Provider Manual

Montana, Idaho, and Wyoming

Introduction

The Mountain Health CO-OP (CO-OP) Provider Manual is intended for use by our network, which includes physicians, ancillary providers, and contracted facilities/vendors, including their practice managers and office staff.

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The information in this manual does not replace the Professional Provider/Facility Agreement signed by the contracted or employed provider. This provider manual is considered an extension of the contract, an attachment to and thereby part of the executed CO-OP Professional Provider/Facility Agreement and/or any payment agreement between the CO-OP and Provider/Facility.

Mission Statement

We offer non-profit member-governed health insurance that promotes member engagement and provides access to high-quality medical care.

History

Welcome to Mountain Health CO-OP (CO-OP). We value and honor your distinctive connection with our members.

The CO-OP was formed under the Affordable Care Act's provision, which allowed for the creation of Consumer-Oriented and Operated Plans (CO-OPs).

The CO-OP operates in three states: Montana, Idaho, and Wyoming. In 2014, the CO-OP offered its first coverage to individuals and employer groups in Montana. In 2015, with the implementation of the Affordable Care Act, we began providing coverage to individuals and employer groups in Idaho. In 2021, the CO-OP expanded into Wyoming.

The CO-OP has partnered with Wipro Health Plan administrators (WHPS) as our third-party administrator (TPA). WHPS performs functions such as claims, customer service, billing, and enrollment.

The Co-Op has partnered with Personify Health (HealthComp) as our medical management administrator. Personify performs functions such as utilization management, case, and disease management, population health, and appeals.

Purpose

This manual provides helpful and reliable information and guidelines. It is organized into sections that reference information about policies and procedures and can be used as a training tool about the CO-OP. We use the term "provider" throughout this manual to refer to physicians and/or providers.

Please check our website at www.mountainhealth.coop for updates and the latest version.

Member Rights and Responsibilities

The CO-OP's member rights and responsibilities statement is as specified below:

A Member has the right to:

I. Members have the right to receive information about their health plan, its practitioners and providers, and members' rights and responsibilities.

II. Members have the right to courteous treatment. We respect your right to:
   - A. Be treated with respect and recognition of your dignity. We will not discriminate in the care offered to you based on race, religion, national origin, sex, age, sexual preference, type of illness, or financial status.
   - B. Be addressed in a manner that is comfortable to you.
   - C. Know your health care providers. You have the right to ask all personnel involved in your care to introduce themselves, state their position, and explain what they are going to do for you.

III. Members have the right to available and accessible services, including emergency services. Responsibility for payment for such services will be determined by Your coverage.

IV. Members have the right to privacy.

V. Members have the right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.

VI. Members have the right to be informed about their health care and to receive information about proposed treatments and alternatives. Members have the right to an explanation from health care providers of:
   - A. Diagnosis
   - B. Recommended treatment and alternatives to treatment
   - C. Potential outcomes and/or prognosis
   - D. Significant benefits and risks of each alternative

VII. Members have the right to participate with providers in making decisions about their care. These rights generally include:
   - A. Giving informed consent, i.e. agreeing to treatment based on a full explanation of your disease and the risks and benefits or proposed treatment, as well as alternative treatments.
   - B. Refusing diagnostic procedures or treatment. It is your right to decide whether you wish to be treated, and if so, by which method of treatment.

VIII. Members have the right to appropriate confidentiality of all medical and financial records in accordance with state and federal law. Generally, your medical records will not be released to persons outside your health plan unless you grant permission in writing, or we are required or permitted, under applicable law, to use or release this information. Certain examples of permitted releases of information are:
   - A. If required by a court order
   - B. To medical personnel in a medical emergency
   - C. As necessary to facilitate complaint investigations or inspections by federal or state entities
   - D. To qualified personnel for research, audit or program evaluation, as long as individuals cannot be identified

IX. Members have a right to voice complaints or appeals about their health plan or the care provided.
X. Members have the right to make recommendations regarding the plan's member rights and responsibilities.

A Member has the responsibility to:

I. Members have the responsibility to understand their health problems and to participate in developing mutually agreed upon treatment goals to the greatest degree possible. Once members and their health care provider(s) have agreed upon a treatment plan, it is the member's responsibility to follow the prescribed plan and instructions for care. Advise the health care provider treating you if you are unable to follow a treatment plan.
II. Members have the responsibility to make informed decisions. Because you are responsible for the decisions you make about your care, we encourage you to gather as much information as you need to make your decisions.
III. Members have the responsibility to be honest and to provide, to the extent possible, information that the health plan needs to administer plan benefits and its providers need to provide care. Provide an accurate and complete medical history.
IV. Members have the responsibility to report changes in their health. Tell your doctor about any changes in your health.
V. Members have the responsibility to know their providers. Try to know the names and the positions of everyone who cares for you (doctors, dentists, nurses, etc.).

Contacts

Eligibility/Benefits Claims Issues and Disputes Refunds and Recoveries	24 x 7 online via Provider Portal at https://mountainhealthcoop.vbagateway.com/ Monday – Friday, 8:00 AM to 6:00 PM MST Phone 1-800-299-6080
Paper Claims	PO Box 30311 Salt Lake City, UT 84130
Payer ID Payer Name	MHC01 Mountain Health CO-OP
Provider Relations	1-800-299-6080
Credentialing	**mhccred@mhc.coop**
Mountain Health CO-OP's Clearinghouse	Optum Change Healthcare **Payer Name:** Mountain Health CO-OP **Institutional CPID:** 7565 **Professional CPID:** 2499 **Payer-assigned Payer ID:** MHC01 **Payer Enrollment Required:** No **Secondary Claims Accepted:** Yes **Payer Location:** Montana, Wyoming, Utah **Claims Fee:** NA https://marketplace.optum.com/ 1-800-527-8133 Transactions available: electronic claim submission and real-time eligibility (270/271)
EDI support after hours	clearanceedi.support@optum.com
Prior-Authorizations	1-833-412-4144 **Fax 559-243-7012** **Email UMFax@healthcomp.com** **Enroll at mycarehc.com** Prior Authorization Form
Pharmacy Prior-Authorization	1-833-412-4144 **Fax 559-243-7012** Pharmacy Prior Authorization Form
Provider Portal Issues	provider@mhc.coop

Provider Disputes or Provider Appeal on Behalf of Member	Phone: 800-643-4416 Fax: 985-898-1505 Mail HealthComp UM Department P.O. Box 45018 Fresno, CA 93718-5018 Email UMFax@healthcomp.com Provider Dispute/Appeals Form
Zelis Appeals	Zelis Appeal form Zelis Fax (855) 250-3338 Zelis Email providerservices.integrity@zelis.com
Provider Contracting	provider@mhc.coop or call: 1-800-299-6080, Option 6

Definitions

Benefit Plan means any group, or individual, insured, or self-funded health care plan offered by the CO-OP or administered by the CO-OP on behalf of a Payer, which entitles Member to receive Covered Services through specified networks of Participating Providers and Participating Facilities under terms and conditions specific to Member's Benefit Plan type, and, if applicable, obligates the CO-OP or its Payers to pay for Covered Services on behalf of Member.

Clean Claim means any claim submitted by a Provider that:

- is received timely by the CO-OP or its administrator;
- has a corresponding referral, if required;
- if filed on paper, is submitted on a UB04, CMS-1500 or successor claim form(s) with all the necessary elements;
- if submitted electronically, is submitted in compliance with the applicable federal and state regulatory authority and uses only permitted standard code sets;
- includes all relevant information and/or information required by the CO-OP or its administrator;
- requires no other information to determine other carrier liability or to investigate possible fraud;
- complies with billing guidelines and Medical Policies;
- has no defect or impropriety;
- includes substantiating documentation; and
- does not require special processing that would prevent timely payment.

Clinical Management Committee means CO-OP providers or other persons who are designated by the CO-OP to, among other things, administer the CO-OP medical affairs.

CMS means the Center for Medicare & Medicaid Services.

Coinsurance means a payment, usually calculated as a percentage of the cost of services that a Member is required to make for Covered Services under Member's Benefit Plan.

Copayment means a payment, usually a fixed dollar amount, which a Member is required to make for Covered Services under Member's Benefit Plan.

Covered Services means those Medically Necessary and, when applicable, authorized services that Members are entitled to receive under Member's Benefit Plan.

