Provider Administrative Handbook

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Service Operations: 888.806.3400

www.hchhealthplan.com

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Contents

WELCOME TO HEALTHCARE HIGHWAYS

Healthcare Highways is excited to have you participate in our provider network.

The provider network is Healthcare Highways' (HCH) proprietary network that is growing rapidly and will cover the states of Oklahoma and Texas. This Administrative Handbook provides the policies, processes and guidelines for providers participating in our network.

PARTICIPANT ACCESS TO THE HEALTHCARE HIGHWAYS NETWORK

Plan administration differs as outlined in this Administrative Handbook depending on how a Participant accesses the provider network. Healthcare Highways provider network access occurs two ways as indicated in the chart below. Sample ID cards can be found on page 5 and in Appendix A.

Participants access the Network 2 ways:	The Participant's ID Card identifies how the Participant accesses the network:	Responsible party for Plan Administration:	Refer to these pages of this Administrative Handbook for Information:
As a Healthcare Highways Health Plan Participant (HCP HP)	"Healthcare Highways Health Plan" (HCH HP) name and logo appear on the front of the ID card.	Healthcare Highways Health Plan (HCH HP)	pp. 6-12 applies to both ways the network is accessed; pp. 13-30 provides information specific to the HCH HP
Clients and Employers access the Network (but they did not purchase the HCH HP)	The Employer's, Client's or Administrator's name will be clearly identified on the front of the ID card.	Third Party Plan Administrators	pp. 6-12 applies to both ways the network is accessed; pp. 31-37 provides information specific to network access plans

NOTE: Applicable Laws, Regulations and Contractual Provisions: This Administrative Handbook outlines the general operational policies and procedures Providers should follow to ensure compliance with Healthcare Highways requirements for claim payment, UM, credentialing, quality program and claim/UM appeals. All applicable laws, regulations and Provider contract terms shall supersede those specific areas of this Administrative Handbook when what is contained in them conflicts with this document. All provisions of this document not in conflict with applicable laws, regulations and contractual provisions remain in effect for contracted providers.

IMPORTANT INFORMATION TO KNOW

The table below provides important information you need to know along with contact information when you need assistance:

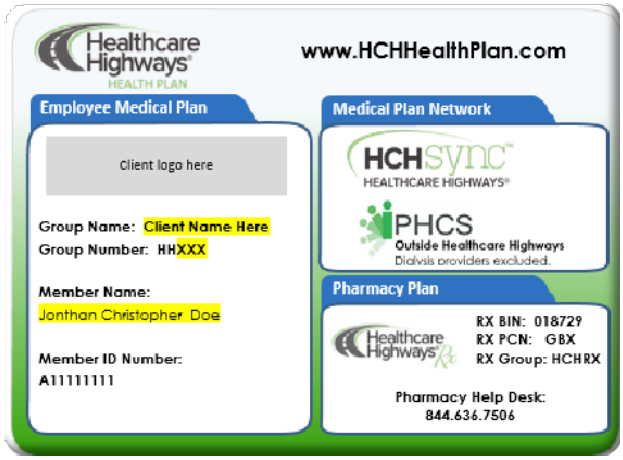
Information Source	Healthcare Highways Health Plan Participants	Network Access Plan Only Participants
Online Eligibility and Benefits	www.HCHHealthPlan.com Requires a brief initial registration process	Refer to the participant's ID card
List of In Network Providers	https://www.healthcarehighways.com/members/	Refer to the participant's ID card or in Texas visit: www.healthcarehighways.com/provider-search
Claims and Eligibility Inquiries	800.397.9524	Refer to the participant's ID card
Customer Service	888.806.3400	Refer to the participant's ID card
Medical Management and Precertification	866.353.8162 614.818.3236 (fax) Online Intake: HTTPS://HCHhealthplan.getprecert.com	Refer to the participant's ID card
Electronic Claim Filing Payor ID	HCH01	Refer to the participant's ID card
Claims Address	Healthcare Highways Health Plan PO Box 16817 Lubbock, TX 79490-6817	Refer to the participant's ID card
Provider Demographic Updates	www.hch.operations@healthcarehighways.com Fax: 214.390.2139 Healthcare Highways Health Plan Attn: Network Operations 6300 Fallwater Trail, Suite 120 The Colony, TX 75056	Same as Health Plan.
Pharmacy Information	Healthcare Highways RX will be the PBM for many accounts. The pharmacy benefit manager will be identified on the front of the ID card.	Refer to the participant's ID card

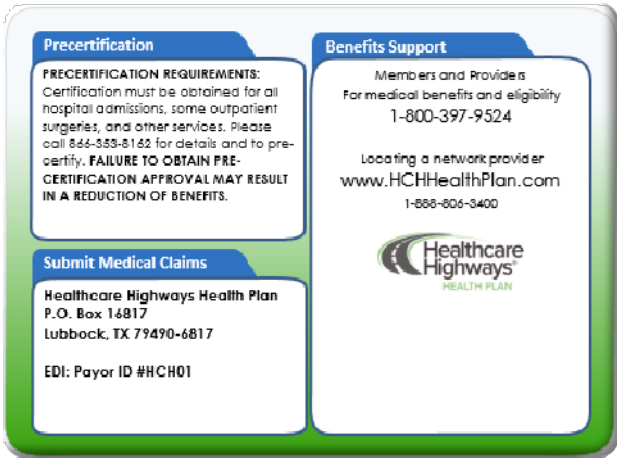
SAMPLE PARTICIPANT ID CARDS

(See all network versions in Appendix A)

HEALTHCARE HIGHWAY HEALTH PLAN

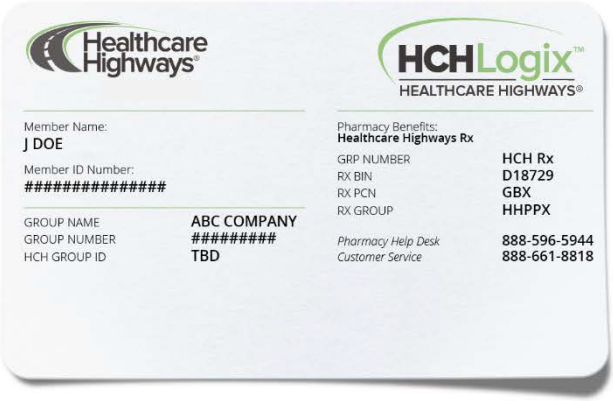
SAMPLE Healthcare Highways Health Plan ID card:





HEALTHCARE HIGHWAY NETWORK ACCESS ONLY

SAMPLE Healthcare Highways Network Access Only ID Card:



Section 1

Healthcare Highways Network

The policies, procedures and guidance in this section apply to covered services you provide to all Healthcare Highway Participants.

Proprietary Information

All information and materials provided to you by Healthcare Highways, Clients or Administrators remain proprietary to Healthcare Highways, Client or Administrators. This includes, but is not limited to, your Participating Provider Agreement and its terms, conditions, and negotiations, any Program, rate or fee information, Healthcare Highways Client or Administrator lists, any administrative handbook(s), and/or other operations manuals. You may not disclose any of such information or materials or use them except as may be permitted or required by the terms of your Healthcare Highways Participating Provider Agreement.

Verifying Eligibility and Benefits

It's important to check the Participant's eligibility and benefits prior to rendering services. This helps ensure that the claim is submitted correctly, allows you to collect copayments, coinsurance and deductible amounts, and secure pre-cert as required and reduces denials for non-covered services.

Please note that while coinsurance and deductible amounts may be accurate at the time benefits are provided, other provider claims could be processed prior to yours changing the coinsurance and/or deductible amounts a Participant owes. When Participants are due a refund, Providers should refund such amounts as soon as possible but no later than 15 days following receipt of an explanation of payment showing the correct Participant responsibility that should have been collected.

Access Standards

Primary Care Providers must arrange for 24-hour coverage of their patients, seven days per week. If you are unable to provide care and are arranging for a covering physician, we ask that you arrange for care from other providers who participate with the Healthcare Highways network, so that services may be covered under the Participant's network benefit. To find the most current directory of Healthcare Highways' Network of Providers, go to www.hchhealthplan.com/provider-search or www.healthcarehighways.com/providers.

HCH has established standards for appointment access and after-hours care to help ensure timely access to care for Participants.

Preventive Care	Four (4) Weeks
Regular/Routine Care	Two (2) Weeks
Urgent Care	Same Day
Emergency Care	See below
After-Hours Care	For PCPs, 24 hours, seven days per week

Preventive care is defined as medical care that seeks to prevent illnesses, for example, yearly mammograms or regular checkups.

Routine care is defined as the regular care you get from your primary care physician or specialty providers. Routine care can be checkups, physicals, health screenings and care for health problems like diabetes, hypertension and asthma.

Urgent care is defined as a health situation that is not an emergency but is severe or painful enough that medical treatment is required to prevent serious deterioration of the patient's condition or health.

Emergency care is defined as medical services required for the immediate diagnosis and treatment of health conditions which, if not immediately diagnosed and treated, could lead to serious physical or mental disability or death.

After-Hours Care is medical care provided after the regular practice schedule of physicians. Usually after-hours care is designed to deliver 24-hour-a-day and 365-day-a-year patient care coverage for emergencies, triage, pediatric care, or hospice care.

It is important that every Participant calling your office after-hours is provided emergency services or directions whether a line is answered by a live person or by a recording. Callers with an emergency are expected to be told to:

- Hang up and dial 911
- Go to the nearest emergency room

In non-emergent circumstances, we would prefer that you advise callers who are unable to wait until the next business day to:

- Go to a network urgent care center at www.healthcarehighways.com/provider-search or www.hchhealthplan.com/provider-search
- Stay on the line to be connected to the physician on call
- Contact their applicable telemedicine providers
- Leave a name and number with your answering service (if applicable) for a physician or qualified health care professional to call back within specified time frames
- Call an alternative phone or pager number to contact you or the physician on call

Provider Privileges

Providers who provide care to patients in a facility must have privileges at applicable participating facilities or arrangements with a participating practitioner to admit and provide facility services to Participants. This helps our Participants get access to appropriate care and to minimize their out-of-pocket costs, including, but is not limited to, full admitting hospital privileges, ambulatory surgery center privileges, and/or dialysis center privileges.

Referrals

Participants should be directed to Healthcare Highways participating providers when referring them for care. Our participating provider network can be found at www.healthcarehighways.com/provider- search or www.hchhealthplan.com/provider-search. Referring to participating providers minimizes a Participant's out-of-pocket costs.

