PAYOR MANUAL

OHIO HEALTH CHOICE
PAYOR MANUAL
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OHIO HEALTH CHOICE OVERVIEW

Payor Manual: The Ohio Health Choice Payor Manual includes information on policies, procedures, communication tools, network demographics, and billing guidelines necessary for accessing Ohio Health Choice network products. Updates are issued as necessary.

Ohio Health Choice is a preferred provider network that employs a partnership approach to the delivery of health care in order to improve quality while reducing costs. Ohio Health Choice relies on selective contracting with Participating Providers and Facilities for our networks, financial incentives in Payors' medical benefit plans to encourage patient participation, and appropriate use of medical resources.

Ohio Health Choice does not determine benefits or eligibility, nor do we pay claims. Providers submit their claims and direct their questions regarding benefits to the Third Party Administrator (TPA), as noted on the insured's identification card.

The cooperation enjoyed between Ohio Health Choice, its providers, and its clients helps to provide quality health care services for the employers and their employees. Our organization looks forward to establishing a positive and proactive relationship with your associates!

OHIO HEALTH CHOICE NETWORKS OVERVIEW

Ohio Health Choice has two separate networks. They are Preferred Health Choice and Preferred Health Choice Plus. Both networks encompass hospitals, allied and physician providers.
Both networks are represented by their own logo appearing on an ID Card. Both networks also have different reimbursement rates. Both networks have been established throughout Ohio and some contiguous counties of border-states utilizing provider specific credentialing criteria. Payors may choose their own national network if a travel network is needed.

Hospitals included in the Ohio Health Choice networks must meet two measures of excellence. First, they must provide quality medical care services in a safe environment. Second, the range of medical care services are to be provided in the most appropriate facility setting and at reasonable cost. Various methodologies are utilized by Ohio Health Choice to negotiate reimbursement structures including aggressive discounts off of billed charges, per diem, DRG and other types of arrangements.

Membership to Ohio Health Choice networks is open to medical professionals who meet or exceed credentialing standards and accept the Ohio Health Choice fee schedule. Physicians are contracted by completing the Interested Practitioner Request Form found on our website at www.ohiohealthchoice.com., under Provider Forms. Please fax completed form to 330-996-8201 ATTN: Provider Relations. Allied providers are also accepted into Ohio Health Choice networks and must meet or exceed credentialling standards. Reimbursement schedules will vary among allied providers, allowing Ohio Health Choice to negotiate maximum discounts.

Note the following:

- **An Ohio Health Choice network logo must appear on all member medical identification cards and cards must be shown to providers prior to accessing medical care to be eligible for network discounts.**

- **Providers participating in the Ohio Health Choice networks are to be reimbursed directly by Payors.**

- **Provider discounts may be applied to clean claims if paid within thirty days of receipt. The provider can refuse to accept the standard discount on any claims not paid within 30 days.**

- **On occasion, providers may bill less than our allowable charges. Therefore the contracted provider reimbursements may not reflect any additional savings or discounts.**

- **Our contracts with providers require compliance with the Ohio Health Choice fee schedule and billing guidelines.**

- **Some emergency room physicians, radiologists, anesthesiologists and pathologists rendering services at Preferred Health Choice and Preferred Health Choice Plus network facilities may not be members of the Preferred Health Choice or Preferred Health Choice Plus networks.**

- **The physicians and facilities listed in our directories are updated nightly and reflect providers of the Ohio Health Choice networks found on our website at** www.ohiohealthchoice.com**. The website directories are only as accurate as the providers keep us informed. If you are aware of a relocation, retired, or deceased provider, please advise Ohio Health Choice at 800-554-0027.**

It is the member's responsibility to check the status of the provider's Preferred Health Choice membership at the time of service.

OHIO HEALTH CHOICE NETWORK PRODUCTS

Network Products

PHC and PHC+: Preferred Health Choice and Preferred Health Choice Plus
A traditional Preferred Provider Organization (PPO) requiring plan design incentives. Preferred Health Choice and Preferred Health Choice Plus offers access to a broad network of preferred providers, including primary care physicians and specialists. Hospitals and ancillary facilities such as urgent care centers, freestanding laboratories and surgery centers are also included.

