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I — Introduction

A. Company overview

Welcome
We appreciate your participation in our networks and value the services you provide to our members. The goal of Coventry Health Care of Illinois, Inc. (“Coventry Health Care”) is to develop and sustain strong, mutually beneficial relationships with our providers and their office staff.

Coventry Health Care is an NCQA accredited managed care organization that offers a variety of products and services.

Business focus
The health plan has implemented critical business plan initiatives to reach new heights of care quality, member satisfaction, employer confidence and financial viability. The most significant initiatives include the following:

- Empowering Provider Relations representatives to handle issues at a local level
- Changing the underwriting methodology from community rating to adjusted community rating
- Refining internal operational expenses to increase performance efficiency
- Committing to quality medical management and the overall health needs of plan members
- Focusing efforts on preventive care/HEDIS initiatives
- Providing interactive Internet services and value-added services

Compliance and ethics program
Coventry Health Care is dedicated to conducting business in accordance with the highest level of ethical standards and uncompromising integrity, and in compliance with the federal, state and local laws governing its business. These commitments apply to the directors, officers, employees and representatives of our company. They are apparent in our relationships with shareholders, customers (enrollees, federal providers, state and local governments), vendors, competitors, auditors and all public and government bodies. It is the responsibility of all employees and entities to conduct business in a manner consistent with the company’s reputation as a leader in the health care industry.

In-Network providers
HMO plan members must use in-network providers to receive coverage for services. Services provided to an HMO plan member by an out-of-network or non-participating provider must have prior authorization from the health plan. Non-authorized services from an out-of-network or non-participating provider will be denied as member responsibility.

PPO and POS plan members are encouraged to seek medical services from in-network providers in order to have the most coverage, but they may utilize a provider of their choice at a lower benefit level, as described in each plan member's schedule of benefits.

Please be aware that our provider directory is subject to change. It is important for your office to verify the participation of any provider with Customer Service at 800-431-1211 or on our website www.chcillinois.com before referring a plan member to an alternate provider.

Purpose of this manual
The purpose of this manual is to answer your questions about administering health care services to our plan members. This manual covers administrative policies and procedures, as well as other pertinent information. We will update the provider manual two times per year. Any significant changes are communicated in writing and the most current version can be found on our website. Our primary form of provider communication is done through email or by fax. It is important that you supply us with accurate contact information so that you may receive important announcements related to your practice. This manual is specific to Coventry Health Care of the Illinois, Inc. The provider manual for workers' compensation and auto can be found at http://www.coventrywcs.com/provider-services/document-library/index.htm incorporated herein by reference.
B. Roles of Provider Relations and Customer Service

Provider Relations
Provider Relations representatives act as internal advocates for providers to ensure that their concerns are addressed and resolved. These representatives may visit providers’ offices to assess operational and contractual issues and to keep providers informed of current policies and procedures. Provider Relations representatives are responsible for specific geographic regions, generally located in the regions they service.

- Phone number: 800-562-5792

Customer Service
Customer Service representatives are available to assist you with any questions regarding eligibility, benefit issues, remittance advice/check issues and claim payment issues.

- Phone number: 800-562-5792
- Hours of operation: Monday through Friday, 8 a.m. to 6 p.m. CST

C. Integration of Coventry and Aetna
Update on our integration—what you need to know
As you may know, Coventry and Aetna are now one company. Although we’re one company, we’ll continue to operate separate Coventry and Aetna networks in Illinois and Missouri. In January 2016, Coventry members began transitioning to Aetna claim systems. As part of this change, members receive new ID cards. See below for a sample.

Your current Coventry participation agreement still applies
The terms in your agreement still apply to members with these new ID cards. This doesn’t impact your participation in the Coventry or Aetna networks.

Direct your patients to in-network providers to save
When needed, direct members to other in-network providers. These providers may vary, depending on which network the member uses. You can find a list of in-network providers at:

- www.aetna.com (Aetna)
- www.chcmissouri.com (Coventry members with “Accessing the Missouri <Coventry logo>” on the front of their ID card)
- www.chcillinois.com (Coventry members with “Accessing the Illinois <Coventry logo>” on the front of their ID card)
We’ll process claims based on Aetna’s policies, not Coventry’s

For Coventry members administered on Aetna claim systems, we’ll process claims based on Aetna clinical and claim payment policies, which may vary from Coventry’s.

Where you should send claims
Please send claims to the address listed on the back of the member ID card.

We’re here to help
Just e-mail us at CHCILMOPROVIDERINFORMATION@aetna.com if you have questions.

II — PLAN MEMBER INFORMATION

A. Plan member ID cards

All plan members receive their ID cards shortly after enrollment. Members must present their card at the time services are rendered. Each card includes the member’s name, benefit plan type, ID number, group name and number, and the name of the primary care provider (PCP) if applicable. The cards also list the copayments or coinsurance for office visits, prescriptions and inpatient services. The ID card also contains important Customer Service phone numbers for each plan, our pharmacy vendor, and our behavioral health vendor. Benefits vary among product lines. Sample ID cards can be found in the Appendix of the Provider Manual in Section IX.

If a member is a recent enrollee and has not received an ID card, he or she must present a copy of the enrollment form. Therefore, it is important to reference ID card for the correct copay or coinsurance amount.

Auto and Workers’ Comp clients do not provide ID cards to insureds/injured parties. Providers will need to access the Client/Payor list on directprovider.com in order to determine whether they are participating in the Auto or Workers’ Comp network for that member.

B. Verification of plan member eligibility

Please check the member ID card, enrollment form or another form of identification to verify identity. Eligibility can then be confirmed by calling Customer Service at 800-431-1211 or by accessing www.directprovider.com.

C. Plan member copayments

Members are responsible for paying any applicable copay to in-network providers at the time of service. Each ID card indicates the copay required. Otherwise, final member liability will be determined upon adjudication of the claim and listed on the remittance advice.

D. Out-of-pocket maximum

The out-of-pocket maximum is the greatest liability that a member will incur before their benefits are covered at 100 percent of eligible expense. Services excluded from the annual out-of-pocket maximum include copayments, deductibles, prescription copayments, mental health care and non-covered services.

E. Transition of care

The health plan ensures the continuity of care for plan members receiving ongoing treatment for chronic or acute medical conditions in the event that a provider leaves our network. This means that care is not disrupted at a critical point in treatment as a result of discontinuing a contract between a provider and the plan.

If a provider leaves our network for reasons other than the termination of a contract due to situations involving imminent harm to a patient or a final disciplinary action by a state licensing board, but remains within our service area, impacted plan members are notified of the transitional services available and are assisted in selecting a new provider using the options of specialty care form.
The member may request to continue an ongoing course of treatment with the provider for 90 days of the enrollment or renewal date, or within ninety (90) days from the date of the change in the provider’s contract (for reasons other than quality deficiencies). Transitional periods like these are approved under the following circumstances:

1. The member has an ongoing active course of treatment for a chronic or acute medical condition (not to exceed 90 days from the date the contract is terminated).

2. The member has entered the second or third trimester of pregnancy at the time of the provider’s disaffiliation, including the provision of postpartum care directly related to the delivery. The health plan authorizes care during the transitional period only if:

   1. The provider will continue to accept reimbursement from the health plan at the rates in place prior to the start of the transitional period; and agrees not to seek any reimbursement from the plan member except applicable copayments.
   2. The provider will adhere to the health plan’s policies including, but not limited to, those regarding quality improvement, utilization management and availability of member records.

Within 15 days after the receipt of a member’s completed request for transitional services, the health plan notifies the plan member of the determination in writing. If denied, the health plan will cite a specific reason for denial, which may include a refusal to accept our reimbursement rates, failure to adhere to our quality improvement requirements, failure to provide necessary medical information related to the plan member’s care, or any failure to comply with our policies and procedures.

F. Plan member hold harmless

The Plan Member Hold Harmless clause (outlined in your participating provider agreement) is in accordance with state and federal law. Contracted providers are prohibited from seeking payment from plan members for any covered service with the exception of copayments, coinsurance, deductibles and charges for non-covered services delivered on a fee-for-service basis.

G. My Online Services℠

Coventry is committed to making sure our providers receive the most advanced and latest information, technology and tools available to ensure their success and support their work in caring for our members. To make it easier for them, our members can access their account information online at chcillinois.com and register for My Online Services℠ using the information on their ID card to:

- Manage claims
- Track medications
- Utilize wellness tools (e.g., health risk assessment and personalized digital coaching)
- Schedule and track doctor appointments
- Obtain a copy of their member ID card
- Update personal health record
- Locate a participating provider or pharmacy

To register, members need the following:

- Member number
- Date of birth
- Home zip code
- Email address
- Accept registration agreement
III — PROVIDER INFORMATION

A. Physician responsibilities

1. Comply with the terms of your contract or agreement.
2. Inform plan members, prior to providing non-covered services, that the plan shall not be financially responsible and that the plan member is financially liable for such services.
3. When refusing to provide services for which the plan member believes he or she is entitled, providers are required to notify that member of his/her rights to appeal a decision.
4. Cooperate with the health plan’s quality and utilization management programs, which are designed to assure the appropriateness of health care services that are provided for plan members and to achieve desired health outcomes.
5. Provide, arrange, or coordinate 24-hour coverage for health care services for plan members in accordance with accepted and recognized professional standards.
6. Inform the health plan in writing of any revocation or suspension of your license or certification.
7. Inform the health plan of changes in licensure status, tax identification number, phone number, address, status at in-network hospitals, loss of liability insurance and any other change that would affect your status with the health plan.
8. Provide access to the health plan or its designee to examine the provider’s facilities, books and medical records to assure compliance with any and all obligations required of the provider under the practitioner contract or this manual.
9. Provide accurate and current contact information for your practice.
10. Collect copayments from the plan member, preferably at the time of service. Copayments for office visits and prescriptions are listed on the plan member’s ID card. Aetna applies copayment/coinsurance amounts in all circumstances. It is considered unacceptable billing practice and contractually prohibited for providers to waive a copayment/coinsurance obligation.
11. Provide requested information (e.g. medical records) to the health plan in a timely manner.
12. Submit accurate claims data to prevent the following:
   - Fraud is the knowing and willful deception, misrepresentation or reckless disregard of the facts with the intent to receive an unauthorized payment.
   - Abuse is a practice that, although not considered a fraudulent act, may directly or indirectly cause financial loss. Abuse usually does not involve a willful intent to deceive.
   - Billing error is the incorrect submission of services rendered due to factors such as an uneducated office staff, coding illiteracy, staff turnover, etc.
13. When scheduling care, members should be able to see participating providers according to the guidelines below:
   - **Routine primary care:** within 7 Days
   - **After hours care:** each primary care physician must have a reliable 24 hours a day/7 days a week answering service or machine with a beeper or paging system. A **recorded message or answering service that refers members to emergency rooms is not acceptable.**
   - **Urgent Care:** Urgent care appointments: same day or within 24 hours

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

Credentialing
Credentialing—We use a standard application and a common database called the Council for Affordable Quality Healthcare (CAQH) to gather credentialing information. Our recredentialing process. We reassess a provider’s qualifications, practice and performance history every three years, depending on state and federal regulations and accrediting agency standards. This process is seamless to providers who are due for recredentialing and whose applications are complete within CAQH. We’ll send providers (whose applications aren’t complete within CAQH) three reminder letters. The letters will ask them to update their recredentialing data. If they don’t respond to the letters, we’ll call them. How can I check the status of my recredentialing application? Call our Credentialing Customer Service department at 1-800-353-1232. Adding a new provider to your group: Go to [https://www.aetna.com/health-care-professionals/join-the-aetna-network/how-to-apply.html](https://www.aetna.com/health-care-professionals/join-the-aetna-network/how-to-apply.html)

**C. Physician providing services to family plan members**

A plan member may not choose a family member, member of household or self as a PCP. Any medical service provided to a plan member from a family member, member of household or self is not reimbursed by the health plan. Referrals and/or diagnostic tests ordered by a provider acting as a PCP for a family member, member of household or self are not approved nor reimbursed by the health plan.

**D. Provider sanctions**

Actions by a provider that are not in accordance with health plan policies may result in penalties to the noncompliant provider.

The sanction process is as follows:

- First occurrence: A letter is sent to the provider stating the policy.
- Second occurrence: A call is placed to and a reminder letter is sent to the provider, reiterating the policy and advising of the possibility of a financial penalty for subsequent violations.
- Third occurrence: A warning letter is sent, advising the provider of the scope of the sanction (including possible termination). The health plan negatively remits future claims payments for any charges incurred due to provider’s noncompliance.
- Fourth occurrence: The available information regarding all occurrences is forwarded to the health plan’s medical director to be reviewed in accordance with the corrective action plan.

**E. Process for terminating a provider/patient relationship**

There are times when a provider can refuse service to a patient due to an unsatisfactory provider/patient relationship. Examples of such instances include, but are not limited to:

- A patient being abusive to the provider/and or the provider’s office staff, or behaving disruptively in a provider’s office.
- A patient repeatedly refusing to accept procedures or treatment that an in-network provider recommends or who is frequently noncompliant with the treatment plan.
- A patient absent for multiple appointments without calling to notify the provider.

The provider should notify the health plan in writing that he or she is unable to continue caring for the patient and state the desire to discontinue the relationship and why.

The Provider Relations representative reviews the letter from the provider. If the reason for discontinuation of care is different from the reasons listed above, the representative will involve the health plan’s medical director.

After a decision is made, the Provider Relations representative directs Customer Service to send the plan member a letter to notify him/her that the provider is terminating the plan member’s care. The provider should also send the plan member a letter explaining that the plan member should select another provider and to call Customer Service at 800-431-1211 if [ ]
he or she needs assistance. The provider should also notify the plan member that he or she would only be available to them for the next 30 days for emergencies. The member must select a new provider.

F. Confidentiality statement

To manage our plan member’s health insurance benefits, we may need to view their personal health information. We often use this data to coordinate care, measure quality improvement and process bills correctly. We do not use or release member information without the member’s authorization beyond the routine uses for treatment, payment or other health care operations. A personal representative legally authorized to act on their behalf must give this consent for plan members who are unable to act on their own behalf and are unable to give consent.

We have taken a number of steps to protect our plan member’s personal health information. We protect access to our buildings and computer systems. We restrict access to personal health information to only those employees who need the information to carry out their job duties. These employees are assigned special security levels that give access to this data. Paper documents containing personal health information are destroyed when they are no longer needed. All employees sign contracts agreeing to follow our confidentiality policies. If an employee violates these policies, we take disciplinary action, up to and including, termination of employment.

We continuously measure the quality of care and service that our plan members receive. Whenever possible, we limit the use of data that may identify a plan member. For instance, we may decide not to use names or Social Security numbers. We also only allow a small group of people to access this information.

We require our in-network providers to protect the privacy of our plan members. Providers must demonstrate the following:

- Medical records are never placed where the public can see them.
- Offices are locked when closed for business.
- A policy or procedure regarding privacy of medical information is in place.

When we contract with a company to help manage our plan member’s benefits, the company must agree to our privacy policies. We do not permit any group to contact our plan members for marketing purposes. We do not share any personal health information with employers that act as plan sponsors without certification that the specific protections required by the federal HIPAA Privacy Rule are in place.

G. Changes in practice address or status

The Centers for Medicare & Medicaid Services (CMS) requires Medicare Advantage plans and Qualified Health Plans (QHPs) to maintain accurate directories. Having your up-to-date information allows us to do that.

Please fax or mail any additions, deletions or changes to the Provider Relations department at:
Fax to 800-698-2043 or mail to Coventry Health Care, 2110 Fox Drive, Suite A, Champaign, IL 61820.

Change requests should be submitted 30 days prior to the effective date of the change to ensure that our systems are updated. The health plan must be notified of a change to any of the categories below:

- Tax identification number (need copy of current W-9)
- Office, credentialing or billing address
- Telephone or fax number
- Specialty
- Board certification information
- New providers added to the practice (please allow time for credentialing)
- Licensure (DEA, CDS, state licensure or malpractice insurance)
- Group affiliation
- Hospital privileges
- Adverse actions taken by a hospital, Board of Medical Examiners, managed care organization, or other entity that is responsible to report to the National Practitioner Data Bank
If a provider leaves a practice or plans to change locations, or open a new location, the health plan’s Provider Relations department must receive written notification as far in advance as possible. Providing information before the change occurs ensures the following:

- The provider and practice information is properly listed in the provider directory.
- All payments made to the provider/practice are properly reported to the IRS.
- There is no disruption in claim payments and claims are processed correctly according to the provider’s/practice’s contract.

