



PROVIDER MANUAL

FOREWORD

This **Participating Provider Manual** has been prepared to assist Ohio Health Choice (OHC) participating providers and their staff in understanding the Ohio Health Choice Medical Management Program and Preferred Provider Organization (PPO) protocols. The goal of Ohio Health Choice is to keep participating providers as informed as possible so that as the Medical Management Program (formally known as the Utilization Management/Quality Management Program or UM/QM) is implemented, changes in existing office routines will be minimized.

This Manual is also designed to be an operational guide to assist providers in participating in the Medical Management Program.

This Manual should be retained as a reference for all Ohio Health Choice matters.

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**OHIO HEALTH CHOICE
PROVIDER MANUAL
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I. INTRODUCTION

A. Ohio Health Choice Philosophy

Ohio Health Choice is a health care management company that employs a partnership approach to the delivery of quality health care while reducing costs. Ohio Health Choice relies on independent, selective contracting with participating providers and facilities, financial incentives in its Payors' medical benefit plans to encourage patient participation, appropriate use of medical resources, and a Medical Management Program designed to work cooperatively with participating providers.

The ultimate effectiveness of Ohio Health Choice's private practice, fee-for-service response to the escalating cost of health care depends in large part on the cooperation of our participating providers in providing cost-effective, quality health care.

B. Definitions

The following definitions are to help our participating providers and their staff understand the special meanings of certain terms used in this Manual:

Covered Services – “Covered Services” means only the Medically Necessary Health Care Services purchased under and provided pursuant to a Plan.

Current Procedural Terminology (CPT) - A list of descriptions and identifying codes for reporting medical services and procedures performed by providers. Published annually, the CPT is also useful in the administration of claims processing. To obtain a copy, contact the American Medical Association.

Eligible Persons - The persons entitled to receive Covered Services pursuant to a benefit Plan offered by an Ohio Health Choice Payor.

Emergency - A sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably result in any of the following:

1. Placing the patient's health in permanent jeopardy;
2. Causing serious impairment to bodily functions;
3. Causing serious and permanent dysfunction of any body organ or part;
4. Causing other serious medical consequences.

Facility Provider – “Facility Provider” means a health care entity or organization, such as a hospital or a nursing home, that provides health care services.

Medically Necessary or Medical Necessity - Health care services or supplies which are determined to be:

1. Appropriate for the symptoms, diagnosis, or treatment of the injury or disease;
2. Provided for the diagnosis or direct care and treatment of the injury or disease;
3. Within standards of good medical practice within the organized medical community;
4. Not primarily for the convenience of the eligible person or of any participating provider providing Covered Services to the eligible person;
5. An appropriate supply or level of service needed to provide safe and adequate care.

Provider Relations Department - The department at Ohio Health Choice that manages:

1. Processing of all agreements with participating providers and facilities and the handling of provider and facility inquiries regarding those agreements;
2. Renewing agreements with participating providers and facilities;
3. Monitoring the volume and specialties of participating providers within existing provider networks;
4. Updating all participating provider files regarding disciplinary actions taken by various regulatory and disciplinary bodies.

Outpatient Surgery (or Ambulatory Surgery) - Surgical procedures that are performed while the patient is not confined as an inpatient in a hospital or other health care facility; such surgical procedures may be performed in the outpatient surgical department of a hospital, in a free-standing Ambulatory Surgical Center (ASC), or in a provider's office when it is used as an alternative to a hospital or ASC.

Participating Providers (or Providers) - The physicians and other health care providers, other than facilities who have entered into agreements with Ohio Health Choice, to provide Covered Services to eligible persons.

Payor - "Payor" means an insurance carrier, self-insured Employer, employee benefits plan, government agency, third party administrator, multiple employer trust, pre-paid plan or other entity which has the obligation to provide, purchase or arrange for and administer certain Health Care Services for eligible persons. Provider understands and agrees that Ohio Health Choice is not a Payor and does not make final determinations regarding the payment or denial of claims.

Reimbursement Schedule - "Reimbursement Schedule" means the schedule of maximum reimbursement amounts established by Ohio Health Choice and accepted by Payor and Provider as compensation to a provider for providing the Covered Services. The Reimbursement Schedule is attached hereto as "Schedule 1" and may be amended or supplemented by Ohio Health Choice from time to time. If provider is not a Facility Provider, then provider may review the applicable Reimbursement Schedule by requesting, in writing, the same from Ohio Health Choice.

Medical Management Program - A compilation of various managed health care programs as described in this Manual, which were developed and are administered by Ohio Health Choice.

II. PROVIDER INFORMATION

A. Participating Providers

Any information changes to your business practice (i.e., change of address, tax ID, etc.) must be submitted in writing to the Ohio Health Choice Provider Relations Department.

B. Provider Directories

After acceptance by Ohio Health Choice and execution of Ohio Health Choice's application and written agreement, participating providers may be listed in a Provider Directory published by Ohio Health Choice or its Payors. These directories are updated on a monthly basis via the Ohio Health Choice website (www.ohiohealthchoice.com).

