evergreen HEALTH

2017

Provider Manual

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MEMBER INFORMATION

MEMBER HELD HARMLESS

Evergreen Health will make payments to providers only for Covered Services which are rendered to eligible members and are determined by Evergreen Health to be medically necessary. Payment may not be sought from the member for any balances remaining after Evergreen Health's payment for Covered Services.

If a service requires prior authorization and one is not obtained, the service will be administratively denied because Evergreen Health's administrative requirements were not followed. In those cases, the provider will be liable for all charges and the member cannot be balance-billed.

The provider should not specifically charge, collect a deposit from, seek compensation, remuneration or reimbursement from or have any recourse against members or persons other than Evergreen Health or a third party payer for Covered Services provided according to your Evergreen Health Provider Agreement.

MEMBER CONFIDENTIALITY

Evergreen Health is committed to protecting our members' personal information and health records. Evergreen Health does not disclose member information to anyone without obtaining consent from an authorized person(s), unless we are permitted or required to do so by law.

When a member joins Evergreen Health, the member agrees to give Evergreen Health access to Protected Health Information ("PHI"). PHI, as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), is information created or received by a health care provider, health plan, employer or health care clearinghouse, that relates to: (i) the past, present, or future physical or mental health or condition of an individual, the provision of health care to the individual, or the past, present or future payment for provision of health care to the individual; (ii) identifies the individual, or with respect to which there is a reasonable basis to believe the information can be used to identify the individual; and (iii) is transmitted or maintained in an electronic medium, or in any form or medium.

Access to PHI allows Evergreen Health to work with providers, to decide whether a service is a Covered Service and thus pay clean claims for Covered Services using the members' medical records. Medical records and claims are generally used to review treatment and to conduct quality assurance activities. It also allows Evergreen Health to look at how care is delivered and to carry out programs that will improve the quality of care Evergreen Health members receive. This information also helps Evergreen Health manage the treatment of diseases to improve our members' quality of life.

MEMBER RIGHTS AND RESPONSIBILITIES

Evergreen Health members have certain rights and responsibilities. They include but shall not be limited to the following:

- A right to receive information about Evergreen Health, its services, practitioners, and providers
- A right to be treated with respect and recognition of a member's dignity, as well as a right to security and privacy
- A right to participate with providers in decision-making regarding their health care
- A right to candid discussions of appropriate or medically necessary treatment options for our members' conditions, regardless of their cost or benefit coverage
- A right to voice appeals and complaints about Evergreen Health or the care provided, without fear of retaliation
- A right to make recommendations about Evergreen Health members' rights and responsibilities
- A right to more information regarding their rights and responsibilities
- A responsibility to provide, to the fullest extent possible, information that Evergreen Health and its practitioners or providers need in order to care for our members
- A responsibility to follow the plans and instructions for care that a member has agreed to with their practitioners and providers
- A responsibility to understand a member's health problems and participate in developing mutually agreed-upon treatment goals to the degree possible
- A responsibility to pay co-payments, co-insurance, deductibles or any other cost shares

EMERGENCY SERVICES AND AFTER HOURS CARE

An Emergency is defined by Evergreen Health as the sudden onset of a medical condition with acute symptoms of sufficient severity [including severe pain] such that a member may reasonably believe that the lack of immediate medical attention could result in any of the following:

- Permanently placing the member's health in jeopardy
- Causing serious impairments to body functions
- Causing serious or permanent dysfunction of any bodily organ or part

In the event of an Emergency, members have been instructed to go immediately to the nearest emergency room facility. Members cared for in an Emergency setting have been instructed to contact their Primary Care Provider (PCP) as soon as it is medically possible or within twenty-four (24) hours after receiving care. The PCP will be responsible for providing and/or arranging any necessary follow-up services. Any co-insurance or co-payments will apply based on the member's benefit plan.

For Emergency services within Maryland, the PCP or his/her designee must be available twenty-four (24) hours a day, seven (7) days a week to assist members needing Emergency services.

For Emergency services outside Maryland, Evergreen Health will pay reasonable charges for Emergency services received from non-participating providers if a member is injured or becomes ill while outside the

service area. It is the member's responsibility to contact Evergreen Health within twenty-four (24) hours of receiving out-of-area Emergency care.

URGENT SERVICES

Urgent Care services are for the treatment of symptoms that are non-life threatening but require immediate attention.

The member should always first attempt to contact and receive care instructions from his/her PCP. Treatment at a participating Urgent Care center will be covered by Evergreen Health without a referral, but co-insurance and/or co-payments will apply based on member's coverage.

OBSERVATION STATUS

Evergreen Health recognizes the hospital setting Observation, as a legitimate level of care in order to aggressively treat and monitor patients. Monitoring is performed to assess the need for inpatient admission. Decisions should be reached generally within twenty-four (24) hours, but should never exceed forty-eight (48) hours. Prior to the 48th hour, Evergreen Health requires facilities to provide clinical review for stays in Observation lasting over twenty-four (24) hours, and will render determination for payment based upon medical necessity. Members will be assessed appropriate out-patient cost-shares for these Services based on members' coverage.

CONTINUING OR FOLLOW-UP TREATMENT

Continuing or follow-up treatment, as it relates to follow-up after Emergency services, is covered. Payment for covered benefits from out-of-network providers is limited to medically necessary treatment required before the member can reasonably be transported to a participating hospital or returned to the care of the PCP, if applicable.

PROVIDER INFORMATION

PRODUCTS

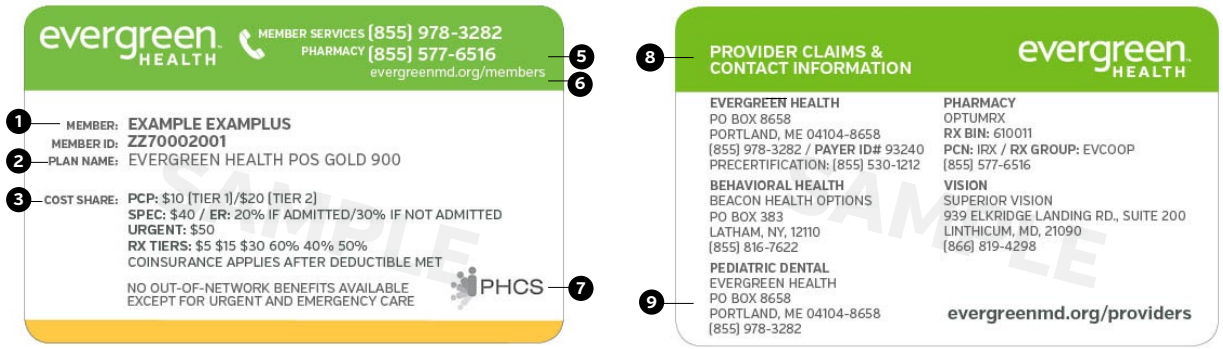
Evergreen Health offers a choice of plans:

1. **Evergreen Health POS**
   This is a traditional fee-for-service plan with a nationwide network. Members enrolled in Evergreen Health POS plans are encouraged to select a participating primary care provider; referrals are not required for in-network specialty services. Members also have out- of-network benefits and can be seen by non-participating providers at a higher cost share. An authorization is needed if a member wishes to receive care from an out-of- network specialist utilizing in-network benefits.

2. **Evergreen Health HMO/Evergreen Health National HMO**
   Members in these plans are encouraged to select a primary care provider and may obtain primary care services from any primary care provider participating in Evergreen Health's network of participating providers. The Evergreen Health HMO network is limited to providers who are located within Maryland and outlying counties. The HMO national network consists of providers who participate in both the Evergreen Health provider network and our leased network, Private Health Care Systems (PHCS). It should be noted that these plans do not offer out-of-network benefits.

3. **Evergreen Health Select**
   This is a unique plan that offers a selected network of providers and hospitals who have partnered with Evergreen Health to keep costs down while working with our members to obtain outstanding health outcomes.. Members access all their services from within this network; there are no-out-of-network benefits

MEMBER ID CARDS



UNDERSTANDING THE MEMBER ID CARD

1. Member Name
2. Unique member identification number
3. Plan name
4. Group number for plan, only listed if a member receives insurance through an employer
5. Amount member pays for care, different amounts for PCP, ER, specialist, and urgent care
6. Member services phone number
7. Pharmacy benefits phone number
8. Evergreen Health website for members
9. We partner with PHCS to provide access to one of the largest independent provider networks in the nation
10. Provider claims and contact information
11. Dental contact information, for members with dental benefits. Not available on all plans.

PROVIDERS DESIGNATED AS PRIMARY CARE PROVIDERS (PCPS)

Evergreen Health recognizes Family Practitioners, General Practitioners, Geriatric Practitioners, Internal Medicine Practitioners, Pediatric Practitioners, Obstetrics/Gynecology Practitioners and Nurse Practitioners as Primary Care Providers (PCPs).