Covering Provider means a provider designated by the primary care provider to offer health care services in the temporary absence of the primary care provider.

Deductible means a payment, usually, a fixed dollar amount, which a Member is obligated to pay and is required to meet in full each calendar or contract year before the CO-OP or Payer is obligated or begins to make payments for Covered Services.

Emergency means, unless otherwise defined in an applicable Benefit Plan, a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in: (a) placing the patient's health in serious jeopardy; (b) serious impairment of bodily function; (c) serious dysfunction of any bodily organ or part. Severe bleeding, unconsciousness, and fracture are examples of Emergencies. Notwithstanding any other provision in this Agreement, the CO-OP or administrator shall not deny payment for Emergency services provided by Provider to Members in accordance with USC 42, Section 1395 et seq of the Emergency Medical Treatment and Active Labor Act (EMTALA).

Medical Record means the health record or medical record of a Member that documents the medical services received by that person, including without limitation inpatient discharge summary, outpatient and emergency medical service documentation or any referral consultant reports.

Medically Necessary means, unless otherwise defined in an applicable Benefit Plan, services or supplies that are necessary and appropriate according to accepted standards of medical practice in the community in which Provider practices and consistent with practice guidelines for the treatment of a Member's illness or injury or the preventive care of the Member.

- Medically appropriate, so that expected health benefits (such as but not limited to, increased life expectancy, improved functional capacity, prevention of complications, relief of pain) materially exceed the expected health risks;
- Necessary to meet the health needs of the Member, improve physiological function and required for a reason other than improving the appearance;
- Rendered in the most cost-efficient manner and setting appropriate for the delivery of the health service;
- Consistent in type, frequency, and duration of treatment with scientifically based guidelines of national medical research, professional medical specialty organizations or governmental agencies that are generally accepted as federal authorities on the services, supplies, equipment, or facilities for which coverage is required;
- Consistent with the diagnosis of the condition at issue;
- Required for reasons other than the comfort or convenience of the Member or Member's physician or another provider; and
- Not experimental or investigational as determined by Company under its Experimental Procedures Determination Policy and Clinical Management Committee. (A copy of the Experimental Procedures Determination Policy is available upon request.)

Medical Policies means the medical policies and procedures adopted by the CO-OP, as amended from time to time at the discretion of the CO-OP, and the current version may be obtained through the CO-OP's website. Notice of changes to the Medical Policies will be available on the CO-OP website or through electronic media. In the event of a conflict between the Medical Policies and the terms of this Agreement, the terms of this Agreement will apply.

Member means a person covered under a Benefit Plan who has enrolled in a health care plan offered or administered by the CO-OP.

Non-Covered Services means those Provider Services or other services, supplies, or drugs that are not a Covered Service under an applicable Benefit Plan, including, but not limited to, investigational, not Medically Necessary, or not properly authorized services.

Participating Facility means a hospital, ambulatory care center, birthing center, skilled nursing facility, short-stay facility, laboratory facility, urgent care facility, or any other health care facility that enters into an agreement with the CO-OP to provide certain Covered Services to Members.

Participating Provider means a physician, physician group, other health professionals, or Participating Facility that is legally qualified, licensed, and credentialed to provide medical services or supplies under applicable law and that has entered into an agreement with the CO-OP to provide Covered Services to Members, including a Covering Provider.

Participating Provider Network means a network of Participating Providers that have contracted with the CO-OP to provide medical services to Members in accordance with specific payment and related policies and procedures established by the CO-OP for such a network.

Payer means any entity, including without limitation a health maintenance organization, preferred provider organization, exclusive provider organization, benefit plan sponsor, administrator, insurer, employer, union trust, or governmental agency, or network (a) that has entered into, or may in the future enter into, a contract with the CO-OP pursuant to which the CO-OP agrees to provide, arrange to provide or allow access to the network for the provision of Covered Services to Members of that entity for certain compensation, and (b) is obligated to provide reimbursement for Covered Services on behalf of a Member in accordance with Member's Benefit Plan.

Pre-authorization means the CO-OP's prior approval of the Medical Necessity of Services provided to Members under the terms of their Benefit Plan.

Primary Care Provider means a Participating Provider who meets the requirements of the CO-OP for status as a Primary Care Provider and who agrees to provide primary care services to Members in accordance with the applicable Benefit Plan. Primary Care Providers may include generalists in family practice, general practice, internal medicine, obstetrics/gynecology, pediatrics, and other Participating Providers as determined by the CO-OP.

Provider Manual means the CO-OP's provider manual to inform Provider of relevant information, policies, procedures, and guidelines. The Provider Manual may be changed from time to time as allowed herein, and the current version may be obtained through the CO-OP's website. The Provider Manual is an extension of the formal contract between the Provider and Mountain Health CO-OP.

Provider Services means those facilities, equipment, professional services, supplies, drugs, and other medical services as applicable, which are within a Participating Provider's professional competence, professional license, and authorization to provide services subject to the CO-OP credentialing process.

Service Area means the geographic served by Provider.

Specialist Provider means a Participating Provider who is a physician, other than a Primary Care Provider, who is professionally qualified to practice his or her designated specialty.

Physicians and Providers

Provision of Covered Services

Providers must be aware of benefit plans' covered services and inform members of covered services as well as other programs and resources available to members for prevention, education, and treatment. Practitioners may freely communicate with patients about their treatment, regardless of benefit coverage limitations.

Provider Services

Contracting providers shall have a covered provider available twenty-four (24) hours a day, seven (7) days a week. Covering providers shall be in-network as well. In-network (INN) physicians are encouraged to direct members to INN contracting providers to render services. Pertaining to participating facilities, covering facilities will follow the same guidelines above. In the event of emergencies, covering providers and facilities are not obligated to utilization management prior authorizations.

Contracted professional providers may NOT bill for services provided to their own immediate family members.

Credentialing & Re-Credentialing

The purpose of the CO-OP Credentialing Program is to ensure that our network consists of high-quality providers who meet clearly defined standards. The Co-Op and it's contracted CVO will perform credentialing responsibilities for CO-OP providers that are not credentialed by another network entity through a formal delegation agreement and ensure that the credentialing program follows the standards set forth by the National Committee for Quality Assurance (NCQA).

The Co-Op's credentialing team has collaborated with the following organizations:

- NCQA certified Credentials Verification Organization (CVO), Medversant
- Council for Affordable Quality Healthcare (CAQH) ProView. Proview is the trusted electronic solution and industry standard for universal credentialing applications to offer our providers an efficient credentialing process enabling them to minimize the time between contracting with the CO-OP and providing services to our members. To log-on to CAQH Proview visit https://proview.caqh.org/Login/Index?ReturnUrl=%2f

To allow our credentialing team to access the CAQH applications for your group, please visit the CAQH link above and grant permission to the CO-OP to receive your application. If you have not completed your one-time credentialing application, which enables multiple healthcare organizations nationwide to view your application, we encourage you to do so at no cost. Visit the CO-OP's website at www.mountainhealth.coop under the provider tab to learn more about joining our network.

The CO-OP requires that all PAs and other mid-level providers complete credentialing. Once credentialed, they must submit claims under their name and NPI for our commercial plans. Providers should check the website for further information regarding the credentialing process.

Credentialing is required every three (3) years for all physicians and other types of health care professionals practicing under their license as permitted by state law.

For a copy of the CO-OP's credentialing policies and procedures, or to check on the status of your credentialing or re-credentialing application, please contact provider credentialing at mhc.coop@medversant.com

To initiate credentialing for new providers within your practice, please complete our Provider Add form that can also be found on our website, mountainhealth.coop/provider

The result of your credentialing application is based on information such as complaints, grievances, malpractice history, and board certifications. Providers have the right to review information from these sources that support their credentialing application and correct erroneous information. Additionally, providers may appeal an adverse credentialing determination under certain circumstances (please see Provider Rights section for more information).

Initial Credentialing: Provider Pre-Screening

Providers who are newly applying for contracting and credentialing with the CO-OP are subject to the below pre-screening criteria. An answer in the affirmative to one or more of the screening questions will not result in an automatic denial of network participation, however if applicant does not meet criteria, a decision will be made regarding network participation by the CO-OPs VP of Provider Networks and/or Medical Director, with participation of the Credentialing Committee. Providers do not have any appeal rights on initial contracting/credentialing decisions.

