to compensate providers for health care services rendered to members. These payment arrangements may include, but are not limited to, withholds, bonus payments, capitation, and fee-for-service discounts
- Make recommendations regarding Coventry Health Care’s member rights and responsibility policy

Members’ Responsibilities to Providers
Coventry Health Care members have the responsibility for cooperating with providers of health care services by:

- Providing information needed by health care professionals
- Informing office and facility staff of their coverage with Coventry Health Care and notifying office and facility staff if their coverage ends
- Following instructions and guidelines given by health care providers
Failure to comply with recommended treatment is an option for members. However, when a member fails to comply with the recommended treatment, Coventry Health Care will have no further liability to pay for treatment for the particular condition until such time that the member later decides to follow the prescribed treatment, assuming the prescribed treatment is a covered service. Coventry Health Care will not be responsible for payment of services that may otherwise be covered services but that in Coventry Health Care’s discretion are the direct result of the member’s initial refusal to follow the recommended treatment.

- Cooperating with practitioners and providers of health care services by understanding their health problems and participating in the development of a mutually agreed-upon treatment goal to the degree possible

Members’ Responsibilities to Know How and When to Seek Care
Coventry Health Care members have the responsibility of knowing their health benefits, as well as any procedures required for seeking care, such as:

- Knowing whether they are seeking care from a participating or non-participating provider. In most cases, benefits will vary according to the participation status of the provider delivering covered services
- Verifying the current participation status of any provider for their specific benefit plan prior to receiving services
- Always obtaining any required preauthorization as described in the member’s Evidence of Coverage, Certificate of Insurance or Plan Document. If they need to seek services from a non-participating specialist, they will need to ensure that Coventry Health Care has approved the services before receiving covered services
- Understanding the terms and limitations of preauthorization for covered services and for POS and PPO members, whether preauthorization are approved at the in-network or out-of-network benefit level
- Obtaining preauthorization from Coventry Health Care prior to continuation of care if they or a covered family member are receiving health care from a non-participating provider when they enroll. For POS and PPO members, this applies only if they want the services to be eligible for payment at the in-network benefit level. They should consult with their PCPs or treating physicians who will call Coventry Health Care to obtain preauthorization
- Knowing the Preauthorization requirements that apply to the member’s benefits and understanding the terms of preauthorization
- Understanding the role of their primary care physician in the coordination of their overall health care
- Notifying Coventry Health Care of a change in their primary care physician prior to seeking care from that physician as described in their Evidence of Coverage, Certificate of Insurance or Plan Document
• Accessing behavioral health and substance abuse services as described in their Evidence of Coverage, Certificate of Insurance or Plan Document
• Promptly notifying Coventry Health Care of any address or telephone number changes. If correspondence is not received because a member has failed to notify Coventry Health Care of an address change, the member’s or covered dependent’s coverage could be terminated or not renewed in accordance with the terms and conditions of the member’s Evidence of Coverage, Certificate of Insurance or Plan Document. The member will be responsible for expenses he/she incurs as a direct result of not notifying Coventry Health Care of any address or telephone number change
• Checking with their employers regarding dependent eligibility and notifying Coventry Health Care within thirty-one (31) days of any changes
• Making sure all family members are aware of the correct procedures for obtaining benefits through Coventry Health Care

Failure of the member to meet the responsibilities listed in this section may cause the member to be financially responsible for services provided.

For CoventryCares members, please refer to Section 14.8.

8.7 - Preventive Care Guidelines
The Coventry Health Care website provides information on healthy living including preventive health guidelines. Information can be obtained on our website at www.chcva.com » Providers » Document Library.

8.8 - Clinical Practice Guidelines
Our clinical practice guidelines are available on our website at www.chcva.com » Providers » Document Library. These guidelines are reviewed and approved by our Clinical Advisory Committee. This review is conducted annually and at any time the guidelines are changed or new clinical guidelines become available. We adopt guidelines that are relevant to our membership for the provision of such medical and behavioral health services and programs provided by the health plan.

Access to our guidelines are also available in each of our Provider Newsletter editions. A hardcopy of any adopted guideline can be provided to practitioners upon their request.
Participation Appeal Process

9.1 - Grievance Guidelines
The following actions shall entitle a practitioner to a hearing before the Grievance Panel:

- In any instance where the corrective action will be required to be reported to the National Practitioner Data Bank
- In any instance where the practitioner’s contract with the plan is terminated for cause under the terms of the contract
- In any instance where either the Vice President of Network Development or the Medical Director deems it would be in the best interest of the members or the plan that the practitioner be entitled to a hearing
- Lack of malpractice insurance coverage
- Insufficient malpractice insurance coverage (must be $1 Million/$1.5 Million)

If the practitioner falls within one of the categories defined above, the Medical Director shall notify the practitioner in writing of the basis for his/her decision to terminate. The notification will include the following:

- The action that has been proposed to be taken against the practitioner
- The reasons for the actions; e.g., the practitioner’s quality of delivering medical services is below reasonable standards of quality or safety of care consistent with prevailing standards of medical practice or medical ethics
- That the practitioner may request a hearing on the proposed action within 30 calendar days of his/her receipt of the notice
- The rights of the practitioner at the hearing

If the practitioner requests a hearing, the Medical Director or designee shall schedule the hearing date. The practitioner will be notified in writing via certified mail of the time, place, and date of the hearing. The date of the hearing shall not be more than 30 calendar days after the date of notice. The notice must also include a list of witnesses, if any, expected to testify on behalf of the plan.

If the practitioner does not request a hearing within 30 calendar days of his or her receipt of the action notice, he or she will waive the right to have a hearing regarding the proposed notice.

The Grievance Panel shall be appointed by the Senior Medical Director, and shall consist of the Medical Director and two network practitioners who have had no involvement in the matter under consideration. The practitioners chosen may not be in direct economic competition with the practitioner subject to the action. The Senior Medical Director shall function as the chairperson.
At the hearing the practitioner affected by the proposed action shall have the right to:

- Be represented by an attorney or other person of the practitioner’s choice
- Have a record made of the proceedings, copies of which may be obtained by the practitioner upon payment of any reasonable charges associated with the preparation of the material
- Call, examine, and cross-examine witnesses
- Present evidence that is determined to be relevant by the grievance panel
- Submit a written statement at the close of the hearing

9.2 - Hearing Process
Prior to evidence or testimony, the chairperson shall announce the purpose of the appeal hearing and the procedure that will be followed for the presentation of evidence.

Presentation of Evidence by Coventry Health Care
Coventry Health Care will present the oral testimony and submit the documentary evidence upon which it relies in support of its determination to terminate the practitioner. The practitioner and/or the practitioner’s counsel will have the opportunity following the submission of such evidence to question any witness(es) who gave testimony on behalf of Coventry Health Care.

Presentation of Evidence by Practitioner
After the completion of Coventry Health Care’s submission of evidence, the practitioner shall present any evidence he/she deems necessary to rebut or explain the situation or events described by Coventry Health Care as contributing to the termination decision. Such evidence may be witness testimony or documentary evidence. Coventry Health Care shall have the opportunity to question any witness questioned by the practitioner.

Rebuttal
In the event the practitioner raises factual matters during the course of his/her presentation of evidence and/or questioning of Coventry Health Care’s witnesses, Coventry Health Care may present any additional witnesses or submit additional documents to rebut the practitioner’s submission of such evidence. The practitioner has a right to question any additional witnesses that are then presented by Coventry Health Care.

Summary Statements
Upon the completion of Coventry Health Care’s and the practitioner’s submission of their testimony and evidence, Coventry Health Care and the practitioner shall make a brief closing statement summarizing their position.

Examination by the Grievance Panel
Throughout the course of the hearing, the Grievance Panel may question any witness giving oral testimony.
9.3 - Evidentiary Standards
The oral testimony and documentary evidence provided by Coventry Health Care and the practitioner shall be reasonably related to the specific issues or matters that are the subject matter of the action and as raised by the appeal. The Grievance Panel has the right to refuse to consider testimony or evidence that is not relevant to their decision. The strict rules of evidence applicable in a court of law shall not apply to this hearing. In the event a party objects to the presentation of any evidence, the grounds shall be stated for such objection, and the Grievance Panel shall determine whether or not such evidence shall be admitted. The Grievance Panel shall determine the relative weight to be given to any evidence submitted to its review.

9.4 - Grievance Panel Decision
Standard Review – Upon completion of the hearing, the Grievance Panel shall make a final written recommendation within 14 calendar days of the hearing date.

Majority Vote – Subsequent to the hearing, the Grievance Panel shall convene and privately discuss the evidence presented at the hearing. The Grievance Panel shall have the ability to uphold, reject, or modify the recommended action, and its decision will be based solely on the evidence provided at the hearing.

The Grievance Panel’s decision shall be by the affirmative vote of the majority of its members. The Panel shall prepare a written decision identifying the evidence relied upon and its reasons for its decision. A copy of the written decision shall be provided to the practitioner and Coventry Health Care. The action of the Grievance Panel will be final.

9.5 - Effect of Termination
In the event the Grievance Panel’s decision is to uphold termination, the participation status of the practitioner shall cease within 60 calendar days following the date of the Grievance Panel’s decision. The practitioner shall not submit claims to Coventry Health Care for health services provided to members after the effective date of termination. Practitioner must give prompt, individual written notice of termination to all current patients whom the termination will affect. Practitioner must inform all members initially seeking the physician’s services of the termination. The practitioner shall be entitled to payment for past services rendered to Coventry Health Care enrollees prior to the effective date of the practitioner’s termination.

In the event that Grievance Panel’s decision is not to terminate the practitioner, the practitioner shall continue as a participating provider with Coventry Health Care. The Panel may decide on a probation period during which time there would be ongoing review.
10 Provider Complaint & Appeal Procedures

Coventry Health Care has appeal procedures for both its members and its providers. The provider appeal procedures are discussed in this section. Providers may appeal when a claim has been denied or paid at a reduced level of benefits, or if preauthorization was not granted for a requested service. Appeals are classified as either administrative or utilization management.

Issues concerning the Coventry Health Care Payment Policy Program are not appealable and are handled as discussed in Section 4.13 of this Provider Manual.

Providers who have questions regarding the following Complaint or Appeal Procedures or who want assistance in filing a reconsideration or an appeal, should contact the respective Customer Service Department.

For questions concerning Commercial Complaint or Appeal Procedures, call 800.627.4872 between 8:00 a.m. and 6:00 p.m. Monday - Friday.

For questions concerning CoventryCares Complaint or Appeal Procedures, call 800.279.1878 between 8:30 a.m. and 5:00 p.m. Monday - Friday.

10.1 - Definitions

Inquiry: Any question from a provider regarding issues such as benefits information, claim status, or eligibility.

Complaint: Any expression of dissatisfaction expressed by a provider regarding an issue in the Health Plan.

Appeal: An appeal is a request by the provider when the resolution of a complaint or reconsideration is not resolved to the provider’s satisfaction and the provider appeals the Health Plan’s decision within the prescribed time frames.

Adverse Decision: An adverse decision is a determination by the health plan, or its designated review entity, that based upon information provided, a request for a service does not meet the health plan’s requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness or is determined to be experimental or investigational and the requested service is therefore denied, reduced or terminated or payment is not provided or made, in whole or in part, for the requested service. When the policy includes coverage for prescription drugs and the service rendered or proposed to be rendered is a prescription for the alleviation of cancer pain, any adverse determination shall be made within 24 hours of the request for coverage.
Adverse Administrative Decision: An adverse benefit determination that is based on the member's benefit plan and in accordance with the member's plan documents and NOT based on medical judgement or Medical Criteria.

Examples:
- Services that require preauthorization, but the preauthorization is not called in
- Not covered services: i.e, hearing aids, exercise equipment, splints, work related injuries

Adverse Benefit Determination: An adverse benefit determination is (i) a determination by the health plan, or its designated utilization review entity that, based on the information provided, a request for services under the health plan's benefit plan upon utilization review does not meet the health plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness or is determined to be experimental or investigational and the requested service is therefore denied, reduced or terminated or payment is not provided or made, in whole or in part, for the requested service; (ii) the denial, reduction, termination or failure to provide or make payment, in whole or in part, for a service based on the member's eligibility to participate in the health plan's benefit plan as determined by the health plan; (iii) any review determination that denies, reduces or terminates or fails to provide or make payment, in whole or in part, for a service; (iv) a rescission of coverage determination as defined in 38.2-3438; or (v) that for individual policies only, any decision to deny individual coverage in an initial eligibility determination.

Clinical Peer Reviewer: A clinical peer reviewer is a practicing health care professional who holds a nonrestricted license in a state, district or territory of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment that is under appeal.

Peer to Peer: A review of medical necessity between the treating physician and a physician or peer of the treating health care provider who represents Coventry Health Care. At any time prior to Coventry Health Care rendering an adverse decision, the treating provider is entitled to review the issue of medical necessity with a physician or peer of the treating health care provider who represents Coventry Health Care.

Physician Advisor: A physician advisor is a physician licensed to practice medicine in Virginia or under a comparable licensing law of a state of the United States and who provides advice regarding the medical necessity of a service to the Health Plan as part of its utilization review activities. With the exception of Expedited Appeals, a Physician Advisor who reviews cases under appeal shall be a peer of the treating health care provider, shall be board certified in the same or similar specialty as the treating health care provider, and shall be specialized in a discipline pertinent to the issue under review.

Reconsideration: A review of an adverse decision by the Health Plan's Medical Director, a physician advisor, a peer of the treating provider who is licensed in
the provider’s same or similar specialty, or a panel of other appropriate health care providers with at least one physician advisor or peer of the treating health care provider on the panel. The treating provider on the member’s behalf may request a reconsideration. Reconsiderations are a voluntary option to the appeal process and are only for a treating provider acting on a member’s behalf. A member is not required to have the treating provider go through the reconsideration process on the member’s behalf before filing an appeal and the treating provider is not required to go through the reconsideration process before filing an appeal.

**UM Appeal:** A UM appeal is an appeal of a determination made by the health plan, or its designated review entity, that based upon information provided, a request for a service does not meet the health plan’s requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness or is determined to be experimental or investigational and the requested service is therefore denied, reduced or terminated or payment is not provided or made, in whole or in part, for the requested service.

### 10.2 - Provider Complaint/Grievance Procedure

A complaint/grievance is any expression of dissatisfaction expressed by a provider regarding an issue in the Health Plan. If a provider is dissatisfied with any issue regarding the Health Plan, the provider may contact the respective Customer Service Departments at the number(s) listed above. Complaints/grievances must be received within 90 calendar days of the date of the incident that gave rise to the complaint. Complaint determinations will be made within 30 calendar days of receipt of the complaint/grievance.

### 10.3 - Post-Service Claim Review

Post-service claim reviews are available only for one of the following categories:

- Timely filing denial
- Services not authorized denial

The request must be received by Coventry Health Care within 90 calendar days of the date on the remittance advice reflecting the claim denial and/or the partial payment of a claim.

The provider can submit a post-service claim review request by writing to:

Coventry Health Care of Virginia, Inc.
Attn: Claims Department
P.O. Box 7704
London, KY 40742
800.627.4872

Within 10 working days of receipt of the post-service claim review request, the claim and any additional information that has been provided will be reviewed. The provider will be notified of the outcome of the post-service claim review via his/her next scheduled remittance advice.
Post Service Claim Reviews are optional. A provider may appeal a claim denial without utilizing the Post Service Claim Review process by following the Administrative appeal process described in Section 10.5.

10.4 - Reconsideration
 Requests for reconsideration must be received within 90 calendar days of the date of the initial notification of the denial. The request for reconsideration should be sent to the same address as listed for appeals below.

If the treating provider on behalf of the member chooses to request a reconsideration of a medical necessity determination, a decision is made by either Coventry Health Care’s Medical Director, a Physician Advisor, a peer of the treating provider who is licensed in that provider’s same or similar specialty, or a panel of other appropriate health care providers with at least one (1) Physician Advisor or peer of the treating health care provider on the panel.

If the treating provider on behalf of the member requests that the adverse decision be reviewed by a peer of the treating provider at any time during the reconsideration process, the request for reconsideration shall be vacated and considered a member appeal as set out in the individual member’s plan documents. In such cases, the member shall be notified that the reconsideration has been vacated and an appeal initiated, all documentation and information provided or relied upon during the reconsideration process shall be converted to the appeal process, and no additional actions shall be required of the treating provider to perfect the appeal.

The treating provider shall be notified verbally at the time of the determination of the reconsideration of the adverse decision and in writing no later than 10 working days following Coventry Health Care’s receipt of the request. Both verbal and written notification will include the criteria used in making the decision, the clinical reason for the adverse decision, alternate length of treatment of any alternate treatment recommended, and the contact and process information needed to appeal this decision.

Reconsiderations are optional. A member or a treating provider acting on a member’s behalf may appeal an adverse decision without utilizing the reconsideration process.

10.5 - Administrative Appeals
 If a provider is not satisfied with an initial benefit determination that does not involve medical judgment, the provider may appeal the adverse administrative decision. The appeal request must be received by Coventry Health Care within 90 calendar days after the provider’s receipt of the initial notification of the benefit determination. The appeal should include the following information:

- Member’s name
- Provider’s name
- Date(s) of service
• Providers mailing address
• Clear indication of the remedy or corrective action being sought and an explanation of why the health plan should “reverse” the adverse administrative decision, and
• Copy of documentation to support the reversal of the decision

The provider may also include written comments, documents records and other information relevant to the appeal.

This information should be mailed or faxed to:

Appeals Coordinator  
Coventry Health Care of Virginia, Inc.  
9881 Mayland Drive  
Richmond, VA 23233-1458  
Fax # 866.669.2410

Coventry Health Care has 30 working days from the date of receipt to render a decision on the appeal. Once a decision has been made, a letter is sent back to the provider and member informing them of that decision.

There is only one level of administrative appeal through Coventry Health Care.

10.6 - UM Appeal of an Adverse Decision

If a provider is not satisfied with an initial benefit determination that does involve medical judgment, the provider has the right to request a UM appeal. The request must be received by Coventry Health Care within 90 calendar days after the provider’s receipt of the initial notification of the adverse benefit determination. The UM Appeal request should include all original documentation as well as the reason for the UM appeal request, any new information you wish to provide and mail or fax to:

Appeals Coordinator  
Coventry Health Care of Virginia, Inc.  
9881 Mayland Drive  
Richmond, VA 23233-1458  
Fax # 866.669.2410

These cases are reviewed by a peer of the treating physician who is board certified in that provider’s same or similar specialty in Virginia or under comparable law in a state within the United States who was not involved in any previous reviews and is not the subordinate of any individual who made any prior adverse decisions. Notification of the decision will be provided within 30 working days from receipt of the initial appeal request.

Urgent Care (Expedited) Appeal

An Urgent Care Appeal is an appeal for which a requested service requires preauthorization, an adverse benefit determination has been rendered, the requested service has not been provided and the application of the time periods
for making non-urgent care determinations could seriously jeopardize: (a) the life or health of the Member or the Member's unborn child; or (b) the Member's ability to regain maximum function.

An Urgent Care Appeal is also an Appeal involving: (a) care that the treating physician deems urgent in nature; (b) the treating physician determines that a delay in the care would subject the Member to severe pain that could not be adequately managed without the care or treatment that is being requested; or (c) the Member is a cancer patient and the delay would subject the Member to pain.

The Appeal Committees decision must be communicated as soon as possible, but not later than 72 hours after receipt of the urgent care appeal request. However, for cases relating to the alleviation of cancer pain, the notification will be made within 24 hours from the receipt of the request.

**Member Appeals**
The Member Complaint and Appeal procedures are explained in the individual member plan documents. However, a participating provider, who is the treating provider, may always act on behalf of the member during the appeal process.

Requests for a status on a commercial appeal should be directed to our Commercial Customer Service Department at 800.627.4872. Commercial Customer Service business hours are Monday through Friday from 8:00 a.m. to 6:00 p.m.

Requests for a status on a CoventryCares appeal should be directed to our CoventryCares Customer Service Department at 800.279.1878. CoventryCares Customer Service business hours are Monday through Friday from 8:30 a.m. to 5:00 p.m.

**For CoventryCares Providers:** Before appealing to the Department of Medical Assistance Services (DMAS), you must first exhaust all appeal processes available through Coventry Health Care. All provider appeals to DMAS must be submitted in writing and within 30 days of Coventry Health Care's last date of denial to the DMAS Appeals Division, 600 East Broad St. Richmond, VA 23219.
11 Health Management Programs

11.1 - Preventive Health Guidelines

Our preventive health guidelines are reviewed annually through the Clinical Advisory Committee and are based on nationally recognized guidelines from organizations such as the United States Preventive Services Task Force and the American College of Obstetrics and Gynecology. The guidelines are made available to all members annually and are distributed to providers in the Provider Manual (See Sections 8.7 and 13.0 Preventive Health Guidelines and Preventive Services Standards). They also are available on our website at www.chcva.com » Providers » Document Library.

We have developed interventions in common areas of preventive care through the following efforts:

- Mailed reminders to parents about keeping their children’s immunizations up to date
- Mailed lists to PCPs about members needing immunizations
- Mailed information annually to women about routine preventive care. Mailed reminders to women who have not had Pap smears or mammograms within the recommended time frame
- Mailed reminders regarding the importance of vaccines to members over 65. For those members 64 and under with chronic health conditions, they will also receive mailed reminders about getting vaccines
- Members can elect to sign up for email reminders by utilizing their personalized, password protected My Online Services at our website

11.2 - Disease Management Programs

Coventry Health Care provides disease/health management for conditions that can be improved through active management. 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 physician’s care plan. The member is identified by various methods including, but not limited to, claims, pharmacy, laboratory, physician, caregiver, health appraisal results, information from electronic health records, data from utilization management, and self-referral. The provider may refer a member to disease management by contacting Customer Service. The member has the option to opt in by self-referral by calling Customer Service; or, if they chose not to participate, they may opt out by calling Customer Service or speaking with a disease management staff member.

Coventry Health Care supports the provider in ensuring that your patients understand how to best manage their conditions. This may be accomplished by various means including newsletters to members discussing various health
conditions and importance of compliance; quarterly educational mailing regarding the member's disease specific condition; and, if indicated, telephonic outreach from our Disease Management Call Center. Providers may utilize DirectProvider.com to obtain lists of members with compliance issues as related to Healthcare Effectiveness Data and Information Set measures (HEDIS).

The Clinical Practice Guidelines that support each of our disease management programs is found on our website at www.chcva.com » Providers » Document Library.

