



Advantage Care Network, Inc.

Participating Provider Manual

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Membership Requirements

Participation with *Advantage Care Network, Inc.*, (*ACN*) is afforded to qualified, competent and professionally licensed health practitioners. This appointment is only available to providers who have met the current criteria and have undergone a thorough credentialing process in which the provider's qualifications, standing and licensure have been verified by *Advantage Care Network, Inc.* The process of verification is handled by *ACN* in a manner which, when implemented, ensures that the providers in the network consistently meet the highest standards available.

Sex, race, religion, creed, national origin, or any other criteria lacking professional justification shall not be considered in determining qualifications for participants in *Advantage Care Network, Inc.*

ACN shall not discriminate against providers who deal primarily with "high-risk" populations and/or those providers who specialize in treatment of costly conditions.

This Manual will serve as your reference guide to your participation with *Advantage Care Network, Inc.* It details our joint and individual obligations and responsibilities. As an overview, we have summarized your responsibilities as a preferred provider. Again, this is only a summary. The contract governs all aspects of the agreement made by and between *Advantage Care Network, Inc.* and the provider.

CREDENTIALING

a. Initial Credentialing Process

Advantage Care Network, Inc. is required to credential all new providers prior to participation in the network. The applicant shall complete the standardized credentialing application and deliver a completed application to *Advantage Care Network, Inc.*, to include proof of licensure, proof of current malpractice insurance coverage, applicable credentialing fees, and other applicable documents. Utilizing our current NCQA accredited primary source verification company, all licensing and accreditation documents are verified as per the current NCQA guidelines.

To be considered complete, the credentialing application shall require the following detailed information. These requirements are to be included with the Texas Standardized Application, New Mexico Credentialing Application or NCQA approved Application which can found at:
<http://www.advantagecarenetwork.com/forms>

- Hospital Affiliations Letters
- Professional license(s) and Certificates
- Current malpractice insurance coverage
- Professional Specialty Information
-

Current federal DEA license(s) and state controlled substance certificates(s) (if applicable), and detailed information regarding any past suspension, revocation or limitation of the applicant's license

- Attestation/Consent Release Form found on the website address:
<http://www.advantagecarenetwork.com/forms>
- Copy of the CMS Letter containing your NPI & Taxonomy Number
- Synopsis of any malpractice reports

b. Re-Credentialing Process

Advantage Care Network, Inc. is required to re-credential all Participating Providers on a three-year schedule. Therefore, when the re-credentialing period approaches, you will be asked to review and submit an updated application, current license(s), current malpractice insurance coverage and applicable re-credentialing fees. As a current Advantage Care Network Provider, the expectation is that all documentation, licenses and scope of practice are updated on an annual basis to maintain a current provider file. Refer to the current criteria below. but are not limited to:

- ◆ Changes in hospital admitting privileges
- ◆ Professional Liability coverage (terminations, transfers, changes in coverage levels)
- ◆ Malpractice judgments, settlements or pending cases
- ◆ Changes in any of the following: (to include a denial, revocation, suspension, reduction, limitation, probation, non-renewal, or voluntarily relinquished or withdrawal or failure to proceed with an application involving the following):
 - Licenses in any state
 - Other health-related professional registrations/licenses
 - DEA/Controlled Substances Registration
 - Academic appointments
 - Membership on any hospital staff
 - Clinical privileges at any hospital
 - Other institutional affiliation or status or privileges
 - Health-related professional society membership or fellowship/Board certifications
 - Medicare, Medicaid or other third party payer sanctions
 - Any conviction of or pleading no contest to any criminal charges (other than motor vehicle violations)
 - Any convictions of or pleading no contest to a drug or alcohol related offense
 - Any sanctions by a PSRO, PRO or similar federal or state agency
 - Any other type of sanction
 - Any physical or mental health condition, including alcohol or drug abuse, that affects or that may reasonably be expected to progress within the next two years to the point of affecting your ability to practice your profession or place your patients at increased risk.

Please note that sending in expired documents will delay the credentialing/re-credentialing process. The application will be considered incomplete and will be sent back to you.

In the event of a change to the following, please submit written notice: address/website with in 10 days of the change:

**Change in office location
Change in telephone number, fax number
Addition of an office location
Change in Tax ID number
Addition/Deletion of a provider**

A provider being considered for participation with Advantage Care Network will be evaluated utilizing the current criteria, to include a provider's education, licensing, credentials, and current status, as well as current economic and business needs.

REFERRAL OF MEMBERS TO OTHER PROVIDERS

In the event you need to refer your patient for services outside of your scope of practice, please refer to the Online Provider Directory for a current listing of participating providers. The online provider directory is located at the website address below:

<http://www.advantagecarenetwork.com>

If you have any questions please contact us at:

HealthSCOPE Benefits, Inc. / Advantage Care Network, Inc.
7430 Remcon Circle, Building C
El Paso, Texas 79912
(915) 581-8182 or 1-800-854-2339

www.healthscopebenefits.com
www.advantagecarenetwork.com

Credentialing/Re-Credentialing Criteria:

The Criteria include, but are not limited to the following:

PROFESSIONAL CREDENTIALS (TIER 1)

