Participating Provider Manual

Providers

Hospitals

Ancillary Service Providers
HealthyCT (HCT) is a non-profit, commercial health insurance company focused on the people of Connecticut. Created as part of federal health care reform, HealthyCT is a “CO-OP,” or Consumer Operated and Oriented Plan. Our vision is to create an entirely new approach to health insurance; one that supports the delivery of high-quality, patient-centered medical care with strong physician-patient relationships at its foundation.

We are honored to have this privilege and we are looking forward to working with our members and their health care partners to change the way health insurance is delivered. We look forward to working together with you to help the citizens of Connecticut have access to high quality health care.

This Participating Provider Manual is not intended to be a complete explanation of services, benefits, limitations and exclusions related to HealthyCT products. Any discrepancies between the Manual and the applicable member plan document (Certificate of Coverage, or COC), policy or the Service Agreement (Plan documents) will be resolved in favor of and governed by the terms and provisions of those documents.

This Participating Provider Manual is also not intended to be a complete explanation of all provider rights and responsibilities. Please refer to your provider agreement for specific information. The relationship between HealthyCT and its contracted providers is that of independent contractors and neither HealthyCT nor any participating provider is an employee or agent of the other.
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Please visit www.healthyct.org/providers for more information and services, including our Provider Manual, news/updates, forms, member eligibility, copayments/deductibles, detailed claims/payment information and more. You will need to log into our secure Provider Portal to perform many administrative services.

**General Information**
- Confirm member eligibility 855-208-1641
-Copayment
-Claims Information
-Inquiries/Disputes (non-clinical)
-Be prepared to enter your NPI.

Online: www.healthyct.org/providers

**Network Partnerships**
- Check the status of an application (855-458-4928)
-Add or Remove a Provider from your Practice
-Contractual Inquiries

Follow prompts to a Network Specialist or Provider Advocate

**Fax Numbers**
- New Provider Requests: 203-774-5731
-Provider Updates: 203-774-5727
-Provider Advocates: 203-774-5733

Note: All providers associated with a group must be participating.

**Medical Management**

**General Requests, Prior Authorization, Appeals (Medical Necessity) and Notification**
Phone: 855-458-4928

**Case Management Services**
Fax: 855-817-5701

**Appeals (Medical Necessity)**
Fax: 855-817-5697

**Prior Authorization & Notification**
The prior authorization list is available in the online Provider Manual. Fax requests to the appropriate area below.

**Medical/Surgical, PT/OT, Chiropractic & Radiology Services:**
855-817-5696

**Home Care and Home Care IV Fusion Services:**
855-817-5702

**Behavioral Health Services:**
855-817-5703

**In-Patient Services:**
855-817-5704

**Electronic Claims Submission**
Payer ID or Carrier Code: Xerox/ACS: 77180
Emdeon: 45336
EDI Phone Support: 800-952-0495
Or Email Support: edicommercialsupportteam@xerox.com

**Electronic Funds Transfer & Electronic Remittance Advice via Emdeon**
Phone: 866-506-2830
Fax: 615-238-9615

Electronically enroll in EFT:
http://www.emdeon.com/epayment/

Electronically enroll in ERA:
http://www.emdeon.com/enrollment/

**NOTE:** You must be registered for ERA in order to enroll in EFT. For more information:
http://www.emdeon.com/resourcerepdfs/ePaymentEnrollment.pdf

**Services Provided by Separate Vendors**

**Catamaran (Pharmacy Benefit Manager)**
Customer Service: 855-577-6549
Prior Authorization
Phone: 800-626-0072
Fax: 866-511-2202

**Delta Dental (Dental Benefit Manager)**
Customer Service
Phone: 800-663-6435
Online: http://www.deltadentalnj.com/HealthyCT-AboutUs/

**Laboratory/Pathology**
HealthyCT has a preferred relationship with Quest Diagnostics and participating hospitals/hospital-affiliated laboratories or pathology groups.

Services rendered outside the state of Connecticut will be considered in-network when utilizing the PHCS Healthy Directions network only.
Automated Capabilities and Contact Information
We encourage you to take advantage of HealthyCT’s secured Provider Portal online. The portal enables you to perform numerous efficiency and cost saving functions by reducing or eliminating many manual, paper based tasks.

Our online automated tools allow you to do the following:
- Self-registration for you or your office staff;
- Access eligibility and member benefits;
- View member benefit accumulators;
- Receive reimbursement through direct deposit/electronic fund transfer (EFT);
- Receive automated electronic remittance advice (ERA);
- Review Explanation of Payments (EOP);
- Ability to search multiple member records at the same time;
- Check status of claims; and
- Access News, Forms and other important Provider content.

Standards of Participation Requirements
Your participation is determined by completion and acceptance of your participating provider agreement and credentialing application. To avoid delays in compensation and gaps in participation it is critical that you contact us whenever you are adding or deleting from your practice. It is also important that you maintain accuracy of your demographic information in CAQH, as well as informing us, as we are relying on this information for our provider directory and the claims payment system. Notification of your effective date will be given upon credentialing approval.

Individual vs. Group Agreements
- Individual providers are defined as those who provide us with a social security number or tax identification number (TIN) that is associated to their name alone.
- Group Providers are defined as those who provide us with a tax identification number (TIN) that is associated to either their name as a PC, LLC, Partnership or to a group business name. All eligible providers within a tax identification number (TIN) will be considered participating.
- If you are an individual provider and a member of a group practice you must sign an individual agreement in addition to the group agreement if you wish to be participating in both practices. A separate agreement is required for each tax identification number (TIN) which you bill under.

Changes to your Practice
New individual providers or providers joining a group practice must apply for participation and receive credentialing approval prior to rendering services to our members. In addition we must receive notification of providers leaving a group practice.

Changes to your panel (new patient acceptance)
We require written notice sixty (60) days prior to a provider closing their panel and no longer accepting new patients.
**Credentialing Standards**

The purpose of the credentialing program is to strive to assure that our network consists of quality providers who meet clearly defined criteria and standards. It is our objective to give access to quality care for our members.

The credentialing program has been developed in accordance with state, federal and NCQA accreditation guidelines. In accordance with those standards, you will not be considered a participating with our network until the credentialing process has been completed.

**Criteria**

This policy gives an overview of the criteria that are applied to applicants for initial participation, recredentialing and ongoing participation in our network. Please be aware that you will be recredentialed at least every thirty-six (36) months. Additionally, we will monitor sanctions on an ongoing basis.

The following represents the standards for participation in our network:

We require you to use the Council for Affordable Quality Healthcare (CAQH) application. We will use this as our sole source for credentialing as well as for the provider directory information. The advantage to using CAQH is that it provides a single, uniform online application allowing you to enter your information free of charge. You can then access, manage and revise your information at your convenience.

By completing and maintaining your CAQH application you will:
- Affirm the completeness and truthfulness of representations made in the application;
- Indicate a willingness to provide additional information required for the credentialing process;
- Authorize us to obtain information regarding your qualifications, competence or other information relevant to the credentialing review;
- Release us and our independent contractors, agents and employees from any liability connected with the credentialing review; and
- Provide current malpractice insurance coverage.

We will review the CAQH application for information, including, but not limited to:
- Inability to perform the essential functions of the position, with or without accommodations;
- Any restrictions on your practice;
- Illegal drug use;
- History of loss of license and/or felony convictions; and
- History of loss or limitation of privileges, or disciplinary actions.

As we progress through the credentialing process, we, or our designee, will conduct primary source verification to assure that you have:
- A current, unencumbered state medical license;
- A valid, unencumbered Drug Enforcement Agency (DEA) or Chemical Dependency Services (CDS) certificate, as applicable;
- Documentation of continuous work history for the previous five years, along with a written explanation of any gaps longer than six months (initial credentialing only). Example of gaps may include new practicing providers without work history, sickness or sabbaticals;
- Evidence of adequate education and training for the services you are contracting or contracted to provide;
• Evidence of admitting privileges in good standing, with no reduction, limitation or restriction of privileges, with at least one of our participating hospitals or surgery centers, or a documented coverage arrangement with a credentialed/contracted provider of a like specialty;

• Malpractice insurance coverage that meets the standards as set forth in your contract;

• Applicable supporting documentation; and

• An up-to-date attestation, confirming the correctness and completeness of the application.

If we are unable to recredential a practitioner within the thirty-six (36) month time frame because the practitioner is on active military assignment, maternity leave or a sabbatical, but the contract between the practitioner remains in place, we may require recredentialing of the practitioner upon his or her return. The practitioner must notify us as soon as possible, but no later than sixty (60) calendar days of his/her return and their license must be active before he or she resumes seeing patients. If either party terminates the contract or there is a break in service of more than thirty (30) calendar days we will initially credential the practitioner before the practitioner regains their participation status.

If a practitioner is administratively terminated for reasons beyond our control i.e. failure to provide completed credentialing information and then is reinstated within thirty (30) calendar days, we will recredential the practitioner as long as the practitioner provides documentation showing reasons for termination were beyond their control. We will initially credential the practitioner if reinstatement is more than thirty (30) days after termination.

**Leave Of Absence**

A participating independent Provider who is taking a leave of absence from their practice must submit a written notice to our credentialing department stating a start date for the contemplated leave of absence and estimated return date. All leave of absences are reviewed by the Chief Medical Officer or his/her designee. The written notice must contain a statement of your relevant activities during the leave of absence. No leave of absence may exceed twelve (12) months unless under special circumstances (i.e., service in the armed forces) which would be reviewed by the Chief Medical Officer or his/her designee.

If, during a leave of absence, you become due for recredentialing and are unavailable (a minimum of three attempts of contact must be made), you will be administratively terminated. Administrative terminations are reported to the credentialing committee. Upon return from leave of absence you may reapply through the credentialing department.

During a leave of absence, you may hire a locum tenens to work under your contract; however, if that timeframe should be greater than ninety (90) days, the locum tenens provider would be required to be fully credentialed through the credentialing department.

**Locum Tenens**

We recognize that provider offices and facilities occasionally need the services of locum tenens to cover for: vacations, leaves of absence, illness or accident; or, in the case of facilities, during recruitment periods or staffing shortages.
We will reimburse locum tenens providers at the participating provider rate who are providing services to our members on a short-term basis. Our policy is as follows:

- Locum Tenens are utilized by participating providers within their office setting or by a participating facility that has a short-term need for specific services.
- You must inform us of who the locum tenens provider is covering for.
- Credentialing of locum tenens by us is not required under NCQA credentialing standards. We do not assume responsibility for credentialing of locum tenens providers unless they are actively rendering services for more than 90 days.
- In all circumstances, the ultimate responsibility for ensuring the use of an appropriately trained and qualified locum tenens provider rests with the utilizing provider or facility.
- You are required to notify us of your intended use of a locum tenens prior to the use of such services. We will collect certain information about the locum tenens to aid in the appropriate and timely reimbursement of services provided.
- Locum tenens used by you must agree to accept our established reimbursement, and any other stipulations as desired by us.
- Military, maternity or sabbatical leave.

**Hospitals and Ancillary Service Providers**

We require initial participation review and recredentialing (at least every thirty six (36) months), in accordance with state, federal and NCQA accreditation guidelines for the following entities:

- Hospitals;
- Home health care agencies;
- Skilled nursing facilities (SNFs);
- Free-standing ambulatory surgical centers (ASCs), including abortion clinics; and
- Other providers as deemed necessary.

You must submit a signed hospital or ancillary provider contact and credentialing application and applicable supporting documentation for processing. The documentation, at a minimum, must include:

- Evidence of a current, unencumbered state facility license;
- Copy of a current accreditation certificate appropriate for the facility. If not accredited, a copy of the most recent Department of Health and Human Services (DHHS) certification review with any related corrective action plan (CAP) and DHHS CAP acceptance letter;
- Centers for Medicare/Medicaid Services (CMS) provider number;
- Professional and general liability insurance coverage that meets our requirements; and
- Overview of the facility’s quality improvement program (upon request).

You are responsible for ensuring that we have up-to-date contact information (including address, email address, telephone number and fax number) through the entire application process and during the term of your Agreement.

**Providers’ Rights**

**Right of Review**

You have the right to review information obtained by us for the purpose of evaluating your credentialing or recredentialing application. This includes non-privileged information obtained from any outside source (e.g., malpractice insurance carriers, state licensing boards, Board Certification or the National Provider Data Bank), but does not extend to review of information, references or recommendations protected by law from disclosure. You may request to review such information at any time by sending a
written request via letter or fax to us. We will notify you within five (5) five business days of the date and time when such information will be available for review at our credentialing department.

You have the right to request your status within our network. Upon written request, our credentialing department will provide details of your current status in the credentialing or recredentialing process.

**Notification of Discrepancy**

You will be notified via phone, letter or fax, when information obtained by primary sources varies substantially from information provided on your application. Examples of information at substantial variance include reports of a practitioner’s malpractice claim history, actions taken against your license/certificate, suspension or termination of hospital privileges or board certification expiration. You will be notified of the discrepancy during our primary source verification process. Sources will not be revealed if information obtained is not intended for verification of credentialing elements or is protected from disclosure by law.

**Correction of Erroneous Information**

If you wish to dispute the accuracy of information provided by a primary source, you must submit a written notice to us via letter or fax, along with a detailed explanation, to us. This notification must occur within five (5) business days of being notified a discrepancy or of your review of the credentialing file.

Failure to dispute the accuracy of any discrepancy in primary source information as provided in this section shall be deemed an acceptance by you of the information provided by the primary source and shall constitute a waiver of subsequent objections to that information.

Upon receipt of notification, we will re-verify the primary source information in dispute. If the primary source information has changed, correction will be made immediately to your credentialing file. You will be notified in writing, via letter or fax that the correction has been made to your file. If, upon re-review, the primary source information remains inconsistent with the information you provided, our credentialing department will notify you via letter or fax. You may then provide proof of correction by the primary source body to our credentialing department via letter or fax within ten (10) business days. We will repeat re-verification of primary source information if such documentation is provided.

You should submit correspondence regarding your rights to:

HealthyCT
Credentialing Department
35 Thorpe Avenue, Suite 104
Wallingford, CT 06492

These rights are distributed with initial credentialing and recredentialing mailings. Provider rights are also posted on our website, [www.HealthyCT.org](http://www.HealthyCT.org).

**Approval, Denial, or Termination of Credentialing Status**

Our Chief Medical Office/Medical Director or his/her designee reviews a listing of all providers, hospitals and ancillary service providers meeting our criteria and approves their admittance or continued participation in the network.

Please note, regardless of your rights for an appeal or fair hearing, we reserve the right to take immediate action if and when patient risk is identified. Any such action will become reportable to the
Connecticut State Licensing Board and to the National Practitioner Data Bank pursuant to the Quality Improvement Act of 1986 and to such other State or federal agencies as may be required by law.

Administrative denials and terminations are based on a provider’s failure to submit complete credentialing or recredentialing verification information in a timely manner, or on a failure to meet our standards of participation. These denials and terminations are not appealable but the provider may reapply by following the application process. Denials and terminations are for all lines of business, consistent with health plan, state and federal regulatory requirements and NCQA accrediting standards.

We rely on a peer review process, via our credentialing committee, to review files with a history of adverse actions. These actions include, but are not limited to, member quality of care complaints, potential quality indicators, impaired health, substance abuse, healthcare fraud and abuse, criminal history and similar conditions. This process determines whether you should be admitted or retained as a participant in our network. Notification of all decisions (approval, denial, limitation, suspension, or termination) will be made within sixty (60) days of the said decision. If the decision is anything but an approval, the notice will include the reason for the determination as well as instructions on how to appeal it or request a fair hearing.

The objective of the appeal is to provide a process of due diligence to those providers, hospitals or ancillary service providers whose participation in our provider network has been denied, reduced, suspended or terminated for Quality of Care concerns and/or disciplinary action taken for cause. The appeal process is an informal appeal and does not constitute a Fair Hearing; rather it is an opportunity for you to be heard. You may elect to appear for your appeal in person, via teleconference or submit additional information or reasoning on his/her behalf in writing. It is important to know that you may bypass the appeal and request a formal Fair Hearing.

**Appeal Process**

If you wish to appeal the decision, you must submit a written request within thirty (30) calendar days from the date of the notice of an adverse participation determination. An overview of the process is as follows:

- Upon receipt of the written request for an appeal, the Credentialing Manager will send you an Acknowledgement of Appeal. It will contain dates of upcoming committee schedules and time frames for which to submit additional written documentation.
- The requested appeal shall be held no more than forty-five (45) days from the date your request was received by the credentialing department.
- If a request for an appeal is not requested by the practitioner within thirty (30) days of the notice, the practitioner will be notified via correspondence of your denial/termination from the network due to your failure to request an appeal.
- A credentialing committee member will be excused from the proceedings if there is a semblance of competition or personal knowledge of or relationship with you.
- It is important to know that while the appeal process is not a legal judicial process, and no rules of any court apply, you have the right to be advised by and accompanied by an attorney or other person of your choosing.

**Fair Hearing**

**Fair Hearing Panel**
The credentialing committee chairperson or designee will appoint a hearing panel of at least three (3) providers and one (1) alternate who participates in our network.

- All hearing panel members and you must attend the fair hearing in person.
Employment by us, or any subsidiary or affiliate, or an independent contract with us or any subsidiary or affiliate, will not disqualify an individual from participation as a hearing panel member, provided such individual meets all other conditions for panel member or hearing officer status.

In the event that a fair hearing panel quorum is not met, the hearing officer may opt to grant continuance within forty five (45) calendar days from the date of the scheduled hearing.

Hearing Officer

- We shall appoint an independent hearing officer to preside at the hearing. The appointed hearing officer is not entitled to vote.

- The hearing officer will ensure that you and we have a reasonable opportunity to be heard and to present all relevant information in an efficient and expeditious manner, and shall ensure proper decorum is maintained. No person will be permitted to disrupt or otherwise interfere with the Fair Hearing. The hearing officer may, at his/her discretion, recess and reconvene the hearing from time to time to ensure a fair and adequate hearing.

- In addition to other rights and duties outlined herein, the hearing officer will be authorized to take the following actions:
  - Determine the order and procedure for presenting information during the hearing;
  - Determine which Fair Hearing panelist shall serve as the alternate;
  - Rule on procedural matters and disputes; and
  - Decide what information may be considered.

The powers and authority identified above are not exclusive; the hearing officer shall have full and sole authority to make any rulings on any matters regarding the hearing process.

You have the right to inspect and copy, at your expense, any non-privileged documents in the Credentialing Department possession or under its control containing information relied upon by us in recommending the proposed action. Such documents will be made available to you as soon as practicable following receipt of the practitioner’s hearing request.

The identity of panel members and the hearing officer shall be made known to you not less than twenty (20) business days prior to the hearing, and any challenge which reasonably can be made prior to the hearing shall be delivered in writing to the hearing officer not less than ten (10) business days prior to the hearing.

Your failure to appear at the hearing, or failure to appear prepared to proceed with the hearing at the appointed time, without good cause, will result in the credentialing committee action to be immediately final and not subject to further consideration or review, unless otherwise directed by the hearing officer.

The hearing officer will be empowered to grant a continuance upon agreement of the parties or upon a showing of good cause by the requesting party. Requests must be in writing and must be delivered to the hearing officer not less than ten (10) business days prior to the hearing. In his/her sole discretion and for good cause shown, the hearing officer may grant a request made less than ten (10) business days prior to the hearing if the request could not reasonably have been made within the prescribed time period.
Completion/Conclusion of Proceedings

The hearing process will be completed in a reasonable time. The hearing officer is available to assist the panel with guidance on any procedural matters that may arise during the deliberations.

Finality of Decision

- Within thirty (30) calendar days following the completion of the hearing, the credentialing department and practitioner will receive the hearing panel’s written decision.
- If the decision is made to terminate you from the network, the effective date of the termination shall be the date the officer releases his/her final decision on the case.
- The decision of the hearing panel will be final and not subject to further review and will be reported to the NPDB, as appropriate and as required.

Reapplication after Denial or Termination

If you have been denied or terminated due to quality of care issues may be required to wait three (3) years from the date the adverse decision is final and the applicant or affected party has exhausted all applicable hearing rights to reapply to the HCT network.

