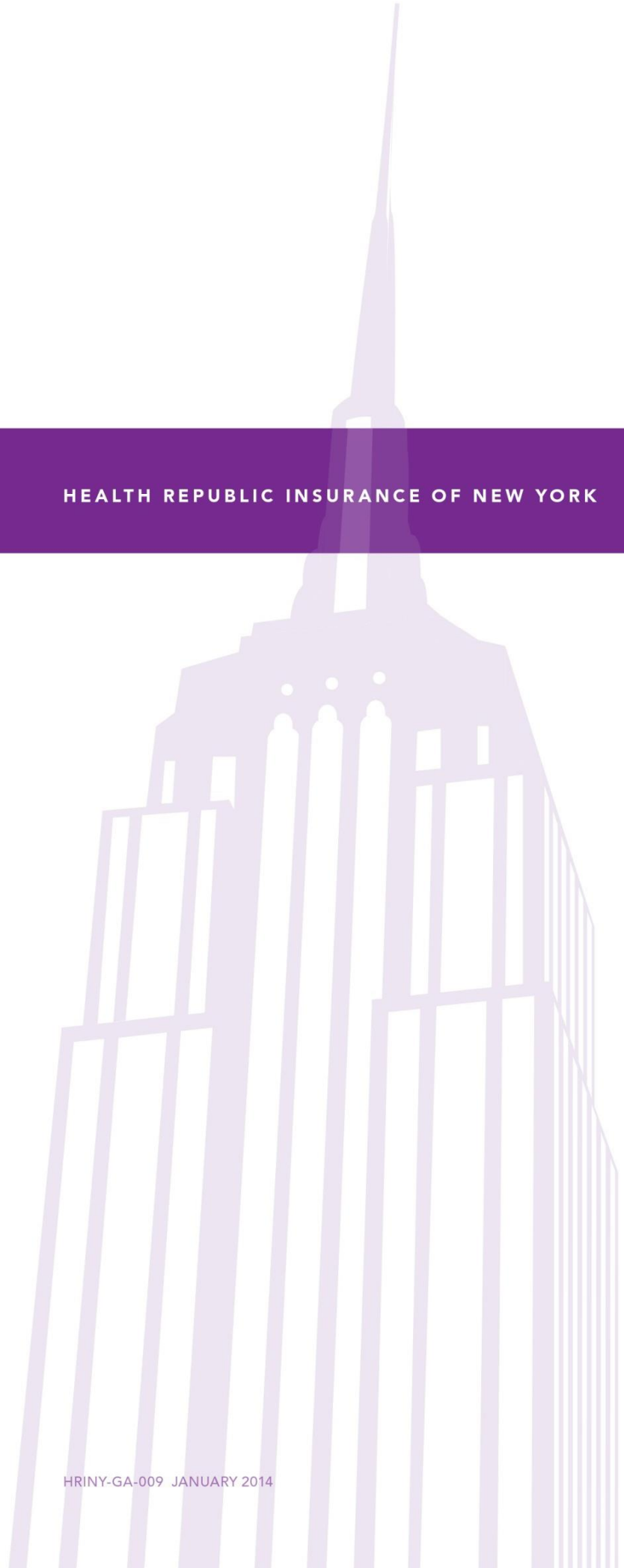
HEALTH REPUBLIC INSURANCE OF NEW YORK

Provider Manual



HEALTH REPUBLIC
INSURANCE

Not-For-Profit. For People.

HRINY-GA-009 JANUARY 2014

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Summary of Contact Information

Contact Information for Providers

Issue	Contact	Phone/fax number
Obtain precertification	Utilization Managment	888-990-5702 Fax 315-433-5442
Claims status inquiries	Claims	888-990-5702
Contract questions – provider contracted with MagnaCare	MagnaCare Provider Relations	800-235-7267
Contract questions – provider contracted with HRINY	HRINY Provider Relations	646-679-4575 914-703-9182
Refer members to case management	Case Management	888-990-5702 Fax 315463-1483
Obtain copies of medical policies	Customer Service	888-990-5702
Verify coverage and benefits	Customer Service	888-990-5702
Pharmacy	US Script	1-855-339-4803
Submit appeal Expedited Appeal	Utilization Managment	In writing to: Health Republic Insurance of New York PO Box 6329 Syracuse, NY 13217-6329 888-990-5702 Fax 315-433-5442
Submit Claims, Appeals, and COB information	Claims	To Submit Electronic Claims: Emdeon (WEB MD) 800.845.6592 Payer ID # 16111

Important Telephone Numbers for Utilization Management

Pre-certification:

888-990-5702

Case Management:

888-990-5702

Health Republic Insurance of New York
30 Broad Street, 34 Floor
New York NY 10004

Main phone numbers:
888-990-5702

800-235-7267

Health Plan Information

About HRINY
Health Republic Insurance of New York is a true not-for-profit program and New York's only CO-OP -- Consumer Operated and Oriented Plan. CO-OPs are private, member-governed health insurance companies formed across the country as part of the Affordable Care Act. Health Republic Insurance of New York (HRINY) is dedicated to providing quality care and affordable health insurance coverage to individuals and small businesses throughout the state of New York.

HRINY is licensed as a health insurance company under Article 43 of New York State Public Health Law as Freelancers Health Service Corporation dba Health Republic Insurance of New York. In addition, HRINY has been deemed a qualified health plan for participation in the New York State of Health.

Essential Health Benefits
The Affordable Care Act is designed to provide Americans with access to quality, affordable health insurance. To achieve this goal, health plans offer a core package of items and services, known as "essential health benefits", to individual and small groups, both on and off the New York Health Plan Marketplace. The services include:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care

Product Overviews
HRINY offers three types of products, on and off the Health Exchange, to individuals and small groups. All products cover the essential health benefits. Preventive services are covered and require no copayment. As designed by the Affordable Care Act, each plan is offered in metal tiers that represent the approximate actuarial value of the plan: Bronze 60%, Silver 70%, Gold, 80%, and Platinum. Members who select a lower actuarial value pay a lower premium, but are at risk of higher out of pocket costs until they reach the out-of-pocket maximum. Once members or their families reach the out of pocket maximum, they have no additional copayments or coinsurance.

Members with an income lower than 400% of the Federal Poverty Level may be eligible for premium subsidies. They are required to take the Silver level plans.

The three product types are:

1. **EssentialCare** is the standard benefit design on the New York State of Health marketplace. It is available in all of the metal tier levels.
2. **PrimaryCare Select** has an innovative design that seeks to foster a relationship between members and their "primary physician". Members have no copayment for office visits when they see their selected primary physician. There also are no copayments for mental health and substance abuse services and diabetes supplies. These plans are available at the Silver, Gold and Platinum levels.
3. **PrimarySelect EPO** has the same features as the PrimarySelect plan except that members are required to select a primary physician who is part of a patient centered medical home. This product is available only at the Silver level and in the following counties: Nassau, Queens, New York, Bronx, Westchester, Essex, and Hamilton.

Primary Physicians
When a PrimarySelect or PrimarySelect EPO member chooses a "primary physician", they have no copayment for any office visit. The name of the primary physician is printed on the member ID card to ensure the copayment is not collected inappropriately during the office visit.

Physicians with training in primary care specialties are preferred as primary physicians. This includes MDs or DOs trained in Family Practice, Internal Medicine, Pediatrics, or Obstetrics and Gynecology. Specialists with training in the primary care specialties, such pulmonary medicine or infectious diseases, may also be a primary physicians. In rare instances, other types of doctors may be identified as the primary physician. This will be determined by the plan medical director. A nurse practitioner listed in the provider directory also can be selected to serve as a member's primary physician.

There are two ways for members to select or change their primary physician: on-line and by telephone with assistance from a Member Services representative. The change goes into effect the next business day. A new card will be sent to the member within ten days. Members can change primary physicians up to five times a year.

Quality Improvement Plan

Health Republic Insurance of New York has adopted a Quality Improvement Program, which is developed, implemented and overseen by the Quality Improvement Committee of the Board of Directors. This committee includes practicing physicians participating with HRINY.

Mission and Values

The Quality Improvement Program includes initiatives and activities that promote high-quality, cost effective care. Specifically, the plan describes activities that support HRINY as a not-for-profit, member-driven corporation dedicated to providing quality care and affordable health insurance coverage to individuals and small businesses throughout New York State. This mission is consistent with its creation under the Patient Protection and Affordable Care Act as a consumer-operated and oriented plan (CO-OP).