H. Access to and copying of records

The provider should not bill the plan member or health plan for expenses related to copying medical records in the following circumstances:

- When the records are used in making a determination regarding whether or not a service is covered.
- When the records are requested by a state or federal agency, including the Centers for Medicare and Medicaid.
- When the records are used to assist the plan’s quality improvement, utilization review and risk management programs.

The provider should allow access to all records, books and papers related to professional and ancillary care provided to plan members. The provider must agree to maintain all plan member records for services rendered for at least seven years. These documents should be available for photocopying during normal business hours.

I. Notification to providers

When Coventry Health Care of Illinois has any material changes or modifications to the Provider Manual or updates to the prior authorization requirements (additions or removals), notice will be made in advance of the change. The notification of these changes may be communicated to the provider via fax, email and/or standard mail.

J. External vendors

There may be times when you are contacted by one of Coventry Health Care Inc. or Coventry Health Care of Illinois, Inc.’s third-party contracted vendors. Coventry has contracts with various entities to review high-dollar claims, perform audits for medical necessity, to conduct DRG audits and to review auto or worker’s compensation claims.

IV - QUALITY IMPROVEMENT

The goal of the Quality Improvement program is to facilitate consistent delivery of high quality coordinated member care and service throughout Coventry Health Care by assessing and improving care/service processes and outcomes. The health plan is committed to improving the health of our plan members, expanding the knowledge of our employers, building relationships with our business partners, and increasing the success and satisfaction of our providers. Coventry Health Care of Illinois, Inc. is an NCQA accredited managed care organization that offers a variety of products and services.

Quality standards

Practitioner office site quality

Site Visit--Office site visits are made to network practitioners after receiving a member’s complaint to evaluate the physical accessibility, physical appearance, adequacy of waiting and exam room space related to the settings in which member care is delivered. Standards are set for office site criteria and medical record keeping practices. If a site visit is required for member complaints to evaluate the physical accessibility, physical appearance, adequacy of waiting and examining room space, the medical record keeping practices are also evaluated to assess methods used to maintain confidentiality of member information and for keeping information in a consistent, organized manner for ready accessibility. No site visit is required for complaints regarding availability or medical records keeping. The Coventry Office Assessment criteria are stated in the practitioner agreements and business criteria of the practitioner agreements. The medical record keeping practice standards are stated in the Coventry Medical Record Criteria that are distributed to practitioners.
We use practitioner/provider performance data to improve the quality of service and clinical care our members receive. Accrediting agencies require that you let us use your performance data for this purpose.

**Cultural, ethnic, racial and linguistic needs of members**

The health plan has processes in place to ensure that the cultural, ethnic, racial and linguistic needs of members are met. Examples of functions performed to measure needs:

- Annual review of membership demographics (preferred language, ethnicity, race)
- Local and National geographic population demographics and trends derived from publicly available sources
- Network assessment
- Health status measures such as those measured by HEDIS as available
- Evaluation of member satisfaction survey

**Primary care accessibility coverage requirements**

When scheduling care, members should be able to see participating providers according to the guidelines below:

- **Routine primary care**: within 7 Days
- **After hours care**: each primary care physician must have a reliable 24 hours a day/7 days a week answering service or machine with a beeper or paging system. A **recorded message or answering service that refers members to emergency rooms is not acceptable**
- **Urgent Care**: Urgent care appointments: same day or within 24 hours

**24-Hour physician access**

Health plan members are instructed upon enrollment to contact their primary care provider (PCP) prior to seeking medical care, except in true medical emergencies. To ensure that medical services are available to members at all times, in-network PCP’s must observe the following guidelines regarding after-hours coverage:

1. Maintain a 24-hour answering service so the PCP, or an on-call, in-network PCP may respond to plan members seeking medical care after regular office hours, OR
2. Maintain a telephone-answering device with an outgoing message providing adequate information as to where medical care may be obtained after regular office hours. A hospital or ER should not be used for 24-hour coverage in non-emergent situations. Providers should include a home phone number or the name and number of the provider on-call. An answering machine stating, “I will return your call” is not sufficient, adequate or appropriate coverage.
3. When referring a plan member to a hospital for emergency or urgent care, please be sure to provide a local, in-network hospital if possible.

**A. Preventive Care**

At Coventry Health Care, we encourage members to receive preventive care services. The Affordable Care Act (ACA) requires specific preventive services and drugs to be covered at 100 percent when they are received through participating providers. Members who use our network providers will receive preventive care services and specific drugs paid at 100 percent. *This may vary based on self-funded (ASO) groups benefit structure. Please call Customer Service to verify coverage for preventive care.
Coverage for preventive services

Here are some examples of the preventive services that will be covered with no copay, coinsurance or deductible.

### Child Preventive

- Exams: Preventive office visits including well child care
- Immunizations (vaccines for children, birth to age 18 – doses, recommended ages and populations vary):
  - Influenza (flu)
  - Pneumonia
  - Hepatitis A
  - Hepatitis B
  - Tetanus, Diphtheria, Pertussis (Td/Tdap)
  - Varicella (chicken pox)
  - Measles, Mumps, Rubella (MMR)
  - Polio
  - Rotavirus
  - Meningococcal
  - Human Papillomavirus (HPV)
  - Screening Tests: hearing, vision, phenylketonuria (newborns), sickle cell disease (newborns)
  - Newborn Preventive Treatment: ocular medication against gonorrhea for all newborns

### Adult Preventive

- Exams: Preventive office visits including well woman exam
- Immunizations (vaccines for adults – doses, recommended ages and populations vary):
  - Influenza (flu)
  - Pneumonia
  - Hepatitis A
  - Hepatitis B
  - Tetanus, Diphtheria, Pertussis (Td/Tdap)
  - Varicella (chicken pox)
  - Measles, Mumps, Rubella (MMR)
  - Meningococcal
  - Zoster
  - Human Papillomavirus (HPV)
  - Screening Tests: breast cancer, cervical cancer, colorectal cancer, prostate cancer, HIV, routine blood and urine, cholesterol, osteoporosis

### Clinical practice guidelines

Coventry adopts evidence-based clinical practice guidelines from nationally recognized sources. These guidelines have been adopted to promote consistent application of evidence-based treatment methodologies and made available to practitioners to facilitate improvement of health care and reduce unnecessary variations in care. Coventry reviews the CPGs every two years or more frequently if national guidelines change within the two-year period. CPGs that have been formally adopted can be found on the Coventry Health Care website at www.chcillinois.coventryhealthcare.com. Once on the site, go to Providers > Document Library > Clinical Practice Guidelines.

The CPGs are provided for informational purposes only and are not intended to direct individual treatment decisions. All patient care and related decisions are the sole responsibility of providers. These guidelines do not dictate or control a provider’s clinical judgment regarding the appropriate treatment of a patient in any given case.

### Preventive health guidelines

Coventry adopts nationally accepted evidence-based preventive services guidelines from the U.S. Preventive Services Task Force (USPSTF) and the Centers for Disease Control and Prevention (CDC). Where there is a lack of sufficient evidence to recommend for or against a service by these sources, or conflicting interpretation of evidence, we may adopt recommendations from other nationally recognized sources. These guidelines are available on the Coventry Health Care website at www.chcillinois.coventryhealthcare.com. Once on the site, go to Providers > Document Library > Preventive Health Guidelines. We review guidelines every two years unless updates from recognized sources warrant more frequent review.
C. HEDIS (Health Care Effectiveness Data and Information Set)

The Healthcare Effectiveness Data and Information Set (HEDIS®) is a set of standardized performance measures designed to ensure that the public has the information it needs to reliably compare performance of managed health care plans. The HEDIS measures are related to many significant public health issues such as cancer, heart disease, asthma, diabetes and utilization of preventive health guidelines. HEDIS also includes a standardized survey of consumer experiences that evaluate health plan performance in areas of customer service, access to care and claim processing.

The health plan collects HEDIS data each year (usually in the spring). During this time, select providers’ offices are given a list of plan members with medical records to be reviewed. A health plan nurse schedules a mutually agreeable date and time to review the records, at which point providers are asked to send the requested records to the health plan or pull the charts for review on-site. The provider will be expected to designate a place to conduct the review if the nurse chooses to do so onsite.

HEDIS data collection frequently asked questions:

Why do health plans collect HEDIS data?

The collection and reporting of HEDIS data are required by the Center for Medicare and Medicaid Services (CMS) for Medicare Advantage members. Accrediting bodies such as the National Committee for Quality Assurance (NCQA), and many states also require that health plans report HEDIS data. The HEDIS measures are related to many significant public health issues such as cancer, heart disease, asthma, diabetes and utilization of preventive health services. This information is used to identify opportunities for quality improvement for the health plan and to measure the effectiveness of those quality improvement efforts.

How are HEDIS measures generated?

HEDIS measures can be generated using three different data collection methodologies:

• Administrative (uses claims and encounter data)
• Hybrid (uses medical record review on a sample of members along with claims and encounter data)
• Survey

Why does the plan need to review medical records when it has claims data for each encounter?

Medical record review is an important part of the HEDIS data collection process. The medical record contains information such as lab values, blood pressure readings and results of tests that may not be available in claims/encounter data. Typically, a plan employee will call the physician’s office to schedule an appointment for the chart review. If there are only a few charts to be reviewed, the plan may ask the provider to fax or mail the specific information.

How accurate is the HEDIS data reported by the plans?

HEDIS results are subjected to a rigorous review by certified HEDIS auditors. Auditors review a sample of all medical record audits performed by the health plan, so the plan may ask for copies of records for audit purposes. Plans also monitor the quality and inter-rater reliability of their reviewers to ensure the reliability of the information reported.

Is patient consent required to share HEDIS related data with the plan?

The HIPAA Privacy Rule permits a provider to disclose protected health information to a health plan for the quality related health care operations of the health plan, including HEDIS, provided that the health plan has or had a relationship with the individual who is the subject of the information, and the protected health information requested pertains to the relationship. See 45 CFR 164.506(c) (4). Thus, a provider may disclose protected health information to a health plan for the plan’s HEDIS purposes, so long as the period for which information is needed overlaps with the period for which the individual is or was enrolled in the health plan.

May the provider bill the plan for providing copies of records for HEDIS?

According to the terms of their contract, providers may not bill either the plan or the member for copies of medical records related to HEDIS.

How can providers reduce the burden of the HEDIS data collection process?

We recognize that it is in the best interest of both the provider and the plan to collect HEDIS data in the most efficient way possible. Options for reducing this burden include providing the plan remote access to provider electronic medical records.
(EMRs) and setting up electronic data exchange from the provider EMR to the plan. Please contact your Provider Relations representative or the plan’s Quality Improvement department for more information.

**How can providers obtain the results of medical record reviews?**

The plan’s Quality Improvement department can share the results of the medical record reviews performed at your office and show you how your results compare to that of the plan overall.

## V - MEDICAL MANAGEMENT

### A. Important phone numbers

<table>
<thead>
<tr>
<th>Service</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Service Pre-Authorization Department</td>
<td>866-557-8748</td>
</tr>
<tr>
<td>Health Service Pre-Authorization Fax</td>
<td>800-224-2009</td>
</tr>
<tr>
<td>Customer Service Department</td>
<td>800-431-1211</td>
</tr>
<tr>
<td>MHN Behavioral Health (MHNnet)</td>
<td>800-423-8070</td>
</tr>
<tr>
<td>National Imaging Associates (NIA)</td>
<td>800-642-7835</td>
</tr>
<tr>
<td>Triad Health Care (dba eviCore)</td>
<td>888-584-8742</td>
</tr>
<tr>
<td>New Century Health</td>
<td>877-624-8601</td>
</tr>
<tr>
<td>MedSolutions (MSI) dba as eviCore</td>
<td>888-693-3211</td>
</tr>
</tbody>
</table>

Prior authorization lists can be found on our website at [www.chcillinois.com](http://www.chcillinois.com) and [chcillinoismedicare.com](http://chcillinoismedicare.com) under providers, Prior authorization section.

### B. Prior authorization

The prior authorization process provides a mechanism to ensure that all plan members receive medically necessary services in a timely, cost-effective manner, by appropriately trained and skilled providers and provider organizations. This process also ensures appropriate management of care by consistently applying criteria based on nationally established guidelines for elective procedures to eliminate variability among reviewers. This process also guarantees that the health plan obtains the appropriate information to manage issues related to benefit determination, appropriate site of care, and determination of medical necessity. Additionally, this process gives providers and plan members adequate and timely notification of authorization decisions and alternatives. Copies of criteria used in Utilization Management (UM) decisions can be obtained from directprovider.com.

The health plan requires providers/plan members to request prior authorization for certain services in order for payment to be received. In response to prior authorization requests, the plan evaluates the request for medical necessity (as appropriate) and determines if the service is a covered benefit. Failure to obtain prior authorization may result in non-payment as outlined in this manual and in contracts, and may result in financial liability for the provider. Coventry Health Care of Illinois’ medical management department authorizes services based on medical review at the time the call was made to the Pre-Authorization department. Authorizations determine the level of care for inpatient and outpatient services. Claims are paid according to how Coventry Health Care authorized the service.

Prospective reviews are based solely on the medical information obtained by the Health Services staff at the time of the review determination. The plan may reverse an adverse determination only when the information provided is materially different from that which was reasonably available at the time of the original determination.

Emergencies should be treated without prior authorization. The health plan should be notified of the emergency care given on the next business day. Please note that non-urgent after hours requests will be reviewed the next business day.
1. Prior authorization data requirements

When calling the Pre Authorization Department for prior authorization, please have the following information available:

- Member’s name
- Member’s ID number
- Requested service
- Requesting provider’s name, telephone number and name of caller
- Member’s PCP or attending provider’s name
- Diagnosis and ICD-9 Diagnosis Code, CPT and HCPCS codes
- Supporting history and physical findings if criteria is applicable
- Appropriate test results
- PCP/Specialists evaluation and treatment with dates
- Place of service
- Recent (current) medical chart notes
- Evaluation and anticipated treatment plan for therapies

2. Prior authorization through www.directprovider.com

Prior authorization requests can also be submitted through www.directprovider.com. Prior authorization requests are assigned a number and once the review is completed, the determination notice is sent back to the provider via www.directprovider.com. Additional information available on www.directprovider.com includes:

- Verification of whether or not a service requires prior authorization by CPT code
- Viewing status of an authorization request
- Utilization Management Criteria

3. Specialty referrals

HMO/POS
Members may see in-network providers at any time without a referral. (See Services Requiring Prior Authorization section of this manual for a list of services requiring prior authorization). Coventry providers should refer HMO members to specialists within the appropriate network. If POS members use out of network providers, they receive benefits according to the POS (out-of-network) benefit plan option.

Select and Advanta (PPO), Advanta Value (PPO), and Advanta Select (PPO) PPO
PPO members do not require a referral to see specialists. (See Services Requiring Prior Authorization section of this manual for a list of services requiring prior authorization). PPO members have a strong financial incentive through lower copays, deductibles and coinsurance to utilize PPO in-network providers. Members may choose to utilize out-of-network providers but they’ll face higher out-of-pocket costs. Therefore, Coventry asks all in-network PPO providers to refer PPO patients to other PPO in-network providers.

Coventry Advanta (HMO)
PCPs must refer Coventry Advanta (HMO) members to specialists within the Advanta HMO networks. A referral number is required. Specialists are responsible for confirming they have a referral before seeing these members. Coventry will not retroactively authorize referrals to specialists. NOTE: Please remember that the member is never responsible for obtaining a referral or for hand-carrying a referral number to the specialist’s office.

Coventry Total Care (HMO)/Carelink from Coventry
Coventry Total Care/Carelink from Coventry PCP’s must refer members to specialists within the Coventry Total Care/Carelink from Coventry network.

In all cases, specialists are required to report a preliminary diagnosis and treatment plan to the member’s PCP within two weeks from the date of the first office visit. Two weeks after treatment or evaluation is complete, the specialist is required
to provide the PCP with a detailed member summary. Each intermediate encounter should also engender written communication within two weeks.

5. National Imaging Associates, Inc. (NIA) (Outpatient Imaging Program)

The health plan has an agreement with National Imaging Associates, Inc. (NIA) for advanced outpatient imaging management services. Under the terms of the agreement, the plan retains ultimate responsibility and control over claim adjudication and all medical policies and procedures. The enhanced outpatient imaging program is managed under the terms of your participation agreement. Please go to the website www.chcillinois.com to review the Outpatient Imaging Program Quick Reference Guide and specific program instructions.

