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Welcome! The goal of Coventry Health Care of Georgia Inc. is to develop and sustain strong, mutually beneficial relationships with our providers and their office staff. We encourage your active participation in the Health Plan and appreciate your comments. By working together, we create a unique team of people working together to deliver the most appropriate health care in the most cost efficient manner. We share a common goal of preserving the quality of care for patients who seek the benefits and preventative care of a managed care plan within traditional physician/patient relationships.

The purpose of this manual is to answer important questions about administering health care services to Coventry Health Care members. This manual is referenced as part of the Provider Agreement between you and Coventry Health Care. The manual describes administrative policies and procedures, as well as other pertinent information.

From time to time, it will be necessary to update this manual. When this happens, you will receive replacement pages, along with an explanation of the changes. You will also receive periodic fax blast updates, which will provide you with valuable information. Please add those updates to the back of this manual for future reference.
Overview of Coventry Health Care

Coventry Health Care was formed in April 1998 by combing the staff, resources, and expertise of Coventry Corporation and Principal Health Care, Inc. Coventry Health Care is a public, multi-regional managed care company with health plans located throughout the Midwest, Mid-Atlantic, and Southeast. It is headquartered in Bethesda, MD. Coventry is traded on the New York Stock Exchange under the symbol CVH. In 2005, Coventry purchased First Health and CCN which made the company nationwide.

- More than 3700 employees of Coventry Health Care and its subsidiaries
- Over 2.5 million members
- HMO locations in 19 states covering more than 21 metropolitan markets in the Midwest, Mid-Atlantic, and southeast.

PRODUCTS AND SERVICES

Traditional HMO Products
Point of Service Products
Open Access Products
Preferred Provider Organization (PPO) Products
Leased Networks
Worker’s Compensation Product
Medicare Risk and Medicaid Products
Managed Care Provider Networks

GROWTH

Coventry Health Care is now in a strategic position to continue growing in existing markets as well as to expand into new regions. Coventry Health Care now serves over 21 metropolitan markets and will continue to add additional markets.

EXPERIENCE

Coventry Health Care has extensive experiences in group medical benefits and a proven record of leadership in plan design and administration. Its core
management team is composed of individuals who average over 18 years of experience in the managed care industry.

Coventry Health Care of Georgia is a prepaid health care delivery system, based on an Independent Practice Association (IPA) model HMO. Unlike group-model HMOs that employ health care professionals, Coventry Health Care of Georgia contracts with physicians who are in private practice. Each member of the Health Plan selects a primary care physician, who coordinates all aspects of the member’s health care.

Coventry Health Care of Georgia’s service area is comprised of 67 counties in the state of Georgia. These counties are located in the following major areas:

- In and around Metro Atlanta
- Macon area
- Savannah area
- Augusta area
- Waycross area

Please refer to our Provider Directory for a complete map.
Who to Contact for More Information

Please contact the following departments when you have any comments or inquiries:

Access Coventry Corporation at www.cvty.com
Access Coventry Health Care of Georgia at www.chcga.com
Access CHC of GA member eligibility and claims via our free website at www.directprovider.com
Access member eligibility and claims via Emdeon Office at www.emdeon.com
Access First Health at www.firsthealth.com

Coventry Health Care of Georgia

Contact Information

(800) 395-2545
• Benefits inquiries
• Claims inquiries
• Eligibility verification
Interactive Voice Response Service available along with fax confirmations.

(800) 470-2004, ext. 2503
(678) 202-2100, ext. 2503
(678) 202-2153 for employees of CHC of Georgia
(866) 599-3720 fax number
• Pre-authorization for hospital and selected outpatient services
- Referral authorizations
- Discharge planning

(877) 215-4101

(877) 554-9137 fax number

(800) 470-2004, ext. 2501
(678) 202-2100, ext. 2501

(866)-341-0359 fax number

- Provider participation questions including reimbursement and contracts
- Contracts, forms, etc.
- Office orientation needs

(800) 470-2004
(678) 202-2100

Always confirm the mailing address for claims on the back of the member identification card. Some products may have an alternate address and phone number.

Coventry Health Care of Georgia Inc.

P.O. Box 7711

London, KY 40742

Electronic Payor Number: 25127

Mail appeals to:

Appeals Department

Coventry Health Care of Georgia, Inc.
1100 Circle 75 Parkway
Suite 1400
Atlanta, GA 30339

For updates on appeal status, please contact Customer Service at (800) 395-2545.

Mail all correspondence other than claims to:

Coventry Health Care of Georgia, Inc.
1100 Circle 75 Parkway
Suite 1400
Atlanta, GA 30339

**SouthCare PPO**

**Contact Information**

Please refer to member identification card for customer service preauthorization and claims information.

Provider participation and contract questions handled out of Coventry Health Care of Georgia office

(800) 470-2004 extension 2501

(866) 341-0359 fax number

**First Health**

**Contact Information**

First Health, CCN Network Leased Business (First Health Network)
Please refer to member identification card for customer service, preauthorization and claims information. Provider participation and contract questions handled out of Coventry Health Care of Georgia office

(800) 470-2004 extension 2501

(866) 341-0359 fax number

First Health Direct (Coventry Health Care National Network)

For any questions related to the status of receipt or payment of a claim call the payor-specific billing telephone number listed on the patient’s benefit card. For any questions about how the claim was paid according to your contract, please call First Health/CCN Provider Services at 1-800-937-6824.
Administrative Procedures

This section details administrative procedures of the Coventry Health Care of Georgia, Inc. health maintenance organization (HMO).

Participating Providers

Participating providers include those physicians, hospitals, skilled nursing facilities, urgent care centers or other duly licensed institutions or health professionals that have a contract with Coventry Health Care of Georgia. In order for a member in an HMO plan to be eligible for covered services, participating providers must be utilized unless non-participating providers are specifically authorized by CHC before services are rendered. Point of Service (POS) products allow the member to receive covered services from non-participating providers usually at a reduced level of coverage.

Please be aware that our Directory is subject to change. You should verify the participation status of a provider with Customer Service or via the web before referring a patient. They can be reached at (800) 395-2545 or www.chcga.com.
Member Identification

All Coventry Health Care of Georgia members, including minor dependent children, receive a CHC identification card shortly after enrollment. Members must present their card to their Provider at the time services are rendered. If the Member is a recent enrollee who has not yet received a card, he/she must present a copy of the enrollment form. The ID card will list the member’s name, member number, PCP if required, group name and number, the benefit plan type, as well as copayments or coinsurance for office visits, prescriptions, outpatient and inpatient services. Benefits vary among our different product lines. Therefore, it is important to reference the Member ID card for the correct copayment or coinsurance amount. The ID card will also contain important Customer Service phone numbers for CHC, our Pharmacy Vendor, and our Mental Health Vendor.

To verify a Member's eligibility:

Check the Member’s ID card, enrollment form, or other identification card. Please note that the last two digits in the ID number indicate whether the Member is a subscriber (01), spouse (02), or dependent (03 – 99). Eligibility can then be confirmed by calling Customer Service or by logging onto WebMD office. For capitated providers, you can refer to your Membership/Capitation Report as well.

How to Read a Coventry HealthCare of Georgia Identification Card

When you receive an identification card, there are four key areas to look at to determine what type of benefit plan that the member has. Those key items are:

1. **Logo(s)**- Look for the Coventry Health Care of Georgia Logo to identify that the member will be accessing the CHC HMO contracts. Refer to the ASO exceptions section for details on Coventry’s ASO relationships. The Coventry Health and Life Logo is used for Coventry’s insured PPO products. When you see this logo, you will also see a corresponding network logo (SouthCare, CCN, PHCS, 1st Health) which represents the network contracts that the member is accessing.

2. **Plan Type**- The plan type refers to the type of benefit plan that the member has (HMO, POS, Plus). Please refer to the
Benefit Plan Type Grid to determine the exact benefit plan of the member.

3. **PCP Name** - The member’s PCP’s name will be displayed in this field. If the member’s benefit plan is one of our Open Access Plans, which does not require a PCP, this field will state “Open Access No PCP” or the PCP field will not be on the card.

4. **Network Type** - The network type refers to network that the member is accessing. Options that you may see are as follows: “PCP required” meaning that the plan is a HMO plan with a PCP; “Open Access” meaning that the plan is Open Access with no PCP required; “SouthCare”, “1St Health”, “PHCS” meaning that the member is a PPO member accessing that network.

5. **Member Responsibility Section (Copay)** - This section will show the member’s responsibility at the time of service. You may see different columns representing In-network versus Non-Network levels of benefit. Refer to the ASO section for details on the columns on those cards.

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**HMO Template**

**POS Template**

**Premier (Open Access) Template**

**Premier Plus (Open Access) Template**
ASO RELATIONSHIPS

Coventry Health Care of Georgia provides the administration of several self-funded benefit plans. These administrative services only (ASO) accounts access our Coventry Health Care of Georgia HMO network with a few exceptions or steerage guidelines. Please contact Customer Service for coverage and network information. The members of ASO

Coventry PPO Template

1st Health Network

ASSURANT Health

Reserved id75

POLICY:

For network provider information visit www.chga.com/providersearch.asp or call 1-866-823-7476

Original Effective Date: 02/21/2004

Individual Assurant Health

Open Access Templates

ASSURANT Health

Franklin

EMPLOYER: RESERVED-REBRANDING TEST CASE

GROUP: CERT: 1

$20 / $45 PCT & $40 / $75 SPEC

For network provider information visit www.chga.com/providersearch.asp or call 1-866-823-7476

Original Effective Date: 04/01/2003
accounts which access the Coventry Health Care of Georgia network will have the Coventry Health Care of Georgia logo on their card.

**Copayment/ Coinsurance Collection**

Members are responsible for paying copayments to participating providers at the time of service. Each member’s ID card indicates the amount of the copayment required. The member is responsible for only one copayment per office visit and you may collect only one copayment per member per day. When you submit your claim, do not subtract the copayment from the patient’s bill. CHC will subtract this amount from the final bill.

- Coventry Health Care of Georgia applies the Threshold copay logic to claims. This logic means that an office visit copayment should be collected for all visits to the provider’s office if you are billing for those services.

A copayment should not be collected when a member has a visit for follow-up care that is included in the global fee for a procedure or situation. Prenatal visits only require one initial copayment.

Many benefit plans now carry coinsurance and deductible charges along with copayments. When you see patients with these types of benefits, the amounts for which the member is liable will appear on the remittance advice.

Under no circumstances should you charge the Member more than the copayment amount. CHC will pay you for covered services in accordance with your CHC provider contract. If payment is denied because you did not follow CHC procedures, you may not seek payment from the Member.

You may bill a Member for non-covered services, if the Member has been notified in advance that CHC may not cover or continue to cover specific services and the Member chooses to receive the service. Nonetheless, you may not bill a Member if you do not follow CHC utilization management requirements. You may bill a Member for the following non-covered services:

- Examinations and immunizations required by a third party. Immunizations for travel.
- Procedures for cosmetic purposes.

When in doubt about a member’s responsibility, please contact our Customer Service Department.
• Experimental procedures as determined by CHC.

• Missed appointments that are not canceled in advance, if this type of payment is in accordance with your standard office policies.

• Routine foot care (except when covered for Members with diabetes or as specified in the benefit plan).

• Other services excluded from the Member’s benefit plan.

Failure to Pay Copayments
If a member has a history of not paying copayments, or the provider consistently finds it difficult to collect from the Member, the provider should contact the Customer Service Department. The member will be contacted by telephone to discuss the nonpayment. If necessary, the member will be notified in writing that his or her failure to pay the required copayment may result in the termination of coverage 31 days from the date indicated on the notice. If the member pays all copayments within this 31 day period, coverage will remain in force.

Changes in Practice Address or Status
Please notify CHC Provider Relations Department in writing within five (5) calendar days for any additions, deletions, or changes to the following:

• Tax Identification number

• Office or Billing Address

• Telephone or Fax Number

• Specialty

• New physician additions to the practice (please allow time for credentialing)

• Licensure (DEA, DPS, state licensure, or malpractice insurance)

• Group Affiliation

• Hospital Privileges
- Adverse actions taken by a hospital, Board of Medical Examiners, Managed Care Organization, or other entity that is responsible to the National Practitioner Data Bank.

If a provider leaves or if plans exist to change locations, open a new locations, or if plans exist to leave the current practice, written notification should be provided as far in advance as possible to the CHC Provider Relations Department prior to the change. By providing the information prior to the change, the following is ensured:

- The practice address is properly listed in the CHC directory.
- All payments made to the practice are properly reported to the IRS.
- There is no disruption in claims payments and claims are processed correctly according to the provider’s contract.
- CHC members are notified in a timely manner to change their PCP if they so desire as a result of the change.
Benefit Plan Options

Coventry Health Care of Georgia offers a wide variety for benefit plan options for our members to choose from. This section will assist you in determining the benefits of our members.

Types of Benefit Plans

HMO, Point of Service, and Open Access products are available to both large and small companies with as few as two employees. The amount of benefits provided and premium required depends upon the product and benefit plan selected. The product descriptions are only summaries of benefits, exclusions and limitations. Please contact our Customer Service Department for a complete description of the member’s benefits.

Coventry Health Care offers several HMO options such as Gold, Select, and Secure. All HMO plans require members to select a primary care physician to assist in coordination of their health care. Members must receive services from Coventry Health Care of Georgia’s HMO network. Members must receive a verbal referral to a specialist from their PCP. Members have open access to OB/GYN, dermatology, and ophthalmology providers. Providers must follow the Standard Coventry Precertification list. Members have no out of network benefits.

Coventry Health Care offers several Point of Service (POS) benefit plans to its members. These benefit plans are known as Maximum Choice plans. They all require members to choose a PCP to coordinate their care. They have different levels of benefit within the plan. There is the in-network HMO (Choice 1) level of coverage where all of the care is coordinated by
the PCP and received from participating providers. Choice 2 is the self referral in-network option where members can go to participating providers without the involvement of the PCP for a higher copayment level. Finally, there is the Choice 3 or out of network level of coverage where the member can seek services from a nonparticipating provider. These services will be subject to a deductible as well as coinsurance. All three levels are subject to the standard CHC Precertification List.

