Provider Manual

Montana, Idaho, and Wyoming

July 2022

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.

The information communicated in this manual does not take the place of the Professional Provider/Facility Agreement signed by the contracted or employed provider. This provider manual is

considered 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 the distinctive connection that you share with our members.

The CO-OP was formed under the Affordable Care Act's provision, which offered the opportunity to create Consumer-Oriented and Operated Plans (CO-OP.)

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 in Idaho to individuals and employer groups.

The CO-OP has partnered with the University of Utah Health Plans (UUHP) as our Third-Party Administrator (TPA). UUHP performs functions such as claims, customer service, medical management, billing, and enrollment.

Purpose

The purpose of this manual is to provide helpful and reliable information and guidelines. The manual 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 specifies that our members have the right to:

A member has the right to:

1. Receive information about the organization, its services, its practitioners and providers and member rights and responsibilities.
2. To be treated with respect and recognition of their dignity and their right to privacy.
3. To participate with practitioners in making decisions about their health care.
4. A candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
5. Voice complaints or appeals about the organization or the care it provides.
6. Make recommendations regarding the organization's member rights and responsibilities policy.

A member has the responsibility to:

7. Supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.
8. Follow plans and instructions for care that they have agreed to with their practitioners.
9. Understand their health problems and participate in developing mutually agreed-upon treatment goals, to the extent possible.

Contacts

Eligibility/Benefits Claims Issues and Disputes Refunds and Recoveries	24 x 7 online via Provider Portal at www.mountainhealth.coop or Monday – Friday, 8:00 AM to 5:00 PM call 1-855-447-2900
Paper Claims Payer ID	CO-OP Claims - UUHP PO Box 45180 Salt Lake City, Utah 84145-0180 SX155
Provider Relations	MHCProviderRelations@hsc.utah.edu 1-855-477-2900
Credentialing	Provider.credentialing@hsc.utah.edu
EDI Claims	uuhpedi@hsc.utah.edu or 1-801-587-2638 Payer Id SX155
EDI support after hours	1-801-587-6000 or http://uhealthplan.utah.edu/EDI/
Prior-Authorizations	1-801-587-2851 Electronic Prior Authorization Form
Pharmacy Prior-Authorization	1-855-885-7695 Electronic Pharmacy Prior Authorization Form Fax: 801-213-1359
Provider Portal Issues	1-801-587-7322
Provider Disputes or Provider Appeal on Behalf of Member	Electronic Provider Dispute Form Member Consent Form
Provider Contracting	provider@mhc.coop or call: 1-855-447-2900, 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 who agrees in writing with Provider to provide call coverage for Provider to provide certain Covered Services to Members in accordance with the terms and conditions of this Agreement.

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.

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. UUHP will perform delegated credentialing responsibilities for CO-OP providers that are not credentialed by another network entity (i.e., Brightpath, etc.) and ensure that the credentialing program follows the standards set forth by the National Committee for Quality Assurance (NCQA).

UUHPs' credentialing team has collaborated with the following organizations:

- NCQA certified Credentials Verification Organization (CVO) Verisys
- 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, or the University of Utah Health Plans to receive your application. If you have not completed your one-time credentialing application that 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 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 to correct erroneous information. Additionally, providers may appeal an adverse credentialing determination.

The CO-OP requires that all PAs and other mid-level providers complete credentialing. Once they are 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 provider.credentialing@hsc.utah.edu or (801) 587-2838 Option 3.

To initiate credentialing for new providers with your practice, please contact the CO-OP Provider Relations at 855-447-2900 or email MHCProviderRelations@hsc.utah.edu .

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. The plan must include the name(s) of the hospital and the practitioner(s) providing backup.

Accessibility

Appointment Availability Times

Type of Care	Primary Care Providers	Specialty Providers	Behavioral Health
Urgent Care	Within 24 Hours	Within 24 Hours	Within 48 hours Non-life-threatening emergency 6 hours Life-threatening emergency Immediately
Routine Care	Within 30 Days	Within 30 Days	Within ten business days
Preventive Care	Within 60 Days	NA	NA

A PCP is defined as a generalist in any of the following areas:

- Family Practice
- General Practice
- General Internal Medicine
- Obstetrics/Gynecology (by physician's choice)
- General Pediatrics

A PCP can be a Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), Nurse Practitioner, Resident, or Physician Assistant.

Appointment Scheduling

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.

After Hours Care

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.

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, 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. 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, 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.

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 1-855-447-2900. 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 1-855-447-2900.

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 1-855-447-2900. You can also check member eligibility through the provider portal at https://mhc.healthtrioconnect.com/app/index.page?