Notification of Provider Changes

Healthcare Highways is committed to providing you and our Participants an excellent service experience with the most accurate and up-to-date information about the Healthcare Highways network including accurate phone numbers and addresses of our participating providers and facilities. It is important that Healthcare Highways receive proactive notification of any changes which should be updated in the Healthcare Highways database including the below examples:

- Office and/or billing address(es) and phone number(s)
- Provider email address
- A change in physician panel status: accepting new patients, current patients only or closed to all new patients
- Hospital affiliation(s)
- Provider's specialty
- The provider's license(s)
- Tax identification number (requires submission of W-9)

- NPI(s)
- Office hours
- Any changes to participating providers in the group

Providers failing to provide such information may cause claim payment delays and any applicable late claims payment penalties will not apply.

UPDATING YOUR INFORMATION WITH HEALTHCARE HIGHWAYS

Providers can update their information using any of the following options:

- Online using the "Provider Updates" form at www.hchhealthplan.com or http://www.healthcarehighways.com/providers, in the Providers section of the site.

Please complete the online form as needed. You can either attach additional pertinent documents *(such as your W9, or licensure)* to the online form before submission, or send them separately to HCH via email, secure fax, or mail.

When sending additional documents via email or secure fax, please note **"Provider Update"** in the subject line of your communication, and let us know that you have also sent information via our online website form, so we can ensure that we have received all information submitted.

- Email: hch.operations@healthcarehighways.com
- Work directly with your Provider Relations contact
- Call us at: 888.806.3400
- Secure Fax: 214.390.2139
- Mail: Attn: Network Operations, 6300 Fallwater Trail, Suite 120, The Colony, TX 75056 Please allow up to thirty (30) days for HCH to make the requested changes in our system.

PREVENTION OF FRAUD, WASTE AND ABUSE

If a Provider or Provider Organization identifies potential fraud, waste or abuse (FWA), they must report it to Healthcare Highways immediately. Healthcare Highways maintains a telephone and email FWA reporting system as a mechanism for Provider Organizations, providers, employees, Participants, and others to: hch.operations@healthcarehighways.com.

Report concerns and possible violations of law, regulations, policies, procedures; ask questions about the Compliance Program; and seek advice about how to handle compliance related situations at work.

The FWA Reporting System is anonymous. All calls are treated confidentially, and senders/callers can remain anonymous if they so choose. Callers may be asked whether they are willing to identify themselves so that an issue may be followed up with the caller after the call ends. Retaliation against anyone who raises a concern is prohibited.

If you have a compliance-related question, concern, or suspect a problem, please call the Healthcare Highways Fraud Line at 888.806.3400.

CHARGING PARTICIPANTS ADDITIONAL FEES

You may collect Participant financial responsibility for Covered Services. However, it is not appropriate to charge Participants fees beyond copayments, coinsurance, or deductibles as described in the Participant benefit plans. This includes fees for membership/concierge practices or other administrative fees. This does not prevent you from charging Participants nominal fees for missed appointments, medical record requests/transfers or completion of camp/school forms.

CHARGING PARTICIPANTS FOR NON-COVERED SERVICES

You may seek and collect payment from Participants for services not covered under the applicable benefit plan, provided you first obtain the Participant's written consent to render payment for the services that are not covered. The consent must be signed and dated by the Participant prior to rendering the specific service(s) in question. Retain a copy of this consent in the Participant's medical record. If you know, or have reason to suspect, the service may not be covered (as described below), the written consent also must include: (a) an estimate of the charges for that service; (b) a statement of reason for your belief the service may not be covered; and (c) planned services which are not covered services, a statement that HCH HP or plan administrator has determined the service is not covered and that the Participant, with knowledge of this determination, agrees to be responsible for those charges.

BALANCE BILLING

Providers may not balance bill Participants for additional payment of covered services beyond a Participant's cost share amounts (copayments, deductibles, or coinsurance) associated with their benefit plan.

NETWORK PARTICIPATION – CLAIM ADMINISTRATION

CLAIMS SUBJECT TO SUBROGATION AND COORDINATION OF BENEFITS

Healthcare Highways benefit plans are subject to subrogation and Coordination of Benefits (COB) rules.

SUBROGATION

To the extent permitted under applicable state and federal law and the applicable benefit plan, we reserve the right to recover benefits paid for a Participant's health care services when a third party causes the Participant's injury or illness.

COORDINATION OF BENEFITS (COB)

Coordination of Benefits is administered according to the Participant's benefit plan and in accordance with applicable law. We accept secondary claims electronically as well as paper claims. When filing for secondary payment submit the payment advice/EOB from the primary payor with your claim as the secondary. Medical necessity determinations of the primary payor will be accepted by Healthcare Highways as the secondary payor. When coordinating benefits with Medicare, if Medicare is the primary payor, we will process up to the Medicare allowed amount. CMS determines the rules for instances when Medicare processes claims as the primary or secondary payor.

BENEFIT MAXIMUMS

When a Participant's annual benefit maximum for a particular type of Covered Service has been met, you may not "balance bill" Participants for the difference in billed charges and the Contract Rates. However, unless otherwise stated in your provider agreement, you may bill the Participant for the Contracted Rate once the Participant has reached the Benefit Program Maximum.

A benefit maximum limits the Healthcare Highways cumulative responsibility for payment of a select set of services to some annual dollar amount or service encounters such as chiropractic or long term acute care. Benefit maximums apply annually when the patient remains a Participant under a Program. When a service, treatment or supply is not covered pursuant to the Program and/or does not qualify under any circumstance as a Covered Service for the Participant, Network Providers may bill the Participant at your billed charges for the "excluded" service.

NETWORK PARTICIPATION – QUALITY MANAGEMENT

QUALITY MANAGEMENT PROGRAM

The Quality Management (QM) program focuses on helping to ensure access to the delivery of health care services for all our members through the implementation of a comprehensive, integrated, systematic process that is based on quality improvement principles. The Program includes the following areas:

Measuring adherence to physician service standards in areas such as wait times for appointments, in- office care and practice size and availability. To measure this, we use compliance data, and random surveys of Provider office scheduling time frames.

Evaluating and resolving complaints originating from various sources including Participants, Clients and Administrators regarding the delivery of health care services and managing resolution through a standard process.

Monitoring performance of QM-related functions which includes activities such as oversight of medical policies and procedures, clinical coverage policies, medical record maintenance, encounter reporting, and regulatory compliance.

PROVIDER CREDENTIALING AND RECREDENTIALING

The Healthcare Highways network credentialing process is designed to provide initial and ongoing assessment of the provider's ability to deliver patient care and treatment within limits defined by licensure, liability coverage, certification and/or accreditation.

Healthcare Highways is responsible for the credentialing process unless you participate through a physician organization that has been delegated credentialing by Healthcare Highways. If credentialing is not delegated and required by Healthcare Highways, applicable providers will be contacted to initiate the credentialing process.

FACILITIES

Healthcare Highways credentials acute inpatient facilities, behavioral health facilities, skilled nursing facilities, ambulatory surgery centers and home health providers.

Healthcare Highways verifies:

- State license
- Accreditation
- Excluded Parties List System
- Office of the Inspector General
- National Provider Identifier

Following the verifications, the Medical Committee reviews facility applications for final approval.

PHYSICIANS / PROVIDERS

Physician credentialing uses CAQH applications and attestations. All physicians that meet requirements are referred to the Credentialing and Peer Review Committee for final approval.

Following are the Healthcare Highways credentialing criteria:

- Verification of unrestricted state medical license with appropriate licensing agency
- Verification of valid, unrestricted DEA certificate and CDS certificate, if required by the state
- Verification of clinical privileges in good standing on the medical staff at a participating hospital
- Board certification status with the American Board of Medical Specialties or the American Osteopathic Association
- Verification of education and training
- Review of work history (not needed for recredentialing)
- Verification of prior sanctioning activities by regulatory bodies and by CMS
- Review of malpractice claims history
- Verification of adequate malpractice insurance
- Proof of appropriate professional licensing (only for practitioners whose professions do not require medical licensure)

Recredentialing of providers occurs every three years. Information from Quality Management (QM), Utilization Management (UM), Participant Services, and Appeals & Grievances is considered at the time of recredentialing. Provider status and performance is continuously monitored between recredentialing cycles by Healthcare Highways or its delegated entity. Ongoing monitoring of reports by regulatory agencies of sanctions, limitations on licensure, and complaints are also performed between re- credentialing cycles.

Healthcare Highways complies with applicable state and federal requirements and NCQA standards in credentialing and recredentialing its providers. Providers must maintain good standing with state and federal regulatory and licensing bodies.

CREDENTIALING DELEGATION AND OVERSIGHT

Healthcare Highways may delegate credentialing activities to contracted Provider Organizations that have administrative capacity to provide such services and meet delegation requirements as demonstrated in a pre-delegation review. Approved Provider Organizations shall execute a delegation agreement at the time of approval.

Healthcare Highways performs, and requires delegated entities to perform ongoing internal audits to ensure the credentialing status of its providers remains current. Audits include validation of licensure, malpractice, DEA, OIG and other sanctions, and current status of applicable certification and/or accreditation. This oversight includes annual audits of the delegated Provider Organizations credentialing documentation and procedures.

NON-DISCRIMINATION POLICY

Healthcare Highways has the following processes and criteria in place to prevent discriminatory credentialing. Any delegated entities must similarly comply.

- Tracking and trending of reasons for denial and/or termination

- Semi-annual audits of files in process for greater than six (6) months to determine compliance with practitioner contact criteria
- Non-discrimination clause on the “Statement of Confidentiality” signed by Participants, staff, and guests of the Credentialing Committee on an annual basis
- Non-discrimination statement on Credentialing Committee attendance sign-in form. Information submitted to the Credentialing Committee for approval, denial or termination must not designate a provider’s race, ethnic/national identity, gender, age, sexual orientation, types of procedures performed.

SECTION 2

HEALTHCARE HIGHWAYS HEALTH PLAN

The policies, procedures and guidance in this section apply to covered services you provide to Participants in the Healthcare Highways Health Plan.