Coventry Health Care of Georgia has recently begun offering a line of open access HMO products, which use the CHC HMO network. There are several different benefit plans available such as Value, Flex, Premier, Premier Plus, and a line of individual and group plans administered by Assurant Health. The benefit designs of all of these plans differ but they all have a common theme of direct access to specialists. The Value plans still require the members to select a PCP and have copay differentials between PCP and Specialist visits but no referrals are required. The Flex plan is an open access plan that gives the members a prefunded credit card to use for copayments and other medical services. The Premier plans have introduced higher copays along with deductibles and coinsurance for most other services as a means to controlling health care costs. The Premier Plus plans are the same as the Premier with the addition of out of network coverage. All of these plans use our HMO network and must follow the CHC Standard Precertification List. The individual and group plans offered by Assurant Health access our HMO network. Their benefit plans differ as well as their precertification requirements. Please consult the member’s identification card for their Customer Service Department.

Coventry Health Care of Georgia markets a PPO (preferred provider organization) product in areas outside of our HMO Service Area. These plans are underwritten by Coventry Health and Life Insurance. The networks that they access will vary from SouthCare to 1st Health depending on the location. These members will have a card with Coventry on it but they are not HMO members. While the benefit structure is a PPO, most plan procedures will work the same way as those of the HMO. Your office must be participating with the network identified on the ID card to release in-network benefits.

Coventry Health Care of Georgia provides the administration of several benefit plans funded by employer groups. These ASO (administrative services only) plans will have benefit plans; networks and guidelines that will vary based on the employer’s discretion. In these plans, the employer, not CHC has the ultimate payment responsibility to the provider. To see if you participate in each of these plans, please contact Provider Relations. To get more information about these benefit plans or for specific member information, please contact Customer Service.
Coventry contracts with several ancillary providers for supplemental benefits such as dental, mental health, pharmacy, chiropractic, and vision.

**Dental**

The Certificate of Coverage excludes coverage for dental care services unless the services are provided under a supplemental benefit rider. The only exception to this exclusion is coverage for emergency services after an accident for a period of twenty-four hours following the accident.

**Mental Health/Substance Abuse Services**

American Psych Systems (APS) provides access to inpatient and outpatient mental health and substance abuse services for members. Under state law, all members have 20 55-minute outpatient sessions per year. Any other coverage is contingent upon having purchased a supplemental rider. Members can obtain a referral to an APS participating practitioner and/or facility by calling APS at (800) 305-3720. No referral is required.

**Pharmacy Services**

Caremark provides the administration of the drug benefit riders. All prescriptions must be filled at a participating pharmacy. Questions regarding general pharmacy benefits should be directed to Customer Service at (800) 395-2545. Questions regarding pharmacy benefits and pharmacy and drug coverage should be directed to Caremark Customer Service at (800)378-7040. All drug prior authorization requests should be directed to (877) 215-4101.

CHC has developed a drug formulary to maintain that high quality cost-effective pharmaceuticals are dispensed to members. The formulary consists of a list of medications that are approved for use by the Coventry Health Care Pharmacy and Therapeutics Committee (P&T Committee). This committee is composed of physicians from various medical specialties and pharmacist. Periodic changes to the formulary occur based upon the decisions of the P&T Committee, and are published annually.

Generic drugs provide cost-effective drug therapy. Most prescription benefit plans provide a lower copay for the member when they receive generic medications. Providers are encouraged to prescribe generic products. However, if a member insists on the brand name product for a medication included in the CHC Maximum Allowable Cost List (MAC), the patient will be required to pay the cost difference between the brand name drug and the MAC amount in addition to the copayment. If you prescribe medicines that
are not included on the formulary, your patients may incur the cost of the medication. In some cases, dosage limitations and prior authorization requirements apply for certain drugs.

Drugs requiring prior authorization can be found on our website at www.chcga.com.

Vision Services

Services for routine eye exams may or may not be covered under a member’s benefit plan. If covered, services are performed by Coventry Health Care of Georgia participating vision services provider. CHC is currently contracted with Avesis to provide the network of participating optometrists and ophthalmologists. Directly contracted providers (optometrists or ophthalmologists) cannot perform routine vision services. These providers can only provide services for disease or injury to the eye. In addition, Avesis providers can only provide routine services.

Chiropractic Coverage

CHC has limited chiropractic coverage under the medical benefit. These services should be provided by our contracted chiropractic vendor, ActivHealthCare. Members can also purchase a chiropractic rider that gives them a greater number of visits. These members must also utilize our contracted chiropractic vendor, which currently ActivHealthCare. To determine providers who are participating with ActivHealthCare, please refer to their website at www.activhealthcare.com.
Primary Care Physicians

This section details the responsibilities of the primary care physicians, and explains how members are transferred, as well as the procedure for closing and reopening patient panels.

Primary care physicians are defined as physicians who specialize in Family Practice, Internal Medicine, Pediatrics, or General Practice. The primary care physician (PCP) provides or coordinates all aspects of the member’s health care. Primary care physicians must never discriminate or differentiate in the treatment of members based on race, gender, age, religion, health status, or source of payment.

Responsibilities

The responsibilities of primary care physicians include:

- Providing primary care services to members
- Maintaining centralized medical records for members
- Coordinating all aspects of members’ health care
- Making referrals to appropriate participating specialty providers, ancillary services, and facilities
- Providing 24-hour coverage so that health care services are available to members in the primary care physician’s absence
Meeting the credentialing/recredentialing requirements of Coventry Health Care of Georgia, Inc.

Following Utilization Management/Quality Management guidelines and adhering to Coventry Health Care policy and procedure

Notifying Coventry Health Care of changes in address, licenses, liability insurance, or any other issue which could affect his or her ability to effectively render medical care

Coventry Health Care has developed standards for accessibility and availability of primary care physicians for members. Although there may be exceptional circumstances, every effort must be made to adhere to these standards.

- Minimum of 20 hours each week of regularly scheduled office hours for treatment of patients for a one-physician practice and minimum of 30 hours for a two or more physician practice
- Response time to urgent calls no greater than 30 minutes after notification
- Ability to accept a minimum of 250 new members at the time of application
- No more than an average of five patients scheduled and seen each hour for routine office visits for adult medicine, and six for pediatrics
- Member waiting time for urgent care visits – same day
- Member waiting time for non-urgent/non-emergency, but symptomatic office visit- not more than one week
- Member waiting time for a routine non-symptomatic office visit- not more than one month
- Average office waiting time should be no more than thirty (30) minutes from the appointed time before medical personnel see the patient.
Primary care physicians must be available to members 24 hours a day, 7 days a week. When the primary care physician is unavailable, coverage should be arranged through a Coventry Health Care Physician. A taped telephone message directing patients to the emergency room is not acceptable as an alternative to arranging for coverage by another physician.

The covering physician should report calls and services to the member’s primary care physician in the usual manner.

Covering physicians, whether participating or not, must adhere to all administrative requirements and agree to not bill the member for services other than copay. When arrangements are made with non-participating covering physicians, the primary care physician is responsible for securing a signed Covering Physician Agreement.

When a covering physician sends a claim to CHC, covered services will be reimbursed at the rate contracted with the primary care physician at the time services were rendered.

Primary care physicians are responsible for the following billing claims procedures:

- Collecting applicable copayments, coinsurance, and deductibles from members, and ensuring members are not balanced billed for covered services.

- Submitting claims or encounter data using HCFA 1500 forms with current CPT-4, HCPCS, and ICD-9 codes within 30 days of the date of service. Claims submitted more than 90 days following the date of service will be denied, unless the claim was returned for further information.

Patient encounter reports from primary care physicians provide CHC with valuable information about the HMO’s quality of care and utilization of services. This aggregate information is used to track data according to HEDIS methodology and continuously improves service and quality of care to members.

Primary care physicians are required to submit patient encounter information for all services.

Member lists are available upon request. Contact Provider Relations at (678)202-2100, ext 2501 or (800) 470-2004, ext. 2501.
If a member wishes to transfer to another participating primary care physician, the member should request the transfer by telephoning Customer Service at (800)395-2545 or by logging onto the Member Channel at www.chega.com. When contacting the Customer Service Department, the member will be informed of the effective date of the change.

A physician may also request that a member transfer to another PCP. To facilitate this process, the physician must send written notification of the request to the following address:

Coventry Health Care of Georgia  
Provider Relations Department  
1100 Circle 75 Parkway  
Suite 1400  
Atlanta, GA 30339

Upon receipt of this notification, the Customer Service Department will notify the member in writing. The letter serves as a 30 day notice to the member to choose a new primary care physician, and to continue receiving care from his or her current primary care physician until the transfer becomes effective. A copy of this letter is also sent to the primary care physician, who must forward a copy of the member’s medical records to the new primary care physician.

Please note that a physician may not request a member transfer for reasons of race, gender, age, religion, health status or source of payment.

Patient Panel

The size of your member panel is limited only by your ability to provide services in accordance with CHC guidelines, appointment availability, and office accessibility. You must give the Provider Relations Department at least ninety (90) days prior written notice if you do not want to accept additional CHC members on your panel. Once a panel is closed, any member who is not already an established patient cannot select that physician as his or her primary care physician. Physicians will not be able to close their panel to CHC members as long as their panel is open to other health plans.

A PCP can reopen a closed panel by submitting a request in writing to Provider Relations Department. The change will be made on the first day of the month following submission of the request. Additional time may be necessary to update printed material, such as the Provider Directory.
Specialist Physicians

Unlike a primary care physician, a specialist is usually not the first provider from whom the member seeks care. This section discusses the responsibilities of the specialist and provides specific information for some specialties.

Specialists provide covered services to members that have been referred from their primary care physician or via self referral. Contact with the PCP is encouraged throughout the specialist’s treatment of the member.

Responsibilities

The responsibilities of the Specialist physician include:

• Providing the requested specialty services

• Working closely with the PCP to enhance continuity of medical care and providing written recommendations on the appropriate treatment program

• Obtaining precertification through the CHC Health Services Department for certain healthcare services as specified in the Precertification/Authorization Section of this manual

• Complying with CHC Quality Improvement Program policies and procedures
• Using designated participating laboratory, hospital and other ancillary providers and pharmacy services

• Complying with all of CHC policies and procedures

• Submitting general medical information required by HEDIS (Health Plan Employer Data Information Set) upon request of the plan

• Ensuring the Member has the opportunity to fully participate in all treatment decisions related to their health care

• Meet all of the CHC credentialing and recredentialing requirements

The specialist’s appointment availability for Members should comply with the following standards, as appropriate for the presenting complaint/condition:

• Minimum of 20 hours each week of regularly scheduled office hours for treatment of patients for a one-physician practice and minimum of 30 hours for a two or more physician practice

• Response time to urgent calls no greater than 30 minutes after notification

• No more than an average of five patients scheduled and seen each hour for routine office visits for adult medicine, and six for pediatrics

• Member waiting time for urgent care visits – same day

• Member waiting time for non-urgent/non-emergency, but symptomatic office visit - not more than one week

• Member waiting time for a routine non-symptomatic office visit - not more than one month

• Must be available and accessible twenty-four (24) hours/day, seven (7) days/week. Coverage must be arranged if you are not available and the covering physician should be a CHC participating provider. A taped telephone message directing patients to the emergency room is not acceptable as an alternative to arranging for coverage by another physician.
• Average office waiting time should be no more than thirty (30) minutes from the appointed time before medical personnel see the patient.

CHC has adopted the policy of open access to specialists. This means that the member’s PCP may direct the member to see a certain specialist but no prior notification to the Plan is required or the member may self refer to any participating specialist. Therefore, referral numbers are no longer given nor required. If the services requested require precertification, an authorization number will still be required and should be obtained through Health Services.

In accordance with State regulations, Coventry Health Care does not require its members to obtain a referral from their primary care physician as a condition of coverage for services rendered from a participating OB/GYN, Ophthalmologist or Dermatologist. To ensure compliance with this law, we request that primary care physicians do not place any barriers to their patients requesting access to these providers.

Specialists are responsible for the following billing and claims procedures:

• Collecting only applicable copayments, coinsurance, and deductibles from members, and ensuring members are not balance billed for covered services.

• Submitting claims or encounter data using HCFA 1500 forms with current CPT-4, HCPCS, and ICD-9 codes within 30 days of the date of service. Any claim submitted more than ninety (90) day following date of service will be denied, unless the claim was returned for further information.

Specialists are responsible for submitting a Consultation Report to the referring primary care physician. The report must include the following:

• Description of Services

• Clinical Impressions

• Recommended treatment

Specialists may initially give this report to the referring primary care physician verbally. However, we request that a written report also be sent to the referring primary care physician.
Specialist must never discriminate or differentiate in the treatment of members based on race, gender, age, religion, health status, or source of payment.

The Obstetrician (OB) must notify Coventry Health Care of all pregnant members at the time of the member's initial office visit. The Health Service Department will then assign an authorization number to each pregnant member. The OB will use this authorization number for all pre-delivery or prenatal services. This notification will also serve to enroll the member in a Healthy Baby Program. The Health Services Department will issue a separate authorization number for the actual delivery upon admission to the hospital.

**Billing and Reimbursement for Maternity Claims**

The OB should not submit any claims until after the delivery of the newborn, or the care is transferred to another OB. The OB should submit all prenatal services, ancillary services, delivery of newborn, and other services on a HCFA 1500 form. CHC will reimburse the physician under a global OB fee. The global fee reimburses the physician for all provided professional services beginning from the initial office visit, to prenatal and postnatal phases of the pregnancy. Most benefit plans contain an initial copayment to be paid to the provider. For all additional maternity visits, no copayment will be due from the member.

