Montana and Mountain Health CO-OP Provider Manual

In Montana:
Access Care
Connected Care

In Idaho:
Link
Access Care
Engage

Revision Date: 10/15/2017

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Introduction

The Montana and Mountain Health CO-OPs (MHC) Provider Manual is intended for use by physicians, ancillary providers, and contracted facilities/vendors as well as their practice managers and office staff.

The information communicated in this manual does not take the place of physician service agreement signed by the contracted or employed provider. **This provider manual is considered an attachment to and thereby part of all executed MHC Provider Services agreements as referenced thereto and incorporated therein.**

History

Montana and Mountain Health CO-OPs

Welcome to Montana and Mountain Health CO-OP (MHC). We value and honor the distinctive connection that you share with our members.

MHC was formed under the Affordable Care Act's provision which offered the opportunity to create consumer oriented and operated plans – CO-OP.

MHC operates in two states: Montana and Idaho. MHC offered its first coverage to individuals and employer groups in 2014 in Montana, with the implementation of the Affordable Care Act and began offering coverage to individuals and employer groups for Idaho in 2015.

MHC has partnered with the University of Utah Health Plans (UUHP) as our Third- Party Claims Administrator beginning with member coverage January 1, 2018. UUHP will be performing claims and medical management functions on behalf of MHC, as well as coordinating billing and enrollment functions.

We believe Montana's and Idaho's doctors and hospitals should be fairly compensated for the work they perform. By making health insurance affordable for more members, we're helping providers like you deliver the treatment your patients need while reducing your unreimbursed care. We hope you'll join the multitude of Montana and Idaho providers who have partnered with us already.

To learn more or join our network, please go to the MHC website under "Providers" and "Join Our Network" and fill out the provider application and email it to us or call us at 1-855-447-2900

Purpose

The purpose of this manual is to answer important questions about administering health care services to MHC members. The manual describes administrative policies and procedures, as well as other pertinent information. From time to time, it will be necessary to update the manual.

Please check our website at www.mhc.ccop for the latest version.

Contacts

Provider Contracting	Provider Portal at www.mhc.coop or call: 1-855-447-2900
Network Credentialing Verification	mhcproviderrelations@hsc.utah.edu
Patient Eligibility/Benefits	24 x 7 online via Provider Portal at www.mhc.coop **or** Monday – Friday, 8:00 AM to 5:00 PM call 1-855-447-2900
Claims Issues/Paper Claims	University of Utah Health Plans PO Box 45180 Salt Lake City, Utah 84145-0180 Or call: 1-855-447-2900
Provider Relations	MHCProviderRelations@hsc.utah.edu
EDI Claims	See p. 12 for instructions or customerservice@uhin.com or 1-877-693-3071
EDI 270/271 Issues	See p. 12 for instructions, or for issues after hours contact U of U Help Desk at 1-801-587-6000
Prior-Authorizations	1-801-587-2851
Appeals	1-855-447-2900
Pharmacy Prior-Authorization	1-866-236-5976
First Health Network Inquiries	1-855-447-2900
Refunds & Recoveries	1-855-447-2900
U Link Issues	1-833-843-2485
Medical Necessity Review Requests	University of Utah Health Plans Attn: UM Department PO Box 45180 Salt Lake City, Utah 84145

Montana Products

In **Montana,** we offer two main categories of plans:

Connected Care Plans

Connected Care plans offer our lowest premiums and a provider network that emphasizes preventive care to maintain affordability with limited provider choices in Billings, Great Falls, and Missoula. Individual, Family and Native American Plans on Connected Care fall into four categories:

- Bronze
- Silver
- Gold
- Catastrophic

Access Care Plans

Access Care PPO plans are accepted statewide by a large network of healthcare providers across Montana. Individual, Family and Native American Plans on Access Care fall into these categories:

- Bronze
- Silver
- Gold

Montana Health Co-Op also offers Group Coverage for small and large business.

Idaho Products

Link Plans

Link plans offer our lowest premiums and a provider network that emphasizes preventive care to maintain affordability. Available ONLY to residents of the Treasure, Magic and Wood River Valleys, as well as the McCall area.

Individual, Family and Native American Plans on Connected Care fall into four categories:

- Bronze
- Silver
- Gold
- Catastrophic

Access Care Plans

Access Care PPO plans feature an array of in-network doctors and hospitals.

Individual, Family and Native American Plans on Access Care fall into five categories:

- Bronze
- Silver
- Gold
- Catastrophic

Engage Care Plans

Engage plans feature two tiers of in-network providers to offer a balance of choice and cost savings. Available ONLY in these counties: Benewah, Bonner, Boundary, Kootenai and Shoshone.

Individual, Family and Native American Plans on Access Care fall into these categories:

- Bronze
- Silver
- Gold
- Catastrophic

Mountain Health Co-Op also offers Group Coverage for small and large business.

Member Access Standards

Appointment Availability Times

Type of Care	Primary Care Providers	Specialty Providers
Urgent Care	Within 24 Hours	Within 24 Hours
Routine Care	Within 30 Days	Within 30 Days
Preventive Care	Within 60 Days	

A PCP is defined as a generalist in any of the following areas:

- Family Practice
- General Practice
- General Internal Medicine
- Obstetrics/Gynecology (by physician's choice)
- General Pediatrics

A PCP can be a Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), Nurse Practitioner, Resident or Physician Assistant.

Appointment Scheduling

Providers are required to have implemented an appropriate scheduling system which allows for adequate allotments of time for different appointment types, and allows for adequate slots reserved for urgent / acute care.

The provider's telephone system shall be adequate to handle the volume of calls coming into the office.

Office Wait Times

For scheduled appointments with PCPs and Specialists, members should not wait longer than 45 minutes before being taken back to an exam room. Once in the exam room, the member should not wait longer than 15 minutes before seeing the provider.

After Hours Care

MHC requires all providers to have back up coverage during off hours or scheduled days out of the office and to have telephone coverage 24 hours per day, 7 days per week. The use of in office recordings must state the operating hours of the office, whom to contact if after hours, and direct the member to call 911 if it is an emergency.

PCP providers are required to return member calls within two (2) hours of being contacted, or have a mechanism in place to direct members to the appropriate after-hours care.

