



Provider Manual

HMO/Point of Service

Personal | Flexible | Local





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Introduction

Provider Manual HMO/Point of Service

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Welcome to Network Health Plan,

Network Health Plan/Network Health Insurance Corporation (NHP/NHIC) welcomes you as a partner in providing quality health care for our HMO/POS members.

For more than 25 years, Network Health Plan has been providing high quality health care services to our area communities. I am proud to lead an organization which services more than 80,000 members and works with local and area health care providers.

Network Health Plan's commitment to high quality services has been affirmed by receiving the National Committee for Quality Assurance (NCQA) Excellent accreditation. This ranking has been earned through our dedication to continuous quality improvement, and going beyond just providing health care coverage. You will find that Network Health Plan places a high emphasis on providing health, wellness and prevention education for our members and community.

We are pleased that you are part of the Network Health Plan provider network. Providers play a crucial role in helping us ensure that our members have convenient access to high quality health care.

To Your Health,

Shelia Jenkins
President
Network Health Plan/Network Health Insurance Corporation

The Network Health Plan/Network Health Insurance Corporation (NHP/NHIC) Provider Manual is an annual publication. It has been prepared to assist you in understanding NHP/NHIC policies, procedures, and important contact information. This manual is intended to serve as a reference tool for contracted providers and staff. While the information contained in this manual was correct at the date of publication, NHP/NHIC reserves the right to revise or alter the material contained herein, including but not limited to policies, procedures, products and other information detailed in the manual. Please take time to familiarize yourself with the information. NHP/NHIC will be referred to as “NHP” throughout the remainder of this manual.

Revisions to policies and procedures that directly impact our practitioners and providers will be shared through letters, our website www.networkhealth.com, and/or personal office visits made by NHP staff. NHP updates will be posted to the website on Friday’s when applicable. You may contact our Customer Service Department at (920) 720-1300 or (800) 826-0940. NHP’s Customer Service Department hours are: Monday, Wednesday, Thursday and Friday 8:00 a.m. to 5:00 p.m. and Tuesday 8:00 a.m. to 4:00 p.m.

Contact List

Network Health Plan (NHP) is committed to providing quality healthcare to our members. Our staff is also committed to providing prompt and friendly service to the participating providers who have partnered with us to achieve this goal. Please use the telephone numbers below should you need to speak with us regarding the following issues, or need additional information:

Coverage Verification / Claim Questions / Payment Questions / Referral Procedure Questions / Benefit and Policy Determination:

Customer Service Department

Toll Free at: (800) 826-0940 or Local at: (920) 720-1300
Fax: (920) 720-1909

Case Management Assistance / Tertiary Specialist Referrals / Health Management Program Information / Inpatient Hospitalization and Prior Authorization Request:

Care Management Department

Toll Free at: (800) 236-0208 or Local at: (920) 720-1600
Fax: (920)720-1902

Behavioral Health Department

Toll Free at: (800) 555-3616 or Local at: (920) 720-1340
Fax: (920) 720-1903.

Medical Policy Issues / Physician Profiling

Medical Director

(920)720-1601

Notification of Changes in Any Provider Demographic Info. / Confirmation of Provider Participation in NHP Panels:

Provider Data Services

Toll Free at:(800) 945-1178 or Local at: (920) 720-1565
Fax: (920)720-1913
e-mail: provdatasvs@networkhealth.com

Contract Request / Existing Contract Questions

Managed Care Contracting

Toll Free at: (800) 207-5769 or Local at: (920) 720-1550
Fax (920)720-1901

Credentialing / Recredentialing / Practitioner & Provider Assistance

Medical Staff Services / Credentialing

Toll Free at: (800) 511-4901 or Local at: (920) 720-1670

Quality Improvement / Disease Management

Quality Improvement

Toll Free at (800) 236-0208 or
Local at: (920)720-1655

Disease Management

Toll Free at: (800) 236-0208 or
Local at: (920)720-1651

NHP Customer Service Department

NHP's Customer Service Representatives are available to assist members and providers with questions and/or concerns. Customer Service Representatives maintain direct contact with our Claims and Group Administration Departments. They can provide current information on claim processing, member eligibility, and plan benefits. If a Customer Service Representative is unable to answer your question, they will direct you to the appropriate person(s).

Providers who encounter members, who have questions regarding their benefits, should instruct the member to call NHP's Customer Service Department with their questions. As a provider, you may not always be aware of your patient's benefit plan or costs involved. For this reason, NHP recommends that providers refrain from quoting member benefits. Providers are encouraged to contact NHP's Customer Service Department to verify member eligibility, benefits and authorization requirements.

Customer Service Representatives can be reached at (920) 720-1300 or 1-800-826-0940 on Monday, Wednesday, Thursday and Friday from 8:00 am to 5:00 pm and Tuesday from 8:00 am to 4:00 pm.

NHP/NHIC-Members' Rights and Responsibilities

Abstract/Purpose:

Network Health Plan/Network Health Insurance Corporation (NHP/NHIC) is committed to treating members in a manner that respects their rights.

I. POLICY:

NHP/NHIC is committed to treating members in a manner that respects their rights.

NHP/NHIC is committed to communicating Members' Rights and Responsibilities with members, employers, providers, and employees. All NHP/NHIC members, employers, contracted providers, and employees will be notified in writing of the Plan's Members' Rights and Responsibilities.

II. PROCEDURE:

The Members' Rights and Responsibilities will be printed in the HMO and POS plan Members Certificate of Coverage and the NHP/NHIC Practitioner Directory. All subscribers will receive a copy of the Members' Rights and Responsibilities upon enrollment.

The Members' Rights and Responsibilities will be printed annually in the plan member newsletter.

The Members' Rights and Responsibilities will be included in the Plan's Practitioner Manuals and Employers' Administrative Guides.

Members and Practitioners will be notified of revisions, as they occur, via the intranet.

All Plan employees will be issued a copy of the Members' Rights and Responsibilities and are expected to be familiar with them.

III. MEMBER RIGHTS AND RESPONSIBILITIES:

As a member of Network Health Plan/Network Health Insurance Corporation, you have certain rights and responsibilities. Network Health Plan/Network Health Insurance Corporation is committed to providing you with services that respect your rights. Your Member handbook and certificate of Coverage contain important information regarding your benefits, rights and responsibilities, which include but are not limited to the following.

MEMBER RIGHTS...

- A. Members have a right to receive information about the managed care organization, its services, its practitioners and providers, and members' rights and responsibilities.
- B. Members have a right to be treated with respect and recognition of their dignity and right to privacy.
- C. Members have a right to participate with practitioners in decision making regarding their health care.
- D. Members have a right to a candid discussion of appropriate or medically necessary treatment option for their conditions, regardless of cost or benefit coverage.
- E. Members have a right to voice complaints or appeals about the managed care organization, the care provided and/or the use and disclosure of protected health information.
- F. Members have a right to select a Primary Care Practitioner and to change for any reason.
- G. Members have the right to review your medical records with your Primary Care Practitioner.
- H. Members have the right to receive prompt and courteous service from representatives regarding benefit interpretations, eligibility information, claims inquiries or other related matters when contacting Network Health Plan/Network Health Insurance Corporation.
- I. Members have the right to be informed of your diagnosis, treatment and prognosis from your practitioner in terms you understand.
- J. Members have the right to refuse treatment and to be informed of the probable consequences of your actions.
- K. Members have the right to make recommendations regarding the organizations members' rights and responsibilities.

MEMBER RESPONSIBILITIES...

- A. Members are responsible to communicate openly with participating providers or health plan personnel. If you have questions with the treatment plan you have the responsibility to discuss your concerns and make certain you understand the explanation and instructions.
- B. Members are responsible to read and understand your benefits as outlined in your Summary of Member Responsibility Table and Certificate of Coverage.
- C. Members are responsible to follow the established policies and procedures set forth by NHP/NHIC as outlined in your Certificate of Coverage.
- D. Members are responsible to follow the plans and instructions for care that they have agreed on with their practitioners.
- E. Members are responsible to treat all participating providers or health plan personnel respectfully and courteously.
- F. Members are responsible to provide, to the extent possible, information that the managed care organization and its practitioners and providers need in order to care for them.

- G. A Member has the responsibility to notify his or her health care provider(s) and NHP/NHIC of changes in insurance coverage, eligibility, address or phone number.
- H. To keep scheduled appointments or give adequate notice of delay or cancellation.
- I. A member has the responsibility to constructively express his or her concerns or dissatisfaction regarding NHP/NHIC or their health care provider so that we can rectify the situation.
- J. A member has the responsibility to participate in understanding their health problems and developing mutually agreed upon treatment goals.

NHP/NHIC-Privacy & Confidentiality of Member Information & Records

Abstract/Purpose:

State, Federal law and the National Committee for Quality Assurance (NCQA) requires a Managed Care Organization (MCO) to ensure that anyone who handles Protected Health Information (“PHI”) maintains its confidentiality. PHI includes medical records, claims, benefits and other administrative data that are personally identifiable. Use of aggregated data in which an individual’s personal information is not identifiable to a statistically significant degree is not subject to privacy restrictions.

I. Policy:

State, Federal law and the National Committee for Quality Assurance (NCQA) requires a Managed Care Organization (MCO) to ensure that anyone who handles Protected Health Information (“PHI”) maintains its confidentiality. PHI includes medical records, claims, benefits and other administrative data that are personally identifiable. Use of aggregated data in which an individual’s personal information is not identifiable to a statistically significant degree is not subject to privacy restrictions.

Maintaining confidentiality encompasses how PHI is collected, maintained and used. This accountability extends to the entities with which information is shared. Compliance with the policies is demonstrated through audits, employee, employer/plan sponsor, agent, broker and consultant confidentiality agreements, business associate agreements/addendums and external review.

II. Procedure:

A. Member Consents

1. A member has the opportunity to determine the appropriate uses of his or her PHI. The member must authorize in writing, the release or refusal to release any and all information; unless required or exempt by law.
2. Consents must specify the type of information to be disclosed, how the information is used, by whom the information will be used, the purpose for which the information is used, the type of healthcare provider making the disclosure and the time period for which the consent applies.

a. Routine Consent:

The Membership Application signed by the employee at the time of enrollment covers future, known or routine needs for uses of PHI. It does not provide for release of information beyond the uses specified on the application.

Example: Uses specified on one of the Plans enrollment forms includes, utilization review, coordination of benefits and or reimbursement with other health or insurance programs.

b. **Special Consents:**

The Plan affords its members the right to consent specifically to requests for PHI in the following instances:

- treatment pertaining to mental illness, developmental disability, alcoholism, drug abuse or HIV infections
- treatment received from non-contracted practitioners/providers
- workers compensation or auto insurance claims
- marketing purposes
- research

c. **Authorized Consents:**

For cases in which the Plan is required to obtain informed consent for treatment or special consent for the release of and access to PHI from members who lack the ability to give consent, the following persons can be authorized by the member;

- guardian or legal custodian of a minor member.
- guardian of a member adjudged incompetent.
- personal representative or spouse of a deceased member.
- any person authorized in writing by the member.

If no spouse survives a deceased member, an adult member of the deceased member's immediate family may qualify. A court appointed temporary guardian of PHI may also qualify to sign consent for the release of information. In cases involving court decrees or appointments, NHP/NHIC must utilize court documents to determine the validity of the consent.

B. *Access to health plan information and Protected Health Information*

1. The following entities may request access to the member's PHI at NHP/NHIC; members, employees, employers/plan sponsors, agents, brokers, practitioners, providers, third parties such as vendors or consultants, non-contracted practitioners and/or providers, oversight organizations and researchers.

- a. **Member:**

The member has the right to contact the Plan to obtain access to his or her PHI for review, comment and correction of any errors. Members should also be directed to the originating source of the health information to correct errors.

- b. **Employees:**

The member's privacy is protected internally within the Plan's administrative functions by;

- identifying employees who have access to PHI;
- restricting automated system access to only those employees whose job description requires access;
- requiring all new employees, during orientation, to read and understand the confidentiality policies, as well as include provisions for actions if employees inappropriately use or disclose PHI;
- requiring all employees, and non-employee committee members' to sign either NHP/NHIC's Confidential Healthcare Information Agreement or a Business Associate Agreement if applicable.

- c. **Employers:**

The Plan ensures that the use and disclosure of Protected Health Information is consistent with the requirements of the Privacy Rule. NHP/NHIC prohibits sharing members' PHI with any employer/plan sponsor, agent, and/or broker without a signed and dated Business Associate Agreement/Addendum or a PHI Confidentiality Agreement (see related document). The Agreements acknowledge that PHI must be safeguarded and agrees to the following:

- i. To not use or disclose PHI other than as permitted by NHP/NHIC documents or required by law;
- ii. Ensure that agents and subcontractors of the employer/plan sponsor, agent and/or broker agree to the same restrictions and conditions as the employer/plan sponsor, agent and/or broker with regard to PHI;
- iii. Prohibit the use of PHI by the employer/plan sponsor, agent and/or broker for employment or other benefit related decisions;
- iv. Notify the organization of any use or disclosure of PHI that is inconsistent with the uses and disclosures established in the plan documents;
- v. Allow individuals access to PHI, including access to amend PHI;
- vi. Make necessary information available to the organization in order to provide individuals with accountings of disclosure;
- vii. Procedures for return, destruction and restrictions of further use of PHI by employer/plan sponsor, agent and/or broker;
- viii. Identify the employer/plan sponsor, agent and/or broker who have access to PHI; and
- ix. Include provisions for actions if employer/plan sponsor, agent and/or broker inappropriately use or disclose PHI.

The Plan also ensures that PHI shared with employers, if implicitly or explicitly identifiable, requires a specific consent by the member. Explicit information is clearly identifiable with member names. Implicit information does not include specific member names but includes information that may be used to identify members.

d. **Practitioners/Providers/Other Third Parties:**

The Plan ensures that contractual agreements with third parties that provide clinical and administrative services incorporate confidentiality requirements into the agreement.

e. **Non-contracted Practitioners/Providers:**

The Plan will verify how the information will be used and obtain from the practitioner/provider a signed agreement that indicates their compliance with specific confidentiality policies governing the use of information shared by the Plan.

f. **Oversight Organizations:**

The Plan ensures that accrediting bodies, state and federal agencies include in their contracts, terms that describe their responsibility to maintain the confidentiality of any PHI that they receive. To the extent possible, these organizations should minimize their access to personally identifiable health information. Aggregated and or de-identified data should be used when ever feasible.

g. **Researchers:**

The Plan ensures that the intended research has had appropriate reviews for and contains necessary controls to protect the confidentiality of the member.

h. **All Treatment Settings:**

The Plan ensures protection of privacy in all treatment settings. Site visit criteria includes adequacy of medical/treatment recordkeeping and confidentiality of records.

C. ***Use of aggregated data*** in which an individual's PHI is not identifiable to a statistically significant degree is not subject to privacy restrictions.

D. ***Use and protection of Protected Health Information for quality measurement.***

The Plan minimizes the identifiability of the data used for quality measurement and protects the information from inappropriate disclosure.

Quality initiatives that include collection of measurement data are planned and approved by the Quality Management Committee (QMC) annually. Ad hoc requests for additional quality measurements that are not significantly addressed in the approved quality work plan require separate approval by the QMC.

All Plan employees reviewing PHI off site will sign a confidentiality agreement as requested and protect the information from being viewed by unauthorized personal.

E. *Quality Management Committee (QMC) responsibilities*

QMC has designated the Commercial Compliance and Privacy Committee to create and review the Confidentiality policy and to review the practices regarding collection, use and disclosure of medical information.

The QMC Approves:

- confidentiality policies for the organization;
- mechanisms to oversee the application of the policies;
- opportunities for reducing collection of unnecessary data;
- removing identifying data as close to its source as possible;
- levels of authorized user access to data across the delivery system including practitioners, their staff and the Plans administrative staff;
- mechanisms for adhering to specific requests to limit access to data; appeals process to address member concerns regarding confidentiality of data; and,
- a process to review requests to use member data and, if applicable, review internal requests and external request to access data for quality improvement activities.

The Privacy and Confidentiality of Member Information and Records Policy is reviewed by the Plan's Compliance Officer for compliance with state and federal regulations and approved by the QMC. This policy will be reviewed and revised as needed, or at least every two years.

For related policies see: NHP/NHIC-Notice of Privacy Practices, Business Information Protection Policy and/or Computer Security.

Protected Health Information Confidentiality Agreement

Network Health Plan (“NHP”) and Network Health Insurance Corporation (“NHIC”) take our customers’ personal privacy seriously. Before releasing Protected Health Information (“PHI”) NHP and NHIC require a signed and dated PHI Confidentiality Agreement.

NHP and NHIC are obligated under the statute and regulations implementing the Health Insurance Portability and Accountability Act of 1996 (“Privacy Rule”) to ensure that the use and disclosure of PHI is consistent with the requirements of the Privacy Rule. By signing this Agreement you the employer/plan sponsor, agent and/or broker understands and acknowledges that PHI must be safeguarded and agrees to the following:

- Not use or disclose PHI other than as permitted by Plan documents or required by law.
- Ensure that agents, brokers and subcontractors of the employer/plan sponsor agree to the same restrictions and conditions as the employer/plan sponsor, agent and/or broker with regard to PHI.
- Prohibit the use of PHI by the employer/plan sponsor, agent and/or broker for employment or other benefit related decisions.
- Notify the Plan of any use or disclosure of PHI that is inconsistent with the uses and disclosures established in the Plan documents.
- Allow individuals’ access to PHI, including access to amend PHI.
- Make necessary information available to the organization in order to provide individuals with accountings of disclosures.
- Procedures for return, destruction and restrictions of further use of PHI by the employer/plan sponsor, agent and/or broker.
- Identify employer/plan sponsor employees, agents and/or brokers who have access to PHI. And,
- Include provisions for actions if employer/plan sponsor employees, agents and/or brokers inappropriately use or disclose PHI.
- Prohibits the disclosure of NHP/NHIC’s proprietary business information.

Please sign, date and return this document to NHP/NHIC in the enclosed self-addressed stamped envelope.

Name

Date

Employer, Agent or Broker Name

Title

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- H. To keep scheduled appointments or give adequate notice of delay or cancellation.
- I. A member has the responsibility to constructively express his or her concerns or dissatisfaction regarding NHP/NHIC or their health care provider so that we can rectify the situation.
- J. A member has the responsibility to participate in understanding their health problems and developing mutually agreed upon treatment goals.

NHP/NHIC-Complaint-Appeal (Grievance) Resolution Policy and Procedure

Abstract/Purpose:

All verbal or written complaints and grievances received at Network Health Plan/Network Health Insurance Corporation (NHP/NHIC) will be investigated and resolved in a consistent and timely manner, in accordance with state, federal and National Committee of Quality Assurance (NCQA) standards.

I. Policy Purpose:

All verbal or written complaints and grievances received at Network Health Plan/Network Health Insurance Corporation (NHP/NHIC) will be investigated and resolved in a consistent and timely manner, in accordance with state, federal and National Committee of Quality Assurance (NCQA) standards. An expedited process will be implemented whenever a Complaint or Grievance has been determined to be of an urgent clinical nature. All Complaints and Grievances will be monitored, tracked and trended in a central database maintained by the Customer Service Department and reported at least quarterly to the Quality Improvement Committees and/or Service Subcommittee. A grievance or complaint may be made by or on behalf of our member.

Per the State of Wisconsin Office of the Commissioner of Insurance members are not required to submit a grievance request within a specified timeframe.

II. Applicable Definitions:

NCQA: Classifies dissatisfaction with the administration or claims practices of or provision of services by NHP/NHIC as an Appeal.

OCI: Classifies dissatisfaction with the administration or claims practices of or provision of services by NHP/NHIC as a Grievance. The definition of a complaint is the same for both NCQA and OCI.

****For the purpose of this policy, Grievances and Appeals will be one in the same and stated as Grievances.***

Adverse Determination: A determination by or on behalf of a member that the treatment does not meet the health benefit plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness or experimental treatment including a request for a referral to an out of network provider when the member believes the clinical expertise of the out of network provider is medically necessary.

Appeal (AKA Grievance): Any dissatisfaction with the administration or claims practices of or provision of services by NHP/NHIC which is expressed by or on behalf of a member.

Central Complaint Area (CCA): Customer Service Department

Complaint: An expression of dissatisfaction made to NHP/NHIC by or on behalf of the member.

Senior Plus Grievance: An expression of dissatisfaction made to NHP/NHIC by or on behalf of the Senior Plus member (same as a Complaint but categorized as a Grievance in accordance with HCFA regulations). (*See related policy: **Grievance/Appeal (Appeal) Resolution Policy and Procedure for SeniorPlus Products***)

Plan Representative: NHP/NHIC Representatives who are trained and experienced in addressing member's complaints and grievances. This includes the Customer Service Representatives who are assigned to answer member telephone calls placed to the Customer Service Department as well as departmental Managers, Member Advocates, Quality Coordinators, or other designated employees of NHP/NHIC. In order to better service NHP/NHIC members, employees in each department who have member interaction are trained to receive member inquiries and complaints in order to allow response to occur in a timely manner.

Pre-Service Grievance: Is any written or electronically submitted request to change an adverse determination for care or service that the organization must approve, in whole or in part, in advance of the member obtaining care or services.

Post- Service Grievance: Is any written or electronically submitted request to change an adverse determination for care or services that have already been received by the member or an expression of dissatisfaction with the administration or claims practices of or provision of services by NHP/NHIC which is expressed by or on behalf of a member.

Resolution is said to have occurred when:

- A. All pertinent information has been gathered to make an informed decision;
- B. The decision has been communicated to the member, and;
- C. No further member follow-up is needed.

Expedited Urgent Complaint: An expression of dissatisfaction, which has been determined to be of clinically urgent nature by the Quality Improvement Department.

Inquiry: Any first request to review a decision, determination or denial of a claim, service, referral authorization, or benefit made by or on behalf of our member.

Grievance Review Meeting: Informal (initial) review of a case. In this meeting the file is reviewed to see if benefits can be provided prior to the Grievance Committee Meeting. If the denial is upheld at this meeting, the case is automatically referred to the Grievance Committee.

Expedited Urgent Grievance: Any dissatisfaction with the administration or claims practices of or provision of services by NHP/NHIC which is expressed by or on behalf of a member, which has been determined to be of clinic urgent nature by the Quality Improvement Department (QI).

Department of Insurance Inquiry: A request from the state Department of Insurance for information concerning an inquiry, Complaint or Grievance filed by or on behalf of a member through the Office of the Commissioner of Insurance state regulatory agency.

Independent Review Organization (IRO): An external review company not associated with Network Health Plan/Network Health Insurance Corporation that reviews a case for final determination that is based on medical necessity.

Quality of Care, Service or Access Complaints: Any written expression of dissatisfaction with quality of care, service or access will be classified as a grievance and follow the grievance resolution process.

III. **Procedure:**

A. **All contacts**, verbal and written, are assessed by a Plan Representative to determine if it is a complaint, grievance or a Department of Insurance inquiry.

1. Some inquiries may be identified by the Plan Representative as a potential complaint or grievance. To improve the customer service provided by NHP/NHIC, each plan representative is given limited authority to take action on these cases in an effort to educate our members and still retain the business. The limitations are clearly defined in the Inquiry Decision Authority Parameters.
2. When an inquirer asks for elevation of their call to a higher level of authority, the plan representative should handle the inquiry as indicated according to the Call Elevation Handling Procedure.
3. If contact is written the issue is automatically referred to the CCA to begin the grievance process.

B. **Complaints**

1. A Plan Representative receives a complaint. If the complaint cannot be addressed immediately, the Representative will explain the Complaint Process to the member. The Plan Representative will complete a Complaint/Appeal Form (COAF) (*see related document*), designate an

appropriate primary and secondary code and forward it to the CCA. The CCA will log the complaint in the database, assign a case number and assign a Member Advocate.

2. The Member Advocate will document the substance of the complaint and all steps taken in the investigation (i.e. medical records request, denial file from Care Management) in the Complaint and Grievance Database. The substance of the complaint, the Member Advocate assigned to the case, and the final response will be documented in call log using the most appropriate call type.
3. If clinical urgency is identified by either the member, the Member Advocate, or if the complaint pertains to clinical care or access, the Member Advocate will immediately refer the complaint to the QI Department. If the QI Department determines clinical urgency, the process for Expedited Urgent Complaint and Expedited Urgent Grievance Policy and Procedure will be followed (*see related policy: **Expedited Grievance (Senior Plus “Fast Appeal”) Policy and Procedure***). The member will receive a written response including the disposition of the complaint and member grievance rights, if applicable, within 45 working days or less.

C. **Expedited Urgent Complaint**

1. If clinical urgency is identified by either the member, the Member Advocate, or if the complaint pertains to clinical care or access, the Member Advocate will immediately refer the complaint to the QI Department. If the QI Department determines clinical urgency, the process for Expedited Urgent Complaint and Expedited Urgent Grievance Policy and Procedure will be followed (*see related policy: **Expedited Grievance (Senior Plus “Fast Appeal”) Policy and Procedure***).

D. **Expedited Urgent Grievance**

1. In the case of an urgent care request an expedited grievance will be offered.
 - a. An expedited review begins when a member, representative of the member or a practitioner acting on behalf of the member requests an expedited grievance. An expedited grievance will be granted to all request concerning admissions, continued stay or other health care services for a member who has received emergency services but has not been discharged from the facility.
 - b. The expedited grievance decision and notification to the member and practitioner must be made within 72 hours of the request. If the case is determined to be an Expedited Urgent Grievance refer to the QI Department policy Expedited Urgent Complaint and Expedited Urgent Grievance Policy and Procedure (*see related policy:*

Expedited Grievance (Senior Plus “Fast Appeal”) Policy and Procedure).

E. Pre and Post Grievance Procedure

1. Plan Representative receives a written grievance. All grievances are forwarded to the CCA the day they are received. The grievance, including the envelope will be date stamped and attached to a completed COAF. The CCA reviews the grievance and determines if it is a pre-service or post-service grievance. The grievance, including the receipt date, is entered in the database for tracking and trending, logs the substance of the grievance in call log, and assigns a case number and a Member Advocate. If clinical urgency is identified by the member, Member Advocate or if the grievance pertains to clinical care or access, the Member Advocate will refer the grievance to the QI Department.
2. The Member Advocate sends the member a written acknowledgement of their grievance within five (5) business days following receipt of the grievance request. The acknowledgement will include:
 - a. Notification to the member of his or her grievance rights, including their right to an independent review by an Independent Review Organization (IRO) certified by the State of Wisconsin.
 - b. The member’s right to attend the Committee Meeting. The member may attend via teleconference or by sending a representative on their behalf. If the member chooses to send a representative in their place, proper authorization must be obtained by Network Health Plan/Network Health Insurance Corporation prior to the Grievance Committee Meeting.
 - c. A copy of the grievance process.
 - d. An authorization to release information, if applicable.
 - e. The member has the right to submit written comments, documents, records and other information relevant to their grievance.
3. The Member Advocate will document the substance of the grievance and all steps taken in the investigation in the Complaint and Grievance Database. The substance of the grievance will also be documented in the call log.
4. The Member Advocate is responsible for monitoring the progress of the case and ensuring that it is handled within all necessary time frames using the Grievance File Checklist. The Member Advocate must also ensure that

all related departments have reviewed and have provided any pertinent information to the case.

5. The Member Advocate is responsible for reviewing the substance of the grievance, including all aspects of clinical care involved, and requesting any pertinent additional documentation (i.e. medical records). If the case pertains to a medical necessity issue (denial), the Member Advocate will have the case reviewed by a Board Certified Physician who is certified in the specialty related to the issue.
6. This review must take place before the case is presented to the Grievance Committee. If at anytime during the preparation of the grievance, the Medical Director or Department Manager receives any information indicating that a denial decision should be overturned, the Medical Director or Department Manager will overturn the grievance. The Member Advocate will:
 - a. Prepare a letter to the member explaining the reconsideration decision and the date the decision was made.
 - b. Ensure that Claims Follow-Up form (CFU's) and all necessary activity is completed.
 - c. Update and close the case in the Complaint and Grievance Database, indicating the resolution and rationale for that decision.
7. If the case is overturned prior to committee, the case will not be presented to the Grievance Committee.
8. Each week the grievance file is presented in the Grievance Review Meeting.
9. If there is a delay in handling due to circumstances beyond Network Health Plan/Network Health Insurance Corporation's control, the Member Advocate must send a notification of delay to the member with an explanation for the delay. This notification of delay must be sent to the Member prior to the fifteenth (15th) calendar day for a pre-service grievance and thirtieth (30th) calendar day for a post-service grievance following receipt of the grievance. In no circumstances may the grievance process exceed thirty (30) calendar days for a pre-service grievance and sixty (60) calendar days for a post service grievance.

Per the State of Wisconsin Office of the Commissioner of Insurance NHP/NHIC is required to allow a delay beyond the 30 or 60 days if it is at the request of the member.

10. If the grievance pertains to a medical necessity issue the Member Advocate will appoint at least one person to review the grievance who is a practitioner in the same or similar specialty who typically treats the medical condition, performs the procedure or provides the treatment.
11. The Member Advocate schedules the case for Grievance Committee and sends a notification letter to the member informing them of the scheduled committee time and date, allowing a seven (7) calendar day notice. This notification will include the location of the committee meeting, a map indicating directions to Network Health Plan/Network Health Insurance Corporation, and their right to present their case to the Committee either in person, telephonically or by a representative (utilizing the proper authorization).
12. When the case is fully investigated and prepared for Committee, the Member Advocate forwards the file to the CCA for copying and distribution to the Grievance Committee members.
13. The Member Advocate will present the case to the Grievance Committee. The Committee will wait up to fifteen (15) minutes past the scheduled committee review time for a member to arrive before making a decision on a case. If the member has notified us that they plan to attend, their case may be held for presentation until the end of the committee session for review.
14. After a complete discussion and review by the Grievance Committee a determination will be made on the case. The Member Advocate will notify the member via a letter with the final determination from the Committee. The final determination letter will be sent within five (5) days after the Committee Meeting, not to exceed fifteen (15) working days for a pre-service grievance or thirty (30) working days for a post-service grievance following receipt of the Grievance request. The written notification includes:
 - a. Any clinical or contractual rationale for the decision.
 - b. Any benefit provision, guideline protocol or other similar criteria on which the appeal decision was made.
 - c. Notification that the member, free of charge, upon request, can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based.
 - d. Notification that, upon request, members can obtain the names of the medical expert whose advice was obtained on behalf of the organization in connection with the grievance.