C. Participating Provider Referrals

Ohio Health Choice Agreements with its participating providers require those providers, within the scope of good practice and in the best interests of eligible persons under their care, to attempt to refer such eligible persons requiring referral to other participating providers. Ohio Health Choice requires its providers to refer such eligible persons to other participating providers whenever possible.

Referrals to other participating providers are also important to the eligible persons. A participating provider may provide a considerable reduction in the eligible person's out-of-pocket expenses in comparison with a non-participating provider.

D. Compliance Upon Termination

The Practitioner Agreement may be terminated without cause by either the practitioner or Ohio Health Choice. The terminating party must provide written notice to the non-terminating party per the contractual provisions.

If the Agreement with Ohio Health Choice terminates, the participating provider is obligated to continue to provide Covered Services under the terms of the Agreement to eligible persons who are receiving care from that provider until the conclusion of any course of treatment. In addition, the participating provider is obligated to notify the Ohio Health Choice patient under his/her care that the provider is no longer a participating provider. Upon termination, the provider must discontinue the use of all signs, forms, and other materials identifying the provider as a participating provider.

E. Contracting Facilities

Ohio Health Choice's agreements with its participating providers require those providers to have at least one admitting privilege at an Ohio Health Choice Facility. Ohio Health Choice Agreements also require its providers, within the dictates of good practice and in the best interests of eligible persons under their care, to attempt to refer such eligible persons requiring referral to Ohio Health Choice contracted facilities.

F. Payor Information

Ohio Health Choice contracted Payors are required to issue EOBs for each claim submitted. The EOBs are reviewed and approved by Ohio Health Choice prior to contracting.

1. References to Ohio Health Choice allowables, adjustments, discounts, etc. must include “Ohio Health Choice” for provider identification of network access. If accessing a national network or other Ohio Health Choice network product, the network product must also be referenced. An example:
 - “Ohio Health Choice PPO Discount, not patient responsibility”
2. Any reductions secondary to multiple surgeries, assistant surgeon services, professional component services, staged operations, etc. must be clearly identified on the EOB. (These are not Ohio Health Choice discounts and should not be referenced as such on the EOB.)
3. Payment must be issued to Ohio Health Choice participating provider directly, not to the insured. Participating providers are not required to obtain written assignment.
4. Any changes to the EOB format or content must be reviewed and approved by Ohio Health Choice prior to issuance.
5. Payors are required to issue member ID cards that include:
 - Claim address;
 - Payor phone number;
 - Ohio Health Choice logo



G. Credentialing

Credentialing of Organizational Providers

Organizational Providers subject to credentials review include hospitals, home health agencies, skilled nursing facilities, free standing surgical centers, nursing homes, and mental health or substance abuse inpatient, residential or ambulatory facilities.

Administrative credentialing of organizations is conducted at three-year intervals. The credentials of participating organizations are reviewed, and must meet the following criteria:

1. Is in good standing with state and federal regulatory bodies, as applicable;
2. Lacks Medicare and/or Medicaid sanctions;
3. Maintains current state licensure or certification according to state regulations, if applicable;

4. Is reviewed and approved by an accrediting body recognized by Ohio Health Choice (see below), as applicable; or successfully completes an Ohio Health Choice organizational site assessment;
5. Completes and submits all required organizational credentialing forms and supporting documentation.

Accrediting Bodies Recognized By Ohio Health Choice:

1. Hospitals: Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the Healthcare Facilities Accreditation Program of the American Osteopathic Association (AOA);
2. Home Health: JCAHO, Accreditation Commission for Home Care (ACHC) or Community Health Accreditation Program (CHAP);
3. Skilled Nursing Facilities: JCAHO, AOA, CARF, or Continuing Care Accreditation Commission (CCAC);
4. Ambulatory Surgical Centers: JCAHO, AOA, American Association for Ambulatory Health Care (AAAHC) or American Association of Ambulatory Surgical Facilities (AAASF);
5. Behavioral Health Facilities: JCAHO, AOA, CARF, AAAHC, or the Council on Accreditation (COA) for Children and Family Services.

Credentialing of Practitioners

Ohio Health Choice reviews the credentials of practitioners prior to participation and at least every three years. Practitioners must demonstrate professional competence and appropriate licensure, relevant education, training and/or experience and credentials specified by Ohio Health Choice. Those subject to credentials review include physicians (M.D. or D.O.), podiatrists, chiropractors, optometrists, oral maxillofacial surgeons, advanced practice nurses (C.N.M., C.N.P, and C.N.S), licensed psychologists, independent social workers, and professional clinical counselors.

Ohio Health Choice does not discriminate against any practitioner regardless of race, color, gender, ethnicity, age, religion, sexual orientation or preference, national origin, ancestry; or against any health care professional who serves high-risk populations or who treats chronic conditions or performs types of procedures; or any other grounds prohibited by law.

Participating practitioners must submit the required completed Ohio Department of Insurance Standardized Credentialing Form (ODI), attestation, and necessary supporting documents and comply with credentialing and recredentialing procedures.

