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 and Preferred Provider Organization (PPO) protocols. The goal of Ohio Health Choice is to keep participating providers as informed as possible.

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

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OHIO HEALTH CHOICE
PROVIDER MANUAL
TABLE OF CONTENTS

I. INTRODUCTION

A. Ohio Health Choice Philosophy

Ohio Health Choice is a Preferred Provider Organization (PPO) 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 is 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. Apppropriate 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.

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, fax or email 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 regularly via the Ohio Health Choice website (www.ohiohealthchoice.com) or www.ohioppoconnect.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 partipating 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. Payment must be issued to Ohio Health Choice participating provider directly, not to the insured. Participating providers are not required to obtain written assignment.

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

4. 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 their CAQH number and must ensure that their attestation, and necessary supporting documents are current, 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;

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 or indicate the network provider who will admit on their behalf.

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.

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.

III. COMMUNICATION

A. Customer Service

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 eligiblity, 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**.

B. 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. The member's ID card will contain the number to check eligibility status.

C. 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 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.

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, freestanding 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.

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.

D. 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.

The network hospital is required to call the Inpatient Case Manager with the review within one (1) business day of the admission. Please call the pre-cert number on the patient's ID card.

IV. BILLING GUIDELINES

Ohio Health Choice 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 industry standards and the CMS developed National Correct Coding Initiative (NCCI coding Edits). The following is a list of these edits, which may be applied to submitted provider claims.

A. Modifiers

TC – (Professional Component) Use TC rate from Provider's allowable fee schedule.

26 - (Professional Component) Use 26 rate from Provider's allowable fee schedule.

50 – (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.

62 – (Co-surgeon) – 62.5% of Provider's allowable fee schedule amount.

80, 82, AS – (Assistant Surgeon) – 20% of Provider's allowable fee schedule amount.

81 – (Minimal Assistant Surgeon) – 17% of OHC fee schedule amt

AD, QK, QX, QY – (Anesthesia with medical direction) – 50% of OHC allowable

GQ, GT and/or POS = 02 - (Telehealth) – 80% of OHC allowable (facility rate).

B. Anesthesia

- 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 adds 1 unit, 99140 adds 2 units, 99116 and 99135 add 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.
- Medically supervised care will be reimbursed at 50% for each claim up to 100% of the allowable.
- Please use anesthesia codes as assigned by the ASA. We do accept surgical codes but if they are unable to crosswalk to an ASA code, this will result in a denied claim.
- Anesthesia for Maternity Services will be based on the following formula:
  - 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 unit 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 each hour thereafter.

C. 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 modifiers 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.

D. Multiple Procedure Payment Reduction (MPPR)

If claim has multiple CPT Codes flagged by CMS as eligibility for multiple procedure reduction on the same service date, then highest billed code is repriced to 100% of the fee schedule amount. Remaining codes are each repriced to 50% of the fee schedule amount.
This is typically applied to surgical claims.

E. Billed Charges

All claims are reduced to the lesser of billed charges or fee schedule amounts except for ASC, Per Diem and DRG claims where the provider contract specifically prohibits this reduction.

F. Codes not priced by CMS

If Medicare does not price a CPT or HCPC code, OHC will reprice it based on the amount listed in the provider's contract for unassigned codes... All repriced codes must have an RVU value as assigned by CMS or a billable status code. Codes without one of these items will be repriced to $0.

G. Facility Rates

Based on Medicare guidelines, some CPT codes will reprice to a lower facility rate when the Place of Service code indicates that the procedure was performed in a facility setting.

V. 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 a HCFA, UB or other claim forms acceptable to Payor, within ninety (90) 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 infomation 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, NPI
    b) Patient Name and Date of Birth and ID number
    c) Employer Name, Union, or Group;
    d) Employer Group Policy Number;
    e) Pertinent CPT, HCPCS and ICD-10 codes;
    f) Date(s) of Service;

3. When obtaining billing information from a patient, it is necessary to properly identify them as an Ohio Health Choice PPO member.

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 unless that is indicated on the ID card. 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-10-CM Diagnostic Codes

ICD-10-CM diagnostic codes are required for a complete and proper claim form.

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.

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 as determed by the EOB.

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 a HCFA or UB within ninety (90) days for Individuals and Group Providers and ninety (90) days for Facilities, after providing Covered Services to eligible persons.

E. Claim Payment Resolution 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.

Call the Payor for questions related to benefits, UM or eligibility. The Payor will request the following information:

a) Insured's name/patient's name;
b) Insured's ID number;
c) Employer group number or name;
d) Date(s) of service and claim information (billed charged amount, attending physician's name and tax ID number).

The phone number of the Payor (TPA) is on the ID card or you can obtain this information by calling our customer service department at 1-800-554-0027. Make sure that you have the name of the person with whom you spoke and document the phone number in order to follow-up if necessary.

Contact Ohio Health Choice Customer Service. Ohio Health Choice Customer Service Department can answer any questions regarding contracted rates, billing guidelines and network status. The number is 800-554-0027. Ohio Health Choice will communicate to the Payer if an error was made regarding claim adjudification.