Reporting Requirements

We will comply with the reporting requirements of all applicable state and federal agencies, including, but not limited to the HCQIA, regarding adverse credentialing and peer review actions. All activities conducted pursuant to this appeals process are in reliance on the privileges and immunities afforded by the HCQIA and requirements of all applicable state and federal agencies.

Delegated Credentialing

We may delegate the responsibility for activities associated with credentialing and recredentialing verification. Credentialing procedures used by another entity may vary from our procedures, but must be consistent with our internal policies, state and federal regulatory requirements and NCQA accrediting standards. We do not authorize these entities to grant temporary privileges.

Prior to entering into a delegation agreement, and throughout the duration of any delegation agreement, the oversight of delegated activities must meet or exceed our standards. We will oversee delegated responsibilities on an ongoing basis through an annual audit, or more frequently if the delegated entity is placed on a corrective action plan.

We can revoke the delegation of any or all credentialing activities if the delegated entity is deemed noncompliant with established credentialing standards. We retain the right, based on quality issues, to terminate or restrict the practice of individual Providers, Organizational Providers and sites in its network, regardless of the credentialing delegation status of the group.

Terminated Contracts and Reassignment of Members

We may notify members directly if your participation status is terminated as a result of the recredentialing verification process. This does not relieve you of your obligation to notify your patients of any change in status. We will assist in the reassignment of these members to another contracted provider to assure continuity of care.
Provider Responsibilities
This section describes our standards on access to care, office site visits, medical record documentation, Member confidentiality, and Member marketing information for participating Providers. In applying the standards listed below, participating Providers have agreed they will not discriminate against any Member on the basis of age, race, creed, color, religion, sex, national origin, sexual orientation, marital status, physical, mental or sensory handicap, and place of residence or socioeconomic status. Also, participating Providers may not limit their practices because of a Member’s medical (physical or mental) condition or the expectation for the need of frequent or high cost care.

Provider Performance Data
All Providers and Organizational Providers must allow HealthyCT to use performance data. As contracted entities with HealthyCT all Practitioners and Organizational Providers are required to comply with the HCT quality improvement programs and HEDIS data collection to improve the quality of care and services and the member’s experience. This may include, but is not limited to, cooperation with potential quality of care investigations, facilitation of practice sight visits and medial record evaluations, collection and evaluation of data, and participation in the HealthyCT QI programs.

Practitioners and Organizational Provider will make the Member’s medical records and other personally identifiable information available to HCT for purposes including preauthorization, concurrent review, quality improvement, (including HEDIS data collection) and payment processing. Data may also be used for analysis and recovery of overpayments due to fraud and abuse. Medical records must be made available to the State for management audits, financial audits, program monitoring and evaluation, licensure or certification of facilities or individuals, and as otherwise required by state law. The Practitioners and Organizational Providers are required to HCT and the State, on request, all financial data and reports, and information concerning the appropriateness and quality of services provided, as require.

Aggregated and detailed data may also be used for:
- Peer performance comparisons for Quality Programs
- Our Advanced Practice Medical Payment Model for Patient Centered Medical Homes
- State of Connecticut’s Consumer Report Card

Access to Care

Primary Care Providers (PCP)
PCPs are required to act as a health care manager for members to arrange and coordinate their medical care, including but not limited to, routine care and follow-up care after the receipt of emergency services. The following represents our expectation for access to care.
- You must have 24/7 on-call capability
- Offer timely accessibility for appointments to members within the following guidelines:
  - **Medical**
    - Emergency Care = Immediate
    - Urgent Care = Within 24 Hours
    - Routine Care = Within 14 Days
    - Preventive Care/Routine Physical Exam = Within 4 Weeks
    - In Office Wait Time = Not to exceed 30 Minutes
    - Return Phone Calls (After Hours) for Urgent Problems = Within 30 Minutes
Behavioral Health

- Emergency Care = Immediate
- Non-Life Threatening Emergency = Within 6 Hours
- Urgent Care = Within 24 Hours
- Routine Care = Within 10 Business Days
- In Office Wait Time = Not to exceed 30 Minutes
- Return Phone Calls (After Hours) for Urgent Problems = Within 30 Minutes

Specialist

Provide continuity and coordination of care by sending a written report to PCPs regarding any and all treatment or consultation provided to members regardless of whether the service resulted from a PCP referral or the member made his/her own arrangements.

Patient Centered Medical Homes

Our vision is to develop a progressive health plan that facilitates the delivery of efficient, evidence-based medical care through a consumer-focused and patient-centered health care delivery model. We are dedicated to increasing the quality of care, stabilizing health insurance premium costs and providing access to affordable health insurance. To accomplish this vision, we will:

- Support the establishment of the patient-physician relationship and Patient Centered Medical Home as cornerstones of the health care delivery model
- Support the transition of primary care providers to a Patient-Centered Medical Home (PCMH) that requires the meaningful use of health information technology (for example, EMR/EHR, disease registries, and e-prescribing).
- Implement the use of clinical decision support (CDS) tools and systems to provide evidence-based information and treatment options to providers as a principal care management process
- Engage community-based resources to provide care coordination and continuity to at-risk patients
- Focus on contracting with providers that agree to care delivery practices (PCMH, EMR/EHR’s, electronic exchange of information, use of CDS tools, etc.) with exceptions for critical access/rural areas where providers may lack some of these capabilities.

Federally Qualified Health Center (FQHC)

Federally Qualified Health Centers are federally funded, nonprofit health centers which provide comprehensive preventive and primary care in areas where primary care resources are limited. Normally a team-based approach to primary care, relying on advanced practice nurses, physician assistants, and other non-physician practitioners as well as physicians. FQHCs offer “one-stop health care”—primary and preventive health care visits, lab services, dental and behavioral health services and case management all under the same roof.

Site Visits

The credentialing department will review and investigate all member complaints related to provider sites. We will request a site visit if there have been more than three (3) complaints filed within a twelve (12) month period of time or sooner depending on the severity of the complaint(s). Member complaints regarding practitioner office sites are forwarded to the QI Department where they are tracked and monitored on an ongoing basis. When the threshold for number of member complaints is met, the Provider Network Management staff conducts an on-site review of the practitioner’s office.

In addition to member complaints, sources for monitoring may also include:

- HCT staff concerns identified during Utilization Management, Disease Management, Complex Case Management, and/or Network related activities.
The Credentialing Committee may, at its discretion, also request a site visit to be conducted at any time as a result of any credentialing, recredentialing and/or ongoing monitoring activity.

HCT also monitors information from external sources, including media events which are screened on an ongoing basis. If the identified issue is related to the quality of a practitioner office site, it will be managed according to the standards established by this policy.

At a minimum, site visits are conducted within sixty (60) calendar days of the complaint threshold being met or sooner if the issue is of an urgent nature.

- Our Provider Advocate or designee will conduct the evaluation using our Site Evaluation Tool used to evaluate the following categories:
  - Physical accessibility, including compliance with the Americans with Disabilities Act;
  - Physical appearance;
  - Adequacy of waiting and examining room space;
  - Adequacy of Medical Treatment Record Keeping; and
  - Other, including safety.

Each criterion on the site tool is scored. There are several must pass elements:

- Medical records are stored in a secure area that is inaccessible to unauthorized individuals. The area is locked or someone is present at all times during open hours.
- A separate health record is maintained for each member.
- All controlled drugs are stored in locked areas at all times.

If any of the above elements are found to be defective, you will automatically fail your site visit and be asked to remediate in an expeditious manner. Otherwise, you must obtain a score of 85% or above. When appropriate, you will be asked to create a corrective action plan (CAP). It will outline the deficiencies found during the site visit and the actions that you are to put in to place to rectify the situation. The CAP will be approved by us. You will have six (6) months to complete the CAP. We will verify the results by reviewing our written documents and conducting a follow-up site visit.

Sites that comply with a CAP within the allotted time period will remain in our network. Our credentialing committee will consider administrative termination of network participation if you:

- Refuse an office site evaluation;
- Do not meet a CAP within the six (6) month timeline; or
- Refuse to participate in a CAP.

**Medical Records**

As per state and federal regulations pertaining to the documentation, retention and destruction of patient medical records, we require that patient medical records are retained for seven (7) years after the last treatment date, or three years from the patient’s death. There are different legal retention requirements for different types of reports and you are responsible for meeting all of those legal requirements.

If you close your practice you or your agent must inform patients by notice published in a local newspaper and send a letter to each patient seen within the past three years. According to Connecticut State Law (DPH Regs. 19a-14-44) the patient’s medical records must be kept sixty (60) days after the notice.
Hospitals have a longer retention policy as required by the state. We require all facilities to abide by the state and federal laws.

Patients shall have access to their medical records upon written request, or their duly authorized representative, you shall furnish a copy of the patient’s health record. This includes but is not limited to bills, radiology reports and/or films, copies of lab reports, records of prescriptions and any other information used in assessing the patient’s health condition. Records are to be released to patients within 30 days from the date the request is received. Any cost associated with copies of medical records must be in accordance with state regulations.

Medical Record Audits
We expect you to maintain a single, confidential medical record for each patient. This record includes documentation of all pertinent information regarding medical services rendered in the Primary Care Practitioner’s (PCP) office or other settings, such as, hospital emergency departments, inpatient and outpatient hospital facilities, specialist offices, the patient’s home (home health), laboratory and imaging facilities.

We may conduct medical record reviews. Medical record reviews assess the quality of medical record documentation and develop and implement initiatives to improve it, as necessary.

Medical records will be audited for the following standards:

- Medical records are stored in a secure manner that allows access to authorized personnel only. Protected Health Information (PHI) is protected against unauthorized or inadvertent disclosure and staff receives periodic training in confidentiality of Member information. Medical records are safeguarded against loss or destruction and are maintained according to state requirements.
- Complete and consistent documentation in patient medical records is an essential component of quality patient care. We adhere to medical record requirements that are consistent with national standards on documentation.
- Elements in the medical record are organized in a consistent manner, and the records are kept secure.
- Patient’s name or identification number is on each page of record.
- Entries are legible.
- All entries are dated.
- All entries are initialed or signed by the author.
- Personal and biographical data are included in the record.
- Current and past medical history including age appropriate physical exams, serious accidents, operations and illnesses are documented.
- Allergies and adverse reactions are prominently listed or noted as "none" or "NKA."
- Information regarding personal habits such as smoking and history of alcohol use and substance abuse (or lack thereof) is recorded when pertinent to proposed care and/or risk screening.
- An updated problem list is maintained.
- Patient's chief complaint or purpose for visit is clearly documented.
- Clinical assessment and/or physical findings are recorded. Appropriate working diagnoses or medical impressions are recorded.
- Plans of action/treatment are consistent with diagnosis.
- Unresolved problems from previous visits are addressed in subsequent visits.
- Follow-up instructions and time frame for follow-up or the next visit are recorded as appropriate.
• Current medications are documented in the record, and notes reflect that long-term medications are reviewed at least annually by the practitioner and updated as needed.
• Health care education provided to patients, family members or designated caregivers is noted in the record and periodically updated as appropriate.
• Screening and preventive care practices are in accordance with the HCT Preventive Health Guidelines.
• An immunization record is up to date (for members 21 years and under) or an appropriate history has been made in the medical record (for adults).
• Requests for consultations are consistent with clinical assessment/physical findings.
• Laboratory and diagnostic reports reflect practitioner review.
• Patient notification of laboratory and diagnostic test results and instructions regarding follow-up, when indicated, are documented.
• There is evidence of continuity and coordination of care between primary and specialty care practitioners or other providers.
• Documentation of referral services in the member’s medical record.
• Forwarding of pertinent information or findings to specialist.
• Entering findings of specialist in the member’s medical record.

Guidelines for Providers
The following represent guidelines that we promote and may monitor:
• Practice open physician/patient communication and to freely discuss available treatment options, including medication treatment options, with your patients regardless of the benefit coverage limitations. Providers shall not be penalized for discussing medically necessary or appropriate care and the available options with their patients.
• Adhere to our policies and administrative requirements as put forth in provider updates, newsletters, and your provider agreement with us, provider manual and on our website.
• Obtain informed consent prior to the start of any procedure or treatment.
• Maintain liability insurance coverage as required in the provider agreement.
• Utilize efficient delivery of medical services to maximize health care resources and improve the quality of care delivered.
• Refrain from rendering services to and billing for their family members (including in-laws).
• Adhere to proper coding procedures based on CMS (Centers for Medicare and Medicaid Services) and NCCI (National Correct Coding Initiative) edits.
• Submit claims with appropriate HCPC, CPT and/or Revenue Code on the applicable CMS-1500 or UB-04 billing form.
• Provide access to care twenty-four (24) hours a day, seven (7) days a week, 365 days a year. It is your responsibility to provide coverage when unavailable. Examples of acceptable after hour access and systems, and 24/7 coverage is as follows:
  o Answering service directing the member to the covering physician;
  o Voice mail directing the member to the covering physician;
  o Phone forwarded to physician, covering physician or other health care professional; and
  o Answering machine that provides Urgent/Emergent instructions (as the first point of instruction), contact information of the covering physician and an option to directly contact the provider or covering provider in case of emergencies. It is not acceptable if the answering machine only refers the member to the Emergency Room or to call 911.
• All providers associated with a group TIN will be compensated at a participating provider level of reimbursement.
Provider, Hospital and Ancillary Service Providers Terminations

You are required to submit a written notification of the intent to terminate per your Agreement with us. Once received, we will initiate the process to notify affected members and to launch initiatives to assure continuity of care and safety of our members in compliance with state and federal mandates as well as NCQA standards.

At least thirty (30) calendar days prior to the termination date, we will provide written notification to members affected by the termination of a provider or practice group in general, family and internal medicine or pediatrics, and help them select a new practitioner.

Members affected by your termination are identified by those for which there have been claims paid to the office within the last twelve (12) months.

Members will have continued access to you, as follows.

- Continuation of treatment through the current period of active treatment, or for up to ninety (90) calendar days, whichever is less, for members undergoing active treatment for a chronic or acute medical condition; and
- Continuation of care through the postpartum period for members in their second or third trimester of pregnancy.

We will determine if there are pending prior authorizations or if members are in case management. We will send necessary communications to the terminating provider, hospital and ancillary service providers as well as the affected members according to state law. Members in our case management or disease management programs will be called by their case management nurse who will assist them with continuity of care.

Overview of Product(s)

Product Features

We offer commercial medical benefits to individuals and employer groups.

- All plans cover the Essential Health Benefits;
- In-network and out-of-network coverage;
- PCP selection is not required, but strongly suggested;
- All plans include an out-of-pocket maximum to limit the financial exposure for our members. Co-payments, deductibles, and co-insurance may apply; and
- Office visits for primary care, behavioral health and specialists are covered prior to the deductible for many of our plans.

Plan Descriptions

Our mission is to improve the health and wellness of your members. We offer a variety of health care plans tailored to meet the individual needs of your members. All of our plans provide the same comprehensive set of medical benefits including office visits to family doctors, specialists and behavioral health clinicians, emergency room care, hospital stays, outpatient surgery and prescription drugs.

Please refer to [www.healthycare.org](http://www.healthycare.org) for plan descriptions.
Member Eligibility and Benefits

Our members will be provided an identification card that they should present to you at the time of their visit. It is recommended that you verify eligibility each time a member receives services.

How to check member eligibility:

- IVR Interactive Voice Recognition – 24/7
- Online Provider Portal - 24/7
- Provider Service – 8am – 6pm EST, 855-208-1641

Individual / Family Identification Card Sample

The following are samples of our ID cards. Each unique member could have their own ID card. Upon renewal, dependents will appear on the same ID card as the subscriber.

ID Card Legend

Located in Member ID#:

- NX = ON Exchange
- FX = OFF Exchange
- ####= Last 3 digits represent individual person identifier

Located in the Group ID#:

- I = Individual/Family
- S = Small Group
- P = SHOP (small group health options plan)
- L = Large Group

Individual/Family Identification Card Sample

John E. Appelseed
Healthy Partner Preferred
ID HCTFX123456789001
Group HCTFX1435849
BIN 610011
PCN IRX
RX Group HCT
Plan Code 060
Payer# 77180

This card does not guarantee eligibility for coverage.
Member Grace Period

The grace period can last one month or three months, depending on certain circumstances:

- **One-month Grace Period**: For members who don’t get a government tax credit, or subsidy, that pays part of their premium.
- **Three-month Grace Period**: For members who get a government subsidy by purchasing their coverage at Access Health CT (the Exchange). Members who enrolled at Access Health CT have the letters “NX” in their member ID number.

Confirming Member Eligibility

Please be sure to confirm your patients’ eligibility and grace period status prior to providing services. This is especially important if the letters “NX” appear in their member ID number. To verify this information, you must call 1-855-208-1641, Monday through Friday, 8:00am-6:00pm (ET).

Exclusions and Limitations

The following is a list of services, supplies, etc., that are excluded and/or limited. Refer to the members Certificate of Coverage for specific information.

1. Abdominoplasty, lipectomy, and panniculectomy.

2. All assistive communication devices.

3. Ambulance services that are non-Medically Necessary, including chair car to and from a provider’s office for routine care or if the transport services are for a Member’s convenience, except for transportation costs related to transplants. See Benefits Section for Inpatient Services - Transportation, Lodging and Meal Expenses for Transplants.

4. Any Treatment for which there is Insufficient Evidence of Therapeutic Value for the use it is being prescribed for.

5. Any treatment or service related to the provision of a non-covered benefit, including educational and administrative services related to the use or administration of a non-covered benefit, as well as evaluations and medical complications resulting from receiving services that are not covered (“Related Services”), unless both of the following conditions are met:
• The Related Services are Medically Necessary acute inpatient care services needed by the Member to treat complications resulting from the non-covered benefit when such complications are life threatening at the time the Related Services are rendered, as determined by us, and
• The Related Services would be a Health Service if the non-covered benefit was covered by the Plan.

6. Attorney fees.

7. Behavioral conditions with the following diagnoses:
• Caffeine-related disorders,
• Communication disorders,
• Learning disorders,
• Mental retardation,
• Motor skills disorders,
• Relational disorders,
• Sexual deviation, or
• Other conditions that may be a focus of clinical attention not defined as mental disorders in the most recent edition of the American Psychiatric Association’s “Diagnostic and Statistical Manual of Mental Disorders.”

8. Benefits for services rendered before the Member's Effective Date under this Plan or after the Plan has been rescinded, suspended, canceled, interrupted or terminated, except as otherwise required by the law.


10. Cardiac rehabilitation for Phase IV.

11. Care, treatment, services or supplies to the extent the Member has obtained benefits under:
• Applicable law,
• Government program,
• Public or private grant, or
• Any plan or program for which there would be no charge to the Member in the absence of this Plan.

However, services obtained in a Veteran’s Home or Hospital for a non-service connected disability, or as required by the law, are covered. Also covered is care, treatment or services that are otherwise Medically Necessary and provided in a Veteran’s Hospital.

12. Chiropractic manipulation of the cervical spine that is long term or maintenance in nature and spinal manipulation services to treat children 12 years of age or younger for any condition.

13. Clinical trial services as follows:
• Costs for non-Health Services,
• Costs of Experimental Or Investigational medications or devices not approved for sale by the FDA,
• Costs that are inconsistent with widely accepted and established regional or national standards of care for a particular diagnosis, or costs for services that are performed specifically to meet the requirements of the clinical trial,
• Costs that would not be covered by your Plan for a non-Experimental Or Investigational treatment,
• Facility, ancillary, professional services and/or medication costs paid for by grants or funding for the trial, and/or
• Transportation, lodging, food or other travel expenses for the Member or any family member or companion of the Member.