Billing and Claims Payment

Claims Submission Requirements

Providers should submit claims on standard forms (CMS 1500 for professional services and UB04 for facility services), or the appropriate 837 HIPAA compliant transaction EDI file within timely filing requirements. All necessary information for correct processing of the claim should be included on or attached to the claim form, including:

- Enrollee/Patient Name (exactly as it reads in the ID card)
- Identification Number of Patient/Subscriber
- Patient's Date of Birth
- Patient's Address
- Provider's Name
- Provider's Tax Identification Number
- Provider's NPI
- Provider's Practice and Billing Addresses
- Other Insurance Information (if applicable and known)
- Date(s) of Service
- Medical Diagnosis ICD-10 Code(s) (Codes should be obtained from the Medical Diagnosis Code Handbook for the year corresponding to the date of service.)
- Procedure codes (CPT4) or Revenue codes identifying services on claim (CPT codes should be obtained from the CPT Code Handbook for the year corresponding to the date of service).
- Billed Charges for each service on claim.
- Supporting Documentation including operative reports, emergency room reports, medical records supporting diagnosis when requested, etc.
- Explanation of Benefits from Primary Payer (if applicable).

MHC prefers you to submit claims electronically. If you need to submit a paper claim, please submit paper claims to the following address for processing:

University of Utah Health Plans
P.O. Box 45180
Salt Lake City, Utah 84145-0180

Claims will be processed and remittance advices sent to the provider in accordance with the timeliness provisions set forth in the providers participating provider agreement.

Clean Claims

A clean claim is any claim submitted by a Provider that:

- is received timely by MHC;
- has a corresponding referral, if required;
- if submitted on paper, is submitted on a UB04, CMS-1500 or successor claim form(s) with all required elements;
- if submitted electronically, is submitted in compliance with the applicable federal and state regulatory authority and uses only permitted standard code sets;
- includes all relevant information and/or information required by MHC;
- requires no other information to determine other carrier liability or to investigate possible fraud;
- complies with the billing guidelines and medical policies;
- has no defect or impropriety;
- includes substantiating documentation; and
- does not require special processing that would prevent timely payment

Claims Review and Audit

Provider acknowledges MHC's right to review Provider's claims prior to payment for appropriateness in accordance with MHC's medical necessity policies and procedures, and in accordance with industry standard billing rules including, but not limited to, current UB manuals and editors, CPT and HCPCs coding, CMS, and/or other industry standard bundling and unbundling rules, National Correct Coding Initiatives (NCCI) Edits, and FDA definitions and determinations of designated implantable devices. Provider acknowledges MHC's right to audit and review on a line item basis, or other such as basis as deemed appropriate by MHC, and MHC's right to exclude inappropriate line items, to adjust payment, and to reimburse Provider at the revised allowed level.

Remittance Advice

MHC will send a summary remittance advice to the provider's office for each claim period summarizing all claims processed for that provider by patient. Each claim is assigned a number and clearly identifies provider, patient, dates of service, billed charges, allowed amount, paid amount and reason codes for any processing decisions.

Provider payments will be issued via Electronic Funds Transfer (EFT), Virtual Credit Card, or by paper check. If provider does not use EFT then a paper check for form of payment will be the default. Virtual Credit Card is another option of payment; for more information please contact Provider Relations.

If you have a question on processing or payment of a claim, please contact an MHC Member Service Representative. The representative can research the claim based on claim number, patient, provider and dates of service.

MHC also offers on-line capability to verify processing or payment of a claim through U Link, our new Provider Portal. If you would like to learn more about U Link, please contact Provider Relations at 1-833-843-2458.

Timely Filing Requirement

The timely filing limit for primary claims is 1 year from the date of service. The timely filing limit for secondary claims is 365 days from the primary payer's EOB adjudication date. The provider will have the opportunity to correct any billing or coding error within 365 days of the denial related to any such claim submission.

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

Overpayments/Refunds

If MHC determines that a claim has been overpaid, MHC will recover the balance due by way of offset or retraction from current and/or future claims. Provisions for repayment of refunds included in the Provider's agreement with MHC shall supersede those contained in this manual.

If overpayments are identified through the Fraud, Waste and Abuse department, provider will be notified in writing and will be given sixty (60) days to dispute or refund the overpayment. If Provider fails to submit the balance due within sixty (60) days of notification, MHC may recover the balance due by way of offset or retraction from current and/or future claims.

Please notify MHC immediately if you discover an error requiring reprocessing of the claim.

Coordination of Benefits

MHC may not be the primary payer in certain circumstances, including services covered by a property owner's liability insurance policy, the Medicare Program, or an injury or illness caused by a third party. The provider should submit the claim to the payer or party primarily responsible for the claim. If the claim is subject to coordination of benefits, the remittance advice from the primary payer will need to be submitted with the claim if you are submitting a paper claim.

In the event a commercial plan or third party is primary, MHC will pay the lesser of the remaining billed charges or the allowable amount had MHC been the primary payer. Payment by MHC will be reduced by the amount of reimbursement from the primary payer. If compensation is recovered from a third-party payer, the provider is expected to refund any amounts paid by MHC for covered medical services.

For specific questions regarding coordination of benefits, call 1-855-447-2900.

Electronic Claims Filing

Electronic data interchange (EDI) presents substantial advantages for providers and payers alike. By utilizing electronic claims submission, providers benefit by seeing an increase in efficiency, productivity and cash flow, whereas payers benefit in the reduction of data entry errors and faster turn-around times.

Of the electronic claims submitted to MHC, 80% do not require processor intervention. Our average turn-around time for electronic claims (date claim is received electronically to the check being received in the provider's office) is eight days.

MHC presently accepts the following HIPAA-compliant transactions: 837 P (Professional Claims), 837 I (Institutional Claims), 270 (Eligibility Request) 276 (Claim Status Request)

UUHP's EDI connection is as a member of the Utah Health Information Network (UHIN), a non-profit coalition of payers, providers and other interested parties, including state government, in Utah. Numerous options are available for electronic claims submission through UHIN. Please visit http://www.uhin.org/ for more information. If a provider is not a member of UHIN, other options are available for sending EDI claims

The steps in setting up EDI with MHC are relatively simple:

1. Contact EDI support
2. Review information on our website- http://uhealthplan.utah.edu/EDI/
3. Fill out Trading Partner Form and return by fax, email or online.
4. Send a Test File for review and sign off
5. Once the Test File is good, the provider can move to production right away

The entire process of setting up EDI, from initial contact to production ready, can take as little as a few days.

For more information or questions, please visit our website and/or contact:

EDI Information Coordinator Phone:
(801)587-2638 or (801)587-2639
Fax: (801)281-6121
Email Address: MHCedi@hsc.utah.edu
Website: http://uhealthplan.utah.edu/EDI/

Corrected Claims/Adjustments

When submitting a corrected claim, it must be identified by one of the following:

1. UB04 -3rd digit of the bill type 7 (XX7).
2. CMS 1500 – Modifier CC and 3rd digit of the bill type 7 (XX7).

Corrected claims or adjustments will be adjudicated within the timeframes set forth as described in the **Timely Filing** section.