The outpatient imaging program applies to commercial HMO/POS, PPO members, as well as members of our Coventry Medicare Advantage product. Prior authorization is required for the following advanced outpatient radiology procedures:

- CT / CTA
- MRI / MRA
- CCTA
- Nuclear cardiology
- PET scan
- Nuclear stress (MPI)
- Stress echo
- Diagnostic nuclear medicine

NOTE: It is the ordering physician’s responsibility to obtain authorization. Providers rendering the above services should verify that the necessary authorization is obtained. Failure to do so may result in nonpayment of your claim.

The health plan initiated protocols as part of our outpatient imaging program to evaluate providers of diagnostic imaging services. The primary purpose of the program’s evaluation protocols is to assure that all advanced imaging providers meet minimum standards required to adequately perform the technical and professional components of these services. Compliance with the medical management program and administrative procedures, including our outpatient imaging program standards for the technical and professional components of these services is a requirement under the terms and conditions of your participation agreement.

While the outpatient imaging program is part of the health plan’s procedures, our radiology management vendor, National Imaging Associates, Inc. (NIA), administers the process in this capacity to review all contracted providers performing advanced diagnostic imaging services. If you perform any diagnostic imaging services, you are required to complete a privileging application.

Outpatient cardiac catheterizations

Effective August 1, 2015, National Imaging Associates (NIA) began managing the authorization process for outpatient cardiac catheterizations for Coventry Health Care of Missouri and Coventry Health Care of Illinois members. Coventry requires prior authorization for non-emergent, outpatient cardiac catheterizations. This includes CPT codes 93452 through 93461. The health plan will still manage authorizations for inpatient and emergency procedures. **Note:** This only applies to fully insured commercial and Medicare members.

Key points to know

- The ordering physician is responsible for getting prior authorization. To do so, go to [www.RadMD.com](http://www.RadMD.com). Or, call **1-800-642-7835** for CHC of Illinois members and **1-800-642-7339** for CHC of Missouri members.
- The facility must ensure that the physician got prior authorization. We recommend that the facility develop a process to ensure that this happens.
- We may deny payment to the physician and facility for procedures done without authorization.
- The member can’t be balance-billed for these procedures.

5. RadMD.com

RadMD.com is NIA’s website where providers can submit authorization requests, review the status and review the clinical guidelines for various tests and procedures. Access to RadMD.com is free, but you first must login and receive a user name and password. For additional information on how to use RadMD.com, please go to NIA’s website at [www.RadMD.com](http://www.RadMD.com).
6. New Century Health (NCH) (Oncology Pathway Solutions Program)

New Century Health ("NCH") manages the Oncology Pathway Solutions program that utilizes clinical guidelines based on nationally recognized, evidence-based criteria for determining medical necessity in cancer care. It streamlines the complex administrative process associated with chemotherapy pre-authorizations. It also allows us to work closely with you and your staff to develop a team approach in delivering quality patient care. The program will allow for peer-to-peer discussions with medical oncologists who have the understanding and background to discuss treatment regimens. The administrative benefits of the program will expedite the authorization review process.

Key features offered by NCH:

- Provider web portal available 24/7/365, offering:
  - Real-time authorizations when selecting evidence-based NCH treatment care pathways
  - Reduced documentation requirements
  - Real-time status of authorization requests
  - Eligibility verification

- Supportive telephonic authorization staff available at 877-624-8601, option 5, available Monday through Friday, 8 a.m. - 8 p.m. EST. Language assistance services available for those who need them.

- Fax authorization requests can utilize one submission form for all regimens

- Pre-certification can be obtained via fax at 877-624-8602

- Quick turnaround on authorization requests submitted via fax or phone.

- Peer-to-peer consultations by medical oncologists

- An NCH provider representative is available to provide support as needed

Prior authorization process

Chemotherapeutic drugs and supporting agents require pre-authorization by NCH if administered in a physician’s office, elective inpatient, outpatient or ambulatory setting. This applies to all Coventry Medicare and Commercial members ages 18 and older. These drugs must be authorized prior to administration. The requesting physician must complete the NCH Chemotherapy Request Form (CTR). To access and submit the CTR:

- Login onto NCH’s provider web portal at my.newcenturyhealth.com, or
- Fax to NCH at 877-624-8602, or
- Call NCH’s Utilization Management Intake department at 877-624-8601, option 5 (Monday through Friday, 8 a.m. – 8 p.m. EST).

Please note: The new prior authorization process applies to services for Coventry members with coverage under both fully insured and Medicare products. It does not include self-funded or Carelink products.

Timeframe for prior authorization requests

Selection of evidence-based regimens or NCH treatment care pathways will grant instant authorization. All other requests will be processed within 72 hours from receipt of a complete CTR. This process may take longer if the request requires verification or additional clinical information.

Duration of drug authorization

Chemotherapeutic and supporting agents, including hematology drugs, may be authorized up to 180 days.
8. Triad Healthcare (dba eviCore healthcare) (Pain Management Program/Large Joint Inpatient and Outpatient Procedures)

Prior authorization requests for pain management and large joint (hip and knee) services are handled by Triad Healthcare Inc. The pain management program applies to commercial HMO/POS, PPO members, as well as members of our Coventry Medicare Advantage products.

For more information, contact Triad at 888-584-8742 or visit the Triad website at www.triadhealthcareinc.com. Hours of operation are 8 a.m. to 6 p.m. Monday through Friday. For a full list of procedure codes for pain management and large joint procedures please visit http://www.triadhealthcareinc.com/cvty/cpt.aspx

9. MedSolutions, Inc. (MSI) dba eviCore

MedSolutions, Inc. (MedSolutions) manages the prior authorization process for radiation oncology services. This applies to all Coventry Health Care of Illinois and Coventry Health Care of Missouri commercial and Coventry Medicare Advantage members. Please note: The new prior authorization process applies to services for Coventry Health Care members with coverage under both fully insured and Coventry Medicare Advantage products. It does not include self-funded products or Carelink/Total Care.

Prior authorization is required for radiation therapy using any of the following modalities:

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

Coventry will continue to manage the prior authorizations for inpatient radiation oncology treatment. The ordering physician is responsible for obtaining prior authorization for outpatient radiation oncology services. The rendering facility must ensure that prior authorization is obtained. Payment to the treating physician and rendering facility will be denied for any procedures performed without the required authorization, as well as for units or fractions exceeding the authorized treatment plan. The member cannot be balance-billed for such procedures.

The Radiation/Oncology Clinical Guidelines are posted at http://www.medsolutions.com/documents/guidelines. This program is designed to work directly with radiation therapy providers to develop a treatment plan which is consistent with the standards developed and accepted by the American Society for Radiation Oncology (ASTRO), the American College of Radiology (ACR) and other nationally recognized cancer networks.

To request a prior authorization, you may use the 24/7 Web Portal (www.medsolutionsonline.com), call (888) 693-3211, or fax a MedSolutions request form (available on Web Portal) to (877) 791-4110.

C. Concurrent review

Concurrent Review is a method for reviewing inpatient medical care at the time the care is being rendered and is conducted through onsite review of the medical record or via telephone with the hospital case managers. Hospitals are responsible for notifying the Coventry Health Care Pre-Authorization Department by telephone, fax, www.directprovider.com or Change Healthcare/Emdeon office of all admissions and observation stays within one business day.

Main objectives of the Concurrent Review staff are:

- Continuously monitoring the medical necessity, level of care and quality of care
- Ensure the efficient management of inpatient days
- Develop discharge plans in conjunction with the provider, member, member’s family and/or hospital discharge planner.
Coventry Health Care utilizes nationally recognized criterions in the review process:

These criteria serve as an objective basis for review decisions and case management. In addition, the Health Services staff, along with the Medical Directors, applies clinical judgment and draws on considerable managed care experience, as consideration is given to co-morbidities/complications and the limitations of the healthcare delivery system for facilitating the management of care with the optimal use of resources. Focus is on providing the appropriate care in the appropriate amount at the most efficient level of service based on individual member.

When a Concurrent Review Coordinator identifies and inpatient stay that doesn’t meet criteria for the level of care being provided, the case is referred to the Medical Director for a determination. In some cases, the Medical Director may consult with a physician advisor within the appropriate specialty. If requested, the Medical Director is available to the attending provider for a peer to peer to discussion.

Determinations and Notifications are usually made within 24 hours of receipt of a complete request.

**D. Case management**

Coventry Health Care members have access to unrivaled Complex Case Management, a collaborative process between Coventry Health Care, the member and their health care provider. Case management is "a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet an individual’s and a family’s comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes.

It is designed to assess, plan, implement and evaluate the services required to meet an individual’s health care needs, using available resources as necessary. This process is aimed at producing the highest quality outcomes in the most efficient, cost-effective manner for both the member and Coventry Health Care.

Our Complex Case Management program is staffed by registered nurses who have an understanding of the case management process, health care management, service delivery, awareness of cultural diversity and community resources and support. Complex Case Managers are encouraged to continue their professional development by obtaining certification as a certified case manager, attending classes offering continuing education credits/certified case management credits and attending relevant seminars.

Coventry Health Care’s Complex Case Management program is a telephonically managed care model, supported by written communication for education or reference. The program is designed to assist members with complex, chronic or catastrophic illnesses to enhance the coordination, continuity, and quality of care. Complex Case Managers focus on:

- Engaging members and building trust through superior customer service
- Collaborating with the member, family, caregiver and provider to ensure they understand and use resources available within Coventry Health Care’s network, as well as understanding their health insurance benefits and any financial responsibility that may belong to the member
- Influencing behaviors through education and ensuring compliance with the provider’s treatment plan

Members who may benefit from Complex Case Management services are identified through Coventry Health Care’s utilization review process and utilization flags. In addition, members are referred for Complex Case Management evaluations from other Coventry Health Care departments such as Disease Management and Customer Service. Members also may be referred for an evaluation by their employer group, Coventry Health Care providers or by self-referral. We welcome referrals from treating physicians to our case management program. You can submit a referral through the toll-free phone number on the member ID card or For more information, please contact: Customer Service toll-free 800-431-1211 8 a.m. to 6 p.m. Monday through Thursday, 8 a.m. to 5 p.m. on Friday. Once we decide that a member is right for case management and the member or caregiver agrees to it, we make an individualized plan. We work with the member, the member’s family, physician(s), and other healthcare professional(s).

**Transplants**

To initiate organ Transplant and New Technology services, physicians must contact the Pre-Authorization Department. The available network for transplant services includes several well-known institutions in the United States of America. It does not include all of the transplant programs at participating network hospitals.
Transplant requests require prior authorization by the Pre-Authorization Department. Actual benefit coverage is subject to all health care coverage provisions, including eligibility status and contractual limitations in effect when services are provided.

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

- Asthma
- CAD
- COPD
- Diabetes
- Heart failure

Our aim is to proactively reach out to members and engage them in managing their health, by emphasizing prevention through education, supporting the physician-patient relationship and reinforcing compliance with their physicians' care plan. Members are identified by various methods including, but not limited to, claims, pharmacy, health risk assessments, physician referral, caregiver referral, or self-referral. To refer a commercial member to a disease management program, call the disease management call Center at 1-800-579-5755. To refer a Coventry Medicare Advantage member, call customer service at 1-866-784-4916.

E. Additional information
Evaluation of new technology
Coventry Health Care evaluates benefit coverage for new medical technologies or new applications of existing technologies on an ongoing basis. These technologies may include medical procedures, drugs and devices. The following factors are considered when evaluating the proposed technology:

- Input from appropriate regulatory bodies
- Scientific evidence that supports the technology’s positive effect on health outcomes
- The technology’s effect on net health outcomes as it compares to current technology

The evaluation process includes a review of the most current information obtained from a variety of authoritative sources including medical and scientific journals, medical databases and publications from specialty medical societies and the government.

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

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

Utilization management medical criteria
Coventry uses the following protocols based on national criteria and reviewed by the Quality Improvement/Utilization Management committee:

- Coventry Health Care corporate policies including, but not limited to, new technology assessments and medical review policies
- Nationally recognized medical management criteria
  - American College of Obstetrics and Gynecology criteria
o Specialty society and internally developed guidelines and policies
o Medicare coverage issues
o National Comprehensive Cancer Network guidelines

The medical criteria used in the decision making process will be provided upon request by contacting the Customer Service Representative number listed on the back of the member’s ID card. Criteria may be viewed on Directprovider.com or a hard copy may be requested...

Peer-to-peer requests

If a provider does not agree with a decision of one of Coventry Health Care of Illinois' Medical Directors, he or she has the opportunity to speak with the Medical Director who made the decision at 314-506-1708. Providers will have 14 calendar days from the date a Commercial denial is issued to ask for a peer-to-peer discussion with a Coventry medical director. This discussion is optional.

Peer-to-peer discussions should occur within 1 business day of the request for a peer-to-peer request. Peer-to-peer requests for external vendors will be handled by the external vendor (i.e. NIA, ICORE, and Triad). For our Coventry Medicare Advantage members, we offer an opportunity for a peer-to-peer discussion before a denial is issued. You’ll receive the right medical director’s information when we call about the intended denial.

Policy for financial incentives

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

Our decisions are based entirely on appropriateness of care and service and the existence of coverage, using nationally recognized guidelines and resources.

We do not pay or reward practitioners, employees or other individuals for denying coverage or care.

Financial incentives do not encourage our staff to make denials of coverage. In fact, our utilization review staff is trained to focus on the risks of members not adequately using certain services.

We do not encourage utilization decisions that result in underutilization.

VI — CLAIMS

A. Submission of claims

Providers should submit claims and encounter data for all services provided to plan members directly to the health plan according to the terms of your contract.

Submit claim or encounter data using the current Centers for Medicare and Medicaid Services (CMS) 1500 form or UB04 form with current CMS coding and according to current CMS billing requirements.

- Do not submit a duplicate claim for payment within 30 days of the original submission.
- Payor ID for electronic claims: 25133
- Mail paper claims to:
  Coventry Health Care of Illinois, Inc.
  P.O. Box 7141
  London, KY 40742
Medicare crossover

There is no need to file the explanation of Medicare benefits (EOMB) and a claim if the EOMB states it was forwarded to the health plan. We receive the claim and payment information directly from Medicare and your claims are processed according to the information that we receive from Medicare crossover.

B. Claim inquiries

Providers' inquiries regarding claim payment should be directed to the customer service at 866-784-4916, Monday through Friday, 8 a.m. – 6 p.m. CST.

Please be prepared to provide the following information to the Customer Service representative:

- Provider's tax ID number
- Plan member's name and ID number
- Plan member's date of birth or age
- Billed amount
- Date of service

C. Electronic transactions

5010 EDI claim format

All claims sent must meet a new set of standards for electronic submission. Change Healthcare/Emdeon, on Coventry's behalf, has implemented special edits to handle some non-5010 data during this transition period that does not exactly cross over to 5010 requirements. These edits will allow Coventry to continue to receive your claims prior to the 5010 mandated date. However, there are a few instances that cannot be handled effectively and may require a change for non-5010 claim submitters. Three of these situations are listed below:

1. Only one 2410 Drug Information Loop can be submitted with a 5010 claim. Any non-5010 claim received with multiple 2410 Drug Information Loops for a single claim line item will be rejected by Change Healthcare/Emdeon.
2. Claims submitted with an "N" for the Release of Information (Loop 2300 CLM 09) will be rejected by Change Healthcare/Emdeon.
3. A Resubmission Reference Number (Loop 2300 REF*F8) must be included on claims submitted with a "7" for the Claim Frequency Code (Loop 2300 CLM05) or Change Healthcare/Emdeon will reject the claim.

Please carefully review all your claim status reports as they may include a new or unexpected rejection that requires correction and resubmission of the claim. In addition to the above three items, please make sure your office has a solution for these key 5010 data changes that were communicated earlier.

5010 claim data changes:

- Billing provider address cannot be a P.O. Box or rural route number
- If a P.O. Box is appropriate for the remit address, it must be sent in the Pay to loop
- Billing provider address and service facility location address must include a nine-digit zip code
- If the patient can be identified by a unique member ID number, the patient is considered to be the “insured.” The patient is reported as the insured in the insured data fields and not in the patient fields. All Coventry Health Care members have unique ID numbers and therefore, must follow this new rule.