HEALTH PLAN – VERIFYING ELIGIBILITY AND BENEFITS

It's important to check the Participant's eligibility and benefits prior to rendering services. This helps ensure that the claim is submitted correctly, allows you to collect copayments, coinsurance and deductible amounts, and secure pre-cert as required and reduces denials for non-covered services. Following are ways to verify eligibility and Participant benefits:

- Online: www.hchhealthplan.com
- Phone: 888.806.3400

Please note that while coinsurance and deductible amounts may be accurate at the time benefits are provided, other provider claims could be processed prior to yours changing the coinsurance and/or deductible amounts a Participant owes. When Participants are due a refund, Providers should refund such amounts as soon as possible but no later than 15 days following receipt of an explanation of payment showing the correct Participant responsibility that should have been collected.

HEALTH PLAN—UTILIZATION MANAGEMENT

Participating providers have agreed to participate in and observe the protocols of Healthcare Highways Health Plan (HCH HP) Utilization Management program. Healthcare Highways Health Plan primarily uses Milliman Care Guidelines to determine medical necessity decisions. For behavioral health, we follow ASAM with TCADA in Texas.

recertification (pre-cert) of services may be initiated following eligibility and benefit verification in the following ways:

- Online at: HTTPS://HCHhealthplan.getprecert.com online pre-cert requires a brief initial set up) Phone by calling: 866.353.8162
- Fax to: 614.818.3236

Providers will be asked to provide clinical information during the precertification process such as: patient ID, name, date of birth and address, diagnosis code(s), CPT code(s), clinical summary, provider and facility details. After initiation of the pre-cert process, the clinical criteria is applied, and the medical necessity determination is made.

HCH HP utilizes Milliman clinical criteria to determine medical necessity for inpatient and outpatient health care services and supplies. Determinations of medical necessity shall include verification that the services are/were provided (a) in accordance with generally accepted standard of practice in the medical community in which the services are being provided or ordered; (b) clinically appropriate, in terms of type, frequency, level, extent, site and duration, and considered effective for the Participant's illness, injury or disease; (c) specifically allowed by the licensing statutes that apply to the provider who renders the service; (d) at least as medically effective as any other standard of care or treatment; and (e) not primarily for the convenience of the Participant, physician or other health care provider.

Precertification may be obtained during the intake process or in some cases our precertification team will contact your office via phone with the approval and certification number when the services requested are approved. When additional information is needed to make the determination, our team will contact your office. Failure to provide required information may lead to a denial of pre-cert. If the pre-cert request does not meet clinical criteria for coverage, we will notify you over the phone and with written correspondence that the request hasbeen denied.

For those situations that are urgent/emergent, Provider must call us at 866.353.8162 within 24 hours of such event. Precertification for emergent events are typically provided immediately, but if not, will be provided no later than the next business day. For services that are non-emergent, we request that you notify HCH HP within 7-10 days prior to procedure, if time permits, to allow sufficient time to review. All reviews, for non-emergent services will typically be responded to within 3 business days.

Precertification of services does not constitute a verification of eligibility and does not guarantee payment. Services (other than ER) are authorized after Participant eligibility is verified and clinical data has been reviewed and determined to be Medically Necessary. Payment will be determined after the claim is filed and is subject to, including but not limited to, eligibility, benefit coverage and validation that services provided correspond to what was pre-certified by HCH HP.

When appropriate, pre-cert could trigger a referral to Case Management and/or Care Coordination teams. These referrals can be triggered based on diagnosis, length of stay, and Participant needs (see below on Case Management).

The following services require precertification:

Inpatient Admissions

- Acute care hospital
- ER patients who are admitted (contact HCH HP as soon as reasonably possible after the Participant presents but no later than 24 hours)
- Long-Term Acute Care
- Rehabilitation Facility
- Skilled Nursing Facility
- Mental Health/ Substance Abuse

Outpatient Services

- Back Surgeries of any type
- Knee Surgeries of any type
- Hysterectomy (including prophylactic)
- Tonsillectomy and Adenoidectomy
- Transplant candidates
- Autism Spectrum Disorders (ABA Therapy)
- Cosmetic Procedures
- Hi-tech imaging (MRI / MRA / MRV, PET, CT, Cardiac Computed Tomographic Angiography (CCTA), CT Angiography (CTA))
- Proton Therapy
- Ultrasounds beyond two for each pregnancy
- Genetic Testing
- Chemotherapy
- Radiation Therapy
- Dialysis
- Experimental/Investigational Procedures (this is dependent on what the Plan defines as E/I)
- Hyperbaric Oxygen
- Injectables (excludes vaccines)
- Outpatient Rehab (Physical, Speech and Occupational Therapy)
- Home Health Care, excludes antibiotics

- Durable Medical Equipment (when retail per item rental or purchase cost exceeds$1,000)

CLINICAL RECONSIDERATIONS

Pre-cert denials will be communicated by phone to your designated representative(s) along with written correspondence to you and the Participant. You may request an initial reconsideration of an adverse determination by contacting us within ten (10) business days of receipt of the decision. A peer to peer review option may be available. If the original determination continues to be upheld, you may request a second level review within thirty (30) days of receiving the second notification. Requests for clinical decision reviews can be made by calling the Appeals Department at 866.353.8162 or by fax 614- 818- 3236 or by mail to Healthcare Highways, Appeals Department, 7400 West Campus Road Ste F-510, New Albany, OH 43054.

Expedited reviews receive priority consideration. Expedited review may be requested by calling 866.353.8162 within 24 hours after receiving an adverse determination. You must state that you are requesting an expedited case review that meets the definition of urgent/emergent care. Determinations will be communicated to you via phone within 72 hours or sooner.

CONCURRENT REVIEW / DISCHARGE PLANNING / TRANSITION OF CARE

Healthcare Highways Health Plan will also engage in telephonic inpatient concurrent review, discharge planning, and transition of care management in coordination with a facility's care management

team. Inpatient cases are monitored for timely discharge, appropriate levels of care, transitioning the Participant from one setting to a different one, and meeting Participant needs at discharge.

CASE MANAGEMENT

Case management identifies those Participants whose diagnoses typically require post-acute care or high level and/or long-term treatment. The case manager works with providers, a Participant's family and care coordinators to formulate a plan that efficiently utilizes health care resources to achieve the optimum patient outcome. Case management services are provided for Participants who may benefit from:

- Change in facility or location of care
- Change in intensity of care
- Arrangements for ancillary services
- Coordination of complex health care services

When case management is indicated, our case management team will reach out to the Participant about case management services. Participants are asked to provide written permission via a consent form that is sent with the case management welcome letter. When Participant consents to case management, the case manager sends a letter to the Participants Primary Care Physician or servicing physician indicating that the Participant in their care has consented to case management and provides the case manager name and contact information so the physician can maintain contact with the case manager. The Participant, physician(s), care coordinator(s), and family are all part of the case management team.

DISEASE MANAGEMENT

Disease management provides monitoring of chronic conditions for patients requiring extensive intervention. HCH HP clients may also elect to engage in specific disease management programs to improve the health of their Participants. Primary care providers and other physicians should encourage their patients to participate in these important programs.

Care Coordination

Care coordination is an important aspect of the Healthcare Highways Health Plan. Our program focuses on helping to ensure access to the delivery of health care services for all our Participants through the implementation of a comprehensive, integrated, and systematic process that is geared toward improving quality and efficiency in health care. The Program includes the following:

- Developing, implementing and improving compliance with clinical practice guidelines for preventive screening, acute and chronic care, and appropriate drug usage, based on the availability of accepted national guidelines, the ability to monitor compliance and aspects of care.
- Identifying high-volume, high-risk and problem-prone areas of care and service affecting HCH HP Participants.
- Utilizing population-based preventive health care audits to assess the level of preventive care rendered across our membership.
- Measuring adherence to physician service standards in areas such as wait times for appointments, in- office care, practice size and availability. Random surveys of Provider office scheduling time frames may occur to measure compliance.
- Evaluating and resolving complaints originating from various sources including Participants, Clients and Administrators regarding the delivery of health care services and managing resolution through a standard process.

Coordinating Care

Care Coordination teams may outreach to Providers and Participants when, through our analytics tools, we identify gaps in care, high risk individuals, chronically ill or other concerns where coordination of care may lead to improved health of Participants. Care Coordination teams should work closely with provider offices to coordinate transitions in care, if appropriate, and, in a manner that does not disturb patient care and/or unnecessarily interfere with office or provider daily duties. Claims data, lab results, pharmacy and other data sources are collected and analyzed to identify gaps in care, high risk participants and participants with chronic conditions as well as utilization trends. Clinical teams can share information with patients, caregivers and providers about benefits, adherence, preventative measures, and other related resources and suggestions that may lead to better health. Much of Care Coordination will be provided via care coordination teams in our contracted Patient Centered Medical Home (PCMH) or Accountable Care Organization (ACO). If you are aware of patients who would benefit from care coordination services, please refer them to your organizations PCMH or ACO or if you do not participate in a PCMH or ACO, our care teams will help. You may contact us at 888.806.3400.

Referrals

While Referrals from Primary Care Providers to Specialty Care Providers are not required, Participants should be directed to in-network providers to minimize Participant out of pocket costs. Visit www.hchhealthplan.com/provider-search to view a list of our participating providers for referrals. HCH HP reserves the right to monitor out of network referral activity.

HEALTH PLAN - CLAIMS INFORMATION AND REIMBURSEMENT POLICIES

CLAIM SUBMISSION

The following elements are required for claim payment:

- Participant's name, address, gender, date of birth (dd/mm/yyyy), relationship to subscriber (policy owner)
- Subscriber's name (enter exactly as it appears on the Participant's health care ID card), ID number, employer group name and employer group number
- Rendering provider's name, their signature or representative's signature, address where service was rendered, "Remit to" address, phone number, NPI and federal TIN
- Referring physician's name and TIN (if applicable)
- Complete service information, including date of service(s), place of service(s), number of services (day/ units) rendered, current CPT and HCPCS procedure codes, with modifiers where appropriate, current ICDCM diagnostic codes by specific service code to the highest level of specificity (it is essential to communicate the primary diagnosis for the service performed, especially if more than one diagnosis is related to a line item)
- Charge per service and total charges
- Detailed information about other insurance coverage
- Information regarding job-related, auto or accident information, if available

ADDITIONAL INFORMATION NEEDED FOR A COMPLETE UB-04 OR CMS-1450 FORM:

Your claim may be pended, rejected or not processed if you omit any of the following:

- Date and hour of admission
- Date and hour of discharge
- Participant status-at-discharge code
- Type of bill code (three digits)
- Type of admission (e.g., emergency, urgent, elective, newborn)
- Current four-digit revenue code(s)
- Attending physician ID
- For outpatient services/procedures, the specific CPT or HCPCS codes, line item date of service, and appropriate revenue code(s) (e.g., laboratory, radiology, diagnostic or therapeutic)
- Complete box 45 for physical, occupational or speech therapy services (revenue codes 0420-0449)

CLAIM EDITING AND BUNDLING

Healthcare Highways uses industry standard claim editing and bundling programs such as CMS and McKesson when processing claims.