11.3 - Diabetes Disease Management Programs
The Diabetes Disease Management Program is based on Clinical Practice Recommendations from the American Diabetes Association (available at www.diabetes.org in the “For Professionals” section). The Diabetes Disease Management Program includes:

- Patient education materials for newly diagnosed diabetics and members with diabetes who are new to Coventry Health Care
- A list of members with diabetes available to each identified PCP via www.directprovider.com
- Flu vaccination reminders sent to all members with diabetes each year
- An annual mailing sent to all members with diabetes reminding them to get dilated retinal eye exams, A1c tests, lipid profiles or tests for kidney function
- Targeted reminders to members with diabetes whose claims do not support they have received dilated retinal eye exams, foot exams, A1c tests, lipid profiles or tests for kidney function (Telephone call reminders may also be made to these members. A list of non-adherent members are available to their identified PCP via www.directprovider.com)
- Telephone calls to review self-care recommendations to members in case management who have had a recent diabetes-related ER visit and/or recent diabetes related inpatient admission
- Individual case management offered to members with diabetes as appropriate

11.4 - Asthma Disease Management Program
Coventry Health Care's Asthma Disease Management Program is based on A Practical Guide for the Diagnosis and Management of Asthma from the National Heart, Lung and Blood Institute. A copy is available at www.nhlbi.nih.gov in the Clinical Guidelines section. Our Asthma Disease Management Program includes:

- Patient education materials for newly diagnosed asthmatics and members with asthma who are new to Coventry Health Care
- A list of members with asthma available to each identified PCP via www.directprovider.com
- Flu vaccination reminders sent to all members with asthma each year
- Targeted reminders to members fitting criteria who are not filling prescriptions per the NHLBI-recommended controller medication
guidelines (Telephone call reminders may also be made to these members. A list of non-adherent members is made available to each identified PCP via www.directprovider.com)
- Telephone calls to review self-care recommendations to members in case management who have had a recent asthma-related ER visit and/or recent asthma related inpatient admission
- Individual case management offered to members with asthma as appropriate

11.5 - Cardiac Disease Management Program
Coventry Health Care’s Cardiac Disease management program is based upon clinical practice recommendations from the American Heart Association (available at www.americanheart.org). The Cardiac Disease management Program includes:
- Patient education materials for newly diagnosed cardiac member and members with cardiac disease who are new to Coventry Health Care
- Flu vaccination reminders sent to members with cardiac disease each year
- Telephone calls to review self-care recommendations to members in case management who have had a recent cardiac disease related ER visit and/or recent cardiac disease related inpatient admission
- Individual case management offered to members with cardiac disease as appropriate

11.6 - Maternity Management Program
Coventry Health Care’s Maternity program is based on the 2013 Coventry Health Care Care Clinical Preventive Services for all pregnant women. Links to these guidelines are located at www.chcva.com. We also follow the American College of Obstetricians and Gynecologists (ACOG) guidelines for all high risk pregnancies and utilize the National Guideline Clearinghouse website as a source of reference for guidelines from ACOG. Our Maternity Program includes:
- Patient education materials for newly identified pregnant members
- Telephonic postpartum depression screening
- Individual case management offered to the high risk pregnant member as appropriate

At the first prenatal visit, it is recommended the physician complete and fax a Coventry Health Care Maternity Notification Form (Attachment B). This form assists us in the identification of high risk factors early in the pregnancy.

11.7 - Chronic Obstructive Pulmonary Disease (COPD) Disease Management Program
Coventry Health Care’s COPD program is based on clinical guidelines developed by the Global Initiative for Chronic Obstructive Lung Disease; World Health Organization; National Heart, Lung and Blood Institute; and the
American Lung Association. Our COPD Program includes:

- Mailings reminding members to have pulmonary function testing annually
- Flu vaccination reminders sent to members with the education materials
- Pneumococcal vaccination reminders per the established guidelines
- Smoking cessation mailings
- Individual case management offered to members with COPD as appropriate

11.8 - Case Management Programs

Coventry Health Care’s Case Management Programs are designed to help members effectively manage their health problems and live a better quality of life. Entrance to case management may be initiated because of a new diagnosis of a chronic medical condition, psychosocial problems influencing health, catastrophic injury or illness, chronic and/or complex medical condition, or noncompliance with the medical plan of care. Case management is a systematic proactive model which utilizes an organized approach to provide early intervention along with a continuum of care, and which includes active patient self-care participation in the maintenance of their optimum state of health. Case management utilizes a multidisciplinary team where care is provided across the spectrum of services along a continuum of seamless care. Patient and family education are high priority components of this approach.

Coordinated health care through case management can reduce health care costs, sick time at work, stress associated with the health care risk, and encourages members to take a more active role with their disease. Case management by specially trained Registered Nurses or Social Worker is an added benefit to the member who has been identified as having a specific health care risk. The goals are to provide effective and cost efficient treatment through multi-level education, protocol development, compliance monitoring, and expert care.

These programs depend on a three-party relationship: the member, his or her physician, and Coventry Health Care’s case manager. The member is identified by various methods including, but not limited to, claims or encounter data, hospital admission or discharge data, laboratory data, pharmacy data, data from utilization management and employer group, physician, caregiver, and self referral. The member has the option to opt in by self-referral by calling the Customer Service Department or if they choose not to participate they may opt out by calling the Customer Service Department or speaking with a case manager. If you have questions about the case management programs or would like to speak with a case manager, please call customer service.

The case management model includes (but is not limited to) the following activities:

- Developing an individualized pathway of care based on input from the medical care team and their treatment plans for the member
- Serving as contact and resource at Coventry Health Care for the member
and the member’s family

- Aiding the member in the management of unique health care risks by coordinating home-based care and access to community support systems
- Providing support and guidance on sociological and psychological issues affecting the high-risk individual and assists in coordinating behavioral health, social services or health department interventions

Our Medicaid outreach representatives provide phone contact to members or, if necessary, will make home visits (within designated locations). Case managers in our Transition of Care, Comorbid Case Management, High Risk Pregnancy and High Risk Neonate Programs offer phone support to our Medicaid members, as well as meeting personally with members in the hospital/provider office or home setting.

If you have any questions about any of our health management programs, please contact the Case Management Division at 800.424.0077. The nurses in our programs practice in accordance with applicable laws regarding patient confidentiality and release of information. Ethical principles guide their practice with respect for the autonomy, dignity, cultural diversity, privacy and rights of the members.
12 Quality Improvement

12.1 - Introduction
Coventry Health Care strives to improve the quality of care and services provided by our Participating Providers through a Quality Improvement Program developed in accordance with the corporate mission and vision, as well as federal and state regulatory requirements. The program supports continuous quality improvement in the areas of clinical, behavioral health care, customer service, patient safety, and access to care services that are provided to Coventry Health Care members.

The Quality Improvement Program Description defines an organized framework for carrying out objective and systematic review of activities to improve the quality of the Coventry Health Care provider network and services for its members. The program provides a mechanism for addressing potential or actual quality of care and quality of service issues that directly and indirectly affect the members and promotes consistency in the application of quality improvement functions throughout the services provided by Coventry Health Care employees and practitioners.

The Quality Improvement Program focuses on the reduction of medical/health care errors. This requires an integrated and coordinated approach. Effective reduction of medical/health care errors and other factors that contribute to unintended adverse patient outcomes in a health care organization requires an environment in which patients, their families, and organizational staff and leaders can identify and manage actual and potential risks to patient safety. This environment encourages recognition and acknowledgement of risks to patient safety and medical/health care errors; the initiation of actions to reduce these risks; the internal reports identifying issues and the actions taken; a focus on processes and systems; and minimization of individual blame or retribution for involvement in a medical/health care error. It encourages organizational education about medical/health care errors and supports the sharing of knowledge that may affect changes leading to improved patient safety.

While Coventry Health Care’s Quality Improvement Program attempts to identify and assist providers in improving the quality of care of members, it is the treating provider’s responsibility to ensure the members are receiving the care that is appropriate for their condition(s).

12.2 - Purpose
The Quality Improvement Program is designed to optimize the quality of the health care system delivered to Coventry Health Care members by providing direction to management for the coordination of both quality improvement and quality management activities across all departments and matrix partners and management/service relationships, including Utilization and Medical
Management, Provider Relations/Network Management, Customer Service, Behavioral Health, Sales, and Marketing and Finance. This is accomplished by using Continuous Quality Improvement (CQI) principles, which is a problem-solving approach utilized when an opportunity for improvement is identified through monitoring performance indicators or from other sources. The steps of the CQI process include:

- Collection of data
- Analysis of data to identify opportunities for improvement
- Identification of possible root causes or barriers
- Selection of opportunities to pursue
- Planning of interventions
- Implementation of interventions
- Re-measurement and analysis to determine effectiveness of interventions

12.3 - Goals and Objectives

The Program outlines quality-monitoring requirements and provides guidance in promoting process improvement initiatives when deficiencies are identified. Quality measurement studies are designed and documented to objectively and systematically monitor and evaluate the quality and appropriateness of care and services provided to members. The program requires the following measurement activities:

- Develop effective methods for measuring the health care and behavioral health care outcomes, member and provider satisfaction, and services provided to Coventry Health Care members, and apply interventions that result in continuous measurable improvements
- Achieve an effective level of administrative, clinical and behavioral health commitment and support for the CQI process
- Ensure a consistent focus on high priority quality issues to include patient safety regarding delivery of care and service
- Assure clinical health care and behavioral health care services are generally available, accessible, and appropriate for the population
- Assure that member medical records are maintained in a confidential manner and with sufficient documentation to facilitate continuity and coordination of care
- Provide oversight of delegated activities, including, but not limited to, behavioral health benefits management and credentialing
- Ensure effective coordination of quality improvement activities with all appropriate functional areas, including, but not limited to, utilization management, member complaints and appeals, provider network services, contracting, sales and marketing, and credentialing as required by state, federal regulations and accrediting and auditing bodies (i.e., Medicaid, NCQA, BOI, etc)
- Ensure the evaluation of member and provider satisfaction information. This review includes member/provider survey data, member complaint and appeal analysis and member satisfaction with access to regular and routine care, urgent and emergency care and after hours care
- Maintain mechanisms to adequately serve the cultural, ethnic and
linguistic needs of members through membership analyses, education of staff and maintenance of a provider network to adequately meet member needs

**12.4 - Confidentiality**

All practitioners and staff involved in the Quality Improvement Program shall maintain the confidentiality of all information that they review. This includes, but is not limited to, medical records, practitioner/provider files and member information, as well as the results of any reviews, deficiencies, or corrective actions taken. All practitioner/provider and member information will be presented for review in a confidential manner. The procedures and minutes of the Executive Quality Management Committee, and any other subcommittees will be open to review by state and federal regulating agencies, accrediting bodies, and where required by law. All physician committee members and employees of Coventry Health Care sign a confidentiality and conflict of interest statement upon entry into their commitment and as required.

Access to member-specific, practitioner-specific, and/or provider-specific peer review quality improvement information is restricted to those staff and/or committee members charged with responsibility for peer review activities. A Regional President, Vice President, Medical Affairs, or Manager of Regulatory Compliance must authorize the use of quality management information for other than described quality improvement purposes. In no event, is member-specific, practitioner-specific, or provider-specific information released to any person or organization outside of the Health Plans unless required by law. Release of information is in accordance with State and Federal laws.

**12.5 - Authority and Responsibility**

The Board of Directors of Coventry Health Care formally delegates the oversight of the Quality Improvement Program to the Executive Quality Management Committee (EQMC). The Board of Directors annually reviews the Quality Improvement/Utilization Management (QI/UM) Program Evaluation, Quality Improvement Program Description, Utilization Management Program Description and the QI/UM Work Plan. The EQMC oversees the activities of the Quality Improvement Program and its committees. Key players involved in the Quality Improvement Program include, but are not limited to:

**Regional Vice President of Quality**: Responsible for the Quality Improvement Program.

**Vice President, Medical Affairs**: Responsible for assisting the Regional Vice President of Quality in the oversight of the Quality Improvement Program. This person reports to the Chief Operating Officer, chairs the EQMC and any other committees as deemed necessary. He/she works closely with the Quality Improvement Director in implementing activities that improve the quality of care and services provided to the membership and is an active clinical consultant for the Quality Improvement department.
Medical Director(s): Responsible for assisting the Regional Vice President of Quality and the Vice President, Medical Affairs in the oversight of the Quality Improvement Program. Reports to the Vice President, Medical Affairs and may act as chairperson for the Credentialing Committee and/or other related committees. They are responsible for reviewing credentialing files and audits, potential or identified quality issues in care or services provided by practitioners/providers, reviewing clinical data for quality improvement studies, and providing input into those studies.

Quality Improvement Director: Responsible for managing the day-to-day activities of the Quality Improvement Program and reviews data to identify the need for clinical studies, policies/procedures and guidelines that impact the membership. This person works closely with the Medical Director(s). This person reports directly to the Regional Vice President of Quality.

Quality Improvement Manager and Quality Improvement Department Staff: Responsible for implementation and follow-through on quality improvement activities such as medical office/record reviews, review of adverse events/never events, member complaints regarding potential quality of care or clinical safety issues, data collection for identified clinical studies, and analysis of the findings. The Quality Improvement Manager reports directly to the Quality Improvement Director.

Vice President of Network Management: Responsible for the oversight and management of the provider network. This person reports to the Chief Operating Officer and is an active member of the EQMC.

Manager, Network Operations: Responsible for the oversight of the credentialing and recredentialing processes. This person reports to the Vice President of Network Management.

12.6 - Program Structure
The Quality Improvement Program is structured to ensure review, identification, and follow-up for all clinical, behavioral health care, safety, and access issues identified in the Coventry Health Care provider network. The Board of Directors has delegated the oversight of Quality Improvement activities to the Executive Quality Management Committee (EQMC). All other subcommittees report to the EQMC.

A. Executive Quality Management Committee

Committee Structure
- Regional Vice President of Quality
- Vice President, Medical Affairs, Chairperson
- Medical Director(s)
- Vice-President(s), Sales and Marketing
- Director, Quality Improvement
Meeting Frequency
The meetings will occur at least four times a year and/or as deemed necessary by the chairperson. Four voting members constitute a quorum. The majority vote of the members will constitute an act of the committee as long as a quorum is present. Reports of the Quality Improvement Department activities will be submitted to the EQMC for review.

Functions/Responsibilities
The EQMC promotes the goals and objectives of the Quality Improvement Program. Responsibilities include, but are not limited to:

- Coordinate the integration of quality improvement activities and leveraging insight and expertise across the health plan to enhance the quality program.
- Review, provide input and ensure distribution of nationally recognized guidelines, including preventive health, for medical practice and education, approving/endorsing action taken by a defined subcommittee related to such guidelines. This may include preventive health and disease management clinical guidelines.
- Oversee and evaluate quality improvement activities carried out by the subcommittees and makes recommendations on the following:
  - Quality Measurement Studies
  - Patient Safety Monitoring & Intervention Activities
  - Quality of Care and Service Complaints
  - Adverse/Never Event Monitoring
  - HEDIS Performance Measures
  - Utilization Management Effectiveness
  - Member and Provider Satisfaction Survey results
  - Ambulatory Medical Record Review
  - Pharmacy and Therapeutic review
  - Credentialing and Recredentialing activities
  - Peer Review
  - Access and Availability Monitoring
- Delegation Oversight
- Patient Safety Activities
- Clinical and Preventive Care Guidelines
- Medical and Behavioral Health Clinical & Service Activities
- Continuity and Coordination of Care
- Member & Provider Communication Supports
- Privacy and Confidentiality Guidelines
- State & Federal Compliance Issues
- Accreditation and/or Certification Requirements and Activities
- Member Demographics, Cultural, Linguistic and Ethnic Needs of Members
- Health Disparities

- Review and approve the annual Quality Improvement/Utilization Management Program Evaluation, Quality Improvement Workplan, and Quality Improvement and Utilization Management Program Descriptions, as well as necessary updates to these documents.
- Monitor quality improvement activities of contracted agencies and entities to which the health plan delegates quality improvement activities.
- Oversee and approve actions taken by the following subcommittees: Clinical Advisory Committee (CAC), Utilization Management Committee, Service Advisory Committee (SAC), Credentialing Committee, Pharmacy and Therapeutics Committee (P&T) and Policy and Procedure Committee (P&P).

B. Clinical Advisory Committee

Committee Structure
The committee is composed of the following voting members:

- Network practitioners representing PCPs (e.g., Internal Medicine, Family Practice, Pediatrics) and designated specialists (e.g., Gastroenterology, Psychiatry, Obstetrics/Gynecology and General Surgery)
- Vice President, Medical Affairs, Chairperson
- Medical Director(s) (member)
- Health Services Director or Manager
- Quality Improvement Director or Designee
- Vice President or Director, Medicaid
- QI Health Care Analysts, Coventry Health Care
- Behavioral Health Representative(s)(upon invitation)
- Administrative Assistant, Quality Improvement (non-voting)

Other practitioners and Coventry Health Care staff may be invited to address specific issues relative to their area of expertise, but shall remain non-voting.
The CAC members may serve unlimited terms, but composition will be reviewed, maintained, and ratified by the EQMC on an annual basis.

**Meeting Frequency**
The meetings will occur at least four times a year and/or as deemed necessary by the chairperson. All members are expected to attend each meeting. Non-attendance for three consecutive meetings will constitute grounds for dismissal by the chairperson. Four voting members will constitute a quorum. The majority vote of the members will constitute an act of the committee as long as a quorum is present.

**Functions/Responsibilities**
- Provide direction on quality improvement initiatives affecting clinical areas
- Review and make recommendations on quality improvement studies and surveys, clinical indicators, member and provider interventions, and policies and procedures
- Review and advise on medical necessity criteria applicable to coverage determinations, clinical practice guidelines, preventive health guidelines and protocols applicable for coverage determinations for approval by the EQMC
- Review demographic, disease and program specific data and recommend clinical indicators to be monitored and interventions to be pursued
- Review the results of the quality improvement activities and utilization management reports and suggest needed actions to assure appropriate follow-up
- Ensure quality health care delivery at the most appropriate level of care in a timely, effective, and efficient manner for members
- Monitor quality improvement activities of contracted agencies and entities to which the health plan delegates quality improvement activities
- Monitor and evaluate all data, including the evaluation of action plans, goals and benchmarks from the following areas:
  - HEDIS Performance Measures
  - Patient Safety Initiatives
  - Adverse/Never Event Monitoring
  - Quality of Care & Service Complaints Analysis & Reporting
  - Physician Communication and Continuity of Provider Care
  - Health Plan Quality Clinical Initiatives, including Pharmacy
  - Ambulatory Medical Record Review
  - Member Epidemiology and Demographics
  - Trends in Clinical Care and Service Access
  - Cultural Competencies and Health Disparities
- Performance Improvement Projects for Medicaid

- Monitor, evaluate, and propose recommendations based on the Coventry Health Care management reports that may include:
  - Ensure review of Clinical Practice Guidelines against approved criteria for consistency
  - Population & Disease Management Programs and Evaluations
  - Quality Improvement Activities for Accreditation
  - Clinical Performance Improvement Activities for Medicaid Programs
  - Continuity and Coordination of Care Metrics
  - Special Clinical Programs/Monitoring
  - Review and make recommendations for Clinical Monitoring and Program Designs specific to Government Programs
  - Review the performance of all delegated entities to assure compliance as specified in the delegated agreement

C. Utilization Management Committee

Committee Structure
The committee is composed of the following voting members:

- Network practitioners representing PCPs (e.g., Internal Medicine and Family Practice, Pediatrics) and designated specialists (e.g., Radiology, and Obstetrics/Gynecology).
- Vice President, Medical Affairs, Chairperson
- Medical Director(s), as assigned
- Vice President, Health Services
- Health Services Directors and Managers
- Quality Improvement Director or Designee
- Vice President or Director, Government Programs
- Director, Network Management or Designee
- Administrative Assistant, Health Services (non-voting)

Other practitioners and Health Plan staff may be invited to address specific issues relative to their area of expertise, but shall remain non-voting.

The UM Committee members may serve unlimited terms, but composition will be reviewed, maintained, and ratified by the EQMC on an annual basis.

Meeting Frequency
The meetings will occur at least four times a year and/or as deemed necessary by the chairperson. All members are expected to attend each meeting. Non-attendance for three consecutive meetings will constitute grounds for dismissal by the chairperson. Four voting members will constitute a quorum. The majority vote of the members will constitute an act of the committee as long as a
quorum is present.

Functions/Responsibilities

- Define the Health Plans’ Utilization Management Program
- Monitor and ensure that all components of the Utilization Management Program are performed appropriately
- Provide direction and leadership for all utilization management activities, receive reports and review findings from utilization management studies and activities related to both clinical and behavioral health care services
- Analyze results of review activities/audits and evaluate data generated through the Utilization Management Program and, where appropriate make recommendations for change in Coventry Health Care's policy, procedure, and/or participating provider network practices
- Monitor, evaluate, and propose recommendations based on the Health Plan's management reports that may include:
  - Pharmacy Metrics
  - Utilization Management Metrics & Audit Results
  - New Technology Specifications & Procedures
  - Member and Provider Satisfaction with Utilization Management
  - Disease and Case Management
- Identify problems and set priorities for their resolution
- Maintain close liaison with other Health Plans’ committees to ensure that any member or participating provider/practitioner network problems are referred to the appropriate committee(s)
- Review and approve the Utilization Management Decision-Making Criteria and references of key program documents
- Establish Inter-Rater Reliability testing metrics of Utilization Management Staff and Physicians for Pre-Service, Concurrent and Post-service decisions
- Establish Inter-Rater Reliability of Clinical Health Services staff
- Evaluate the effectiveness of the Utilization Management Program annually and report impact to the EQMC
- Review and recommend necessary corrective action in the presence of over- and under-utilization
- Review and discuss benefit coverage issues and forward recommended benefit changes to Administration
- Report relevant information and recommendations outlining any trends or identified issues with actions taken that impact other performance measures and clinical based programs
- Report findings and recommendations to the EQMC

D. Service Advisory Committee

Committee Structure
The committee is composed of the following voting members:
Meeting Frequency
The SAC will meet at least four times a year and/or as deemed necessary by the chairperson. Four voting members constitute a quorum. The majority vote of the members present will constitute an act of the committee as long as a quorum is present.

Functions/Responsibilities
- Promote inter-department communication and problem resolution using CQI processes
- Oversee evaluation and improvement efforts related to member and provider satisfaction, access, availability and quality of service
- Analyze and evaluate summary data from the following Quality Improvement activities and make recommendations for improvement:
  - Service Quality Improvement Activities/Studies
  - Local Service Initiatives
  - Member Satisfaction Survey Results – CAHPS and New Member Surveys
  - Provider Satisfaction Survey Results
  - Complaint and Appeal Analysis
  - Utilization Management Service Metrics
  - Credentialing and re-credentialing turn around times
  - Customer Service Organization Abandonment Rate and Speed of Answer Rates
  - Geographic Availability
  - Appointment Accessibility
  - Claim turn around times and accuracy rates
  - Special and cultural needs and preferences of Coventry Health Care members
- Report findings and recommendations to the EQMC

E. Credentialing Committee

Committee Structure
The committee is composed of the following voting members:
• Minimum of four participating practitioners (at least two PCPs)
• Vice President, Medical Affairs, Chairperson
• Medical Director (as needed) (Ad Hoc)
• Quality Improvement Director or Designee
• Health Services Manager or Designee
• Manager, Network Management or Designee
• Credentialing Staff Manager
• Credentialing Verification Center Representative
• Credentialing Specialist(s) (non-voting)
• Administrative Assistant (non-voting)

Other practitioners and Coventry health plan staff may be invited to address specific credentialing issues relative to their area of expertise, but shall remain non-voting.

Meeting Frequency
Monthly basis no less than six times per year. All members are expected to attend each meeting. Members missing two consecutive meetings will be contacted to verify intent to remain on the Committee. Non-attendance for three consecutive meetings will constitute grounds for dismissal by the chairperson.

Functions/Responsibilities:
• Oversee the credentialing and recredentialing activities and to ensure that all policies and procedures are appropriately followed
• Review and make decisions/recommendations on individual credentialing and recredentialing files
• Review and approve the credentialing/recredentialing activities of delegated entities
• Ensure compliance with all accreditation and State regulations pertaining to credentialing and recredentialing, including the review of State sanction reports and Medicare/Medicaid sanctions, of practitioners and organizational providers followed by appropriate recommendations
• Perform peer review functions related to credentialing issues
• Review and provide recommendations on credentialing and recredentialing criteria, standards, policies and procedures
• Assess quality of care, safety, and utilization data related to recredentialing decisions and make recommendations, where appropriate, concerning reduction, suspension, or termination of practitioners in the network
• Evaluate the significance of medical record/site review findings
• Define appropriate corrective measures to be taken and re-audit measures to be implemented in cases where provider performance does not comply with standards
• Report findings and recommendations to the EQMC.
• Monitor, review and evaluate the Delegated Entities conducting Credentialing:
- Review the performance of all delegated entities to assure compliance as specified in the delegated agreement
- Make recommendations to the EQMC in regards to delegating functions to provider organizations
- Assure that annual site visits and appropriate follow-up are performed for each delegated entity
- Request and review corrective action plans for delegates who fail to meet standards
- Report the activities of the delegated entities to the EQMC

F. Pharmacy and Therapeutics Committee

Committee Structure
The committee is composed of the following voting members:

- Minimum of three network participating providers, and a network participating pharmacist
- Vice President, Medical Affairs, Co-Chairperson
- Coventry Health Care, Inc.’s Pharmacy Director, Co-Chairperson
- Medical Director(s)
- Quality Improvement Director

Meeting Frequency
Meets 3-4 times a year. All members are expected to attend each meeting. Members missing two consecutive meetings will be contacted to verify intent to remain on the Committee. Non-attendance for three consecutive meetings will constitute grounds for dismissal by the chairperson.