1. Provider is either (i) a person with an unrestricted license or other authorization to practice in the State of Texas; or (ii) a partnership, professional service corporation or other entity, all of the partners, shareholders, members and provider employees of which have an unrestricted license or other necessary authorization to practice in the State of Texas. A copy of Provider's current valid license shall be provided with Provider's application to Advantage ("Application").
2. Provider, where applicable, has active and unrestricted clinical privileges in Provider's specialty at a minimum of one (1) Participating Provider that has entered into an agreement with Advantage. Provider shall maintain each hospital medical or professional staff appointment and all clinical privileges granted in connection therewith that Provider possessed as of the Effective Date of Provider's Participating Provider Agreement. A letter from each Hospital stating the Provider has such clinical privileges shall be provided with the Application.
3. Provider shall, if permitted under Provider's license, have and maintain unrestricted prescribing privileges. A copy of Provider's current DEA certification and state drug registration, if applicable, shall be provided with the Application.
4. Provider, where applicable, has not and shall not (i) have any hospital appointment or privileges reduced, limited, suspended or terminated or been placed on probation by any hospital at which Provider has had a medical or professional staff appointment or privileges; (ii) been restricted from receiving payments from Medicare, Medicaid or any other third party reimbursement programs; (iii) been subject to disciplinary action by any state or local medical society, specialty society, state board of medical examiners or the Drug Enforcement Agency; or (iv) been subject to sanctions of any kind whatsoever by any person or entity for improper prescribing procedures or actions; PROVIDED, HOWEVER, that, in the sole discretion of Advantage, the foregoing shall not apply to suspensions related to a reasonable delay in completing medical records. Any such actions shall be reported by Provider on the Application.
5. Provider has not been convicted of a felony.
6. Provider is in good general health.
 - 6.1 Provider shall report on the Application any physical or mental problems that may affect Provider's ability to practice Provider's profession. If Provider has such disabilities the Provider shall provide, with the Application, a statement from Provider's personal physician stating that the disabilities shall not interfere with the Provider's ability to provide high quality medical care.
 - 6.2 Provider shall certify on the Application that Provider does not have a history of and is not presently abusing drugs or alcohol. A Provider with a history of drug or alcohol abuse may be considered for membership in Advantage, within the sole discretion of Advantage, if such Provider's personal physician provides a statement that Provider has been rehabilitated and is continuing with the rehabilitation program.
 - 6.3 Provider shall certify on the Application that Provider does not have any communicable and/or chronic infectious diseases that may be potential danger to patients.

7. Provider shall purchase and maintain, at the sole cost and expense of Provider, policies of professional liability insurance in amounts as required by Advantage from time to time. At the present time such insurance shall be a minimum of \$1,000,000 per occurrence/\$3,000,000 aggregate, unless a lesser amount is accepted by Advantage in its sole discretion or where state law otherwise mandates Provider shall authorize the insurance carrier to issue to Advantage a certificate of insurance policies of Provider upon the request of Advantage, and each such policy shall contain an endorsement, requiring the insurer to give Advantage not less than thirty (30) days prior written notice of any cancellation, termination or material alteration of such policy. Notwithstanding the foregoing, Provider shall provide Advantage with notification within fifteen (15) days of any cancellation, termination or material alteration of any such insurance policies. Prior to the expiration or cancellation of any such policy, Provider shall secure replacement of such insurance coverage upon the same terms, and shall furnish Advantage with a certificate and endorsement as described herein. A copy of the issuing section of the policy reflecting such insurance shall be provided with the Application.

8. Provider shall provide the following information on the Application:

8.1 Details of any professional liability actions instituted against Provider or that have resulted in adverse judgments or any financial settlements.

8.2 Details of any pending professional liability actions.

This information shall be reviewed by Advantage. The evaluation shall consider the frequency of such actions, the financial impact of such actions and the clinical circumstances surrounding the alleged acts of malpractice. Advantage is fully cognizant of the current litigious conditions in the United States and its evaluation shall consider the litigious climate as part of the credentialing process. Providers shall not be automatically disqualified from participation in Advantage due to a history of judgments and/or settlements. Advantage has sole discretion in the determination of the impact of this information for purposes of credentialing.

9. If applicable, Physician shall be board certified in a specialty recognized by the American Board of Medical Specialties. Physicians that have recently completed training and are board eligible may be considered for probationary membership pending board certification; PROVIDED, HOWEVER, if a Provider fails to become board certified within the time frame prescribed by the appropriate board, the Participating Provider Agreement of such Provider shall be automatically terminated. A copy of Provider's board certification or a letter from the appropriate board indicating eligibility shall be provided with the Application.

10. The Provider shall provide complete information with respect to professional training which shall include, without limitation, the following:

- 10.1 Undergraduate Education
- 10.2 Medical and/or Professional Education
- 10.3 Internship and Residency
- 10.4 Fellowships
- 10.5 Teaching appointments
- 10.6 Professional publications
- 10.7 References where required on the Application

Advantage has the sole discretion with respect to the determination of the acceptability of such credentials.

11. Provider shall execute the appropriate release of Advantage directing any and all entities that may have information with respect to the ability to practice high quality medicine to provide such information to

Advantage upon request. Such entities include, without limitations, hospitals, medical societies, state examining boards, Medicare intermediaries and other third party payors.