EDI acknowledgement and reject reports

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

- **Initial Reject Report (Change Healthcare/Emdeon report Rpt 05 or equivalent vendor report):** Shows claims rejected by Change Healthcare/Emdeon that were not forwarded to the health plan. These claims should be corrected and resubmitted electronically.
- **Initial Accept Report (Change Healthcare/Emdeon Envoy Report Rpt 04 or equivalent vendor report):** Shows that Change Healthcare/Emdeon accepted the EDI claim and forwarded it to the health plan for processing.
Payor Reject Report (Change Healthcare/Emdeon Report Rpt 11 or equivalent vendor report): States why the Coventry health plan rejected the claim. These claims should be corrected and resubmitted electronically when possible.

Monitoring your EDI reports

Please note that claims appearing on the initial reject report have not met the initial clearinghouse criteria approved by the health plan and have not been sent for adjudication. Any claims appearing on this report must be corrected and should be resubmitted electronically as soon as possible to avoid timely filing issues.

Claims displayed on the initial accept report have passed the clearinghouse edits and have been forwarded to the health plan for additional payor editing. Due to the size of this report, a file summary report may be more appropriate to monitor the number of accepted claims.

It is also important to note that a claim can pass the clearinghouse edits and be displayed on the initial accept report, but still be rejected by the health plan. Claims rejected by the payors will appear on the payor reject report. Any claims appearing on this report should be corrected and resubmitted electronically as soon as possible to avoid timely filing issues.

EDI assistance

Your clearinghouse is usually your first point of contact for resolving an EDI issue related to your practice’s clearinghouse.

Change Healthcare/Emdeon tracks all EDI submissions they receive. This information is readily available for 45 days after the submission. Information on older submissions is also available, but must be forwarded to their research division for follow-up. Change Healthcare/Emdeon can be reached at 877-469-3263.

Electronic Funds Transfers (EFT)

Please refer to our website at www.chcillinois.com click on Providers and you will find the document in the Forms section.

D. Claim status information

How to read your remittance advice

Contact Customer Service at 800-562-5792 if you determine an error has been made in claims processing or payment. You can also review claim status at directprovider.com if you have a user ID and password.

Remittance advice

All contracted providers are reimbursed according to their agreement with the plan. Providers receive a remittance advice for all claims that the health plan receives and processes. This includes responses related to claim payment inquiries. Providers may also obtain copies of remittance advices at www.directprovider.com.

Collection remittance advice

When claims are adjusted and there isn’t a positive balance to offset the negative, your account balance is in a negative status. When this happens, you will receive a collection remittance advice. Every claim paid with a positive amount will apply towards the negative balance until it is a positive balance.

You may clear a negative balance by sending a refund to the health plan. Please make your refund check payable to Coventry Health Care of Illinois, Inc. and mail to:

Coventry Health Care of Illinois, Inc.
Finance Department
2110 Fox Dr., Suite A
Champaign, IL 61820
Recovery of overpayments

The health plan contracts with various companies to handle claims issues with overpayments, third party liability issues and Medicare secondary payor issues. If you receive a refund request on behalf of the health plan, please remit the refund as soon as possible.

Providers have 180 days from date on the remittance advice showing claim adjudication to request claim reconsideration. Claims adjusted due to a recovery or due to a refund do not open the request for review period unless an error was made with the adjudication during the recovery/refund adjustment.

Coventry will not request money back (unless otherwise agreed to by both parties) for any claims after twelve months from the last payment date.

Coventry shall have the right to recover payment or retain portions of future payments in the event that Coventry determines that an individual was not an eligible Plan member at the time of service(s), or in the event of duplicate payment, overpayment and/or payment for non-covered services or fraud.

Reimbursements for plans with an HRA, FSA or HSA

Plan members have an option to have their coinsurance and/or deductible paid directly from their HRA, FSA or HSA accounts to the provider once their claim is processed.

For these types of claims, you receive payments via EFT or paper check in the same manner as with your claims. However, they are not on the same checks and remits as your claims. In this case, you receive a separate EFT payment or check along with an Explanation of Payment (EOP). The EOP and check have Coventry Consumer Choice (C3) listed on them. Providers can also log into directprovider.com to review C3 payment EOBs.

Please contact the Coventry Consumer Choice Hotline at 800-722-1758 if you have questions. This information is also available on www.directprovider.com.

E. Coordination of benefits

Commercial insurance

Coventry determines primary insurance coverage based on the following:

- Subscriber coverage is always primary. If a subscriber has two active policies then the policy that has been in effect longer is primary.
- Dependent coverage when two insurance companies cover the individual is based on the birthday rule. Whichever parent’s birth month is first in the year is the primary insurance plan. If both parents birth month is the same, then primary/secondary goes to the date of the month. The above rules apply unless there is a court order in place.

When our health plan is the primary carrier, we compensate network providers according to the terms of their agreement. If a payment does not cover all charges incurred, the provider may submit a claim to a secondary carrier. However, providers may not seek additional compensation for charges from plan members (excluding copayments, deductibles and coinsurance). Please note that prior authorization requirements still apply for a health plan to consider payment as a secondary payor.

When another insurer is the primary carrier, the provider should first seek payment from primary payor. The health plan determines the allowed amount based on the lesser of the primary payor allowed amount or the terms of the provider contract. Copayments, deductibles and coinsurances will be covered first by the health plan. We will pay the balance up to the determined amount as described above. An explanation of benefits (EOB) must be provided in paper or electronic form in order to calculate reimbursement. Please submit the EOB from the primary payor within the timely filing requirements (outlined in your contract) based on the date of the EOB.

Medicare

Providers are reimbursed according to plan member benefits and in accordance with our policies. Providers who accept assignment receive 100 percent of the Medicare-approved amount when combined with Medicare’s payment. Please note that prior authorization requirements still apply in order for the plan to consider payment as a secondary payor.
Credit bank savings

Commercial plan members may be eligible for reimbursement for any plan member liability (i.e., non-covered services, deductibles, copayments and coinsurance) if the plan member is covered by two insurance plans and our health plan is the secondary payor. Credit bank savings are applied to charges that were originally denied to the plan member. The service provided must be a covered benefit under one of the plans, as written in the plan member’s certificate of coverage. The savings for the plan members are calculated on a calendar-year basis and must be used for services received during that year.

Motor vehicle accidents and personal injury claims

For motor vehicle accidents or personal injury claims, it is important to obtain the proper authorizations for reimbursement. When submitting claims, Box 10 must be completed on the CMS 1500. The health plan is required by the state of Illinois to pay and pursue. Do not hold motor vehicle or personal injury accident claims until settled. Please submit claims within the timely filing requirements outlined in your contract and indicate “Auto Accident” or “Other Accident” on the claim.

If you receive payment by a third-party payor, submit claims with payment information to the health plan. Then, the health plan will coordinate payment for any balance due according to our policies and procedures.

Workers’ compensation

Services covered by workers’ compensation are excluded from coverage under the plan member's medical insurance. When submitting claims covered by workers’ compensation to the health plan, Box 10 must be completed on the CMS 1500 form.

If workers’ compensation insurance denies payment for services as non compensable, the appropriate authorizations must be in place for services to be covered under the plan member's medical benefits. All claims filed must be submitted within the timely filing requirements outlined in your contract from the date of the workers’ compensation denial letter.

F. Claim disputes

The provider review policy ensures providers a systematic, timely, and objective process for expressing dissatisfaction regarding an adverse decision made by Coventry Health Care. The provider will be notified of the outcome of the review via remittance advice.

Appeal: A request for review of initial adverse determination made by the health plan.

Provider medical necessity appeal: The provider disagrees with a medical determination where the provider is liable for the charges. The request for review of the adverse determination must be submitted in writing within 180 days of the adverse determination, and include the rational, including clinical grounds, for requesting a review of the adverse determination and a copy of the adverse determination letter.

1. Health Services will review additional medical records and/or supporting documentation.
2. Once the review is complete, there are no further appeal rights available to the provider.

Provider claim dispute: The provider appeals a claim due to denial of payment or due to a health plan administrative policy that may or may not affect the provider's reimbursement. The review is administrative in nature but could become an appeal to be reviewed for medical necessity. For example, provider claim disputes are filed for issues related to timely filing, no authorization on file or the member did not provide correct insurance information at the time of service.

Member appeal: The provider appeals on the member's behalf for a claim that the member is financially responsible for, or for a denied service that the provider believes is medically necessary. Please refer to QI100.37 on how to appeal on behalf of a member.

Reconsideration: Provider submits additional and/or new information regarding an adverse determination within two weeks of the adverse determination date.

Policy/procedure

To request a review of a claims determination, the provider is required to complete and submit a provider request for review form (located in the Document Library, under the Forms section on our website) along with the supporting documentation as outlined below or use the online claims adjustment function on www.directprovider.com.
To request an online adjustment, please submit a reason for the adjustment and the contact field will be auto-populated. A comment box (per claim line) is also available to add additional notes. When you submit your request, you will receive a secure message along with an issue number for tracking purposes. You will receive a response within 48 hours and resolution is completed within 30 days.

The provider has 180 days from the date of a denial or payment of a claim to request a review. Claims adjusted due to a recovery or refund does not open the request for review period unless an error was made with the adjudication during the recovery/refund adjustment. The provider will receive a response from the health plan within 60 days of receipt of reconsideration request. If the documentation warrants claim adjustment, the remittance advice will serve as a notification. If the information provided does not warrant a claim adjustment, the health plan will send a letter to the provider.

Coding dispute

If a provider disagrees with a decision on how a claim was processed based on a code denial, he or she should complete the request for review form (located in the Document Library, under the Forms section on our website) with a written statement describing his/her concerns along with the supporting documentation.

Utilization management policies and procedures

If a provider wants to express his/her general dissatisfaction with a specific utilization management policy and procedure, he or she should submit in writing his/her dissatisfaction with such policy to the Medical Director. The Medical Director reviews the provider's request. The Medical Director then responds to the provider in writing with the health plan's final decision. If the concern is related to a specific member or authorization and the provider wishes to file an appeal on the member’s behalf, please refer to the QI100.37 policy in the Document Library.

Administrative policies and procedures

If a provider wants to express his or her dissatisfaction with an administrative policy that includes issues regarding non-health-care-related decisions (i.e., claims payment policies and operational issues) the provider should submit his or her disagreement with the policy in writing to the Provider Relations Director. Following internal review by the appropriate person(s), the health plan's final written decision is sent to the provider.

Services provided without authorization

If a provider wants to express his or her dissatisfaction with a claim denied due to no authorization, he or she may submit a completed provider request for review form along with supporting documentation.

- HMO/POS claims without necessary authorization on file are denied to the participating provider with no member responsibility. Post service reviews are not routinely provided, due to design of benefit plan and requirements of providers. If there are extenuating circumstances, the provider should include detail on the provider request for review form.
- HMO member that sees a non participating provider will have the claim denied for no authorization and it will be member responsibility. Any requests for review are routed to the Appeals Department.
- PPO/POS claims without necessary authorization on file deny for medical records. The provider should complete the provider request for review form and submit along with the medical records to Coventry Health Care of Illinois, Inc., P.O. Box 7141, London, KY 40742.

Denial of hospital services

If the provider wants to appeal a denied hospital service or bed day, the provider may submit his or her appeal reason in writing, along with hospital records related to the stay. The provider completes the provider request for review form and sends it to the health plan.

Claims denied due to filing time

Health plan contracts include specific timeframes for filing claims. In a situation where a provider notifies us that they have been denied for timely filing, or they have filed a claim, but the claim is not in our system, the provider must present proof of timely filing within 180 days of the denial notice. The following information is required for review:

- Electronic Claims: a copy of the second level report (called a payor acceptance report) is required.
- Paper claims: a screen shot from your claims system detailing the filing dates (dates filed and insurance company name) is required.
Inaccurate or lacking insurance information

Occasionally, a patient does not report accurate insurance information, or any insurance information at all, until after care has been provided. If the patient corrects or provides insurance information within one year of the date of service, file the claim and include a letter explaining the situation, along with proof that the patient has been billed. If our records support this information as well, we will override timely filing and adjudicate the claim.

However, if this occurs one year past the date of service, do not submit a claim. The patient is fully liable for the charges.

G. Reimbursement policies

The health plan follows reimbursement methodology based upon the nationally accepted coding standards (AMA/CPT) and guidelines of the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), Federal Register and contractual policies/procedures. However, there are times when the plan develops its own claim payment policies (outlined below). Claims are adjudicated on a line-per-line basis for calculation of payments and application of plan member benefits.

All contracted providers must agree to participate in and cooperate with the decisions, policies, processes and rules established by our utilization management program, including, but not limited to: prior authorization requirements, concurrent and/or retrospective reviews and evaluations and reporting of clinical encounter data. The health plan maintains an internal appeal procedure for policy or administrative decisions affecting our providers. As stated in the provider’s contract, the provider agrees to abide by all final determinations.

The health plan determines payment for services based on information provided by the hospital or the in-network provider in accordance with the utilization management program. In some hospital contracts, the rate specified shall apply regardless of the licensure of bed or the department in which the plan member receives care.

Prior authorizations must be obtained for all members, even when our health plan is the secondary insurer. If a provider delivers a service that requires prior authorization, but no prior authorization was obtained, the claim for the service is denied for HMO and POS plan members. For PPO plan members, the claim is reviewed to determine whether the service was medically necessary. If that service meets our criteria, the provider is reimbursed and a penalty is assessed to the plan member for failure to obtain a prior authorization. If the service is found medically unnecessary, the provider is liable for the denied charges.

For inpatient hospital stays that do not meet the criteria for medical necessity, the hospital claim is denied. Provider claims for evaluation and management codes during initial hospital care, subsequent hospital care, and hospital discharge services are denied when the entire hospital stay is denied. Also, failure to notify Coventry Health Care of admissions within twenty-four hours of the admission may result in claim denial and/or a financial penalty assessed up to $10,000 per the timely notification policy.

1. After-Hours evaluation and management codes

Coventry Health Care does not allow payment to providers when after-office-hour codes are billed. These codes are considered incidental to the office visit.

2. Anesthesia/conscious sedation

Anesthesia claims must be billed with current anesthesia CPT codes along with the anesthesia time. Claims billed with a surgical CPT code or without the anesthesia time are denied for incorrect billing. For anesthesia claims, one time unit is defined as fifteen minutes. The procedure time is rounded up to the quarter-hour.

The health plan does not reimburse additional money when “physical status” modifiers P1-P6 or qualifying circumstance codes 99100-99140 are billed. If a procedure does not normally require sedation, conscious sedation is only covered when reported by the provider. There must be documentation in the medical record that supports medical necessity for the use of the IV sedation.

3. Anesthesia modifiers

The anesthesiologist or CRNA must bill a modifier to indicate who performed the services, including the person that provided medical direction or supervision of such service as defined by CMS. This modifier should be entered in the modifier field. If the provider fails to bill a modifier, the claim will be denied.
### Mod | Description | Reimbursement rate
--- | --- | ---
AA | Anesthesia services performed personally by anesthesiologists | 100% of contracted unit rate
AD | Medical supervision by a provider: more than four concurrent anesthesia services | 50% of contracted unit rate
QK | Medical direction of 2, 3 or 4 concurrent anesthesia procedures | 50% of contracted unit rate
QX | CRNA Services: with medical direction by a provider | 50% of contracted unit rate
QY | Medical direction of one CRNA by an anesthesiologist | 50% of contracted unit rate
QZ | CRNA Services: without medical direction by a provider | 100% of contracted unit rate

4. **Anesthesia for neuraxial labor analgesia (labor epidurals)**
   The health plan reimburses anesthesia for neuraxial labor analgesia based upon the basic units, plus patient contact time. Neuraxial labor analgesia for CPT code 01967 is reimbursed at five base units plus face-to-face time units. The health plan reimburses up to a total of eight units for planned vaginal delivery and ten units for a delivery that results in a C-section. This applies when the add-on codes 01968 and 01969 are billed with 01967.