The Quality Improvement Program helps to ensure that HRINY meets its goals. Specifically, HRINY seeks to:

- encourage members to select and establish a relationship with a primary health care provider
- ensure that members have equal access to their benefits, regardless of personal characteristics such as race, ethnicity, gender, sexual orientation, geographic location, primary language or enrollment channel
- ensure that members have access to health promotion and educational resources so they can understand their health status and risks, and learn how to utilize available services
- ensure that health care services are delivered safely, timely, efficiently, effectively, equitably and in a patient-centered manner
- meet or exceed all statewide average quality measures for preventive care, chronic care and patient access
- maximize member satisfaction with HRINY

To help achieve these goals, the Quality Improvement Program includes the following initiatives and activities:

The Population Health Program (PHP)

The PHP supports all quality program activities and objectives. Claims and demographic data are collected and analyzed for the purpose of tracking and developing time sensitive and targeted interventions to improve the quality of care and service. In addition, the PHP offers members:

- the opportunity to complete an online general health appraisal and receive a personalized summary of medical conditions reported that can be shared with their doctor
- health promotion educational materials
- access to a trained Coach who provides guidance on proactive health behaviors and more effective physician-patient communications

Utilization Management

Health Republic Insurance of New York monitors inpatient hospitalizations, the use of outpatient facilities, and certain procedures and medications with the objective of ensuring that treatments are safe, appropriate and cost-effective. HRINY has delegated this responsibility to POMCO, but HRINY closely oversees the performance of this function and reviews the Utilization Management plan on a regular basis. POMCO is accredited for Utilization Management by URAC and serves a large number of self-insured employers in the state of New York.

Case Management
Health Republic Insurance of New York utilizes specially-trained staff (including nurses and social workers) to advise members on treatment guidelines and adherence to clinical regimens. HRINY provides case management services for all patients admitted to the hospital as part of discharge planning. The goal is to optimize coordination of services and to prevent readmission. HRINY also provides case management services to members with complex medical conditions such as transplant, dialysis, infusion service and catastrophic disease management.

Grievances and Appeals
The Quality Improvement Committee oversees the process for complaints and grievances by members and for grievances and appeals by providers.

Member Satisfaction
Health Republic Insurance of New York and its vendors actively respond to and seek to resolve member questions and problems. Complaints, grievances and appeals, their handling and their prompt resolution are tracked by the Member Satisfaction Committee. HRINY has delegated certain customer service activities to POMCO (for claims administration issues) and to Morneau-Shepell (for billing and enrollment issues), but HRINY oversees those activities and provides customer service directly to members on escalated issues.

Credentialing
HRINY collects and confirms information on education, certifications, licensure and legal actions on the providers in the MagnaCare Extra network to ensure there is appropriate access and availability of qualified providers in the service areas.

Quality Improvement Plan
The Quality Improvement Plan is developed and overseen by the Quality Improvement Committee of the Board of Directors. The Quality Improvement Plan is managed by the Quality Improvement Committee which includes practicing physicians from the community. A copy of the 2014 Quality Improvement Program is available by contacting HRINY's Provider Relations department.

Clinical Practice Guidelines and Medical Policies
The Quality Committee reviews and approves Clinical Practice Guidelines and Medical Policies on a regular basis. These are posted in the Provider Section on the HRI website.

Investigation of Quality Care Complaints
The Quality Improvement Committee oversees investigations of quality of care complaints. Investigations may be triggered by members, providers or HRINY staff. An investigation is conducted and a determination is made regarding whether the services under review deviated from the standard of care. Recommendations for corrective action are brought to the Credentialing Committee.

Member Rights and Responsibilities

Rights and Responsibilities

Members of Health Republic Insurance of New York should know what to expect from us, as well as what we ask of them. Nobody knows more about their health than the member and their medical providers. We take responsibility for providing the very best health care services and benefits possible; the member's responsibility is to know how to use them well. We are ready to help in any way.

Members have the right to:

- Å be cared for by people who respect their privacy and dignity.
- Å be informed about the Plan, our providers, and the benefits and services they have available to them as a member.
- Å receive information that helps them select a participating physician or provider whom they trust and with whom they feel comfortable.
- Å a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- Å receive information and clinical guidelines from their health care provider or their health plan that will enable them to make thoughtful decisions about their health care.
- Å actively participate in decisions that relate to their health and their medical care through discussions with their health care provider or through written advance directives.
- Å have access to medical services that are appropriate for their needs.
- Å express a concern and receive a timely response from the Plan.
- Å have their claims paid accurately and promptly.
- Å request a review of any service not approved, and to receive prompt information regarding the outcome.
- Å make recommendations regarding the Member Rights and Responsibilities Policy.
- Å refuse care from specific providers.

Members have the responsibility to:

- Å read and understand the information they receive about the Plan, and call 888-990-5702 if they have questions.
- Å talk openly with their physician or provider and work toward a relationship built on mutual trust and cooperation.
- Å follow the treatment plan agreed upon with their practitioner.
- Å provide to the extent possible medical information their physicians or providers request from them.
- Å do their part to prevent disease and injury. Try to make positive, healthful choices. If they do become ill or injured, seek appropriate medical care promptly.
- Å treat their physicians or providers courteously.
- Å make their required copayment at the time of service.
- Å show their FHSC Member Card whenever they receive medical services.
- Å let us know if they have concerns, or if they feel that any of their rights are being compromised, so that we can act on their behalf.
- Å contact 888-990-5702 within five (5) days of service if they wish to request a review of services provided or appeal a Plan decision.
- Å notify Member Services if their address changes.

Health Republic Insurance of New York, the Plan, has the responsibility to:

- respect and honor member rights.
- ensure timely access to appropriate health care services.
- enable members to see physicians or providers who meet their needs.
- develop a variety of benefits to serve members well.
- assure the ongoing quality of our providers and services.
- contract with providers who are capable, competent and committed to excellence.
- make it easy and convenient for members to appeal any policy or decision that they believe prevents them from receiving appropriate care.
- provide members with accurate up-to-date information about the Plan.
- provide members with information and services designed to help them maintain good health and receive the greatest benefit from the services we offer.
- ensure privacy and confidentiality of member medical records, with access according to law.
- ensure that member interests are well represented in decisions about Plan policy and governance.
- encourage physicians and providers to make medical decisions that are always in a member's best interest.

Member Eligibility Inquires

All inquiries regarding member eligibility are handled by the customer service line at 888-990-5702.

Providers may also use our member portal to verify eligibility:
https://secure.healthx.com/providerportalhealthrepublicny.aspx

Member ID Card

HRINY members will receive their member id card after enrollment and, in most cases, prior to the effective date. Each member (subscriber, dependents, etc.) will receive their own member card. The member ID card is sent to the member's home.

Members receive new ID cards in these situations:

- plan type change
- change in Primary Physician, as the Primary Physician is listed on the card for Primary Select and Primary Select EPO
- lost Card
- reinstatement of Coverage

If a member needs to replace a lost or stolen member ID card, have them call Member Services at 888-990-5702 to request a replacement. The ID card will arrive in the mail within 10 days.

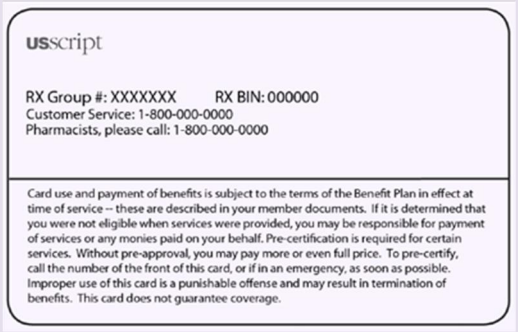
Questions:

Call 888.990.5702

Sample Card for Plan Without Primary Physician Selection

Sample Card For Plan With Primary Physician Selection

Sample Prescription Card



Choosing a Primary Physician

Members in the PrimaryCare Select and PrimarySelect EPO products are advised to choose a primary physician. They are not required to do so, but they do not receive the full value of their benefit design unless they do so. Office visits for members who have selected a Primary Physician have no copayments.

Members may choose a primary physician on-line or by calling the customer service line at 888-990-5702.