The standard global OB fee includes the following:

- Initial Office visit, physical and prenatal profile
- Prenatal visits for obstetrical related problems and routine care
- Labs including venipuncture and specimen handling
- Labor and delivery charges
- Monitoring
- Induction of labor
- Local and regional anesthesia
- Hospital visits for “checks”
- Episiotomy and repair
- Forceps at delivery
- In-hospital care for mother
- Post-partum care following discharge up to 6 weeks, excluding surgical complications
- All Ultrasounds
- All Stress and Non-stress Tests
- Alpha-feto protein

The following are reimbursed outside of the global fee:
- Rhogam (Injection charge is included in global fee)
- Amniocentesis
- Cordocentesis
- Chorionic villus sampling
- Hysterectomy after C-section delivery
- Tubal Ligation following delivery

In the cases involving one of following diagnosis, all ultrasounds and stress tests are also reimbursed in addition to the Global fee:
- Multiple gestation
- Preterm labor
- Excessive vomiting
- Hypertension
- Hemorrhage
- Patients with comorbidities
- Problems associated with amniotic cavity and membranes
- Problems associated with placenta

**OB Patient Transfers**

If a member switches her OB during the course of a pregnancy, the first OB must bill with the appropriate prenatal visit codes and will be reimbursed according to his or her contract. The global OB fee of the OB performing the delivery will be reduced by each service billed by the first OB.
Amniocentesis

Coventry Health Care will provide coverage for medically necessary amniocentesis. Test performed purely for gender determination is not a covered procedure.

Home Uterine Monitoring

Home Uterine Monitoring is a covered benefit when authorized by the Health Service Department and approved by the Medical Director.

Ultrasounds

CHC will provide coverage for ultrasounds with no authorization under the OB Global rate. An initial ultrasound is considered medically necessary and may be performed in all pregnancies at about 10-18 weeks gestation.

Reproductive Endocrinology Services

Coventry only covers the diagnosis of infertility subject to the terms and conditions of each member’s benefit package. Some of the covered services are laboratory tests, semen analysis, and hysterosalpingogram.

Well Woman Exams

Female members are encouraged to undergo a well-woman examination (GYN) once a year by a participating gynecologist or primary care physician.

The Well Woman Exam consists of the following:

- History and Physical examination
- Pelvic and Breast examination
- Pap Smear and interpretation
- UA/Hemoglobin Test
- Mammogram (done at a participating facility)

Well woman exams should be billed using appropriate CPT codes and diagnosis codes.

Breast Cancer Screening
The effectiveness of clinical examination of the breast and mammography screening in the detection of breast cancer in women has been convincingly demonstrated. Coventry Health Care encourages members to adhere to the breast cancer screening recommendations below:

<table>
<thead>
<tr>
<th>Age of Member</th>
<th>Clinical Exam of Breast</th>
<th>Mammography</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ages 35-40</td>
<td>Every 1-3 years</td>
<td>Baseline</td>
</tr>
<tr>
<td>Ages 40-49+</td>
<td>Annual</td>
<td>Every 1-2 Years</td>
</tr>
</tbody>
</table>

**Cervical Cancer Screening**

Early detection of cervical cancer, through the use of routine Pap Smear testing and treatment, can lower mortality. CHC recommends that all women who are, or who have been sexually active or have reached age 18, should have an annual Pap test and pelvic examination. After a woman has had three or more consecutive satisfactory normal examinations, the Pap test may be performed less frequently at the discretion of her physician. CHC covers the standard Pap smear or the Thin Prep but both must be sent to our participating laboratory for processing.
Authorizations

Coventry Health Care requires prior authorization and precertification for certain services. This section will outline those requirements.

Authorizations are required for inpatient and some outpatient hospital admissions, certain medical, surgical, or diagnostic procedures, speech occupational and physical therapy, durable medical equipment, and care by nonparticipating providers. The Authorization list is updated periodically by Coventry Health Care. Please make sure an authorization for applicable services is issued prior to members receiving the services unless it is an emergency. If you are unsure about a particular procedure or for more information, contact Health Services at 800-470-2004.

The physician ordering the care must contact CHC to obtain authorization. Specific medical information is required to determine medical necessity and the availability of benefits. The initial service authorized must be provided within 30 days from the date the authorization is given. In order to allow sufficient time for the authorization process, please contact CHC a minimum of three (3) working days prior to when the service is needed for elective, scheduled procedures and diagnostic testing.

Authorization request can be accepted through several methods including:

- Via phone call to our Health Services Department at 1-800-470-2004
- Via faxed authorization form to Health Service Department 1-866-599-3720
- Via submission through emdeonoffice

Health Services requires the caller to furnish the following information:
• Referring provider name and phone number
• Patient’s name and ID number
• Reason for referral and diagnosis
• Requested provider or facility (to whom the referral is being made)
• Date of referral appointment or procedure
• Specific services requested

Please note additional clinical information may be required to be faxed in as required for review.

The clinical information provided and the plan of treatment will be evaluated and completed by the Preauthorization Nurse within two (2) working days of receipt of all necessary information to make a determination for elective procedures or testing. For urgent or emergent procedures or testing, the determination will be made within twenty-four (24) hours upon receipt of all clinical information. Evaluation using CHC approved criteria will be performed and a decision will be made on the requests.

Unless the patient has received prior authorization from CHC for out-of-network care, or is a member of a plan with out-of-network benefits, all care must be received within the contracted provider network in order for services to be eligible for coverage. Should you refer a member for care outside of the network without an authorization, you may be held responsible for the charges of the services rendered. Please call CHC to verify participation status of providers. Members who have out-of-network benefits may receive care from non-participating providers without an authorization at reduced levels of coverage. It is the Member’s responsibility to ensure an authorization is obtained for procedures that require prior authorization when obtaining them from out-of-network providers.

Coventry Health Care of Georgia encourages primary care physicians to coordinate all aspects of a member’s health care. When it is medically necessary for a member to receive care from a participating specialist, the PCP may give the member a verbal referral or the member can self refer to a participating specialist Primary Care Physicians are encouraged to examine patients prior to referring them to a participating specialist. The following guidelines apply for all verbal referrals:
When issuing a referral, primary care physicians should specify the required services in as much detail as possible, as a courtesy to the specialist.

A referral to a specialist can be given by the PCP without calling CHC. The PCP should make a note in the patient’s file and the specialist should indicate the PCP on the HCFA 1500 when filing the claim.

Should a telephonic referral be issued without the member seeing the PCP no fee may be charged by the PCP.

The HMO Provider Directory, CHC of Georgia Website or Customer Service Department should be used when identifying specialists for referral within the network.

Referrals do not guarantee payment- reimbursement for services is subject to member eligibility and benefit coverage at the time services are provided.

Preauthorization List

Preauthorization is the approval of services by Coventry Health Care as medically necessary before the services are actually rendered. Preauthorization by PCP and specialists are required for the payment of claims for certain services.

Providers may be held responsible for the cost of services when prior authorization is required but not obtained. The member may not be billed for the applicable services. Retroauthorizations are not covered.

The following procedures require prior authorizations for CHC of Georgia members. Please note that this list is subject to change and may be reduced or expanded for self-funded groups. Please contact Customer Service for information on authorization requirements for self-funded groups.

<table>
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<tr>
<th>Procedure</th>
<th>CPT Codes</th>
<th>X denotes needs authorization</th>
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<td>Arthroscopy - Chondrocytes</td>
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<td>Back Surgeries</td>
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<td>Cardiac Imaging Studies</td>
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<td>CT Scans (Sinus)</td>
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<td>Dermatalogic Body Photos</td>
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<td>DME/Prosthetics</td>
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<td>Genetic Testing</td>
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Nerve Release 64722 X
NON-Par Providers X
Orthognathic Surgery 21120-21230, 21244-21249, 21275, 21299 X
PET 78459, 78491, 78492, 78608, 78609, 78810, G0210-0234, G0252-0254, G0296 X
Plastic/Cosmetic Surgery Contact Customer Service X
Abdominoplasty/Panniculectomy/ Lipectomy 15831-15839, 15877 X
Blepharoplasty/Blepharoptosis 15820-15823, 67900-67909, 67916-67924, 67912 X
Breast Augmentation 19316, 19324-19325, 19340 X
Ligation/Stripping Varicose/Sclerotherapy 36468-36471, 37720-37785 X
Reduction Mammoplasty 19316, 19318 X
Prenatal Care Notification only X
PT/OT/ST - for children under 13 92506-92510, 97001-97006, 97110-97546 X
Radiation Tx (IMRT/Proton) 77301, 77418, 77520, 77522, 77523, 77525 X
Radiofrequency Ablation Facets 64622-64627 X
Sleep Studies/CPAP 95805-95811 X
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Transplant 32850-32854, 33930-33945, 38230-38241, 44132-44136, 47135, 47136, 47140, 47141, 47142, 48160, 48550-48556, 50300-50380, 50547, 65710-65755 X

All admissions, outpatient surgeries and other services requiring preauthorization are authorized based on standard medical necessity criteria. Coventry Health Care utilizes criteria from Milliman and Robertson, Inc. Health Care Management Guidelines, and the Institute for Health Care Quality (IHQ), a wholly owned subsidiary of Health Risk Management, Inc., a health care management firm. IHQ created QualityFirst as an interactive, decision-support resource to help users:

- Confirm diagnosis
- Determine the appropriate treatment options
- Determine the correct setting of treatment
- Set a reasonable time frame for treatment
- Utilize the proper resources

In addition, the guidelines also provide physicians with current and consistent criteria and practice parameters that produce congruent medical decisions. Congruent medical decisions lead to improved quality and support prospective, concurrent and/or retrospective care management.
The on-line guidelines were developed with a focus on clinical outcomes. IHQ routinely surveys international literature to ascertain widely accepted practice standards and develops decision algorithms that are evaluated by expert panels of health care practitioners. The guidelines have been used nationwide for nine years in managed care settings. They are continually revised to incorporate the latest medical research findings, feedback from physicians who use the guidelines, and changes in the practice of medicine.

Other criteria resources utilized include Interqual ISD and Milliman and Robertson.

CHC must be informed prior to a patient’s non-emergency hospitalization. Before calling CHC, please be prepared to provide us with the information contained in the list below which will reveal the severity of the illness and/or intensity of service. This information will be used to determine whether or not the care meets CHC criteria for coverage as an inpatient stay.

- General information such as the member’s name and ID number, the admitting physician and the PCP.
- Severity of illness including a history of current illness and diagnosis(es), description of symptoms (frequency/severity), physical findings and outpatient treatment attempted (if applicable). CHC may request lab results, X-ray findings and other significant medical information.
- Plan of treatment such as the medications (IV, IM), invasive procedures, tests monitoring/observation, consultation (if needed during admission, has it been scheduled?), other services (i.e. respiratory treatments, therapies, wound care), activity level (if relevant to treatment plan) and diet (if relevant).
- Anticipated duration of inpatient hospital stay.
- Alternative treatment available such as IV therapy, skilled nursing, physical therapy, home traction.

Hospitalization and the continued stay can be authorized only when the severity of the patient’s illness and/or the intensity of the required services meet the established criteria for acute inpatient care. For inpatient stays, CHC reviews each patient’s chart on a daily basis either on site or via phone and coordinates the length of stay with the admitting physician. CHC nurse reviewers are available to work with you and the hospital staff to coordinate the care a member may need following discharge from the hospital.
Concurrent review is performed prior to the expiration of the assigned length of stay. If the nurse reviewer needs information in addition to that in the patient’s chart, he or she will contact your office. If the member does not appear to meet medical criteria for an inpatient stay, the nurse will discuss alternative care that can be arranged. The Medical Director will be involved in the final decision when a denial appears necessary. You and the member will be notified if medical criteria is not met and benefits are no longer available for coverage of additional inpatient days. If services are denied as not medically appropriate, the claims will be denied and the member can not be held responsible for these denials.

CHC must be notified of an emergency admission within 48 hours. However, earlier notification greatly facilitates the utilization review process, and allows CHC to determine during the stay whether or not medical criteria for coverage is met.

You can contact our Health Service Department at 1-800-470-2004 to notify us of an admission and provide clinical information. Please note that this number can be used twenty-four (24) hours a day for notification.

Coventry Health providers are required to obtain prior authorization for members for the rental or purchase of durable medical equipment. Equipment must be obtained from a participating provider unless the member’s benefit plan allows out-of-network coverage. CHC members may have a benefit limits for DME and limited coverage for orthotics and other medical appliances. Please consult Customer Service to verify the member’s benefits at 1-800-395-2545.

Short-term rehabilitative therapy including physical, speech, occupational and cardiac therapy requires prior authorization for members under the age of 13. Therapy provided on an inpatient or outpatient basis is covered for a limited period of treatment, per condition, if improvement can be expected within this time period. Speech therapy is not covered when treatment is due to developmental delay or failure to progress in a school setting.

Unless specifically outlined in your Provider Contract, physical therapy can not be performed in a physician’s office.

In accordance with state law, all CHC commercial members have access to twenty (20) outpatient evaluation management visits. These visits must be coordinated by our Mental Health Vendor and from one of their
participating providers. Please consult the back of member’s ID card for information on the mental health vendor.

In the member’s Certificate of Coverage, a medical emergency is defined as the following:

“...a condition manifesting itself by acute symptoms of sufficient severity (including pain). This condition may be as result of an injury, sickness, or mental illness which occurs suddenly, and is such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. serious jeopardy to the health of the individual (or unborn child);
2. serious impairment to bodily functions; and
3. serious dysfunction of any bodily organ or part.

Emergency services are covered when they are inpatient and outpatient services that are:

1. furnished by a provider qualified to furnish emergency services; and
2. needed to evaluate or stabilize an emergency medical condition.

When the nature of the illness is a medical emergency and care cannot be properly rendered in the primary care physician’s office, referrals to an emergency room are appropriate.

