PROFESSIONAL OFFICE
&
FACILITY
PROVIDER MANUAL

January 1, 2018

Ascension St. Vincent
Employer Direct
250 West 96th St, Ste
400 Indianapolis, IN
46260

WELCOME!

About Our Company

St. Vincent is part of Ascension, the largest nonprofit health system in the US and the largest Catholic health system in the world.

Through an integrated health delivery network of hospitals and physicians, we offer the coordination of care through a cohesive network which results in better healthcare, lower overall costs and reduced healthcare disparities. This "patient-centered" approach provides a seamless, healthcare delivery system that ensures quality patient outcomes and satisfaction.

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INTRODUCTION

Thank you for your participation in the AdvantUs, LLC (AdvantUs) provider network. AdvantUs contracts with providers throughout central Indiana to provide or arrange for health services covered under various AdvantUs products and benefit plans. This AdvantUs NETWORK Provider Manual is distributed to all healthcare providers that have entered into a contract with AdvantUs as a participating provider. This Manual is referenced in the AdvantUs provider participation agreement, and it provides important information about AdvantUs's guidelines and important policies and procedures. Please read it carefully and reference it as questions arise. If there is any conflict between provisions of this Manual and state or federal law or your written agreement (Agreement) with AdvantUs, the state or federal law or your Agreement takes precedence.

AdvantUs may modify the provisions of this Manual and provide written notice in accordance with the terms of the Agreement. When the words "you" or "your" appear in this Manual, it means the healthcare provider that is party to the Agreement with AdvantUs.

AdvantUs administers self-funded health benefit plans. When the words "MEMBER" or "PARTICIPANT" or "COVERED PERSON" appear in this Manual, it means the individual enrolled in an employer group health plan for which AdvantUs administers services and contracts with your organization to provide services.

IMPORTANT CONTACT INFORMATION

We are here to assist you with questions that may arise from time to time. Please feel free to contact us for assistance:

Ascension St. Vincent Employer Direct
250 West 96th St, Suite 400
Indianapolis, IN 46260
www.AdvantUsnetwork.com

General Questions: including eligibility, claims, benefits and authorizations:

1-800-331-4757

UTILIZATION MANAGEMENT

You are required to cooperate with AdvantUs powered by KBA (Key Benefit Administrators, Inc) in the conduct and oversight of its Utilization Management program. You will be asked to provide AdvantUs with information that is reasonably necessary for AdvantUs to perform these functions. AdvantUs's Utilization Management program includes, but is not necessarily limited to:

- Applying AdvantUs or AdvantUs-approved review criteria and methodologies to review on a prospective, concurrent, and retrospective basis, the appropriateness, level, and utilization of hospital-based technical, professional and ancillary services provided on an inpatient and outpatient basis by your office or Facility;
- Conducting reviews, on a prospective, concurrent, and retrospective basis, of the appropriateness, level and utilization of services. These reviews shall be performed by qualified personnel and may include, at a minimum:
  - Pre-Certification of all elective admissions and selected outpatient surgeries, based on criteria acceptable to AdvantUs;
  - concurrent review of inpatient admissions;
- Retrospective review of non-authorized admissions and selected pre-certified admissions and/or outpatient services; and
- Retrospective authorization reviews done **after** services have begun or have been completed will be considered by AdvantUs for medically necessary services only under the following circumstances:
  - The provider followed appropriate procedures but received invalid information.

    For example, documentation of authorization from an incorrectly identified payer source.
  - The provider's documentation confirms checking eligibility but was provided erroneous information.
  - The provider's records document that the recipient refused or was physically unable to provide the recipient identification information.
- Prospective and/or retrospective review of selected high dollar admissions, diagnostic tests and outpatient procedures, based on criteria acceptable to AdvantUs ;

If prior authorization is not possible, AdvantUs requires you to make best efforts to notify us within five (5) business days of any inpatient admission, outpatient surgery or complex case. AdvantUs may request other information as needed to perform utilization management and case management.

- Authorization time frames:
  - Urgent pre-service review will be done as soon as possible, not to exceed 48 hours

- Non-urgent pre-service review will be done within 15 calendar days of obtaining all necessary information

CASE MANAGEMENT

Case management identifies those Participants whose diagnoses typically require post-acute care or high level and/or long-term treatment. The case manager works with providers and family members to formulate a plan that efficiently utilizes healthcare resources to achieve the optimum patient outcome. Case management services are provided for Participants who may benefit from:

- Change in facility or location of care
- Change in intensity of care
- Arrangements for ancillary services
- Coordination of complex health care services

Always contact the Pre-Certification phone number listed on the Participant's identification card when completing the pre-certification process.