1. (In any state) have you ever lost your license to practice medicine due to disciplinary action, had your license suspended, or is your license currently restricted?
2. Are you able to be insured for professional liability?
3. Are you able to obtain malpractice insurance?
4. Have you currently or ever lost admitting privileges to any affiliated hospital or had your privileges restricted?
5. Have you even been absent from work without justification and without leave of absence such that patient care is adversely affected?
6. Have you ever been found guilty of professional misconduct, violated professional ethics, or otherwise engaged in conduct that, in the reasonable judgment of a professional, posed a risk to patients, exposed an employer or Health Plan to liability, or otherwise disrupted employer/Health Plan operations; or demonstrated a lack of ability, integrity or other professional qualifications?
7. Are you currently excluded from participating in Medicare, Medicaid or other public or private payer program?
8. Have you been a party to an incident that resulted in a reportable event to the National Practitioner Data Bank?
9. If you are a specialist, have you ever failed to maintain board certification or board eligible status in your specialty?

10. Have you ever been found guilty of neglect, willful misconduct or malfeasance in the performance of your duties, dishonesty, or chronic absenteeism?
11. Are you currently suffering from any condition for which you are not being appropriately treated that impairs your judgment or that would otherwise adversely affect your ability to practice medicine in a competent, ethical, and professional manner?
12. Have you ever lost or currently lost your right to prescribe any class of drugs?
13. Have you even been charged with, or convicted of a felony or a misdemeanor crime involving moral turpitude?
14. Have you ever breached any fiduciary duty owed by Provider to an employe or health plan?

Practitioner Rights

New applicants for credentialing are afforded the below rights:

A. Practitioner Rights

   1. The applicant shall have the right to be informed of their application status (Ready for Committee, App In-process, App Incomplete or Missing Information) upon request. The request shall be made via email to: mhc.coop@medversant.com, or by phone to 800-229-6080.
   2. Information on Practitioner Rights can be found in the Provider Manual on our website: www.mountainhealth.coop. Emails will be responded to within 24 hours, and voice mails returned within 48 hours.
   3. The Practitioner will have the opportunity to correct any erroneous information, as applicable, during the 2–3-month credentialing process. Applicants are notified of this right through our Provider Manual.

B. Right to Correct Erroneous Information

   1. Applicants are notified of credentialing information obtained from other sources that varies substantially from that provided by the practitioner via email or phone and outreach will be documented within the practitioners file.
   2. Erroneous information corrections can be made within 30 calendar days. Information must be lined through with black ink, corrections above or to the side and initialed. No white out will be accepted. Corrections can be submitted to: mhc.coop@medversant.com. MHC will document receipt of corrected information in the practitioner's credentialing file within the CVO database within 2 business days of receipt.
   3. Upon request, applicants may review the information s/he has submitted in support of their credentialing or re-credentialing application, including but not limited to:
      i. information from outside sources

ii. malpractice insurance carrier face sheet
iii. state licensing board
iv. DEA agency verification
v. education verification letter from a school
vi. board certification verification, if applicable

4. Mountain Health Co Op (MHC) is not required to reveal sources of information that are not part of our verification requirements or if federal or state law prohibits us, such as NPDB reports. The applicant may view their file in the presence of the Mountain Health Co Op (MHC) Credentials Committee Chair and a member of the credentialing team. Applicants are notified of these rights in the Provider Manual and website: www.mountainhealth.coop

C. Access to Records

1. All requests for access to credentialing records will be presented to an authorized representative of the Mountain Health Co Op (MHC) credentialing team, who will keep a record of requests made and granted. Unless otherwise stated, an individual permitted access under this section will be afforded a reasonable opportunity to inspect the records, and to make notes regarding the requested records in the presence of an authorized representative.
2. The Mountain Health Co Op (MHC) credentialing team and CMO or the designee may have access to all records as needed to fulfill their responsibilities.
3. Consultants or attorneys engaged by Mountain Health Co Op (MHC) may be granted access to records that are necessary to enable them to perform their functions provided that he or she has signed and dated the appropriate "Confidentiality Agreement." The original agreement will be retained by Mountain Health Co Op (MHC).
4. All subpoenas pertaining to credentials records will be referred to the Credentialing Manager who will consult with legal counsel regarding the appropriate response. Representatives of regulatory or accreditation agencies may have access to records as required by law or accrediting rules.
5. Should a file review be requested, staff will set an appointment at the Mountain Health Co Op (MHC) office for the practitioner to review the submitted materials in his or her credentialing file under the following circumstances:
   i. The request is approved by the Mountain Health Co Op (MHC) Credentialing Committee chairperson

ii. Review of the file is accomplished in the presence of the Mountain Health Co Op (MHC) Credentialing Committee chair and Provider Credentialing Consultant

iii. The practitioner understands that he or she may not remove or delete any items from the credentialing file

iv. The practitioner understands that he or she may add an explanatory note or other document to the file for the purpose of correcting erroneous information

6. The applicant attests to the correctness and completeness of all information furnished and acknowledges that any significant misstatement or omission from the application is reason to find that the applicant no longer meets criteria.

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Provider Termination

A. **Not for Cause Terminations-** Unilateral Termination. Relationship under this Agreement may be terminated by either Health Plan or Employee without cause ("not for cause") by giving the other at least ninety (90) days written notice of such unilateral termination. Providers do not have appeal rights when a termination is without cause. Terminations due to failure to respond timely to requests to initiate the recredentialing process are considered not for cause.

B. **Administrative Termination -the** Health Plan may immediately or after consideration by the Credentialing Committee terminate relationship under this Agreement upon the occurrence of any of the following events:
(a) Provider

(i) loses Provider's license to practice medicine in any state, or Provider's license is restricted;

(ii) cannot be insured for professional liability under the same terms, conditions and amounts as other contracted providers contracted by Health Plan;

(iii) cannot be admitted to the medical staff of any affiliated hospital with appropriate privileges, or loses privileges or has privileges restricted, in hospitals where Health Plan conducts its delivery of care;

(iv) is absent from work without justification satisfactory to Health Plan and without leave of absence such that patient care is adversely affected;

(v) has otherwise conducted him/herself in a manner inconsistent with executed Agreement with MHC ;

(vi) has breached or violated professional ethics or engaged in conduct that, in the reasonable judgment of Health Plan, poses a risk to patients, exposes Health Plan to liability, or otherwise disrupts Health Plan operations;

(vii) has demonstrated a lack of ability, integrity or other professional qualifications inconsistent with the objectives of Health Plan;

(viii) is excluded from participating in Medicare, Medicaid or other public or private payer program required by Health Plan; or

(ix) fails to maintain board certified or board eligible status in his or her specialty

(b) Health Plan determines that Provider is guilty of neglect, willful misconduct or malfeasance in the performance of his or her duties hereunder, dishonesty, chronic absenteeism or chronic alcoholism or addiction to drugs which remains untreated and interferes with Provider's performance of duties;

(c) Provider commits, is charged with, or is convicted of a felony or a misdemeanor involving moral turpitude;

(d) Provider breaches any fiduciary duty owed by Provider to Health Plan;

(e) Provider loses his or her right to prescribe any class of drugs;

(f) Provider is unable to obtain malpractice insurance covering Provider commensurate with insurance obtained for other providers who enjoy good standing in relationship to the Health Plan.

An administrative termination may not be appealed in accordance with the Co-Op's Fair Hearings & Peer Review Policy.

C. Termination for Cause- the Health Plan may immediately terminate relationship under this agreement in the event of a serious reportable adverse event, a severe quality of care complaint, or a documented pattern of member complaints are found to be credible. Providers who are terminated for cause are afforded a fair hearing in accordance with the Co-Op's policy regarding Fair Hearings & Peer Review.

Monitoring of Provider Sanctions and Disciplinary Actions

The CO-OP does on-going monitoring of provider sanctions and disciplinary actions. Reports from the Health & Human Services (HHS), Office of Inspector General (OIG), and state licensing boards are reviewed regularly throughout the year. Providers with Medicare / Medicaid sanctions, or who have a business relationship with another provider or entity that has been debarred or excluded, may be terminated from the CO-OP participating networks. Providers who have had restrictions placed upon their license to practice will be presented to the peer review committee for a decision on the appropriate action to be taken.

Credentialing documentation and information are kept confidential, and disclosure is limited to parties who are legally permitted to have access to the information under state and federal law.