Members must notify CHC and their PCP before or within forty-eight (48) hours after an emergency room visit. An authorization is not required for a member to be treated in an emergency room for an emergency condition. However, patients are instructed to contact their PCP for medical advice prior to seeking care, if possible. Follow-up visits to the emergency room are not covered under any circumstances. It is important for the PCP to oversee any follow-up medical care.

Emergency/Urgent Services – In Area

As with all medical services, members should contact their primary care physician when an unexpected illness or injury occurs. The PCP evaluates the situation and directs the patient to the following, as appropriate:

- Visit the primary care physician’s office
Visit a participating specialist
Go to an emergency room of a participating hospital
Go to a participating urgent care facility

In life-threatening emergencies (such as cerebrovascular accidents, myocardial infarctions, poisoning, or respiratory failure), members should seek care at the nearest medical facility.

**Emergency Services- Out of Area**

Life-threatening emergencies (such as cerebrovascular accidents, myocardial infarctions, poisoning, respiratory failure, seizures, and compound fractures) that occur while the member is outside of the service area should be treated at the nearest medical facility. The member must notify the PCP and CHC within 48 hours of the emergency service. Medically necessary services that require follow-up emergency services outside of the service area must be approved by the PCP and CHC.

Hospital admissions that occur as a result of an out-of-area emergency are evaluated on the basis of medical necessity by CHC. The member may be transferred to a participating facility for treatment once the medical condition is stabilized.

Coventry Health Care reviews emergency services claims for medical necessity. If a claim is denied, the member is responsible for the costs of the emergency services rendered and all associated costs incurred as a result of the emergency room visit.

Coventry Health Care also provides coverage for urgent care visits outside of the service area.

All self-injectables require prior authorization before the services are rendered. You may call Health Services at 800-470-2004 to obtain authorization for injectables. The injectables should be obtained from one of our National Vendors. Regardless of who provides the service, the injectables are reimbursed according to national rates negotiated by Coventry Health Care Inc., with various national vendors.
Primary Care Physicians and specialists are reimbursed either through capitation payments or on a fee for service basis. This section outlines the procedures for claims submission.

Physician reimbursement under CHC can be either through capitation payments or on a fee for service basis. Please consult your provider contract to determine your method of reimbursement.

Some physician services are reimbursed on a capitated basis. Capitation is a fixed amount paid to a physician on a monthly basis based on a total number of members either assigned to the physician or in the products covered by the capitation contract. CHC bases its capitation payments on the type of plan and the age and sex of the CHC members. PCP’s are paid capitation each month for Members enrolled on his/her panel as of the 15th day of the month. PCP’s are not paid additional capitation for Members newly enrolled on or after the 16th nor deducted capitation for Members losing eligibility on or after the 16th.

If a PCP’s compensation is on a capitated basis and a service is rendered to a Member that is within the scope of the physician’s license and expertise, the service is considered a capitated service, even if the service is typically rendered by a specialist. However, CHC has defined some services as non-capitated. Please refer to your provider contract for those items which are payable outside of capitation.
Coventry will furnish a monthly capitation report along with each monthly payment. This report verifies the eligibility of each Member on the provider’s panel, as well as the capitation paid for each Member. The report also provides the Member’s identification numbers, enrollment dates, and benefit plans.

Fee for service reimbursement compensates the provider only for services rendered based on the CPT codes submitted. Physician allowances are set by CPT codes. When submitting claims, please include all applicable modifiers to ensure proper payment. Claims submitted to Coventry should include your usual fee for services rendered by CPT code. Proper coding remains the responsibility of the billing provider. Fee charged for services provided to CHC members should be the same as those charged to non-Coventry members for the same services.

Coventry recognizes all valid American Medical Association (AMA) CPT codes ranging from 10000 to 99999 with the exception of unlisted procedures codes such as 69979 or 99199. Deleted codes are not considered valid for dates of services after the codes have been deleted. In addition, all modifiers listed in the AMA CPT manual are recognized and reimbursed according to industry standards. CHC also recognizes HCFA Common Procedure Coding System (HCPCS) and will reimburse them in accordance to the Coventry fee schedule.

Anesthesia services should be billed with base units for surgical anesthetics in accordance with the current editions of the American Society of Anesthesiologists Relative Value Guide (ASARVG) and Crosswalk. Services billed with CPT codes will be denied until submission with ASARVG codes.

**Claims Filing Procedures**

Providers should submit charges on an HCFA 1500 Health Insurance Claim form (or UB92 if applicable) directly to the Claims Address listed on the Member’s Identification Card. Claims should be submitted within ninety (90) days from the date of service unless your contract states otherwise. Coventry will not consider claims for payment submitted more than ninety (90) days after the date of service.

Exceptions will be made for claims involving Coordination of Benefits (COB). Coordination of Benefits is the process of coordinating the payable benefits when the Member is covered by two or more groups benefit plans. COB claims must be submitted within ninety (90) days of the primary
insurer’s Explanation of Benefit (EOB) date and a copy of EOB must be attached to the claim.

The claim should be submitted with the following information included on the claim:

- Member Name and CHC Id Number
- Name of Referring Physician
- Dates of Service
- ICD-9 diagnosis codes
- CPT-4 procedure code with valid modifiers as applicable
- COB information
- Operative report as applicable
- Provider’s tax ID number, name, signature, credentials and UPIN

Coventry Health Care of Georgia processes clean claims to providers within fifteen (15) days in accordance with state laws.

You may call the Customer Service Department to check the status of claims. Our Customer Service Department is available to answer any claim inquiries Monday through Friday between 7 am to 7pm. The phone number is (800)395-2545. You can also check your claims via our interactive voice response system or online with directprovider.com or emdeon Office.

CHC recommends that claims status inquiries not be made unless it has been at least 30 to 45 days since the date of submission. This will allow time for claim processing and mailing of the checks.

It is the responsibility of the Provider to maintain an updated record of their account receivables. CHC recommends that you check your account receivables monthly to determine if there are any outstanding claims. In the event that there are, Provider should contact Customer Service to determine if the claim was received. CHC will not be responsible for claims that were never received and the date of service exceeds the timely filing limit.

For Providers who submit claims electronically, reports are provided to Provider after each submission detailing the claims that were sent and
received. It is the Provider’s responsibility to track this list to ensure that claims were received by CHC. Coventry will not be responsible for claims that were never received when the date of service exceeds the timely filing limit and an EDI report showing acceptance of the claim is not present.

Coventry Health Care of Georgia strictly enforces its timely filing clause in the provider contracts. Claims must be filed within ninety (90) days or within time frames specified in your contract.

Coventry Health Care will make every effort to work with physician’s office having a billing problem. We suggest you contact us as soon as possible should this be a concern or problem.

A process is available for reconsideration of claims denied for failure to file within the deadline. Information, including copies of claims and documentation of previous filing(s) along with proof of prompt follow-up (within 45 days of date of service) which supports your request, should be sent to:

Coventry Health Care of Georgia

P.O. Box 7711

London, KY 40742

It is the responsibility of the Provider to verify Remittances. If the Provider wishes to appeal a payment, the Provider must contact CHC within ninety (90) days of the check date. If the Provider does not notify CHC within ninety (90) days after the receipt of payment, payment is considered final.

The following is an explanation of the remittance advice you will receive for medical services rendered.

Schedule of Payment

Checks are scheduled to run twice a week.

Method of Payment

Payments are made to the provider. The check sum includes payment for all services processed for that practice during the payment cycle. Should a remittance include denied charges or payments requiring adjustment, an
explanation of the denial or adjustment code will be given on the last page of the voucher.

How to Read your Remittance Advice

Here are detailed explanations of the fields on the remittance advice to aid you in reading your remittance advice.

Form Headings

Page _ of _ -- Identifies the page number and the total number of pages in the statement.

Title -- The name we have assigned to this report, will also identify specific Coventry Health Plan/product name.
**Provider #: Provider Name** – The number we assigned to your account and your name.

**Date** – The date the remittance advice, and accompanying check if applicable, is generated by Coventry.

**Claim Detail**

**Patient Name** – The name of the member receiving the services.
**Account #** – Patient account number taken from your claim submission.
**Place of Service** – Identifies the type of facility where the services were provided, e.g., OUTPT HOSPITAL, OFFICE, etc.

**Member #** – Our identification number for the member receiving services.
**Date Received** – The date the claim was received by Coventry Health Care, Inc.
**Processed Date** – The date the claim was processed in our system.

**Claim #** – A unique number that we assign during the claim imaging process. Please provide this number when making claim inquiries as it will speed specific claim retrieval.
**Auth #** – The number that we assign to our referral that is associated with claim, if applicable.
**Claim Provider** – Identifies the name of the provider in the HIPAA compliant format, who performed and billed the service.

**Carrier** – The information in this field may vary by product and account. It indicates the entity responsible for funding the claim, including the employer group if a self-funded arrangement is applicable.
**Network/Division** – Division of referring physician, if a referral is applicable. May also signify network accessed.

**Product** – Indicates which one of our products defines coverage for the member, e.g., HMO-Commercial, PPO, etc.

**Service Dates** – Dates of service corresponding to each procedure code. From first date the member received the service from the provider (from date) through the last date the member received the service from the provider (to date).

**Procedure Code** – Code pertaining to the procedure performed and billed by the provider on the corresponding service date(s).
**Mod Cd** – Indicates the modifier for the procedure code and procedure description, if applicable.

**DRG/APC**- Reflects the specific DRG or APC used to process the claim, if applicable.

**Procedure Description** – Describes the procedure performed for the procedure code indicated.

**CAP Y=yes**, Indicates the claim line was adjudicated as a result of a capitated agreement. **N=No**, indicates the claim line was adjudicated as a result of a fee for service agreement.

**Total Charges** – The amount billed for the procedure(s) performed on the corresponding service date(s).

**Allowed Amount** – Amount of billed charges less any ineligible amounts;

**Ineligible Amount** – Amount that is not covered or is in excess of the provider’s contracted rate and for which the member or provider is responsible.

**Inelig DC** – Disposition Code assigned to indicate the reason for ineligible amount; applicable disposition codes descriptions are noted at the bottom of this report.

**COB DC**- Disposition code assigned to indicate ineligible amount(s) after Coordination of Benefits; applicable disposition codes descriptions are noted at the bottom of the last page of the remittance advice.

**Deductible Amount** – Amount of deductible specified under the member’s Certificate of Coverage.

**Copay Amount** – Amount the member is responsible for paying to the provider at the time services are received, as defined by their Certificate of Coverage.

**Mbr Coins**– Amount coinsurance applied as defined by member’s Certificate of Coverage.

**Mbr Respons** – Total dollars that is member responsibility (as displayed in columns 17, 18 and 19) in addition to any member responsible ineligible amount dollars (as displayed in column 14).

**MBR DC** – Disposition code assigned to indicate the reason for member responsibility; applicable disposition code descriptions are noted at the bottom of the last page of the remittance advice.
ADJ DC – Disposition code assigned to indicate the reason for claim reconsiderations; applicable disposition code descriptions are noted at the bottom of the last page of the remittance advice.

Paid Amount – The amount being paid to the provider, calculated for each service minus member responsibility, if applicable.

Interest Calculations - Interest paid as a result of claim processing that extends beyond the defined number of days allowed by State or Federal regulatory requirements, if applicable.

Check # – The number of the reimbursement check.

Claim Totals – Totals columns

Withhold Amount – Indicates Contractual Withhold; the total dollars withheld for the claim in accordance with the terms and conditions of the provider contractual agreement.

Back-Out & Replacement – If a claim is backed out and replaced by another claim, the claim number of the backed out claim and applicable (negative) dollar amount is listed, as well as the number of the replacement claim.

Back-Out & Refund -- Message indicates specific claim that was backed out as well as the vendor’s refunded dollar amount, check number and check date. The refund represents positive dollars.

Provider Summary
This section provides report totals for the columns, differentiated by Fee for Service and CAP claims. Also included is a summary of any Provider Refunds.

Disposition Code Summary
Summary of reason codes that define any claim adjustments, ineligible amounts, or denials.

Provider Check Summary
Summarizes claim detail.

Check Number – The number of the attached reimbursement check.

Check Date – The date we produced the check.
Check Amount – Total check amount; equals Total Paid Amount + Total Interest Paid + Provider Refunds, as applicable.

Total Interest Paid – Total amount of interest paid from claim detail, as applicable.

Total Withhold Amount – Sum of total Contractual Withhold amounts from claim detail, as applicable. This amount is already accounted for in Total Paid dollars and does not need to be included to calculate Check Amount.

Distribution: Checks and Remittance Advice Summary reports are printed and mailed 1-2 times per week, depending on the specific Health Plan schedule. You may receive more than one check/remittance advice summary in one envelope, since we have individual bank accounts for our various product lines.

If you discover an underpayment in your claim, please notify our Customer Service Department within ninety (90) days of the check date. Customer Service will review the claim. If a correction is needed, they will fix the claim and additional payment will be sent to you on a future remittance/check.

If we have overpaid you, CHC will correct the error by subtracting the overpayment from a future remittance/check and reissue the correct payment. Please notify us so that we can make the appropriate adjustments. Please do not return a check to CHC unless it is specifically requested. If a returned check is requested, please mail it to the following address:

Coventry Health Care of Georgia

Recoveries Department

120 East Kensinger Drive

Cranberry Twp, PA 16066

To send in a refund check, please send it to the following address:

Coventry Health Care of Georgia
Systems Affecting Claims Payment

Coventry Health Care of Georgia uses a variety of systems and procedures in the review of claims. These systems may affect the payment of the claims. The systems noted below contain licensed or copyrighted material. Due to the licensing agreements and copyright laws, Coventry Health Care cannot mass distribute the detailed logarithms, policies, or rules used in these systems. If you have specific questions, please direct them to Customer Service or Provider Relations.