IMPORTANT DEFINITIONS

AdvantUs means AdvantUs, LLC powered by KBA (Key Benefit Administrators, Inc) an Indiana corporation that provides third party administrator and network services.

AdvantUs **AUTHORIZED LOGOS** means those logos displayed in Appendix A of this Manual.

AUTHORIZATION, PRIOR AUTHORIZATION OR PRE-CERTIFICATION means advanced written approval from AdvantUs for Medically Necessary health services covered under the Participant's Plan Document and included on the list of authorization requirements in this Manual.

BALANCE BILLING means when you receive services from a health care provider that does not participate in your insurer's network, the health care provider is not obligated to accept the insurer's payment as payment in full and may bill you for unpaid amount.

CERTIFICATE OF COVERAGE or **SUMMARY PLAN DOCUMENT** means the document evidencing covered health care services that is issued to each Member.

CLEAN CLAIM means, unless otherwise required by law, a completed UB-04 or CMS-1500, as appropriate, or other standard billing format containing all information reasonably required for adjudication, e.g., provider's name, NPI (National Practitioner Identification) number, tax identification number, date of service, procedure code with billed charges, the sponsor's name and policy number, and the Participant's name, address, identification number, patient's date of birth and confirmation of eligibility on the dates of service.

CONTRACT RATES means the rate AdvantUs will reimburse a Participating Provider for services rendered per the Agreement.

COORDINATION OF BENEFITS or **COB** means those provisions by which the Participating Providers or AdvantUs, either together or separately, seek to recover costs of Covered Services provided for an incident of sickness or accident on the part of the Participant , which may be covered by another insurer, service plan, government, third party administrator, or other organization, from that insurer, service plan, government, third party administrator, or other organization subject to any limitations imposed by AdvantUs's contract with the employer group preventing recovery.

CO-PAYMENT means a flat-dollar amount which a patient must pay when visiting a health care provider.

COINSURANCE means a percentage of a health care provider's contracted rate for which the patient is financially responsible under the terms of the policy.

COVERED EMPLOYEE means the individual who meets the eligibility requirements of his/her employer group; who has enrolled in the Plan; and whose premiums have been paid by the individual who has entered into an individual contract directly with AdvantUs and who has paid his/her premiums.

COVERED SERVICES means those Medically Necessary health care services described in the Plan Document, services that are not Medically Necessary shall not be deemed Covered Services.

DEDUCTIBLE means a dollar amount that a patient must pay for health care services each year before the insurer will begin paying claims under a policy.

DISEASE MANAGEMENT is a broad approach to appropriate coordination of the entire disease treatment process that often involves shifting away from more expensive inpatient and acute care to areas such as preventive medicine, patient counseling and education, and outpatient care. The process is intended to reduce health care costs and improve the quality of life for individuals by preventing or minimizing the effects of a disease, usually a chronic condition.

EMERGENCY MEDICAL SERVICES means those Covered Services required for the immediate diagnosis and treatment of an emergency medical condition(s), until the condition is stabilized, including pre-HOSPITAL care and ancillary services routinely available in an emergency department. An "emergency medical condition" is a medical condition with acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate attention to result in:

- Placing the health of the person (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part; or
- Death

EMPLOYER GROUP or **CLIENT** means an organization, firm or governmental entity that has contracted with AdvantUs, to arrange health care services for its employees and, in some cases, retirees, and their respective spouses and/or dependents.

EXPLANATION OF PAYMENT (EOP) or **REMITTANCE ADVICE** means a detailed explanation regarding payment of a medical claim, including allowed amount according to the Provider Agreement and any copayment, coinsurance or deductible amounts falling under the Member or Participant responsibility. This Explanation of Payment will accompany actual payment of the medical claim.

FORMULARY means the list of drugs covered fully or in part by a health plan.

HOSPITAL means an acute care Hospital licensed by the Indiana State Department of Health which, unless otherwise approved by AdvantUs, is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or equivalent accreditation program, and which has agreed to be a Participating Provider with AdvantUs to provide and/or arrange for Covered Services to Participants.

IN-NETWORK PROVIDER means a health care provider (such as a hospital or doctor) that is contracted to be part of the network. The provider agrees to the organization's rules and fee schedules in order to be part of the network and agrees not to *balance bill* patients for amounts beyond the agreed upon fee.