Functions/Responsibilities

- Develop policies and procedures for pharmaceutical management
- Address criteria for prior-authorization of pharmaceuticals and exceptions process
- Make recommendations for additions/deletions to the formulary
- Approve the formulary recommended by Coventry
- Report to the EQMC relevant information and recommendations

12.7 - Quality Improvement Program Activities

The Quality Improvement Program is designed to evaluate and improve the quality and safety of clinical care and service provided to Coventry Health Care’s members and to those we are contracted to provide health plan services. Monitoring is designed to identify and pursue opportunities for improvement. Monitoring activities include care and service that are delivered by contracting primary care practitioners (PCPs) and specialty practitioners. Monitoring extends to both delegated and non-delegated functions. All departments within the health plan are involved in the Quality Improvement process.
Quality Improvement activities are coordinated with other performance monitoring activities and management functions, including but not limited to, Utilization Management, Case Management, Disease Management, Medical Management, Network Management, Credentialing, Complaints and Appeals, Claims, and Customer Service and Delegation Oversight. Upon request, Coventry Health Care will make available to its members, practitioners, providers and partners relevant information about its Quality Improvement Program, including a description of the Quality Improvement Program and a report on Coventry Health Care’s progress in meeting its goals. Information is shared with members and providers through our website, newsletters, member handbooks, explanation of benefits and provider manuals, as examples.

12.8 - HEDIS®
One of our largest QI projects is our participation in the annual NCQA HEDIS® (Healthcare Effectiveness Data Information Set) monitoring. In the 1990s NCQA developed a broad spectrum of clinical and service performance measures with specific technical specifications that allow fair health plan comparisons regarding clinical outcomes and service performance. Much of HEDIS® data sampling is obtained from claims data, however a number of the clinical and access measures require medical record reviews.

Your Coventry Health Care Provider Agreement states that we have the right to review medical records to monitor the quality and appropriateness of treatment of members by our participating providers. The written consent signed by all members at the time of initial enrollment permits disclosure of their medical information to the health plan.

Your cooperation helps us identify ways we can improve the effectiveness of our healthcare systems and focus activities to positively influence member health. HEDIS® results ratings are also an integral part of the health plan accreditation scoring which in part impacts health plan performance rankings nationally and in future planning, can impact provider profiling and contracting.

12.9 - Patient Safety
Coventry Health Care identifies potential quality, safety, and access issues through, but not limited to:

- Adverse and Never events identified by Health Services staff
- Issues and problems identified by case managers
- Complaints from members, providers, or vendors
- Medical record reviews and data abstraction done as part of the quality improvement activities

Adverse Events (AE) and Never Events (as defined by CMS) are investigated through claims review, research on health plan transactional system and review of medical records (if necessary). Per your provider contract, you are responsible for providing medical records upon request. The Quality
Improvement Coordinator will review each potential quality or safety of care issue. The Quality Improvement Coordinator will make a determination as to whether a potential quality or safety of care issue exists. If the Quality Improvement Coordinator determines there is no quality or safety of care issue identified, the case will be closed and logged in the database for tracking and trending. If the Quality Improvement Coordinator determines a quality or safety of care issue may exist, the issue will be forwarded to the Vice President, Medical Affairs, or designee, for a review decision and a provider site visit may be warranted. The Vice President, Medical Affairs, or designee, may determine that a quality or safety of care issue is not apparent and no further investigation of the case is required. If the Vice President, Medical Affairs, or designee, finds that a quality or safety of care issue may be present, the record will be referred to a Peer Reviewer in a related specialty or subspecialty. If the Peer Reviewer feels that a quality or safety of care issue still exists, the case will be presented in summary form to the Credentialing Committee due to the nature of peer review activities.

All confirmed potential quality or safety of care issues are reviewed at the time of reappointment. Quarterly trend analysis summaries are prepared by the Quality Improvement Coordinator and submitted to the Clinical Advisory Committee and issues of concern may be forwarded to the Credentialing Committee. An annual summary of activities resulting from the identification and review of Adverse Events will be presented to the Vice President, Medical Affairs, or designee, for review.

**Member Complaints** are reviewed to:

- Monitor, evaluate, and effectively resolve member issues in a timely manner (within 30 days of receipt by the health plan)
- Identify opportunities for improvement in the quality of provider care and services rendered to health plan members

Member complaints that reference a potential quality or safety of care issue or a quality of service issue are referred to the Quality Improvement Department for investigation, resolution and to provide a mechanism of trending complaints against individual providers for use in the recredentialing process.

The Quality Improvement Coordinator will review each potential quality or safety of care issue. After the complaint is evaluated, the Quality Improvement Coordinator will send the involved practitioner/provider a letter summarizing the member’s complaint and requesting a response to the member’s allegations. The provider is given fourteen (14) calendar days (which is documented on the letter) to respond. Per your provider contract, you are responsible for providing medical records upon request.

If through the review and investigation, the Quality Improvement Coordinator determines there is no quality or safety of care issue identified, the case will be closed and logged in the database for tracking and trending. If the Quality Improvement Coordinator determines a quality or safety of care issue may
exist, the issue will be forwarded to the Medical Director for a review decision. The Medical Director may determine that a quality or safety of care issue is not apparent and no further investigation of the case is required. If the Medical Director finds that a quality or safety of care issue may be present, the record will be referred to a Peer Reviewer in a related specialty or subspecialty. If the Peer Reviewer feels that a quality or safety of care issue still exists, the case may be presented in summary form to the Clinical Advisory Committee for further review. The case also will be presented in summary form to the Credentialing Committee due to the nature of peer review activities.

If three or more member quality of service complaints are received by the Quality Improvement Department within a rolling twelve month period, a site visit will be required related to the following criteria:

- Physical accessibility
- Physical appearance
- Adequacy of waiting and/or exam space
- Attitude

If the member complaint is considered of a critical nature (e.g. serious health risk danger to self or others) a site visit can be initiated at that time.

The Quality Improvement Coordinator or the Provider Relations Representative will schedule the site visit with the practitioner office within thirty days of receipt of the member complaint. Action plans will be instituted with offices that do not meet goals. Follow-up evaluations will occur at least every six months until deficiencies are corrected. All site visit evaluations conducted triggered by these member complaint criteria will be reported to the Medical Director and the Credentialing Committee.

Complaint data are collected, reviewed, and analyzed in aggregate for trends and opportunities for improvement. Analysis of Quality of Care and Quality of Service data is presented to the Clinical Advisory Committee for review and recommendations. Trends identified associated with providers is forwarded to the Credentialing Committee for further review.

12.10 - Demographics, Epidemiology & Health Disparities
Annually, the Health Plans perform at least an annual analysis of membership demographics and epidemiology. The review of this information allows for planning for network cultural/ethnic, age, sex and linguistic adequacy and to develop and maintain relevant programs that address the needs of the membership. Educational resources are made available to assist staff with specific member needs. Translation services are available Coventry-wide to adequately support member needs.

12.11 - 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 admission

12.12 - Behavioral and Medical Continuity and Coordination of Care

To facilitate continuous and appropriate care for members, and to strengthen industry continuity and coordination of care among behavioral and medical practitioners and providers, the designated Health Plan, in collaboration with the contracted Behavioral Health vendor, monitors the continuity and coordination of behavioral care through assessment of the following:

- Appropriate provider diagnosis, treatment and referral of behavioral health disorders commonly seen in primary care
- Provider evaluation of the appropriate uses of psychopharmacological medications
- Management of treatment access and follow-up for members with coexisting medical and behavioral health disorders
- Provider implementation of a primary or secondary behavioral health preventive program
- Encouraging members to allow behavioral health practitioner to share information with the PCP

12.13 - Medical Record Documentation and Monitoring Compliance

Well-documented medical records facilitate communication, coordination and continuity of care, and promotes the efficiency and effectiveness of treatment. Coventry Health Care requires that practitioners have organized medical record keeping systems and standards for availability of medical records. Coventry Health Care establishes medical record documentation standards and distributes its medical record keeping and documentation standards to their practitioners through the provider newsletter and on our website.

In coordination with a QI Department investigation, Provider Relations/Network Management will conduct site reviews to monitor adherence to the medical record keeping and documentation standards on all primary care practitioners and obstetrician/gynecologists.
12.14 - Delegated Activities
Coventry Health Care delegates specific activities based on contractual agreements. Those activities include Utilization Management, Credentialing/Recredentialing, Member Services, Medical Record Review, and Quality Improvement activities. There is an on-site visit by the Representative(s) from the affected designated areas pre-contractually and annually to evaluate compliance with Coventry Health Care, applicable state regulations and NCQA standards. The delegated party is responsible for furnishing quarterly to semiannual reports of all activities with identified trends and action taken to the Director, Network Operations. These reports are trended by the Quality Improvement Department and reported to the Executive Quality Management Committee and Credentialing Committee. When necessary, clinical and utilization issues are forwarded to the appropriate committees for approval and recommendation. A copy of the delegated party’s Quality Improvement Program description and annual evaluation is received annually. They are reviewed and kept on file in the Quality Improvement Department.

12.15 - Health Plan Accreditation Compliance and Annual Ranking
Accreditation compliance challenges the health plan to assure its operations and support to membership meet nationally recognized standards of service and facilitation of member quality health care. Accreditation is a state bureau of insurance requirement. Participation requires full HEDIS monitoring of effectiveness of care and access to services, CAHPS member satisfaction surveys and operational performance standards on an ongoing basis.

12.16 - Medicaid Program Compliance
As a Medicaid participating managed care organization, the Health Plans are responsible for complying with CMS and state based regulatory standards requiring oversight through an external quality review organization. This oversight involves annual auditing, record review and required performance improvement projects. Compliance is defined through HEDIS, CAHPS and other required monitoring.

12.17 - Annual Quality Improvement Program Evaluation, Review and Approval
The annual evaluation of the Quality Improvement Program is conducted to assess the overall effectiveness of the Health Plans’ quality management processes. The evaluation reviews all aspects of the Program with emphasis on determining whether the Program has demonstrated improvements in the quality of provider care and services that are provided through the Health Plan. The annual evaluation includes:

- An assessment of whether the year's goals and objectives were met
- A review of whether human and technological resources are adequate
- A summary of quality improvement activities and whether improvement were realized
• The impact the quality improvement process had on improving health care and services to members
• Potential and actual barriers to achieving goals, and
• Recommendations for quality improvement program revisions and modifications for the coming year.

The annual evaluation is reviewed and approved by the Executive Quality Management Committee and the Governing Body. The results of the annual quality program evaluation are used to develop and prioritize the annual quality workplan for the upcoming year.

You may request a copy of our annual program evaluation to view our clinical and service outcomes.
13.1 - Preventive Health Guideline Development Policy

Purpose

To identify the preventive health services that Coventry Health Care, Inc. promotes to its members and providers, which serve as recommendations for individuals at “normal risk.” Individuals in certain higher risk categories may require earlier or more frequent screening exams and this should be decided through physician/patient collaboration.

Policy

Coventry Health Care, Inc. develops prevention/early detection guidelines using evidence-based recommendations on preventive services. Guidelines address these categories of members:

- Children/adolescents
- Adults
- Elderly members
- Members who require prenatal/perinatal care

Coventry Health Care, Inc. preventive health guidelines do not reflect reimbursement or payment.

Process: Development & Updates

- Guidelines are developed through Corporate Medical Management Department and receive final approval by the Vice President Medical Officer
- Coventry Health Care, Inc. Preventive Health Guidelines are reviewed at least on an annual basis, or whenever new scientific evidence and/or regulatory changes necessitate revisions
- The Vice President Medical Officer has final review and approval of all updates made to the Preventive Health Guidelines
- The corporate medical team of Coventry Health Care, Inc. annually adopts the CDC’s immunization schedules recommended by the Advisory Committee on Immunization Practices, the American Academy of Pediatrics and the American Academy of Family Physicians and whenever any new scientific evidence and/or regulatory change necessitate revisions
• Updates to the Preventive Health Guidelines and the CDC Immunization Schedules are communicated from the corporate Medical Management Unit to the Health Plans QI Departments

• Our local health plan Clinical Advisory Committee which includes external practicing physicians who review the guidelines as well

Distribution
The preventive guidelines and immunization schedules are then posted to our website for public access and to the provider portal at www.directprovider.com. These can be found on our website at www.chcva.com » Providers » Document Library » Preventive Health Guidelines.

The following pages outline the Preventive Service Standards.
The 2013 Coventry Preventive Health Guidelines review includes a review of the 2012/2013 updates to the U.S. Preventive Services Task Force (USPSTF) Guide to Clinical Preventive Services, in addition to other recognized guidelines/recommendations compared to Coventry’s 2012 Preventive Health Guidelines. The 2013 review is inclusive of recommendations of the Affordable Care Act of 2010, comprising previous USPSTF updates with an “A” or “B” recommendation, in addition to guidelines supported by the U.S. Department of Health Resources and Services Administration (HRSA) developed by the American Academy of Pediatrics.

The review is performed annually during the first quarter of the year. Section A includes a summary of the updates to the Coventry guidelines. Full details on the recommendations can be found in Appendix A (USPSTF), Appendix B (Alternate Sources) and Appendix C (HRSA).

A. Updates to Coventry’s Preventive Health Guidelines

- **Cervical Dysplasia Screening**: Recommends screening for cervical cancer/dysplasia in women ages 21 to 65 years with cytology (Pap smear) every 3 years or, for women ages 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years.
  Source: USPSTF March 2012
  Updated the following guideline:
  - 11-24 guideline – updated guideline and renamed to Cervical Dysplasia/Cancer screening (Papanicolaou (PAP) test)

- **Cervical Cancer Screening**: Recommends screening for cervical cancer/dysplasia in women ages 21 to 65 years with cytology (Pap smear) every 3 years or, for women ages 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years.
  Source: USPSTF March 2012
  Updated the following guidelines:
  - 11-24 Guideline
  - 25-64 Guideline
  - 65+ Guideline

- **CPR Counseling** - Unable to locate previous recommendation and no new recommendation –
  Source: NA
  Removed from the following guideline
  - 65+ guideline

- **Dental Health**: Counsel for properly fitted mouth guards for youths involved in sporting activities that carry risk of oral facial injury.
  Source: AAP 2008
  Added to the following guideline
  - 0-10 Guideline
• **Fall Prevention in Community –Dwelling older adults:** For community dwelling adults aged 65 years or older or who are at increased risk for falls recommend exercise or physical therapy and vitamin D supplementation to prevent falls.
  Source USPSTF 2013
  Added to the following guideline
  o 65+ guideline

• **HIV Screening:** Strongly recommend screening all adolescents, women and adults at increased risk for human immunodeficiency virus (HIV).
  Added the word “women” to the following guidelines:
  o 11-24 guideline
  o 25-64 guideline

• **HPV Testing:** HPV Screening/Testing to begin at age 30 and occur no more frequently than every 3 years. (See Papanicolaou (PAP) test.)
  Source USPSTF: 2012; HRSA: 2012
  Reworded the following guidelines:
  o 25-64 guideline
  o 65+ guideline

• **Injury Prevention Burn Prevention:** Hot water max 120 degrees; don’t heat formula/milk in microwave.
  Source AAP: 2009
  Added to the following guideline:
  o 0-10 guideline

• **Injury Prevention:** Counseling: Smoke alarms installed and maintained
  Source AAP: 2009
  Added to the following guideline:
  o 0-10 guideline
  o 11-24 guideline
  o 25-64 guideline
  o 65+ guideline

• **Injury Prevention:** Counseling: Safely lock/store firearms.
  Source AAP: 2007
  Reworded the following guidelines to match recommendation (removed reference to drugs, toxic substance and matches):
  o 0-10 guidelines

• **Injury prevention alcohol and Drug use:** Reword guideline to match recommendations and change header to “**Injury prevention: Alcohol.**” Removed reference to drugs
  Source: ICSI: 2012
  Reworded and renamed the header the following guideline:
  o 11-24 guideline
  o 25-64 guideline
  o 65+ guideline
- **Obesity Screening and Counseling (adults):** Screen all adults for obesity. Clinicians should offer or refer patients with a body mass index (BMI) of 30 kg/m² or higher to intensive, multicomponent behavioral interventions.
  Source USPSTF: 2012; HRSA: 2012
  Added “with a body mass index (BMI) of 30 kg/m² or higher to intensive, multicomponent behavioral interventions” to the following guidelines:
  - 11-24 guidelines
  - 25-64 guideline
  - 65+ guideline

- **Offer Chorionic Villus sampling:** Removed guideline and replace with “Screening with Aneuploidy (extra or missing chromosome)
  Source: ACOG: 2007
  Removed from the following guideline:
  - Pregnancy guideline

- **Offer Multiple Marker Testing:** Removed guideline and replace with “Screening with Aneuploidy (extra or missing chromosome)
  Source: ACOG: 2007
  Removed from the following guideline:
  - Pregnancy guideline

- **Screening for Aneuploidy (extra or missing Chromosome):** Counsel on screening and invasive testing for aneuploidy to all pregnant women who present for prenatal care before 20 weeks of gestation. Offer screening and diagnostic testing based on risk factors
  Source: ACOG: 2007
  Added to the following guideline:
  - Pregnancy guideline

- **Screening Adults Aged 50 years or older for hearing loss:** Removed guideline; the USPSTF concluded the evidence is insufficient to assess the balance of benefits and harms of this screening.
  Source USPSTF 2012; AAFP.2013
  Removed from the following guideline
  - 25-64 guideline
  - 65+ guideline

- **Screening and counseling for interpersonal and domestic violence:** Counseling: Screening and counseling for interpersonal and domestic violence for all women.
  Source USPSTF: 2013; HRSA: 2010
  Added “for all women” to the following guidelines:
  - 11-24 guidelines
  - 25-64 guideline
  - 65+ guideline

- **Skin Cancer Counseling:** Counsel children, adolescents, and young adults aged 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer
Source USPSTF: 2012
Added to the following guideline:
  o 0-10 guideline
  o 11-24 guideline

• **STIs counseling**: Counseling: Sexual Behavior - High-intensity behavioral counseling to prevent sexually transmitted infections (STIs) for all sexually active adolescents, women and for adults at increased risk for STIs.  
  Source USPSTF: 2008; HRSA: 2012  
  Added “women” and deleted “comprehensive, developmentally appropriate counseling to reduce unwanted pregnancies” to the following guidelines:
  o 11-24 guidelines
  o 25-64 guideline
  o Pregnant Women

• **Well Woman Visit**: Well Woman preventive care visit annually for adult women to obtain the recommended preventive services that are aged and developmentally appropriate, including preconception and prenatal care.  
  Source: ACOG 2012; ACA/HRSA 2008/2012  
  Added to the following Guideline:
  o 11-24 Guideline
  o 25-64 Guideline
  o 65 + Guideline
  o Pregnant Women Guideline
Appendix A:

All USPSTF Recommendations reviewed for consideration:

Cervical Dysplasia Screening and Cervical cancer screening [Listed on Guideline as Papanicolaou (Pap) Test (Women)]

Recommendation: These recommendations apply to women who have a cervix, regardless of sexual history. These recommendations do not apply to women who have received a diagnosis of a high-grade precancerous cervical lesion or cervical cancer, women with in utero exposure to diethylstilbestrol, or women who are immunocompromised (such as those who are HIV positive).

- The USPSTF recommends screening for cervical cancer in women ages 21 to 65 years with cytology (Pap smear) every 3 years or, for women ages 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years.
  
  Grade: A Recommendation.

- The USPSTF recommends against screening for cervical cancer in women younger than age 21 years.
  
  Grade: D Recommendation.

- The USPSTF recommends against screening for cervical cancer in women older than age 65 years who have had adequate prior screening and are not otherwise at high risk for cervical cancer.
  
  Grade: D Recommendation.

- The USPSTF recommends against screening for cervical cancer in women who have had a hysterectomy with removal of the cervix and who do not have a history of a high-grade precancerous lesion (i.e., cervical intraepithelial neoplasia [CIN] grade 2 or 3) or cervical cancer.
  
  Grade: D Recommendation.

- The USPSTF recommends against screening for cervical cancer with HPV testing, alone or in combination with cytology, in women younger than age 30 years.
  
  Grade: D Recommendation.

HIV Screening:

Recommendation:

- The U.S. Preventive Services Task Force (USPSTF) strongly recommends that clinicians screen for human immunodeficiency virus (HIV) all adolescents and adults at increased risk for HIV infection.
  
  Grade: A Recommendation.

- The USPSTF makes no recommendation for or against routinely screening for HIV adolescents and adults who are not at increased risk for HIV infection.
  
  Grade: C Recommendation.

Obesity screening and counseling: adults (Listed on Guidelines as Assess for Obesity)

Recommendation:

- The USPSTF recommends screening all adults for obesity. Clinicians should offer or refer patients with a body mass index (BMI) of 30 kg/m² or higher to intensive, multicomponent behavioral interventions.
  
  Grade: B Recommendation

Screening and counseling for interpersonal and domestic violence.

Recommendation remains:
● The USPSTF recommends that clinicians screen women of childbearing age for intimate partner violence, such as domestic violence, and provide or refer women who screen positive to intervention services.
Grade: B Recommendation.
● The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening all elderly or vulnerable adults (physically or mentally dysfunctional) for abuse and neglect.
Grade: I Statement.

**STIs Counseling:**
Recommendation remains:
● The USPSTF recommends high-intensity behavioral counseling to prevent sexually transmitted infections (STIs) for all sexually active adolescents and for adults at increased risk for STIs.
Grade: B Recommendation.
● The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of behavioral counseling to prevent STIs in non-sexually-active adolescents and in adults not at increased risk for STIs.
Grade: I Statement.

**Fall prevention in Community-Dwelling older Adults.**
Recommendation:
● The USPSTF recommends exercise or physical therapy and vitamin D supplementation to prevent falls in community-dwelling adults aged 65 years or older who are at increased risk for falls.
Grade: B Recommendation.
● The USPSTF does not recommend automatically performing an in-depth multifactorial risk assessment in conjunction with comprehensive management of identified risks to prevent falls in community-dwelling adults aged 65 years or older because the likelihood of benefit is small. In determining whether this service is appropriate in individual cases, patients and clinicians should consider the balance of benefits and harms on the basis of the circumstances of prior falls, comorbid medical conditions, and patient values.
Grade: C Recommendation.

**Skin Cancer Counseling:**
Recommendation:
● The USPSTF recommends counseling children, adolescents, and young adults aged 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.
Grade: B Recommendation.
● The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of counseling adults older than age 24 years about minimizing risks to prevent skin cancer.
Grade: I Statement.
Appendix B: Alternate Sources

Screening for Aneuploidy (extra or missing Chromosome (ACOG 2007)):
Recommendation:
Screening and invasive diagnostic testing for aneuploidy (extra or missing chromosome) should be available to all women who present for prenatal care before 20 weeks of gestation regardless of maternal age. Women should be counseled regarding the differences between screening and invasive diagnostic testing. The choice of screening test depends on many factors, including gestational age at first prenatal visit, number of fetuses, previous obstetric history, family history, availability of nuchal translucency measurement, test sensitivity and limitations, risk of invasive diagnostic procedures, desire for early test results, and options for earlier termination.

Dental Health (AAP 2008):
Recommendation:
- Counsel for properly fitted mouth guards for youths involved in sporting activities that carry risk of oral facial injury.