- e. A list of NHP/NHIC's Grievance Committee Panel members
 - f. Information regarding the member's right to an Independent Review Organization (IRO)
 - g. Notification that the member is entitled to receive, free of charge, upon request, reasonable access to and copies of all documents relevant to the member's appeal. Relevant documents include documents or records relied upon in making the appeal decision and documents and records submitted in the course of making the appeal decision.
 - h. Notification that the member is entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). Once the member has exhausted the grievance process they have the right to file suit in Federal Court under Section 502 (a) of ERISA.
 - i. Notification that the member may have other dispute options, such as mediation. To find out what they have available they can contact their local U.S. Department of Labor Office and the State insurance regulator agency.
15. In the event that a decision is rendered and time constraints do not allow for written notification to meet the time guidelines, a telephone call should be attempted. Written notification will follow.
 16. Grievance Committee will not include the person who was involved in the initial determination or who is a subordinate of any person involved in the initial determination. In order to render a decision there must be a quorum of three (3) Committee members. The Chairperson is a standing voting member and will cast a vote in the event of a tie. The Grievance Committee meets weekly, unless there are no cases.
 17. The Member Advocate will update call log and the Complaint and Grievance Database with the final determination and resolution date.
 18. The completed grievance file will be audited by the Member Advocate for compliance with this policy including resolution time frames and consistency with other NHP/NHIC policies (i.e. benefit interpretations, contract language, etc.)
 19. All completed grievance files will be retained in the Customer Service Department in locked filing cabinets for the current and previous year. Purged files from the Customer Service Department will be retained in a locked storage room for a minimum of three (3) years.

20. All completed quality of care, service or access grievances will be retained in the Quality Improvement Department in locked filing cabinets for the current and previous year. Purged files from the Quality Improvement Department will be retained in a locked storage room for a minimum of three (3) years.
21. Upon request the Member Advocate must provide the member access to and copies of all documents relevant to the member's grievance, including pertinent medical records.

F. **Independent Review Organization (IRO)**

Standard Process

Whenever an adverse determination or an experimental treatment determination is made the member or a member's authorized representative has the right to request an independent review.

1. Members will be required to go through the NHP/NHIC Internal Grievance process before initiating an IRO, unless:
 - a. NHP/NHIC and the member agree that the matter may proceed directly to the independent review.
 - b. The IRO determines that the health condition of the insured is such that requiring the insured to use the internal grievance procedure prior to the independent review would jeopardize the life or health of the member.
2. When NHP/NHIC resolves a grievance involving an adverse determination, including services that were determined cosmetic, the member will be notified of their right to file an IRO. The notice will include:

A listing of the available IROs certified by the Office of the Commissioner of Insurance (OCI).

- a. A fact sheet on the Independent Review Process in Wisconsin.
 - i. On a monthly basis a Member Advocate will check the OCI web-site for updates to the listing of IRO's certified by the State and changes to the Fact Sheet on the Independent Review Process. The Member Advocate will also document the date the web-site was reviewed and forward to the Manager on a quarterly basis to be included in the Corporate Compliance Plan.

- b. An explanation of how to request an independent review, including:
 - i. Statement that the member may choose and IRO from an enclosed list of IROs certified by the State of Wisconsin.
 - ii. Statement that the member must submit a filing fee of \$25 payable to the IRO with the request. Statement will also explain that the filing fee will be refunded if the member prevails in the review, either in whole or in part.
 - iii. Statement that the total cost of the denied coverage must exceed \$282 (current at the time this policy was approved).
 - iv. Notice that the request for independent review must be sent to NHP/NHIC, unless the review is an urgent matter.
 - v. Statement that the insured must complete the internal grievance process, unless NHP/NHIC and the member agree to bypass the internal grievance process or if the member's health condition would be jeopardized if required to go through NHP/NHIC's internal grievance process.
 - c. Members have four (4) months from the date of the adverse determination, experimental treatment determination or final internal grievance notification, whichever is later, to request an IRO.
 - d. The IROs decision is binding on NHP/NHIC and the member.
3. IRO Timeframes

The Member Advocate will provide written notice to the OCI, IRO and ETF for a State of Wisconsin Member, within two (2) business days of receiving the request for independent review.

- a. The OCI written notice will include:
 - i. Case number
 - ii. Type of determination, i.e. adverse or experimental determination
 - iii. Date received by NHP/NHIC
 - iv. Name of chosen IRO

- v. General subject of the request
- b. The OCI notice should be faxed to Barbara Belling, at (608)-261-8579

The OCI notice will not include any information that could identify the insured, including name and social security number.

The IRO notice will include the above and:

- i. Name of member
- ii. Name of authorized representative, if applicable \$25 filing fee
- c. The ETF notice, faxed to Kari Zika at (608) 267-0633 will include:
 - i. Name of subscriber
 - ii. Brief description of issue, including grievance category code
 - iii. Date of member's request
- d. Within five (5) business days of receiving the request for independent review the Member Advocate will submit documentation to the IRO.
- e. Within two (2) business days of receiving the documentation the IRO will determine if the information is reviewable by the IRO. If it is not reviewable the IRO will notify NHP/NHIC, the member, and the OCI.
- f. Within five (5) business days of receiving the documentation the IRO may request additional information from NHP/NHIC or the member.
- g. If additional information is requested the member or NHP/NHIC has five (5) business days to submit requested information. Within thirty (30) business days of receiving all requested information the IRO will make a final decision.
- h. Within two (2) days of making the final decision the IRO will notify both NHP/NHIC and the member. The final decision is binding on NHP/NHIC and the member. If the IRO ruled in favor of the member the Member Advocate will ensure the \$25.00 filing fee is refunded to the member.

- i. Within thirty (30) days of receipt of the bill the fees will be paid to the IRO. The Member Advocate will monitor the payment process and obtain copy of the check to assure payment within 30 days.

Expedited IRO Process

If the member requests an expedited IRO the timeframes stated in Section 3 a, b & c must be followed for notification and payment guidelines. The following timeframes must be followed for submission of materials:

- i. Within one (1) day after receiving the notice of the request for independent review the Member Advocate will submit documentation to the IRO.
- ii. Within two (2) business days after receiving the information the IRO shall request additional information, if applicable.
- iii. Within two (2) days after receiving the request the member or NHP/NHIC shall submit the requested information or an explanation of why the information is not being submitted.
- iv. The IRO shall make its decision within 72 hours after the expiration of the timeframes listed above.

G. Department of Insurance Inquiry

All Department of Insurance Inquiries (DOI) should be forwarded directly to the Member Advocate. The Member Advocate will date stamp the DOI, initiate a COAF, and log the substance of the DOI into the Complaint and Grievance Database and call log.

1. The Member Advocate is responsible for reviewing and investigating all issues that relate to the inquiry. When or where appropriate, corrective action should be taken.
2. Within ten (10) working days or the set time frame on the DOI and upon completion of the investigation of the inquiry the Member Advocate will prepare a written response to the member and to the OCI.
3. In the event of a delay, a notice of delay, including an explanation as to the reason for the delay will be sent to the OCI and Member.
4. A final response is required to both the State of Wisconsin and to the member.

5. The Member Advocate will update call log and the Complaint and Grievance Database with the final determination and will file the completed inquiry in a locked filing cabinet, retained in the Customer Service Department.

H. Tracking and Trending Reports

1. A Complaint and Grievance tracking and trending database will be maintained by the Customer Service Manager.
 - a. Information regarding tracking complaints and grievances will include, but is not limited to, primary codes, secondary call type codes and severity level codes (Attachment C), compliance to resolution time frames set forth in this policy, benefit interpretations and contract language; members, employers group, product, providers, etc.
 - b. The Customer Service Manager will prepare trending reports and analysis regarding the types and volume of complaints and grievances.
2. Tracking and trending reports will be submitted to the Quality Management Committee and the Service Sub Committee on a quarterly basis.

I. State of Wisconsin employee trust funds (ETF) groups

State of Wisconsin groups may continue the Grievance process through ETF. All final grievance letters will include an attachment indicating how to proceed with the grievance process through ETF.

J. Grievance Review Meeting

The Grievance Review meeting takes place every Friday. The Member Advocate notes the status of the grievance and presents the information they have obtained thus far. If the Member Advocate, Customer Service Supervisor or the Claims Supervisor recommends the case be overturned prior to committee, the option is reviewed at this time, and a determination is made. If either the Customer Service or Claims Supervisor does not feel they have sufficient information, the Member Advocate will continue to investigate and obtain additional information so a determination can be made at the next Grievance Review Meeting. All cases not overturned in the Grievance Review Meeting will be brought to the Grievance Committee within fifteen (15) calendar days for pre-service grievances and thirty (30) calendar days for post-service grievances from the date received. If a delay is made for circumstances beyond the plan's control, the case will be presented within thirty (30) calendar days for pre-service grievances and sixty (60) calendar days for post service grievances.

NHP/NHIC-Expedited Grievance Policy and Procedure

Abstract/Purpose:

All expedited grievances received at Network Health Plan/Network Health Insurance Corporation (NHP/NHIC) will be investigated and resolved in a consistent and timely manner in accordance with the state Office of the Commissioner of Insurance (OCI) and the National Committee for Quality Assurance (NCQA).

I. POLICY:

An expedited grievance is a request to change an adverse determination for urgent care. Urgent care is any request for medical care or treatment with respect to which the applications of the time period for making a non-urgent care determination:

- Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, or
- In the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed with the care or treatment that is the subject of the request, or
- A physician with knowledge of the insured's medical condition determines that the grievance shall be treated as an expedited grievance.

Requests for admissions, continued stays or other health services for members who have received emergency services and have not yet been discharged must receive an expedited review.

The expedited grievance decision must be made as expeditiously as the medical condition requires, but no later than 72 hours from the time the health plan receives the expedited request. In order to maintain compliance, the following is required:

- o Initially, the physician receives verbal notification of the expedited decision within 72 hours or less of the health plan receiving the expedited request.
- o A written notification of the expedited decision is sent to the member or member's representative and the practitioner within 72 hour or less of the practitioner receiving the verbal notification.

Expedited grievances are reviewed by Quality Improvement department registered nurses. The Medical Director and/or any NHP/NHIC staff members who were part of the initial decision will not be involved in the expedited decision.

With the exception of timeframes and specific processes listed, the expedited process will follow the processes outline in the related NHP/NHIC Complaint-Appeal (Grievance) Resolution Policy and Procedure.

II. **VALUES:**

The expedited grievance process supports the value of service by providing a process to facilitate the provision of care in a timely manner. It also supports the value of integrity by including process steps that comply with state and/or federal regulations.

III. **DEFINITIONS:**

Expedited grievance – A request to change an adverse determination for urgent care.

Urgent Care – Any request for medical care or treatment with respect to which the applications of the time period for making a non-urgent care determination:

- Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, or
- In the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed with the care or treatment that is the subject of the request, or
- A physician with knowledge of the insured's medical condition determines that the grievance shall be treated as an expedited grievance.

Member Representative – Members may be represented by anyone they choose, including an attorney. According to Wisconsin Administrative Code, Chapter Ins 18, Subchapter II, Ins 18.03(5), written expression of authorization for representation is not required if any of the following applies:

- The person is authorized by law to act on behalf of the insured
- The insured is unable to give consent and the person is a spouse, family member or the treating provider
- The grievance is an expedited grievance and the person represents that the insured has verbally given authorization to represent the insured.

Same or Similar Specialty - The same specialty refers to a practitioner with similar credentials and licensure as those who typically and currently treat the condition in question in the grievance. A similar specialty refers to a practitioner who routinely and currently treats the same problems as those in question in the grievance and who routinely treats similar complications of those problems.

IV. **PROCEDURES:**

Upon receipt of the Expedited Grievance, the Quality Improvement Supervisor and/or Quality Improvement Coordinator (QIC) will evaluate the expedited request for clinical urgency using criteria outlined in this policy.

In order to facilitate the expedited process, as soon as Care Management personnel (Medical or Behavior Health) or Member Advocates of the Customer Service Complaint Center become aware of the expedited request, they will begin efforts to obtain a signed Authorization for Disclosure of Protected Health Information. The member or their representative requesting the expedited grievance will be informed of the urgency of obtaining the signed release. Care Management personnel involved in the initial adverse decision will provide all relevant documentation and medical records to the Quality Improvement Supervisor and/or QIC. During the transition of a denial to an expedited status, excellent communication skills between the involved departments and Quality Improvement staff are essential for achieving compliance and providing the member with excellent customer service.

If Grievance does not meet criteria:

If the grievance does not meet the criteria for the expedited process, the QIC will verbally notify the member or the member's representative and practitioner and will provide rationale of why the request does not meet the criteria for the expedited process. They will be informed of the right to file a grievance if they choose. A written notification of the decision explaining why the expedited grievance does not meet the criteria will be mailed to the member or their representative along with information outlining the post service grievance process and its timeframes. The QIC will notify Member Advocates of the Customer Service Complaint Center of this occurrence.

If Grievance does meet criteria:

- If the grievance meets the criteria for the expedited process and has not already been entered into the system by the Customer Service complaint center, the Quality Improvement Department Assistant (QIA) will assign a case number to the expedited grievance and enter it into the Credentialer Complaint/Grievance Database and Tracking Spreadsheet.
- If medical records are needed, the signed Authorization for Disclosure of Protected Health Information obtained by Care Management is utilized. If the records are not found on Meditech, a phone call is placed to the practitioner/provider to request immediate access to the records. If necessary, the QIC will go on site to review the records.
- When all necessary information is gathered, the QIC reviews the grievance with the Medical Director and QI Supervisor.

1. If the acquired additional information supports the original request, the initial denial may be overturned by the Medical Director. The grievance is then resolved, and the requesting practitioner immediately receives verbal notification. A written notice is mailed to the practitioner and the member, or member representative, within 72 hours of the verbal notification as outlined in Section F: Notification of Expedited Grievance Decision.
 2. If the denial is not overturned after acquiring additional information, the Medical Director will have no further participation in the decision for the remainder of the expedited process. The QI Supervisor/QIC will continue the process.
- The QIC prepares a summary of the grievance and consults with a same or similar specialty practitioner who was not involved in the original adverse decision.
 - The same or similar specialty practitioner will review the information provided. He/she will then make a decision to uphold or reverse the denial. The decision, along with supporting rationale, will then be communicated to the QIC and/or QI Supervisor.
 - Notification of Expedited Grievance Decision:

The QIC or QI Supervisor will immediately notify the practitioner verbally of the expedited grievance decision. This verbal notification will take place within 72 hours from the time the grievance was received at NHP/NHIC. Written notification of the decision will be sent to the member or member's representative and the practitioner within 72 hours following the verbal notification to the practitioner. Written notification of grievance rights will include:

1. Specific reason(s) for the grievance decision using wording that is easily understood.
2. A reference to the benefit provision, guideline, protocol or other similar criterion that was used to base the decision.
3. Notification that upon request, the member can obtain free of charge a copy of the actual benefit provision, guideline, protocol, or other similar criterion that was used to base the decision.
4. Notification that the member is entitled to receive free of charge, upon request, reasonable access to and copies of all documents relevant to the member's grievance. Relevant documents include the documents or records that were either submitted during or relied upon during the course of making the grievance decision.

5. A list of titles and qualifications of the individual(s) participating in the review, regardless as to whether the advice was relied upon in making the decision. (Participant names are not included in the notification, but will be provided if requested by the member).
 6. A description of the next level of grievance, including the right to an Independent Review Organization (IRO) and any relevant written procedures, if all or part of the expedited request was not overturned.
 7. Notification that the member is entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). Once the member has exhausted the grievance process they have the right to file suit in Federal Court under Section 502 (a) of ERISA.
 8. Notification that the member may have other dispute options, such as mediation. To find out what they have available they can contact their local U.S. Department of Labor Office and the State insurance regulator agency.
- Timeframe for the Expedited Grievance:

The expedited process begins when the expedited request is received at NHP/NHIC. The decision and the verbal notification of that decision must be completed within a 72 hour timeframe that starts from the time of the initial receipt of the request. Written notification of the decision will be mailed to the member or member's representative and practitioner within 72 hours following the verbal notification to the practitioner.
 - The QIC completes the grievance file, which is marked Privileged and Confidential, and the file will be retained in a locked area of the Quality Improvement department. An electronic record of the expedited grievance will be maintained in the Credentialer/Grievance database.

NHP/NHIC-Medical Record Review Process Uses Established Standards

Abstract/Purpose:

In order to facilitate communication, coordination and continuity of care, and to promote efficient and effective treatment, Network Health Plan/Network Health Insurance Corporation (NHP/NHIC) has established standards to assure medical records are well-documented for HMO/POS and Medicare Advantage members.

I. POLICY:

- A. NHP/NHIC requires medical records to be maintained in a manner that is current, detailed and organized to permit effective, confidential patient care and quality review. Medical record policies, procedures and documentation standards must discuss the following:
- Medical record content
 - Medical record organization
 - Ease of retrieving medical records
 - Confidential patient information
 - Standards and performance goals for participating practitioners
- B. NHP/NHIC systematically reviews medical records on all HMO/POS primary care practitioners (PCPs) who are not using electronic medical records and have fifty or more commercial members and Medicare Advantage practitioners who have treated fifty (50) or more members within the previous year. The primary care medical record will reflect all services provided:
- directly by the PCP,
 - all ancillary services and diagnostic tests ordered by a practitioner, and
 - all diagnostic and therapeutic services for which a member was referred by a practitioner, such as: home health nursing reports, specialty physician reports, hospital discharge reports, and physical therapy reports.
- C. NHP/NHIC has established a performance standard of 80% for each criterion reviewed and will institute actions for improvement when the performance standard on any of the criteria is not met. The medical record review must occur within a 36 month timeframe of the practitioner's start date and recur every two years from the time of the initial review.

- D. NHP/NHIC distributes the medical record standards to practitioners and appropriate staff members on an annual basis as well as at the time of practitioners' orientation. Overall aggregate medical record review results are reported in the annual quality program evaluation.

II. **PROCEDURE:**

A medical record review is scheduled and conducted by an NHP/NHIC reviewer. Ten (10) members are randomly chosen from a monthly claims report of the previous year. The results are scored and recorded on the Medical Record Audit Tool. (See related documents – NHP/NHIC Medical Record Review tool and NHP/NHIC Medicare Medical Record Review tool.)

The Medical Record Review Tools contain the following criteria:

- **Confidentiality of medical records** – Records are stored securely, only authorized personnel have access to records, and staff receives periodic training in member information confidentiality.
- **Medical record documentation standards** – Each medical record must include history and physicals, allergies and adverse reactions, problem list, medications, documentation of clinical findings and evaluation for each visit, and preventive services/risk screening.
- **Organized medical record keeping systems/standards for the availability of medical records**- Medical records are organized and stored in a manner that allows easy retrieval. Medical records are stored in a secure manner that allows access by authorized personnel only.
- **Performance goals to assess the quality of medical record keeping** – The practitioner must meet a quantifiable performance goal for the requirements of medical record keeping. NHP/NHIC's performance standards are set at 80% or above for each criterion reviewed.

Results of the medical record review are sent to the practitioner within thirty days or less of the review. If any of the criteria scored less than 80%, a proposed action plan will be included, and the practitioner will be given the opportunity to discuss the proposed action plan with a Quality Improvement representative.

NHP/NHIC-Site Visit and Medical Record Keeping Practices

Abstract/Purpose:

NHP/NHIC sets standards and thresholds for office-site criteria and medical/treatment record-keeping practices for all practitioners within its network.

I. POLICY:

Network Health Plan/Network Health Insurance Corporation (NHP/NHIC) sets standards and thresholds for office-site criteria and medical/treatment record-keeping practices for all practitioners within its network.

The office-site criteria include standards and thresholds for each of these categories.

- Physical Accessibility
- Physical Appearance
- Adequacy of Waiting and Examining Room Space
- Availability of Appointments
- Adequacy of Treatment of Record Keeping

The organization conducts an office site visit if it receives a member complaint about the quality of a practitioner's office related to the above criteria. Site complaints are forwarded from member advocates to the following: site visit surveyor, CVO Medical Staff Services Coordinator, and NHP/NHIC Credentialing Coordinator.

II. PROCESS:

A site visit is scheduled and conducted within 60 (sixty) days of receipt of a complaint. The organization uses a standardized site visit survey form that incorporates office-site criteria to assess each office about which it has received a member complaint. The survey form is completed at the time of or shortly after each site visit.

The structured site visit review process includes, but is not limited to, an assessment of the site: physical accessibility, physical appearance, adequacy of waiting and examining room space, availability of appointments, and adequacy of medical/treatment recordkeeping and confidentiality of records. Results from the site visit and medical/treatment recordkeeping practices will be documented and scored on the Office Survey Tool. (See related document NHP/NHIC Office Survey Tool) NHP/NHIC requires a performance standard of 80%-100%. Results of the site visit will be placed in the credentials file of each practitioner located at the site.

If the site achieves the performance standard, a copy of the site visit results will be forwarded to the site manager/designee with a copy to each practitioner at the site.

If the site does not meet the performance standard, a copy of the site visit results, outlining the deficient areas, and a proposed corrective action plan will be forwarded to the site

manager/designee with copy to each practitioner at the site. The site manager/practitioners will be given the opportunity to respond to the corrective action plan. The site visit results, corrective action plan, and response from site manager/practitioners, if any, will be reviewed by the Credentials Committee. The site must implement the corrective action plan within six months of the complaint. NHP/NHIC will revisit the site at least every six months until the site achieves the performance standard. If the site continues to be out of compliance with NHP/NHIC standards the site visit report is forwarded to the Credential Committee. After one year of continued non-compliance the Credentials Committee will review and make recommendations to improve to the Quality Management Committee (QMC). QMC will make a final decision on the action to be taken.

When a practitioner relocates or opens an additional office NHP/NHIC will be notified of the change. Notices of new sites will be forwarded to the Credentialing Department from the Managed Care Contracting Department when an address change has been received from a contracted site. Notices may also be received from the practitioner as part of his/her recertification application. Such notices will be confirmed with the Managed Care Contracting Department to determine if such sites will be contracted sites.

Network Health Plan/Network Health Insurance Corporation

MEDICAL RECORD REVIEW

GOAL --- 80 %

PROVIDER :

LOCATION :

AUDIT DATE :

Medical Record Standards CRITERIA	MEMBERS										COMMENTS	SCORE	≥80%
	1	2	3	4	5	6	7	8	9	10			
1. Significant illnesses, medical and psychological conditions are indicated on the problem list.													
2. Medication allergies and adverse reactions are prominently noted in the record. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record.													
3. Medical records are legible, organized, and signed.													
4. All current medication(s) are listed.													
5. Past medical history (for patients seen three or more times) is easily identified and includes serious accidents, operations, and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, immunizations, operations, and childhood illnesses.													
6. Documentation of clinical findings and evaluation for each visit.													
7. Preventive services/risk screenings are included with each history and physical.													

Network Health Plan/Network Health Insurance Corporation has established medical record documentation standards to assure records are well documented in order to facilitate communication, coordination, and continuity of care and promote the efficiency and effectiveness of treatment.

Network Health Plan/Network Health Insurance Corporation

MEDICAL RECORD REVIEW

GOAL--- 80%

PROVIDER: LOCATION: AUDIT DATE

Medical / Treatment Record Keeping (circle one)			
1 Confidentiality of medical records	Y	N	<ul style="list-style-type: none"> • Records are stored securely • Only authorized personnel have access to records • Staff receive periodic training in member information confidentiality
2. Organized medical record keeping systems/standard for the availability of medical records.	Y	N	<ul style="list-style-type: none"> • Medical records are organized and stored in a manner that allows easy retrieval • Medical records are stored in a secure manner that allows access by authorized personnel only

Auditor Signature

Date

NETWORK HEALTH PLAN OFFICE SURVEY TOOL

Location: **Audit Date:**

% of score	CRITERIA	X = YES	O = NO	DEFINITION
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15%	1. Physical Accessibility			
	A. Facility easily accessible.			Easily accessible via safe, public thoroughfare/public transportation.
	B. Clearly marked facility sign.			A sign, plaque, or other indication of facility location is in a highly visible spot.
	C. Patient/handicapped parking.			Adequate parking, including handicapped designation.
	D. Office is handicapped accessible.			Ramp to bypass any stairs. Elevators if above first floor. Wide doors.
	E. Restrooms handicapped accessible.			Wide doors, grab bars.
	F. Exits clearly marked and accessible.			Appropriate numbers of signs indicating office exits are posted in highly visible locations.
	G. Home office only			
	1. Office must have a separate entrance for clients/patients.			
	2. Office must be used only for business and may not be used as part of the living area.			
	3. There must be waiting area separate for the living area.			
	4. There must be a restroom separate from the living area			
	5. Practitioner must have a separate telephone line that is not accessible to other household residents or household staff.			
	Total			

NETWORK HEALTH PLAN OFFICE SURVEY TOOL

15%	2. Physical Appearance			
	A. Neat, clean and well maintained.			The clerical areas, examination rooms, lab, etc. are clean and neat with adequate lighting and ventilation.
	B. Fire extinguisher/evacuation route posted			Observed during tour.
	C. All controlled drugs are inaccessible to patients.			Controlled drugs are kept in a double-locked cabinet.
	D. Written control procedures if narcotics on site.			Validate documented procedures.
	E. System for check/disposal of expired medications.			Identified staff person responsible. Process is being followed.
	F. Needle disposal system.			Observed during tour.
	G. Biohazard disposal system.			Observed during tour.
	Total			
10%	3. Adequacy of Waiting and Exam Room Space			
	A. Adequate patient seating.			Adequate size and comfort in the waiting room.
	B. Patient education materials.			Observed during tour.
	C. Exam/counseling rooms large enough.			Large enough for 3 people.
	D. Exam/counseling rooms clean and private.			Observed during tour.
	Total			
10%	4. Maintenance of Confidentiality			
	Written Policies/Procedures exist.			Observed during tour.
	Total			

NETWORK HEALTH PLAN OFFICE SURVEY TOOL

30%	5. Availability/Accessibility		
	A. Office hours are posted.		Observed during tour.
	B. Written policies/procedures exist for appointment scheduling for Primary Care Practitioners.		
	1. Urgent care:		Med – Same day BH – 48 Hours (Defined as symptoms with sudden or recent onset requiring intervention the same day)
	2. Routine care:		Med – 7 days BH – 10 days (Defined as non-urgent symptomatic condition that is medically stable)
	3. Preventive Care: (Medical Only)		30 Days. (Defined as a preventive health evaluation without medical symptoms for existing patients. ie. routine exam, annual physical)
	4. Emergent, Non Life Threatening (BH only)		6 hours
	5. Life Threatening, Emergent problem:		Immediate Access
	C. Written Policies/Procedures exist for after hours coverage.		24-hour care coverage provided. Acceptable coverage includes the telephone answered by a messaging center/switchboard operator, answering service or by an answering machine with instructions on how to obtain access to care.
	D. Written policies/procedures exist for medical emergencies.		Properly identify emergency conditions and appropriately triage such cases (manage in office or make alternative arrangements such as ICS or ER).
	Total		
20%	6. Adequacy of Medical / Treatment Record Keeping		
	A. Protected from public access.		Medical/Treatment records are stored in area not accessible to the public.
	B. A designated staff member is responsible.		Verified?
	C. Identified by patient name and/or number.		Records should be easily identifiable.
	D. Individualized medical/treatment records.		Separate records for each family member/patient.
	E. Policy on availability.		Policy to address irretrievability, timeliness of completion and release of information.
	F. Medical/Treatment record is organized and provides		The medical/treatment record contains:

NETWORK HEALTH PLAN OFFICE SURVEY TOOL

areas for appropriate documentation.			1) Patient's name or ID number on each page 2) Personal/demographical data to include the address, employer, home and work telephone numbers. 3) A problem list to indicate significant illnesses/ medical conditions 4) Notation of medication allergies, adverse reactions or documentation of no known allergies ie; NKDA/NKA 5) Medication List (If applicable). 6) PCPs Only—Immunization record
Total			
Grand Total			

NETWORK HEALTH PLAN'S goal is 80-100%

GENERAL COMMENTS/RECOMMENDATIONS:

NHP/NHIC-Complaint-Appeal (Grievance) Resolution Policy and Procedure

Abstract/Purpose:

All verbal or written complaints and grievances received at Network Health Plan/Network Health Insurance Corporation (NHP/NHIC) will be investigated and resolved in a consistent and timely manner, in accordance with state, federal and National Committee of Quality Assurance (NCQA) standards.

I. **Policy Purpose:**

All verbal or written complaints and grievances received at Network Health Plan/Network Health Insurance Corporation (NHP/NHIC) will be investigated and resolved in a consistent and timely manner, in accordance with state, federal and National Committee of Quality Assurance (NCQA) standards. An expedited process will be implemented whenever a Complaint or Grievance has been determined to be of an urgent clinical nature. All Complaints and Grievances will be monitored, tracked and trended in a central database maintained by the Customer Service Department and reported at least quarterly to the Quality Improvement Committees and/or Service Subcommittee. A grievance or complaint may be made by or on behalf of our member.

Per the State of Wisconsin Office of the Commissioner of Insurance members are not required to submit a grievance request within a specified timeframe.

II. **Applicable Definitions:**

NCQA: Classifies dissatisfaction with the administration or claims practices of or provision of services by NHP/NHIC as an Appeal.