Institutional and Supply Providers

The CO-OP ensures that all institutional and supply providers have met their respective certifications, that they have current licenses to operate in their respective states, that they are in good standing with state

and federal authorities and have adequate liability coverage. Credentialing is completed upon initial contracting and then every three (3) years.

- Birthing centers, ambulatory surgery centers, and outpatient hospitals must have a clear, written plan of transfer and transition of care in emergency circumstances and admitting privileges. The plan must include the name(s) of the hospital and the practitioner(s) providing backup.

Accessibility

Appointment Availability Time

<table>
<tr><td rowspan="2">Primary Care</td><td>Regular & Routine Care Appointments</td><td colspan="3">Urgent Care Appointments</td></tr>
<tr><td>Within 30 Days</td><td colspan="3">48 Hours</td></tr>
<tr><td rowspan="2">Behavioral Health</td><td>Initial Visit Appointment</td><td>Non-Life Threatening Emergency</td><td>Follow Up Appointments</td><td>Urgent Care Appointments</td></tr>
<tr><td>Within 10 Business Days</td><td>Refer member to Crisis Center or Emergency Department</td><td>Within 30 Days</td><td>Within 48 hours</td></tr>
<tr><td rowspan="2">Specialty Care</td><td>Initial Visit Appointment</td><td colspan="3" rowspan="2"></td></tr>
<tr><td>Within 30 Days</td></tr>
<tr><td>Appointment Scheduling</td><td colspan="4">Providers are required to have implemented an appropriate scheduling system that allows for adequate allotments of time for different appointment types ensuring allowances for same-day urgent, acute care appointments.</td></tr>
<tr><td>After Hours Care</td><td colspan="4">Providers should have sufficient backup coverage for after-hours care and to have telephone coverage 24 hours per day, seven days per week. The use of in-office recordings should state the regular office hours, whom to contact if after hours, and direct the member to call 911 if it is an emergency.</td></tr>
<tr><td>Telehealth</td><td colspan="4">Mountain Health Co-Op fully supports the use of telehealth services to improve access to care for its members. Due to the ruralness of the areas we serve, it is key for our members to have access to quality, convenient and affordable healthcare. Telehealth, sometimes known as telemedicine, must be a synchronous platform, for reimbursement. Examples of synchronous telehealth services are not limited to two-way video calling between a provider and patient, live video evaluations, live physical therapy evaluations, live video mental health care, and consultations between primary care and a medical specialist. Office visits via synchronous telehealth will be reimbursed at the same rate as in person care. Submission of claims with a "POS 10, 95 or 02-Telehealth" should be appended to identify that the service was provided via telehealth. Mountain Health Co-Op follows CMS and other National coding guidelines. See Section Billing, Claims Payment and Claims Editing for more information.</td></tr>
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Physician and Provider Contract Provisions

Organizational Facilities

Providers shall maintain organizational facilities that adhere to NCQA, and regulatory requirements as required by state or federal law. Non-NCQA accredited facilities shall be subject to onsite visits for credentialing purposes at the discretion of the CO-OP. Providers must write prescriptions on tamper-resistant prescription pads, in accordance with Section 1903(i)(23) of the Social Security Act for tamper-resistance.

Medical Records

Participating providers shall maintain confidential, complete medical records for all CO-OP members in accordance with state and federal laws.

To fulfill activities such as payment of claims, quality improvement, State and/or Federal reporting, credentialing, Risk Adjustment and HEDIS, the CO-OP may conduct medical record audits. The audits may include evaluation of the following:

- legibility
- identifying patient information
- entries dated and timed
- completed problem list
- completed medication list
- clear notation of allergies
- documentation of immunizations and preventive health screening as applicable
- progress notes for each visit that include plans for follow up and/or return visits
- providing appropriate supporting medical documentation to plan for referral and or prior authorization requests
- Advance Directives

All medical records, chart notes, procedures, and orders submitted for review must be signed and dated by the rendering practitioner. All medical records must be submitted without cost to the health plan. A medical record that does not contain a valid signature may result in claim denials or recovery of overpayments. Signatures added to documentation following a claim denial will not be accepted. This is modeled after requirements in the Centers for Medicare and Medicaid Services (CMS) Medicare Program Integrity Manual (MPIM). Specifically, Section 3.3.2.4

The CO-OP encourages Specialists to provide consultation notes to the PCP in charge of the member's health. Medical records must be provided at no cost. Medical Records will be made available for inspection by the CO-OP, its assigned representatives, and/or Federal & State agency representatives during reasonable business hours.

Patient records should be kept for at least seven (7) years.

Patient Confidentiality and HIPAA

Providers, their employees, and business associates agree to safeguard the privacy and confidentiality of CO-OP members and agree to abide by the rules and regulations outlined in the Federal Health Insurance Portability and Accountability Act (HIPAA) of 1996.

Written authorization is required from the member for all uses and disclosures of Protected Health Information (PHI) EXCEPT uses and disclosures for Treatment, Payment and Health Care Operations (TPO). Releases and disclosures of PHI should be done according to a standard of 'minimum necessary,' meaning only the amount of information needed to fulfill a specific purpose or task should be released.

TPO may include, but is not limited to:

- Patient Referrals
- Providing information to family or friends who care for, or will be caring for a CO-OP member as an authorized representative
- Providing the information required to the CO-OP for processing and claims payment, and or authorizations
- Complying with the CO-OP's QA/QI activities, HEDIS reporting and/or other CO-OP programs centered on the improvement and measurement of patient care

The CO-OP is responsible for ensuring members' privacy and also adhering to stringent confidentiality regulations as required by Federal law. This means that the identity of any caller claiming to be a member must be verified before any information concerning the member is given. This will be accomplished by obtaining the member's identification number, date of birth, address, and/or last four of a social security number. Must have a combination of at least three identifiers.

NOTE: Providers must supply Tax ID Number (TIN) and NPI when requesting patient information.

Compliance with CO-OP Policies and Procedures

Provider shall comply and participate with all CO-OP Utilization Management Programs, Quality Improvement Programs, to include but not limited to HEDIS reporting, NCQA, peer review, credentialing & re-credentialing activities, national correct coding initiatives and Complaint/Grievance Policies and Procedures. Providers agree to cooperate with the CO-OP's QI activities to improve the quality of care and services, and member experience, and agree to allow the CO-OP to use their performance data for QI activities. In addition, Providers shall abide by policies and procedures related to covered services, billing of enrollees, emergency services, and other Policies and Procedures as defined by the CO-OP concerning each plan the Provider participates in.

If a Provider determines to admit a Member to an inpatient facility, and/or refer a Member to a facility for outpatient diagnostic/surgical services, Provider agrees to admit and/or refer Member to a Participating Facility for all non-emergent Provider Services, or to obtain Pre-authorization to perform such services at a non-Participating Facility before the services being rendered. Failure to refer Member to a Participating Facility for non-emergent Provider Services, or failure to obtain a Pre-authorization for services at a Participating or non-Participating Facility, may result in the denial of Provider's claims arising from such services and forfeiture of payment by Provider, as compliance with such requirements is a condition of

payment. Where payment is denied for failure to follow these requirements or those in the Provider Manual or Medical Policies, Member shall not be billed for such services. In the event of an emergency requiring the Member's referral to a non-Participating Facility, Provider agrees to use Provider's best efforts, and cooperate with the CO-OP or its administrator, to transfer Member to a Participating Facility as soon as it is medically feasible.

Notification of an inpatient admission must be made within 48 hrs. of the emergent inpatient admission to allow utilization management concurrent review to take place.

Licensure and Insurance

Providers shall maintain current licensure, malpractice liability insurance, specialty board certification, when applicable, hospital privileges, and a current CAQH application.

- Licensed Clinical Professional Counselor Candidate Billing Procedure
    - **Services provided by a LCPC candidate must be billed under the supervising, licensed & credentialed provider's NPI.**
    - **No modifier required.**

Notification of Changes

Provider shall notify CO-OP Provider Relations in writing immediately upon a change in statuses such as an address, malpractice, licensure, hospital privileges, Medicare / Medicaid sanctions, and/or other disciplinary actions or other changes in your credentialing. Changes in ownership or management structure, accreditation status, and all healthcare providers changes must also be communicated in writing. Please submit provider rosters regularly, if available.

Provider Directory

Providers regularly review the CO-OP provider directories found on the CO-OP's website to ensure all provider information is accurate and complete.