All providers participating with Evergreen Health are listed in the provider directory, which is provided to members and made available to the public online at www.evergreenmd.org/find a doctor provider-directory. For our leased provider network, Private Health Care Systems, Inc. ("PHCS"), please select "Our Partner Network" located on the same page.

THE ROLE OF THE PRIMARY CARE PROVIDER

The PCP is responsible for managing all the health care needs of an Evergreen Health member as follows:

- Manage the health care needs of Evergreen Health members who have chosen the practitioner as their PCP
- Ensure that members receive treatment as frequently as is necessary based on the member's condition
- Develop an individual treatment plan for each member
- Submit accurately and timely information for clinical care coordination
- Comply with Evergreen Health's prior authorization procedures

- Refer members to appropriate Evergreen Health participating providers
- Comply with Evergreen Health's Quality Management and Utilization Management programs
- Use appropriate designated ancillary services
- Comply with Emergency care procedures
- Comply with Evergreen Health access and availability standards as outlined in this manual, including after-hours care
- Bill Evergreen Health on the CMS 1500 form or electronic equivalent in accordance with industry standard billing guidelines
- Ensure that, when billing for services provided, coding is specific enough to capture the acuity and complexity of a member's condition and ensure that the codes submitted are supported by proper documentation in the medical record
- Comply with Preventive Screening and Clinical Guidelines
- Adhere to Evergreen Health's medical record standards as outlined in this manual

THE ROLE OF THE SPECIALIST PHYSICIAN

Each Evergreen Health member is entitled to see a specialist physician for certain services required for treatment of a given health condition. The specialist physician is responsible for managing all the health care needs of an Evergreen Health member who has been referred to her/him or has presented for treatment pursuant to the guidelines below:

- Provide specialty health care services to members as needed
- Collaborate with the member's PCP to enhance continuity of health care and appropriate treatment
- Provide consultative and follow-up reports to the referring provider in a timely manner
- Comply with access and availability standards as outlined in this manual including after-hours care
- Comply with Evergreen Health's prior authorization process
- Comply with Evergreen Health's Quality Management and Utilization Management programs
- Utilize the CMS 1500 or UB04 claim form in accordance with Evergreen Health's billing guidelines when submitting claims
- Ensure that, when billing for services provided, coding is specific enough to capture the acuity and complexity of a member's condition and ensure that the codes submitted are supported by proper documentation in the medical record
- Refer members to appropriate Evergreen Health participating providers
- Submit claim and encounter information to Evergreen Health accurately and timely
- Follow Evergreen Health's medical record standards as outlined in this manual

ADMINISTRATIVE, MEDICAL AND/OR REIMBURSEMENT POLICY CHANGES

From time to time, Evergreen Health may amend, alter or clarify its policies. Examples of this include, but are not limited to, regulatory changes, changes in medical standards and modification of Covered Services.

Evergreen Health will communicate changes to this Provider Manual through the use of a variety of methods including but not limited to:

- Email
- Provider Letter
- Newsletters
- Facsimile

Providers are responsible for the review and inclusion of policy updates in this Provider Manual and for complying with these changes upon receipt of these notices. Evergreen Health will follow all statutory/ regulatory notification requirements and provide thirty (30) days advanced notice of any material change.

COMMUNICATION AMONG PROVIDERS

PCPs are expected to provide the specialist physician with relevant clinical information regarding the member's care. The specialist physician must provide the PCP with information about his/her visit with the member in a timely manner, not to exceed thirty (30) calendar days following the date of the visit. The PCP must document in the member's medical record his/her review of any reports, labs, or diagnostic tests received from a specialist physician.

MEMBER ASSIGNMENT TO NEW PCP

If you no longer wish to be an Evergreen Health member's PCP, the Evergreen Health Provider Relations department must be notified in writing prior to notifying the member. Contract notification requirements must be followed. Notification can be mailed or faxed to:

Attn: Provider Relations Department
Evergreen Health
3000 Falls Road, Suite 1
Baltimore, MD 21211
Phone: (443) 475-0105
Fax: (410) 235-2891

Additionally, you must give the member thirty (30) days advanced notice prior to the release. To avoid perceived patient abandonment, please follow AMA guidelines on "Ending the Patient-Physician Relationship" **(http://www.ama-assn.org/ama/pub/physician-resources/legal-topics/patient-physician-relationship- topics/ending-patient-physician-relationship.page)**.

PROVIDER PARTICIPATION

Providers may be directly contracted with and credentialed by Evergreen Health or alternatively participate in our leased partner network, PHCS, in accordance with the guidelines below.

HOSPITAL/ANCILLARY AND MEDICAL PRACTITIONER CREDENTIALING

Hospital/Ancillary providers wishing to participate in the Evergreen Health network are required to submit credentialing information. This information is verified to confirm that our credentialing requirements are met. This includes, but is not limited to:

- Valid, current, unrestricted licensure appropriate for facility type, if applicable
- Current malpractice coverage at or above $1 million per occurrence and $3 million aggregate
- Current facility accreditation
- Medicare/Medicaid certification or proof of participation, if not accredited
- Governmental survey performed within the past three years, if not accredited
- Acceptable history of previous or current license sanctions and Medicare/Medicaid sanctions

Medical practitioners wishing to participate in the Evergreen Health provider network are also required to submit credentialing information. This information is verified to confirm that our credentialing requirements are met. This includes, but is not limited to:

- Valid, current, unrestricted licensure
- Valid, current Drug Enforcement Agency (DEA) and Controlled Dangerous Substance (CDS) registration
- Appropriate education and training in field of practice
- Board certification
- Review of work history
- Current malpractice coverage at or above $1 million per occurrence and $3 million aggregate
- Active, unrestricted admitting privileges at a participating network hospital or other arrangements with a participating practitioner to admit and provide hospital coverage at a participating network hospital
- Acceptable history of professional liability claims
- Acceptable history of previous or current state sanctions, Medicare/Medicaid sanctions, restrictions on licensure, hospital privileges and/ or limitations on scope of practice
- Attestation to reasons for an inability to perform the essential functions of a clinical provider that could impose significant health and safety risks to members/enrollees; lack of present illegal drug use; history of loss of license and felony convictions; history of loss or limitation of privileges or disciplinary action

To make sure that Evergreen Health has obtained correct information to support credentialing applications and make fair credentialing decisions, providers have the right, upon request, to review this information, to correct inaccurate information, and to obtain the status of where providers are in the credentialing process. Requests should be communicated in writing and sent by mail, email, or fax to:

Attn: Credentialing Manager
Evergreen Health
3000 Falls Road, Suite 1
Baltimore, MD 21211
Fax: (410) 235-2891
Email: credentialing@evergreenmd.org

Evergreen Health accepts the Maryland Uniform Credentialing Form and Coalition for Affordable Quality Healthcare (CAQH) Universal Provider Datasource application. With an updated online interface, new providers can complete their application online. When the application is complete, the provider will have authorized Evergreen Health to access their data.

To start, please complete the online application. Be sure to authorize Evergreen Health to access your information and fax CAQH your supporting documents and attestation. CAQH will fax or email you notification that your application is complete and has been forwarded to Evergreen Health. Evergreen Health will then begin the credentialing process. Alternatively, please download and print the (CAQH) Universal Provider Datasource form, complete, and return to CAQH.

REDUCTION, SUSPENSION OR TERMINATION OF PRIVILEGES

All providers who participate in the Evergreen Health provider network, either through a direct contract or by being available through our Partner Network, PHCS, are subject to the terms outlined in the participation agreement with Evergreen Health. The participation agreement, in following Maryland law, provides for immediate termination under the following situations:

1. Provider Group's license or certificate to render health care services is put on probation, suspended or revoked;
2. Provider Group engages in fraud, or knowingly permits fraud by another in connection with Provider Group's obligations under this Agreement; or
3. Provider Group's is determined to be incompetent to provide Covered Services to Members or is believed to have committed patient abuse.
4. A material number of Provider Group's Primary Care Physicians, Specialty Care Physicians, or other Health Care Professionals experience the situations enumerated in Sections 8.3.1 through 8.3.3, above, such that Provider is unable to meet its obligations under this Agreement.

Participating providers may be subject to termination for other actions, as outlined in the following policies: Peer Review Policy (CS-QI-004-13), Credentialing and Recredentialing Policy (CS-CR-001-13), Provider Code of Conduct (CS-QI-005-14), Practitioner Termination, Appeal Rights and Notification to Authorities Policy (CS-QI-007-14), and Ongoing Monitoring of Providers Policy (CS-CR-005-14).

In every instance, Evergreen Health will conduct a complete investigation by reviewing all available evidence. Documentation utilized in the review may include, but not be limited to: chart review of outpatient and inpatient care; complaint summaries; peer/staff complaints; and interviews with the provider.