Copayments and Deductibles

Primary Select Benefit Design Highlights

Deductibles and Maximums	Platinum	Gold	Silver
Deductible (Single)	$0	$250	$2000
Max Out of Pocket Limit (Single)	$1400	$3500	$6350
Cost Sharing (Co-Insurance)	20%	20%	20%

Cost Sharing-Medical Services	Platinum	Gold	Silver
Inpatient/SNF/Hospice-Facility (per admission)	Coinsurance after Deductible is Met		
Outpatient- Facility	Coinsurance after Deductible is Met		
Surgeon (Inpatient)	Coinsurance after Deductible is Met		
Surgeon (Outpatient)	Coinsurance after Deductible is Met		
PRIMARY PHYSICIAN	$0	$0	$0
Other Primary Care	$15	$25	$30
Specialist	$75	$75	$75
PT/OT/ST	$30	$30	$30
ER (Co-Pay after Deductible is Met)	$250	$250	$250
Ambulance	$100	$150	$150
Urgent Care	$100	$100	$100

Outpatient Services	Platinum	Gold	Silver
Diagnostic and Routine Laboratory and Pathology	$75	$75	$75
Diagnostic and Routine Imaging	$75	$75	$75
Mental/Behavioral Healthcare (Outpatient)	$0	$0	$0
Substance Abuse Disorder Services (OP)	$0	$0	$0
Diabetic Care and Supplies	$0	$0	$0
Chemotherapy	$15	$25	$30
Radiation Therapy	$15	$25	$30
Dialysis	$15	$25	$30
Home Health Care	$15	$25	$30

Prescription Drugs	Platinum	Gold	Silver
Tier I (Selected Generics)	$0	$0	$0
Tier II (Other Generics)	$35	$35	$35
Tier III (Brand and Specialty)	$70	$70	$70

Essential Care Benefit Design Highlights

Deductibles and Maximums	Platinum	Gold	Silver
Deductible (Single)	$0	$600	$2000
Max Out of Pocket Limit (Single-Incl. Deductible)	$2000	$4000	$5500

Outpatient Services	Platinum	Gold	Silver
Pre-Admission/Pre-Operative Testing	$0 Copay		
Diagnostic and Routine Laboratory and Pathology	$35	$40	$50
Diagnostic and Routine Imaging	$35	$40	$50
Chemotherapy	$15	$25	$30
Radiation Therapy	$15	$25	$30
Dialysis	$15	$25	$30
Mental/Behavioral Healthcare	$15	$25	$30
Substance Abuse Disorder Services	$15	$25	$30
Home Health Care	$15	$25	$30
Hospice	$15	$25	$30

Cost Sharing-Medical Services	Platinum	Gold	Silver
Inpatient/SNF/Hospice-Facility (per admission)	$500	$1000	$1500
Outpatient- Facility	$100	$100	$100
Surgeon (Inpatient, Outpatient)	$100	$100	$100
PCP	$15	$25	$30
Specialist	$35	$40	$50
PT/OT/ST-rehabilitative and habilitative therapies	$25	$30	$30
ER	$100	$150	$150
Ambulance	$100	$150	$150
Urgent Care	$55	$60	$70
DME/Medical Supplies (After Deductible)	10%	20%	30%

Prescription Drugs	Platinum	Gold	Silver
Tier I (Selected Generics)	$10	$10	$10
Tier II (Other Generics)	$30	$35	$35
Tier III (Brand and Specialty)	$60	$70	$70

High Deductible Plans

High Deductible Plans	Bronze	Catastrophic
Deductible (Single)	$3000	$6,350
Max Out of Pocket Limit (Single-Incl. Deductible)	$6350	$6,350
Cost Sharing (All Parameters)	50%	0%
Prescription Drugs	$10/$35/$70	0%

Complaints, Grievances and Appeals

All complaints, grievances and appeals are handled through the Member Services department. Members who have complaints are asked to call or write. A detailed investigation of any member complaint is conducted. Members will receive confirmation that the complaint was received, as well as notification of the outcome of the investigation.

Members who are concerned that a claim may have been paid incorrectly can file a grievance. They will receive prompt confirmation that their grievance was received and a written response within 30 days. An appeal can be requested by a member, the ordering provider, or an advocate formally designated by the member. The first step in the appeal process is reconsideration by the original physician issuing the denial. The medical reviewer may overturn the original determination or allow the case to proceed to appeal. The next step in the appeal process is a review by a physician not involved in the original determination. All information in the initial request, as well as any additional information that has become available, is reviewed. The physician issues a final determination that will result in an approval of the original outcome or an overturn.

An appeal of an adverse decision (denial) regarding an urgent claim will be decided within 72 hours after the appeal request is filed. An appeal of an adverse decision regarding a pre-service claim will be decided within 30 days after the appeal request is filed. An appeal of an adverse decision regarding a post-service claim will be decided within 60 days after the appeal request is filed.

HRINY 's appeal process complies with state and/or federal regulations including Employee Retirement Income Security Act (ERISA) regulations. Appeals must be submitted in writing and mailed to the HRINY appeals department within 60 days from the date of the written denial. HRINY may reserve the right to maintain denial of benefits without further review for any appeals received more than 60 days after the initial notice of claim denial. Appeals should be submitted to the address listed at the beginning of this guide.

An external appeal can be requested by a member, the ordering provider, or an advocate formally designated by the member. The request for an external appeal is processed in accordance to guidelines developed by the New York State Department of Health.

Provider Relations

Participating Provider Network
The HRINY network consists of two parts: MagnaCare contracted facilities and providers, and providers directly contracted with HRINY. The MagnaCare network consists of more than 77,000 providers in New York, New Jersey and Connecticut, and includes a broad range of practitioners. These providers are listed on the both the HRINY website and the MagnaCare website. In addition, HRINY has direct contracts with a number of Federally Qualified Health Centers (FQHCs). The providers at these centers are also listed on the HRINY website and the centers are listed in a separate section of the website (labeled "Participating FQHCs").

Non-participating Providers
HRINY has no out-of-network benefit, and non-participating providers have a limited role in the care of members. There are two scenarios possible: out-of-area emergency services and unique specialty care. If a member is travelling and requires emergency care and/or hospitalization, services will be reimbursed at the prevailing Medicare rate. If medically necessary specialized services are not available through participating providers, then a separate settlement agreement will be negotiated. All such services require prior approval.

Role of Provider Relations
The Provider Relations team is committed to collaborating effectively with our providers. Ensuring timely and appropriate payment is the primary function of this group. The primary point of contact for MagnaCare contracted providers is MagnaCare Provider Relations, which can be contacted at 800-235-7267. If a case cannot be resolved through the normal channels, then providers are invited to call 646-679-4575. The Provider Relations team is the primary point of contact for FQHCs.

HRINY's Provider Relations staff provides support and education to providers. In addition, the Provider Relations department manages the relationships with directly-contracted providers and oversees MagnaCare provider activities. Providers who are contracted with MagnaCare should contact the MagnaCare Provider Relations department for questions regarding credentialing, participation status, payment rates, etc. Providers contracted directly with HRINY should contact HRINY's Provider Relations department for similar concerns.

Credentialing
Delegation of Credentialing
HRINY delegates all credentialing activities to MagnaCare and oversees the work of the MagnaCare Credentialing Committee (as it pertains to HRINY) through the Quality Improvement Committee. In some instances, MagnaCare may delegate its credentialing activity to an appropriately qualified delegate.

MagnaCare Credentialing Policies
MagnaCare policies on Credentialing are quoted below:

Mission Statement
The mission of MagnaCare is to provide our members with access to a high quality health care network at a reasonable cost. We strive for our network to offer, at a minimum, a comprehensive range of institutional, medical, surgical, and ancillary health care services.

Policy Statement
In keeping with our goal of a high quality provider network, the MagnaCare Networks will include recognized allopathic, osteopathic, and podiatric specialists, as well as other health care professionals such as audiologists, certified social workers, chiropractors, nurse practitioners, physical therapists, etc. Each provider

who applies for admission within the MagnaCare Networks will be categorized according to their specialization. Providers will be appointed without regard to race, color, sex, age, national origin, religion, marital status, sexual orientation, types of procedures, types of patients the practitioner specializes in, or disability, unless such disability interferes with the ability of the practitioner to provide quality health care.

The ancillary network will be comprised of conveniently located and appropriately licensed ancillary providers such as home health care agencies, laboratories, durable medical equipment (DME) providers, etc., throughout the MagnaCare coverage area.