Claim Notes

Claim notes, claim line notes (professional claims only) and claim billing notes (institutional claims only) can be submitted in the electronic file. MHC will not know if the claim note(s) affect the claim payment, therefore MHC will pend any claims with claim notes for review. If the notes you are submitting do not affect claim payment, the claims will take longer to process as they will require manual review. Consequently, we ask that you limit claim notes to information such as:

- Accident details

- Auto or subrogation detail
- Any special circumstances

Claims Editing

MHC follows National Correct Coding Initiative (NCCI) guidelines/edits. These coding edits are developed based on procedures referenced in the American Medical Association's (AMA) Current Procedural Terminology (CPT) Manual and the Healthcare Common Procedure Coding System (HCPCS) Manual.

Mid-Level Provider Reimbursement

Unless otherwise stated in the signed participating agreement, MHC follows Medicare Guidelines for reimbursement of mid-level providers.

Member Information

Member Identification

MHC will provide an identification card to members listing their name and their assigned ID number. The entire ID number must be used for billing and inquiries.

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

- Member name, member ID number, group name
- Summary of key member copay, deductible and coinsurance responsibilities
- Pharmacy information
- How to contact MHC for eligibility, benefits, prior authorization and utilization management
- Claims submission information
- Locating a participating provider

MyChart

MHC members can check claim status, eligibility, and out-of- pocket benefits on MyChart.
https://mychart.med.utah.edu/mychart/default.asp

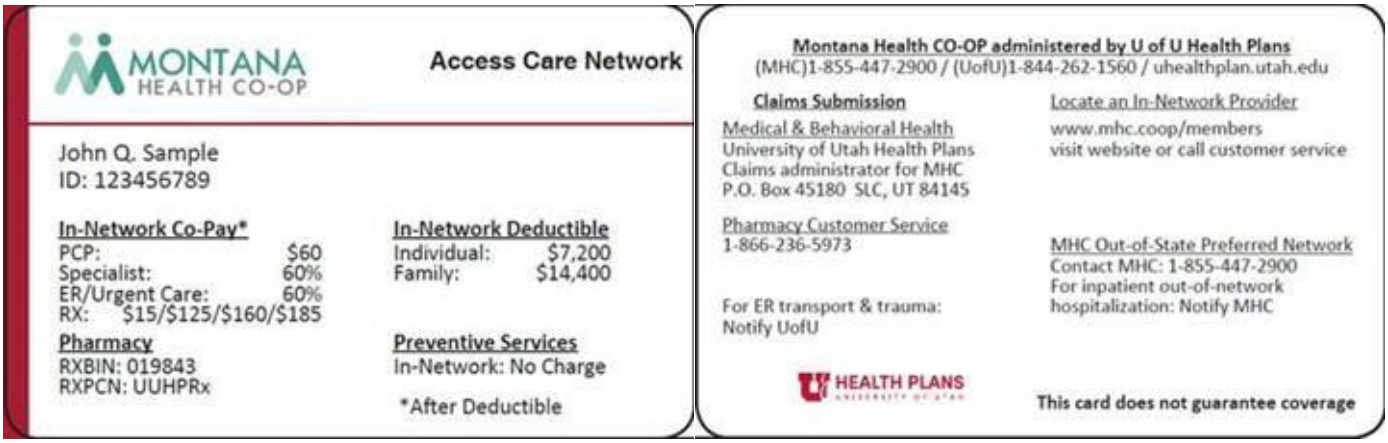
Member Eligibility

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

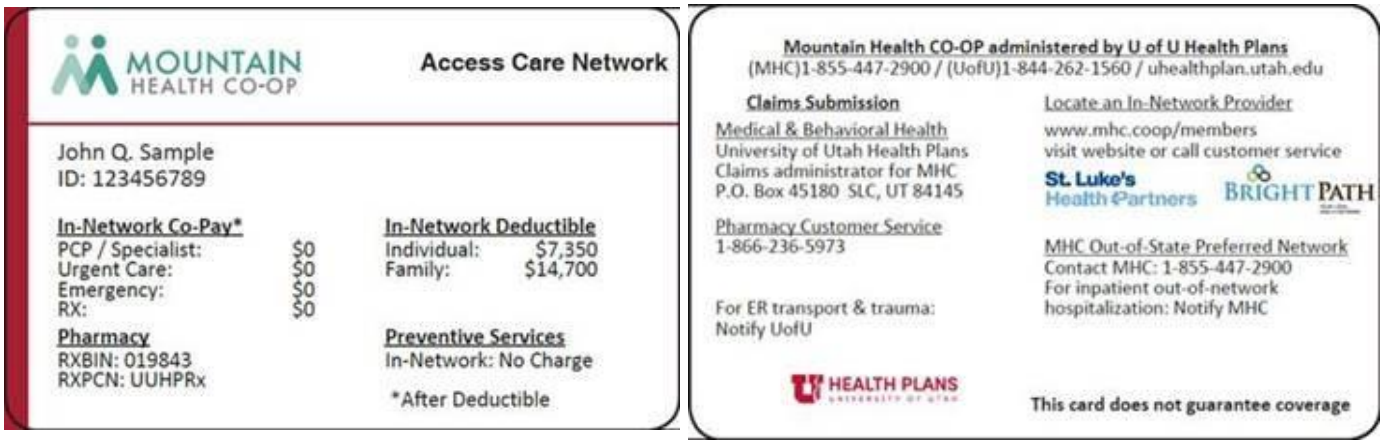
To ensure member eligibility, you should ask for a copy of the member ID card. If the patient does not have his/her member card, please contact MHC at 801-587-6480 or 1-888-271-5870.

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

Montana Health CO-OP ID Card



Mountain Health CO-OP ID Card



Billing Members

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

Member Hold Harmless

The "No Billing of Members" clause, outlined in the Provider Agreement, is in accordance with state and federal law. Participating providers may **not** seek payment directly from members, except for required copayments, annual deductibles, or coinsurance. Contracted providers should collect fees for any non-covered services directly from the member. Providers should not balance bill the member for the difference between the contracted amount and the total billed charges.

Not Medically Necessary: Provider is not prohibited from collection from Members payment for services that are not Medically Necessary provided that the Member or a person legally responsible for

Member has been notified by Provider in advance in writing that such services are not Medically Necessary and that Member or a person legally responsible for Member has explicitly consented to pay for such services prior to the services being rendered. The written notification must be specific and not part of the provider's general financial policy and not signed under duress.