14. Concierge services (which means the fees a provider charges as a condition of selecting or using his/her services).

15. Cosmetic Treatments and procedures, including but not limited to:
• Abdominoplasty, partial abdominoplasty, repair of diastasis recti, abdominal liposuction or suction assisted lipectomy of the abdomen,
• Any medical or Hospital services related to Cosmetic Treatments or procedures,
• Benign nevus or any benign skin lesion removal (except when the nevus or skin lesion causes significant impairment of physical or mechanical function),
• Benign seborrheic keratosis,
• Blepharoplasty unless the upper eyelid obstructs the pupil and blepharoplasty would result in a significant improvement in the upper field of vision.
• Body piercing,

• Breast augmentation, (except as described in the "Reconstructive Surgery" or "Durable Medical Equipment (DME) Including Prosthetics" subsections of the "Benefits" section or as otherwise required by the law),
• Dermabrasion or other procedures to plane the skin, including, but not limited to:
• Acne related services such as blue light treatment of acne, injections to raise acne scars, and removal of acne cysts,
• Electrolysis,
• Excision of loose or redundant skin and/or fat after the Member has had a substantial weight loss,
• Facelift surgery or rhytidectomy,
• Injection of collagen or other fillers or bulking agents to enhance appearance,
• Liposuction,
• Otoplasty,
• Phototherapy or laser therapy for the treatment of skin conditions, except for the treatment of psoriasis,
• Reversal of inverted nipples,
• Scar revision, septorhinoplasty, or rhinoplasty, Skin tag removal,
• Spider vein removal (including, but not limited to sclerotherapy),
• Tattooing or removal,
• Thigh, leg, hip, or buttock lift procedures,
• Treatment of craniofacial disorders, except as otherwise described in the “Craniofacial Disorders” subsection of the “Benefits” section,
• Treatment of melasma,
• Varicose vein treatment, except when there is a history of ulcers or bleeding from a varicose vein and/or severe venous insufficiency as defined by HealthyCT, and
• Vascular birthmark removal.
16. Custodial Care, convalescent care, domiciliary care, long term care or rest home care. Also care provided by home health aides that is not patient care of a medical or therapeutic nature and care provided by non-licensed professionals.

17. Dental services, except as otherwise described in the “Benefits” section or any supplemental Rider or endorsement to this Policy.

18. Educational services, except as otherwise described in the “Autism Services” or “Birth To Three Program (Early Intervention Services)” sections:
   - Screening and treatment associated with learning disabilities
   - Special education and related services
   - Testing, training, rehabilitation for educational purposes


20. Experimental or Investigational treatment, except as otherwise described in the “Bypassing The Internal Appeal/Grievance Process” subsection of the “Claims Filing, Questions And Complaints, and Appeal/Grievance Process” section.

21. Family planning and Infertility services, including but not limited to:
   - Contraceptive drugs and devices, except to the extent insurance law requires coverage for these items. When they are covered, they are covered under the “Prescription Contraception” subsection of the “Benefits” section,
   - Home births (except that complications of home births are covered),
   - Infertility services not specifically covered under the “Infertility Services” subsection of the “Benefits” section or under Prescription Drug Benefit, including but not limited to:
     - Cryopreservation (freezing) or banking of eggs, embryos, or sperm,
     - Genetic analysis and testing, except as described in the “Infertility Services” or “Genetic Testing” subsections of the “Benefits” section including, but not limited to:
       - All other genetic testing services, as well as genetic testing panels not endorsed by ACOG or ACMG,
       - Genetic testing kits available either direct to the consumer or via a physician prescription,
       - Genetic testing only for the benefit of another family member,
       - Genetic testing to guide personalized medicine,
       - Pharmacogenetics or Pharmacogenomics, and
       - Whole genome or whole exome genetic testing,
     - Medications and devices for sexual dysfunction,
     - Recruitment, selection and screening, and any other expenses of donors (donors of eggs, embryos, and sperm),
     - Reversal of surgical sterilization,
     - Surrogacy and all charges associated with surrogacy such as prescription drugs or egg harvesting, fertilization or implantation, except when the egg harvesting is performed on the Member.
   - Labor doulas and labor coaches.

22. Gynecomastia surgery.

23. Health club membership and exercise equipment.
24. Home health aide care that is not patient care of a medical or therapeutic nature.

25. Hypnosis, (except as an integral part of psychotherapy), biofeedback (except when ordered by a physician to treat urinary incontinence) and acupuncture (except for Pain Management when medically necessary).

26. Infant formulas, food supplements, nutritional supplements and enteral nutritional therapy, except as provided in the "Nutritional Supplements and Food Products" subsection of the "Benefits" section or under our Prescription Drug Benefit.

27. Massage, except when part of a prescribed physical or occupational therapy program if that program is a covered benefit.

28. Medical supplies, equipment or prosthetics that are not durable or that are not on our list of covered equipment.

Examples of excluded equipment include, but are not limited to:
- Any item not primarily medical in nature or not mainly used in the treatment of disease or injury,
- Any item or service which is not covered by the federal Medicare program,
- Assistive technology and adaptive equipment, including but not limited to:
  - Communication boards, computers, equipment or devices,
  - Gait trainers,
  - Prone standers,
  - Supine boards,
  - Other equipment not intended for use in the home,
- Beds, bedding and bed-related items,
- Clothing or body wear, except as otherwise covered in the “Benefits” section,
- Comfort or convenience items, including but not limited to:
  - Furniture or modifications to furniture,
  - Home climate control devices,
  - Tubs, spas or saunas,
- Compression and cold therapy devices,
- Compression or antiembolism stockings,
- Cryotherapy; polar packs,
- Exercise equipment,
- Foot orthotics, except if the Member is diabetic,
- Hearing aids, except as described in this subsection,
- Home or automobile equipment or modifications,
- Items used to perform or assist with personal hygiene,
- Lifts of any type,
- Mechanical stretch devices for treatment of joint stiffness (pre- or post-surgery) or joint contractures,
- Myoelectric or electronic prosthetic devices,
- Power mobility devices, such as wheelchairs, scooters and stairway lifts
- Pneumatic compression devices for the treatment of lymphedema or the prevention of deep vein thrombosis,
• TENS units or other neuromuscular stimulators and related supplies, either internal or external, for the treatment of pain or other medical conditions,
• Wigs, hair prosthetics, scalp hair prosthetics or cranial prosthetics, except as described in the “Benefits” section.

29. New Technology for which we have not yet made a coverage policy.

30. Non-Medically Necessary ambulance/medical transportation services.

31. Non-licensed professionals.

32. Non-Medically Necessary services or supplies.

33. Non-medical supportive counseling services (individual or group) for alcohol or substance abuse (e.g., Alcoholics Anonymous).

34. Non-surgical treatment of Temporomandibular joint (TMJ) dysfunction or Temporomandibular disease (TMD) syndrome. This exclusion includes but is not limited to the following: behavioral modification, physical therapy, appliance therapy such as occlusal Appliances (splints) or adjustments, and Prosthodontic therapy.

35. Overnight or day camps focused on illness or disability.

36. Over-the-counter (OTC) items of any kind, including but not limited to home testing or other kits and products, except as provided in the “Benefits” section of the COC.

37. Physical therapy, occupational therapy, speech therapy or chiropractic therapy that is long term or maintenance in nature.

38. Private room accommodations or private duty nursing in a facility.

39. Routine foot care (except when the Member is a diabetic), including, but not limited to: the evaluation or treatment of subluxations (structural misalignments of the joints) of the feet, and the elevation or treatment of flattened arches and the prescription of supportive devices.

40. Routine physical exams at an Urgent Care Center.

41. Sensory and auditory integration therapy, unless covered under the “Autism Services” or “Birth To Three Program (Early Intervention Services)” subsections of the “Benefits” section.

42. Services and supplies exceeding the benefit maximums.

43. Services and supplies not specifically included in this document.

44. Services or supplies rendered by a physician or provider to himself/herself, or rendered to his/her family members, such as parents, grandparents, spouse, children, step-children, grandchildren or siblings.

45. Services required by or received at a Wilderness Camp or a boarding school, including:
  • Medications, including prophylactic, Physical examinations, blood tests, Supplies,
  • Vaccinations/immunizations.
46. Services required by third parties or pursuant to a court order, including:
   - Blood tests,
   - Medications, including prophylactic,
   - Physical examinations,
   - Supplies,
   - Vaccinations/immunizations.

47. Services obtained for foreign or domestic travel, including:
   - Camp,
   - Employment,
   - Insurance,
   - Licensing,
   - Pursuant to a court order,
   - School.

48. Solid organ transplant and bone marrow transplant transportation costs, including, but not limited to:
   - Any expenses for anyone other than the transplant recipient and the designated traveling companion,
   - Any expenses other than the transportation, lodging and meals described in the “Benefits” section,
   - Local transportation costs while at the transplant facility,
   - Rental car costs.

49. Speech therapy for stuttering, lisp correction or any speech impediment not related to illness or injury, except as described in the “Benefits” section.

50. Sports medicine clinic services and treatments and the services of a personal trainer. In addition, there is also no coverage for any diagnostic services related to any of these programs, services or procedures.

51. Surgical procedures using an artificial disc.

52. Third party coverage, such as other primary insurance, Workers' Compensation and Medicare will not be duplicated.

53. Transportation, accommodation cost, and other nonmedical expenses related to Health Services (whether they are recommended by a physician or not), except as otherwise described in the “Benefits” section.

54. Treatment of snoring, including, but not limited to:
   - Laser-assisted uvulopalatoplasty,
   - Snore guards,
   - Somnoplasty, and any other snoring-related appliances.

55. Ventricular assist devices, except for bridge to heart transplantation.

56. Vision services including, but not limited to:
• Adult routine eye care, eye glasses and contact lenses,
• Eye surgeries and procedures primarily for the purpose of correcting refractive defects of the eyes, including, but not limited to:
  o Laser surgery,
  o Orthokeratology, and
  o Radial keratomy,
• Vision and hearing examinations (except as described in the “Eye Care” and “Hearing Screenings” subsections of the “Benefits” section),
• Vision therapy and vision training.

57. War related treatment or supplies, whether the war is declared or undeclared.

**Member Disenrollment**

We reserve the right to terminate coverage for members who:

- Are no longer eligible;
- Fail to pay their monthly premium and exhaust the applicable grace period;
- Commit fraud;
- Commit acts of physical or verbal abuse; or
- Persistently refuse to comply with medically necessary treatments.

You are responsible for seeking reimbursement from members who have been terminated if the services were rendered after the member’s termination date.

**Members’ Rights and Responsibilities**

This section explains the rights and responsibilities of our members as written in the member handbook. Also included in this section is information about providing interpreter services and enrollee self-determination regarding advance directives and organ donation.

**Member Rights**

HealthyCT (HCT) is committed to treating its members in a manner that respects their rights as well as providing access to quality health care. The following are the members’ rights and responsibilities:

**Member Rights:**

- A right to receive information about HCT, its services, its practitioners and providers and member rights and responsibilities.
- A right to be treated with respect and recognition of their dignity and their right to privacy.
- A right to participate with practitioners in making decisions about their health care.
- A right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- A right to voice complaints or appeals about HCT or the care it provides.
- A right to make recommendations regarding HCT’s member rights and responsibilities policy.

**Member Responsibilities:**

- A responsibility to supply information (to the extent possible) that HCT and its practitioners and providers need in order to provide care.
- A responsibility to follow plans and instructions for care that they have agreed to with their practitioners.
A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

**Interpreter Services**

All eligible Members who are Limited English Proficient (LEP) are entitled to receive interpreter services for all types of appointments and for assistance with filing a complaint or appeal. These services are at no cost to the Member. An LEP individual may have a limited ability or inability to read, speak, or write English well enough to understand and communicate effectively. You are responsible for assuring interpreter services are made available.

**Enrollee Self Determination**

Advance Directives are a written choice for health care. There are two (2) types of Advance Directives in CT; the living will and the appointment of a health care representative. Written Advance Directives tell you how your patient chooses to receive medical care in the event they are unable to make end-of-life decisions. You must honor Advance Directives to the fullest extent permitted by law.

You must document the presence of an Advance Directive in a prominent location of the medical record. You must also discuss Advance Directives with a member and provide appropriate medical advice if the Member desires guidance or assistance. Under no circumstances may you refuse to treat a patient or otherwise discriminate against a patient because they have completed an Advance Directive.

**Health Care Representative**

A Health Care Representative is authorized to make any and all health care decisions on the behalf of your patient when they cannot make the choices for themselves. This includes making the decision whether to withhold or withdrew life support systems.

**Living Will**

A living will is a document that states a patient’s wishes regarding any kind of health care they may receive. This document can also tell you whether they want life support systems to keep them alive or whether they do not want to receive such treatment, even if it results in death.

**Claims Administration**

The claim operations department processes all medical claims received from you utilizing standard claim forms. We accept the standard UB04 and CMS1500 claim forms when billing claims via paper. We accept electronic billing using EDI technology and encourage providers to utilize electronic capability whenever possible. All claims received are edited from a data completeness perspective to ensure that we have all of the necessary information required to process a claim. If a claim is billed with incomplete data, we will try to obtain the necessary information in order to expedite the claim processing timeframes. Our goal is to ensure accurate and timely claim processing in order to meet our contractual and regulatory obligations.

**Clinical Documentation**

Clinical Documentation may be needed in order to adjudicate a claim. Examples include, but are not limited to:

- Supporting documentation for use of modifier 22; and
- Documentation for unlisted codes.
**Claim Submissions**
We accept both electronic and paper claim submissions. We strongly encourage the use of electronic submission as it is the most effective and efficient means of claims submission.

**Electronic Claim Submissions**
We accept claims through the Xerox EDI Gateway as well as Emdeon. Contact your clearinghouse for more specific information on submitting electronic claims.

**Paper Claim Submissions**
Paper claims for medical, behavioral health and vision can be submitted to:
HealthyCT
PO Box 33728
Indianapolis, IN 46203-0728

**Clean Claim Requirement**
We follow Connecticut General Statutes with regards to claim payment timeframes. If a claim does not contain all the information necessary for payment, we have thirty (30) days to request additional information and thirty (30) days after receiving the requested information to pay the claim without interest.

For information submitted on a CMS 1500 form, as periodically updated and revised, the following minimum requirements must be complete and received by the insurer before the form will be considered a claim.

<table>
<thead>
<tr>
<th>Item Number</th>
<th>Item Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a</td>
<td>Insured’s ID number</td>
</tr>
<tr>
<td>2</td>
<td>Patient’s name</td>
</tr>
<tr>
<td>3</td>
<td>Patient’s birth date and sex</td>
</tr>
<tr>
<td>4</td>
<td>Insured’s name</td>
</tr>
<tr>
<td>10a</td>
<td>Patient’s condition – employment</td>
</tr>
<tr>
<td>10b</td>
<td>Patient’s condition – auto accident</td>
</tr>
<tr>
<td>10c</td>
<td>Patient’s condition – other accident</td>
</tr>
<tr>
<td>11</td>
<td>Insured’s policy group number (if provided on I.D. card)</td>
</tr>
<tr>
<td>11d</td>
<td>Is there another health benefit plan?</td>
</tr>
<tr>
<td>17a</td>
<td>I.D. number of referring physician (if required by insurer)</td>
</tr>
<tr>
<td>21</td>
<td>Diagnosis</td>
</tr>
<tr>
<td>24A</td>
<td>Dates of service</td>
</tr>
<tr>
<td>24B</td>
<td>Place of service</td>
</tr>
<tr>
<td>24D</td>
<td>Procedures, services or supplies</td>
</tr>
<tr>
<td>24E</td>
<td>Diagnosis code</td>
</tr>
<tr>
<td>24F</td>
<td>Charges</td>
</tr>
<tr>
<td>24G</td>
<td>Days or Units</td>
</tr>
<tr>
<td>Item Number</td>
<td>Item Description</td>
</tr>
<tr>
<td>-------------</td>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td>24I</td>
<td>ID Qualifier - NPI</td>
</tr>
<tr>
<td>24J</td>
<td>Rendering Provider ID #</td>
</tr>
<tr>
<td>25</td>
<td>Federal tax I.D. number</td>
</tr>
<tr>
<td>28</td>
<td>Total charge</td>
</tr>
<tr>
<td>31</td>
<td>Signature of physician or supplier with date</td>
</tr>
<tr>
<td>33</td>
<td>Physician’s, supplier’s billing name, address, zip code &amp; phone</td>
</tr>
</tbody>
</table>

For information submitted on a HCFA UB-04 form, as periodically updated and revised, the following minimum requirements must be complete and received by the insurer before the form will be considered a claim.

<table>
<thead>
<tr>
<th>Item Number</th>
<th>Item Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Provider name and address</td>
</tr>
<tr>
<td>5</td>
<td>Federal tax I.D. number</td>
</tr>
<tr>
<td>6</td>
<td>Statement covers period</td>
</tr>
<tr>
<td>12</td>
<td>Patient name</td>
</tr>
<tr>
<td>14</td>
<td>Patient’s birthdate</td>
</tr>
<tr>
<td>15</td>
<td>Patient’s sex</td>
</tr>
<tr>
<td>17</td>
<td>Admission date</td>
</tr>
<tr>
<td>18</td>
<td>Admission hour</td>
</tr>
<tr>
<td>19</td>
<td>Type of admission</td>
</tr>
<tr>
<td>21</td>
<td>Discharge hour</td>
</tr>
<tr>
<td>42</td>
<td>Revenue codes</td>
</tr>
<tr>
<td>43</td>
<td>Revenue description</td>
</tr>
<tr>
<td>44</td>
<td>HCPCS/CPT4 codes</td>
</tr>
<tr>
<td>45</td>
<td>Service date</td>
</tr>
<tr>
<td>46</td>
<td>Service units</td>
</tr>
<tr>
<td>47</td>
<td>Total charges by revenue code</td>
</tr>
<tr>
<td>50</td>
<td>Payer I.D.</td>
</tr>
<tr>
<td>51</td>
<td>Provider number</td>
</tr>
<tr>
<td>58</td>
<td>Insured’s name</td>
</tr>
<tr>
<td>60</td>
<td>Patient’s I.D. number (policy number and/or social security number)</td>
</tr>
<tr>
<td>62</td>
<td>Insurance group number (if on I.D. card)</td>
</tr>
<tr>
<td>67</td>
<td>Principal diagnosis code</td>
</tr>
<tr>
<td>76</td>
<td>Admitting diagnosis code</td>
</tr>
<tr>
<td>80</td>
<td>Principal procedure code and date</td>
</tr>
<tr>
<td>81</td>
<td>Other procedures code and date</td>
</tr>
<tr>
<td>Item Number</td>
<td>Item Description</td>
</tr>
<tr>
<td>-------------</td>
<td>---------------------------------------</td>
</tr>
<tr>
<td>82</td>
<td>Attending physician’s I.D. number</td>
</tr>
</tbody>
</table>

For the purpose of this manual, the terms "claim for payment," "reimbursement to health care providers," "claim for reimbursement," "claim," "request," and "request for payment" used in the statute shall be collectively referred to as a "claim" or "claims."

**Claim Edits**

We review medical billing information and coding for accuracy and appropriateness. This is designed to detect coding patterns such as unbundling, integral procedures and mutually exclusive procedures. We will also develop payment policies that outline the appropriateness for billing scenarios that are applied after all other claim edits have already been applied. In cases where there is conflict between resources, we will apply the edits we deem most appropriate.

**Modifier Payment Policy**
Modifiers provide a means to report or indicate a service or procedure that has been performed, has been altered, or can be altered by a specific circumstance without changing the procedure code. Modifiers are used to ensure accuracy in proper coding, payment, and claims editing.

Please refer to the most updated industry standard coding guidelines for a complete list of modifiers and their usage.

The below Modifier Table may have an impact to claim payment. References to fee schedule are not a guarantee of payment.