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 855-447-2900.

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 following page 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)

The CO-OP uses a vendor for post service, pre-payment audit, and review of certain claims to ensure correct coding and billing guidelines are followed.

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 SX155. 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:

CO-OP/University of Utah Health Plans
P.O. Box 45180
Salt Lake City, Utah 84145-0180

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 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, 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 uhealthplan.utah.edu/for-providers/edi.php 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 844-262-1560. Be prepared to provide a claim number, patient, provider, and dates of service.

The CO-OP also offers the on-line capability to verify processing or payment of a claim through U Link, our Provider Portal. To learn more about U Link, please contact Provider Relations at 1-833-843-2458.

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. The begin to count the days on the date the claim is received. 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 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 1-844-262-1560.

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 in 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), 270 (Eligibility Request) 276 (Claim Status Request).

The steps in setting up EDI with the CO-OP are relatively simple:

1. Contact EDI support
2. Review information on our website- https://uhealthplan.utah.edu/for-providers/edi.php
3. The CO-OP's EDI Payer ID is SX155
4. Fill out Trading Partner Form and return by fax, email, or online.
5. Send a Test File for review and sign off
6. Once the Test File is good, the provider can move to production right away

For more information or questions, please visit our website and/or contact:

EDI Information Coordinator Phone:
(801)587-2638 or (801)587-2639
Fax: (801)281-6121
Email Address: uuhpedi@hsc.utah.edu
Website: https://uhealthplan.utah.edu/for-providers/edi.php

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.

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 Events (SRE).

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 SRE 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 required 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.

Provider Disputes

A provider dispute is a process for providers to raise awareness and concerns of an adverse determination such as payment terms and claim edits. The provider dispute process is administered through a process in which a provider may inquire or dispute the terms of the provider contract with the CO-OP. Any dispute subject to terms under the member contract with the CO-OP must be processed as a formal member appeal. Disputes are initiated through the online form located on the website or click here.

The provider dispute process does not apply to issues related to the contract between the member and the CO-OP. These items must be initiated through the formal member appeal process. Examples include:

- Utilization management determinations (e.g., claims for services considered not medically necessary, experimental/ investigational, cosmetic);
- Pre-service/authorization/referral requirements;
- Benefit/eligibility determinations (e.g., claims for noncovered services);
- The initiation of a provider dispute does not require written correspondence and may be made via telephone, email, or fax. See table 1.0 for contact information.

Once a dispute is received, the CO-OP will research the issue and determine a course of action. If a determination is made in favor of the provider, the claim(s) will be reprocessed within the timeframe noted in Table 1.0. 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. The final determination will be provided in writing by the CO-OP.

See the submission timeline below for more details.

Formal Member Appeal

Any dispute subject to terms under the member contract with the CO-OP, such as Benefit/eligibility determinations, must be processed as a formal member appeal and must include a signed member consent form if submitted by the provider. A formal member appeal may be initiated if the adverse determination is related to one of the below mentioned categories.

- Utilization management determinations (e.g., claims for services considered not medically necessary, experimental/investigational, cosmetic);
- Benefit/eligibility determination (e.g., claims for noncovered services).

A formal member appeal will only be accepted from a provider by the CO-OP when accompanied by a consent form, which can be found at https://mountainhealth.coop/providers/ or here. If a member consent form is not included with the appeal request, the appeal will be denied. We are able to accept a consent signed by the member's Executor of the Estates or Power of Attorney.

To initiate a formal member appeal, the provider must submit in writing the nature of the dispute and justification to overturn the initial determination. Copies of pertinent medical records and other forms of documentation that will aid the CO-OP's review should be included with the submission. The appeal must be submitted to the CO-OP within the timeline described below. A determination of each appeal will be provided within the guidelines in Table 1.0.

External Review

Adverse determinations related to medical necessity review may qualify for external review. Adverse determinations eligible for external review are:

a. Rescissions of coverage; and
b. Medical judgement, including those adverse benefit determinations that are based on requirements for medical necessity, health care setting, level of care, or effectiveness of a covered benefit or adverse benefit determinations that certain treatments are experimental or investigational.

If a provider is filing an external review on behalf of a Member, please contact Provider Relations for filing instructions at 1-855-447-2900, Option 6, as the process differs by state.

In most cases, the appeals right must be exhausted. External reviews must be filed with 120 days after the date of receipt of a notice of an adverse benefit determination or a final internal adverse benefit determination.

Additional Appeal Options

Upon mutual agreement, the CO-OP and Providers may enter Arbitration or Mediation in an attempt to resolve items outstanding. Providers must initiate this additional appeal option in writing.

