This manual is specific to Coventry Health and Life Insurance Company

Payors for First Health products provide their administrative services and documentation independently from this manual. For additional company information, please refer to the quick reference guides.
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1. Introduction

Welcome

The goal of Coventry Health and Life Insurance Company (Health Plan) is to develop and sustain strong, mutually beneficial relationships with our providers and their office staff. We appreciate your participation in our networks and welcome and encourage your comments.

History

Coventry Health and Life Insurance Company is a wholly-owned subsidiary of Coventry Health Care, Inc. (Coventry). Coventry is a national managed health care company based in Bethesda, Maryland, operating Health Plans, insurance companies, network rental service companies and workers' compensation services companies. Coventry provides a full range of risk and fee-based managed care products and services, including HMO, PPO, POS, Medicare, Medicaid, workers' compensation, auto and network lease products to a broad cross-section of employer and government-funded groups, government agencies and other insurance carriers and administrators in all 50 states as well as the District of Columbia and Puerto Rico. On January 28, 2005, Coventry acquired First Health Group Corp. (First Health). The acquisition combines Coventry’s strength in operating local Health Plans with First Health’s national provider network and administrative expertise. The combined entity has built upon Coventry’s longstanding practice of providing customer service and improving quality of care at the local level. The national parent provides centralized expertise in areas such as technology, training and administrative support.

Vision Statement

We intend to revolutionize the health care industry in our markets through innovation, quality performance and commitment to our customers and constituents. Our aim is to offer products and services that will responsibly improve the quality of life of all we serve. We will conduct business affairs in an ethical and financially prudent manner through employee development, involvement and empowerment, while demonstrating compassion to our members and setting a standard for others to achieve.

Purpose of this Manual

The purpose of this manual is to answer important questions about administering health care services to members. The manual describes administrative policies and procedures, as well as other pertinent information. From time to time, it will be necessary to update this manual. Please check our website, www.chcoklahoma.com, for the latest version. Any significant changes will be communicated.

This manual is specific to Coventry Health Care’s Oklahoma service areas. 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.
Compliance and Ethics Program

The Health Plan is dedicated to conducting its business in accordance with the highest standards of ethical conduct. We are committed to conducting business activities with uncompromising integrity and in full compliance with the federal, state and local laws governing its business. This commitment applies to relationships with shareholders, customers (enrollees, federal providers, state and local governments), vendors, competitors, auditors and all public and government bodies. Most importantly, it applies to directors, officers, employees and representatives of our company.

It is the responsibility of every Health Plan employee to uphold high ethical standards that exemplify professionalism and promote confidence in the organization. Furthermore, all entities of the Health Plan shall conduct business in a manner consistent with the company’s reputation as leaders in the health care industry.

Who to Contact for More Information

Customer Service Center
Coventry Health and Life Insurance Company 866-219-7695
Coventry Pre-certification 877-837-8914
Coventry RX Prior Authorization 877-215-4098
First Health 800-937-6824
Mental Health Network 866-607-5970
Coventry Workers’ Compensation Services www.coventrywcs.com 800-937-6824
Coventry Auto Solutions www.coventryautosolutions.com 800-793-6074

Provider Relations
Oklahoma City Provider Inquiries 405-945-1236
Tulsa Provider Inquiries 918-747-6697
Toll Free 866-219-7659

Contracting
Oklahoma City 405-945-1228
Tulsa 918-712-4357

Marketing
Oklahoma City 405-945-1201
Tulsa 918-712-4354

2. Administrative Procedures

Overview

This section details administrative procedures for the Health Plan’s product. The information provided describes claims processing, member billing and identifies the Health Plan and provider responsibilities.
**Provider Accessibility Standards**

To assure the best service possible for our members, we ask you to adhere to the following standards for appointment scheduling, availability and waiting time. Although there may be exceptional circumstances, every effort must be made to adhere to these standards.

<table>
<thead>
<tr>
<th>Access Standard Description</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hours of Operation</strong></td>
<td>• 20 regularly schedules hours per week for a one-physician practice</td>
</tr>
<tr>
<td></td>
<td>• 30 hours per week for a two-physician practice (or more)</td>
</tr>
<tr>
<td><strong>Medically Necessary Services</strong></td>
<td>• 24 hours per day, 7 days per week</td>
</tr>
<tr>
<td></td>
<td>• If unavailable, coverage should be arranged through a Coventry provider</td>
</tr>
<tr>
<td><strong>Routine Office Visit—Non Symptomatic</strong></td>
<td>• Within 30 days</td>
</tr>
<tr>
<td><strong>Routine Physical</strong></td>
<td>• Within 30 days</td>
</tr>
<tr>
<td><strong>Urgent Care Visit—Symptomatic</strong></td>
<td>• Within 24 hours (depending on severity of symptoms)</td>
</tr>
<tr>
<td><strong>Emergency Care Visit</strong></td>
<td>• Immediate</td>
</tr>
<tr>
<td><strong>OB Access</strong></td>
<td>• 1st and 2nd trimester: 1 week</td>
</tr>
<tr>
<td></td>
<td>• 3rd trimester: 3 days</td>
</tr>
<tr>
<td><strong>Provision of After-hours Services</strong></td>
<td>• Sufficient to maintain 24-hour-per-day, 7 days-per-week coverage</td>
</tr>
<tr>
<td><strong>Telephone On-hold Time During Office</strong></td>
<td>• Less than 5 minutes</td>
</tr>
<tr>
<td>Hours (waiting to speak to a receptionist)</td>
<td></td>
</tr>
<tr>
<td><strong>Response Time to Urgent Telephone Call</strong></td>
<td>• Within 20 minutes of notification</td>
</tr>
<tr>
<td>from Member</td>
<td></td>
</tr>
<tr>
<td><strong>Waiting Time in Office</strong></td>
<td>• Reasonable for Scheduled Appointment, e.g., 30 minutes</td>
</tr>
</tbody>
</table>

Coventry utilizes the various methods to monitor and verify the above requirements are being met on an ongoing basis: on-site office review; member complaints; random telephone surveys; and customer satisfaction surveys (CAHPS).

**Billing Members/Copayments**

Participating providers may not seek payment directly from members, except for required copayments, annual deductibles or coinsurance. Providers should collect fees for any non-covered services directly from the member. Providers should not collect for health care services or benefits determined to be not medically necessary, unless the member has agreed in writing prior to the delivery of the service. Providers should not balance-bill the member for the difference between the contracted amount and the total billed charges.

**Copayments**

Copayments vary according to the member’s particular benefit plan. Refer to the member’s identification card.

Each member’s identification card indicates the amount of copayment the member is required to pay. The member is responsible for only one copayment per office visit and is responsible for paying the copayment to Participating Providers at the time of service.
Questions regarding the member’s copayment, annual deductible, coinsurance or non-covered service should be directed to the Customer Service Operations (CSO) at 866-219-7695.

**Failure to Pay Copayments**
If a member has a history of not paying copayments, or the provider consistently finds it difficult to collect from the member, the Provider should contact CSO at 866-219-7695.

**Out-of-Pocket Maximum**

An out-of-pocket maximum is the amount of covered expenses, which must be paid each calendar year by a member before the payment percentage of the Health Plan increases. The individual out-of-pocket maximum applies separately to each member. The family out-of-pocket maximum applies collectively to all members in the same family. The Health Plan will pay 100 percent of the allowable (except for copayments and the charges excluded, including the PPO discount) for any covered family member during the remainder of the year.

Some services that are excluded from applying towards the annual out-of-pocket maximum include copayments, deductibles, prescription copayments mental healthcare services and non-covered services.

Contact CSO for specific information on copayment and benefit maximums at 866-219-7695.

**Claims**

**Submission of Claims**
Providers shall submit claims and encounter data for all office visits and other services regardless of the method of reimbursement. Submit claims for covered services directly to the Health Plan according to the terms of your contract. Do not submit a duplicate claim for payment within 90 days of the original submission.

Unless otherwise directed by the Health Plan, submit claim or encounter data using the current centers for Medicare and Medicaid Services (CMS) 1500 forms or UB92 form with current CMS coding, current International Classification of Diseases, current ICD version available and current Procedural Terminology Fourth Edition (CPT4) coding. Also include the following information:

- Patient name
- Patient identification number and suffix
- Provider name
- Provider federal tax identification number
- Procedures and diagnosis using CPT-4, HCPCS, and current ICD codes

All services performed on the same day, should be submitted together as one claim.

Inpatient services should not be billed prior to discharge, except when the stay is 60 or more days.

Upon receipt of a clean claim, the Health Plan shall make payments to the participating provider in accordance to the terms of the agreement.
See the Quick Reference Guide regarding claims submission addresses (www.chcoklahoma.com).

When an incomplete claim is received, the claim will be denied and the remittance advice will state what information is needed in order to reconsider the claim.

The Health Plan requires appropriate documentation and coding to support payment for covered services. The provider shall have the opportunity to correct any billing or coding error within 30 days of the denial related to any such claim submission. The Health Plan shall have the right to recover payment or retain portions of future payments in the event that the Health Plan determines that an individual was not an eligible member at the time of services, or in the event of duplicate payment, overpayment or payment for non-covered services or fraud.

When the Health Plan is not the payor, the Health Plan shall have no obligation and liability with respect to any claim or fee for health care services rendered.

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**Medical Record Review Guidelines**

1. Medical records are stored in a secure manner that allows easy retrieval and access by authorized staff only.
2. Each page must contain member’s name or member ID number.
3. Personal/biographical data includes address, employer, home and work telephone numbers and marital status.
4. All entries must contain author identification with a signature.
5. All entries must be dated.
6. The record is legible to someone other than the writer.
7. Significant present and past illnesses and medical conditions including surgeries are indicated on the problem list.
8. A list of current medications is located in current progress notes, or on Problem or Medication list.
9. Medication allergies and adverse reactions must be prominently noted in the record at the first visit. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record.
10. Past medical history (for patients seen three or more times) is easily identified and include serious accidents, operations and illnesses.
11. For patients 14 years and over, there is appropriate notation concerning use of cigarettes, alcohol and substance abuse (for patients seen three or more times) in accordance with Coventry’s preventive health guidelines.
12. If the member is a smoker, there is documentation that the member was advised to quit smoking (counseling for smoking cessation).
13. The medical record documents appropriate subjective information for presenting complaints, (i.e., description of presenting symptom, review of past medical history appropriate to the presenting complaint and review of symptoms appropriate to the presenting complaint).
14. The medical record documents an appropriate physical examination for the presenting complaints of each visit.
15. The medical record documents appropriate vital signs for the presenting complaints of each visit.
16. Unresolved problems from previous visits are addressed in subsequent visits. Problems that should be addressed include: major health problems within the past 6–12 months and acute, minor health problems within the past 1–2 months.
17. Lab, x-ray and other diagnostic studies are ordered as appropriate for presenting symptoms and/or comprehensive exam.
18. Working diagnoses are consistent with findings, (i.e., specifically documented and consistent with physical exam).
19. Treatment plans are consistent with diagnoses, (i.e., instructions to patient are specifically documented).
20. Encounter forms or notes have a notation, when indicated, regarding follow-up care, calls or visits. The specific time of return is noted in days, weeks, months or PRN.
21. Review for under and over-utilization of consultants.
22. If consultation is requested, there is a note form the consultant in the record that shows review by the PCP.
23. Consultation reports requiring action and abnormal lab, x-ray and other reports have an explicit notation in the record of follow-up plans.
24. There is documentation that the provider is ordering or recommending age appropriate preventive health screenings (e.g., colonoscopy for age 50 and above, mammograms for females age 40 and above, appropriate immunization records, etc.). If the patient refuses the services, there is documentation of counseling/education provided along with reason services were refused.
25. For Coventry Medicare Advantage members (age 65+), there is documentation that indicates whether or not the member has executed an advance directive. Advance directives are written instructions, such as living wills or durable powers of attorney for health care, recognized under state law and signed by a member, that explain the member’s wishes concerning the provision of health care if the member becomes incapacitated and is unable to make those wishes known.

Electronic Claim Filing

We encourage providers to file claims electronically. Accurate electronic submission can reduce the claim resolution time and eliminate the potential for data entry errors. The Health Plan accepts electronic claims for all our products through Direct Provider and Emdeon (WebMD/Envoy).

Emdeon, on behalf of the Health Plan, verifies that all EDI claims contain the required data elements such as billed amount, procedure codes, tax ID number, etc. The process also checks for coding validity.

It is very important to assure that the correct member ID number is submitted. If there cannot be a systematic match of the member’s eligibility record, the claim will not be accepted. The key component of member selection is the member’s 11-digit member ID number. Correct date of birth is also important. Newborn claims are generally not good candidates for electronic submission, as it is common for the claims to be received prior to the baby’s eligibility being added to the system.

In order to assure the most accurate provider record match, claims should be submitted with the Medicare National Provider Identifier (NPI) or other agreed upon provider number. The correct field for this number is:

- Box 33, NPI# field for Health Care Financial Administration (HCFA) submission
- Box 51, provider number for UB92 submissions
The following types of claims **cannot** be submitted electronically:

- Claims with homegrown or invalid CPT/revenue codes or modifiers
- Anesthesia claims
- Claims with more than 38 lines of service
- Claims older than 365 days
- Claims with attachment documentation
- Specialty claims such as pharmacy, workers’ compensation and coordination of benefits

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**Emdeon Office**

Emdeon Office is a single, easy-to-use solution providing instant connectivity to a universe of commercial and government payors. Emdeon Office interfaces with the provider's existing management system and runs on a PC using standard internet browsers. The privacy of transactions is protected with the highest level of internet based security. Emdeon Office is HIPAA-compliant.

**Who benefits?**

Hospitals business offices, provider practices, billing services and ancillary providers who:

- Have or can acquire internet access
- Have a need to improve office staff efficiency
- Have a significant number of the Health Plan patients
- Deals with multiple payors

**Transactions available on Emdeon Office**

- Patient eligibility
- Claims inquiry
- Provider lookup
- Authorization submission
- Authorization inquiry
- Electronic remittance advice

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**Directprovider.com**

DirectProvider.com is a secure portal that offers providers better transactions, broader content and more useful information. The portal is a one-stop, self-service tool for providers designed to deliver another alternative channel for faster service and lower costs. The portal offers

- Secure access
- Viewable remittances
- Claim inquiry
- Claim history, including information about receipt, processing and adjudication of a claim
- Claim level rejection, claim editing and resubmission
- Eligibility inquiries, including benefit information
• Electronic funds transfer and payment inquiry
• Medical management technology assessment tools
• Secure messaging between providers and Health Plan

Announcements for updates and future enhancements can be found on www.chcoklahoma.com.

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**Fee Schedule Distributer**

Detailed fee schedule maximums can be obtained from the Fee Schedule Distributor available through DirectProvider.com. If you need assistance in obtaining access to DirectProvider.com or need assistance in using Coventry’s fee schedule distributor tool, please contact our service center at 800-937-6824, option 3. If your office has never used the DirectProvider.com application, then the service center can assist you in getting an administrator login for your practice.

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**Inquiries about Claims**

Provider inquiries regarding claims payment should be directed to CSO at 866-219-7695. Please be prepared to provide the following information to the customer service representative:

- Patient’s name and ID number
- Patient’s date of birth or age
- Date of service
- Description of service
- Billed amount

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**Policy for Financial Incentives**

At Coventry, we are committed to ensuring appropriate health services for our members. We support open communication between our members and their doctors regarding treatments that may or may not be medically appropriate or necessary. Utilization decisions are based solely on the appropriateness of care and service and the existence of medical coverage. Financial compensation to our Health Services staff and consultants is completely independent of the quantity and types of decisions they make. Our employees do not receive rewards for issuing denials, nor do they receive financial incentives to make decisions that otherwise limit medically-necessary care.

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**Pharmacy**

For the majority of our employer groups, the Health Plan has contracted with Express Scripts (formerly Medco) for the administration of drug benefits. All prescriptions must be written by a participating provider and filled at a participating pharmacy.
Formulary Policy

The Drug Formulary is the foundation of drug therapy quality improvement and cost containment efforts in managed care organizations. Its purpose is to optimize patient care through rational selection and use of drugs and to ensure quality plus cost-effective prescribing. The drugs included in this formulary support that goal.

The formulary can be obtained at www.chcoklahoma.com

How to Use the Online Searchable Formulary

Within the company’s formulary, you may search for pharmaceutical products using several different methods.

- First, searches can be conducted by simply clicking on the appropriate first letter of the drug name under the Alphabetical Search section.
- Secondly, a search can be made by drug name using the Brand & 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 the Go button.
- Or lastly, click on the appropriate drug class (e.g., “Anti-infective Agents”) under the Therapeutic Class Search section.

Please be aware that some medications require preauthorization and are noted on the formulary listing with a “PA.” Members seeking prior authorization for a medication should speak with their provider. Forms submitted by members cannot be accepted. Forms are to be used by prescribing physicians and require the physician’s signature. These forms can be viewed and downloaded from www.chcoklahoma.com.