5. **Assistant surgeon/co-surgeon modifiers**
   Assistant surgeon services are reimbursed based on modifiers billed as follows:

<table>
<thead>
<tr>
<th>Mod</th>
<th>Description</th>
<th>Reimbursement rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>62</td>
<td>Two surgeons</td>
<td>62.5% of allowed amount for primary surgeon</td>
</tr>
<tr>
<td>80</td>
<td>Assistant surgeon (licensed medical professional)</td>
<td>20% of allowed amount for primary surgeon</td>
</tr>
<tr>
<td>81</td>
<td>Minimum assistant surgeon (unlicensed assistant)</td>
<td>10.5% of allowed amount for primary surgeon</td>
</tr>
<tr>
<td>AS</td>
<td>Assistant at surgery service (non MD/DO)</td>
<td>16% of allowed amount for primary surgeon</td>
</tr>
<tr>
<td>82</td>
<td>Assistant surgeon (when qualified resident surgeon not available)</td>
<td>16% of allowed amount for primary surgeon</td>
</tr>
</tbody>
</table>

- Payment will be made to only one assistant surgeon unless prior approval is obtained
- Payment for an assistant surgeon’s service from a teaching facility is allowed if an -82 modifier is used
- Payment is only allowed for co-surgeons’ (both providers) bills when prior approval is obtained

6. **Average wholesale price (AWP)**
   Coventry Health Care uses Medi-Span as the source for AWP pricing. Medi-Span has been a nationally recognized and widely used publisher of AWP pricing for over 20 years.

7. **Chiropractic services**
   Copayments collected from plan members cannot exceed more than 50 percent of your contractual reimbursement per Illinois state law.
   Benefits for plan members (as defined by the plan member's certificate of coverage) are: musculoskeletal conditions that can be expected to improve with chiropractic therapy through the manipulation of the spinal column and/or other skeletal structures. The medical condition must reasonably be expected to improve with short-term chiropractic treatment.
   - **Spinal manipulation service**: The health plan will follow the CMS diagnosis code list for spinal manipulation coverage and also the requirement of the acute treatment (AT) modifier. Claims outside of these guidelines will be denied.
• **Evaluation and management (E/M) reimbursement:** Initial E/M services will only be covered for patients under chiropractic care. Additional E/M services are reimbursable when a patient presents a new condition.

8. **Consult codes**

Coventry Health Care follows the coding standards that the Centers for Medicare and Medicaid Services ("CMS") have in place for consult codes. Coventry Health Care of Illinois does not reimburse consult codes for providers reimbursed on current year Medicare. This CMS guideline went into effect in 2010.

9. **Copayments**

Copayments apply to office visits billed with an Evaluation and Management code. 

- Obstetrical patients with an office copay benefit, are required to make one copay at the time of the initial visit, and will not be charged additional copayments for subsequent visits.
- It is the responsibility of the provider to collect copayments from members at the time of service. Copayments collected from plan members cannot exceed more than 50 percent of your contractual reimbursement per Illinois state law. Providers are permitted to collect a copay from the patient, even if the service was denied for no authorization or denied for timely filing.

10. **Coinsurance/deductibles**

The member may be liable for coinsurance and/or deductible amounts instead of a copay. In this case, providers are expected to bill the member for the coinsurance/deductible after the plan has processed the claim and calculated the appropriate deductible/coinsurance amounts.

A Qualified High-Deductible Health Plan (QHDHP) requires that a member's deductible is met before the health plan makes a payment (unless such service qualifies as a preventive service). The remittance advice will instruct the provider's office to bill the member directly.

*Note: Based on feedback from the provider community, we have made the decision to allow up-front collections on QHDHP. Deductibles and coinsurance may be collected at the time of service if you are comfortable estimating the contractual allowable for the service being provided. If you choose to collect at the time of service, you are not permitted to turn members away on the basis of an inability to pay at that time. Upon receiving remittance advice and payment from the plan, all payments in excess of the allowable amount under the terms of your agreement must be reimbursed to the member. It is important to note that collecting deductibles and coinsurances at the point of service is not permitted under the standard benefit plan designs (non-QHDHP). Member ID cards clearly identify those enrolled in QHDHP.*

11. **Diabetic management**

- **Diabetic supplies:** Any diabetic patient or a patient with gestational diabetes, who has a Pharmacy Benefit and needs a blood glucose monitor should use LifeScan monitors, such as Ultra Smart®, Ultra2® or Ultra Mini®. The provider may call Customer Service at 800-431-1211 to request a meter for a plan member. The request is then routed to the Fulfillment Center and a prescription for the appropriate meter is shipped to the plan member's home. The plan member may take that prescription to redeem their monitor at any in-network pharmacy.

- **Medical nutritional therapy:** Individual and group diabetic nutritional counseling is covered up to 3 visits for a new diagnosis and up to 2 medically necessary visits following a significant change in condition for the following diagnosis codes billed with the appropriate procedure and/or revenue code.

12. **Durable Medical Equipment (DME)**

The health plan pays the cost of the rental equipment at the contractual purchase price, and the provider deducts up to three months' paid rental charges from the contractual purchase price. The plan never pays more than the purchase price for the rental of an item unless Medicare is the primary insurer. In that case, the health plan follows Medicare rules for rental versus purchase.

13. **Experimental and investigational services**

The health plan evaluates benefit coverage for new medical technology (e.g. medical procedures, drugs, devices) on an ongoing basis. The following factors are considered when evaluating the proposed technology:

- Final approval status from appropriate regulatory bodies.
- Scientific evidence that permits conclusions concerning the effect of the technology on health outcomes.
• Technology that improves the net health outcome, and is as beneficial as any established alternatives.

The evaluation process includes a review of the most current published, authoritative medical and scientific information pertaining to the proposed technology. We obtain information from a variety of sources including applicable medical and scientific journals, medical databases, specialty medical societies and applicable government publications. Plan member benefits do not cover charges incurred for investigational and experimental services. If a provider performs services that are investigational and experimental without notifying and/or without acknowledgement by the plan member that they have no coverage for the services, the provider is responsible for the denied services.

14. Genetic testing

Prior authorization is required for lab tests for the purpose of genetic testing. These services are often excluded benefits, which are only payable when approved in advance. It is important that ordering physicians obtain prior authorization before requesting such services with participating lab vendors.

15. Hospital-acquired condition (HAC) or never events

Consistent with CMS policy, the health plan will not reimburse providers for the extra care resulting from HAC’s listed on the CMS website found at POA/HAC: http://www.cms.hhs.gov/HospitalAcqCond/. In addition, the health plan prohibits passing these charges on to plan members.

16. Hospital readmission policy

Plan reserves the right to enforce CMS guidelines regarding Hospital In-Patient Readmissions based upon 31 day Readmission Reviews*. All admissions that qualify for Readmission Review * under this policy will be evaluated according to Plan guidelines using diagnosis detail present on claims and corresponding medical records for the admissions under review. Plan retains the right to deny claims which qualify as Readmissions either retrospectively through the Readmission Review process or concurrently as part of the Concurrent Review process.

Readmissions are reviewed when they occur during the concurrent review process (in order to perform review, the discharge summary along with medical records may be requested):
• Within 31 days of the initial discharge
• Because of the same diagnosis, or a similar or related diagnosis
• At the same facility

* Readmission reviews

(Rev. 264; Issued: 08-07-08; Effective Date: 08-01-08; Implementation Date: 08-15-08)

Readmission review involves admissions to an acute, general, short-term hospital occurring less than 31 calendar days from the date of discharge from the same or another acute, general, short-term hospital (see §1154(a)(13) and 42 CFR 476.71(a)(8)(ii)). Neither the day of discharge nor the day of admission is counted when determining whether a readmission has occurred.

17. High-dollar review of outpatient and inpatient claims

Claims with approved amounts over $50,000 are subject to high-dollar review. Itemized bills are required for the review. For facility bills, the following items are considered inclusive and are not separately reimbursable:
• Non itemized supplies
• IV nursing care /IV flushes
• Bedside glucose testing by nurse
• Gloves, gowns, syringes
• Reusable minor medical supplies such as bedside commodes, bedpans, urinals, canes, crutches, restraints, walkers
• Injection charges
• Pharmacy charge – profile
• Other identified nursing charges
• Lab draw, venipuncture, capillary draws, heel sticks in ICU/CC; peripheral or central line done by nursing
• Equipment charges, such as feeding pumps, microscopes, anesthesia machine, suction machine and video equipment in surgery
• Personal items such as slippers, lotions, powders, deodorant, admission kits (except MD), toothettes, denture care kits and under pads
Deniable items in an intensive care unit
- Cardiac monitoring, BP monitoring
- Pulse ox monitoring
- Lab draw, venipuncture
- Equipment charges
- IVAC, IMEDS
- Assessment charges
- Any of the above acute care charges

18. Inpatient room and board discrepancy
Inpatient contracts (at are paid at a percentage of billed charges or billed charges are reviewed at the line item level for a match on authorized room and board (RandB) bed level of care compared to the billed RandB bed level of care. If a discrepancy exists between the authorized RandB level of care and the billed RandB, the claims processor will request a review of the authorization based on the medical records from the concurrent review nurse. If there is an error with the authorization, the authorization is updated and claim is sent for processing. If the initial determination was correct, there is no change to the authorization. The provider may appeal adjudication of the claim after payment is received by submitting medical records along with a written statement supporting their argument for the higher level of reimbursement.

21. Laboratory/pathology codes
The health plan pays either the individual tests, or the appropriate panel of tests (depending on which is of least cost) when a CPT code for a panel is available. For example, if a comprehensive metabolic panel (CPT code 80054) is billed, additional charges for the following tests are not accepted, except after medical review of submitted documentation to support the medical necessity of the additional tests for codes 80500-80502.

The plan pays for surgical pathology CPT codes 88300-88399. If the same provider bills for both technical and professional components, no modifier should be used and payment is based on a global fee.

For all other codes, the plan follows the federal RVU database from the federal register to identify procedures that are 100 percent technical, with no professional component (not allowed with -26 modifier). Denials will be sent for inappropriate use of modifier -26. The health plan does not recognize a professional component for any clinical laboratory codes not listed in the federal RVU database.

22. Modifiers
Coventry Health Care requires providers to bill according to CMS standards and to document services in the patient's medical records according to CMS guidelines. Additional information will be requested for certain modifiers via claim line denial on the provider’s remittance advice.
- -25 modifier is used for billing a significant, separately identifiable evaluation and management service by the same provider, on the same day of the procedure, or other service. Anytime an evaluation and management visit code and a procedure are performed on the same day, the -25 modifier must be submitted on the evaluation and management code.
- -33 modifier was developed by the American Medical Association (AMA) to assist in fulfilling an aspect of the Patient Protection and Affordable Care Act (PPACA). The PPACA requires all health care insurance plans to begin covering preventive services and immunization without any cost sharing. These benefits go into effect when employer groups renew or change. Coventry Health Care will allow this as long as the diagnosis billed is a preventive diagnosis. The logic in our system will still use the diagnosis and CPT code to pay a preventive claim. This applies to non-health-care-reform plans in place or those that have been grandfathered in.
- -50 modifier is used to identify bilateral surgical procedures. Claims should be billed as a one line item with a -50 modifier (representing two procedures).
- -51 modifier is used to identify multiple procedures performed by the same provider, on the same patient, in the same operative session. Reductions are made on subsequent procedures by 50 percent. Therefore, it is recommended that providers bill their full fee for each procedure. Submitted codes will be reviewed, and may combine the “unbundled” procedures or provide a more appropriate code according to CPT guidelines and generally accepted coding conventions, including correct coding initiative.
- -54 modifier indicates that the surgeon is billing the surgical care only. It is used when all or part of the postoperative care is relinquished to a physician who is not a member of the same group. The modifier is
appended to the procedure code that describes the surgical procedure performed that has a 10 or 90-day postoperative period.

- **-55 modifier** indicates that a physician, other than the surgeon, is billing for part of the outpatient postoperative care. It is also used by the surgeon when providing only a portion of the post discharge post-operative care. Append the -55 modifier to the procedure code that describes the surgical procedure performed that has a 10 or 90-day postoperative period.

- **-57 modifier** identifies an evaluation and management service performed for the purpose of a decision to perform surgery on the same day as a major surgery. All uses of the -57 modifier with codes other than evaluation and management when no surgery was performed on the same date of service are denied as invalid modifier usage. The health plan pays an evaluation and management code with a -57 modifier and a surgical procedure code if it is determined that the decision for surgery was not made at a visit within the last 30 days.

- **-59 modifier** identifies a distinct procedural/service that is not normally reported together, but is appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate injury. CMS has clarified that the provider should not use the -59 modifier solely based on the fact that the two codes are different procedures/surgeries, which is often stated by a provider on an appeal.

- **-78 modifier** is billed when there is an unplanned return to the operating room by the same physician following the initial procedure, for a related procedure during the postoperative period.

### 23. Multiple surgeries

The policy for the payment of multiple surgeries is as follows:

- When two surgical procedures are done in the same operative session, reimbursement is based upon the highest RVU procedural code (unless your contract states otherwise). The highest RVU procedural code is reimbursed at 100 percent of the fee schedule. The second highest RVU procedural code is reimbursed at 50 percent of the fee schedule. Any additional multiple surgeries are reduced to 25 percent. The -51 modifier is applied to multiple surgical procedural codes based on their descending RVU value.

- Facilities must bill each procedure individually with appropriate charges assigned to each line.

- Authorization rules are applied based on the authorization requirement of the primary surgical procedure based on the federal RVUs. If the primary procedure does not require authorization, the entire surgical claim is paid regardless of the authorization requirements of any of the secondary procedures. If the primary procedure requires authorization and there is not an authorization on file, the health plan denies the entire claim.

### 24. Non-covered services

The health plan does not reimburse for services billed for administrative or legal services, sales tax, or special handling or stat charges. These services are not covered and not billable to the plan member. The provider is responsible for such services.

### 25. Nursing home residents

- Nursing home residents who have a health reason which requires that they be seen by a provider may either go to the provider’s office, or be seen at the nursing home. No authorization is required for the plan to cover visits made by a provider to see a plan member in the nursing home for a health reason.

- In situations where a third party such as the Illinois Department of Public Health, requires a nursing home resident to be seen, the health plan does not reimburse for these types of visits. Our certificate of coverage excludes visits required by third parties. These visits can be billed to the plan member, as this is not a covered service.

- All nursing home stays must receive prior authorization in order for the plan to reimburse the nursing home for the stay. Also, the in-network skilled nursing facility must have a contract for Part B services to be covered by the health plan as the secondary carrier.

### 26. Nutritional counseling/diabetic self-management training

Individual nutritional counseling is covered up to three visits (one date of service per visit) for certain diagnosis such as those listed below. After the third visit, services are denied to the member as not a covered benefit.

- Obesity
- Hypertension
• Hypercholesterolemia
• Heart Conditions
• Group sessions, are not a covered benefit, and are denied to the member

27. Observation
Observation stays up to 24 (twenty-four) hours does not require prior authorization. **28. Obsolete codes**
Due to HIPAA requirements, Central Management Services (CMS) will no longer apply the 90-day grace period when a code is obsolete. The health plan also follows these guidelines:

- ICD-10 CM codes are updated annually in October. The ICD-10 DM codes submitted on claims must be valid at the time the service is provided.
- CPT/HCPCS are updated annually in January. The CPT/HCPCS code on the claim must be valid for the date of service.

29. Obstetrical care
- False labor charges do not require authorization and are payable as billed. Observation charges billed as a labor check will be paid up to five hours without an authorization. These charges are reported using revenue code 720 or 721.
- Obstetrical admissions do not require prior authorization for normal OB deliveries based on the 48 or 96-hour federal law. This applies for DRG’s 765, 766, 767, 768, 774, and 775. Other DRG’s are subject to prior authorization requirements.
- Global obstetrical (OB) care covers routine antepartum (pre-natal), delivery, and postpartum care provided by a physician to a member who has been effective with Coventry Health Care during the entire course of their pregnancy.

30. Office supplies
Supplies that are a normal part of providing services should not be reported separately. If the procedure cannot be done without the supply, then the supply is considered "incidental to the procedure.” All supplies billed with an office visit or office procedure must be reported with the correct HCPCS code. The health plan does not allow payment for supplies and materials purchased by the provider over and above those usually included with the office visit or other services rendered.

31. Oral medication
Oral medications are only covered under the member’s pharmacy benefit and must be obtained at a participating pharmacy.