MEDICALLY NECESSARY means medical, surgical, hospital or other treatment which:

- A Participant requires for treatment or diagnosis of a condition, disease, bodily injury or mental disorder, as determined by one or more Participating Physicians;
- Is in accordance with generally accepted medical practice standards in effect at the time of treatment and in conformity with the professional and technical standards adopted by AdvantUs's Quality Improvement and Utilization Review program(s);
- Is the most appropriate level of care or supply that can safely be provided and is consistent with the symptoms and diagnosis, and with the type, level, treatment setting and/or length of service or supply needed to provide adequate care and treatment; and, Is not primarily or the convenience of the Covered Person, the Participant 's family, the Participant 's physician or another provider.

MEMBER, COVERED PERSON, OR PARTICIPANT means an individual who is entitled to receive Covered Services described in the Plan Document.

NON-COVERED SERVICES means those health care services that are not benefits under the Covered Person's Plan Document and are, therefore, the financial responsibility of the Covered Person or another carrier.

OUT-OF-NETWORK PROVIDER is a health care provider (such as a hospital or doctor) that is not contracted to be part of the organization's network. Depending on the organization's rules, an individual may not be covered at all or may be required to pay a higher portion of the total costs when he/she seeks care from an out-of-network provider.

PARTICIPATING PHYSICIAN means a licensed physician who participates in the AdvantUs network through a written service contract, or is an employed physician with a hospital or other entity contracted with AdvantUs, to provide Covered Services to Participants.

PARTICIPATING PROVIDERS means licensed physicians and other health care professionals, Hospitals, skilled nursing facilities (hereinafter referred to as SNFs), home health care agencies or other providers of health care services who have entered into written agreements with AdvantUs or another Participating Provider to provide Covered Services to Participants.

PRIMARY CARE PHYSICIAN means the Participating Physician selected by a Participant or to whom the Participant has been otherwise assigned, to assume total management of the non-emergency medical needs of the Participant, render

primary care services and to coordinate the provision of the other health care services to the Participant. All of the following may be designated as Primary Care Physicians: Internists, Pediatricians, OB-Gynecologists, General Practitioners and Family Practitioners.

PROTECTED HEALTH INFORMATION (PHI) means individually identifiable health information that is a subset of health information, including demographics information collected from an individual, and:

- Related to the past, present, or future physical or mental health or condition of an individual; the provisions of health care to an individual; or the past, present, or future payment for the provision of health care to an individual;
- That identified the individual; or
- With respect to which there is a reasonable basis to believe the information can be used to identify the individual

SELF-FUNDED OR SELF INSURED PLAN means a health plan arrangement whereby an employer provides health benefits to employees by assuming the direct financial risk for payment of claims for health benefits.

THIRD PARTY ADMINISTRATOR (TPA) means a company and/or organization that may collect premiums, process health insurance claims, and/or provide administrative services for employee health benefit plans for another entity without taking any financial risk.

THIRD PARTY LESEE means a party that has entered into an agreement with AdvantUs to have access to the Participating Providers for health care services and the Contracted Rates as described in the Agreement.

NETWORK PARTICIPATION

PROPRIETARY INFORMATION

All information and material provided to you by AdvantUs or AdvantUs Clients remain proprietary to AdvantUs or the AdvantUs Client. This includes, but is not limited to, your Agreement and its terms, conditions, and negotiations, Contract Rates or fee information, AdvantUs Client lists, any administrative policy(ies), and/or other operations manuals. You may not disclose any of such information or materials or use them except as may be permitted or required by the terms of your Agreement.

ADVANTUS RIGHTS AND OBLIGATIONS

The obligations of AdvantUs powered by KBA (Key Benefit Administrators, Inc) include, but are not limited to, the

following:

- Conduct the day-to-day administrative operations and services for employer group sponsored self-funded health benefit plans;
- Maintain a system of Member identification;
- Maintain and publish a listing of Participating Physicians;
- Operate quality and utilization management, credentialing, re-credentialing, and Member grievance programs;
- Transmit payments and fees to Hospital and its Participating Physicians in accordance with the terms and conditions of the Agreement;
- Establish and enforce policies, procedures, and standards (“AdvantUs policies"), to ensure AdvantUs’s continued compliance with State, Federal and operational regulations and requirements; and
- Monitor and oversee all duties of participating provider under the Agreement.

For a complete description of AdvantUs’s Rights and Obligations, please refer to your contract.