12. Advantage reserves the right to require independent verification of any and all of the Credentialing Criteria.

13. Advantage reserves the right to require applicable credentialing/re-credentialing fees.

ECONOMIC AND BUSINESS NEEDS CRITERIA (TIER II)

The Professional Credentials constitute the Credentialing Criteria for the professional qualifications of Providers. Providers qualifying under the Professional Credentials shall be evaluated by Advantage to determine if such Provider fulfills the Economic and Business Needs Criteria. The Economic and Business Needs Criteria of Advantage regard the economic evaluation of the Provider and a determination of the need for additional Providers, additional specialties and/or additional geographical representation:

14. Advantage shall utilize available data sources to evaluate, where possible, *the cost effectiveness of the patterns of practice of a Provider. The evaluation factors may include, without limitation: frequency of service; intensity of service; average cost per DRG; average cost per encounter; usage of ancillary services; and a Provider's fee. A significant differentiation by Provider in any of the parameters subject to this evaluation may indicate a practice style and philosophy incompatible with the business objectives of Advantage. Advantage may determine, in its sole discretion, to decline to execute a Participating Provider Agreement or terminate an existing Participating Provider with any Providers based upon this or any other information.*

15. Advantage shall utilize available data sources to evaluate, where possible, *the quality and cost effectiveness of the provider. The evaluation factors may include morbidity data, mortality data, recidivism (for mental health and substance abuse Facilities), average length of stay, occupancy rate, readmission rates, cesarean section rates, infection rates and other indicators as determined by Advantage. A significant differentiation by the provider in any of the parameters subject to this evaluation may disqualify the provider pursuant to the Credentialing Criteria.*

16. It is anticipated that the number of Providers qualifying pursuant to the Professional Credentials shall exceed the number of Providers required by Advantage. Therefore, a Provider qualifying under the Professional Credentials shall be evaluated under the Economic and Business Needs Criteria by Advantage to determine if Provider's participation enables Advantage to better fulfill its business needs. The evaluation shall include; without limitation: Provider's specialty; the need for a Provider in a specific geographic area; the number of Providers necessary to service the population; the relationship of a Provider to other Participating Providers; and, unique skills such as foreign language proficiency. Qualification under the Economic and Business Needs Criteria shall be in the sole discretion of Advantage. A qualifying Provider may become a Participating Provider immediately or at a subsequent time as Advantage expands its services, patients and/or area.

17. From time to time, Advantage may, in its sole discretion, to fulfill its business objectives, offer Participating Provider Agreements to Providers deemed to be competent Providers who may not fulfill each aspect of the Credentialing Criteria. Input may be sought from Payors. For example, if Advantage required a Provider with a specific specialty or a specific location and a board certified Provider was unavailable, the requirement for board certification may be waived in that location for a particular Provider otherwise qualified. Geographic consideration with respect to access to medical care may cause Advantage to accept a provider in the best interest of Eligible Persons.

HealthSCOPE Benefits, Inc. Employer Groups

<u>GROUP NAME</u>	<u>GROUP ID</u>
County of El Paso	COUN
Diocese of El Paso	DIOCE
HealthSCOPE Benefits	HSB
Housing Authority	HOUS
San Elizario ISD	SANEL
Sisbarro	SISB
Superior	SUPE
Ysleta Del Sur Pueblo	YDSP
Ysleta ISD	YSLET

<u>LIMITED BENEFITS PLANS</u>	<u>GROUP ID</u>
Max E-Stores	MAXE

Please be advised that the following plans have access to *Advantage Care Network, Inc.*:

**ASSURANT Health
CoastalComp HealthNetworks**

HealthSCOPE Benefits

Hospital Affiliations

Group	Hospital Affiliations
County of El Paso	OPEN ACCESS PPO
Ysleta ISD	OPEN ACCESS PPO
Housing Authority	OPEN ACCESS PPO
Superior	OPEN ACCESS PPO
Ysleta Del Sur Pueblo	OPEN ACCESS PPO
San Elizario ISD	OPEN ACCESS PPO
Catholic Diocese of El Paso	OPEN ACCESS PPO
HealthSCOPE Benefits	OPEN ACCESS PPO

CUSTOMER CARE - MEMBER ELIGIBILITY

ONLINE ACCESS TO ELIGIBILITY & CLAIMS

Providers may access information online at www.healthscopebenefits.com 24 hours a day 7 days a week.

The following information can be obtained by visiting our online claims and customer care web site:

- Claims status
- Eligibility status
- Schedule of Benefits
- Online copy of Explanation of Benefits

To register, you will need to obtain a user id and password by following these simple steps:

- Go to www.healthscopebenefits.com
- Click on the provider tab
- Click on view claims status
- Enter company name
- Click no when asked if you have registered for a user name and password
- Complete the registration form and click submit
- Your user name and password will be sent to you via email

For further assistance please contact Customer Care at (915) 581-8182 or 1-800-854-2339.

MEDICAL MANAGEMENT

HealthSCOPE Benefits, Medical Management Department is licensed as a Utilization Review Agent with the Texas Department of Insurance. The HealthSCOPE Benefits, Inc. Utilization Management Program is a systematic evaluation of the entire scope of healthcare services that a member receives while enrolled in the health plan. The purpose of Utilization Management is to ensure that Members receive healthcare services that are medically necessary, appropriate to the patient's condition, provided in a cost-effective and quality manner, and rendered in the appropriate setting.

The Utilization Management Plan applies to all age categories and range of diagnoses. Utilization Review activities are focused on high volume, high risk and problem prone areas. The Utilization Management Plan will apply to all eligible membership in order to achieve equitable, optimal healthcare services. The Utilization Management Program goals and objectives will be accomplished utilizing a process of healthcare assessment through prospective, concurrent, retrospective review of services, and case management.

Personnel employed by or under contract with the Medical Management Department to perform utilization review are appropriately trained and qualified and if applicable, currently licensed. Any personnel obtaining information regarding a patient's specific medical condition, diagnosis and treatment options or protocols directly from the physician, healthcare provider, either orally or in writing, and who are not Physician are nurses, or healthcare providers qualified to provide the service requested by the provider.