OBSTETRICAL CARE BUNDLING REIMBURSEMENT POLICIES

Maternity care includes antepartum care, delivery services, and postpartum care. This policy describes reimbursement for global obstetrical (OB) codes and itemization of maternity care services. In addition, the policy indicates what services are and are not separately reimbursable to other maternity services. Unless otherwise specified, for the purposes of this policy Same Group Physician and/or Other Health Care Professional includes all physicians and/or other healthcare professionals of the same group reporting the same federal tax identification number.

Global Obstetrical Care - Global Obstetrical Care as defined by the American Medical Association (AMA), "the total obstetric package includes the provision of antepartum care, delivery, and postpartum care." When the Same Group Physician and/or Other Health Care Professional provides all components of the OB package, report the global OB package code.

Antepartum Care Only - Accommodates for situations such as termination of a pregnancy, relocation of a patient or change to another physician. In these situations, all the routine antepartum care (usually 13 visits) or global (OB) care may not be provided by Same Group Physician and/or Other Health Care Professional.

Delivery Services Only - Includes admission to the hospital, the admission history and physical examination, management of uncomplicated labor, vaginal delivery (with or without episiotomy, with or without forceps), or cesarean delivery.

Postpartum Care Only - Includes the postpartum period to be six weeks following the date of the cesarean or vaginal delivery.

Delivery + Postpartum Care - Sometimes a physician performs the delivery and postpartum care with minimal or no antepartum care. In these instances, the CPT book has codes for vaginal and cesarean section deliveries that encompass both services. The following are CPT defined delivery plus postpartum care codes:

Code(s)	Description	Code Type
59400	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care	Global Obstetric
59510	Routine obstetric care including antepartum care, cesarean	Global Obstetric
59610	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care, after previous cesarean delivery	Global Obstetric
59618	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery.	Global Obstetric
59425	Antepartum care only; 4-6 visits	Antepartum Care Only
59426	Antepartum care only; 7 or more visits	Antepartum Care Only
59409	Vaginal delivery only (with or without episiotomy and/or forceps)	Delivery Services Only
59514	Cesarean delivery only	Delivery Services Only
59612	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps)	Delivery Services Only
59620	Cesarean delivery only, following attempted vaginal delivery after previous cesarean delivery	Delivery Services Only
59430	Postpartum care only (separate procedure)	Post-Partum Care Only
59410	Vaginal delivery only (with or without episiotomy and/or forceps); including postpartum care	Delivery + Post-Partum
59515	Cesarean delivery only; including postpartum care	Delivery + Post-Partum
59614	Vaginal delivery only, after previous cesarean delivery (with or without episiotomy and/or forceps); including postpartum care	Delivery + Post-Partum
59622	Cesarean delivery only following attempted vaginal delivery after previous cesarean delivery; including postpartum care.	Delivery + Post-Partum

High Risk/Complications - A patient may be seen more than the typical 13 antepartum visits due to high risk or complications of pregnancy. These visits are not considered routine and can be reported in addition to the global obstetrical codes. The submission of these high risk or complication services is to occur at the time of delivery, because it is not until then that appropriate assessment for the number of antepartum visits can be made. HCH HP will separately reimburse for E/M services associated with high risk and/or complications when modifier 25 is appended to indicate it is significant and separate from the routine antepartum care and the claim is submitted with an appropriate high risk or complicated diagnosis code.

E/M Service with an Obstetrical (OB) Ultrasound Procedure - HCH HP follows ACOG coding guidelines and considers an E/M service to be separately reimbursed in addition to an OB ultrasound procedures (CPT codes 76801-76817 and 76820- 76828) only if the E/M service has modifier 25 appended to the E/M code. If the patient is having an OB ultrasound and an E/M visit on the same date of service, by the Same Individual Physician or Other Health Care Professional, per ACOG coding guidelines the E/M service may be reported in addition to the OB ultrasound if the visit is identified as distinct and separate from the ultrasound procedure. Per CPT guidelines, modifier 25 should be appended to the E/M service to identify the service as separate and distinct.

Multiple Gestation - HCH 's HP reimbursement for twin deliveries follows ACOG's coding guidelines for vaginal, cesarean section, or a combination of vaginal and cesarean section deliveries.

OBSERVATION

Except when modified per your participation agreement, an Observation Stay is an alternative to an inpatient admission that allows reasonable and necessary time to evaluate and render medically necessary services to a Participant whose diagnosis and treatment are not expected to exceed 24 hours but may extend to 48 hours upon approval by HCH HP, and the need for an inpatient admission can be determined within this specific period. HCH HP separately reimburses observation services performed in an HCH HP contracted facility only under specific circumstances.

Observation stays that are discharged within the 24-hour time window do not require pre-cert and can be billed as outpatient, pre-cert may extend the observation to 48 hours.

Inpatient Admission Following Observation Stay - If an observation stay is within 48 hours and followed by an inpatient admission, only the inpatient stay will be paid. The inpatient stay requires prior authorization and should be billed separately. If an observation stay exceeds 48 hours, it should be billed as an inpatient stay and will be subject to prior authorization.

Emergency Department Services Preceding Observation Stay - When emergency department services precede an observation or inpatient stay, the emergency department services are incidental to the observation and inpatient stay and therefore are not reimbursed separately but per the inpatient payment agreed to in the participation agreement, unless your Participating Provider Agreement states differently.

Obstetrical Observation Stay - When an obstetrical patient is placed in observation status: The entire episode is considered an inpatient admission if delivery occurs prior to discharge. The episode is considered an observation stay if delivery does not occur and the Participant is sent home. Reimbursement includes diagnostic testing performed in conjunction with an obstetrical observation stay.

Observation stay is not considered an appropriate designation for the following, and is therefore not reimbursed:

- Preparation for, or recovery from, diagnostic tests (e.g., fetal non-stress test, sleep studies)
- The routine recovery period following a surgical day care or an outpatient procedure
- Services routinely performed in the emergency department or outpatient department
- Observation care services submitted with routine pregnancy diagnoses
- Retaining a Participant for socioeconomic factors
- Custodial care

HOSPITAL BASED CLINICS

HCH HP reimburses professional providers for covered services provided in a facility clinic setting when reported on a professional CMS 1500 form with a place of service office. This reimbursement includes both the professional services and the associated overhead. HCH HP will not separately reimburse a facility for facility clinic visits and services billed on a UB-04 when reported with revenue codes 510-519, 520-529 and any successor codes unless your Participating Provider Agreement states differently.

The technical and overhead component of the facility clinic visit is included in the benefit paid to the professional provider for professional services, which encompasses but is not limited to E&M services in a clinic setting. The facility may not seek reimbursement for any technical or overhead component of the clinic charge from HCH HP or the Participant. The Participant is held harmless for these clinic charges.

510 – 519	Bill with appropriate CPT/HCPCS codes; E&M codes will be denied.
520 - 529	Bill with appropriate CPT/HCPCS codes; E&M codes will be denied.
960 - 969	Bill with appropriate E&M codes.

G0463 Hospital Outpatient clinic visit for assessment and management of a patient is not reimbursed.

TRANSFERS

In cases where a patient is transferred during an inpatient stay between acute care facilities, HCH HP may reimburse both the transfer and the transferee depending on the terms of your Participating Provider Agreement.

For hospitals reimbursed using a DRG base rate, HCH HP reimburses the transferring hospital the lesser of the per diem rate and the total negotiated case rate. The per diem rate is calculated by dividing the negotiated rate by the geometric mean length of stay for the assigned DRG. For hospitals reimbursed at a per diem rate, the payment is calculated at the negotiated per diem rate.

The receiving hospital is paid at the negotiated rate.

READMISSIONS

For all inpatient stays reimbursed at a case rate, HCH HP reserves the right to review readmissions for the same or related conditions within 15 days of discharge.

If HCH HP determines upon review that a readmission arose from premature discharge or failure of the facility to manage the discharge properly, HCH HP will potentially deny payment for either the readmission or the original stay, regardless of the medical necessity of the readmit.

ASSISTANT SURGEON REIMBURSEMENT

An assistant surgeon is considered medically necessary when the complexity of the operation necessitates the primary surgeon have additional skilled operative assistance from: 1) Another surgeon, 2) Licensed Physician Assistant, 3) Registered Nurse First Assistant. HCH HP provides coverage for assistant surgeons based on guidance from the Centers for Medicare and Medicaid Services (CMS).

An assistant surgeon is distinguished from an “assistant-in-surgery.” Generally, assistants-in-surgery are non-MD professionals such as nurses, operating room technicians, or other specially trained professionals, whose services are included in the primary surgeon’s, or the facility’s, reimbursement. These services are not separately reimbursed.

There may be times when a physician elects to utilize more than one assistant during the operative session. However, only one assistant per operative session will be reimbursed. Claims for services of an assistant surgeon should be filed with modifier 80, 81, 82 or AS. Use of modifiers is required for proper payment.

Healthcare Highways follows criteria based on the CMS National Physician Fee Schedule Relative Value File (NPFS) status indicators. All codes in the NPFS with the following status code indicator "2" for "Assistant Surgeons" are considered by HCH HP to be reimbursable for Assistant Surgeon services, as indicated by an Assistant Surgeon modifier (80, 81, 82, or AS).

Health care professionals acting as assistant surgeons should report their services under a surgeon's provider number.

Reimbursement - HCH HP's standard reimbursement for qualified assistant surgeon services is 16% of the allowable amount when performed by a physician and 14% of the allowable amount when performed by a non-physician (as defined above). This percentage is based on CMS.

CO-SURGEONS / TEAM SURGEONS REIMBURSEMENT POLICIES

The use of multiple surgeons for a single procedure is considered medically necessary when the nature and/or complexity of the procedure necessitates contribution and expertise from more than one surgeon. HCH HP provides coverage for multiple surgeons based on guidance from the Centers for Medicare and Medicaid Services (CMS).