OCI: Classifies dissatisfaction with the administration or claims practices of or provision of services by NHP/NHIC as a Grievance. The definition of a complaint is the same for both NCQA and OCI.

****For the purpose of this policy, Grievances and Appeals will be one in the same and stated as Grievances.***

Adverse Determination: A determination by or on behalf of a member that the treatment does not meet the health benefit plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness or experimental treatment including a request for a referral to an out of network provider when the member believes the clinical expertise of the out of network provider is medically necessary.

Appeal (AKA Grievance): Any dissatisfaction with the administration or claims practices of or provision of services by NHP/NHIC which is expressed by or on behalf of a member.

Central Complaint Area (CCA): Customer Service Department

Complaint: An expression of dissatisfaction made to NHP/NHIC by or on behalf of the member.

Senior Plus Grievance: An expression of dissatisfaction made to NHP/NHIC by or on behalf of the Senior Plus member (same as a Complaint but categorized as a Grievance in accordance with HCFA regulations). *(See related policy: **Grievance/Appeal (Appeal) Resolution Policy and Procedure for SeniorPlus Products**)*

Plan Representative: NHP/NHIC Representatives who are trained and experienced in addressing member's complaints and grievances. This includes the Customer Service Representatives who are assigned to answer member telephone calls placed to the Customer Service Department as well as departmental Managers, Member Advocates, Quality Coordinators, or other designated employees of NHP/NHIC. In order to better service NHP/NHIC members, employees in each department who have member interaction are trained to receive member inquiries and complaints in order to allow response to occur in a timely manner.

Pre-Service Grievance: Is any written or electronically submitted request to change an adverse determination for care or service that the organization must approve, in whole or in part, in advance of the member obtaining care or services.

Post- Service Grievance: Is any written or electronically submitted request to change an adverse determination for care or services that have already been received by the member or an expression of dissatisfaction with the administration or claims practices of or provision of services by NHP/NHIC which is expressed by or on behalf of a member.

Resolution is said to have occurred when:

- A. All pertinent information has been gathered to make an informed decision;
- B. The decision has been communicated to the member, and;
- C. No further member follow-up is needed.

Expedited Urgent Complaint: An expression of dissatisfaction, which has been determined to be of clinically urgent nature by the Quality Improvement Department.

Inquiry: Any first request to review a decision, determination or denial of a claim, service, referral authorization, or benefit made by or on behalf of our member.

Grievance Review Meeting: Informal (initial) review of a case. In this meeting the file is reviewed to see if benefits can be provided prior to the Grievance Committee Meeting. If the denial is upheld at this meeting, the case is automatically referred to the Grievance Committee.

Expedited Urgent Grievance: Any dissatisfaction with the administration or claims practices of or provision of services by NHP/NHIC which is expressed by or on behalf of a member, which has been determined to be of clinic urgent nature by the Quality Improvement Department (QI).

Department of Insurance Inquiry: A request from the state Department of Insurance for information concerning an inquiry, Complaint or Grievance filed by or on behalf of a member through the Office of the Commissioner of Insurance state regulatory agency.

Independent Review Organization (IRO): An external review company not associated with Network Health Plan/Network Health Insurance Corporation that reviews a case for final determination that is based on medical necessity.

Quality of Care, Service or Access Complaints: Any written expression of dissatisfaction with quality of care, service or access will be classified as a grievance and follow the grievance resolution process.

III. **Procedure:**

- A. **All contacts**, verbal and written, are assessed by a Plan Representative to determine if it is a complaint, grievance or a Department of Insurance inquiry.
 1. Some inquiries may be identified by the Plan Representative as a potential complaint or grievance. To improve the customer service provided by NHP/NHIC, each plan representative is given limited authority to take action on these cases in an effort to educate our members and still retain the business. The limitations are clearly defined in the Inquiry Decision Authority Parameters.
 2. When an inquirer asks for elevation of their call to a higher level of authority, the plan representative should handle the inquiry as indicated according to the Call Elevation Handling Procedure.
 3. If contact is written the issue is automatically referred to the CCA to begin the grievance process.

B. Complaints

1. A Plan Representative receives a complaint. If the complaint cannot be addressed immediately, the Representative will explain the Complaint Process to the member. The Plan Representative will complete a Complaint/Appeal Form (COAF) (*see related document*), designate an appropriate primary and secondary code and forward it to the CCA. The CCA will log the complaint in the database, assign a case number and assign a Member Advocate.
2. The Member Advocate will document the substance of the complaint and all steps taken in the investigation (i.e. medical records request, denial file from Care Management) in the Complaint and Grievance Database. The substance of the complaint, the Member Advocate assigned to the case, and the final response will be documented in call log using the most appropriate call type.
3. If clinical urgency is identified by either the member, the Member Advocate, or if the complaint pertains to clinical care or access, the Member Advocate will immediately refer the complaint to the QI Department. If the QI Department determines clinical urgency, the process for Expedited Urgent Complaint and Expedited Urgent Grievance Policy and Procedure will be followed (*see related policy: **Expedited Grievance (Senior Plus “Fast Appeal”) Policy and Procedure***). The member will receive a written response including the disposition of the complaint and member grievance rights, if applicable, within 45 working days or less.

C. Expedited Urgent Complaint

1. If clinical urgency is identified by either the member, the Member Advocate, or if the complaint pertains to clinical care or access, the Member Advocate will immediately refer the complaint to the QI Department. If the QI Department determines clinical urgency, the process for Expedited Urgent Complaint and Expedited Urgent Grievance Policy and Procedure will be followed (*see related policy: **Expedited Grievance (Senior Plus “Fast Appeal”) Policy and Procedure***).

D. Expedited Urgent Grievance

1. In the case of an urgent care request an expedited grievance will be offered.
 - a. An expedited review begins when a member, representative of the member or a practitioner acting on behalf of the member requests an expedited grievance. An expedited grievance will be granted to all request concerning admissions, continued stay or other health care services for a member who has received emergency services but has not been discharged from the facility.

- b. The expedited grievance decision and notification to the member and practitioner must be made within 72 hours of the request. If the case is determined to be an Expedited Urgent Grievance refer to the QI Department policy Expedited Urgent Complaint and Expedited Urgent Grievance Policy and Procedure (*see related policy: Expedited Grievance (Senior Plus “Fast Appeal”) Policy and Procedure*).

E. Pre and Post Grievance Procedure

1. Plan Representative receives a written grievance. All grievances are forwarded to the CCA the day they are received. The grievance, including the envelope will be date stamped and attached to a completed COAF. The CCA reviews the grievance and determines if it is a pre-service or post-service grievance. The grievance, including the receipt date, is entered in the database for tracking and trending, logs the substance of the grievance in call log, and assigns a case number and a Member Advocate. If clinical urgency is identified by the member, Member Advocate or if the grievance pertains to clinical care or access, the Member Advocate will refer the grievance to the QI Department.
2. The Member Advocate sends the member a written acknowledgement of their grievance within five (5) business days following receipt of the grievance request. The acknowledgement will include:
 - a. Notification to the member of his or her grievance rights, including their right to an independent review by an Independent Review Organization (IRO) certified by the State of Wisconsin.
 - b. The member’s right to attend the Committee Meeting. The member may attend via teleconference or by sending a representative on their behalf. If the member chooses to send a representative in their place, proper authorization must be obtained by Network Health Plan/Network Health Insurance Corporation prior to the Grievance Committee Meeting.
 - c. A copy of the grievance process.
 - d. An authorization to release information, if applicable.
 - e. The member has the right to submit written comments, documents, records and other information relevant to their grievance.
3. The Member Advocate will document the substance of the grievance and all steps taken in the investigation in the Complaint and Grievance Database. The substance of the grievance will also be documented in the call log.
4. The Member Advocate is responsible for monitoring the progress of the case and ensuring that it is handled within all necessary time frames using the Grievance File Checklist. The Member Advocate must also ensure

that all related departments have reviewed and have provided any pertinent information to the case.

5. The Member Advocate is responsible for reviewing the substance of the grievance, including all aspects of clinical care involved, and requesting any pertinent additional documentation (i.e. medical records). If the case pertains to a medical necessity issue (denial), the Member Advocate will have the case reviewed by a Board Certified Physician who is certified in the specialty related to the issue.
6. This review must take place before the case is presented to the Grievance Committee. If at anytime during the preparation of the grievance, the Medical Director or Department Manager receives any information indicating that a denial decision should be overturned, the Medical Director or Department Manager will overturn the grievance. The Member Advocate will:
 - a. Prepare a letter to the member explaining the reconsideration decision and the date the decision was made.
 - b. Ensure that Claims Follow-Up form (CFU's) and all necessary activity is completed.
 - c. Update and close the case in the Complaint and Grievance Database, indicating the resolution and rationale for that decision.
7. If the case is overturned prior to committee, the case will not be presented to the Grievance Committee.
8. Each week the grievance file is presented in the Grievance Review Meeting.
9. If there is a delay in handling due to circumstances beyond Network Health Plan/Network Health Insurance Corporation's control, the Member Advocate must send a notification of delay to the member with an explanation for the delay. This notification of delay must be sent to the Member prior to the fifteenth (15th) calendar day for a pre-service grievance and thirtieth (30th) calendar day for a post-service grievance following receipt of the grievance. In no circumstances may the grievance process exceed thirty (30) calendar days for a pre-service grievance and sixty (60) calendar days for a post service grievance.

Per the State of Wisconsin Office of the Commissioner of Insurance NHP/NHIC is required to allow a delay beyond the 30 or 60 days if it is at the request of the member.

10. If the grievances pertain to a medical necessity issue the Member Advocate will appoint at least one person to review the grievance who is a practitioner in the same or similar specialty who typically treats the medical condition, performs the procedure or provides the treatment.

11. The Member Advocate schedules the case for Grievance Committee and sends a notification letter to the member informing them of the scheduled committee time and date, allowing a seven (7) calendar day notice. This notification will include the location of the committee meeting, a map indicating directions to Network Health Plan/Network Health Insurance Corporation, and their right to present their case to the Committee either in person, telephonically or by a representative (utilizing the proper authorization).
12. When the case is fully investigated and prepared for Committee, the Member Advocate forwards the file to the CCA for copying and distribution to the Grievance Committee members.
13. The Member Advocate will present the case to the Grievance Committee. The Committee will wait up to fifteen (15) minutes past the scheduled committee review time for a member to arrive before making a decision on a case. If the member has notified us that they plan to attend, their case may be held for presentation until the end of the committee session for review.
14. After a complete discussion and review by the Grievance Committee a determination will be made on the case. The Member Advocate will notify the member via a letter with the final determination from the Committee. The final determination letter will be sent within five (5) days after the Committee Meeting, not to exceed fifteen (15) working days for a pre-service grievance or thirty (30) working days for a post-service grievance following receipt of the Grievance request. The written notification includes:
 - a. Any clinical or contractual rationale for the decision.
 - b. Any benefit provision, guideline protocol or other similar criteria on which the appeal decision was made.
 - c. Notification that the member, free of charge, upon request, can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the appeal decision was based.
 - d. Notification that, upon request, members can obtain the names of the medical expert whose advice was obtained on behalf of the organization in connection with the grievance.
 - e. A list of NHP/NHIC's Grievance Committee Panel members
 - f. Information regarding the member's right to an Independent Review Organization (IRO)
 - g. Notification that the member is entitled to receive, free of charge, upon request, reasonable access to and copies of all documents relevant to the member's appeal. Relevant documents include documents or records relied upon in making the appeal decision

and documents and records submitted in the course of making the appeal decision.

- h. Notification that the member is entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). Once the member has exhausted the grievance process they have the right to file suit in Federal Court under Section 502 (a) of ERISA.
 - i. Notification that the member may have other dispute options, such as mediation. To find out what they have available they can contact their local U.S. Department of Labor Office and the State insurance regulator agency.
- 15. In the event that a decision is rendered and time constraints do not allow for written notification to meet the time guidelines, a telephone call should be attempted. Written notification will follow.
- 16. Grievance Committee will not include the person who was involved in the initial determination or who is a subordinate of any person involved in the initial determination. In order to render a decision there must be a quorum of three (3) Committee members. The Chairperson is a standing voting member and will cast a vote in the event of a tie. The Grievance Committee meets weekly, unless there are no cases.
- 17. The Member Advocate will update call log and the Complaint and Grievance Database with the final determination and resolution date.
- 18. The completed grievance file will be audited by the Member Advocate for compliance with this policy including resolution time frames and consistency with other NHP/NHIC policies (i.e. benefit interpretations, contract language, etc.)
- 19. All completed grievance files will be retained in the Customer Service Department in locked filing cabinets for the current and previous year. Purged files from the Customer Service Department will be retained in a locked storage room for a minimum of three (3) years.
- 20. All completed quality of care, service or access grievances will be retained in the Quality Improvement Department in locked filing cabinets for the current and previous year. Purged files from the Quality Improvement Department will be retained in a locked storage room for a minimum of three (3) years.
- 21. Upon request the Member Advocate must provide the member access to and copies of all documents relevant to the member's grievance, including pertinent medical records.

F. Independent Review Organization (IRO)

Standard Process

Whenever an adverse determination or an experimental treatment determination is made the member or a member's authorized representative has the right to request an independent review.

1. Members will be required to go through the NHP/NHIC Internal Grievance process before initiating an IRO, unless:
 - a. NHP/NHIC and the member agree that the matter may proceed directly to the independent review.
 - b. The IRO determines that the health condition of the insured is such that requiring the insured to use the internal grievance procedure prior to the independent review would jeopardize the life or health of the member.
2. When NHP/NHIC resolves a grievance involving an adverse determination, including services that were determined cosmetic, the member will be notified of their right to file an IRO. The notice will include:

A listing of the available IROs certified by the Office of the Commissioner of Insurance (OCI).

- a. A fact sheet on the Independent Review Process in Wisconsin.
 - i. On a monthly basis a Member Advocate will check the OCI web-site for updates to the listing of IRO's certified by the State and changes to the Fact Sheet on the Independent Review Process. The Member Advocate will also document the date the web-site was reviewed and forward to the Manager on a quarterly basis to be included in the Corporate Compliance Plan.
- b. An explanation of how to request an independent review, including;
 - i. Statement that the member may choose and IRO from an enclosed list of IROs certified by the State of Wisconsin.
 - ii. Statement that the member must submit a filing fee of \$25 payable to the IRO with the request. Statement will also explain that the filing fee will be refunded if the member prevails in the review, either in whole or in part.
 - iii. Statement that the total cost of the denied coverage must exceed \$282 (current at the time this policy was approved).

- iv. Notice that the request for independent review must be sent to NHP/NHIC, unless the review is an urgent matter.
 - v. Statement that the insured must complete the internal grievance process, unless NHP/NHIC and the member agree to bypass the internal grievance process or if the member's health condition would be jeopardized if required to go through NHP/NHIC's internal grievance process.
- c. Members have four (4) months from the date of the adverse determination, experimental treatment determination or final internal grievance notification, whichever is later, to request an IRO.
 - d. The IROs decision is binding on NHP/NHIC and the member.

3. IRO Timeframes

The Member Advocate will provide written notice to the OCI, IRO and ETF for a State of Wisconsin Member, within two (2) business days of receiving the request for independent review.

- a. The OCI written notice will include:
 - i. Case number
 - ii. Type of determination, i.e. adverse or experimental determination
 - iii. Date received by NHP/NHIC
 - iv. Name of chosen IRO
 - v. General subject of the request
- b. The OCI notice should be faxed to Barbara Belling, at (608)-261-8579

The OCI notice will not include any information that could identify the insured, including name and social security number.

The IRO notice will include the above and:

- i. Name of member
 - ii. Name of authorized representative, if applicable \$25 filing fee
- c. The ETF notice, faxed to Kari Zika at (608) 267-0633 will include:
 - i. Name of subscriber

- ii. Brief description of issue, including grievance category code
 - iii. Date of member's request
- d. Within five (5) business days of receiving the request for independent review the Member Advocate will submit documentation to the IRO.
- e. Within two (2) business days of receiving the documentation the IRO will determine if the information is reviewable by the IRO. If it is not reviewable the IRO will notify NHP/NHIC, the member, and the OCI.
- f. Within five (5) business days of receiving the documentation the IRO may request additional information from NHP/NHIC or the member.
- g. If additional information is requested the member or NHP/NHIC has five (5) business days to submit requested information. Within thirty (30) business days of receiving all requested information the IRO will make a final decision.
- h. Within two (2) days of making the final decision the IRO will notify both NHP/NHIC and the member. The final decision is binding on NHP/NHIC and the member. If the IRO ruled in favor of the member the Member Advocate will ensure the \$25.00 filing fee is refunded to the member.
- i. Within thirty (30) days of receipt of the bill the fees will be paid to the IRO. The Member Advocate will monitor the payment process and obtain copy of the check to assure payment within 30 days.

Expedited IRO Process

If the member requests an expedited IRO the timeframes stated in Section 3 a, b & c must be followed for notification and payment guidelines. The following timeframes must be followed for submission of materials:

- i. Within one (1) day after receiving the notice of the request for independent review the Member Advocate will submit documentation to the IRO.
- ii. Within two (2) business days after receiving the information the IRO shall request additional information, if applicable.
- iii. Within two (2) days after receiving the request the member or NHP/NHIC shall submit the requested information or an explanation of why the information is not being submitted.

- iv. The IRO shall make its decision within 72 hours after the expiration of the timeframes listed above.

G. Department of Insurance Inquiry

All Department of Insurance Inquiries (DOI) should be forwarded directly to the Member Advocate. The Member Advocate will date stamp the DOI, initiate a COAF, and log the substance of the DOI into the Complaint and Grievance Database and call log.

1. The Member Advocate is responsible for reviewing and investigating all issues that relate to the inquiry. When or where appropriate, corrective action should be taken.
2. Within ten (10) working days or the set time frame on the DOI and upon completion of the investigation of the inquiry the Member Advocate will prepare a written response to the member and to the OCI.
3. In the event of a delay, a notice of delay, including an explanation as to the reason for the delay will be sent to the OCI and Member.
4. A final response is required to both the State of Wisconsin and to the member.
5. The Member Advocate will update call log and the Complaint and Grievance Database with the final determination and will file the completed inquiry in a locked filing cabinet, retained in the Customer Service Department.

H. Tracking and Trending Reports

1. A Complaint and Grievance tracking and trending database will be maintained by the Customer Service Manager.
 - a. Information regarding tracking complaints and grievances will include, but is not limited to, primary codes, secondary call type codes and severity level codes (Attachment C), compliance to resolution time frames set forth in this policy, benefit interpretations and contract language; members, employers group, product, providers, etc.
 - b. The Customer Service Manager will prepare trending reports and analysis regarding the types and volume of complaints and grievances.
2. Tracking and trending reports will be submitted to the Quality Management Committee and the Service Sub Committee on a quarterly basis.

I. State of Wisconsin employee trust funds (ETF) groups

State of Wisconsin groups may continue the Grievance process through ETF. All final grievance letters will include an attachment indicating how to proceed with the grievance process through ETF.

J. Grievance Review Meeting

The Grievance Review meeting takes place every Friday. The Member Advocate notes the status of the grievance and presents the information they have obtained thus far. If the Member Advocate, Customer Service Supervisor or the Claims Supervisor recommends the case be overturned prior to committee, the option is reviewed at this time, and a determination is made. If either the Customer Service or Claims Supervisor does not feel they have sufficient information, the Member Advocate will continue to investigate and obtain additional information so a determination can be made at the next Grievance Review Meeting. All cases not overturned in the Grievance Review Meeting will be brought to the Grievance Committee within fifteen (15) calendar days for pre-service grievances and thirty (30) calendar days for post-service grievances from the date received. If a delay is made for circumstances beyond the plan's control, the case will be presented within thirty (30) calendar days for pre-service grievances and sixty (60) calendar days for post service grievances.

Product Information/Lines of Business

NHP's Customer Service Department will be happy to assist you in determining benefits for specific services. The information below is provided to give you a broad overview of NHP's various products, including the different lines of business. In addition to these lines of business, NHP offers custom funding options for groups which have their own benefit plan designs. Most products have various levels of copayments, coinsurance, deductibles, out-of-pocket maximums, and lifetime limitations. Please refer to the Member's Identification card (ID) for the applicable out-of-pocket expenses. A sample ID card is attached for your review. Please contact NHP's Customer Service Department if you require additional benefit and claims information. The telephone number for the Customer Service Department is (920) 720-1300 or 1-800-826-0940, TTY 1-800-947-3529. Customer Service hours are: Monday, Wednesday, Thursday and Friday 8:00 am to 5:00 pm, Tuesday 8:00 am to 4:00 pm. Keep in mind that final benefit determinations cannot be made until the actual claim has been submitted and processed.

HMO (Health Maintenance Organization)

This is a health care financing and delivery system that provides comprehensive health care services for members in a particular geographic area. NHP's HMO requires the use of specific Plan practitioners and providers.

- Members are strongly encouraged to choose a Primary Care Practitioner (PCP).
- The PCP coordinates member's care.
- Verbal referrals may be required for non-primary care services, including specialty care.
- Prior Authorization from NHP is required for some services. Please refer to the Prior Authorization List in this manual or access on line at www.networkhealth.com.
- Some services may require a member copayment at the time of service (please refer to the member's ID card).

POS (Point of Service)

This plan is similar to the HMO plan. It allows members the choice to receive care or services from either a participating (NHP-contracted) or a non-participating (non-contracted) healthcare provider. However, the member must pay a higher share of the total cost when going outside the participating provider panel.

- POS members are strongly encouraged to choose a PCP.
- POS members must follow the HMO requirements (see requirements above) to receive the maximum in-plan benefit level.

PPO (Preferred Provider Organization)

This plan offers a program in which contracts are established with healthcare or medical service providers. These providers are referred to as preferred providers.

- Generally speaking, the benefit contract provides significantly better benefits to members for services received from preferred providers, thus encouraging members to utilize these providers for their healthcare.
- Members are generally allowed benefits from non-preferred (non-contracted) provider services, usually on an indemnity basis with significant copayments, coinsurance and/or deductibles.

- NHP may provide one or both of the following provider panels:
 - Network Health Plan
 - Network/Prevea

Network Options

This plan provides a unique health insurance solution for a business that matches the employee population wherever they reside.

- The business must have an NHP insurance product.
- Business must have 51 or more employees.
- 85% of the employee population must reside in Wisconsin.
- No more than 5% of the employee population may be residing in any one state other than Wisconsin.

Self-Funded Plans

This plan is defined as a job-based health insurance plan that is paid for by the employer. Employers pay the claims cost incurred by the covered persons enrolled in the plan, and this cost varies from month to month based on health care use by the covered persons. Self-funded plans are governed by ERISA instead of state insurance law and generally tend to reduce costs associated with insuring employees.

Medical Assistance HMO Coverage

The Medicaid program has offered HMO coverage to some of its members. Those members who have chosen coverage through NHP will be identified by swiping the magnetic strip on the back of their Forward Card or by contacting the Medicaid program for eligibility information. NHP has contracted with Managed Health Services to provide billing, eligibility, admissions and referral information for its Medicaid members. Please do not call NHP regarding these members. Instead, provider offices can directly call Managed Health Services at 1-800-222-9831 or (414) 345-4628 for assistance.

Millennium Information for Primary Care Practitioner

Some of your patients may now be members of Network Health Plan's Millennium. To identify them, there will be a distinct Millennium logo on their member card.

Millennium is a health insurance product from Network Health Plan that emphasizes wellness. Through Millennium, members are given opportunities to engage in wellness activities, including a Health Risk Assessment (HRA) with biometrics, and they are encouraged to develop a preventative relationship with their primary care physician (PCP). In return, members receive financial rewards for meeting their wellness goals.

The physician's role in the Millennium program is extremely important to its success. Because of this, Network Health Plan rewards members who attend a preventive visit. The purpose of this visit, as communicated to Millennium members is:

- Preventive exam
- Care coordination
- Review of medications, immunizations
- Review of Screenings
- Review of Health Risk Assessment and biometrics
- Lifestyle factor modification – adopting healthy lifestyle choices
- Follow up as Needed

To give you access to your patients' health risk information:

1. Health Risk information will be readily accessible, located in the Meditech electronic medical record under "Outside Dictation Reports" data source of PCI. Millennium members are also encouraged to print their health risk information and bring it with them to their preventative visit.
2. If you do not have access to Meditech, use the intranet listing for instructions on how to request access. <http://www.affinityhealth.org/object/about-healthprof-meditech>
3. Most Millennium patients will complete a WebMD Health Risk Assessment. If they have not taken this step, please encourage them to participate in this important component of their health insurance plan.
4. You will now have more comprehensive point-of-care tools to address pre-disease states. The additional information will allow you to more effectively address concerns and treat potential health problems. The Health Risk Assessment identifies pre-disease high and moderate risk factors, as well as readiness to change. Recommendations from the HRA are based on the risk severity as well as willingness on the part of the patient to make positive changes.
5. The program also gives attention to full, five-digit ICD9 diagnosis coding for patient. ICD9s are the basis for data reports and disease management interventions.

You as a PCP have a vital role in the success of Millennium, through your encouragement and guidance into healthy living. We are very excited about this wellness initiative, since it represents the coordinated efforts of an integrated health system to produce a robust new generation of preventive care.

If you have any questions, please feel free to contact me. To learn more about Millennium, please visit www.networkhealth.com

Deb Anderson
Director, Millennium Products
Network Health Plan/Network Health Insurance Corporation
1570 Midway Place
Menasha, WI 54952
920 720-1732
danderso@networkhealth.com

Sample Member Card**



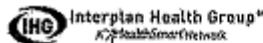
www.networkhealth.com

Send Claims to:
Network Health Plan
PO Box 568
Menasha, WI 54952

Affinity NurseDirect:
1-800-362-9900 Toll-Free
(920) 738-2230 Appleton
(920) 231-6578 Oshkosh



**Customer Service/servicio al cliente/
xav tau kev pab tus xov tooj yog:**
1-800-826-0940
(920) 720-1300 (local)
1-800-947-3529 (for hearing impaired)



Prior Authorization:
1-866-642-9702 for CT, MRI, MRA, PET, and Nuclear Cardiology scans
1-800-555-3616 or (920) 720-1340 (local) for Behavioral Health/Substance Abuse services
1-800-236-0208 or (920) 720-1600 (local) for all other services

Network Health Plan must be notified within 48 hours of an inpatient admission.

HMO plans underwritten by Network Health Plan
POS plans underwritten by Network Health Insurance Corporation and Network Health Plan

Primary Care Practitioner Information

Members may choose a Primary Care Practitioner (PCP) from the following areas:

- Family Practice
 - Internal Medicine
 - Pediatrics
 - General Practice
 - Nurse Practitioner
 - Physician Assistant (working for Primary Care)
- Ongoing communication is expected between the Primary Care Practitioner (PCP) and any specialist who is providing care to the PCP's patient to ensure continuity of care.
 - Patients should be involved and counseled on preventive health measures.
 - The PCP's office is asked to schedule all elective outpatient procedures (x-ray, lab, CTs and other specialty care) with a contracted provider or facility.
 - The PCP is expected to use the least expensive preferred drug in a therapeutic class that will meet the patient's physiological need.
 - Hospitalized patients should be progressed as aggressively as their condition warrants and the PCP should pro-actively address utilization of alternative levels of care (i.e. home care, skilled nursing facility, outpatient rehab, and outpatient therapies). PCPs should contact the Care Management Department for assistance with transitioning of care by calling (920) 720-1600 or 1-800-236-0208.
 - Patients should be admitted to contracted facilities; and transferred to contracted hospital facilities when medically stable.

The PCP is required to evaluate a patient's progress and condition before extending an order for physical, speech, and/or occupational therapies.

NHP/NHIC-Access-Practitioner/Plan Standards

Abstract/Purpose:

Network Health Plan/Network Health Insurance Corporation (NHP/NHIC) establishes mechanisms to ensure members have access to primary care services, behavioral health services, and member services.

I. POLICY:

Network Health Plan (NHP) establishes mechanisms to ensure members have appropriate access to primary care, behavioral health care, and medical specialty care.

NHP members are to experience prompt telephone access to the health plan's various member service representatives. Valid methodology will be used to collect and perform data analysis to measure performance against standards for the following:

- A. PCP Appointment Access
- B. Behavioral Health Appointment Access
- C. Specialist Appointment Access
- D. OB-GYN Appointment Access
- E. Member Services Telephone Access
- F. Behavioral Health Care Management Telephone Access
- G. Medical Care Management Telephone Access

II. VALUES:

The mission of Affinity Health System is supported by adherence to the following values: Service, Creativity, Teamwork and Integrity. The NHP/NHIC policy on Practitioner/Plan Access Standards was developed with these core values in mind. The standards listed in this policy support the value of Service as it seeks to anticipate, understand and respond to individual, organizational, and community needs as they access healthcare services. NHP/NHIC exercises its values of Creativity and Teamwork to clearly communicate its access expectations to all network practitioners, encouraging the achievement of best practice goals.

III. **PRACTITIONER ACCESS STANDARDS:**

A. **PCP Services Appointment Access:**

NHP/NHIC requires all health care practitioners to provide access to health care services without excessive scheduling delays. Practitioners will have policies and procedures in place to properly identify emergency conditions and appropriately triage such cases. Triage involves identifying which cases can be managed in the office or making alternative arrangements, e.g. emergency room, for cases which cannot be safely managed in the office setting. Each NHP/NHIC PCP will provide 24-hour medical care coverage for members.