Practitioner Rights in the Credentialing Process

Practitioners have the right to:

1. Review information obtained by Ohio Health Choice and used in evaluating the individual's credentialing application with the exception of information that is protected by federal or state statutes governing peer review or other applicable laws;

2. Correct erroneous information regarding the practitioner obtained through the credentialing process (such as information received regarding licensure, malpractice claims history and board certification). If information received in the credentialing process varies substantially from the information supplied by the practitioner, the practitioner receives written notification of the variation and an opportunity to provide a written response;
3. Information regarding the status of their credentialing application. Following submission of an ODI form for credentialing or recredentialing, a practitioner may contact a Ohio Health Choice Credentialing staff member at (330) 996-1783 to inquire about the status of his/her application. The practitioner is informed of the status of the application including any incomplete items, pending verifications, and the status in the review process.

Credentialing Selection Committee

The Credentialing Selection Committee is a standing committee responsible for professional review functions including credentialing and recredentialing of practitioners. It is chaired by an Ohio Health Choice Medical Director and includes network primary care practitioners and specialists in its membership.

Practitioner Participation Criteria

1. **Licensure**
All practitioners must hold a current, valid license in their discipline in the state(s) in which they practice. In addition, advanced practice nurses must hold a certificate of authority for the corresponding area of practice, as governed by the state in which they practice.
2. **Federal Drug Enforcement Agency (DEA) certificate.** Physicians, podiatrists and dentists must hold a current and unrestricted DEA certificate.
3. **Malpractice and Liability Insurance Coverage**
A minimum of \$1,000,000 per occurrence and \$3,000,000 per aggregate coverage is required for all participating practitioners except chiropractors. Required coverage for chiropractors is \$1,000,000 per occurrence and \$1,000,000 per aggregate. A copy of the practitioner's current malpractice insurance coverage must be provided to Ohio Health Choice on an annual basis when the prior coverage has expired.
4. **Hospital Privileges**
Physicians, oral maxillofacial surgeons, and certified nurse midwives (who perform deliveries) must maintain medical staff privileges at a minimum of one Ohio Health Choice network hospital.
5. **Education and Training**
Physicians and all other practitioners must have completed the education and training required for licensure by the respective professional state licensing board and must limit their practice to the area of their general or specialty training.

6. **Board Certification**

Board certification is not required.

7. **Practitioner Professional History**

A practitioner must have an absence of a history of the following elements:

1. Current illegal drug use;
2. A loss, curtailment or suspension of medical staff privileges or disciplinary activity;
3. Denial or cancellation of professional liability insurance;
4. Professional liability claims;
5. Professional disciplinary action.

Or, in the case of a practitioner with a history of the listed elements, there is evidence that this history does not demonstrate probable substandard professional performance or business practices.

Participation Exclusions

Practitioners meeting the following criteria are ineligible for participation with Ohio Health Choice:

1. Current or active Medicare or Medicaid sanctions;
2. Conviction or entering a plea of nolo contendere to a felony or a crime of moral turpitude.

Adverse Credentialing Actions and Appeals

The Credentialing Selection Committee may propose a range of actions to address a participating practitioner's failure to comply with Ohio Health Choice credentialing criteria or standards for quality, utilization or conduct. The Committee initiates action it deems appropriate based on the review. Examples of such actions include but are not limited to the following:

1. Require the practitioner to submit and adhere to a corrective action plan;
2. Monitor the practitioner for specified period of time, followed by a committee determination about whether substandard performance or non-compliance with Ohio Health Choice requirements continues;
3. Require the practitioner to use peer consultation for specified types of care;
4. Require the practitioner to obtain training in specified types of care;
5. Limit practitioner's scope of practice in the treatment of Ohio Health Choice members;
6. Temporary suspension of practitioner participating status;
7. Termination of practitioner participating status.

When the intended adverse credentialing action alters the conditions of the practitioner's participating status, an appeal of the action is made available to the practitioner. The levels of appeal are as follows:

1. Reconsideration Level of Appeal is made available when an initial intended adverse action has been made on:

- a) Determination related to the practitioner's competence, professional conduct, utilization **or**
 - b) Failure to comply with other standards (i.e. failure to maintain the required malpractice insurance amounts, etc.). **It is the only level of appeal available to a practitioner for failure to comply with standards unrelated to professional conduct or utilization.**
2. Panel Hearing Level of Appeal is only available when an intended suspension (>30 days) or termination **has been based on a determination related to the practitioner's competence, professional conduct or utilization.** This level of appeal is only available if the determination made at the Reconsideration level is to uphold the original decision.

Notice of Appeal Rights

Written notice of the intended adverse credentialing action is sent via certified mail to the practitioner prior to implementation of the action. No actions are implemented until the practitioner has been advised of applicable appeal rights and until the allowable time period for appeal has expired (unless the health of any patient using the Ohio Health Choice network is determined to be in imminent danger because of the action or inaction of a participating practitioner, wherein the Medical Director immediately suspends or restricts the practitioner participation status).