NWOHP Choice: (Northwest Ohio Health Partnership) is a PPO that does require plan design incentives. The network product features NWOHP in Hancock and Seneca counties with Blanchard Valley Hospital System being prominent and Ohio Health Choice (PHC) in the rest of the state

PHC & FRONTPATH Combination Product: The product is defined by high utilization in NW Ohio. We join 2 networks together, identified by tax id ownership, and designated geographical areas. FrontPath network covers NW Ohio and PHC contracts are used for the rest of the state. All claims go to FrontPath where they are repriced and sent on to a payer. The rest of the claims that don't fall under the FrontPath network will come to OHC where we will reprice and send back to a payer for adjudication.

MARKETING & SALES

The account management staff at Ohio Health Choice is available to support your sales personnel on a daily basis. Aside from the communications listed below, our associates are prepared to assist your brokers with potential client presentations, new employer orientations, general broker in services and other marketing or sales needs.

The following sales and marketing tools are available, upon request, at Ohio Health Choice. Please provide your written request specifying type and volume needed, and allowing reasonable turnaround time. You can call 800-554-0027 and choose Sales & Marketing prompt or ask Customer Service to transfer the call to the Sales and Marketing Department.

- Zip Code Accessibility commonly referred to as a GEO report
- Provider Disruption based upon a claim file for the proposed group.
- Potential Savings Analysis

OHIO HEALTH CHOICE
NEW BUSINESS NOTIFICATION PROCEDURE

Payors must communicate information on new employer groups accessing network products. This form must also be used to communicate amendments to or termination of current employer groups. Accurate and timely completion of this form will ensure appropriate implementation of the group's program. Please review the Ohio Health Choice Network Product Description to ascertain which network product your client will be accessing. If further clarification is required please contact Ohio Health Choice.

PROCEDURE:

1. Completion of an Ohio Health Choice New Business Notification (NBN) form is required for each employer group accessing a specific Ohio Health Choice product. Your account manager will provide assistance in the completion of this form. The completed NBN should be submitted to the Ohio Health Choice Account Management department at least 15 days prior to the proposed effective date.

2. This form must also be completed for any amendments or revisions. Terminations must be communicated in writing to Ohio Health Choice.

3. A policy, group or plan number must be assigned to all employer groups. This number must be noted on the insured's I.D. card.

4. An employer agreement is also required if the life count of the group is 50+ lives. You may obtain an agreement form by calling the Sales and Account Management department at 800-554-0027.

5. NBN forms are available by calling 800-554-0027 and choosing Sales and Account Management, or by contacting your Sales Representative directly.

IDENTIFICATION CARDS

All eligible insureds must be provided an identification (ID) card by their Plan Administrator. The ID card will indicate access to Ohio Health Choice products and must be presented to providers upon receipt of medical services.

1. ID card format and content must be reviewed and approved by Ohio Health Choice prior to Payor access of Ohio Health Choice Network.

2. ID card must include, but is not limited to, the following information:

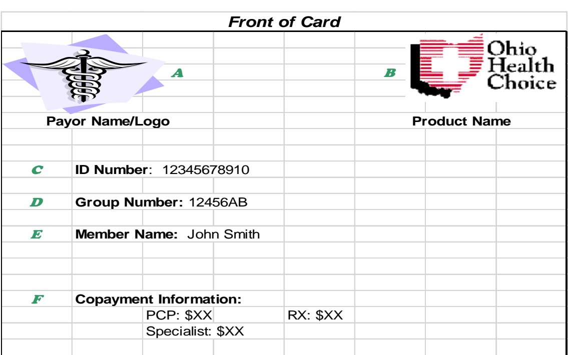
    - Ohio Health Choice Product logo
    - Name of Payor/Claims Administrator
    - Insured Name and Identification Number
    - Group, Plan or Policy Number
    - Office Copayment amount (if applicable)
    - Claims submittal address, to indicate Payor's name with Ohio Health Choice Repricing P.O. Box, or Payor's name and address if Payor is receiving claims first
    - Address and telephone number for eligibility, benefits and claims inquiries
    - Utilization Management information to include minimum requirements and telephone number
    - Any special vendor information such as a PBM