32. Out-of-network referrals for HMO/POS plan members
- HMO members must have their physician obtain prior authorization for any services provided out of network by a non participating provider. If prior authorization is not obtained, the services are denied to the member
- POS members obtaining services from an out of network provider will be reimbursed at the member’s out-of-network benefit level

33. Pain management
- **Urine drug testing:** Urine drug screenings may be part of pain management contract protocol between a patient and physician. Coventry Health Care will cover an initial screening and random testing up to twice annually. In addition to the initial screening and random screenings, specific testing may be performed when there are medical conditions to suggest the need. All urine drug screenings should be performed by a participating laboratory.
- **Post-operative pain management:** Post-operative pain management is payable when billed by an Anesthesiologist and when billed with modifier -59. Authorization not required as long as the code is submitted in conjunction with a surgical procedure the same day.
34. Private room
Most benefit plans specifically explain private rooms under non-covered items with the statement “charges in excess of the semi-private room rate are not eligible”. This means that private room charges are specifically excluded from standard coverage, unless the patient has a diagnosis that would require them to be placed in a private room away from other patients or the facility only has private rooms.

Private room charges are represented with revenue codes 110-119. If your hospital contract reimburses based off of the DRG billed, then this will not impact the payment if the patient is in a private room.

35. Radiology codes
- Radiology services and radiologists are reimbursed based on the use of the appropriate CPT modifier:
  - Global (technical and interpretation): No modifier required
  - Technical: TC modifier
  - Professional: -26 modifier

36. Spinal surgeries
Spinal surgeries require prior authorization of the procedure and the supplies and/or implants that will be used. Health Services will request this information at the time of authorization and determine the supply/implant coverage. If this information is not provided at time of authorization, the services will be reviewed when the claim is submitted and denials issued to the provider.

37. Telemedicine
Telemedicine, frequently referred to as tele-health, is the use of electronic technologies to provide and support health care services when distance separates the physician and patient. Telemedicine services are medical services provided via telephone, the Internet or other communications networks or devices that do not involve direct, in-person patient contact. There are applicable federal and state regulations governing the practice of telemedicine.

The FDA has defined the term ‘telemedicine’ as the delivery and provision of healthcare and consultative services to individual patients, and the transmission of information related to care, over distance, using telecommunications technologies. Telemedicine also incorporates:
- Direct clinical, preventive, diagnostic and therapeutic services and treatment;
- Consultative and follow-up services;
- Remote monitoring;
- Rehabilitative services; and
- Patient education

When medically appropriate, telemedicine services are covered as written in the member’s Certificate of Coverage. The CPT codes are typically accompanied with a GQ or GT modifier.

38. Wellness/preventive visits
Patients being treated for a preventive visit (immunizations, annual physical, etc.), should be billed with the preventive/general medical examination code as well as the primary diagnosis and all other appropriate diagnosis codes based on member’s conditions.

VII – PHARMACY
For the majority of our employer groups, the health plan is contracted with Express Scripts for the administration of drug benefits. All prescriptions must be written by an in-network provider and filled at an in-network pharmacy to be covered.

A. Pharmacy drug formulary
The health plan has a drug formulary for all commercial plan members. This formulary is developed by the Coventry Health Care Pharmacy and Therapeutics (P&T) committee in conjunction with input from the health plan Pharmacy and Therapeutics (P&T) committee. Medications are arranged into tiers. Tier One drugs include preferred generic and some over-the-counter medications, which are the most economical for your patient. Tier Two medications are formulary,
preferred brand drugs. Tier Three includes non-preferred generic and brand name medications not listed in Tiers One or Two, which are not excluded. Plan members’ copayments may vary depending on the product tier. Specialty medications generally are subject to their own copay/coinsurance amounts depending on formulary status.

Changes to the prescription drug list are based on recommendations from the P & T Committee and modifications may occur quarterly. Changes occur in the following ways:

- Deletions from the formulary typically occur once a year effective each January 1. These are based on reviews of new medications, generic equivalents, and clinical therapies approved by the FDA.
- Additions to the formulary are generally made on a quarterly basis, but can be made anytime throughout the year. These additions are subject to the P & T committee’s decision that the medication’s efficacy, safety, side effects, adverse reactions, second-line therapy and cost-effectiveness profile meets Coventry’s standards.
- Newly introduced medications by the FDA are generally placed on Tier Three and may require prior authorization until the drug is reviewed by the P & T committee. This review process helps ensure that the drug is safe for our plan members.
- Certain newly introduced medications by the FDA may be restricted from coverage until the drug is reviewed by the P&T committee. This review process helps ensure that the drug is safe for our plan members.

The formulary can be obtained on our website www.chcillinois.com.

**How to use the online searchable formulary**

On our website’s pharmacy section, you may find the formulary for pharmaceutical products using several different search methods.

- Searches can be conducted by simply clicking on the appropriate first letter of the drug name under the alphabetical search section.
- A search can be made by drug name using the brand and generic name search option where products are listed by both brand (trade) and generic (chemical) names. Click in the entry box, type the first few letters (e.g. Zoc) or the entire drug name (e.g. Zocor), and click Go.
- Click on the appropriate drug class (e.g. anti-infective agents) under the therapeutic class search section.

Please be aware that some medications require prior authorization (PA), step therapy (ST) or have a quantity limit (QL). Medications labeled as specialty pharmacy (SP) require procurement via our contracted specialty pharmacy, Accredo. Plan members seeking prior authorization for a medication should speak with their provider about covered alternatives or for assistance with the submission to the plan. Forms submitted by plan members cannot be accepted since requests for prior authorization generally involve questions of medical necessity. Forms are to be used by prescribing providers and require the provider’s signature. These forms can be viewed and downloaded from our website www.chcillinois.com (several medication-specific forms can be obtained by calling the Coventry Pharmacy Call Center at 877-215-4098).

**Generic drug policy**

Generic substitution is mandatory if the FDA has determined the generic to be therapeutically equivalent to the brand product. These medications are noted in the formulary. These drugs are covered at a generic (Tier One) reimbursement level and maximum allowable cost (MAC) limits of reimbursement have been defined. If a provider indicates “Dispense as written”, or if a plan member insists on the brand name for a medication listed on the MAC list, the plan member may incur the cost difference between the brand name products and the MAC amount in addition to the appropriate brand copay. For medications that have a very narrow therapeutic window, generic substitution is not required (examples: Coumadin, Dilantin).

**B. Pharmacy prior authorization**

To promote appropriate utilization, certain high-risk or high-cost medications may require prior authorization to be eligible for coverage under the plan member’s prescription benefit. These drugs are designated in the formulary as “prior authorization required”.

The P & T committee establishes prior-authorization criteria. In order for a plan member to receive coverage for a medication requiring prior authorization, the provider or pharmacist should call the Pharmacy call center at 877-215-4100 to request a prior authorization form or obtain it from our website below. The request should be faxed to 877-554-9137. All prior authorization request forms can be found on our website www.chcillinois.com.
C. Quantity limits
Medication quantity limits are established for different reasons. Limits are set because some medications have either a maximum limit recommended by the FDA, or a maximum dose suggested by medical literature. Many commonly used once daily drugs have limits since these drugs are proven to be safe and effective when taken once daily. Additionally, taking two pills daily instead of one pill of equal strength may double the cost of therapy without necessarily improving the health benefit to the plan member. Other drugs are on the list as a safeguard to make sure that plan members do not receive a prescription for a quantity that exceeds recommended dosage limits.

D. Diabetic supplies
Diabetic blood glucose test strips are covered if the employer purchases this benefit. For those plan members, only LifeScan One Touch brand test strips are available on the formulary. Insulin is a covered benefit.

E. Self-administered injectables and other specialty prescription medications
Specialty medications, like self-administered injectables (SAIs), are provided to the patient for at-home use. Other specialty medications include but are not limited to the oral, topical, inhaled and implanted routes of administration. These medications may be limited to a 30 day supply and must be obtained through our preferred specialty pharmacy, Accredo. Copayments are assessed at the time the prescription is ordered. To request prior authorization for specialty medications, including SAIs, providers may download the forms from our website www.chcillinois.com and fax to the Pharmacy Call Center at the number listed on the form.

Covered oncology/transplant drugs
All oncology and transplant drugs are covered for FDA-approved indications. Some may require authorization for coverage.

Anti-retrovirals (HIV/AIDS)
Please refer to the health plan’s formulary as most drugs are covered.

F. Pharmacy network
Members may have their prescriptions filled through the wide network of contracted pharmacies. Please refer plan members to their provider directory for a comprehensive list of in-network pharmacies. Additionally, members may search for a participating pharmacy on our website.

G. Mail order
The health plan provides the convenience of mail-order pharmacy drug purchasing through the Medco Pharmacy (Medco is now a part of the Express Scripts family of pharmacies) for plan members on long-term, maintenance medications. Members can purchase a 90-day supply of medication for one to three copayments, depending on their pharmacy benefit. Prescription drugs that require close monitoring, or drugs that are considered controlled substances by federal or state law, are excluded from the mail order pharmacy program. The lists of medications that are excluded from the mail order program are indicated in the formulary, which can be found on our website www.chcillinois.com.

H. Maintenance drug program
In addition to Express Script’s mail order service, Coventry Health Care members may obtain maintenance medications through pharmacies that are specifically contracted for Coventry Health Care to provide 90-day supply services.

I. Appeal rights
Contracted health care providers may prescribe, recommend or order a medication, but that does not imply that such a medicine is a covered benefit. Deciding whether or not to prescribe a non-covered medication is between the provider and the patient. A denied request for medication coverage indicates that the health plan is not responsible for charges incurred. With the consent of the plan member, you may request reconsideration of a decision on behalf of the plan.
member if you believe this decision was made in error. All requests should be made by calling the Customer Service at 800-431-1211, Monday through Friday, 8 a.m. to 6 p.m. CST, or by writing to the address below:

Coventry Health Care of Illinois
ATTN: Pre-Authorization Department
2110 Fox Drive, Suite A
Champaign, IL 61820

J. Injectable medications

Injectable medications are categorized as a medical benefit unless defined as covered under pharmacy by the Pharmacy department. This benefit includes medications that are administered via a needle or infusion method. The health plan’s injectable benefits are arranged so as to pay either on a third-tier copay structure (non-preferred brand), or as a coinsurance.

Injectable Insulin, Lovenox, Glucagon, Imitrex, methotrexate, heparin, testosterone, contraceptives, and bee sting kits are categorized under the plan member’s pharmacy benefit. Certain injectable medications may be obtained at an in-network pharmacy, unless the medication is required to be obtained at our specialty vendor (Accredo) under the specialty benefit.

Injectable medications are not available through the mail order program, with the exception of insulin vials. Most injectable medications are available through the Coventry Health Care Specialty Injectable Program.

Injectable medications administered in the provider’s office are subject to either an office copay or coinsurance, determined by the member’s plan design.

K. Direct source injectable program

To contain escalating pharmaceutical costs and reduce duplicate payments, some injectables can be purchased directly through a Coventry-designated vendor. Each vendor bills Coventry for the medication dispensed, and contacts the plan member for any copay or coinsurance requirement, leaving you only to bill the health plan directly for the administration of the drug.

Providers may still choose to administer the medication in their office. Certain vendors may be utilized to obtain these injectable medications and all have the capability of furnishing supplies necessary for administration and delivery to your office within 24-48 hours. The pre-authorization department will assist you in coordinating which vendor supplies medications. You may also request that your patients who self-administer injectables have their specialty injectable medications and necessary administration supplies shipped directly to their home.

In addition to the convenience of delivery and the elimination of provider out-of-pocket expenses for these drugs, these vendors are available 24 hours a day, 365 days a year for the following services:

- Call-in or fax prescriptions
- Consultation with an experienced pharmacist specially trained in injectable drugs
- Patient support and service from pharmacists and customer service staff
- Enhanced compliance to prescribed therapy
- Education on injectable drugs and disease states
- Access to nurses and pharmacists for answers to questions about their drug and disease state
- Injectable drug refill reminders and a convenient drug reorder process

VIII. COVENTRY MEDICARE ADVANTAGE

A. Medicare

Medicare is a Federal Health Insurance Program established in 1965 as an amendment to the Social Security Act. It provides hospital (Part A) and supplemental medical (Part B) coverage for people 65 years of age and older, certain disabled people, and those of any age with End Stage Renal Disease (ESRD).
The Medicare Program is administered by The Center for Medicare and Medicaid Services (CMS), formerly Health Care Financial Administration (HCFA), of the U.S. Department of Health and Human Services (DHHS).

B. Coventry Health Care's Medicare Advantage plans

Coventry Health Care has entered into a contract with CMS that authorizes Coventry Health Care (also referred to as MAO, otherwise referred to as Medicare Advantage Organization) to provide comprehensive health services to persons who are entitled to Medicare benefits and who choose to enroll in Medicare Advantage (MA) or (MAO) plans.

Coventry Health Care assumes full financial risk for the continuing health care of the Medicare plan member in return for a prepaid monthly payment from CMS. In receipt of these Federal funds, Coventry Health Care and its contracted entities are obligated to comply with certain laws applicable to the Medicare Program.

Coventry Medicare Advantage plan members may be required to pay monthly premiums to Coventry Health Care for their coverage; however, they must be eligible for Medicare Part A and are required to continue paying their Medicare Part B premiums.

C. Coventry Medicare Advantage Part D (MAPD) plans

Advantra (PPO), Advantra Value (PPO), Advantra Select Plus (PPO), Coventry Advantra (HMO), and Total Care (HMO) are the names of MAPD plans offered by Coventry Health Care and administered by Coventry Health Care of Illinois, Inc. Coventry Medicare Advantage plans includes all of the benefits of original Medicare and Part D (prescription) drug coverage, plus many extras, such as an annual preventive visit, fitness benefits, preventive dental care and more (extra benefits vary by plan). Coventry Medicare Advantage plans are not Medigap policies or Medicare Supplemental Plans.

We are pleased to announce that Coventry Health Care of Illinois, Inc.'s (Coventry Health Care) Medicare Advantage (PPO) has been awarded four and one-half Stars by CMS for 2016. Our Total Care (HMO) was awarded 4 stars.

CMS rates Medicare Advantage plans on a 1-5 star scale, with 5 stars representing the highest quality. Stars score provide an overall measure of a plan’s quality. It is a cumulative indicator of the quality of care, access to care, responsiveness, and beneficiary satisfaction provided by the plan and its’ network providers. We thank you for your commitment to quality and service, as well as for your support to our programs which helps our Medicare members to achieve their treatment goals.

D. Interpreter services

Non-English speaking Coventry Medicare Advantage plan members can request Interpreter Services through the Customer Service Department at 866-784-4916. Upon receipt of a call, the Customer Service Department will connect the member with someone who can assist them with their customer service needs.

E. Claims submission

It is recommended that you submit claims within 90 days from the date of service on a CMS 1500 Form. Coventry Health Care Medicare Advantage has adopted the standard billing guidelines so that completion of the CMS Form is consistent with Medicare guidelines. Please include your NPI number on each claim form submitted.

Mail to: Coventry Health Care Medicare Advantage, P.O. Box 7141, London, KY 40742

F. Plan member input in treatment plan

Physicians should always consider the plan member's input when discussing proposed treatment options. For plan members who are unable to fully participate in their treatment decision, it is the right of those plan members to be represented by parents, guardians, family other conservators. Physicians are expected to educate plan members regarding their health needs, share findings of medical history and physician examinations, discuss potential treatment options (without regard to plan coverage), side effects of treatment and management of symptoms; and to recognize the plan member has the final course of action among clinically accepted choices.

G. Emergent/urgent/out of area services
Emergency care situations

Emergency services for both inpatient and outpatient services are covered if: (1) furnished by a qualified provider and; (2) needed to evaluate or stabilize an emergency condition. Emergency care requires no prior authorization.

An emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate attention to result in (1) serious jeopardy to the health of the individual (or an unborn child); (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

Medically necessary emergency services and post-stabilization care are covered regardless of where a plan member receives treatment, even if they are provided by a doctor or facility that is not contracted to participate in the Coventry Health Care Coventry Medicare Advantage plans.

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

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

Urgent Care situations

Urgent care for plan members is covered within the United States. If possible, plan members are instructed to call their Physician before seeking care. However, if this is not an option, plan members may seek care from a hospital emergency room and should inform their Physician of urgent services they have received within 48 hours, or as soon as possible.

Out of Area situations

Emergent care for plan members is covered whether the need arises in or out of the service area, in the United States and abroad. Services will be authorized to prevent further deterioration of the plan member’s health prior to returning to the service area.

Non-emergent care provided to plan member temporarily out of the service area is subject to the plan member’s out of network benefits. A temporary absence is defined as an absence from the Coventry Health Care Coventry Medicare Advantage service area lasting for 6 months or less.