The written notice sent to the practitioner contains:

1. The type of action intended (i.e. suspension, termination, etc.);
2. The reason for the action;
3. Any standards relied upon;
4. A description of the applicable appeal rights;
5. Instructions, including time frames, regarding submission of an appeal request;
6. The effective date of the proposed action.

A. Participating Provider-Patient Services

To help ensure patient satisfaction and reduce the frequency of non-meritous complaints against participating providers, Ohio Health Choice maintains a Customer Service Department to respond to questions, problems, or misunderstandings. Ohio Health Choice works with participating providers and their office staff to resolve issues that may arise in understanding Ohio Health Choice services or procedures. Ohio Health Choice's Customer Service staff is available telephonically at 1-800-554-0027 during normal business hours each business day to respond to provider questions concerning any Ohio Health Choice service or procedure; Ohio Health Choice interfaces with Payors, patients, and policyholder representatives to assist in the resolution of issues and to communicate with Payors regarding Ohio Health Choice services. However, any questions concerning patient eligibility, Covered Services or benefits should be handled directly with the appropriate Payor. **Ohio Health Choice does not have information regarding eligibility, covered services or benefits.**

III. MEDICAL MANAGEMENT PROGRAM

A. Overview

Ohio Health Choice Medical Management works closely with our network practitioners to coordinate the delivery of health care for all Ohio Health Choice members. Our goal is to help assure that all members have access to quality and medically appropriate care, provided in a cost effective manner, and rendered so that maximum benefits are available under the member's plan. Ohio Health Choice encourages and expects network physicians to communicate freely with every patient concerning all treatment options available to them, regardless of the patient's benefit or coverage limitations.

Medical Management activities include Utilization Management and Medical Review. Case Management activities are also conducted under the direction of the Payor. Licensed nurse professionals, under the direction of the Ohio Health Choice Medical Director, provide oversight and coordination of the following activities:

Utilization Management, which includes concurrent review and short term case management/discharge planning for all inpatient confinements for acute hospital care, hospice, rehabilitation and skilled nursing facilities and the management of the associated home health care needs. Utilization review may be completed on-site or by telephonic review.

1. Pre-service evaluation of non-routine covered services and out-of-network requests;
2. Provision of case management to assist in the long-term management of acute and chronic conditions, including catastrophic illnesses and injuries and the planning and management of anticipated preventive care and medical needs;
3. Post service review of claims when prior notification or medical information was required to define medical necessity. Post service review (retrospective review) is not a standard component of the medical management program and is a special service purchased by the clients (Payors);
4. Analysis of practitioner and member satisfaction surveys and complaints to identify and improve the utilization process;
5. Analysis of utilization patterns to determine the over- or under- utilization of services.

Ohio Health Choice Medical Management utilizes nationally recognized and accepted utilization management criteria, guidelines and protocols for determination of medical necessity. All guidelines and criteria are reviewed and updated on an annual basis by physician committees that are representative of the local medical community. Upon request, a copy of the guidelines or criteria used in the review of the health service under consideration will be provided to the practitioner. The specific criteria may be sent to the practitioner or read to the practitioner over the telephone.

Eligibility

Eligibility, coverage and the nature and extent of plan benefits available at the time services are provided must be verified by the applicable benefits office (not Ohio Health Choice). Ohio Health Choice's determination that a hospital admission, procedure or extended length of stay is medically necessary is not a determination of the patient's eligibility or of benefit eligibility under the applicable Plan, and does not signify or imply that benefits will be payable.

Obstetric Notification

When a pregnancy is confirmed, a representative from the attending physician's office should notify Ohio Health Choice and call the Medical Management Department. Pre-certification is not required for network physicians or facilities. This notification is requested so that we may enroll the member in the pregnancy program and when necessary to initiate case management for high-risk members.

The following information is requested:

1. Member's Name;
2. Member's Ohio Health Choice identification number;
3. Date of Initial OB visit;
4. Name of physician and telephone number;
5. Expected Date of Confinement;
6. Expected Hospital for Delivery;
7. Identification of High Risk Pregnancies.

Referrals

The Ohio Health Choice program is structured so that the Primary Care Physician or network physician provides the coordination of care that produces effective and personal care for his or her patients. Referral procedures are in place only when requested by the plans (Payors). This mechanism is in place for a small percentage of the Ohio Health Choice population. When a patient requires the care and services of a network specialty care physician, hospital or other network practitioner, the PCP (or network physician for the PPO program) places a referral or a request for coverage of network specialty care by calling the Medical Management Department.

Out-of-Network Care

Prior approval must be received before arranging care provided outside of the network by calling the Medical Management Department. Information must be provided that indicates the necessity of arranging care outside the network at the time of the request. The Medical Management Department

will notify the requesting practitioner once the out-of-network request is evaluated. Many plans impose a penalty for out of network care without authorization/notification.

Pre-Service Review and Benefit Determinations

Ohio Health Choice uses recognized criteria to assess medical necessity and based upon the members benefit plan, the following services require pre-service review or benefit determination.