All covered services authorized or approved by the Medical Management Department must be medically necessary. Medical necessity means that the covered services prescribed are known by the majority of licensed practitioners to be safe and effective for the diagnosis or treatment of that injury or illness. The Medical Management Department's Utilization Review Process, in regards to determining medical necessity, is guided by nationally recognized criteria, called Milliman Care Guidelines. Milliman Care Guidelines span the continuum of patient care and describe the best practices for treating common conditions in a variety of care settings. Milliman Care Guidelines are utilized as a screening guide and are not intended to be a substitute for practitioner judgment. Utilization review decisions are made in accordance with currently accepted medical or healthcare practices, taking into account special circumstances of each case that may require deviation from the norm stated in the screening criteria. Criteria are used for the determination of medical necessity but not for the denial of services. The Medical Director reviews all potential denials.

Utilization Review Process

1. Prior Authorization Process

The prior authorization process requires the review of elective or impending hospitalization prior, (at least seven (7) days), to admission. The prior authorization process includes two levels of review, a Level I review and a Level II review. A Level I review is conducted by nurse reviewers with clinical knowledge and experience in utilization review. The nurse reviewers screen cases for appropriateness using Milliman Care Guidelines.

When the case meets screening criteria, the nurse authorizes the case and if it involves an inpatient stay assigns an initial or expected length of stay. The nurse enters all pertinent information into the claims payment system issues a prior authorization number. The provider is notified of the decision and given the prior authorization number for billing purposes.

Requests for elective medical and surgical admissions not meeting criteria are referred to the Medical Director for Level II review. The Medical Director reviews all documentation pertaining to the case. Telephonic consultation with the attending physician may be initiated when insufficient or conflicting information is obtained during Level I review. After a determination is made by the Medical Director, the case is processed appropriately.

For inpatient and outpatient prior authorization requirements, please refer to current Medical Management Guidelines. Each prior authorization request requires minimal information for consideration. Refer to the current prior authorization form for basic information needed to perform the review.

2. Concurrent Review

Concurrent review is initiated on those admissions that remain in the inpatient setting passed the initial or expected length of stay issued. In addition concurrent review is also initiated for those cases that involve unplanned and/or emergent admissions. Concurrent review verifies the need for continued hospitalization, determines the appropriateness of treatment rendered in the hospital setting, and monitors the quality of care to ensure professional standards of care are met. Information assessed during the review includes: additional days/service/procedures proposed; reasons for extensions; clinical information to support the appropriateness and level of service proposed; and whether the diagnosis is the same or changed.

Concurrent review is conducted throughout the inpatient stay, with each hospital day approved based on the patient's condition. Each day is evaluated for medical necessity. The need for Case Management or discharge planning services is assessed during each concurrent review, meeting the objective of planning for the most appropriate and cost-effective alternative to inpatient care.

If at any time, the patient's stay ceases to meet inpatient criteria or if discharge criteria are met, or alternative care options exist, the nurse contacts the provider and obtains additional information to justify the continuation of the hospitalization. When the medical necessity for the case cannot be determined, the case is referred to the Medical Director to review the continued stay request. After a determination is made by the Medical Director, the case is processed accordingly.

3. Retrospective Review

Retrospective Review is the initial review of any service that has already been received by a member. This may include weekend admissions, emergency care or out of network admissions. If a retrospective review is conducted, a determination will be made within 30 days of receiving all of the necessary information.

4. Discharge Planning

Discharge Planning is a method of controlling costs and directing the appropriate services upon discharge from the hospital.

For patients who have not fully recovered or do not require the highly specialized and expensive services of acute hospital care, discharge planning ensures that the patient receives the most timely appropriate, safe and cost-effective discharge through home healthcare or appropriate placement in a lower level of care setting. Discharge planning should occur as early as possible in a patient's hospital stay. The Medical Management Nurse reviews the post-hospital needs of the member.

When necessary, the Medical Management Nurse works with the UM/UR staff of the hospital to arrange for services needed before the member is discharged from the hospital.

5. Confidentiality of Medical Records

The Medical Management Department Personnel preserve the confidentiality of individual medical records to the extent required by law. Personnel do not disclose or publish individual medical records, personal information, or other confidential information about a patient obtained in the performance of utilization review without the prior written consent of the patient or as otherwise required by law. Personnel may provide confidential information to a third party under contract or affiliated with the Medical Management Department for the sole purpose of performing or assisting with utilization review. Information provided to third parties will remain confidential.

Information generated and obtained by employees in the course of utilization review is retained for at least two years if the information relates to a case for which an adverse decision was made at any point or if the information relates to a case that may be re-opened.

The Medical Management Department provides to the Texas Insurance Commissioner on request individual medical records or other confidential information for determination of compliance with the Texas Administrative Code, Title 28, § 19.1714.

Adverse Determination and Appeals Process

1. Adverse Determination

In the event of an adverse determination or denial issued, written notification is sent by the Medical Management Department to the provider and the member. If the member is hospitalized the written notification is sent only to the provider. This notification includes the following, the principal reason(s) for the adverse determination, the clinical basis for the adverse determination, a description or the source of the screening criteria that were utilized as guidelines in making the determination and a description of the procedure for the appeal process.

In any instance where the Medical Management Department Personnel questions the medical necessity or appropriateness of the healthcare services, the healthcare provider who ordered the services is afforded a reasonable opportunity to discuss the plan of treatment for the patient and the clinical basis for the decision with a physician prior to issuance of an adverse determination.

2. Post Stabilization Denial

Denial of post stabilization care subsequent to emergency treatment as requested by a treating physician or provider is provided within the time frame appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no case to exceed one hour of the request. Notification is made to the treating physician or healthcare provider.