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
<th>Compensation Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td>Unusual procedural services</td>
<td>Reviewed by Medical Director for additional compensation</td>
</tr>
<tr>
<td>25</td>
<td>Significant, separately identifiable E&amp;M service by the same physician on the same day as the procedure or other service</td>
<td>HCT fee schedule/allowed amount1</td>
</tr>
<tr>
<td>26</td>
<td>Professional component</td>
<td>HCT fee schedule/professional component allowed amount</td>
</tr>
<tr>
<td>33</td>
<td>To identify a preventive service for which patient cost sharing does not apply under the Patient Protection and Affordable Care Act, It is appropriate to use with a CPT code that is a diagnostic/treatment service being performed as a preventive service.</td>
<td>HCT fee schedule/allowed amount</td>
</tr>
<tr>
<td>50</td>
<td>Bilateral procedure</td>
<td>150% of HCT fee schedule/allowed amount</td>
</tr>
<tr>
<td>51</td>
<td>Multiple procedure</td>
<td>100%, 50%, 25%, of HCT fee schedule/allowed amount</td>
</tr>
<tr>
<td>52</td>
<td>Reduced services</td>
<td>50% of HCT fee schedule/allowed amount</td>
</tr>
<tr>
<td>53</td>
<td>Discontinued procedure</td>
<td>20% of HCT fee schedule/allowed amount</td>
</tr>
<tr>
<td>54</td>
<td>Surgical care only</td>
<td>80% of HCT fee schedule/allowed amount</td>
</tr>
<tr>
<td>55</td>
<td>Postoperative management only</td>
<td>10% of HCT fee schedule/allowed amount</td>
</tr>
<tr>
<td>56</td>
<td>Preoperative management only</td>
<td>10% of HCT fee schedule/allowed amount</td>
</tr>
<tr>
<td>Modifier</td>
<td>Description</td>
<td>Compensation Impact</td>
</tr>
<tr>
<td>----------</td>
<td>-------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>59</td>
<td>Distinct procedural service</td>
<td>50% of HCT fee schedule/allowed amount</td>
</tr>
<tr>
<td>62</td>
<td>Two surgeons</td>
<td>62.5% of the fee schedule allowed amount for each surgeon. Two surgeons: when two surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding the modifier ‘- 62’ to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s) are performed during the same surgical session, separate code(s) may also be reported with the modifier ‘-62’ added.</td>
</tr>
<tr>
<td>66</td>
<td>Surgical team</td>
<td>Pend and send to HCT for review; if allowed pay at 62.5% of HCT fee schedule</td>
</tr>
<tr>
<td>73</td>
<td>Discontinued Outpatient Procedure prior to Anesthesia administration</td>
<td>50% of HCT fee schedule/allowed amount</td>
</tr>
<tr>
<td>74</td>
<td>Discontinued Outpatient Procedure after Anesthesia administration</td>
<td>70% of HCT fee schedule/allowed amount</td>
</tr>
<tr>
<td>78</td>
<td>Return to the operating room for a related procedure during the postoperative period</td>
<td>80% of HCT fee schedule/allowed amount</td>
</tr>
<tr>
<td>80</td>
<td>Assistant surgeon</td>
<td>16% of HCT fee schedule/allowed amount - This assistant at surgery is providing full assistance to the primary surgeon. This modifier is not intended for use by non-physicians assisting at surgery (e.g. Nurse Practitioners or Physician Assistants).</td>
</tr>
<tr>
<td>81</td>
<td>Minimum assistant surgeon</td>
<td>16% of HCT fee schedule/allowed amount - 81 represents minimal assistant at surgery by another physician. This assistant at surgery is providing minimal assistance to the primary surgeon. This modifier is not intended for use by non-physicians assisting at surgery (e.g. Nurse Practitioners or Physician Assistants).</td>
</tr>
<tr>
<td>82</td>
<td>Assistant surgeon (when qualified resident surgeon not available)</td>
<td>16% of HCT fee schedule/allowed amount - 82 represents assistant at surgery by another physician when a qualified resident surgeon is not available to assist the primary surgeon. This modifier is not intended for use by non-physicians assisting at surgery (e.g. Nurse Practitioners or Physician Assistants).</td>
</tr>
<tr>
<td>Modifier</td>
<td>Description</td>
<td>Compensation Impact</td>
</tr>
<tr>
<td>----------</td>
<td>-------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>AS</td>
<td>HCPCS Level II modifier – represents a non-physician assisting at surgery.</td>
<td>14% of HCT fee schedule/allowed amount -</td>
</tr>
<tr>
<td>LL</td>
<td>Lease/rental</td>
<td>HCT DME fee schedule/Rental fee</td>
</tr>
<tr>
<td>MS</td>
<td>6 month maintenance and servicing fee</td>
<td>HCT DME fee schedule/Rental fee</td>
</tr>
<tr>
<td>RR</td>
<td>Rental equipment</td>
<td>HCT DME fee schedule/not to exceed purchase price</td>
</tr>
<tr>
<td>SA</td>
<td>Nurse practitioner—Non-surgical (PCNS, APRN, RNCS)</td>
<td>85% of HCT’s applicable physician fee schedule/allowed amount, when billed by a psychiatrist</td>
</tr>
<tr>
<td>SL</td>
<td>State-supplied vaccine</td>
<td>0% of HCT fee schedule/allowed amount</td>
</tr>
<tr>
<td>TC</td>
<td>Technical component</td>
<td>HCT fee schedule/technical component allowed amount</td>
</tr>
</tbody>
</table>

**Claim Payments**

Claims are processed and remitted on a weekly basis. Payments are issued through electronic fund transfers or paper checks. An ERA or paper explanation of payment will be generated to be sent along with the monies reimbursed.

**Member Grace Period**

What happens to claims during the Grace Period:

- We will continue to pay members’ claims for services received during a one-month grace period or during the first month of a three-month grace period.
- We will pend claims for services they receive during the second and third months of the grace period.
- If members pay the full amount they owe by the end of the third month, we will process the pended claims.
- If they do not pay the full amount by the end of the third month, we will terminate their membership back to the last day of the first month of the grace period. We will deny all pended claims incurred during the second and third months. You can bill your patients directly. Per federal law, this includes claims for prior authorized services.

**Grace Period Examples**

Let's say a member paid for February but missed the March 1 due date for March coverage.

If the member has a one-month grace period:

- He or she has until March 31 to pay the premium owed.
- We will process claims for services the member received during March and pay you based on the member’s coverage.
- If the member does not pay their premium by March 31, we will cancel his or her policy.
- If the member has a three-month grace period:
  - He or she has until May 31 to pay the March, April and May payments in full. And to continue coverage after May 31, his or her June premium is due June 1.
  - We will process claims for services you provide in March and pay you based on the member’s coverage.
  - We will pend claims for services you provide during April or May, and notify you of that.
  - If we don’t receive the member’s payment in full by May 31, we will cancel his or her policy.
Confirming Member Eligibility
Please be sure to confirm your patients’ eligibility and grace period status prior to providing services. This is especially important if the letters “NX” appear in their member ID number. To verify this information, you must call 1-855-208-1641, Monday through Friday, 8:00am-6:00pm (ET).

APRN Reimbursement
Service rendered by an APRN are reimbursed at 85% of the MD Fee Schedule.

Connecticut Vaccine Program (CVP)
HealthyCT will comply with the mandated Connecticut Vaccine Program (CVP), managed by the State Department of Public Health.

Details about the program—including a complete list of the vaccines that will be impacted by the mandate and other provider resources—are available at www.ct.gov/dph. The Connecticut Vaccine Program Mandate is for children birth through 18 years of age.

When a CVP vaccine is given to our member, providers should submit a claim with the appropriate vaccine CPT code, the SL (State Supplied Vaccine) HCPCS Level II modifier and zero dollars as the billed charge. We will reimburse providers for the vaccine administration in accordance with the provider’s contract, but the CVP vaccine will not be reimbursed.

Failure to submit the vaccine CPT code will result in non-payment of the vaccine administration code. In addition, if the vaccine CPT code is not submitted, we will not be able to collect important quality information regarding immunizations provided to our members.

There are some vaccines that the CVP will not provide for children or adolescents that are covered by HealthyCT at no cost-share to members. These vaccines will be reimbursed in accordance with the provider’s contract and fee schedule.

Injectables and Immunizations
Injectables and immunizations will be reimbursed at Average Sale Price (ASP) + 10%. If there is no ASP allowable, the reimbursement would be Average Wholesale Price (AWP) – 15%. This fee schedule will be updated on a quarterly basis.

Genetic Testing
The newborn genetic screening program as defined by the State of Connecticut is covered without prior authorization. Some molecular genetic testing is covered when a Member has or is thought to have certain clinical genetic conditions.

Coverage for molecular genetic testing will be available only:
- When the Member has obtained genetic counseling from either a genetic counselor or a board-certified or board-eligible geneticist;
- An appropriate evaluation has been performed consisting of:
  - A complete history;
  - A complete physical examination;
  - Conventional diagnostic studies;
• Three generation pedigree charts;
• When a diagnosis cannot be made using routine history, physical examination, and diagnostic testing and there remains the possibility of a genetic condition that will affect the Member’s health; and
• When the result of the molecular genetic testing will directly impact the Member’s treatment.

Fraudulent Claims (FWA)
We will conduct standard reviews to ensure appropriateness of rendered services and billing.

Electronic Funds Transfer (EFT/ERA)
If you are a participating provider, we can issue an EFT to your bank account in lieu of printing a check for your payment. Selecting this service accelerates the cash collection process for your office. To implement electronic funds transfer, the following is required:

• Your bank name and address;
• Your bank ABA or routing transit number;
• Your account name and number;
• The type of account to which funds will be transferred (checking or savings account); and
• Your provider or group number.

Your bank may require a letter of authorization to accept electronic transactions from us into your account. We may also request you provide us with a spec sheet from your bank or a copy of a voided check. (Deposit slips are not acceptable.)

Mail or fax a copy of the authorization letter along with the required information requested above. Be sure to notify us of any changes in bank information.

Frequently Asked Questions
We offer electronic remittance advice (ERA) and electronic fund transfer (EFT) through Emdeon to reduce:

• Administrative work - convenient record-keeping with no more paper handling;
• Claims-related problems - get paid faster than via standard postal mail; and
• Check-processing expenses - direct deposit saves time and money with fewer processing fees.

What is ERA?
ERA provides details on multiple claims and helps improve business office workflow by allowing the adjudicated claim information to be automatically posted to accounts receivable systems. We can send an ERA to any provider who registers with an approved clearinghouse. The ERA complies with HIPAA 835 requirements making it consistent with other payers and is acceptable nationwide.

What is EFT?
EFT automates the distribution of funds into accounts using automated clearinghouse processing to reconcile accounts receivable, which provides significant savings in check processing fees. Before EFT, providers were required to open the mail, pull the check, enter the data into their system, get the checks to the bank, wait for them to clear, reconcile books, and more. EFT is safe, secure, efficient, and less expensive than paper check payments and collections.

Refer to the Quick Reference Guide in the front of this manual for specifics on EFT and ERA.
Filing Limits
The filing limit for initial claims submissions is one hundred twenty (120) days from the date the services were rendered. If the claim involves coordination of benefits (COB) you must submit the bill within six (6) months of the date of service, or within six (6) months of the date of discharge for hospitals. When submitting a claim when we are the secondary payor please submit the denial letter, remit, EOB or take back notice from another carrier.

Refunds/Overpayments
We will make every attempt to identify claims overpayments prior to adjudication of a claim. If we identify an overpayment we will send out a notice of the overpayment and ask that you provide a refund within thirty (30) days from receipt of notice for overpayment request. If you dispute the overpayment request you must contact us within thirty (30) days of receipt of the notice of overpayment. The Overpayment Refund Request letter from us will outline the specific information required on the claim. However, in the event that you independently identify an overpayment from us, the following steps should be taken:

- Return a check made payable to the same entity that made the overpayment in question;
- It is preferred that you send a copy of the Remit Advice that accompanied the overpayment as this will expedite our adjustment of your account; and
- If the Remittance Advice is not available, the following information must be provided: member name, service date, payment amount, member ID, vendor name, provider tax ID, provider number, vendor number and reason for the overpayment refund. Please note that if the Remit Advice is not available, it will take longer for us to process the overpayment refund on your account.

The overpayment refund and applicable details should be sent to the following address:
HealthyCT
PO Box 33519
Attn: Claim Correspondence/Claim Appeals
Indianapolis, IN 46203-0519

If a provider is contacted by a third party overpayment recovery vendor acting on our behalf, you should follow the overpayment refund instructions provided by the vendor.

If you believe that you have received a check from us in error and have not cashed that check, you should return the check to the address noted above with the applicable Remittance Advice and a cover letter indicating why the check is being returned.

Corrected Claims
A corrected claim must be filed within forty-five (45) days from receipt of the original payment and/or denial. If you determine that the original claim was not billed correctly or that additional information requires consideration, you can submit a corrected claim using the appropriate bill type.

When resubmitting a corrected claim, you may do so electronically or via paper. You should resubmit the corrected claim(s) using the same address as the initial claim submission.

Adjustments
To ensure that the claim department has adequate information to process claim adjustments and corrected claims in an accurate and timely manner, we require that you submit all necessary claim forms and adjustment requests within (sixty) 60 days from the date of the original denial.
If you dispute the original payment or denial of a claim you must submit all appropriate documentation attached to the explanation of payment/benefits along with a written explanation as to the reason of the dispute.

**Provider Inquiry / Dispute (Non Clinical)**

**Definitions**

**Inquiry:** A verbal, written or e-mailed request from a provider for information that is not a dispute or related to any adverse determination for medical necessity or benefits. Examples may include but are not limited to: participation status, claim or check status, HCT policies and procedures, website registration, etc.

**Dispute:** A verbal, written or emailed request of dissatisfaction from a provider acting on his/her own behalf that is not related to any adverse determination for medical necessity or benefits. Disputes are specifically related to credentialing, fee schedule, or other contract-related matters, coding, modifiers, bundling or other claim-related issue.

Provider inquiries / disputes, per participating agreements, are to be received by HCT no later than four (4) months from the date of remittance or six (6) months if COB issues exist. After this four (4) or six (6) month period no further adjustments of payment shall be made. HCT will provide a resolution to inquiries within two (2) business days and of not more than twenty (20) business days for provider disputes.

Written inquiries / disputes and applicable details should be sent to the following address:

HealthyCT
PO Box 33519
Attn: Claim Correspondence/Claim Appeals
Indianapolis, IN 46203-0519

**Billing of Members**

**Copayments**
You are required to collect copayments from members for services performed in the office setting for which you submit a claim and when we are the primary plan.

**Coinsurance**
You are to submit claims to us to allow for processing before billing the member for any coinsurance. This will allow you to verify the coinsurance amount on your EOB and then you may bill the member for their portion of the bill.

**Deductibles**
You are to submit claims to us to allow for processing before billing the member for any deductible. This will allow you to verify the deductible amount that is not fulfilled on your EOB and then you may bill the member for their portion of the bill. Deductibles for Large and Small group plans run on a plan year and the benefits accrue on the calendar year. Deductibles for individual plans run on a calendar year and the benefits accrue on a calendar year basis.
Covered Services
You may not bill members for any service covered by their benefit plan. You are allowed to bill the amount indicated on the EOB which would be the member’s copayment, coinsurance or deductible.

Non-Covered Services
Members should only be billed the amount indicated on the EOB as the member responsibility. If you are not sure whether a member is liable, please contact provider services prior to billing the member.

Refunds/Overpayments by Members
If you receive an overpayment from a member we request that you refund the patient the appropriate amount back according the EOB in a timely manner.

Member Payments
It is not recommended to collect deductible or coinsurance payment at the time services are rendered unless you are sure that the member will be responsible for that amount. You may request a credit card imprint as to ensure payment along with a form of written guarantee that the member will be responsible for what is due. Terms and use of the credit card imprint should be provided to the member. We would suggest consulting your legal counsel on the appropriateness of credit card imprints.

Coordination of Benefits
Coordination of Benefits (COB) is a way of determining the order in which benefits are paid and the amounts that are payable when a member is covered under more than one health plan. If a member is entitled to receive benefits under another group insurance plan, the benefits under the member’s plan will be coordinated with benefits under the other plan up to 100% of the member’s responsibility. We are not liable for more than we would have been liable as the primary payer.

The Member
Must notify us of other coverage and will be responsible for payment of all non-covered services; and shall never be liable for more than their applicable cost share (e.g., copayments, coinsurance, deductibles, etc.) under their Plan.

Provider Responsibility
- You must bill the other health plan insurance/insurer first, when we are the secondary carrier.
- When submitting a claim to us as secondary carrier, you must also include the Claim Summary or Explanation of Benefits (EOB) from the other health plan.
- You must indicate the other health plan insurance on the bill you submit to us.
- You must submit the procedure codes which are required per your contract.
- If you submit procedure codes which are not on your contract/fee schedule, the claim will be denied.

Effect on Payment
HealthyCT as Primary Carrier:
We will pay the full contracted, allowable amount minus applicable cost-sharing or adjustments. (The patient may receive reimbursement from the secondary carrier for any out-of-pocket expenses incurred, such as the copayments, coinsurance and deductibles.)

HealthyCT as Secondary Carrier:
The following rules apply when we are the secondary carrier
• Payment will not be made until we receive a copy of the Claim Summary or Explanation of Benefits (EOB) indicating the amount paid by the primary carrier.
• We will pay up to the member’s responsibility under the primary carrier or our contracted amount, whichever is lower.
• We recommend that the copayment not be collected at the time of service. Once you receive payment from all carriers, determine if there is any remaining billable balance. Most balance billing occurs when the member has a deductible that needs to be satisfied, such as a Medicare Part B deductible or a commercial carrier deductible.
• The filing limit for claims where we are secondary is one hundred eighty (180) days after the issue date of the last Claim Summary or EOB received from the primary carrier. Claims denied as beyond the filing limit by the primary carrier will not be accepted for payment by HealthyCT.

Note: If the member has medical coverage under their auto carrier, the auto carrier would be primary for claims related to the auto accident, up to the policy maximum.

Order of Benefit Determination
Following are some generally applicable rules for determining which plan is primary or secondary. If you have any questions, please contact Provider Services

<table>
<thead>
<tr>
<th>Member with Commercial Plan</th>
<th>Primary Carrier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subscriber</td>
<td>HealthyCT</td>
</tr>
<tr>
<td>Subscriber’s spouse without other group health insurance.</td>
<td>HealthyCT</td>
</tr>
<tr>
<td>Subscriber’s spouse with other carrier group health insurance.</td>
<td>Other</td>
</tr>
<tr>
<td>Dependent child when both parents have insurance, and are not separated or divorced.</td>
<td>Determined by the Birthday Rule*</td>
</tr>
</tbody>
</table>
| Child whose parents are divorced or legally separated but whose health coverage has not been ordered by the courts. | • First: the Plan of the parent with custody of the child;  
• Then, the Plan of the spouse of the parent with custody of the child; and  
• Finally, the Plan of the parent not having custody of the child. |
| Child whose health coverage has been ordered by the courts. | Court Decree |

<table>
<thead>
<tr>
<th>Member with Medicare</th>
<th>Primary Carrier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active employee is 65 or older and if the group he/she works for has fewer than 20 employees.</td>
<td>Medicare</td>
</tr>
<tr>
<td>Retired employee is eligible for Medicare and has Medicare Part A &amp; B.</td>
<td>Medicare</td>
</tr>
</tbody>
</table>

* Birthday Rule: Primary carrier is the health plan/insurer of the parent whose month and day of birth occurs earlier in the calendar year. If parents share the same birthday, the primary carrier is the health plan that has been in effect longer.

Ancillary/Hospital Services
Our claim system will process claims based, at a minimum, on Centers for Medicare & Medicaid Services (CMS) and National Correct Coding Initiative (NCCI) edits. We follow coding edits that are based on
industry sources, including, but not limited to, CPT guidelines from the American Medical Association, specialty organizations, and CMS. In coding scenarios where there appears to be conflicts between sources, we will apply the edits we determine are appropriate.

We will inform you of new policies or material changes to existing policies by fax, mail, email or notice on our website.

We also evaluate medical billing information to detect coding patterns such as unbundling, integral procedures, and mutually exclusive procedures. We reserve the right to audit documentation in order to verify coding and billing accuracy.

**Interim Billing**

Claims qualify for interim payment on the 30th day of a consecutive inpatient stay, and at 30-day intervals thereafter. Claims for advance interim payment can be submitted via electronic data interchange (EDI).

**DRG or Inpatient Case Rate reimbursed providers**

- Use Type of Bill 112 for the first claim and Type of Bill 113 for continuing claims.
- When reporting the admission date, the admission date of any 113 bill types should equal the admission date of the preceding 112 bill type. For 113 bill, type the admission date is not required to fall within the "Statement Covers Period" date span.
- Covered days must be equal to or greater than thirty (30) days.
- Use Patient Status Code 30, still patient.

Once the patient is discharged, you are required to submit a final bill and should have a complete 'admit through discharge', reiterating all charges submitted on prior interim bills using Type of Bill 111. The interim bills previously paid will be reversed. The final bill will be processed for the entire length of stay. The final bill can be submitted via EDI transaction.

**Providers not DRG or Inpatient Case Rate reimbursed**

- Use Type of Bill 112 for the first claim and Type of Bill 113 for continuing claims
- When reporting the admission date, the admission date of any 113 bill types should equal the admission date of the preceding 112 bill type. For 113 bill types, the admission date is not required to fall within the "Statement Covers Period" date span.
- Covered days must be equal to or greater than thirty (30) days.
- Use Patient Status Code 30, still patient.