PREFERRED PROVIDER RESPONSIBILITIES AND REQUIREMENTS

As a Participating Provider in the **AdvantUs** network, you are responsible for meeting certain requirements for continued participation. In addition to the terms and provisions in your Agreement you have the responsibility for:

- The care and treatment of Participants under your care. You must ensure that all care is rendered in accordance with generally accepted medical practice and professionally recognized standards and within the scope of your applicable license, accreditation, registration, certification and privileges;
- Complying with any and all applicable state and/or federal laws related to the delivery of health care services and the confidentiality of PHI, taking all precautions to prevent the unauthorized disclosure of such Participant's medical and billing records;
- Complying with AdvantUs and AdvantUs Client requests for copies of a Participant's medical and billing records for those purposes which AdvantUs and/or its Clients deem reasonably necessary, including without limitation and subject to any applicable legal restrictions, quality assurance, medical audit, credentialing or re-credentialing;
- Cooperating with the Quality Improvement and Utilization Management programs of AdvantUs or AdvantUs 's Client; and
- Meeting the AdvantUs credentialing criteria, as referred to later in this section

CREDENTIALING

It is the policy of AdvantUs to credential and re-credential Participating Providers using NCQA standards and state and federal guidelines.

<u>Practitioners who must be credentialed;</u>

- Practitioners who have an independent relationship with AdvantUs:
  - Medical Doctors
  - Osteopaths
  - Podiatrists
- Hospital based practitioners who have an independent relationship with AdvantUs such as:
  - Anesthesiologist with pain-management practices
  - Cardiologist
  - University faculty who are hospital based and who also have private practices
- Dentist who provide care under the organizations medical benefit:
  - Endodontists
  - Oral Surgeons
  - Periodontists

- Non-physician practitioners who have an independent relationship with AdvantUs and who provide care under our benefits:
  - Nurse Practitioners
  - Nurse Midwives
  - Physician Assistants
  - Optometrists
  - Physical therapists
  - Occupational therapists
  - Speech and language therapists

AdvantUs credentials and re-credentials the following health delivery systems:

- Hospitals
- Home health agencies
- Skilled nursing facilities
- Free-standing surgical centers

The following criteria will be reviewed for each delivery system:

- Confirm the provider is in good standing with state and federal regulatory bodies
- If provider has been accredited – confirm this from the accrediting bodies website
  - Hospital approved accrediting bodies; Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and American Osteopathic Association (AOA)
  - Home health agencies approved accrediting bodies; JCAHO and Community Health Accreditation Program (CHAP)
  - Skilled Nursing Facilities; JCAHO
  - Free-standing surgical centers; JCAHO and American Association for Accreditation of Ambulatory Surgery Facilities (AAAAFF)
- Conduct onsite quality assessment if the provider is not accredited; in the case where the provider has had a CMS or state review this can be used in lieu of accreditation.
- Confirm at least every three years that the provider continues to be in good standing with state and federal regulatory bodies and, if applicable, is reviewed and approved by an accrediting body.

Verification sources used:

- Council for Affordable Quality Healthcare (CAQH)
- Indiana Professional Licensing Agency - http://www.in.gov/pla/
- National Practitioner Data Bank/Healthcare Integrity and Protection Data Bank https://iqrs.npdb.hrsa.gov/
- Office of Inspector General http://exclusions.oig.hhs.gov
- Indiana Patient's Compensation Fund – http://www.indianapcf.com
- DEA – http://www.deadiversion.usdoj.gov/webforms/dupeCertLogin.jsp
- ABMS – http://www.boardcertifieddocs.com

Verification time limits:

Licensure; 180 days (prior to the CC meeting)

AdvantUs must confirm that practitioners hold a valid, **current state license** or certification, which **must be in effect at the time of the Credentialing Committee (CC) decision**. Verification must come directly from the state licensing or certification agency, if a web site is used it must be from the appropriate state licensing agency.

Malpractice history; 180 calendar days

AdvantUs must obtain confirmation of the past five years of history of malpractice settlements from the malpractice carrier or must query NPDB.

Work History; 180 calendar days

AdvantUs must obtain a minimum five year relevant work history through the practitioner's application or curriculum vitae. This history does not require primary source verification. A gap of six months or more must be reviewed and clarified either verbally or in writing, verbal communication must be appropriately documented.

Board Certification; 180 calendar days

AdvantUs must obtain board certification verification and this information must be current within 180 days. If the provider is not board certified he/she must provide 25 category 1 CME's for initial and 50 category 1 CME's for re-credentialing.

Application, Attestation; 365 calendar days

AdvantUs will obtain from the provider the application/attestation that is within 365 calendar days of the CC review and decision.

PRIOR AUTHORIZATION REQUIREMENTS

The following Covered Services require Prior Authorization when the Participant's identification card includes one of the Authorized Logos shown in Appendix A. You will be notified promptly when there is a change to the network's standard Prior Authorization requirements, or when a network client requires a modified list of Prior Authorization requirements. You may also visit www.AdvantUsnetwork.com for a current listing of all network Prior Authorization requirements.

Provider MUST obtain prior authorization through Key Benefit Administrators, Inc.