Finding Pharmacy Information Online

The following information may be found on our website by selecting chcoklahoma.com > Services and Support > Providers > Prescription Documents:
- A list of preferred pharmaceuticals, including any restrictions and/or preferences
- A list of medications which require prior authorization, and applicable criteria
- A list of medications which require step-therapy, including the medications which must be tried/failed prior to coverage
- A list and explanation of medications which have limits or quotas
- Copayment and coinsurance requirements, and the medications or classes to which they apply
- Procedures for step-therapy, prior authorization, generic substitution, preferred-brand interchange and therapeutic interchange
- Information on the use of pharmaceutical management procedures
- Criteria used during the evaluation of new medications for inclusion on the formulary
- A description of the process for requesting a medication coverage exception

Generic Drugs

Generic drugs provide a way to provide drug therapy at substantial cost savings to both the employer funding the prescription benefit and the patient receiving the prescription drug benefit.
Most prescription benefit plans provide a lower copay for the member when they receive generic medications. Most prescription benefit plans provide a lower copay for the member when they receive a generic medication.

A generic drug is chemically identical, and bioequivalent to its brand-named counterpart in dosage, form, safety, route of administration, quality, performance characteristics and intended use. The appearance is not identical. Generic drugs are typically sold at substantial discounts from the branded product. Providers can be assured that FDA-approved generic drugs are held to the same rigid standards as the brand name drugs as dictated by the U.S. Food and Drug Administration (FDA). Providers are encouraged to prescribe generic products.

In the formulary list, generic medications are identified by an asterisk (*) next to the medication name.

**Quantity Limits**

Quantity limits are set on medications for different reasons. Many commonly used once daily drugs have limits since these drugs are proven to be safe and effective when taken once daily. Secondly, the different strengths of many of these drugs cost the same amount of money. For example, taking two tablets of a lower strength may be twice as expensive as taking one tablet of a higher strength. The quantity limit will enforce the lower cost option.

The limits are reviewed and determined by clinical staff, pharmacy directors and/or the Pharmacy and Therapeutics Committee. The quantity limits are based on FDA-approved dosing schedules and the medical literature related to the particular drug.

**Self-Injectable Medications**

The Health Plan will provide coverage of medically necessary self-injected medications used in a treatment plan for a covered illness. Self-injectable medications that are covered under the pharmacy benefit plan are listed in the formulary list. These are subject to applicable copays, limitations and authorization criteria.

**Specialty Pharmacy Provider**

Coventry has contracted with Express Scripts to provide most of the prescription drug needs of members receiving self-administered injectable medications, immunosuppressive drugs and antiviral agents for HIV and hepatitis. To enroll members, please call 877-834-8657.

**Access to and Copying of Records**

The Provider should not bill the member or the Health Plan for expenses related to copying of medical records in the following circumstances:

- Used in order for making a determination regarding whether a services is a covered service for which payment is due
- Requested by a state or federal agency, including the Centers for Medicare and Medicaid
- Used in order to assist the Health Plan’s quality improvement, utilization review and risk management programs
The provider should allow access to all records, books and papers relating to professional and ancillary care provided to members. This includes financial, accounting and administrative records. These documents should be available for photocopying during normal business hours.

The provider agrees to maintain all member records for services rendered for at least seven years.

**Coordination of Benefits**

Coordination of benefits (COB) provision applies when a member has health care coverage under more than one plan. When two or more plans pay benefits, the rules for determining the order of payment are as follows:

- The primary plan pays or provides its benefits as if the secondary plan or plans did not exist
- A plan that does not contain a COB provision that is consistent with this provision is always primary
- A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan

**Effect on the Benefits of the Plan**

When the Health Plan is secondary, the Health Plan may reduce the payment so that not more than 100 percent of total allowable expenses are paid. The difference between the payments that the plan would have paid had the plan been the primary plan shall be recorded as discount to the Health Plan.

**Claims or Benefit Appeals**

If the provider would like to request a review of the claims issue, please follow the Health Plan guidelines regarding appropriate documentation below. Due to HIPAA privacy and security rules, please do not send this information via email. If you would like an electronic format, the information can be forwarded with the appropriate documentation.

**Administrative**

The Health Plan provides for one level of appeal, or reconsideration, for administrative issues, such as an error has been made due to claim check, timely filing or the claim has been denied for no pre-certification.

The first step a provider should make is to contact CSO to inquire about the claim. If the outcome is not satisfactory to the provider, an appeal, or reconsideration, may be submitted. Any additional information the provider wishes to have considered should be submitted with the letter of appeal. The appeal should include backup documentation, an explanation as to why you feel the initial determination or payment was incorrect and the desired outcome.

Providers are asked to submit appeals on a timely basis, no more than 90 days from date of issuance of the denial (or adverse payment) on these administrative issues. The Health Plan will make a determination on the appeal within 30 calendar days of the initiation process.

The 90-day time limit does not apply if the claim was not paid according to the agreed upon rate as stated within the contract.
An administrative appeal, or reconsideration, may be submitted to the Health Plan at the following address:

**Coventry Health and Life Insurance Company**  
Attn: Provider Reconsideration Request  
P.O. Box 7708  
London, KY 40742  
Fax: 701-250-5392

**Medical Necessity**  
For appeals based in whole or in part on medical judgment, the request will be reviewed by a Medical director and/or a physician designee who has training and experience in the field of medicine relevant to the issue in question.

A written inquiry may be submitted to the Appeals department at the following address:

**Coventry Health and Life Insurance Company**  
Attn: Appeals Department  
9401 Indian Creek Parkway, Suite 1300  
Overland Park, KS 66210

**Expedited Appeals**  
An expedited appeal is available for those situations in which the provider believes that the timeframe for the standard appeal would seriously jeopardize the life and health of the member or would jeopardize the member’s ability to regain maximum function. Expedited status only applies to pre-service appeals based in whole or in part on medical judgment. Requests for expedited review can be made by the member, participating provider, nonparticipating provider or a person authorized to act on behalf of the member. Requests for expedited review may be made by telephonic contact, fax or written correspondence.

- The provider notifies the medical director or designee or clinical nurse reviewer orally by telephone or through written correspondence that an expedited review is being requested. The Health Plan will accept additional information from the attending physician or other ordering provider over the telephone or via fax, or other acceptable means.

- The medical director or designee determines whether an appeal constitutes an expedited appeal.

**3. Member Information**

The Health Plan reimburses providers only for medically necessary and covered services rendered to eligible, enrolled members. Please note that the member ID card does not guarantee member eligibility. Members may terminate their coverage with the Health Plan without surrendering their cards. See Table 2 for an example of the Health Plan member ID card.

In order to ensure member eligibility, you should check the patient’s member ID card. If the patient does not have their member ID card, please contact CSO at 866-219-7695 to verify eligibility. Auto and workers’ compensation clients do not provide ID cards to insureds/injured parties. Providers will
need to access the Client/Payor list on www.directprovider.com in order to determine whether they are participating in the auto or workers’ compensation network for that member.

DirectProvider.com will allow providers to access eligibility verification and claims status inquiry. If you are currently not signed up with DirectProvider.com and are interested, you may sign up at www.directprovider.com. Network support may also be contacted at 866-629-3975. Simply tell them that you are a participating provider and that you are interested.

Member Rights and Responsibilities (provided to every member)

As a member of Coventry Health Care, you have certain rights and responsibilities. Knowing your rights and responsibilities helps ensure that you get the covered services and care that you need.

You have the right to:

• Receive information about the organization, its services, its practitioners and providers, and member rights and responsibilities
• Be treated with respect and recognition of your dignity and your right to privacy
• Participate with practitioners in making decisions about your health care
• A candid discussion of appropriate or medically necessary treatment options for your 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

You have the responsibility to:

• 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 you have agreed to with your practitioners
• Understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible

Preventive Health and Wellness Programs

As a health plan, Coventry is concerned about our members’ health and wellness. To ensure our members receive the preventive health screening tests and information to assist them in leading a healthier lifestyle, Coventry has designed numerous programs to educate our members and assist them with managing their own health and wellness. Coventry also works with our members and their health care providers to ensure continuity of care and assist in caring for our members. We have designed programs that range from comprehensive disease management to outreach reminders. Disease Management programs include Diabetes, COPD, Asthma, Coronary Artery Disease, Chronic Kidney Disease and Congestive Heart Failure Management. Contact is made with all members who have a condition coordinated through our program. We connect with members through educational mailings or phone calls from health education associates. These programs strive to continually improve the quality of life for our members by focusing on improving care and coordination of necessary services. Members gain a greater understanding of the disease, and learn self-management strategies and self-monitoring techniques.
Examples of some of our preventive services are flu shots, breast cancer screening exams, cervical cancer screening exams, childhood immunizations and general preventive health guidelines. We also stratify our outreach to members regarding issues that are specific to their sex and/or age group.

Coventry members receive a copy of our member newsletter “LivingWell” two times a year. This newsletter contains information on maintaining a healthy lifestyle and other health care topics. “LivingWell” also is a good source of information on how to use their benefits and gain the most from their Coventry membership.

Please contact customer service for the most current benefit plan information for the specific member.

Preventive Health Guidelines

A review of the medical literature is performed to establish the scientific basis for the preventive health guidelines. The guidelines are reviewed annually, or as new information becomes available. It is important to realize that these recommendations are intended to establish an acceptable level of preventive care. Providers must use their own judgment in the care of individual members. These guidelines are available on the Coventry Health Care website at www.chcoklahoma.com > Services and Support > Providers > Document Library > Preventive Health Guidelines.

Wellness tools that Coventry offers our members include:

Medicare Advantra Silver Sneakers®
- Coventry Medicare Advantage members have access to more than 11,000 fitness locations across the country, with amenities such as exercise equipment and SilverSneakers® group fitness classes as part of their health plan at no extra cost
- Help Medicare Advantage members find out more at silversneakers.com or by calling 888-423-4632 (TTY/TDD: 711), Monday through Friday, 8 a.m. to 8 p.m. EST

Coventry WellBeing
Comprehensive wellness programs designed to engage members in their health and provide tools and resources for education and improvement. Coventry WellBeing is an online health improvement program that includes a Succeed® health risk assessment (HRA), personalized digital health coaching, a personal health record, tools & trackers and a multitude of wellness resources for maximum member engagement.

Succeed: Health Risk Assessment
- Free online risk evaluation tool to help members improve their wellness through behavior change.
- A summary report of the results and a personalized plan are created for the member.

Digital Coaching Programs
- Balance® weight management.
- Breathe® tobacco cessation
- Relax® stress management
• Nourish® nutrition improvement
• Move® physical activity
• Achieve™ cholesterol management
• Care® for blood pressure
• Care® for sleep
• Care® for depression

Tracking Tools
Step by Step™ allows participants of digital coaching programs to track their progress. Additionally, members with iPhone® and iPod® touch can track their progress through their mobile devices. The iPhone can track distance and upload results directly to the website.

Personal Health Record (PHR)
Track My Health is a tool that allows member to view, store, track and maintain personal health information securely on the web. Coventry populates select fields using claims data while members also have the ability to update their own PHR.

Kids’ Health
• Access to thousands of medically reviewed articles, animations, features, and age-appropriate news for kids and teens.
• Offers updated information specific to children’s health. Parents and children can access age-appropriate information about parenting, general health, medical problems, development, emotions, fitness, nutrition and safety.

Prevention: International Fitness Club Network (IFCN)
• Guaranteed lowest health club membership rates
• Preferred pricing on home fitness equipment
• Free one-week trial memberships

Discount Programs
• IFCN (mentioned above)
• EyeMed: Vision discounts
• QualSight: LASIK discounts
• Life Coaching

4. Credentialing

Overview

This credentialing process is designed to ensure that all provider applicants meet the Health Plan’s requirements prior to acceptance into its network and continue to meet them prior to renewal of network membership.
The Health Plan utilizes the services of Coventry’s Credentials Verification Center (CVC). This arrangement provides centralized and standardized credentialing support. Coventry’s credentialing policy has adopted the highest industry standards, plus all applicable state regulations.

**Process**

To request a provider agreement or to check on the status of your application, please contact 866-219-7659. The enrollment packet and agreement is inclusive for all Coventry brands. Please allow 90-120 days for the credentialing process to be completed. In addition for any services rendered by any physician assistant or nurse practitioner to be processed at in-network benefits, a state-approved credentialing application must be submitted.

**Recredentialing**

From time to time, participating providers are re-credentialed and will be asked to complete a recredentialing application. The primary source verification of credentials is conducted. The Health Plan will contact the provider to initiate the recredentialing process.

All information is referred to the CVC, which makes the recommendation for a provider’s continued participation. Providers are notified in writing when the process has been completed.

Also, the recredentialing process helps us keep our information current. We realize that your information may change before you are scheduled to be recredentialed. Please contact our Provider Relations department if any of your information should change. Please refer to **Table 4.**

**Applicant Rights for Credentialing and Recredentialing**

- Applicants have the right, upon request, to be informed of the status of their application. Applicants may contact credentialing staff via telephone or in writing to inquire as to the status of their application.
- Credentialing staff will respond to the applicant’s request for information either via telephone or in writing of the status of their application. Coventry Health Care of Kansas, Inc. (Coventry) is not required to provide the applicant with information that is peer-review protected. Information reported to the National Practitioner Data Bank (NPDB) is considered confidential and shall not be disclosed. An applicant will be advised that they may complete a self-query to obtain information that is contained in the NPDB.
- Applicants have the right to review the information submitted in support of their credentialing application. This review is at the applicant’s request.
- The applicant will be notified in writing of initial credentialing decisions within sixty (60) days of being reviewed for credentialing.
- Credentialing staff will notify the applicant in writing of any information obtained during the credentialing process that varies significantly from the information provided to the Health Plan by the applicant.
- Should the information provided by the applicant on their application vary substantially from the information obtained and/or provided to Coventry by other individuals or organizations...
contact as part of the credentialing and/or recredentialing process, credentialing staff will contact the applicant via fax or postal mail within 180 days from the date of the signed attestation and authorization statement to advise the applicant of the variance and provide the applicant with the opportunity to correct the information if it is erroneous.

- The applicant will submit any corrections in writing within fourteen (14) calendar days to the credentialing staff. Any additional documentation will be kept as part of the applicant’s credential file.

### Office Site Evaluations

The provider should permit the Health Plan, any federal or state agency or the U.S. Department of Health and Humans Services to conduct periodic site evaluations of the provider’s facilities, office and records.

Coventry has established a policy to ensure that the offices of all practitioners participating in the commercial or Medicare Advantage plans meet Coventry’s office site standards for physical accessibility, physical appearance, adequacy of waiting and examining room space, and adequacy of medical/treatment record keeping and do not exceed Coventry’s complaint thresholds of three or more complaints in a rolling six month period related to office site quality.

### Performance Policy

Member complaints are monitored on an ongoing basis. If a member complaint is received regarding the quality of a practitioner’s office related to physical accessibility, physical appearance, adequacy of waiting and examining room space, or adequacy of medical/treatment record keeping, a full investigation will be initiated by a staff member from the Provider Relations or Quality Improvement department. This investigation will include gathering information from both the member and the practitioner regarding the incident. If there is no history of office site related complaints for the practitioner during the previous six months and there are no significant threats to patient safety or welfare, the medical director may choose to close the complaint and track and trend for future recurrences.

If three or more complaints are received within a rolling six month timeframe regarding the quality of a practitioner’s office site, a site survey will be completed by a member of the Quality Improvement or Provider Relations department. Site reviewers will be trained to conduct an evaluation against the office site criteria described below. A site visit will be completed within 60 days from the date of receipt of the member complaint. The following criteria with standards will be reviewed during the site visit.

#### 1. The office is accessible

- The sidewalks, building and vehicle entrances are well marked and in good repair.
  - The building and/or office is easily identified from the street with a prominently displayed sign or number.
  - The entrance is readily identified. The surface of the parking lot and pavement/walkway to the office entrance is in good repair (no cracks or holes), free of broken glass or other hazards.
  - If the office is within a larger building or complex, the physician or practice name is displayed on the building directory.
- Ramps are available for entrance to the building and elevators are available for offices above the ground floor for physically disabled patients who are unable to access the office by stairs.
- Doors should not resist opening by the frail or disabled when assistance is not available.

- Parking is adequate to provide spaces for the personnel and at least twenty percent of the average daily appointment schedule. A reasonable number of parking spaces must be designated handicapped.
  - Handicapped parking spaces are readily identified with signage.
  - Handicapped parking is available near an entrance.
  - There are spaces available for twenty percent of an average daily appointment schedule for the practitioner, including parking for the staff.
  - An access ramp to the sidewalk is available if one is required.

- Doorways throughout the office are adequately wide for wheelchairs and other assisted passage.
  - All doorways are wide enough to accommodate wheelchairs and other assisted passage.

- Lavatories available and handicapped accessible to patients and personnel.
  - At least one handicap toilet with assistive grab-bars is available and/or is large enough for a person in a wheelchair to gain access.

- Exits are clearly marked.
  - Exits from the office are clearly marked with signage.