Non-Covered Services: Provider may collect from Members payment for certain services up to the amount allowed under this agreement but only provided that the Member or a person legally responsible for Member has been notified by Provider in advance in writing that such services are not Covered Services and that Member or a person legally responsible for Member has explicitly consented to pay for such services prior to the services being rendered. In no event will MHC or the related Payer be responsible for any amounted owed to Provider for Non- Covered Services in the event Provider is unable to collect from Member.

Copayments

A copayment is a fixed amount that a member is responsible to pay to the provider at the time of service (i.e. office visits). Some benefit plans have an equal copayment for PCP and Specialists. Some benefit plans may have a split copayment where the specialist copayment is higher than the PCP copayment. Copays are generally excluded from the out-of-pocket maximum.

Copayments vary according to the member's benefit plan. Refer to the member's ID card.

Each member's ID card indicates the amount of copayment the member is required to pay. The member is responsible for only one copayment per office visit, and is responsible for paying the copayment to MHC participating providers at the time of service.

Deductibles

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

Coinsurance

Coinsurance is the percentage of eligible medical expense that is payable by the member and MHC which will total 100% of the provider's contracted amount.

Out-of-Pocket Maximum

An out-of-pocket maximum is the amount of covered expenses which must be paid each calendar year by a member toward the cost of health care. The individual out-of-pocket maximum applies separately to each member. The family out-of-pocket maximum applies collectively to all members in the same family. MHC will pay 100% of the allowable (except for copayments and the charges excluded, including the PPO discount) for any covered family member during the remainder of the year. Some products and services that do not apply toward the annual out-of-pocket maximum include copayments, deductibles, prescription copayments, mental healthcare services, and non-covered services. Contact Customer Service at 1-855-447-2900 for specific information regarding the MHC member's copayment, annual deductible, coinsurance, non-covered service or copayment and benefit maximums.

Member Rights and Responsibilities

Member Rights

- Member to be treated with respect and dignity and a right to privacy by practitioners/providers, nurses, medical staff, administrative staff and other employees.
- Receive information about the Plans offered by MHC, our practitioners/providers, our services, and Members' rights and responsibilities.
- Members also have the right to know about any procedures that need to be followed for the Member to get care.
- Be informed about their health in a way that they can understand. If the Member is sick, they have the right to be told about their illness, care options and prospects for recovery.
- Openly discuss with their practitioner / provider all appropriate or medically necessary treatment options, regardless of cost or benefit coverage.
- Be involved in decisions about their healthcare. Members have the right to approve any medical service after receiving the information needed to make a choice. Members have the right to refuse medical treatment even when the practitioner/provider says the Member needs it.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- Privacy - Members have the right to keep their medical information and records confidential subject to Federal and State law.
- See their medical record. Members also have the right to ask for corrections to it and receive a copy of it.
- Voice complaints or appeals about the health plan or the care it provides. Members can call Member Services if they have a complaint.
- Appeal MHC decisions.
- Receive a reasonable and timely response to a request for service, including evaluations and referrals.
- Dis-enroll from one of the Plans offered.
- Ask for a second opinion about their medical condition.
- Receive interpreter services, and not be asked to bring a friend or family Member with them to act as an interpreter.
- Request information about their Plan, their practitioners/providers, or their health in the Member's preferred language.
- Receive a copy of their Plan's drug formulary on request.
- Receive nondiscriminatory medical care MHC providers (applicable to provider's scope of practice) regardless of age, gender, color, ethnic origin, sexual orientation, marital status, income status or medical diagnosis or condition.
- Continue enrollment in their selected Plan without regard to adverse changes in health or medical condition.
- Receive the appropriate, highest quality of medical care.
- Members are free to exercise their rights without any fear of retaliation or being treated differently.

Member Responsibilities

- Be familiar with and ask questions about their health benefits, plan requirements, covered services, and contact information. If Members have a question about their benefits, call Member Services.
- Provide information to MHC, its practitioners and providers, including their Member ID Card, or plan information as needed in order to provide care.
- Obtain services only from participating providers unless in an emergency when participating providers are not available or closest provider or when services out-of-network have been approved by the plan.
- Understand their health problems. Be active in making decisions with their practitioner to develop agreed upon treatment goals and do all they can to meet the goals.
- Follow an agreed upon healthcare plan of care and healthcare instructions, or obtain a second opinion if they do not agree with the plan of care.
- Build and keep a strong patient-provider relationship. Members have the responsibility to cooperate with their provider and staff. This includes being on time for visits or calling their provider if they need to cancel or reschedule an appointment.
- Report fraud or wrong doing to MHC or the proper authorities. Pay their Premiums and co-payments as required by their health care coverage.
- Notify MHC Member Services immediately upon a change in status: marriage, divorce, death in the family or addition to the family.
- Make best effort to maintain good health through healthy lifestyle and obtaining necessary and appropriate medical care.
- Always discuss health information in any newsletter or on any web site with your doctor to make sure it is appropriate for you. Never use this information to replace your doctor's advice.

Appeals

Appeals must be received within 180 days from the date of the MHC determination notification/Notice of Action (NOA) letter or Explanation of Benefit (EOB). MHC will review and provide notification of decisions to the member for first-level, second-level, and expedited appeals.

MHC will respond to appeals: Pre-service Appeals within 30 calendar days of receipt of the request. Post-service Appeal within 45 calendar days of receipt of the request. Expedited Appeals within 72 hours of receipt of the request. Voluntary External Appeals within 45 days of the receipt of request and Voluntary Expedited External Appeals within 72 hours of the receipt of your request.

MHC may extend the timeframes for appeal resolutions, including expedited appeals, by up to 14 calendar days if the enrollee requests or agrees to extend the appeal timeframe or MHC determines and documents that there is need for additional information and how the delay is in the enrollee's interest. If MHC extends the timeframes, a written notice of the reason for the delay will be given to the enrollee.

Appeals may be received via mail, in person delivery, fax, or orally. Oral appeals may be made by calling 844-262-1560. Written requests can be sent to: University of Utah Health Plan, 6053 South Fashion Square Dr., Suite 110, Murray, UT 84107; or Faxed to: (801) 281-6121. The appeal may be completed, using the online form, located on the MHC's website: mhc.coop.

A Provider or other authorized representative may appeal on behalf of the member if the member or member's legal guardian authorize, in writing, disclosure of personal information for the purposes of the appeal. A Consent form is available on the website: mhc.coop.

Voluntary External (Routine or Expedited) Appeal

Available to members/Policy holders. The review and decision is made by an Independent Review Organization (IRO) at no cost to the member, after the member has exhausted the applicable non-voluntary levels of appeals, or if MHC has failed to adhere to internal appeal requirements. The Voluntary External appeals must be requested within 180 days of the member receipt of the notice of the prior adverse decision. The IRO will decide within 45 days after receipt of the request.