3. Appeals for an Adverse Determination

Appeals may be made orally or by written communication. An enrollee, a person acting on behalf of the enrollee or the enrollee's physician or healthcare provider may appeal an adverse determination orally or in writing. Within five working days from receipt of the appeal, the Medical Management Department sends the appealing party a letter acknowledging the date of receipt of the appeal.

The letter includes a reasonable list of documents needed to be submitted by the appealing party for the appeal. If the appeal is made orally, the Medical Management Department sends a one page appeal form to the appealing party.

Appeals are forwarded to the Physician who was not involved in the previous determination. After review of the appeal, the Medical Management Department issues a response letter to the patient, a person acting on behalf of the patient, or the patient's physician or healthcare provider explaining the resolution of the appeal.

The letter includes a statement of the specific medical and/or contractual reason for the resolution, the clinical basis for such decisions, and the specialization of any physician or other provider consulted. Written notification to the appealing party of the determination of the appeal is made as soon as practical, but in no case later than 30 days after the date the health plan receives the appeal.

4. Expedited Appeals

Expedited appeals are available for emergency care denials, denials of care for life threatening conditions, and denials of continued stay for hospitalized patients. Expedited appeals are reviewed by a healthcare provider who has not previously reviewed the case. Such appeals are completed within a time frame appropriate for the medical immediacy of the condition, procedure, or treatment, but in no event exceed one working day from the date all information necessary to complete the appeal is received. The Medical Management Department provides written confirmation of expedited appeal decisions within two working days of providing initial notification, if the initial notification was not in writing.

HealthSCOPE Benefits, Inc.

Medical Management Guidelines

INPATIENT PRIOR AUTHORIZATION REQUIREMENTS:

Hospital Admission	Pre-admission authorization is required for elective and impending hospitalization prior to the admission (at least 7 days). Elective admissions will be denied for payment unless prior authorized. ADMISSIONS: REQUIRE TIMELY NOTICE FROM THE HOSPITAL. CLINICAL INFORMATION MUST BE CALLED IN AND MAY BE LEFT ON CONFIDENTIAL VOICE MAIL.
Non-Elective Admissions on Weekends or Holidays	Notification should be left on voice mail. <i>No elective admissions should occur on Weekends without prior authorization.</i>
OB Admission	Notification is required.
Admission to NICU	<i>Notification must be made within 24 hours of a transfer.</i>

- **EFFECTIVE APRIL 22, 2009, NO PRIOR AUTHORIZATION NEEDED FOR SLEEP STUDIES (CPT CODES: 95805, 95808, 95810, 95811, 95806 AND 95807)**

MANDATORY PRIOR AUTHORIZATION LIST

- Inpatient Hospitalization/Services, including Mental Health
- Inpatient Emergency Services (within 24 hours)
- Outpatient Surgeries (hospital/other than office) except epidural injections
- MRI, MRA, CT Scan, PET, SPECT
- Home Health Care, Skilled Nursing, and Hospice
- Outpatient Wound Care
- Cardiac Catheterizations
- Therapies (speech, occupational, physical)
- Dialysis
- Chemotherapy
- Radiation
- Botox injections
- Sclerotherapy
- DME

-
- ◆ Authorizations cannot be issued without the appropriate information to determine medical necessity. An authorization number will be assigned to the case once complete information is received.
 - ◆ Referrals and Prior authorization requests are returned to the requesting provider via fax within 24 to 48 business hours of receipt of properly completed form.
 - ◆ Extensions must be authorized one day prior.
 - ◆ No prior authorization needed for outpatient emergency services.
(Emergency: an illness or accident in which the onset of symptoms is both sudden and so severe as to require immediate medical or surgical treatment. This includes accidental injuries or medical emergencies of a life-threatening nature or when serious impairment of bodily functions would result if treatment were not rendered immediately).
 - ◆ Please note Prior Authorization is required for secondary coverage under HealthSCOPE Benefits, Inc., unless Medicare is their primary coverage.
 - ◆ No prior authorization required for members with Medicare as primary coverage.

HealthSCOPE Benefits, Inc.
PRIOR AUTHORIZATION FORM

PLEASE FILL OUT THE FORM COMPLETELY AND SUBMIT DOCUMENTATION REGARDING
THE DIAGNOSIS FOR WHICH SERVICES ARE BEING REQUESTED TO FAX NUMBER:
(915) 760 – 8613

PRECERT/AUTHORIZATION #: _____

DATE OF REQUEST: _____ **CONTACT PERSON:** _____

PHONE NUMBER: _____ FAX NUMBER: _____

NAME OF CARDHOLDER: _____ I.D.# _____

PATIENT NAME: _____ GROUP#: _____ D.O.B.: _____

PHYSICIAN REQUESTING SERVICES: _____

SERVICE REQUESTED: _____ CPT CODE: _____

DIAGNOSIS: _____ ICD-9 CODE: _____

FACILITY/HOSPITAL: _____ TELEPHONE#: _____

TIN: _____ FAX NUMBER: _____

OUTPATIENT INPATIENT D.O.S.: _____

THERAPIES: PT, OT, ST, HOME HEALTH CARE & WOUND CARE **PLEASE PROVIDE FREQUENCY & DURATION,** (BEGINNING & ENDING DATES): _____

SUPPORTING DOCUMENTATION SHOULD INCLUDE THE FOLLOWING:

PROVIDER PROGRESS NOTES YES NO OTHER: _____

SPECIALIST NOTES/CONSULT REPORTS YES NO OTHER: _____

*TURN AROUND TIME WILL BE FROM 24 TO 48 HOURS FROM THE TIME OF RECEIPT OF PROPERLY COMPLETED FORM WITH PERTINENT CLINICAL INFORMATION AS APPROPRIATE. IF YOU DO NOT RECEIVE A RESPONSE AFTER 48 HOURS CONTACT THE MEDICAL MANAGEMENT DEPARTMENT AT 915-231-4277. **WORKING HOURS ARE: 8:00 A.M. TO 5:30 P.M., MONDAY THROUGH FRIDAY. TELEPHONES WILL BE ANSWERED BY VOICE MAIL ON WEEKENDS, HOLIDAYS AND AFTER HOURS.***

NO PRIOR AUTHORIZATION REQUIRED FOR MEMBERS WITH MEDICARE AS PRIMARY COVERAGE

“This authorization for services is not a guarantee of payment. Any benefits are subject to the payment of premium or employer contribution for the date on which services are rendered. An authorization for services or a description of benefits is not an acknowledgement that premium or employer contribution has been paid. All claims are subject to medical necessity, other contract limitations and provisions and services must be provided or authorized by the Attending Physician.”

REVISED 02/09/06

REVISED 07/01/06

REVISED 03/28/07

REVISED 03/23/09

CLAIMS PROCESSING

As a Participating Provider of Advantage Care Network, the expectation is that all claims are submitted for services rendered to Covered Individuals, in a timely manner and are required to include the following elements:

- Group ID
- Member name, patient name, age, sex, social security number, diagnosis, date of birth for patient
- A complete HCFA 1500 or UB92 claim form to include actual date of service, CPT/HCPCS codes, and charges
- Provider Signature on claim: Each paper claim form submitted must have the handwritten signature (or signature stamp) of the provider or an authorized representative in the appropriate block of the claim form. Providers delegating signature authority to a member of the staff or to a billing service remain responsible for the accuracy of all information on a claim submitted for payment. Claims prepared by computer billing services or office-based computers may have “signature on file” printed in the signature block. Printing of the provider’s name instead of “signature on file” is not acceptable
- Applicable documents to assist with coordination of benefits for those members with multiple coverage, such as Medicare
- For laboratory claims please include a diagnosis provided by the ordering Physician
- Prior authorization number for those services that require such authorization
- Claims need to be submitted to HealthSCOPE Benefits prior to filing deadline.

**Please Submit Claims to: HealthSCOPE Benefits
P.O. Box 612900
Dallas, Texas 75261-2900**

INQUIRY PROCESS

In the event of a claim denial, HealthSCOPE Benefits, Inc. shall provide a written explanation of the claim denial, to include:

- The specific reason(s) for the denial of the claim
- Specific reference to Plan provision(s), if applicable, i.e. non-covered benefits (cosmetic procedures, infertility treatment)
- Request for additional information from the provider and/or the member, (i.e. medical records, pre-existing condition, itemized billing or prior authorization)

When the provider does not concur with the denial and/or is submitting the requested information, the written request must be received at HealthSCOPE Benefits within 60 days following receipt of the explanation of benefits. Please send the following:

- Submit provider inquiry in a letter format and provide specific details for this particular claim inquiry
- Submit with the inquiry a copy of an explanation of benefits, claim, medical records and/or a signed doctor's order if applicable
- Ensure that all the information submitted corresponds with the date(s) of service in question.

Upon receipt of timely and complete documentation, the inquiry will be reviewed and a final determination will be rendered. Please note that a provider inquiry may involve referrals to other departments, i.e. Medical Management. The notification of this final determination will be sent to the provider within 30 days of receipt of inquiry.

ONLINE ACCESS TO CLAIMS & ELIGIBILITY

Providers may access information online at www.healthscopebenefits.com 24 hours a day 7 days a week.

The following information can be obtained by visiting our online claims and customer care web site:

- Claims status
- Eligibility status
- Schedule of Benefits
- Online copy of Explanation of Benefits

To register, you will need to obtain a user id and password by following these simple steps:

- Go to www.healthscopebenefits.com
- Click on the provider tab
- Click on view claims status
- Enter company name
- Click no when asked if you have registered for a user name and password
- Complete the registration form and click submit
- Your user name and password will be sent to you via email

For further assistance please contact Customer Care at (915) 581-8182 or 1-800-854-2339.

HealthSCOPE Benefits

Appeal Deadlines for All Plans

Group	Appeal Deadline
Catholic Diocese of El Paso	60 days from date of explanation of benefits
County of El Paso	60 days from date of explanation of benefits
HealthSCOPE Benefits	60 days from date of explanation of benefits
Housing Authority	60 days from date of explanation of benefits
San Elizario ISD	60 days from date of explanation of benefits
Sisbarro	180 days from date of explanation of benefits
Superior	No time frame designated
Ysleta Del Sur Pueblo	60 days from date of explanation of benefits
Ysleta ISD	60 days from date of explanation of benefits

Advantage Care Network, Inc.