2. Physical appearance

- The office is clean and free of dust, litter and debris
- Furniture is stable and in good repair
- Waiting rooms and exam rooms are well lit
- Seating is available for 20 percent of the average number of daily appointments
- Office hours are posted
- Hallways and floor are clean, maintained, and free of equipment and clutter
- Climate control is maintained at a comfortable level.
- Personnel are available to answer questions and assist waiting patients.
- Reception desk personnel are available to serve patients within five minutes of arrival
- Respiratory etiquette is promoted and supplies for containing secretions are available
- Exam room is picked up from the last patient and there is clean exam paper on all exam tables
- Personnel are available to answer questions and assist waiting patients.
- Reception desk personnel are available to serve patients within five minutes of arrival
- Respiratory etiquette is promoted and supplies for containing secretions are available
- Dirty instruments and treatment trays have been removed and surfaces are free of spills, litter
- Floors are “broom” clean.
- Exam room equipment is suitable to the primary population with consideration given to patients with need for adapted or assistive equipment (i.e. obese and/or pediatric blood pressure cuffs and step stools.)
- Patient privacy attire is used during exams.
3. Safety
- Presence and use of sharp containers; emptied when 2/3 full
- Fire extinguishers and alarms are located in easily accessible locations
- Fire extinguishers are inspected within the past one year and staff assisting you with this evaluation readily knew where it was when asked
- Emergency numbers are posted, i.e. fire, police, ambulance
- Narcotics are kept in a locked cabinet
- Emergency procedures are in place for evacuation of the office personnel and patients, i.e. tornadoes and fire
- Prescription pads are out of sight and not in any area in the office where a patient may be left unattended for any period of time
- All prescription drugs and samples are stored in an area of restricted access

4. Medical Record Keeping
- Medical records are kept secure and confidential
- Records can be easily retrieved
- Secure and password protected login for electronic medical records
- Computers are locked when staff walk away

After the site review is completed, the Coventry representative will review the results with the practitioner’s office manager or designee. The results of the site visit will be sent to the practitioner. If the site survey does not meet Coventry’s criteria, the practitioner must develop an action plan for improvement. Coventry will reevaluate the site at least every six months and reassess areas where the site was initially deficient until performance standards have been met. If Coventry receives a complaint about the same office, but for a different standard, Coventry performs a visit, but only on the specific performance standard pertaining to the complaint. All follow up office site reviews that result in noncompliance with Coventry office site quality will be reviewed by Coventry’s Quality Improvement committee for further review and determination.

Should there be a concern that an office site related issue poses a significant threat to patients’ safety and/or welfare, Coventry may take immediate action to restrict or limit member access to the provider pending resolution of the issue.

5. Utilization Management

Utilization Management

By reviewing how health care resources are utilized by members, the Health Plan may identify and evaluate timeliness of services provided, medical necessity utilizing evidence-based procedure reviews, utilization patterns, continuity of care and clinical outcomes.

Utilization review is performed under the following circumstances.

- Prospective or preservice review – Review of services prior to the scheduled date. Services include, but are not limited to, elective inpatient admission and outpatient procedures or diagnostics that require precertification.
• Concurrent care review – Review that occurs at the time care is rendered. For confinement in an acute care setting or skilled nursing or rehabilitation facility, concurrent review may be conducted onsite or by telephone with the utilization review department or otherwise designated department at each facility.

• Retrospective or postservice review – Review of services that were not precertified by the Health Plan, after the services have been provided.

Timing of Utilization Review Decisions

The timeframe for making utilization review decision is as follows:

• Prospective or pre-service review – Two business days from the date that the Health Plan receives all necessary information. In the event that the Health Plan does not receive all necessary information in 14 calendar days after the request for services, a decision will be made based on the information received. In the case of a determination to certify an admission, procedure or service, the Health Plan shall notify the provider rendering the service by telephone within 24 hours of making the initial certification, and provide written or electronic confirmation of the telephone notification to the member and the provider within two business days of making the initial certification.

• Concurrent care review – Determination regarding an initial approval of admission will be made within one business day from the date that the Health Plan receives all necessary information. The Health Plan shall notify by telephone the provider rendering the service within one business day of making the determination and provide written or electronic confirmation to the member and the provider within one business day after the telephone notification. Verbal notification for an extended stay or additional services shall include the number of extended days or next review date, the new total number of days or services approved and the date of admission or initiation of services. All verbal notifications shall be made to the provider within one business day from the date that the Health Plan receives all necessary information.

• Retrospective or postservice review – Thirty calendar days from the date that the Health Plan receives the request for determination. The Health Plan shall provide written notice of determination to the member within 10 business days of making the determination, not to exceed the 30-calendar-day timeframe.

• In the case of an adverse determination for an initial determination and/or concurrent review determination, the Health Plan shall notify by telephone the provider rendering the service within 24 hours of making the adverse determination, and provide written or electronic notification to the member and the provider within one business day of the telephone notification.

Pre-certification and Referrals

Providers shall use their best efforts, in accordance with accepted professional standards for rendering quality care, to make referrals to other participating health care practitioners or facilities. The list of
health care practitioners and facilities that participate in the Health Plan shall be made available through the company's website, www.chcoklahoma.com.

Refer to Table 3 for a list of procedures that require precertification from the Health Plan. Providers should call the Health Plan for precertification prior to services being performed. The Health Plan’s Health Services toll-free phone number is 877-837-8914. Precertification can also be obtained via fax at 866-341-2409.

Failure to obtain precertification will result in a reduction of benefits.

It is important to note that under the terms of the Health Plan, precertification only determines medical necessity and appropriateness; all other terms of the Health Plan are then applied. If the Health Plan precertifies a covered service, the Health Plan shall not subsequently retract the precertification after the covered services have been received, or reduce payment unless: (1) Such precertification is based on a material misrepresentation or omission about the member’s health condition or the cause of the health condition; or (2) the Health Plan terminates before the health care services are provided; or (3) the member’s coverage under the Health Plan terminated.

What To Do If You Do Not Agree With a Coventry Decision (QI Medical Advisory Committee Review/Reconsideration)

If a provider does not agree with a decision of one of Coventry’s medical directors, he/she may have the opportunity to speak with the medical director who made the decision. Peer-to-peer discussions should occur within one business day of the adverse decision.

Language Assistance

Coventry offers TDD/TYY services for deaf, hard of hearing and speech impaired members. Language assistance via the language line is available for members to discuss Utilization Management issues. To reach a telecommunications device for the deaf, members can dial TTY 711 or 800-877-8973.

Medical Necessity Criteria

Coventry has adopted the proprietary guidelines for use with the Coventry of Kansas plans, including Coventry of Oklahoma. These guidelines are developed with the aid of practitioners and specialty experts and are based on current scientific evidence. The criteria are shared with Coventry participating providers upon request. Information regarding proprietary guidelines is also available at: www.directprovider.com.

Call Covering Services

Providers shall arrange for 24-hour practice coverage. Providers should make arrangements with a participating provider to provide coverage to their patients when applicable.
Continuity of Care

In the event the provider's contract is terminated, the provider should continue to provide care up to 90 days (or as may be additionally required to transfer the member's care). Examples of this circumstance include pregnancy, life threatening illness and disability.

On-Call Nurse

A registered nurse is available by pager after business hours Monday–Friday, and on weekends and holidays, by calling 877-513-2744. The registered nurse is available to answer questions regarding medical necessity, network providers, initiate urgent or expedited appeals, etc. Discharge planning is also available through the on-call registered nurse who arranges for home care and durable medical equipment, as needed. The on-call registered nurse has access to Coventry’s medical director if a medical determination is needed.

Clinical Practice Guidelines

Clinical Practice Guidelines are evidence-based and updated at least every two years. You will be advised of updates in the provider newsletter “Network Connection.” To request a copy of the Clinical Practice Guidelines, please contact Coventry or go to www.chcoklahoma.com > Providers > Document Library > Clinical Practice Guidelines.

Utilization Management Criteria

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

- Coventry corporate policies including, but not limited to, new technology assessments and medical review policies
- Proprietary guidelines, Milliman and Robertson HealthCare Management guidelines and other nationally recognized medical management criteria
- American College of Obstetrics and Gynecology criteria
- Specialty society and internally developed guidelines and policies
- Medicare coverage issues
- National Comprehensive Cancer Network guidelines

Current versions of our prior authorization requirements and related schedules are available on our website at www.chcoklahoma.com. The following materials are modified throughout the year: the medical injectable prior authorization list, the prior authorization list for prescription drugs and the self-administered injectable medications list. All new injectable drugs require prior authorization unless you are otherwise notified. Contact your Provider Relations representative at 405-945-1236 if you have any questions or would like paper copies of our schedules.
Complex Case Management

The goal of complex case management is to encourage appropriate use of health care services on a case-by-case basis. Complex case management is an individualized patient-specific process to coordinate the delivery of cost-effective, high quality care in the timeliest manner to ensure optimal patient outcomes. Potential case management cases are identified by a variety of sources, including claims, authorizations, physician and member referrals, specific diagnoses and system generated flags based on utilization.

Case Management includes but is not limited to:
- Ensure services are provided at the most appropriate setting
- Care coordination between the patient and their health care team
- Serve as patient/family advocate to facilitate open communication, understanding and involvement in the treatment plan
- Provide educational materials for member to develop successful self-management skills of their condition

Provider referrals to case or disease management may be made by calling 816-460-4220 or 800-468-1442, ext. 4220.

Disease Management

Disease management programs focus on managing health risk factors and identifying potential high-risk members early. We provide educational materials to help members self-manage their conditions and avoid complications. We provide outreach to these affected members through condition specific reminders and mailings and we encourage individuals to receive annual flu vaccines as well as pneumonia vaccines as appropriate.

The targeted conditions are diabetes, asthma, congestive heart failure, coronary artery disease, high risk obstetrical conditions, chronic obstructive pulmonary disease and chronic kidney disease.

Provider referrals to case or disease management may be made by calling 816-460-4220 or 800-468-1442, ext. 4220

Evaluation of New Technology

Coventry 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. Contact your Provider Relations representative if you have any questions.

**Wellness and Preventative Care**

Members can take advantage of FirstHelp™ at no charge. FirstHelp has registered nurses available by phone 24 hours a day, seven days a week to answer health related questions.

FirstHelp can be reached at 800-622-9528.

**Medical Management Programs**

Members may take advantage of the Health Plan’s medical management programs. These programs strive to continually improve the quality of life for members. The programs available include the management of complex conditions such as diabetes, congestive heart failure, end-stage renal disease and asthma.

6. **Provider Roles and Responsibilities**

The Health Plan and its providers are partners in the health care of Health Plan members. Because of this mutual responsibility, we require providers to adhere to the following standards:

**Credentialing**

Agree to meet credentialing and recredentialing requirements of Coventry. The Health Plan encourages providers to contact their provider relations representative at any time if they require further details on requirements for participation.

All potential provider/practitioners who submit an application for participation within the provider network(s) are subject to this process to ensure that a consistent process is established and followed to determine whether a provider’s request for application to the network will be accepted or denied. The Health Plan will only accept as participating providers those providers/practitioners:

- For which there is a network need
- That willingly accept the terms of the negotiated contracts, including reimbursement rates
- Successfully pass the Health Plan’s credentialing standards

**Confidential Member Information**

Members’ information is confidential and must be stored securely. Provider staff members should receive periodic training on member information confidentiality. Only authorized personnel should have access to medical records.
Quality of Service and Clinical Care

Practitioner/provider performance data is used to improve the quality of service and clinical care for our members. Accrediting agencies require that providers provide access to performance data for this purpose.

Primary Care Provider

Primary Care Providers (PCPs) are defined as physicians/practitioners who specialize in:

- General medicine
- Family practice
- Internal medicine
- Obstetrics/gynecology
- Pediatrics

A PCP’s role is:

- Manage and coordinate the overall health care of members
- Make appropriate referrals to participating providers
- Obtain prior authorization for any referrals to nonparticipating providers
- Provide or arranging for on-call coverage 24 hours a day, seven days a week. The covering provider reports call and services provided to the member’s PCP in their usual manner. When coverage arrangements are made with a nonparticipating provider, the PCP must advise the covering provider about Health Plan requirements with regard to referrals, use of emergency facilities and hospital authorization process.
- Accept new members unless Coventry has been provided with written notice of a closed panel

Specialist Provider

Specialist Providers (SPCs) are defined as physicians/practitioners other than primary care.

- Render or arrange any continuing treatment, including hospitalization, which is beyond the specific treatment by the PCP
- Communicate any assessments or recommended treatment plans
- Obtain prior authorization for specified nonemergent inpatient and specified outpatient covered services

Physician Extenders

Physician extenders are defined as the following provider types:

- Physician Assistants (PA)
- Nurse Practitioners (NP)

Reimbursement for services rendered by a nurse practitioner or physician assistant shall be 85 percent of the then current Coventry Market Fee Schedule (CMFS) or provider’s eligible billed charges, whichever is lesser.
Authorizations

Get prior authorization from the Health Plan for services listed on the Pre-Authorization Quick Guide. Have available all necessary information, which includes member #, diagnosis, procedure, date, facility, surgeon, “in” or “out” patient procedure, length of stay and medical information. Be specific as to testing or procedures needing authorization. Some procedures will need to meet Coventry Health Care’s criteria. These nationally recognized criteria are written by physician peers and are available upon request.

*Please note:* Providers (PCPs, SPCs, hospitals, facilities) may be held responsible for the cost of service(s) where prior-authorization is required, but not obtained, or when place of service does not match authorization. The member shall not be billed for applicable service(s).

Referrals

Referrals to nonparticipating providers, regardless of level-of-care, require prior authorization. Referral approval does not guarantee authorized services are covered benefits. Retroactive referrals are not valid and will be the financial responsibility of the member or provider as, determined by the Health Plan. Benefits are always contingent upon member eligibility at the time of service. Understand that prior authorization is approved based upon the present information that has been made available to the Health Plan. Payment for prior authorization of covered services is subject to the PCP’s referral, compliance with the Health Plan Utilization Management Program, contractual limitations and exclusions, and coordination of benefits. Accept medical necessity and utilization review decisions; refer to the Grievance and Appeal Section of this Manual if you disagree with a claim that has been processed.

Copays, Coinsurance, Deductibles

Agree to collect only applicable copayments, coinsurance and/or deductibles, if any, from members. Except for the collection of copayments, coinsurance and/or deductibles as set forth above, providers shall look only to the Health Plan for compensation for medically necessary covered services.

Appointment Accessibility Standards

Standards for PCPs, specialists and behavioral health providers are to comply within the following guidelines.

- Hours of operation: 20 hours per week for a one-provider practice; 30 hours per week for a two-or-more-provider practice
- Medically necessary services within the same day
- Emergency care visit available 24 hour per day, seven days per week
- Urgent care visit (symptomatic) within two calendar days
- Nonurgent office visit (symptomatic) within seven calendar days
- Routine office visit (nonsymptomatic) within 30 days
- Routine physical within 30 days
- Waiting time in office should not exceed 30 minutes in most instances
7. Provider Reimbursement

Overview

The Health Plan reimburses providers for medically necessary covered services, in accordance with their provider agreements. Reimbursement for services rendered by a nurse practitioner or physician assistant shall be 85 percent of the then-current CMFS or provider's eligible billed charges, whichever is lesser.

Business Rules

The Health Plan applies business rules when claims are adjudicated. These rules encompass the industry standard practices for claims processing. The business rules are applied when claims are submitted with modifiers, multiple procedures or other separately identifiable coding aspects of a claim.

Claims Editing Information

The Health Plan accepts the American Medical Association's (AMA) guidelines that state the code(s) reported/billed “accurately identifies the service performed.” The Health Plan also requires compliance with the HIPAA standardized code sets and thus only considers valid and current ICD, CPT-4 and HCFA Common Procedural Coding System (HCPCS) codes with their appropriate modifiers, for reimbursement. We also agree with AMA’s statement in their introduction to the CPT-4 manual, that, “inclusion or exclusion of a procedure does not imply any health insurance coverage or entitlement to reimbursement.” Consistent with today’s industry standards, the Health Plan applies edits including but not limited to those that are defined under the CMS Correct Coding Initiative Guidelines (CCI).

Systems Affecting Claims Payment

Health Plan uses a variety of systems and procedures in the review of claims. These systems may affect the payment of the claims. The systems noted below contain licensed or copyrighted material. Due to the licensing agreements and copyright laws, Coventry cannot mass distribute the detailed logarithms, policies or rules used in these systems. If you have specific questions, please direct them to Customer Service or Provider Relations.

GMIS\Correct Coding Initiative\iHealth\Bloodhound

These are automated claims auditing systems that verify the clinical patterns of professional claims. They are integrated with our claims processing system, IDX, and identify inappropriate billing practices. Coding validation programs help to ensure that claims are paid correctly based on clinical patterns and is designed to prevent overpayment. Through the edit process, the system advises Health Plan’s claims processors when inappropriate billing occurs. Programs analyze data and identify and correct all major types of inappropriate code irregularities. Specific Current Procedural Terminology (CPT) codes may be considered incidental to the major procedure performed on the patient. The use of modifiers, duplicate claims, assistant surgeon billing and the identification of possible cosmetic
surgery are examples of claims issues evaluated. In addition, the age and sex appropriateness of a CPT code is considered. The program is intended to consistently apply industry guidelines to all claims. Questions about system edits on specific claims should be directed to Customer Service.

**Healthcare Recoveries, Inc. (HRI)**

Proprietary databases are used to review claims with diagnosis codes that are appropriate for investigation of third-party liability or workers’ compensation. HRI conducts investigation and recovers on Coventry’s behalf.