Nondiscriminatory Credentialing and Recredentialing Policy
MagnaCare does not make credentialing or recredentialing decisions based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation, type of procedures performed (e.g., abortions), or type of patients treated (e.g., Medicaid). In an effort to meet the intent of this policy, MagnaCare requires each participating member of the Provider Credentialing Committee to execute a statement verifying that decisions made by the committee member will be made in a nondiscriminatory manner. This statement is stored with committee meeting minutes.

To ensure nondiscriminatory credentialing and recredentialing, any complaints alleging discrimination will be reviewed by the committee. The committee will make every effort to provide a response within fifteen (15) business days. When review and response exceeds the fifteen (15) business day goal, correspondence acknowledging receipt of the complaint and projected review and response timeline will be forwarded to the complainant.

Confidentiality Policy
All files are confidential, and information in the file may only be released to duly authorized individuals or entities, for the purpose of maintaining the accuracy and completeness of the required information in the file, in the normal, good faith conduct of peer review, as required by law, or as agreed to in the executed MagnaCare initial or recredentialing Provider Application or Agreement.

As such, MagnaCare staff and committee members are required to sign a confidentiality statement *(see Attachment A)*. Additionally, it is the responsibility of the Provider Credentialing Committee (PCC) to monitor, review, and assure confidentiality compliance by all MagnaCare employees. Representatives for health plans, visitors, or reviewers must also sign a Confidentiality Form prior to reviewing files.

All documentation and information received by MagnaCare for credentialing purposes is confidential and will be distributed ONLY on a need-to-know basis.

All files will be stored in a locked area or on a secured computer system, not readily accessible to staff or visitors.

Provider Initial Application and Recredentialing Guidelines
Initial network applicants will complete and sign a Provider Application and providers already in the network will complete a MagnaCare Participating Provider Recredentialing Application. Provider responses and supporting documentation will be carefully reviewed by the Provider Credentialing Department to assure that all critical responses and needed documentation are provided and that the application and attestation signature dates do not exceed 365 calendar days from the date of receipt.

If there is a discrepancy between the information obtained during the credentialing process, and that submitted by the provider, the provider will be notified, in writing, advising of such discrepancy. The provider will have an opportunity to correct the discrepant information.

Verification of the information provided in the application includes:

a. Verification of education and professional training through ABMS or AOA board certification or through the appropriate state board if primary source documentation is confirmed.

b. Verification of Board Certification when applicable through ABMS or AOA during initial credentialing and reverification at recredentialing.

c. Verification of a valid, current, registered state license by querying the issuing state's licensing board.

d. Verification of the DEA and CDS (if applicable) by obtaining current copies of certificates.

e. Verification of the NYS Workers Compensation number by querying the New York State Workers Compensation Board (if applicable).

f. Verification of hospital staff privileges by the applicant's completion of the hospital facility section of the application. The application must sign the attestation certifying this information is true and correct.

g. The applicant must complete the Medical Liability History section of the application and attest that the information is true and correct. The Medical Director reviews all malpractice claim history to ensure acceptable levels are not exceeded.

h. Verification of past and/or current adverse determinations by state disciplinary board(s) or other state agency(ies) are obtained by direct state agency or FSMB query and/or published agency(ies) reports. Federal government adverse rulings regarding Medicare and/or Medicaid participation are obtained from queries of or reports issued from the Office of Inspector General.

i. Verification of current work history. Work history is verified by obtaining a Curriculum Vitae (CV) without any gaps of more than 180 calendar days.

Provider Initial Application and Re-credentialing Process and Procedures
(Providers are to be scheduled for Re-credentialing every 36 months)
Once a health care provider's initial or re-credentialing application is determined by the Credentialing Department to be complete, with adequate primary source verification and ready for physician review, the application and all accompanying documentation are to be forwarded to the Credentialing Department Medical Director. The Medical Director is to review the application and supporting documentation to confirm compliance with the requirements for network participation as outlined in the MagnaCare Credentialing Criteria and Process Document.

Clean applications are reviewed by the Credentialing Manager. Clean applications are defined as those applications that meet MagnaCare's minimum Credentialing criteria and have no malpractice history and/or sanction history. A listing of these providers is submitted to the PCC. *See Attachment B: Addendum to MagnaCare Credentialing Program, 5) Provider Initial Application and Recredentialing Process and Procedures, a) Review of "Clean" provider applications.*

If approved, the provider will be notified, in writing, within thirty (30) calendar days. If the provider is not approved, a letter is to be sent to the provider within thirty (30) calendar days of the final adverse determination, indicating non-approval of an initial application.

If a non-approval of Recredentialing, the provider will be notified in writing within (30) calendar days of the final adverse determination, indicating non-approval of a Recredentialing application. The termination from the network will be in accordance to the terms of the applicable clause in the executed MagnaCare Provider Agreement. In the case of termination of a current network provider, the notification letter will be mailed Certified Mail/Return Receipt Requested.

In cases of initial appeal of adverse provider enrollment determinations, the application, documents, and any appeals are to be reviewed by the PCC, which is to meet monthly or at least quarterly as needed. The provider will be notified within 30 days of the PCC determination.

Provider Application Process

Providers who want to participate in the Magnacare network -- broad range of products including HRINY -- may apply directly to Magnacare for both contracting and credentialing at **888-624-6275.**

Federally Qualified Health Centers and Accountable Care-like organizations may contract directly with HRINY. Please contact **the plan at** *646.679.4575.*

Updating Practice Information

It is the responsibility of the provider to update the plan regarding changes in staff or address. Magnacare providers should contact **888-624-6275.** FQHCs should contact 646-679-4575.

Utilization Management

HRINY contracts with POMCO, a URAC accredited organization for utilization and claims management. HRINY oversees and reviews all POMCO policies and procedures as well as their ongoing activities. Telephone numbers (identified at the beginning of this manual) are the initial points of contact for all utilization management and claims concerns.

Role of the Primary Physician

Members are not required to have or use primary physicians in any of the HRINY products. However, we strongly encourage members to designate and coordinate their care with a primary care physician. The copayments for office visits with designated primary physicians are zero for several products (PrimarySelect and PrimarySelect EPO), which provides a strong incentive for members to establish and maintain a relationship.

HRINY products do not require prior approval for referrals to participating primary physicians; nonetheless, referrals to participating physicians are a first step in coordinating care.

Member selection of a Primary Physician

At the time of enrolment, members are advised to select a doctor to coordinate their care. At HRINY we call this designated physician a "primary physician". Most members will select a doctor from one of the traditional primary care specialties such as Family Practice, Internal Medicine, or Pediatrics. In some instances, members can select from other medical subspecialties such as Infectious Disease, Cardiology, or Obstetrics and Gynecology. Other proposed specialties will be reviewed by the plan medical director. Members can select or change a primary physician online. In the event of a question, members should contact customer service. Members may change their primary physician up to five times a year.

Covered Services

Medical Policies

Medical polices that are the basis of claims payment are developed by POMCO and approved by HRINY. InterQual criteria are used when determining medical necessity and/or appropriateness. These are criteria supplemented by guidelines developed by CMS and professional societies. Copies of these policies can be obtained by calling 888-990-5702.

Out of Network Services

HRINY members do not require referrals to participating specialists. However, HRINY provides no out-of-network benefit and all medical services by non-participating providers in other than emergency settings must be pre-approved. Members having difficulty identifying a participating provider that might provide a unique service should contact POMCO directly at 888-990-5702. Information in support of prior approval will be collected to support their referrals.

Emergency Services

HRINY does not require prior approval of emergency service in- or out-of network. If hospitalization is required, then admission and a concurrent review will occur as described below.

Utilization Review Procedures

To maintain close oversight of medical services, HRINY performs prospective and concurrent review of a broad range of services. Elective procedures that will be performed in facilities will require prior approval, as do a number of office-based procedures. All inpatient admissions undergo concurrent review.

Non-Participating Provider Services Are Not Covered Except As Required For Emergency Care. Please Also Refer To The "Exclusions and Limitations" Section Of The Certificate of Coverage For Services That Are Not Covered By The Health Plan

Prior Approval List

HRINY maintains and regularly updates a list of procedures that require prior approval. This manual is available online and is updated regularly. All elective admissions and all procedures performed in facilities require prior approval. Services and procedures listed below all require prior approval unless specifically excluded.