DEFINITIONS

- A1. **Advantage or Advantage Care Network** is defined as the network for the purchaser. Advantage provides general provider services. Advantage or Advantage Care Network provides Purchaser, network services and is not financially responsible for payment of claims.
- A2. **Allied Health Care Professional** is defined as a Physician Assistant, Nurse Practitioner, Certified Registered Nurse Anesthetists, Physical, Speech or Occupational Therapist, or other individual who is qualified and has been accepted by Advantage to render health services, and who has an agreement with a Participating Provider or Advantage to provide health services for Members.
- A3. **Attachments** are referenced to and thereby made a part of this contract to ensure that the Physician is fully aware of any amendments to the original agreement
- A4. **Billing Procedure** is defined as the usual and customary billing format and procedure that is used by insurance companies, third party payors and governmental payors such as Medicare and Medicaid.
- A5. **Capitation Payment** is defined as a predetermined periodic payment that may be made to Provider by Purchaser for providing certain Covered Services for each Participant who is a member of Provider's Patient Panel.
- A6. **Centers for Medicare and Medicaid Services (CMS)** is defined as the agency of the federal government that is responsible for the administration of the Medicare program and overseeing the administration of the Medicaid program.
- A7. **Clean Claim** is defined as a manually or electronically submitted claim that contains all the required data elements necessary for accurate adjudication without the need for additional information from outside of Purchaser's system and contains no deficiency or impropriety, including lack of substantiating documentation as required by Advantage or Purchaser, or particular circumstance requiring special treatment that prevents timely payment from being made by Purchaser, as applicable.
- A8. **Commercial Member** is defined as a Participant in a health plan specified within a subscribed contract that may or may not receive health care services according to the terms of the subscriber policy and is neither a Medicare nor Medicaid participant.
- A9. **Committee** means a committee of Contracting Physician chosen by Advantage, one of whom shall be designated as chairman of the committee. The Committee shall serve as the principal liaison between the Contracting Physician and Advantage.
- A10. **Contracting Health Care Facility** is defined as a health care facility, other than a hospital, that has contracted with Advantage to provide Covered Services for Participants in accordance with the terms of this Agreement.
- A11. **Contracting Hospital** is defined as a hospital that has contracted with Advantage to provide Covered Services for Participants in accordance with the terms of this Agreement.
- A12. **Contracting Physician** is defined as a Doctor of Medicine (M.D.), a Doctor of Osteopathy (D.O.), Doctors of Podiatric Medicine, (D.P.M.), Doctors of Optometry,(O.D.), Doctors of Chiropractic Medicine, (D.C.), or Oral Surgeons (D.D.S) who is duly licensed to practice medicine in the state(s) in

which he or she practices, who satisfies participation criteria established by Advantage and who has entered into a contractual Agreement with, or whose Group has entered into a contractual Agreement with, or who is otherwise engaged by Advantage to provide Covered Services for Participants as either a Primary Care Physician (as hereinafter defined) or Referral Physician (as hereinafter defined).

- A13. **Co-payment** is defined as a fixed fee that the Member is required to pay for certain Health Services in accordance with the specific Participant's Plan Benefits for services covered by the Plan.
- A14. **Covered Services** is defined as those health care services Participants are entitled to receive as set forth in the Purchaser's Agreement appropriate for such member, and as may be modified by Purchaser from time to time.
- A15. **Emergency** means an illness or injury requiring health care services in a hospital emergency room or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the person's condition, sickness or injury is of such nature that failure to get immediate medical care could result in: (i) placing the patient's health in serious jeopardy; (ii) serious impairment to bodily functions; (iii) serious dysfunction of any bodily organ or part; (iv) serious disfigurement; or (v) in the case of a pregnant woman, serious jeopardy to the health of the fetus. .
- A16. **Emergency Services** means those Covered Services Medically Necessary to treat Emergency conditions.
- A17. **Established Patient** means a Participant covered by Purchaser whose name appears on a Provider's monthly member roster or who is confirmed by Purchaser as an individual who has chosen that particular Provider.
- A18. **Fee-For-Service Payment** means a payment to Provider by Purchaser for certain Covered Services that is the lower of the Provider's billed and usual charge or Advantage's established fee schedule.
- A19. **Grievance Procedure** means the system for the receipt, handling and disposition of Member complaints and grievances.
- A20. **Group** means a Professional Corporation, partnership, or association of Physician.
- A21. **Group Practice** means if the Physicians are a professional corporation, association, or partnership ("Group"), the terms of this Agreement apply to each Physician who provides Physician Services for Participants for or on behalf of the Group. Each Physician providing services for or on behalf of the Group must accurately complete an Advantage Physician Credentialing or Re-credentialing application. The provisions for termination of this Agreement apply to the Group and separately to each Physician providing Physician Services for the Group.
- A22. **Identification Card** means the card that identifies individuals as Participants. The fact that an individual possesses an Identification Card shall not obligate Purchaser to pay for covered services if the individual is not a Participant at the time such services are rendered.
- A23. **Inpatient Authorization Number** means the number assigned by current Utilization Review Agent, when it establishes the medical necessity of the Inpatient Services for Participants rendered by Provider.
- A24. **Inpatient Services** means those services the Hospital usually provides to persons admitted as inpatients. Such services include, but are not limited to, general routine inpatient care, intensive and

cardiac care, behavioral health care, special nursing services, diagnostic testing services, pharmaceutical services, laboratory, radiology and pathology services.