Provider Responsibilities

Provision of Covered Services

Providers must be aware of benefit plans' covered services and inform enrollees of covered services; as well as other programs and resources available to enrollees for prevention, education and treatment. Practitioners may freely communicate with patients about their treatment, regardless of benefit coverage limitations.

Provider Services

Provider Services shall be available from a Provider, or from a Covering Provider, 24 hours a day, seven (7) days per week. Provider agrees that the Covering Provider shall be a Participating Provider. If Provider Services are rendered by any person other than a Participating Provider, Provider shall (i) notify MHC or MHC (where applicable) prior to referring Member to a non-Participating Provider, and (ii) use best efforts to notify such provider of utilization management requirements. In the event of an Emergency, Provider is not obligated to provide such prior notifications. Pertaining to Participating Facilities, services shall be available from Participating Facility twenty-four (24) hours a day, seven (7) days a week. If facility services are rendered by any facility other than a Participating Facility, facility shall (i) notify MHC's utilization management department prior to referring Member to a non-Participating Facility, and (ii) use best efforts to notify such facility of MHC's utilization management requirements. In the event of an Emergency, facility is not obligated to provide such prior notifications.

Credentialing and Re-credentialing

The purpose of the MHC Credentialing Program is to ensure that the MHC provider networks consist of high quality providers that have met clearly defined standards. UUHP will perform Delegated Credentialing responsibilities for MHC and ensure that the credentialing program follows the standards set forth by the National Committee for Quality Assurance (NCQA).

UUHP's credentialing team has collaborated with National Committee for Quality Assurance (NCQA) certified Credentials Verification Organization (CVO) CredSimple, and CAQH ProView, the trusted electronic solution and industry standard for universal credentialing applications in order to offer our providers an efficient credentialing process enabling them to minimize the time between contracting with MHC, and providing services to our members.

To allow our credentialing team to access the CAQH applications for your group, please visit the CAQH site at www.caqh.org and grant permission to MHC and the University of Utah Health Plans to receive

your providers' applications. If your providers have not completed their one-time credentialing application enabling multiple healthcare organizations nationwide, we encourage them to do so at no cost to them, resulting in time savings for you, by going to the following link: http://www.caqh.org/sites/default/files/solutions/proview/guide/PR-QuickRef.pdf

To initiate credentialing for new providers with your practice, simply send the following to our credentialing team at provider.credentialing@hsc.utah.edu:

- Provider's first and last names with middle initial
- Provider's title
- Provider's specialty
- Provider's date of birth
- Provider's CAQH#
- Provider NPI
- Primary Practice Location
- Credentialing contact name and email address

(For example, John Q. Public, MD – Family Medicine – 01-01-1951 – CAQH 12345678 – NPI 1234567890 – Doctors Medical Clinic – Mary Smith – mary.smithcredentialing@gmail.com.*)*

The decision to accept or reject a practitioner's application is based on information generated through primary source verifications, complaints and grievances, malpractice history, board certifications and peer recommendations. Other sources of information may be considered as appropriate and relevant at the sole discretion of the Credentialing Committee members. For unfavorable decisions, providers may consult the Practitioner Appeal Rights in the credentialing policies and procedures.

MHC requires that all PAs and other mid-level providers complete credentialing. Once PAs are credentialed, they must submit claims under their own name and NPI for our commercial plans

Initial credentialing and re-credentialing every three (3) years is required for all physicians and other types of health care professionals practicing under their own license as permitted by state law.

For a copy of the MHC credentialing policies and procedures, please contact provider credentialing at provider.credentialing@hsc.utah.edu or (801) 587-2838 Option 3.

Monitoring of Provider Sanctions and Disciplinary Actions

MHC does on-going monitoring of provider sanctions and disciplinary actions. Reports from the Health & Human Services (HHS), Office of Inspector General (OIG) and state licensing boards are reviewed regularly throughout the year. Providers with Medicare / Medicaid sanctions, or who have a business relationship with another provider or entity that has been debarred or excluded, may be terminated from the MHC participating networks. Providers who have had restrictions placed upon their license to practice will be presented to the peer review committee for a decision on the appropriate action to be taken.

Credentialing documents and information are kept confidential and disclosure is limited to parties who are legally permitted to have access to the information under state and federal law.

Institutional and Supply Providers

MHC ensures that all institutional and supply providers have met their respective certifications, that they have current licenses to operate in their respective state that they are in good sta*ndin*g with state and federal authorities, and have adequate liability coverage. Credentialing is completed upon initial contracting and then every three (3) years.

- Birthing centers must have clear, written plan of transfer and transition of care in emergency circumstances. The plan must include the name(s) of the hospital and the OB/GYN practitioner(s) providing backup.

Provider Complaints

MHC recognizes that we cannot assist our members in getting the health care they need without you. As such, our goal is to provide GREAT customer service to our providers.

If something is not working, or if we're doing a great job, please let us know.

On Behalf of a Member

A complaint on behalf of a member about health plan benefits or health care services must be registered within one year of the service date.

Send a written complaint to:

University of Utah Health Plans Grievance Coordinator
6053 Fashion Square Dr. Suite 110
Murray, UT 84107

Upon receipt of your complaint, the Grievance Coordinator will then send a letter of acknowledgement to the complainant.

Regarding Health Plan Policies

A complaint about health plan policies may be submitted at any time to the provider relations department.

Please call Provider Relations at:

- 1-855-447-2900
- Or send a written complaint to:

MHC Provider Relations
6053 Fashion Square Dr. Suite 110
Murray, UT 84107

MHC providers should email Provider Relations at MHCProviderRelations@hsc.utah.edu.

Upon receipt of your complaint, the Provider Relations representative will then send a letter of acknowledgement to the complainant.

Service Delivery / Non-Discrimination

Providers are required contractually to render covered services to MHC members in an appropriate, timely, cost-effective manner, consistent with customary medical care standards and practices. Services will be delivered in a culturally and linguistically appropriate manner, thereby including those with limited English proficiency or reading skills, those with diverse cultural and ethnic backgrounds, the homeless and individuals with physical or mental disabilities. To arrange translation services please contact the MHC member services at 1-855-447-2900. Practitioners and Providers may openly discuss with members all appropriate or medically necessary treatment options, regardless of benefit coverage limitations.