Authorization Determination Timeframes: *Health Republic Insurance of New York requires the following timeframes to make a determination once we have been provided all of the necessary information. Please note that we may extend the determination timeframe if we do not have all of the necessary information to make a determination.*

Non-urgent Pre-service requests---Within 3 business days of receipt of request
Urgent Pre-service requests---Within 72 hours of receipt of request
Urgent Concurrent Review---Within 24 hours of receipt of request
Post-service request---Within 30 calendar days of receipt of request

HRINY Prior Approval List (effective through 12/31/2014)

EMERGENCY CARE AND AMBULANCE SERVICES	
Non-Emergency Ambulance Services	• **Preauthorization Required**
INPATIENT CONFINEMENTS & SERVICES	
Inpatient Hospital For Continued Confinement	• **Preauthorization Required ***(Preauthorization is Not Required for Emergency Admissions, But Plan Must Be Notified Within 1 Business Day of Admission)**
Skilled Nursing Facility	• **Preauthorization Required---***Coverage For Up To 200 Days Per Plan Year**
End of Life Care	• **Preauthorization Required**
Inpatient Hospice	• **Preauthorization Required---***Coverage of Up To 210 Days Per Plan Year**

Cardiac and Pulmonary Rehabilitation	• **Preauthorization Required**
RADIOLOGY SERVICES	
Diagnostic Radiology Services • Performed in a PCP Office • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services (Ambulatory)	• **Preauthorization Required** • **Preauthorization Required** • **Preauthorization Required**
Therapeutic Radiology Services (Radiation Therapy) • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services	• **Preauthorization Required** • **Preauthorization Required**
PROFESSIONAL SERVICES AND OUTPATIENT CARE	
Dialysis • Performed in a PCP Office • Performed in a Freestanding Center or Specialist Office • Performed as Outpatient Hospital Services • Performed by a Non Par Provider Out Of The Service Area	• **Preauthorization Required** • **Preauthorization Required** • **Preauthorization Required** • **Preauthorization Required** (***Stipulations / Limits Apply---See Certificate of Coverage)
Home Health Care (Nursing, PT/OT/ST, Infusion Therapy)	• **Preauthorization Required (***40 Visits Per Plan Year—Total For All Disciplines)**
Hospice Care • Inpatient	• **Preauthorization Required---***Coverage of Up To 210 Days Per Plan Year**

• Outpatient	• **Preauthorization Required---***Coverage of Up To 5 Visits For Family Bereavement Counseling**
Infertility Services	• **Preauthorization Required** (*****Exclusions Apply—See Certificate Of Coverage))**
Infusion Therapy • Performed in a PCP Office • Performed in Specialist Office • Performed as Outpatient Hospital Services	• **Preauthorization Required** • **Preauthorization Required** • **Preauthorization Required**
Outpatient Hospital Surgery Facility Charge	• **Preauthorization Required**
Surgical Services: Including, But Not Limited To: Oral Surgery (Limits Apply), Reconstructive Breast Surgery, Other Reconstructive & Corrective Surgery (Stipulations Apply), Transplants, Sclerotherapy, and Interruption of Pregnancy (Limits Apply) • Inpatient Hospital Surgery • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center • Office Surgery	****Based On Medical Necessity** *****See Certificate of Coverage For Limits / Stipulations** • **Preauthorization Required** • **Preauthorization Required** • **Preauthorization Required** • **Pre-Authorization**
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES	
Inpatient Mental Health Care (Continuous Confinement in a Hospital)	• **Preauthorization Required.** *****(Preauthorization is Not Required for Emergency Admissions But Plan Must Be Notified Within 1 Business Day of Admission)**
Inpatient Alcohol / Substance Use Services (Continuous Confinement in a Hospital)	• **Preauthorization Required**

Specialty Pharmacy
All medications identified at Tier 4 in the Health Republic Insurance Formulary require prior approval. Details are in the Pharmacy section of the manual. Requests for prior approval of the medication must precede authorization of home care or use of a facility.

Inpatient Admissions **- All inpatient admissions require an authorization:**
All non-emergent inpatient admissions must be pre-certified. Providers must notify HRINY of all emergent inpatient admissions within 48 hours of admission. HRINY does not require authorization of emergency room services or any emergent service required to provide stabilization of an emergent condition. All facility admissions are reviewed for medical necessity. This includes inpatient detoxification and mental health services, acute, sub-acute and skilled nursing rehabilitation, long term acute care, and inpatient hospice.

Outpatient Facility Procedure **- Any use of an outpatient facility requires an authorization.**
The approval for use of an outpatient facility can be obtained at the same time as approval for a procedure.

Medical Necessity Review and Denials
Nurses review clinical support information for an inpatient stay, procedure or service that requires approval. In the majority of instances, material presented by treating providers will meet the appropriate guideline or medical policy and will be approved. When the information presented is not complete or does not meet criteria, the complete set of information is presented to a clinical peer of the requesting provider.

Prior to a denial, efforts are made to contact the requesting or treating physician to conduct a peer-to-peer discussion. After two attempts, a denial is issued. The timeframe for responding to a request for approval of clinical service is 48 hours.

Appeals Process
An appeal can be requested by a member, the ordering provider, or an advocate formally designated by the member. The first step in the appeal process is reconsideration by the original physician issuing the denial. The medical reviewer may overturn his original determination or allow the case to proceed to appeal.

The next step in the appeal process is a review by a physician not involved in the original determination. All information in the initial request, as well as any additional information that has become available, is reviewed. The physician issues a final determination, which results in an approval of the original request or an overturn.

A member or provider can initiate an expedited appeal by calling customer service or the utilization review line directly. POMCO, a URAC Accredited Utilization Review agent, maintains all timeframes in compliance with New York State law and URAC guidelines.

External Appeals
An external appeal can be requested by a member, the ordering provider or an advocate formally designated by the member. The request for an external appeal is processed in accordance to guidelines developed by the NYSDOH. Information regarding the appeals process is placed in every denial letter.

Member and Provider Access to Medical Policies
Prospective members, members and providers will be provided with copies of medical policies and clinical guidelines upon request. Members and prospective members are invited to call Customer Service. Providers should call 888-990-5702.

Behavioral Health Services
Inpatient behavioral health services require the same type of review process as other inpatient stays. Physicians who need assistance with behavioral health referrals can call 888-990-5702, option 3.

An external appeal can be requested by a member, the ordering provider, or an advocate formally designated by the member. The request for an external appeal is processed in accordance to guidelines developed by the New York State Department of Health.

Referrals to case management
HRINY provides case management services as part of discharge planning for all patients admitted to the hospital. The goal is to optimize coordination of services and prevent readmission. POMCO provides case management services to other members with complex medical issues such as transplantation, dialysis, infusion service and catastrophic disease. If a provider believes a patient under care may benefit from case management services, please call 315-463-1483.

Durable Medical Equipment, Orthotics & Prosthetics and Disposable Medical Supplies
DME, disposable medical supplies, orthotics, prosthetics, diabetic supplies including insulin pumps, CGM (Continuous Glucose Monitors), and testing supplies are covered benefits for HRINY members who require such services to aid in the treatment of illness or injury or to improve bodily function.

The provider must document in the member's medical record that these items are medically necessary. The items listed below may be obtained through a participating DME provider with a provider's written order and the appropriate authorization from HRINY.

HRINY contracts with a large number of providers through the MagnaCare network.

Population Health Program, Disease Management Program and Case Management Program

Population Health Program (PHP)
The Population Health Program works to engage members in managing their own health, improve the utilization of primary and preventive services, and reduce risk of hospitalizations and high cost interventions. Fundamentally, the PHP program helps members take charge of their health and their healthcare and alters cost and quality trends through efficient and effective member interventions. The PHP is embedded in the member experience of the health plan and will be a significant contributor to customer satisfaction and brand loyalty.