Service Delivery / Non-Discrimination

Providers are contractually obligated to render covered services to CO-OP members in an appropriate, timely, cost-effective manner, consistent with conventional medical care standards and practices. Services will be delivered in a culturally and linguistically appropriate manner, thereby including those with limited English proficiency or reading skills. This will consist of those with diverse cultural and ethnic backgrounds, the homeless, and individuals with physical or mental disabilities. To arrange translation services, please contact CO-OP member services at 1-800-299-6080. Practitioners and Providers may openly discuss with members all appropriate or medically necessary treatment options, regardless of benefit coverage limitations.

Providers shall also, in compliance with Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, Title II of the Americans with Disabilities Act of 1990, provide access and treatment without regard to race, color, sex, sexual orientation, religion, national origin, disability or age. Additionally, the provider shall not, within their lawful scope of practice, discriminate against members from high-risk populations or who require treatment of costly conditions.

Any provider with concerns regarding the provision of services or employment based on disability, or compliance questions should be referred to Member Services at 1-800-299-6080.

Doctors are not Rewarded for Denying Care

The CO-OP reminds our practitioners/providers that decisions about utilization management (UM) are based only on whether care is appropriate and whether a member has coverage for benefits. The CO-OP does not reward doctors or others for denying benefits or care. UM decisions are based only on appropriateness of care, service and existence of coverage and providers do not get rewarded or receive financial incentives for issuing denials.

Member Identification

The CO-OP will provide an identification card to members listing their names and their assigned ID number. The entire ID number must be used for billing and inquiries.

Although there may be some slight variation in where certain information appears on the ID cards, the cards typically include the following:

- Member name, member ID number
- Summary of the member copay, deductible, and coinsurance responsibilities
- Pharmacy information
- How to contact the CO-OP for eligibility, benefits, prior authorization, and utilization management
- Network affiliation
- Claims submission information
- Locating a participating provider

For additional information regarding participating providers in Mountain Health CO-OP's provider networks visit our website: Montana/Idaho/Wyoming: Find a Doctor

Member Eligibility

The CO-OP reimburses providers only for medically necessary and covered services rendered to eligible, enrolled members. Benefits and eligibility can be verified through the Provider Portal or by calling 1-800-299-6080. You can also check member eligibility through the provider portal at https://mountainhealthcoop.vbagateway.com/.

To ensure member eligibility, you should ask for a copy of the member ID card. If the patient does not have his/her member card, please contact the CO-OP at 800-299-6080.

Please note that the member ID card does not guarantee member eligibility. Members may terminate their coverage with the CO-OP without surrendering their cards. See the end of this manual for examples of CO-OP ID cards.

Balance Billing

The "No Billing of Members" clause, outlined in the Provider Agreement, is in accordance with state and federal law. Participating providers may not seek payment directly from members for covered services, except for required copayments, annual deductibles, or coinsurance. Contracted providers should collect fees for any non-covered services directly from the member. Providers should not balance bill the member for the difference between the contracted amount and the total billed charges.

Not Medically Necessary/Non-Covered Service

A provider is prohibited from collecting payment from members when services are delivered that are not medically necessary or non-covered. Providers may obtain an advanced benefit notification (ABN) before rendering services when services are not medically necessary, and the member understands and has consented to pay for those services rendered. The written ABN must be specific and not part of the provider's general financial policy and not signed under duress.

Billing and Claims Payment

The CO-OP follows CMS guidelines in regard to coding and billing. Below are some examples of guidelines the CO-OP follows when reviewing claims for appropriate payment:

- Global billing periods
- MS-DRG payment structures and criteria
- Procedure code/rev code unbundling
- Assistant surgeon allowances
- Multiple procedure reductions
- E/M guidelines
- National Correct Coding Initiatives (NCCI)
- Medicare Claims Processing Manual
- Pricing above MS-DRG, APC, AWP/AWS and EAPG
- Itemized Bill Review

The CO-OP uses a vendor for post-service, pre-payment, and post-payment audit and review of certain claims to ensure correct coding, billing, and pricing guidelines are followed. Participating providers are subject to claim editing and review of post-payment audit for billing practices, including overpayment reductions.

Claims Submission Requirements

Providers should submit claims on standard forms within timely filing requirements. Please see CMS for appropriate filing forms and guidelines.

The CO-OP prefers you to submit claims electronically through the EDI system using payer code MHC01. Go to our website at www.mountainhealth.coop, select provider then claims submission. Electronic claims result in faster reimbursement, improved accuracy, and reduced costs associated with forms, envelopes, and postage. If you need to submit a paper claim, please submit to the following address for processing:

Mountain Health CO-OP
PO Box 30311
Salt Lake City, UT 84130

Remittance advice will be sent to the provider in accordance with the timeliness provisions in the providers' contract.

Clean Claims

A clean claim is any claim submitted by a Provider that:

- is received within 365 days of the date of service by the CO-OP;
- has a corresponding referral, if required;
- if submitted on paper, is submitted on a UB04, CMS-1500 or successor claim form(s) with all required elements per CMS guidelines;
- if submitted electronically, is submitted in compliance with the applicable federal and state regulatory authority and uses only permitted standard code sets;
- complies with the billing guidelines and medical policies;
- has no defect or impropriety;
- includes substantiating documentation; and
- does not require special processing that would prevent timely payment

Claims Review and Audit

Provider acknowledges the CO-OP's right to review claims before or after payment for appropriateness in accordance with the CO-OP's medical necessity policies and procedures. Claims payment may also be reviewed against industry-standard billing rules including, but not limited to, current UB manuals and editors, CPT and HCPCs coding, CMS, and/or other industry-standard bundling and unbundling rules, National Correct Coding Initiatives (NCCI) Edits, pricing models, and FDA definitions and determinations of designated implantable devices. Provider acknowledges the CO-OP's right to audit and review on a line-item basis as deemed appropriate and the right to adjust payment and to reimburse providers at the revised allowed amount.

Remittance Advice and Electronic Funds Transfer (EFT)

The CO-OP will send a summary remittance advice to the provider's office for each claim period summarizing all claims processed for that patient by the provider. Each claim is assigned a number and identifies provider, patient, dates of service, billed charges, allowed amount, paid amount, and reason codes for any processing decisions.

Provider payments will be issued via Electronic Funds Transfer (EFT) or by paper check. If the provider does not use EFT, then a paper check will be the default.

Visit https://marketplace.optum.com/, call -800-527-8133, or email clearanceedi.support@optum.com for more information about:

- Accepting transactions
- Enrolling for EDI

- Submitting claims
- Receiving assistance

If you have a question on processing or payment of a claim, please contact CO-OP Member Service Representative at 1-800-299-6080. Be prepared to provide a claim number, patient, provider, and dates of service.

The CO-OP also offers the online capability to verify the processing or payment of a claim through VBA, our Provider Portal. To learn more, please contact Provider Relations at 800-299-6080.

Timely Filing Requirement

The timely filing limit for primary claims is one year from the date of service. The timely filing limit for adjusted claims is 365 days from the date of service.

Provider understands and agrees that failure to submit claims in accordance with the requirements of this section may result in the denial of such claims as untimely filing.

Prompt Pay

The CO-OP will process clean claims no later than thirty (30) days from the date in which we receive the claim. If additional information is required to process the claim, the claim is no longer considered clean, and the time clock stops. Additional information will be requested from the Provider in writing. Once the additional information is received, the CO-OP will process the claim no later than thirty (30) days from which the additional information was received.

If the CO-OP fails to process a claim within thirty (30) days when no additional information was needed, or within thirty (30) days of the receipt of additional information, the CO-OP will pay interest of 10% annual interest calculated from the date on which the claim was due. If an interest payment is $5.00 or more, the interest will be paid with the claim. Interest payments less than $5.00 will not be paid.

Overpayments/Refunds

If the CO-OP determines that a claim has been overpaid, the CO-OP will recover the balance of claims not older than twelve (12) months due by way of offset or retraction from current and/or future claims. Provisions for repayment of refunds included in the Provider’s agreement with the CO-OP shall supersede those contained in this manual.

If overpayments are identified through the Fraud, Waste and Abuse department, the provider will be notified in writing and will be given sixty (60) days to dispute or refund the overpayment. If Provider fails to submit the balance due within sixty (60) days of the notification, the CO-OP may recover the balance due by way of offset or retraction from current and/or future claims.