Prior Authorization Requirements

- Inpatient Hospitalization
- Partial Hospitalization
- Advanced imaging: PET/SPECT & MRI's (Spine only)
- Durable Medical Equipment > than $750
- Home Health
- Skilled Nursing Facility
- Chemotherapy/Radiation
- Cardiac & Pulmonary Rehab
- Physical Therapy (> 8 visits)
- Occupational Therapy (> 8 visits)
- Speech Therapy (> 8 visits)
- Corrective Appliances/Prosthesis
- Biotech Drugs*(See Below)
- Transplants

***FOR MARIAN UNIVERSITY**:

Specialty Pharmacy Prior Authorizations

*Biotech medication requests will be completed by:
CVS/Caremark Pharmacy:
Prior Authorization Phone: 877-860-6415

In cases where multiple procedures are performed, and when it is clinically appropriate, be sure to confirm benefit eligibility for each procedure.

For Pre-Determinations: **Group No: _______** **Group Name: _____________________**

FAX: 317-284-7473

Please include the following information:

Date: _______________________

Requested By:	
Location:	
Phone number and extension:	
Fax number:	

Member ID#:	
Patient's name:	
Date of Birth:	

Ordering Physician's name	
Facility:	
Date of Service:	

Diagnosis or ICD 10 code(s)	
Procedure(s):	
CPT code(s):	

CLAIMS

CLAIMS SUBMISSION

Please submit paper claims to the address indicated on the Participant's identification card. All electronic claims must be submitted through the EDI payer ID listed on the Participant's identification card. Claims must be submitted using a UB-04 or CMS- 1500 claim format. The National Provider Identifier (NPI) is a **required** identifier on all electronic health care transactions. AdvantUs recommends you submit the NPI as part of your standard submission practice. Unless otherwise specified in your Agreement, all claims must be submitted within one hundred eighty (180) days of the rendering of service or AdvantUs (or Client) may refuse payment.

CLAIMS REIMBURSEMENT

In exchange for Covered Services provided to Participants, AdvantUs or the Client will pay your provider in accordance with the Contract Rates and provisions specified in your Agreement. Except for Copayments, Coinsurance, Deductibles, Non-Covered Services, and amounts collected through coordination of benefits, your facility has agreed to accept the Payment as payment in full for Covered Services.

AdvantUs or the Client will process Clean Claims within thirty (30) days of the receipt of the Clean Claim, or the timeframe described in the Agreement. Should your facility determine AdvantUs or its Client is not paying Clean Claims in a timely manner, please contact the AdvantUs Provider Relations Department to discuss. AdvantUs and the Client reserve the right to audit paid claims on a retrospective basis for up to the period described in the Agreement. In any case involving fraudulent reports, AdvantUs and the Client will have the right to question or audit the bill or item up to the period permitted by state and federal laws.

FAILURE TO SUBMIT A CLEAN CLAIM

If AdvantUs or Delegate receives a claim that is not a Clean Claim containing all complete and accurate information required for adjudication, or if AdvantUs has some other stated dispute with the claim, AdvantUs will either pend the claim and request additional information or deny the claim back to the billing provider and provide notification as to the information required to finalize processing of the claim.

COORDINATION OF BENEFITS (COB)

AdvantUs or Client is Primary

Coordination of benefits will follow the Employer (Summary Plan Document). Please contact Customer Services (1-800-331-4757) for questions on specific Employer Guidelines, to determine Primary and Secondary Coverage.

BALANCE BILLING

Please be sure to review the Explanation of Payment (EOP) form sent to you by AdvantUs or the Client. The EOP may be customized by Client, in which case, AdvantUs will provide you with a sample format to add to this Manual. The EOP is used to determine the amount billable to the Participant. At the time of the visit, you may collect any Copayment due. Following the receipt of an EOP, you may also bill for Deductibles and Coinsurance, if any as specified in the Participant's Plan Document, and/or payment for Non-Covered Services. In the event that you collect fees from the Participant that exceed the Participant's responsibility, you must refund those fees to Participant promptly upon notice of overpayment.

As specified in your Agreement, a Participant cannot be billed for the difference between your billed charges and the Contract Rate. However, you may bill the Participant for the Contracted Rate once the Participant has reached the benefit maximum described in the Participant's Plan Document.

CLAIMS PAYMENT INQUIRIES

If you have a question regarding the status or accuracy of a claims payment, please call our Provider FAX BACK service at 1-888-494-4600

PROVIDER APPEAL PROCESS

As indicated in your Agreement, you have the right to appeal any claim, dispute, or controversy arising out of, or relating to, the interpretation, performance or breach of contract or payment. A Provider may file an appeal within 90 calendar days from the date on the received remit. AdvantUs will ensure that all such requests for appeal are responded to in a timely and fair manner.