Using the third next available appointment methodology, the maximum time period between a request for an appointment and the date offered will be:

1. Life threatening, Emergent Care: Immediate access
2. Urgent Care: Same Day access
Defined as symptoms occurring with sudden or recent onset requiring medical intervention the same day
3. Regular and Routine Care: Next calendar day access
Defined as non-urgent symptomatic, medically stable condition
4. Preventive Care: <21calendar day's access
Defined as a preventive health evaluation for existing patients such as annual physical exams without medical symptoms.
5. After Hours Care: Acceptable coverage includes:
 - a. Clinic/staff member answers the telephone
 - b. Message center/switchboard operator
 - c. Answering service, or by an answering machine with instructions on how to obtain access to care. If a recording device is used, clear instructions for obtaining care in emergent and urgent conditions must be included.
 - d. For all other conditions, one of the following access options:
 - Phone number or pager number of a contracted covering practitioner.
 - NurseDirect's phone number or other nurse triage phone line.
 - Directions to an NHP/NHIC-contracted urgent care center directly associated with the contracted group.

- **Note:** Directing members to the emergency room to obtain all after-hours care is not acceptable.

If a practitioner's schedule cannot accommodate the member requesting an Urgent Care or Routine Care appointment within these time intervals, an appointment will be offered with an alternative practitioner, nurse practitioner, physician assistant or certified nurse midwife at the same location, or if none are available at that location, another location will be offered. If an Urgent Care appointment or a Routine Care appointment request cannot be scheduled within the appropriate timeframe, referral to an urgent care clinic may be offered as an alternative. The member may choose to decline alternatives and accept a delayed appointment with the practitioner.

B. Behavioral Health Services Appointment Access:

The maximum time period between a request for an appointment and the time/date offered will be:

1. Emergent, Life Threatening: Immediate access
2. Emergent, *non-Life threatening: 6 hours
3. Urgent Care: 48 hours
4. Routine Care: 10 business days

Note: *Members with non-life threatening emergencies may be directed to the emergency room.

C. Specialist Service Appointment Access:

Using the third next available appointment methodology, the following types of High Volume Medical Specialists are selected and surveyed for consult or new patient appointment within 5 calendar days:

1. Allergy
2. Cardiology
3. Dermatology
4. ENT
5. Endocrinology
6. Gastroenterology
7. Neurology
8. Neurosurgery

9. Hematology/Oncology
10. Ophthalmology
11. Orthopedics
12. Pulmonology
13. Rheumatology
14. Urology

D. OB-GYN Services Appointment Access:

Using the third next available appointment methodology. OB-GYN practitioners will be surveyed for:

1. GYN consultation: Within 5 calendar days
2. Annual GYN exam: Within 21 calendar days

IV. PLAN ACCESS STANDARDS:

A. Member Services Telephone Access:

1. Customer Service: >89% of calls answered within 30 seconds**.
2. Customer Service: Average speed of answer: <50 seconds**
3. Customer Service: Telephone abandonment rate: <5%
4. Customer Service: Percent of First Call Resolution: >89%

B. Behavioral Health Care management Telephone Access

1. Behavior Health: >85% of calls answered within 30 seconds**
2. Behavior Health: Average speed of answer <30 seconds**
3. Behavior Health: Telephone abandonment rate: <5%

C. Medical Care Management Telephone Access

1. Care Management: >85% of calls answered within 30 seconds.**
2. Care Management: Average speed of answer < 30 seconds.**
3. Care Management: Telephone abandonment rate <5%

** Measures refer to a live, non-recorded voice.

V. **Office Hours/Office Wait Time:**

- A. NHP/NHIC requires health care practitioners to have office hours that accommodate the needs of NHP/NHIC members. These hours should be clearly posted and communicated to members.
- B. Members have a right to receive timely treatment without unreasonable delays waiting for the practitioner, either in the examination room or the waiting room. However, because of the unpredictable nature of health care needs, delays are sometimes unavoidable.
- C. Members can expect the courtesy of being informed when waiting time is anticipated to be more than 30 minutes. Alternatives to waiting should be offered, as appropriate.
- D. NHP/NHIC requires practitioners to be readily accessible by telephone. NHP/NHIC members have the right to expect courteous and prompt service when contacting their practitioner for appointments or for general information. When communicating about a medical condition, they will speak with an individual with training appropriate to address their needs. Response to patient telephone calls will be prompt and reliable:
 - 1. All phones will be answered within 30 seconds of the first ring.
 - 2. Emergency Care calls, weekdays or after-hours, will be dealt with immediately.
 - 3. Urgent Care calls, weekdays or after-hours, will be responded to within 30 minutes
 - 4. Routine Care calls will be returned by the end of the day, unless other arrangements are made with the patient.
 - 5. For offices with electronic measurements, call abandonment rate will be less than 5%. If such measurement is not available, very good or excellent satisfaction with access to the office by telephone will be maintained as measured by surveys to be performed by NHP/NHIC.

VI. **MONITORING OF STANDARDS:**

- A. Practitioner Access Standards will be monitored on a regular basis using the following tools:
 - 1. PCP Appointment Access Survey - a minimum of annually
 - 2. Specialist Appointment Access Survey – a minimum of annually
 - 3. Behavioral Health Appointment Access Survey - a minimum of annually
 - 4. PCP After Hours Telephone Survey - annually

5. Access complaints data analysis - quarterly
 6. Member satisfaction survey data analysis – annually
 7. Customer Service telephone indicators – quarterly
 8. Behavioral Health telephone indicators – quarterly
 9. Care Management telephone indicators – quarterly
- B. A multidisciplinary team will do a final, overall annual analysis of the data collected throughout the year and present it in the Quality Program evaluation.
- C. Results of the various surveys and rates collected throughout the year, whether completed three times, four times or annually are monitored and reported to Quality Management Committee (QMC) at the time of completion.. Other leadership groups within NHP and/or the integrated system, when identified as appropriate, will receive appointment access data and analysis.
- D. Practitioners or sites with identified opportunities for improvement will be contacted in a timely manner regarding the survey results, and a follow-up measurement may be scheduled.
- E. Performance not meeting these standards, with failure to make significant progress in meeting standards may result in one or more of the following actions:
1. Closing of primary care panels
 2. Contracting with additional practitioners, if needed.

NHP/NHIC-Availability–Practitioner/Plan Standards

Abstract/Purpose:

Network Health Plan/Network Health Insurance Corporation (NHP/NHIC) ensures its network has sufficient numbers and types of practitioners practicing primary, behavioral health and specialty care.

I. **POLICY:**

NHP/NHIC maintains an adequate network of primary, medical specialty and behavior health care practitioners and monitors how effectively the network meets the needs and preferences of its membership. Standards must be realistic for the community, delivery system and clinical safety. NHP/NHIC is required to demonstrate it measures both the number and geographic distribution of the above mentioned practitioner categories.

- A. **Practitioners Providing Primary Care** include family practice, general medicine, internal medicine, and pediatrics. NHP/NHIC must ensure the following occurs:
- Establish quantifiable and measurable standards for the number of practitioners providing primary care.
 - Establish quantifiable and measurable standards for the geographic distribution of practitioners providing primary care.
 - Annually analyze performance against the standards for the number of practitioners providing primary care.
 - Annually analyze performance against the standards for the geographic distribution of practitioners providing primary care.
- B. **Practitioners Providing Medical Specialty Care.** NHP/NHIC must ensure the following occurs:
- Defines which practitioners serve as high-volume medical SCPS
 - Establishes quantifiable and measurable standards for the number of medical SCPS
 - Establishes quantifiable and measurable standards for the geographic distribution of medical SCPS
 - Annually analyzes performance against the standards.
- C. **Practitioners Providing Behavioral Health (BH) Care.** NHP/NHIC must ensure the following occurs:
- Defines which practitioners serve as high-volume BHPS

- Establishes quantifiable and measurable standards for the number of BHPs
- Establishes quantifiable and measurable standards for the geographic distribution of BHPs
- Annually analyzes performance against the standards.

II. **VALUES:**

The Availability policy supports our mission and our values of Teamwork and Stewardship in ensuring we have an adequate number of providers to promote the health and well being of the communities we serve. This policy also supports our value of Service by providing a process to evaluate and ensure that NHP/NHIC's member population will have access to PCPs and/or specialists.

III. **III. DEFINITIONS:**

- A. Practitioners defined as primary care include: Physicians, Advanced Practice Nurse Prescribers, NHP/NHIC approved Certified Nurse Practitioners and NHP/NHIC approved Certified Physician Assistants. All of the practitioners work in the specialties of Family Practice, General Practice, Internal Medicine and Pediatrics.
- B. Key high volume specialists (HVSs) are defined as the top 10 medical specialties with the greatest number of member encounters per year. (See related document "Key High Volume Specialists" for current list.)
- C. High volume behavioral health specialists (BH HVSs) are defined as those BH practitioners who treated at least 50% of the members receiving behavioral health services of the following defined specialties Psychiatrists/APNPs- those who prescribe and monitor medications; Behavior Health Clinicians- those psychologists and masters-prepared therapists who provide mental health assessments and counseling; and AODA counselors-those whose specialty is treating substance abuse.
- D. Employment status is defined as: Full-time includes a minimum of 4.5 days per week devoted generally to patient care activities in the office setting, with no fewer than 36 hours of face-to-face patient contact.

Regular part-time includes a minimum of 3.5 days per week devoted generally to patient care activities in the office setting, with no fewer than 20 hours of face-to-face patient contact.

○ **STANDARDS:**

The following standards have been established to monitor the availability and geographic distribution of practitioners and providers in relation to the commercial membership.

MONITOR	FREQUENCY OF REPORT	STANDARD
PCP to member ratio	3 times per year	1 PCP per 500 members
Miles to PCP - urban*	3 times per year	3 PCPs within 8 miles of home
Miles to PCP - rural**	3 times per year	3 PCPs within 20 miles of home
Miles to Specialist - urban*	Every 4 months	1 Specialist within 20 miles of home
Miles to Specialist - rural**	3 times per year	1 Specialist within 30 miles of home
Miles to Hospital - urban*	3 times per year	1 Hospital within 30 miles of home
Miles to Skilled Nursing Facility - urban & rural	3 times per year	1 SNF within 30 miles of home
Miles to BH HVS - urban*	Annually	1 within 20 miles of home
Miles to BH HVS - rural**	Annually	1 within 30 miles of home

* Urban is defined as a member population of >1,000 per square mile

** Rural is defined as a population of <1,000 per square mile

Complaints related to availability issues will be monitored quarterly and have a goal of =0.25 per 1000 members.

○ **DATA ANALYSIS:**

Decision Support produces the Geographic Availability Report using GeoAccess software three times per year. The report is then forwarded to the Quality Improvement Department for review and final analysis before presentation to the Quality Management Committee (QMC).

NHP/NHIC-Primary Care Model of Health Care-Specialty Care Access- Standing Specialty Referrals

Abstract/Purpose:

Network Health Plan/Network Health Insurance Corporation (NHP/NHIC) operates under a Primary Care Model of health care for NHP/NHIC managed care members. The PCP is responsible for directing the member's care, including preventive routine care and the coordination of specialty care.

I. Policy:

Network Health Plan/Network Health Insurance Corporation (NHP/NHIC) operates under a Primary Care Model of health care for NHP/NHIC managed care members. The NHP/NHIC products to which this applies are: HMO and POS.

- Plan members must select a Primary Care Practitioner (PCP) who is associated with NHP/NHIC upon enrollment in the Health Plan
- PCPs are responsible for directing the member's care, including preventive routine care (per the NHP/NHIC Preventive Care Guidelines) and the coordination of specialty care.
- PCPs are responsible for arranging and requesting authorization for specialty care outside of the plan provider network when network providers are unavailable or inadequate to meet a member's medical needs.
- NHP/NHIC maintains a list of those practitioners who may be selected as PCP's.
- NHP/NHIC provides for direct access to health care providers other than PCPs as required by State and/or Federal regulations and as determined by the plan. (See: Referral Requirement Expectations below).

II. Guidelines:

- **PCP Selection**
 1. Adults may select PCPs from
 - a. General Practice
 - b. Family Practice
 - c. Internal Medicine
 2. PCPs for children may be selected from:
 - a. General Practice
 - b. Family Practice
 - c. Pediatrics
 3. Allied Health Professionals (nurse practitioners and/or physician assistants) working in the above settings may also be selected.

- **Specialist as a PCP**
 1. With the agreement of the specialist, members may select an in-network specialist as their PCP.
 2. Criteria: The member must have a condition which requires regular, frequent, and ongoing specialty care for most of their medical care. (An example of this is a member on chronic renal dialysis who chooses a nephrologist as a PCP.)
 - a. NHP/NHIC, in allowing a specialist to serve as a PCP, expects the specialist to function as a PCP by providing to the member all the expected services of a PCP. This includes comprehensive, coordinated care and adherence to NHP/NHIC's Clinical and Preventive Care Guidelines.
 - b. NHP/NHIC has approved physicians of the following specialties to be selected as a PCP:
 - i. Cardiology
 - ii. Infectious Disease
 - iii. Nephrology
 - iv. Oncology
 - v. Pulmonology
 - vi. Pediatric Pulmonology Rheumatology Gastroenterology

- **Specialty Access Process:**
 1. Members have open access to all plan providers including but not limited to:
 - a. Optometry or Ophthalmology,
 - b. Obstetric/Gynecology,
 - c. Chiropractors
 - d. Dentists, for preventive dental care if part of member's benefit plan.
 - e. Mental Health or Substance Abuse providers
 - i. NHP will cover MH/SA services subject to a member's plan benefit limits as described in the Summary of Member Responsibility Table. Coordination of care between MH/SA practitioners is encouraged.
 2. Specialty providers should collaborate with the PCP before referring for additional care.
 - a. Providers must obtain a member' consent prior to sharing their MH/SA Privileged Health Information (PHI).
 3. NHP/NHIC does not require prior notification or authorization through the Plan for any in-network specialty referrals.

- **Out-of-Network Specialty Authorization Process:**
 1. Any out-of-network specialty care requires an authorization from NHP/NHIC as required under the current Care Management Department authorization process.
 - a. The member's PCP coordinates and requests out of network specialty authorizations on behalf of the member.
 - b. NHP/NHIC Care Management (CM) reviews the request to ensure services are not available from an in-network provider or are inadequate to meet the member's needs and that services are medically necessary according to established criteria.

NHP/NHIC-Continuity of Care-Terminating Obstetric Care

Abstract/Purpose:

NHP/NHIC will provide for continuity of obstetric care to its members who are in their second or third trimester of pregnancy and receiving obstetric services from an OB/GYN, Family Practice or General Practice provider who is no longer participating with NHP/NHIC.

I. Policy:

NHP/NHIC will provide for continuity of obstetric care to its members who are in their second or third trimester of pregnancy and receiving obstetric services from an OB/GYN, Family Practice or General Practice provider who is no longer participating with NHP/NHIC. This policy applies when the provider is in marketing materials that were provided at the time of the member's open enrollment, enrollment, or most recent coverage renewal, whichever is later, with NHP/NHIC. (See WI Stats 609.24 (1) & (2). Members in their second or third trimester at the time of practitioner termination will be allowed to see the obstetric provider until the completion of the postpartum care for the member and her infant. Members who are in their first trimester at the time of practitioner termination, who is not a primary care physician, will be allowed to see the terminated obstetric provider for the remainder of the course of treatment or 90 days from the date of the practitioner's termination, whichever is shorter. This continuity of care provision does not apply to a practitioner who is no longer practicing in the service area, is terminated for professional misconduct, or retires or otherwise is no longer caring for patients in the same manner of their prior practice.

II. Procedure:

- A. Managed Care Contracting ("MCC") or Provider Data Services ("PDS") receives a termination notice from the provider or becomes aware of the fact that the OB/GYN will no longer be participating.
- B. PDS fills out a provider termination form, completing all information regarding the reason for the termination, including but not limited to: whether or not the practitioner is remaining in any part of the NHP/NHIC service area, if the provider is being terminated for cause, if the practitioner is retiring and no longer seeing patients, etc.
- C. The completed provider termination form is forwarded to the Group Administration Department within five (5) business days of the date MCC becoming aware of the provider's change in status.
- D. PDS will terminate the provider in all applicable databases with the actual termination date.
- E. When a provider is continuing to practice within NHP/NHIC/NHIC's service area, NHP/NHIC will utilize the following process:

1. Group Administration requests the same day it receives the termination notice a list from Decision Support of all the members that the terminating provider has seen in the last twelve (12) months. Group Administration will supply Decision Support with the Practitioner Name; Practitioner Number; Practitioner Type i.e., OB/GYN, and the termination date.
 2. A mail merge file of the members who have seen the terminating provider in the last 12 months will be sent by Decision Support within two (2) business days to the Group Administration Department.
 - a. When the practitioner is an OB-GYN provider, Group Administration will need to know all members age 13 and older.
 3. The Group Administration Department sends the appropriate members a notification letter, no later than 30 days prior to the termination or 15 days following the date the insurer received the provider's termination notice, whichever is later. (see Ins 9.35) When the terminating practitioner provides OB/GYN care, letters are addressed and mailed to the individual members.
 4. After ninety (90) days, unauthorized services with the terminated specialist will be denied for HMO members and paid at the out-of-plan benefit level for POS members. (This does not apply to members in their 2nd and 3rd trimester. If the member is in their 1st trimester and receiving obstetric care from their Primary Care Physician, please refer to Policy #00188 for applicable timeframes).
- F. The NHP/NHIC Care Management Department receives a request from either the member or the member's provider, to authorize care with the provider who will no longer be a participating provider.
- G. Care Management verifies the member's due date to ensure she is in her second or third trimester.
- H. An authorization is entered into the system to allow the member to continue to receive care with the provider until the completion of postpartum care for the member and her infant.
- I. The "Authorization" letter is sent to the member and her provider, authorizing the care.
- J. This policy does not extend to authorizing care by a non-participating provider for the woman's infant, unless medically indicated and appropriate.

NHP/NHIC-Site Visit and Medical Record Keeping Practices

Abstract/Purpose:

NHP/NHIC sets standards and thresholds for office-site criteria and medical/treatment record-keeping practices for all practitioners within its network.

I. POLICY:

Network Health Plan/Network Health Insurance Corporation (NHP/NHIC) sets standards and thresholds for office-site criteria and medical/treatment record-keeping practices for all practitioners within its network.

The office-site criteria include standards and thresholds for each of these categories.

- Physical Accessibility
- Physical Appearance
- Adequacy of Waiting and Examining Room Space
- Availability of Appointments
- Adequacy of Treatment of Record Keeping

The organization conducts an office site visit if it receives a member complaint about the quality of a practitioner's office related to the above criteria. Site complaints are forwarded from member advocates to the following: site visit surveyor, CVO Medical Staff Services Coordinator, and NHP/NHIC Credentialing Coordinator.

II. PROCESS:

A site visit is scheduled and conducted within 60 (sixty) days of receipt of a complaint. The organization uses a standardized site visit survey form that incorporates office-site criteria to assess each office about which it has received a member complaint. The survey form is completed at the time of or shortly after each site visit.

The structured site visit review process includes, but is not limited to, an assessment of the site: physical accessibility, physical appearance, adequacy of waiting and examining room space, availability of appointments, and adequacy of medical/treatment recordkeeping and confidentiality of records. Results from the site visit and medical/treatment recordkeeping practices will be documented and scored on the Office Survey Tool. (See related document NHP/NHIC Office Survey Tool) NHP/NHIC requires a performance standard of 80%-100%. Results of the site visit will be placed in the credentials file of each practitioner located at the site.

If the site achieves the performance standard, a copy of the site visit results will be forwarded to the site manager/designee with a copy to each practitioner at the site.

If the site does not meet the performance standard, a copy of the site visit results, outlining the deficient areas, and a proposed corrective action plan will be forwarded to the site manager/designee with copy to each practitioner at the site. The site manager/practitioners will be given the opportunity to respond to the corrective action plan. The site visit results, corrective action plan, and response from site manager/practitioners, if any, will be reviewed by the Credentials Committee. The site must implement the corrective action plan within six months of the complaint. NHP/NHIC will revisit the site at least every six months until the site achieves the performance standard. If the site continues to be out of compliance with NHP/NHIC standards the site visit report is forwarded to the Credential Committee. After one year of continued non-compliance the Credentials Committee will review and make recommendations to improve to the Quality Management Committee (QMC). QMC will make a final decision on the action to be taken.

When a practitioner relocates or opens an additional office NHP/NHIC will be notified of the change. Notices of new sites will be forwarded to the Credentialing Department from the Managed Care Contracting Department when an address change has been received from a contracted site. Notices may also be received from the practitioner as part of his/her recredentialing application. Such notices will be confirmed with the Managed Care Contracting Department to determine if such sites will be contracted sites.

In the event a practitioner joins a participating practitioner office site, in which complaints have been noted, these complaints will be reviewed as part of the initial credentialing file documentation for that practitioner.

NHP/NHIC-Medical Record Review Process Uses Established Standards

Abstract/Purpose:

In order to facilitate communication, coordination and continuity of care, and to promote efficient and effective treatment, Network Health Plan/Network Health Insurance Corporation (NHP/NHIC) has established standards to assure medical records are well-documented for HMO/POS and Medicare Advantage members.

I. POLICY:

- A. NHP/NHIC requires medical records to be maintained in a manner that is current, detailed and organized to permit effective, confidential patient care and quality review. Medical record policies, procedures and documentation standards must discuss the following:
- Medical record content
 - Medical record organization
 - Ease of retrieving medical records
 - Confidential patient information
 - Standards and performance goals for participating practitioners
- B. NHP/NHIC systematically reviews medical records on all HMO/POS primary care practitioners (PCPs) who are not using electronic medical records and have fifty or more commercial members and Medicare Advantage practitioners who have treated fifty (50) or more members within the previous year. The primary care medical record will reflect all services provided:
- directly by the PCP,
 - all ancillary services and diagnostic tests ordered by a practitioner, and
 - all diagnostic and therapeutic services for which a member was referred by a practitioner, such as: home health nursing reports, specialty physician reports, hospital discharge reports, and physical therapy reports.
- C. NHP/NHIC has established a performance standard of 80% for each criterion reviewed and will institute actions for improvement when the performance standard on any of the criteria is not met. The medical record review must occur within a 36 month timeframe of the practitioner's start date and recur every two years from the time of the initial review.
- D. NHP/NHIC distributes the medical record standards to practitioners and appropriate staff members on an annual basis as well as at the time of practitioners' orientation. Overall aggregate medical record review results are reported in the annual quality program evaluation.

II. PROCEDURE:

A medical record review is scheduled and conducted by an NHP/NHIC reviewer. Ten (10) members are randomly chosen from a monthly claims report of the previous year. The results are scored and recorded on the Medical Record Audit Tool. (See related documents – NHP/NHIC Medical Record Review tool and NHP/NHIC Medicare Medical Record Review tool.)

The Medical Record Review Tools contain the following criteria:

- **Confidentiality of medical records** – Records are stored securely, only authorized personnel have access to records, and staff receives periodic training in member information confidentiality.
- **Medical record documentation standards** – Each medical record must include history and physicals, allergies and adverse reactions, problem list, medications, documentation of clinical findings and evaluation for each visit, and preventive services/risk screening.
- **Organized medical record keeping systems/standards for the availability of medical records**- Medical records are organized and stored in a manner that allows easy retrieval. Medical records are stored in a secure manner that allows access by authorized personnel only.
- **Performance goals to assess the quality of medical record keeping** – The practitioner must meet a quantifiable performance goal for the requirements of medical record keeping. NHP/NHIC's performance standards are set at 80% or above for each criterion reviewed.

Results of the medical record review are sent to the practitioner within thirty days or less of the review. If any of the criteria scored less than 80%, a proposed action plan will be included, and the practitioner will be given the opportunity to discuss the proposed action plan with a Quality Improvement representative.

Practitioners who have scored 100% in all criteria for two consecutive audits will have the date of their next audit extended to five (5) years. Any practitioner who passes the five years audit but fails to maintain a score of 100% will revert back to receiving a two-year audit.

Practitioners who fail the audit with a score less than 80% will receive follow-up audits. In order to assess for improved medical record documentation, a follow up review on the failed criteria is conducted every six months until the practitioner meets the performance standard. If a practitioner fails three or more consecutive reviews, the medical director is notified and will contact the practitioner to discuss a mutually agreed upon plan of corrective action. The medical director will notify the Centralized Credential Committee in writing of the practitioner's failed reviews and correction plan. If the practitioner fails to improve the medical director will present the issue to the Quality Management Committee (QMC). Upon the committee's review, QMC will determine the final action.

Contracting, Credentialing & Provider Data Services

Provider Data Services

Provider Data Services (PDS) is a department within NHP, a part of Affinity Health System.

The PDS Department is responsible for identifying providers who participate with Affinity Health System and NHP. PDS maintains provider demographic data (provider name, addresses, title, specialty, locations where provider practices/provides services, group(s) provider is participating with, federal tax identification number, State License number, DEA number, NPI number, Taxonomy Codes). Responsibilities of this department include extracting provider data for contracted external Third Party Administrators/Payers and Practitioner Directory and Member Reference Guide.

The PDS Department is located at 1570 Midway Place, Menasha, WI 54952. The staff can be accessed Monday through Friday, 8:00 a.m. to 4:30 p.m. at (920) 720-1565 or 1-800-945-1178. The department fax number is (920) 720-1913 and the central email address is provdatasvs@networkhealth.com.

Closing/Reopening Office Practice to NHP Members

Please note that practitioners are expected to comply with their clinic's internal processes for closed and reopened practices, and with the terms of their NHP contract.

Practitioners or their designated contact person must provide written notification of a closed or reopened practice to NHP's PDS Department. The written notification should be directed to 1570 Midway Place, Menasha, WI 54952 or faxed directly to the PDS Department at (920) 720-1913.

NHP's Credentialing and Peer Review Committees may opt to close a practice if quality issues or excessive scheduling delays are identified. The practitioner will be notified in writing of the committee's decision and the effective date of closure.

NHP Credentialing Process

The purpose of credentialing is to provide a thorough review of physicians and other licensed or certified practitioners to ensure that prospective plan practitioners are qualified by education, experience, reflect commitment to high quality, and cost effective medical care for participation in NHP's provider panel.

Credentialing is conducted in a manner that does not discriminate on the basis of age, sex, race, creed, color, national origin, or religion. A review will be conducted on every file that is denied by the Credentialing Committee to ensure that the denial was non-discriminatory. The Medical Director or Designee will appoint a peer to review the denial to ensure that the decision was made in a non-discriminatory manner. Practitioners shall be notified within 60 calendar days of the committee's credentialing decision. Practitioners have the right, upon request, to be informed of the status of their credentialing application. In situations where there is a question regarding any primary source verification findings or if requested by the Credentialing Committee, an additional investigation or review may be initiated. This applies to all practitioners including PPO practitioners when applicable and is consistent with Affinity Health System's mission and values of integrity, teamwork, service, and justice.

NHP will credential practitioners who have an independent relationship with the Plan. An independent relationship exists when NHP selects and directs its members to see a specific practitioner or group of practitioners. Practitioners to which credentialing applies include:

- Doctor of Medicine (M.D.); Doctor of Osteopathic Medicine (D.O.); Doctor of Dental Science (D.D.S.) who provide care under the medical benefit program; Doctor of Podiatric Medicine (D.P.M.); Doctor of Chiropractic (D.C.); and Doctor of Optometry (O.D.).
- Behavioral health care practitioners to include psychiatrists and physicians who are certified in addiction medicine; doctoral and/or master's level psychologists (PhD, PsyD) who are state certified or state licensed; master's level clinical social workers who are state certified or state licensed; master's level clinical nurse specialists or psychiatric nurse practitioners who are nationally or state certified or state licensed; and other behavioral health care specialists who are licensed, certified, or registered by the state to practice independently.
- Nurse practitioners and physicians assistants who work in primary care settings, who provide direct patient care, who make referrals to specialists and/or have prescriptive duties.
- APNP and midwives who are licensed, certified, or registered by the state to practice independently.
- Urgent care physicians and anesthesiologist who work outside the hospital setting.

NHP does not credential practitioners who practice exclusively within the in-patient hospital setting or within free standing facilities (e.g. surgical centers) who provide care for NHP members only as a result of the member being directed to the hospital/facility. Practitioners to which credentialing does not apply includes:

- Anesthesiologists without pain management practice
- Assistant surgeon
- Athletic trainers
- Audiologists
- Critical care
- Dieticians
- Emergency medicine
- Hospital based urgent care
- Hospitalists
- Locum tenens
- Medical toxicology
- Neonatal-Perinatal medicine
- Nuclear medicine
- Nutritionist
- Occupational therapists
- Physical therapists
- Speech/Language therapists
- Pathologists
- Radiologists
- Radiation-Oncology
- Radiology-Vascular interventional
- NP/PA/RN/Surgical techs in specialty practices

NHP maintains the right to do an assessment of need on any given prospective practitioner requesting participation. This is based on number of practitioners per member, geographic location, and services provided.

All prospective plan practitioners must successfully complete the credentialing process before a contract is executed. NHP will not allow provisional or temporary credentialing of practitioners on the basis of incomplete credentials verification.

Only credentialed practitioners are included in the NHP Provider Directory. No practitioner who falls within the scope of NHP's credentialing will be listed individually by name in NHP's Directory unless they have been credentialed for their specialty or subspecialty of practice. All listings in provider directories and other member materials shall be consistent with credentialing data, including education, training, certification, and specialty.

Please note the credentialing process MUST be completed, which includes receiving notification of NHP's approval, prior to caring for NHP members. Please contact NHP's Managed Care Contracting Contract Administrators immediately upon your decision to add any practitioner, remove any practitioner or change an organizational provider's location for your group. These changes require you to complete either the Provider Information Form (PIF) or the Facilities Information Form (FIF), which are located at www.networkhealth.com. Completed forms must be submitted to the Contract Administrators to initiate the credentialing process if applicable. For adding providers, the Contract Administrators will notify you if credentialing is required, based on NHP's credentialing process. For terminated practitioners NHP requires notification of the termination date and whether or not the practitioner will remain in the area. Managed Care Contracting can be reached at (920) 720-1550 or 1-800-207-5769. The department fax number is (920) 720-1901.