**Special Investigative Unit (SIU)**

SIU provides comprehensive fraud and abuse detection services for Health Plan. These services include training claims staff on fraud detection and reporting, the prospective investigation of claims for potential abuse, and the ongoing monitoring of claims paid data to identify claims paid to “suspect” providers. Identification of “suspect” providers and other services are based on the SIU proprietary review protocol. Services include the validation of the tax identification number and licensures of providers from zip code areas where prior billing abuse has been widespread.

**MedCost Recovery Systems, Inc.**

Through electronic transfer of data, MedCost Recovery Systems employs proprietary logarithms to identify episodes of care that are aberrant. These records are audited against Health Plan hospital contracts, and if medical charts do not support the charges and services billed, recovery is initiated.

**Proprietary Claims Payment Guidelines**

In addition to the GMIS ClaimCheck System, Coventry supplements its claims policies with proprietary claims payment guidelines. These guidelines are generally developed on a national level by the medical management staff at Coventry’s corporate headquarters and approved at the local Health Plan level prior to use. Examples of areas of care where proprietary claims payment guidelines exist include but are not limited to, chiropractic care, payment of supplies and policies on the applicability of copayments.

**Reimbursement Determinations**

The Health Plan schedule of allowances represents the maximum reimbursement amount for each covered service that corresponds to any given medical service code. The basis of determining valid medical service codes are from CPT, HCPCS or National Drug Codes (NDC). For covered services represented by a single code, the maximum reimbursement amount is the allowance amount determined by Health Plan or the provider’s usual charge for the service, whichever is less. In many cases, Health Plan allowances are based upon measures of relative value such as Average Wholesale Price (AWP), Average Sale Price (ASP), the Federal Resource Based Relative Value Scale (RBRVS), American Society of Anesthesiologists (ASA) units and Medicare laboratory and Durable Medical Equipment (DME) rates.

If on the same day or within the same episode of care, the same patient receives more than one service, then the total allowance amount may be less than the sum of the charges for individual billed service codes. Service codes may be subject to bundling via Health Plan multiple, incidental,
rebundling and global claims payment processing rules. The details of rebundling logic will vary from one carrier to another. The concepts of quantity limits, as well as multiple, incidental, rebundling and global processing in many instances are industry standards employed by many carriers, including Medicare.

**Age/Sex Restrictions**

Some services are allowed for only one sex (e.g., provider should not submit CPT code 58150 for a hysterectomy for a male patient). Some services are allowed only for certain age ranges (e.g., provider should not submit CPT code 43831 for a gastrostomy, neonatal for feeding a 45-year-old patient).

**Experimental/Investigational Services/Supplies/Drugs**

A health product service, supply or drug is deemed experimental/investigational by Health Plan according to the following criteria following coverage eligibility criteria: Any drug not approved for use by the FDA; any drug that is classified as investigational new drug (IND) by the FDA; any drug requiring preauthorization that is proposed for off-label prescribing; any health product or service that is subject to Investigational Report Board (IRB) review or approval; any health product or service that is the subject of a clinical trial that meets criteria for Phase I, II or III as set forth by FDA regulations; any health product or service that is considered not to have demonstrated value based on clinical evidence reported by peer review medical literature and by generally recognized academic experts. A drug, device, procedure or other service will be experimental or investigational if Health Plan makes such a determination based upon criteria noted, unless otherwise noted in the Certificate of Coverage documents. Experimental or investigational services are not covered.

**Global Processing**

For some medical services (in most instances, surgical services), Health Plan will impose global surgery processing rules, wherein some services (in most instances evaluation and management services) are incidental to other services (in most instances procedural services) when provided with a defined time period and in conjunction with the procedural service. Health Plan follows HCFA conventions regarding global designations and time periods for major and minor surgery.

**History Edits**

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

**Incidental Claims Processing**

An incidental procedure is one that is performed at the same time as a more complex primary procedure that does not require significant, additional provider resources and/or is clinically integral to the performance of the primary procedure. When multiple medical service codes are billed in conjunction, some codes may be considered incidental to other codes and may not be considered toward the total allowance for the aggregation of billed codes. A code which is a subset of another code based on an objective interpretation of CPT verbiage will be considered incidental to the latter code. Codes which are “components” of “comprehensive” codes based on the Health Care Financing Administration’s Correct Coding Initiative will be considered incidental to the latter. In addition, Health Plan may also consider a code incidental to another if the incremental value of the former is
less than one-fourth of its usual value when provided in combination with the latter. In many instances, this occurs when the lesser services do not pertain to different route of access, different organ systems, different pathological processes or to multiple trauma.

**Medical Necessity**

Medical necessity is defined by Coventry as the use of services or supplies as provided by a hospital, skilled nursing facility, physician or other provider required to identify or treat a member’s illness or injury and which, as determined by Health Plan, are: (1) consistent with the symptoms or diagnosis and treatment of the member’s condition, disease, ailment or injury; (2) appropriate with regard to standards of good medical practice; (3) not solely for the convenience of the member, his/her participating provider, hospital or other health care provider; and (4) the most appropriate supply or level of service which can safely be provided to the member. When specifically applied to an inpatient admission, it further means that the member’s medical symptoms or condition requires that the diagnosis or treatment cannot be safely provided to the member in an outpatient setting. Services listed in the schedule of benefits are covered only if they are medically necessary.

**Multiple Surgeries/Procedures**

When two or more different medical service codes are provided to the same patient (usually by the same provider on the same date of service), for covered surgical services provided in a single operative session, reimbursement would be made at the full allowance amount for the procedure with the highest RVU units, plus half of the usual allowance for the second medical service code, and one-fourth of the usual allowance amount(s) for each subsequent procedure. All multiple surgery/procedural services are pended and sent to a Medical Claims Review Unit for review and determination of reimbursement.

**Rebundling Claim Processing**

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

**Billing for Electronic Communication**

Health Plan does not allow billing of charges associated with telephone, email, or other electronic communications or consultations. These charges are not billable to Health Plan and are also not billable to the patient.

**Durable Medical Equipment**

Primarily and customarily used for medical purposes and is generally not useful in the absence of a sickness or injury. Equipment must be durable and withstand repeated use, necessary and appropriate for the treatment of the sickness or injury or to improve the function of a malformed body part, useful to the patient and not usable by other household members.
DME Rentals

The amount of monies paid for rental of DME shall not exceed the purchase price. If the equipment is initially rented, then a decision is made to authorize the purchase, the rental payments will be applied toward the purchase price. If an authorization has approved a rental for an extended period and paying the rental would exceed the purchase price, providers will be reimbursed the purchase price only, and may not balance-bill or collect from the member. If rental costs have exceeded the purchase price and the claims have already been paid, then a request for refund letter will be generated.

Capped Rental

Items in this category are paid on a monthly rental basis, not to exceed a period of continuous use of 13 months.

Oxygen Concentrators

Should be converted to purchase, an oxygen concentrator would only be available for rent if it were unable to be purchased.

Maintenance contracts

Must be billed with modifier “MS.” This modifier is allowed only on oxygen concentrators (E1390-1392 and E0430-E0435). If the MS modifier is billing with any other CPT, the line will be denied as non-covered.

DME Supplies

DME supplies that are used directly with purchased equipment will be allowed as a covered benefit and will be applied towards the medical supplies benefit as long as they are not an over-the-counter item.

DME Authorization Requirements

All rentals require authorization regardless of the billed charges. DME purchases $1,000 or less in total billed charges can be allowed without authorization. DME purchases more than $1,000 in total billed charges must be authorized.

Surgical Follow up days

In a global surgical package a single fee is paid to the physician for preoperative, intraoperative, and postoperative services. This means payment of the global fee for the procedure includes all services necessary to prepare for and recover from the procedure. When billing for global surgery, the date of service is always the date of surgery.
Facility/Non-facility charges

Facility/non-facility charges are sometimes referred to as Place of Service (POS) modifier pricing. POS is a legitimate, industry standard pricing that reflects the reduced resource cost to a health care professional for performing a patient service in a facility the provider does not own. The costs for maintaining the staff, equipment, and facility are billed by a separate entity, thus resulting in two separate bills for professional and facility services. Medicare and most commercial and workers’ compensation payors will separate a facility and professional component for some 1,600 CPTs that are routinely billed from both facility and office settings.

Modifers

Coventry accepts most standard modifiers; however, some may require clinical review. A modifier can be added to a CPT code to describe a unique service or procedure that was performed in the medical setting. The modifier can be reported by adding a two-digit number (or alphabetic characters) after the appropriate CPT code.

Some modifiers are used to just describe a unique situation and do not change reimbursement. They are used to prompt an insurance company to consider payment that would normally be denied.

Other modifiers do affect reimbursement. The correct use of a modifier can increase or decrease a provider’s reimbursement. Since payment determinations are made from modifiers, it is very important that a basic knowledge base is developed.

8. Facility Reimbursement

Hospitals and Surgery Center Providers

Overview
The Health Plan reimburses facilities for medically necessary covered services, in accordance with their provider agreements.

Business Rules
The Health Plan applies business rules when claims are adjudicated. These rules encompass the industry standard practices for claims processing. The business rules are applied when claims are submitted with modifiers, multiple procedures or other separately identifiable coding aspects of a claim. Whereas the previous sections provide a description of systems affecting claims payment, this section provides specific information about the types of rules applied to claims billed by providers.

<table>
<thead>
<tr>
<th>Scenario</th>
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<td>A. Outpatient Surgery rate applies only</td>
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<tr>
<td>B. Outpatient Surgery with Observation</td>
<td>B. Outpatient Surgery rate applies only</td>
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<tr>
<td>C. Outpatient Surgery transfer to Inpatient</td>
<td>C. Inpatient rate applies only</td>
</tr>
<tr>
<td>D. Emergency Room Services with or transfer to Outpatient Surgery</td>
<td>D. Outpatient Surgery rate applies only</td>
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<tr>
<td>E. Emergency Room with transfer to Observation</td>
<td>E. Observation case rate applies only</td>
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<tr>
<td>F. Emergency Room Services with or transfer to Cardiac Catheterization, PTCA</td>
<td>F. Cardiac Catheterization, PTCA case rate applies only</td>
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<tr>
<td>G.</td>
<td>Emergency Room Services with MRI, CT Scan or other diagnostic testing</td>
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<td>P.</td>
<td>Outpatient Surgery with MRI, CT Scan, or other diagnostic testing</td>
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<td>Q.</td>
<td>Outpatient Surgery with Observation</td>
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<td>R.</td>
<td>Outpatient Surgery transfer to Inpatient</td>
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<td>S.</td>
<td>Emergency Room with transfer to Outpatient Surgery</td>
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<tr>
<td>T.</td>
<td>Emergency Room with or transfer to Observation</td>
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<td>U.</td>
<td>Emergency Room with or transfer to Cardiac Catheterization</td>
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<td>V.</td>
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<td>Y.</td>
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<td>Z.</td>
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<tr>
<td>AA.</td>
<td>Cardiac Catheterization with MRI, CT Scan or other diagnostic testing</td>
</tr>
<tr>
<td>BB.</td>
<td>Outpatient Cardiac Catheterization with transfer to Inpatient</td>
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<tr>
<td>CC.</td>
<td>Any other Outpatient service that converts to an Inpatient admission</td>
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<td>DD.</td>
<td>Outpatient Cardiac Catheterization with Outpatient surgery</td>
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<td>Inpatient Stop loss with trauma/burn</td>
</tr>
<tr>
<td>II.</td>
<td>Outpatient Radiation therapy claim</td>
</tr>
</tbody>
</table>

**Additional Information:**

- **G.** Emergency Room Services case rate applies only
- **H.** Inpatient rate(s) applies only
- **I.** Observation case rate applies only
- **J.** Cardiac Catheterization or PTCA case rate applies only
- **K.** Inpatient rate(s) applies only
- **L.** Cardiac Catheterization or PTCA case rate applies only
- **M.** PTCA case rate only
- **N.** Inpatient rate(s) applies only
- **O.** Inpatient rate(s) applies only
- **P.** If the provider has an ASC arrangement on their fee schedule, the claim falls under the ASC arrangement
- **Q.** If the provider has an ASC arrangement in their fee schedule and the observation is 23 hours or less then the claim falls under the ASC arrangement. Nothing additional is paid for the observation.
- **R.** All transfers to Inpatient pay as an inpatient claim
- **S.** The entire claim is paid at the ER discount
- **T.** If the observation is 23 hours or less then the entire claim is paid at the ER discount. If the observation is greater than 23 hours and the provider has observation language in their fee schedule then the claim defaults to the observation case rate.
- **U.** The entire claim is paid at the ER discount
- **V.** The entire claim is paid at the ER discount
- **W.** All transfers to inpatient pay as an inpatient claim
- **X.** If the provider has observation wording on their schedule, the MRI/CT scan will be included in the observation rate
- **Y.** Cardiac Catheterization would pay
- **Z.** All transfers to inpatient pay as an inpatient claim
- **AA.** The MRI/CT scan will be included in the Cardiac Catheterization rate
- **BB.** All transfers to inpatient pay as an inpatient claim
- **CC.** All transfers to inpatient pay as an inpatient claim
- **DD.** Cardiac Catheterization rate applies
- **EE.** Whole claim paid at trauma/burn rate
- **FF.** If HCD carve out billed per procedure code >$1000, carve outs paid at percent billed. If HCD carve out billed per procedure code <$1000, $0 paid for HCD because covered in remainder or ER payment
- **GG.** Only Implants and HCDs >$1000 per revenue code would be deducted from billed charges prior to determining if claim hits stop loss threshold. If the account still exceeds threshold, the implants/HCD line items are paid at implant/HCD percent, then per diem is paid for all days prior to meeting the stop loss threshold then stop loss percent billed is paid for all charges > stop loss threshold
- **HH.** Whole claim paid at trauma/burn rate
- **II.** Paid at contracted radiology percent of Medicare RBRVS fee schedule
9. Supplemental Benefits

Overview

The Health Plan contracts with ancillary providers for supplemental benefits such as dental, mental
health, pharmacy and vision. This section explains how these services are accessed by members.

Dental

The Evidence of Coverage (EOC) excludes coverage for dental care services unless the services are
provided under a supplemental benefit rider.

Please contact CSO for detailed information on dental benefits provided through the Health Plan.

Mental Health

The Health Plan is contracted with Mental Health Network (MHNet) to provide access to inpatient
and outpatient mental health services for members. Members with mental health coverage can obtain
a referral to a MHNet participating practitioner and/or facility by calling MHNet at 866-607-5970.

Vision Services

Services for routine eye exams may or may not be covered under member’s benefit plan. Please
contact CSO at 866-219-7695 for detailed information on vision benefits provided through the Health
Plan.

10. Medicare Plans

Overview

The Health Plan has entered into a contract with CMS that authorize Coventry to provide
comprehensive health services to persons who are entitled to Medicare benefits and who chose to
enroll in a Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO).

What is 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 Prescription Drug Improvement and Modernization Act (MMA) of 2003 was
enacted by President Bush on December 8, 2003, and is available to everyone who is Medicare eligible.
Medicare prescription drug coverage (sometimes referred to as “Medicare Part D”) works differently
than Medicare Part A or Part B. To get this coverage, members choose a plan from a private company
and may elect to pay the plan directly or have Part D premiums withheld by Social Security. Members may qualify for reduced premiums and increased cost sharing if they meet certain income requirements.

The Medicare program is administered by CMS, formerly HCFA, of the U.S. Department of Health and Human Services (DHHS).

To be eligible to join our Health Plan, Medicare beneficiaries must live in our service area and either be entitled to Medicare Part A and/or be enrolled in Medicare Part B. If a Medicare beneficiary currently pays a premium for Medicare Part A and/or Medicare Part B, they must continue paying their premium in order to keep Medicare Part A and/or Medicare Part B and to remain a member of our Plan.

What is Coventry Advantage (HMO)?
Coventry Advantage is a Medicare HMO program for people with Medicare offered by the Health Plan. Coventry Advantage includes all the benefits of original Medicare coverage, plus many extra benefits offered to HMO members, such as preventive care.

How Does It Work?
The HMO member selects a PCP who coordinates their care. Members can use network physicians and specialists who have agreed to accept our payment to them as payment in full and members are responsible for only a copayment or coinsurance for covered services. The exception to this requirement includes emergency services within the service area and emergency or urgently needed services outside the service area unless otherwise indicated in the HMO Evidence of Coverage.

Members do not pay a monthly premium to Coventry for their HMO coverage. Members must be eligible for Medicare Part A and Part B and are required to continue paying their Medicare Part B premium.

What is Coventry Freedom PPO?
Coventry Freedom is a Medicare PPO program offered and administered by the Health Plan. Coventry Freedom includes all the benefits of original Medicare coverage, plus many extra benefits offered to PPO members, such as preventive care.

How Does It Work?
The PPO offers greater flexibility, freedom, and savings. Members are not required to select a PCP. They can choose to visit any Medicare participating doctor, any specialist or any hospital at any time. Members can use network physicians and specialists who have agreed to accept our payment to them as payment in full and members are responsible for only a copayment or coinsurance for a doctor or specialist visit. If Members choose providers outside the network, they are still eligible for benefits, but their cost share will be higher.