At the conclusion of the investigation, the Chief Medical Officer, in consultation with the Provider Advisory & Credentialing Committee (PACC), may elect to pursue one of the following actions:

- Implementation of a corrective action plan
- Implementation of a monitoring plan relative to billing and/or member satisfaction
- Closure of PCP panels
- Suspension with notice to terminate
- Special letter of agreement between the provider and Evergreen Health outlining expectations and/or limitation of range of services the provider may supply to members

In addition to consulting with the PACC, the Chief Medical Officer may determine it necessary to appoint other providers to the PACC on an ad hoc basis in order to seek the appropriate specialized expertise in the medical field that is the subject of the case or issue presented.

If a decision is made to terminate or sanction the provider, Evergreen Health will notify the provider in writing of the reason(s) for the termination or sanction, his/her right to appeal the determination and the appeal process.

Actions taken by Evergreen Health that concern provider quality deficiencies will follow National Committee for Quality Assurance (NCQA) standards. In those cases, the provider may appeal the decision in accordance with NCQA standards, and as delineated in the Peer Review Policy (CS-QI-004-13) and Ongoing Monitoring

of Providers Policy (CS-CR-005-14), and Practitioner Termination, Appeal Rights and Notification to Authorities Policy (CS-QI-007-14).

CHANGES IN PROVIDER INFORMATION

To keep the provider practice information current, please notify Provider Relations in writing regarding changes to practice information. Participating providers should provide written notice to Evergreen Health no less than sixty (60) days in advance of any changes to their practice or, if advanced notice is not possible, as soon as possible thereafter. Updates can be mailed or faxed to:

Attn: Provider Relations Department
Evergreen Health
3000 Falls Road, Suite 1
Baltimore, Maryland 21211
Fax: (410) 235-2891

Changes to a provider practice may include:

- Practice address
- Billing address
- Fax, email or telephone number
- Hospital affiliations
- Practice name
- Providers joining or leaving the practice (including death or retirement)
- Provider taking a leave of absence
- Practice mergers and/or acquisitions
- Adding or closing a practice location
- Tax Identification Number (please include W-9 form)
- National Provider Information number changes and additions
- Changes in practice office hours, practice limitations, or gender limitations

By providing this information in a timely manner, the provider will ensure that their practice is listed correctly in the provider directory. Please note, failure to provide up to date and correct information regarding their practice and the physicians that participate may result in the denial of claims.

BACK-UP COVERAGE

When the provider is not available to provide service to patients, the provider must arrange effective coverage through another provider who is a provider in the Evergreen Health's network.

AFTER HOURS CARE

PCPs or covering providers are expected to be available by telephone 24 hours a day, 7 days a week to respond to patient's health concerns. PCPs should call back members within sixty (60) minutes of voicemail or answering service messaging for urgent requests.

OPEN/CLOSED PANEL

You may close your panel to new members with at least thirty (30) days prior written notice to Provider Relations. If you wish to accept a new member into a closed panel, the provider must also notify Provider Relations in writing. Written notification is also required when you elect to re-open the panel to new members. Requests for opening and closing a panel should be mailed or faxed on your letterhead to:

Attn: Provider Relations Department
Evergreen Health Cooperative Inc.
3000 Falls Road, Suite 1
Baltimore, Maryland 21211
Fax: (410) 235-2891

REIMBURSEMENT

Participating providers agree to accept the allowed amount as payment in full for services. Participating providers may not bill the member for amounts that exceed the allowed amount for Covered Services. Members are liable for deductibles, co-payments and co-insurance for Covered Services.

PHYSICIAN ASSISTANTS

Covered Services rendered by Physician Assistants (PAs) are eligible for reimbursement under the following circumstances:

- The PA is under the supervision of a physician as required by local licensing agencies. Services rendered by the PA are submitted under the supervising physician's name and provider number.
- Evergreen Health does not contract with PAs. PA services are to be submitted under the supervising physician's name and provider number.

PLAN ADMINISTRATION POLICY

In order to ensure compliance with Evergreen Health plans' policies and procedures, our Plan Administration Policy is provided below. In short, providers cannot require the payment of charges for Covered Services above and beyond co-insurance, co-payments and deductibles.

Participating providers shall not charge, collect from, seek remuneration or reimbursement from or have recourse against members for Covered Services, including those that are inherent in the delivery of Covered Services. Charging for medical office administration and expense is not in accordance with either the participation agreement or this Provider Manual, except as set forth below. Such charges for administrative services shall include, but not be limited to: annual or per visit fees to offset the increase of office administrative duties and/or overhead expenses, malpractice coverage increases, writing prescriptions, copying and faxing, completing referral forms or other expenses related to the overall management of patients and in compliance with state and federal laws and regulations that apply to health care providers. The provider may look to the member for payment of deductibles, co-payments, co-insurance, and/or for providing specific health care services not covered under the member's health benefit plan. In addition, the practice may charge for some administrative services, which may include for example, fees for completion of certain forms not connected with the providing of Covered Services, missed appointment fees, and charges for copies of medical records when the records are being processed directly for the member.

Fees or charges for some administrative tasks, such as those enumerated above may not be assessed against all members in the form of an office administrative fee, but rather to only those members who utilize the administrative service.

ACCESS STANDARDS

Evergreen Health establishes standards for appointment access and after-hours care to make sure that there is timely access to care for members. Performance against these established standards is measured at least annually. Evergreen Health's standards are shown in the table below.

TYPE OF SERVICE	STANDARD
Preventive Care	within four (4) weeks
Regular/Routine Care Appointment	Within fourteen (14) days
Emergency Care	Immediate
Urgent Care Appointment	Same day
After-Hours Care	24 hours/Seven (7) days a week for PCPs

LABORATORY

Laboratory Corporation of America ("LabCorp") and Quest Diagnostics, LLC. are the preferred laboratories for Evergreen Health and are cost-effective choices when referring patients. Members can easily schedule appointments online through LabCorp's or Quest's websites. Members referred to either LabCorp or Quest require an order on the provider's letterhead, prescription pad, or lab form/eform.

It is the expectation that providers who perform laboratory or imaging tests at any site will obtain and/or maintain the appropriate federal, state, and local licenses and certifications, training, quality controls, and

safety standards pertinent to the tests performed. Providers should always obtain verification of benefits prior to ordering laboratory services. Information regarding a member's specific benefit plan can be verified by calling Provider Customer Service at **(855) 978-3282**.

RADIOLOGY

Evergreen Health's preferred radiology network is a cost-effective choice for members. For a listing of preferred radiology sites, please visit our website at **www.evergreenmd.org/provider-directory** and select "Tier 1". Members referred to a participating radiology facility require a written order on the provider's letterhead, prescription pad, or order form.

PHARMACY/OPTUMRX

OptumRx is the Pharmacy Benefits Manager (PBM) for all Evergreen Health plans. OptumRx works with Evergreen Health to administer prescription drug benefits. OptumRx performs prior authorization services and pays claims related to retail, mail, and specialty pharmaceutical services. Please call OptumRx at **(855) 577-6516** if you have questions.

Evergreen Health's online formulary is regularly updated: drugs are placed on the formulary based on their quality, effectiveness, safety and cost. To access the online formulary, visit **www.evergreenmd.org/formulary**.

Some drugs require prior authorization and step therapy under the Evergreen Health prescription drug program. Additionally, some drugs have quantity limits. These requirements are noted in the online formulary. Next to each drug name, you will see a notation of PA (Prior Authorization), ST (Step Therapy) and/or QL (Quantity Limits) if these requirements apply to the particular drug. We have posted OptumRx's Prior Authorization request form on our website for your use as well as a listing of specialty drugs that must be obtained through OptumRx's partner, BriovaRx. Visit **www.evergreenmd.org/formulary** to obtain this information. All authorizations, including those for specialty medications, should be faxed to OptumRx using the Authorization Request form or by calling OptumRx at **(855) 577-6516**.

INJECTABLES AND SPECIALTY DRUGS

Providers may provide injectable drugs in their office and bill Evergreen Health directly. However, any specialty medications must be acquired directly from OptumRx's partner, BriovaRx. The specialty medication list can be found online by visiting **www.evergreenmd.org/formulary**. All authorization requests, including those for specialty medications, should be faxed to OptumRx using the Authorization Request form located at **www.evergreenmd.org/formulary** or by calling OptumRx at **(855) 577-6516**. Medications administered in the provider's office are covered under the member's medical benefit, not their prescription drug benefit. Prescription drug benefits cover injectable medications only when they are self- administered.

DENTAL CARE

Evergreen Health covers pediatric dental care for members up to age nineteen (19) who are enrolled in our individual and small group benefit plans. The toll free number for providers is **(855) 978-3282**.