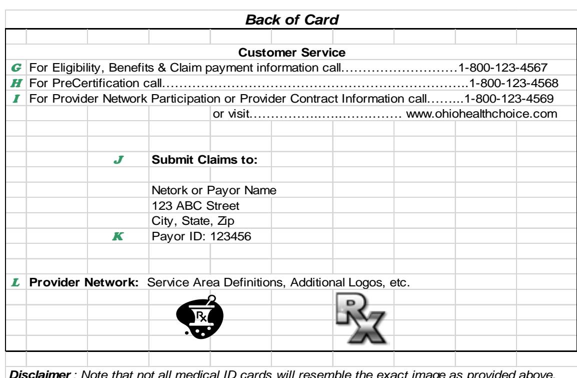
3. ID card must be issued to each eligible insured accessing the networks of Ohio Health Choice. Note: The insured must be instructed to present ID card to provider each time insured, and/or eligible dependent, accesses medical services. Failure to present ID card at time of service may result in a refusal by the provider(s) to accept discounts.

4. **Any changes to the ID card format or content must be reviewed and approved by Ohio Health Choice prior to issuance to insureds accessing product networks.**

5. Please contact the Ohio Health Choice Marketing Support Department at 800-554-0027 for actual camera-ready art.

EXAMPLE IDENTIFICATION CARD





A This is the payor who is responsible to adjudicate (pay) medical claims as repriced by the network (see B) in accordance with the member/patient's employer group benefit plan design including: eligibility, deductibles, copays, etc.

B This is the network of hospitals, doctors, and other providers that are considered in-network for the member/patient's benefit plan. The network will reprice the claims as submitted by the provider to the contracted amount and forward them to the payor (see A) for payment.

C This is the patient's Family ID number under their benefit plan. Often, each member of the family will be assigned a suffix to this ID number to provide a unique ID for each member of the family.

D This is the Group Number to which the patient is assigned. The member's employer may have one or multiple group numbers set up with their Payor.

E Member Name is the patient's name and will often list the other members of the family that participate under their plan.

F Copayment Information is often provided that applies to the patient's benefit plan for common types of visits such as to a Primary Care Physician (PCP) or Specialist.

G This is the Payor's (See A) customer service number that you can call to receive answers to any questions you may have regarding the adjudication (payment) of your claim and what benefit levels apply to the services. The Payor can also verify the patient's eligibility prior to delivery of the service.

H If the patient must obtain precertification for a service before having it delivered, the provider or patient would call this number for the party who is responsible for the medical/utilization management for that patient.

I This is the Network's (See B) customer service number that you can call to receive information on a provider's participation in the network and product for which the patient is a member. The Network can also answer questions regarding the provider's contract with the network including contracted discounts applicable.

J This is where the provider should submit patient claims for processing (including network discount processing and claim adjudication by your payor). Depending on the arrangement determined by the Payor and the Network, either party may receive the claim first. It is important to direct the claim as stated on the Patient's ID card to ensure expeditious adjudication.

K When receiving claims electronically, this is the appropriate party's electronic ID for claim submission.

This is where additional information can be found for which network of providers applies for certain service areas if the patient is traveling outside of their primary network area. The provider will want to ensure that they understand which network applies for the services they are going to provide. If the interpretation of the medical card is still confusing, the Payor (See A) can be contacted to advise.

EXPLANATION OF BENEFITS PROCEDURE

Network **providers**, and **insureds** receiving medical services, must receive an Explanation of Benefits (EOB) for each claim submitted.

1. EOB format and content must be reviewed and approved by Ohio Health Choice prior to Payor access of Ohio Health Choice Network Products.

2. EOB must include, but is not limited to, the following information:

   - Patient, and insured, name
   - Received and processed date
   - Payor’s claims address and inquiry telephone number on the actual EOB, not just check alone
   - Provider name
   - Date(s) of service and charges submitted
   - Ohio Health Choice allowable or discount
   - Copayments, deductible, coinsurance and/or ineligible amounts
   - Total amount paid
   - Total amount Ohio Health Choice adjustment/discount
   - Total amount billable to patient

- Indication to whom benefit(s) were paid.