Coventry Freedom members may pay a monthly premium to the Health Plan for their PPO coverage. Members must be eligible for Medicare Part A and Part B and are required to continue paying their Medicare Part B premium.
Who to Contact Regarding Medicare Plans

Medicare Customer Service:
To speak with a customer service representative, please call 1-800-727-9712 (TDD 1-866-347-2459) Monday through Friday, 8 a.m. to 6 p.m. CST, (and during open enrollment from November 15 through March 1, between 8:00 a.m. to 8:00 p.m. CST). Saturday hours are available between 9:00 a.m. to 3:00 p.m. CST. If you have questions regarding Part D Prescription Drugs, please call 800-727-9712, and press Option 1. (TDD/TTY users should call 866-347-2459). You can call 24 hours a day, seven days a week.

- Benefit inquiries
- Claims inquiries
- Eligibility verification

Prescription Drug coverage:
Customer Service: 800-727-9712 (TDD 866-347-2459) Monday through Friday, 8 a.m. to 6 p.m.
Exceptions and prior authorization inquiries: Phone: 877 215-4098; Fax: 877-554-9139

Express Scripts
- 866-505-6162HMO Customer Service
- 866-294-9803 PPO Customer Service

MHNet Behavioral Health
- 866-607-5870 (TDD 877-266-2099, 24 hours per day, seven days per week

Provider Relations
Wichita: 800-664-9251, Monday through Friday, 8 a.m. to 5 p.m. CST
816-221-8400 (TDD 866-347-2459) Monday through Friday, 8 a.m. to 5 p.m. CST
866-795-3995 (TDD 866-347-2459) Monday through Friday, 8 a.m. to 5 p.m. CST

- Provider participation questions
- Contracts, forms, etc.
- Office orientation needs

Provider Appeals
Coventry Health Care of Kansas, Inc.
Attn: Appeals Department
9401 Indian Creek Parkway, Suite 1300
Overland Park, KS 66210

Fax: 866-769-2408 or 816-460-4952

Reconsiderations
800-727-9712, Monday through Friday, 8 a.m. to 6 p.m. CST. From November 15 through March 1, Saturday hours are available between 9:00 a.m. to 3:00 p.m. CST. (TDD 866-347-2459) Monday through Friday, 8 a.m. to 5:pm. CST.

Coventry Health Care, Inc.
P.O. Box 7370
London, Kentucky 40742
Sales/Marketing
816-460-4702 (TDD 1-866-347-2459) Monday through Friday, 8 a.m. to 5 p.m., CST, or toll free at 866-533-5160 (TDD 1-866-347-2459) Monday through Friday, 8 a.m. to 5 p.m., CST.

Claims
Mail Medicare claims to Coventry Health Care, Inc., to:

Coventry Health Care, Inc.
P. O. Box 7370
London, Kentucky 40742

Medicare claims can now be submitted electronically. The payor ID number is 25133.

Member Identification Card

Coventry Health Care provides every Medicare Advantage member with an identification card shortly after joining the Health Plan. The identification card contains the following information:

- Member name
- Coventry ID number
- PCP's name, network affiliation and phone number (HMO members only)
- Office visit copay
- Prescription drug group numbers
- Customer Service claims and pharmacy contact information

 Emergent/Urgent Care/Renal Dialysis Services

Emergency Care
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.

Emergency medical condition means 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 needed emergency services and poststabilization care are covered no matter where members are, even if they are provided by a doctor or facility that is not contracted with Health Plan. Poststabilization care is medically necessary, nonemergency services needed to ensure that the enrollee remains stabilized from the time that the treating hospital requests authorization from Health Plan until (1) the member is discharged, (2) a contracted physician arrives and assumes responsibility for the enrollee's care, or (3) the treating physician and Health Plan agree to another arrangement.

Medicare HMO members receiving emergency services are requested to notify their PCP for follow-up care by calling the phone number listed on their card within 48 hours, or as soon as possible.
PPO members should also contact their personal physician and Health Plan customer service by calling the phone number listed on their card.

**Renal Dialysis Services**
Renal dialysis services are covered from qualified dialysis providers when the member is temporarily absent from the Plan’s service area. For Medicare HMO members, their PCP should coordinate these services; however, no authorization is required. PPO members should contact Health Plan customer service for prior authorization by calling the phone number listed on their ID card.

**Urgent Care**
In-area: Members must call their PCP or the FirstHelp 24-hour nurse advice line at 800-622-9528 (TDD Kansas: 800-766-3777; TDD Missouri: 800-735-2966). There is always a health professional on call to assist with coordination of appropriate services.

Out-of-area: If possible, members are instructed to call their PCP before seeking care; however, if this is not an option, members may seek care from an urgent care center and should inform their PCP of urgent services they have received within 48 hours, or as soon as possible.

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**Provider Performance Policy**
Coventry has developed a provider performance policy as an aid to educating providers regarding specific requirements critical to managed care.

**Purpose**
To facilitate the continuous quality improvement process by ensuring provider compliance with the Health Plan quality management program.

**Sanctions**
Network Development, in conjunction with the CEO/legal counsel, may levy sanctions as detailed in the sanction policy documented in the provider manual disseminated to group physicians. Initial sanctions involve a letter of warning, whereas sanctions for repeated violations may involve a financial penalty and if necessary, contract termination. Please refer to section two of this manual for the entire policy.

The sanction process consists of five steps that include:
- Verbal notification
- Written notification
- Written warning
- Financial sanction
- Provider contract termination

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**Provider Appeals**
Medicare Advantage plans are authorized to make benefit determinations in accordance with Medicare guidelines.

These determinations are never intended to limit, restrict or interfere with the physician’s judgment. In all cases, decisions regarding treatment continuation or termination, treatment alternatives or the provision of medical services are between the physician and the patient. Medicare Advantage plans are not obligated to pay for unauthorized care. If the provider does not agree with the determination and
the matter cannot be resolved informally, Medicare Advantage plans maintain a physician appeals process through which all providers (physician, facility or ancillary) may appeal a medical management issue or benefit determination.

Coventry recognizes that providers may occasionally encounter situations in which the operation of the Health Plan does not meet their expectations. When this occurs, the provider is encouraged to call the matter to the attention of Coventry. Providers shall in writing state the reason(s) for lack of concurrence with the decision.

Applies To: Participating providers. This process is specific to provider appeals relating to payment of claims and does not replace member appeal policies or providers acting as the member’s authorized representative.

Purpose: To ensure consistent processes are followed when addressing, documenting and handling provider appeals.

Policy: All complaints involving provider adverse payment determinations that cannot be resolved by the Health Plan to the satisfaction of the provider will be addressed using the following procedures.

I. DEFINITIONS

Inquiry – Any question from a provider regarding issues received by a customer service representative in CSO (e.g., benefits information, claim status, or eligibility).

Complaint – Any expression of dissatisfaction expressed by a provider regarding an issue in the Health Plan, which may be resolved by the customer service representative in CSO.

Administrative Appeal/Reconsideration – Any request by a provider concerning the reimbursement of a claim prior to a review by the Health Plan. Claim payment reconsideration's may include, but are not limited to claim check edits, untimely filings, cosmetic procedures, AWP for J code price disputes, anesthesia modifiers, E&M as surgical global, qualifying circumstances and services not prior authorized, etc. For example, the claim check system is set up to auto-deny cosmetic claims based on diagnosis. When the provider sends in his notes, the first time review of those notes is done by the Medical Claims Review Nurse (MCRN) based on specific guidelines and is considered the “claims reconsideration.” They can make the decision to approve based on the guidelines. If the procedure is still considered cosmetic in nature after the MCRN review, all of the information is sent to the medical director for review. If the medical director upholds the initial claim rejection, the provider can then appeal.

Medical Necessity Appeal – Medical necessity appeals are related to a claim payment dispute or a denial of a prior authorization request, when such disputes of denials are based in whole or in part on a medical judgment. These may include, but are not limited to, decisions regarding an admission or a continued stay; or determinations that a service does not meet Coventry’s requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness; and payment for the service is subsequently denied, reduced or terminated.

Part D Appeal – Any of the procedures that deal with the review of adverse coverage determinations made by the Part D plan sponsor on the benefits under a Part D plan the enrollee or the enrollee’s representative believes they are entitled to receive, including a delay in providing or approving the
drug coverage (when a delay would adversely affect the health of the enrollee), or on any amounts the enrollee must pay for the drug coverage.

Provider Appeal – A provider appeal is a request by the provider for consideration of a Health Plan issued denial for service(s) that were provided. Coventry Medicare Advantage plans are authorized to make benefit determinations as referenced in the Evidence of Coverage. Medicare Advantage plans are obligated to ensure that services are provided in a culturally competent manner consistent with professionally recognized standards of health care.

Provider Appeals Process
There are two types of appeals: Administrative and medical necessity. There is one level of medical necessity and one level of administrative appeal.

Filing a Provider Administrative Appeal
Administrative appeals are usually related to a claim payment dispute. These may include, but are not limited to payment amounts based on claim edits, the use of modifiers, global billings; or payment denials due to untimely filing of the claims or failure to prior authorize services.

The first step a provider should make is to contact CSO to inquire about the claim. If the outcome is not satisfactory, an appeal may be the next step. Any additional information the provider wishes to have considered during the appeal review process should be submitted with the letter of appeal. The appeal request should include the following information:

- Member name
- Provider name
- Date(s) of service
- Clear indication of the remedy or corrective action being sought and an explanation of why the Health Plan should “reverse” the adverse benefit determination
- Copy of documentation to support the reversal of decision (e.g., emergency details, date, time, symptoms, why the member did not contact the PCP, etc.)

To inquire about a claim payment, the provider should call 800-727-9712. To file a written administrative appeal, the request should be mailed to:

Coventry Health Care, Inc.
P.O. Box 7370
London, Kentucky 40742

Filing a Provider Medical Necessity Appeal
Medical necessity appeals are related to a claim payment dispute or a denial of a prior authorization request, when such disputes or denials are based in whole or in part on a medical judgment. These may include, but not limited to, decisions regarding an admission or a continued stay; or determinations that a service does not meet Coventry’s requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness; and payment for the service is subsequently denied, reduced or terminated. If the adverse determination had been made prior to services being performed, such as a denial of a prior authorization request, the provider may request an initial reconsideration. This is accomplished through peer to peer review process with a Coventry medical director. To initiate a peer to peer review, please contact Coventry at 816-460-4302.
If the outcome of the peer to peer review is not satisfactory, or if the service that has already been provided, an appeal may be the next step. As a provider, you may file a pre-service appeal on the member's behalf; however, you are required to provide supporting documentation that the member has been notified and agrees to the appeal. Any additional information the provider wishes to have considered during the appeal review process should be submitted with the letter of appeal. The appeal request should include the following information:

- Member name
- Provider name
- Date(s) of service
- Clear indication of the remedy or corrective action being sought and an explanation of why the Health Plan should “reverse” the adverse benefit determination
- Copy of documentation to support the reversal of decision, e.g. complete copy of inpatient records (e.g., physician orders, H&P, consultations, labs, radiology reports etc.), physician office records, ambulance notes, etc., including but not limited to dictations.

To file a written medical necessity appeal, the request should be sent to:

Coventry Health Care  
Attn: Appeals Department  
9401 Indian Creek Parkway, Suite 1300  
Overland Park, KS 66210  
Fax number: 866-769-2408 or 816-460-4952

**Filing a Part D Appeal**

**Standard Part D Appeal**

As a provider you may submit a standard appeal on the member's behalf. Standard Part D appeals are processed within seven calendar days.

When a member files an appeal, the physician is also required to provide a supporting statement. The member’s written appeal will not be addressed until the supporting physician statement is received by the Health Plan.

The physician’s supporting statement must indicate that the preferred drug for the treatment of the enrollee’s condition: (1) Would not be as effective as the requested drug; and/or (2) Would have adverse effects.

If the statement is not received, the plan will make a redetermination based on the evidence available.

**Expedited Part D Appeal**

The prescribing physician may request that the plan expedite a redetermination in situations where applying the standard time frame could seriously jeopardize the enrollee’s life, health or ability to regain maximum function. The plan accepts both oral and written requests. A request for payment of a benefit already provided to an enrollee is not eligible to be reviewed as an expedited redetermination.

The prescribing physician may provide oral or written support for a request made by an enrollee. The plan must expedite a redetermination if it determines, or prescribing physician indicates, that applying the standard time frame could seriously jeopardize the life or health of the enrollee or the enrollee’s ability to regain maximum function. If the plan approves a request to expedite a redetermination, it must be completed and give the enrollee (and the physician involved, as appropriate) notice of its
decision as expeditiously as the enrollee’s health condition requires, but no later than 72 hours after receiving the request.

Member Grievance or Medicare Appeals Process

The member also has the right to dispute an adverse determination. The plans asks that all providers cooperate and comply with all Coventry Medicare Advantage plans and Medicare requirements regarding the processing of member appeals and grievances, including the obligation to provide information within the timeframe reasonably requested for such purpose.

There are two types of procedures for resolving member complaints:

- **Appeals Procedure**
  An “appeal” is the type of complaint made when a member wants us to reconsider and change a decision we have made about what services are covered or what we will pay for a service. For example, if we refuse to cover or pay for services the member thinks we should cover, they can file an appeal. If Coventry or one of our Health Plan providers refuses to give them a service they think should be covered, the member can file an appeal. If Coventry or one of our Health Plan providers reduces or cuts back on services the member has been receiving, they can file an appeal. If they think we are stopping their coverage of a service too soon, the member can file an appeal.

- **Grievance Procedure**
  A “grievance” is the type of complaint a member makes if they have any other type of problem with Coventry or one of our Health Plan providers. For example, the member would file a grievance if they have a problem with things such as the quality of care, waiting times for appointments or in the waiting room, the way the doctors or others behave, being able to reach someone by phone or get the information they need, or the cleanliness or condition of the doctor’s office.

For further guidance on the appeal and grievance process, you or the member may contact Member Services, Monday through Friday, 8:00 a.m. until 6:00 p.m. and on Saturday 9:00 a.m. to 3:00 pm. The member may also refer to their Evidence of Coverage booklet for instructions. Also included in this chapter is a flow chart describing the coverage determination process and timelines for medical and Part D prescription drug benefits.

**Important Message from CMS Appeals Process**

**An Important Message (IM) from Medicare**

This regulation is in effect to ensure that Medicare beneficiaries enrolled in the Medicare Advantage plans are provided with the appropriate information regarding their Medicare coverage and appeal rights with regards to hospital stay and discharge plans.

An I.M. is provided to hospitalized members, or the member’s representative at admission or within two days postadmission for review and signature. The hospital will deliver a second I.M. to the member or representative no earlier than two days prior to discharge. The member or representative has the right to appeal the discharge. It is the responsibility of the member to notify the Quality Improvement Organization (QIO) for review.
If the member requests an appeal from the QIO, the member must do so by noon of the expected discharge date. The QIO will notify Coventry and the facility of the appeal and the facility is required to submit a copy of the complete medical record before close of business on the day the appeal is filed. The QIO will make a decision no later than one business day after it receives all necessary information and will notify the member, Coventry and the facility of the outcome.

A Detailed Notice of Discharge (DND) will be delivered to the patient or Designated Power of Attorney (DPOA) by Coventry staff, or hospital staff, as agreed upon by Coventry and hospital provider, no later than noon of the day following the notice by the QIO for appeal. If the patient is unable to make coherent decisions and the DPOA is not available, Coventry will call the DPOA, explain the contents of the DND and send the DND by certified mail to the DPOA.

Notice of Medicare Noncoverage for Skilled Nursing Facilities (SNF), Home Health Agencies (HHA) and Comprehensive Outpatient Rehabilitation Facilities (CORF)

When coverage is being terminated for SNF, HHC or CORF services, the provider must deliver a notice of Medicare noncoverage to the patient no later than two days or visits before the covered services are scheduled to end.

Coventry will direct you on the timing of the notice delivery but it will be helpful to anticipate the event based on prior authorization of visits. The provider is responsible for delivering the notice of Medicare noncoverage to the individual or individuals’ authorized representative no later than two days or visits before the covered services end. Delivery requires a signed acknowledged receipt of the notice. In circumstances where notice is intended for an authorized representative that is not immediately available, CMS allows for telephone notice followed by a mailing of the notice to the representative. In the event, you are unable to deliver the notice, you should document in the medical record the rationale why the notice was not given to the member (e.g., family takes member home early).

The notice triggers the individual’s right to an expedited review process. That review is conducted by the QIO, a CMS contractor for your state. As explained in the notice, the individual must request an appeal no later than noon of the day before the termination date. Upon receipt of the request for an appeal, the QIO notifies Coventry and you. At the same time, Coventry is responsible for issuing a detailed explanation of why coverage is ending and the provider is responsible for delivery of this letter as well. The provider will be required to send Coventry a copy of the signed notice as well as applicable medical records as soon as possible because Coventry must submit this information to the QIO no later than 4:30 p.m. on the day that the QIO notifies Coventry of an appeal. The QIO will notify Coventry and the provider of the outcome of the expedited review within 1 day of receipt of all records and information.