Provider shall also, in compliance with Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, Title II of the Americans with Disabilities Act of 1990, and provide access and treatment without regard to race, color, sex, sexual orientation, religion, national origin, disability or age. Additionally, provider shall not, within their lawful scope of practice, discriminate against members from high-risk populations or who require treatment of costly conditions. Any provider with concerns regarding the provision of services or employment on the basis of disability, or compliance questions should be referred to the Member Services at 1-855-447-2900.

Doctors are not Rewarded for Denying Care

MHC reminds our practitioners/providers that decisions about utilization management (effective use of services) are based only on whether care is appropriate and whether a Member has coverage. MHC does not reward doctors or others for denying coverage or care. UM decisions are based only on appropriateness of care and service and existence of coverage. MHC does not reward practitioners/providers or other individuals for issuing denials of coverage or service care; and UM decision-makers do not receive financial incentives.

Organizational Facilities

Providers shall maintain organizational facilities that adhere to NCQA and regulatory requirements as required by state or federal law. Non-NCQA accredited facilities shall be subject to onsite visits for credentialing purposes at the discretion of MHC. Providers must write prescriptions on tamper-resistant prescription pads, in accordance with Section 7002(b) of the U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act of 2007.

Medical Records

Participating providers shall maintain confidential, correct, legible and complete medical records for all MHC members. Medical records and other PHI are to be stored in a secure location.

To fulfill activities such as, but not limited to, payment of claims, quality improvement, State and/or Federal reporting, credentialing, and HEDIS, MHC may conduct medical record audits. The audits may include, but are not limited to, evaluation of the following:

- legibility,
- patient identifying information,
- entries dated and timed,
- completed problem list,
- completed medication list,

- clear notation of allergies,
- documentation of immunizations and preventive health screening as applicable,
- progress notes for each visit that include plans for follow up and/or return visits,
- providing appropriate supporting medical documentation to plan for referral and or prior authorization requests, and
- Advance directives.

MHC encourages Specialists to provide consultation notes to the PCP in charge of the member's health. Medical records must be provided at no cost to MHC, and shall be made available for inspection by MHC, its assigned representatives, and/or Federal & State agency representatives during reasonable business hours.

Patient records should be kept for at least seven (7) years.

Patient Confidentiality and HIPPA

Providers, their employees and business associates agree to safeguard the privacy and confidentiality of the MHC members, and agree to abide by the rules and regulations set forth in the Federal Health Insurance Portability and Accountability Act of 1996 "HIPAA".

Written authorization is required from the member for all uses and disclosures of Protected Health Information (PHI) EXCEPT uses and disclosures for Treatment, Payment and Heath Care Operations (TPO). Releases and disclosures of PHI should be done according to a standard of 'minimum necessary', meaning only the amount of information needed to fulfill a specific purpose or task should be released.

TPO may include, but is not limited to:

- Patient Referrals,
- Providing information to family or friends who care, or will be caring for a MHC member,
- Providing the necessary information to MHC for processing and payment claims, and or authorizations,
- Complying with MHC's QA/QI activities, HEDIS reporting and/or other MHC programs centered on the improvement and measurement of patient care.

MHC is responsible to ensure members' privacy and also adhere to stringent confidentiality regulations as required by Federal law. This means that the identity of any caller purporting to be a member must be verified before any information concerning the member is given. This will be accomplished by obtaining the member's identification number and date of birth. Failing that, the member will be required to provide social security number, date of birth and address to ensure the member is actually on the line.

NOTE: Providers must supply Tax ID Number (TIN) and NPI when requesting patient information.

Compliance with MHC Policies and Procedures

Provider shall comply and participate with all MHC Utilization Management Programs, Quality Improvement Programs, Credentialing & Re-credentialing activities, and Complaint/Grievance Policies and Procedures. Providers agree to allow MHC to use their performance data. In addition, Provider shall

abide by policies and procedures related to covered services, billing of enrollees, emergency services, and other Policies and Procedures as defined by MHC with respect to each plan Provider participates in.

Licensure and Insurance

Provider shall maintain current licensure, malpractice liability insurance, specialty board certification when applicable, hospital privileges.

Notification of Changes

Provider shall notify MHC Provider Relations in writing immediately upon a change in status: address, malpractice, licensure, hospital privileges, Medicare / Medicaid sanctions and/or other disciplinary actions or other changes in your credentials.

Complaint Resolution

Provider shall cooperate with MHC personnel to resolve any complaints identified MHC members, other providers or any entity involved in the patient's care.

Utilization Review Management Program

Our Utilization Review Management Program is administered by University of Utah Health Plans ("U of U Health Plans"). Our Utilization Review Management Program provides for Prospective Utilization Review to assure that certain prescribed treatments and elective procedures are medically necessary and appropriate.

Prospective Utilization Review requires the covered person to obtain pre-authorization for certain prescribed treatments and elective procedures before the treatments and procedures are rendered. The covered person must contact the Utilization Review Management Program representative to obtain the pre-authorizations at 1-801-587-2851.

How to use the Utilization Review Program

To use the Utilization Review Management Program, the Covered Person need only to call 1-801-587-2851.

The covered person may have a representative place the call. A representative may be the physician, the covered facility, or the covered person's authorized representative (e.g., family member). The Utilization Review Management Program representative will give the individual who calls a reference number to verify that the call has been received and a file started.

The individual who calls the Utilization Review Management Program will need to provide the following information:

1. The name and other information to identify the covered person for whom treatment has been prescribed and requires Pre-authorization;
2. The policy owner's name and policy number;
3. The name and telephone number of the attending Physician;
4. The name of the covered facility where the covered person will be admitted, if applicable;
5. The proposed date of admission, if applicable; and

6. The proposed treatment.

PLEASE NOTE: Authorization by the Utilization Review Management Program representative does not verify a covered person's eligibility for coverage under this policy, nor is it a guarantee that benefits will be paid for a proposed treatment. Benefit payment will be made for a covered person only in accordance with all the terms and conditions of this policy.

This Utilization Review Management Program does not include:

1. Routine claim administration; or
2. Determination that does not include determinations of Medical Necessity or appropriateness.

Utilization Review Deadlines

- *For prospective determinations (service not yet occurred):* fifteen (15) days;
- *For retrospective determinations (service has already occurred):* thirty (30) days;
- *For expedited determinations (urgent care):* as soon as possible (72-hour maximum) The insurer may seek a 15-day deadline extension for prospective and retrospective determinations.

Medical Treatments Requiring Pre-authorization

Plan Notification (pre-authorization) is required for any inpatient admission, including admissions to a hospital, chemical dependency treatment center, mental illness treatment center, chemical dependency or psychiatric residential treatment facility, intensive outpatient programs, or other medical procedures or services, (or as may be noted for a covered benefit), as soon as the provider recommends or schedules to allow the Utilization Review Management Program to begin working with the covered person on the benefit management for the service. Plan Notification requires contacting the Utilization Review Management Program in writing or by telephone.