You may request an appeal either verbally or in writing, by contacting:

Ascension St. Vincent Employer Direct
250 West 96th St, Suite 400
Indianapolis, IN 46260
(T) 317.583.4134

Required information for submitting disputes:

Disputes about a claim must include:

- Provider's name
- Provider's tax identification number
- Provider's contact information

- Copy of the UB or CMS-1500
- An explanation of the issue, including claim number
- Date of service
- An explanation of why the provider believes the payment amount, request for additional information, request for reimbursement of claim overpayment, or other incorrect actions taken.

Disputes clinical in nature must include:

- Provider's name
- Provider's tax identification number
- Provider's contact information
- Copy of the UB or CMS-1500
- An explanation of the issue, including claim number
- Date of service
- Medical Records
- An explanation of why the provider believes the payment amount, request for additional information, request for reimbursement of claim overpayment, or other incorrect actions taken.

MODIFIERS

Unless otherwise defined in your Agreement, following is the AdvantUs Standard Modifier Reimbursement Schedule. If modifier is not listed below then payment is 100% of the applicable Fee Schedule as defined in your Agreement with AdvantUs. If CPT/HCPCS and modifier combination is not on the Fee Schedule then payment will be default rate as defined in your Agreement with AdvantUs.

Modifier	*Description*	*Modifier Reimbursement*	*How will it pay?*
22	Unusual Procedural Services	100%	When procedure is billed with modifier 22 AdvantUs will pay 100% of applicable Fee Schedule or if not on the Fee Schedule AdvantUs will pay 100% of applicable default rate as defined in the contract.
23	Unusual Anesthesia	100%	When procedure is billed with modifier 23 AdvantUs will pay 100% of applicable Fee Schedule or if not on the Fee Schedule AdvantUs will pay 100% of applicable default rate as defined in the contract.
24	Unrelated E&M Services by the same Physician During a Post-Operative Period	100%	When procedure is billed with modifier 24 AdvantUs will pay 100% of applicable Fee Schedule or if not on the Fee Schedule AdvantUs will pay 100% of applicable default rate as defined in the contract.
25	Significant , Separately Identifiable E&M Service by the same Physician on the same day of the Procedure or Other Service	100%	When procedure is billed with modifier 25 AdvantUs will pay 100% of applicable Fee Schedule or if not on the Fee Schedule AdvantUs will pay 100% of applicable default rate as defined in the contract.
26	Professional Component	100%	When procedure is billed with modifier 26 AdvantUs will pay 100% of applicable Fee Schedule or if not on the Fee Schedule AdvantUs will pay 100% of applicable default rate as defined in the contract.

<table>
<tr><th>Modifier</th><th>Description</th><th>Modifier Reimbursement</th><th>How will it pay?</th></tr>
<tr><td>33</td><td>Preventative Services</td><td>100%</td><td>When procedure is billed with modifier 33 AdvantUs will pay 100% of applicable Fee Schedule or if not on the Fee Schedule AdvantUs will pay 100% of applicable default rate as defined in the contract.</td></tr>
<tr><td>47</td><td>Anesthesia by Surgeon</td><td>100%</td><td>When procedure is billed with modifier 47 AdvantUs will pay 100% of applicable Fee Schedule or if not on the Fee Schedule AdvantUs will pay 100% of applicable default rate as defined in the contract.</td></tr>
<tr><td>50</td><td>Bilateral Procedures</td><td>150%</td><td>When procedure is billed with modifier 50 AdvantUs will pay 50% of applicable Fee Schedule or if not on the Fee Schedule AdvantUs will pay 50% of applicable default rate as defined in the contract.

NOTE: In order to get proper reimbursement for the bilateral procedure provider should bill two lines as shown below

<table><tr><td>CPT/HCPCS</td><td>Modifier</td><td>Days or Units</td></tr><tr><td>64721</td><td></td><td>1</td></tr><tr><td>64721</td><td>50</td><td>1</td></tr></table>
Line 1 will pay 100% of applicable Fee Schedule or if not on the Fee Schedule will pay 100% of applicable default rate as defined in the contract.

Line 2 will pay 50% of applicable Fee Schedule or if not on the Fee Schedule will pay 50% of applicable default rate as defined in the contract.