Injury prevention alcohol (ICSI 2012):
Recommendation:
- 7-12 Years • Reinforce alcohol abuse prevention and education.
- 13+ Years • Don't ride with someone who is under the influence of alcohol; Prevent others from driving in this condition: "Friends don't let friends drive drunk."; Reinforce not drinking and driving, and the dangers of it; Abstinence if driving
- Adult: Have a designated driver; Discuss characteristics of dependency; Advise all females of childbearing age of the harmful effects of alcohol on a fetus and the need for cessation during pregnancy; Reinforce not drinking and driving; Advise patients to not ride with someone under the influence of alcohol and to prevent him or her from driving.
- There is no evidence-based information, but it is unlikely that simple counseling messages will suffice, so when individuals with problems due to their drug use are found, the primary aim here should be to refer patients with this problem to specialized treatment programs.

Injury Prevention Hand guns (AAP: 2007)
Recommendation remains:
- Keep handguns out of places where children live and play. If parents choose to keep a firearm in the home, the unloaded gun and ammunition must be kept in separate locked cabinets

Injury Prevention – Burn (AAP: 2009)
Recommendation remains:
- Hot-water temperature should be set at a maximum of 120°F to avoid scald burns. Parents should be advised not to carry their infant and hot liquids or foods at the same time. Milk and formula should not be heated in the microwave because it can heat unevenly, causing pockets of liquid hot enough to scald the infant’s mouth. Electrical outlets should be covered with devices that will not pose a choking hazard.
- Smoke alarms in the home should be installed and maintained.
Appendix C:  
HRSA Recommendations (Affordable Care Act)

**HIV screening**  
Recommendation remains;  
Counseling and screening for HIV infection for all sexually active women annually

**Human papillomavirus testing**  
Recommendation remains:  
High-risk human papillomavirus DNA testing in women with normal cytology results. Screening should begin at 30 years of age and should occur no more frequently than every 3 years.

**Screening and counseling for interpersonal and domestic violence.**  
Recommendation remains:  
- Screening and counseling for interpersonal and domestic violence annually.

**Well Woman Visit:**  
Recommendation Remains:  
- Well-woman preventive care visit annually for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care. This well-woman visit should, where appropriate, include other preventive services. Annual, although HHS recognizes that several visits may be needed to obtain all necessary recommended preventive services, depending on a woman’s health status, health needs, and other risk factors.
ADDENDUM

September 13, 2013

PREVENTIVE HEALTH GUIDELINES

In follow-up to the release of the 2013 Coventry Preventive Health Guidelines, it was identified that additional updates to the guidelines are needed to support additional updated recommendations to the U.S. Preventive Services Task Force (USPSTF) Guide to Clinical Preventive Services. Actuary and Claims have been notified of the following changes summarized below:

A. Updates to Coventry's Preventive Health Guidelines

- **Hepatitis C Virus infection screening, adults** - Screening for hepatitis C virus (HCV) infection in persons at high risk for infection. Also screening for HCV infection to adults born between 1945 and 1965. Source USPSTF June 2013. Added to the following Guideline:
  - 11-24 Guideline
  - 25-64 Guideline
  - 65+ Guideline

- **HIV Screening** - Screen all adolescents and adults ages 15 to 65 years for human immunodeficiency virus (HIV). Younger adolescents and older adults who are at increased risk should also be screened. Updated to the following Guideline:
  - 11-24 Guideline
  - 25-64 Guideline
Appendix A:

U.S. Preventive Services Task Force (USPSTF) 2013 recommendations (April through July 2013)

Alcohol misuse: screening and counseling (5/2013)
Recommendation:
The USPSTF recommends that clinicians screen adults aged 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse. (Current Coventry Recommendation on Guidelines 11-24; 25-264; 65+)

Hepatitis C Virus infection screening: adults (6/2013)
Recommendation:
The USPSTF recommends screening for hepatitis C virus (HCV) infection in persons at high risk for infection. The USPSTF also recommends offering one-time screening for HCV infection to adults born between 1945 and 1965.

HIV screening: nonpregnant adolescents and adults (4/2013)
Recommendation:
The USPSTF recommends that clinicians screen for HIV infection in adolescents and adults ages 15 to 65 years. Younger adolescents and older adults who are at increased risk should also be screened.

HIV screening: pregnant women (4/2013)
Recommendation:
The USPSTF recommends that clinicians screen all pregnant women for HIV, including those who present in labor who are untested and whose HIV status is unknown. (Current Coventry Recommendation on Guidelines: Pregnant woman)
Coventry Health Care utilizes the U.S. Preventive Services Task Force (USPSTF) evidence-based recommendations that have in effect a rating of “A” or “B” in the current recommendation of the USPSTF, in addition to other recognized guidelines/recommendations, for clinical preventive services. The guidelines serve as recommendations for individuals at “normal risk”. Coventry’s Preventive Health Guidelines will also include individuals with “risk factors” that impact a large number of members and/or have potential for significant adverse health outcomes. Clinicians and patients should work together to make decisions about which preventive services are most appropriate for individual patients. Some individuals in certain higher risk categories may require earlier or more frequent screening exams and this should be discussed with their physicians.

Coventry Health Care, Inc. preventive health guidelines do not reflect reimbursement or payment practices.

## CLINICAL PREVENTIVE SERVICES (BIRTH TO 10 YEARS)

<table>
<thead>
<tr>
<th>PREVENTIVE SERVICES</th>
<th>RECOMMENDATION</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Autism Screening</td>
<td>Screen for autism at 18 and 24 months of age</td>
<td>HRSA/AAP: 2008</td>
</tr>
<tr>
<td>Behavioral Assessments</td>
<td>Perform psychosocial/behavioral assessment at the newborn, 3 to 5 days, and 1, 2, 4, 6, 9, 12, 15, 24, and 30 month well-baby visits. Repeat at age 3 and yearly thereafter through age 21.</td>
<td>HRSA/AAP: 2008</td>
</tr>
<tr>
<td>Blood Pressure Screening</td>
<td>Blood pressure measurements for infants and children with specific risk conditions should be performed prior to age 3. Yearly screening should be performed at 3 through 21 years of age.</td>
<td>HRSA/AAP: 2008</td>
</tr>
<tr>
<td>Chemoprophylaxis Gonorrhea prophylactic medication: newborns</td>
<td>Recommend prophylactic ocular topical medication for all newborn infants against gonococcal ophthalmia neonatorum.</td>
<td>USPSTF: 2011</td>
</tr>
<tr>
<td>Developmental Screening and Surveillance</td>
<td>Screen at the 9, 18, and 30 month well-baby visit. Perform surveillance at age 3 to 5 days; 1, 2, 4, 6, 12, and 24 months; age 3; and yearly thereafter through age 21.</td>
<td>HRSA/AAP: 2008</td>
</tr>
<tr>
<td>Dyslipidemia Screening</td>
<td>Risk Assessment to be performed and action to follow if positive at age 24mo, 4 yrs, 6yr, 8 yr, 10yr, Then yearly ages 11 through 17 and once ages 18 through 21. If screening conducted as part of the action, and results are normal repeat every 3-5 years</td>
<td>HRSA/AAP: 2008</td>
</tr>
<tr>
<td>Hearing Loss Screening</td>
<td>Screen for hearing loss in all newborn infants. Risk Assessment to be performed and action to follow if positive at age 24mo, 4 yrs, 6yr, 8 yr, 10yr, Then yearly ages 11 through 17 and once ages 18 through 21</td>
<td>HRSA/AAP: 2008 AAP Bright Star 2012</td>
</tr>
<tr>
<td>Hematocrit or Hemoglobin Screening</td>
<td>Screen for iron deficiency anemia at 12 months. Risk assessment to be performed and action to follow if positive at 4, 18, 24 months and yearly ages 3 through 21</td>
<td>HRSA/AAP: 2008</td>
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<tr>
<td>Hemoglobinopathy Screen</td>
<td>Screen all newborns for sickle cell disease.</td>
<td>USPSTF: 2007</td>
</tr>
<tr>
<td>Hypothyroidism Screening</td>
<td>Screen all newborns using T4 and or TSH for congenital hypothyroidism</td>
<td>USPSTF: 2008</td>
</tr>
<tr>
<td>Iron Supplementation</td>
<td>Routine iron supplementation for asymptomatic children aged 6 to 12 months who are at increased risk for iron deficiency anemia.</td>
<td>USPSTF: 2006</td>
</tr>
<tr>
<td>Lead Screening</td>
<td>Perform risk assessment and then appropriate action if positive at 6, 9, 18 months, 3 through 6 years visits. At the 12 and 24 months visit, perform risk assessment or screening based on universal screening requirements for patients with Medicaid or high prevalence areas.</td>
<td>HRSA/AAP: 2008</td>
</tr>
<tr>
<td>Medical History</td>
<td>Comprehensive history that is relevant to the age-specific encounter to assess strengths, accomplish surveillance and enhance understanding of child and family. Prenatal, for high risk or first time parents; then at the newborn, 3-5 days, 1, 2, 4, 6, 9, 12, 15, 18, 24, and 30 months well-baby visit; at 3 years, and then yearly thereafter through age 21.</td>
<td>HRSA/AAP: 2008</td>
</tr>
<tr>
<td>Oral Health Risk Assess</td>
<td>Primary Care Provider/Pediatrician: perform a risk assessment with appropriate follow-up if required at the 6 and 9 month well-baby visit. At 12, 18, 24, and 30 month well-baby visit, either screen or perform risk assessment. At 3 and 6 years, an oral risk assessment should be made; if the primary water source is deficient in fluoride, consider oral fluoride supplementation. If the patient does not have a dental health provider, a referral should be made.</td>
<td>HRSA/AAP: 2008</td>
</tr>
<tr>
<td>Phenylketonuria (PKU) Screening</td>
<td>Screen all newborns before discharge from the nursery. Infants who are tested in the first 24 hours of age should receive a repeat screening test by 2 weeks of age.</td>
<td>USPSTF: 2008</td>
</tr>
<tr>
<td>Retinopathy of Prematurity (ROP) Screen</td>
<td>Retinal screening exam performed by an ophthalmologist for infants with low birth weight (&lt;1500g) or gestational age of 32 weeks or less and infants weighing between 1500 and 2000g or gestational age of more than 32 weeks with an unstable clinical course.</td>
<td>AAP: 2006</td>
</tr>
<tr>
<td>Screening for Obesity</td>
<td>Perform weight and height (length) measurements for newborns through 18 months. Measure BMI at each visit from 24 months through the age of 21. Screen children aged 6 years and older for obesity and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status.</td>
<td>HRSA/AAP: 2008, USPSTF: 2010</td>
</tr>
<tr>
<td>Tuberculin Test</td>
<td>Risk Assessment to be performed and action to follow if positive at age 1, 6, 12, 18 and 24 months then yearly</td>
<td>HRSA/AAP: 2008</td>
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<td>Vision Screening</td>
<td>A risk assessment should be performed with appropriate follow-up if required at the newborn evaluation, at the 3-5 days follow-up visit, and at each well baby visit at 1, 2, 4, 6, 9, 12, 15, 18, 24, and 30 months; A screen should be performed at 3 years of age (re-screen in 6 months if uncooperative), Screen at 4, 5, 6, and 8 years of age with a risk assessment performed at age 7. Alternate each yearly well-child visit with a screen or risk assessment between the ages of 8 through 18.</td>
<td>HRSA: 2008</td>
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<td>USPSTF: 2011,</td>
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<td>AAP: 2010</td>
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<tr>
<td>Counseling</td>
<td>Injury Prevention</td>
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<td>Car safety Seats: <strong>Infants</strong>: (2 years and under) Rear-facing as long as possible. Forward-facing seat with a full harness as long as they fit. <strong>Toddlers Preschoolers</strong>: (2 years and older) Rear-facing as long as possible. Forward-facing seat with a full harness as long as they fit. <strong>School-aged children</strong>: Booster seats until adult belts fit correctly (usually when a child reaches about 4’ 9” in height and is between 8 and 12 years of age).</td>
<td>AAP: 2011</td>
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<td></td>
<td>Choking caution: the shape, size, and consistency of food, coins, toys, and balloons may increase their potential to cause choking in infants and young children. Readily available poison control and emergency phone numbers</td>
<td>ICSI:2012</td>
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<td>CPR training for parents/caretakers givers</td>
<td>AAP:2007</td>
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<td></td>
<td>Always wear bicycle helmet; avoid bicycling near traffic</td>
<td>AAP:2009</td>
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<td></td>
<td>Maintain working smoke detector, flame retardant sleepwear</td>
<td>AAP:2009</td>
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<td>Hot water temperature at or below 120 degree F</td>
<td>USDA:2010</td>
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<td>Do not heat formula/milk in microwave</td>
<td>HRSA: 2008</td>
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<td></td>
<td>Safely lock/store firearms</td>
<td>AAP:2009</td>
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<td></td>
<td>Pool fence- never leave infant/young children around any body of water unsupervised.</td>
<td>AAP:2009</td>
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<td>Diet and Exercise</td>
<td>AAP:2010</td>
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<tr>
<td></td>
<td>Breast-feed, iron-enriched formula and foods (infants and toddlers). Limit trans and saturated fat and cholesterol; maintain caloric balance; emphasize grains, fruits, vegetables</td>
<td>AAP:2009</td>
</tr>
<tr>
<td></td>
<td>Regular physical activity</td>
<td>USDA:2010</td>
</tr>
<tr>
<td></td>
<td>Dental Health</td>
<td>AAP:2008</td>
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<td></td>
<td>Regular visits to dental care provider</td>
<td>AAP:2008</td>
</tr>
<tr>
<td></td>
<td>Limit sugar and juice drinks and discourage a child sleeping with a bottle; any bottle taken to bed should only contain water. Twice daily brushing with fluoride toothpaste and flossing. Children under 2, brush teeth with plain water. Counsel for properly fitted mouth guards for youths involved</td>
<td>AAP:2008</td>
</tr>
<tr>
<td>in sporting activities that carry risk of oral facial injury.</td>
<td>USPSTF: 2012</td>
<td></td>
</tr>
<tr>
<td>Skin Health</td>
<td>AAP: 2009</td>
<td></td>
</tr>
<tr>
<td>Counsel children, adolescents and young adults aged 10-24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce the risk for skin cancer</td>
<td>AAP: 2006</td>
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<tr>
<td>Substance Use</td>
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<tr>
<td>Avoid second hand smoke</td>
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<tr>
<td>Anti-tobacco message</td>
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### CLINICAL PREVENTIVE SERVICES (11 TO 24 YEARS)

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<tbody>
<tr>
<td>Alcohol and Drug Use Assessment</td>
<td>Perform risk assessment with appropriate follow-up action if needed for adolescent age 11 through 21.</td>
<td>HRSA/AAP: 2008</td>
</tr>
<tr>
<td>Assess for Problem Drinking</td>
<td>Screening and behavioral counseling interventions to reduce alcohol misuse by adults, including pregnant women.</td>
<td>USPSTF: 2004</td>
</tr>
<tr>
<td>Behavioral Assessments</td>
<td>Psychosocial/behavioral assessment at the newborn, 3-5 days, and 1, 2, 4, 6, 9, 12, 15, 24, and 30 months well-baby visits; repeat at 3 years and then yearly thereafter through 21 years of age.</td>
<td>HRSA/AAP: 2008</td>
</tr>
<tr>
<td>Blood Pressure Screening</td>
<td>Blood pressure measurements for infants and children with specific risk conditions should be performed prior to age 3 years. Yearly screening should be performed for all persons ≥3 years of age.</td>
<td>HRSA/AAP: 2008, USPSTF: 2007</td>
</tr>
<tr>
<td>Breast (Ovarian) Cancer Screening</td>
<td>Women whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes be referred for genetic counseling and evaluation for BRCA testing.</td>
<td>USPSTF: 2005</td>
</tr>
<tr>
<td>Breast Cancer Preventive Medication</td>
<td>Recommends clinicians discuss chemoprevention with women at high risk for breast cancer and at low risk for adverse effects of chemoprevention. Clinicians should inform patients of the potential benefits and harms of chemoprevention.</td>
<td>USPSTF: 2002</td>
</tr>
<tr>
<td>Chlamydia Screen (Women &lt;24 years)</td>
<td>Routine screening for Chlamydia in all sexually active women age &lt;24 and in older women who are at increased risk.</td>
<td>USPSTF: 2008</td>
</tr>
<tr>
<td>Developmental Screening and</td>
<td>Screen at the 9, 18, and 30 months well-baby visits. Perform surveillance at 3-5 days, 1, 2, 4, 6, 12, and 24 months, 3</td>
<td>HRSA/AAP: 2008</td>
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<td><strong>PREVENTIVE SERVICES</strong></td>
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<tr>
<td>Surveillance</td>
<td>years and yearly thereafter through the age of 21.</td>
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<td>Dyslipidemia Screening</td>
<td>Risk Assessment to be performed and action to follow if positive at age 24mo, 4 yrs, 6yr, 8 yr, 10yr, Then yearly ages 11 through 17 and once ages 18 through 21. If screening conducted as part of the action, and results are normal repeat every 3-5 years</td>
<td>HRSA/AAP: 2008</td>
</tr>
<tr>
<td>Folic Acid in Neural Tube Defects Prevention</td>
<td>All women planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid.</td>
<td>USPSTF: 2009</td>
</tr>
<tr>
<td>Gonorrhea Screen</td>
<td>Screen all sexually active women, including those who are pregnant, for gonorrhea infection if they are at increased risk for infection.</td>
<td>USPSTF: 2005</td>
</tr>
<tr>
<td>Hct/Hgb screening</td>
<td>Screen for iron deficiency anemia at 12 months. Risk assessment to be performed and action to follow if positive at 4, 18, 24 months and yearly ages 3 through 21.</td>
<td>HRSA/AAP: 2008</td>
</tr>
<tr>
<td>Hearing Loss Screening</td>
<td>Screen for hearing loss in all newborn infants. Risk Assessment to be performed and action to follow if positive at well baby visits through 3 years and annually ages 11 through 21. Rescreen at 4 yrs, 5 yrs, 6yrs, 8 yrs, 10yrs, Then yearly ages 11 through 17 and once ages 18 through 21.</td>
<td>HRSA/AAP: 2008</td>
</tr>
<tr>
<td>Hepatitis C (HCV) screening</td>
<td>Screening for hepatitis C virus (HCV) infection in persons at high risk for infection.</td>
<td>USPSTF: 2013</td>
</tr>
<tr>
<td>HIV Screening</td>
<td>Screen all adolescents and adults ages 15 to 65 years for human immunodeficiency virus (HIV). Younger adolescents and older adults who are at increased risk should also be screened.</td>
<td>USPSTF: 2013</td>
</tr>
<tr>
<td>Lipid Disorder Screening</td>
<td>Men: recommend screening men aged 20 to 35 for lipid disorders if they are at increased risk for coronary heart disease and strongly recommends screening men aged 35 and older for lipid disorders. Women: recommends screening women aged 20 to 45 for lipid disorders if they are at increased risk for coronary heart disease and strongly recommends screening women aged 45 and older for lipid disorders if they are at increased risk for coronary heart disease.</td>
<td>USPSTF: 2008</td>
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<td>Medical History</td>
<td>Comprehensive history that is relevant to the age-specific encounter to assess strengths, accomplish surveillance and enhance understanding of child and family. Prenatal, for high risk or first time parents; then at the newborn, 3-5 days, 1, 2, 4, 6, 9, 12, 15, 18, 24, and 30 months well-baby visit; at 3 years, and then yearly thereafter through age 21.</td>
<td>HRSA/AAP: 2008</td>
</tr>
<tr>
<td>Papanicolaou (Pap) Test (Women)</td>
<td>Recommend screening for cervical cancer/dysplasia in women ages 21 to 65 years with cytology (Pap smear) every 3 years or, for women ages 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years.</td>
<td>USPSTF: 2012  ACOG: 2012</td>
</tr>
<tr>
<td>Screening for Depression</td>
<td>Screen adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up.</td>
<td>USPSTF: 2009</td>
</tr>
<tr>
<td>Screen for Major Depressive Disorder</td>
<td>Screen all adolescents 12 to 18 years of age for major depressive disorder (MDD) when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavior or interpersonal), and follow-up.</td>
<td>USPSTF: 2009</td>
</tr>
<tr>
<td>Screening for Obesity</td>
<td>Screen adolescents 11-18 years of age for obesity (height, weight, and BMI) and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status. Screen adults for obesity using body mass index and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults.</td>
<td>USPSTF: 2010  HRSA/AAP: 2008</td>
</tr>
<tr>
<td>Syphilis Screening</td>
<td>Screen persons at increased risk for syphilis infection.</td>
<td>USPSTF: 2004</td>
</tr>
<tr>
<td>Tuberculin Test</td>
<td>Risk Assessment to be performed and action to follow if positive at age 1, 6, 12, 18 and 24 months then yearly</td>
<td>HRSA/AAP: 2008</td>
</tr>
<tr>
<td>Type 2 Diabetes Mellitus Screen</td>
<td>Screen for type 2 diabetes in asymptomatic adults with sustained BP (either treated or untreated) greater than 135/80 mm Hg</td>
<td>USPSTF: 2008</td>
</tr>
<tr>
<td>Vision Screening</td>
<td>A risk assessment should be performed with appropriate follow-up if required at the newborn evaluation, at the 3-5 days follow-up visit, and at each well baby visit at 1, 2, 4, 6, 9, 12, 15, 18, 24, and 30 months; A screen should be performed at 3 years of age (re-screen in 6 months if necessary).</td>
<td>HRSA/AAP: 2010  USPSTF: 2011</td>
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<tr>
<td><strong>Well Woman Visit</strong></td>
<td>Preventive care visit annually for adult women to obtain recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care.</td>
<td>HRSA:2012  ACOG: 2012</td>
</tr>
<tr>
<td><strong>Counseling</strong></td>
<td>Injury Prevention</td>
<td>AAP: 2011</td>
</tr>
<tr>
<td></td>
<td>Children who have outgrown their booster seats (usually 4’9” in height and is between 8 and 12 years of age) should ride with a lap and shoulder seat belt in the back seat until 13 years of age.</td>
<td>AAP: 2007;  AAMA 2004  AAP:2007</td>
</tr>
<tr>
<td></td>
<td>Lap-shoulder belts for adolescent/adults</td>
<td>AAP:2009</td>
</tr>
<tr>
<td></td>
<td>Bicycle/motorcycle/ATV helmets</td>
<td>AAP:2007</td>
</tr>
<tr>
<td></td>
<td>Smoke Alarms installed and maintained</td>
<td>USMA: 2010</td>
</tr>
<tr>
<td></td>
<td>Removal of firearms or separation of ammunition and firearms and stored in separate locked cabinets.</td>
<td>AAP:2007</td>
</tr>
<tr>
<td></td>
<td>Sports safety including safety equipment and eyewear</td>
<td>AAP:2007</td>
</tr>
<tr>
<td></td>
<td>Diet and Exercise</td>
<td>USDA: 2010</td>
</tr>
<tr>
<td></td>
<td>Limit trans and saturated fat and cholesterol; maintain caloric balance; emphasize grains, fruits, vegetables</td>
<td>USDA: 2010</td>
</tr>
<tr>
<td></td>
<td>Regular physical activity</td>
<td>USDA: 2010</td>
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<td></td>
<td>Dental Health</td>
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<td></td>
<td>Regular visits to dental care provider</td>
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<td>Floss and brush with fluoride toothpaste twice daily</td>
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<td></td>
<td>Adequate calcium intake</td>
<td>USDA: 2010</td>
</tr>
<tr>
<td></td>
<td>Counsel for properly fitted mouth guards for youths involved in sporting activities that carry risk of oral facial injury.</td>
<td>USDA: 2010</td>
</tr>
<tr>
<td></td>
<td>Skin Health</td>
<td>USDA: 2010</td>
</tr>
<tr>
<td></td>
<td>Counsel children, adolescents, and young adults aged 10 to</td>
<td>USDA: 2010</td>
</tr>
</tbody>
</table>

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Health Resources and Services Administration/Bright Futures/American Academy of Pediatrics, 2012  
American Academy of Pediatrics (AAP) Policy  
American Medical Association (AMA) Policy  
American Dental Association (ADA) Policy  
United States Department of Agriculture (USDA), 2010  
Institute for Clinical Systems Improvement Preventive Health guidelines 2012
### CLINICAL PREVENTIVE SERVICES (11 TO 24 YEARS)

<table>
<thead>
<tr>
<th>PREVENTIVE SERVICES</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.</td>
<td>USPSTF: 2012</td>
</tr>
<tr>
<td></td>
<td>Substance Abuse Reinforce alcohol abuse and prevention education. Do not ride with someone under the influence and do not let others drive. Advise all females of childbearing age the effects of alcohol on a fetus.</td>
<td>ICSI: 2012</td>
</tr>
<tr>
<td></td>
<td>Avoid second hand smoke; Anti tobacco message</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Domestic Violence Screening and counseling for interpersonal and domestic violence for all women.</td>
<td>USPSTF:2013</td>
</tr>
<tr>
<td></td>
<td>Sexual Behavior High-intensity behavioral counseling to prevent sexually transmitted infections (STIs) for all sexually active adolescents, women and for adults at increased risk for STIs.</td>
<td>HRSA: 2012</td>
</tr>
</tbody>
</table>
Coventry Health Care utilizes the U.S. Preventive Services Task Force (USPSTF) evidence-based recommendations that have in effect a rating of “A” or “B” in the current recommendations of the USPSTF, in addition to other recognized guidelines/recommendations, for clinical preventive services. The guidelines serve as recommendations for individuals at “normal risk”. Coventry’s Preventive Health Guidelines will also include individuals with “risk factors” that impact a large number of members and/or have potential for significant adverse health outcomes. Clinicians and patients should work together to make decisions about which preventive services are most appropriate for individual patients. Some individuals in certain higher risk categories may require earlier or more frequent screening exams and this should be discussed with their physicians.