Table 1.0

Inquiry Level	Submission Timeframe	Notice of Determination	Contacts
Provider Dispute	180 calendar days from date of notice	60 calendar days	**Phone**: (801) 587-6480 or (888) 271-5870 **Fax:** (801) 587-9985 **Mail:** 6053 Fashion Square Drive Ste 110 Murray Utah 84107 **Online**: www.mhc.coop
Formal Member Appeal	180 calendar days from date of notice	60 calendar days (ID & MT) 45 calendar days (WY) 30 calendar days for pre-service denials (ID, MT & WY) 72 hours for expedited reviews (ID, MT & WY)	*Signed member consent form required* **Phone**: (801) 587-6480 or (888) 271-5870 **Fax:** (801) 587-9985 **Mail:** 6053 Fashion Square Drive Ste 110 Murray Utah 84107 **Online**: www.mhc.coop
External Review	120 calendar days from date of member appeal determination notice	45 days for Montana & Wyoming 42 days for Idaho 72 hours for expedited reviews in all three states	*Signed member consent form required* *Clearly indicate External Review Request* Call Provider Network for state specific filing instructions at 855-447-2900, Option 6.

Regarding Health Plan Policies

A dispute about health plan policies may be submitted at any time to the provider relations department.

Please call Provider Relations at:

- 1-833-843-2485 Or send a written dispute to:
  CO-OP Provider Relations
  6053 Fashion Square Dr. Suite 110
  Murray, UT 84107

Utilization Management

Our Utilization Management Program is administered by the University of Utah Health Plans (UUHP). 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 855-447-2900, Option 5 or requested via email at UUHP_UM@hsc.utah.edu.

Prospective utilization review requires the provider to obtain pre-authorization for certain services, and 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 855-447-2900, Option 5-1. 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 determinations 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 admission, 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, and 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 that specify 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 pended claims and a review for medical necessity.

If sufficient supporting medical records are not included, the prior authorization will be dismissed. A provider can resubmit the prior authorization with the supporting medical records to restart the process.

In the event of an adverse decision on a Utilization Review, Providers have an opportunity to 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 days of the receipt of the denial to ensure the case is discussed in the timeliest manner.

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, the information will be requested relevant only to the specific service or payment of the claim.

Population Health Management

Access to Case Management

Care Management staff help members with their health care and community service needs at the right time, right setting, and for the best value. The CO-OP CM program offers our members individual attention to help meet health care goals while demonstrating awareness for our members cultural and linguistic

needs and preferences. This program is no-cost 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; and are required to respond to requests for information or consultation from CM staff. Care Management Services can be obtained by calling 1-888-271-5780, option 2. Providers may also submit a request or ask for additional information online at www.uhealthplan.utah.edu/care-management/.

Tools Available to Assist in Managing Members

In partnership with the University of Utah, the CO-OP offers Clinical Practice Guidelines for preventive health, medical, and behavioral health, as well as interactive Shared Decision-Making Aids, 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. Additionally, the Co-Op service territory is home to thirteen Native American Reservations across Montana, Idaho, and Wyoming, and twenty-two federally recognized tribes. Providers are encouraged to familiarize themselves with the resources below:

Translation services:

- Providers and members in need of a qualified interpreter can call 801-587-6480, Option 6 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: 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 websitehttps://mountainhealth.coop/pharmacy/
or by calling the Pharmacy Customer Service number 855-885-7695.

Prescription drugs benefits are arranged by tiers 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 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 Mediations, 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 drugs 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 is limited to a maximum of a 30-day supply unless 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 - Per prescription or refill received from the Preferred Provider Mail Order Pharmacy, Non- Preferred Provider Mail Order Pharmacy, or select retail pharmacies, is limited to a maximum of a 90-day supply.
3. Specialty pharmacy - Per prescription or refill at designated specialty pharmacy is limited to a maximum of a 30-day supply.

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 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 that are 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
- 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

In accordance with 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;
- May own 5% or more in the University of Utah Health Plan's equity and is ineligible for participation in Medicare and Medicaid, or is affiliated with an ineligible individual, due to debarment, suspension, or exclusion from these 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 web site at http://www.oig.hhs.gov/fraud/report-fraud/index.asp or the National Health Care Anti-Fraud Association web site 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 1-855-447-2900.

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 mothers' 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, the attending provider may decide, after consulting with the mother, 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 time of delivery. 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.

An official site visit may be completed by a member of the Provider Relations and/or Utilization Management (must be an RN/LPN) teams upon receipt of a complaint regarding the environmental aspects of the office or if the facility is not accredited or certified.