Total reimbursement for the bilateral procedure is 150%.</td></tr>
</table>

Modifier	Description	Modifier Reimbursement	How will it pay?
51	Multiple Procedures	100% for Primary Procedure, then 50% for all additional Procedures	When multiple procedures other than E&M services are performed on the same day or in the same session, by the same provider modifier 51 will be appended to all secondary procedures and Multiple Procedure discount will apply. Primary Procedure - AdvantUs will pay 100% of applicable Fee Schedule or if not on the Fee Schedule AdvantUs will pay 100% of applicable default rate as defined in the contract. Secondary Procedure - AdvantUs will pay 50% of applicable Fee Schedule or if not on the Fee Schedule AdvantUs will pay 50% of applicable default rate as defined in the contract for each Secondary Procedure.
52	Reduced Service	80%	When procedure is billed with modifier 52 AdvantUs will pay 80% of applicable Fee Schedule or if not on the Fee Schedule AdvantUs will pay 80% of applicable default rate as defined in the contract.
53	Discontinued Procedure	50%	When procedure is billed with modifier 53 AdvantUs will pay 50% of applicable Fee Schedule or if not on the Fee Schedule AdvantUs will pay 50% of applicable default rate as defined in the contract.
54	Surgical Care Only	70%	When procedure is billed with modifier 54 AdvantUs will pay 70% of applicable Fee Schedule or if not on the Fee Schedule AdvantUs will pay 70% of applicable default rate as defined in the contract.

Modifier	Description	Modifier Reimbursement	How will it pay?
55	Postoperative Management Only	30%	When procedure is billed with modifier 55 AdvantUs will pay 30% of applicable Fee Schedule or if not on the Fee Schedule AdvantUs will pay 30% of applicable default rate as defined in the contract.
56	Postoperative Management Only	20%	When procedure is billed with modifier 56 AdvantUs will pay 20% of applicable Fee Schedule or if not on the Fee Schedule AdvantUs will pay 20% of applicable default rate as defined in the contract.
57	Decision for Surgery	100%	When procedure is billed with modifier 57 AdvantUs will pay 100% of applicable Fee Schedule or if not on the Fee Schedule AdvantUs will pay 100% of applicable default rate as defined in the contract.
58	Staged or related procedure or service by the same physician or other qualified Health Care professional during the postoperative period	100%	When procedure is billed with modifier 58 AdvantUs will pay 100% of applicable Fee Schedule or if not on the Fee Schedule AdvantUs will pay 100% of applicable default rate as defined in the contract.
59	Distinct Procedural Service	100%	When procedure is billed with modifier 59 AdvantUs will pay 100% of applicable Fee Schedule or if not on the Fee Schedule AdvantUs will pay 100% of applicable default rate as defined in the contract.
62	Two Surgeons	125%	When procedure is billed with modifier 62 AdvantUs will pay 125% of applicable Fee Schedule or if not on the Fee Schedule AdvantUs will pay 125% of applicable default rate as defined in the contract.

Modifier	Description	Modifier Reimbursement	How will it pay?
66	Surgical Team	100%	When procedure is billed with modifier 66 AdvantUs will pay 100% of applicable Fee Schedule or if not on the Fee Schedule AdvantUs will pay 100% of applicable default rate as defined in the contract.
76	Repeat Procedure by the same Physician	100%	When procedure is billed with modifier 76 AdvantUs will pay 100% of applicable Fee Schedule or if not on the Fee Schedule AdvantUs will pay 100% of applicable default rate as defined in the contract.
77	Repeat Procedure by a different Physician	100%	When procedure is billed with modifier 77 AdvantUs will pay 100% of applicable Fee Schedule or if not on the Fee Schedule AdvantUs will pay 100% of applicable default rate as defined in the contract.
78	Return to the OR or Related Procedure during the Postoperative Period	100%	When procedure is billed with modifier 78 AdvantUs will pay 100% of applicable Fee Schedule or if not on the Fee Schedule AdvantUs will pay 100% of applicable default rate as defined in the contract.
79	Unrelated Procedure or service by the same physician or other qualified Health Care professional during the postoperative period	100%	When procedure is billed with modifier 79 AdvantUs will pay 100% of applicable Fee Schedule or if not on the Fee Schedule AdvantUs will pay 100% of applicable default rate as defined in the contract.
80 81 82	Assistant Surgeon Minimum Assistant Surgeon Assistant Surgeon(when qualified resident surgeon is not available)	20%	When procedure is billed with modifier s 80, 81, AS AdvantUs will pay 20% of applicable Fee Schedule or if not on the Fee Schedule AdvantUs will pay 20% of applicable default rate as defined in the contract.