In addition to credentialing practitioners, NHP shall conduct a pre-contractual assessment of each organizational provider and an ongoing assessment thereafter of at least every three years, of each organizational provider with which it contracts. These assessments shall evaluate and determine whether the organizational provider meets or continues to meet the standards of participation established by NHP for organizational providers. This includes but not limited to, accreditation, relevant licensure, and good standing with appropriate agencies.

Organizational providers include hospitals, home health agencies, hospices, clinical laboratories, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, outpatient physical therapy and speech pathology providers, ambulatory surgery centers, providers of end-stage renal disease services, providers of outpatient diabetes self-management training, portable x-ray suppliers, rural health clinics, federally qualified health centers, and behavioral health facilities providing mental health or substance abuse services in an inpatient, residential, or ambulatory setting.

Note: NHP reserves the right to delegate credentialing and/or recredentialing activities. If you have questions regarding the credentialing process please contact an NHP Provider Education Coordinator at (920) 720-1513 or (920) 720-1522 for assistance.

Locum Tenens: If your office utilizes Locum Tenens, claims must be submitted with 'Locum Tenens' in field 19 on the claim form (HCFA1500). This then alerts the NHP Claims Department to process the claim appropriately. If this is not done, the claim may be denied as a non-participating provider rendering services.

On-Call Coverage or Covering Provider: NHP recommends the use of NHP participating providers for coverage purposes. However, we recognize that some physicians may need to utilize physicians outside their practice for coverage purposes. If your office utilizes a non-NHP participating physicians or physicians outside of your practice for coverage, the covering provider claims must be submitted with 'Covering Provider' in field 19 on the claim form (HCFA1500). This then alerts the NHP Claims Department to process the claim appropriately. If this is not done, the claim may be denied as a non-participating provider rendering services.

MEMO:

Network Health Plan Provider Information Form

W-9 MUST BE INCLUDED WITH PROVIDER INFORMATION FORM	LAST NAME/SUFFIX	
	FIRST NAME/ MIDDLE INITIAL	
	GENDER	MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>
	DEGREE (MD, DO, ETC)	
	WISCONSIN LICENSE #	
	START DATE	
	NPI #	
	TAXONOMY CODE	
	ACCEPT MEDICAID?	YES <input type="checkbox"/> NO <input type="checkbox"/>
	DATE OF BIRTH	
	LANGUAGES SPOKEN	
	BOARD CERTIFICATION	
	PRIMARY SPECIALTY	
	SECONDARY SPECIALTY	
	LOCUM TENEN	START _____ END _____
	PRIMARY OFFICE NAME	
	PRIMARY CARE PROVIDER	YES <input type="checkbox"/> NO <input type="checkbox"/>
	HOURS PER WEEK	FT=20+ <input type="checkbox"/> PT=< 19 <input type="checkbox"/> PTC=COVERING <input type="checkbox"/>
	ADDRESS	
	CITY, STATE AND ZIP	
COUNTY		
PHONE #		
FAX #		
LOCATION NPI -IF APPLICABLE		

PLEASE ATTACH ANY ADDITIONAL OFFICE INFORMATION ON SEPARATE SHEET

NAME AND ADDRESS TO SEND NHP CREDENTIALING APPLICATION :

NAME	
ADDRESS	
CITY, STATE ZIP	
PHONE #	
E-MAIL ADDRESS	

BILLING INFORMATION (AS LISTED IN BOX 33 ON THE HCFA CLAIM FORM)

PAY TO THE ORDER OF	
ADDRESS	
CITY, STATE, ZIP	
PHONE #	
FEDERAL TAX ID	
ORGANIZATION NPI NUMBER	
NAME AND TITLE OF PERSON LEGALLY AUTHORIZED TO SIGN CONTRACT	
ADDRESS TO SEND AGREEMENT	
E-MAIL ADDRESS	

Please assist us with keeping your information accurate by contacting Provider Data Services with changes:

provdatasvs@networkhealth.com 920/720-1565 800/945-1178 fax 920/720-1917

Website: www.networkhealth.com

The medical specialties listed below are recognized and may be credentialed by Network Health Plan (NHP/NHIC). Please indicate by checking the appropriate box, which specialties from this list you request to be considered for NHP/NHIC credentialing and recredentialing. NHP/NHIC specialty credentials will be granted consistent with the criteria established by the Credentialing Committee. **Will not appear in NHP/NHIC directories*

Specialty	Specialty description	
Allergy & Immunology	Allergy & Immunology	<input type="checkbox"/>
Anesthesiology	*Anesthesiology	<input type="checkbox"/>
	*Critical Care Medicine	<input type="checkbox"/>
	Pain Management	<input type="checkbox"/>
		<input type="checkbox"/>
Behavioral Health	Autism In Home Services	<input type="checkbox"/>
	Behavioral Health	<input type="checkbox"/>
	Behavioral Health-Child & Adolescent	<input type="checkbox"/>
	Chemical Dependency	<input type="checkbox"/>
	Marriage & Family Therapy	<input type="checkbox"/>
	Neuropsychology - Clinical	<input type="checkbox"/>
	Occupational Therapist-Autism In Home Services	<input type="checkbox"/>
	Speech Therapist-Autism In Home Services	<input type="checkbox"/>
	Psychology - Child & Adolescent	<input type="checkbox"/>
	Psychology - General	<input type="checkbox"/>
Chiropractic	Chiropractic	<input type="checkbox"/>
Colon-Rectal Surgery	Surgery - Colon Rectal	<input type="checkbox"/>
Dentistry	Endodontics	<input type="checkbox"/>
	General Dentistry	<input type="checkbox"/>
	Oral & Maxillofacial Surgery	<input type="checkbox"/>
	Pediatric Dentistry	<input type="checkbox"/>
	Periodontics	<input type="checkbox"/>
	Prosthodontics	<input type="checkbox"/>
Dermatology	Dermatology	<input type="checkbox"/>
	Dermatopathology	<input type="checkbox"/>
	Immunology	<input type="checkbox"/>
	Pediatric Dermatology	<input type="checkbox"/>
Emergency Medicine	*Emergency Medicine	<input type="checkbox"/>
	*Medical Toxicology	<input type="checkbox"/>
Family Practice	Adolescent Medicine	<input type="checkbox"/>
	Family Medicine	<input type="checkbox"/>
	General Practice	<input type="checkbox"/>
	Geriatric Practice	<input type="checkbox"/>
	Hospice and Palliative Medicine	<input type="checkbox"/>
	*Hospitalist	<input type="checkbox"/>
	Neuromusculoskeletal Medicine	<input type="checkbox"/>
	Sports Medicine	<input type="checkbox"/>
Internal Medicine	Adolescent Medicine	<input type="checkbox"/>
	Cardiology/Cardiovascular Disease	<input type="checkbox"/>
	Cardiology - Interventional	<input type="checkbox"/>
	Cardiac Electrophysiology	<input type="checkbox"/>
	*Critical Care Medicine	<input type="checkbox"/>
	Endocrinology/Diabetes & Metabolism	<input type="checkbox"/>
	Infectious Disease	<input type="checkbox"/>
	Internal Medicine	<input type="checkbox"/>
	Gastroenterology	<input type="checkbox"/>
	Geriatric Medicine	<input type="checkbox"/>
	Hematology	<input type="checkbox"/>
	*Hospitalist	<input type="checkbox"/>
	Integrative Medicine	<input type="checkbox"/>
	Lipidology	<input type="checkbox"/>
	Nephrology	<input type="checkbox"/>
	Oncology	<input type="checkbox"/>
	Pulmonary Medicine	<input type="checkbox"/>
	Rheumatology	<input type="checkbox"/>
	Sleep Medicine	<input type="checkbox"/>
	Sports Medicine	<input type="checkbox"/>
Medical Genetics	Genetics	<input type="checkbox"/>
	Genetic Counselor	<input type="checkbox"/>
Neurological Surgery	Neurosurgery/Neurological Surgery	<input type="checkbox"/>
	Pediatric Neurosurgery	<input type="checkbox"/>
Nuclear Medicine	* Nuclear Medicine	<input type="checkbox"/>
	*Critical Care Medicine	<input type="checkbox"/>
Obstetrics & Gynecology	Gynecologic Oncology	<input type="checkbox"/>
	Gynecology	<input type="checkbox"/>
	Maternal & Fetal Medicine	<input type="checkbox"/>
	*Perinatal Medicine	<input type="checkbox"/>
	Obstetric & Gynecology	<input type="checkbox"/>
Ophthalmology	Ophthalmology	<input type="checkbox"/>
	Optometry	<input type="checkbox"/>
	Retina/Vitreo Disease	<input type="checkbox"/>
Orthopaedic Surgery	Orthopaedic Spine Surgery	<input type="checkbox"/>
	Orthopaedic Surgery	<input type="checkbox"/>

Specialty	Specialty description	
Otolaryngology	Surgery - Hand	<input type="checkbox"/>
	Sports Medicine	<input type="checkbox"/>
	*Audiology	<input type="checkbox"/>
	Ears, Nose & Throat/Otolaryngology	<input type="checkbox"/>
	*Speech Therapy	<input type="checkbox"/>
	*Speech Therapy - Child & Adolescent	<input type="checkbox"/>
	Pediatric Otolaryngology	<input type="checkbox"/>
Pathology	*Pathology	<input type="checkbox"/>
Pediatrics	Adolescent Medicine	<input type="checkbox"/>
	Lipidology	<input type="checkbox"/>
	*Neonatal-Perinatal Medicine	<input type="checkbox"/>
	*Neonatology	<input type="checkbox"/>
	Pediatrics	<input type="checkbox"/>
	Pediatric Cardiology	<input type="checkbox"/>
	*Pediatric Critical Care Medicine	<input type="checkbox"/>
	Pediatric Endocrinology/Diabetes & Metabolism	<input type="checkbox"/>
	Pediatric Gastroenterology	<input type="checkbox"/>
	Pediatric Hematology/Oncology	<input type="checkbox"/>
	Pediatric Nephrology	<input type="checkbox"/>
	Pediatric Ophthalmology	<input type="checkbox"/>
	Pediatric Physiatry	<input type="checkbox"/>
	Pediatric Pulmonology	<input type="checkbox"/>
	Pediatric Rheumatology	<input type="checkbox"/>
Sports medicine	<input type="checkbox"/>	
Physical Med & Rehab	*Athletic Trainer	<input type="checkbox"/>
	Neuromusculoskeletal Medicine	<input type="checkbox"/>
	*Occupational Therapy	<input type="checkbox"/>
	*Occupational Therapy - Child & Adolescent	<input type="checkbox"/>
	Pain Management	<input type="checkbox"/>
	Pediatric Rehabilitation Medicine	<input type="checkbox"/>
	Physical Medicine & Rehabilitation	<input type="checkbox"/>
	*Physical Therapy	<input type="checkbox"/>
*Physical Therapy - Child & Adolescent	<input type="checkbox"/>	
Rehabilitation Psychology	<input type="checkbox"/>	
Plastic Surgery	Plastic Surgery	<input type="checkbox"/>
	Ophthalmic Plastic Surgery	<input type="checkbox"/>
Podiatry	Podiatry	<input type="checkbox"/>
Preventive Medicine	Aerospace Medicine	<input type="checkbox"/>
	Hyperbaric Medicine	<input type="checkbox"/>
	Occupational Medicine	<input type="checkbox"/>
	Preventive Medicine	<input type="checkbox"/>
Psychiatry & Neurology	Addiction Psychiatry	<input type="checkbox"/>
	Forensic Psychiatry	<input type="checkbox"/>
	Geriatric Psychiatry	<input type="checkbox"/>
	Neurology	<input type="checkbox"/>
	Pain Management	<input type="checkbox"/>
	Psychiatry-General	<input type="checkbox"/>
Psychiatry & Neurology	Vascular Neurology	<input type="checkbox"/>
	Psychiatry - Child & Adolescent	<input type="checkbox"/>
Radiology	Sleep Medicine	<input type="checkbox"/>
	*Radiology	<input type="checkbox"/>
Surgery	*Radiation Oncology	<input type="checkbox"/>
	*Radiology - Vascular & Interventional	<input type="checkbox"/>
	*Assistant Surgeon	<input type="checkbox"/>
	Cardiovascular /Vascular Surgery	<input type="checkbox"/>
	Pediatric Surgery	<input type="checkbox"/>
	Surgery	<input type="checkbox"/>
	Surgery - Hand	<input type="checkbox"/>
	*Surgical Critical Care	<input type="checkbox"/>
	Surgical Oncology	<input type="checkbox"/>
	Vascular Surgery	<input type="checkbox"/>
Thoracic Surgery	Cardiothoracic/Thoracic Surgery	<input type="checkbox"/>
	Thoracic Surgery	<input type="checkbox"/>
Urology	Urology	<input type="checkbox"/>
Other	Acupuncture	<input type="checkbox"/>
	*Dietician	<input type="checkbox"/>
	*Hospital Based Urgent Care	<input type="checkbox"/>
	*Urgent Care	<input type="checkbox"/>
	*NP/PA/RN/ST in Specialty Practices	<input type="checkbox"/>
	*Nutrition	<input type="checkbox"/>
	Administrative Physician	<input type="checkbox"/>

MEMO:

Network Health Plan Facility Information Form

W-9 MUST BE INCLUDED WITH FACILITY INFORMATION FORM

LOCATION NAME	
ADDRESS	
CITY	
STATE	
ZIP CODE	
COUNTY	
GENERAL PHONE NUMBER	
MEDICARE CERTIFICATION #	
NUMBER OF STAFFED MEDICARE CERTIFIED BEDS	
NPI#	
CAN FACILITY RECEIVE MAIL AT THIS ADDRESS	YES <input type="checkbox"/> NO <input type="checkbox"/>
IF NO WHERE SHOULD MAIL BE SENT? NAME	
ADDRESS	
CITY	
STATE	
ZIP CODE	
PHONE	
FAX	
E-MAIL ADDRESS	
URL (WEBSITE) ADDRESS	

PLEASE FILL OUT ADDITIONAL FORM FOR EACH LOCATION

REMIT INFORMATION	
EXACT NAME/TITLE ON 1099 TAX FORM	
FEDERAL TAX IDENTIFICATION	
REMIT TO NAME	
REMIT TO ADDRESS	
REMIT TO CITY	
REMIT TO STATE	
REMIT TO ZIP CODE	
REMIT TO PHONE NUMBER	

NAME AND ADDRESS TO SEND NHP CREDENTIALING APPLICATION :

NAME:	
ADDRESS	
CITY, STATE ZIP	
PHONE #	
E-MAIL ADDRESS	

NAME AND TITLE OF PERSON LEGALLY AUTHORIZED TO SIGN CONTRACT	
ADDRESS TO SEND AGREEMENT	
PHONE AND E-MAIL	

For Contractor Administrator Use Only KK LJ
 HMO/POS PPO MED PPO

Please assist us with keeping you information accurate by contacting Provider Data Services with changes: provdatasvs@networkhealth.com
 920/720-1565 800/945-1178 fax 920/720-1917 Website: www.networkhealth.com

The medical specialties/Services listed below are recognized by Network Health Plan and Network Health Insurance Corporation (NHP/NHIC). Please indicate which specialties/services are available at your facility by checking the appropriate box. NHP/NHIC specialty credentials will be granted consistent with the criteria established by the Credentialing Committee.

* Will not appear in NHP/NHIC directories.

PLEASE RETURN THIS FORM WITH THE ATTACHED COMPLETED FACILITY INFORMATION FORM

Specialty/Service Description	
Ambulance Service *	<input type="checkbox"/>
Ambulatory Surgery Center	<input type="checkbox"/>
Arrhythmia Monitoring/Cardiac Monitoring	<input type="checkbox"/>
Audiology	<input type="checkbox"/>
Behavioral Health Facility	<input type="checkbox"/>
Breast Prosthetics	<input type="checkbox"/>
Dialysis	<input type="checkbox"/>
Drug and Alcohol Facility	<input type="checkbox"/>
Durable Medical Equipment	<input type="checkbox"/>
EEG & Sleep Studies – Remote	<input type="checkbox"/>
Fitness Center	<input type="checkbox"/>
Hearing Aids	<input type="checkbox"/>
Home Health Care	<input type="checkbox"/>
Home Infusion	<input type="checkbox"/>
Hospice	<input type="checkbox"/>
Hospital	<input type="checkbox"/>
Hospital Based Urgent Care	<input type="checkbox"/>
Laboratory *	<input type="checkbox"/>
Mammography Facility	<input type="checkbox"/>
Magnetic Resonance Imaging	<input type="checkbox"/>
Occupational Therapy	<input type="checkbox"/>
Occupational Therapy - Child & Adolescent *	<input type="checkbox"/>
Pain Management	<input type="checkbox"/>
Physical Therapy	<input type="checkbox"/>
Physical Therapy - Child & Adolescent *	<input type="checkbox"/>
Prosthetics / Orthotics	<input type="checkbox"/>
Rehabilitation Facility	<input type="checkbox"/>
Skilled Nursing Facility	<input type="checkbox"/>
Speech Therapy	<input type="checkbox"/>
Speech Therapy - Child & Adolescent *	<input type="checkbox"/>
Transitional Rehabilitation Unit	<input type="checkbox"/>
Urgent Care Services (Facility)	<input type="checkbox"/>
Wound Vac Therapy	<input type="checkbox"/>

Care Management, Utilization Management & Health Programs

The Care Management strategy is to promote the optimal health of NHP members. The programs and processes have been developed to maintain and/or improve quality, care, and service. The Care Management Program is to monitor and manage medically necessary and covered services for inpatient and outpatient care, as well as, ongoing chronic and/or complex health care needs through case management. The Care Management Program is based on nationally and locally accepted standards of medical practice. The Care Management Program has been developed in collaboration with NHP physicians, providers, medical office staff, care management staff, NHP leadership, administration, and operations. NHP's Medical Director is continuously involved in the development, refinement, and daily operations of the Care Management Program. The goals of the Care Management Program are:

- Provide a structured process to continually monitor and evaluate the delivery of health care and services to our members
- Improve clinical outcomes
- Improve practitioner and member satisfaction
- Meet or exceed established quality standards

PCPs may refer a member to a NHP participating specialist without notifying NHP. Collaboration between the PCP and specialist is still expected (see Primary Care Practitioner Information section of this manual). NHP will monitor trends and provide feedback to PCPs periodically to assist them with re-directing members.

The Utilization Management Program requires authorization or notification for specific services and procedures (please refer to the Services Requiring Authorization List, which is updated yearly). You may access the appropriate authorization request forms within this manual or at www.networkhealth.com. The Pre-Service determinations are based on medical necessity, potential redirection to an appropriate Plan physician or provider, or other coordination of care and services. Requests for Pre-Service authorization may be submitted by fax, telephone, or by mail. Pre-Service determinations for non-urgent services are given to the practitioners and members via oral, written, or electronic notification within 14 calendar days of the request. Pre-Service determinations for urgent services which are approved are given to the practitioner and member via oral, written, or electronic notification within 72 hours of the request. Pre-Service denial determinations are given within 72 hours of the request by written or electronic notification. (If oral denial notification is given with 72 hours, electronic or written notification will follow within 3 calendar days.)

Post-Service decisions are determinations of medical necessity and/or appropriate level of care when the care has already been received. Notification of Post-Service decision denial determinations is given electronically or in writing to the practitioner and member within 30 calendar days of the request.

Concurrent review decisions are reviewed for the extension of previously approved ongoing care. This includes the review of inpatient care as it is occurring or ongoing ambulatory care. Concurrent review provides the opportunity to evaluate the ongoing medical necessity of care being provided and supports the health care provider in coordinating a member's care across the continuum of health care services. Inpatient concurrent review is done telephonically by Utilization Management staff and continuous for the duration of the inpatient stay. Urgent concurrent review decisions are made and the practitioner and member are notified within 24 hours of the request. Requests to extend a course of ambulatory treatment previously approved that does not meet the definition of urgent care will be handled as a new request (pre-service or post-service) and the appropriate time frames will be followed.

Medical necessity is defined as, health care services or supplies that:

1. Are appropriate and necessary to identify, diagnose, or treat a Bodily Injury or Illness;
2. Are appropriate for and consistent with the member's diagnosis in accord with generally accepted standards of the medical community;
3. Are not primarily custodial care, maintenance therapy, or facilitative services;
4. Are provided in the least intense, most cost effective setting or manner needed for the member's Bodily Injury or Illness;
5. Could not have been furnished in a practitioner's office if the services or supplies are institutional care;
6. Are not primarily educational in nature
7. Are not for the member's vocation, comfort, convenience, exercise, physical fitness, or recreation;
8. Are not to improve the appearance of the member or the convenience of the provider.

Medical necessity decision making requires the consistent application of utilization criteria. NHP uses nationally published and locally developed criteria, in which, Plan practitioner and provider input is solicited. NHP follows CMS, Federal, State and NCQA standards in making utilization decisions. The determination of appropriateness of care is based upon written criteria founded on sound clinical evidence and the existence of coverage outlined in the member's applicable Certificate of Coverage. Criteria is applied consistently to medical necessity decisions, in a manner that is responsive to individual member needs, and the characteristics of the local delivery system. Plan providers may review NHP's utilization management criteria. The criteria is reviewed and approved annually. The Utilization Management staff will provide members and/or practitioners with a copy of specific criteria upon request. This copy is for the practitioner's own use, and may not be released to others without permission from NHP.

If you have questions about utilization decisions or the utilization process, please call NHP's Care Management Department Monday-Friday 8:00 am to 5:00 pm at (920) 720-1600 or (800) 236-0208. Callers have the option of leaving a message 24 hours a day, seven days a week. Messages are retrieved at 8:00 am Monday-Friday, as well as, periodically during the day. All calls are returned promptly. Calls received after business hours are returned the next business day. Communication may also be done via fax, courier system, or U.S. mail.

Physicians and practitioners may contact the Care Management Department at (920) 720-1600 or 1-800-236-0208 to speak with NHP's Medical Director or designees or a Behavioral Health reviewer to discuss a denial decision, Express Scripts (ESI) may be contacted at (800) 570-8090 to discuss pharmacy denial decisions with a pharmacist. National Imaging Associates (NIA) may be contacted at (866) 642-9702 to discuss imaging denials with a physician reviewer.

Case Management

Case management services facilitate improvement of health care delivery, manage and promote quality, cost-effective outcomes. Services include coordination of services, assistance with access to care, condition monitoring, initial and ongoing evaluation and assessments, and the development of a case management plan with short and long term goals. Our Case Management Coordinators (CMC) provides individual case management to NHP members who are high-risk or have complex medical needs. Our CMCs work one-on-one with members who have complex health care diagnoses such as cancer, trauma, ESRD, high-risk obstetrical, and complex neonatal. Case management services assist members in navigating the care system and aid in obtaining necessary services in an optimal setting. Case management is conducted in collaboration with the physician, supports the physician/member relationship, and promotes adherence to an established treatment plan. Members are notified of their selection for case management and given the option to participate. The areas of case management are:

- Trauma/Multiple Services
- Head injury/spinal cord injury/amputation
- Home care needs (IV therapy, PT, OT, ST, wound vac)
- HIV/AIDS
- Transplants
- Cardiopulmonary, deep vein thrombosis/pulmonary embolism
- Acute coronary syndrome/open heart surgery/stroke
- High risk OB/pediatrics/genetics
- Fetal anomalies/spinal bifida
- Out of plan referrals for OB/Peds
- NICU/preterm labor
- Pediatric seizure/cardiac disorders
- Diabetes
- Oncology

If you have a patient who may be a transplant candidate, please call the NHP Care Management Department at (920) 720-1600 or 1-800-236-0208, prior to discussing the transplant program with your patient. Exclusions and limitations do exist in benefits for transplants. Care management can help determine a member's eligibility and provide you with the listing of available transplant institutions to which NHP members may go for covered benefits.

Care management can also assist you by contacting Optum. This transplant benefit management company partners with NHP in finding transplant centers of excellence, including volume of transplants and facility success rates. Coordinating your patient's care with NHP as soon as possible will help in obtaining the best care and benefit for your patient, the family and you.

Members may be referred to NHP for case management services via Nurse*Direct* referral, inpatient discharge planning referral, self referral, utilization referral, disease management referral or primary care or specialist practitioner referral.

If you have questions or have a referral for case management you may call the Care Management Department Monday through Friday 8:00 a.m. to 5:00 p.m. at (920) 720-1600 or 1-800-236-0208. Callers have the option of leaving a message 24 hours a day, seven days a week. Messages are retrieved at 8:00 a.m. Monday through Friday, as well as, periodically during the day. All calls are returned promptly. Communication may also be done via fax, courier system or U.S. mail. You may also access the case management referral form at: http://intranet.affinityhealth.org/object/NHP_Case_Management_Form.html

Please contact NHP's Care Management Department at 1-800-236-0208 or (920) 720-1600 if you have any questions regarding Care Management Department's policies or procedures.

Health Management

Health Management Programs (HMP) focuses on disease management. The goal of disease management is to improve overall health by identifying members who are at risk or diagnosed with a specific disease and enrolling them in a disease management program. These programs emphasize prevention of complications and disease progression through evidence-based practice guidelines and member self-management. These programs support the practitioner/member relationship and are measured for clinical and economic outcomes. NHP currently has health management programs in:

- Diabetes
- Asthma
- Heart and Stroke
- Depression

Diabetes Health Management Program

The goal of the Diabetes HMP is to ensure that members who have diabetes have the materials and knowledge they need to maintain good glycemic control, avoid long-term complications, and improve overall quality of life. Based on the member's needs, the HMP staff work with the member and the member's PCP to provide information and encouragement about: healthy lifestyles, blood sugar control, and prevention of complications. Depending on the member's situation, this is provided through mailings, phone contact, through individual case management, and coordination care in collaboration with the member's PCP. NHP also offers a workshop, Living with Chronic Conditions: A six week, 2 ½ hour self management program that teaches new strategies and skills to help those manage challenges for living with a chronic conditions.

Asthma Health Management Program

The goal of the Asthma HMP is to provide members with the resources and support to actively participate in the management of their asthma or their child's asthma. Benefits of participation in the Asthma HMP include:

- Telephonic support by an HMP RN if needed.
- Periodic educational mailings and information on asthma for adults and children.
- Asthma Action Plan (self-management tool for managing asthma)
- Workshop offering – Living Well with Chronic Conditions: A six week, 2 ½ hour self management program that teaches new strategies and skills to help those manage the challenges of living with a chronic condition.

NHP works closely with the member's PCP to ensure that the member or their child is staying healthy and preventing complications in an effort to help the member and their child lead a full and active life.

Chronic Obstructive Pulmonary Disease (COPD) Program

The goal for the COPD HMP is to help members to better understand and manage their condition, to avoid complications, hospitalizations, and to help members take steps to a healthier lifestyle. This program may be accomplished through staged mailings and by working with the HMP RN and the member's PCP to assist in setting goals for better management. The following are offerings and opportunities for members:

- Telephonic support by an HMP RN if needed.
- Staged educational mailings and information on COPD.
- My COPD Action Plan and Checklist (self management tool for managing COPD).
- Workshop offering – Living Well with Chronic Conditions: A six week, 2 ½ hour self management program that teaches new strategies and skills to help those manage the challenges of living with a chronic condition.

NHP works closely with the member's PCP to coordinate and focus on the member's condition and the plan of care.

Heart & Stroke Health Management Program

The goal of the Heart & Stroke HMP is to improve the quality of life of the members we serve through secondary prevention of arterial disease. This is done by providing members who have arterial disease with early education and care after having had a related event. Based on the member's needs, the HMP staff work with the member and the member's PCP to provide information and encouragement about: healthy lifestyles, importance of following your treatment plan, and self-management. Depending on the member's situation, this is provided through mailings, phone contact, individual case management, and coordination of care in collaboration with the member's PCP. NHP also offers a workshop, Living with Chronic Conditions: A six week, 2 ½ hour self management program that teaches new strategies and skills to help those manage challenges for living with a chronic conditions, such as a heart condition.

Depression Health Management Program

The Depression Care Management HMP encourages member adherence to their current plan of treatment, provides ongoing mood and symptom monitoring, and education on depression to help the member manage their depression. The HMP is designed to reinforce the goals established between the member and their prescriber by providing additional support through periodic educational mailings and telephone calls from NHP's Behavioral Health Care Management Coordinators.

Other Health Programs/Resources

Calling It Quits

Commercial members are eligible to receive up to a \$400 lifetime reimbursement for nicotine or non-nicotine cessation products. In order to qualify, the member must enroll in the Call It Quits program through NurseDirect 1-800-362-9900. The free telephonic program is available 24 hours a day, seven days a week.

Members submit copies of their receipts along with NurseDirect's signed document verifying the member remained smoke-free for at least four months to NHP, PO Box 568, Menasha, WI 54952.

Please encourage your patients to take advantage of the free telephonic Call It Quits program and NHP's reimbursement of up to \$400. If you require additional NHP's Call It Quits program brochures, please contact your NHP Provider Education Coordinator.

Affinity NurseDirect

Network Health Plan is proud to offer the services of Affinity NurseDirect to our members. Affinity NurseDirect is a free 24-hour telehealth information service. Affinity NurseDirect is staffed by registered nurses and health professionals who can answer our members' questions about illness, injury, or other health-related problems. Services offered by Affinity NurseDirect include:

Consultation and Expert Advice. The experienced registered nurses at Affinity NurseDirect are available to assist with health care concerns 24 hours a day, 365 days a year. The staff can assist you getting an appointment for your acute care needs with your provider during the day or night if indicated.

Physician Referral, Service Information. For those who are new to the area or looking for a new physician, Affinity NurseDirect can give information on over 1,200 healthcare providers, as well as, give information on outpatient and hospital services available throughout the area.

Classes, Screening, Programs. Affinity NurseDirect can provide the latest information on special classes, health screenings, and valuable preventive programs sponsored by Affinity Health System. Class and other program information and registration are available via the phone and also available online at <http://www.affinityhealth.org/page/health-classes>.