All Medicare Advantage plan enrollees receiving services from a SNF, HHA or CORF will require delivery of the notice of noncoverage. Failure to meet this responsibility creates the risk of a finding of non-compliance with Medicare conditions of participation.
Medicare Advantage Internal Grievance Process

Important Information on Member Request for a Service
Members have the right to file a grievance with Medicare Advantage if they are in any way dissatisfied with the Health Plan(s) or its contracted providers. The following is a list of examples in which the Medicare Advantage grievance procedure could be used:

- Problems with the quality of the medical care received, including quality of care during a hospital stay
- If a member feels that they are being encouraged to leave (disenroll from) the Health Plan
- Problems with the service received from Member Services
- Problems with how long a member has to wait on the phone, in the waiting room, or in the exam room
- Problems with how long a member has to wait in a network pharmacy
- Problems getting appointments when needed or waiting too long for them
- Waiting too long for prescriptions to be filled
- Rude behavior by doctors, nurses, receptionists, network pharmacists or other staff
- Cleanliness or condition of doctor’s offices, clinics, network pharmacies or hospitals
- If a member disagree with our decision not to give a “fast” decision or a “fast” appeal
- A member believes our notices and other written materials are hard to understand
- We don’t give a decision within the required time frame (on time)
- We don’t forward a case to the independent review entity if we do not give you a decision on time
- We don’t give required notices

A member is encouraged to resolve the complaint informally by working with their member services representative. A member service representative will review, research and resolve member complaints in a timely and equitable manner. Members will be informed of the resolution in writing within 30 days.

An exception to the 30-day resolution process is the expedited or fast grievance process. Medicare Advantage will respond to member’s complaint within 24 hours of notification to Medicare Advantage, only if this issue is in regards to Medicare Advantage’s decision to give the member a fast appeal or if Medicare Advantage takes an extension to our initial decision to appeal.

If a complaint cannot be informally resolved, members have the option to file a written complaint for review by the plan’s grievance committee.

If a member wishes to appeal the decision of the initial grievance committee, they can request a second level review.

If you are informing a member that you are not authorizing a service or telling a member that the service is not covered, you must provide to the Health Plan a copy of the member request form and inform the member that they have a right to appeal. Please direct any members with questions regarding the Medicare appeals process or the Health Plan’s internal grievance process to the Medicare Advantage Member Services department.
The Medical Benefit Coverage Determination Process is provided in the table below.

Complaint process for what benefit or service the Plan will approve or what the Plan will pay for

<table>
<thead>
<tr>
<th>Standard</th>
<th>Expedited</th>
</tr>
</thead>
</table>
| **Pre Service:** 14 day time limit  
**Payment:** 60 day time limit | **Pre-Service:** 72 hour time limit  
**Payment requests cannot be expedited** |
| Organization Determination | |
| Health Plan Reconsideration  
**Pre-Service:** 30 day time limit  
**Payment:** 60 day time limit | Health Plan Reconsideration  
72 hour time limit  
**Payment requests cannot be expedited** |
| 60 days to file | 60 days to file |
| Independent Review Entity Reconsideration  
**Pre Service:** 30 day time limit  
**Payment:** 60 day time limit | Independent Review Entity Reconsideration  
72 hour time limit  
**Payment requests cannot be expedited** |
| 60 days to file | 60 days to file |
| Appeals Level 3 | Appeals Level 2 |
| Appeals Level 4 | Medicare Appeals Council |
| Appeals Level 5 | Federal District Court  
**Amount in controversy requirement must be met** |
| 60 days to file | 60 days to file |
| Medicare Advantage Member Rights and Responsibilities |

Medicare Advantage members have the right to:

**Timely, Quality Care**

- Choice of a qualified contracting PCP and contracting hospital
- Candid discussion of appropriate of medically necessary treatment options for their condition, regardless of cost or benefit coverage
Timely access to PCP and referrals to specialists when medically necessary
Timely access to all covered services, both clinical and nonclinical
To go to a women’s health specialist without a referral
Access to emergency services without prior authorization when they, as a prudent layperson, acting reasonably would have believed that an emergency medical condition existed and payment will not be withheld in cases where they seek emergency services
Actively participate in decisions regarding their own health and treatment options
Receive urgently needed services when traveling outside the Health Plan’s service area or in Health Plan’s service area when unusual or extenuating circumstances prevent them from obtaining care from their PCP (HMO members only).

Treatment with Dignity and Respect

- Be treated with dignity, respect and fairness at all times, and to have their right to privacy of their medical records and personal health information recognized
- Exercise these rights regardless of their race, physical or mental ability, ethnicity, gender, sexual orientation, creed, age, religion or their national origin, cultural or educational background, economic or health status, English proficiency, reading skills, or source of payment for their care. Expect these rights to be upheld by both Medicare Advantage and contracting providers.
- Confidential treatment of all communications and records pertaining to their care. They have the right to access their medical records. Medicare Advantage must provide timely access to your records and any information that pertains to them. Written permission from them or their authorized representative shall be obtained before medical records can be made available to any person not directly concerned with your care or responsible for making payment for the cost of such care.
- They have the right to know how their health information has been given out and used for non-routine purposes
- Be involved in decisions to withhold resuscitative services, or forgo or withdraw life-sustaining treatment
- Extend their rights to any person who may have legal responsibility to make decisions on their behalf regarding their medical care
- Refuse treatment or leave a medical facility, even against the advice of physicians (providing they accept the responsibility and consequences of the decision)
- Complete an advance directive, living will or other directive to their contracting medical providers.

Medicare Advantage Information

- To be informed of Medicare Advantage policies and procedures regarding services, benefits, providers, and our member rights and responsibilities and be notified of any significant changes
- Information about Medicare Advantage and covered services written in a manner that truthfully and accurately provides information in a format that is easy to read and understand
- Know the names and qualifications of physicians and health care professionals involved in their medical treatment
- Receive information about an illness, the course of treatment and prospects for recovery in terms that they can understand
• Information regarding how medical treatment decisions are made by the contracting medical group or Coventry, including payment structure
• Information about their medications – what they are, how to take them and possible side effects
• To receive a notice that tells about their privacy rights and explains how we protect the privacy of their health information
• To ask Health Plan providers to make corrections or additions to their medical records
• Receive as much information about any proposed treatment or procedure as they may need in order to give an informed consent or to refuse a course of treatment. Except in cases of emergency services, this information shall include a description of the procedure or treatment description, the medically significant risks involved, any alternate course of treatment or non-treatment and the risks involved in each, and the name of the person who will carry out the procedure or treatment.
• Reasonable continuity of care and to know in advance the time and location of an appointment, as well as the physician providing care
• Be advised if a physician proposes to engage in experimentation affecting their care or treatment. They have the right to refuse to participate in such research projects or experimental treatment.
• Be informed of continuing health care requirements following discharge from inpatient or outpatient facilities
• Examine and receive an explanation of any bills for non-covered services, regardless of payment source
• General coverage and Health Plan comparison information
• Utilization control procedures
• Summary of statistical data on grievances and appeals that members have filed against the Medicare Advantage program
• The financial condition of Coventry
• Summary of provider compensation agreements
• To make recommendations regarding the organization’s member rights and responsibilities policies.

Timely Problem Resolution

• Make complaints and appeals without discrimination and expect problems to be fairly examined and appropriately addressed
• Responsiveness to reasonable requests made for services
• Receive a detailed explanation from Coventry Health Care of Kansas, Inc. (CHCKS) if you believe that a Health Plan provider has denied care that you believe you are entitled to receive

As a member of Medicare Advantage, they have the responsibility to:

• Provide their physicians or other care providers the information needed in order to care for them
• Do their part to improve their own health condition by following treatment plans, instructions and care that they have agreed on with their physician(s)
• Understand their health problems and participate in developing mutually agreed upon treatment goals to the degree possible
• Behave in a manner that supports the care provided to other patients and the general functioning of the facility
• Accept the financial responsibility for any copayment or coinsurance associated with covered services received while under the care of a physician or while a patient at a facility
• Accept the financial responsibility for any premiums associated with membership in Medicare Advantage plans
• Review information regarding covered services, policies and procedures as stated in their evidence of coverage information
• Ask questions of their physician. If they have a suggestion, concern, or a payment issue, we recommend they call the Medicare Advantage Customer Service (number of located on back of ID card)

Quality Improvement Organization QIO Review

The QIO, an independent agency, has contracted with the secretary of DHHS to review records of the medical care provided to Medicare Advantage members when they register complaints concerning quality of access or to care.

Members also have the right to an immediate review by the QIO if the member believes that they are being discharged from the hospital, skilled nursing facility, home health services or comprehensive outpatient rehabilitation Facility (CORF) too soon. When Medicare Advantage issues a member a notice of discharge, the notice is subject to QIO review.

Medicare Advantage will contact your office as needed to obtain medical records upon QIO request. Please provide any requested records as soon as possible so that the Quality Improvement Committee (QIC) can complete their review. Direct any questions regarding the QIO and the review process to our Health Services department.

Independent Quality Review

CHCKS Medicare Advantage maintains an agreement with the Kansas Foundation for Medical Care (KFMC), a QIO-approved by CMS. The purpose of this agreement is to focus on the development and implementation of cooperative projects as a method to improve the quality of care in the State and to help Medicare risk beneficiaries makes informed health care choices. Quality of care includes access, appropriateness and desired outcomes to care and consumer satisfaction.

Unique Services

Medicare Advantage offers a more comprehensive benefit package for its members compared to fee-for-service Medicare, Medigap or Medicare supplement plans. Examples of these service enhancements are described below. Please note that Medicare Advantage services have coverage limitations that are different from the Coventry HMO and PPO products. In most cases, the coverage limitations follow Medicare fee for service coverage guidelines.

Please note: Members are subject to the copayment indicated on their identification card for certain services.

Outpatient Services

Preventive Care – Routine physicals are covered once per year.
Diagnostic X-Ray – These services need to be coordinated by the PCP or attending physician.

Mammograms are covered annually. As required by CMS, members may self-refer to a contracted facility for the annual screening mammogram. Medicare Advantage does remind each member that they should also have a breast exam by their PCP or a contracted gynecologist in conjunction with obtaining a mammogram.

DME and Prosthetic Appliances – Medicare Advantage follows Medicare guidelines for coverage of DME, prosthetics and orthotic devices. Prosthetic devices must be on the Medicare’s list of approved prosthetic devices. A copayment or coinsurance may apply.

Diabetic Supplies – Diabetes and self-monitoring training and supplies includes coverage for glucose monitors (Lifescan Models), test strips, lancets and self-management training. A copayment or coinsurance may apply.

Gynecological Visit – Medicare members are entitled to one office visit per year for a routine annual exam including a pap smear without a referral from the PCP or attending physician when using a Medicare Advantage contracted gynecologist. A copayment may apply.

Mammography Screening – Medicare members have direct access (through self-referral) to screening mammography.

Immunizations and Vaccinations – Medicare members have direct access (through self-referral) for influenza and pneumococcal vaccines and their administration and are covered in full. All other vaccines are covered under Part D (prescription drug) benefits. See information about NuFactor VaxAmerica distribution for access to these vaccines.

Oral Surgery – Medicare members have coverage for initial treatment received within 24 hours of an accidental injury. Benefits also include nondental treatment relating to medically diagnosed congenital defects, birth abnormalities, or treatment for tumors and cysts (including pathological examination) of jaw, cheeks, lips, tongue, roof and floor of mouth.

Extraction, replacement and restoration of teeth are not covered.

Hearing Aid Benefit – Advantage members may have coverage for hearing aids every three years up to the allowance listed in the member’s Evidence of Coverage.

Fitness Benefit – Health club membership and fitness classes offered through the SilverSneakers® program. For additional information please refer to the member’s Evidence of Coverage.

Podiatry – Routine foot care is covered two times a year with no PCP referral or attending physician to a contracted podiatrist. A copayment may apply.

Chiropractic Care – Medicare Advantage follows Medicare guidelines for chiropractic services.

Inpatient Services

Skilled Nursing – Medically necessary coverage is limited to 100 days per Medicare benefit period. The three-day hospital stay requirement will be waived. No prior hospitalization is required.
Inpatient Behavioral Health – Mental Health: Medicare Advantage members have a lifetime limit of 190 days for care in a psychiatric hospital. Benefit limitations follow Medicare guidelines. The telephone number for MHNet is 866-607-5970, (TDD 877-266-2099).

Other Covered Services (pre-authorization is not necessary) – The following services are not routinely covered by fee for service Medicare, but are covered under Medicare Advantage.

Vision Care – Advantage members may be entitled to routine eye exams by a routine vision provider once per year, subject to a copayment. Medicare Advantage members are also entitled to eyeglasses or contact lenses once every year up to the allowance listed in the member’s copayment schedule.

Advantage members, regardless of the benefit plan selected are also entitled to benefits for eyeglasses or contact lenses after cataract surgery. This benefit follows the Medicare guideline for coverage.

Pharmacy – Advantage individual members have the Medicare Part D prescription drug coverage pharmacy benefit that is subject to limitations. Members also have coverage for Medicare Part B drugs and diabetic supplies through the pharmacy network. Please refer to the member summary of benefits for more specific information. Those members that are covered through an employer benefit plan have prescription drug coverage. The Part D formulary for Advantage products are accessible online through the www.chcadvanta.com website, as well as the epocrates.com website. Please contact the Customer Service department for more information on prescription drug coverage for Advantage members.

Obtaining Vaccines for Medicare Advantage members

NuFACTOR VaxAmerica Network is a nationwide network of professional Part D vaccine administration centers. The centers are located at in-network doctors’ offices, clinics, pharmacies and long-term care facilities. The vaccination centers work with members and doctors to obtain a Part D vaccine prescription and schedule the member’s vaccination appointment at a center that is convenient for them. The member has only one copayment for the vaccine and its administration.

NuFACTOR VaxAmerica Network provides the following Medicare Part D covered vaccinations:

<table>
<thead>
<tr>
<th>Vaccination</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diphtheria</td>
<td>Hemophilus B (H.Flu)</td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>Hepatitis B</td>
</tr>
<tr>
<td>Herpes Zoster (Shingles)</td>
<td>Human Papillomavirus (Gardasil)</td>
</tr>
<tr>
<td>Japanese Encephalitis</td>
<td>Measles</td>
</tr>
<tr>
<td>Meningococcal Meningitis</td>
<td>Mumps</td>
</tr>
<tr>
<td>Pertussis (Whooping Cough)</td>
<td>Polio</td>
</tr>
<tr>
<td>Rabies</td>
<td>Rubella (German Measles)</td>
</tr>
<tr>
<td>Tetanus</td>
<td>Typhoid</td>
</tr>
<tr>
<td>Varicella (Chickenpox)</td>
<td>Vaccine combinations</td>
</tr>
</tbody>
</table>

To facilitate access and support for Coventry members, we encourage doctors to fax a member’s prescriptions for these vaccines to NuFACTOR at 877-432-6258. NuFACTOR will contact members to arrange for the vaccine and services.

NuFACTOR is approved by Coventry to dispense and administer covered vaccines to our members, and NuFACTOR meets our service guidelines. NuFACTOR will arrange for the vaccine and the
clinical services to provide the vaccine, offering a simple one-step process for Coventry members. The NuFACTOR network offers convenient, high quality sites of administration for vaccines.

**NuFACTOR VaxAmerica Network** is easy and cost-effective:
- VaxAmerica providers are all in-network—more than 8,000 providers across 50 states
- No standing in line for shots
- Vaccine appointments are scheduled by friendly customer care representatives
- Vaccines are professionally administered in a convenient location
- Only one copayment
- Confirmation of vaccination is faxed to the doctor’s office

Members are encouraged to ask their doctor about NuFACTOR VaxAmerica Network, or contact Coventry customer service using the phone number on their card. To schedule a Part D vaccine appointment, including the shingles vaccination, members can call NuFACTOR VaxAmerica at 800-883-9958.

If a doctor would like to become a member of the NuFACTOR network, they can call 877-494-4484 for more information or go directly to our signup sheet on-line at [www.joinactivecarenetwork.com](http://www.joinactivecarenetwork.com). For complete information on the VaxAmerica Network and locations, visit Essentials and look under *Part D vaccines.*

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**Advance Directive**

An advance directive is a written formal document, written by the member in advance of an incapacitating illness or injury.

When an Medicare Advantage member visits your office, we ask that you discuss Medicare advance directives and document in the medical records whether or not the member has executed an advance directive.

Advance Directive examples are at the end of this chapter.

**Accessibility Standards**

Coventry has developed standards for accessibility and availability of primary care physicians for 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 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
- Member waiting time for urgent care visits — within 24 hours
- Member waiting time for a routine nonsystematic office visit — not more than two weeks
- Member requesting a routine physical exam — not more than four weeks
Special Status Medicare Members

CMS reimburses contractors at different rates for each member based on age, sex, county of residence, and also on the classification into one of five special status categories.

The special status categories include:

- Institutional status
- End stage renal disease
- Medicare/Medicaid dual eligible
- Hospice
- Working aged

It is important that you understand the different special status categories and take the actions defined below when you identify a member who meets the special status definition.

Institutional status is defined as an individual enrolled in a Medicare Advantage plan who has been a resident in a skilled nursing facility, nursing facility, ICF/MR, psychiatric hospital, rehabilitation hospital, long-term care hospital, swing-bed hospital for at least 30 consecutive days.

If you are making rounds on a member in one of these facilities and the member has been there for more than 30 days, please make sure your utilization management contact is aware of this member. These types of members must be submitted to CMS each month for CMS to provide the Health Plan with a higher reimbursement rate.