Certain services require pre-service review with Ohio Health Choice. Pre-service review facilitates the coordination of health care for Ohio Health Choice members. Information must be received as soon as the decision has been made to initiate these services. Ohio Health Choice's review may be requested by telephone or facsimile. For elective admissions or procedures, Ohio Health Choice recommends that the requests should be initiated at least ten (10) days prior to the scheduled admission or procedure. In all cases, the provider/practitioner and member will receive written notice of the results of the review. If the service is determined not to be a covered benefit, Medical Management will notify the provider/practitioner and member. The member may appeal the decision through the appeal process.

Different plans impose different review requirements. While most plans mandate review of all hospital admissions, not all plans require review of outpatient surgery procedures (i.e. procedures to be performed in an outpatient surgery department or GI lab of a hospital, free-standing ambulatory surgery center or in a provider's office or surgical suite). Because of possible penalties for failure to obtain review when required, providers/practitioners should determine plan requirements prior to treatment.

Services, which typically require pre-service review, include but are not limited to the following:

1. Admission to a skilled nursing facility;
2. Admission to a physical rehabilitation facility;
3. Out of area and out of network services including elective admission to a non-participating (non-network) facility;
4. Home health care and home infusions;
5. Hospice care;
6. Procedures requiring benefit determination that are potentially cosmetic, non covered, investigational or experimental and transplants.

Cosmetic procedures as defined by Ohio Health Choice include, but are not limited to:

1. Rhinoplasty;
2. Breast augmentation;
3. Face lift;
4. Liposuction.

Other potentially non-covered procedures include, but are not limited to:

1. Gastric stapling;
2. Reduction mammoplasty;
3. TMJ or any jaw surgery;

4. Abdominal wall surgery;
5. Scar revision.

All coverage information is subject to change and limited to the provisions of the applicable coverage contract. In addition, such information is not intended to dictate treatment decisions nor create commitment for payment of benefits.

If pre-service review is required but not conducted, coverage may not be available or penalties may apply. The network practitioner or provider may not bill the member or any other party for denied services unless the member has entered into an agreement with the provider to pay for the services prior to the service being rendered.

All coverage information is subject to change and limited to the provisions of the applicable coverage contract. In addition, such information is not intended to dictate treatment decisions nor create commitment for payment of benefits.

Elective Hospital Acute Inpatient Admissions

Pre-service notification is required for many plans. If notification and authorization is not conducted prior to the admission, penalties may be applied per the plan design.

All network hospital inpatient acute care is reviewed for medical necessity and appropriate level of care at the time of admission. The network hospital is required to call the Inpatient Case Manager with the review within one (1) business day of the admission.

Notification of Emergent or Urgent Admissions and Observation Stays

The Medical Management Department must be notified within twenty-four (24) hours of admission or observation stay or within one (1) business day of it. An administrative denial may result from failure to provide notification on a timely basis.

If the network hospital or attending physician fail to provide information regarding the concurrent inpatient stay, in most circumstances the member is not financially responsible for charges incurred associated with the inpatient stay.

Concurrent Urgent Utilization/Case Management

At the time of admission and throughout the stay, inpatient confinements for acute hospital care, observation, hospice, rehabilitation and skilled nursing are reviewed for medical necessity, intensity and appropriateness of location of service. Utilization review may be completed on-site or by telephonic review.

Cases are reviewed by a Nurse Professional. If the case does not meet medical criteria, or if the services could be provided in a less intense setting, the nurse will notify the PCP or attending physician for additional medical information and to discuss alternatives. If the nurse requests additional medical information, the information must be provided within twenty-four (24) hours of

the request or on the next business day. If criteria for the admission are not met, the case is referred to the Medical Director for review.

Determination will be made within one (1) business day after receipt of all required information. If the criteria are not met, the PCP, attending Physician and the member will be notified in writing. The denial letter explains the reason for the denial including an easily understandable summary of the medical necessity criteria used, the total number of days or services denied, the number telephone number to reach a physician reviewer to discuss the determination, a telephone number to call if you would like to request the medical necessity criteria used and a description of the appeal rights to initiate an expedited or standard appeal.

For an emergency out-of-network admission, the Case Manager may forward the clinical information to the PCP to coordinate the member's care and facilitate the transfer of the member to a network facility under the direction of the PCP.

The Inpatient Case Manager also monitors discharges and may suggest alternatives to continued hospitalization, such as post hospital care at home where a more familiar setting may assist in the recovery. The Case Manager works with the attending physician to determine the most appropriate discharge plan for the patient. The Case Manager facilitates and manages the associated home health care needs of the patient.

Post-Service Review

Any service requiring review (pre-service review, determination of benefit or concurrent review) that was not reviewed prospectively or concurrently is reviewed post-service to assure medical necessity and appropriateness. Examples of such services are those that are provided in an out-of-network/out-of-area setting and all inpatient admissions. These services are evaluated based on the medical necessity and appropriateness criteria for the service provided.