Pre-authorization must be obtained for:

1. Benefits that specify that pre-authorization is required (including in-patient admission); and
2. Procedures listed in the Pre-authorization Medical Treatments List.

Failure to obtain the required pre-authorization prior to receiving services will result in pended claims and a review for medical necessity.

Pre-authorization Medical Treatment List

The following medical treatments require pre-authorization:

- Ambulance for non-emergent services
  - Transportation by fixed-wing aircraft (plane)
  - Elective (non-emergency) transportation by ground, ambulance or medical van
- Autologous chondrocyte implantation
- BRCA testing (genetic testing for breast cancer risk)
- Cochlear device and/or implantation
- Dialysis visits
- Dorsal column (lumbar) neurostimulators: trial or implantation

- Electric or motorized wheelchairs and scooters
- Gastrointestinal (GI) tract imaging through capsule endoscopy
- Hip surgery to repair impingement syndrome
- Hyperbaric oxygen therapy
- pre-implantation genetic testing
- Injectables
    - Antineoplastic Agents for non-emergent services
    - Antigout Agents for non-emergent services
    - Blood-Clotting Factor Injectables for non-emergent services
    - Bone Resorption Inhibitors
    - Alpha 1-proteinase inhibitor (human)
    - Antiemetics for non-emergent services o Botulinum toxins
    - Cardiovascular — PCSK9 inhibitors
    - Corticosteroids
    - Enzyme replacement drugs
    - Erythropoiesis-stimulating agents for non-emergent services
    - Functional Gastro-intestinal Disorder Drugs
    - Granulocyte-colony stimulating factors
    - Growth hormone
    - Hepatitis C drugs
    - Hereditary angioedema agents for non-emergent services
    - HER2 receptor drugs
    - Hormones and Hormone Modifiers
    - Immunoglobulins for non-emergent services
    - Immunologic agents for non-emergent services
    - Injectable infertility drugs
    - Osteoporosis drugs
    - PEGylated interferons
    - Pulmonary arterial hypertension drugs for non-emergent services
    - Respiratory injectables for non-emergent services
    - Viscosupplementation
- Inpatient confinements (all)
    - Such as, surgical and nonsurgical confinements; confinements in a skilled nursing facility; mental health rehabilitation facility; substance abuse rehabilitation facility; and maternity and newborn confinements that exceed the standard length of stay (LOS)
- Gender Reassignment Surgery
- Lower limb prosthetics
- Nonparticipating freestanding ambulatory surgical facility services, when referred by a participating provider
- Observation stays more than 24 hours
- Osseointegrated implant
- Osteochondral allograft/knee
- Power morcellation with uterine myomectomy, with hysterectomy or for removal of uterine fibroids

- Proton beam radiotherapy
- Reconstructive or other procedures that may be considered cosmetic
    - Blepharoplasty/Canthoplasty
    - Breast reconstruction/breast enlargement
    - Breast reduction/mammoplasty
    - Cervicoplasty
    - Excision of excessive skin due to weight loss
    - Lipectomy or excess fat removal
    - Surgery for varicose veins, except stab phlebectomy
- Referral or use of nonparticipating physician or provider for non-emergent services, unless the member understands and consents to the use of a nonparticipating provider under their out-of-network benefits when available in their plan
- Spinal procedures
- Artificial intervertebral disc surgery
- Cervical, lumbar and thoracic laminectomy/laminotomy procedures
- Spinal fusion surgery
- Transplants
- Uvulopalatopharyngoplasty, including laser-assisted procedures
- Ventricular assist devices for non-emergent services

Utilization Review Process

When the Utilization Review Management Program representative conducts utilization reviews, the utilization review will include the following provisions.

Utilization Review for Mental Health Treatment

When utilization review is conducted for outpatient mental health treatment, the Utilization Review Management Program representative will only request information that is relevant to the payment of the claim.

When a utilization review requires disclosure of personal information regarding the patient or client, including:

1. Personal and family history; or
2. Current and diagnosis of a mental disorder;

the identity of that individual will be concealed from anyone having access to that information in order that the patient or client may remain anonymous.

Request for Information

The Utilization Review Management Program representative may request only information that is relevant to the payment of a claim for utilization review of outpatient mental health treatment.

Disclosure of Personal Information

When a utilization review requires disclosure of personal information regarding the patient or client, including:

1. Personal and family history; or

2. Current and past diagnosis of a mental disorder;

the Utilization Review Management Program representative will conceal the identity of that individual from anyone having access to that information in order that the patient or client may remain anonymous.

Determinations Made on Appeal or Reconsideration

A utilization review determination that is:

1. Made on appeal or reconsideration; and
2. Adverse to a patient or to an affected health care provider;

may not be made on a question relating to the necessity or appropriateness of a health care treatment without prior written findings, evaluation, and concurrence in the adverse determination by a health care professional trained in the relevant area of health care. Copies of the written findings, evaluation, and concurrence will be provided to the patient upon the covered person's written request to the Utilization Review Management Program within thirty (30) days of determination.

A determination made on appeal or reconsideration that health care treatment rendered or to be rendered are medically inappropriate may not be made unless the health care professional performing the utilization review has made a reasonable attempt to consult with the patient's attending health care provider concerning the necessity or appropriateness of the health care treatment.

Prescription Drugs

Covered prescription drugs are provided in the Prescription Drug Formulary for this policy. The formulary may be obtained on the MHC website or by calling the Customer Service number.

Prescription drugs benefits are arranged by tiers to provide a structure for member cost-sharing in each category.

Generally, the structure is as follows:

- Tier 0 = Preventive
- Tier 1 = Preferred Generic
- Tier 2 = Preferred Brand and Non-Preferred Generic
- Tier 3 = Non-Preferred Brand
- Tier 4 = Preferred Specialty Drugs

Prescribing Units

The Prescribing Unit of a Prescription Drug or Specialty Drug dispensed by a pharmacy pursuant to one (1) Prescription Order or Refill shall be limited to the lesser of:

- The quantity prescribed in the Prescription Order or Refill; or
- A 31-day supply
- The quantity limit for a specific drug; or
- The amount necessary to provide a 31-day supply according to the maximum dosage approved by the Food and Drug Administration for the indication for which the drug was prescribed; or

- Depending on the form and packaging of the product, the following:
    - Tablets/capsules/suppositories – 100; or
    - Oral liquids – 480 cc; or
    - Commercially prepackaged items (such as but not limited to, inhalers, topicals, and vials) – 1 unit (i.e., box, tube or inhaler); or
    - Self-Administered Injectables – a sufficient amount to provide the prescribed amount for four (4) weeks.