GMIS ClaimCheck System

This is an automated claims auditing system that verifies the clinical patterns of professional claims. It is integrated with our claims processing, IDX, and identifies inappropriate billing practices. GMIS's system, ClaimCheck, helps to ensure that claims are paid correctly based on clinical patterns and is designed to prevent overpayment. Through the edit process, the system advises CHC's claims processors when inappropriate billing occurs. ClaimCheck analyzes data and identifies and corrects all major types of inappropriate code irregularities. Specific CPT codes may be considered incidental to the major procedure performed on the patient. The use of modifiers, duplicate claims, assistant surgeon billing and the identification of possible cosmetic surgery are examples of claims issues evaluated by ClaimCheck. In addition, the age and sex appropriateness of a CPT code is considered. ClaimCheck is intended to consistently apply American Medical Association guidelines to all claims. Questions about ClaimCheck system edits on specific claims should be directed to Customer Service.

Healthcare Recoveries, Inc. (HRI)
Proprietary databases are used to review claims with diagnosis codes that are appropriate for investigation of third party liability or worker’s compensation. HRI conducts investigation and recovers on Coventry’s behalf.

**Special Investigative Unit (SIU)**

SIU provides comprehensive fraud and abuse detection services for CHC. These services include training claims staff on fraud detection and reporting, the prospective investigation of claims for potential abuse, and the ongoing monitoring of claims paid data to identify claims paid to “suspect” providers. Identification of “suspect” providers and other services are based on the SIU’ proprietary review protocol. Services include the validation of the tax identification number and licensures of providers from zip code areas where prior billing abuse has been widespread.

**MedCost Recovery Systems, Inc.**

Through electronic transfer of data, MedCost Recovery Systems employs proprietary logarithms to identify episodes of care that are aberrant. These records are audited against CHC hospital contracts, and if medical charts do not support the charges and services billed, recovery is initiated.

**Proprietary Claims Payment Guidelines**

In addition to the GMIS ClaimCheck System, Coventry supplements its claims policies with proprietary claims payment guidelines. These guidelines are generally developed on a national level by the medical management staff at Coventry Health Care’s corporate headquarters and approved at the local CHC level prior to use. Examples of areas of care where proprietary claims payment guidelines exist include but are not limited to, chiropractic care, payment of supplies, and policies on the applicability of copayments.

**Reimbursement Determinations**

Whereas the previous sections provides a description of systems affecting claims payment, this section is designed to provide some specific information about the types of rules applied to claims billed by providers to Coventry Health.
The CHC schedule of allowances represents the maximum reimbursement amount for each covered service that corresponds to any given medical service code. The basis of determining valid medical service codes are from Current Procedural Terminology (CPT), HCFA Common Procedural Coding System (HCPCS), or National Drug Codes (NDC). For covered services represented by a single code, the maximum reimbursement amount is the allowance amount determined by CHC or the provider’s usual charge for the service, whichever is less. In many cases, CHC allowances are based upon measures of relative value such as Average Wholesale Price (AWP), the Federal Resource Based Relative Value Scale (RBRVS), American Society of Anesthesiologists (ASA) units and Medicare laboratory and Durable Medical Equipment (DME) rates.

If on the same day or within the same episode of care, the same patient receives more than one service, then the total allowance amount may be less than the sum of the charges for individual billed service codes. Service codes may be subject to bundling via CHC multiple, incidental, rebundling and global claims payment processing rules. The details of rebundling logic will vary from one carrier to another. The concepts of quantity limits as well as multiple, incidental, rebundling and global processing in many instances are industry standards employed by many carriers, including Medicare.

Age/Sex Restrictions

Some services are allowed for only one sex (e.g., provider should not submit CPT code 58150 for a hysterectomy for a male patient). Some services are allowed only for certain age ranges (e.g. provider should not submit CPT code 43831 for a gastrostomy, neonatal for feeding a 45 year old patient).

Experimental/Investigational Services/Supplies/Drugs

A health product service, supply or drug is deemed experimental/investigational by CHC according to the following criteria following coverage eligibility criteria:

- Any drug not approved for use by the Food and Drug Administration (FDA); any drug that is classified as IND (investigational new drug) by the FDA; any drug requiring pre-authorization that is proposed for off-label prescribing.

- Any health product or service that is subject to Investigational Report Board (TRB) review or approval.
Any health product or service that is the subject of a clinical trial that meets criteria for Phase I, II, or III as set forth by FDA regulations.

Any health product or service that is considered not to have demonstrated value based on clinical evidence reported by peer-review medical literature and by generally recognized academic experts.

A drug, device, procedure, or other service will be experimental or investigational if CHC makes such a determination based upon criteria noted, unless otherwise noted in the Certificate of Coverage documents. Experimental or investigational services are not covered.

**Global Processing**

For some medical services (in most instances surgical services), CHC will impose global surgery processing rules, wherein some services (in most instances evaluation and management services) are incidental to other services (in most instances procedural services) when provided with a defined time period and in conjunction with the procedural service. CHC follows HCFA conventions regarding global designations and time periods for major and minor surgery.

**History Edits**

These edits apply to once-in-a-lifetime procedures, such as an appendectomy. These edits also apply to items such as drugs or supplies with monthly limits. History edits may also apply to certain codes, which denote services for a specified time period such as weekly or monthly radiology or renal dialysis.

**Incidental Claims Processing**

An incidental procedure is one that is performed at the same time as a more complex primary procedure that does not require significant, additional physician resources and/or is clinically integral to the performance of the primary procedure. When multiple medical service codes are billed in conjunction, some codes may be considered incidental to other codes and may not be considered toward the total allowance for the aggregation of billed codes. A code which is a subset of another code based on an objective interpretation of CPT verbiage will be considered incidental to the latter code. Codes which are “components” of “comprehensive” codes based on the Health Care Financing Administration’s Correct Coding Initiative, will be considered incidental to the latter. In addition, CHC may also consider a
code incidental to another if the incremental value of the former is less than one-fourth of its usual value when provided in combination with the latter. In many instances, this occurs when the lesser services do not pertain to different route of access, different organ systems, different pathological processes, or to multiple trauma.

**Laboratory Services**

Laboratory services provided by an outside or reference lab that is not the applicable contracted laboratory provider (Quest Diagnostics) will not be reimbursed to the provider of service by CHC. In this instance, the provider may not bill the Member/patient or CHC for the laboratory services. There are certain laboratory services which are allowable in office. They are as follows:

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In addition, CHC will allow a drawing fee (CPT code 36415, 364510, G0001) to be reimbursed in office. Specimen handling fee 99000 is not reimbursed.

85610 is allowed in office for the following specialties only: Hematology/Oncology, Cardiology/Cardiovascular Medicine.

85002, 85007, 85008 is allowed in office for Hematology/Oncology providers only.

**Medical Necessity**

Medical necessity is defined by Coventry as the use of services or supplies as provided by a hospital, skilled nursing facility, physician, or other provider required to identify or treat a member’s illness or injury and which, as determined by CHC, are: (1) consistent with the symptoms or diagnosis and treatment of the member’s condition, disease, ailment or injury; (2) appropriate with regard to standards of good medical practice; (3) not solely for the convenience of the member, his/her participating physician, hospital, or other health care provider; and (4) the most appropriate supply or level of service which can safely be provided to the member. When specifically applied to an inpatient admission, it further means that the member’s medical symptoms or condition requires that the diagnosis or treatment cannot be safely provided to the member in an outpatient setting. Services listed in the schedule of benefits are covered only if they are medically necessary.
Modifiers

Coventry Health accepts most standard modifiers, however some may require clinical review.

Multiple Surgeries/Procedures

When two or more different medical service codes are provided to the same patient (usually by the same provider on the same date of service), for covered surgical services provided in a single operative session, reimbursement would be made at the full allowance amount for the procedure with the highest RVU units, plus half of the usual allowance for the second medical service code, and one-fourth of the usual allowance amount(s) for each subsequent procedure. All multiple surgery/procedural services are pended and sent to a Medical Claims Review Unit for review and determination of reimbursement.

Rebundling Claim Processing

Procedure unbundling occurs when two or more procedures are used to describe a service when a single, more comprehensive procedure exists that more accurately describes the complete service performed by the provider. For some combinations of medical service codes, CHC will allow the allowance amount for the totally different service code while disallowing the billed medical service code. CHC refers to this as rebundling processing. Medical service codes to which billed services combine are usually a superset of the billed codes. An example would be a set of laboratory codes that are all contained within a single panel or multi-channel test. Less frequently, CHC will combine billed codes into a code which is not a superset of billed charges, but does represent the value of the combined medical services billed.

Billing for Electronic Communication

CHC does not allow billing of charges associated with telephone (such as 99371-99373), email, or other electronic communications. These charges are not billable to CHC and are also not billable to the patient.
Specialty Services

Coventry Health Care of Georgia contracts with ancillary providers for specialty services such as laboratory, radiology, and home health care. This section explains how these services are accessed by HMO Members.

Laboratory services must be performed by a Coventry Health Care of Georgia participating laboratory. CHC maintains a contract with Quest Diagnostics, Inc., formerly SmithKline Beecham Laboratories, to provide outpatient lab services for members. Quest Diagnostics labs provide the following:

- All necessary supplies
- Request forms
- Specimen pick-up
- Accurate, prompt test results

The telephone number for Quest Diagnostics, Inc. is (770)934-9200 or (800) 767-7525.

Although CHC maintains a contract with Quest to provide lab services, we recognize the need for urgent lab work to make a diagnosis, or to treat the patient while in the provider’s office. When this situation occurs, some lab procedures can be billed to CHC and the provider will be reimbursed according to the fee schedule.
In office Lab List

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36410, 36415, G0001 are reimbursed in office as well. Specimen Handling 99000 is not a reimbursable item.

85610 is allowed in office for the following specialties only: Hematology/Oncology, Cardiology/Cardiovascular Medicine.

85002, 85007, 85008 is allowed in office for Hematology/Oncology providers only.

All preadmission laboratory testing must be performed by a CHC contracted lab. For members scheduled for elective admission, all preadmission diagnostic work-ups including lab, radiology, and supporting specialty consultations, must be referred to free-standing contracted providers.

Radiology

Routine X-rays must be performed by the contracted radiologist or radiology facilities listed in the Provider Directory. Exceptions are noted below.

X-rays performed in the physician’s office are paid only if the physician has been contracted for radiology services. Physicians other than radiologists may submit claims for urgent radiology services when the procedure is necessary to confirm a suspected diagnosis, as follows:

- To rule out fracture(s) or to confirm the corrected reduction of a fracture
- To rule out pneumonia
- To rule out an abdominal obstruction or other possible surgical condition when the patient presents with acute abdominal pain, nausea, vomiting and/or fever
- To diagnose the presence of a foreign body
Follow-up X-rays in the physician’s office may be performed if the following conditions exist:

- Pneumonia is documented
- Patient is being treated for Pulmonary Sarcoidosis
- Healing of fracture

For a listing of the radiology procedures that require pre-authorization, please refer to the PreAuthorization Listing in this manual.

**Home Health Care**

All home health services must be performed by a Coventry Health Care participating agency, and require pre-authorization from the Health Service Department.

Coventry Health Care of Georgia maintains a contract to provide home health services for members. Home Health services provides the following:

- Home Infusion Therapies
- Respiratory Care Services
- Women's Health Services
- Home Sleep Diagnostic Program
- Respiratory Medications
- Home Medical Equipment

**Durable Medical Equipment and Supplies**

All DME and supplies should provided by a participating provider. Certain DME and supplies must be preauthorized. Please refer to Preauthorization for the listing.
Injectable Medications

Coventry Health Care has contracted with preferred vendors for the supply of expensive injectable medications. These medications require preauthorization by our Health Service Department. Our Health Service Department will assist in you in making arrangements for the delivery of the medications to your office or the patient’s home. The authorization request can be faxed to our Health Service Department using the corresponding form. A list of our vendors and the medications they supply is as follows:

**Provider** | **Disease / Condition**
---|---
**CVS ProCare**<br>recipients<br>1-800-238-7828<br>www.cvsprocare.com | HIV/AIDS ; Organ Transplant recipients<br>direct delivery to patient
**Caremark Therapeutic Services**<br>1-877-834-8657<br>www.caremark.com | Growth hormones; hepatitis C; hemophilia; Gauchers Disease; RSV<br>direct delivery to patient or delivery to physicians office
**McKesson Specialty Pharmaceuticals**<br>1-877-848-2797<br>1-877-848-2798<br>www.vitarx.com | Multiple Sclerosis, Crohns Disease, rheumatoid arthritis, infertility, chemo agents, post-chemo, deep vein thrombosis, (DVT), dialysis, & others.<br>direct delivery to patient or physicians office
**Priority Healthcare**<br>1-866-4PH-TEAM (1-866-474-8326)<br>1-866-856-2093 | Pulmonary Hypertension (Remodulin therapy)<br>Psoriasis<br>direct delivery to patient or physicians office<br>www.priorityhealthcare.com
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<th>Company</th>
<th>Services</th>
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<td><strong>TAPCare</strong></td>
<td>Endometriosis; Prostate cancer;</td>
<td>1-800-689-9093</td>
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<td>Central precocious puberty</td>
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<td>delivery of Lupron products to</td>
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<td>physicians office</td>
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<td><strong>TheraCom</strong></td>
<td>Pulmonary Hypertension (Flolan</td>
<td>1-877-Flolan-4</td>
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<td>direct delivery to patient or</td>
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<td><strong>Chronimed</strong></td>
<td>Fuzeon</td>
<td>1-866-694-6670</td>
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<td>Prolastin, Gamimune N, Kogenate FS</td>
<td>1-800-305-7881</td>
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<td><strong>Wyeth Direct</strong></td>
<td>Prevnar</td>
<td>1-800-666-7248</td>
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Utilization and Quality Management

Utilization management tracks health care costs while assuring the quality of and access to health care; while quality management assures that all health care services provided to members meet the highest standards of quality. This section details the processes of utilization and quality management at Coventry Health Care of Georgia.