Coordination of Benefits

The order of benefit determination rules governs the order in which each member plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may

reduce the benefits it pays so that this plan does not make payments that would exceed 100% of this plan's total allowable expense.

The CO-OP may not be the primary payer in certain circumstances. The provider should submit the claim to the payer or party primarily responsible for the claim. If the claim is subject to coordination of benefits, the remittance advice from the primary payer will need to be submitted with the claim if you are submitting a paper claim.

For specific questions regarding coordination of benefits, call 1-800-299-6080.

Electronic Claims Filing

Electronic data interchange (EDI) presents substantial advantages for providers and payers alike. By utilizing electronic claims submission, providers benefit by seeing faster reimbursement, reduced costs, and improved accuracy. Electronic claims filing will help your office improve efficiency and productivity and see faster turnaround times.

The CO-OP presently accepts the following HIPAA-compliant transactions: 837 P (Professional Claims), 837 I (Institutional Claims), and 270 (Eligibility Request).

Optum Change Healthcare
Payer Name: Mountain Health CO-OP
Institutional CPID: 7565
Professional CPID: 2499
Payer-assigned Payer ID: MHC01
Payer Enrollment Required: No
Secondary Claims Accepted: Yes
Payer Location: Montana, Wyoming, Utah
Claims Fee: NA
https://marketplace.optum.com/
1-800-527-8133

Corrected Claims/Adjustments

When submitting a corrected claim, it must be identified by one of the following:

It is preferred to receive corrected claims via Electronic Data Interchange (EDI) transactions. To request a claim be corrected, submit the following information in Loop 2300 of an X-837 electronic claim form:

1. In segment **CLM05-3**, insert the appropriate "Claim Frequency Type" code (may be displayed by your software as a dropdown field):
   6 – *Adjustment of prior claim*
   7 – *Replacement of prior claim*
   8 – *Void/cancel a prior claim*
2. Enter the Original Claim Number in the **REF*F8** "Payer Claim Control Number" field

Notes:

- Report every line associated with the corrected claim to ensure the full claim is reprocessed.

Refer to your 5010 Implementation Guide for additional information.

If you must submit a corrected claim on a paper claim form:

- UB-04 Facility Claim Form –
    - Enter the "Claim Frequency Type" code (6, 7, or 8) as the 3rd digit of box 4 "Type of Bill" (e.g., 137 indicates a correction to a Hospital Outpatient claim)
    - Enter the payer's original claim number in box 64 "Document Control Number."
- CMS-1500 Health Insurance Claim Form – Enter the correct "Resubmission Code" and the "Original Ref (claim) Number" in box 22 of the form

Corrected claims or adjustments will be adjudicated within the timeframes set forth, as described in the Timely Filing section.

Claim Notes

Claim notes, claim line notes (professional claims), and claim billing notes (institutional claims) can be submitted in the electronic file. All claim notes will stop and pend a claim for manual review. Consequently, we ask that you limit claim notes to information such as:

- Accident details
- Auto or subrogation detail
- Any special circumstances

Claims Editing

The CO-OP follows the National Correct Coding Initiative (NCCI) guidelines, Medicare Claims Processing Manual Guidelines, AMA guidelines, ICD-10 and CPT guidelines.

Mid-Level Provider Reimbursement

The CO-OP follows Medicare Guidelines for reimbursement of mid-level providers.

Never Events (NE), Hospital-Acquired Conditions (HAC) and Serious Reportable Events (SRE)

If a healthcare service is categorized as a "Never Event" (NE), neither the CO-OP nor the member is financially responsible for payment of the services. "Never Events" include the categories of Hospital-Acquired Conditions (HAC) and Serious Reportable Adverse Events (SRAE).

Providers shall not seek payment from the CO-OP nor its members for services or services directly associated or related to a "Never Event."

If the diagnosis was not present on admission and the review determines a NE, HAC or SRAE has occurred,

- DRG reimbursement: The DRG payment will be reduced. The claim will be reimbursed as if the HAC diagnosis was not present on the claim.
- For other reimbursement methodologies, all other services and supplies related to the HAC event/diagnosis will be removed prior to claim payment.
- For “Never Events,” all supplies and services related to treatment to the “Never Event” will be removed prior to claim payment.

Updated List, Never Events

Hospital-Acquired Condition (Present on Admission Indicator), CMS

ICD-10 HAC List, CMS

CMS, JA6405, Wrong Surgical or Other Invasive Procedure Performed on a Patient; Surgery or Other Invasive Procedure Performed on the Wrong Body Part, and Surgical or Other Invasive Procedure Performed on the Wrong Patient

Coding guidelines related to Present on Admission (POA)

- For discharges occurring on or after October 1, 2008, hospitals will not receive additional payment for cases in which one of the selected conditions was not present on admission. That is, the case would be paid as though the secondary diagnosis were not present.
- CMS also requires hospitals to report present on admission information for both primary and secondary diagnoses when submitting claims for discharges on or after October 1, 2007.

Member Complaint & Grievance Resolution

Provider shall cooperate with the CO-OP personnel to resolve any complaints and grievances identified by members, other providers, or any entity involved in the patient’s care. A complaint could involve either a quality of care concern or service related complaint.

Appeals

Mountain Health Co-Op intends to resolve most provider complaints through the informal dispute process, leaving the formal provider appeal process as the mechanism to resolve more complex issues. By separating provider and member appeals, we allow the member appeal process to proceed in an expedited manner and provider disputes to be handled in a less formal manner when appropriate.

The provider dispute and appeal process are administered through a manner in which a provider may inquire about the terms of the Provider Contract or appeal denials clinical in nature such as medical necessity, investigational status, or contractual exclusion. Disputes and Formal Appeals are initiated through the form found on the website, Appeal Form, or can be submitted through the mycarehc.com portal.

Provider Dispute

A provider dispute is an informal process for providers to raise awareness, concerns, and disputes such

as an adverse determination such as payment terms, bundling, denial for no prior authorization, and claim edits. The dispute process is the first step in the claim dispute process.

The provider dispute process does not apply to the following, which must proceed through the formal appeal process:

- Utilization management determinations (e.g. post-service claims for services considered not medically necessary, experimental/ investigational, cosmetic);
- Pre-service/authorization/referral requirements;
- Benefit/eligibility determinations (e.g., claims for noncovered services);

Once a dispute is received, the party working on the case will research the issue and determine a course of action. If a determination is made in favor of the provider, the claim(s) in dispute will be routed for adjustment. If a determination is made in favor of the plan, the provider will be notified of the findings and justifications of the decision and additional education as needed. This communication may be made in writing or by telephone. Documentation of the provider dispute and determination will be made in a CRM for tracking purposes.

See the submission timeline below for more details.

Provider Appeal Process

First Level Appeal

Utilization management, preservice, post-service, and benefit determinations are to be processed through the formal appeal process. To initiate a first-level appeal, the provider must submit in writing the nature of the appeal and justification to overturn the initial determination. Copies of pertinent medical records and other forms of documentation that will aid in Mountain Health Co-Op's review should be included with the submission. The appeal must be submitted within the timeline described below. A determination of each appeal will be provided within the guidelines in Table 1.0

If a provider appeal is submitted on one day and a member appeal is submitted for the same case, within the appeal processing time and no determination has been made for the provider appeal (ex. provider appeal is submitted on Monday, a member appeal is submitted on Wednesday), both appeals will be processed concurrently. Information will be gathered from both appeals and used to make a determination so both appeals have the same outcome.

Second-Level Provider Appeal

Providers may proceed with a second-level appeal if they disagree with the Co-Op's determination from the first-level appeal. The second level of appeal must be in writing, including why the provider disagrees with the decision and provides new materials to support their position. The second-level appeal must be submitted within 30 calendar days of the first-level determination. Additional medical records and other forms of documentation not previously submitted should accompany the second-level appeal. If no new documentation is supplied the dispute may be dismissed.

Second-level appeals require a review by a panel of at least (3) Director level and Vice Presidents within

Mountain Health Co-Op to include medical management and provider contracting teams; participants not included in the first-level appeal. The panel will review the Providers' first-level appeal and supporting documents. Participants reviewing the second-level appeal must have the pertinent skill set to review and make a determination of the type of appeal, such as medical necessity, contractual, or coding. Mountain Health Co-Op will respond in writing to the provider within the timelines indicated below.