VISION CARE

Routine vision and eyewear is covered for members up to age 19 through Superior Vision under all benefit plans. Adult routine vision and eyewear benefits through Superior Vision are covered under several benefit plans, please contact member services at **(855) 978-3282** to verify benefits.

CLAIMS

ELIGIBILITY AND BENEFITS VERIFICATION

All participating providers are responsible for verifying members' benefits and eligibility for each visit.

Please note that membership data is subject to change; members can be retroactively terminated for various reasons. When this occurs, Evergreen Health's claims unit will recover payments made for such ineligible members. In those instances, the member is liable for all billed charges. The provider is encouraged to work with the member to collect payment for visits or services rendered when the member was not eligible for health benefits.

Member eligibility and benefits can be verified in any of the following ways:

By Phone: Call The Provider Services Department phone number, **(855) 978-3282**, to verify eligibility via an automated service. Alternatively, a provider may speak with a Provider Services Representative to verify benefits.

Online: Evergreen Health providers will have online access to an eligibility verification system **www.evergreenmd.org/providerportal**.

Each member is issued an individual membership identification (ID) card. The ID card contains member and provider information, including the member's identification number, plan code, and co-payment amounts. Since changes do occur with eligibility, the card alone does not guarantee member eligibility.

CLAIMS SUBMISSION PROCESS

To support our paperless initiative and improve the claims processing experience, Evergreen Health strongly encourages participating and non-participating providers to submit all claims electronically.

Evergreen Health understands that certain claims require additional information and cannot be submitted electronically. However, we urge all providers to take advantage of the benefits of filing electronically, whenever possible.

Evergreen Health Clearinghouse – Emdeon, Payor ID – 93240

Providers interested in using Emdeon should contact Emdeon's customer service office and ask them how to enroll. Providers may also contact the Claims Department at **(855) 978-3282**, for more information.

Paper claims must be submitted on the most current CMS 1500 or UB04 forms. All information must fit properly in the blocks provided.

ICD-10, CPT and HCPCS codes in the medical record must match what is being requested for authorization and what is billed to Evergreen Health.

Clean claims will be paid within 30 days, in accordance with Maryland law. To inquire about claims status, please contact the Claims Department at **(855) 978-3282** Evergreen Health follows the CMS National Correct Coding Initiative when adjudicating claims.

TIMELY FILING OF CLAIMS

To expedite claims processing, please report services for only one provider per claim. If more than one provider in your practice renders services for a given member, separate claims must be submitted for each provider.

Claims must be submitted, per Maryland law, to Evergreen Health at the following address within one hundred eighty (180) calendar days from the date of service:

Evergreen Health Claims Processing Center
P.O. Box 331429
Corpus Christi, TX 78463

Claim denials that are overturned on appeal will be paid within thirty (30) calendar days of the decision. Evergreen Health will not take any punitive action against the provider for utilizing the provider appeal process.

ADMINISTRATIVE CLAIMS APPEALS

Claims submitted beyond the timely filing limit will be rejected for payment. If the claim is rejected, and there exists proof via an Explanation of Benefits (EOB) that the claim was submitted to Evergreen Health within timely filing requirements, a request for reconsideration may be made by filing an Administrative Claims Appeal. For electronic claims, a confirmation from the clearinghouse is needed by Evergreen Health showing that Evergreen Health successfully accepted the claim. Print-outs from billing systems are not acceptable timely filing documentation.

Timely filing reconsideration requests must be received within ninety (90) working days from the date of original rejection notification on the EOP. Requests received after the EOB date will not be accepted and the charges may not be billed to the member.

Claims appeals should be sent to the address listed below within ninety (90) working days of the denial as indicated on the Explanation of Payments. Please send a written request outlining reasons for appeal along with all necessary documentation to the Evergreen Health Claims Appeals Department. The appeal should include an explanation of the reason for appeal, a copy of the claim and the Explanation of Payment at a minimum. A claims appeal must include a clearly-expressed desire for reevaluation, with an indication as to why the denial was believed to have been issued incorrectly. For example, a situation in which Evergreen Health receives only an Explanation of Benefits with items circled would not constitute a dispute and would be handled as a correspondence.

Evergreen Health will make a decision on the claims appeal within sixty (60) working days of receipt of the appeal. All claims appeals should be sent to the following address:

Evergreen Health Claims Appeals
3000 Falls Road, Suite 1
Baltimore, Maryland 21211
Fax: (888) 975.1538
Email: Claimsappeals@evergreenmd.org

Claim denials that are overturned on appeal will be paid within thirty (30) calendar days of the decision. Evergreen Health will not take any punitive action against the provider for utilizing the provider appeal process.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) COMPLIANT CODES

To comply with the requirements of HIPAA, Evergreen Health will, upon request, add the HIPAA-compliant codes and corresponding reimbursement rates to the fee schedule when they are released by the American Medical Association (AMA) or CMS. These updates are made quarterly through the calendar year.

WORKERS' COMPENSATION

Health benefits programs administered by Evergreen Health exclude benefits for services or supplies if the participant obtained or could have obtained benefits under a Workers' Compensation Act, the Longshoreman's Act, or a similar law. Affected claims should only be filed if workers' compensation benefits have been denied or exhausted. In the event that Evergreen Health benefits are inadvertently or mistakenly paid despite this exclusion, Evergreen Health will exercise its right to recover its payments.

SUBROGATION

Evergreen Health reserves its rights concerning subrogation and reimbursement rights as permitted under subrogation. Subrogation requires the member to turn over to Evergreen Health any rights the member may have against a third party. A third party is any person, corporation, insurer or other entity that may be liable to a member for an injury or illness. The right applies to the amount of benefits paid by Evergreen Health for injuries or illnesses where a third party could be liable.

COORDINATION OF BENEFITS

Coordination of Benefits (COB) occurs when a member has health care coverage under more than one health plan. If COB applies, Evergreen Health will follow the order of payment rules as described in the member's plan agreement.

Whether Evergreen Health is the primary or secondary carrier, benefits are provided as described in the member's plan agreement.

HEALTHCARE PLAN EFFECTIVENESS DATA AND INFORMATION SET (HEDIS®)

The Healthcare Effectiveness Data and Information Set (HEDIS®), a standardized data set, is developed and maintained by the National Committee for Quality Assurance (NCQA), an accrediting body for managed care organizations. The HEDIS® measurements enable comparison of performance among HMO, PPO and POS plans.

The sources of HEDIS® data include administrative data (claims/encounters) and medical record review data. All records are handled in accordance with Evergreen Health privacy policies and in compliance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy rules. Only the minimum necessary amount of information, which will be used solely for the purpose of this HEDIS® initiative, will be requested. HEDIS® is considered a quality-related health care operation activity and is permitted by the HIPAA Privacy Rule [see 45 CFR 164.501 and 506].

BEHAVIORAL HEALTH

BEHAVIORAL HEALTH SERVICES

Evergreen Health provides comprehensive mental health and substance abuse services to its members through its delegation agreement with Beacon Health. The goal is to treat the member in the most appropriate, least restrictive level of care possible, and to maintain and/or increase functionality. The Beacon Health provider network is comprised of mental health and substance abuse service providers who identify and treat members with behavioral healthcare needs.

Evergreen Health providers can access the Beacon Health provider manual, forms and instructions via: **www.valueoptions.com/providers/Providers.htm** or providers may call toll free **(855) 816-7622**.

Evergreen Health encourages and facilitates the exchange of information between and among physical and behavioral health providers, member follow-up is essential. High risk members are evaluated and encouraged to participate in Beacon Health's Case Management program. This Case Management program combines education, care coordination, and support to increase members' knowledge and encourage compliance with treatment and medications. Beacon Health works with its providers to become part of the strategy and the solution to provide quality behavioral health services. Behavioral health services are available to provide for the early detection, prevention, treatment, and maintenance of the member's behavioral health care needs. Behavioral health services are both interdisciplinary and multidisciplinary. A member may need one or multiple types of behavioral health providers, and the exchange of information among these providers is essential. Services may be provided by, but not limited to; a psychiatrist, addictionologist, licensed psychologist, licensed social worker, licensed professional counselor, or psychiatric nurse practitioner.

Mental health and substance abuse benefits cover the continuum of care from the least restrictive outpatient levels of care to the most restrictive inpatient levels of care.