HCH HP follows criteria based on the CMS National Physician Fee Schedule Relative Value File (NPFS) status indicators. All codes in the NPFS with status code indicators "1" or "2" for "Co-Surgeons" are considered by HCH HP to be eligible for Co-Surgeon services as indicated by the co-surgeon modifier 62.

All codes in the NPFS with the status code indicators "1" or "2" for "Team Surgeons" are considered by HCH HP to be eligible for "Team Surgeon" services as indicated by the team surgeon modifier 66. Use of modifiers is required for proper payment. Physicians acting in the more limited capacity of an "Assistant Surgeon", should bill with modifiers 80 or 82, and are not eligible for co-surgeon reimbursement

Each co-surgeon should submit the same Current Procedural Terminology (CPT) code with modifier 62. Consistent with CMS guidelines, HCH HP will reimburse co-surgeon services at 62.5% of the allowable amount to each surgeon subject to additional multiple procedure reductions if applicable. The allowable amount is determined independently for each surgeon and is the amount that would be given to that surgeon performing the surgery without a co-surgeon.

Each Team Surgeon should submit the same CPT code with modifier 66 along with written medical documentation describing the specific surgeon's involvement in the total procedure. HCH HP will review each submission with its appropriate medical documentation and will make reimbursement decisions on a case-by-case basis.

NON-REIMBURSABLE SERVICES REIMBURSEMENT POLICIES

Consistent with guidelines specified by the Centers for Medicare and Medicaid Services (CMS), HCH HP does not reimburse for the procedures or categories of codes outlined in this policy. This list is not all-inclusive. Denials include non-covered services defined as exclusions in the Participant's benefit program, payment included in the allowance of another service (i.e., global) and procedure codes submitted that are not eligible for payment.

Coding Category II CPT Codes (XXXXF) - These codes are intended to facilitate data collection about quality of care. Use of these codes is optional, not required for correct coding, and may not be used as a substitute for Category I codes.

Category III CPT Codes (XXXXT) - Temporary codes for emerging technology, services and procedures. Services should be resubmitted with an unlisted code. Supporting documentation is required with the claim.

Bundled Services/Supplies (Status "B" or "T" Procedure) Codes identified with a CMS indicator of "B" or "T" (bundled code) in the CMS NPFS (National Physician Fee Schedule), will not be separately reimbursed to physicians by HCH HP. Payments for these procedures are always bundled into payment for other services and separate payment is never made.

PC/TC Indicator 5 Codes - HCH HP denies "Incident To" codes identified with a CMS PC/TC indicator 5 in the NPFS when reported in a facility place of service when billed by a physician. Modifiers -26 and TC cannot be used with these codes.

ANESTHESIA

HCH HP reimburses anesthesia based on the concepts of basic values, time unit values, and conversion factors. Basic values are defined by the ASA and time units are calculated on a 15-minute interval basis and rounded to the nearest decimal point (e.g. 32 minutes of anesthesia equals 2.1 time units). Conversion factors are either explicitly listed in your Participating Provider Agreement or based on CMS localities.

Anesthesia time starts when the anesthesiologist begins to prepare the patient for induction and ends when the patient can safely be placed under postoperative supervision. The following formula is used to determine anesthesia reimbursement:

(Base Value + Time Units) x Conversion Factor = Reimbursement Physical status modifiers.

BILATERAL PROCEDURES

Bilateral procedures are procedures performed on both sides of the body during the same encounter on the same day. HCH HP follows the bilateral procedure CMS standards in the NPFS (National Physician Fee Schedule) for adjustment of payment.

Bilateral services must be billed on a single line with modifier -50 appended. Modifier -50 is not applicable to procedures that are bilateral by definition, or procedures with descriptions that include such terminology as "bilateral" or "unilateral." Do not use Modifiers RT and LT when modifier -50 applies

Reimbursement Procedure Eligible for Bilateral Payment Adjustment Status Indicator 1: If the procedure is billed with the -50-bilateral modifier, a 150% payment adjustment applies. Status Indicator 3: Services in this category are generally radiology procedures or other diagnostic tests which are not subject to the special payment rules for other bilateral procedures with CMS status indicator 1. If a procedure is reported with modifier -50, payment is based on 100% of the standard reimbursement for each side.

IN-OFFICE PHYSICIAN LABORATORY SERVICES (IPLS)

The In-Office Physician Laboratory Services (IPLS) is a list of laboratory procedural/testing codes that HCH HP will reimburse its Physicians to perform in their offices. This list represents procedures/tests that HCH HP Physicians can perform in their offices and will be reimbursed by HCH HP. All other lab procedures/tests

must be performed by one of the participating laboratories in HCH's HP network or reimbursement to the physician’s office is reduced to a level according to the terms of Providers’ Participating Agreement.

CPT Code	Description
81000	Urinalysis nonauto w/scope
81001	Urinalysis auto w/scope
81002	Urinalysis nonauto w/o scope
81003	Urinalysis auto w/o scope
81025	Urine pregnancy test
82247	Bilirubin total
82270	Occult blood feces
82272	Occult blood feces 1-3 tests
82803	Blood gases any combination
82948	Reagent strip blood glucose
82962	Glucose blood test
83014	H pylori drug admin
83026	Hemoglobin copper sulfate
83655	Assay of lead
83861	Microfluid analy tears
84146	Assay of prolactin
84443	Assay thyroid stim hormones
85007	Bl smear w/diff wbc count
85013	Spun microhematocrit
85018	Hemoglobin
85025	Complete cbc w/auto diff sbc
85027	Complete cbc automated
85651	Rbc sed rate nonautomated
86403	Particle agglut antibody scrn
87070	Culture other specimen aerobic
87081	Culture screen only
87177	Ova and parasites smears
87210	Smear wet mount saline/ink
87220	Tissue exam for fungi
87804	Influenza assay w/optic Strep a assay w/optic
87880	Strep a assay w/optic
88738	Hgb quant transcutaneous
89060	Exam synovial fluid crystals
89300	Semen analysis w/huhner
89310	Semen analysis w/count
89320	Semen anal vol/count/mot
89321	Semen anal sperm detection
89322	Semen anal strict criteria

DRUG TESTING

Claims for specific, multiple drug class CPT and HCPCS codes for presumptive and definitive drug tests, will be reimbursed following Medicare's policy. This means that only those presumptive and definitive drug testing CPT/HCPCS codes outlined in this policy will be reimbursed. Reimbursement is subject to medical record documentation, including appropriately documented orders, correct CPT/HCPS coding, participant benefits and eligibility.

QUANTITY LIMITS

HCH's policy is to allow reimbursement for up to one definitive or one presumptive drug test per date of service, limited to 20 reimbursable units total per plan year unless a participant's benefit plan specifically allows for more.

REIMBURSABLE CODES

- Presumptive Drug Test 80305, 88306, 80307
- Definitive Drug Test G0480, G0481, G0482, G483 and G0659

Mid-Level Providers

Healthcare Highways reimbursement for the mid-level specialties listed in the table below is equal to 85% of the physician's allowable when billed by physician with modifier SA.

Specialty Physician Assistant Nurse Practitioner CRNA	Audiologist Physical Therapist	Certified Clinical Nurse Nurse Midwife
Certified Surgical Assistant Nutritionist		

MULTIPLE PROCEDURES REIMBURSEMENT

When multiple procedures are performed on the same day, by the same group, physician, or other healthcare professional, reduction in reimbursement for secondary and subsequent procedures will occur. HCH HP follows the multiple procedure CMS standards for reduction of payment. The use of modifier 51 appended to a code is not a factor in determining which codes are considered subject to multiple procedure reductions.

Surgical / Endoscopic Procedures (Status Indicators 2 & 3) - If a procedure is reported on the same day as another procedure with an indicator of 2 or 3, the procedures with the greatest reimbursable amount will be paid at 100% followed by 50% for the next greatest reimbursable amount followed by 25% for all subsequent procedures. Payment is based on the lower of: (a) the actual charge or (b) the fee schedule amount reduced by the appropriate percentage.

Special rules for multiple endoscopic procedures apply if an endoscopic procedure is billed with another endoscopy in the same family (i.e., another endoscopy that has the same base procedure). The base procedure for each code with this indicator is identified in the Endobase field of the CMS NPFS Relative Value File. The multiple endoscopy rules are applied to a family before ranking the family with the other procedures performed on the same day (for example, if multiple endoscopies in the same family are reported on the same day as endoscopies in another family or on the same day as a non-endoscopic procedure). If an endoscopic procedure is reported with only its base procedure, the base procedure is not separately payable. Payment for the base procedure is included in the payment for the other endoscopy.

Imaging / Radiology (Status Indicator = 4) - If a diagnostic imaging procedure is billed with, or reported in the same session on the same day, as another diagnostic imaging subject to a multiple imaging reduction (services with an '88' diagnostic imaging family indicator), HCH HP pays 100% of the technical component for the highest priced procedure, and 50% for the technical component of each subsequent procedure.

Cardiovascular Services (Status Indicator = 6) - For cardiovascular services, full payment is made for the service with the highest payment. Payment is made at 75 percent for subsequent services furnished by the same physician (or by multiple physicians in the same group. Reduction is taken only on the technical component; the professional component is paid at 100% for all procedures.

Ophthalmology Services (Status Indicator = 7) - For ophthalmology services, full payment is made for the service with the highest payment. Payment is made at 75 percent for subsequent services furnished by the same physician (or by multiple physicians in the same group practice, to the same patient on the same day). Reduction is taken only on the technical component; the professional component is paid at 100% for all procedures.

Global / Case Rate Adjustment - When a procedure requires a multiple procedure reduction but is billed as a global / case-rated procedure, HCH HP will apply an appropriate technical component reduction on a fixed 60% of the total payable amount. If a professional component payment reduction is appropriate, it is applied on a fixed 40% of the total payable amount.

UNLISTED AND UNSPECIFIED PROCEDURES

Unlisted procedure codes are used when the services performed do not have specific codes assigned to them. When submitting claims with such unlisted or unspecified procedures, it is necessary to attach supporting documentation describing the services that were performed. Such documentation should include the following information:

- A clear description of the nature, extent, and need for the procedure or service
- Whether the procedure was performed independently of other services provided, or if it was performed at the same surgical site or through the same surgical opening
- Any extenuating circumstances which may have complicated the service or procedure
- Time, effort, and equipment necessary to provide the service
- The number of times the service was provided

When submitting documentation, designate the portion of the report that identifies the test or procedure associated with the unlisted procedure code.