3. References to Ohio Health Choice allowables, adjustments, discounts, etc. must include "Preferred 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 Preferred Health Choice Discount, not patient responsibility"

4. 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.) Keep in mind some provider contracts do not allow for reductions outside of the contract**

5. An EOB must be issued to Ohio Health Choice participating providers, and insureds, for each claim submitted, including those occasions of non-payment secondary to application of benefit design (deductibles, exclusions, etc.) or requests for additional information.

6. **Payment must be issued to Ohio Health Choice participating provider directly, not to insureds. Participating providers are not required to obtain written assignment.**

7. Any changes to the EOB format or content must be reviewed and approved by Ohio Health Choice prior to issuance.

OHIO HEALTH CHOICE BILLING PAYOR INVOICES

Ohio Health Choice will issue monthly billing invoices for services provided to contracted Payors. This information is obtained from the Ohio Health Choice New Business Notification Form based on the products and services that have been purchased. Payment is due within 30 days of receipt of the invoice.

Procedure:

1. Billing invoices will be generated the first week of each month.

2. The Payor will review the invoice and, if necessary, adjust the number of eligible employees enrolled with Ohio Health Choice on the invoice.

3. The amount payable will be the number of participating employees multiplied by unit price. If the employer count has changed, please indicate the adjustment on the billing invoice. If Ohio Health Choice is to receive a percent of savings payment, the most recent payment will be indicated on the monthly invoice. Please indicate the actual payment on the invoice when payment is submitted.

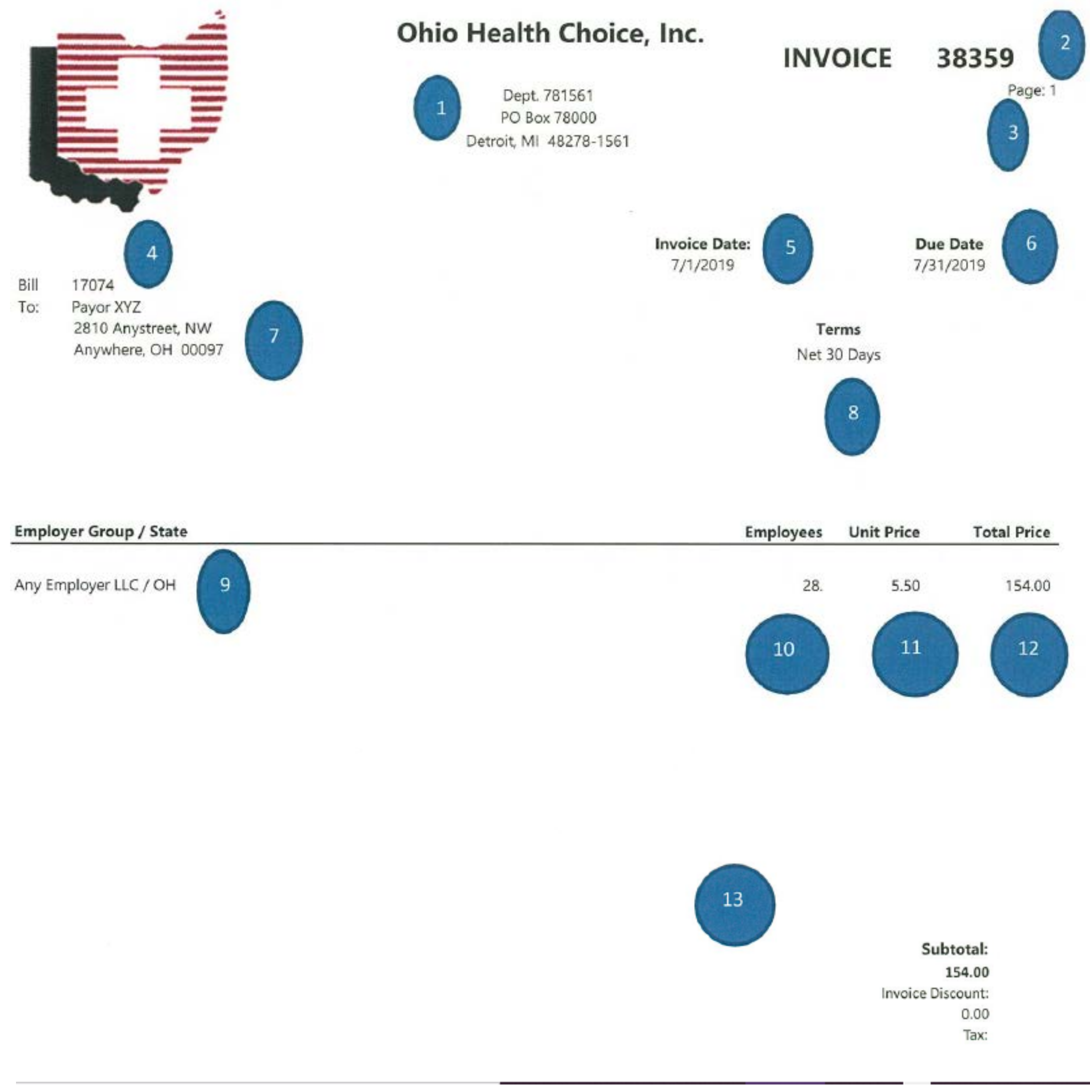
4. Payments via check are to be remitted to the Ohio Health Choice Lockbox with a copy of the invoice showing any adjustments made by the Payor. The billing invoice number should also be referenced on each payment remitted.