As a final bill, DRG or Case Rate exempt providers are to submit a Type of Bill 114 with the remaining days and charges since the last interim bill (it would not have to be thirty (30) days).

**Observation**

Observation Stay is an alternative to an inpatient admission that allows reasonable and necessary time to evaluate and render medically necessary services to a member whose diagnosis and treatment are not expected to exceed 24 hours. However, the timeframe may be exceeded to allow for adequate assessment so the need for an inpatient admission can be determined. Appropriateness of and length of stay in observation status will be determined by InterQual Criteria. Prior authorization is required when a patient is admitted for an observation stay as well as when an observation stay converts to an inpatient admission.
Inpatient Admission Following Observation Stay

- All related observation services that occur within three (3) days of the date of admission are included in Case rate or DRG-based reimbursement.

Outpatient Procedure Related to Observation Stay

- No separate observation reimbursement will be made for observation services related to an outpatient surgical procedure or other outpatient procedure and are considered part of the routine recovery period for the procedure.
- Routine recovery is not expected to exceed 24 hours.

Obstetrical Observation Stay

When an obstetrical patient is placed in observation status:

- If delivery occurs prior to discharge, the entire episode is considered an inpatient admission.
- If delivery does not occur and the member is sent home, the episode is considered an observation stay.
- Reimbursement includes diagnostic testing performed in conjunction with an obstetrical observation stay.
- Services submitted with routine pregnancy diagnoses will not be reimbursed for observation care.

Hospital Responsibilities specific to Observation Services

When a member who was placed in observation status converts to inpatient status, the hospital must notify us within 24 hours or next business day. The hospital must provide us with a daily census for those members placed in/or discharged from observation status during the previous 24 hours.

Observation stays are not considered an appropriate designation for the following, and is therefore, not reimbursed:

- Preparation for, or recovery from, diagnostic tests (e.g., fetal non-stress test, sleep studies);
- The routine recovery period following an outpatient surgical procedure or an outpatient procedure;
- Services routinely performed in the emergency department or outpatient department;
- Observation care services submitted with routine pregnancy diagnoses;
- Retaining a member for socioeconomic factors; and Custodial care.

Helpful Hints for Billing Observation Services that are converted to Inpatient Services:

- Use Field Locator 46 to report the number of observation hours.
- Use the same UB-04 form to bill observation services when following an ER visit, outpatient surgical procedure or other outpatient procedures.
- Use the same UB-04 form as the inpatient admission to bill observation services that convert to an inpatient admission.
- Enter the inpatient admission date in Form Locator 6 (statement covers period) as the beginning (from) date of the UB-04 form. Do not include the observation date within the statement covers period date range; this will cause the claim to deny as billed incorrectly because the number of admission days will not equal the number of days indicated by the statement covers period.
- Enter the date on which the patient was admitted for inpatient services or other start of care in Field Locator 12.
- Enter the time at which the patient was admitted for inpatient services or other start of care in Field Locator 13; hours are entered in two-digit military time (e.g., use 14 for 2:00 p.m.).
Multiple Outpatient Procedures

Multiple outpatient procedures performed in the same surgical session, including but not limited to, procedures in the CPT code range 10000-36414 and 36417-69999, will be reimbursed at 100% of the agreed upon reimbursement for the highest allowable procedure, 50% of the agreed upon reimbursement for the second highest allowable procedure and 25% of the agreed upon reimbursement for the third highest allowable procedures. Payor will reimburse for a maximum of three (3) procedures per surgical session. Any and all additional procedures performed during the same surgical session will not be separately reimbursed, but will be considered paid, as included in and part of the reimbursement amount of the first three (3) procedures, and members may not be billed for such additional procedures.

Claim Hierarchy

The following payment rules apply when a Participant is admitted or placed under observation care after receiving outpatient services on the same calendar day or when two (2) or more distinct outpatient services are performed on the same calendar day:

<table>
<thead>
<tr>
<th>Category</th>
<th>Reimbursement Provisions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Department Services with or transfer to Ambulatory Surgery.</td>
<td>Ambulatory Surgery rate applies.</td>
</tr>
<tr>
<td>Emergency Department Services with or transfer to Observation.</td>
<td>Observation case rate applies only.</td>
</tr>
<tr>
<td>Emergency Department Services with or transfer to Cardiac Catheterization, PTCA</td>
<td>Cardiac Catheterization, PTCA case rate applies only.</td>
</tr>
<tr>
<td>Emergency Department Services transfer to Inpatient.</td>
<td>Inpatients rate(s) applies only.</td>
</tr>
<tr>
<td>Observation transfer to Inpatient.</td>
<td>Inpatient rate(s) applies only.</td>
</tr>
</tbody>
</table>

Anesthesiology

Start & End Time

Anesthesia time is defined as the period during which an anesthesia practitioner is present with the patient.

Anesthesia time starts when the anesthesiologist begins to prepare the patient for induction and ends when the anesthesiologist is no longer in personal attendance.

Base Units and Time Factors

Based off of Medicare rules, units are determined by dividing the actual anesthesia time by 15 minutes or fraction thereof. Since only the actual time of a fractional unit is recognized, the time unit is rounded to one decimal place.

Multiple Surgical Procedures

Based on American Society of Anesthesiology (ASA) billing guidelines, only one anesthesia code is to be submitted when the administration of anesthesia for multiple surgical procedures are performed during the same operative session. Choose the anesthesia code representing the most complicated procedure. The time reported is the combined total for all the procedures.

Physical Status Modifiers

Additional reimbursement will be allowed for the following physical status modifiers when appended to the base anesthesia code as reflected in your fee schedule:

- Modifier P3 = A patient with severe systemic disease
- Modifier P4 = A patient with severe systemic disease that is a constant threat to life
Modifier P5 = A moribund patient who is not expected to survive without the operation

HealthyCT does not recognize unit values for the following physical status modifiers, and no additional reimbursement is made:
  Modifier P1 = A normal, healthy patient
  Modifier P2 = A patient with mild systemic disease
  Modifier P6 = A declared brain-dead patient whose organs are being removed for donor purposes

Qualifying Circumstances
HealthyCT will allow separate reimbursement for the following qualifying circumstances:
  99116 – Anesthesia complicated by utilization of total body hypothermia
  99135 – Anesthesia complicated by utilization of controlled hypotension

No additional units will be allowed for the following qualifying circumstances:
  99100 – Anesthesia for a patient of extreme age (under 1 year of age and over 70 years old)
  99140 – Anesthesia complicated by emergency condition

Monitored Anesthesia Care (MAC)
Is a payable service when the following HCPCS modifiers are appended to the anesthesia management service:
  QS – Monitored anesthesia care service
  G8 – Monitored anesthesia care for deep complex, complicated, or markedly invasive surgical procedure
  G9 – Monitored anesthesia care for patient who has a history of severe cardiopulmonary disease

Anesthesia for Obstetrical Services
Neuraxial labor analgesia for planned vaginal delivery and anesthesia for C-Section are based on the actual time unit, in addition to your fee schedule allowance. Additional reimbursement will be allowed for failed vaginal delivery leading to C-Section delivery.

Certified Registered Nurse Anesthetist (CRNA)
A CRNA is a registered nurse who is licensed by the state in which the nurse practices and who:
Is currently certified by the Council on Certification of Nurse Anesthetists or the Council on Recertification of Nurse Anesthetists; or has graduated within the past 18 months from a nurse anesthesia program meeting the standards of the Council of Accreditation of Nurse Anesthesia Educational Programs and awaits initial certification.

Payment will be provided for covered CRNA services when reported with one of the following HCPCS modifiers:
  QX – CRNA service: with medical direction by a physician
  QZ – CRNA service: without medical direction by a physician

Payment for the administration of anesthesia under these circumstances is based on the base unit value assigned to the surgical procedure plus time units and eligible modifying units (if any). Medically directed CRNA services will be paid at 50% of the calculated payment. A separate charge for the medical direction by a physician will be considered, up to the remaining 50%, when billed by the physician. When a CRNA is not medically directed, the full allowed rate is considered payable to the CRNA.
Medical Direction & Supervision of Anesthesia Administration

HealthyCT recognizes CMS’ definition of medical direction and supervision. Only an anesthesiologist will be reimbursed for medical direction services of procedures performed by a CRNA or qualified individual as follows:

- 50% of the allowable amount recognized for the service to the anesthesiologist and 50% to the CRNA or other qualified individual
- Supervision of more than four concurrent procedures is based on three base units unless documentation of the anesthesiologist is present for intubation; if so, reimbursement is based on four base units.

When billing for the medical direction of anesthesia procedures, the following HCPCS modifiers should be used:

- AD – Medical supervision by a physician: more than four concurrent anesthesia procedures
- QK – Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving qualified individuals
- QY – Medical direction of one certified registered nurse anesthetist (CRNA) by an Anesthesiologist

Post-OP Pain Management

E&M services

Evaluation and Management (E&M) services for postoperative pain management on the day of surgery are considered part of the usual anesthetic service and are not separately reportable.

Postoperative Pain Control

When provided principally for postoperative pain control, peripheral nerve blocks (both injection or continuous infusion), and neuraxial (spinal, epidural) injections can be separately reported on the day of surgery using the appropriate CPT procedure with modifier-59 (Distinct Procedural Services) and one (1) unit of service. These services should not be reported on the day of surgery if used as the primary anesthetic technique or as a supplement to the primary anesthetic technique.

Note: Modifier 59 requires that the medical record substantiate that the procedure or service was a distinct or separate service performed on the same day.

Daily Management of Therapeutic Epidural Management (CPT code 01996)

Management of epidural or subarachnoid drug administration is separately reportable if performed after the day on which the catheter was inserted. Payment will not be allowed for both the catheter insertion and the daily management of the drug when done on the same day. Do not report an E&M service code in addition to CPT code 01996 if the only service provided is management of an epidural/subarachnoid drug administration. Payment is limited to one unit of service per day regardless of the number of visits necessary to manage the catheter per postoperative day.

Durable Medical Equipment (DME)

Durable Medical Equipment (DME)

Durable medical equipment (DME) is equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally not useful in the absence of illness or injury. We reimburse contracted providers for durable medical equipment for the treatment of illness or injury or to improve the functioning of a body part, for use in the member’s home, within the applicable benefit. The DME must be medically necessary. Some DME items require prior authorization, refer to
the Prior Authorization Requirement List. The DME provider is responsible for maintenance of items that they own.

Rent to Purchase Guidelines
Rental of DME is appropriate when the prescribing provider specifies that the covered item is medically necessary for a limited duration of time. Claims for rented DME items must be submitted for the period they are used by the member, but not exceeding the allowed maximum rental period of 10 to 13 months.

- Equipment that may be rented or purchased will be reimbursed up to, and not exceed, the purchase price or allowed amount of the item or,
- When the cost is expected to be less than the long term rental of an item.
- You may not bill us or the member for additional rental amounts.
- You may not bill for both the rental and purchase of the same DME item at the same time.
- Oxygen and Ventilators are typically excluded from the rent to purchase arrangement, unless otherwise specified by the prescribing provider.
- When the item is not available for rental a purchase arrangement will be made.
- The following HCPCS are considered continuous rentals and not subject to rental guidelines, E0424, E0431, E0433, E0434, E0439, E0461, E0463, E0464, E1390, E1391, E1392, K0738.

Home Health Services
Medically Necessary home health services must be provided by a licensed Home Health Agency and Prior-Authorized. Home health services are covered if:

- We determine that Hospitalization or admission to a Skilled Nursing Facility would otherwise be required; or
- The Member is diagnosed as terminally ill and his/her life expectancy is six (6) months or less; or
- A plan of home health care is ordered by a physician and approved by us.
- The home health services must be medical and therapeutic health services provided in the Member’s home, including:
  - Nursing care by a registered nurse or licensed practical nurse;
  - Social services by a Masters-prepared social worker provided to, or on behalf of, a terminally ill Member;
  - Physical, occupational or speech therapy;
  - Hospice care for a terminally ill patient (i.e., having a life expectancy of six (6) months or less); or
  - Certain medical supplies, medications and laboratory services.

There is no coverage for:

- Custodial Care;
- Convalescent care;
- Domiciliary care;
- Long term care;
- Rest home care; or
- Home health aide care that is not patient care of a medical or therapeutic nature.

Benefit maximums do not apply to Hospice care.

Skilled Nursing and Rehabilitation Facilities
Medically Necessary skilled nursing care is covered if such care is provided:
• At a Skilled Nursing Facility;
• At an acute Rehabilitation Facility; or
• On a specialized inpatient rehabilitation floor in an acute care Hospital.
Please refer to the member’s benefit plan for any limitations.

The following limitations and conditions apply to the Skilled Nursing Facility/Rehabilitation Facility benefits:
• In order to be covered, the skilled nursing care must be for intense rehabilitation or sub-acute medical services, or as a substitution for inpatient Hospitalization.
• Your orders must specify the skills of qualified health professionals such as registered nurses, physical therapists, occupational therapists, or speech pathologists, required for your patient’s care in the facility.
• Admissions and continued stay requests will be reviewed by us using nationally recognized measures to determine if the skilled nursing care will result in significant functional gain or improvement to the Member’s medical condition.
• The services in the Skilled Nursing Facility/Rehabilitation Facility must be provided directly by, or under the supervision of, a skilled health professional, and admission must be prior-authorized by us.

Ambulatory Surgery Center
Ambulatory Surgery Centers are medical facilities designed and equipped to handle surgery, pain management, and certain diagnostic procedures, like a colonoscopy that do not require overnight hospitalization. Ambulatory services include procedures performed by a doctor on an outpatient basis, whether in a Hospital, at a Hospital Outpatient Surgical Facility, at an Ambulatory Surgery Center, or a birthing center. If a medically necessary ambulatory surgery or a certain radiological diagnostic procedure is performed in an Ambulatory Surgery Center, the member may be required to pay an ambulatory services Cost-Share amount.

Some ambulatory services may require prior-authorization; refer to the prior authorization list.

Laboratory Services
HealthyCT has a preferred relationship with Quest Diagnostics for all outpatient laboratory and pathology services for our members. Quest Diagnostics is a full-service laboratory. In addition, participating hospitals and hospital-affiliated laboratories or pathology groups can provide laboratory/pathology services to our members.

Participating physicians and healthcare professionals are required to refer HealthyCT members or their specimens to one of our participating laboratory/pathology providers.

Vision Benefits

Pediatric Vision Benefits
Individuals, Small Group and SHOP members are identified by “HCTNX or HCTFX followed by I, S or P” in the Group number on the Members Identification Card (NX=on exchange & FX=off exchange).

There are no routine covered services for members age 19 or older within the above plans. Covered services are limited to members under the age of 19 years. All covered services will be reimbursed at the fees established by HealthyCT (a representative schedule is included in Attachment A) with the
exception of glasses or contact lenses which are subject to a maximum allowable reimbursement detailed below. Covered services include:

- One (1) vision examination allowed per year without Medical diagnosis.
- One (1) pair of glasses or one (1) set of contact lenses allowed per year.
- Maximum allowance for frames is $65.00; the maximum allowance (including frames) for single vision lens is $224.45 and flat-top bifocals is $254.47.
- Provider must offer the member a choice of at least 20 frames without any member cost share.
- Maximum allowance for contact lenses including the fitting is $200.00.
- If a member chooses a frame other than that available through the collection covered in full by HealthyCT, then the member must pay any difference in cost between the $65.00 allowance and the cost of the frames selected, minus a 20% discount off the retail price of the frames. If the member chooses contact lenses that exceed the $200.00 allowance, the member must pay the difference between the allowance and the cost of the contacts selected, minus a 20% discount off the retail price of the contacts. It is the provider’s responsibility to explain to the member that there are options available that are fully covered by HealthyCT and that any additional cost is the responsibility of the member. The member will be required to sign a waiver indicating that they were offered glasses fully covered by HealthyCT and understand they will be responsible for any additional costs, minus the 20% discount. In no case will HealthyCT’s liability exceed the maximum allowance for frames/ lenses/contacts and the provider must agree not to bill HealthyCT for charges over the maximum allowance.

Annual Routine Vision Exams
Large group members are identified by “HCTFXL” in the Group number on the Members Identification Card.

Hardware is not a covered service for large group members of any age.

Routine examinations are covered for all ages under the large group benefit plans. The specialist copay is applicable.

Medical Management Program
The purpose of our Medical Management Program is to ensure that medically necessary services are rendered at the appropriate level of care, in a timely and cost effective manner. The Medical Management Program involves close interaction and coordination of member information between you and our case managers. We manage utilization management (prior authorizations, concurrent review and retrospective review), case management, complex case management, disease management and wellness programs.

Conflict of Interest
It is the policy of HealthyCT (HCT) that all utilization review decisions are based on the appropriateness of health care services and supplies, in accordance with the definition of medical necessity and the benefits available under the member’s coverage. Only physicians can make denials of coverage of health care services and supplies based on lack of medical necessity. We do not reward or provide financial incentives to individuals performing utilization review services for issuing denials of coverage. There are no financial incentives for such individuals that would encourage utilization review decisions that results in underutilization.
Our nurses, medical directors, other professional providers, and independent medical consultants who perform utilization review services for the plans are not compensated or given incentives based on their coverage review decisions. Medical directors and nurses are salaried employees of the plans, and contracted external physicians and other professional consultants are compensated on a per-case-reviewed basis, regardless of the coverage determination.

**Utilization Management (UM)**

**Availability of Utilization Management Staff**

HCT clinical staff is available during normal business hours from 8:30 a.m. through 5:00 p.m. (EST) for inbound utilization management (UM) related requests via our toll free number or fax. We also provide access to clinical staff for urgent and emergent UM issues 24 hours per day, 7 days per week through an answering service and an on-call licensed health care professional at our toll free number, 1-855-458-4928. See Quick Reference Guide for access information.

**Utilization Management Criteria**

HCT licenses its utilization management decision making criteria from McKesson Health Solutions LLC. This criteria is available on the HCT website or by calling, writing, or faxing a request to the following contact information:

HealthyCT  
35 Thorpe Avenue, Suite 104  
Wallingford, CT  06492  
Attn: Prior Authorization  
Phone:  855-805-4325  
Fax:  855-817-5697

All denial letters include the rational for the denial and the clinical criteria used to make the denial decision.

Providers acknowledge that HealthyCT is providing access to utilization management criteria and associated clinical content (“Criteria/Content”) to Providers subject to the terms and conditions contained in its agreement with McKesson Healt Solutions LLC, which may be updated from time to time at HealthyCT or its licensors’ sole discretion without notice. Provider’s right to access and use the Criteria/Content is non-transferable, nonexclusive, and is for the sole purpose of providing care to HealthyCT’s members. Providers will limit access to the Content/Criteria to (i) only employees and agents of Providers and further (ii) only to the extent necessary to review/evaluate the clinical content relevant to the Providers specialty area or related to the care of a specific member’s condition. Providers will protect the confidentiality of the information contained in and provided by the Criteria/Content and to which it has access to under this Agreement, by using at the least the degree of care and security it uses to protect its own confidential information. Providers acknowledge and agree that any unauthorized disclosure or distribution of the confidential information may result in irreparable injury to HealthyCT or HealthyCT’s licensor(s), entitling the injured entity to obtain immediate injunctive relief in addition to any other legal remedies available. Providers will not modify, translate, decompile, disclose, create nor attempt to create any derivative work of the Criteria/Content. Providers acknowledge that the Criteria/Content is in no way intended to prescribe, designate or limit medical care to be provided o procedures to be performed. Providers accept responsibility for and acknowledge that it will exercise its own independent judgment in the use of the Criteria/Content and will be solely responsible for such use. Providers agree to indemnify and hold HealthyCT, and its affiliates, officers, agents, licensors or other partners, and employees, harmless from any claim, demand or damages,
including reasonable attorneys’ fees, arising out of Hospital’s and Groups’ use of the Criteria/Content or from its violation of the intellectual property rights or confidentiality obligations contained in the agreement. Providers acknowledge that the Criteria/Content, including all applicable rights to patents, copyrights, trademarks and trade secrets inherent therein and appurtenant thereto, are the sole and exclusive properties of third parties, including HealthyCT’s licensors, who have licensed such rights to HealthyCT. Providers agree that no rights in the Criteria/Content are hereby conveyed to Providers except to the extent that Providers have the right to access the Criteria/Content. THE CRITERIA/CONTENT ARE PROVIDED TO PROVIDERS “AS IS”, “WITH ALL FAULTS”, AND “AS AVAILABLE”. In addition, HealthyCT’s licensors will not for any reason be deemed a party to the agreement, and Providers will look solely to HealthyCT for the performance of any obligations due to Providers hereunder. HEALTHYCT, ITS AFFILIATES, AGENTS AND LICENSORS CANNOT AND DO NOT (i) WARRANT THE ACCURACY, COMPLETENESS, CURRENTNESS, NONINFRINGEMENT, MERCHANTABILITY, OR FITNESS FOR A PARTICULAR PURPOSE OF THE MATERIALS, INFORMATION AND SERVICES AVAILABLE THROUGH THE WEBSITE, OR (ii) GUARANTEE THAT THE MATERIALS, INFORMATION OR SERVICES WILL BE ERROR-FREE, OR CONTINUOUSLY AVAILABLE, OR FREE OF VIRUSES OR OTHER HARMFUL COMPONENTS. HealthyCT has the right to modify or terminate Providers access to the software at any time or for any reason, including but not limited to Providers violation of any terms of this Agreement.