Convenient Over-the-Phone Library of Health Information. Affinity NurseDirect's Health Information Library has more than 1,500 health topics available. Call Affinity NurseDirect at 1-800-362-9900 and press 1 and then simply follow the directions to listen to a topic of your choice.

Affinity Nurse*Direct*'s prerecorded library includes:

Health Information Library – Topics on general health subjects and issues

Parent Information Line – More than 300 child health and parenting topics

Women's Information Line – Timely health topics and information unique to women's health

Customized Information Topics – Helpful information about Affinity Health System

Nurse*Direct* can be reached at the following numbers:

Fox Cities: **(920)738-2230**

Oshkosh: **(920) 231-6578**

Toll Free: **1-800-362-9900**

* Please note: This service should not be used to diagnose a health-related problem or as a substitute for medical care.

NHP/NHIC-Policy on Incentives for Utilization Decisions

Abstract/Purpose:

NHP/NHIC does not reward, in any way, practitioners or other individuals conducting utilization review for denying coverage for care or service. In addition, practitioners, Care Management staff and the supervisors of this staff receive no financial incentive to encourage decisions that result in under-utilization. NHP/NHIC monitors under-utilization as a quality improvement indicator and identifies potential barriers to member access to care and service.

I. POLICY:

- All Network Health Plan/Network Health Insurance Corporation (NHP/NHIC) practitioners and Care Management staff involved in utilization decisions, including supervisors of care management staff and the Medical Director, make utilization decisions based solely on appropriateness of care and service, and on benefit coverage. The determination of appropriateness of care is based on written criteria founded on sound clinical evidence. Benefit coverage is based on the existence of coverage as outlined in the appropriate Coverage Booklet (Certificate of Coverage, Evidence of Coverage or It's Your Choice booklet.) The written criteria are reviewed and approved annually by actively participating practitioners. NHP/NHIC provides members or practitioners copies of specific criteria upon request.
- NHP/NHIC does not reward in any way practitioners, or other individuals conducting utilization review, for denying coverage for care or service. In addition, practitioners, Care Management staff and the supervisors of this staff receive no financial incentive to encourage decisions that result in under-utilization. NHP/NHIC monitors under-utilization as a quality improvement indicator and identifies potential barriers to member access to care and service.
- NHP/NHIC does not prohibit providers from advocating on behalf of members within the utilization management process
- All practitioners and Care Management staff, including management staff and the Medical Director, involved in utilization authorization and policy decisions are informed of this policy.

II. PROCEDURE:

NHP/NHIC distributes a statement describing this policy to:

- A. Practitioners via newsletter and/or email notice and practitioner orientation, annually
- B. Providers via newsletter and/or email notice, annually
- C. Members via the "Practitioner Directory and Member Reference Guide"

- D. Employees via newsletter and/or email notice and new employee orientation, annually
- E. Community, including all NHP/NHIC membership, via Affinity Health System quarterly magazine, annually.

Services Requiring Authorization (HMO) Effective 1/1/10

The following services for our Commercial members require prior authorization from Network Health Plan/Network Health Insurance Corporation. Obtain prior authorization by calling the Care Management Department at 1-800-236-0208 or (920) 720-1600. For Behavioral Health services call 1-800-555-3616 or 920-720-1340.

ALL SERVICES TO BE PROVIDED BY A NON-PARTICIPATING PROVIDER/FACILITY
ALL TRANSPLANT SERVICES, INCLUDING EVALUATION/WORK-UP

ALL HOSPITAL INPATIENT SERVICES INCLUDING SKILLED NURSING FACILITY,
REHABILITATION AND BEHAVIORAL HEALTH

ALL SERVICES CONSIDERED EXPERIMENTAL, INVESTIGATIONAL, OR RESEARCH
Including all CPT Category III codes (Experimental, investigational services list available for reference)

THE FOLLOWING OUTPATIENT SURGICAL PROCEDURES:

- Implantable Cardioverter-Defibrillator Insertion
- Implantable Spinal Neurostimulator Insertion
- Implantable Pain Pump Insertion
- Cochlear Implants
- Breast Reduction, Breast Implant Removal/Replacement, Prophylactic Mastectomy
- Keratoplasty
- Port Wine Stain removal
- Rhinoplasty, rhytidectomy
- Uvulopalatopharyngoplasty (UPPP) and SRUP, RAUP, LAUP
- Sclerotherapy
- Blepharoplasty, canthoplexy, canthoplasty
- Panniculectomy
- Otoplasty
- Pectus excavatum repair
- All procedures that could be considered cosmetic

THE FOLLOWING SELECT SERVICES:

- Acupuncture
- DME and orthotics over \$750.00 (based on Medicare Fee Schedule, if not on Schedule, then purchase price) and: Scooters, insulin pumps, continuous glucose monitoring devices, electric breast pumps (Kimberly Clark employer group has \$300.00 dollar requirement: DME Grid available for reference)
- Repairs and Replacement of DME over \$500.00 (Kimberly Clark employer group has \$300.00 dollar requirement)
- Prosthetics over \$1000.00 (based on Medicare Fee Schedule, if not on Schedule then purchase price; DME Grid available for reference)
- Home Health Care & Hospice Services
- Home IV Therapy
- Genetic Testing Services
- PT/OT/ST upon initial visit for treatment (evaluation allowed without authorization)
- Facility-to-facility and/or non-emergent ambulance transfers
- Dental Care for Accidents
- Hospital or ambulatory surgery center charges in conjunction with dental care

- TMD surgical services
- All non-emergent ambulatory CT, MRI, MRA, PET, Nuclear Cardiology scans *
- Autism Treatment
- Psychological and Neuropsychological Testing
- Psychotherapy Visits upon initial visit for treatment (evaluation allowed without authorization)
- Substance Abuse Treatment
- Mental Health and Substance Abuse Transitional Care including: Partial Hospitalization, Day Treatment, and Intensive Outpatient Services and Substance Abuse Residential Care
- Obstetrical Care (This is notification only and is used for Case Management purposes)

PLEASE NOTE:

*CT, MRI, MRA, PET and Nuclear Cardiology scans are prior authorized through National Imaging Associates at 1-866-642-9702.

*Refer to the Commercial Preferred Drug List for authorization requirements regarding medications given in an ambulatory or outpatient setting.

Access authorization request forms, and other provider reference tools, including genetic testing, potentially experimental and DME codes requiring authorization on NHP's Provider Landing Page at: http://www.networkhealth.com/object/nhp_providers

For hard copies of authorization request forms and/or genetic testing, potentially experimental, and DME codes requiring authorization, please contact the Care Management Department.

CONTACT: Care Management Department (for prior authorization/case management) 1-800-236-0208 or (920) 720-1600. Fax # 920-720-1902. For Behavioral Health services call 1-800-555-3616 or 920-720-1340 Fax # 920-720-1903. Customer Service Department (for benefits and eligibility) 1-800-826-0940 or (920) 720-1300.

All services must be medically necessary and will be reviewed retrospectively to determine benefit availability, certificate of coverage provisions, and claim payment agreements when a claim is submitted.

Network Health Plan/Network Health Insurance Corporation Authorization Request Form

Fax Request *Commercial* Care Management Dept: 920-720-1903
Medicare Care Management Dept: 920-720-1916
Telephone: *Commercial* Care Management Dept: 920-720-1600
Medicare Care Management Dept: 920-720-1602

***Form Completed by:**

***Date Form Completed:**

MEMBER INFORMATION	ORDERING PROVIDER INFORMATION	RENDERING PROVIDER INFORMATION
*Member/Patient Name:	*Ordering Provider:	*Rendering provider or facility: NPI #:
*DOB:	Provider Phone:	Phone #: Fax #:
Member #:	*Fax #:	Billing provider (If different than rendering):
*Diagnosis: ICD-9:		Billing Provider NPI #:

#	*Planned Date of Service	*CPT or HCPCS Code	*Service Description	*Comments/Rationale for service
1				
2				
3				
4				
5				

***Required Fields**

If you have questions about benefits, please call Customer Service at 1-800-826-0940 or 920-720-1300 for NHP Commercial members and 1-800-378-5234 or (920) 720-1345 for Medicare Advantage members.

NHP Only	Authorization #:	# Units Approved
Care Management Coordinator: _____	Date Received:	Start Date: End Date

Network Health Plan/Network Health Insurance Corporation

Therapy Authorization Request Form

Fax Request to Care Management Department at 920-720-1903
 Care Management Department Telephone: 920-720-1600

*Form Completed by:
 *Date Form Completed:

If this is a request to extend services, please enter the original authorization number:

MEMBER INFORMATION

ORDERING PROVIDER INFORMATION

RENDERING PROVIDER INFORMATION

*Member/Patient Name:

*Ordering Provider:

*Rendering Provider & Facility:

*DOB:

Phone #:

Phone #:

Member ID #:

Fax #:

*Fax #:

*Diagnosis:

Tax ID:

ICD-9:

Type of Therapy (PT, ST or OT)	Beginning Date of Service	Ending Date of Service	Number of Visits (Visits per Therapy Grid if initial request) (If extension request, please provide supporting therapy notes)	Comments
1	_____	_____		
2	_____	_____		
3	_____	_____		
4	_____	_____		
5	_____	_____		
6	_____	_____		
7	_____	_____		
8	_____	_____		

*** Required Fields**

If you have questions about benefits, please call Customer Service at 1-800-826-0940 or 920-720-1300 for NHP Commercial members and 1-800-378-5234 or (920) 720-1345 for Medicare Advantage members. If there is insufficient information, the form will be returned.

NHP Only	Authorization #:	# Units Approved
Care Management Coordinator: _____	Date Received: _____	Start Date: _____ End Date: _____

NHP/NHIC-Medical Policy-Genetic Testing

Abstract/Purpose:

The purpose of this policy is to provide guidance for decisions related to genetic testing.

Refer to a member's COC to determine a member's eligibility and coverage limitations when making a specific coverage determination because Employer Group contracts may vary.

I. Description:

“A genetic test is the analysis of human DNA, RNA, chromosomes, proteins, or certain metabolites in order to detect alterations related to a heritable disorder. This can be accomplished by directly examining the DNA or RNA that makes up a gene (direct testing), looking at markers co-inherited with a disease-causing gene (linkage testing), assaying certain metabolites (biochemical testing), or examining the chromosomes (cytogenetic testing).” (1) Genetic tests are conducted for a number of purposes, including predicting disease risk, newborn screening, determining clinical management, identifying carriers, and establishing prenatal or clinical diagnoses or prognoses in individuals, families, or populations.

II. Medical Indicators:

A. Genetic testing may be medically necessary when all of the following criteria are met:

1. There must be a reasonable expectation based on family history, pedigree analysis, risk factors, and/or symptomatology that a genetically determined condition exists.

a. Rationale:

Many genetic tests are imperfect predictors of either existing disease or disease susceptibility, particularly when used in the context of population screening, where individuals without family histories of disease, risk factors or symptoms are tested. For example, the probability exists that a disease may still occur, even when a negative test result is obtained. Conversely, a specific disease may not occur when there is a positive test result. While these concepts hold true for at-risk individuals as well, the probability of both these occurrences is greater in population screening, so test results are more difficult to interpret in a manner that will meaningfully impact health outcomes. With a few limited exceptions (e.g., PKU testing), general screening of populations for diseases that can be attributed to genetic mutations is not advocated in the published scientific literature.

2. The genotypes to be detected by a genetic test must be shown by scientifically valid methods to be associated with the occurrence of the disease, and the analytical and clinical validity of the test must be established. The observation must be independently replicated and subject to peer review.

- a. Rationale:
Analytical Validity
Analytical validity is an indicator of how well a test measures the property or characteristic it is intended to measure, and it is made up of three components:
- analytical sensitivity: the test is positive when the relevant gene mutation is present;
 - analytical specificity: the test is negative when the gene mutation is absent; and
 - reliability: the test obtains the same result each time.

- b. Clinical Validity
Clinical validity in genetic testing is a measurement of the accuracy with which a test identifies or predicts a clinical condition and involves the following:
- Clinical sensitivity: the probability that the test is positive if the individual being tested actually has the disease or a predisposition to the disease
 - Clinical specificity: the probability that the test is negative if the individual does not have the disease or a predisposition to the disease
 - Positive predictive value: the probability that an individual with positive test results will get the disease
 - Negative predictive value: the probability that an individual with negative test results will not get the disease
 - Heterogeneity: different mutations within the same gene may cause the same disease and can result in different degrees of disease severity; a failure to detect all disease-related mutations reduces a test's clinical sensitivity
 - Penetrance: the probability that the disease will appear when a disease-related genotype is present. Penetrance is incomplete when other genetic or environmental factors must be present for a disease to develop.
 - There are both benefits and risks associated with genetic tests. Genetic tests that are not fully assessed for analytical and clinical validity prior to their use in clinical practice have the potential for causing harm to patients. For example, patients who are wrongly classified as at-risk may be subjected to increased and unnecessary surveillance or treatments, some of which may be harmful, or even irreversible. Likewise, false negative test results may lead to delays in diagnosis and treatment.

3. A probable therapeutic benefit of the test must be established for the member, i.e. test results will directly impact clinical decision making and/or clinical outcomes for the member who is the subject of the test.

- a. Rationale:
The development of genetic tests that can diagnose or predict

disease occurrence has far outpaced the development of interventions to treat, improve or prevent those same diseases. Therapeutic benefit refers to the ability of genetic test results, either positive or negative, to provide information that is of value in the clinical setting. Specifically for positive test results, this could involve instituting treatments or surveillance measures, making decisions concerning future conception, or avoiding harmful treatments. Negative test results can have therapeutic benefit in that unnecessary treatments or surveillance can be avoided. In the absence of such interventions, the benefits of testing are limited.

4. Genetic testing of children to verify current symptomatology or predict adult onset diseases is not considered medically necessary unless direct medical benefit will accrue to the child, and in the case of adult onset disease, this benefit would be lost by waiting until the child has reached adulthood.

- a. Rationale:

- It is generally accepted in the published literature that unless useful medical intervention can be offered to children as a result of testing, formal testing should wait until the child is old enough to understand the consequences of testing and request it for him or herself. Ethical concerns related to the testing of children include the breach of confidentiality that is required by revealing test results to parents, the lack of ability to counsel the child in a meaningful way regarding the risks and benefits of testing, the impact a positive test could have in terms of discrimination, and the potential psychological damage that could occur from distorting a family's perception of the child.

B. Additional Information

1. It may be necessary to offer pre-test genetic counseling from a qualified professional as well as post-test genetic counseling. This will be at the discretion of the provider and/or medical director.

- a. Rationale:

- The consequences of genetic testing and the interpretation of genetic test results is complex. Positive test results do not necessarily mean that an individual will develop a specific disease. Conversely, negative test results do not necessarily mean that an individual will not develop the disease for which testing is completed. Multiple mutations could exist for a single disease, some of which could be missed in testing. Not all mutations have the same effects in terms of disease severity. Some diseases may be caused by the interaction of both genetic and environmental factors. Effective treatments may not be available for some diseases; this is known as a "therapeutic gap."

There may be significant emotional and psychological effects as a result of genetic testing. This complexity and the benefits and risks of genetic testing should be fully disclosed to individuals prior to testing, just as counseling concerning the test results should be available.

2. To provide guidance for appropriate reasons for referral for genetic services, the Professional Practice and Guidelines Committee of the American College of Medical Genetics has generated lists of more common reasons for referral. The lists are divided into pediatric, prenatal, and adult indications and can be found at www.acmg.net under publications and practice guidelines.

III. **Coverage**

NHP may extend coverage of genetic testing for medically necessary indications as noted in this policy.

IV. **Limitations/Exclusions**

NHP considers genetic testing that does not meet the criteria as indicated not a covered service.

V. **References**

- A. www.genetests.org/ (verified 11/04/08)
- B. Secretary's Advisory Committee on Genetic Testing. A public consultation on oversight of genetic tests. December 1, 1999 - January 31, 2000. National Institutes of Health. www4.od.nih.gov/oba/sacgt/gtdocuments.html (verified 11/04/08)
- C. American Society of Human Genetics/American College of Medical Genetics Report. Points to consider: ethical, legal, and psychosocial implications of genetic testing in children and adolescents. *Am J Hum Genet* 1995; 57:1233-41. Available at www.acmg.net (verified 11/03/08)
- D. American College of Medical Genetics, ACMG Practice Guidelines, Indications for genetic referral: a guide for healthcare providers. June 2007, Vol. 9, No. 6: 385-3891241 www.acmg.net (verified 11/03/08)
- E. Holtzman, Neil A., MD, MPH, Watson, Michael S, ed. Promoting Safe and Effective Genetic Testing in the United States. Final Report of the Task Force on Genetic Testing. The Johns Hopkins University Press. Baltimore, 1997. Last reviewed April 2006. Available at www.genome.gov (verified 11/03/08)
- F. Hayes Genetic Testing Service; Hayes Inc. www.hayesinc.com (verified 11/6/08)

Regulatory Body: NCQA

Network Health Plan/Network Health Insurance Corporation Genetic Testing Authorization Request Form

MEMBER INFORMATION

*Member/Patient Name:
 *DOB:
 Member ID#:

ORDERING PROVIDER INFORMATION

*Ordering Provider:
 Phone #:
 *Fax #:

RENDERING PROVIDER INFORMATION

*Rendering provider or facility:
 Phone #: Fax #:
 Billing provider:
 (If different than rendering)

Fax Request to Care Management Department at 920-720-1903

***Form Completed by:**

Care Management Department Telephone: 920-720-1600

***Date Form Completed:**

*******Please include any clinical notes or office notes that would support request*******

*Planned Date of Service	*CPT or HCPCS Code	*Service Description – (Name of test requested)	*Diagnosis/Purpose of Test	*How will the genetic test results change/impact future medical management of the member?
-----------------------------	-----------------------	--	----------------------------	--

***Required Fields**

If you have questions about benefits, please call Customer Service at 1-800-826-0940 or 920-720-1300 for NHP Commercial members and 1-800-378-5234 or (920) 720-1345 for Medicare Advantage members.

NHP Only	Authorization #:	# Units Approved
Care Management Coordinator: _____	Date Received: _____	Start Date: End Date

Durable Medical Equipment, Orthotic and Prosthetic Provider Authorization Request Process

- For all requests, complete all fields under Member Information, Ordering Provider Information and Rendering Provider Information.
- If this is an extension of a previous request, enter the original authorization number on the upper right hand corner of the form.
- If a rental request:
 - Enter beginning date of service
 - Enter estimated ending date of service
 - Enter the HCPCS code for requested item
 - Enter the description of the item correlating with the HCPCS code
 - Select rental
 - Enter number of time periods requested
 - Enter daily or monthly frequency
 - Skip purchase price field
 - Enter retail rental price
 - Note rental price is only necessary if “rent to purchase” may apply to this item
 - Enter any additional information that will clarify request
- If a purchase request:
 - Enter beginning date of service
 - Skip ending date of service field
 - Enter the HCSPCS code for the requested item
 - Enter the description of the item correlating with HCSPCS code
 - Select Purchase, designate new or used
 - Enter the number of units requested
 - Skip frequency field
 - Enter retail purchase price
 - Note purchase price is only necessary if “rent to purchase” may apply to this item
 - Skip rental price field
 - Enter any additional information that will clarify the request including warranty and maintenance information
- If rent to purchase is applicable:
 - Complete all fields
 - The NHP Care Management Coordinator will determine at what point the item will be considered purchased based upon the contracted rental price and contracted purchase price. An authorization will then be entered for a limited number of time periods.

- All DME and orthotics over the dollar limits noted on the authorization list (based upon the Medicare Fee Schedule purchase price) require authorization. This includes but is not limited to scooters, insulin pumps, continuous glucose monitoring devices, and electric breast pumps. Refer to the “DME grid” for non-covered (nc) or excluded (x) items. If needed, please contact NHP for a copy of the “DME grid.” The grid is updated annually and delivered to DME providers.
- All prosthetics over the dollar limits noted on the authorization list (based upon the Medicare Fee Schedule purchase price) require authorization. Refer to the “DME grid” for non-covered (nc) or excluded (x) items.
- Repair and Replacement of DME require authorization if over the dollar limits noted on the authorization list. Include any warranty information in the Comments.
 - Replacement supplies if under the respective dollar limit do not require authorization.
- Submit the Certificate of Medical Necessity for all Medicare patients as soon as it is available.
- Include the NHP authorization number and any applicable modifiers (rental or purchase) on your claim
- Fax the completed form to NHP/NHIC Care Management at 920-720-1902

NHP/NHIC DME, Orthotic, & Prosthetic Authorization Request Form

Fax Request *Commercial Care Management Dept: 920-720-1903* *Form Completed by:

Telephone: *Commercial Care Management Dept: 920-720-1600* *Date Form Completed:

If this is a request to extend services, please enter the original authorization number:

MEMBER INFORMATION	ORDERING PROVIDER INFORMATION	RENDERING PROVIDER INFORMATION
*Member/Patient Name:	*Ordering Provider:	*Rendering Provider & Facility:
*DOB: Member ID #:	Phone #:	Phone #:
*Diagnosis:	Fax #:	*Fax #:
ICD-9:		NPI #:

D M E	Beginning Date of Service	Estimated Ending Date of Service	HCPCS Item Code	Item Description	Rental, Purchase, Used or Repair	# of Time Periods or Units Requested	Frequency	Purchase or Repair \$	Rental \$	Comments/Warranty Information
1										
2										
3										
4										
5										
6										
7										
8										

***Required Fields**

If you have questions about benefits, please call Customer Service at 1-800-826-0940 or 920-720-1300 for NHP Commercial members and 1-800-378-5234.

If item is a rental with the possible rent-to-purchase, enter the rental and purchase prices.

NHP Only	Authorization #:	# Units Approved
Care Management Coordinator: _____	Date Received: _____	Start Date: _____ End Date: _____

Infusion, Home Health and Hospice Services

Provider Authorization Request Process

- For all requests, complete all fields under Member Information, Ordering Provider Information, and Rendering Provider Information
- If this is an extension of a previous request, enter the original authorization number on the upper right hand corner of the form
- If a request for Home Health Visits:
 - Enter the name of the contact person, contact's phone and fax numbers (If only one contact person, just enter it once.)
 - Enter the type of care, choosing from the drop down list of RN, PT, OT, ST, RT, Aide or SW (if multiple types of care are requested, complete a separate line for each)
 - Enter the first date of service
 - Enter the expected last day of service
 - Enter the total number of visits requested
 - Enter whether hospice or home health, choosing from the drop down list
 - Enter any comments for clarification
- If a request for Home IV Therapy:
 - Enter the name of the infusion service contact person, the contact's phone and fax numbers
 - Enter the type of access/line (central line, PICC, etc)
 - Enter the method of delivery
 - Enter the dates of service
 - Enter the provider's drug order
 - Enter the NDC code for the drug ordered and any diluents
 - Enter the type of infusion device used to administer the drug if applicable (portable pump, bulb device, etc)
 - Enter the number of visits requested
 - Enter any comments for clarification: E.g. teaching needs related to site care or self administration
 - **Prior authorization for infusion services is not required when only the drug is being provided.** This may however require authorization through ESI if it on the list of drugs requiring authorization. One exception to the ESI process is State of Wisconsin employees, these requests are processed at NHP. through P&T Committee (the same criteria ESI applies).
 - **If the infusion service being rendered involves a per diem charge, the service does require authorization.**
 - **If the infusion service being rendered involves WIVA nursing services as well, the number of nursing visits will also be added to the form. Include the NHP authorization number on your claim. Fax the completed form to 920-720-1902**

NHP/NHIC Infusion, Home Health and/or Hospice Services Authorization Request Form

Fax Request: Commercial Care Management Dept: 920-720-1903

*Form Completed by:

Telephone: Commercial Care Management Dept: 920-720-1600

*Date Form Completed:

MEMBER INFORMATION	ORDERING PROVIDER INFORMATION	RENDERING PROVIDER INFORMATION
Member/Patient Name:	Ordering Provider:	Home Health Provider:
DOB:	Phone #:	Phone #:
Member #:	Patient Hospitalized:	Fax #:
Diagnosis:	Hospitalized Facility:	NPI #:
ICD-9:	Discharge date:	

If this is a request to extend services, please enter the original authorization number:

HOME VISITS	Type of Care	1 st Date of Service	Estimated Last Date of Service	Total # of Days/Units Requested	Hospice or Home Health?	Comments
Contact person: Phone: Fax:	-				-	
Contact person: Phone: Fax:	-				-	
Contact person: Phone: Fax:	-				-	
Authorized by NHP:						

IV THERAPY		Type of Line:			Method of Delivery:		
	Method of Delivery:	Method of Delivery:	NDC Code	Infusion Device	# of Per Diem Units	# of RN Visits	Comments
1							
2							
3							

***Required Fields**

If you have questions about benefits, please call Customer Service at 1-800-826-0940 or 920-720-1300 for NHP Commercial members and 1-800-378-5234.

NHP Only	Authorization #:	# Units Approved
Care Management Coordinator: _____	Date Received: _____	Start Date: _____ End Date: _____

Network Health Plan/Network Health Insurance Corporation Dialysis Authorization Request Form

Fax Request Commercial Care Management Dept: 920-720-1903

*Form Completed by:

Telephone: Commercial Care Management Dept: 920-720-1600

*Date Form Completed:

If this is a request to extend services, please enter the original authorization number:

MEMBER INFORMATION	ORDERING PROVIDER INFORMATION	RENDERING PROVIDER INFORMATION
*Member/Patient Name:	*Ordering Provider:	*Rendering Provider & Facility:
*DOB:	Phone #:	Phone #:
Member ID #:	Fax #:	*Fax #:
*Diagnosis:		NPI #:
ICD-9:		

		Beginning Date of Service	Ending Date of Service	Number of Visits	Comments
1					
2					
3					
4					
5					
6					
7					
8					

*** Required Fields**

If you have questions about benefits, please call Customer Service at 1-800-826-0940 or 920-720-1300 for NHP Commercial members and 1-800-378-5234 or (920) 720-1345 for Medicare Advantage members. If there is insufficient information, the form will be returned.

NHP Only	Authorization #:	# Units Approved:
Care Management Coordinator: _____	Date Received: _____	Start Date: _____ End Date: _____

NHP/NHIC-Experimental-Investigational Treatment Determinations

Abstract/Purpose:

Experimental or investigation services are those treatments, procedures, services, supplies, drugs, devices or technologies (“Treatments”) that are not known to be safe or effective or that are used in a way that deviates from generally accepted standards of the U.S. medical community.

Refer to a member's applicable coverage booklet to determine a member's eligibility and coverage limitations when making a specific coverage determination because Employer Group contracts may vary. CMS coverage determinations and rules apply to Medicare Advantage products.

I. **Policy:**

Services which are experimental, investigational or for research purposes are those treatments, procedures, services, supplies, drugs, devices or technologies (“Treatment(s)”) that are not known to be safe or effective or that are used in a way that deviates from generally accepted standards of the U.S. medical community.

Services which are non-experimental are those:

- that are discrete and identifiable technologies, regimes or modalities which are regularly and customarily used to diagnose or treat illness and
- for which there is conclusive, generally accepted evidence that such technology, regimen or modality is safe and effective or
- for which there is an existing relevant NHP/NHIC Medical Policy, Intergual or Milliman Guideline licensed by NHP/NHIC for application to the service being requested

NHP/NHIC’s Medical Director or designee will determine if a treatment is experimental, investigational or for research purposes.

In making an experimental/investigational determination the Medical Director or designee takes into consideration whether the Treatment is commonly performed or used on a widespread basis, whether conventional methods have been exhausted for the member, and whether the Treatment is reimbursed by CMS or other insurers. In the absence of conclusive, generally accepted evidence the Medical Director or designee may confer with the ordering and/or like-specialty practitioner to determine if the Treatment is a generally accepted standard of the U.S. medical community.

NHP/NHIC provides notice to members of experimental/investigational treatment determinations (approvals and denials) within 5 working days of receiving all of the required clinical information upon which the determination is based. Members are notified of all denial determinations in writing per policy 03508 Utilization Management Decisions, Timeframes, Notice Content and Process (*see related policy*).

II. **Experimental/Investigational Determination Criteria:**

- A. Treatments are determined to be experimental, investigational or for research purposes when at least one of the following is met:
 1. There is reliable evidence showing that the treatment:
 - a. Is the subject of an ongoing Phase I or Phase II clinical trial;
 - b. Is the research, experiment, study or investigational arm of an ongoing Phase III clinical trial; or
 - c. Is otherwise under study to determine its maximum tolerated dose, its toxicity, its efficacy or safety or its efficacy compared with a standard means of treatment or diagnosis.
 2. The treatment is related to or involves a research protocol. The purpose of such a protocol must be primarily to determine the safety or effectiveness of a Treatment. This includes, but is not limited to, a protocol of the U.S. Department of Health and Human Services (HHS) or any of its Agencies, Bureaus, Institutes or Divisions.
 3. An Institutional Review Board (IRB) acting for the treating institution must review and approve the Treatment on an individual basis. An IRB is any person or group of persons charged with deciding whether the treating institution will or may be used to provide a particular Treatment. Your treating Practitioner is not an IRB.
 4. A consent or release that HHS or the U.S. Food and Drug Administration (FDA) requires the member to sign describes the Treatment as Experimental, Investigational, or for Research Purposes. This applies to any consent or release that a person acting on behalf of the member must sign.
 5. The Treatment is any drug or device that the FDA or other federal or governmental agency must approve but, at the time the drug or device is furnished, has not been approved for marketing.

6. Reliable evidence showing that the prevailing opinion among experts regarding the Treatment is that further studies or clinical trials are needed to show it is safe and reliable. A Treatment is not safe and reliable if more studies or clinical trials are needed to determine its maximum tolerated dose, its toxicity, its efficacy, its safety or its efficacy as compared with standard means, treatment or diagnosis.

a. Reliable evidence includes, but is not limited to, peer-reviewed medical literature and technology assessment organizations. NHP/NHIC accesses technology assessments from Hayes, Inc. and considers a Hayes "C" rating or lower as experimental/investigational.