Claims submitted with unlisted procedure codes and without supporting documentation will be denied. No additional reimbursement is provided for special techniques/equipment submitted with an unlisted procedure code. When performing two or more procedures that require the use of the same unlisted CPT code, the unlisted code should only be reported once to identify the services provided (excludes unlisted HCPCS codes; for example, DME/unlisted drugs). Unlisted codes for DME, orthotics, and prosthetics require appropriate NU, RR or MS modifier to be considered for reimbursement. All other unlisted procedure codes appended with a modifier will be denied.

Required Documentation to file unlisted or unspecified procedures:

Procedure Type	Service Code Range	Required Documentation
Surgical procedures	CPT Codes 10021–69990	Operative or procedure report
Radiology/imaging procedures	CPT Codes 70010–79999	Laboratory or pathology report

Medical procedures	CPT Codes 90281–99607	Office notes and reports
Unlisted HCPCS procedure codes		Operative or procedure report
Unclassified drug codes		NDC Number with full description, name, strength of drug
Unlisted HCPCS DME codes		Provide narrative on the claim

MEDICALLY UNLIKELY, MUTUALLY EXCLUSIVE AND COMPONENT PROCEDURES

Healthcare Highways reimburses providers for services that are medically appropriate and adhere to CMS standard coding conventions. HCH HP follows Medicare National Correct Coding Initiative (NCCI) standards for not reimbursing services that are mutually exclusive, medically unlikely, or component services reported alongside more comprehensive procedures.

Mutually exclusive procedures are codes that cannot reasonably be done at the same anatomic site, during the same patient encounter, or the coding combination represents two methods of performing the same service. An example of mutually exclusive procedures is the repair of an organ, performed by two different methods since only one method can be chosen to repair the organ. Mutually exclusive coding combinations are considered submitted in error and only one of the services will be reimbursed. The Medicare National Correct Coding Initiative (NCCI) has published procedure-to-procedure (PTP) claims edits that prevent inappropriate payment in these scenarios. HCH HP adopts these claims edits and will not reimburse providers for mutually exclusive procedures.

Medically unlikely procedures are codes that are anatomically or clinically limited with regard to the number of times they may be performed on a single day. In addition to the PTP edits, NCCI has published medically unlikely claims edits (MUEs) that prevent payment for an inappropriate number or quantity of the same service on a given day. HCH HP adopts these claims edits and will not reimburse providers for services flagged as medically unlikely.

Comprehensive and Component Procedures NCCI's PTP edits also address component and comprehensive procedures. Services that are integral to another service are component parts of the more comprehensive procedure. The PTP edits prevent payment for component services reported alongside comprehensive services. HCH HP adopts these claims edits and will not separately reimburse providers for component services if reported alongside comprehensive services.

SURGICAL SUPPLIES

This policy describes the reimbursement methodology for general surgical supplies associated with outpatient physician surgical services. Consistent with CMS, HCH HP does not reimburse providers for general surgical supplies.

Supply Code 99070 For reimbursement of covered medical and surgical supplies, an appropriate Level II HCPCS code must be submitted. The non-specific CPT code 99070 (supplies and materials, except spectacles, provided by the physician, hospital, ambulatory surgical center or other qualified healthcare professional over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)) is not reimbursable in any setting.

Surgical Tray Code A4550 CPT code will not be reimbursed separately. This code is part of a physician's practice expense and thus reimbursement of this code is included in the payment of other codes billed by the physician.

DUAL PREVENTATIVE & PROBLEM-ORIENTED VISIT

Preventive Medicine Services include annual physical and well child examinations, usually separate from disease related diagnoses. Occasionally, an abnormality is encountered or a pre-existing problem is addressed during the Preventive visit, and significant elements of related Evaluation and Management (E/M) services are provided during the same visit. When this occurs, HCH HP will reimburse the Preventive Medicine service plus the following problem-oriented E/M service codes when that code is appended with modifier 25. If the problem-oriented service is minor, or if the code is not submitted with modifier 25 appended, it will not be reimbursed.

When a Preventive Medicine service and other E/M services are provided during the same visit, only the Preventive Medicine service will be reimbursed.

Screening services include cervical cancer screening; pelvic and breast examination; prostate cancer screening; digital rectal examination; and obtaining, preparing and conveyance of a Papanicolaou smear to the laboratory. These screening procedures are included in (and are not separately reimbursed from) the Preventive Medicine service rendered on the same day for Participants age 22 years and over.

PROVIDER CLAIM INQUIRY PROCESS

If you believe your claims have not been paid correctly, contact HCH HP Service Operations by calling 888.806.3400. If we are unable to resolve your concern at the time of the phone call, your request will be escalated to a Provider Service team member who will respond within five (5) business days. If your inquiry is not resolved by following the above, you may initiate the Provider Inquiry Process by writing to us within 180 days from the date of receipt of explanation of payment (or per your provider agreement). Provider Inquiries shall be reviewed and responded to within thirty (30) days.

WHAT TO SUBMIT FOR A PROVIDER CLAIMS INQUIRY

Attach all supporting materials, such as Participant-specific treatment plans, clinical records, calculations for payment based on contract terms, or the coding guidance used to code the claim(s) to the formal appeal request, based on the reason for the request. Include information which supplements your prior adjustment submission that you wish to be included in the appeal review. HCH HP's decision will be rendered based on the materials available at the time of formal appeal review. If you are appealing a claim denied because filing was not timely:

- Electronic claims - include confirmation HCH HP received and accepted your claim
- Paper claims - include a copy of a screen print from your accounting software to show the date you submitted the claim
- Claims submitted after the filing deadline - per your agreement due to a delay in payment from a primary payor may be submitted to HCH HP by submitting a copy of the primary payor's payment advice/EOB and your secondary claim

All proof of timely filing must also include documentation that the claim is for the correct Participant and the correct date of service and sent to the correct address.

WHERE TO SEND YOUR HCH HP CLAIM INQUIRY

Healthcare Highways Health Plan Appeals Unit
PO Box 2739
Little Rock, AR 72203

RETROACTIVE ELIGIBILITY CHANGES

Eligibility under a benefit contract may change retroactively if:

- HCH HP receives information an individual is no longer a Participant
- The Participant's policy/benefit contract has been terminated
- The Participant decides not to purchase continuation coverage after employment terminates
- The eligibility information we receive is later determined to be incorrect

If you have submitted a claim(s) affected by a retroactive eligibility change, a Claim Review may be necessary. The reason for the reconsideration will be reflected on the EOB. If you are enrolled in Electronic Data Interchange (EDI) and/or Electronic Remittance Advice (ERA), you will not receive an EOB; however, you will be able to view the transaction online or in the electronic file you receive from HCH HP. If a refund is requested, you will be given at least 30 business days to refund the payment, or as provided by applicable law or your agreement with HCH.

ELECTRONIC DATA INTERCHANGE (EDI)

The fastest way HCH HP can communicate with you is electronically. EDI is the preferred method for conducting business transactions with our providers. Using EDI to exchange information with HCH HP has many advantages:

- Send and receive information faster
- Identify submission errors immediately and avoid processing delays
- Exchange information with multiple payors
- Reduce paper, postal costs and mail time
- Cut administrative expenses

If you are not taking advantage of all available electronic transactions, you are not maximizing your savings and experiencing the full benefits of EDI.

GETTING STARTED

- Before submitting your EDI claims add the HCH HP payor ID: HCH01 (HCH zero one) to your profile for electronic claims.
- If you have a practice management or hospital information system, contact your software vendor to determine what electronic transactions are offered.
- Contact clearinghouses to review which electronic transactions can interact with your software system.

ELECTRONIC FUNDS TRANSFER (EFT) AND ELECTRONIC REMITTANCE ADVICE (ERA)

HCH HP partners with ECHO Health for EFT and ERA support. All network providers who are already registered with ECHO can add HCH HP by going to the website below. If you are not currently enrolled with ECHO you can register at the website below, where enrollment instructions will be provided. There is no cost to enroll with ECHO. HCH HP can provide a paper form by request if you prefer to enroll with ECHO in that manner. Helpful information is provided on the website, as well as the form at: https://view.echohealthinc.com/EFTERA/EFTERAInvitation.aspx. If additional assistance is needed, please call HCH HP at 888.806.3400.

ECHO also provides Electronic Remittance Advices (ERAs); Providers can enroll in this feature and can add HCH HP by following the EFT process.

SECTION 3

HEALTHCARE HIGHWAYS NETWORK ACCESS

The policies, procedures and guidance in this section apply to covered services you provide to Participants accessing only the Healthcare Highways network.

NETWORK ACCESS - VERIFYING ELIGIBILITY AND BENEFITS

It's important to check the Participant's eligibility and benefits prior to rendering services. This helps ensure that the claim is submitted correctly, allows you to collect copayments, coinsurance and deductible amounts, and secure pre-cert as required and reduces denials for non-covered services. Please refer to the Participant's identification card for the Customer Service phone number to verify eligibility and benefits.

Please note that while coinsurance and deductible amounts may be accurate at the time benefits are provided, other provider claims could be processed prior to yours changing the coinsurance and/or deductible amounts a Participant owes. When Participants are due a refund, Providers should refund such amounts as soon as possible but no later than 15 days following receipt of an explanation of payment showing the correct Participant responsibility that should have been collected.

NETWORK ACCESS - UTILIZATION MANAGEMENT

You are required to participate in and observe the protocols of Client or Administrator's Utilization Management programs for health care services rendered to Participants. Utilization Management requirements may vary by Client or Administrator, and by the Participant's Program and may include, but is not limited to, pre-cert, concurrent review, and retrospective review. Utilization Management programs may also include case management, disease management, maternity management, and mental health management services.

Pre-Cert of Services

Most Utilization Management programs used by Client or Administrators require Pre-Cert. Please verify any certification or other Utilization Management requirements at the time you verify benefits and eligibility. As part of the Certification process, please be prepared to provide the following information by telephone, fax, or through any other method of communication acceptable to the Client or Administrator's Utilization Management program:

- Client or Administrator name
- Group policy number or name
- Policyholder's name, social security number and employer (group name)
- Patient's name, sex, date of birth, address, telephone number and relationship to policyholder
- Participating Provider's name and specialty, address and telephone number
- Facility name, address and telephone number
- Scheduled date of admission/treatment
- Diagnosis and treatment plan
- Significant clinical indications
- Length of stay requested

Based upon the Client or Administrator's Utilization Management program you may be required to obtain Pre-cert for the following:

- Inpatient admissions
- Outpatient surgery
- Emergency admissions - Pre-cert of all admissions following an emergency room visit is usually required within forty-eight (48) hours after the admission

- Length of stay extensions - In the event a length of stay extension is required for those health care services initially requiring pre-cert, you may be required to obtain additional pre-cert from the Utilization Management program prior to noon of the last certified day.