RESPONSIBILITIES OF BEHAVIORAL HEALTH PROVIDERS:

- Provide treatment in accordance with accepted standards of care
- Provide treatment in the least restrictive level of care possible
- Communicate on a regular basis with other medical and behavioral health providers who are treating or need to treat the member
- Direct members to community resources as needed to maintain or increase member's functionality and ability to remain in the community

RESPONSIBILITIES OF THE PRIMARY CARE PROVIDER:

The PCP can participate in the identification and treatment of their members' behavioral health needs. His/her responsibilities include:

- Screening and early identification of mental health and substance abuse issues
- Treating members with behavioral health needs within the scope of his/her practice and according

to established clinical guidelines. These could be members with co-morbid physical and minor behavioral health problems or those members refusing to access a mental health or substance abuse provider, but requesting treatment

- Consultation and/or referral of complex behavioral health patients or those not responding to treatment
- Communication with other physical and behavioral health providers on a regular basis

ACCESS TO CARE:

Members may access behavioral health services as needed:

- Members may self-refer to any in-network behavioral health provider for initial assessment and evaluation, and ongoing outpatient treatment
- Members may access their PCP and discuss their behavioral health needs or concerns and receive treatment that is within their PCPs scope of practice. Referrals are not required to receive most in-network outpatient mental health or substance abuse services.
- Medical Record documentation: when requesting prior authorization for specific services or billing for services provided, behavioral health providers must use the DSM 5 classification system and document a complete diagnosis
- The provision of behavioral health services requires progress note documentation that corresponds with day of treatment, the development of a treatment plan, and discharge plan as applicable for each member in treatment

COORDINATION OF CARE:

Coordination of Care is essential to maintain member stability. Behavioral health providers and PCPs, as applicable, are required to:

- Evaluate if member was hospitalized for a behavioral health condition within seven (7) and thirty (30) days post-discharge
- Provide those members receiving care with contact information for any emergency or urgent matter arising that necessitates communication between the member and the provider
- Evaluate member needs when the member is in acute distress
- Communicate with the member's other healthcare providers
- Identify those members necessitating follow-up and refer to Beacon Health's behavioral health focused Case Management program
- Discuss cases as needed with a peer reviewer

This coordination assures promotion of the delivery of services in a quality-oriented, timely, clinically appropriate, and cost-effective manner for the members. Beacon Health's utilization management staff base their utilization-related decisions on the clinical needs of members, the member's plan agreement and Beacon Health's developed criteria.

CLINICAL SERVICES

OVERVIEW

Evergreen Health coordinates health care services to ensure appropriate utilization of health care resources. This coordination assures promotion of the delivery of services in a quality- oriented, timely, clinically appropriate, and cost-effective manner for its members.

Evergreen Health will perform all functions of Utilization Management (UM) in compliance with state and federal laws, regulations, and NCQA standards. The UM Department performs utilization reviews, when applicable, to ensure that the requested services meet medical necessity criteria as outlined in the member's health benefit plan. Evergreen Health currently utilizes the following criteria:

Habilitative Services for children up to age nineteen (19) for the treatment of autism and autism spectrum disorders.

- The Hayes Rating for new and emerging technologies
- Maryland Surgical Treatment for Morbid Obesity Guidelines
- Maryland Designated Criteria: "Guidelines of Perinatal Care" – the current version prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists
- Milliman Care Guidelines for ambulatory care, general recovery care, home care, inpatient and surgical care, chronic care and recovery facility care
- National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines in Oncology– available at **www.nccn.org**

Other information taken into consideration includes the clinical needs of the member, the appropriateness of care, scientifically-based clinical criteria and treatment guidelines in the context of provider and/or member-supplied clinical information and other relevant information.

Evergreen Health in no way rewards or incentivizes, either financially or otherwise, providers, utilization reviewers, clinical care managers, physician advisers or other individuals involved in conducting utilization review, for issuing denials of coverage or service, or inappropriately restricting care.

UTILIZATION MANAGEMENT GOALS

To ensure that services are authorized at the appropriate level of care and are covered under the member's health benefit plan

- To monitor utilization practice patterns of Evergreen Health's participating providers
- To provide a system to identify high-risk members and ensuring that appropriate care is accessed
- To provide utilization management data for use in the process of re-credentialing providers
- To educate members, providers, contracted hospitals, ancillary services, and specialty providers about Evergreen Health's goals for providing quality, value-enhanced managed health care
- To improve utilization of Evergreen Health's resources by identifying patterns of over- and under-utilization that have opportunities for improvement

UTILIZATION MANAGEMENT FUNCTIONS

- Prior Authorization
- Decisions and Timeframes
- Concurrent Review
- Retrospective Review
- Discharge Planning
- Case Management
- Disease Management

PRIOR AUTHORIZATION

The participating PCP or specialist is responsible for requesting prior authorization for certain procedures/services, all scheduled and/or elective admissions, certain outpatient services, and for requesting services in the home. Evergreen Health requires requests to be submitted at least five (5) business days in advance of the admission, procedure, or service. As part of the prior authorization process, Evergreen Health reserves the right to determine the place of service for any requested service.

Providers should call **(855) 530-1212**, Monday through Friday between the hours of 8:00 a.m. and 6:00 p.m. ET. Evergreen Health also accepts authorization requests submitted through the confidential fax line: **(844)-414-8860**. Services requiring prior authorization are listed in the appendix section of this manual, as well as on Evergreen Health's website. The presence or absence of a service or procedure on the list does not determine coverage or benefits. Call **(855) 978-3282** to verify benefits and visit limitations, coverage, and member eligibility.

The UM Department, under the direction of licensed nurses and certified medical directors, documents and evaluates requests for prior authorization, including:

- Verification that the member is enrolled with Evergreen Health at the time of the request for authorization
- Verification that the requested service is a covered benefit under the member's health benefit package
- Determination of the appropriateness of the services (medical necessity)
- Verification that the service is being provided by the appropriate provider and in the appropriate setting
- Verification of other insurance for coordination of benefits

The UM Department processes the authorization request, renders a determination and notifies the provider of the decision within two business days of receipt of information necessary to make the determination. Examples of clinical information required for a determination include, but are not limited to:

- Member name and identification number or date of birth
- Location of service (e.g., hospital or surgical center setting)
- Primary care provider name
- Servicing/Attending provider name

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- Date of service
- Diagnosis
- Service/Procedure/Surgery description and CPT or HCPCS code(s)
- Clinical information supporting the need for the service to be rendered

Notification of an emergency admission must be sent to Evergreen Health within forty –eight (48) hours, or the next business day after admission (whichever comes last). Providers are expected to discuss the member's condition and treatment plan with our nurse coordinator. All other after-hour emergency requests, including emergency requests on weekends and holidays, should call (855) 530-1212. Providers are asked to follow prompts to voice mail and provide information concerning the emergent situation and a call-back number. An on-call nurse will return the emergent request within the hour.

DECISIONS AND TIMEFRAMES

Emergency

An Emergency Medical Condition is 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, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

For members who go to an emergency room for treatment, an attempt should be made in advance to contact the PCP unless it is not medically feasible due to a serious condition that warrants immediate treatment.

Expedited

An expedited review can be requested when the provider believes that waiting for a decision under the standard time frame could place the member's life, health, or ability to regain maximum function in serious jeopardy. Expedited requests will be determined within twenty-four (24) hours or as soon as the member's health requires and criteria for emergent review are met. The request will be processed as a standard request if it does not meet criteria for an expedited review.

Routine

Once all relevant information is submitted for the requested services, Evergreen Health is required by Maryland law to render a determination within two (2) business days. Once the UM Department receives the request for authorization, it will be reviewed using nationally recognized industry standards or evidence-based approved criteria. If the request for authorization is approved, Evergreen Health will assign an authorization number and enter the information into the member's records. This authorization number must be used to reference the admission, service or procedure.

INPATIENT CONCURRENT REVIEW

Concurrent Review is the process of initial and continual reassessment of the medical necessity and appropriateness of inpatient care during an acute care hospital admission, rehabilitation admission, skilled nursing facility, or other inpatient admission in order to ensure that Covered Services are being provided at the appropriate level of care, and that services are being administered according to the individual facility contract. Evergreen Health requires admission notification for the following:

- Elective admissions
- ER and urgent admissions (including maternity)
- rehabilitation, LTAC and SNF Admissions
- Transfers to another acute facility, acute
- Newborns admitted to NICU or remaining in the hospital after the mother is discharged
- Observation confinements exceeding 24 hours
- Admissions following outpatient procedures or observation status

Receipt of an admission notification does not guarantee or authorize payment. Payment of Covered Services is contingent upon coverage within an individual member's benefit plan, medical necessity review (except for Maryland mandated maternity confinements), the facility being eligible for payment, any claim processing requirements, and the facility's participation agreement with Evergreen Health .

Emergent or urgent admission notification must be received within the latter of forty eight (48) hours of the admission or next business day. If the member's condition is unstable and the facility is unable to determine coverage information, Evergreen Health requests notification as soon as it is determined, including an explanation of the extenuating circumstances. Timely receipt of clinical information supports the care coordination process to evaluate and to communicate vital clinical information to hospital professionals and discharge planners. Failure to comply with notification timelines and/or failure to provide timely clinical documentation to support admission or continued stay could result in an adverse determination or reimbursement reduction.