Post service review (retrospective review) is not a standard component of the Medical Management program and is a special service purchased by clients. A case is considered to be retrospective when the initial notification of rendered services is made to Ohio Health Choice after the services have been rendered and a review for medical necessity is performed retrospectively. (For example, there is not a call made to Ohio Health Choice prior to the admission and there is not a call prior to the patient's discharge.)

Medical Necessity Denials

If your requests for services are denied by the Ohio Health Choice physician reviewer, you will receive a written notice that includes the following information:

1. The total number of days or services denied;
2. The reason why the day(s) or services were denied (including an easily understandable summary of the medical necessity criteria used);
3. The telephone number to reach a physician reviewer to discuss the determination;
4. A telephone number to call if you would like to request the medical necessity criteria used; and
5. A description of the appeal rights to initiate an expedited or standard appeal.

Case Management

Case Management is designed to evaluate and assist in the coordination of care along the health care continuum. Members are identified in a variety of ways that include self or family referral, health risk screening, marketing, employer referrals, practitioner referrals, and referrals from disease management.

Case Management consists of working with patients, helping them to maintain wellness, obtaining information about health care issues, maintaining and/or improving the patient's quality of life, and coordinating care for plan members. This is accomplished through interactions with the patient and his/her physician and other health care providers, medical record review, conferences with family, and/or supportive friends. The case manager assesses the patient's needs and assists in planning, intervention, and evaluation. This process also incorporates, when applicable, the use of medical appropriateness criteria and plan benefits to certify services and appropriate level of care.

Throughout this process, the case manager may seek available alternative benefits or services tailored to meet the patient's individual needs. Funding for alternative benefits may include the use of acceptable community resources. Treatment plans are developed collaboratively with the patient or guardian, primary care physician and the involved providers. Patient education is provided as the opportunity arises with each case.

Patients with social concerns may be followed by a social worker whose functions include coordination of community services, follow-up of social concerns, and health plan education. The goal of the social worker is to remove barriers that keep patients from receiving appropriate and timely health care services.

Ohio Health Choice recognizes the need for continuation of care and services for patients who join Ohio Health Choice while in the active course of treatment. An active course of treatment is one in which discontinuation would cause a recurrence or worsening of the condition under treatment and interfere with anticipated outcomes or the patient is in the second or third trimester of pregnancy. At the time of enrollment, the patients are given an opportunity to complete a Transition of Care application. A new patient who is in an active course of treatment, may under certain circumstances, continue with the current treating provider/practitioner (who may be non-network or non-participating) and receive maximum allowable benefit coverage. Transition plans for continuity of care are reviewed on an individual basis for new patients.

1. Hypertension (adult);
2. Migraine (adult);
3. Pregnancy.

B. BILLING GUIDELINES

The Medical Management Program prescribes billing guidelines which all participating providers are required to observe with respect to treatment provided to eligible persons. In general, these billing guidelines are based on the Physicians' Current Procedural Terminology (CPT), as published

by the American Medical Association and accepted by industry standards. The following are examples of claim editing that may be applied to a claim, resulting in further reduction of payment:

1. **Surgical Global Service.** (Source: Physician Payment Review Commission (PPRC), Annual Report to Congress, 1989; as modified and accepted by Ohio Health Choice)
2. **Multiple Surgeries.** Multiple surgeries performed at the time of the primary operation which (i) are not encompassed by the CPT code for the primary operation, (ii) add significant time and/or complexity to the primary operation, and (iii) are clearly identified, may be billed and reimbursed separately from the Surgical Global Service Fee for the primary operation. Ohio Health Choice recommends payment according to the following:
 - a) 100% (full fee) for the primary surgery;
 - b) 50% of the fee for the second procedure;
 - c) 50% of the fee for the third procedure;
 - d) 50% for each subsequent procedure.
3. **Maternity Global Service.** (Source: Modified CPT)
4. **Fragmentation.** (Unbundled Billing) (Source: Modified CPT)
5. **Consultations.**
Refer to the current CPT for the definition of a consultation and four subcategories, as well as specific reporting instructions.
6. **Anesthesia Billing Guidelines.** (Source: CPT, ASA Crosswalk, and ASARVG as supplemented and accepted by Ohio Health Choice). Time units are defined as 15 minutes per unit. Exception: Vaginal and Cesarean Deliveries. See formula listed below.

Reimbursement Schedule amounts for anesthesia are based on the American Society of Anesthesiologists Relative Value Guide (ASARVG) only for Anesthesia CPT codes; reimbursement for other services is based on unit values.

The Anesthesia Billing Guidelines adopt the full description of all anesthesia procedure codes and the anesthesia guidelines in the CPT book.

Anesthesia for Maternity Services will be based on the following formula:

- a) Labor epidural anesthesia ending in delivery:
Five (5) base units plus four (4) time units for the first hour
One (1) time unit per each hour thereafter;

- b) Labor epidural anesthesia ending in C-section:
Seven (7) base units, two (2) units for emergency, one (1) unit per hour for labor time and actual fifteen (15) minute time units for the duration of the C-section.