7. The Treatment is any FDA approved drug or compounded prescription that is used in a manner that significantly deviates from the generally accepted standards of the U.S. medical community.

8. In the absence of reliable evidence (i.e., studies or clinical trials), the Treatment is not recognized as standard of care or as acceptable medical practice to treat the member's illness or injury or is used in a way that deviates from generally accepted standards of the U.S. medical community.

B. Although a Treatment is deemed experimental/investigational according to the above criteria, the Medical Director or designee within her/his sole discretion may make a determination to approve the Treatment.

1. Experimental Treatment may be approved by the Medical Director or designee when the experimental/investigational Treatment

a. is for a life threatening illness or condition or for an intractable condition and all of the following are met.

i. lower risk conventional treatment methods have been exhausted.

ii. no alternative methods are available or appropriate.

iii. there is reasonable, generally accepted evidence that such Treatment is safe and effective (e.g., in relief of symptoms and duration).

III. COVERAGE:

Treatments that are experimental, investigational or for research purposes are excluded by NHP/NHIC Certificate of Coverage and State of Wisconsin Employee's It's Your Choice. NHP/NHIC Medicare Advantage Evidence of Coverage also excludes experimental treatments except as covered by Original Medicare or under an approved clinical trial.

- . Routine patient care provided to a patient during the course of treatment in a cancer clinical trial that are consistent with the usual and customary standard of care are covered by NHP/NHIC as required by and limited to State of Wisconsin Statute 632.87 (6).
 1. Routine patient care means all health care services, items and drugs that are typically provided in health care, including those provided to a member during the course of treatment in a cancer trial (all phases) for a condition or any of its complications and those services are consistent with the usual and customary standard of care including the type and frequency of any diagnostic modality.
 2. Routine patient care **does not** include:
 - a. the health care service, item or investigational drug that is the subject of the cancer clinical trial.
 - b. any health care service, item or drug provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the member
 - c. investigational drugs or devices that have not been approved for market by the FDA
 - d. transportation, lodging, food or other expenses for member of a family member or companion of the member that are associated with travel to or from a facility providing the cancer clinical trial
 - e. any services, items or drugs provided by the cancer clinical trial sponsors free of charge
 - f. any services, items or drugs eligible for reimbursement by a party other than the insurer
 3. Coverage of routine patient care during the course of treatment in a cancer clinical trial is limited to cancer clinical trials meeting **all** the following criteria:

- a. A purpose of the trial is to test whether the intervention potentially improves the trial participant's health outcomes
- b. The treatment provided as a part of the trial is given with the intention of improving the trial participant's health outcomes.
- c. The trial has therapeutic intent and is not designed exclusively to test toxicity or disease pathology.
- d. The trial does one of the following:
 - i. Tests how to administer a health care service, item, or drug for the treatment of cancer
 - ii. Tests responses to a health care service, item, or drug for the treatment of cancer
 - iii. Compares the effectiveness of health care services, items, or drugs for the treatment of cancer
 - iv. Studies new uses of health care services, items, or drugs for the treatment of cancer.

4. The trial is approved by one of the following:
 - a. A National Institute of health, or one of its cooperative groups or centers, under the federal department of health and human services.
 - b. The FDA
 - c. The Federal Department of Defense
 - d. The Federal Department of Veteran Affairs

IV. **REFERENCES:**

- . NHP/NHIC Certificate of Coverage 2009, Defined Terms: Experimental, Investigational or for Research Purposes
- A. NHP/NHIC Medicare Advantage Evidence of Coverage 2009: Medical care and services that are not covered.
- B. State of Wisconsin Employee's It's Your Choice, 2009 Definitions: Experimental
- C. State of Wisconsin Statute 632.855 Requirements if experimental treatment limited. & 632.87 (6) Restrictions on health care service (routine patient care)

Regulatory Body: OCI

State of Wisconsin Statute 632.855 Requirements if experimental treatment limited. & 632.87 (6) Restrictions on health care service (routine patient care)

NHP Behavioral Health Care Management Department

All outpatient behavioral health sessions for therapy require an authorization. You may obtain authorization by filling out the **Outpatient Treatment Request-Initial** form and faxing it to NHP. If the member requires visits beyond those initially authorized, please request additional visits by completing the **Outpatient Treatment Request-Concurrent** form and faxing it to NHP.

If more than 20 outpatient therapy sessions have been obtained and more sessions are requested, a focused or more in-depth clinical utilization review is required. In order to initiate this review, the provider should submit the **Outpatient Treatment Request – Concurrent** form along with the member's most recent treatment plan and the progress notes from the previous five (5) therapy sessions. NHP will contact the provider by telephone if additional information is needed in order to make an authorization determination.

Members may see a participating Alcohol and Other Drug (AODA) counselor for an initial assessment without a referral or authorization. Treatment provided at any level of care after the initial assessment will require prior authorization. This request should be made by faxing the **Outpatient Treatment Report for AODA Services-Initial to NHP**. If additional AODA care is required, providers should use the **Outpatient Treatment Report for AODA Services-Concurrent** Request Form. If a change in level of AODA services is necessary for the member, the provider should then submit the **Outpatient Treatment Report for AODA Services-Concurrent** Request Form. A request for alternate level of care can be indicated under the section titled Treatment Request, History and Risks. Both forms are available via the link on the right side of this page.

Members may see a participating psychologist for an initial assessment prior to psychological or neuropsychological testing without a referral or authorization. Any subsequent psychological and/or neuropsychological testing requires prior authorization. The testing psychologist is required to submit the completed **Psychological Testing Request or Neuropsychological Testing Request** form along with the appropriate supporting clinical documentation. Both forms are available via the link on the right side of this page.

Please note: The initial evaluation (CPT 90801) and psychiatric services (90805, 90807, 90862, and 90870) do not require authorization. These services will apply toward the member's benefit year maximum outpatient visit limit, if applicable

Depression Care Management Program

NHP/NHIC is pleased to announce our Depression Care Management Program to help support patients diagnosed with major depressive disorder. The Depression Care Management Program encourages member adherence to their current plan of treatment and provides ongoing mood and symptom monitoring and education on depression to help the patient manage their depression.

The Depression Care Management Program is designed to reinforce the goals established by you with your patient by providing additional support through periodic educational mailings and telephone calls from our health care professionals.

Referral to the Depression Care Management Program is easy. Simply contact the Behavioral Health Care Management Team at (920) 720-1340 or (800) 555-3616 or complete the attached referral form and fax or mail it to us. If using the referral form, please complete the patient information section, and if time permits, provide any additional health information in the medical information section.

NHP/NHIC recognizes and appreciates your central role in the health of our members. We hope that you will use this program as an adjunct to meeting the health goals you establish with your patients. We look forward to assisting you in meeting those goals.

Depression Care Management Program

The Depression Care Management Program is designed for patients with major depressive disorder. The program provides coaching and support by care management staff to help improve your patient's adherence to treatment for depression. To refer your patient to the Depression Care Management Program, simply complete the patient information in the box below. If time permits, please provide additional information in the medical information section. Referrals may be faxed or mailed to: NHP Behavioral Health, 1570 Midway Place, Menasha, WI 54952, Fax: (920) 720-1903. If you would like information on the Depression Care Management Program, please call (920) 720-1340 or (800) 555-3616.

Patient and Referral Information

The following patient has a current diagnosis of major depressive disorder and should be offered enrollment in the Depression Care Management Program.

Patient name: _____ M / F Date of birth: _____

Referred by: _____ Phone: _____ Date: _____

Physician name and signature (if required): _____

Patient Medical Information (optional)

Date of diagnosis: _____ Is the patient receiving counseling? Yes No

Is the patient currently taking antidepressant medication?

Medication: _____ Dosage: _____ Date started: _____

Medication: _____ Dosage: _____ Date started: _____

Medication: _____ Dosage: _____ Date started: _____

Has the patient ever been hospitalized for depression in the past? Yes DC Date: _____ No

Does the patient have any co-morbid medical conditions (e.g., diabetes)? No Yes

If "Yes," please list: _____

Does the patient have any co-occurring mental health conditions? No Yes *Please check all that apply:*

- | | |
|--|---|
| <input type="checkbox"/> Alcohol dependence | <input type="checkbox"/> Phobias |
| <input type="checkbox"/> Anxiety disorder | <input type="checkbox"/> Post-traumatic stress disorder |
| <input type="checkbox"/> Bipolar disorder | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Obsessive-compulsive disorder | <input type="checkbox"/> Social phobia |
| <input type="checkbox"/> Panic disorder | <input type="checkbox"/> Substance dependence |

Other _____

Thank you for referring your patient to the Depression Care Management Program.

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Network Health Plan Outpatient Treatment Request for Behavioral Health Services—Initial

Use this form to request authorization for outpatient sessions after you have completed your initial evaluation.

Please complete the member and rendering provider information boxes below.

Please complete and fax this form to NHP (920) 720-1903 for commercial members and (920) 720-1916 for Medicare members.
 Address: Network Health Plan 1570 Midway Place, Menasha, WI 54952. Attn: Behavioral Health Care Management Department
 Provider questions: (920) 720-1340 or (800) 555-3616

MEMBER INFORMATION			RENDERING PROVIDER INFORMATION	
Member's Name:			Provider Name :	
Member DOB:			Provider Fax #:	
Member ID #:			Provider Phone #:	
Primary Diagnosis:			Date of Initial Evaluation:	
Information below to be completed by NHP staff only				
Authorization Number	Effective Date of Authorization	Number of Sessions Authorized	End Date of Authorization	NOTES
				Any additional sessions authorized will be added to this episode of care using the same authorization number when possible. If further sessions are needed, please

CM Referral Tech _____

Date Authorized _____

Reviewed by Behavioral Health Coordinator? Y _____ N _____

BH Coordinator Signature _____

Date Reviewed _____

BHCM NOTES:

Network Health Plan Outpatient Treatment Request for Behavioral Health Services-Concurrent

Please complete and fax this form to NHP (920) 720-1903 for commercial members and (920) 720-1916 for Medicare members.
Address: Behavioral Health Care Management Department Network Health Plan 1570 Midway Place Menasha, WI 54952
Provider questions: (920) 720- 1340 or (800) 555-3616

Member Name: _____ Date of Birth: _____

Age: _____ Therapist Name: _____

Facility: _____

Phone Number: _____ Fax

Number: _____

Requesting ____ additional sessions Axis I

Diagnosis: _____

Behavior/Symptoms: Check all that apply within the last 5 sessions:

- Suicidal/Homicidal Ideation
 - Psychosis
 - Unwilling/Unable to follow medication regimen
 - Weight loss/weight gain
 - Sleep disturbance/insomnia
 - Self-injurious behavior symptoms)
 - Reckless/high risk behaviors (list symptoms) (list symptoms)
 - Anxiety (list symptoms) symptoms)
 - Co-morbid medical condition(s)
 - Difficulty concentrating/making decisions
 -
 - Other _____
- Active substance use/medication misuse
 - Loss of interest/anhedonia
 - Disordered eating
 - Fatigue/loss of energy
 - Angry outbursts/irritability
 - Impulsive/agitated behaviors (list
 - Child/Adolescent disruptive behaviors
 - Elevated/Expansive mood (list
 - Depressed mood (list symptoms)
 - Feelings of hopelessness or worthlessness

Functional Impairment: Check all that apply within the last 5 sessions:

- Stabilized on psychotropic medication regimen
 - Decrease in social contact/social avoidance
 - Change in productivity at school or work
 - LOA due to psych condition
 - Conflictual/hostile relationships
 - Responds to limits with difficulty hostility
 -
 - Other _____
- Decrease in ability to care for self or others
 - Absences from school/work
 - Suspensions/Detentions
 - Easily frustrated
 - Poor/intrusive boundaries
 - Occasional arguments/verbal

Attendance: >= 80% over past five scheduled visits Yes No Session frequency:

_____ x a month Individual Group Family Medication Management with MD/APNP

Support : Unavailable Involved in community support group
Family/friends involved, supportive

Treatment Goals: (Current and measurable)

1. _____

2. _____

Signature: _____

Date: _____

**** If more than 20 sessions have been authorized, please also include the 5 most recent progress notes with your request.****

For NHP Use: Authorization #: _____ _____ additional sessions authorized for a total of _____ Authorization Valid: _____ NHP Staff Signature: _____

PSYCHOLOGICAL TESTING REQUEST CHECKLIST

FAX to: Network Health Plan 920-720-1903

Member Name:

DOB:

Testing Psychologist Name: Phone () Fax ()

Who referred this patient to you?

What was the identified goal for this referral?

Date of Initial Assessment:

	Please fill out boxes 1-5 and answer questions 6-8. The following information is required for the secondary review to take place. The review can not begin until all of the listed information is submitted to Network Health Plan.	Check here if Included as attachments
1	Patient Demographics: Male <input type="checkbox"/> Female <input type="checkbox"/> Age	<input type="checkbox"/>
2	Patient Diagnosis:	<input type="checkbox"/>
3	Description of symptoms <i>and</i> functional impairment:	<input type="checkbox"/>
4	History: <ul style="list-style-type: none"> ▪patient psychiatric/medical ▪family psychiatric/medical (if applicable) ▪psychological testing <i>and</i> results/findings 	<input type="checkbox"/>
5	Assessment to date: <input type="checkbox"/> clinical interview with patient <input type="checkbox"/> interview with family <input type="checkbox"/> direct observation of parent-child interactions <input type="checkbox"/> consultation with school/other caregiver <input type="checkbox"/> brief inventories or rating scales <input type="checkbox"/> assessment by another mental health professional <input type="checkbox"/> consultation with pediatrician <input type="checkbox"/> review of records No assessment completed to date <input type="checkbox"/>	<input type="checkbox"/>

6. What specific question (s) is the testing intended to answer?

7. What action will be taken /How will treatment for this member be changed based on the results?

8. Hours requested : CPT 96101 CPT 96102 CPT 96103

Please see checklist of tests to be administered

Or List below the test (s) to be administered:

NEUROPSYCHOLOGICAL TESTING REQUEST

FAX to: Network Health Plan 920-720-1903

1. **Member Name:** _____ **DOB:** _____
Age: _____ **Gender:** _____ **NHP Member number:** _____

Testing Psychologist Name _____ Phone () _____ Fax () _____
Date of Initial Assessment _____ Referral Source: _____

2. **Choose A or B:**

A. Acute brain insult/Pervasive Developmental Disorder suspected/confirmed:

- Traumatic brain injury
 confirmed by imaging dated _____
 history of head injury **with** loss of consciousness/post-traumatic amnesia
- Anoxic/hypoxic brain injury
 History of intracranial surgery
 Confirmed neurotoxin exposure
 Cerebrovascular accident
 Encephalitis
 Pervasive developmental disorder

Testing History:

- No previous testing **and** cognitive impairment suspected/evident
 Previous testing performed **and** neurologic deficit confirmed
 unexpected change in symptoms within last 4 mo **and**
 no more than 1 testing episode within last 12 mo.
 retesting planned to evaluate response to new treatment **and**
 no more than 1 testing episode within last 12 mo.
 retesting planned to assess functioning
 1 previous episode of testing **and** no testing within last 6 mo.
 at least 2 previous episodes of testing **and** no testing within last 3 yrs

B. Other Neurologic condition:

- Condition:
 Brain tumor in remission/ with slow progression
 Cerebral palsy/Static encephalopathy
 Epilepsy diagnosed **and** seizures at least 1x/mo
 Hydrocephalus **with** shunt placement
 Language disorder suspected/diagnosed
 Multiple sclerosis suspected/confirmed
 Cognitive impairment suspected/confirmed

Testing History:

- No previous testing
 Previous testing performed:
 unexpected change in symptoms within last 4 mo **and**
 no more than 1 testing episode within last 12 mo.
 retesting planned to evaluate response to new treatment **and**
 no more than 1 testing episode within last 12 mo.
 retesting planned to assess functioning:
 1 previous episode of testing **and** no testing within last 12mo.
 at least 2 previous episodes of testing **and** no testing within last 3 yrs

3. **Medication/Substance Use will not confound results:**

- Patient on medication **and** drug effects ruled out of cause of cognitive impairment
 Substance abuse/dependence **and** at least 10 days sobriety
 No medication/substance use

4. **Hours Requested:** _____ CPT 96118 hrs CPT 96119 hrs CPT 96120 hrs

Test Checklist Attached: **Addtl Info Attached:**

Network Health Plan Outpatient Treatment Request for AODA Services – Initial

Please complete and fax this form to NHP (920) 720-1903 for commercial members and (920) 720-1916 for Medicare members.

Address: Behavioral Health Care Management Department Network Health Plan 1570 Midway Place Menasha, WI 54952

Provider questions: (920) 720- 1340 or (800) 555-3616

Member Name:		Date of Birth:		Age:	
Therapist Name:		Facility:			
Phone Number:		Fax Number:			
Assessment Date:		Axis I Diagnosis:			
Substance(s) of Abuse:		Amt/Freq of use:		Date of Last Use:	
Substance(s) of Abuse:		Amt/Freq of use:		Date of Last Use:	

Safety Risk: Check all that have occurred in the last week:

- | | |
|--|--|
| <input type="checkbox"/> Suicidal/homicidal ideation | <input type="checkbox"/> Arrest/confirmed illegal activity |
| <input type="checkbox"/> Family/Intimate partner violence | <input type="checkbox"/> Change in appearance/self-care |
| <input type="checkbox"/> Psychotic symptoms | <input type="checkbox"/> Self mutilation |
| <input type="checkbox"/> Increased irritability/angry outbursts | <input type="checkbox"/> Found with drugs/paraphernalia |
| <input type="checkbox"/> Unexplained injury/accident/fall | <input type="checkbox"/> Amnesia or blackout |
| <input type="checkbox"/> Lying, manipulating drug seeking behavior | <input type="checkbox"/> Reckless/impulsive behavior |
| <input type="checkbox"/> At risk of loss of: (residence? health? license?) _____ | |

Functional Impairment: Check all that have occurred in the last month:

- | | |
|--|---|
| <input type="checkbox"/> Withdrawn | <input type="checkbox"/> Decreased social contacts |
| <input type="checkbox"/> Nonverbal or hostile | <input type="checkbox"/> Threatening or accusatory |
| <input type="checkbox"/> Occasional arguments | <input type="checkbox"/> Relationships termed or strained |
| <input type="checkbox"/> Change in credit use | <input type="checkbox"/> Cult or gang activity |
| <input type="checkbox"/> Negative or using peers productivity | <input type="checkbox"/> Change in school or work |
| <input type="checkbox"/> Change in care of dependents | <input type="checkbox"/> Easily manipulated by peers |
| <input type="checkbox"/> Actual/perceived target of social rejection | <input type="checkbox"/> Absences from school or work |
| <input type="checkbox"/> Received warning from school/employer (emotional/physical/sexual) | <input type="checkbox"/> Abused/Abusive |
| <input type="checkbox"/> Inadequate coping skills issues | <input type="checkbox"/> Residence/support system |
| <input type="checkbox"/> Change in hobbies/activities | <input type="checkbox"/> Other impairment: |

Treatment History:

- Prior treatment No prior treatment

Dates: _____ type: _____ location: _____.

Dates: _____ type: _____ location: _____.

Requested Treatment:

Requesting: Partial Hospital (PH) Intensive Outpatient (IOP) Outpatient

If requesting PH/IOP please complete: sessions meet for _____ hours _____ days a week for _____ weeks.

Compliance: expected to adhere agrees with treatment unable or unwilling

Signature: _____

Date: _____

For NHP Use:
 Authorization #: _____ Sessions Authorized _____
 Authorization Valid: _____ NHP Staff
 Signature: _____

Network Health Plan Outpatient Treatment Request for AODA Services - Concurrent

Please complete and fax this form to NHP (920) 720-1903 for commercial members and (920) 720-1916 for Medicare members.
Address: Behavioral Health Care Management Department Network Health Plan 1570 Midway Place Menasha, WI 54952
Provider questions: (920) 720- 1340 or (800) 555-3616

Member Name: _____ Date of Birth: _____ Age: _____
Therapist Name: _____ Facility: _____
Phone Number: _____ Fax Number: _____
Substance(s) of Abuse: _____ Axis I Diagnosis: _____
Current level of treatment: Inpatient/ Partial Intensive Outpatient Outpatient

Check all services provided in the last 5 sessions:

- Clinical assessment Psychiatric/medication eval Substance evaluation
- Tox screen/breathalyzer Behavioral contract Goal-directed treatment plan
- 12-step/self-help group-suggested Ind/group/fam therapy ___ x week
- education group ___ x week
- Other: _____

Symptoms/Behavior: Check all that apply within the last 5 sessions:

- Preoccupation with getting high Preoccupation with past drugging experiences
- Drug glorification
- Reckless/impulsive behaviors Nonresponsive to interventions Drug seeking
- Frequent mood swings Failure to maintain abstinence Self-mutilation
- Guilt/remorse/shame Irritability Psychosis
- Labile mood Anxious Depressed

Functional Impairments: Check all that apply within the last 5 sessions:

- Socially withdrawn Verbal warning school/work Written warning school/work
- Unable/unwilling to ask for help Unable to develop sober support Decreased productivity
- After hours crisis intervention Difficulty engaging in treatment Easily manipulated by peers
- Interpersonal conflict Social isolation/alienation Poor/intrusive boundaries
- No positive connections Inadequate coping skills Requires monitoring
- Enabling support system Marginal positive connection Requires reinforcement
- Pregnancy Co-occurring medical condition
- Co-occurring psychiatric condition
- Poor impulse control Change in hobbies/activities Absences from school/work
- Difficulty caring for dependents Housing concerns Good impulse control
- Decreased social contacts Nonverbal or hostile interactions Threatening or accusatory
- Occasional arguments Relationships termed or strained Abused/Abusive

Adherence to Current Treatment: Check all that apply within the last 5 sessions:

- Attendance at least 80% Identifies goals Identifies sober supports
- Identifies triggers Engages in treatment milieu
- Engages with positive peer group
- Attends community/self-help group Unable to adhere to treatment
- Other _____

Requested Treatment:

Requesting: Partial Hospital (PH) Intensive Outpatient (IOP) Outpatient

If requesting PH/IOP please complete: sessions meet for _____ hours _____ days a week for _____ weeks.

Signature: _____ Date: _____

For NHP Use:
Authorization #: _____ additional sessions authorized for a total of _____
Authorization Valid: _____ NHP Staff Signature: _____
Revised: March 2010

Network Health Plan Request for Residential AODA Services - Initial

To request AODA Residential treatment authorization, please complete and fax this form to NHP at (920) 720-1903.

Address: Behavioral Health Care Management Department Network Health Plan 1570 Midway Place Menasha,
WI.54952

Provider questions: (920) 720- 1340 or (800) 555-3616

Member Name: _____

Diagnosis: _____

Date of Birth: _____ Age: _____
() _____

Phone: _____

Member #: _____

FAX #: () _____

Facility name: _____

Admission Date: _____

Last _____

use: _____

Substance of choice: _____

Amt/Freq of use: _____

Clinical Indicators (Please check all that apply):

- Potential for improvement in symptoms/behavior and agrees to work on personal recovery plan
- Discharged/Transfer from detoxification/inpatient rehabilitation within last 24 hours and medically stable
- Active substance use within last week and minimal risk of withdrawal Severe cravings
- Poor impulse control
- Jailed/incarcerated and lacks sober living skills and recovery environment post-release
- Transitional youth and lacks sober living skills and recovery environment
- Severe and persistent high-risk behavior and unable to be managed safely in less intense level of care
- Arrest/confirmed illegal activity Re-arrest for non-violent crimes and drug court referral
- Endangering behavior High-risk sexual activity
- Persistent and daily substance-related behavior Seeking drugs/alcohol
- Using drugs/alcohol Can be managed safely at residential level of care

Functional Impairment: For the following, check all that have occurred in the last month:

- Socially withdrawn Sexually abusive Physically abusive
- Affiliation with/ Participation in cult activities Severe and persistent interpersonal conflict
- Hostile and accusatory Intimidating interactions
- Suspended/ terminated/ Quit / Expelled from work/ school
- Unemployed and unable to seek work Unable to care for/Neglect of dependent children/vulnerable adults
- Exposes dependent children/vulnerable adults to physical/sexual abuse
- Removal from current living situation by authorities Eviction/Foreclosure
- Unable to perform activities of daily living without supervision

Treatment History and Risks:

Prior treatment (list month/year and facility name)

Inpatient/Detox _____

Residential _____

IOP: _____

Outpatient/Other _____

No previous treatment

Risks: Unable to apply recovery skills No positive connection to family/sober peers
 Inadequate coping skills Self-destructive behaviors Requires intense monitoring and reinforcement
 Pregnancy/Co-occurring medical/psychiatric condition History of nonadherence with treatment

Support System: Unavailable Abusive High risk environment
 Intentional sabotage of treatment

FOR NHP USE ONLY

Authorization number _____ Number of days authorized _____ Valid through _____

Concurrent review is needed on _____ by submitting the Residential AODA Concurrent form.

BHCM _____

Network Health Plan Request for Residential AODA Services - Concurrent

To request AODA treatment sessions, please complete and fax this form to NHP at (920) 720-1903.
Address: Behavioral Health Care Management Department Network Health Plan 1570 Midway Place Menasha,
WI.54952

Provider questions: (920) 720- 1340 or (800) 555-3616

Member Name: _____
Date of Birth: _____ Admission date: _____
Member #: _____ Estimated discharge date: _____
Facility name: _____ Telephone #: _____
Reviewer name: _____ FAX #: _____

Adherence to Current Treatment: Check all that apply within the last TWO weeks:

AODA programming attendance: at least 90% of required programming
 less than 90% of required programming Explain: _____

Personal recovery plan: Identifying goals and triggers
 Identifying sober supports and engagement with positive peer group

Services (check all that apply):

Clinical assessment daily Individual/Group therapy 3X/wk Support system/Family therapy 2X per month
 Recovery/Education group at least 1X/daily Individualized treatment plan
 Behavioral contract/Symptom Management Plan
 Toxicology screens/ Quantitative drug analysis as needed

Symptoms/Behavior (check all that apply):

Drug glorification Preoccupation with getting high/past drugging experiences
 Severe Cravings Reduced Cravings Overwhelming guilt/remorse/shame
 Diminished guilt/remorse/shame Reduced drug -seeking/glorification behaviors
 Drug seeking Physical altercation/Angry outbursts
 Self-mutilation Decreased frequency/intensity of self-mutilation
 Suicidal ideation without intent Suicidal ideation without plan/intent and no firearms in home
 Independent living skills improving Interpersonal conflict improving/controlled
 Homicidal ideation without intent Easily frustrated and poor impulse control
 Frequent mood swings/Emotional lability Mood/Emotional lability improving/controlled
 No physical altercations/angry outbursts
 Symptoms/ Behavior improved and discharge planned within 2 weeks
 Treatment goals not met Discharge placement pending

Functioning: (check all that apply):

Socially withdrawn Frequent interpersonal conflict Hostile and accusatory
 Intimidating interactions Easily manipulated by peer group
 Difficulty following instructions/engaging in treatment
 Unable to establish positive staff/peer relationships
 Unable to perform activities of daily living independently
 Improved independent functioning Therapeutic passes planned to transition to alternate level of care
 Inadequate coping skills and unable to remain sober without consistent intervention and structure
 Difficulty responding to limits Lacks consistent ability to apply recovery skills
 Marginal positive connection to family/sober peers
Support system Unavailable Abusive High risk environment
 Intentional sabotage of treatment Unable to manage intensity of symptoms

Treatment Request:

Requesting ___ additional days of AODA Residential treatment
Requesting Alternate level of care: Residential therapeutic group home
Facility: _____ Admission date: _____

For NHP use only

Authorization number _____ Additional days authorized ___ Valid through _____
Concurrent review is needed on _____ by submitting the Residential AODA Concurrent form.
BHCM _____

National Imaging Associates (NIA)

NHP has delegated to NIA the utilization management process for authorization approvals and denials of CT, MRIs, MRAs, PET, and Nuclear Cardiology imaging studies for non-hospitalized members done on an ambulatory, non-emergent basis. An NIA physician reviews all authorization requests that do not meet NIA's medical necessity criteria. NIA provides written notification of authorization requests that do not meet medical necessity criteria. NIA provides written notification of authorization denials to the provider and the member, which includes the reason for the denial and the appeal rights.

All radiological studies (CT, MRIs, MRAs, PET, and Nuclear Cardiology Studies) require Prior Authorization through NIA. You may contact NIA at 1-866-642-9702. NHP cannot authorize these studies and you will be directed to NIA.

You may also request prior authorizations for these studies at www.radmd.com. A login and password will be granted 48 hours after you complete your registration. You may request an authorization and verify the authorization status by using NIA on-line. You may view NHP's clinical criteria at www.radmd.com at Clinical Guidelines.

If there is a change in date or facility on an effective authorization for a radiological study through NIA, please contact our Care Management Department at (800) 236-0208 to make those changes.

NHP has listed the NIA Claims Matrix at www.networkhealth.com under the Provider tab, followed by the heading of NIA-Radiology Authorizations. The NIA Claims Matrix will assist you in requesting the appropriate study in conjunction with NHP's Clinical Criteria, as well as, verifying appropriate billing.

Please note, the authorization request must match the submitted claim. If the authorization and the claim do not match, the claim will be denied as no authorization and it will be provider liability.

The NIA RadMD Request an Exam Tip Sheet, the NIA RadMD Quick Start Guide, and an example of NIA Claims Matrix are included in this manual for your review. If you have questions or concerns regarding requesting studies online with NIA, please contact NHP's Provider Education Coordinators at (920) 720-1513 or (920) 720-1522.



Claim Resolution Matrix 2010

NIA has developed the following matrix in an effort to help its clients set up their claim processing systems. This matrix is designed to assist in the resolution of claims adjudication and claims questions related to those services managed by NIA. The matrix below contains all those CPT-4 codes NIA manages on behalf of its clients. The codes listed are set up utilizing what would be seen on a professional HCFA 1500 claim and not UB-92 claim. The inclusion of a code(s) also doesn't imply that the service would be approved, only that if we received a request for that service, it would be managed by NIA.