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<tbody>
<tr>
<td>Aspirin for the Prevention of Cardiovascular Disease</td>
<td>Aspirin for men age 45 to 79 years is recommended when the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm due to an increase in gastrointestinal hemorrhage. A aspirin is recommended for women age 55 to 79 years when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage.</td>
<td>USPSTF: 2009</td>
</tr>
<tr>
<td>Assess for Obesity</td>
<td>Screen all adults for obesity. Clinicians should offer or refer patients with a body mass index (BMI) of 30 kg/m2 or higher to intensive, multicomponent behavioral interventions.</td>
<td>USPSTF: 2012 HRSA:2008</td>
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<tr>
<td>Assess for Problem Drinking</td>
<td>Screening and behavioral counseling interventions to reduce alcohol misuse by adults, including pregnant women.</td>
<td>USPSTF:2004</td>
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<tr>
<td>Assess Tobacco Use and Tobacco-Caused Disease</td>
<td>Ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products.</td>
<td>USPSTF: 2009</td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>Routine screening for all persons ≥18 years of age.</td>
<td>USPSTF:2007</td>
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<tr>
<td>Breast (Ovarian) Cancer Screening</td>
<td>Women whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes be referred for genetic counseling and evaluation for BRCA testing.</td>
<td>USPSTF: 2005</td>
</tr>
<tr>
<td>Breast Cancer Preventive Medication</td>
<td>Recommends clinicians discuss chemoprevention with women at high risk for breast cancer and at low risk for adverse effects of chemoprevention.Clinicians should inform patients of the potential benefits and harms of chemoprevention.</td>
<td>USPSTF: 2002</td>
</tr>
<tr>
<td>Chlamydia Screen (Women &lt;24 years)</td>
<td>Routine screening for Chlamydia in all sexually active women age &lt;24 and in older women who are at increased risk.</td>
<td>USPSTF:2007</td>
</tr>
<tr>
<td>Diabetes Screening</td>
<td>Screen for type 2 diabetes in asymptomatic adults with sustained B P ( treated or untreated) greater than 135/80 mmHg</td>
<td>USPSTF: 2008</td>
</tr>
<tr>
<td>Fecal Occult Blood Test</td>
<td>Screen for colorectal cancer using annual fecal occult blood</td>
<td>USPSTF: 2008</td>
</tr>
</tbody>
</table>
## CLINICAL PREVENTIVE SERVICES (25 TO 64 YEARS)

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<tbody>
<tr>
<td>and/or Sigmoidoscopy/Colonoscopy</td>
<td>Testing, sigmoidoscopy every 5 years, or colonoscopy every 10 years, in adults, beginning at age 50 years and continuing until age 75 years</td>
<td></td>
</tr>
<tr>
<td>Folic Acid in Neural Tube Defects Prevention</td>
<td>All women planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid.</td>
<td>USPSTF: 2009</td>
</tr>
<tr>
<td>Gonorrhea Screen</td>
<td>Screen all sexually active women, including those who are pregnant, for gonorrhea infection if they are at increased risk for infection.</td>
<td>USPSTF: 2005</td>
</tr>
<tr>
<td>Hepatitis C (HCV) screening</td>
<td>Screening for hepatitis C virus (HCV) infection in persons at high risk for infection.</td>
<td>USPSTF: 2013</td>
</tr>
<tr>
<td>HIV Screening</td>
<td>Screen all adolescents and adults ages 15 to 65 years for human immunodeficiency virus (HIV). Younger adolescents and older adults who are at increased risk should also be screened.</td>
<td>USPSTF: 2013, HRSA: 2012</td>
</tr>
<tr>
<td>Human papillomavirus testing</td>
<td>HPV Screening/Testing to begin at age 30 and occur no more frequently than every 3 years. (See Papanicolaou (PAP) test.)</td>
<td>USPSTF: 2012, HRSA: 2012</td>
</tr>
</tbody>
</table>
| Lipid Disorder Screening                                   | Men: recommend screening men aged 20 to 35 for lipid disorders if they are at increased risk for coronary heart disease and strongly recommends screening men aged 35 and older for lipid disorders.  
Women: recommends screening women aged 20 to 45 for lipid disorders if they are at increased risk for coronary heart disease and strongly recommends screening women aged 45 and older for lipid disorders if they are at increased risk for coronary heart disease. | USPSTF: 2008, AAP: 2008 |
| Mammogram + Clinical Breast Exam (Women >40 years)         | Screen for breast cancer every 1-2 years, with mammography alone or mammography and annual clinical breast examination for women > 40 years. Clinicians should discuss the potential benefits versus potential harms and the limitations of screening based on age. | USPSTF: 2009      |
| Osteoporosis Screening                                     | Screen women 65 and older and younger women whose fracture risk is equal or greater than that of a 65 year-old white female who has no additional risk factors. | USPSTF: 2011      |
| Papanicolaou (Pap) Test (Women)                            | Recommend screening for cervical cancer/dysplasia in women ages 21 to 65 years with cytology (Pap smear) every 3 years or, for women ages 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years. | USPSTF: 2012      |
| Screening for Depression                                   | Screen adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis. | USPSTF: 2009      |
## CLINICAL PREVENTIVE SERVICES (25 TO 64 YEARS)

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<tr>
<td>Syphilis Screening</td>
<td>Screen persons at increased risk for syphilis infection.</td>
<td>USPSTF: 2004</td>
</tr>
<tr>
<td>Tuberculin Test</td>
<td>Risk assessment to be performed and action to follow if positive at age 1, 6, 12, 18 and 24 months then yearly</td>
<td>HRSA/AAP: 2008</td>
</tr>
<tr>
<td>Well Woman Visit</td>
<td>Well-Woman preventive care visit annually for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care.</td>
<td>ACOG: 2012, HRSA: 2012</td>
</tr>
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</table>

### Counseling
- Lap-shoulder belts
- Bicycle/motorcycle/ATV helmets
- Smoke alarms installed and maintained
- Safe storage/removal of firearms

**Injury Prevention**

**Diet and Exercise**
- Limit trans and saturated fat and cholesterol; maintain caloric balance; emphasize grains, fruits, vegetables
- Regular physical activity
- Adequate calcium intake

**Substance Abuse**
- Avoid tobacco use
- Responsible alcohol use
- Avoid alcohol use if pregnant

**Menopause**
- Strategies for preventing chronic diseases in perimenopausal and postmenopausal women. This approach should consider individual risk factors and preferences in selecting effective

**REFERENCE**
- AAP: 2011
- AAP: 2007, ACOG: 2004
- AAP: 2009
- AAP: 2007
- USDA: 2010
- AAP: 2006
- USPSTF: 2009
- USPSTF: 2004
- AMA: 2005
- ICSI: 2011
### Clinical Preventive Services (25 to 64 Years)

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<td>Interventions for reducing symptoms and gaining relief while providing an opportunity to discuss the importance of preventing menopause-related disease processes.</td>
<td></td>
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<tr>
<td>Dental Health</td>
<td>Regular visits to dental care provider. Floss and brush with fluoride toothpaste twice daily</td>
<td>HRSA:2008</td>
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<td></td>
<td>Domestic Violence</td>
<td>ADA:2013</td>
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<td></td>
<td>Screening and counseling for interpersonal and domestic violence for all women.</td>
<td>USPSTF: 2013</td>
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<td>Sexual Behavior</td>
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<tr>
<td></td>
<td>High-intensity behavioral counseling to prevent sexually transmitted infections (STIs) for all sexually active adolescents and for all sexually active adolescents, women and for adult at increased risk for STI's</td>
<td>USPSTF: 2008</td>
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Coventry Health Care utilizes the U.S. Preventive Services Task Force (USPSTF) evidence-based recommendations that have in effect a rating of “A” or “B”, in addition to other recognized guidelines/recommendations, for clinical preventive services. The guidelines serve as recommendations for individuals at “normal risk”. Coventry's Preventive Health Guidelines will also include individuals with “risk factors” that impact a large number of members and/or have potential for significant adverse health outcomes. Clinicians and patients should work together to make decisions about which preventive services are most appropriate for individual patients. Some individuals in certain higher risk categories may require earlier or more frequent screening exams and this should be discussed with their physicians.

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### CLINICAL PREVENTIVE SERVICES (65 AND OLDER)

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</thead>
<tbody>
<tr>
<td>Abdominal Aortic Aneurysm (AAA)</td>
<td>One-time screening for abdominal aortic aneurysm (AAA) by ultrasonography in men aged 65 to 75 years who have ever smoked.</td>
<td>USPSTF: 2005</td>
</tr>
<tr>
<td>Aspirin for the Prevention of Cardiovascular Disease</td>
<td>Aspirin for men aged 45 to 79 years is recommended when the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm due to an increase in gastrointestinal hemorrhage. A aspirin is recommended for women age 55 to 79 years when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage.</td>
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<td>Breast (Ovarian) Cancer Screening</td>
<td>Women whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes be referred for genetic counseling and evaluation for BRCA testing.</td>
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American Dental Association (ADA) Policy
American Medical Association (AMA) Policy
United States Department of Agriculture (USDA), 2010
Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, 2010
Institute for Clinical Systems Improvement Preventive Health guidelines 201, 2012
## Clinical Preventive Services (65 and Older)

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<th>Preventive Services</th>
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<tbody>
<tr>
<td>Blood Pressure</td>
<td>Routine screening for all persons ≥18 years of age.</td>
<td>USPSTF: 2007</td>
</tr>
<tr>
<td>Cervical Cancer/ dysplasia screening (Papanicolaou (Pap) Test (Women))</td>
<td>Recommends screening for cervical cancer/dysplasia in women ages 21 to 65 years with cytology (Pap smear) every 3 years or, for women ages 30 to 65 years who want to lengthen the screening interval, screening with a combination of cytology and human papillomavirus (HPV) testing every 5 years.</td>
<td>USPSTF: 2012</td>
</tr>
<tr>
<td>Fall prevention in Community-Dwelling older Adults</td>
<td>For community dwelling adults aged 65 years or older or who are at increased risk for falls, recommend exercise or physical therapy and vitamin D supplementations to prevent falls.</td>
<td>USPSTF: 2013</td>
</tr>
<tr>
<td>Fecal Occult Blood Test and/or Sigmoidoscopy/Colonoscopy</td>
<td>Screen for colorectal cancer using annual fecal occult blood testing, sigmoidoscopy every 5 years, or colonoscopy every 10 years, in adults, beginning at age 50 years and continuing until age 75 years.</td>
<td>USPSTF: 2008</td>
</tr>
<tr>
<td>Hepatitis C (HCV) screening</td>
<td>Screen for HCV infection to adults born between 1945 and 1965.</td>
<td>USPSTF: 2013</td>
</tr>
<tr>
<td>Human papillomavirus testing</td>
<td>HPV Screening/Testing to begin at age 30 and occur no more frequently than every 3 years. (See Papanicolaou (PAP) test.)</td>
<td>HRSA: 2012 USPSTF: 2012</td>
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<tr>
<td>Lipid Disorder Screening</td>
<td>Men: strongly recommends screening men aged 35 and older for lipid disorders. Women: strongly recommends screening women aged 45 and older for lipid disorders if they are at increased risk for coronary heart disease.</td>
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<td>Mammogram + Clinical Breast Exam (Women ≥ 40 years)</td>
<td>Screen for breast cancer every 1-2 years, with mammography alone or mammography and annual clinical breast examination for women ≥ 40 years. Clinicians should discuss the potential benefits versus potential harms and the limitations of screening based on age.</td>
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<td>Osteoporosis Screening</td>
<td>Screen women 65 and older and younger women whose fracture risk is equal or greater than that of a 65 year-old white female who has no additional risk factors.</td>
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<td>Tuberculin Test</td>
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<td>Type 2 Diabetes Mellitus Screen</td>
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<td>Vision Screening</td>
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<td>Well Woman Visit</td>
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# Clinical Preventive Services (65 and Older)

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<td><strong>Domestic Violence</strong></td>
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<td>Screening and counseling for interpersonal and domestic violence for all women.</td>
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<td>Regular visits to dental care provider</td>
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<td></td>
<td>Floss and brush with fluoride toothpaste twice daily</td>
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**COVENTRY HEALTH CARE**
**CLINICAL PREVENTIVE SERVICES**
**2013**

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<tr>
<td><strong>FIRST VISIT</strong></td>
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<tr>
<td>Assess for Problem Drinking</td>
<td>Screening and behavioral counseling interventions to reduce alcohol misuse by adults, including pregnant women.</td>
<td>USPSTF:2004</td>
</tr>
<tr>
<td>Assess Tobacco Use and Tobacco-Caused Disease</td>
<td>Ask all pregnant women about tobacco use and provide augmented, pregnancy-tailored counseling for those who smoke.</td>
<td>USPSTSF: 2009</td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>Screen for high blood pressure</td>
<td>USPSTF: 2007</td>
</tr>
<tr>
<td>CBC</td>
<td>Perform a CBC at the first prenatal visit</td>
<td>ICSI: 2009</td>
</tr>
<tr>
<td>Chlamydia Screen</td>
<td>Screen all pregnant women aged 24 years and younger and older pregnant women at increased risk for chlamydia infection.</td>
<td>USPSTF:2008</td>
</tr>
<tr>
<td>Gonorrhea Screen</td>
<td>Screen all sexually active women, including those who are pregnant, for gonorrhea infection if they are at increased risk for infection.</td>
<td>USPSTF:2008</td>
</tr>
<tr>
<td>Hepatitis B Surface Antigen</td>
<td>Screen for hepatitis B virus (HBV) infection in pregnant women at their first prenatal visit.</td>
<td>USPSTF: 2009</td>
</tr>
<tr>
<td>HIV Screening</td>
<td>Screen all pregnant women for HIV</td>
<td>USPSTF: 2005</td>
</tr>
<tr>
<td>Iron Deficiency Anemia Screen</td>
<td>Routine screening for iron deficiency anemia in asymptomatic pregnant women.</td>
<td>USPSTF:2006</td>
</tr>
<tr>
<td>Offer Hemoglobinopathy Screening</td>
<td>Offer screening for hemoglobinopathies with hemoglobin electrophoresis or other tests of comparable accuracy to appropriate pregnant women at the first prenatal visit.</td>
<td>ACOG:2007</td>
</tr>
<tr>
<td>Rh (D) Typing, Antibody Screen</td>
<td>Strong recommendation for Rh (D) blood typing and antibody testing for all pregnant women at their first prenatal visit.</td>
<td>USPSTF:2004</td>
</tr>
<tr>
<td>Syphilis Screening</td>
<td>Screen all pregnant women for syphilis infection.</td>
<td>USPSTF:2009</td>
</tr>
<tr>
<td>Screening for Aneuploidy (extra or missing Chromosome)</td>
<td>Counsel on screening and invasive testing for aneuploidy to all pregnant women who present for prenatal care before 20 weeks of gestation. Offer screening and diagnostic testing based on risk factors.</td>
<td>ACOG: 2007</td>
</tr>
</tbody>
</table>

**American Academy of Pediatrics (AAP) Policy**
**American Medical Association (AMA) Policy**
**United States Department of Agriculture (USDA), 2010**
**American College of Obstetricians and Gynecologists**
## PREVENTIVE SERVICES (PREGNANT WOMEN)

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<tbody>
<tr>
<td>Well-Woman Visit</td>
<td>Well-woman preventive care visit annually for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care.</td>
<td>ACOG 2012 HSRA: 2012</td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>Screen for high blood pressure</td>
<td>USPSTF: 2007</td>
</tr>
<tr>
<td>Breastfeeding</td>
<td>Offer structured breastfeeding education and behavioral counseling programs during pregnancy and after birth to promote breastfeeding.</td>
<td>USPSTF: 2008</td>
</tr>
<tr>
<td>Rh (D) Typing, Antibody Screen</td>
<td>Repeat Rh (D) antibody testing for all unsensitized Rh (D) negative women at 24-28 weeks gestation.</td>
<td>USPSTF:2004</td>
</tr>
<tr>
<td>Screening for gestational diabetes.</td>
<td>Screening for gestational diabetes In pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.</td>
<td>HRSA: 2012</td>
</tr>
<tr>
<td>Urine Culture (12-16 weeks)</td>
<td>Recommendation to screen for asymptomatic bacteriuria with urine culture for pregnant women at 12-16 weeks of gestation or at the first prenatal visit, if later</td>
<td>USPSTF:2008</td>
</tr>
<tr>
<td>Counseling</td>
<td>Injury Prevention&lt;br&gt;Car safety Seats:&lt;br&gt;Infants: (2 years and under) Rear-facing as long as possible. Forward-facing seat with full harness as long as they fit. Lap-shoulder belts for adults&lt;br&gt;Diet and Exercise&lt;br&gt;Limit Trans and saturated fat and cholesterol; consume iron rich foods consumed with vitamin C, an iron enhancer for iron absorption; consume adequate folic acid&lt;br&gt;Substance Abuse&lt;br&gt;Avoid passive smoking. Advise on the harmful effects of alcohol on a fetus and the need for cessation.</td>
<td>AAP: 2011 USDA: 2010 USPSTF: 2009 ICSI: 2012</td>
</tr>
</tbody>
</table>
**Figure 1. Recommended immunization schedule for persons aged 0 through 18 years – 2013.**

(For those who fall behind or start late, see the Catch-Up schedule (Figure 2)).

These recommendations must be read with the footnotes that follow. For those who fall behind or start late, provide catch-up vaccination at the earliest opportunity as indicated by the green bars in Figure 1. To determine minimum intervals between doses, see the catch-up schedule (Figure 2). School entry and adolescent vaccine age groups are in bold.

### Vaccines

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Birth</th>
<th>1 mo</th>
<th>2 mo</th>
<th>4 mos</th>
<th>6 mos</th>
<th>9 mos</th>
<th>12 mos</th>
<th>15 mos</th>
<th>18 mos</th>
<th>19–23 mos</th>
<th>2–3 yrs</th>
<th>4–6 yrs</th>
<th>7–10 yrs</th>
<th>11–12 yrs</th>
<th>13–15 yrs</th>
<th>16–18 yrs</th>
</tr>
</thead>
</table>

### Footnotes — Recommended immunization schedule for persons aged 0 through 18 years—United States, 2013

1. **Hepatitis B (HepB) vaccine. (Minimum age: birth)**
   - Routine vaccination: At birth.
   - **Note:** For those who fall behind or start late, see the Catch-Up schedule (Figure 2).
   - Administer monovalent HepB vaccine to all newborns before hospital discharge.
   - For infants born to hepatitis B surface antigen (HBsAg)-positive mothers, administer HepB vaccine and 0.5 mL of hepatitis B immune globulin (HBIG) within 12 hours of birth. These infants should be tested for HBsAg and antibody to HBsAg (anti-HBs) to 1 to 2 months after completion of the HepB series, at ages 9 through 18 months (preferably at the next well-child visit).
   - If mother’s HBsAg status is unknown, within 12 hours of birth administer HepB vaccine to all infants regardless of birth weight. For infants weighing <2,000 grams, administer HBIG in addition to HepB within 12 hours of birth. Determine mother’s HBsAg status as soon as possible and, if the infant is HBsAg positive, administer HBIG for infants weighing ≥2,000 grams (no later than age 1 week).
   - Doses following the birth dose:
     - The second dose should be administered at age 1 or 2 months.
     - Monovalent HepB vaccine should be used for doses administered before age 6 weeks.
     - Infants who did not receive a birth dose should receive 3 doses of a HepB-containing vaccine on a schedule of 0, 1 to 2 months, and 6 months starting as soon as feasible. See Figure 2.
     - The minimum interval between dose 1 and dose 2 is 4 weeks and between dose 2 and 3 is 8 weeks. The final (third or fourth) dose in the HepB vaccine series should be administered no earlier than age 24 weeks, and at least 16 weeks after the first dose.
     - Administration of a total of 4 doses of HepB vaccine is recommended when a combination vaccine containing HepB is administered after the birth dose.
     - Catch-up vaccination:
       - Unvaccinated persons should complete a 3-dose series.
       - A 2-dose series (doses separated by at least 4 months) of adult formulation Recombivax HB is licensed for use in children aged 11 through 15 years.
       - For other catch-up issues, see Figure 2.

2. **Rotavirus (RV) vaccines. (Minimum age: 6 weeks for both RV-1 [Rotavirus] and RV-5 [Rotarix]).**
   - Routine vaccination:
     - Administer a series of RV vaccine to all infants as follows:
       1. If RV-1 is used, administer a 2-dose series at 2 and 4 months of age.
       2. If RV-5 is used, administer a 3-dose series at ages 2, 4, and 6 months.
       3. If any dose in series RV-5 or RV-1 product is unknown for any dose in the series, a total of 3 doses of RV vaccine should be administered.
     - Catch-up vaccination:
       - The maximum age for the first dose in the series is 14 weeks, 6 days.
       - Vaccination should not be initiated for infants aged 15 weeks or older.
       - The maximum age for the final dose in the series is 8 months, 0 days.
       - If RV-1 (Rotarix) is administered for the first and second doses, a third dose is not indicated.
       - For other catch-up issues, see Figure 2.

3. **Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 weeks)**
   - Routine vaccination:
     - Administer a 5-dose series of DTaP vaccine at ages 2, 4, 6, 15–18 months, and 4 through 6 years. The fourth dose may be administered as early as age 12 months, provided at least 6 months have elapsed since the third dose.
     - Tdap can be administered regardless of the interval since the last tetanus and diphtheria toxoid-containing vaccine.
     - Administer a dose of Tdap vaccine to pregnant adolescents during each pregnancy (preferred during 27 through 36 weeks gestation) regardless of number of years from prior Td or Tdap vaccination.
     - For other catch-up issues, see Figure 2.

4. **Tetanus and diphtheria toxoids and acellular pertussis (Tdap) vaccine. (Minimum age: 10 years forBooster, 11 years for Adacel).**
   - Routine vaccination:
     - Administer dose 1 at age 11 through 12 years.
     - For other catch-up issues, see Figure 2.