7. Billing Guidelines for Chiropractic Providers

Reimbursement for chiropractic services will be based on the following guidelines:

- a) Maintain treatment standards consistent with the Guidelines For Chiropractic Quality Assurance and Practice Parameters and the Low Back Clinical Practice guidelines;
- b) Bill using the new Chiropractic Manipulative Treatment codes (98940-43). Additional E/M Services are to be billed separately using modifier -25, if and only if the patient’s condition requires a significant separately identifiable E/M service (CPT 99211-99215), above and beyond the usual pre-service and post-service work associated with a chiropractic visit;
- c) Not to bill for more than two (2) physical therapy modalities per visit; after two physical therapy/modalities the reimbursement will be zero;
- d) Not to bill for thermography, computerized muscle testing, computerized x-ray analysis, in office exercises, surface EMG tests, or vitamin therapy;
- e) Not to bill for x-rays solely for the purpose of alignment measures;
- f) Make prompt referrals to an appropriate medical doctor (orthopaedist, neurologist) whenever it appears that the patient has a condition that falls outside the scope of chiropractic practice;
- g) Not to bill for Applied Kinesiology (Chiropractic AK) techniques used for the purpose of diagnosis, assessment, or treatment monitoring;
- h) Not to bill for treatment of children for conditions that lack strong clinical research supporting the appropriateness of such care;
- i) Not to bill for manipulative therapy under anesthesia.

To use only the following CPT codes for billing initial office visit for eligible persons:

99201 99202 99203 99204 99205

To use only the following CPT codes for billing radiology services provided to eligible persons:

| | | | | |
|-------|-------|-------|-------|-------|
| 72010 | 72110 | 73010 | 73100 | 73564 |
| 72020 | 72114 | 73020 | 73110 | 73590 |
| 72040 | 72120 | 73030 | 73120 | 73600 |
| 72050 | 72170 | 73050 | 73140 | 73610 |
| 72070 | 72190 | 73060 | 73500 | 73620 |
| 72080 | 72202 | 73070 | 73510 | 73630 |
| 72090 | 72220 | 73080 | 73550 | 73650 |
| 72100 | 73000 | 73090 | 73560 | 73660 |

To use only the following CPT codes for billing for physical therapy services provided to eligible persons:

97001-97004 and 97010-97799

8. Assistant Surgeon Guidelines

An Assistant Surgeon is a physician who actively assists the principal surgeon in the performance of the surgery. However, use of an Assistant Surgeon will not be considered to be Medically Necessary under the Medical Management Program when the services could be supplied by a surgical nurse, surgical technician, physician assistant, or other paraprofessional. Ohio Health Choice generally follows Medicare determination on a code by code basis, which are covered under the surgeons' fees (20% of OHC allowable).

The Medical Management Program prohibits billing for an Assistant Surgeon for procedures not identified as requiring an Assistant Surgeon, unless during the PAR process the requesting provider has obtained Ohio Health Choice's determination that the use of an Assistant Surgeon is Medically Necessary. If payment is made by the Payor for the use of an Assistant Surgeon for a procedure not identified as requiring an Assistant Surgeon (and the use was not determined by Ohio Health Choice to be Medically Necessary through the PAR process), the provider may be required to refund the entire payment to the Payor. Repeated violations may result in disciplinary actions by Ohio Health Choice, including possible termination of the provider's Ohio Health Choice Agreement.

9. Misuse of Procedure/Service Codes

All billing codes must accurately reflect the services provided. In addition, Ohio Health Choice prohibits billing codes which are outside the participating provider's specialty inappropriate for the place of service, or inappropriate for the diagnosis.

IV. CLAIM AND BILLING INFORMATION

A. Submission of Claim Forms

Ohio Health Choice's agreements with its participating providers require those providers to accept assignment of eligible persons' claims for reimbursement for Covered Services, obtain necessary authorization from eligible persons to bill Payors on Universal Insurance Claim forms, Superbills, UB92 or other claim forms acceptable to Payor, within thirty (30) days for Individuals and Group Providers and ninety (90) days for Facilities, after providing Covered Services to eligible persons.

The following should be noted when obtaining billing information for submitting claims on Ohio Health Choice members:

1. Ohio Health Choice members are identified on their insurance card with the Ohio Health Choice or National Affiliate plan logo.
2. The following information is required to properly submit a claim:
 - a) Provider Name, Group Name, Tax ID Number, Address, Phone Number, State License;
 - b) Patient Name and Date of Birth;
 - c) Name and Social Security Number of Named Eligible;
 - d) Name of PAYOR (Insurance Carrier, TPA, etc.);

- e) Employer Name, Union, or Group;
 - f) Employer Group Policy Number;
 - g) Pertinent CPT, HCPCS and ICD-9-CM codes;
 - h) Executed Patient Assignment;
 - i) Date(s) of Service;
 - j) PAR Authorization Number when applicable;
 - k) Type, print, or stamp Ohio Health Choice on top of the billing form.
3. When obtaining billing information from a patient, it is necessary to properly identify them as an Ohio Health Choice PPO member. The name of the appropriate Payor must also be included.
 4. The Payor's address for claim submissions must **always** be obtained from the patient ID card.
 5. The Payor may **not** necessarily have all claims going to the same address but rather to **various claims submission addresses**. This depends on the employer group; some Payors may have multiple claims submission addresses. Refer to the insureds' ID cards for the appropriate address.
 6. If the patient is not able to provide complete insurance information, the patient should be billed directly for services rendered.