Additional Appeal Options

Upon mutual agreement, MHC and Providers may enter Arbitration or Mediation in an attempt to resolve items outstanding. Providers must initiate this option in writing. Outside of arbitration and mediation, additional levels of appeals post the second level are not available and are exhausted. Decisions are final.

Table 1.0

Dispute or Appeal Level	Timeframe for submission from the date of Adverse Determination	MHC/TPA response timeframe from the date of receipt	Contacts
Provider Dispute – related to claim(s) edits, pricing, contractual	Within 180 calendar days of the adverse determination	30 calendar days	**Phone**: 800-643-4416 **Fax:** 985-898-1505 **Mail:** HealthComp UM Department PO Box 45018 Fresno, CA 93718-5018
First Level Provider Appeals – related to denials for medical necessity, investigational, contract exclusions	For Preservice Denials -Within 90 calendar days of the initial adverse determination **For Post- Service Denials** – Within 180 days of the initial adverse determination	60 calendar days	**Phone**: 800-643-4416 **Fax:** 985-898-1505 **Mail:** HealthComp UM Department PO Box 45018 Fresno, CA 93718-5018
Second Level Provider Appeal - related to denials for medical necessity, investigational, contract exclusions	Within 30 calendar days of the decision of the First Level Appeal	30 calendar days	**Phone**: 800-643-4416 **Fax:** 985-898-1505 **Mail:** HealthComp UM Department PO Box 45018 Fresno, CA 93718-5018

For more information, see the Provider Appeal and Dispute Policy on MHC's website, www.mountainhealth.coop.

Utilization Management

Our Utilization Management Program is administered by Personify Health (HealthComp). Our Utilization Management Program provides for prospective utilization review to assure that specific prescribed treatments and elective procedures are medically necessary and appropriate. Copies of UM criteria can be obtained by contacting the UM team at 833-412-4144, requested via email at UMFax@healthcomp.com.

Prospective utilization review requires the provider to obtain pre-authorization for certain services, inpatient stays, observation level of care, behavioral health, and pharmaceuticals before the treatments and procedures are rendered. The provider must contact the Utilization Management Program representative to obtain the pre-authorization. You can find the most up-to-date prior authorization forms on our website at: www.mountainhealth.coop/providers/.

How to use the Utilization Management Program

The covered person may have a representative place the call. A representative may be the physician, the covered facility, or the covered person's authorized representative (e.g., family member). The Utilization Review Management Program representative will give the individual who calls a reference number to verify that the call has been received and a file started.

Providers can speak with UM staff by calling 833-412-4144. The individual who calls the Utilization Review Management Program will need to provide the following information:

1. The name and other information to identify the covered person for whom treatment has been prescribed and requires Pre-authorization;
2. The Insured's name and ID number;
3. The name and telephone number of the attending Physician;
4. The name of the covered facility where the insured will be admitted, if applicable;
5. The proposed date of admission, if applicable; and
6. The proposed treatment

PLEASE NOTE: Authorization by the Utilization Review Management Program representative does not verify a covered person's eligibility for coverage under this policy, nor is it a guarantee that benefits will be paid for a proposed treatment. Benefit payment will be made for a covered person only in accordance with all the terms and conditions of this policy.

This Utilization Review Management Program does not include:

1. Routine claim administration; or
2. A determination that does not include establishment of Medical Necessity or appropriateness.

Utilization Review Deadlines

- *For prospective determinations (service not yet occurred):* fifteen (15) days;
- *For retrospective determinations (service has already occurred):* thirty (30) days;

- *For expedited determinations (urgent care):* as soon as possible (72-hour maximum.) The insurer may seek a 15-day deadline extension for prospective and retrospective determinations.

Medical Treatments Requiring Pre-authorization

Plan Notification (pre-authorization) is required for inpatient admissions, including admissions to a hospital, chemical dependency treatment center, mental illness treatment center, psychiatric residential treatment facility, intensive outpatient programs, long-term acute care facilities, skilled nursing facilities, or other medical procedures or services. Plan Notification requires contacting the Utilization Review Management Program in writing or by telephone.

Pre-authorization must be obtained for:

1. Benefits specifying that pre-authorization is required (including inpatient admission); and
2. Procedures listed in the Pre-authorization Medical Service List or Pre-authorization Code Look-up Tool

Failure to obtain the required pre-authorization before receiving services may result in denied claims. Providers may submit additional info and a review for medical necessity.

In the event of an adverse decision on a Utilization Review, Providers can discuss the case with a Medical Director in a peer-to-peer telephone call. A peer-to-peer call must be made within (14) fourteen calendar days of receiving the denial to ensure the case is discussed promptly.

Pre-authorization Medical Treatment List

To review a complete list of services that require preauthorization, visit www.mountainhealth.coop/providers.

Utilization Review for Mental Health Treatment

When utilization review is conducted for outpatient mental health treatment, information relevant only to the specific service or payment of the claim will be requested.

Population Health Management

Access to Case Management

Care Management staff help members with their health care and community service needs at the right time, setting, and for the best value. The CO-OP CM program offers our members individual attention to help them meet their healthcare goals while demonstrating awareness of their cultural and linguistic needs and preferences. This program is free for our members and includes services such as education, advocacy, and coordination of needed services.

CO-OP providers are encouraged to identify and refer members to the Case Management program when appropriate. They are required to respond to requests for information or consultation from CM staff. Case Management Services can be obtained by calling 833-412-4144. Providers may also submit a request or ask for additional information online at UMFax@healthcomp.com.

Tools Available to Assist in Managing Members

Clinical Practice Guidelines for preventive, medical, and behavioral health, as well as interactive Shared Decision-Making Aids, are available at www.mountainhealth.coop/about.

Cultural Competency & Language Resources

Providers are trusted with rendering care to a diverse membership with different levels of health literacy and confidence in the healthcare system, as well as racial, ethnic, and religious backgrounds that inform behaviors and choices about healthcare. The Co-Op is committed to supporting providers in ensuring members receive culturally competent and linguistically appropriate care. The Co-Op service territory is home to thirteen Native American Reservations across Montana, Idaho, and Wyoming, as well as twenty-two federally recognized tribes. Providers are encouraged to familiarize themselves with the resources below:

Translation services:

- Providers and members needing a qualified interpreter can call 800-299-6080 for translation services.

Culturally Competent Communication:

- https://cccm.thinkculturalhealth.hhs.gov/ Office of Minority Health Cultural Competency Resources, Physician's Practical Guide to Culturally Competent Care
- https://thinkculturalhealth.hhs.gov/resources/library

Caring for American Indians & Alaska Natives:

- Culture Card: A Guide to Build Awareness: American Indian and Alaska Native https://store.samhsa.gov/sites/default/files/d7/priv/sma08-4354.pdf
- Cultural Competence in Caring for American Indians and Alaska Natives: **American Indian and Alaska Native Culture Card | SAMHSA Publications and Digital Products** ~~https://www.ncbi.nlm.nih.gov/books/NBK570619/~~

Trauma informed Care:

- https://www.traumainformedcare.chcs.org/what-is-trauma-informed-care/
- https://www.acesaware.org/ace-fundamentals/principles-of-trauma-informed-care/

Prescription Drugs

Covered prescription drugs are provided in the Prescription Drug Formulary. The formulary may be obtained on the CO-OP website https://mountainhealth.coop/pharmacy/
or by calling the Pharmacy Customer Service number 855-885-7695.

Tiers arrange prescription drug benefits to provide a structure for member cost-sharing in each category.

Generally, the structure is as follows:

Exchange plans – Individual and Small Group

- Tier 1: Preferred Generics
- Tier 2: Non-Preferred Generics/Preferred Brands
- Tier 3: Non-Preferred Brands
- Tier 4: Specialty (Most specialty drugs require PA and must be filled at the Plan's designated Specialty Pharmacy)
- Tier 5: Preventive (see PRESCRIPTION DRUGS WITH ENHANCED BENEFITS section below)

Commercial Large Group plans

- Tier 1 = Preferred Generic
- Tier 2 = Preferred Brand and Non-Preferred Generic
- Tier 3 = Non-Preferred Brand
- Tier 4 = Preferred Specialty Drugs

Note: PREV on the formulary identifies Preventative Drugs required by the Affordable Care Act to be offered at no cost share.