5. **Haemophilus influenzae type b (Hib) conjugate vaccine. (Minimum age: 6 weeks)**
   - Routine vaccination:
     - Administer a Hib vaccine primary series (three doses) to all infants. The primary series doses should be administered at 2, 4, and 6 months of age; however, if PRP-OMP (PedvaxHIB or Comvax) is administered at 2 and 4 months of age, a dose at 6 months is not indicated. One booster dose should be administered at age 12 through 15 months.
     - Hib vaccine (PRP-T) should be used only for the booster (final) dose in children aged 12 months through 4 years who have received at least 1 dose of Hib.
     - Catch-up vaccination:
       - If dose 1 was administered at ages 12–14 months, administer booster (as final dose) at least 8 weeks after dose 1.
       - If the first 2 doses were PRP-OMP (PedvaxHIB or Comvax), and were administered at age 11 months or younger, the third (and final) dose should be administered at age 12 through 15 months at least 8 weeks after the second dose.
       - If dose 1 was administered at age 7 through 11 months, administer the second dose at least 4 weeks later and a final dose at age 12 through 15 months, regardless of Hib vaccine (PRP-T or PRP-OMP) used for first dose.
     - For unvaccinated children aged 15 months or older, administer only dose 1.

This schedule includes recommendations in effect as of January 1, 2013. Any dose not administered at the recommended age should be administered at a subsequent visit, when indicated and feasible. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Vaccination providers should consult the relevant Advisory Committee on Immunization Practices (ACIP) statement for detailed recommendations, available online at http://www.cdc.gov/vaccines/pubs/acip-list.htm. Clinically significant adverse events that follow vaccination should be reported to the Vaccine Adverse Event Reporting System (VAERS) online (http://www.vaers.hhs.gov) or by telephone (800-822-7967).Suspected cases of vaccine-preventable diseases should be reported to the state or local health department. Additional information, including precautions and contraindications for vaccination, is available from CDC online (http://www.cdc.gov/vaccines) or by telephone (800-CDC-INFO [800-232-4636]).

This schedule is approved by the Advisory Committee on Immunization Practices (http://www.cdc.gov/vaccines/acip/index.html), the American Academy of Pediatrics (http://www.aap.org), the American Academy of Family Physicians (http://www.aafp.org), and the American College of Obstetricians and Gynecologists (http://www.acog.org).

**NOTE:** The above recommendations must be read along with the footnotes of this schedule.
7. Inactivated poliovirus vaccine [IPV]. (Minimum age: 6 weeks)

Routine vaccination:
- Administer a series of IPV at ages 2, 4-6 months, with a booster at age 4-6 years. The final dose in the series should be administered on or after the fourth birthday and at least 6 months after the previous dose.

Catch-up vaccination:
- In the first 6 months of life, minimum age and minimum intervals are only recommended if the person is at risk for imminent exposure to circulating poliovirus (i.e., travel to a polio-endemic region or during an outbreak of poliomyelitis). If 4 or more doses are administered before age 4 years, an additional dose should be administered at age 4 through 6 years.
- A fourth dose is not necessary if the third dose was administered at age 4 years or older and at least 6 months after the previous dose.
- If both OPV and IPV were administered as part of a series, a total of 4 doses should be administered, regardless of the child’s current age.
- IPV is not generally recommended for U.S. residents aged 18 years or older.

8. Influenza vaccines. (Minimum age: 6 months for inactivated influenza vaccine [IIV]; 2 years for live, attenuated influenza vaccine [LAIV])

Routine vaccination:
- Administer influenza vaccine annually to all children beginning at age 6 months. For most healthy, non-immunocompromised children aged 49 years, either LAIV or IIV may be used. However, LAIV should NOT be administered to some persons, including 1) those with asthma, 2) children 2 through 4 years who had wheezing in the past 12 months, or 3) those who have any underlying medical conditions that predispose them to influenza complications.
- Children with chronic medical conditions (including sickle cell disease), immunosuppressive or immunodeficiency disorders, chronic lung disease (including asthma if treated with high-dose oral corticosteroids), diabetes mellitus, cerebrospinal fluid leak, or cochlear implant.
- Children with anatomic or functional asplenia (including sickle cell disease), other hemoglobinopathies, congenital or acquired asplenia, or splenic dysfunction.
- Children with immunocompromising conditions: HIV infection, chronic renal failure and nephrotic syndrome, chronic liver disease, severe combined immunodeficiency, primary immunodeficiency, or an immunocompromising condition.

Special populations:
- Administer at least 8 weeks after the last dose of PCV to children aged 2 years or older with certain underlying medical conditions (see footnote 6).
- Vaccinated persons with high-risk conditions:
  - For children aged 24 through 71 months with certain underlying medical conditions (see footnote 6), a single revaccination with IPV should be administered after 5 years to children with anatomic or functional asplenia (including sickle cell disease) or an immunocompromising condition.

9. Meningococcal conjugate vaccines (MCV). (Minimum age: 6 weeks for Hib-MenCY, 9 months for MenB-MCV4, 2 years for MenB-MCV4-CRM)

Routine vaccination:
- Administer MCV4 vaccine at age 11–12 years, with a booster dose at age 16 years.
- Adolescents aged 11 through 18 years with human immunodeficiency virus (HIV) infection should receive a 2-dose primary series of MCV4, with at least 8 weeks between doses. See MMWR 2011; 60:1018–1019 available at http://www.cdc.gov/mmwr/pdf/wk/mm6030.pdf.
- For children aged 2 through 10 years with high-risk conditions, see below.

Catch-up vaccination:
- Administer MCV4 vaccine at age 13 through 18 years if not previously vaccinated.
- If the first dose is administered at age 13 through 15 years, a booster dose should be administered at age 16 through 18 years with a minimum interval of at least 8 weeks between doses.
- If the first dose is administered at age 16 years or older, a booster dose is not needed.
- For other catch-up issues, see Figure 2.

Additional information:
- For contraindications and precautions to use of a vaccine and for additional information regarding that vaccine, vaccine providers should consult the relevant ACP statement available online at http://www.cdc.gov/vaccines/schedules/downloads/acip-list.htm.
- For the purposes of calculating intervals between doses, 4 weeks = 28 days. Intervals of 4 months or greater are determined by calendar months.
FIGURE 2. Catch-up immunization schedule for persons aged 4 months through 18 years who start late or who are more than 1 month behind —United States • 2013

The figure below provides catch-up schedules and minimum intervals between doses for children whose vaccinations have been delayed. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Use the section appropriate for the child’s age. Always use this table in conjunction with Figure 1 and the footnotes that follow.

### Persons aged 4 months through 6 years

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Minimum Age for Dose 1</th>
<th>Minimum Interval Between Doses</th>
<th>Dose 1 to dose 2</th>
<th>Dose 2 to dose 3</th>
<th>Dose 3 to dose 4</th>
<th>Dose 4 to dose 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B</td>
<td>Birth</td>
<td>4 weeks</td>
<td>8 weeks and at least 16 weeks after first dose; minimum age for the final dose is 24 weeks</td>
<td>4 weeks</td>
<td>6 months</td>
<td>6 months</td>
</tr>
<tr>
<td>Rotavirus</td>
<td>6 weeks</td>
<td>4 weeks</td>
<td>4 weeks&lt;sup&gt;a&lt;/sup&gt;</td>
<td>4 weeks</td>
<td>6 months</td>
<td>6 months&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>Diphtheria, tetanus, pertussis</td>
<td>6 weeks</td>
<td>4 weeks</td>
<td>4 weeks&lt;sup&gt;a&lt;/sup&gt;</td>
<td>4 weeks&lt;sup&gt;a&lt;/sup&gt;</td>
<td>8 weeks (as final dose)</td>
<td>8 weeks (as final dose)</td>
</tr>
<tr>
<td>Haemophilus influenzae type b</td>
<td>6 weeks</td>
<td>4 weeks</td>
<td>4 weeks&lt;sup&gt;a&lt;/sup&gt;</td>
<td>4 weeks&lt;sup&gt;a&lt;/sup&gt;</td>
<td>8 weeks (as final dose)</td>
<td>8 weeks (as final dose)</td>
</tr>
<tr>
<td>Pneumococcal&lt;sup&gt;4&lt;/sup&gt;</td>
<td>6 weeks</td>
<td>4 weeks</td>
<td>4 weeks&lt;sup&gt;a&lt;/sup&gt;</td>
<td>4 weeks&lt;sup&gt;a&lt;/sup&gt;</td>
<td>8 weeks (as final dose)</td>
<td>8 weeks (as final dose)</td>
</tr>
<tr>
<td>Inactivated poliovirus&lt;sup&gt;4&lt;/sup&gt;</td>
<td>6 weeks</td>
<td>4 weeks</td>
<td>4 weeks&lt;sup&gt;a&lt;/sup&gt;</td>
<td>4 weeks&lt;sup&gt;a&lt;/sup&gt;</td>
<td>6 months&lt;sup&gt;b&lt;/sup&gt;</td>
<td>6 months&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>Meningococcal&lt;sup&gt;13&lt;/sup&gt;</td>
<td>6 weeks</td>
<td>4 weeks</td>
<td>4 weeks&lt;sup&gt;a&lt;/sup&gt;</td>
<td>4 weeks&lt;sup&gt;a&lt;/sup&gt;</td>
<td>see footnote 13</td>
<td>see footnote 13</td>
</tr>
<tr>
<td>Measles, mumps, rubella&lt;sup&gt;6&lt;/sup&gt;</td>
<td>12 months</td>
<td>4 weeks</td>
<td>4 weeks&lt;sup&gt;a&lt;/sup&gt;</td>
<td>4 weeks&lt;sup&gt;a&lt;/sup&gt;</td>
<td>4 weeks&lt;sup&gt;a&lt;/sup&gt;</td>
<td>6 months&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
<tr>
<td>Varicella&lt;sup&gt;7&lt;/sup&gt;</td>
<td>12 months</td>
<td>3 months</td>
<td>3 months</td>
<td>3 months</td>
<td>3 months</td>
<td>3 months</td>
</tr>
<tr>
<td>Hepatitis A&lt;sup&gt;11&lt;/sup&gt;</td>
<td>12 months</td>
<td>6 months</td>
<td>6 months</td>
<td>6 months</td>
<td>6 months</td>
<td>6 months</td>
</tr>
</tbody>
</table>

### Persons aged 7 through 18 years

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Minimum Age for Dose 1</th>
<th>Minimum Interval Between Doses</th>
<th>Dose 1 to dose 2</th>
<th>Dose 2 to dose 3</th>
<th>Dose 3 to dose 4</th>
<th>Dose 4 to dose 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tetanus, diphtheria, tetanus, diphtheria, pertussis&lt;sup&gt;5&lt;/sup&gt;</td>
<td>7 years&lt;sup&gt;4&lt;/sup&gt;</td>
<td>4 weeks</td>
<td>4 weeks&lt;sup&gt;a&lt;/sup&gt;</td>
<td>4 weeks&lt;sup&gt;a&lt;/sup&gt;</td>
<td>4 weeks&lt;sup&gt;a&lt;/sup&gt;</td>
<td>6 months</td>
</tr>
<tr>
<td>Human papillomavirus&lt;sup&gt;14&lt;/sup&gt;</td>
<td>9 years</td>
<td>Routine dosing intervals are recommended&lt;sup&gt;d&lt;/sup&gt;</td>
<td>4 weeks&lt;sup&gt;a&lt;/sup&gt;</td>
<td>4 weeks&lt;sup&gt;a&lt;/sup&gt;</td>
<td>4 weeks&lt;sup&gt;a&lt;/sup&gt;</td>
<td>6 months</td>
</tr>
<tr>
<td>Hepatitis A&lt;sup&gt;11&lt;/sup&gt;</td>
<td>12 months</td>
<td>6 months</td>
<td>6 months</td>
<td>6 months</td>
<td>6 months</td>
<td>6 months</td>
</tr>
<tr>
<td>Hepatitis B&lt;sup&gt;1&lt;/sup&gt;</td>
<td>Birth</td>
<td>4 weeks</td>
<td>8 weeks (and at least 16 weeks after first dose)</td>
<td>6 months</td>
<td>6 months</td>
<td>6 months</td>
</tr>
<tr>
<td>Inactivated poliovirus&lt;sup&gt;4&lt;/sup&gt;</td>
<td>6 weeks</td>
<td>4 weeks</td>
<td>4 weeks&lt;sup&gt;a&lt;/sup&gt;</td>
<td>4 weeks&lt;sup&gt;a&lt;/sup&gt;</td>
<td>6 months&lt;sup&gt;c&lt;/sup&gt;</td>
<td>6 months&lt;sup&gt;c&lt;/sup&gt;</td>
</tr>
<tr>
<td>Meningococcal&lt;sup&gt;13&lt;/sup&gt;</td>
<td>6 weeks</td>
<td>8 weeks&lt;sup&gt;a&lt;/sup&gt;</td>
<td>8 weeks&lt;sup&gt;a&lt;/sup&gt;</td>
<td>8 weeks&lt;sup&gt;a&lt;/sup&gt;</td>
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<td>8 weeks&lt;sup&gt;a&lt;/sup&gt;</td>
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<tr>
<td>Measles, mumps, rubella&lt;sup&gt;4&lt;/sup&gt;</td>
<td>12 months</td>
<td>4 weeks</td>
<td>4 weeks&lt;sup&gt;a&lt;/sup&gt;</td>
<td>4 weeks&lt;sup&gt;a&lt;/sup&gt;</td>
<td>4 weeks&lt;sup&gt;a&lt;/sup&gt;</td>
<td>6 months&lt;sup&gt;c&lt;/sup&gt;</td>
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<tr>
<td>Varicella&lt;sup&gt;7&lt;/sup&gt;</td>
<td>12 months</td>
<td>3 months</td>
<td>3 months</td>
<td>3 months</td>
<td>3 months</td>
<td>3 months</td>
</tr>
</tbody>
</table>

**NOTE:** The above recommendations must be read along with the footnotes of this schedule.

### Footnotes — Recommended immunization schedule for persons aged 0 through 18 years—United States, 2013

For further guidance on the use of the vaccines mentioned below, see: [http://www.cdc.gov/vaccines/pubs/acip-list.htm](http://www.cdc.gov/vaccines/pubs/acip-list.htm)

1. Hepatitis B (HepB) vaccine. (Minimum age: birth)

**Routine vaccination:**

At birth:
- Administer monovalent HepB vaccine to all newborns before hospital discharge.
- For infants born to hepatitis B surface antigen (HBsAg)-positive mothers, administer HepB vaccine and 0.5 mL of hepatitis B immune globulin (HBIg) within 12 hours of birth. These infants should be tested for HBsAg and antibody to HBsAg (anti-HBs) 1 to 2 months after completion of the HepB series, at age 9 through 18 months (preferably at the next well-child visit).
- If mother’s HBsAg status is unknown, within 12 hours of birth administer HepB vaccine to all infants regardless of birth weight. For infants weighing ≥2,000 grams, administer HBIG in addition to HepB within 12 hours of birth. Determine mother’s HBsAg status as soon as possible and, if she is HBsAg positive, also administer HBIG for infants weighing ≥2,000 grams (no later than at age 1 week).

**Doses following the birth dose**

- The second dose should be administered at age 1 or 2 months. Monovalent HepB vaccine should be used for doses administered before age 6 weeks.
- Infants who did not receive a birth dose should receive 3 doses of a HepB-containing vaccine on a schedule of 0, 1 to 2 months, and 6 months starting as soon as feasible. See Figure 2.
- The minimum interval between dose 1 and dose 2 is 4 weeks and between dose 2 and 3 is 8 weeks. The final (third or fourth) dose in the HepB vaccine series should be administered no earlier than age 24 weeks, and at least 16 weeks after the first dose.
- Administration of a total of 4 doses of HepB vaccine is recommended when a combination vaccine containing HepB is administered after the birth dose.

**Catch-up vaccination:**

- Unvaccinated persons should complete a 3-dose series.
- A 2-dose series (doses separated by at least 4 months) of adult formulation Recombivax HB is licensed for use in children aged 11 through 15 years.
- For other catch-up issues, see Figure 2.

2. Rotavirus (RV) vaccines. (Minimum age: 6 weeks for both RV-1 (Rotarix) and RV-5 (RotaTeq). Routine vaccination:

- Administer a series of RV vaccine to all infants as follows:
  1. If RV-1 is used, administer a 2-dose series at 2 and 4 months of age.
  2. If RV-5 is used, administer a 3-dose series at ages 2, 4, and 6 months.
- If any dose in series was RV-5 or vaccine product is unknown for any dose in the series, a total of 3 doses of RV vaccine should be administered.

**Catch-up vaccination:**

- The maximum age for the first dose in the series is 14 weeks, 0 days.
- Vaccination should not be initiated for infants aged 15 weeks 0 days or older.
- The maximum age for the final dose in the series is 8 months, 0 days.
- If RV-1 (Rotarix) is administered for the first and second doses, a third dose is not indicated.
- For other catch-up issues, see Figure 2.

3. Diphtheria and tetanus toxoids and acellular pertussis (DTaP) vaccine. (Minimum age: 6 weeks)

**Routine vaccination:**

- Administer a 5-dose series of DTaP vaccine at ages 2, 4, 6, 15–18 months, and 4 through 6 years. The fourth dose may be administered as early as age 12 months, provided at least 6 months have elapsed since the third dose.

**Catch-up vaccination:**

- The fifth (booster) dose of DTaP vaccine is not necessary if the fourth dose was administered at age 4 years or older.
- For other catch-up issues, see Figure 2.

4. Tetanus and diphtheria toxoids and acellular pertussis (Tdap) vaccine. (Minimum age: 10 years for Boostrix, 11 years for Adacel.)

**Routine vaccination:**

- Administer 1 dose of Tdap vaccine to all adolescents aged 11 through 12 years.
- Tdap can be administered regardless of the interval since the last tetanus and diphtheria toxoid-containing vaccine.
Additional information:
- For additional information and precautions to use of the vaccines mentioned below, see: http://www.cdc.gov/vaccines/pubs/acip-list.htm.
- For the purposes of calculating intervals between doses, 4 weeks = 28 days. Intervals of 4 months or greater are determined by calendar months.
- Information on travel vaccine requirements and recommendations is available at: http://www.cdc.gov/travel/page/nations.htm.
# Recommended Adult Immunization Schedule—United States - 2013

Note: These recommendations must be read with the footnotes that follow containing number of doses, intervals between doses, and other important information.

### VACCINE → AGE GROUP →

<table>
<thead>
<tr>
<th>VACCINE</th>
<th>AGE GROUP</th>
<th>19-21 years</th>
<th>22-26 years</th>
<th>27-49 years</th>
<th>50-59 years</th>
<th>60-64 years</th>
<th>≥ 65 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influenza</td>
<td>1 or 2</td>
<td>1 dose annually</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella</td>
<td>1 or 2</td>
<td>2 doses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles, mumps, rubella (MMR)</td>
<td>1 or more doses</td>
<td>1 dose</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumococcal polysaccharide (PPSV23)</td>
<td>1 dose</td>
<td>1 dose</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meningococcal conjugate (PCV13)</td>
<td>1 dose</td>
<td>1 dose</td>
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<tr>
<td>Hepatitis A</td>
<td>1 or 2</td>
<td>3 doses</td>
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<tr>
<td>Hepatitis B</td>
<td>1 or 2</td>
<td>3 doses</td>
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</tbody>
</table>

*Covered by the Vaccine Injury Compensation Program

For all persons in this category who meet the age requirements and who lack documentation of vaccination or have no evidence of previous infection:

- Zoster vaccine recommended regardless of prior episode of zoster
- Recommended if some other risk factor is present (e.g., on the basis of medical, occupational, lifestyle, or other indications)
- No recommendation

Additional information about the vaccines in this schedule, extent of available data, and contraindications for vaccination is also available at www.cdc.gov/vaccines or from the CDC-INFO Contact Center at 800-CDC-INFO (800-232-4636) in English and Spanish, 8:00 a.m. - 8:00 p.m. Eastern Time, Monday-Friday, excluding holidays.

Use of trade names and commercial sources is for identification only and does not imply endorsement by the U.S. Department of Health and Human Services.

The recommendations in this schedule were approved by the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP), the American Academy of Family Physicians (AAFP), the American College of Physicians (ACP), American Academy of Ophthalmology (AAO), American College of Obstetricians and Gynecologists (ACOG) and American College of Nurse-Midwives (ACNM).

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### VACCINE ▶ INDICATION ▶

<table>
<thead>
<tr>
<th>VACCINE</th>
<th>INDICATION</th>
<th>Pregnancy</th>
<th>Immunocompromising conditions (excluding human immunodeficiency virus [HIV] infection)</th>
<th>HIV infection</th>
<th>CD4+ T lymphocyte count</th>
<th>Men who have sex with men (MSM)</th>
<th>Heart disease, chronic lung disease, chronic alcoholism</th>
<th>Apnea (including sleep apnea in pediatric patients and persistent complement deficiencies)</th>
<th>Chronic liver disease</th>
<th>Kidney failure, end-stage renal disease, receipt of hemodialysis</th>
<th>Diabetes</th>
<th>Healthcare personnel</th>
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<tr>
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<td>1 dose IIV annually</td>
<td>1 dose</td>
<td>1 dose IIV annually</td>
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<tr>
<td>Tetanus, diphtheria, pertussis (Td/Tdap)</td>
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<td>Contraindicated</td>
<td>1 dose</td>
<td>1 dose</td>
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<td>Varicella</td>
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<td>Human papillomavirus (HPV) Male</td>
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</tbody>
</table>

*Covered by the Vaccine Injury Compensation Program

For all persons in this category who meet the age requirements and who lack documentation of vaccination or have no evidence of previous infection:

- Zoster vaccine recommended regardless of prior episode of zoster
- Recommended if some other risk factor is present (e.g., on the basis of medical, occupational, lifestyle, or other indications)
- No recommendation

These schedules indicate the recommended age groups and medical indications for which administration of currently licensed vaccines is commonly indicated for adults ages 19 years and older, as of January 1, 2013. For all vaccines being recommended on the Adult Immunization Schedule: a vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Licensed combination vaccines may be used whenever any components of the combination are indicated and when the vaccine's other components are not contraindicated. For detailed recommendations on all vaccines, including those used primarily for travelers or that are issued during the year, consult the manufacturers’ package inserts and the complete statements from the Advisory Committee on Immunization Practices (www.cdc.gov/vaccines/pubs/acip-list.htm). Use of trade names and commercial sources is for identification only and does not imply endorsement by the U.S. Department of Health and Human Services.
2. Influenza vaccination
- Annual vaccination against influenza is recommended for all persons aged 6 months and older.
- Persons aged 6 months and older, including pregnant women, can receive the inactivated influenza vaccine (IIV).
- Healthy, nonpregnant persons aged 2–49 years without high-risk medical conditions can receive either intranasally administered live, attenuated influenza vaccine (LAIV) or the standard dose IIV.
- Persons who are at increased risk for complications of influenza should receive IIV, unless contraindicated.

3. Tetanus, diphtheria, and acellular pertussis (Tdap) vaccination
- Administer one dose of Tdap to pregnant women during each pregnancy (preferred during 27–36 weeks gestation), regardless of number of prior doses at or after 18 years of age.
- Administer Tdap to all other adults who have not previously received Tdap for whom vaccine is available.
- Tdap can be administered regardless of whether the person received Tdap previously.
- Adults with an unknown or incomplete history of completing a 3-dose primary vaccination series with 10- or 13-valent containing vaccines should begin or complete a primary series vaccination including a Tdap dose.
- The second dose should be administered 6–12 months after the first dose.

4. Varicella vaccination
- For persons with a previous episode of varicella or zoster (as defined below) should receive 2 doses of single-antigen varicella vaccine or a varicella-zoster immune globulin.
- For persons who were younger than 19 years of age at the time of an varicella vaccine or zoster immune globulin recommendation and are at least 18 years of age and 5 years past the date of their most recent varicella disease or vaccination, a single dose of zoster vaccine is recommended.