Member Engagement:
In a high performing health system, patient engagement is crucial. Medical literature demonstrates that patients who are informed and supported with coordinated care will have a better consumer experience and better health outcomes. The definition of patient engagement varies widely in the public health literature, but is defined here to frame the operational process and outcome measures:

1. selection of a primary physician
2. completion of the on-line General Health Assessment (GHA)
3. regular visits to a primary physician
4. adherence to recommended preventive services
5. referral and/or adherence to the disease management program
6. response to outreach from the PHP

PHP Member Engagement Approaches
A variety of tactics are available to support patient outreach and engagement, which are conducted on an electronic platform. The program design is engineered to leverage efficiencies through the use of electronic means, including:

- standardized emails and text message campaigns
- condition specific push notifications
- physician alerts (admissions and ER visits, etc.)
- targeted mailings
- telephone call(s) with wellness navigator (personal coaching)
- referral to case management
- website content
- use of incentives

Patient Education Materials
At the core of the member experience is the Member Access section of the website. The website is designed to facilitate the engagement process through selection of a primary physician, completion of the GHA (supported by use of an incentive) and exploration of a large library of interactive health resources. Completion of the GHA is likely to trigger further exploration of the Smart Engage health library.

Role of the Wellness Navigator
The wellness navigator is charged with enhancing the engagement of members at risk through motivational interviewing strategies. The highest priorities are to encourage members to select a physician and complete the GHA. The wellness navigators conduct campaigns (e.g. targeted mailings, telephone and email) to promote regular screenings and use of preventive services. They also engage members who

might benefit from better coordination of care (such a persons who use the emergency department and fail to follow up with their primary physician). Additional campaigns focus on behavioral risk factors, such as smoking, and disease states such as diabetes and depression.

Disease Management Programs (DM)

The PHP incorporates all of the concepts of disease management. Health assessment data and claims information asthma, diabetes, COPD and CHF) is used to identify gaps in care and opportunities for enhanced coordination of care across the treatment continuum. Members are stratified by level of engagement and severity of illness, which leads to the creation of interventions appropriate to their condition. The most significant cases are referred to case management. Interventions appropriate to the level of risk are conducted by the wellness navigators and case managers.

Case Management Programs

The case management program seeks to enhance coordination of services for members at high risk (e.g. transplants, dialysis, chemotherapy and maternity neonates). Claims and pharmacy data are reviewed to identify members who might benefit from nurse-led interventions. Case management services are provided as part of discharge planning for all hospital admissions. Physicians who believe their patient would benefit from case management should call 888-890-5702, and select option 2.

Reimbursement for Care Coordination Services

HRINY provides reimbursement for a variety of services that support effective care coordination and improve patient health. Criteria for telephone and electronic visits with an established physician and for a variety of screening and counselling services are described below. Physicians with unusual patterns of billing will be audited for compliance with documentation standards.

99441 Telephone evaluation and management (E&M) service provided by a physician to an established patient, parent or guardian. The service does not originate from a related E&M service provided within the previous seven days nor does it lead to an E&M service or procedure within the next 24 hours or at the soonest available appointment. Entails 5 to 10 minutes of medical discussion

99442 11 to 20 minutes of medical discussion

99443 21 to 30 minutes of medical discussion

99444 Online medical evaluation - physician non-face-to-face E&M service to patient/guardian or health care provider. It does not originating from a related E&M service provided within the previous 7 days

99495 Transitional Care Management Services (Moderate Complexity):

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days post-discharge
- Medical decision-making of at least moderate complexity during the service period
- Face-to-face visit, within 14 calendar days post-discharge

99496 Transitional Care Management Services (High Complexity):

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days post-discharge
- Medical decision making of high complexity during the service period
- Face-to-face visit, within 7 calendar days post-discharge

Health Promotion
CPT codes 99401–99404 are designated to report services provided to individuals at a face-to-face encounter for the purpose of promoting health and preventing illness or injury. Preventive medicine counseling and risk factor reduction interventions will vary with age and should address such issues as:

- diet and exercise (such as related to obesity, hyperlipidemia)
- substance misuse/abuse
- tobacco use and cessation
- sexual practices, and STD/STI prevention
- screening procedures and laboratory test results available at the time of the encounter

Risk factor reduction services are used for persons without a specific illness for which the counseling might otherwise be used as part of treatment.

These codes are not to be used to report counseling and risk factor reduction interventions provided to patients with symptoms or established illness.

Behavior Change Interventions
CPT codes 99406–99412 are designated to report services provided to individuals at a face-to-face encounter and are utilized for persons who have a behavior that is often considered an illness itself, such as tobacco use and addiction, substance abuse/misuse or obesity.

Behavior change services may be reported when performed as part of the treatment of conditions related to, or potentially exacerbated by, the behavior, or when performed to change the harmful behavior that has not yet resulted in illness. Behavior change services involve specific, validated interventions of assessing readiness for change and barriers to change, advising a change in behavior, assisting by providing specific suggested actions and motivational counseling, and arranging for services and follow-up.

Documentation for smoking cessation services and detailed information about billing for smoking cessation counseling is available at the New York State Department of Health website for smoking cessation resources: http://www.nysmokefree.com/Subpage.aspx?P=0&P1=70

CPT 99406 Intermediate: smoking and tobacco-use cessation counseling visit (3 - 10 minutes); for symptomatic patients, 1-3 minutes

CPT 99407 Intensive: smoking and tobacco-use cessation counseling visit (more than 11 minutes); for symptomatic patients, 1-3 minutes

99408 Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes

99409 Greater than 30 minutes

99411 2 previous medical group visits

97802 Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes.

97803 Re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes

97804 Group (2 or more individuals), each 30 minutes, Statdoc

HRINY contracts with StatDoc to support members with low level clinical problems who might go to the emergency room. Board Certified Emergency Room Physicians complete a telephonic and electronic assessment.

Pharmacy

Programs and Covered Services
Pharmacy services are a covered benefit for Health Republic Insurance of New York members. A comprehensive and up-to-date formulary is available on the HRINY web site. Pharmacy services are provided by the HRINY pharmacy benefit manager (PBM) US Script and its network of participating pharmacy providers.

Some medications require step therapy, prior authorization (PA) or have limitations on age, dosage and/or maximum quantities. If there are any questions, you may call the US Script Help Desk at 1-855-339-4803. A list of participating pharmacies is available from the US Script website at www.usscript.com.

Health plan members should present their HRINY identification cards to pharmacy staff when accessing pharmacy services. The US Script corporate logo and phone number appear on the member ID card. All prescriptions must be filled at a HRINY participating pharmacy. HRINY may require prior authorization of certain pharmaceuticals.

Health Republic Insurance Formulary
Health Republic Insurance of New York has partnered with US Script to provide a robust pharmacy benefit to its members. To access the most recent version of the formulary, visit https://newyork.healthrepublic.us, click on 'Provider' page and follow the link to the 'Formulary.' You may also click on 'What We Offer' and select 'Individual or Small Group,' and then scroll down to 'Medication Coverage'. The same formulary information is available to both members and providers.

Pharmacy and Therapeutics Committee Process
The US Script Pharmacy and Therapeutics Committee (P&T) process includes the selection of drugs considered to be the top choices based on their safety, effectiveness and value for our formulary.

The P&T process is led by an independent group of practicing doctors, pharmacists and other health care professionals responsible for the research and decisions surrounding our drug list/formulary. This group meets regularly to review new and existing drugs, and to choose the top medications for our Formulary.

The P&T process also helps improve customer health through programs such as drug utilization review, medication safety promotion and compliance encouragement.

US Script uses a balanced approach to drug list/formulary management, based on a combination of research, clinical guidelines and member experience. The latest developments and submission guidelines from around the world are considered when developing and maintaining this list.

HRINY plans have adopted a formulary that is based on the benchmark requirements provided by the New York State Department of Health and is consistent with other formularies for plans on the New York State of Health. Providers are encouraged to consider the comparative cost and efficacy of pharmaceutical alternatives when prescribing medication for HRINY members.

When a step therapy or prior approval is required, the prescriber should contact US Script directly. A provider can assist a member in filing a request for an exception to cover a non-formulary prescription by the same method. All prescription coverage exception determinations are made by US Script (HRINY's pharmacy benefits manager).

Quantity Limitations
Quantity limitations have been implemented on certain medications to ensure the safe and appropriate use of the medications. Quantity limitations are approved by the US Script P&T Committee and noted throughout the formulary. Please note the following maximum days supply for medications without the QL indicator is 34 days.

Step Therapy
Medications requiring step therapy are listed with an "ST" notation throughout the formulary list. The US Script claims system will automatically check the member profile for evidence of prior or current usage of the required agent. If there is evidence of the required agent on the member's profile, the claim will automatically process. If not, the claims system will notify the pharmacist that a prior authorization (PA) is required.

Age Limits
Some medications on the formulary may have age limits. These are set for certain drugs based on FDA approved labeling and for safety concerns and quality standards of care. Age limits align with current FDA alerts for the appropriate use of pharmaceuticals.