Utilization management occurs by reviewing how health care resources are utilized by members and identifies and evaluates appropriateness, timeliness, medical necessity, utilization patterns and clinical outcomes.

Utilization management at Coventry Health Care consists of the following functions:

- Pre-authorization of hospital admissions and outpatient services to determine medical necessity.
- Concurrent review of inpatient care to ensure appropriate treatment and length of hospital stay.
- Retrospective review of health care service and costs
- Use of alternative resources and settings
- Case management
• Disease management programs

• Oversight of delegated utilization management functions

Telephonic or onsite concurrent inpatient reviews include the following:

• Reviewing that continued inpatient care is medically necessary and based on assessments of documentation present in the medical record, on observation of the member, and in consultation with the treating physician, Medical Director, and ancillary providers as needed using approved criteria.

• Reviewing that care is provided efficiently and effectively in the appropriate setting and at the appropriate level of care

• Facilitating timely and comprehensive discharge planning that includes assessment, planning and follow-up to ensure continuity of care

• Decreasing risk and improving quality through identifying and monitoring risk-related guidelines in accordance with CHC Quality Management Plan

• Intervening at the direction of the Plan Medical Director when medical necessity is not met, care does not meet acceptable standards, or resources are not utilized appropriately

Initial concurrent review assessment occurs within one working day of admission or notification. Days are approved prospectively when medical necessity and length of stay criteria is met. If upon review days are denied for delay of treatment, facility and treating physician charges associated with those days will be denied. Member can not be held liable for these charges.

Out of network admissions and out of area emergency admissions are reviewed as soon after notification as possible. The facility is notified that coverage will cease when the patient is stable enough to be transferred or discharged.

The Health Services Coordinator or Case Manager at Coventry may retrospectively review medical records of a discharged member. The following are examples of situations in which a review may be performed:

• Questionable need for admission

• Admissions that occur without CHC knowledge
Case management provides high quality, cost effective service to members who have encountered, or have the potential to utilize, significant medical services. Case management includes but is not limited to:

- Treating patients in the least restrictive setting or environment
- Providing services at the most appropriate site
- Providing support for Primary Care Physicians with complex cases
- Managing patient’s real and perceived needs
- Serving as a patient/family advocate

All inpatients are evaluated for discharge planning needs to monitor cost-effective follow-up. Discharge planning includes, but is not limited to:

- Determining the resources of the family and/or significant others, and including them appropriately in the discharge planning process
- Determining the level of post-discharge care
- Determining if, when, and at what level post-discharge facility care is needed
- Initiating appropriate patient and family education regarding post-discharge care
- Coordinating key contacts to arrange for home care or equipment needs, (e.g., ancillary providers for durable medical equipment (DME), home care services, supplies, etc.)

Quality Management

The Quality Management Committee is an interdisciplinary committee composed of Plan practicing providers and staff who are involved in QM
activities. Their purpose is to oversee and direct comprehensive, planned, and systematic process of monitoring and evaluating the quality of care and services provided to Plan members. This includes, but is not limited to, the monitoring and evaluation of quality of care and services with respect to credentialing and recredentialing functions, utilization management functions, and pharmaceuticals and therapeutics used in the treatment of Plan members. Coventry defines Quality of care as the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

Coventry Health Care supports the recommendations by the Institute of Medicines (“IOM”) report on patient safety through the development of an internal adverse events listing which includes the “Never Events” identified by the IOM. The IOM defines an adverse event as an injury resulting from a medical intervention, in other words, it is not due to the underlying condition of the patient. A preventable adverse event is an error that does not result in injury. (IOM, 1999)

Coventry Health Care monitors the safety of its Members by the identification of potential and/or actual adverse events by the referral of events from any part of the health delivery system, including hospitals, pharmacies, and physicians’ offices. All staff are provided with the list of adverse events and are asked to refer any that are observed. Member complaints are also monitored for any adverse events. The Quality Management Department in consultation with the Medical Director investigates, tracks, analyzes and brings referred adverse events to the peer review committee for action. Coventry Health Care will not reimburse procedures/services rendered in connection with or as a result of an identified adverse event.

As a back up to ensuring that all events are identified, inpatient claims are reviewed in Coventry’s information system and quarterly reports are monitored by the Quality Management Department.

Medical errors and other adverse events are monitored to identify patterns of preventable events and events related to individual network providers. This report, Adverse Event is provided by Corporate IS. Patterns or individual cases are investigated and action is taken to make improvements.

The following are the Adverse Events which are tracked by CHC:
<table>
<thead>
<tr>
<th>Adverse Events</th>
<th>Investigation/ Monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Unexpected deaths.</td>
<td>100% cases/ Monitor for trends</td>
</tr>
<tr>
<td>2. Unexpected brain damage following treatment or procedure.</td>
<td>100% cases/ Monitor for trends</td>
</tr>
<tr>
<td>3. Unexpected patient return to the Operating Room in the same admission.</td>
<td>Investigate per Medical Director/ Monitor for trends</td>
</tr>
<tr>
<td>4. Hospital incurred trauma.</td>
<td>Investigate per Medical Director/ Monitor for trends</td>
</tr>
<tr>
<td>5. A patient operated on for repair of laceration, perforation, tear or</td>
<td>Investigate per Medical Director/ Monitor for trends</td>
</tr>
<tr>
<td>puncture of an organ, subsequent to the performance of an invasive procedure.</td>
<td></td>
</tr>
<tr>
<td>6. An unplanned removal of an organ or part of an organ during an operative</td>
<td>100% cases/ Monitor for trends</td>
</tr>
<tr>
<td>procedure.</td>
<td></td>
</tr>
<tr>
<td>7. Hospital acquired infection.</td>
<td>Investigate per Medical Director/ Monitor for trends</td>
</tr>
<tr>
<td>8. Unexpected cardiac or respiratory arrest, including newborns with Apgar</td>
<td>Investigate per Medical Director/ Monitor for trends</td>
</tr>
<tr>
<td>equal to or less than four (4) at birth, requiring resuscitation in the</td>
<td></td>
</tr>
<tr>
<td>delivery room.</td>
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<tr>
<td>9. Suicide, Attempted and Actual</td>
<td>100% cases/ Monitor for trends</td>
</tr>
<tr>
<td>10. Unexpected amputation due to poor outcome of any procedure or treatment.</td>
<td>100% cases/ Monitor for trends</td>
</tr>
<tr>
<td>11. Wrong patient/wrong site (surgery/radiology).</td>
<td>100% cases/ Monitor for trends</td>
</tr>
<tr>
<td>12. Cardiac arrest in Operating Room or Recovery Room.</td>
<td>100% cases/ Monitor for trends</td>
</tr>
<tr>
<td>13. Second or third degree burns as a result of any procedure or treatment.</td>
<td>100% cases/ Monitor for trends</td>
</tr>
<tr>
<td>14. Misdiagnosis in Emergency Room resulting in permanent injury or death.</td>
<td>100% cases/ Monitor for trends</td>
</tr>
<tr>
<td>15. Newborn with unexpected asphyxia/brain damage.</td>
<td>100% cases/ Monitor for trends</td>
</tr>
<tr>
<td>16. Unexpected maternal or neonatal death.</td>
<td>100% cases/ Monitor for trends</td>
</tr>
<tr>
<td>17. Ambulatory surgery that results in an inpatient admission secondary to a</td>
<td>Investigate per Medical Director/ Monitor for trends</td>
</tr>
<tr>
<td>surgical complication.</td>
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</tr>
<tr>
<td>18. Retention of Foreign object in a patient after surgery or a procedure.</td>
<td>100% cases/ Monitor for trends</td>
</tr>
<tr>
<td>19. Stage 3 or 4 pressure ulcers acquired after admission to a healthcare</td>
<td>Investigate per Medical Director/ Monitor for trends</td>
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</tr>
<tr>
<td>20.</td>
<td>Severe allergic reaction during hospitalization.</td>
</tr>
<tr>
<td>21.</td>
<td>Medication Error during hospitalization.</td>
</tr>
<tr>
<td>22.</td>
<td>Unexpected re-admission within one week of discharge.</td>
</tr>
<tr>
<td>23.</td>
<td>Fall incurred during hospitalization</td>
</tr>
</tbody>
</table>
Physician Participation Information

Your participation with Coventry Health Care of Georgia comes with some guidelines. This section outlines those guidelines.

A Physician must complete an application, sign two (2) Physician Agreements and be fully credentialed in order to be approved for participation and treat any Coventry Health Care of Georgia members. Once the Physician Agreements have been executed, an original copy will be returned to the provider for his/her records.

The CHC network is open for application by a particular provider/provider specialty type if at least one of the following criteria is met:

a. Coventry Health Care of Georgia, Inc. access and availability standards are not being met in that area.

b. There appears to be a need in the market place for a particular specialty due to referral patterns.

c. There is a member or group demand for a certain provider or a particular specialty even though access and availability standards are being met.

d. A certain provider’s participation is in the best interest of the Plan and meets the business needs of the Plan.

e. Adding a certain provider or specialty would positively impact new sales and retention, even though access and availability standards are being met.

Once a determination has been made to add the provider to the network and reimbursement has been mutually agreed upon, the provider must meet
quality of care and quality of service standards as well as CHC’s minimum administrative requirements as follow:

- Has a current and active unrestricted license;
- Has a current DEA certificate, if applicable;
- Has a current states Controlled Drug Substance (CDS) certificate, if applicable;
- If a practitioner, has current malpractice insurance coverage that meets CHC minimum requirements;
- Is not currently excluded from the Medicare or Medicaid program, or any other Federal Health Care Program;
- If a facility, is accredited through one of the recognized accreditation organizations.

Physicians will be solely responsible for the treatment and medical care provided to a member, and the maintenance of their relationship with a member. CHC will not exercise control or direction over, nor will be liable for, the manner or method by which the physician provides professional services under the Physician Agreement. Physicians can and must freely communicate with members regarding appropriate treatment alternatives and/or the treatment options available to them. Coventry is entitled to deny payment for physician services to a member which it determines are not covered services. A coverage denial does not absolve physicians of his/her professional responsibility to provide appropriate medical care to members.

Coventry values physician input and views it as an important element of the management structure of Coventry Health. From time to time, you may be asked to participate in a variety of professional committees. Your participation in these committee will be greatly appreciated.

Coventry Health Care of Georgia recredential providers every three years. At this time, we verify that the physician has a current medical license, sufficient medical malpractice coverage, hospital privileges, and board certification. Medical malpractice claims filed during the last three years are reviewed. Quality Improvement issues, Utilization Management issues and member complaints are also considered during this process. Decisions about recredentialing are made by CHC’s credentialing committee.

All CHC of Georgia providers will be required to sign a written agreement. These agreements can be signed by the individual provider, a group practice, an Independent Physician Association (IPA), or a Provider Hospital Organization (PHO).
The agreements will have at the least contain the following elements:

- A listing of all individuals or entities that are covered under the agreement
- Conditions for participation
- Obligations and responsibilities of CHC and the provider including any obligations to participate any CHC programs
- Events that may result in the reduction, suspension, or termination of network participation privileges
- Access to medical records
- Health care services to be provided and any restrictions
- Claims submission requirements and restrictions
- Payment methodology
- Mechanisms for provider dispute
- Term of the contract and procedures for terminating the contract
- Confidentiality of patient health information
- Prohibitions regarding discrimination against consumers

Please contact our Provider Relations Department if you do have a copy of your contract or see that the items above are missing from the contract you have.

To ensure and evaluate the accessibility of services and the quality of care, Coventry Health performs on-site reviews of PCP and OB/GYN physician offices along with high volume specialists. The audit consists of a survey addressing office policies and procedures.

The site visit is completed by a member of the CHC provider relations department and the office manager or physician in the practice. It surveys the office on policies and procedures in place such as those to schedule appointments, handle emergencies, and ensure patient confidentiality. Coventry Health Care considers these reviews educational and will work with the office to improve areas in which the office is weak. After a review, the office receives a written report if any deficiencies are noted.
Coventry Health Care is committed to treating members in a manner that respects their rights as members.

As a member of a Coventry Health Care of Georgia, Inc. (“Coventry”) Health Plan, they have the right to:

- Receive information about the Health Plan, its services, practitioners and your rights and responsibilities.
- Be treated in a manner reflecting respect for your privacy and dignity as a person.
- Not be discriminated against because of age, disability, health status, race, color, religion, sex, or national or ethnic origin.
- Be informed regarding diagnosis, treatment and prognosis in terms that you can be expected to understand.
- Participate in the decision making process regarding your medical care. Your health care professional should advise you of treatment alternatives so that you and he/she may select the appropriate treatment plan.
- Receive sufficient information to enable you to give informed consent before the initiation of any procedure and/or treatment.
- Refuse treatment to the extent permitted by law and to be made aware of the potential medical consequences of such action.
- Expect that all communications and records pertaining to your health care will be treated as confidential, and that no such records will be released without your authorization. Your signature on the enrollment form constitutes permission for release of medical records to Coventry for you and your family dependents as listed on the enrollment form.
- Select your own personal physician from among Coventry’s participating Primary Care Physicians and to expect that physician to provide quality care, and to arrange for and coordinate all care you receive.
- Expect reasonable access to medically necessary services.
- Be provided Coventry’s grievance process, and voice grievances, complaints and offer suggestions about us and/or the services we provide.
- Request satisfaction statistics and a description of the provider compensation arrangement.
- Call the Health Plan whenever you have a question about your benefits.