Reimbursement Reductions for Untimely Admission Notification

If a facility does not provide timely admission notification as described above, reimbursement penalties will apply as follows:

- Admission notification received after it was due, but prior to patient discharge: the penalty is one hundred percent (100%) of the average daily contract rate for the days preceding notification
- Admission notification received after patient was discharged: the penalty is one hundred percent (100%) of the contract rate (entire stay)

Ancillary services performed during the inpatient stay will be paid or clinically reviewed for medical appropriateness as required by HSCRC. Evergreen Health complies with individual facility contract requirements for concurrent review decisions and timeframes. Evergreen Health is responsible for final authorization.

Evergreen Health's preferred method for Concurrent Review is communication between Evergreen Health's Concurrent Review nursing staff and the facility's UM staff within forty-eight (48) hours of an admission or before the last covered day. If clinical information is not received within seventy-two (72) hours of admission or last covered day, the case may be evaluated with the information Evergreen Health has available, however, an Administrative Denial may be issued for failure to meet timeliness requirements. If it is not feasible for the facility to contact Evergreen Health via phone, facilities may fax the member's clinical information within forty-eight (48) hours of admission or next business day to **(844) 414-8860**. For admission requests to a skilled nursing facility, information about a recent physical medicine and rehabilitation or physical, occupational and/or speech therapy consult is preferred, along with the most recent notes for therapy(ies) or recent medical status, and expected skilled treatment and service requirements to be submitted for review.

Following an initial determination, the Concurrent Review nurse will request additional updates from the facility on a case-by-case basis. Evergreen Health, will render a determination within one day of receipt of a request that contains sufficient clinical data. Evergreen Health's nurse will make every attempt to collaborate with the facility's utilization or Case Management staff and, when necessary, request additional clinical information in order to provide a favorable determination. If an Evergreen Health Certified Medical Director deems that the service or confinement does not meet medical necessity criteria, an adverse determination (a denial) will be issued. The Concurrent Review nurse or designee will notify the provider(s) e.g. facility, attending/ordering provider verbally and in writing of the adverse determination. The criteria used in making the determination is available to the provider/facility and/or member upon request. To request a copy of the criteria on which a decision was made, please contact **(855) 530-1212**.

If the attending or requesting provider does not agree with the determination, the provider is given the opportunity to submit further information and can request to speak with the Certified Medical Director. The Certified Medical Director will either reverse the original determination and authorize the confinement or uphold the adverse determination.

For pre-service requests, Evergreen Health will approve the request or issue a denial if the request does not meet criteria for medical necessity. This document will include information on the members' or their representatives' right to file a grievance (appeal), as well as instructions on how to submit. The facility is responsible for delivering the notice to Evergreen Health members during confinements in acute, rehab and skilled nursing facilities.

RETROSPECTIVE REVIEW

Retrospective Review is the process of determining medical necessity after services have already been rendered. Evergreen Health limits retrospective review to the following instances:

1. Member ID unknown during emergent service.
2. When the inpatient discharge occurred over a weekend and there are outstanding days for review.
3. When there is a short-stay with insufficient time for the provider to submit clinical information concurrently.
4. When the member is admitted to a non-participating facility on an emergent basis.

5. When administrative appeals have been overturned and medical necessity review is required

For any requests for Retrospective Review, Evergreen Health shall notify the provider, in writing, of its determination within a reasonable timeframe, but no later than thirty (30) calendar days after the receipt of the request.

NOTIFICATION OF ADVERSE DETERMINATIONS (DENIALS)

Adverse determinations are issued when a pre-service, Concurrent or Retrospective Review request does not meet Evergreen Health's medical necessity requirements and therefore the requested service falls outside the scope of the member's covered benefits.

Adverse determinations may be appealed by the member, the member's authorized representative or the requesting physician.

CLINICAL APPEALS (GRIEVANCES)

An adverse determination is a decision by Evergreen Health not to authorize a service or procedure or denial of payment because the service did not meet criteria and therefore was not medically necessary or appropriate. The provider, acting on the member's behalf, can appeal an adverse determination by submitting to the health plan a grievance letter that outlines the issues and includes supporting documentation.

The grievance letter should include:

- Patient name and identification number
- Claim number or Reference Number
- Admission and discharge dates (if applicable) or date(s) of service
- A copy of the original claim or Explanation of Benefits denial information and/or adverse determination (denial) letter/ notice
- Supporting clinical notes or medical records including: lab reports, X-rays, treatment plans, progress notes, etc.
- The name and address to which the grievance outcome should be mailed.

Grievance letters should be mailed or faxed to:

Evergreen Health Grievance Department
3000 Falls Road, Suite 1
Baltimore, MD 21211
Fax: 844-414-8860
Email: clinicalservices@evergreenmd.org

All grievance letters must be submitted to Evergreen Health within one hundred and eighty (180) days from the date of the denial letter or within ninety (90) working days of the date of the Claims Denial (EOP). Evergreen Health will respond in writing within thirty (30) – sixty (60) calendar days of receipt of the grievance letter (depending on whether or not services have been already rendered).

DISCHARGE PLANNING/ACUTE CARE MANAGEMENT

Discharge planning is a critical component of the process that begins with an early assessment of the member's potential discharge care needs in order to facilitate transition from the acute setting to the next level of care. Such planning includes preparation of the member and his/her family for any discharge needs along with initiation and coordination of arrangements for placement and/or services required after acute care discharge. Evergreen Health's Concurrent Review and Case Management staff will coordinate with the facility discharge planning team to assist in establishing a safe and effective discharge plan. The Concurrent Review and Case Management staff and nurses will facilitate the communication for all needed authorizations for services, equipment and skilled services upon discharge.

AFTER HOURS

For the convenience of our providers and members, Evergreen Health accepts requests via facsimile (fax) during and outside of normal business hours. Utilization Management staff, however, does not monitor and retrieve faxed documentation routinely outside of normal business hours. In these circumstances, the time of receipt for non-urgent requests is considered the day the fax is received; although, the request will not be processed until the next business day.

CONTINUITY OF CARE

Evergreen Health's policy is to comply with Maryland's § 15-140(f) of the Insurance Article for providing new members notice of their rights for continuity of care. Evergreen Health recognizes that new members may have already begun treatment with a provider who is not in Evergreen Health's

network, or have initiated treatment that requires prior authorization under their benefit plans. Under these circumstances, Evergreen Health will work to coordinate care with the provider by identifying the course

of treatment already ordered and offering the member a transition period. For all conditions other than pregnancy, the time limit is ninety (90) days or until the course of treatment is completed, whichever is sooner. The ninety (90)-day limit is measured from the date the member's coverage starts with Evergreen Health. For pregnancy, the time limit lasts through the pregnancy and the first visit post-partum visit.

Evergreen Health will review provider prescribed plans of care (including prescriptions, DME, medical supplies, prosthetic and orthotic appliances, and any other on-going services) initiated prior to a new member's enrollment. Members may submit previous plan's approval or pre-authorization to satisfy a prior approval requirement for those services if they are covered under member's plan with Evergreen Health. For members transitioning from Maryland's Medical Assistance fee-for-service program, you may not use the prior approval unless it is for behavioral health or dental benefits authorized by a third-party administrator.

When a provider leaves Evergreen Health's network and a member is in an active course of treatment, our Health Care Management staff is available to assist the provider and member in minimizing any potential disruption in care. If Evergreen Health terminates a participating provider, Evergreen Health will work to transition a member into care with a participating physician within Evergreen Health's network. Evergreen Health is not responsible for the health care services provided by the Evergreen Health terminated providers following the date of termination unless the member is still in a course of treatment.

For additional information about continuity of care or to request authorization for such services, please contact Evergreen Health's Prior Authorization Department at **(855) 530-1212**.

COORDINATION OF CARE PROCESS

PROCESS OVERVIEW

Evergreen Health considers the PCP to be the member's primary point of entry into the Evergreen Health care delivery system for all outpatient care. The PCP is expected to coordinate all their patients' visits to specialists and for any needed ancillary services. The specialist or ancillary provider is expected to communicate back to the PCP, in a timely manner, via consultative reports or care plans any significant findings, recommendations for treatment and the need for any ongoing care or services

PROCESS GUIDELINES

PCPs should coordinate care only with Evergreen Health participating specialists for outpatient visits. Non-participating specialist' visits require prior authorization unless a member has a POS plan.

If an HMO plan member is in an active course of treatment with a non-participating specialist at the time of enrollment, Evergreen Health will evaluate requests for continuity of care. In these cases, a PCP referral is not required, but an authorization must be obtained for appropriate claims processing.

For further details, please refer to the Continuity of Care section of this manual.