5. Human papillomavirus (HPV) vaccination
- Two vaccines are licensed for use in females, bivalent HPV vaccine (HPV2) and quadrivalent HPV vaccine (HPV4), and one HPV vaccine is licensed for use in males (HPV2).
- For females, either HPV2 or HPV4 is recommended on a 3-dose series for routine vaccination at age 11 to 12 years, and for those aged 13 through 26 years, if not previously vaccinated.
- For males, HPV2 is recommended on a 2-dose series for routine vaccination at age 11 to 12 years and for those aged 13 through 21 years, if not previously vaccinated.
- HPV vaccination is recommended for men who have sex with men (MSM) through age 26 years for those who did not get any or all doses when they were younger.
- HPV vaccination is recommended for immunocompromised persons (including those with HIV infection) through age 26 years for those who did not get any or all doses when they were younger.
- A routine series for HPV can be accelerated to 2 doses.

6. Zoster vaccination
- A single dose of zoster vaccine is recommended for adults aged 50 years and older regardless of whether they report a prior episode of herpes zoster. Although the vaccine is licensed by the Food and Drug Administration (FDA) for use among older adults, it can be administered to persons aged 50 years and older. ACIP recommends that vaccination begins at age 60 years.
- Persons aged 60 years and older with a history of herpes zoster or a medical condition that may be complicated by zoster should receive zoster vaccine.

7. Measles, mumps, rubella (MMR) vaccination
- Adults born before 1957 generally are considered immune to measles and mumps. All adults born in 1957 or older should have documentation of 1 or more doses of MMR vaccine unless they have a medical contraindication to the vaccine, or laboratory evidence of immunity to one of the three diseases.

8. Pneumococcal polysaccharide (PPSV23) vaccination
- Vaccinate all persons with the following indications:
  - Adults aged 65 years and older
  - Adults aged younger than 65 years with chronic lung diseases including chronic obstructive pulmonary disease, asthma, and emphysema
  - Chronic cardiovascular disease, diabetes mellitus, chronic renal failure, nephrotic syndrome, chronic liver disease (including cirrhosis), alcoholism, cirrhosis, intemperance, cerebrovascular disease, dyslipidemia, immunocompromising conditions, and functional or anatomic asplenia (e.g., sickle cell disease or splenectomy), and for persons with immunocompromising conditions.

9. Revaccination with PPSV23
- One time revaccination 5 years after the first dose is recommended for persons aged 19 through 64 years with chronic renal failure or nephrotic syndrome, functional or anatomic asplenia: (e.g., sickle cell disease or splenectomy), and for persons with immunocompromising conditions.

10. Pneumococcal conjugate 13-valent vaccination (PCV13)
- All adults aged 65 years and older with immunocompromising conditions (including chronic renal failure and nephrotic syndrome), functional or anatomic asplenia, CFS flares or cellular immune, and who have previously received 1 dose of PCV13 or PPSV23 should receive a single dose of PCV13 to begin a series.
- Adults aged 65 years and older with the aforementioned conditions who have previously received one or more doses of PCV13 should receive a dose of PCV13 one or more years after the last PCV13 was received. For those that require additional doses of PCV13, PCV13 should be given no sooner than 4 weeks after PCV13 and at least 5 years since the most recent dose of PCV13.
- When indicated, PCV13 should be administered to patients who are uncertain of their vaccination status and there is no record of previous vaccination.
- Adults aged 65 years and older should be revaccinated by the Food and Drug Administration (FDA) for use among and can be administered to persons aged 50 years and older, ACP recommends PCV13 for adults aged 19 years and older with the specific medical conditions noted above.

11. Meningococcal vaccination
- Administer 2 doses of meningococcal conjugate vaccine quadrivalent (MCV4) at least 6 months apart to adults with functional asplenia or persistent complement component deficiencies.
- Refer to the Advisory Committee on Immunization Practices (ACIP) statement for recommendations for administering Td/Tdap as prophylaxis in wood management (see footnote 3).

12. Hepatitis A vaccination
- Vaccinate any person experiencing protection from hepatitis A virus (HAV) infection and persons with any of the following:
  - Individuals who have sex with men and persons who use injection or noninjection illicit drugs.
  - Persons who have experienced sexual contact with an unvaccinated person who is an international adoptee.
  - Sexual partners of persons who are in a long-term, mutually monogamous relationship (e.g., persons with more than one sex partner in the previous 6 months or single men who are not in a long-term, mutually monogamous relationship who are at risk for exposure to HAV infection).
  - Persons who work in day-care centers, nonresidential day-care facilities for persons with developmental disabilities; and international travelers to countries with high or intermediate prevalence of hepatitis A, and
  - Persons who have close contact with persons at high risk for severe disease (e.g., health-care personnel who care for severely ill persons or patients with immunocompromising conditions) or who are at risk for exposure or transmission (e.g., teachers, child care employees, residents and staff members of institutional settings, including correctional institutions; college students; military personnel; and adults and children in households with children, nonpregnant women of childbearing age who are at risk for exposures or transmission).
14 CoventryCares of Virginia

The rules applicable to the CoventryCares of Virginia product are essentially the same rules applicable to the commercial products throughout this Manual. Areas where the rules or processes may be different for the CoventryCares program are listed below.

14.1 - Member Numbers and Identification Cards
CoventryCares member numbers are 10-digit numbers that begin with 005 and are assigned by the CoventryCares member enrollment system. The entire number must be used for billing and inquiries. Each family member receives a card listing their:

- Name
- ID number
- Medicaid number
- PCP name and telephone number
- Effective date
- Behavioral health telephone number
- Pharmacy Help Desk telephone number

Medicaid members have benefits for non-emergent transportation services and the contact number to request transportation services is also listed on the ID card. If the member is enrolled in the FAMIS program, this will be identified in the top right-hand side of the card. FAMIS members have a copayment indicated on their card. FAMIS members do not have benefits for non-emergent transportation services.

For behavioral health care and substance abuse treatment, the member may self-refer or be referred by their PCP. The telephone number for the vendor providing behavioral health and substance abuse services is listed on the member’s ID card.

14.2 - Management of After-Hours Access To Service
CoventryCares provides access to care 24 hours a day, seven days a week. This benefit helps ensure overall quality and continuity of care and prevents inappropriate and inefficient use of emergency room facilities for routine, non-emergent care.

The PCP is responsible for directing a member’s after-hours, holiday, and weekend care. The PCP may direct a patient to seek care at an emergency facility or urgent care center, or give recommendations, prescribe treatments or medications until the member can visit the PCP office.

A CoventryCares member will access care after normal working hours by contacting their PCP. Members and contracted providers are advised that the
PCP is to return a call for authorization of services or direct a member’s care within 30 minutes. In the event that the 30 minutes has elapsed, the facility or member can call CoventryCares for assistance. The CoventryCares 24-hour Nurse Line, staffed by registered nurses, is available to members 24 hours a day/7 days a week including holidays at 877.878.8940. The CoventryCares 24-hour Nurse Line will provide advice regarding services such as seeking emergency care, specific health care concerns, and other services needed after regular business hours.

Emergencies should be treated immediately. An emergency is defined as a sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson to result in:

1. Serious jeopardy to the mental or physical health of the member
2. Danger of serious impairment of the member’s bodily functions
3. Serious dysfunction of any of the member’s bodily organs, or
4. Serious jeopardy to the health of the fetus in the case of a pregnant woman

CoventryCares members are informed that the PCP and CoventryCares must be notified of any emergency care by the next business day to ensure payment. True emergency care does not require any advance notification to CoventryCares prior to the delivery of services.

In some cases, we may pay a participating provider a reduced fee for emergency services. When we pay a reduced fee, the member is not responsible for any of the emergency facility or provider charges.

Every provider participating in the CoventryCares network must understand the mutual responsibility which CoventryCares and the individual provider have for providing emergency services. Please note the following:

- Emergency department referrals must be authorized by the next business day to ensure appropriate payment.
- Members should be instructed to contact the PCP’s office for any follow-up care after an ER visit (e.g., suture removal, dressing change, etc.).

Our network includes urgent care centers that are an alternative to hospital emergency rooms. We encourage you to refer your patients to an urgent care center when appropriate. Check the provider search section of our website for a list of urgent care centers. You can also call Customer Service at 800.279.1878, Monday - Friday, 8:30 a.m. - 5:00 p.m. for a list.

14.3 - Copayment Collection
CoventryCares Medicaid members do not have copayments.

The FAMIS ID card has information regarding applicable copayments for office visits, prescriptions, outpatient and inpatient services. There are two levels of copayments for FAMIS members: therefore, it is important to reference the
member card for the correct copayment amount. Copayments for office visits should be collected by the physician’s office. All other copayments are to be collected by the appropriate provider. Also, providers can access copayment responsibility through the voice response system at 800.449.1944.

14.4 - Coinsurance and Deductibles
CoventryCares members do not have coinsurance or deductibles.

14.5 - Preauthorized Care
CoventryCares must preauthorize certain services, drugs, and supplies for its members. Please refer to Attachment B for a list of procedures.

Additional information concerning preauthorizations
The preauthorization list is updated by us from time to time. If you are not sure about a certain service or injectable or if you would like a copy of the most current listing, call CoventryCares Customer Service at 800.279.1878.

14.6 - Patient Self-Determination Act
All providers are required to comply with the Patient Self-Determination Act (COBRA ‘90, Sections 4206 and 4751) as described below:

- Maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider about patient rights under state law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.
- Provide written information to all adult individuals on patient policies concerning implementation of such rights.
- Document any moral or religious objections that would stop a member from making advance directives. Ensure this documentation is part of the member’s medical record.
- Document in the patient’s medical record whether or not the individual has executed an advance directive.
- Not condition the provision of care or otherwise discriminate against a patient based on whether or not he/she has executed an advance directive:
  - Ensure compliance with requirements of state law (whether statutory or recognized by the courts) concerning advance directives.
  - Provide (individually or with others) education for staff and the community on issues concerning advance directives.

An Advance Directive Form and additional information about advance directives are also available from the Virginia Hospital and Healthcare Association at www.vhha.com.

14.7 - Customer Service/Member Eligibility/Claims Status

CoventryCares Customer Service representatives can be reached at 800-279-1878.
We have a voice response system available to providers 24 hours a day, 7 days a week for providers who need to check member eligibility and the status of a claim. Providers may reach this information line by calling 800.449.1944. These services are also available on www.directprovider.com.

14.8 - Members’ Rights and Responsibilities
We are committed to treating members in a manner that respects their rights as members.

Member Rights
CoventryCares members have the right to:

- Be treated with respect and dignity
- Privacy and confidentiality
- Private health care visits and to have their health records kept confidential
- Tell us about any problems they have with our providers. We will look into the problem and address it
- Get details about CoventryCares services, benefits, and providers
- Get information about their rights and responsibilities
- Be a part of decisions the member and doctor make about their health care. The CoventryCares doctor is required to discuss treatment alternatives and all appropriate treatment options available to the member
- Enroll with other HMOs that contract with DMAS
- Choose and change their PCP
- Request and receive a copy of their medical records
- See and correct all personal information collected by us
- Tell the doctor that they do not want treatment
- Not be held or kept away from others as a way to force, punish or pay back just for our convenience
- Be able to exercise these rights without being treated badly by us or our providers
- Get information from us in a way that meets their needs based on their condition and/or in a way they can understand
- Make suggestions for what should be included as member rights and responsibilities
- Ask for a description of all types of payment arrangements that we use to pay providers for health care services for CoventryCares members. These payment arrangements may include withholds, bonus payments, capitation, and fee-for-service discounts. CoventryCares must respond to the member request in 10 working days
- Be told at least 14 days before there are any program or site changes that affect the member
Member Responsibilities
CoventryCares members have the responsibility for cooperating with providers of health care services:

- Carry their CoventryCares ID card at all times and show it to all health care providers
- Let providers know when their CoventryCares coverage ends
- Give information needed by health care providers so the providers can treat them
- Make and keep doctor visits and to call ahead to cancel when they cannot make it
- Get medical care from providers in the CoventryCares network.
  This does not apply to: (a) care for family planning, or (b) care for emergencies
- Follow instructions given by their doctor on how to stay healthy, get the needed immunizations for themselves and their children, and know what care they should get for any medical conditions they may have
- Call CoventryCares Customer Service at 800.279.1878; TDD 711 if they lose their ID card. To call CoventryCares Customer Service if they do not get their card in the mail
- Let CoventryCares Customer Service and their local Department of Social Services (DSS) know if they change their name, address or phone number or have a change in personal information like birth, marriage, death or other health insurance. This allows CoventryCares Customer Service to reach the member to send information
- Ask their doctor to get preauthorization for care when required
- Learn how to tell the difference between emergencies and when they need urgent care. Know where and how to get care for each
- Use the emergency room only for emergencies.
- Follow the advice of their PCP
- Learn about prescribed drugs. Know the reasons for taking them. Know how to take them
- Transfer their health records to their PCP
- Call CoventryCares Customer Service at 800.279.1878; TDD 711 or 800.828.1120 to change their PCP before they get care from a new PCP

14.9 - Medicaid Eligibles Excluded from Managed Care
Not all individuals in Medicaid are eligible for managed care. The following groups of individuals should be enrolled in Fee-For-Service Medicaid and should be covered by the Department of Medical Assistance Services (DMAS): Individuals who are inpatients in the Western State Hospital, Southwestern VA Mental Health Institution, Eastern State Hospital, HW Davis Medical Center, Southern Virginia Mental Health Institution, Western State HM&S, Northern Virginia Mental Health Institution, The Commonwealth Center for Children and Adolescents, Central State Hospital, Southwestern State HM&S, Catawba Hospital and Piedmont Geriatric Hospital. Individuals who are in pre-assignment to the CoventryCares product and who are in these facilities may request exclusion from managed care coverage. These requests must be made
through DMAS. Other individuals who are excluded include:

- Members approved by DMAS as inpatients in long-stay hospitals
- Individuals who are participating in foster care or subsidized adoption programs except children who are in foster care in regions DMAS has identified
- Individuals, other than students, who permanently live outside their area of residence for greater than 60 consecutive days, except those individuals placed there for medically necessary services funded by CoventryCares or another Medallion II plan. **This exclusion also applies to FAMIS members**
- Individuals who receive hospice services in accordance with DMAS criteria
- Individuals with other comprehensive group or individual health insurance coverage, including Medicare, insurance provided to military dependents, and any insurance purchased through the Health Insurance Premium Payment Program, except as set forth in CoventryCares’s contract with DMAS
- Newly eligible Medicaid enrollees who are in their third trimester of pregnancy and who request exclusion by the 15th of the month in which their enrollment becomes effective. Exclusion may only be granted if the enrollee’s obstetrical provider (physician or hospital) does not participate with any of the state contracted MCOs. Exclusions requests may be made by the enrollee, MCO or obstetrical provider
- Individuals who have been pre-assigned to CoventryCares, who have been diagnosed with a terminal condition, and who have a life expectancy of six months or less
- Individuals who are inpatient in hospitals, other than those listed in the first bullet above, at the scheduled time of enrollment or who are scheduled for inpatient hospital stay or surgery within 30 days of the enrollment effective date in CoventryCares
- Individuals under age 21 who are enrolled in DMAS authorized Residential Treatment Facility (RTF) programs
- Certain individuals between birth and age three certified by the Virginia Department of Behavioral Health and Developmental Services as eligible for services under the Individuals with Disabilities Education Act who are granted exception by DMAS
- Individuals who are participating in Plan First (family planning waiver)
- Individuals who are enrolled in DMAS home and community based waivers prior to enrollment into managed care or individuals who are enrolled at any time in the Technology Assisted Waiver
- Individuals who are eligible and enrolled in the Virginia Birth-Related Neurological Injury Compensation Fund, commonly known as the Birth Injury Fund
- Aliens/Refugees enrolled in Refugee Medicaid Assistance (RMA), only individuals enrolled with RMA coverage are excluded
14.10 - Loss of Eligibility for Medicaid or FAMIS

CoventryCares members may lose eligibility for Medicaid or FAMIS; therefore, it is important to verify eligibility every time a Medicaid member or FAMIS member sees you for care. The following events may indicate that a patient is no longer enrolled in CoventryCares:

- Cessation of Medicaid or FAMIS eligibility
- Individuals, other than students, who permanently live outside their area of residence for greater than 60 consecutive days, except those individuals placed there for medically necessary services by CoventryCares or other Medallion II plan
- Individuals who have other comprehensive group or individual health insurance coverage, including Medicare, insurance provided to military dependents, and any insurance purchased through the Health Insurance Premium Payment Program
- **For Medicaid members only**, inpatient admission, in accordance with DMAS guidelines, to a nursing facility or State mental hospital.
- **For Medicaid members only**, transfer to a Medicaid eligibility category not included in CoventryCares’s contract with DMAS.
- **For Medicaid members only**, voluntary selection of care through a DMAS-approved hospice program

14.11 - Communication Standards

We want to ensure that documents for its CoventryCares members, such as the member handbook, are comprehensive, yet written easily enough for everyone to understand. Before publication, all documents achieve a Flesch total readability score of 40 or better. We also contract with local agencies that will translate our documents into other languages. Coventry Health Care of Virginia, Inc. contracts with Language Line Translation Services for members with limited English proficiency. If our CoventryCares members with limited English proficiency contact us about their coverage benefits, we will conference call Language Line to translate for these members. For individuals with hearing impairment, CoventryCares uses TTY/TDD 711. Members may also reach us through Virginia Relay at TDD: 800.828.1120 or Voice: 800.828.1140.

As a provider of services, you should be aware of members who do not speak English or who have hearing impairments. Under Title VI of the Civil Rights Act and the Federal Rehabilitation Act, interpreter services must be available to ensure effective communication regarding treatment, medical history, or health education. We will arrange and pay for trained professionals when technical, medical, or treatment information needs to be discussed with the CoventryCares member.

**Providers must offer the member access to interpreter services, even when the member brings a friend or family member to interpret.**

In this event, the member must still be offered interpreter services and be informed that the services are offered at no charge; the friend or family member should not be used to interpret unless specifically requested by the member,
after having been advised of the availability of free interpreter services through CoventryCares. Please call CoventryCares Customer Service at 800.279.1878 to request either language or signing interpreter services for CoventryCares members. If interpreter services are declined, document this in the members’ medical record. This documentation could be important if a member decides that the interpreter they have chosen has not provided them with full knowledge regarding their medical history, treatment or health education.

During the credentialing process for CoventryCares, we ask you what other languages you speak so that we may refer our members with special language needs to you. If you have not updated us on your language capabilities, please contact your Provider Relations Representative at 804.747.3700 or 800.424.0077, if outside of the Richmond area.

14.12 - Special Needs Populations

CoventryCares considers the following categories of members to be special needs populations:

- Children with special physical and mental health care needs
- Individuals with a physical disability
- Individuals with delays in development or a developmental disability
- Individuals who are homeless
- Individuals with HIV/AIDS

CoventryCares members with a disabling condition or chronic illness may have a specialist as a PCP. If you have a member that would benefit from a specialist acting as a PCP or if you are a specialist that is willing to be a PCP for a member, please contact CoventryCares Customer Service 800.449.1944 to make the request.

14.13 - Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

Early and periodic screening, diagnosis and treatment is a federally mandated comprehensive child health program for Medicaid members. We provide or arrange for EPSDT services for CoventryCares Medicaid members under the age of 21. We notify CoventryCares members about EPSDT through the member handbook, the member newsletter, and various mailings.

Network providers shall be subject to CoventryCares’s documentation requirements for EPSDT services. EPSDT services shall also be subject to the following additional documentation requirements:

- The medical record shall indicate which age-appropriate screening was provided in accordance with the periodicity schedule.
- Documentation of a comprehensive screening shall, at a minimum, contain a description of the components described herein. CoventryCares recommends that you send reminders to parents when screenings, immunizations, etc. are due. CoventryCares will provide
transportation services for CoventryCares Medicaid members who need assistance to and from their medical appointments.

**EPSDT Screenings**
Providers should use the following guidelines to provide comprehensive EPSDT services to CoventryCares members.

1. Comprehensive, periodic health assessments or screenings, from birth through age 20 for Medicaid and birth through age 18 for children with FAMIS coverage, at intervals which meet reasonable standards of practice, as specified in the EPSDT medical periodicity schedule established by DMAS. The medical screening shall include:
   - A comprehensive health and developmental history, including assessments of both physical and mental health development
   - A comprehensive unclothed physical examination, including vision and hearing screening; dental inspection; and a nutritional assessment

2. Appropriate immunizations according to age, health history and the schedule established by the Advisory Committee on Immunization Practice (ACIP) for pediatric vaccines. Immunizations shall be reviewed at each screening examination, and necessary immunizations must be administered.

3. Appropriate laboratory tests at participating lab facilities. The following recommended sequence of screening laboratory examinations should be provided by CoventryCares's participating providers; additional laboratory tests may be appropriate and medically indicated (e.g., ova and parasites) and shall be obtained as necessary.
   - Hemoglobin/hematocrit.
   - Urinalysis.
   - Tuberculin test (for high-risk groups).
   - Blood lead assessment using blood level determinations as part of scheduled periodic health screenings appropriate to age and risk must be done for children according to the following schedule:
     - At age 12 months and at age 24 months of age
     - Between the ages of two to six years if the child has not previously been screened for lead poisoning

All screenings shall be done through a blood lead level determination. Results of lead screenings, both positive and negative results, shall be reported to the local Department of Health.

4. Health education/anticipatory guidance

5. Referral for further diagnosis and treatment or follow-up of all correctable abnormalities uncovered or suspected

6. EPSDT screening services shall reflect the age of the child and shall be provided periodically according to the following schedule:
   - Neonatal exam
• Under 6 weeks
• 2 months
• 4 months
• 6 months
• 9 months
• 12 months
• 15 months
• 18 months
• 24 months
• Annually from ages 3 through 21 years

EPSDT Vision Services
Participating providers should perform periodic vision assessments appropriate to age, health history and risk, which include assessments by observation (subjective) and/or standardized tests (objective), provided at a minimum according to DMAS’ EPSDT periodicity schedule. At a minimum, these services shall include diagnosis of and treatment for defects in vision, including eyeglasses. Vision screening in an infant shall mean, at a minimum, eye examination and observation of responses to visual stimuli. In an older child, screening for visual acuity shall be done.

EPSDT Hearing Services
All newborn infants will be given a hearing screening before discharge from the hospital after birth. Those children who do not pass the newborn hearing screening, those who are missed, and those who are at risk for potential hearing loss should be scheduled for evaluation by a licensed audiologist.

Participating providers should perform periodic auditory assessments appropriate to age, health history and risk, which include assessments by observation (subjective) and/or standardized tests (objective), provided at a minimum at intervals recommended in DMAS’ EPSDT periodicity schedule. At a minimum, these services shall include diagnosis of and treatment for defects in hearing, including hearing aids.

Hearing screening shall mean, at a minimum, observation of an infant’s response to auditory stimuli. Speech and hearing assessment shall be part of each preventive visit for an older child.

EPSDT Dental Services
Dental screening in this context shall mean, at a minimum, observation of tooth eruption, occlusion pattern, presence of caries, or oral infection. A referral to a dentist at or after one year of age is recommended. A referral to a dentist shall be mandatory at three years of age and annually thereafter through age 20 for Medicaid members and through the age of 18 for children with FAMIS coverage.

Other EPSDT Services
Participating providers should perform such other medically necessary health care, diagnostic services, treatment, and other measures as needed to correct or
ameliorate defects and physical and mental illnesses and conditions discovered by the screening services.

14.14 - Transportation
Our CoventryCares product covers emergency and nonemergent transportation for Medicaid members. FAMIS members are ONLY eligible for emergency transportation. Nonemergent transportation is provided for Medicaid members to ensure that members have necessary access to and from providers of medical services. For Medicaid members, transportation is available for all covered services whether the service is reimbursed by CoventryCares or fee-for-service Medicaid through DMAS. Transportation includes: public transportation, taxicab, ambulance, and a wheelchair van. CoventryCares covers air travel for critical medical needs.

CoventryCares has a contracted vendor to provide non-emergency transportation to Medicaid members. Members must call at least three days prior to a scheduled appointment to arrange transportation. The number to call is 800.734.0430.