**Decision Making Criteria**

Health care management decisions are made based on the member’s benefit plan and the proposed health care treatments, drugs and supplies for that member.

We use McKesson’s InterQual® criteria as our primary source of criteria for utilization management decision-making. The InterQual® criteria cover the continuum of care, from an acute setting through home care and outpatient treatment. The criteria provide us with the following:

- Enables appropriate selection of health service, avoiding unnecessary risk associated with under/over-utilization;
- Promotes care that matches to the evidence, avoiding use of ineffective care and underuse of effective care;
- Provides impartial best-practice parameters based on an individual member’s presentation
- Fosters optimal timing and setting for delivery of appropriate care;
- Facilitates rapid, systematic care decisions through easy-to-use decision trees, enabling reduction of unintended variation and waste; and
- Offers a common resource for decision-making, promoting consistent decision making across all populations and geographies.

**Member Decision Making Process**

Adult patients have the right to determine what, if any, medical treatment they will receive. If the patient can understand the nature and consequences of the health care decisions that they are being asked to make, the patient may agree to treatment that may help them or they may refuse treatment even if the treatment might keep them alive longer.

We will provide written information to members with respect to their rights about the medical care they receive. You have the responsibility to provide patients with information that can help them to make a decision. You will need to explain:

- What treatments may help the patient;
- How each treatment may affect the patient, that is, how it can help them and what, if any, serious problems or side effects the treatment is likely to cause;
• What may happen if the patient decides not to receive treatment; and
• The fact that the final decision on treatment is the patient’s to make.

All of this information is provided so the patient can exercise their right to decide treatment wisely.

Utilization Management Decisions
Health care treatments, drugs and supplies that are not part of the member’s benefit plan or are not medically necessary are not covered. We will determine if a treatment, drug or supply is medically necessary and, therefore, covered. If health services can be provided in more than one medically appropriate setting, we may determine which setting is eligible for benefit coverage and the services must be provided in that setting in order for the member to be eligible for coverage.

During the utilization management process, you must cooperate with medical record requests needed for the utilization management process for purposes of:
• Prior Authorization;
• Concurrent review;
• Discharge planning; and
• Retrospective review.

The information requested may include, but not limited to, clinical information, treatment plan, operative notes, patient status, discharge planning needs, barriers to discharge and discharge date. When conducting the review, we shall collect only the information necessary, including pertinent clinical information, to make medical necessity or benefit determinations and consult with the treating Provider as indicated. As appropriate, we may request clinical information that includes, but is not limited to, the following:
• Office and/or hospital records;
• A history of the presenting problem;
• A clinical exam;
• Diagnostic testing results;
• Treatment plans and progress notes;
• Patient psychosocial history;
• Information on consultations with the treating practitioner;
• Evaluations from other health care Providers and providers;
• Photographs;
• Operative and pathological reports;
• Rehabilitation evaluations;
• A printed copy of criteria related to the request;
• Information regarding benefits for services or procedures;
• Information regarding the local delivery system;
• Patient characteristics and information; and
• Information from responsible family member.

Note: We reserve the right to use third-party vendors to administer benefits, including utilization management services.

HealthyCT Medical Policies are available on the secured provider portal, a hard copy is available by request by calling us at 855-208-1641.
Prior Authorization

We may require prior authorization for selected procedures, services and items including, but not limited to, elective inpatient admissions, home health, specific outpatient services, behavioral health services and specific pharmaceuticals. We require you to submit a request for prior authorization for elective procedures/services fifteen (15) days prior to the date of service.

Prior authorization will not be implemented in a manner that discriminates on the basis of factors including age, disability, or length of life.

Please see Appendix A for a list of our Prior Authorizations and refer to the Quick Reference Guide in the front of this manual for appropriate fax and phone numbers. Forms are also located at www.healthyct.org.

The following are considered during the review process:

- Is the service being requested a covered benefit for the member?
- Are the planned services to be performed being done in the appropriate and safe setting?
- Is the service medically necessary after review of the member’s specific medical condition and in line with evidenced based criteria?
- Is the service available within our provider network?

We will render a determination as expeditiously as possible to meet member needs and accommodating the clinical urgency of the situation but no later than regulatory guidelines ensuing timeliness and continuity of care. Decisions are communicated to member, provider and facility (when appropriate) in writing via mail or fax. The requesting provider will be notified verbally.

Any new technology, service or procedure that becomes Food and Drug Administration approved or any current technology, service or procedure that becomes approved for a new indication, requires prior authorization.

Cancellation of Prior Authorization Services

If a Member has lost or will lose eligibility and has an approved prior authorization, we will notify the requesting provider three days prior to the requested date of service that the authorization will be cancelled due to ineligibility. We may limit an authorization’s timeframe if a member’s renewal is coming due at the time of the authorization.

Reversal of a prior-authorization determination upon post-service review:

We may reverse an approved prior-authorized treatment, service or procedure on post-service review. This can occur when:

- Medical information provided to us or our designated vendor, upon concurrent or post-service review, is materially different from the information presented during the pre-authorization review;
- Information existed at the time of the original pre-authorization review, but was withheld; and had the withheld information been made available to us, the treatment, service or procedure would not have been authorized.

Concurrent Review

Concurrent review is an integrated process that is performed simultaneously and collegially by several members of the Medical Management team, including our Chief Medical Officer. Sources for concurrent review may include but are not limited to our:
• Nurses gathering information from hospital medical records at the facility (on-site).
• Nurses gathering information from hospital utilization management staff telephonically.
• Medical directors gathering information from the treating or primary provider(s) rendering care.

The process of authorization approval is applied to an entire stay, or to a single or group of days, during the admission.

Administrative denials at participating facilities, i.e.: delay in testing, discharge planning, etc., are not a member liability. The financial liability lies with the facility. In no circumstances will a member be held financially liable for delays in service stemming from facility issues or late discharges.

**Discharge Planning**

Discharge planning is a process used to determine a member’s needs for a smooth transition from one level of care to another. Only a provider can authorize a patient’s release from the hospital, but the actual process of discharge planning can be completed by a social worker, nurse, case manager or other person. A team approach is used for the most complicated medical conditions.

In general, the basics of a discharge plan are:
• Evaluation of the patient by qualified personnel;
• Discussion with the patient or his representative;
• Planning for homecoming or transfer to another care facility;
• Determining if caregiver training or other support is needed;
• Referrals to home care agency and/or appropriate support organizations in the community; and
• Arranging for follow-up appointments or tests.

The discussion with the member and/or member’s family and you needs to include:
• The physical condition of the member both before and after hospitalization;
• Details of the types of care that will be needed; and
• Whether discharge will be to a facility or home.

It also should include information on whether the member's condition is likely to improve; what activities he or she might need help with; information on medications and diet; what extra equipment might be needed, such as a wheelchair, commode, or oxygen; who will handle meal preparation, transportation and chores; and possibly referral to home care services.

**Retrospective Review**

HealthyCT (HCT) recognizes that circumstances may require that medical necessity reviews be performed after services are rendered under limited circumstances including but not limited to:
• When a hospital/facility is unaware of a member’s insurance coverage at the initiation of service. In this scenario, it is the responsibility of the hospital/facility to obtain authorization as soon as that information is obtained.
• If the hospital/facility discovers that a patient is an eligible HCT member after he or she is discharged but he or she was incorrectly classified under different insurance coverage.
• If the patient is discharged prior to medical review being completed (i.e.: urgent/emergent admissions where the admission and discharge occur during non-business hours)
• Mismatch of authorization and claim elements such as admission date, discharge date, level of care, etc.
Hospital Notification Policy

We require notification of admissions to ensure care coordination, and to ensure that all inpatient hospital services are medically necessary and consistent with the member’s diagnosis or condition and cannot be provided on an outpatient basis.

Hospitals shall notify us of scheduled hospital admissions as soon as such admissions are scheduled. In the event of an urgent/emergent admission, hospitals shall notify us of an urgent/emergent admission/observation stay within 24 hours or the next business day. During a hospital stay, a hospital shall make information related to the admission available to us during the course of a member’s hospitalization.

Notifications must include the following information:
- Caller/requester name and contact information;
- Member’s name, ID number, date of birth, and gender;
- Date of admission, or expected date of admission;
- Type of admission; emergent or elective;
- Expected date of discharge;
- Admitting provider’s name and National Provider Identifier (NPI);
- Admitting or principal diagnosis and a secondary diagnosis descriptor with codes, according to the most recent ICD code;
- Primary or principal procedure descriptor with code, when applicable, according to the most recent ICD code and anticipated date of surgery;
- Whether the member is a transfer from another hospital;
- Reason for, and source of, the admission; and
- Specific medical criteria and information, as requested by us, to determine whether or not the admission is necessary.

Out-of-Network Urgent Care

We are responsible for covering urgently needed care, emergency services and certain post-stabilization care at the in-network level. All other services, including preventive care and those that can be scheduled, must be provided by network provider unless the member uses his/her out of network benefit.

In determining whether a benefit request shall be considered an urgent care request, an individual acting on our behalf shall apply the judgment of a prudent layperson. A prudent layperson is one who possesses an average knowledge of health and medicine. A request determined to be urgent by a health care professional with knowledge of the covered person’s medical condition shall be deemed an urgent care request.

Post-stabilization, Urgent and Emergent Care

We cover the screening and stabilization of members without prior approval, where a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed. Services will be covered without question if authorized by you or approved by our authorized representative.

Once stabilized, the member may be transferred to a contracted facility when:
- The attending provider at the non-contracted facility and the provider reviewer both; agree that the member is clinically stable for transfer;
• The Member is expected to remain stable during transfer;
• Appropriate services are available at the contracted facility; and
• The contracted facility has a bed available at the appropriate level of care.

Radiology Services
High dollar radiology services require authorization. We manage high dollar radiology, including nuclear cardiology testing (See prior authorization list) using InterQual criteria

ER Program
The purpose of our ER Recidivism Program is to identify and redirect members who are utilizing the emergency room for urgent and non-urgent care. We will encourage these members to seek non-emergent care from their PCP. Furthermore, the program seeks to identify members who do not have an established relationship with a PCP and assist them to find a participating provider in their geographic area.

The program uses proactive communication and outreach to both members and providers to minimize unnecessary ER utilization and encourage a strong and effective primary care/patient centered medical home relationship.

The ER Recidivism Program is a multidisciplinary approach to decrease inappropriate ER use through intensive care coordination; including the promotion of planned services and regularly scheduled primary care visits. The goals of the program include:
• Reduction of inappropriate ER utilization;
• Reduction in hospital admissions due to a misuse of ER services;
• Reduction in inappropriate prescriptions; and
• Provision of education and resources needed by the member, including a network of providers and diversion services.

Transition of Care
New Members
New members to HealthyCT that are under the care of non-participating provider are eligible for transition of care services to facilitate minimal disruption of care and permit a member in an active course of treatment to continue this treatment for a transitional period of time, without penalty, at their in-network benefit level.

The transition of care program provides qualifying members with the ability to continue services with a non-participating provider under certain circumstances. These may include, but are not limited to members:
• Receiving chemotherapy or radiation therapy;
• Members on hospice;
• Members who are in the process of staged surgeries;
• Members who are receiving outpatient treatment for a mental illness or for substance abuse and have had a least one (1) treatment session within thirty (30) days prior to the effective date;
• Members receiving treatment for an exacerbation of a chronic illness;
• Members who are in the post-operative period;
• Members who are pregnant and in the 2nd or 3rd trimester;
• Members receiving home care services; and
• Members whose provider has terminated with the network (voluntary or involuntary).

For a member to be considered for transition care, an active course of treatment must have been initiated prior to his/her enrollment date or prior to the date a provider was terminated from or left the network.

Continuation of treatment shall continue through the current period of active treatment, or for up to ninety (90) calendar days, whichever is less.

Exceptions to ninety (90) calendar day coverage for transition can be made when:
• A member requires only routine monitoring for a chronic condition; for example, if a member sees a Provider for monitoring of chronic asthma but is not in an acute phase of the condition;
• We discontinued a contract based on a professional review action;
• A member has been assigned to a provider group rather than to an individual provider who discontinued his or her contract with the organization, and the member has continued access to alternate providers in the contracted group.
• A provider is unwilling to continue to treat a member or accept our payment or other terms such as:
  o To continue the member’s treatment for an appropriate period of time (based on transition plan goals);
  o To share information regarding the treatment plan with the organization;
  o To continue to follow the organization’s UM policies and procedures; and
  o To not charge the member an amount beyond any required copayment.

Member’s Benefits End
If our member’s coverage of services ends while a member still needs medically necessary care, we will educate the member about alternatives for continuing care and how to obtain care, as appropriate.

• Identifying qualified individuals: Qualified individuals are identified by case managers or requests for an extension of previously approved services that could not be granted due to benefit limitations but which the member needs.

• Identifying available resources and educating members: The case manager is responsible for identifying available resources within the local community. The case manager discusses alternative care and resources available to the member. Additionally, notification of alternative resources such as local or state funded agencies is included within the denial notification.

Disease Management (DM) Programs – Asthma and Diabetes
We are responsible for meeting the health needs of our members by actively intervening to help educate them on how to better manage their asthma or diabetes. Through data analysis, members with asthma and diabetes are identified and encouraged to participate in our disease management programs. We will work with you to identify your patients that would benefit from our disease management programs and you can partner with our case managers to ensure the best possible outcomes for your patients.

Members are identified using a variety of data sources (e.g. claims, pharmacy, referral, utilization management) and assigned a severity level. Interventions vary in timing and frequency and are based severity level. All members identified will receive a welcome letter which will explain the program and afford them the opportunity to decline participation.
You will receive regular reports about their patients, our members, who are participating in our Disease Management programs.

Disease management is a multidisciplinary, continuum-based approach to health care delivery that proactively identifies populations with, or at risk for, chronic medical conditions. Disease management supports the practitioner-patient relationship and plan of care, emphasizes the prevention of exacerbation and complications using cost-effective, evidence-based practice guidelines and patient empowerment strategies such as self-management. Behavioral health problems can interfere with the ability of a member with a chronic medical illness to fully cooperate and benefit from planned clinical interventions. For this reason, efforts are made to identify co-morbid behavioral conditions, especially depression, to encourage appropriate behavioral health treatment and co-management with medical and behavioral health. The following represent potential triggers for DM:

- New Member Health Survey available to new members in their enrollment packet;
- Member-reported health needs;
- Calls made to our Customer Service Department;
- Pharmacy and lab data indicating the incidence of a specific condition;
- Emergency room utilization reports, hospital inpatient census reports, authorization requests and transitional care;
- Claims data (inpatient and encounter);
- Care coordination requests;
- Provider referrals;
- Referrals from Patient Centered Medical Homes (PCMHs) and Federally Qualified Health Centers (FQHCs); and
- Our clinical staff referrals (Utilization Management, case management, and or Complex Case Management processes).

If you believe your patient would benefit from disease management, you can call our medical management department or fax a request with pertinent information. We will reach out to your patient, our member, and complete an assessment. The member will have the option to opt-out of the program. We will keep you informed by including you in communications to our members, specifically when we enroll our member in disease management and periodically as necessary thereafter.

**Complex Case Management (CCM)**

Complex case management (CCM) is the coordination of care and services provided to members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services (i.e.: transplants, HIV/AIDS, progressive degenerative disorders and metastatic cancers). The goal of complex case management is to help members regain optimum health or improved functional capability, in the right setting and in a cost-effective manner. It involves comprehensive assessment of the member’s condition; determination of available benefits and resources; and development and implementation of a case management plan with performance goals, monitoring and follow-up.

We conduct an annual assessment of the characteristics and needs of our population and update processes accordingly. Members eligible for CCM include those with physical or developmental disabilities (special needs), serious mental illness, multiple chronic conditions, severe injuries and many others. The following data will be used to identify members for complex case management:

- Claim or encounter data;
- Predictive modeling for stratification purposes;
- Hospital discharge data;
• Pharmacy data, if applicable;
• Data collected through the UM process, if applicable;
• Data supplied by purchasers, if applicable (purchaser-supplied data (e.g., from state and federal agencies or employers) to identify members for complex case management);
• Data supplied by member or caregiver, if applicable; and
• Data supplied by Providers, if applicable.

Additionally, members can be referred to the program as follows:
• New Member Health Survey available to new members in their enrollment packet;
• Health Information Line, if applicable;
• DM program referral;
• Discharge planner referral;
• Utilization Management referral, if applicable;
• Member or caregiver referral; and
• Provider referral.

Characteristics of our population will be taken into consideration when designing or revising the complex case management program, as well as in defining the program structure and resources such as staffing ratios, clinical qualifications, job training, external resource needs, cultural competency requirements and the like. Members will be given written information about the program, including instructions on how to use the services, become eligible participants, and how to opt in/opt out.

Triggers for CCM
During the prior authorization or concurrent review process our nurse may refer members with the following issues to the Medical or Behavioral CCM nurse for review and assessment:
• Lack of an established and/or ineffective treatment plan;
• Compromised patient safety;
• Over/under/inappropriate utilization of services;
• Premature/delayed discharge from the appropriate level of care;
• Permanent/temporary alteration in functional status;
• Permanent/temporary alteration in functional status w/ current/new impact on daily activities;
• High cost injuries/illnesses;
• Non-adherence to treatment/medications; missed appointments;
• Medical/psychosocial/functional complications;
• Lack of education of disease course/process;
• Lack of family/social support;
• Lack of financial resources to meet health needs;
• Exhaustion of benefits or anticipated exhaustion of benefits, and
• Specialized needs:
  o Transplant
  o High Risk Obstetrics
  o Pain Management
  o Transition of Care

Criteria for Inclusion in CCM
The process of selecting appropriate members for CCM relies on information from multiple data sources, including claims and pharmacy history. We have a dedicated team of nurse case managers (CM) who provide services for these individuals. The range of services is broad and includes, but is not
limited to, education, community services outreach, coordination among multiple providers and medication reconciliation. Indicators may include, but are not limited to:

- Members with a “critical” risk score identified through our predictive modeling software
- Members with three (3) or more chronic conditions* with multiple hospital admissions and/or multiple Emergency Room visits in six (6) months
- Members with prolonged acute hospital stays (>14 days) or high dollar cases (over $100,000) and are at risk for severe complications and repeat hospitalizations
- Members with head trauma or spinal cord injury
- Transplants
- Members with other, complex, extenuating circumstances where the Case Manager determines the benefit of inclusion beyond standard criteria

*Chronic Conditions include:

- Diabetes
- Renal Failure
- COPD
- Pulmonary HTN
- CHF
- Multiple Sclerosis
- Parkinson’s Disease
- Chronic Liver Disease
- HIV/AIDS
- Schizophrenia
- Bipolar
- Substance abuse

Any of these criteria will trigger a screening assessment of the member for participation in CCM. Member agreement for participation is required.

**Complex Case Management (CCM) Referrals:**

HealthyCT identifies members eligible for CCM via electronic or data-related sources and referral sources.