- A25. **Medicaid Participant** means a Participant who is eligible for Medicaid benefits who has enrolled in and has assigned benefits in the Purchaser's benefit program.
- A26. **Medical Director** means a Physician or his/her designee employed by Advantage to oversee Advantage's Credentialing, Re-credentialing, and Quality Management responsibilities.
- A27. **Medical Group** means a health care entity, which is comprised of more than one physician.
- A28. **Medically Necessary** means services or supplies which are: (1) provided for the diagnosis or care and treatment of a medical condition; (2) appropriate and necessary for the symptoms, diagnosis or treatment of a medical condition; (3) within standards of medical practice recognized within the local medical community; (4) not primarily for the convenience of the Participant; nor the Participant's family, Physician or another provider; and (5) performed in the least costly setting or manner appropriate to treat the Participant's medical condition.
- A29. **Medicare Participant** means a person designated by the Social Security Administration to receive Medicare benefits and who has enrolled in and has assigned benefits in the Purchaser's benefit program.
- A30. **Non-Covered Services** shall mean those healthcare services not provided as eligible benefits under the Purchaser's Agreement.
- A31. **Occupational Injury** is the necessary medical treatment provided to participating employees for accidental, work related, on the job injuries.
- A32. **Outpatient Services** means those services that the hospital usually provides for patients in the outpatient service department, or those services provided by a Provider in an Outpatient basis in the community.
- A33. **Participant or Eligible Participant** means any employee, purchaser, enrollee, beneficiary, insured, policyholder or any other person who is eligible to receive Covered Services provided by a Purchaser, the cost of which services are to be paid by a Purchaser pursuant to a Purchaser Agreement.
- A34. **Participating Provider** means a Provider that has a contract with Advantage.
- A35. **Participating Provider Agreement** refers to the agreement between Advantage and a Provider for the provision of Covered Services for Participants.
- A36. **Participating Provider Manual** means the document distributed to Participating Providers which describes Advantage's: Individual Purchaser's Program Requirements, Network Administrative Procedures, Current Utilization Review requirements as per current Utilization Management Company and/or Purchaser and Quality Assurance policies, Programs and Benefit Plans, and the service area in which Advantage offers such Programs and Benefit Plans.
- A37. **Patient Panel** means those Participants who have designated a specific Provider or are otherwise assigned to Provider as the primary source for certain Covered Services pursuant to a Service Agreement or Program Requirements.
- A38. **Physician Services** means those Covered Services rendered by Physician.

- A39. **Plan** refers to, collectively, the procedures, contractual relationships and activities described herein with respect to Participants, Advantage, Purchasers and Providers.
- A40. **Prior Authorization/ Pre-Certification** means a procedure by which a medical service, including Covered Services, facility admissions, or other medically necessary service is reviewed for benefit determination. Once authorized a service may be paid in accordance with a previously determined schedule.
- A41. **Primary Care Physician** means an Advantage Physician who has elected to be designated as a Primary Care Physician by Advantage and who meets all other requirements for Primary Care Physician contained in Advantage's rules and regulations, or in this Agreement.
- A42. **Privacy Rule** (*HIPAA Standards for Privacy of Individually Identifiable Health Information* (the Privacy Rule)) means the regulations found at 45 C.F.R. Part 164. The Department of Health and Human Services (HHS) published the Privacy Rule on December 28, 2000, and adopted modifications of the Rule on August 14, 2002. The Privacy Rule (45 CFR Part 160 and Subparts A and E of Part 164) provides the first comprehensive Federal protection for the privacy of health information. Which were promulgated by the Secretary of the United States Department of Health and Human Services to implement the standards for privacy of individually identifiable health care information pursuant to the Health Insurance Portability and Accountability Act of 1996.
- A43. **Program Requirements** means the current rules, regulations, policies and procedures of Purchaser that establish conditions to be followed by Participating Providers in providing Covered Services as contained in the most current Participating Provider Manual.
- A44. **Programs** means the Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), Exclusive Provider Organization (EPO) and other types of health care coverage which Advantage has contracted to manage.
- A45. **Provider** means any Contracting Hospital, Contracting Health Care Facility, Contracting Physician, or Contracting Allied Health Care Professional.
- A46. **Purchase Agreement** means any agreement, involving Advantage, an insurer, sponsor, or other entity, and an employer, labor union, trust or other organization or entity, or an individual, that specifies health care services to be provided to, or arranged or reimbursed for Participants and the terms and conditions under which those services are to be provided or reimbursed.
- A47. **Purchaser** means any insurance company, health benefits program, employer or union benefit or pension fund or trust, or any other entity providing indemnification for reimbursement of medical services rendered to Participants that have contracted with Advantage to participate in the Plan.
- A48. **Quality Management** means the program established and operated by Advantage or its designee relating to the quality of Covered Services provided to Participants.
- A49. **Referral Authorization** means the approval by a Participant's Primary Care Provider in a format determined by Advantage or Payor, which may be an electronic format, for a health care professional or facility to render certain Covered Services to the Participant.
- A50. **Referral Physician** means any Participating Physician who provides Physician Services for Participants within the range of their medical specialty, who elects to be designated as a Referral Physician by Advantage, and who meets all other requirements for a Referral Physician contained in

Advantage's Provider Manual or in this Agreement.

- A51. **Service Area** means the geographic area in which Advantage is licensed to or otherwise may lawfully operate.
- A52. **Specialty Care Physician** means Physician duly licensed to practice medicine who has a contractual arrangement with Advantage to provide certain Covered Services for Participants, and who is not a Primary Care Physician
- A53. **Third Party Administrator** (or "Designated Claims Agent") means any organization that is responsible through contract for the administration of claims with Advantage or a Purchaser.
- A54. **Urgent Care Center** a healthcare facility licensed by the state of Texas that is physically, organizationally, and financially separate from a hospital and its primary purpose is the provision of immediate, short term medical care for minor but urgent medical conditions.
- A55. **Urgent Medical Problem** means an acute medical condition that is not immediately life threatening but which requires care not generally available in the office setting. The Member is required to first contact his/her Primary Care Provider for instructions.
- A56. **Utilization Management Plan** means a process executed by current Utilization Review Agent to review and determine whether certain Provider services provided or to be provided care are medically necessary as determined by Medical Director (or his designee).