End Stage Renal Disease (ESRD) is defined by CMS as the state of renal impairment that appears to be irreversible and permanent, and requires a regular course of dialysis or kidney transplantation to maintain life.

If 36 months or more has elapsed since a kidney transplant, the person is no longer considered to have ESRD status.

End Stage Renal Disease (ESRD) is defined by CMS as the state of renal impairment that appears to be irreversible and permanent, and requires a regular course of dialysis or kidney transplantation to maintain life.

If 36 months or more has elapsed since a kidney transplant, the person is no longer considered to have ESRD status.

It is very important that you inform your utilization management contact of any enrolled members who now meet the ESRD definition. The Health Plan receives a higher reimbursement from CMS for members who are ESRD. ESRD status is reported to CMS through the ESRD network organization located in 18 geographic areas in the United States. The provider, usually a contracted nephrologist or renal dialysis facility, submits the completed CMS 2728-U4, “Medical Evidence Report Form,” to the applicable ESRD network organization.

The ESRD network organization reviews the form and transmits the data to CMS electronically. CMS will notify the Health Plan of members who are ESRD and pay the Health Plan at a higher rate.

Note: Advantage may be secondary payor for individuals who have both Medicare coverage and employer group Health Plan coverage.

Medicare/Medicaid dual eligible is an individual who is covered under both the Medicare and Medicaid programs. A qualified Medicare beneficiary (QMB), has the state Medicaid program pay for annual Medicare Part A deductible, Medicare Part A coinsurance, monthly Medicare Part B premium, annual Part B deductible and Medicare Part B coinsurance.
Hospice is defined by BMS as a benefit for a member who has a terminal illness who and is expected to live six months or less and has selected Medicare certified hospice coverage. Prospective members are entitled to enroll in Medicare Advantage if they are receiving hospice coverage.

A Medicare Advantage member becomes Medicare certified for hospice when they complete a hospice election form. This form is usually provided by a Medicare certified home health or hospice provider. The provider then submits the form along with the provider bills to the fiscal intermediary. The fiscal intermediary pays the hospice claims, not Medicare Advantage. It is very important that you inform your utilization management contact of any enrolled members who elect hospice care. Medicare Advantage receives a lower reimbursement rate from CMS for members that are Medicare certified hospice since the fiscal intermediary is paying the claims.

Working Aged is defined as the CMS Medicare Advantage risk payment category for an individual who is defined as eligible for Medicare and (1) is either working for an employer with more than 20 employees or (2) has a spouse with coverage under an employer group health plan which covers the Medicare Advantage member.

The Health Plan receives a lower payment rate from CMS for these members. If you identify a member with employer group health plan coverage in addition to their Medicare Advantage coverage, please inform Medicare Advantage member services. If a member is working aged, you should bill the other carrier as primary and Medicare Advantage as the secondary payor.

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**Record Retention**

As a requirement of Medicare, all providers must maintain for a period of 10 years, books and in certain instances described in the Medicare Advantage regulation, periods in excess of 10 years for more records, documents and other evidence of accounting procedures and practices, physical facilities and equipment and records related to Medicare enrollees and any additional relevant information CMS may require.

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**Claims and Encounter Submission**

It is recommended that you submit claims within 90 days from the date of service on a CMS 1500 form. Coventry has adopted the standard billing guidelines so that completion of the CMS form is consistent with Medicare guidelines.

- You must include your UPIN number on each claim form submitted
- All hospitals (inpatient and outpatient) services and physician services information are required to be submitted to CMS
- The mailing address for Coventry Medicare Advantage claims is:

  Coventry Health Care  
P.O. Box 7370  
London, KY 40742

- For electronic submission, please use payor ID #25144
Important Provider Encounter Information Regarding Medicare Advantage Risk Adjustment Payment Methodology

The Balanced Budget Act of 1997 specifically required implementation of a risk adjustment method payment methodology. Beginning in 2004, Medicare Advantage organizations received 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 Balanced Budget Act of 1997, Medicare Advantage organizations must collect and submit all inpatient hospital, outpatient hospital and physician encounter data to CMS on all enrolled Medicare Advantage HMO and PPO 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 clinical modification 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 the Medicare Advantage program 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.

(1) Provider should provide ongoing training to staff regarding appropriate use of ICD-CM code set for reporting diagnoses
(2) Submit all diagnosis that impact the patient evaluation, care and treatment:
   - Main reason for a visit or admission
   - Co-existing acute condition
   - Chronic conditions
   - Permanent past conditions
(3) Providers should periodically review their claim/encounter data submission to ensure that they are accurate, complete and truthful and are supported by the medical record or other relevant documentation
(4) Provider should fully communicate diagnosis details to coding staff, so that the visit or admission is coded to the highest level of specificity known

Importance of Medical Record Documentation

- 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
Referral/Authorization

Coventry Advantage HMO

When a PCP wishes to refer a Medicare HMO member to a specialist, they must refer to an Medicare HMO contracted provider. Medicare HMO members may self-refer to contracted specialists for gynecological visits, annual screening mammography, and immunizations for influenza and pneumococcal vaccines. A list of providers can be found in the Medicare Advantage provider directory. Certain services require prior authorization. Please refer to the Coventry website at www.chcoklahoma.com for more information.

Coventry Medicare Freedom PPO: Medicare members in the Freedom PPO are not required to see Medicare HMO contracted providers. They may have a higher out of pocket or coinsurance cost sharing.

For covered services that require prior authorization by a network provider, members may call Coventry’s Health Authorization department at 1-877-837-8914 or 816-460-4670, (TDD, 1-866-347-2459) Monday through Thursday 8:00 a.m. to 5:30 p.m., and Friday 8:00 a.m. to 5:00 p.m., CST. If the service is approved, an approval letter is sent to the Medicare Advantage HMO member and the provider performing the 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.

Mental Health/Substance Abuse Referrals

Mental/health/substance abuse services are covered through 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 1-866-607-5970 (TDD, 1-877-266-2099) and is also listed in the provider directory.

Complex Case Management

The goal of complex case management is to encourage appropriate use of health care services on a case-by-case basis. Complex case management is an individualized patient-specific process to coordinate the delivery of cost-effective, high quality care in the timeliest manner to ensure optimal patient outcomes. Potential case management cases are identified by a variety of sources, including claims, authorizations, physician and member referrals, specific diagnoses and system generated flags based on utilization.

Case Management includes but is not limited to:

- Ensure services are provided at the most appropriate setting
- Care coordination between the patient and their health care team
- Serve as patient/family advocate to facilitate open communication, understanding and involvement in the treatment plan
- Provide educational materials for member to develop successful self-management skills of their condition

Provider referrals to case or disease management may be made by calling 816-460-4220 or 800-468-1442, ext. 4220.
Disease Management

Disease management programs focus on managing health risk factors and identifying potential high-risk members early. We provide educational materials to help members self-manage their conditions and avoid complications. We provide outreach to these affected members through condition specific reminders and mailings and we encourage individuals to receive annual flu vaccines as well as pneumonia vaccines as appropriate.

The targeted conditions are diabetes, asthma, congestive heart failure, coronary artery disease, high risk obstetrical conditions, chronic obstructive pulmonary disease and chronic kidney disease.

Provider referrals to case or disease management may be made by calling 816-460-4220 or 800-468-1442, ext. 4220

Quality Improvement

The goal of the quality improvement program is to facilitate consistent provider delivery of high quality coordinated member care and Health Plan administrative services.

For comprehensive information describing the QI department and 2013 QI Program updates, please visit our website at www.chcoklahoma.com > Providers > Document Library > 2013 QI Program.

The Quality Improvement Department

The Quality Improvement department is staffed with health care professionals. The department is led by the Health Plan’s senior medical director and Health Services vice-president who are responsible for the overall operation of the department.

Committees

The following committee structure supports the quality improvement processes and other activities at Coventry. The Health Plan’s internal QIC reports to the President and CEO, who reports to the board of directors on the various quality improvement initiatives.

Quality Improvement Committee

The purpose of the Health Plan’s QIC is to oversee quality improvement issues for all departments in the Health Plan. Its members consist of representatives of the Health Plan’s functional departments. Oversight of the quality improvement issues by the QIC supports consistency of Health Plan administrative services. This committee meets at least monthly to review the following areas:

- Preventive health and wellness
- Disease management
- Network development
- Credentialing and delegation
- Utilization management
- Customer service
- Provider relations
- Communications
Quality Management/Utilization Management/Pharmacy and Therapeutics Committee
This Committee consists of a medical director (or designee) and Health Plan participating physicians. This committee monitors and evaluates the quality of medical care rendered by participating providers to all plan members. In addition, the committee may be called upon to determine whether a quality of medical care issue exists, impose corrective actions based upon severity levels; provide educational feedback to providers and provide a summary report of activities. Potential quality of care issues can be referred to the Health Plan’s QI staff from various sources including member complaints, case management, concurrent review nurses and quality improvement screens. This committee also reviews the Health Plan’s prior authorization criteria and HEDIS results. Additions or deletions to the Health Plan’s formulary may also be reviewed by this committee.

Healthcare Effectiveness Data and Information Set (HEDIS)
HEDIS results are used to measure the effectiveness of the Health Plan’s QI initiatives. 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. HEDIS results are based on statistically valid random samples of members. The HEDIS results are subjected to a rigorous review by certified HEDIS auditors.

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

- Administrative (uses claims and encounter data)
- Hybrid (uses medical record review along with claims and encounter data)
- Survey

Medical record review is an important part of the HEDIS data collection process. The medical record contains information such as lab values and results of tests that may not be available in the administrative data. A QI nurse 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 office may choose to fax or mail the specific information. 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, 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.

Consumer Assessment of Health Plans Study (CAHPS)
- Coventry uses a certified survey firm to administer the CAHPS member satisfaction survey to a sample of our adult commercial members. CMS is responsible for the administration of the CAHPS member satisfaction survey to a sample of our Medicare products members. The CAHPS survey provides information on the experiences of members while they are members of a Health Plan and gives a general indication of how well the plan meets members’ expectations.
The scores summarize member responses in the areas including but not limited to:

- Courteous and helpful office staff
- Customer service
- Getting care quickly
- Getting needed care
- Flu shot rates
- Health plan rating
- Specialist rating

Through this survey, we can assess how well we are serving the physicians who care for our members and take measures, where indicated, to improve service. In addition to service standards, these surveys contain open questions that will allow you to address any unlisted topics. We encourage our participating physicians to take part in our satisfaction surveys.

**Reviews for Outside Agencies**

Various state or federal regulatory agencies (to ensure compliance with applicable laws, regulations and contractual requirements) may audit Coventry’s participating providers. Providers’ medical records may be audited by CMS, by CMS through the Kansas QIO and accreditation agencies such as URAC. We would appreciate your cooperation during such audits, as outlined in you agreement with Coventry.

**Medical Records**

Providers should safeguard the privacy of the member’s medical record. 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 member information should be available to be transferred upon request by the member, or authorized representative, to any organization with which the member may subsequently enroll, or to a provider to ensure continuity of care.

Ensure timely access by member to pertinent records and information upon request. Members can be charged a reasonable fee for copies of records (usually $15.00 retrieval fee and $0.10 per page).

The provider must abide by all federal and state laws regarding confidentiality, documentation on whether or not a member has executed an advance directive and disclosure for mental health records and medical records.

The Health Plan’s medical record standards for Medicare members include the following:

1. Personal and biographical data is easily identified in the medical record.
2. Identifiable problem list including significant illness, medical and psychological conditions by the conclusion of the third visit.
3. Medication allergies/adverse reactions are listed at the first visit or a notation that the patient has no known allergies or history of adverse reaction.
4. The medical record documents presenting complaints, diagnoses and treatment plans for each visit.
5. The medical record documents past medical history, physical examinations, necessary treatments and possible risk factors for the member relevant to the particular treatment.
6. Identification of all providers participating in the member’s care and information on services furnished by these providers, e.g., consults, laboratory, x-ray, and other diagnostic studies are ordered as appropriate for the presenting symptoms and/or comprehensive exam.
7. The medical record documents prescribed medications, including dosage and date of initial or refills.
8. Information on advance directives has been reviewed.

CMS Requirements

Please be advised that marketing material communication that promote, communicate or explain the Medicare Health Plan to Medicare Advantage members require approval by CMS. Health education materials are generally not under the purview of CMS marketing review.

The Health Plan has various CMS-approved materials that we can make available to you for you to announce your participation with the Coventry Medicare Advantage program. Please contact the Medicare Advantage marketing department if you are interested in pursuing any communication to members of your practice regarding the Advantage program.

Senior Health Questionnaire

All new members are sent a senior health questionnaire within the first 90 days of enrollment. The questionnaire is completed by the member and sent back to Coventry.

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

Medicare Advantage requests that the member discuss their senior health questionnaire with their PCP or attending physician. The information from the senior health questionnaire may assist the PCP or attending physician in providing direction regarding the member’s health needs and potential treatment options. This will allow the member to participate in the development of their own treatment plan. Advantage will also assist in the coordination of care for complex or serious disease cases with the PCP or attending physician and will inform members of any follow-up care and provide training in self-care through the case management or disease management program.

Laws and Regulations

All Health 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 members without regards to the race, color, religion, sex, ethnic origin, age or disability of such person, or any other classification prohibited by law.

Coventry’s policy, as well as the federal law, is that no form of discrimination prohibited by law will be permitted on the basis of sex, race, color, disability, age, religion or ethnic origin, and that all members will have access to their medical services at all contracted provider facilities.

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**Member Access to Care and Information from Plan Providers**

Medicare members have the right to get timely access to plan providers and to all services covered by Medicare Advantage. “Timely access” means that members get appointments and services within a reasonable period of time. Members have the right to get full information from their doctors when they get medical care. Members have the right to participate fully in decisions about their health care, which includes the right to refuse care. If Medicare Advantage members need to talk with their PCP or get medical care when their PCP’s office is closed, and it is not a medical emergency, the member should call the PCP number listed on their Advantage membership card. There will always be a doctor on call 24 hours a day, seven days a week, to help them.

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**Disclosure of Information**

At the request of the Medicare Advantage 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 members’ satisfaction and health outcomes (2) establish and facilitate a process for current and prospective beneficiaries to exercise their right to choose Medicare services.

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**Continuation of Benefits**

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

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**External Review**

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

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**Plan Provider Termination Notice**

The Medicare Advantage organization must make a good faith effort to notify 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 Medicare Advantage organization and the provider shall provide at least 60 days advance written notice in the event that the Medicare Advantage 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 Health Plan’s medical policies, QI and medical management programs.

Exclusion of Certain Persons

Provider shall not and shall ensure that no provider with which the provider contracts shall employ or contract for the provision of healthcare with individuals excluded from participation in Medicare.

Physician Incentive Plans

Provider shall specify payment and incentive arrangements in all contracts with other providers and shall ensure that all such payment and incentive arrangements shall be structured consistent with the physician incentive plan requirements and limitations imposed by the Medicare Advantage program.

Exclusion of Certain Persons

Provider shall not and shall ensure that no provider with which the provider contracts shall employ or contract for the provision of healthcare with individuals excluded from participation in Medicare.

Physician Incentive Plans

Provider shall specify payment and incentive arrangements in all contracts with other providers and shall ensure that all such payment and incentive arrangements shall be structured consistent with the physician incentive plan requirements and limitations imposed by the Medicare Advantage program.

Prompt Payment Requirements

Providers must agree to prompt payment provision terms between the Medicare Advantage organizations and suppliers of which are developed and agreed to by both the Medicare Advantage organization and the relevant provider.

All Medicare Advantage members receive an advance directive document as part of their membership materials.
Extra copies can be obtained through our Medicare Advantage Customer Service department at 800-727-9712.

Medicare Provider Training and Education

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 1 or related entity 2. 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 CMS, and other requirements in light of your contracted relationship with Coventry. As a result, you, your entity, any downstream entities 3 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 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 at: 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.

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.

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COVENTRY HEALTH CARE
MEDICAL CARE ADVANCE DIRECTIVE POLICY

Coventry believes in the right of the patient to make the appropriate decisions concerning their care. We also understand that in some medical situations, that power may not be within the patient’s realm of physical or mental capacities. Medicare Advantage believes in and supports a patient’s right to make advance arrangements for the direction of his/her medical care in these instances.

The states of Kansas and Missouri recognize and enforce the provisions of the Patient Self-Determination Act of 1990. In response to this legislation both states recognize two forms of medical care advance directive.

- “Living will”
Health care agent designation (durable power of attorney)

Coventry requires each of our network and contracted providers to notify and educate the member/patient about their rights and how to exercise them. The following is the policy followed by Medicare Advantage.

1. Coventry 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
   - Any policy of the HMO regarding these rights

2. Any document of medical care advance directives executed by the 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 will monitor the compliance of its provider offices by reviewing advance directive processes at regular medical record reviews.

5. Coventry will conduct orientation and continuing education with providers, their staffs and the staff of Coventry, which will include education about advance directives. Coventry will provide written material on advance directive rights for the distribution through the medical offices.

6. Coventry will require each provider to inform each adult member about the medical care advance directions 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
   - At the time of the initial advice on hospice care

Coventry 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 PCP that has compatible beliefs with the patient.

**Advance Directive Procedures**

1. **Training** – All Medicare Advantage customer service staff must complete training about advance directives, including what it is, what form it must take, how it is executed and used, where it is maintained, the provider involved, and so on.
2. Providers will receive advance directives training as a part of their orientation.