- Electronic/data sources include: claims data, encounter data, hospital discharge data, pharmacy data, data from utilization management processes, data from purchasers and caregivers/members, and providers/practitioners.
- Referral sources include referrals from: health information line, disease management program, discharge planners, utilization management program, inpatient case managers, member/caregiver self-referrals and practitioners/providers.

If you believe your patient would benefit from complex case management, you can call our medical management department or fax a request with pertinent information. We will reach out to your patient, our member, and complete an assessment. The member will have the option to opt-out of the program. We will keep you informed as to the member’s progress via fax updates.

**Clinical Practice Guidelines**

Evidence based, clinical practice guidelines are known to be effective in improving health outcomes with the aim of guiding decisions and criteria regarding diagnosis, management, and treatment in specific areas of healthcare. Promotion of these guidelines to practitioners and treatment partners is essential in the effort to improve health care quality and reduce unnecessary variation in care. Upon assessing the needs of our membership, HealthyCT has adopted the following clinical practice guidelines to assist members and their treatment partners in achieving and maintaining improved health:

- Asthma
- Diabetes
We use guidelines based on sound scientific and clinical evidence developed by nationally recognized professional sources like the National Heart Lung and Blood Institute, the American Diabetes Association, and the American Academy of Pediatrics, for example.

These guidelines are available to all practitioners on the HCT website. They are reviewed, updated when appropriate, and adopted by our quality committee at least every 2 years or sooner if there are significant changes to treatment protocols.

**Preventive Service Guidelines:**
Preventing disease and detecting health issues at an early stage is essential to living a healthy life. Preventive service guidelines assist members and their treatment partners in being proactive about the recommended screenings and tests necessary for early detection and prevention. HCT adopts guidelines that are evidence based and developed by nationally recognized sources. To that end, HCT has adopted the recommendations of the U.S. Preventive Services Task Force (USPSTF) in their The Guide to Preventive Services. This guide is available to all practitioners on the HCT website. They are reviewed, updated when appropriate, and adopted by our quality committee at least every 2 years or more frequently if there are significant changes to preventive care recommendations.

If you would like a paper copy of the above guidelines, please contact the Provider Partnerships department at the number on the Quick Reference Guide.

**Appeals and Grievances**
A member or member’s representative may file an appeal or grievance of an adverse determination with us no later than one hundred eighty (180) calendar days after member or member’s representative, as applicable, receives the notice of an adverse determination.

**Appeals**
An appeal may be submitted if you are dissatisfied with an adverse medical necessity determination. We are committed to a fair and thorough process for making denial and appeal decisions. We require appropriate professionals to review all medical necessity denials of health care services offered under its medical and behavioral health benefit.

We will provide the member or member’s authorized representative a notice of an initial adverse determination with a copy to the practitioner and organizational provider. The notice may be provided in writing by mail or by electronic means and will set forth, in an understandable and readable language to be understood by the member or the member’s authorized representative. Information to be included in the notification:

- Information sufficient to identify the benefit request, including the date of service, if applicable, and the health care professional;
- The specific reason or reasons for the adverse determination and a description of the clinical guidelines used in reaching the denial;
- Identification of the specific health benefit plan provisions on which the determination is based;
- A description of any additional material or information necessary to complete the request; and
- A description of the our internal appeal process that includes:
Both the standard and expedited appeal processes, including the member’s right to and conditions for obtaining an expedited reconsideration for service requests and the rest of the appeal process.

- Time limits applicable to such process or procedures
- The contact information for the appeal and grievance department handling internal appeals.
- A statement that the member or, if applicable, the member’s authorized representative is entitled, pursuant to the requirements of our internal grievance process, to
  - Submit written comments, documents, records and other material relating to the covered person’s benefit request for consideration by the individual or individuals conducting the review, and
  - Receive from us, free of charge upon request, reasonable access to and copies of all documents, records and other information relevant to the member’s benefit request.

- If the adverse determination is based on medical necessity or an experimental or investigational treatment or similar exclusion or limit, the written statement of the scientific or clinical rationale for the adverse determination and an explanation of the scientific or clinical rationale used to make the determination that applies the terms of the health benefit plan to the member’s medical circumstances, a statement that an explanation will be provided to the covered person free of charge upon request, and instructions for requesting a copy of such explanation.

- A statement explaining the right of the member to contact the commissioner’s office or the Office of the Healthcare Advocate at any time for assistance or, upon completion of our internal appeal process, to file a civil suit in a court of competent jurisdiction. Such statement will include contact information.

An appeal for medical necessity as soon as possible after you receive the original decision, but no later than 180 calendar days after the Prior Authorization request was denied or 180 calendar days after the claim for benefits was denied, whichever comes first. If you fail to submit your request within the 180 calendar days, you lose your right to an Appeal.

At any time during the appeal process, we have may request additional information to make our decision.

**Internal Appeal Process**

HealthyCT has one level of appeal. A practitioner who holds a non-restricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review will review the case. You will be given the rational for the decision as well as any other remedy available to you within thirty (30) days for a prospective medical/surgical appeal if we have enough information. A behavioral health case will be automatically expedited (see below). A retrospective appeal will be responded to within thirty (30) days.

**Expedited Process (Internal)**

You may request an expedited appeal if you believe the requested health care service or course of treatment meet the following:

- When the time period for making a non-urgent care request determination could seriously jeopardize the life or health or patient’s ability to regain maximum function, or
• In the opinion of a health care professional with knowledge of the patient’s medical condition, would be subjected to severe pain that cannot be adequately managed without the health care service or treatment being requested.

You will receive a response within 72 hours for a medical/surgical case or twenty-four (24) hours for a behavioral health case.

External Appeal Process
If you are dissatisfied with the internal appeal process, you (on behalf of the member) may submit an appeal to the State of CT.

Grievances
Grievances are those that do not involve an adverse medical necessity determination, (may also be referred to as an appeal in a Provider Agreement).

Examples include:
• Claims payment, handling or reimbursement for health care services; or
• Any matter pertaining to the contractual relationship between a covered person and a health carrier.

We will confirm receipt of the grievance no later than three business days following our receipt of the grievance. Such confirmation notice will include that the member or member’s representative is entitled to submit written material to us to be considered when conducting a review of the grievance. The notice will also contain the name, address and telephone number of the individual or department designated to coordinate the review and instructions for requesting the specific rule, guideline, protocol or other similar criterion which was relied upon to make the adverse determination will be provided to the member or Provider (on behalf of the member) free of charge upon request. A staff member who was not involved in the original decision will review the grievance.

We will notify the member or member’s representative in writing, of our decision no later than twenty business days after receipt of the grievance. However, if we are unable to comply with this time period due to circumstances beyond our control, the time period may be extended for up to ten (10) business days, provided that on or before the twentieth business day after receipt we provide the member or member’s representative written notice of the extension and the reasons for the delay.

Quality Improvement Programs

Overview
The Quality Improvement Program (QI Program) is a company-wide program of continuous quality improvement in all aspects of health plan operations. As such, the scope of the QI Program extends well beyond the delivery of clinical services to encompass the core processes of the managed care program, i.e., clinical program management, network management, provider credentialing, provider relations, claims processing, membership accounting, marketing, member services and information systems.

The QI Program is the means by which we collaborate with our network (primary care, medical specialists and behavioral health specialists) to identify and meet the health care needs of our members. Our overarching goal is to improve health outcomes. Health is not just physical, but also emotional and social. Therefore, a variety of community and public health partners are encouraged to
engage with us to address the quality and safety of clinical care and health services provided to our members.

We have established a quality improvement program structure that allows for thorough discussion and consideration of quality improvement activities from multi-disciplinary areas. The Chief Medical Officer (CMO) and the Behavioral Health Medical Provider have substantive input into the QI program as evidenced in the committee structure. We contractually requires each delegated entity to establish internal quality improvement programs in order to ensure providers/vendors have processes in place to comply with the requirements of state and federal regulatory agencies and NCQA standards.

Potential Quality of Care (PQOC) Member Complaints

We have a formal clinical review process for reviewing PQOC complaints. This process provides for a consistent and equitable treatment of the member’s or member’s representative’s issues. PQOC complaints include verbal or written clinical complaints from members or members’ representatives, about the healthcare and/or services that a member has received or is trying to receive. Individuals who are no longer members, but were at the time of the incident, may also file such complaints. Additionally, PQOC complaints may be identified through the systematic review of a variety of data sources, including but not limited to:

- Information gathered through the UM process;
- Referrals by health plan staff or providers;
- Facility and provider office site reviews;
- Data analysis; claims, authorizations, pharmacy;
- Member/provider satisfaction surveys;
- Medical records audits; and
- Member grievances.

PQOC complaints may include the following types of issues:
- Potential quality of care issues;
- Access to care or delay in care;
- Provider behavior including attitudes and service delivery;
- Office staff issues including attitudes and service delivery;
- Environmental issues such as physical accessibility, physical appearance, adequacy of the waiting and examining room space, etc.;
- Pharmacy issues; and
- Cultural/Linguistic complaints including complaints regarding provision of language services, race, color, religion, sex, sexual orientation, national origin, age, handicap, veteran status.

Urgent PQOC complaints include verbal or written complaints from members or member’s representatives regarding clinical issues of such an urgent nature that it is deemed that a delay in the review process might 1) seriously adversely affect the life and/or health of the member, 2) seriously adversely affect the member’s ability to regain maximum function, and/or 3) pose an interruption in the ongoing immediate treatment of the member. These cases are immediately triaged to the CMO for review and action.

Examples of urgent PQOC complaints may include, but are not limited to those related to a member:
- having pain and not being able to reach the PCP’s office;
• currently out of medications due to a delay in delivery of the order from managed mail;
• member is scheduled for upcoming surgery, and the PCP will not release necessary medical records; and
• member is unable to reach the practitioner’s office to schedule an urgent appointment.

Processing of PQOC complaints may be accomplished through request and review of pertinent medical records, input from you or the facility involved, and review of previous trends, or other sources as indicated by the reported issue and forwarded to the appropriate party. Not all PQOC complaints will require you to submit medical records, however if it is determined that we need to contact you regarding a PQOC complaint, please remember that:
• You are required to send our QI staff the requested records;
• If the records are not received, we will contact you; and
• Depending on the severity of the potential issue, if records are not received, further action may be necessary, including, but not limited to, termination from our network.

Once all medical information is received, the PQOC is processed within thirty (30) calendar days of receipt of the information.

Cases involving urgent attention (i.e., emergent situation) are directly sent to the Chief Medical Officer (CMO) for appropriate action. If the CMO determines that a situation exists where immediate action is required to protect the life or well-being of a member or any person, or to reduce substantial and imminent likelihood of significant impairment of the life, health, or safety of any patient or prospective patient, the CMO may summarily suspend a your credentialled status.

In this instance, the case would be prepared and presented to the Credentialing & Peer Review Committee (CPRC) along with pertinent medical records. If the CPRC determines that a potential or actual quality issue does not exist, the complaint is closed (although it may be reopened at any time based upon future trending).

You will be given an opportunity to discuss (written/telephonic/in-person) the case. You will be given thirty (30) calendar days to respond to our letter of concern, either in writing or by phone interview with our CMO and/or CPRC. If the CPRC desires additional information before making a determination, a follow-up letter will be sent to you. You will receive a final determination letter that will include specifics about the case.

Once the case is reviewed, the CPRC may request that you be put on a corrective action plan that can be monitored.

If a Corrective Action Plan (CAP) is initiated; it is included in the complaint case file. A notice shall be given to you within seven (7) calendar days following the recommendation of such action. A CAP includes the goals, objectives, deliverables, time frames, persons responsible, follow-up and evaluation of CAPs as recommended by the CPRC. The time frame for providers to respond to a corrective action plan is thirty (30) days.

**Pharmacy Program**

We partner with Pharmacy Benefit Manager, Catamaran, in the delivery of quality pharmaceutical health care.
HealthyCT’s Drug List

Tiered Cost-Share
A tiered cost share approach uses different co-payments for medications in various categories such as generic, preferred, non-preferred and specialty drugs to promote use of specific cost-effective agents.

HealthyCT has two different types of formularies: closed and open. A closed formulary means that drugs not on the formulary list are typically not covered. However, if there is a medical reason that a member would need to use a non-formulary drug, for example, they are allergic to the formulary drug, then the practitioner can call Catamaran for a prior authorization (PA). An open formulary has a relatively unrestricted list of drug choices. In this case the member may see a higher co-pay/coinsurance for non-preferred drugs.

How to identify which formulary you have:
- Closed Formulary (Essential Health Benefits): Individual and Small Groups: If the Group ID has the letter “I” or “S”. Ex: HCTFXI00000 or HCTFXS00000
- Open Formulary (National): Large Groups: If the Group ID has the letter “L” in it. Ex: HCTFXL00000
- To determine which drugs are on PA, use the Catamaran drug look-up tool.

Preventive Medications are covered without member cost sharing, as required by the Affordable Care Act.

Pharmacy & Therapeutics Committee (P&T)
HealthyCT has delegated the functions of the P&T Committee to Catamaran. The P&T Committee is an independent group that includes practicing doctors, pharmacists and other health care professionals responsible for the research and decisions surrounding our Drug Formulary. The committee is responsible for objective evaluation, review, guidance, and clinical recommendations for the safe therapeutic use of products. P&T Committee members exercise their professional judgment in making determinations based on clinical and scientific evidence and analyses.

The pharmacy program is evaluated at least annually and updated if necessary and appropriate. Actively practicing physicians licensed in the State of Connecticut review the pharmacy criteria and give input to the P&T Committee. These physicians are of the same or similar specialty as the physician that would be prescribing the drug.

Over the Counter Medications
Our pharmacy benefit provides coverage of certain over the counter (OTC) medications with a practitioner’s prescription, subject to the terms and conditions as identified through the Catamaran drug look up tool.

Pre-Authorization Requirements
Some drugs require prior authorization or may be listed as exclusions to ensure appropriate access and use. Before these drugs will be covered, the provider must forward the medical rationale for the drug selection to the Catamaran Prior Authorization Department.

Drugs on the pre-authorization list are not covered when submitted for payment by the pharmacy unless they have been prior authorized by, Catamaran. You can obtain the appropriate Prior
Authorization form from Catamaran by calling 800-626-0072. The completed form should then be faxed to Catamaran Prior Authorization at 866-511-2202.

Catamaran collects only the information necessary to certify the prescription and requires only the sections of the medical record necessary in that specific case to certify medical necessity or appropriateness of the prescription.

Prior Authorization adverse determinations (denials) can only be made by a pharmacist or physician based on the prior authorization criteria. Therefore, if a pharmacy technician determines he/she cannot approve a prior authorization request as the request does not meet the clinical criteria, the request will be forwarded to a clinical pharmacist or a physician for decision making. If the clinical pharmacist or physician renders a denial the pharmacy technician will notify you and member.

**Specialty Prescription Drugs**

All specialty prescription drugs require Prior Authorization. You can determine if a medication is a specialty drug by calling Catamaran at 866-511-2202 or visiting [https://ctrx.benefits.catamaranrx.com/rxpublic/portal/memberMain?customer=HCT](https://ctrx.benefits.catamaranrx.com/rxpublic/portal/memberMain?customer=HCT)

You can contact Catamaran’s Specialty Pharmacy, BriovaRx, at 855-4Briova (855-427-4682) to acquire specialty medications. The specialty drugs will be shipped to the member’s home. Specialized counseling and education is available from the specialty pharmacies regarding proper administration, storage, dosage, drug interactions, and side effects of these specialty drugs. HealthyCT does not mandate the use of BriovaRx for specialty drugs that are administered in a hospital or physician office.

**e-Prescribing**

Electronic prescribing is the electronic transfer of prescription information from you to a participating retail or mail order pharmacy. It improves your patient’s safety by helping to reduce medication errors. It also allows you access to key information about your patient’s medical history, formulary and potential drug interactions. E-prescribing also speeds up the time it takes to process medication refills, resulting in greater convenience for you, your patients, and pharmacists.

**Mail Order Prescriptions – Optional Program**

The mail service pharmacy fills prescriptions for long-term conditions such as asthma, diabetes, and hypertension. Information about the mail order program is included in the member’s plan documents. HealthyCT allows its members the same benefit at a local pharmacy or using the mail order program.

**Quantity Limits**

For some drugs, we will only cover a limited amount of the drug per prescription or per time period. These determinations are based on the drug manufacturer’s labeling, FDA guidelines and medical literature as well as input from the Catamaran P&T Committee.

**Generic Substitution, Therapeutic Interchange and Step-Therapy**

- **Generic Substitution:** the dispensing of a chemically equivalent but less expensive drug in place of a brand-name product that has an expired patent.
- **Step therapy:** The practice of beginning drug therapy for a medical condition with the most cost-effective and safest drug therapy and progressing to other more costly or risky therapy, only if necessary
• Therapeutic Interchange: The practice of replacing a patient’s prescription drugs with chemically different drugs that are expected to have the same clinical effect.

When making decisions regarding the substitution programs above, Catamaran assesses:
• Efficacy as well as the type and frequency of the side effects and potential drug interactions among alternative drug products.
• The likely impact of drug product on patient compliance when compared to alternative products.
• The benefits, risks and potential outcomes for consumers.

You can find the drugs in these categories, on our website at www.healthct.org via the link for “RX+Dental”, select “Visit the Catamaran website” and then select the appropriate “Formulary” for the plan or you can call Catamaran’s Customer Service Department at 855-577-6549.

Appendixes
Prior Authorization Requirements
For Services Rendered On or After June 1, 2015
Inpatient Services

- Acute Behavioral Health Admissions
- Inpatient Hospice
- Inpatient Rehabilitation
- Medical/Surgical Inpatient Admissions
- Partial Behavioral Health Programs
- Residential Treatment Facilities
- Skilled Nursing Facility Admissions
- Sub-Acute Care Admissions

Services/Procedures/Devices/Programs

Ambulance
- Air and Non-emergent Ground

Behavioral Health
- Intensive Outpatient Program (IOP)
- Neuropsychological Testing
- Psychological Testing, except for children diagnosed with cancer

Cosmetic Procedures (Potential)
- Potentially Cosmetic Procedures
  - Blepharoplasty and Brow Ptosis Repair
  - Breast Reduction Surgery
  - Breast reduction/Mastopexy
  - Breast Repair/Reconstruction (Not Following Mastectomy)
  - Breast Augmentation
  - Canthoophexy/Canthoplasty
  - Cervicoplasty
  - Chemical Peels
  - Laser Treatment for Cutaneous Vascular Lesions
  - Rhinophyma Surgical/Laser Treatment
  - Rhinoplasty, Septoplasty, and Repair of Vestibular Stenosis
  - Sclerotherapy (Varicose Vein Treatment)

Dental Surgery
- Facility and Anesthesia

DME/Prosthetics
- Cranial Remodeling Bands (Helmets)
- Custom Wheelchair
- Hospital Bed and Mattress
- Prosthetic limbs; Whole Limb or Part of Limb

ENT
- Septoplasty
- Temporomandibular Joint Surgery (TMJ)

Genetic Testing
- Breast, Ovarian and Colorectal Cancers

Infertility Services/Treatments
- Services, Treatment and Drugs (Except Clomid)
- Pre-implementation Genetic Testing

Other
- Biofeedback
- Clinical Trials
- Experimental/Investigational Procedures
- Fecal Bacteriotherapy
- Gender Dysphoria Treatment/Services including Gender Reassignment Surgery
- Home Healthcare: All services
- Hyperbaric Oxygen Therapy
- Orthognathic/Jaw Surgery
- Sleep Studies (Except for Location of Service = Home)
- Uvulopalatopharyngoplasty, including Laser-Assisted Procedures
- Uvuloplasty and Laser Assisted Uvuloplasty (LAUP)
## Services/Procedures/Devices/Programs (continued)

### Out-of-Network Services
- Only when requesting in-network level of coverage
- Physical Therapy after the first 10 visits annually

### Radiology
- CT, MRI/MRA, SPECT, PET
- Nuclear Cardiology

### Spinal Surgery
- Inpatient and Outpatient

### Transplants
- Pre-evaluation and at time of transplant (except cornea)

### Rehabilitative and Habilitative Services
- Applied Behavioral Analysis
- Occupational Therapy after the first 10 visits annually

### Notification Requirements
Please notify us via phone or fax if you are treating our members for the following:
- Maternity After First Prenatal Visit
- Birth to Three Program
- Dialysis

### Contact Information

<table>
<thead>
<tr>
<th>Medical Management</th>
<th>Phone:</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Requests, Prior Authorization, Appeals (Medical Necessity) and Notification</td>
<td>855-458-4928</td>
</tr>
<tr>
<td>Case Management Services</td>
<td></td>
</tr>
<tr>
<td>Phone:</td>
<td>855-817-5701</td>
</tr>
<tr>
<td>Appeals (Medical Necessity)</td>
<td></td>
</tr>
<tr>
<td>Fax:</td>
<td>855-817-5697</td>
</tr>
</tbody>
</table>

### Prior Authorization & Notification
The prior authorization list is available in the online Provider Manual. Fax requests to the appropriate area below.