As a member of a Coventry Health Plan, they have the responsibility to:
• Read your Certificate of Coverage (agreement). You are subject to all of the Health Plan rules, terms, conditions, limitations and exclusions in the agreement.
• Seek care through your Primary Care Physician (PCP) if the plan you have selected requires you have a PCP.
• Call Customer Service if you wish to change your PCP.
• Always identify yourself as a Coventry member when calling a provider for an appointment and when obtaining health care services.
• Always present your Coventry member identification card when obtaining health care services.
• Keep scheduled appointments or, if necessary, call to cancel appointments as early as possible. Remember, your Primary Care Physician or participating provider may bill you if you fail to keep a scheduled appointment.
• Inform us of any additional health insurance coverage your family may have so that payments can be properly coordinated between us and the other insurer.
• Cooperate with your health care professionals and follow their advice for treatment of injuries or illnesses.
• Give the provider the information necessary to provide health care.
• Know how to recognize an urgent care condition versus a medical emergency and what to do if one should occur.
• Let us know of any changes in your name, address, phone number, marital status, and family status.
• Report health care fraud and abuse.
Provider Appeal Process

Coventry Health Care of Georgia recognizes that providers may occasionally encounter situations in which the operation of CHC does not meet their expectations. When this occurs, the provider is encouraged to call the matter to our attention. This section outlines the process to do so.

This appeal process applies to all providers and facilities. This process is specific to Provider Appeals and does not replace, and is separate and apart from, Member Appeal policies or Providers acting as the Member’s Authorized Representative. The Purpose of this policy is to ensure consistent processes are followed when addressing, documenting and handling Provider Appeals.

Adverse Determinations Appeals

The Appeal Coordinator ("AC") is responsible for the acknowledgement, documentation and resolution of all Appeals. In the case of Appeals based in whole or in part on a medical judgment, the AC works with the Health Plan’s Health Services (“Health Services”) staff in obtaining the appropriate clinical information.

Coventry Health Care recognizes each member’s right to privacy and holds that all medical information is to be treated with the strictest confidence and only the minimum amount necessary is to be shared with others when it is appropriate for ensuring delivery of health care services, administration of health care benefits or health care payments, or as otherwise required by law.
I. DEFINITIONS

Inquiry
Any question from a Provider regarding issues received by a Customer Service Representative in the Customer Service Center (“CSO”) (e.g., benefits information, claim status, or eligibility).

Complaint
Any expression of dissatisfaction expressed by a Provider regarding an issue in the Health Plan, which may be resolved by the Customer Service Representative in the CSO.

Claims Payment Reconsideration
Any request by a Provider concerning the reimbursement of a claim prior to a review by the Health Plan. Claim payment reconsideration’s may include, but are not limited to claim check edits, untimely filings, cosmetic procedures, AWP for J code price disputes, anesthesia modifiers, E&M as surgical global, qualifying circumstances, etc. For example, the claim check system is set up to auto deny cosmetic claims based on diagnosis. When the provider sends in his notes, the first time review of those notes is done by the MCRN based on specific guidelines and is considered the "claims reconsideration". The MCRN can make the decision to approve based on the guidelines. If the procedure is still considered cosmetic in nature after the MCRN review, all of the information is sent to the medical director for review. If the medical director upholds the initial claim rejection, the provider can then appeal.

Provider Appeal
A Provider Appeal is a request by the Provider for consideration of a Health Plan issued adverse determination. Provider includes facilities.

II. PROVIDER APPEAL PROCESS

A. Filing a Provider Appeal

1. If a Provider is dissatisfied with the Health Plan’s Adverse Determination and contacts a Health Plan Customer Service
Representative, the Customer Service Representative should educate the Provider of the right to Appeal and the steps for filing an Appeal. The Provider is advised to send a written request to the Health Plan AC within ninety (90) calendar days after receipt of the initial notification of Adverse Determination or as specified in his/her contract. If the Provider contacts Health Services or Provider Relations staff regarding the Adverse Determination, the Plan staff will educate the Provider on Appeals and ask the Provider to send the written request to the Plan AC within ninety (90) calendar days after Provider’s receipt of the initial notification of Adverse Determination or as specified in his/her contract. Requests for Appeals received after such ninety (90) calendar day period or as specified in the provider’s contract, will not be eligible for review under the Health Plan’s internal Appeal process.

If a Non Participating Provider is dissatisfied with the Health Plan’s Adverse Determination, the Customer Service Representative should educate the Provider of the right to Appeal and the steps for filing an Appeal. The Provider is advised to send a written request to the Health Plan AC within 180 days after receipt of the initial notification of Adverse Determination. If the Provider contacts Health Services or Provider Relations staff regarding the Adverse Determination, the Plan staff will educate the Provider on Appeals and ask the Provider to send the written request to the Plan AC within 180 days after the Provider’s receipt of the initial notification of Adverse determination. Requests for Appeals received after the 180 day period will not be eligible for review under the Health Plan’s internal Appeal process.

3. The Provider is instructed to include the following in the written Appeal indicating:
   - Member name;
   - Provider name;
   - A description of the service which was denied;
   - Date(s) of service;
• Clear indication of the remedy or corrective action being sought and an explanation of why the Health Plan should “reverse” the Adverse Determination; and
• Copy of documentation which the provider believes supports the reversal of the Health Plan’s decision (e.g., emergency details, date, time, symptoms, why the member did not contact the PCP, etc.), if any.

B. Inquiries/complaints

1. All inappropriate receipts will be handled as follows:
   All Provider inquiries/complaints received by the AC which are not a provider appeal as defined in this policy should be copied and returned to the Customer Service Representative or appropriate Health Plan staff. The CSO or the appropriate Health Plan staff (i.e. Provider Relations Representative) notifies the Provider of the receipt of the inquiry/complaint within three (3) business days. The inquiry/complaint must be resolved within thirty (30) calendar days.

C. Provider Appeal Process
   a. Those Provider requests that meet the definition of an Appeal will be handled in accordance with the following process:

   • Appeal will be logged in the Appeals Database along with entry into Customer Service Console.
   • Cover sheet will be completed and distributed to the appropriate department for decision.
   • When a decision has been made, resolution will be entered into the Database as well as the CSC, and the provider will be notified of the determination.
   • Provider appeals will be processed within fifteen (15) calendar days for pre-service appeals, and thirty (30) calendar days for post-service appeals.

D. Provider Administrative Appeals will be reviewed by one (1) manager or senior manager of the Health Plan who will consider the Provider Appeal based upon the plan documents and the information submitted by the provider.

E. Provider Medical Necessity Appeals will be reviewed by a like or similar specialty physician not previously involved in the case, who holds an active unrestricted license to practice medicine and is board
certified (if applicable) by the American Board of Medical Specialties or the Advisory Board of Osteopathic Specialists from the major areas of clinical services (doctors or osteopathic medicine).

F. The AC prepares a file folder for each case. File preparation includes:
   • Member name;
   • Case level identification that indicates date received;
   • Appeal type, category & reason;
   • Deadline date for resolution (i.e., thirty (30) calendar days from receipt of the request for Appeal for post-service and fifteen (15) calendar days for pre-service);
   • Actual completion date;
   • Health services information, if necessary;
   • All information submitted by the provider to support his or her appeal;
   • Name of medical director or individual who made the initial adverse benefit determination;
   • Names and titles of (s) the person reviewing the Appeal; and
   • Name, title and specialty of healthcare consultants utilized, if appropriate.

G. If the initial denial is reversed, the AC will:
   • Send a decision letter within fifteen (15) calendar days for pre-service appeals, and thirty (30) calendar days for post-service appeals from receipt of the appeal;
   • The approval letter should instruct the provider how to obtain the approved services (e.g., contacting Health Services to schedule the procedure);
   • The appeal decision will be documented in all applicable systems; and
   • Provide notification to the CSO to overturn the adverse determination, if necessary.

H. If the decision is adverse to the provider, the AC:
   • Send a decision letter within fifteen (15) calendar days for pre-service appeals, and thirty (30) calendar days for post-service appeals from receipt of the appeal;
• The denial letter shall advise the provider of the reason for the decision;
• The clinical rationale for adverse benefit determinations based on whole or in part on a medical judgment, will be provided in writing, upon request;
• The provider is notified that this is the final level of Appeal; and
The appeal decision will be documented in all applicable systems.

**Provider Participating Status Dispute Resolution**

The resolution process outlined below provides a mechanism for participating providers with Coventry Health Care of Georgia, Inc., (CHC) to resolve issues between the participating provider and the plan that may result in a change in network status of the provider, as such network status change relates to CHC’s review of the provider’s professional competency and/or conduct or clinical quality.

Any Participating provider that wishes to use this dispute resolution mechanism will be afforded the process described in this policy while protecting members and respecting providers’ rights. The primary objective of the dispute resolution policy is to provide prompt and appropriate responses to credentialing and recredentialing disputes.

**Procedures relating to denial of participation status for quality concerns**

A provider may be denied continued participation status for quality concerns based on the competence or professional conduct of a provider, which affects or could affect the health or welfare of a patient or patients.

Examples of such quality concerns include but are not limited to:

- Evidence of substandard treatment rendered to patients
- Malpractice judgements/settlements
- In any instance where corrective action will be required to be reported to the National Provider Data Bank
- In any instance where a provider’s contract with the Plan is terminated for cause under the terms of the contract
- Current Medicare or Medicaid Sanctions
- Loss of accreditation or certification status if a facility or ancillary provider
Prior to taking any final action to deny continued participation status to a provider for quality concerns, the provider will be entitled to pursue the appeal process outlined below.

If the Credentialing Committee has made the determination to not renew a provider’s reappointment for reasons based on quality concerns, the provider shall be notified in writing by the Medical Director of the decision and the reasons for it. The provider may request an appeal, within thirty (30) days of receipt of the decision letter. The provider must make this request to the Medical Director in writing.

A. Participating Provider Dispute Resolution Process: Type A

The appeal will be reviewed by at least one authorized representative of the organization who was not involved in the initial decision that is the subject of the dispute. The provider will be given the opportunity to submit additional information relevant to the issue. This information must be submitted in writing along with the appeal request. All documents shall be maintained in strict confidence by all participants.

The additional information submitted will be reviewed and a determination will be made. The findings and recommendations will be submitted to the Medical Director within 15 days of receipt of the appeal.

The Medical Director shall notify the provider, who requested the informal hearing, of the decision within fifteen (15) days of receiving the decision. This notice will be sent via certified mail, return receipt requested.

If the decision is to uphold the recommendation of the Credentialing Committee to deny the provider continued participation, the provider will be granted the right to appeal this recommendation before a formal appeals committee.

If the decision is to overturn the recommendation of the Credentialing Committee to deny the provider participation, the dispute will not need to go to the next level of appeal.
B. Participating Provider Dispute Process: Type B Peer Review Panel

The Type B Peer Review Panel Process is available to participating providers if one of the following occurs:

- CHCGA and the provider agree by mutual consent to use this review dispute resolution process
- The participating provider presents information to challenge the findings of the Type A Dispute Process

First Level Appeals Procedures:

The First Level appeal will be held before a panel of at least three (3) qualified individuals who were not involved in the initial decision, at least one of which must be a participating provider not otherwise involved in Plan management and who is a clinical peer of the provider that filed the dispute. At this first level appeal, the provider will be given the opportunity to present additional information relevant to the issue, and the panel will have the opportunity to ask questions pertinent to the dispute.

The Panel members shall review and discuss the findings of fact. The Panel shall render a decision and notify the Medical Director within fifteen (15) days following the end of the panel. The Medical Director shall notify the provider, who requested the appeal, of the Panel’s decision within fifteen (15) days of receiving the Panel’s decision. This notice will be sent via certified mail, return receipt requested.

If the decision of the first level appeals is to uphold the recommendation of the Credentialing Committee to deny the provider continued participation, the provider will be granted the right to appeal this recommendation before a second level formal appeals committee.

Second Level Formal Appeals Procedures:

In order for a provider to request a second level formal appeal, the provider must request an appeal on the proposed action within thirty (30) days of his or her receipt of the notice. This request must be made to the Medical Director in writing.
If the provider does request an appeal, the appeal shall be held within thirty (30) days of receipt of the provider’s request unless CHC and the provider agree to an extension.

If the provider does not request an appeal within thirty (30) days of his or her receipt of the aforementioned notice, he or she will have waived the right to appeal the decision.

The Second Level appeal will be held before a panel of at least three (3) qualified individuals who were not involved in the initial decision or first level appeal, one of whom must be a participating provider not otherwise involved in Plan management and who is a clinical peer of the provider that filed the dispute. At this second level appeal, the provider will be given the opportunity to present additional information relevant to the issue, and the panel will have the opportunity to ask questions pertinent to the dispute.

The Panel members shall review and discuss the findings of fact. The Panel shall render a decision and notify the Medical Director within fifteen (15) days following the end of the panel. The Medical Director shall notify the provider, who requested the appeal, of the Panel's decision within fifteen (15) days of receiving the Panel’s decision. This notice will be sent via certified mail, return receipt requested.

The decision of the Panel shall be final and binding on both the provider and CHC. If that decision is to terminate the provider's contract, the contract shall be terminated at the time specified by CHC in its initial notice of termination. If the decision is to not renew a contract, the contract shall expire at the end of its then current term.

C. Provider Status

1. The provider’s status as a participating provider will remain in effect during the dispute and appeal process, unless suspension is based on any of the reasons noted in Section C.2. below.

2. The provider’s participation may be immediately suspension if the participating provider’s conduct presents an imminent risk of harm to a member(s); or, if there has occurred
unacceptable quality of care, fraud, patient abuse, loss of clinical privileges or licensure, or loss of professional liability coverage, incompetence, or loss of authority to practice in the provider’s field; or if governmental sanctions has impaired the provider’s ability to practice or participate in Medicare, Medicaid or any other government program.

3. A participating provider who does not meet the terms and conditions of his/her provider contract may be terminated without the right of appeal.
Electronic Solutions

Coventry Health Care of Georgia has a wide array of electronic solutions to assist you in the management of our members. This section outlines those solutions.

The world today offers a wide variety of electronic solutions to make your everyday duties quicker and easier.

Coventry's has introduced its free provider website www.directprovider.com.

√ A user-friendly secure provider site that gives you the information you need to know to get your claims paid quickly and efficiently.
√ A one-stop shop for the Coventry family of health plans.
√ Information directly from the health plan so the information is accurate and fast.
√ A service that is free to Coventry providers.