3. The provider manual will contain appropriate documentation on advance directives procedures, sample forms, and sample correspondence to member to acknowledge receipt and information about medical records documentation.

Communication to the Member

1. Each member will receive the brochure Medical Care Advance Directives: The Right to Decide.

2. If the member decides to choose an advance directives option, they can obtain an appropriate form from:
   - Customer service
   - Physician
   - Hospital

3. Once the member selects the appropriate option it should be executed according to the jurisdiction of the member’s residence.
   - Kansas – accepts a witness on the living will and notarization of the durable power of attorney
   - Missouri – requires a witness on the living will and notarization of the durable power of attorney

4. The member should retain a copy of the executed advance directives form. The original should be forwarded to their physician to assure a mutual understanding. The member should also supply this form to any other physician or specialist that is currently rendering care. In the event of hospitalization, the member should present the advance directive forms to be entered into his/her hospital record or execute a hospital supplied form.

5. The member should also provide a copy of the advance directive to family members or close friends that could assist the member in the event of an illness or injury in which they are incapacitated and cannot express their wishes to medical personnel.

Customer Service Procedures

1. When members call requesting an advance directives form, please send health care directives, instructions for health care directives and copy of the flow chart – how to select an advance directive.

2. Provided brief directions for the completion and use of the form that you will send.

3. Document the call and action into Navigator.
Health Care Directive

Take a copy of this with you whenever you go to the hospital or on a trip

I, _____________________________ (Please Print) SS# _______________ (Optional) want everyone who cares for me to know what health care I want.

I always expect to be given care and treatment for pain or discomfort even if such care may affect how I sleep, eat or breathe.

I would consent to, and want my agent to consider my participation in federally regulated research related to my disorder or condition.

I want my doctor to try treatments/interventions on a time-limited basis when the goal is to restore my health or help me experience a life in a way consistent with my values and wishes. I want such treatments/interventions withdrawn when they cannot achieve this goal or become too burdensome to me.

I want my dying to be as natural as possible. Therefore, I direct that no treatment (including food or water by tube) be given just to keep my body functioning when I have:

- a condition that will cause me to die soon
- a condition so bad (including substantial brain damage or brain disease) that I have no reasonable hope of achieving a quality of life that is acceptable to me

An acceptable quality of life to me is one that includes the following capacities and values. (Describe here the things that are most important to you when you are making decisions to choose or refuse life-sustaining treatments.)

Examples:
The ability to:
- Recognize family or friends
- Communicate
- Feed myself
- Make decisions
- Take care of myself
- Be responsive to my environment

If you do not agree with one or other of the above statements, draw a line through the statement and put your initials at the end of the line.

In facing the end of my life, I expect any agent (if I have one) and my caregivers to honor my wishes, values and directives. For further clarification, please refer to my Caring Conversations workbook, which is located at ________________________________

Be sure to sign the reverse side of this page, even if you do not wish to appoint a durable power of attorney for healthcare decisions.

Talk about this form and your ideas about your health care with the person you have chosen to make decisions for you, your doctors, family, friends and clergy. Give each of them a completed copy.

You may cancel or change this form at any time. You should review it often. Each time you review it, put your initials and the date here _____.

Medicare has neither reviewed, nor endorses this information. This document is provided as a service by the Center for Practical Bioethics. For more information, call the Center for Practical Bioethics at 816-221-1100, email bioethic@practicalbioethics.org or visit their website at www.practicalbioethics.org.
Durable Power of Attorney for Healthcare Decisions

Take a copy of this with you whenever you go to the hospital or on a trip

It is important to choose someone to make health care decisions for you when you cannot make or communicate decisions for yourself. Tell the person you choose what health care treatments you want. The person you choose will be your agent. He or she will have the right to make decisions for your health care. If you DO NOT choose someone to make decisions for you, write NONE on the line for the agent’s name.

I, ______________________________, SS# ________________ (optional), appoint the person named in this document to be my agent to make my health care decisions.

This document is a durable power of attorney for health care decisions. My agent’s power shall not end if I become incapacitated or if there is uncertainty that I am dead. This document revokes any prior durable power of attorney for health care decisions. My agent may not appoint anyone else to make decisions for me. My agent and caregivers are protected from any claims based on following this durable power of attorney for health care. My agent shall not be responsible for any costs associated with my care. I give my agent full power to make all decisions for me about my healthcare, including the power to direct the withholding or withdrawal of life-prolonging treatment, including artificially supplied nutrition and hydration/tube feeding. My agent is authorized to:

- Consent, refuse, or withdraw consent to any care, procedure, treatment, or service to diagnose, treat, or maintain a physical or mental condition, including artificial nutrition and hydration
- Permit, refuse, or withdraw permission to participate in federally regulated research related to my condition or disorder
- Make all necessary arrangements for any hospital, psychiatric treatment facility, hospice, nursing home, or other healthcare organization; and, employ or discharge healthcare personnel (any person who is authorized or permitted by the laws of the state to provide healthcare services) as he or she shall deem necessary for my physical, mental, or emotional wellbeing
- Request, receive, review, and authorize sending any information regarding my physical or mental health, or my personal affairs, including medical and hospital records; and execute any releases that may be required to obtain such information
- Move me into or out of any state or institution
- Take legal action, if needed
- Make decisions about autopsy, tissue and organ donation, and the disposition of my body in conformity with state law
- Become my guardian if one is needed

In exercising this power, I expect my agent to be guided by my directions as we discussed them prior to this appointment and/or to be guided by my health care directive (see reverse side).

If you DO NOT want the person (agent) you name to be able to do one or other of the above things, draw a line through the statement and put your initials at the end of the line.

Agent’s name ______________________________ Phone_________ Email_____________________

Address _______________________________________________________________________

If you do not want to name an alternate, write “none.”
Alternate Agent’s name_________________________________ Phone_________ Email____________________________
Address __________________________________________________________________________________________________

**Execution and Effective Date of Appointment**

My agent’s authority is effective immediately for the limited purpose of having full access to my medical records and to confer with my health care providers and me about my condition. My agent’s authority to make all health care and related decisions for me is effective when and only when I cannot make my own health care decisions.

**SIGN HERE** for the durable power of attorney and/or healthcare directive forms. Many states require notarization. It is recommended for the residents of all states. Please ask two persons to witness your signature who are not related to you or financially connected to your estate.

Signature________________________________ Date______________

Witness________________________________ Date______________

**Notarization:**

On this ___ day of _______ , in the year of ______ personally appeared before me the person signing, known by me to be the person who completed this document and acknowledged it as his/her free act and deed. IN WITNESS WHEREOF, I have set my hand and affixed my official seal in the county of______________, state of ______, on the date written above.

Notary Public __________________________________________
Commission Expires____________________________________

Keep in mind this is a legal document. You should consider having a lawyer help you prepare it. It is important to sign this form and keep a copy at home. You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can’t. You may want to give copies to close friends or family members as well.

**What if I change my mind after I make an Advance Directive?**

You are free at any time to make changes to either form of advance directive as well as to revoke or cancel your previous documents. You should try to maintain the document with changes and dates of the changes. Be sure your primary care physician is advised of any changes. It is also very important that you discuss your wishes with your designated guardian, spouse, adult child, your parent, adult sibling, adult relative or close friend. Help your loved ones support your choices when you can no longer communicate them.
What should I do with my Advance Directive when I complete it?

Be sure to inform or discuss those closest to you of your wishes. Include your doctor, lawyer, family and close friends in your decision, what documents you have executed, and where they are located. The following suggestions may assure that everyone has knowledge of your choice:

- Keep a copy of your advance directive and any updates in a place where it can be located
- Be sure your primary care physician has a copy in your medical file
- In the case of an emergency, keep a card or note in your purse or wallet stating where your advance directive can be located
- If you designate an agent or representative, be sure that they have copies of your advance directives
- Make sure when you update your directive that you make everyone involved aware of the changes

If you have any questions about your advance directives, discuss it with those in charge of your care. There are many local agencies that provide help and information on advance directives. There are also many forms available to use or model your documents from. Your primary care physician and hospital should have forms available for your use. If you need assistance in locating a resource, please call Coventry Medicare Advantage customer service at 1-800-727-9712.
TABLE 1

Remittance Advice Summary Report

Additional remittance advice summary report information can be obtained at [www.chekoklahoma.com](http://www.chekoklahoma.com). You can download, view and print the document(s) using Adobe Acrobat Reader. Acrobat Reader is free and can be downloaded from the Health Plan website. A screenshot is displayed below as an example.

### FORM HEADINGS

1. **Page**—Identifies the page number and the total number of pages in the statement.
2. **Title**—Identifies the name of the report and the specific Coventry Health Plan/product name.
3. **Provider #: Provider Name**—Unique identifier assigned to all providers for claims processing and provider name.

### CLAIM DETAIL

- **Patient Name**—The name of the member receiving the service.
- **Account #**—Patient account number assigned by provider, billed on claim and reflected back for accounting purposes.
- **Place of Service**—Identifies the location services where rendered, e.g., OUTPT HOSPITAL, OFFICE, etc.
- **Member #**—Unique identifier for the member receiving the services.
- **Date Received**—The date the claim was received by Coventry Health Care, Inc.
- **Processed Date**—The date the claim was adjudicated.
- **Claim #**—A unique number that is assigned during the initial processing stage. Please provide this number when making claim inquiries as it will speed specific claim retrieval.
- **Auth. #**—The number that is assigned to each authorization request which applies to the claim being processed, if applicable.
- **Claim Provider**—Identifies the name of the provider who performed the service.
- **Carrier**—The information in this field may vary by product and account. It indicates the entity responsible for funding the claim, including the employer group if a self-funded arrangement is applicable.
- **Network/DIVision**—Division of referring physician, if a referral is applicable.
- **Product**—Indicates which of our products provides coverage for the member, e.g., HMO-Commercial, PPO, etc.
- **Service Dates**—Dates of service corresponding to each procedure code. From the first date the member received the service from the provider (admission date) through the last date the member received the service from the provider (discharge date).
- **Proc Code**—Code pertaining to the procedure performed by the provider on the corresponding service date(s).
- **Mod Cd**—Indicates the modifier appended to the billed procedure code by the provider, if applicable.
- **DRG/APC**—Reflects the specific DRG or APC used to process the claim, if applicable (reserved for future usage).
- **Procedure Description**—Describes the procedure performed for the code indicated.
- **Cap**—Y=Yes, which indicates if the claim was adjudicated as a result of a capitated agreement. N=No, which indicates the claim was adjudicated as a result of a fee for service agreement.
- **Total Charges**—The amount billed for the procedure(s) performed on the corresponding service date(s).
- **Allowed Amount**—Amount allowed for the covered service(s) performed (contracted rate).
- **Ineligible Amount**—The dollar amount that is not covered by the member’s Certificate of Coverage or is in excess of providers contracted rate and for which the member or provider is responsible.
- **Prv DC**—Provider disposition code is assigned to outline the reason for ineligible amount; applicable disposition codes are noted at the bottom of each page of the Remittance Advice.
- **Deductible Amount**—Amount of deductible specified under the member’s Certificate of Coverage.
- **Copay Amount**—Amount of the copayment that the member is required to pay at the time services, as defined by the member’s Certificate of Coverage.
- **Mbr Coins**—Amount the provider may bill the member, based on the coinsurance percentage in the member’s Certificate of Coverage.
- **Mbr Respn**—Total Amount of approved claim dollars that is the member’s responsibility for payment, equals the sum of columns 15, 17 and 18.
### Remittance Advice Summary - COVENTRY HEALTHCARE

**Provider:** 1214001 - JOE FAMILY PRACTICE

#### Claim Details

<table>
<thead>
<tr>
<th>Claim #</th>
<th>Auth'd #</th>
<th>Carrier</th>
<th>Date Rendered</th>
<th>Date Processed</th>
<th>Processed Date</th>
<th>Claim Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>1214001</td>
<td>098765</td>
<td>COVENTRY HEALTH CARE</td>
<td>01/01/2023</td>
<td>01/22/2023</td>
<td>01/22/2023</td>
<td>DOE FAMILY PRACTICE</td>
</tr>
</tbody>
</table>

#### Claim Information

<table>
<thead>
<tr>
<th>Claim Type</th>
<th>Amount</th>
<th>Payment Term</th>
<th>Paid %</th>
<th>Carrier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>$12345</td>
<td>Net Payment</td>
<td>100%</td>
<td>COVENTRY HEALTH CARE</td>
</tr>
</tbody>
</table>

#### Rejected Claims

<table>
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<tr>
<th>Claim #</th>
<th>Auth'd #</th>
<th>Carrier</th>
<th>Date Rendered</th>
<th>Date Processed</th>
<th>Processed Date</th>
<th>Claim Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>1214002</td>
<td>098765</td>
<td>COVENTRY HEALTH CARE</td>
<td>01/01/2023</td>
<td>01/22/2023</td>
<td>01/22/2023</td>
<td>DOE FAMILY PRACTICE</td>
</tr>
</tbody>
</table>

#### Provider Summary

- **Provider:** 1214001 - JOE FAMILY PRACTICE
- **Claim Totals:** $12345
- **Paid Claims:** $12345
- **Provider Information:**
  - NPI: 1234567890
  - Tax ID: 123456789

#### Prohibited Services

- **Prohibited Services:** None

#### Prohibited Providers

- **Prohibited Providers:** None

#### Prohibited Contracts

- **Prohibited Contracts:** None

#### Prohibited Claims

- **Prohibited Claims:** None

#### Prohibited Payment

- **Prohibited Payment:** None
TABLE 2

MEMBER IDENTIFICATION CARD

Your new Identification card is here!

Your Coventry Health Care identification card serves as your key to our network of health care services. Simply present your identification card whenever you receive care from a physician, hospital, or other participating provider.

Your identification card contains important information about your benefits. Please carry your identification card with you at all times to help us serve you in the most efficient manner possible.

Please visit us at www.chcoklahoma.com
TABLE 3

Commercial (HMO, POS, PPO),
Individual and Advantra Prior Authorization List

Coventry Health Care (“Coventry”) requires prior authorization prior to services being performed for the procedures listed below. If you have any questions please call Coventry’s Health Services department at 877-837-8914.

**Benefit limitations for cosmetic, dental and infertility still apply.** If you have questions about benefits please call the customer service phone number on your ID card.

**New Update:** Prior authorization requirement added for radiation oncology effective 02/01/2013.

- Chemotherapy Herceptin and Avastin
- Durable medical equipment purchase over $500 and all rental items except oxygen—no authorization required on oxygen
- Experimental and investigational services, devices and drugs
- Gamma knife and cyber knife
- Genetic testing and counseling
- Home health care infusions ([click here for attached list](#))
- Home health aide
- Hospice—inpatient
- Hyperbaric services
- Imaging—PET or PET/CT fusion scans, MRI/MRA, CT, CTA and CCTA
- Implantable pain and insulin pumps, spinal stimulators and trials and peripheral stimulators
- Injectable medications and infusions ([click here for attached list](#))
- Inpatient hospital admissions/observation stays/ LTAC
- Lab tests for specialty disease markers
- Neuropsych testing
- Nuclear cardiology in outpatient hospital setting (CPT codes billed with A9500 or A9505)
- Orthotics and prosthetics
- Pain management (all services beyond initial evaluation)
- Radiation oncology
- Rehabilitation, full- or partial-day and inpatient (including cardiac and pulmonary rehabilitation)
- Rhinoplasty
- Septoplasty
- Skilled nursing admissions
- Sleep studies
- Transplants
- Varicose vein surgical treatments including sclerotherapy

We follow CMS guidelines for inpatient-only procedures for our Advantra members.

**Failure to obtain required authorization will result in denial of payment for the services.**
**TABLE 4**

**PROVIDER CHANGE IN PRACTICE FORM**

In an effort to keep records updated and to ensure proper claims payment, please complete this form when any of the below takes place within your practice. Your cooperation and participation are greatly appreciated. Please make copies if you have additional information changes. If you have a change in your Tax ID #, please contact Provider Relations at (405) 945-1236. **FORM MUST BE RECEIVED 30 DAYS PRIOR TO THE EFFECTIVE DATE OF THE CHANGE.**

Date these changes became effective: _______________________________________________

Practice name: __________________________________________________________________

Provider name(s): __________________________________________________________________

We are making changes to our: Office Info. __________ Billing Info. __________ Tax ID __________

Current address: __________________________________________________________________

Current phone: __________________________ Current fax: __________________________

New address: __________________________________________________________________

New phone: __________________________ New fax: __________________________

Current tax ID number(s): __________ New tax ID number(s): __________

Current billing address: __________________________________________________________________

Current billing phone: __________________________ Current billing fax: __________________________

New billing address: __________________________________________________________________

New billing phone: __________________________ New billing fax: __________________________

Other changes you would like for us to know about: __________________________________________________________________

Office manager/contact: __________________________ Email address: __________________________

Please sign and date: __________________________________________________________________

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*Please return this form to Coventry Health and Life Insurance Company:*

Toll Free: (866)219-7659 Fax Number: (405)945-1238
Website: www.chcoklahoma.com
Office Address: 3030 NW Expressway St., Ste. 625, Oklahoma City, OK 73112