   Remit to: Ohio Health Choice
   Dept. 781561
   PO Box 78000
   Detroit, MI 48278-1561

5. A new business notification form must be completed for any amendments, revisions or terminations.

6. ACH payments are now accepted. Please contact our Accounting Department to set up ACH payment options.

Questions regarding Payor billing invoices should be directed to our Accounting Department.



Ohio Health Choice, Inc.

INVOICE 38359 (2)

Page: 1 (3)

(1) Dept. 781561
PO Box 78000
Detroit, MI 48278-1561

Invoice Date: 7/1/2019 (5)

Due Date 7/31/2019 (6)

Bill To: 17074 (4)
Payor XYZ
2810 Anystreet, NW
Anywhere, OH 00097 (7)

Terms
Net 30 Days (8)

Employer Group / State	Employees	Unit Price	Total Price
Any Employer LLC / OH (9)	28. (10)	5.50 (11)	154.00 (12)

(13)

Subtotal:
154.00
Invoice Discount:
0.00
Tax:

OHIO HEALTH CHOICE PAYOR INVOICES DETAIL EXPLANATION

1. Ohio Health Choice Remit Address
2. Invoice Number : The unique number that is assigned to the monthly invoice. This number should be referenced on your monthly remittance to Ohio Health Choice.
3. Page Number: The number of pages of the invoice.
4. Customer ID: The three number codes that identifies the contracted Payor.
5. Invoice Date: The date the invoice was produced.
6. Due Date: Date remittance is due to Ohio Health Choice
7. Invoiced To: Name of Payor or Party that is responsible for the remittance Of Payment.
8. Payment Terms: The number of days to remit payment.
9. Company or Group Name: The name of the contracted client.
10. Employees: The number of employees enrolled with the OHC network.
11. Unit Price: The amount charged per employee based on product selected.
    .
12. Extension: The total of employees multiplied by unit price or the most recent Payment received by Ohio Health Choice.
13. Total : Total Invoice amount less payment received amounts. The client Is to remit this amount.

OHIO HEALTH CHOICE PAYOR ELIGIBILITY

Eligibility:

Ohio Health Choice uses member eligibility data for its active employer groups for the following purposes:

1. Claims Repricing – The member data, including group # and unique member ID is included in the matching criteria we use in our claims repricing processes. It ensures that we are able to match the member to the correct network product and apply the appropriate reimbursement. Ohio Health Choice does not reject claims based on eligibility, but this data is important for the efficiency and accuracy of the claims repricing process.
2. Reporting/Network Recruitment - Ohio Health Choice aggregates the data on its participating members to assist in network recruitment efforts. It allows us to ensure that the composition of the participating providers in our network will meet the needs of our customers.

Eligibility Data:

Ohio Health Choice prefers to receive member data according to the industry standard EDI 5010/834 format. Outside of the basic required fields, the only business requirement is that the values of either "MM (Major Medical)" or "HLT (Health)" should appear in the health coverage segment HD03. If you are not able to produce a 834 file, there are alternative methods. Ohio Health Choice does maintain processes to import text, csv, and Excel spreadsheet files, and uses data mapping tools to ensure that the data is loaded correctly.