Drug Formulary, Preauthorization, and Prescription Drug Supply Limits

The prescription drugs are based on the drug formulary for the policy. Therefore, only those prescription drugs listed in such drug formulary will be covered.

Certain prescription drugs require pre-authorization. Visit the MHC website and search the formulary to determine if a pre-authorization is required.

The supply limits for prescription drugs are as follows:

1. Per prescription or refill at a retail Preferred Provider Pharmacy or retail Non-Preferred Provider Pharmacy is limited to a maximum of a 31-day supply based on the FDA- approved dosage regardless of the manufacturer packaging;
2. Per prescription or refill received from the Preferred Provider Mail Order Pharmacy or Non-Preferred Provider Mail Order Pharmacy is limited to a maximum of a 90-day supply based on the FDA-approved dosage regardless of the manufacturer packaging. However, Self-Administered Injectable Drugs are limited to a maximum of a 31-day supply per prescription or refill received from the Preferred or Non-Preferred Provider Mail Order Pharmacy.

Exclusions

No benefits will be payable for the following:

1. Non-legend drugs other than insulin.
2. Anabolic Steroids.
3. Fluoride supplements.
4. Over-the-counter drugs that do not require a prescription.
5. Any drug used for the purpose of weight loss.
6. Prescription Drugs for cosmetic purposes, including the Treatment of alopecia (hair loss), e.g., Minoxidil, Rogaine.
7. Prescription Drugs used for erectile dysfunction. Certain drugs used for erectile dysfunction may be covered if Medically Necessary and the Covered Person receives Preauthorization.
8. Therapeutic devices or appliances, including:
    a. Needles;
    b. Syringes;
    c. Support garments; and
    d. Other nonmedicinal substances; regardless of intended use, unless otherwise specified as a Covered Benefit under this provision.
9. Diabetic infusion sets, which include: (a) a cassette; (b) needle and tubing; and (3) one insulin-pump during the warranty period. Diabetic-infusion sets and accessories for insulin pumps are covered under the Durable Medical Equipment Benefit.

10. Drugs or items labeled “Caution – limited by federal law to investigational use, or experimental drugs even though the Covered Person is charge for the item.
11. Immunization agents;
12. Biological sera;
13. Blood or blood plasma.
14. Prescription Drugs which are to be taken by or administered to the Covered Person, in whole or in part, while the Covered Person is a patient in: (a) a Hospital; (b) rest home; (c) sanitarium; (d) extended care facility; (e) convalescent hospital; (f) nursing home; or (g) similar institution which operates or allows to be operated on its premises; or (h) a facility for dispensing pharmaceuticals; medications in these situations is part of the facility’s charge.
15. Any Prescription Drug refill: (a) in excess of the number specified by the Physician; or (b) dispensed after one year from the Physician’s original order.
16. Replacement prescription Drugs or Prescription Drugs due to loss, theft or spoilage.

Rules and Regulations

Fraud Detection and Prevention

MHC will prevent and detect fraudulent/abusive behavior and comply with state and federal fraud and abuse requirements by:

- Utilizing controls to prevent and detect fraudulent/abusive behaviors.
- Claims system pre-processing checks
- Claims system edit reports
- Member and provider complaints/fraud and abuse reports
- Utilization management reviews - prospective, concurrent, and retrospective.
- Credentialing and re-credentialing reviews to identify patterns of suspected incidents, and detect confirmed incidents in the form of Medicare or Medicaid exclusions.

In accordance with federal regulation 42CFR 438.214 (d), MHC will not include any individual in the provider network who:

- May have been debarred, suspended, or otherwise excluded from participation in Medicaid or Medicare programs;
- May have an affiliation with an individual who has been debarred, suspended or otherwise excluded from participation in Medicaid or Medicaid programs;
- May own 5% or more in the University of Utah Health Plan's equity and is ineligible for participation in Medicare and Medicaid, or is affiliated with an individual who is ineligible, due to debarment, suspension, or exclusion from these programs.

MHC encourages providers to institute a compliance plan to prevent and detect fraud and abuse. The Office of Inspector General (OIG) has published guidance for physician practices to assist in the development of a compliance plan: Final Compliance Program Guidance for Individual and Small Group Physician Practices PDF (65 FR 59434; October 5, 2000).

For further information about fraud and abuse detection and prevention, please visit the OIG's web site at http://www.oig.hhs.gov/fraud/report-fraud/index.asp, or the National Health Care Anti-Fraud Association web site at http://www.nhcaa.org/.

Reporting Fraud and Abuse

If you suspect fraud and abuse, you may report it to MHC Compliance Officer at 1-855-447-2900.

Newborn and Mothers' Health Protection Act

MHC honors the Newborn's and Mothers' Health Protection Act of 1996. The Newborns' Act regulates that all health plans and insurance issuers do not restrict a mothers' or newborns' benefits for a hospital length of stay that is connected to childbirth to less than 48 hours following a vaginal delivery and 96 hours following a cesarean section. However, the attending provider may decide, after consulting with the mother, to discharge the mother or newborn child earlier.

If the delivery is in the hospital, the 48-hour (or 96-hour) period starts at the time of delivery. If the delivery is outside the hospital and then later admitted to the hospital in connection with childbirth, the period begins at the time of admission.

Follow-up care is required for women and infants discharged early following vaginal and cesarean section births. Women and infants discharged less than 48 hours following a vaginal birth or 96 hours following a cesarean section delivery should receive post-delivery follow-up care within 24-72 hours following the discharge.

Site Audits and Ensuring Appropriate Physical Facilities

Office Site Audits are one method of ensuring that the providers with whom we contract provide, among other things, services in a clean and accessible environment that is appropriately staffed, have the appropriate medical equipment and devices for the services rendered, appropriate medical record keeping practices and take reasonable steps to safeguard the integrity and confidentiality of our members' protected health information.

An official site visit may be completed by a member of the Provider Relations & Utilization Management (must be an RN/LPN) teams upon receipt of a complaint regarding the environmental aspects of the office or if the facility is not accredited or certified. The provider must correct the listed deficiencies within the time frames given to at least a score of 90% to remain a contracted provider.

The Site Audit Questionnaire shall address the following physical aspects of the office:

- Physical accessibility
- Physical appearance
- Adequacy of waiting room space
- Adequacy of exam room space
- Privacy/HIPAA compliance
- Registration process
- Medical record keeping
- Staff/patient interaction