To expediate payment, the appropriate billing form with executed patient assignment should be submitted directly to the appropriate claims office address which appears on the ID card. Do not submit claims to Ohio Health Choice directly; OHC is not a Payor.

B. Procedure Codes

The billing form must include the correct CPT and HCPCS procedure codes. Failure to include the CPT code(s) will delay payment. CPT codes are updated annually by a special committee of the American Medical Association. Every year a significant number of additions, deletions, and revisions in terminology are reported in a new CPT book. All participating providers are encouraged to obtain the most current edition and to use only valid CPT codes.

C. Use of ICD-9-CM Diagnostic Codes

ICD-9-CM diagnostic codes are required for a complete and proper claim form. These codes help avoid confusion over patient diagnosis.

D. Collection of Co-Payments / Deductibles and Co-Insurance

1. To reduce participating providers' administrative costs and avoid misunderstandings between them and their patients, Ohio Health Choice suggests that participating providers not collect from eligible persons until after the Payor has paid its portion and informed the provider's office of the balance owed by the patient. As an exception, if the eligible person's ID card shows a Time of Service payment for each medical service rendered, the provider's office should collect the Time of Service payment as indicated (usually \$5-\$15).

2. Ohio Health Choice's agreements with its participating providers require those providers not to balance bill eligible persons for any amount above the maximum amount in the Reimbursement Schedule or any service not determined Medically Necessary by Ohio Health Choice.
3. Participating providers may collect and/or bill eligible persons directly for:
 - a) Any deductible, co-payment or co-insurance for Covered Services specified in the applicable Plan in amounts which, when added to the Payor's payment, do not exceed the applicable Reimbursement Schedule for such Covered Services;
 - b) Any services that are not Covered Services;
 - c) Any Covered Services provided to eligible persons after the benefits set forth in the Plan, to which the eligible person is entitled, have been exhausted.

NOTE: Ohio Health Choice's agreements with its Providers do not limit or prohibit billing eligible persons for non-covered services.

4. Ohio Health Choice's Agreements with its participating providers require those providers to accept assignment of eligible persons' claims for reimbursement for Covered Services, obtain necessary authorization from eligible persons to bill Payors, and to bill Payors directly on Universal Insurance Claim forms, Superbills, UB92 or other claim forms acceptable to Payor, within thirty (30) days for Individuals and Group Providers and ninety (90) days for Facilities, after providing Covered Services to eligible persons.

E. Billing Errors

The following are the more common billing errors:

1. Billing for hospital/office visits during the follow-up period. The Surgical Global Service includes post-operative care;
2. Billing for services provided to patients who have duplicate medical coverage without indicating on the claim form that duplicate coverage exists (when the provider or his staff is aware of the duplicate charge);
3. Billing for hospital visits without hospitalization. This is most commonly billing for hospital visits after the patient has been discharged;
4. Billing for anesthesia charges without surgery. This is most commonly billing for anesthesia services when the planned surgery was cancelled.

F. Claim Payment Resolution Fee Schedule Issues

Claims errors are most often related to missing units, multiple surgical procedures, missing line items, or physician network status error. Below are recommended steps and guidelines to avoid these common mistakes.

1. **Call the Payor.** The Payor must be contacted directly to resolve any reimbursement or adjudication issues. The Payor will request the following information:
 - a) Insured's name/patient's name;

- b) Insured's social security number;
- c) Employer group number or name;
- d) Date(s) of service and claim information (CPT code billed, charged amounts, units, attending physician's name and tax ID number).

Make sure that you have the name of the person with whom you spoke with and document the phone number in order to follow-up if necessary. Most Payors will request a copy of the original claim.

2. **Contact Ohio Health Choice Customer Service.** If you have difficulty getting resolution from the Payor, please contact the Ohio Health Choice Customer Service Department for assistance. A representative will ask you for the name of the individual you contacted at the Payor's office and a copy of the claim and EOB.

If you receive reimbursement for a specific code that you believe to be unusually low, please submit your request for review in writing directly to the Payor. The Payor will need the following information:

- a) A letter of explanation regarding the reason for review;
- b) Copy of the claim;
- c) Operative notes (if applicable).

The Payor will check that the proper benefits were applied and the Ohio Health Choice Fee Schedule was followed appropriately. NOTE: Adjustments to the Ohio Health Choice maximum allowable for unusual/complicated procedures is determined by the Payor.

If the claim was processed correctly, the Payor will forward the fee review request and documentation to Ohio Health Choice for review. If the Payor responds directly to you, forward all documentation to the Customer Service Department at Ohio Health Choice. Ohio Health Choice responses will be communicated to the Payor.