Renal dialysis services are covered from qualified dialysis providers when the plan member is temporarily absent from the Plan’s service area. The plan member’s physician should coordinate these services. However, no prior authorization is required.

H. Authorizations

PPO plan requires authorizations by the health plan for certain services. Examples of services requiring prior authorization are inpatient admissions, advanced radiology services, some injectable medications, some outpatient surgeries and procedures and behavioral health services. If the authorization is not obtained prior to the service, the claims will be denied for medical records. Health Services will review for medical necessity after the medical records are received.

If plan members use non-plan providers for services they are still eligible for benefits, but their cost share will be higher. Claims for services received without authorization will deny for medical records on initial submission and reviewed for medical necessity upon receipt of the medical records.

Plan members can request prior authorization through the use of non-network providers by contacting Customer Service. If a review is required by a Medical Director, the provider may also be notified by telephone. Denial notices are sent if the services are not authorized.

Coventry Total Care (HMO): A Partnership with SwedishAmerican and Coventry Total Care (HMO): A Partnership with Methodist are HMO plans that requires authorization for services provided by any provider other than the member’s Primary Care Physician in addition to the services requiring prior authorization.

- Referrals from the member’s Primary Care Physician are required for specialty services.
- All services provided by network providers other than the member’s Primary Care Physician require prior authorization.
- Standard prior authorization list applies.
If plan members use non-plan providers for services they have no benefits and will be financially responsible for the charges. Outpatient Surgery services include Cardiac Catheterizations, Stint placement and endoscopy procedures. Coventry Total Care members may utilize any SwedishAmerican affiliated provider for lab services. Copayments apply for lab services as defined on the summary of benefits.

For a complete listing of services requiring authorization, please go to www.chcillinois.com under Prior Authorization.

**Mental health/substance abuse referrals**
Mental Health/Substance Abuse services are covered through MHNet Behavioral Health (MHNet). MHNet has a multidisciplinary team of mental health professionals available 24 hours a day, seven days a week. The phone number for MHNet is 800-423-8070.

**I. Complex case management and disease management**
Coventry Health Care’s complex case management program offers special assistance to members with serious and complex, medical needs and promotes quality of care to reduce the likelihood of extended, more costly health care. Coventry Health Care’s complex case management staff includes experienced registered nurses and social workers who are trained to educate the member and members of the health care team about the health plan benefits, cost factors and community resources so that the informed decisions can be made. The complex case manager is frequently the link between the member, providers, the plan, and the community. They work closely with the member and family as well as the providers to ensure open communication, patient understanding and involvement with the treatment plan. They assist members by getting information and expediting the delivery of services.

**Specialized case management programs offered to members include:**
- Transplant case management
- Condition management – Tele-monitoring program for CHF and COPD
- Advanced illness
- High risk OB
- Breast cancer

**Disease Management (DM) programs offered to members includes:**
- Asthma
- Chronic obstructive pulmonary disease (COPD)
- Congestive heart failure (CHF)
- Coronary artery disease (CAD)
- Diabetes

**Quality improvement programs**
Annual Chronic Care Improvement Programs (CCIPs) and Quality Improvement Projects (QIPs) are implemented and maintained for Coventry Medicare Advantage HMO and PPO members in accordance with CMS requirements. These quality improvement programs are designed and conducted to have a beneficial effect on health outcomes and beneficiary satisfaction.

An annual CCIP is in effect for MA members with chronic conditions to help improve health outcomes and quality of care. Several programs are available to support your patients and to help them make healthy lifestyle choices.

An annual QIP is in effect for MA members and will focus on a significant aspect of clinical and non-clinical care and health disparities to help improve health outcomes, improve satisfaction and quality of care. Programs are available to encourage your patients to get the care and preventive services they need.

**J. Plan member grievance or Medicare appeal process**
The provider shall cooperate and comply with all Coventry Health Care and Medicare requirements regarding the processing of plan member appeals and grievances, including the obligation to provide information within a reasonable
timeframe. Coventry Health Care has established a separate Customer Service Department dedicated to Coventry Medicare Advantage plan members.

The first step of the plan member appeal process begins after Coventry Health Care processes an organization determination on behalf of one of its' plan members. An organization determination is any determination made by a health care provider or by the Plan regarding the receipt of treatment or payment of services. A plan member must receive this determination, whether favorable or a denial, within 14 days of a service request, or within 60 days of a claim payment request, unless an expedited determination is necessary. Please refer to our website for a listing of Medicare Advantra policies.

K. Coventry Health Care Medicare Advantage plan member rights and responsibilities

Upon enrollment, Coventry Health Care presents Medicare members with an Evidence of Coverage that sets forth their rights and responsibilities. The member rights and responsibilities as set forth in the Evidence of Coverage are reproduced below for your information.

Our plan must honor your rights as a member of the plan
• We must provide information in a way that works for you (in languages other than English, in Braille, in large print, or other alternate formats, etc.) To get information from us in a way that works for you, please call the Customer Service phone number on the back of the member ID card.

Our plan has people and free language interpreter services available to answer questions from non-English speaking members. We can also give you information in Braille, in large print, or other alternate formats if you need it. If you are eligible for Medicare because of a disability, we are required to give you information about the plan's benefits that is accessible and appropriate for you.
If you have any trouble getting information from our plan because of problems related to language or a disability, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and tell them that you want to file a complaint. TTY users call 1-877-486-2048.

We must treat you with fairness and respect at all times
You have the right to be treated with respect and recognition of your dignity and your right to privacy. Our plan must obey laws that protect you from discrimination or unfair treatment. We do not discriminate based on a person's race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' Office for Civil Rights 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call us at Customer Service. If you have a complaint, such as a problem with wheelchair access, Customer Service can help.

We must ensure that you get timely access to your covered services and drugs.
• As a member of our plan, you have the right to choose a primary care provider (PCP) in the plan’s network to provide and arrange for your covered services. Call Customer Service to learn which doctors are accepting new patients. We do not require you to get referrals to go to network providers.
• As a plan member, you have the right to get appointments and covered services from the plan’s network of providers within a reasonable amount of time. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

We must protect the privacy of your personal health information
Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.
· Your "personal health information" includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
· The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a “Notice of Privacy Practice,” that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?
· We make sure that unauthorized people don’t see or change your records.
· In most situations, if we give your health information to anyone who isn’t providing your care or paying for your care, we are required to get written permission from you first. Written permission can be given by you or by someone you have given legal power to make decisions for you.
· There are certain exceptions that do not require us to get your written permission first.

These exceptions are allowed or required by law.
  o For example, we are required to release health information to government agencies that are checking on quality of care.
  o Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.

You can see the information in your records and know how it has been shared with others
• You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your healthcare provider to decide whether the changes should be made.
• You have the right to know how your health information has been shared with others for any purposes that are not routine.

If you have questions or concerns about the privacy of your personal health information, please call Customer Service.

L. Quality Improvement Organization (QIO)

The Quality Improvement Organization (QIO), an independent agency, has contracted with KEPRO to review records of the medical care provided to Coventry Medicare Advantage plan members when they register complaints concerning quality of access or to care.

Plan members also have the right to an Immediate Review by the QIO if the plan member believes that they are being discharged from the hospital Skilled Nursing Services, Home Health Services or Rehabilitation Services too soon. When a Notice of Discharge is given to the plan member, the notice is subject to QIO Review.

Coventry Health Care will contact your office to obtain medical records upon Quality Improvement Organization’s request. All reviews will be performed by a board-certified physician of like specialty, who not involved in the original determination, and has no relationship to Coventry Health Care. Please direct any questions regarding the Quality Improvement Organization and the Review Process to our Medicare Appeals department. KEPRO can be contacted at their toll free number 855-408-8557, fax number 844-834-7130, or by writing to, 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609

M. Independent quality review

Coventry Health Care maintains an agreement with the Illinois Foundation of Quality for Health Care, a Quality Improvement Organization approved by CMS. The purpose of this agreement is to focus on the development and implementation of cooperative projects in order to improve the quality of care in the State and to help Medicare risk beneficiaries make informed health care choices. Quality of care includes access, appropriateness and desired outcomes to care and consumer satisfaction.
N. Unique services

Coventry Medicare Advantage offers a more comprehensive benefit package for its plan members compared to Fee-For-Service Medicare, Medigap or Medicare Supplement Plans. Examples of these service enhancements are described below.

- First dollar coverage, no deductible
- Annual out of pocket maximum on copayments and coinsurance for both in-network and out-of network on the PPO
- Annual out of pocket maximum on copayments for in-network on the HMO
- Preventive Care is covered for routine physicals and gynecological examinations
- Part D coverage
- SilverSneaker® - Health club membership and fitness classes

Please note that Coventry Medicare Advantage products have coverage limitations that are different from the Coventry Health Care commercial products. In most cases, the coverage limitations follow Medicare Fee for Service coverage guidelines. Please note: Plan members are subject to the copay indicated on their identification card for certain services.

O. Coventry Health Care advance directive policy

Coventry Health Care believes in the right of the patient to make the appropriate decisions concerning his/her care. We also understand that in some medical situations, that power may not be within the patient’s realm of physical or mental capacities. As a Preferred Provider Organization, we believe in and support a patient’s right to make advance arrangements for the direction of his/her medical care in these instances.


- Living Will
- Health Care Power of Attorney (Durable Power of Attorney)

Coventry Health Care requires each of our network providers to notify and educate the plan member about his/her rights and how to exercise them. The following is the policy followed by Coventry Health Care.

1. Coventry Health Care makes the provision in their Medicare provider contracts to require each provider to inform individuals about their rights.
   - Under state law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to invoke medical care Advance Directives
   - The provider’s policy with respect to the implementation of medical care Advance Directives; and
   - Any policy of the Preferred Provider Organization regarding these rights

2. Any document of medical care Advance Directives executed by the plan member is included at least by copy in the individual’s medical record. Documentation of declination to execute such right will also become a part of the permanent record.

3. The existence of a medical care Advance Directive will not cause or create a change in the provision of care provided or result in any discrimination against the individual because of this choice. This provision shall, not, however, be construed to require care in conflict with the medical care Advance Directives.

4. Coventry Health Care will monitor the compliance of its provider offices by reviewing Advance Directive processes at regular medical record reviews.

5. Coventry Health Care will conduct orientation and continuing education with providers, their staffs and the staff of Coventry Health Care which will include education about Advance Directives. Coventry Health Care will provide written material on Advance Directive rights for the distribution through the medical offices.

6. Coventry Health Care will require each provider to inform each adult plan member about the medical care advance directives in the following situations:
   - For hospital provider, at the time of the patient’s admission
   - For a SNF, at the time of admission
   - At the time of admission to a nursing facility as a resident
   - At the time of arranging for home health care, before the patient comes under the care of the home health provider or
   - At the time of the initial advice on hospice care
Coventry Health Care further believes in the rights of any provider to object to the implementation of medical care advance direction. Those providers are required to inform the patient of their objection, how that will impact the request for medical care Advance Directive and provisions for referral or reassignment to a new physician that has compatible beliefs with the patient.

**P. Accessibility standards**

Coventry Health Care has developed standards for accessibility and availability of physicians for plan members. Although there may be exceptional circumstances, every effort must be made to adhere to these standards.

- Providers must be available for medically necessary services 24 hours a day, seven days a week
- The hours of operation must be convenient and accessible to all plan members regardless of sex, race, or gender
- Minimum of 20 hours each week of regularly scheduled office hours for treatment of patients for a one-physician practice and minimum of 30 hours for a two or more physician practice
- Response time to urgent calls no greater than 30 minutes after notification
- No more than an average of five patients scheduled and seen each hour for routine office visits for adult medicine, and five for pediatrics
- Plan member waiting time for urgent care visits - within 24 hours
- Plan member waiting time for a non-urgent/non-emergency, but symptomatic office visit - not more than one week
- Plan member waiting time for a routine non-systematic office visit - not more than two weeks
- Plan member requesting a routine physical exam - not more than 4 weeks

**Q. Record retention**

As a requirement of Medicare, all providers must maintain for a period of ten years books and in certain instances described in the Medicare Advantra regulation, periods in excess of ten years for more records, documents and other evidence of accounting procedures and practices, physical facilities and equipment and records related to Medicare plan members and any additional relevant information CMS may require.

**R. Risk adjustment payment methodology for Medicare Advantage**

The Balanced Budget Act of 1997 specifically required the implementation of a Risk Adjustment Method Payment methodology. Starting in 2004, Medicare Advantra Organizations will receive a portion of their payment from CMS based on the “health status” of the Medicare beneficiary. The payment model recognizes diagnoses from inpatient hospital data and ambulatory settings.

Based on the Balance Budget Act of 1997, Medicare Advantra Organizations must collect and submit all inpatient hospital, outpatient hospital and physician encounter data to the Center of Medicare and Medicaid Services (CMS) on all enrolled Medicare Advantra HMO and plan members.

Effective July 1, 2002, all encounters submitted to CMS must contain all relevant diagnoses noted during hospital inpatient stays and hospital outpatient and physician visits.

All hospitals and physicians must use current valid International Classification of Diseases - 9th Edition - Clinical Modification (ICD-10-CM) Codes; report all diagnoses related to service performed and justified by medical record documentation and following coding guidelines using the most specific code.

All providers who participate in Coventry Medicare Advantage programs are required to submit complete and accurate claims data and maintain clear, concise and complete medical record documentation practices.

The following procedures have been identified to assist providers in complying with the regulatory requirements of submitting encounter information.

Provider should provide ongoing training to staff regarding appropriate use of ICD-10-CM code set for reporting diagnoses.
Submit all diagnosis that impact patient evaluation, care and treatment:

- Main reason for a visit or admission
- Co-existing acute condition
- Chronic conditions
- Permanent past conditions

Providers should periodically review their claim/encounter data submission to ensure that they are accurate, complete and truthful and are supported by the medical records or other relevant documentation.

Provider should fully communicate diagnosis details to coding staff, so that the visit or admission is coded to the highest level of specificity known.

S. Balance billing plan members

Plan members enrolled in Coventry Medicare Advantage plans do not pay more than plan allowed cost sharing. In situations where providers ordinarily are permitted to balance bill, they must obtain this balance billing from the MAO. The rules for balance billing are listed below by type of provider:

- Contracted provider. There is no balance billing paid by either the plan or the plan member
- Non-contracting “participating provider”. There is no balance billing paid by either the plan or the plan member
- Non-contracting, non-participating provider. The MAO pays permitted balance billing (up to 15% of the Original Medicare rate in the case of physicians’ services); the plan member, only pays plan-allowed cost sharing
- Non-contracting, non-participating DME supplier. The MAO owes the non-contracting non-participating (non-par) DME supplier the difference between the plan member’s cost sharing and the DME supplier’s bill; the plan member only pays plan-allowed cost sharing

A participating provider is a provider that signs an agreement with Medicare to always accept assignment. The MACs post lists of participating providers. Participating providers may never balance bill because they have agreed to always accept the Medicare allowed amount as payment in full. A non-participating provider may accept assignment on a case-by-case basis and indicates this by checking affirmatively field 27 on the CMS 1500 claims form; in such a case, no balance billing is permitted.

T. Coordination of Benefits (COB)

An MAO may contract with employers or State Medicaid Agencies to furnish benefits that complement those that an employee or retiree receives under an MA plan. Some examples of complementary benefits include the following:

- The employer, State Medicaid Agency or an association pays, or is financially responsible, for some, or all, of the MA plan’s basic premiums, supplemental premiums, or cost sharing;
- The employer, State Medicaid Agency or an association provides other employer-sponsored (or State-sponsored) services that may require additional premium and cost sharing; and
- The employer, the State Medicaid Agency or an association purchases a non-Part D drug benefit from the MAO

As provided in section 10.12 these complementary benefits are not within CMS jurisdiction as they are not considered benefits offered by the MAO under an MA plan.

U. Importance of medical record documentation and retention

- Accurate risk adjusted payment relies on complete medical record documentation and diagnostic coding
- CMS annually conducts risk adjustment data validation by medical record review
- The medical record chronologically documents the care of the patient and is an important element contributing to high quality care

Resources - ICD-9-CM Coding

- www.hcfa.gov/medlearn/cbticd9.htm (for a computer-based course on ICD-9-CM)
Providers should safeguard the privacy of the plan member’s medical records. Original medical records should be released only in accordance with Federal or State laws, court orders or subpoenas.