Our requirement is that eligibility data is to be sent weekly (or at a minimum, monthly). Secure file transfer methods, including encryption will be utilized. Ohio Health Choice does maintain a ftp site to transfer data with its business partners, but we can also pick up the files from external ftp connections and web portals.

Our technical staff will work with you to determine the file format, the transfer method, and the steps required for a successful implementation of the eligibility data solution.

OHIO HEALTH CHOICE DEMOGRAPHIC FILES

Network Information: Depending on the product(s) a Payor is accessing from Ohio Health Choice, network demographic files may be made available to the Payor. These files, produced monthly (within the first 5 business days of the month), include a full list of active providers and locations (service and billing) with the associated TIN. These files also include notices of terminations and closed locations within the network product. The demographic files are made available for download on the Ohio Health Choice ftp site. Our technical staff will coordinate the steps to create your sign on credentials and guide you through the steps to access the provider demographic data.

OHIO HEALTH CHOICE COMMUNICATIONS

CUSTOMER SERVICE

The Customer Service Department responds to members' questions, problems and concerns related to the Ohio Health Choice network, its providers and payors.

You may contact Ohio Health Choice at 800-554-0027, Monday through Friday, 8:00 a.m. to 5:00 p.m., to request network participation or a referral to a participating provider or facility, or answer any questions on Ohio Health Choice products or services.
Ohio Health Choice also has an automated telephone answering system in addition to "live" operators during regular business hours. If the automated attendant is reached, the caller should follow the prompts to be guided to the department needed.

WEBSITE: Our website is www.ohiohealthchoice.com. It offers the most accurate provider status and service locations. You are able to retrieve important information pertaining to new business notification forms, explanations on Ohio Health Choice products and services. You can see EDI repricing guides as well as provider and member services from our website.

DEMOGRAPHIC FILES: The demographic files are made available for download on the Ohio Health Choice ftp site. Our technical staff will coordinate the steps to create your sign on credentials and guide you through the steps to access the provider demographic data.

NETWORK PROVIDER BILLING OVERVIEW

Providers participating in the networks are to be reimbursed directly by Payors. Currently, hospital and allied providers are contracted for various reimbursement methodologies:

1. Discounts: Percent of billed charges, to include inpatient and outpatient services, unless otherwise noted.

2. Per Diems/Diagnostic related Groups (DRGs): Maximum daily reimbursement/per admission case rate. *Per diem and DRG amount must be paid even when the per diem /DRG exceeds the billed amount*. UB92 claim form is usually submitted with standard charges; Payor will identify type of service(s) provided according to per diem or DRG categories.

3. Case rates: which are paid by CPT groupers, most generally at Surgery Centers

4. Negotiated Rates: Maximum purchase or rental allowable for service(s), usually negotiated with home health care or durable medical equipment companies, are submitted with standard charges on a UB04 or HCFA 1500 claim form. OHC's contracts follow CMS guidelines. In general, Medicare pays for rental of DME items, when covered under the plan, for a period of continuous use not to exceed 10 months. At the point of a 10 month rental, patient takes over ownership of equipment. The Payor will need to monitor the monthly rental usage to ascertain when the cap purchase price is met.

5. AWP – Average wholesale pricing on pharmaceuticals.

6. CPT Fee Schedule: A Resource Based Relative Value System for reimbursement according to specific service or procedure, as coded according to the AMA CPT Manual issued yearly. HCFA 1500 claim form is usually submitted with standard charges.

7. **Note: the fee schedule is not a UCR or R&C reimbursement schedule**. OHC adheres to CMS billing and reimbursement guidelines.

Ohio Health Choice's agreements with its participating providers requires those providers to accept assignment of member's claims for reimbursement for covered services. Generally, Ohio Health Choice participating providers will bill on a HCFA 1500 Claim form within 90 days after providing covered services.

Out-of-Network Care

Prior approval must be received before arranging care provided outside of the network by calling the Medical Management Department listed on the patient's ID card. Information must be provided that indicates the necessity of arranging care outside the network at the time of the request. The Medical Management Company 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.