Pharmacy Prior Authorization (PA) Process
The formulary includes a broad spectrum of generic and brand name drugs. Clinicians are encouraged to prescribe from the formulary for their patients who are members of HRINY. Some preferred drugs require PA. Formulary Medications requiring PA are listed with a "PA" notation throughout the formulary.

Specific Exclusions
The following drug categories are not part of the formulary:

- oral vitamins and minerals (except those listed in the formulary)
- drugs and other agents used for cosmetic purposes or for hair growth
- OTC drugs (except those listed in the formulary)

Pharmacy Drug Tiers
Drug tiers have been structured to allow member copayments to match the underlying ingredient cost.

Tier 1 - Preferred Generic Drugs- lowest copayment
The lowest cost generic medications in any drug class are placed in this category. Generic drugs are chemically identical to brand drugs, but are priced at a fraction of the cost and offer an excellent value to the member. To gain FDA approval, a generic drug must:

- contain the same active ingredients as the branded drug (inactive ingredients may vary)
- be identical to the brand drug in strength, dosage form, safety and route of administration
- be of the same quality, performance characteristics and use indications
- be manufactured under the same strict standards of the FDA's good manufacturing practice regulations required for branded products

If a generic is chosen, the practitioner must leave blank the "DAW" (Dispense As Written) box. This way, the pharmacist will fill the prescription with the generic drug.

Tier 2 - Preferred Brand Drugs and Higher Cost Generic Medications-medium copayment
We have identified a listing of formulary brand drugs available at a lower copay than drugs in the nonpreferred drug category. This generally happens when there are several equally effective, FDA-approved brand name drugs by different manufacturers for treatment of a particular condition.

Tier 3 - Nonpreferred Brand and Generic Drugs-highest copayment

Drugs in the nonpreferred category generally have a similar, more cost effective drug available in either the preferred generic drug category (tier 1) or the preferred brand drug category (tier 2).
Most new FDA-approved drugs are initially placed in tier 3 for about six months until the P&T Committee reviews them for safety, efficacy and clinical comparisons. At that time, the drug may be moved into a different tier.

Tier 4 -HRINY --Specialty Medications

This tier uses a pharmacy vendor to help manage the care members receive who need oral and injectable specialty medications. The vendor verifies eligibility, submits requests for prior authorization and bills the member-appropriate co-payments or co-insurance for medications. Providers must order specialty medications directly through the delegated vendor.

Working with HRINY's Pharmacy Benefit Manager (PBM)

HRINY works with US Script to administer pharmacy benefits, including the PA process. Certain drugs require PA to be approved for payment by HRINY. These include:

- all medications not listed on the formulary
- some HRINY preferred drugs (designated PA on the formulary)

Follow these guidelines for efficient processing of your PA requests:

1. Complete the HRINY/US Script form: *Medication Prior Authorization Request Form.*
2. Fax to US Script at **1-866-399-0929.**
3. Once approved, US Script notifies the prescriber by fax.
4. If the clinical information provided does not explain the reason for the requested PA medication, US Script responds to the prescriber by fax, offering formulary alternatives.
5. For urgent or after-hours requests, a pharmacy can provide up to a 72-hour supply of most medications by calling the US Script Pharmacy Help Desk at: **1-800-460-8988**.

A phone or fax process is available for PA requests.

US Script Contacts:

Prior Authorization Fax:	1-866-399-0929
Prior Authorization Phone:	1-866-399-0928
Clinical Hours	Monday - Friday 10:00 a.m.-8:00 p.m. (EST)
Mailing Address	US Script, 2425 W Shaw Ave., Fresno, CA 93711

When calling, please have patient information, including HRINY ID number, complete diagnosis, medication history and current medications readily available.

- **If the request is approved**, information in the online pharmacy claims processing system will be changed to allow the specific members to receive this specific drug.
- **If the request is denied**, information about the denial and appeal rights will be provided to the clinician.

Clinicians are requested to utilize the formulary when prescribing medication for those patients covered by the HRINY pharmacy program. If a pharmacist receives a prescription for a drug that requires a PA request, the pharmacist should attempt to contact the clinician to request a change to a product included in the HRINY formulary.

Working with HRINY's Specialty Pharmacy Provider

Certain medications are only covered when supplied by HRINY's preferred specialty pharmacy provider, AccariaHealth. These products are listed on the formulary as Tier 4. It is preferred that physicians using specialty medications seek prior approval before initiating therapy. In most instances, AccariaHealth will be able to support a replacement program with timely delivery of medication to your office or outpatient facility.

Providers can request that AccariaHealth deliver the specialty drug to the office/member. If you would like AccariaHealth to deliver the specialty drug to the office/member, call US Scripts at **1-**866-399-0928 or fax the request form to 1-866-399-0928 for prior authorization. If approved, AccariaHealth will contact the provider or member for delivery confirmation.

Mail Order Option

HRINY offers a 90 day supply (3 month supply) of maintenance medications. Please visit our website at www.HRINY.com for a listing of products considered maintenance medications. Contact an HRINY Provider Service Representative if you have any additional questions regarding this program. To transfer a current prescription to mail order, you may call RxDirect at 1-800-785-4197.

Exception Requests

In the event that a clinician or member disagrees with the decision regarding coverage of a medication, the clinician may issue an appeal by submitting additional information to US Script. The additional information may be provided verbally or in writing. A decision will be rendered and the clinician will be notified with a faxed response. If the request is denied, the clinician will be notified of the appeals process at that time.

An expedited appeal may be requested at any time the provider believes the adverse determination might seriously jeopardize the life or health of a patient by calling the HRINY complaint and grievance coordinator at 1-866-329-4701. A response will be rendered the same day as receipt of complete information. In circumstances that require research, a same day response may not be possible.

Billing and Claims

Verification of Eligibility
All inquiries regarding member eligibility are handled by the customer service line at 888-990-5702.

Providers may also use our member portal to verify eligibility after February 1, 2014.
https://secure.healthx.com/providerportalhealthrepublicny.aspx

Co-payments and Deductibles
Co-payments and deductibles vary significantly with HRINY product type and are described on pages 11-13 of this manual. Copayments for physician office visits are also listed on the front of the ID card. Once a member achieves the out of pocket maximum, the member should not pay any additional copayment or deductible.

Claims Submission
ELECTRONIC
HRINY is Health Insurance Portability and Accountability Act (HIPAA) compliant and can accept electronic claims (also known as the "837"). Our third party administrator, the POMCO Group, embraces the concept of electronic transactions and will continue to assist providers to become Electronic Data Interchange (EDI) compliant.

To Submit Electronic Claims:
Emdeon (WEB MD)
800.845.6592
Payer ID # 16111

If electronic submission is not available, a separate CMS-1500 or UB-04 claim form must be submitted for each patient. All claims must contain the enrollee's ID number, plan code, service dates, itemized charges with Current Procedural Terminology (CPT) codes, diagnosis codes, place of service, name of provider rendering care, provider tax ID number and any other pertinent information necessary for claim consideration. Any claims with attachments, such as explanation of benefits or operative reports, must be sent by mail and cannot be accepted in an electronic format.

Claims Processing Overview
HRINY follows National Correct Coding Initiative (NCCI) guidelines developed by the United States government. The Centers for Medicare and Medicaid Services (CMS) developed the NCCI to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims. The CMS developed its coding policies based on coding conventions defined in the American Medical Association's (AMA) CPT manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices.

Professional and Technical Components
Professional and technical components of global CPT procedures may be coverable when submitted separately for allowable services per the American Medical Association CPT manual. Providers should use the appropriate modifiers on the claim form to ensure correct reimbursement.

Assistant Surgeon

Procedures being performed by the assistant surgeon must be allowable for the surgical procedure per AMA's CPT manual.

Coordination of Benefits
The Coordination of Benefits sets rules for the order of payment of covered charges when two or more plans provide health care coverage. When a person is covered by two or more plans, the plans will coordinate benefits when a claim is received. The plan that pays first, according to the rules, will pay as if there were no other plan(s) involved. The secondary and subsequent plan(s) will pay the balance due up to 100% of the total allowable expenses.

Request for Additional Information for Claim Review
If we have determined that additional information is required, please provide this information within forty-five (45) days of receipt of EOB. Additional information should be mailed to the following address:

Health Republic Insurance of New York
PO Box 6329
Syracuse, NY 13217-6329

If the requested information is not received within 45 days, the claim will be closed.