Drug Formulary, Preauthorization, and Prescription Drug Supply Limits

Value Preventative Drug List is available for all CO-OP plans, including our Commercial Group Plans. Coverage is provided at no member cost share for certain categories or preventative medications and before deductibles are met. Drug categories considered in the Value Preventative list are Respiratory Medications, Diabetic Supplies, Diabetic Medications, Cholesterol Medications, Cardiovascular Medications, Bone Medications, Antidepressant Medications, and Anticoagulant Medications. Not all drugs in these categories are covered, but there are options available under each. These are in addition to medications considered preventative under the Affordable Care Act (ACA).

Value Preventative Drug categories are marked with on the formularies.

Preventative Drugs required by the Affordable Care Act to be offered at no cost share are marked with on the formularies.

To access the formulary, please visit the following website: https://www.mountainhealth.coop/pharmacy.

The prescription drugs are based on the drug formulary for the member's policy. Therefore, only those prescription drugs listed in such a drug formulary will be covered.

Certain prescription drugs require pre-authorization. Visit the CO-OP's website at www.mountainhealth.coop/pharmacy and search the formulary to determine if a pre-authorization is required.

The supply limits for prescription drugs are as follows:

1. **Retail pharmacy**—Per prescription or refill at a retail Preferred Provider Pharmacy or retail Non-Preferred Provider Pharmacy, a maximum of a 30-day supply is available unless the pharmacy is participating in our retail 90-day program, which then allows up to a **90-day supply** at those specific pharmacies.
2. **Mail-order pharmacy—**A 90-day supply is limited to a maximum per prescription or refill received from the Preferred Provider Mail-Order Pharmacy, Non-Preferred Provider Mail-Order Pharmacy, or select retail pharmacies.
3. **Specialty pharmacy—**A 30-day supply is limited to a maximum per prescription or refill at a designated specialty pharmacy.

Specialty Drugs are high-risk, high-cost drugs that are used to treat complex conditions requiring special handling and administration. Specialty drugs require prior authorization and are limited to a **30-day supply**. All specialty drugs must be filled through a designated specialty pharmacy. The Specialty Pharmacy is assigned once a Prior Authorization is approved. Please call Pharmacy Customer Service for additional information.

A Brand-Generic Drug Charge is applied if you elect to receive a Brand-name drug when a generic drug is available, regardless of reason or medical necessity, or if your provider prescribes a Brand-name drug when a generic is available. A brand generic charge is the difference in cost from the generic to the brand name drug. This charge is added to the regular cost-sharing outlined in your benefits summary. The Brand-Generic Charge does not apply towards Deducible or Out-of-Pocket Maximums.

In addition to the Medical Limitations and Exclusions outlined in this document, which also apply to pharmacy benefits, the following are also **excluded** from the Pharmacy Benefit:

1. Anabolic Steroids
2. Biological Sera, Blood, or Blood Plasma
3. Compounded products are limited and may not be covered if a commercial product is available. Prior Authorization may be required.
4. Diabetic infusion sets, which include: (a) a cassette; (b) needle and tubing; and (3) one insulin-pump during the warranty period. Diabetic-infusion sets, pumps and accessories for insulin pumps are covered under the Durable Medical Equipment Benefit.
5. Food Supplements, Special Formulas, and Special Diets
6. Homeopathic Medications
7. Investigational, Experimental, or Unproven Drugs: Drugs labeled "Caution – limited by federal law to investigational use", or experimental drugs, even though a charge is made to the individual.

8. Medications for Cosmetic purposes (for example, but not limited to, cosmetic hair growth and removal products)
9. Medications or immunizations administered for the purpose of prevention of disease when traveling to other countries.
10. Medication samples, including any corresponding administration requirements such as intravenous infusion therapy and office visits for administration.
11. Medications taken or administered while in a provider office or facility: Medication which is taken by or administered to an individual, in whole or in part, while he or she is a patient in a doctor's office, hospital, rest home, sanatorium, extended care facility, convalescent hospital, nursing home or similar institution which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals. (In some cases, this medication is covered under the Medical Benefits portion of the Plan.)
12. Medications covered under a per diem or daily rate for a Skilled Nursing, Long-term Care, or Acute Rehab facility contract—no Charge Medications received under worker's compensation laws, federal, state, or local programs.
13. Medications that are therapeutically the same as an over-the-counter medication
14. Medications that cannot be self-administered
15. Medications used for weight loss.
16. Medications used to treat or enhance fertility.
17. Medications used to treat sexual dysfunction or impotence.
18. Off-label use of Medication, except as outlined in the Off-label Use Policy.
19. Over-the-counter medication (OTC) or other items purchased at a pharmacy other than Prescription Drugs, whether or not there is a Prescription order for the item(s), except as required under PPACA.
20. Pigmenting/De-pigmenting Agents, except as required to treat photosensitive conditions, such as psoriasis.
21. Prescription Drugs in excess of a 90-day supply
22. Prescription order is in excess of the day's supply or Plan's quantity limit.
23. Refills in excess of the number specified by the Physician or any refill dispensed after one year from the Physician's original Prescription order.
24. Testopel pellets
25. Therapeutic devices or appliances, including hypodermic needles, syringes (excluding insulin syringes), support garments, and other non-medicinal substances, regardless of intended use. (In some cases, items may be covered under the Medical Benefits portion of the Plan.)
26. Vitamins and Minerals, except prenatal vitamins or vitamins as required under PPACA. Please note vitamins may be limited to coverage by age and specific dosing requirements.

Rules and Regulations

Fraud Detection and Prevention

The CO-OP will prevent and detect fraudulent/abusive behavior and comply with state and federal fraud and abuse requirements by:

- Claims system pre-processing checks
- Claims system edit reports
- Itemized Bill Review
- Member and provider complaints/fraud and abuse reports
- Utilization management reviews - prospective, concurrent, and retrospective
- Credentialing and re-credentialing reviews to identify patterns of suspected incidents and detect confirmed incidents in the form of Medicare or Medicaid exclusions

Following federal regulation 42CFR 438.214 (d), the CO-OP will not include any individual in the provider network who:

- May have been debarred, suspended, or otherwise excluded from participation in Medicaid or Medicare programs;
- May have an affiliation with an individual who has been debarred, suspended, or otherwise excluded from participation in Medicaid or Medicaid programs;

The CO-OP encourages providers to institute a compliance plan to prevent and detect fraud and abuse. The Office of Inspector General (OIG) has published guidance for physician practices to assist in the development of a compliance plan: Final Compliance Program Guidance for Individual and Small Group Physician Practices PDF (65 FR 59434; October 5, 2000).

For further information about fraud and abuse detection and prevention, please visit the OIG's website at http://www.oig.hhs.gov/fraud/report-fraud/index.asp or the National Health Care Anti-Fraud Association website at http://www.nhcaa.org/.

Reporting Fraud and Abuse

If you suspect fraud and abuse, you may report it to the CO-OP Compliance Officer at 1-800-299-6080.

Newborn and Mothers' Health Protection Act

The CO-OP honors the Newborn's and Mothers' Health Protection Act of 1996. The Newborns' Act regulates that all health plans and insurance issuers do not restrict a mother's or newborns' benefits for a hospital length of stay that is connected to childbirth to less than 48 hours following a vaginal delivery and 96 hours following a cesarean section. However, after consulting with the mother, the attending provider may decide to discharge the mother or newborn child earlier.

If the delivery is in the hospital, the 48-hour (or 96-hour) period starts at the delivery time. If the delivery is outside the hospital and then later admitted to the hospital in connection with childbirth, the period begins at the time of admission.

Follow-up care is required for women and infants discharged early following vaginal and cesarean section births. Women and infants discharged less than 48 hours following vaginal birth or 96 hours following a cesarean section delivery should receive post-delivery follow-up care within 24-72 hours following the discharge.

Site Audits and Ensuring Appropriate Physical Facilities

Office Site Audits are one method of ensuring that the providers with whom we contract provide:

- services in a clean and accessible environment
- appropriately staffed
- have the appropriate medical equipment and devices for the services rendered
- appropriate medical record-keeping practices
- take reasonable steps to safeguard the integrity and confidentiality of our members’ protected health information.

A member of the Provider Relations and/or Clinical Operations team (must be an RN/LPN) teams may complete an official site visit upon receipt of a complaint regarding the office's environmental aspects or if the facility is not accredited or certified.