Many Payors will negotiate with out of network providers and while that is acceptable, please let us know if we can assist the members in calling for a one time authorization for the care being received by an out of network provider.

Ohio Health Choice participating providers are prohibited from billing up front, except for time of service copayments or verified deductibles that have not been satisfied. Providers are not permitted to balance bill for any amounts above the maximum allowables. Participating providers may collect and/or bill insureds directly for:

1. Any deductible, copayment or coinsurance for covered services specified in the applicable plan in amounts which, when added to the Payor's payments, do not exceed the applicable reimbursement schedule for such covered services;

2. Any services that are not covered services; and

3. 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.

Payors are required to reimburse participating providers <u>directly</u> for services not otherwise payable by the member. In the event member deductibles, coinsurance and/or benefit plan limits and exclusions result in non-payment to the provider, <u>an explanation of benefits must be issued to the participating provider communicating status of the claim</u>.

REPRICING OPERATIONAL OVERVIEW

The following section reviews provider billing and Payor claim adjudication guidelines related to Ohio Health Choice network products. These guidelines are generally based upon the physicians' Current Procedural Terminology (CPT), as published and updated annually by the American Medical Association. In some cases, the CPT reference has been modified by Ohio Health Choice for clarification or to avoid confusion, usually by reference to positions taken by other reputable organizations, such as the Physician Payment Review Commission (PPRC). Some of the CPT definitions, guidelines and notes, and some of the positions taken by the other organizations or Ohio Health Choice-adopted policies are discussed herein. Ohio Health Choice reserves final decision on any billing guideline or fee schedule disputes.

A. **<u>Multiple Procedures Payment Reduction</u>**. Multiple procedures 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, but will be reimbursed in accordance with the following:

1. 100% (full fee) for the primary surgery
2. 50% of the fee for the second procedure
3. 50% of the fee for the third procedure
4. 50% for each subsequent procedure

B **<u>Anesthesia Billing Guidelines</u>**

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 Ohio Health Choice unit values.

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

- Units are calculated in 15 minutes increments, with any fraction of 15 minutes rounding up to another full unit.
- Physical Status Codes in the modifier field will increase the number of units. P3 adds 1 unit, P4 adds 2 units, and P5 adds 3 units.
- Special Circumstance CPT Codes will increase the number of units. 99100 adds1 unit, 99140 adds 2 units, 99116 and 99135 adds 5 units.
- All anesthesia must be billed with the appropriate modifier in the first modifier field to denote whether the service was personally performed, medically directed or medically supervised; modifiers AD, QK, QX, and QY.
- Medically supervised care will be reimbursed at 50% for each claim up to 100% of the allowable.

Ohio Health Choice recommends the following guidelines to its Payors for calculating reimbursement for obstetric anesthesia:

Labor anesthesia ending in delivery (Anesthesia CPT 01960, 01967):

- Five (5) base units plus four (4) time units for the first hour
- One (1) time unit per each hour thereafter

C- Section following labor epidural (Anesthesia CPT 01968, must be billed with 01967):

- Three (3) base units plus one (1) time units for every fifteen (15) minutes thereafter

C-Section (Anesthesia CPT 01961):

- Seven (7) base units plus four (4) time units for the first hour
- One (1) time unit per each hour thereafter

C. **Assistant Surgeon Guidelines**

Indicates those procedures which generally require the skills and services of an assistant surgeon.

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 when the services could be supplied by a surgical nurse, surgical technician, or other paraprofessional.

Assistant surgeons should be reimbursed at 20% of the maximum allowables for the services and CPT codes submitted with modifier 80, 82 or AS.

Minimal Assistant Surgeon should be reimbursed at 17% of the maximum allowables for the services and CPT codes submitted with modifier 81.

D **Co-Surgeon Guidelines**

A Co-surgery is when the individual skills of two or more surgeons of different specialties are required to perform surgery on the same patient during the same operative.

A co-surgeon should be reimbursed 62.5% of the maximum allowable for the services and CPT codes submitted with a modifier 62.