<table>
<thead>
<tr>
<th>Medical/Surgical, PT/OT &amp; Radiology:</th>
<th>855-817-5696</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Care and Home Care IV Fusion:</td>
<td>855-817-5702</td>
</tr>
<tr>
<td>Behavioral Health:</td>
<td>855-817-5703</td>
</tr>
<tr>
<td>In-Patient Services:</td>
<td>855-817-5704</td>
</tr>
</tbody>
</table>
Resources and Tools

**Glossary**

**Grievance** A request by a provider or member to change a decision for a non-medically necessary issue (i.e.: claims, administrative denials, benefits)

**Appeal** A formal request by a provider or member for reconsideration of an adverse determination for medical necessity decision (e.g., utilization review recommendation, benefit payment, administrative action, and quality-of-care or service issue).

**Accreditation** The process by which an independent agency or organization evaluates and recognizes a health care facility, provider, health plan or program for purposes of assuring the public of its quality. One such agency is the National Committee for Quality improvement (NCQA).

**Active Course of Treatment** Treatment in which discontinuity could cause a recurrence or worsening of the condition under treatment and interfere with anticipated outcomes. Treatment typically involves regular visits with the practitioner to monitor the status of an illness or disorder, provide direct treatment, prescribe medication or other treatment or modify a treatment protocol.

**Adverse Determination** (A) the denial, reduction, termination or failure to provide or make payment, in whole or in part, for a benefit under the HCT’s health benefit plan requested by a member or a member’s treating health care professional, based on a determination by HCT or its designee utilization review company:

- That, based upon the information provided,
  - upon application of any utilization review technique, such benefit does not meet the health carrier’s requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, or
  - is determined to be experimental or investigational;
- Of a covered person’s eligibility to participate in the health carrier’s health benefit plan; or

(B) Any prospective review, concurrent review or retrospective review determination that denies, reduces or terminates or fails to provide or make payment, in whole or in part, for a benefit under the HCT’s health benefit plan requested by a member or a member’s treating health care professional.

**Ambulatory Setting** A setting in which non-acute care is provided on an outpatient basis to patients who leave the setting on the same day they receive treatment (e.g., urgent care centers, walk-in clinics or outpatient surgery centers).

**Appropriate Care** Medical care provided for a diagnosis that, in terms of medical necessity, setting, types of treatment, duration or length of stay and frequency, is based on a generally accepted medical treatment.

**Attestation** A signed statement indicating that a practitioner personally confirms the validity, correctness and completeness of the credentialing application at the time of application to the health plan.

**Authorized Representative** means

- A person to whom a covered person has given express written consent to represent the covered person for the purposes of this section and sections 38a-591b to 38a-591m, inclusive;
- A person authorized by law to provide substituted consent for a covered person;
- A family member of the covered person or the covered person’s treating health care professional when the covered person is unable to provide consent;
- A health care professional when the covered person’s health benefit plan requires that a request for a benefit under the plan be initiated by the health care professional; or
• In the case of an urgent care request, a health care professional with knowledge of the covered person’s medical condition.

**Applied Behavioral Analysis** Applied Behavioral Analysis means the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior, to produce socially significant improvement in human behavior. Supervision requires at least one hour of face-to-face supervision of the autism services provider for each ten hours of Behavioral Therapy.

**Best Evidence** means evidence based on
- randomized clinical trials,
- if randomized clinical trials are not available, cohort studies or case-control studies,
- if such trials and studies are not available, case-series, or
- if such trials, studies and case-series are not available, expert opinion.

**Birthday Rule** Primary carrier is the health plan/insurer of the parent whose month and day of birth occurs earlier in the calendar year. If parents share the same birthday, the primary carrier is the health plan that has been in effect longer. (See also: Coordination of Benefits).

**Business Associate Agreement** A contract between a covered entity and a business associate that does all of the following.

**Calendar Year** A calendar year is January 1 through December 31 of the same year. When the Member first enrolls, their calendar year begins on their effective date and ends on December 31 of the same year.

**Care Plan** A set of information about the member that facilitates communication, collaboration and continuity of care. The Care Plan is tailored to each individual and takes members physical and behavioral health status into consideration. The care plan includes, but is not limited to, both medical and non-medical information (i.e.: current problem list, medication regimen, advanced directives, baseline physical and cognitive function and support system.

**Case Management** A plan of medically necessary and appropriate health care aimed at managing costs and promoting more effective intervention to meet patient needs. Often, non-traditional benefits are used to promote cost-effectiveness.

**Case Manager** A professional (e.g., nurse, doctor or social worker) who works with Members, providers and insurers to coordinate all services deemed medically necessary for the Member.

**Clinical Peer** means a physician or other health care professional who holds a non restricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review.

**Clinical Criteria** means the written screening procedures, decision abstracts, clinical protocols and practice guidelines used by the health carrier to determine the medical necessity and appropriateness of health care services

**Coinsurance** The percentage of health care expenses that a Member is responsible for paying. For example, if a policy covers 80% of a given expense, the Member’s responsibility, or coinsurance amount, is 20%.
**Complex Case Management** A collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual’s holistic needs through communication and available resources to promote quality cost effective outcomes.

**Concurrent Review** means utilization review conducted during a patient’s stay or course of treatment in a facility, the office of a health care professional or other inpatient or outpatient health care setting, including home care.

**Contract Year** January 1st through December 31st.

**Coordination of Benefits** Also known as COB, this stipulation helps prevent double payments for services covered by more than one policy or program. For example, a person may be covered by his or her own policy, as well as a spouse’s. Eligible medical expenses are covered first by a person’s own policy. Any balance is submitted to the spouse’s health plan for additional consideration. *(See also: Birthday Rule.)*

**Copayment** A fixed amount a Member pays the Agency for each covered service or prescription at the time the service is rendered or the prescription is dispensed; for example, a $15 copayment per office visit or a $5 copayment per prescription.

**Cosmetic Treatments** Any medical or surgical treatment for which the primary purpose is to change appearance as we determine in our sole discretion.

**Cost Sharing** A general term used for out-of-pocket expenses (deductibles, copayments and/or coinsurance) paid by a health plan Member. *(See also: Coinsurance, Copayment, and Deductible)*

**Custodial Care** Those services and supplies furnished to a Member who has a medical condition that is chronic or non-acute in nature which, at our discretion, either:

1. Are furnished primarily to assist the patient in maintaining activities of daily living, whether or not the Member is disabled, including, but not limited to, bathing, dressing, walking, eating, toileting and maintaining personal hygiene; or
2. Can be provided safely by persons who are not medically skilled, with a reasonable amount of instruction, including, but not limited to, supervision in taking medication, homemaking, supervision of the patient who is unsafe to be left alone and maintenance of bladder catheters, tracheotomies, colostomies/ileostomies and intravenous infusions (such as TPN) and oral or nasal suctioning.

These services and supplies are considered Custodial and are not reimbursed or paid, no matter who performs them, even if you do not have a family member, friend or other person to perform them. If skilled home health care services have been Prior-Authorized, the covered Health Services may, under some circumstances, include custodial services, if provided by a home health aide in direct support of the approved skilled home health care.

**Covered Services** Hospital, medical, and other health care services and supplies provided to a Member for which Benefits are paid under a Contract.

**Deductible** The amount a Member must pay out-of-pocket before an insurance policy begins to pay benefits. Deductibles usually are fixed-dollar amounts based on a specific benefit period (such as $200 per year.)

**Delegated** A health plan function managed by an outside company. When this document refers to determinations, Prior-Authorizations or other decisions made under the terms of that Delegated Program, such determinations or Prior-Authorizations other decisions are made by the outside company on our behalf.
Disease management  An approach to healthcare that teaches patients how to manage a chronic disease. Patients learn to take responsibility for understanding how to take care of themselves to avoid potential problems or exacerbation, or worsening, of their health problem.

Dispute  A verbal, written or emailed request of dissatisfaction from a provider acting on his/her own behalf that is not related to any adverse determination for medical necessity or benefits. Disputes are specially related to credentialing, fee schedules, or other contract related matters, coding, modifiers, bundling or other claim related matters.

Durable Medical Equipment (DME) including prosthetics consists of non-disposable equipment which is primarily used to serve a medical purpose that is generally not useful to a person in the absence of illness or injury and is appropriate for use in the home.

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson with an average knowledge of health and medicine, acting reasonably, would have believed that the absence of immediate medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

Essential Health Benefits The Affordable Care Act ensures health plans offered in the individual and small group markets, both inside and outside of the Health Insurance Marketplace, offer a comprehensive package of items and services.

Exchange (Access Health CT) The Connecticut Health Insurance Exchange (Access Health CT) was established as a quasi-public agency to satisfy the requirements of the federal Affordable Care Act. The Exchange is a marketplace where eligible individuals and small groups will be able to shop for and purchase health insurance coverage, beginning in October 2013.

Experimental OR Investigational A service, supply, device, procedure or medication (collectively called "Treatment") will, in our sole discretion, be considered Experimental or Investigational if any of the following conditions are present:

1. The prescribed Treatment is available to you or your Eligible Dependents only through participation in a program designated as a clinical trial, whether a federal Food and Drug Administration (FDA) Phase I or Phase II clinical trial, or an FDA Phase III experimental research clinical trial or a corresponding trial sponsored by the National Cancer Institute, or another type of clinical trial; or
2. A written informed consent form or protocols for the Treatment disclosing the experimental or investigational nature of the Treatment being studied has been reviewed and/or has been approved or is required by the treating facility's Institutional Review Board, or other body serving a similar function or if federal law requires such review and approval; or
3. The prescribed Treatment is subject to FDA approval and has not received FDA approval for any diagnosis or condition.

If a Treatment has multiple features and one or more of its essential features are Experimental Or Investigational based on the above criteria, then the Treatment as a whole will be considered to be Experimental Or Investigational and not covered.

Explanation of Benefits Also known as EOB, this is a printed form sent by an insurance company to a Member after a claim has been filed and adjudicated. The EOB includes such information as the date of service, name of provider, amount covered and patient balance. An Explanation of Medicare Benefits, or EOMB, is similar, except it is sent following submission of a Medicare claim.
**Health Risk Appraisal (HRA)** An assessment of the member’s physical, psychosocial and functional needs that is used to develop a care plan.

**Health Services** Those diagnostic and therapeutic, medical, surgical, and behavioral health services and supplies that are Medically Necessary and available to you and your Eligible Dependents under this Plan. Health Services must be provided or rendered by a licensed health care provider within the scope of his/her license or authorization in accordance with the laws and regulations of the governmental authority having jurisdiction.

**HEDIS** The acronym for Health Plan Employer Data and Information Set. HEDIS is a core set of performance measures to assist employers and other health care purchasers in understanding the value of health care purchases and evaluating health plan performance.

**Home Health Care** An umbrella name of skilled nursing, occupational therapy and other health-related services provided at home by an accredited agency.

**Home Health Agency** A duly licensed agency where:
1. Nursing care is provided by a registered nurse or licensed practical nurse;
2. Home health aide services consisting of patient care of a medical or therapeutic nature are provided by someone other than a registered or licensed practical nurse;
3. Physical, occupational or speech therapy is provided;
4. Certain medical supplies, drugs and medicines prescribed by a physician and laboratory services to the extent such services would be covered if Medically Necessary, as we determine, are provided; and
5. Medical social services are provided by a qualified Masters-prepared social worker to or for the benefit of a terminally ill Member (i.e., having a life expectancy of six months or less).

**Hospice Care** An agency that provides counseling and incidental medical services for a terminally ill (i.e., having a life expectancy of six months or less) individual. To be a Hospice, the agency must:
1. Be licensed in accordance with all laws;
2. Provide 24-hour-a-day, seven days-a-week service;
3. Be under the direction of a duly qualified physician;
4. Have a nurse coordinator who is a registered graduate nurse with clinical experience, including experience in caring for terminally ill patients;
5. Have as its main purpose the provision of hospice services;
6. Have a full-time administrator;
7. Maintain written records of services given to the patient; and
8. Maintain malpractice insurance coverage.

For purposes of this Plan, a Home Health Agency that provides hospice care in the home or a hospice, which is part of a Hospital, will be considered a Hospice.

**Hospital** An institution duly licensed as a hospital by the governmental authority having jurisdiction and a mobile field hospital when isolation care and Emergency Services are provided.

**Inpatient** An individual who occupies a hospital bed - usually overnight - while receiving hospital care, including room, board and general nursing care.

**Inquiry** A verbal, written or e-mailed request from a provider for information that is not a dispute or related to any adverse determination for medical necessity or benefits. Examples may include but are not limited to: participation status, claim or check status, HCT policies and procedures, website registration, etc.

**Intensive Outpatient (IOP)** The level of behavioral health care which is less intensive than Partial Hospitalization, but more intensive than outpatient services. Typically, IOP services are customized to meet the
individual patient’s needs, but have the capacity for a maximum of three to five encounters per week of less than four hours each in duration. The range of services offered is designed to address a mental health or substance abuse disorder in a coordinated, interdisciplinary treatment modality.

Managed Benefits A Managed Benefits program is designed to educate Members about benefit options and encourage them to actively participate in the management of their health care needs. Components of the Managed Benefits program are:

- **Prior authorization of Hospital Admission**: prior authorization of elective admissions up to one business day prior to hospital admission.
- **Emergency or Urgent Admission Review**: Review and authorization of all emergency and urgent admissions up to twenty-four (24) hours or one (1) business days following a hospital admission.
- **Concurrent Stay Review**: Assessment of medical necessity or appropriateness of services as they are being rendered.
- **Nurse Consultant Assistance**: Guidance of a registered nurse who is reached through a toll-free number to help Members through the review process.
- **Case Management**: Comprehensive approach for dealing with costly, catastrophic or complex cases. Needs are identified and a plan of care is initiated to achieve optimum patient outcomes.
- **Behavioral Health Management**: Review and authorization for all in-patient mental health and substance abuse admissions.

Managed Care The blanket term for products that integrate financing and delivery of health care services. This may be accomplished through:

- Arrangements with selected providers to furnish a comprehensive set of health care services to Members.
- Explicit criteria for the selection of health care professionals.
- Formal programs for ongoing quality improvement and utilization review.
- Significant financial incentives for Members to use physicians and services associated with the plan.

Medically Necessary Care "Medically necessary" or "medical necessity" means health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the patient’s illness, injury or disease;
- Not primarily for the convenience of the patient, physician or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease.

For the purposes of this subsection, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with the standards set forth in policy issues involving clinical judgment.

Member Any person who is eligible to receive Covered Services.

NCQA The acronym for National Committee for Quality improvement, a nationally recognized organization that evaluates managed care plans to help purchasers, regulators and consumers assess how well a plan serves its Members. NCQA evaluates health plans in six areas: continuous quality improvement, credentialing, Members’ rights and responsibilities, preventive health services, utilization management and medical records.

Out-of-Network The term for treatment or services rendered by a non-participating provider, usually at a higher out-of-pocket cost to the Member than services rendered by a participating provider.
**Out-of-Pocket Maximum** The total amount (deductible plus coinsurance) that a Member will have to pay for medical expenses under his or her policy during a specified period. This is sometimes also known as the “cost share maximum”.

**Outpatient** An individual whose medical care does not require a hospital bed or overnight admission to the hospital.

**Participating Hospital** A Hospital that has entered into an agreement with us, to provide certain Health Services to you and your Eligible Dependents. A Participating Hospital is a Hospital that when used by a Member typically provides a higher level of benefits, because out-of-pocket Cost-Shares are lower.

**Participating Pharmacy** A select pharmacy that has entered into an agreement with us, to provide covered prescription drugs, medications and supplies to you and your Eligible Dependents. A Participating Pharmacy is a pharmacy that when used by a Member typically provides a higher level of benefits, because out-of-pocket Cost-Shares are lower. A Participating Pharmacy does not include a Hospital pharmacy, even if the Hospital is a Participating Hospital.

**Participating Provider** Any appropriately licensed or certified health care physician, professional or facility designated and accepted as a Participation Provider by HealthyCT to provider Covered Services to Members under the terms of the Policy. This includes without limitation, a hospital, a rehabilitation facility, a home health agency, a home infusion therapy provider, a laboratory, a physician and a psychologist that has, directly or indirectly, entered into a written agreement with HealthyCT to provide Covered Services.

**Participating Provider Manual** A document that contains information concerning a provider’s rights and responsibilities, policies and health plan rules.

**Payor** A person or entity which is liable for funding, administering or insuring Covered Services.

**Plan** Any plan which provides benefits or services for hospital, medical/surgical or other health care diagnosis or treatment on a group basis. Specifically, a health plan or program which is offered, sponsored, insured or administered by HealthyCT or by an entity with HealthyCT has agreed to provide access to Covered Services for Members.

**Practitioner** A professional who provides health care services. Practitioners are usually licensed as required by law.

**Premium** The amount paid to an insurance company for enrollment in an underwritten insurance plan.

**Preventive Care** Comprehensive care that emphasizes prevention, early detection and early treatment of conditions through routine physical exams, immunizations and health education.

**Primary Care Physician (PCP)** A physician, usually a pediatrician, internist or family practice doctor who delivers or coordinates all of a Member’s medical care. As the Member’s first contact, the PCP provides a range of health care services, including initial diagnosis and treatment, health supervision, management of chronic conditions, preventive care and referrals to specialists, when appropriate.

**Prior Authorization** A program in which the medical need for non-emergency hospital admissions is reviewed prior to admission. Typically, Members and/or their physicians must obtain prior approval from the insurer for the hospitalization to obtain maximum coverage under their policies. *(See also: Managed Benefits)*
Prior-Authorization Rules For Non-Emergencies All non-Emergency Inpatient admissions must be Prior
Authorized at least fifteen (15) business days before the Member is admitted. Special Prior-Authorization rules
apply to transplant services. Prior-Authorization must be obtained at least fifteen (15) business days before any
evaluative transplant services are performed.

Prudent Layperson A person who is without medical training and who draws on his/her practical experience
when making a decision regarding whether Emergency medical treatment is needed. A Prudent Layperson will be
considered to have acted “reasonably” if other similarly situated laypersons would have believed, on the basis of
observation of the medical symptoms at hand, that Emergency medical treatment was necessary.

Residential Treatment Facility A treatment center for children and adolescents that provides residential care
and treatment for emotionally disturbed individuals and is licensed and accredited by the governmental authority
having jurisdiction.

Skilled Nursing Facility A facility that accepts patients who need rehabilitation and medical care that is of a
lesser intensity than that received in a hospital.

Therapeutic Equivalent Drug or Supply A drug or supply in the same category as an excluded drug or supply
determined by us to be an effective alternative.

Urgent Care Request A request for a health care service or course of treatment for which the time period for
making a non-urgent care request determination

- could seriously jeopardize the life or health of the covered person or the ability of the covered person to
  regain maximum function, or
- in the opinion of a health care professional with knowledge of the covered person’s medical condition,
  would subject the covered person to severe pain that cannot be adequately managed without the health
care service or treatment being requested.

Utilization Management Utilization management is the evaluation of the appropriateness, medical need and
efficiency of health care services procedures and facilities according to established criteria or guidelines and under
the provisions of an applicable health benefits plan. Utilization management describes proactive procedures,
including discharge planning, concurrent planning, prior authorization and clinical case appeals.

Walk-In Clinic A facility designed to treat common ailments. Examples of common ailments include, but are not
limited to:

- Colds, flu symptoms, sore throat, cough or upper respiratory symptoms;
- Ear or sinus pain;
- Minor cuts, bruises, or scrapes;
- Rash, hives, stings and bites; and
- Sprains.

Walk-In Care Clinic provide basic primary health care and are typically staffed by a nurse practitioner or at the
most physician’s assistant.