CoventryCares has adopted DMAS guidelines to determine transportation needs for CoventryCares Medicaid members.

**Guidelines to determine transportation necessity:**
- Transportation is covered only when no other means of transportation is available to the member. This includes the member not having a car that runs.
- Transportation is covered to the nearest available source of care capable of providing for the member’s medical needs. For transportation purposes, the nearest provider of care is defined as:
  - One who normally serves the community where the member resides. In most cases, the transportation should be within the city or county where the member resides unless transportation to another city or county would be less costly, or
  - The closest provider of specialized care required by the member’s medical needs, or
  - The provider of services with whom the member has maintained a long-term relationship. Transportation to the physician’s or other medical provider’s office is covered when it is within a reasonable distance from the member’s home.

14.15 - Maternity
Each expectant mother is mailed information during her pregnancy that includes a pregnancy health guide and postpartum information on depression and infant development. CoventryCares requests physician notification of a member’s pregnancy to assist us in providing appropriate information and any necessary case management services. Benefits for inpatient care and a home visit(s) are determined in accordance with the criteria outlined in the most
current version of ACOG standards. The length of stay for a vaginal delivery is two nights. The length of stay for a cesarean section delivery is four nights. For mothers or babies whose medical condition warrants additional days, preauthorization is required by CoventryCares. Shorter stays shall occur where member and physician agree.

**Newborn Enrollment**

Newborn children of eligible members (including Medicaid, FAMIS and FAMIS MOMS) will be automatically enrolled with the mother’s health plan, unless mothers choose a different health plan for their child. Newborns will be enrolled in the plan for the birth month, plus two months. To maintain Medicaid eligibility, newborns must have their own Medicaid numbers before the end of the birth month plus two month time frame. **FAMIS MOMS and members with FAMIS insurance should call Cover Virginia toll-free at 1.855.242.8282.**

**14.16 - Abortions**

CoventryCares does not cover induced abortions for CoventryCares Medicaid or FAMIS members. If a CoventryCares member requests an abortion, please have her contact DMAS. DMAS will cover induced abortions that comply with federal Medicaid rules. DMAS will be responsible for payment of these services under the fee-for-service program even though the member remains enrolled with CoventryCares.

**14.17 - BabyCare Program**

CoventryCares covers the BabyCare codes using the same service limitations as DMAS in place of service 11 and 12 without preauthorization. The fees for services are tied to the provider’s fee schedule. We also accept the DMAS forms already in use for the requested services.

Code S5131 requires an authorization for all places of service.

**14.18 - Hysterectomy Procedures**

All hysterectomies require preauthorization. Federal regulations require that members be informed before the operation that a hysterectomy will leave them sterile. As a result, all patients scheduled for a hysterectomy must sign the Acknowledgment of Receipt of Hysterectomy Information form. A copy of this form is included as Attachment G or can be obtained through DMAS or through your Provider Relations Representative. The Hysterectomy Acknowledgment Form must be submitted with claims relating to hysterectomies to ensure reimbursement. In the event of an emergency surgery in which the required forms were not signed, a physician’s statement that prior acknowledgment was not possible is required for claims reimbursement.

**14.19 - Sterilization Procedures**

We follow state and federal regulations regarding sterilization procedures. All claims submitted for sterilization procedures must have a completed “Consent to Sterilization” form to ensure reimbursement. This form is included as
Attachment H, or it may be obtained through DMAS or through your Provider Relations Representative. The patient must be at least 21 years of age, mentally competent and must wait a minimum of 30 days after signing the consent form but no longer than 180 days. This form is available in English and Spanish.

14.20 - Routine Childhood Immunizations
Childhood immunizations are reimbursed differently for Medicaid members and the FAMIS program. Medicaid enrollees aged 0 through 18 are eligible for vaccines through the Virginia Vaccines for Children Program (VFC) that is administered by the Virginia Department of Health (VDH). Primary care physicians who administer childhood immunizations for Medicaid members must enroll in the Virginia Vaccines for Children Program. For more information, call (800) 568-1929 or visit the following link for an application: http://www.vdh.state.va.us/epidemiology/immunization/vfc/vfcForms.htm.

When a Medicaid member aged 0 through 18 needs immunizations, you may obtain these immunizations free from VDH. You should only bill CoventryCares for administering this drug. If you run out of VFC vaccinations, you may use your private stock for Medicaid members and ask the Department of Health to reimburse you. Enrollees in the FAMIS program and Medicaid members aged 19 and 20 are not eligible for VFC vaccines. For immunizations, you must use your own stock of vaccines. For reimbursement, you should bill us for the vaccine and for the administration of the vaccine.

14.21 - Electronic Claims
Providers are highly encouraged to file claims electronically. When submitting claims electronically, please use number 25133 as the Payor ID number.

The regulations promulgated pursuant to the Health Insurance Portability and Accountability Act (HIPAA) require that CoventryCares 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, CoventryCares encourages physicians and medical providers to submit claims electronically. Electronic claims submission can have significant, positive impact on the productivity and cash flow for your practice:

- EDI reduces the paperwork and costs associated with printing and mailing paper claims
- EDI reduces the time it normally takes for us 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
- 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 CoventryCares is easy to establish. Providers can submit directly to Emdeon. Electronic claim submissions will be routed through Emdeon who will review and validate the claims for HIPAA compliance and forward them directly to us. Contact your Provider Relations Representative to begin the process. You can also contact Emdeon directly and Emdeon can provide the electronic requirements and set-up instructions. Providers should call 800.215.4730 for information on direct submission to Emdeon or problems with EDI filing.

EDI claim submitters should review CoventryCares’s EDI Exclusion List and Electronic Claim Submission Requirements. CoventryCares uses the ANSI X12N837 v4010 and v4010A1 implementation guides that have been established as the standard claim transactions for HIPAA. The official implementation guides for claim transactions are available electronically from the Washington Publishing Company website: www.wpc-edi.com.

CoventryCares encourages and recommends regular review of all EDI Acknowledgement and Reject Reports returned to you.

For more information on electronic claims submission, please visit our website at www.chcva.com » Providers » Electronic Solutions.

**14.22 - Claims Filing Procedures**

Submit charges on an HCFA 1500 Health Insurance Claim form, UB92, or UB04 directly to the Claims Department.

- Use a separate claim form for each provider
- Use a separate claim form for each member
- Please submit one claim for all services provided in the same day
- Submit original form to CoventryCares; keep a copy for your files
- Submit a complete and correct claim form
- When applicable, write other insurance information on the claim form. When CoventryCares is secondary, please attach the primary carrier’s Explanation of Benefits (EOB) to the claim
- Include primary diagnosis and all pertinent secondary diagnosis information
- Include the complete CoventryCares provider number, National Provider Identifier (NPI), and provider tax identification number
- Include member’s name, CoventryCares number, Medicaid number, gender and date of birth
- Dates of service
- Type of service
- Charges and units
- Signature of treating provider
- Bill type
- Place of Service
- Procedure Code
- Billing Name, address, zip code, and phone number
- Discharge status
Please note any special circumstances, and/or include office notes with claims submitted for services that require special consideration.

**Remember to include:**
- Authorization Number for hospitalization, outpatient hospital services, and other services or procedures requiring authorization
- Authorization Number for services performed by out-of-network providers
- CPT Procedure Codes - unlisted codes must be accompanied by description of service, test, or procedure before payment will be considered
- ICD-9-CM Diagnosis Code, (four or more digits must be used when required by the guidelines set forth in the most recent ICD-9-CM coding book)
- Modifiers if appropriate
- The accuracy and completeness of claims is necessary to help ensure correct payment in a timely manner

**Initial Submission of Claims**
Claims for CoventryCares members should be sent to:

Coventry Health Care of Virginia, Inc.  
Attn: CoventryCares Claims Department  
P.O. Box 7702  
London, KY 40742

**14.23 - Adjustment Requests**
When filing an adjustment or a corrected claim, please use the address listed below. Adjustment requests must be received by Coventry Health Care within 365 days of the date of service of the claim.

Coventry Health Care of Virginia, Inc.  
Attn: CoventryCares Claims Department  
P.O. Box 7702  
London, KY 40742

**Information and Adjustments**
A Claim Inquiry/Adjustment Request Form should be used whenever resubmitting a claim. The form allows you to put in writing your inquiry about a claim. Attaching this form to resubmitted claims helps us process and/or review requests in a timely manner. Please contact the Provider Relations Department for Claim Inquiry/Adjustment Request Forms. For your convenience, a form is enclosed as *Attachment D* to be used for Adjustments.

**14.24 - Out-of-Pocket Maximums**
Copayments are applied to the member’s benefit year out-of-pocket maximum. The actual amount of the maximum varies among benefit plans. When a member meets their out-of-pocket maximum, they are responsible to present this information to DMAS.
14.25 - Noncovered Services

Any service or supply that is not medically needed or is not a covered service.

- Care from providers not in the CoventryCares network, except for family planning services or services received in an emergency
- Care received from any provider when the care was not preauthorized by CoventryCares as required in this manual
- Administrative services such as phone calls, filling out forms, copying and/or transfer of health records, returned checks, stop-payment on checks, and other such clerical charges
- School-based services. These are therapy, skilled nursing and psychiatric/psychological services outlined in the Individual Education Plan (IEP) and provided to children who qualify under the federal Individuals with Disabilities Act
- Services for, or related to, eye surgery for the purpose of fixing refractive errors, such as radial keratotomy and other refractive eye surgery
- Exams needed only for insurance, employment, school, sports or camp, unless these exams are part of a covered routine health assessment. Immunizations needed for travel and work unless these shots comply with accepted medical practices
- Spinal manipulation; osteopathic manipulation; biofeedback therapy; and acupuncture therapy. FAMIS members have chiropractic care coverage with a maximum benefit of $500 per year
- Care at an assisted living facility or nursing facility. Care for rest cures, respite, domiciliary, residential or convalescent care. Private duty nursing except as (1) covered under the home health care benefit; and (2) provided for children when medically needed. FAMIS members have a skilled nursing home benefit
- Fertility services, including but not limited to, in-vitro fertilization, embryo transplants and fertility drugs
- The reversal of sterilization and complications that result from such procedures
- Procedures, services and supplies related to sex transformations or sexual dysfunction
- The cost of care for problems that federal, state or local law require be treated in a public center. Care or supplies provided or arranged by a government center when no charge would be made if the member had no health benefits insurance. The cost of health care covered under the Medicare program or other insurance. Care for military service-connected disability and conditions that members are entitled to as long as these centers are reasonably easy for a member to access
- Health care or remedial care services by Christian Science nurses are not covered. Health care services at Christian Science Sanatoria long-term stay facilities are not covered
- Medical, surgical or health care supplies that are experimental or
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investigational are not covered. Care or supplies are experimental or investigational if they meet any of the following:

♦ They are in the testing stage or in early field trials on animals or humans

♦ They are under clinical investigation by health professionals or are undergoing clinical trial by any governmental agency, including but not limited to, the Department of Health and Human Services or the Food and Drug Administration (FDA)

♦ Any drug not approved for use by the FDA, any FDA-approved drug prescribed for an off-label use whose effectiveness is unproven based on clinical evidence reported in peer-reviewed medical literature, or any drug that is classified as an Investigational New Drug by the FDA. As used herein, off-label prescribing means prescribing prescription drugs for treatments other than those stated in the labeling approved by the FDA. Drugs for the treatment of a specific type of cancer that are not FDA approved will be covered when they are approved for one type of cancer for which the drug has been prescribed in any of the standard reference compendia. Similarly drugs for the treatment of a specific indication that are not FDA approved will be covered as long as the drug has been approved by the FDA for at least one indication and the drug is recognized for treatment of the covered indication in one of the Standard Reference Compendia or in substantially accepted peer-reviewed medical literature

♦ A health product or service that is subject to Investigational Review Board review or approval

♦ A health product or service that is the subject of a clinical trial that meets criteria for Phase I, II or III as sent forth by FDA regulations, except as specifically covered by defined criteria

♦ They do not have required final federal regulatory approval for commercial distribution for the specific indications and methods of use assessed or has not been approved by the Centers for Medicare and Medicaid Services for coverage by Medicare

♦ A health product or service whose effectiveness is unproven based on clinical evidence reported in peer-reviewed medical literature

• CoventryCares does not provide the Special Supplemental Nutrition Program for Women, Infants and Children (WIC). Coventry Health Care does not provide transportation for members to pick up WIC checks. The Department of Health provides the WIC Program. Expectant mothers will receive information on WIC in their
CoventryCares Baby Matters material. If members want to find out more about WIC, they should call their local health department, or call toll-free 888 WIC FOOD (888.942.3663)

- Care that is not medically necessary. CoventryCares may determine this in its sole discretion. A member's doctor has the right to request an appeal to a decision by sending a request to the Coventry Health Care's Utilization Management Department or sending a request directly to DMAS after the Coventry Health Care appeal process has been exhausted. This process is described in Section 10 of this manual

- Any type of health service, supply or treatment not (1) specifically listed or (2) covered by DMAS

- Some services are covered under Medicaid/FAMIS Plus but not through CoventryCares benefits. Call CoventryCares Customer Service at 800.279.1878 for information on these services. You may also call DMAS to obtain a list of these services

14.26 - Encounter Claims and Other Electronic Data Submission

We submit all claims-related information to DMAS on a monthly basis. CoventryCares must ensure that all electronic data submitted to DMAS are timely, accurate and complete. An encounter is any service received by the CoventryCares member and paid for by us. CoventryCares submits encounters/claims for all services it covers, including, but not limited to, inpatient and outpatient procedures, EPSDT screens, transportation, pharmacy, durable medical equipment (DME), and home health services.

Due to this requirement, CoventryCares requests that all providers follow our filing procedures listed above.

A process is available for reconsideration of claims denied for failure to file within the deadline. Information, including copies of claims and documentation of previous filing(s) supporting the request, should be sent to:

Coventry Health Care of Virginia, Inc.
Attn: CoventryCares Claims Department
P.O. Box 7702
London, KY 40742

In the event you are not satisfied with the outcome, you may initiate the Appeal/Hearing Guidelines procedure included in this manual.

14.27 - Status of Claims

You may call the Customer Service Department to check the status of claims. Customer Service Representatives are available to answer any claim inquiries Monday through Friday between 8:30 a.m. and 5:00 p.m. The number is 800.449.1944. This information is also available through the voice response system at the number listed above and through www.directprovider.com.
CoventryCares recommends that claims status inquiries not be made unless it has been at least 45 days since the date of submission.

### 14.28 - Coordination of Benefits
CoventryCares members should not have other primary or secondary health insurance. If a CoventryCares member has other health insurance, please contact CoventryCares Customer Service. Some members may have health coverage from insurance carriers that duplicates or overlaps with their CoventryCares coverage. This additional coverage may stem from a spouse’s health insurance, non-custodial parent controlled insurance, Workers’ Compensation, motor vehicle insurance, Medicare, or Veteran’s Administration benefits. If other carriers are noted, the PCP should contact CoventryCares Customer Service.

### 14.29 - Writing Prescriptions
The following guidelines apply to the prescription and supply of pharmaceutical items:

- Prescribe according to the Formulary
- Prescribe generic drugs only, unless unavailable
- Call the Pharmacy Call Center at 877-215-4100 to request approval for drugs that require preauthorization; drugs that require preauthorization are noted on the Formulary. You may also fax in a request to 877-554-9137
- CoventryCares does not cover needles or syringes (except for diabetic insulin injection)
- CoventryCares does not cover dietary items, such as sugar or salt substitutes

**Covered Services:**

- Medically needed prescribed drugs; mandatory generic drugs when available; brand name drugs, if medically needed and on CoventryCares’s prescription drug list
- Over-the-counter products covered according to DMAS guidelines when prescribed by a doctor
- Over-the-counter nicotine replacement products
- Injectable insulin, syringes, glucose test strips, lancets and glucose monitors
- Growth hormones and Clozaril, when preauthorized by CoventryCares
- Family planning drugs, such as oral and injectable contraceptive drugs, intrauterine devices (IUDs) and prescription barrier methods
- Prenatal vitamins; pediatric vitamins (in established deficiencies); and vitamins or minerals for dialysis patients
- Self-Administered Drugs on the prescription drug list. If a drug is not on the list an exception must be requested

**Limits:**

- Up to a 31-day supply will be filled per prescription or refill
- Some drugs have a quantity limit (QL)
- Some drugs must be prior authorized

**Not Covered:**
- Drugs that are not medically necessary
- Vitamins, other than those vitamins and minerals listed above
- Anorexiants, except when medically needed
- Drugs prescribed mainly for a cosmetic purpose. This includes Retin-A when used for any purpose other than treatment for severe acne and Minoxidil when used to treat baldness
- Experimental and investigational medications; drugs with no approved Food and Drug Administration (FDA) indications; drugs prescribed for purposes other than the FDA-approved use, unless a drug is recognized for treatment of the covered indication in one of the Standard Reference Compendia or other Peer-reviewed Medical Literature. Cancer drugs that are FDA approved for a certain cancer type may be used for treatment of other types of cancer, provided the drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the Standard Reference Compendia. Any drug approved by the FDA for use in the treatment of cancer pain shall not be denied for coverage on the basis that the dosage is in excess of the recommended dosage of the pain relieving agent, if the prescription in excess of the recommended dosage has been prescribed in compliance with Virginia law for a patient with a specific type of cancer. Drugs on the list requiring prior approval that do not meet the criteria for medical necessity
- Infertility medications
- Drugs not requiring a doctor’s prescription, except for certain over-the-counter drugs
- Drugs for the treatment of erectile dysfunction

If a member is identified as using services or controlled medications in an inappropriate manner, CoventryCares may restrict the member to one primary care physician (PCP) for prescriptions and one pharmacy for prescriptions. The member may also be restricted to one specialist for prescriptions of medications upon approval of CoventryCares. These restrictions shall not apply to emergency services. The provider and pharmacy will be notified and must agree to serve as the restricted provider/pharmacy.

**14.30 - Maternal/Child Case Management**

*Baby Matters* is a program dedicated to promoting healthier babies and protecting the well-being of the mother. As a member of CoventryCares, all expectant mothers are eligible to receive our pregnancy health guide. *Baby Matters*’ educational information follows an expectant mother through prenatal care, delivery, and postpartum care. At the member's first prenatal visit, the physician will complete and fax a Maternity Notification Form. The OB Case Manager will evaluate the risk factors on this form. Case Management and educational interventions will be provided to the member, as appropriate.
This care is designed to serve as a health benefit and is not a substitute for or intended to interfere with the mother’s current medical care.

Other Case Management Services
If you have any questions on the Disease Management Programs or Case Management, please contact us. The Case Managers practice in accordance with applicable laws regarding patient confidentiality and the release of information. Ethical principals guide their practice with respect for the autonomy, cultural diversity, dignity, privacy, and rights of the members.

14.31 - Boys & Girls Club
All children enrolled in the CoventryCares program between the ages of 6 and 18 are eligible for free membership in the Boys & Girls club in the Richmond/Tri-Cities region. For a list of locations, please call Customer Service at 800.279.1878.

14.32 - Early Intervention Services, Women Infants and Children, and Head Start
You may identify members who qualify for Early Intervention Services, Head Start or the Women, Infants, and Children's program.

Early Intervention Services (EIS)
The Infant and Toddler Connection office of the Virginia Department of Behavioral Health and Developmental Services administers the Early Intervention Services program. Early Intervention Services include services that are designated to meet the developmental needs of an infant or toddler with a disability in any one or more of the following areas: physical, cognitive, communication, social or emotional or adaptive development.

For more information, call your local Infant and Toddler Connection office, call the main Infant and Toddler Connection office at 1-804-371-6595, or visit www.infantva.org.

WIC Programs
Women, Infants and Children (WIC) is administered by the Virginia Department of Health. If you identify a woman who would benefit from WIC, please refer her to a local Health Department. We also have WIC information that is supplied to our members through the Baby Matters program. Members may contact CoventryCares Customer Service at 800.279.1878 if they would like information sent to them in the mail about WIC.

Head Start
Head Start services are located throughout CoventryCares's service area. This program has been designed for children between the ages of three and five whose families meet Federal poverty guidelines. Go to the Head Start website for a current list of locations. Click on the county name to find the multiple listings.
14.33 - Children with Special Health Care Needs

Family Voices is a national grassroots network of families and friends speaking on behalf of children with chronic conditions and disabilities. Family Voices is made up of more than 18,000 families and friends, a volunteer coordinator in each state, 10 regional coordinators and staff. To obtain literature about managed care and finding services for children with special needs, contact:

Family Voices National Office
3701 San Manteo Blvd. NE, Ste 200
Albuquerque, NM  87110
505.872.4774
Fax: 505.872.4780
Toll Free: 888.835.5669
www.familyvoices.org

If you access the website, you can find a local Virginia contact.

14.34 - Providers Excluded from Participation in Federal Health Care Programs

CoventryCares is prohibited from participating with or entering into any provider agreement with any individual or entity that has been excluded from participation in federal health care programs, including Medicare, Medicaid or the Children's Health Insurance Program.

The federal Health and Human Services – Office of Inspector General (HHS-OIG) has an online exclusions database available at http://exclusions.oig.hhs.gov/. It is a comprehensive listing of individuals and firms that are excluded from participation in federal health care programs. This database allows providers to screen their practice, managing employees, contractors, etc., to determine whether any has been excluded from participating in federal health care programs.

Providers are encouraged to check their information in the exclusions database on a monthly basis. Providers must immediately report to CoventryCares any exclusion information discovered.

14.35 - CoventryCares Members Assigned to a PCP

PCP panels may be opened or closed by the provider. Please contact your provider representative if you have any questions.
14.36 - Second Opinions

CoventryCares members may need a second opinion at times. If a CoventryCares member is your patient and needs a second opinion, try to locate a participating provider first. Customer Service can assist you in locating a participating provider. If a participating provider cannot be located, the member can get the second opinion from an out-of-network provider.

There is no more cost to members to obtain the second opinion out of network than if the service was obtained in-network.
15 Coventry Health Care, Inc.

Coventry Health Care is wholly owned by Aetna Inc. Aetna is publicly held and traded on the New York Stock Exchange (NYSE: AET). Aetna successfully completed its acquisition of Coventry Health Care in May 2013. Founded in 1853 in Hartford, Connecticut, Aetna is one of the nation's leading providers of health care, dental, pharmacy, group life, and disability insurance, and employee benefits.

Additional information:

<table>
<thead>
<tr>
<th>Business</th>
<th>Phone</th>
<th>URL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coventry Health Care National Network</td>
<td>1-800-937-6824</td>
<td><a href="http://www.coventrynational.com">www.coventrynational.com</a></td>
</tr>
<tr>
<td>First Health</td>
<td>1-800-937-6824</td>
<td><a href="http://www.firsthealth.com">www.firsthealth.com</a></td>
</tr>
<tr>
<td>Coventry Workers’ Comp Services</td>
<td>1-800-937-6824</td>
<td><a href="http://www.coventrywcs.com">www.coventrywcs.com</a></td>
</tr>
<tr>
<td>Coventry Auto Solutions</td>
<td>1-800-793-6074</td>
<td><a href="http://www.coventryautosolutions.com">www.coventryautosolutions.com</a></td>
</tr>
</tbody>
</table>
Attachments

To access the attachments, please select the corresponding document in the Attachments navigation panel to the left. If you have hidden the panel, you can re-open it by clicking on the paperclip icon.

Attachment A: Services Requiring Preauthorization (Commercial)
Attachment B: Services Requiring Preauthorization (Medicaid)
Attachment C: Maternity Notification and Screen Risk
Attachment D: Claim Inquiry/Adjustment Request Form
Attachment E: Provider Reimbursement - Fee Schedule
Attachment F: Advance Directives Information
Attachment G: Acknowledgment of Receipt of Hysterectomy Form
Attachment H: Consent to Sterilization (Also available in Spanish)
Attachment I: Provider Change in Information Notification
Attachment J: Case Management