To obtain pre-cert for the above procedures, call the telephone number provided by the Participant, the Client or the Administrator prior to the date of service to the Participant. You may be required to obtain separate pre-cert for multiple surgical procedures. To facilitate a review, be sure to initiate the pre-certification process a minimum of seven to ten (7-10) days before the date of service.

Concurrent Review

Network Facilities must participate in the Utilization Management program of Concurrent Review. A nurse reviewer performs Concurrent Review to document medical necessity and facilitate discharge planning.

Case Management

Case management identifies those Participants whose diagnoses typically require post-acute care or high level and/or long-term treatment. The case manager works with providers and family Participants to formulate a plan that efficiently utilizes health care resources to achieve the optimum patient outcome. Case management services are provided for Participants who may benefit from:

- Change in facility or location of care
- Change in intensity of care
- Arrangements for ancillary services
- Coordination of complex health care services

Before completing the pre-cert process, always contact the Client or Administrator to obtain eligibility information.

In cases where multiple procedures are performed, be sure to confirm benefit eligibility from the Client or Administrator for each procedure.

Referrals

Refer Participants to Healthcare Highways participating providers when referrals are required. Our participating provider network can be found at www.healthcarehighways.com/provider-search. Referring to participating providers minimizes a Participant's out-of-pocket costs.

Appeals Process for Care Management Decisions

The appeals process may vary by the Client or Administrator's Utilization Management program and/or as mandated by state or federal law. In the event you or a Participant do not agree with a noncertification determination made under the Utilization Management program, you or the Participant has the right to appeal the determination in accordance with the Client or Administrator's Utilization Management program appeals process. To obtain details of the Client or Administrator's Utilization Management program appeals process, please contact the appropriate Client or Administrator.

Failure to observe the protocols of the Utilization Management program may also result in a reduction of benefits to the Participant. You are responsible for notifying the Participant of any potential financial implications associated with failure to observe the Utilization Management Program protocols.

Timely Payment of Claims

Please refer to your Participating Agreement for specific requirements regarding timely payment of Clean Claims. Any payments due by Client shall be reduced by any applicable Copayments, Deductibles, and/or Coinsurance, if any, specified in the Participant's Benefit Program and/or any service for which the Participant's Benefit Program does not provide coverage. Payment by Client or Administrator shall be subject to industry standard coding and bundling rules, if applicable.

Disputing a Claim

As a Network Provider, you and the Client have the right to dispute a claim. When a problem arises, contact Healthcare Highways Service Operations at 888.806.3400 as soon as possible and provide all information pertinent to the problem. If the issue can't be resolved on the call, it will be escalated to a provider service representative who will conduct an inquiry, contacting the Client or Administrator and/or regional provider relations specialist as appropriate.

Failure to Submit a Clean Claim

If a Client or Administrator receives a claim that is not a Clean Claim containing all complete and accurate information required for adjudication or if the Client has some other stated dispute with the claim, they will provide you with written notification prior to payment of the claim. The Client will pay, or arrange for Administrator to pay, you at the Contract Rate(s) for all portions of the claim not in dispute. Please provide complete and accurate information requested within thirty (30) business days of the Client or Administrator's request (unless otherwise specified in your Participating Provider Agreement).

Timeframe for Disputing a Claim

Following your receipt of payment from the Client or Administrator, you may challenge payments made to you during the timeframe as specified in your Participating Provider Agreement (unless otherwise required by law), otherwise such payment shall be deemed final.

Healthcare Highways Client or Administrator is Primary

When a Healthcare Highways Client or Administrator is primary under the COB rules, the Client will pay, or arrange for Administrator to pay, for Covered Services according to the Participant's Program (e.g., 90%, 80%, or any other percent based on the Participant's coinsurance amount) and pursuant to the Contract Rate.

When Client or Administrator is secondary payor then submit the payment advice/EOB from the primary payor with your claim to the Client or Administrator.

Observation Policy

Except when modified per your participation agreement, an Observation Stay is an alternative to an inpatient admission that allows reasonable and necessary time to evaluate and render medically necessary services to a Participant whose diagnosis and treatment are not expected to exceed 24 hours but may extend to 48 hours upon approval by HCH, and the need for an inpatient admission can be determined within this specific period. HCH separately reimburses observation services performed in an HCH contracted facility only under specific circumstances.

Observation stays that are discharged within the 24-hour time window do not require pre-cert and can be billed as outpatient; pre-cert may extend the observation to 48 hours.

Inpatient Admission Following Observation Stay - If an observation stay is within 48 hours and followed by an inpatient admission, only the inpatient stay will be paid. The inpatient stay requires prior authorization and

should be billed separately. If an observation stay exceeds 48 hours, it should be billed as an inpatient stay and will be subject to prior authorization.

Emergency Department Services Preceding Observation Stay - When emergency department services precede an observation or inpatient stay, the emergency department services are incidental to the observation and inpatient stay and therefore are not reimbursed separately but per the inpatient payment agreed to in the participation agreement, unless your Participating Provider Agreement states differently.

Obstetrical Observation Stay - When an obstetrical patient is placed in observation status: The entire episode is considered an inpatient admission if delivery occurs prior to discharge. The episode is considered an observation stay if delivery does not occur and the Participant is sent home. Reimbursement includes diagnostic testing performed in conjunction with an obstetrical observation stay.

Observation stay is not considered an appropriate designation for the following, and is therefore not reimbursed:

- Preparation for, or recovery from, diagnostic tests (e.g., fetal non-stress test, sleep studies)
- The routine recovery period following a surgical day care or an outpatient procedure
- Services routinely performed in the emergency department or outpatient department
- Observation care services submitted with routine pregnancy diagnoses
- Retaining a Participant for socioeconomic factors
- Custodial care

Hospital Based Clinics

HCH reimburses professional providers for covered services provided in a facility clinic setting when reported on a professional CMS 1500 form with a place of service office. This reimbursement includes both the professional services and the associated overhead. HCH will not separately reimburse a facility for facility clinic visits and services billed on a UB-04 when reported with revenue codes 510-519, 520-529 and any successor codes unless your Participating Provider Agreement states differently.

The technical and overhead component of the facility clinic visit is included in the benefit paid to the professional provider for professional services, which encompasses but is not limited to E&M services in a clinic setting. The facility may not seek reimbursement for any technical or overhead component of the clinic charge from HCH or the Participant. The Participant is held harmless for these clinic charges.

510 - 519	Bill with appropriate CPT/HCPCS codes; E&M codes will be denied
520 - 529	Bill with appropriate CPT/HCPCS codes; E&M codes will be denied
960 - 969	Bill with appropriate E&M codes
G0463	Hospital Outpatient clinic visit for assessment and management of a patient is not reimbursed

Transfers

In cases where a patient is transferred during an inpatient stay between acute care facilities, HCH may reimburse both the transfer and the transferee depending on the terms of your Participating Provider Agreement.

For hospitals reimbursed using a DRG base rate, HCH reimburses the transferring hospital the lesser of the per diem rate and the total negotiated case rate. The per diem rate is calculated by dividing the negotiated

rate by the geometric mean length of stay for the assigned DRG. For hospitals reimbursed at a per diem rate, the payment is calculated at the negotiated per diem rate.

The receiving hospital is paid at the negotiated rate.

Readmissions

For all inpatient stays reimbursed at a case rate, HCH reserves the right to review readmissions for the same or related conditions within 15 days of discharge.

If HCH determines upon review that a readmission arose from premature discharge or failure of the facility to manage the discharge properly, HCH will potentially deny payment for either the readmission or the original stay, regardless of the medical necessity of the readmit.

Anesthesia

Healthcare Highways reimburses anesthesia based on the concepts of basic values, time unit values, and conversion factors. Basic values are defined by the ASA and time units are calculated on a 15-minute interval basis and rounded to the nearest decimal point (e.g. 32 minutes of anesthesia equals 2.1 time units). Conversion factors are either explicitly listed in your Participating Provider Agreement or based on CMS localities.

Anesthesia time starts when the anesthesiologist begins to prepare the patient for induction and ends when the patient can safely be placed under postoperative supervision. The following formula is used to determine anesthesia reimbursement:

Base Value + Time Units) x Conversion Factor = Reimbursement Physical status modifiers

In-Office Physician Laboratory Services (IPLS)

The In-Office Physician Laboratory Services (IPLS) is a list of laboratory procedural/testing codes that HCH will reimburse its Physicians to perform in their offices. This list represents procedures/tests that HCH Physicians can perform in their offices and will be reimbursed by HCH. All other lab procedures/tests must be performed by one of the participating laboratories in HCH's network or reimbursement to the physician's office is reduced to a level according to the terms of Providers' Participating Agreement.

PT Code	Description
81000	Urinalysis nonauto w/scope
81001	Urinalysis auto w/scope
81002	Urinalysis nonauto w/o scope
81003	Urinalysis auto w/o scope
81025	Urine pregnancy test
82247	Bilirubin total
82270	Occult blood feces
82272	Occult blood feces 1-3 tests
82803	Blood gases any combination
82948	Reagent strip blood glucose
82962	Glucose blood test
83014	H pylori drug admin
83026	Hemoglobin copper sulfate
83655	Assay of lead
83861	Microfluid analy tears
84146	Assay of prolactin
84443	Assay thyroid stim hormones
85007	Bl smear w/diff wbc count
85013	Spun microhematocrit
85018	Hemoglobin
85025	Complete cbc w/auto diff sbc
85027	Complete cbc automated
85651	Rbc sed rate nonautomated
86403	Particle agglut antibody scrn
87070	Culture other specimen aerobic
87081	Culture screen only
87177	Ova and parasites smears
87210	Smear wet mount saline/ink
87220	Tissue exam for fungi
87804	Influenza assay w/optic Strep a assay w/optic
87880	Strep a assay w/optic
88738	Hgb quant transcutaneous
89060	Exam synovial fluid crystals
89300	Semen analysis w/huhner
89310	Semen analysis w/count
89320	Semen anal vol/count/mot
89321	Semen anal sperm detection
89322	Semen anal strict criteria

Drug Testing

Claims for specific, multiple drug class CPT and HCPCS codes for presumptive and definitive drug tests, will be reimbursed following Medicare's policy. This means that only those presumptive and definitive drug testing CPT/HCPCS codes outlined in this policy will be reimbursed. Reimbursement is subject to medical record documentation, including appropriately documented orders, correct CPT/HCPS coding, participant benefits and eligibility.