It provides benefit information is in a clear, easy to read format (partial sample shown below)
Other Features

Eligibility and Benefits
Eligibility inquiries identify the member's coverage history and primary
care physician history. Detailed benefits information provides copay information, current deductibles, and approved and remaining visits and days. For commercial plans Providers are able to see the exceptions and benefit riders in a clear, easy to read format.

**Claims Inquiries**
Claims can be viewed by status for any 30 day period, and searched by member, claim number, or date range. Most significant is that claims disposition codes are understandable and member responsibility on each claim is clearly displayed. Providers are able to see if there is a pre-existing condition, the authorization number and the line level detail for each claim. By clicking claim history, you can see exactly when we received the claim and how it was transmitted through our system and when.

**Remittance Advices**
Tired of waiting for remittance advices in the mail? directprovider.com has searchable and downloadable remittance advices in .pdf format right on line, without waiting. Remittances can be searched by check or EFT (electronic funds transfer) number, member name and date of birth, payment date, date of service, claim number, or member ID.

The home screen has sections for news, messages, and claims summary for quick links to claims by status.

![Image of the home screen with sections for news, messages, and claims summary for quick links to claims by status.](image)

**Resource Library**
The resource library contains critical forms and manuals for the health plan. It also contains the authorization criteria the health plan uses to guide them to a decision on an authorization request. Providers can view technology assessments that review all the latest treatments and devices. All documents can be printed directly from your screen or downloaded to your personal computer.
Future Developments
Future services that will become available at directprovider.com include viewable member ID cards, secure messaging, authorization lookup and submission, enhanced reporting, and direct claim submission and correction for providers and trading partners. Be sure to keep an eye out for all the latest updates from your Coventry health plan.

How Do I Sign Up?
If your organization has not yet signed up, simply identify who will be the account administrator, go to directprovider.com and click “Register” then fill out the online form. You will be emailed your temporary password within one business day.

If your organization has already registered, simply contact your site administrator who can immediately set up a temporary password for you.

eondeonoffice

Coventry Health Care of Georgia has also teamed up with emdeonOffice to provide your office tools to make your day to day activities in the office quicker and easier. Just imagine the ability to get the information you need when you need it. Just one simple click and you have at your fingertips, eligibility and co-pay information, authorizations and claims status. Imagine getting authorization approvals before the patient has left the building. All of this is possible now through our partnership with emdeonMD Office. We are continually adding and enhancing the services that we provide. The information provided below is just a sample of the services which are available. Please visit the Provider Channel of www.CHCGA.com for the latest products and services as well as Frequently Asked Questions for most services.

Services available through emdeon Office:

By logging onto emdeonoffice and selecting the Coventry HealthCare of Georgia plan, you can perform the following:

- Eligibility Inquiry
- Benefits Inquiry
- Claims Status Inquiry
- Authorization Status Inquiry
- Authorization Submission
**Electronic Remittance Advices**

Coventry Health Care of Georgia also provides other electronic solutions to our providers not associated with emdeon office.

**Electronic Funds Transfers** are available to transfer your claims payments directly to your bank account. Please contact our Provider Relations Department for more information and the necessary forms to set this option up.

**Interactive Voice Response System** is available through our Customer Service phone number at 1-800-395-2545 which allows you to check eligibility, claims and authorization status over the phone without speaking with a Customer Service Representative. You can also choose to get a faxed confirmation of the information you receive.
Health Insurance Portability and Accountability Act (HIPAA)

HIPAA is being addressed as a Coventry Health Care corporate priority. This section outlines our policies surrounding HIPAA.

Coventry has been working on compliance with the Health Insurance Portability and Accountability Act (HIPAA) since the regulations were first issued. Since then, we have established a corporate HIPAA Project Office and have developed a plan for implementation of the HIPAA Administrative Simplification requirements to be in compliance with the deadlines currently in place.

Our overall HIPAA task force includes representatives from each of the Coventry health plans. Our project team includes workgroups that focus on implementation of the privacy, security, transaction standards and code sets, as well as overall education and awareness within each of our health plans.

Since beginning this initiative, we have made significant progress and have every expectation to be in full compliance with each of the regulations by the respective compliance deadlines.

HIPAA Compliance

Coventry Health Care will be compliant with the Privacy Rule requirements by April 14, 2003 and the Standard Transaction Code Sets Rule requirements
by October 16, 2003. We anticipate being compliant with the National Employer Standard by July 30, 2004 and with the Security standards by April 21, 2005.

Coventry filed for the one-year extension on September 26, 2002 and will be fully compliant with HIPAA transactions and code sets by the October 16, 2003 mandatory compliance date. The additional time is allowing Coventry to address Final Rule Addenda updates as well as provide more time to test internally and with our trading partners. Coventry’s compliance extension form states we are filing on behalf of our corporate entities and health plans. Upon request, we can provide the extension confirmation number for each Coventry affiliated covered entity.

Coventry has developed privacy policies and procedures that meet the requirements of the privacy regulations. Coventry is in the process of training all of its employees on privacy policies and procedures and implementing these policies and procedures across all health plans and affiliated entities.

The transactions and code sets effort is primarily in the testing phase. Coventry began testing with some trading partners for some transactions in September 2002. Testing and implementation timelines with trading partners varies by health plan and transaction.

This website will be updated as further information on our progress towards compliance becomes available. Coventry will continue to communicate any pertinent HIPAA updates in our provider newsletters. You may also contact your Coventry Provider Relations Representative if you have additional questions.

Coventry is working with its clearinghouses to educate providers about the changes HIPAA will bring and what Coventry is doing. We will also look to the provider community for their commitment to work together to achieve a smooth transition. Coventry will focus on communicating information related to the transactions and code sets along with other changes that impact our business relationships. Providers should consult their associations, medical societies, vendors or legal counsel about changes that they need to make in their offices.
HIPAA Electronic Transactions

Coventry will conduct standard transactions with business associates and covered entities as mandated by the HIPAA regulations. However, to the extent a transaction is not mandated, we will work with the submitter to determine if engaging in the standard transaction is in both parties' best interests.

Coventry will be ready to accept the standard transactions on or before October 16, 2003. The specific date will depend upon the trading partner and health plan.

Coventry began testing with external trading partners for some transactions in September 2002. Currently our testing efforts are expanding to include all transactions and trading partners. Coventry defines an "external trading partner" as those entities that transmit and connect directly to Coventry.

Coventry's designated clearinghouses and preferred gateways are WebMD Envoy and Gateway EDI. Coventry believes clearinghouses can provide support for the healthcare industry in addressing HIPAA requirements and in overcoming other connectivity challenges.

At this time, we do not accept claim transmissions (837) directly from providers. Claim transactions can be submitted to WebMD Envoy, Gateway EDI or another clearinghouse and your claims will be forwarded to us for processing.

Currently Coventry does not accept eligibility and benefit inquiries (270), claim status inquiries (276), or requests for authorization (278) directly from providers. These transactions can be submitted to WebMD Envoy or one of its channel partners, and WebMD Envoy will generate the appropriate compliant response transaction on Coventry's behalf.

Coventry utilizes SeeBeyond, an enterprise integration system, to manage trading partner exchanges and for transaction and code set validation.

Coventry uses Claredi, a third party testing and certification vendor, to test and confirm our ability to accept and generate HIPAA standard transactions.

Coventry strongly encourages, but will not require, certification for all trading partners to expedite the testing process. Coventry defines a "trading
partner" as those entities that submit transactions and connect directly with Coventry.

At this time, Coventry will continue to sponsor electronic claim transmission services free of charge. There may be fees for setup and connection to a clearinghouse incurred by the provider for electronic remittance advice and other transactions. Other possible costs to providers will be determined by their software vendor and will be based on necessary programming changes or modifications to the billing or practice management software or hospital information system.

Nothing in HIPAA precludes the submission of paper claims. However the spirit and intent of the legislation is to encourage electronic commerce in health care to reduce administrative costs. At this time, there is no surcharge for paper claim submission. Coventry's goal is to increase electronic transaction percentages after HIPAA is implemented.

A Functional Acknowledgement (997) will be sent by Coventry for all HIPAA batch transactions that are received.

**HIPAA CODE SET**

Coventry had adopted many proprietary or locally used codes. These codes served a purpose in the past, but today Coventry believes that replacing "homegrown" codes with standard codes is something that should be done regardless of whether it is required by HIPAA. Coventry is in the process of updating its provider contracts to reflect standard code sets.

Homegrown codes, as well as invalid ICD-9 and HCPCS codes, will be eliminated or replaced. In addition, no new non-compliant medical codes will be added by Coventry. Providers will be required to submit valid ICD-9-CM codes with the highest level of specificity (the correct number of digits) for payment.
Coventry providers should bill "unlisted" (unspecified) codes in cases where there is no national code to represent the service provided. These codes can be located in the *Current Procedural Terminology* manual.

Coventry will migrate to X12 Claims Adjustment Reason Codes for the 835 – Remittance Advice. Coventry has mapped all current disposition codes to valid X12 codes for use on the HIPAA compliant electronic remittance advice. Because the X12 codes are less descriptive than the current disposition codes used by Coventry, we will continue to store the original proprietary adjustment.
reason code in our system to assist in any provider questions.

Coventry is working with WebMD and requesting the X12 committee expand the standard adjustment reason codes available for use under HIPAA.

Paper remittance advices will continue to contain current Coventry disposition codes.

**Electronic Professional Claims Update**

**Top 10 HIPAA Errors**

1. **Missing Rendering Provider Name and Number**
   Rendering Provider name and information are required when different from the Billing Provider or Pay-To Provider. If the Rendering Provider is a person, both the first and last names are required. Use the Employer Identification Number (also known as Federal Tax ID) as the primary identification number. For some Coventry health plans (HealthAmerica, Southern Health Services, Carelink, Group Health Plan, and HealthCare USA) a secondary identification number is required. For all other health plans, a secondary identification number is recommended. Typically, the secondary identification number is the Medicare UPIN number or Facility ID number. See Coventry’s EDI claim submission guidelines for more details on the specific number required.

2. **Missing Service Facility Location**
   If the service was rendered in a place other than the patient’s home or at a different location than the address of the Billing Provider or Pay-to-Provider, then the Service Facility Location code and address are required.

3. **Incorrect usage of Billing/Pay-To Provider Specialty Information (Taxonomy Code)**
   Coventry will not require the Taxonomy code for adjudication. If you choose to submit the Taxonomy Code, you should only do so for the Rendering Provider (or the Billing/Pay-To Provider when there is no Rendering Provider).

4. **Missing Referring Provider Name and Number**
   Either the Employer Identification Number (also known as Federal Tax ID) or UPIN must be sent when a Referring Provider is submitted on the claim. If the Referring Provider is a person, both the first and last names are required.

5. **Missing Subscriber Demographic Information**
   The subscriber’s date of birth and gender are required.

6. **Missing Ordering Provider Name**
   If the Ordering Provider is supplied on the claim and is a person, both the first and last names are required.
7. **Repeating Provider Information in the Claim Header at the Service Line Level**
   Service line provider information should only be sent if the service line provider is different than the claim header provider. Also Coventry Health Care will not adjudicate claims to different providers at the line level. These claims should be submitted separately.

8. **Missing Insurance Type Code**
   If other payers are known to potentially be involved in paying the claim, the Insurance Type Code is required. Examples of Insurance Type Code are: Commercial, Medicare, Medicaid, or Medigap.

9. **Missing Admission Date for Inpatient Hospital Claims**
   The admission date is required on all claims when the patient was admitted to the hospital, including Ambulance claim. It is also required on all inpatient medical visit claims or encounters.

10. **Invalid Procedure Codes**
    All CPT and HCPCS codes, including any modifiers, must be valid on the date of service.

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**Electronic Institutional Claims Update**

**Top 10 HIPAA Errors**

1. **Missing Attending Physician Name and Number**
   Attending Physician name is required on all inpatient claims. If the Attending Physician is a person, both the first and last names are required. Use the Employer Identification Number (also known as Federal Tax ID) as the primary identification number. For some Coventry health plans (HealthAmerica, Southern Health Services, Carelink, Group Health Plan and HealthCare USA) a secondary identification number is required. For all other health plans, a secondary identification number is recommended. Typically, the secondary identification number is the Medicare UPIN number or Facility ID number. See Coventry's EDI claim submission guidelines for more details on the specific number required.

2. **Missing Operating Physician Name and Number**
   Operating Physician name is required when any surgical procedure code is listed on the claim. If the Operating Provider is a person, both the first and last names are required. Use the Employer Identification Number as the primary identification number. For some Coventry health plans (HealthAmerica, Southern Health Services, Carelink, Group Health Plan and HealthCare USA) a secondary identification number is required. For all other health plans, a secondary identification number is recommended. Usually the secondary identification number is the Medicare UPIN number.

3. **Subscriber's Group Number or Group Name**
Either the subscriber's insured group number or insured group name is required, but not both.

4. **Missing Subscriber Demographic Information**
The subscriber's date of birth and gender are required.

5. **Missing Service Line Date**
On outpatient claims, the service date is required at the service line level.

6. **Missing Unit or Basis for Measurement Code**
The Unit or Basis for Measurement Code (days, units, international unit or dosage) is required at the service line level.

7. **Missing Admission Date and Time**
The admission date and time are required on all inpatient claims.

8. **Missing or Invalid Patient Status Code**
The patient status code is required for all inpatient claims. This is the 2-digit code from box 22 of the UB-92.

9. **Incorrect use of Quantity (Day) Information**
The quantity fields are required to be populated on inpatient claims when covered, co-insured, life-time reserved, or non-covered days are reported. These quantity fields should not be used for outpatient claims.

10. **Invalid Procedure Codes**
All procedure codes, including modifiers, must be valid on the claim's date of service.
Future Communications

Coventry Health Care of Georgia will from time to time send out communications to your office which will contain important information about the management of our members. Please use this section to keep future communications in one spot for easy reference.