E. **Chiropractic Guidelines**

- Bill using chiropractic treatment codes (98940-98943 and 97010-97799)
- Not to bill for more than two (2) physical therapy modalities per visit; after two (2) physical therapy modalities the reimbursement will be zero.
- Additional E/M services (99211-99215) maybe billed separately if the patient's condition requires beyond the usual pre-service and post-work associated with a chiropractic visit.
- There will be no reimbursement for DME or Orthotics unless the provider has obtained a separate NPI assigned by CMS to dispense these items.
- There will be no reimbursement for codes that fall outside the scope of chiropractic services.

F. **Procedure to Procedure (PTP)**

Claims are checked against the current CMS Column One/Column Two Correct Coding edit file for NCCI PTP edits. These edits include Lab Panel bundling and mutually exclusive procedures. OHC will reprice any such identified CPT code to $0 with a reason code of "118 - NCCI PTP Edit"

G. **TeleHealth**

Telehealth is the remote delivery of healthcare services by means of telecommunication technology.

- Must be billed from an approved location (originating sites)
- Place of service (POS) 02 – Telehealth; indicates the billed service as a professional telehealth service from a distant site.
- A GQ modifier needs to be added to the professional service CPT or HCPCS code.
- Reimbursement for this service allows 80% of the facilities allowable.

H. **Bilateral Surgery** 150% of Provider's allowable fee schedule amount on CPT code with 50 modifier. Note that in absence of 50 modifier, the combination of modifiers LT and RT on two lines will also be recognized.

The Repricing Department at Ohio Health Choice is responsible for repricing claims submitted by contracted Providers. To ensure proper submission and timely claims turn around the payor should identify what network product the member is enrolled in. The card should clearly display the Payor name with the network product logo. Ohio Health Choice will screen all claims to determine network status of the provider.

1) If the claim is using the PHC or PHC+ network and it is going to OHC first, it should have the P.O. Box 3619 Akron, OH 44309 listed on the employee identification card. ***EDI to OHC is payer id 34189***

2) If the claim is going to the payer first, please use your address on the member ID card.

3) If the claim is using the FrontPath/NWOHP/OHC product, the claim should go to P.O. Box 5810 Troy, MI 48007-5810

Claims are processed on a daily basis. A repricing coversheet will be generated and attached to each claim showing the Ohio Health Choice network status as well as the maximum allowable.

The Ohio Health Choice Repricing System has incorporated the AMA (American Medical Association) billing guidelines and practices. Our providers are contractually obligated to adhere to the AMA CPT (Current Procedural Terminology) guidelines.

- Unusual and/or complicated claims (Modifier 22) will be processed at the standard Ohio Health Choice maximum allowable for the code submitted. An additional allowance may be authorized, subject to Payor review.

- Related, but separately billed procedures and charges, will be re-bundled into one code.

- Reductions to services billed with the following modifiers are taken at Ohio Health Choice

* Any Modifier reduction should not be reflected as an Ohio Health Choice Discount.

(A detailed explanation of these and additional guidelines are included in Section V "The Ohio Health Choice Provider Billing and Payor Claims Adjudication Guidelines" of this manual.)

Note: Ohio Health Choice requests our Payors do not ask providers or members to contact Ohio Health Choice directly to check payment status of claims. Payors should contact Ohio Health Choice Repricing Department to determine if a claim has been repriced. If Ohio Health Choice has repriced the claim, a copy of the repriced claim cover sheet will be forwarded to you. If we have not received the claim, you should direct the provider or member to resubmit the claim to the correct repricing post office address.

Repricing Resolutions
Billings that are not in compliance with the billing guidelines should be forwarded to Ohio Health Choice for review. Non-compliant billings will be called to the attention of the rendering participating provider and may be subject the provider to disciplinary action by Ohio Health Choice, including possible termination of the provider's agreement with Ohio Health Choice (and resulting loss of participating provider status). In addition, in instances where the Payor has paid a provider's billing which was not in compliance with the guidelines, the provider may be required to refund to the Payor the amount of the payment which should not have been billed.

ELECTRONIC DATA INTERCHANGE

Ohio Health Choice prefers to send and receive claims electronically, and is able to implement an EDI connection with any payor who also desires to use EDI for claims transmission. Ohio Health Choice EDI Implementation Guides are available for download on our website www.ohiohealthchoice.com. Payors may contact the Ohio Health Choice Sales and Account Management Department at 800-554-0027 to start the EDI implementation process.