Claims Appeal Process
If a claim for benefits is denied in whole or in part, the member/provider may appeal the claim determination. HRINY has a structured appeal process in compliance with state and/or federal regulations that meets Employee Retirement Income Security Act (ERISA) guidelines in terms of turnaround time frames. The appeal must be in writing and mailed to the HRINY appeals department within sixty (60) days from the date of the written denial. The plan may reserve the right to maintain denial of benefits without further review for any appeals received more than sixty (60) days after the initial notice of claim denial.

All appeals should be mailed to the following address:
Health Republic Insurance of New York
PO Box 6329
Syracuse, NY 13217-6329

HRINY has a fully trained appeals department with an average of 15 years experience. Upon receipt of an appeal, a review is conducted by an appeals specialist who is neither the individual who made the initial determination nor a subordinate of that person. If the adverse benefit determination was based, in whole or in part, on a medical judgment (including whether a particular treatment, drug, etc., is experimental, investigational or not medically necessary or appropriate), the specialist will consult with an appropriate health care professional. Any expert whose advice was obtained in connection with the adverse benefit determination will be identified to the member. The POMCO Group will advise the member of the results in writing of their appeals review.

Process

1. An appeal is received directly by the appeals department.
2. The appeal is reviewed by an appeals specialist. When a medical opinion is warranted, the specialist will send the appeal to an independent physician peer consultant for an opinion and/or recommendation. All appeals are sent directly to a consultant who is board certified in the specific specialty/service in question.
3. The appeal determination sent to the member and/or provider documenting the rationale and applicable benefits found in the Member's Summary Plan Document.
4. If the plan has a second step appeal process, the POMCO Group will send the additional and initial appeal documentation to a different peer consultant of the same specialty for a second opinion.

Appeal Turnaround Time Objective

An appeal of an adverse decision (denial) regarding an urgent care claim will be decided within seventy-two (72) hours after the appeal request is filed. An appeal of an adverse decision (denial) regarding a pre-service claim will be decided within thirty (30) days after the appeal request is filed. An appeal of an adverse decision (denial) regarding a post-service claim will be decided within sixty (60) days after the appeal request is filed.

Common Claim Remark Codes

Listed below are common claim remark codes and descriptions. These codes appear on both the patient's and provider's Explanation of Benefits.

Remark Code 1	Remark Code 2	Remark Code Description
01		Benefits not in force when services were rendered
02	a+	Your plan does not allow these services
03		No benefits for these services at time rendered
	+}	Other carrier's Explanation of Benefits required
06	1	Prenatal care is only payable at end of pregnancy
08	d+	Information submitted does not support services rendered
11		Patient not eligible for benefits under your plan
12		Max lifetime benefit met for this family member
14		Resubmit to your no-fault/auto insurance carrier
15		Resubmit to your employer's compensation carrier
16	3	Surgery considered inclusive with another service
17		Max benefit in a 12 month period
20		Treatments not prescribed by an MD are excluded
25	4	Claim submitted after filing deadline
	5	Duplicate, please see original determination
30		Maximum benefit payable for this type of service
34		Maximum benefits for all services has been paid
35		Paid in accordance with maximum allowable benefit
36		Allowed amount applied towards annual deductible
	6	Info not received, claim closed
39	p+	Payment based on discount/contract agreement
40	Z+	Paid in accordance with coordination of benefits
	8	Requires breakdown of charge, date and diagnosis

45		Payment based on usual and customary allowances
46		Your annual deductible has been met
47		Provider of service not recognized under your plan
48		First 48 hours of nursing services are excluded
54		Reduced due to non-compliance with plan provisions
55	9	Benefit limited to 20% of surgeon's allowed amount
56	0	Multiple surgery reduction applies
75		Plan limits one in a 6 month period
76		Plan limits approved weight reduction programs
	+/	Claim is pending review by our Medical Department
85	+A	Considered as part of another submitted service
86		Not medically indicated for reported condition
	+F	Benefit adjustment of prior claim
93		Appears to be experimental/investigational
9p		Patient responsible only for copayment/deductible
	+p	Payment adjusted to reflect original DRG billed
a2		Payment reduced to 50% due to pre-admission penalty
a7	+B	Services combined under appropriate CPT/CDT code
	S+	Claim pending, need additional information
ab	+†	Thorough review concurs with original determination
ap	+u	Services allowed after review of appeal
ar	+G	Code/benefit adjusted due based on review
	+v	Please resubmit with anesthesia time
aw		Exclusion: determined to be maintenance nature
ax	+J	Rentals are paid to the purchase price of the item
	@+	Partial payment, adjustment pending audit review
B1		Completed claim form requested from insured
b4	+K	Description of service is necessary, please resubmit
b7	=+	Supplemental accident benefit has been applied
b8		Regimen is considered experimental/investigational
be		Appeal closed, documentation has been requested
by		Appeal in review
ca	+z	Info submitted after deadline. Claim denied
CA		Charges previously considered under basic policy
cc		Information not supplied by the enrollee, claim closed
ch		Per consultant's review, claim has been pro-rated
cm		Case management claim
cr		Benefit adjustment of copay(s)
CR		Please rebill appropriate modifier for CRNA service
CS		Please resubmit itemized bill
cu		Please submit proof of creditable coverage
cy		Services denied, does not meet Plan Benefits
D4		This service is limited to 2 per year
D5		Limited to twice every twelve consecutive months
d5	1+	Services do not meet benefit guideline criteria
	b+	Duplicate of a claim currently in process

dc		Patient responsible for deductible coinsurance
DH		Benefit limited to one time per year
DV		Plan limits one service in a 6 month period
e0		Benefit limited to professional fee component
e6	+$	Not medically indicated for reported procedure
F1		Facility must submit claim on UB-04
f7		Services performed more than once in allotted time
f8	)+	New benefit period begins 12 months from this date
fa	\+	Final determination. Appeal process exhausted
g5		Submit to prescription drug carrier for payment
gf	+Q	Services are included in the global fee
gr	+R	Services combined for global reimbursement
	5+	Information from provider required. Please submit
	6+	Please rebill the UB04 with requested information
h2		Please submit copy of UB04 and itemized bill
h6	+S	Payment based on negotiated rate with provider
h8		Plan excludes custodial level of care
hf	?+	Discharge summary required. Please submit
	+:	Provide office note including history & physical
l5	+U	Requested documentation not received, claim closed
ll		Requires invoice for implant per provider contract
	l+	Rebill as inpatient. Claim closed
lr		Inpatient review service
ls		Social Security Number invalid. Cannot locate
lS		Invalid Social Security Number. See comments
j0		Based on clinical data, admission has been denied
j2		Based on medical review, admission is denied
md	+X	Requires medical documentation to support services
me		Considered as a major medical expense
mn		Provider may bill up to PPO/negotiated rate
mo	+Y	Modifier not considered without office notes
nc		Please submit provider's name and credentials
nd	B+	NDC code is missing or invalid. Please resubmit
nl	C+	Paid at in-network level
oc	+a	Please rebill with correct CPT/CDT code
p1		Plan provision copayment applied for this service
P1		Provider must submit claim on HCFA-1500
p3	+b	Appeal date exceeds appeal filing deadline
p4	+c	Payment based on contracted per diem rate
	H+	Patient not responsible for amount not allowed
	y+	Office notes illegible or incomplete. Claim closed
pp		Benefit only allowed when PPO provider is utilized
pr		Private room balance is a patient responsibility
ps		Place of service does not meet benefit criteria
r1	+g	Payment based on average wholesale price

	f+	A refund has been requested
rf		Please submit referring MD's name so that medical documentation may be requested
rl	K+	Received documentation incomplete. Claim closed
rp	+h	Updated Rx required from physician
RS		Patient is liable for balance after payment
ru	M+	Benefit limited to 10% of surgeon's allowed amount
rx		Prescription drug copayment deducted
sc		Services do not comply with plan benefits
sd		Services denied – see final appeal determination
sq		Payment reflects appeal determination
	+s	Information needed – letter sent under separate cover
	}+	Claim closed – W-9 form not received from provider
	n+	Please submit ER report
	k+	Medical records do not support services
	w+	Payment issued at invoice cost
	x+	The patient has no financial responsibility
	+#	Invalid primary diagnosis