All records should be kept confidential and maintained for 10 years and in certain instances described in the Medicare Advantage regulation, periods in excess of 10 years or more. All plan member information should be available to be transferred upon request by the plan member, or authorized representative, to any organization with which the plan member may subsequently enroll, or to a provider to ensure continuity of care.

Ensure timely access by plan member to pertinent records and information upon request. Plan members can be charged a reasonable fee for copies of records.

The provider must abide by all Federal and State laws regarding confidentiality, documentation on whether or not a plan member has executed an Advance Directive and disclosure for mental health records and medical records.

V. CMS requirements

Please be advised that marketing material communications that promote, communicate or explain the Medicare health plan to Coventry Medicare Advantage plan members require approval by the Center for Medicare and Medicaid Services (CMS). Health education materials are generally not under the purview of CMS marketing review.

The Plan can provide CMS approved materials for you to announce your participation with the Coventry Health Care Advantra program. Please contact the Coventry Medicare Advantage Marketing Department if you are interested in pursuing any communication to plan members of your practice regarding Coventry Medicare Advantage products.

Coventry Health Care Advantra Personal Health profiles

All new plan members are sent a Coventry Medicare Advantage Senior Health Questionnaire within the first 30 days of enrollment. The questionnaire is to be completed by the plan member and sent back to Coventry Health Care.

The form asks the plan member a number of questions specific to the plan member’s medical history, as well as questions about lifestyle. The form is also used to educate plan members about the use of Coventry Medicare Advantage contracted providers and to transition plan members into receiving services from contracted providers.

Coventry Health Care requests that the plan member discuss their Senior Health Questionnaire with their physician. The information from the Senior Health Questionnaire will assist the physician or specialist in providing direction regarding the plan member’s health needs and potential treatment options. This will allow the plan member to participate in the development of their own treatment plan. Coventry Health Care will also assist in the coordination of care for complex or serious disease cases with the plan member’s physician or specialist and will inform plan members of any follow up care and provide training in self-care through the Case Management or Disease Management Program.

W. Laws and regulations

All Plan providers must comply with applicable Medicare laws and regulations, including Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, the Rehabilitation Act of 1973, and other laws applicable to recipients of Federal funds.

Providers should provide services to Coventry Health Care plan members without regard to the race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, or source of payment.

Coventry Health Care's policy, as well as the Federal law, is that no form of discrimination prohibited by law will be permitted on the basis of race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), disability, genetic information, or source of payment, and that all plan members will have access to their medical services at all contracted provider facilities.

Plan member access to care and information from plan providers
Coventry Medicare Advantage plan members have the right to get timely access to plan providers and to all covered services. “Timely access” means that plan members get appointments and services within a reasonable period of time. Plan members have the right to get full information from their doctors when they get medical care. Plan members have the right to participate fully in decisions about their health care, which includes the right to refuse care.

**Disclosure of information**

At the request of the MA Organization or CMS, the provider shall disclose all information necessary to (1) administer and evaluate the program, to include quality performance indicators and information regarding plan members’ satisfaction and (2) establish and facilitate a process for current and prospective beneficiaries to exercise their right to choose Medicare services.

**Continuation of benefits**

Provider shall continue to provide covered services to Coventry Medicare Advantage plan members who are hospitalized on the date the CMS contract terminates or expires or if Coventry Health Care becomes insolvent, through the date of each plan member’s discharge or for the remainder of the period for which the plan member’s Medicare premium has been paid.

**External review**

Provider agrees to cooperate with all independent quality review and improvement organization activities required by CMS and/or Coventry Health Care pertaining to the provision of services for Coventry Medicare Advantage plan members.

**Plan provider termination notice**

The MA Organization must make a good faith effort to notify plan members of the termination of a provider’s contract 30 days before the termination is effective. Providers must follow the termination provision as defined in their Physician Agreement, to ensure timely notification.

**Termination without cause**

The MA Organization and the provider shall provide at least 60 days advance written notice in the event that the MA Organization or the provider seeks to terminate the Physician Agreement other than “for cause”.

**Compliance with Medical Management**

Providers must agree to comply with the Plan’s Medical policies, QI and Medical Management Programs.

**Exclusion of certain persons**

Provider shall ensure that no provider with whom the provider contracts, shall employ or contract for the provision of healthcare with individuals excluded from participation in Medicare. Coventry Health Care will not contract with any Provider for participation in the Coventry Medicare Advantage plan if the Provider has opted out of the traditional Medicare program. Health Plan will monitor the Opt-Out list and will terminate from participation in the Coventry Medicare Advantage plan any provider who appears on the list.

**X. Medicare provider training and education**

Coventry Health Care, Inc. (“Coventry”) is pleased to have the opportunity to work with you as a provider or provider organization in delivering high value services to our members. Our association, particularly in relation to our Medicare product lines, relies on a contracted relationship that establishes your entity as a first tier or related entity. As a first tier or related entity, there are several requirements imposed upon you, some by federal law, some by federal regulations as promulgated by the CMS, and other requirements in light of your contracted relationship with Coventry. As a result, you, your entity, any downstream entities and/or related entities under your direction, and in several cases your individual employees who are assigned to work on Coventry's Medicare business, must complete a number of requirements.

The requirements are summarized below and are applicable to your organization, as well as any of your downstream and/or related entity arrangements.
1. **General Compliance and Fraud, Waste and Abuse ("FWA") Training**
You and/or your organization **must** complete general compliance training. In addition, you must complete the FWA portion of the training unless you are deemed to have met the FWA certification requirements through enrollment into Parts A or B of the Medicare program or through accreditation as a supplier of DMEPOS.

You must provide general compliance training to all of your employees, downstream, and related entity arrangements who are assigned to work on Coventry Medicare business initially upon hire and annually thereafter. You must also provide FWA training, initially upon hire and annually thereafter, to all your employees, downstream, and related entity arrangements who are assigned to work on Coventry Medicare business unless these individuals are deemed to have met FWA certification requirements as described above. In addition, your organization **must** provide either Coventry's Code of Conduct ("COC") or your own equivalent COC to all of your employees, downstream, and related entities who are assigned to work on Coventry Medicare business initially upon hire or contract commencement and annually thereafter.

2. **Reporting mechanisms**
You and/or your organization **must** report compliance concerns and suspected or actual misconduct to Coventry.

3. **Exclusion/debarment**
You and/or your organization **must** ensure that none of its employees or downstream and/or related entities that service Coventry Medicare business are on any of the following excluded persons, sanction and debarment lists: HHS Office of Inspector General (OIG); General Services Administration (GSA).

4. **Downstream and related entity oversight**
You and/or your organization **must** ensure that compliance is maintained by you and/or your organization as well as any of your contracted downstream and/or related entities that service Coventry Medicare business.

5. **Offshore operations**
You and/or your organization **must** ensure that you do not engage in offshore operations for Coventry-related Medicare business without the express consent of an authorized Coventry representative. Offshore operations are usually contractually prohibited by Coventry. Any Coventry-approved offshore arrangements are subject to reporting requirements to alert CMS of these activities and therefore must be reported to Coventry before utilization.

You must access the training and compliance materials mentioned above, along with additional information concerning these requirements, available for you on the Coventry Medicare FDR Training and Education Portal under Provider and Provider Group FDRs. This portal can be accessed through the following URL link: [www.CoventryMedicareFDRs.com](http://www.CoventryMedicareFDRs.com).

Further, if you and/or your organization utilizes downstream and/or related entities to perform Coventry Medicare work or serve Coventry Medicare members, that entity is also responsible for satisfaction of all of the above requirements. Due to the unique nature of the relationship between you and your downstream and/or related entities, Coventry expects that you ensure that they receive these requirements.

You and/or your organization are responsible to ensure that evidence of the effectuation for all of the requirements is developed and maintained. This evidence may be in the form of attestations, training logs, or other means determined by you to best represent fulfillment of your obligations. Please be reminded that Coventry and CMS require records to be retained for a period of 10 years, and that your records must be available to Coventry and/or CMS upon request.

Coventry takes these responsibilities very seriously. If you have any questions or concerns regarding this requirement or if you have difficulty accessing the Coventry Medicare FDR Training and Education Portal, please contact Coventry's FDR Governance personnel at corpcompliance@cvty.com.

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1. A first tier entity is defined as any party that enters into a written arrangement acceptable to CMS with a Sponsor (i.e., Coventry) to provide administrative or health care services for a Medicare eligible individual under Part C or Part D.

2. A related entity is defined as any entity that is related to the Sponsor by common ownership or control and a) performs some of the Sponsor’s management functions under contract or delegation; b) furnishes services to Medicare enrollees under an oral or written agreement, or c) leases real property or sells materials to the Sponsor at a cost of more than $2500 during a contract period. 42 CFR 423.501

3. A downstream entity is defined as any party that enters into a written arrangement, acceptable to CMS, below the level of the arrangement between the Sponsor and the first tier entity. These written arrangements continue down to the level of provider of both health and administrative services.
IX. APPENDIX

1. Contacts and references

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<thead>
<tr>
<th>Department</th>
<th>Phone</th>
<th>Toll Free</th>
<th>Website</th>
<th>Fax</th>
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<tr>
<td>Coventry Medicare Advantage Customer Service</td>
<td>n/a</td>
<td>866-784-4916</td>
<td><a href="http://www.chcillinoismedicare.com">www.chcillinoismedicare.com</a></td>
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<tr>
<td>New Century Health (NCH)</td>
<td>n/a</td>
<td>877-624-8601</td>
<td>my.newcenturyhealth.com</td>
<td>877-624-8602</td>
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<tr>
<td>Coventry Pharmacy Service Center</td>
<td>n/a</td>
<td>877-215-4098</td>
<td><a href="http://www.chcillinois.com">www.chcillinois.com</a></td>
<td>877-554-9139</td>
</tr>
<tr>
<td>Customer Service (for fully insured members)</td>
<td>217-366-1226</td>
<td>800-431-1211</td>
<td><a href="http://www.chcillinois.com">www.chcillinois.com</a></td>
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<td>Customer Service (for self funded (ASO) members)</td>
<td>n/a</td>
<td>866-557-8751</td>
<td><a href="http://www.chcillinois.com">www.chcillinois.com</a></td>
<td>701-250-5394</td>
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<tr>
<td>DirectProvider.com</td>
<td>n/a</td>
<td>866-629-3975</td>
<td><a href="http://www.directprovider.com">www.directprovider.com</a></td>
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<td>MedSolutions</td>
<td>n/a</td>
<td>877-215-4098</td>
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<td>Mental Health Network - MH Net (inpatient and</td>
<td>n/a</td>
<td>800-423-8070</td>
<td><a href="http://www.mhnet.com">www.mhnet.com</a></td>
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<td>National Imaging Associates</td>
<td>n/a</td>
<td>800-642-7835</td>
<td><a href="http://www.RadMD.com">www.RadMD.com</a></td>
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<td>Triad Healthcare</td>
<td>n/a</td>
<td>888-584-8742</td>
<td><a href="http://www.triadhealthcareinc.com">www.triadhealthcareinc.com</a></td>
<td>888-229-5680</td>
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Plan Member ID Cards

All plan members receive their ID cards shortly after enrollment. Members must present their card at the time services are rendered. If a member is a recent enrollee and has not received an ID card, he or she must present a copy of the enrollment form. Each card includes the member’s name, benefit plan type, ID number, group name and number, and the name of the primary care provider (PCP) if applicable. The cards also list the copayments or coinsurance for office visits, prescriptions, outpatient services and inpatient services. Benefits vary among product lines. Therefore, it is important to reference ID card for the correct copayments or coinsurance amount. The ID card also contains important Customer Service phone numbers for each plan, our pharmacy vendor, and our behavioral health vendor.

Sample ID Cards for Coventry Health care of Illinois (CHC) can be found on our website www.chcillinois.com in the document library.

Plan member rights and responsibilities

Did you know that as a member of Coventry you have certain rights and responsibilities? Knowing your rights and responsibilities will help you, your family, your provider, and Coventry ensure that you get the covered services and care that you need.
As a CHC member, you have the right to:
- Receive information about the organization, its services, its practitioners and providers and member rights and responsibilities
- To be treated with respect and recognition of their dignity and their right to privacy
- To participate with practitioners in making decisions about their health care
- A candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage
- Voice complaints or appeals about the organization or the care it provides
- Make recommendations regarding the organization’s member rights and responsibilities policy

As a CHC member, you have the responsibilities:
- Supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care
- Follow plans and instructions for care that they have agreed to with their practitioners
- Understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible

HIPAA overview

In response to the Health Insurance Portability and Accountability Act (HIPAA) (effective April 14, 2003), each plan has modified some business practices relating to privacy which may affect our provider communities. Providers will be affected by these modifications in the following ways:

Contacting us by phone

There will be a caller authentication process in which we will ask your staff to provide your tax ID number, as well as identifying plan member demographic information.

E-mailing Protected Health Information (PHI)

Due to privacy and security considerations, the health plan’s policy does not allow the transmission of PHI by unencrypted e-mail over an open network (e.g. standard e-mail). Although we cannot prevent your office from sending e-mails containing PHI, we do discourage it and may not be able to respond via e-mail. When sending PHI, the health plan relies primarily on secure means of communication such as fax and U.S. mail. The plan continues to investigate and implement other secure communication measures as appropriate.

Personal representative

The health plan allows personal representatives—individuals that have been granted legal authority under state law—to assist members by acting on their behalf and/or accessing their personal health information.

Plan member designated individuals

A plan member may also provide written permission to have the assistance of one or more designated individuals in the handling or resolution of questions regarding health care benefits or payments. All calls between the plan and the plan members’ designated individuals are subject to the caller authentication processes.

Claim inquiries

As a continued policy, we do not divulge the diagnosis billed on a claim to plan members or providers. Any plan member’s questions related to a diagnosis are redirected to their provider. Likewise, any provider’s office that requests diagnosis or procedure code information from the submitted claim is asked to contact their billing office.

Provider appeals

Regardless of the type of appeal (written, expedited, or peer-to-peer reviews), both our organization and the provider’s office should exchange the minimum amount of individually identifiable health information necessary to process the review or appeal.
Face-to-face meetings

Please limit the amount of claims given directly to the Provider Relations representative during on-site visits. Utilizing postal mail and/or fax transmissions reduces the risk involved with an employee transporting individually identifiable health information. Mailing claims to the claims address usually allows for faster processing.

Audits of patient's medical records

On an ongoing basis, we conduct quality improvement (QI) activities as required for licensure and accreditation purposes (e.g., NCQA, HEDIS reporting, etc.). We also conduct utilization management (UM) activities to ensure that we continually provide the best quality service to our plan members. As part of our QI and UM processes, the health plan performs periodic audits and requests medical information.

These audits and/or requests may include the review of randomly selected medical records for patients that are current or former plan members of our health plan. These records may be maintained by the provider, and are required of the health plan for licensure and other purposes by both state and federal regulatory bodies, including state insurance departments.

The HIPAA Privacy Rule allows providers to disclose PHI to the health plan, and allows the plan to audit medical information maintained by providers. The health plan only makes requests as allowable under the Privacy Rule of HIPAA. We also only request the minimum amount of information necessary to accomplish the task at hand.

In accordance with the provider contract with Coventry and applicable laws and regulations, participating physicians and other health care professionals are required to treat personal health information (PHI) as confidential. PHI includes: identity of the individual; the relationship of the individual with Coventry; physical or behavioral health status or condition; and payment information for the provision of health care. Coventry established medical record criteria to provide a guideline for fundamental elements of organization, documentation of diagnostic procedures and treatment, communication and storage of medical records. These criteria are applicable to all benefits plans. Performance goals are established to assess the quality of medical record-keeping practices, and audits are conducted no less than every two years. Coventry's performance goal is 85 percent compliance.

In the provider agreements with Coventry, participating physicians and other health care professionals agree to maintain medical records in a current, detailed, organized and comprehensive manner in accordance with customary medical practice, applicable laws and accreditation standards. This requirement survives the termination of the contract, regardless of the cause for termination. You must keep our members’ information confidential and stored securely. You must also ensure your staff members receive periodic training on member information confidentiality. Only authorized personnel should have access to medical records. Coventry has the right to access confidential medical records of Coventry members, for the purpose of claims payment, assessing quality of care, including medical evaluations and audits, and performing utilization management functions. Medical records may be requested as a part of Coventry’s participation in HEDIS. HIPAA Privacy regulations allow for sharing of personal health information (PHI) for purposes of making decisions around treatment, payment, or health plan operations.