COORDINATION OF CARE WITH NON-PLAN PROVIDERS

For members enrolled in Evergreen Health HMO plans, PCPs may coordinate care with non-participating providers under certain circumstances. Prior authorization is also required, and it will be obtained by the plan PCP. In those cases where a prior authorization is given the services and associated claims will be processed as in-network.

PCPs that are having difficulty locating a participating provider for specialty care are encouraged to call Customer Service at **(855) 978-3282** Monday–Friday, 8 a.m. to 5 p.m. ET, or go to **www.evergreenmd.org/provider-directory** to access our online Provider Directory. For the Private Health Care System (PHCS) provider directory go to www.evergreenmd.org/provider-directory and choose "Go To Partner Directory" option. Payment is subject to eligibility on the date of service, plan benefits, limitations and exclusions under the benefit plan.

CASE MANAGEMENT

CASE MANAGEMENT SERVICES

The Evergreen Health Case Management Program is an administrative and clinically proactive process that focuses on coordination of services for members with multiple comorbidities, complex care needs and/or short term requirements for care.

The Program is designed to work as a partnership between members, providers, and other health services staff. The goal is to provide services that will result in the best clinical outcomes for the member. The central concept is early identification, education, and measurement of compliance with standards of care. The Case Management staff strives to enhance the member's quality of life, facilitates provision of evidence-based services in the appropriate setting, and promotes quality cost effective outcomes. Staff members with specific clinical expertise provide support services and coordination of care in conjunction with the treating provider.

CASE MANAGEMENT PROGRAM GOALS

Evergreen Health has developed and actively maintains a detailed set of program objectives available upon request in our Case Management program description. These objectives are clearly stated, measurable, and have associated internal and external benchmarks against which progress is assessed and evaluated

throughout the year. Plan demographic and epidemiologic data, and survey data are used to select program objectives, activities, and evaluations.

CASE MANAGEMENT APPROACH

Evergreen Health's approach is to promote continuity and coordination of care, remove access barriers, prevent complications and improve member quality of life. Evergreen Health employs an episodic and individualized Case Management approach that focuses on identifying, prioritizing, and triaging cases effectively and efficiently.

Evergreen Health's aim is to assess the needs of individual members. To secure members agreement to participate, and to match the scope and intensity of our services to their needs. Results from health risk assessment surveys, eligibility data, retrospective claims data, and diagnostic values will be combined using proprietary rules, and used to identify and stratify members for Case Management intervention.

The plan uses an operational approach to identify and prioritize member outreach; we work closely with members and family/caregivers to close key gaps in education, self-management, and link members and caregivers to available resources. Personalized Case Management is combined with medical necessity review, ongoing delivery of care monitoring, and continuous quality improvement activities to manage target member groups.

Members are discharged from active Case Management under specific circumstances which may include, but are not limited to: stabilization of symptoms or a plateau in disease processes, the completed course

of therapy, member specific goals obtained or the member has been referred to Hospice. A member's case may be re-initiated based on the identification of a transition in care, a change in risk score, or through a referral to Case Management.

HOW TO USE CASE MANAGEMENT SERVICES

Members that can benefit from Case Management come from a variety of referral sources including utilization management activities, predictive modeling, and direct referrals from a PCP or provider. If a provider would like to refer an Evergreen Health member for Case Management services, call **(855) 530-1212**, Monday through Friday between 8:00 a.m. and 6:00 p.m. EST. In addition, our members have access to information regarding the program via outreach and website and may self-refer. Members are contacted by the Case Management staff by telephone or an in-person encounter. The member has the right to opt out of the program. If the member opts in, a letter will be sent to the member and to their provider. Once enrolled, an assessment is completed with the member and a plan of care with goals, interventions, and needs are established and shared.

COORDINATION WITH NETWORK PROVIDERS

Evergreen Health offers member access to a contracted network of facilities, primary care and specialty care physicians, mental health and alcohol and substance abuse specialists, as well an ancillary care network.

Each member receives information on how to access the provider directory, given in- depth information about how to find network providers in his area (by zip code and by specialty), how to select a PCP, conditions under which out-of-area and out-of- network providers may be seen, and procedures for when the member's provider leaves the network. A toll-free Customer Service telephone number is provided, and members with questions are asked to reach out to the plan.

The provider is a key member of the interdisciplinary care team. Our Case Management staff at Evergreen Health will work with you and your staff to meet the unique needs of each member. Case managers work with members and providers to schedule and prepare for member visits, to make sure that identified care gaps are addressed and prescriptions are filled, and to mitigate any non-clinical barriers to care. In cases where provider referrals are necessitated, case managers work closely with members to identify appropriate providers and schedule visits.

COMMUNICATIONS

Evergreen Health provides multiple communication channels for its members. The plan maintains a full-service inbound call program that allows members to inquire about all aspects of their relationship with the plan. Outbound member services and care calls are also made regularly to members to encourage them

to participate in clinical programs and assessment activities provided as part of their health care benefit. In addition to telephonic touch points, Evergreen Health will send educational materials to members in response to identified care gaps and changes in health status. Members also have access to web-based materials, where they can learn more about their benefits, explore additional benefits, search the provider directory, find a pharmacy and query the formulary.

PROGRAM EVALUATION

Evergreen Health continually monitors its programs, and makes changes as needed to its structure, content, methods, and staffing.

Changes to the program are made under two conditions:

1. Changes must benefit members
2. Changes must be in compliance with applicable regulations and guidance

Changes to programs are accompanied by policy and procedure revisions and staff training as required. The program operates under the umbrella of the plan's Quality Improvement Committee (QIC) and is reviewed and updated annually. The plan's Provider Advisory & Credentialing Committee, made up of network providers, also reviews programs and its clinical guidelines at certain intervals and provides improvement recommendations.

CONFIDENTIALITY

Evergreen Health is committed to preserving the confidentiality of its members and providers. Written policies and procedures are in place to ensure the confidentiality of member information. Patient data gathered during the Case Management process are available for the purposes of review only and are maintained in a confidential manner. Employees receive confidentiality training that includes appropriate storage and disposal of confidential information. Employees also sign a confidentiality agreement at the time of their initial company orientation.

CLINICAL PRACTICE GUIDELINES & REFERENCE MATERIALS

Evergreen Health has adopted evidence-based clinical practice and preventive health guidelines as roadmaps for healthcare decision-making targeting specific clinical circumstances. Evergreen Health promotes the use of clinical practice guidelines to:

- Define clear goals of care based on the best available scientific evidence
- Reduce variation in care and outcomes
- Provide a more rational basis for clinical management of some conditions
- Comply with accreditation standards and regulatory expectations

EVIDENCE BASED PRACTICE RESOURCES

Additionally, Evergreen Health is committed to shared decision making and empowering members to understand treatment options. To this end, Evergreen Health providers will only provide trusted evidence to members to allow evidence-based shared decision making conversations. Please follow this link to view evidence-based practice resources: **https://www.evergreenmd.org/providers/reference-guides/clinical-practice-guidelines-reference-materials/**

QUALITY IMPROVEMENT PROGRAM

OVERVIEW

Evergreen Health is committed to providing access to quality health care for all members through continuous planning, implementation and assessment to improve the quality of care and services delivered to our members.

The primary objective of Evergreen Health's Quality Improvement Program (QIP) is to promote and build quality into the organizational structure and processes. The goal is to provide members with affordable and high quality health care choices that emphasize keeping members healthy with a strong focus on prevention, wellness, and continuity of care and application of evidence-based practice.

QUALITY IMPROVEMENT PROGRAM

Evergreen Health seeks to establish, implement and maintain an effective Quality Improvement Program (QIP) structure that:

a. Fosters communication across the organization

b. Collaboratively works towards achievement of established goals

c. Monitors progress of improvement efforts toward established goals, and

d. Provides the necessary oversight and leadership reporting

The QIP has established the following overarching goals to meet this objective:

- Ensure that patient care and service is provided according to established goals and metrics
- Ensure identification and analysis of opportunities for improvement with implementation of actions and follow-up as needed
- Promote consistency in quality program activities
- Assure timely access to and availability of safe and appropriate medical and behavioral health services for members
- Ensure that services are provided by qualified individuals and organizations including
- those with the qualifications and experience appropriate to serve members with complex needs
- Ensure that utilization management decisions are transparent, objective and consistent when applying medical necessity
- Promote the use of evidence- based clinical practice and preventive health guidelines
- Encourage provider and member involvement in maintaining and improving the health of Evergreen Health's members and the individual experience of care (including quality and satisfaction)
- Reduce the per capita cost of health care
- Establish a rigorous delegation oversight process
- Establish adequate infrastructure and resources to support the QIP

QUALITY IMPROVEMENT/UTILIZATION MANAGEMENT COMMITTEE (QI/UMC)

The QI/UMC is responsible for the overall design and implementation of quality improvement activities for Evergreen Health as well as for the oversight of quality improvement activities carried out by other quality sub-committees. The QI/UMC reports these activities to the Board of Directors.