Each procedure is tracked and managed by NIA using the "CPT/HCPCS Code Managed by NIA". The "Allowable Billed Groupings" is meant to outline that if a given procedure is authorized, that any of the listed procedures codes could be submitted on a claim representing that service. This assumes, of course that appropriate rebundling rules are applied and that the service is performed within the date of service validity period. Codes representing contrast agents, radiopharmaceuticals and supplies are not listed on this matrix.

Codes that are submitted by facilities using CMS Outpatient PPS logic (C codes) and utilizing UB 92 claim logic are also not incorporated into this table.

If a family of CPT codes is not listed in this matrix, an exact match is required between the authorized CPT code and the billed CPT code. If the exact match does not occur the claim will be denied.

***Please note: Services rendered in an Emergency Room, Observation Room, surgery center or hospital inpatient setting are not managed by NIA.**

Authorized CPT Code	Description	Allowable Billed Groupings
70336	MRI Temporomandibular Joint	70336
70450	CT Head/Brain	70450, 70460, 70470
70480	CT Orbit	70480, 70481, 70482
70486	CT Maxillofacial/Sinus	70486, 70487, 70488, 76380
70490	CT Soft Tissue Neck	70490, 70491, 70492
70496	CT Angiography, Head	70496
70498	CT Angiography, Neck	70498
70540	MRI Orbit, Face, and/or Neck	70540, 70542, 70543
70551	MRI Internal Auditory Canal	70551, 70552, 70553, 70540, 70542, 70543
70544	MRA Head	70544, 70545, 70546
70547	MRA Neck	70547, 70548, 70549
70551	MRI Brain	70551, 70552, 70553
70554	Functional MRI Brain	70554, 70555
71250	CT Chest	71250, 71260, 71270
71275	CT Angiography, Chest (non coronary)	71275
71550	MRI Chest	71550, 71551, 71552
71555	MRA Chest (excluding myocardium)	71555
72125	CT Cervical Spine	72125, 72126, 72127
72128	CT Thoracic Spine	72128, 72129, 72130
72131	CT Lumbar Spine	72131, 72132, 72133
72141	MRI Cervical Spine	72141, 72142, 72156
72146	MRI Thoracic Spine	72146, 72147, 72157
72148	MRI Lumbar Spine	72148, 72149, 72158
72159	MRA Spinal Canal	72159
72191	CT Angiography, Pelvis	72191
72192	CT Pelvis	72192, 72193, 72194
72196	MRI Pelvis	72195, 72196, 72197
72198	MRA Pelvis	72198
73200	CT Upper Extremity	73200, 73201, 73202
73206	CT Angiography, Upper Extremity	73206
73220	MRI Upper Extremity, other than Joint	73218, 73219, 73220
73221	MRI Upper Extremity Joint	73221, 73222, 73223
73225	MRA Upper Extremity	73225
73700	CT Lower Extremity	73700, 73701, 73702
73706	CT Angiography, Lower Extremity	73706
73720	MRI Lower Extremity, other than Joint	73718, 73719, 73720, 73721, 73722, 73723
73721	MRI Lower Extremity Joint	73721, 73722, 73723, 73718, 73719, 73720
73721	MRI Hip	72195, 72196, 72197, 73721, 73722, 73723
73725	MRA Lower Extremity	73725

Authorized CPT Code	Description	Allowable Billed Groupings
74150	CT Abdomen	74150, 74160, 74170
74175	CT Angiography, Abdomen	74175
74181	MRI Abdomen	74181, 74182, 74183, S8037
74185	MRA Abdomen	74185
74261 ³	Diagnostic CT Colonoscopy (Virtual Colonoscopy, CT Colonography)	74261, 74262
74263 ³	Screening CT Colonoscopy (Virtual Colonoscopy, CT Colonography)	74263
75557	MRI Heart	75557, 75559, 75561, 75563, +75565
75571 ⁴	Coronary Artery Ca Score, Heart Scan, Ultrafast CT Heart, Electron Beam CT	75571, S8092
75572	CT Heart	75572
75573	CT Heart congenital studies, non-coronary arteries	75573
75574	CTA coronary arteries (CCTA)	75574
75635	CT Angiography, Abdominal Arteries	75635
76380	Follow Up, Limited or Localized CT	76380, 70486, 70487, 70488
76390	MR Spectroscopy	76390
77058	MRI Breast	77058, 77059
77084	MRI Bone Marrow	77084
78451	Myocardial Perfusion Imaging – Nuclear Cardiology	78451, 78452, 78453, 78454, 78466, 78468, 78469, 78481, 78483, 78494, 78499 Also included in this auth is the corresponding 9- range (93015-93018) and the radiopharmaceutical charges (A9500-A9605).
78459	PET Scan, Heart	78459, 78491, 78492 Also allow billing for the corresponding Cardiovascular Stress Test 9-range (93015 – 93018).
78472	MUGA Scan	78472, 78473, 78496 Also included in this auth is the corresponding 9- range (93015-93018) and the radiopharmaceutical charges (A9500-A9605).

Authorized CPT Code	Description	Allowable Billed Groupings
78608	PET Scan, Brain	78608, 78609
78813 ^{1,2}	PET Scan	78811, 78812, 78813, 78814, 78815, 78816
78816 ^{1,2}	PET Scan with concurrently acquired CT for attenuation correction and anatomic, localization.	78811, 78812, 78813, 78814, 78815, 78816
0042T	Cerebral Perfusion Analysis CT	0042T
G0235	PET imaging, any site, not otherwise specified	G0235
G0252 ⁵	PET imaging, initial diagnosis of breast cancer and/or surgical planning for breast cancer	G0252
S8037	MR Cholangiopancreatography	S8037, 74181, 74182, 74183

Pharmacy

NHP Pharmaceutical Benefits Management Program is based on optimal standards of medical practice. NHP's Pharmaceutical and Therapeutics Committee develops and monitors all pharmaceutical management policies, procedures, authorization criteria, and the Preferred Medication List.

NHP has delegated to Express Scripts Inc (ESI) the authorization process for prior authorization required medications, non-formulary medications, ample supply, vacation override, quantity level limits, and prescriber status exceptions. An ESI pharmacist reviews all authorization/exception requests that do not meet NHP's criteria. If the pharmacist determines a denial is warranted, ESI provides the verbal and written communication of the denial, the reason for the denial, and how the denial may be appealed. The processing of appeals was not delegated and remains an NHP function.

You may access the Preferred Drug List at:

http://www.networkhealth.com/object/nhp_providers_pharmacy.html

Preferred Drug List

Purpose of the Preferred Drug List

NHP's Preferred Drug List was developed to provide members and practitioners with a listing of the most commonly prescribed medications. This listing includes preferred, non-preferred medications, and indicates which copayment/coinsurance tier applies. Tiers 1, 2, and 4 indicate preferred medications. Tiers 3 and 5 indicate non-preferred medications.

Development of the Preferred Drug List

The Preferred Drug List document was developed by NHP's Pharmacy and Therapeutics Committee (P&T Committee). This committee, composed of practitioners from various medical specialties, reviewed the medications in all therapeutic categories based on safety, effectiveness, and cost.

Preferred Drug List development and maintenance is a dynamic process. The P&T Committee will regularly review new and existing medications to ensure the Preferred Drug List remains responsive to the needs of members and health care providers. The Preferred Drug List will be updated periodically. For the latest version of the NHP Plan Preferred Drug List, log onto <http://www.networkhealth.com> or contact the Customer Service Department at 1-800-826-0940 or 920-720-1300 to request a copy.

Preferred Drug List Medications

The Preferred Drug List applies to prescription medications provided to our members in an outpatient setting. For the most part this is limited to medications obtained from participating pharmacies. Copayments may also apply to medications administered in the practitioner's office. The Preferred Drug List does not apply to medications given in the hospital setting.

Relative Cost Index

Most listings are preceded by a "relative cost index," represented by a series of one to five dollar signs (\$) or five exclamation points (!!!!!). This is a relative indication of the cost to NHP/NHIC for medications within selected therapeutic categories:

\$	product A least expensive
\$\$	product B more expensive than "A"
\$\$\$	product C more expensive than "B"
\$\$\$\$	product D more expensive than "C"
\$\$\$\$\$	product E more expensive than "D"
!!!!!	product F is substantially more expensive than "A-E"

Cost ranges reflect cost per day of a typical prescription.

Unapproved Use of Preferred Drug List Medications

The Certificate of Coverage states a medication will be eligible for coverage only if it is an FDA approved medication used for non-experimental indications. Non-experimental indications include the labeled indication(s) (FDA approved) and other indications accepted as effective by the balance of currently available scientific evidence and informed professional opinion. Experimental and investigational drugs, drugs used for cosmetic purposes, weight loss, or erectile dysfunction are examples of products not eligible for coverage. Members should refer to the Certificate of Coverage for a detailed list of exclusions.

Claims & Subrogation Information

NHP claims policies are intended to serve as a general reference resource and not intended to address every aspect of a reimbursement situation. NHP may use reasonable discretion when interpreting and applying the claims policies to services being delivered in a particular case. The claims policies do not cover all issues related to reimbursement for services rendered to NHP members. NHP claims policies are found at www.networkhealth.com under the provider page.

NHP reserves the right to terminate, change, suspend, or discontinue any claims policies at anytime without notice. Changes made to NHP claims policies will be made effective immediately and posted to the website when applicable. The claims policies are provided on an “as is” and “as available” basis without warranties of any kind, either express or implied. NHP encourages all providers to visit the provider page at www.networkhealth.com on a frequent basis.

If you have questions about the claims policies, please contact NHP’s Customer Service Department at (920) 720-1300 or 1-800-826-0940. The Customer Service Department hours are: Monday, Wednesday, Thursday, and Friday 8:00 a.m. to 5:00 p.m. and Tuesday 8:00 a.m. to 4:00 p.m.

NHP CLAIMS INFORMATION

Claims Mailing Address:

**Network Health Plan
P.O. Box 568
Menasha, WI 54952**

Claim Submission & Subrogation Process: NHP recognizes CPT4 (Level I) and HCPCS (Level II) procedure codes and procedure code modifiers. Local codes (Level III) and associated modifiers are NOT acceptable. These codes are assigned by individual carriers, not recognized nationally, and mandated by HIPPA (The Health Insurance Portability and Accountability Act of 1996).

In order to provide prompt adjudication and payment of claims NHP requires plan providers to file claims on appropriate claim forms and in a timely manner. All claims must be submitted in accordance with the claim filing limit stipulated in your Provider Agreement/Contract. Refer to the Timely Filing Guidelines policy for further details.

All work related claims must be submitted directly to the worker's compensation carrier. If the worker's compensation carrier denies liability then the claim must be submitted to NHP, via a paper claim and must include the worker's compensation denial letter. The information must be received within 90 days of the date on the worker's compensation denial letter. At the time the worker's compensation denial information is received, NHP will follow our internal subrogation process to pursue recovery. Providers are required to indicate on the claim form that the service is related to employment, auto, or other accident. **All plan provisions, including prior authorization requirements will apply.**

Subrogation claims (where the third party may have caused the injury or illness due to an auto accident, a non-work injury, a slip or fall, and/or a defective product) must be submitted directly to NHP for processing. NHP will pursue recovery of those expenses from the at-fault party and/or the liability insurer. **All plan provisions, including prior authorization requirements, will apply.**

All claims must be submitted in a timely manner along with the copy of the denial as outlined in the NHP Timely Filing Guidelines policy.

Electronic Claim Submission: NHP accepts electronic claims from participating and non-participating physician/facility claims by using a single payer identification number (ID). NHP's most utilized clearinghouse is Emdeon (WebMD); however you may utilize other clearinghouses to submit claims to NHP. You will need to contact NHP at the telephone number listed below to obtain the appropriate ID number of the clearinghouses we contract with.

When NHP receives claims electronically a daily report will be generated (EDI Claim/Error Log Report) and mailed on a weekly basis. It is the provider's responsibility to review this report in order to ensure successful electronic claims submission. The report will identify both accepted and rejected claims. Only accepted claims are loaded into our system for claims processing. Rejected claims will be identified and flagged for your review. The primary reason claims are rejected is because NHP cannot identify the member and/or the provider.

If you have questions regarding NHP's Electronic Data Interchange (EDI) process you can contact our EDI Specialist by calling (920) 720-1506.

Claim Resubmissions: All resubmitted claims need to follow NHP's Timely Filing Guidelines. After corrections and enrollment verifications have been made, EDI claims can be resubmitted to NHP either:

- Directly on the EDI Claim/Error Log Report, or
- On the Remittance Advice received.

Corrected Claims: All corrected claims should be submitted via a paper claim and clearly identified. Please indicate by using a modifier CC or note "corrected claim" on the form. This will prevent a provider's claims from being denied as a duplicate submission. Claim resubmissions should be sent to P.O. Box 568, Menasha, WI 54952.

Minimum Claim Elements: The following information must be included on all claims in order for the claim to be considered a clean and complete claim by NHP.

- Subscribers full name and address
- Patients first and last name
- Patient date of birth (month, day and year)
- Patient NHP identification number
- Dates of service
- Current procedure codes
- Current diagnosis codes
- Charges for services
- Provider name and address
- Provider tax identification number
- Patient signature or indication of signature on file
- Provider signature
- Provider NPI number
- Billing Provider NPI number

If any of the above information is missing from the claim, NHP will not be able to process your claim. In addition, NHP will not be able to process the claim if Third Party or Primary Payer information has not been obtained by provider and/or member. If you have questions regarding required fields on a claim, please contact our Customer Service Department at (920) 720-1300 or 1-800-826-0940.

Incomplete and Unclean Claims:

Unclean Claims: If a claim does not include all of the information set forth under minimum claim elements listed above, the claim will be considered unclean and will be denied with the appropriate National ANSI code indicating additional information is required. This denial will hold the provider liable. Members should not be billed when the provider does not bill appropriately.

Incomplete Claims: If a claim contains all the information necessary to be processed, but lacks information necessary for NHP to make a decision on the claim, NHP will notify both the member (via Explanation of Benefits) and providers (via Remittance Advice) that additional information is necessary to make a benefit determination.

Members should not be billed when additional information is required from the provider.

If the necessary information is required from the member, the member may be billed by the provider until the time the member supplies NHP with the appropriate information. An example would be other insurance information from the member. NHP can not determine benefits until we have verified NHP is the member's primary carrier. NHP will process the claim upon receipt of the required information.

Consistent Determinations and Claims Reprocessing: Internal safeguards are in place to ensure that established procedures result in consistent determinations. These safeguards include but are not limited to:

- Periodic and random internal procedural audits
- Periodic and random audits conducted by regulatory agencies, and
- Established utilization review and medical policies

In order to ensure that NHP continuously delivers quality health care at an affordable price and upholds our mission, it is important we safeguard the funds entrusted to us. In order to do this effectively, NHP implemented a loss prevention program known as the Special Investigations Unit (SIU). The SIU utilizes a loss prevention software package that helps in identifying improper billing and detects suspicious claims. The focus of the SIU is to improve the submission and billing practices in order to reduce waste and abuse and disperse funds appropriately.

PLEASE NOTE ~ NHP may reprocess claims retroactively up to 24 months from the original paid date. Reprocessing will occur if the provider was overpaid or underpaid. In these situations the member will receive a notice via Explanation of Benefits (EOB) and the provider will receive notice via Remittance Advice. The provider will be responsible for reimbursing members if the new claim creates a credit to the member.

Provider Education Coordinator

Provider Education Coordinators represent the Commercial lines of business for NHP, which encompasses the Claims Department, Customer Service Department, Care Management Department, and work in conjunction with the Quality Improvement Department. They will provide information, education, and materials for your office and your staff. They will educate and train the provider population as needed in the following areas:

- NHP policies and procedures
- NHP policies concerning authorizations
- Departmental processes and procedure
- Other areas as needed

They will also organize and provide education sessions and re-education as necessary to contracted providers and their respective office staff. Provider Education Coordinators will make onsite visits for the initial education session and a follow-up site visit on an annual basis.

Provider Education Coordinators act as a liaison with the Operational Departments of NHP to preempt issues/concerns regarding providers. They will solicit and encourage open communication from providers and their staff. They will also communicate process improvement opportunities to providers regarding member's complaints and grievances associated with their office.

Please contact the Provider Education Coordinators if you have questions or concerns regarding this manual, processes, procedures, additional reference materials, or education sessions. The Provider Education Coordinators can be reached at (920) 720-1513 or (920) 720-1522.

Provider Disputes: If you disagree with the outcome of a claims processing decision, you should contact NHP's Customer Service Department at 1-800-826-0940 or (920) 720-1300. If you are still not satisfied with the outcome after working with NHP's Customer Service Department you have the right to submit a formal provider dispute. All provider disputes must be submitted in writing and should be sent to:

**Network Health Plan
Attn: Provider Disputes
P.O. Box 120
Menasha, WI 54952**

NHP will review the dispute and render a determination within 45 working days. If the original processing determination is overturned, the claim will be reprocessed within the next processing cycle.

If the determination is upheld, NHP will send a letter to the provider with the notice of our decision and applicable information related to our decision. Provider dispute requests must be received by NHP within 180 days of the date of the provider's remittance advice.

Provider disputes submitted to NHP on behalf of a member will be handled according to the NHP Complaint-Appeal (Grievance) Resolution Policy and Procedure.

Health Care Code Sets: NHP uses a standardized healthcare coding system. Our systems are updated quarterly to ensure we accept and report back to the Office of Commissioner of Insurance (OCI) submitted health care codes as required for compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The quarterly updates include new, deleted or changed codes and descriptions.

Please verify that your office uses current coding manuals to assist in timely submission and reimbursement. If you do not have current coding manuals, we suggest that you obtain one. Below is a list of entities that provide information for industry standard healthcare codes.

- American Medical Association
- The Centers for Medicare and Medicaid Services (HCPCS, IPPS, OPPS)
- American Society of Anesthesiologist Relative Value Guide (ASA)
- US Dept. of Health and Human Services (ICD-9)
- National Uniform Billing Committee (UB Editor)

Claims Coding and Reimbursement

IMPORTANT NOTICE: NHP will NOT provide reimbursement to a treating provider when the service is furnished or ordered for themselves, for immediate family members or any person residing with the provider. This includes prescriptions, services or supplies. Family members include your lawful spouse, child, parent, grandparent, brother, sister or any person related to the rendering provider.

NHP will reimburse providers at the agreed upon schedule of allowance for covered services as indicated in the Provider Agreement/Contract, minus any applicable deductibles, coinsurance, or copayments. Your Provider Agreement/Contract also prohibits you from balance billing NHP members. Payments for missed appointments are not covered by NHP.

NHP uses a customized version of the Ingenix Claims Editing System to process claims in accordance with NHP reimbursement policies. Reimbursement policies are located at www.networkhealth.com/object/provider-claims-policies.html.

Global Days: NHP utilizes the Centers for Medicare and Medicaid (CMS) Global Surgery status indicators, as set forth under the National Physician Fee Schedule Relative Value File to ensure consistent payment for global surgical packages. Patients should not be billed when the provider bills for services within the global day period.

Bundling/Unbundling: NHP utilizes Code Correct and Ingenix which applies National Correct Coding Initiative (NCCI) edits to confirm the proper billing of procedures. Members should not be billed when the provider bills bundled or unbundled.

ICD-9-CM Coding: NHP requires claims to be submitted with current, valid ICD-9-CM codes that are extended to the maximum number of legitimate digits. Members should not be billed when the provider bills with outdated ICD-9 codes.

The primary diagnosis should be the code which justifies the primary reason a patient is being treated. “**E Codes**” should never be submitted as the primary diagnosis code.

Current Procedural Terminology (CPT) Coding: NHP requires that a detailed description of the procedure or service be provided when submitting codes that are unlisted, not otherwise classified (NOC), or not elsewhere specified. Documentation such as office or operative notes is required in these cases. Members should not be billed when the provider bills with outdated CPT codes. If the correct CPT/HCPCS code is not used, services billed may be denied.

Modifiers: In order to ensure correct reimbursement, it is imperative providers submit claims to NHP using appropriate modifiers. Reimbursement for services submitted with reduced services modifiers will be reduced systematically; therefore providers are required to submit full charges to facilitate correct payment.

NHP will not accept a modifier as a separate code (099--). When using modifiers, please place the two digit modifier behind the specific CPT code.

Modifiers are listed in CPT/HCPCS manuals. NHP uses Medicare reimbursement methodology based on the Medicare Physician Fee Schedule Database. This information can be obtained through: www.hhs.cms.gov/PhysicianFeeSched.

Bilateral Procedures: A bilateral procedure should be reported as a single line item, with modifier 50, one unit, and the bill amount at full charge for both procedures. If there are multiple bilateral procedures, follow the same rule, but bill the 51 modifier on the second and subsequent bilateral procedures.

Multiple Surgeries: NHP will process multiple surgery claims as follows:

- 100 percent of the contracted fee for the procedure listed with the highest value allowed on the primary procedure.
- 50 percent of the contracted fee for the procedure listed with the highest value allowed on the second through fifth procedures.

- Claims containing more than five procedures will be considered on a case by case basis. Operative reports may be needed to review these claims.

Multiple Endoscopic: NHP will process multiple endoscopic claims based on the fact that all endoscopies include a diagnostic endoscopy. Endoscopies are grouped into families of codes, each of which includes a code for a diagnostic endoscopy (referred to as the base code). Since the relative value of each endoscopy code includes the value of the base code, NHP will reimburse the value of the diagnostic endoscopy only once.

- The endoscopic procedure with the highest relative fee schedule amount is reimbursed at 100% of the contracted allowable amount.
- The contracted allowable amount for the base procedure is then subtracted from the contracted allowable amount of the remaining endoscopic procedures.

Assistant Surgeons are considered medically necessary for some surgical procedures. If you have any questions whether or not an assistant surgeon would be considered an eligible expense for a certain procedure, please contact NHP's Customer Service Department at 920-720-1300 or 1-800-826-0940. The assistant surgeon must be a participating provider from NHP. Reimbursement for assistant surgeon claims will be processed by NHP as follows:

- 20 percent of the surgical allowed amount for M.D. or D.O. assistant surgeons designated by modifier 80, 81 or 82.
- 10 percent of the surgical allowed amount for a non physician practitioner (Nurse Practitioner (N.P.) and Physician Assistant (P.A.) assistants).

The "AS" modifier may be used on claims for surgical assists that are provided by non physician practitioners.

Timely Filing Guidelines: NHP will reimburse providers within 30 days of receipt of a clean claim. Claims must be submitted within ninety (90) days after the date of service. When NHP is the secondary payer, claims must be submitted to NHP within ninety (90) days after the date of processing listed on the primary payer's Explanation of Benefits or as listed in your Provider Contract.

When a provider's electronic claims are received in our Claims Department, NHP will provide proof of receipt via the EDI Claim/Error Log Report.

If a claim is denied for improper submission, resubmission must be completed by the provider within the filing limit as outlined above.

Please be aware that when a provider fails to submit a claim timely, rights to payment from NHP are forfeited and the provider may not seek payment from the member as compensation for these covered services.

Exceptions to Timely Filing Guidelines: Requests for temporary waiver of the Timely Filing limit must be made in advance due to computer system conversions or other short term circumstances. Such requests are required in writing and submitted to the NHP Manager of Claims.

Proof of Loss: NHP will accept only claims that are in English. All claims must be in writing. If it is not reasonably possible for you to submit your claim within the ninety (90) Days, NHP will still accept the claim until one year after the ninety (90) Days.

Coordination of Benefits (COB): COB claims must be received within the Timely Filing Guidelines policy beginning with the date noted on the primary payer's Explanation of Benefits.

If NHP is secondary the secondary payor, all claims must be submitted via a paper and must include a copy of the primary carrier's EOB. If the primary carrier's EOB is not received with the claim, the claim will be denied.

Prompt Payment: Claims that require additional information or are subject to COB will be adjudicated promptly upon receipt of requested information.

Crossover claims: Claims that are initially filed with CMS and forwarded by CMS to NHP for processing. The timely filing rule for crossover claims is 15 months from the date of the CMS Explanation of Medicare Benefits (EOMB).

If the provider has difficulty obtaining NHP coverage information from the subscriber, claims must be received within the timely filing limit beginning with the date the NHP coverage identified, but no longer than 15 months from the date of service. The provider shall submit supporting documentation to demonstrate measures the provider has taken to obtain this information. Upon receipt of such information the provider must submit claims and supporting documentation within the 15 month filing limit.

Claims for prenatal visits, which would have been normally billed as part of a global obstetrics (OB) charge, must be billed separately due to a change in physician and need to be submitted within the timely filing limit, beginning with the date of delivery.

Retroactive Eligibility Changes: Eligibility under an NHP benefit plan may change retroactively if:

- NHP receives information that a member is no longer eligible for coverage;
- The member's policy has been terminated;
- The member elected not to purchase continuation coverage; or
- The eligibility information NHP originally received is found to be incorrect.

If the office has submitted a claim(s) that is affected by a retroactive eligibility change, NHP has the right to recoup all monies paid after the notification of the eligibility change and/or up to 18 months from the eligibility change. If this occurs the provider has the right to pursue the member/patient for the outstanding balance.

Overpayments: If you identify a claim in which the provider was overpaid by NHP or if NHP notifies the provider of an overpaid claim that the provider does not dispute, we expect you to reimburse NHP within thirty (30) calendar days (or as required by law) from the date you identify the overpayment or from the date of our request. It is NHP's policy to only reprocess claims within 18 months of the original paid date, with the exception of subrogation claims which there is no time limit. Please note, NHP may apply identified overpayment against future claim payments in accordance with the provider contract or as allowed by law.

All overpayment refund requests received from NHP or from one of our contracted recovery vendors should be sent to the name and address of the entity outlined on the refund request letter. All credit balances that you identify should be sent to:

**Network Health Plan
Attn: Claims Recovery
P.O. Box 568
Menasha, WI 54952**

Please include appropriate documentation that outlines the overpayment, including member name, member identification number, date of service, dollar amount paid, and a copy of the remittance advice that was received with the original payment issued by NHP. If the refund is due to COB with another carrier, please include a copy of the other carrier's EOB along with the refund.

If the provider disagrees with the claim reconsideration or an NHP request for an overpayment refund, the provider can file a provider dispute as outlined in the Provide Disputes process.

Waiver Contingency

Providers may use waivers to inform NHP members that they may be financially responsible for charges that are not covered by NHP. Providers may use waivers only in these instances:

- The service is a direct exclusion of NHP's policy
- Maintenance therapy
- Prior authorization request was denied by NHP
- Over the counter products

The waiver must be signed and dated at each visit by the member prior to rendering the service that may not be covered by NHP. Members may seek services that are not covered by NHP, however it is the obligation of the provider to properly inform the member they will be financially responsible for the non-covered service. You must *not* bill our members for non-covered services if you do not comply with this protocol.

Examples of properly issuing a waiver:

A provider contacts NHP to request a genetic test. NHP denies the test based on the fact that it does not meet medical necessity. The provider informs the member that NHP has denied the request. The member chooses to have the test done. The provider should issue the waiver at this time indicating the member will be responsible for the out of pocket costs for the specific service.

A chiropractor informs the member that they have reached a plateau in treatment for a specific injury and they will be discharging the member from active treatment. The chiropractor informs the member that treatment for the injury will become a maintenance therapy service. The chiropractor informs the member that maintenance therapy is not covered by NHP and the member would have to pay out of pocket. The member indicates they will continue with therapy for the injury. The member comes in the following month for therapy; the chiropractor should issue the waiver. The chiropractor should issue a waiver at each maintenance therapy visit thereafter.



Network Health Insurance Corporation
AFFINITY HEALTH SYSTEM

NHP/NHIC Waiver of Liability Release Form

This waiver allows a Network Health Plan/Network Health Insurance Corporation (NHP/NHIC) (contracted) provider to collect charges for services denied as “non-covered” (not an NHP/NHIC benefit) from a NHP/NHIC member when the member has agreed, in writing, to waive his or her balance-billing protection.

I, _____, the NHP/NHIC member, hereby agree to pay the full billed charge(s) for the following service(s) if such service is subsequently denied as non-covered regardless of the fact the NHP/NHIC program will not make payment:

Date: _____ CPT (Code): _____ Estimated Billed Charge: _____

Date: _____ CPT (Code): _____ Estimated Billed Charge: _____

Date: _____ CPT (Code): _____ Estimated Billed Charge: _____

Total (Estimated) Billed Charges: _____

This waiver applies to any and all NHP/NHIC non-covered services indicated above rendered by this provider, including, but not limited to office visits, office procedures, hospital visits, and surgical fees.

I acknowledge that I am signing this statement voluntarily, and that it is not being signed under duress or after the services have already been provided. I understand that by signing this form, I will be fully responsible for the total billed charge(s) for any services denied as non-covered (not a covered NHP/NHIC benefit) and listed above and will pay the provider this amount, regardless of the fact NHP/NHIC will not make payment. I also understand that it is my choice to have these services provided at a future date and time by this provider.

Date: _____

NHP/NHIC Member (or Guarantor’s) Signature: _____

NHP/NHIC Member (or Guarantor’s) Name (Printed): _____

NHP/NHIC Member Number: _____

PROVIDER INFORMATION

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: (____) _____

Examples of inappropriately issuing a waiver:

NHP requires genetic testing to be prior authorized. The provider did not prior authorize the testing and the member had it done. NHP denies the charges for no authorization obtained. The provider may not issue a waiver and may not bill the NHP member for the charges.

A chiropractor informs the member they have reached a plateau in treatment for a specific injury and their care has become maintenance in nature. The chiropractor informs the member that they will be responsible for this visit and issues a waiver.

You may not issue a waiver until the following visit of discharge from active treatment.