QUANTITY LIMITS

HCH's policy is to allow reimbursement for up to one definitive or one presumptive drug test per date of service, limited to 20 reimbursable units total per plan year unless a participant's benefit plan specifically allows for more.

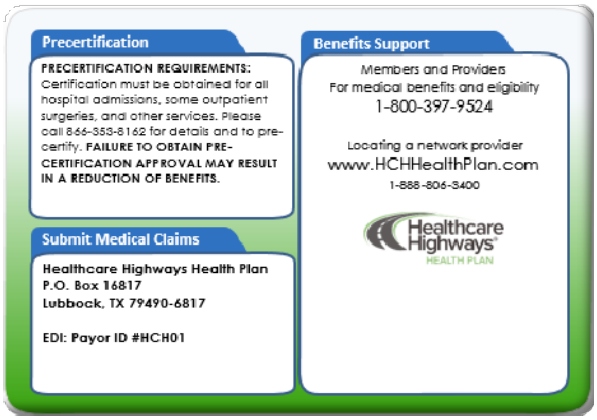
REIMBURSABLE CODES

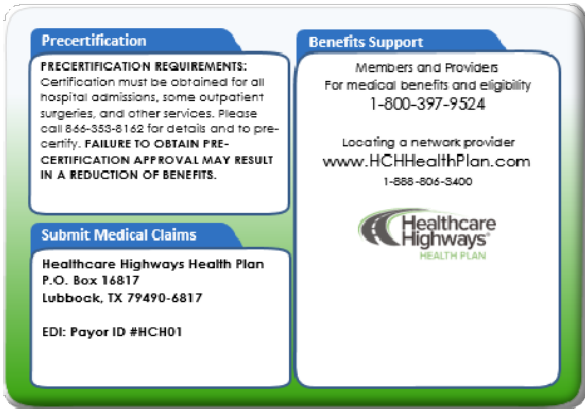
Presumptive Drug Test	80305, 88306, 80307
Definitive Drug Test	G0480, G0481, G0482, G483 and G0659

APPENDIX A: HEALTHCARE HIGHWAYS MEMBER ID CARDS

Healthcare Highways Health Plan ID Cards

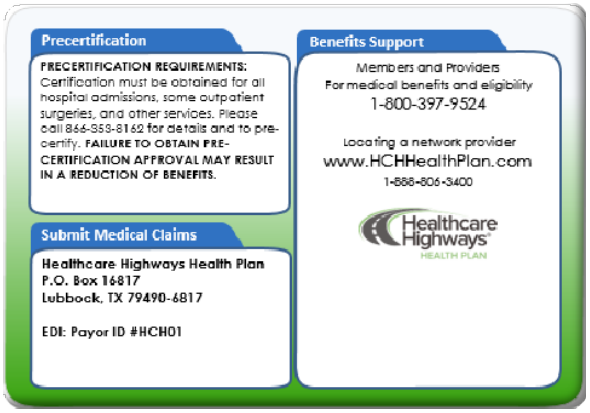
Texas and Oklahoma Based Participants

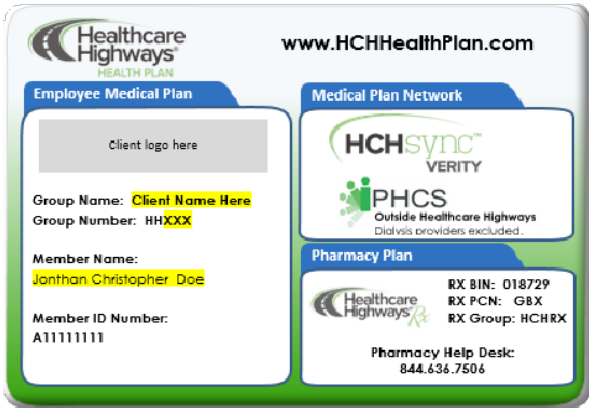


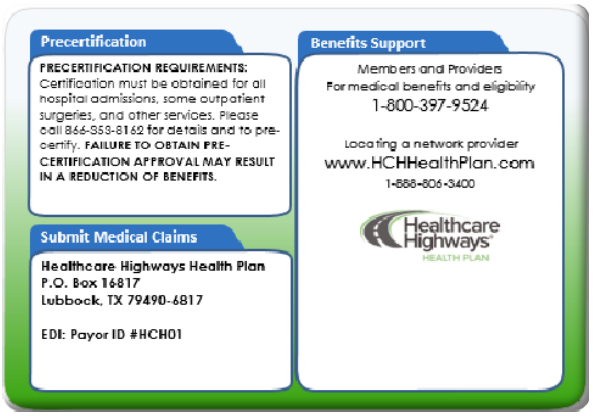


Healthcare Highway Health Plan ID Cards (Continued)

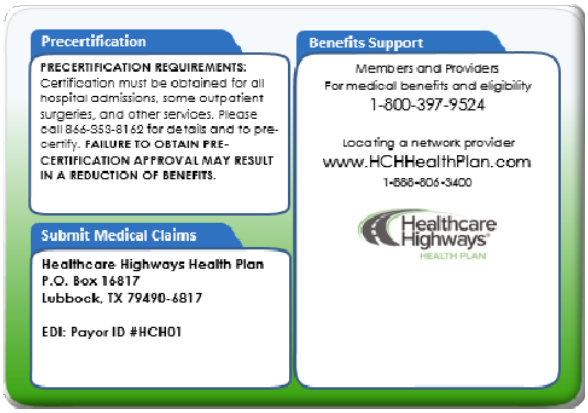
Oklahoma Based Participants





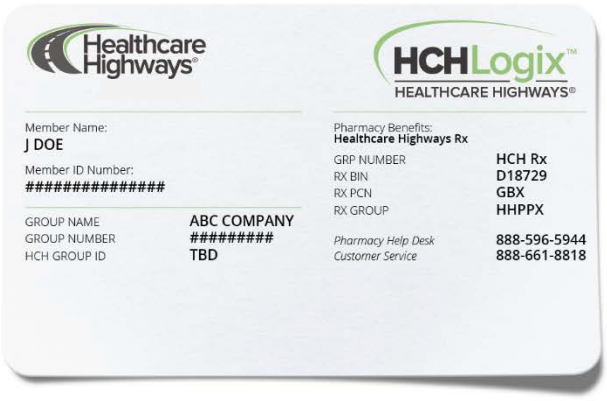


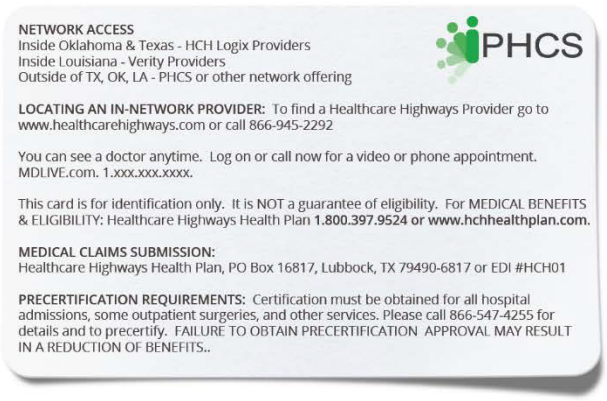
Louisiana Based Participants



Network Access Only ID Cards

Texas and Oklahoma Based Participant





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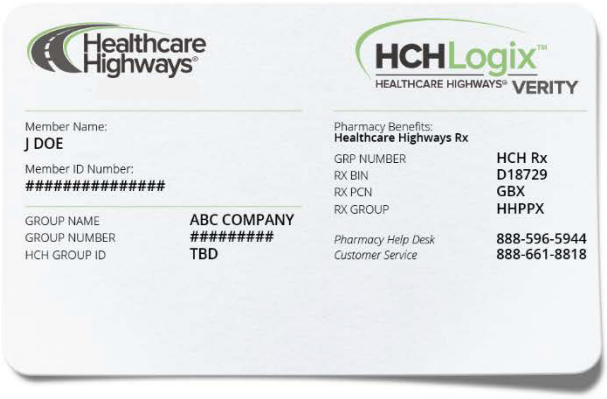
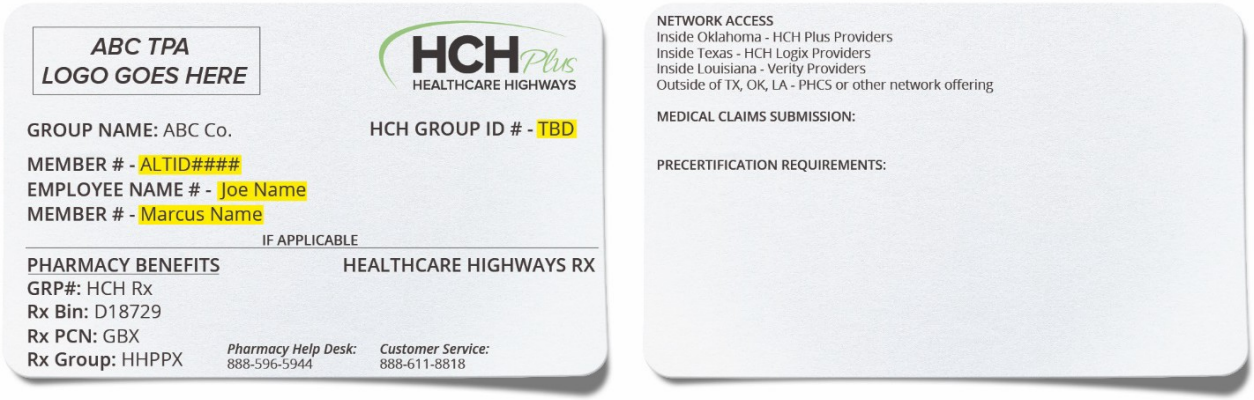


Network Access Only ID Cards (Continued)



Oklahoma Based Participant

Louisiana Based Participant