PROVIDER ADVISORY & CREDENTIALING COMMITTEE (PACC)

The PACC reviews and approves the Evergreen Health network of health care providers, provides peer review related to clinical care, and makes recommendations related to clinical activities such as clinical practice guidelines and utilization management criteria. Practicing provider members of the PACC are selected to reflect the geographic distribution and healthcare needs of our members. The PACC includes provider members participating in the products provided by Evergreen Health.

To obtain a comprehensive description of the QI program, the annual goals, or a list of activities toward achieving those goals, please access our website at: **www.evergreenmd.org/providers**.

COMPLIANCE PROGRAM

OVERVIEW

Evergreen Health is committed to maintaining an effective Compliance Program that complies with all applicable federal and state laws and regulations. The Program reviews health plan business activities, audits the different business units to evaluate potential compliance and legal risks. For example, Evergreen Health has developed written policies and procedures that are designed to establish rules that assist our employees and contractors to carry out their job functions in accordance with all applicable statutory/regulatory requirements. Failure to follow policies and procedures is taken seriously. Non-compliant actions will be fully investigated and if necessary, disciplinary measures will be taken.

FRAUD, WASTE, AND ABUSE

Evergreen Health has no tolerance for the commission or concealment of acts that involve fraud, waste, or abuse. Allegations of such acts will be fully investigated. All employees, members, providers and brokers are asked to immediately report any suspected instances of fraud, waste and abuse. Reporting can be anonymous. Failure to report known or suspected fraud, waste or abuse could result in corrective and/or legal action against the individual who committed the act and/or any individuals who know of the actions and did not report.

Fraud can be characterized as an intentional wrongdoing or the concealment of a wrongdoing that would result in a benefit to the individual who commits the fraud.

Waste can be a thoughtless or careless expenditure, consumption, mismanagement, use or squandering of resources that are owned or operated by Evergreen Health and are used to the detriment of Evergreen Health.

Abuse is the excessive, or improper use of something, or the use of something in a manner that is contrary to the natural or legal rules for its use; the intentional destruction, diversion, manipulation, misapplication, or misuse of resources owned or operated by Evergreen Health.

Evergreen Health encourages anyone who has knowledge or suspicion of any fraud to report it immediately to the Evergreen Health Chief Compliance Officer. Reports can be filed online, can be sent by U.S. mail or phone call should be directed to the Evergreen Health Chief Compliance Officer. All communications will be confidential:

Evergreen Health
3000 Falls Road, Suite 1
Baltimore, MD 21211
(443) 475-0990
Email: fraud@evergreenmd.org

Fraud, waste and abuse reports can also be filed by calling a telephone hotline that is maintained by an independent third party. The telephone call to the hotline can be completely anonymous. The hotline can be called twenty-four (24) hours a day. The phone number is: **(855) 490-1549**.

Any questions regarding fraud, waste and abuse should be directed to the Chief Compliance Officer at the addresses and phone number listed directly above.

DISPUTE RESOLUTION

Any controversy, dispute or claim arising out of or relating to your provider agreement will be resolved, to the fullest extent possible and in accordance with Law, through Evergreen Health plan's internal appeals process, informal meetings and discussions held in good faith between appropriate representatives of the parties. Any remaining claim or controversy will be resolved through litigation where each party bears their own costs for incurred expenses related to the litigation unless such expenses are otherwise allowed by statute.

APPENDIX A

2017 PRIOR AUTHORIZATION REQUIREMENTS AND LIST FOR EVERGREEN HEALTH HOSPITAL INPATIENT SERVICES

All inpatient hospital admissions require prior authorization for elective admissions, notification of admissions, and concurrent review. However, while maternity admissions do require notification, concurrent review is not required unless stay exceeds two days for vaginal delivery, four days for C-section delivery, a newborn is admitted to the NICU, or newborn is detained after mother's discharge. The participating provider must contact Evergreen Health on the member's behalf at least five (5) business days prior to an elective or scheduled admission to the hospital. If the admission cannot be scheduled in advance because it is not feasible to delay the admission for five (5) business days due to the member's medical condition, Evergreen Health must receive notification of the admission as soon as possible but in any event within forty-eight (48 hours following the beginning of the admission or by the end of the first business day following the beginning of the admission, whichever is later. This includes ER and maternity admissions.

INPATIENT MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

Evergreen Health must be contacted for prior authorization at least five (5) business days prior to an elective or scheduled admission to the hospital. If the admission cannot be scheduled in advance because care is required immediately due to the member's condition, Evergreen Health must receive notification of the admission as soon as possible but in any event within twenty-four (24) hours of, or by the end of the first business day, following the beginning of the admission, whichever is later.

In the case of an inpatient mental health and/or substance abuse admission of a member who is determined by the member's physician or psychologist, in conjunction with a member of the hospital staff who has admitting privileges, to be in imminent danger to self or others, Evergreen Health may not render an adverse authorization determination until the later of twenty-four (24) hours after a voluntary admission and seventy-two (72) hours after an involuntary admission.

RELATED INSTITUTION

Related Institution means an organized institution, environment or home that maintains conditions or facilities and equipment to provide domiciliary, personal or nursing care for two or more unrelated individuals who are dependent on the administrator for overnight nursing care or the subsistence of daily living in a safe, sanitary and healthful environment. Related Institution does not include a nursing facility or visiting nurse service that is conducted only by or for adherents of a bona fide church or religious organization, in accordance with tenets and practices that include reliance on treatment by spiritual means alone for healing. The treating provider must contact Evergreen Health's mental health management program for prior authorization at least five (5) business days prior to admission to a related institution.

TRANSPLANTS AND RENAL DIALYSIS

Renal Dialysis and Transplants, including evaluation and related services must be coordinated and prior authorized.

AMBULANCE SERVICES

Evergreen Health requires that all air transportation and elective ground transportation (other than 911 calls) be reviewed for medical necessity. Prior authorization is required for all elective ground transportation with the exception of members enrolled in Small Group plans.

OTHER SERVICES

If the Member requires any of the following services, Evergreen Health must be contacted by the participating provider for prior authorization at least five (5) business days prior to the anticipated date upon which the elective admission, treatment or service will be rendered.

All facility admissions including acute inpatient, acute rehabilitation, long-term acute hospitals. Long-term acute hospitals provide specialized acute care for medically complex members who are critically ill with multi- system complications or failures and require long hospitalization (the average length of stay exceeds twenty-five (25) days), skilled nursing facilities, inpatient hospice

- Hospital observation greater than 24 hours
- Home health services by HHA (PT/OT/ST/RN);
- Home infusion;
- Home hospice
- Diagnostic imaging (PET scans, MRAs, MRIs);
- Proton beam therapy;
- Nuclear cardiology;
- Intensity modulated radiation therapy (IMRT);

Durable medical equipment is generally obtained on a rent to own basis. Not all DME requires prior authorization but a review for medical necessity is always required. Providers need to call the Provider or Member Services number to check to see if prior approval is required. The following is a list of DME that requires medical necessity review:

- All rental equipment to be used for greater than three (3) months not otherwise mentioned below;
- Any equipment with purchase price >$1,000
- Apnea monitors - rental only
- Electric or custom wheelchairs and scooters
- CPAP
- BIPAP - rental only
- Bone growth stimulators - rental only
- High frequency chest compression devices and vests
- Air fluidized and specialty beds - rental only
- Wound vac pumps - rental only
- Diabetic insulin pumps
- Augmentative communicator/speech generator device
- Pediatric feeding chairs or equipment
- Hearing aids (limited to 1 per ear every three (3) years)
- Cochlear implants and supplies
- Any equipment that does not have a defined CPT code (e.g., E1399)

Please note that replacement DME is considered medically necessary when: a) needed for normal wear; or b) the changes in the member's condition warrant additional or different equipment, based on clinical documentation.

Other services requiring Prior-authorization and/or medical necessity review:

Outpatient procedures (not all outpatient tests and services require prior authorization. Providers must call the Provider Services number located on the Member's ID card to check to see if plan approval is required)

- Out of service area provider requests (other than ER/urgent)
- Non-participating providers (only for HMO network plans)
- Chiropractic services after the first twelve (12) visits; Podiatry after the first ten (10) visits
- Infertility services
- Genetic testing during pregnancy and for pediatric members and adults
- Rehabilitative services: physical therapy (after an evaluation and the first twenty (20) visits), occupational therapy, speech& language therapy, and cardiac and pulmonary rehabilitation
- Prosthetics and orthotics
- Ancillary labs or tests performed as in home services
- Partial hospitalization for mental health services
- Intensive outpatient services
- Residential services for substance abuse

For more information
call us at **(443) 475-0105**
or visit us online at
www.evergreenmd.org/providers

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