Modifier	Description	Modifier Reimbursement	How will it pay?
AS	Physician Assistant in surgery		
TC	Technical Component	100%	When procedure is billed with modifier TC AdvantUs will pay 100% of applicable Fee Schedule.
90	Reference (Outside) Laboratory	100%	When procedure is billed with modifier 90 AdvantUs will pay 100% of applicable Fee Schedule or if not on the Fee Schedule AdvantUs will pay 100% of applicable default rate as defined in the contract.
99	Multiple modifiers	Reimbursement as Indicated for the Modifier	Reimbursement as Indicated for the Modifier Submitted
	PHYSICAL STATUS MODIFIERS AND QUALIFYING CIRCUMSTANCES CODES		**Physical status modifiers are used to distinguish between various levels of complexity of the anesthesia service provided. In some cases these modifiers will allow additional reimbursement. If a physical status modifier is appropriate, the provider will bill with it. Below are the valid modifiers and the amount of additional units allowed for each. These units will be added to the time units when the claim is processed.**
P1	A normal healthy patient		Additional Units = 0
P2	A patient with mild systemic disease		Additional Units = 0
P3	A patient with severe systemic disease		Additional Units = 1

Modifier	*Description*	*Modifier Reimbursement*	*How will it pay?*
P4	A patient with severe systemic disease that is a constant threat to life		Additional Units = 2
P5	A moribund patient who is not expected to survive without the operation		Additional Units = 3
P6	A declared brain-dead patient whose organs are being removed for donor purposes		Additional Units = 0
	Qualifying Circumstances codes are used when anesthesia services are provided under particularly difficult circumstances. These procedures should be reported in addition to the ASA code for the anesthesia and should never be reported alone.		
99100	Anesthesia for patient of extreme age, under 1 year and over 70		Additional Units = 1
99116	Anesthesia complicated by utilization of total body hypothermia		Additional Units = 5

Modifier	*Description*	*Modifier Reimbursement*	*How will it pay?*
99135	Anesthesia complicated by utilization of controlled hypotension		Additional Units = 5
99140	Anesthesia complicated by emergency conditions		Additional Units = 2
	ANESTHESIA MODIFIERS		
	THE FOLLOWING MODIFIERS ARE VALID MODIFIERS FOR ASA CODE BILLING		
AA	Anesthesia Service performed personally by Anesthesiologist		100%
AB	Medical direction of won employee(s) by		

Modifier	Description	Modifier Reimbursement	How will it pay?
	Anesthesiologist (not more than 4 employees)		
AC	Medical direction of other than own employee(s) by Anesthesiologist (not more than 4 employees)		
AD	Medical supervision by a Physician: More than 4 concurrent anesthesia procedures		
AE	Direction of residents in furnishing not more than 2 concurrent anesthesia services		
AF	Anesthesia complicated by total body hypothermia		
AG	Anesthesia for emergency surgery on a moribund patient		
QK	Medical Direction of 2,3 or 4 concurrent anesthesia procedures involving qualified individuals		50%
QS	Monitored anesthesia care services (can be billed by CRNA or Physician)		

Modifier	Description	Modifier Reimbursement	How will it pay?
QX	Certified Registered Nurse Anesthetist (CRNA) service: Medical direction by a Physician		50%
QY	Medical Direction of one CRNA by an Anesthesiologist		50%
QZ	CRNA service; without medical direction by a Physician		100%
XJ	Physician directed anesthesia service		

AUTOMATED FAX BACK

The Automated Fax Back system allows providers the ability to check medical claims and current eligibility status for members and dependents in the AdvantUs Network.

Providers will have the option to select an automated interactive voice response and/or a faxed copy of the interactive voice response.

The Automated Fax Back System is accessible by calling the number below.

Commercial Line: 888-494-4600

When calling the Interactive Voice Response System, please have the following information available:

1. Your Provider Fax Number
2. Tax ID Number
3. Member ID Number
4. Member or Dependent DOB
5. Incurred DOS

APPENDIX A: AUTHORIZED LOGOS

AUTHORIZED LOGOS

OTHER AUTHORIZED LOGOS

You may see any of the following logos in combination with an AdvantUs logo, either on the front or the back of the identification card. These logos apply to providers who are not contracted with AdvantUs. **AdvantUs and its Clients will reimburse claims in accordance with the Contract Rates in your Agreement with Sagamore or Multiplan.**

APPENDIX B: PRODUCT SPECIFIC ID CARDS

THIRD PARTY ACCESS – APPROVED BY YOUR FACILITY

1. SELF FUNDED

This is a self-funded benefit plan contracted to access your facility health care services and Contracted Rates with AdvantUs. Covered Services may be provided by Participating Providers listed in the "AdvantUs Provider Directory," which is located at www.AdvantUsnetwork.com. The claims will be reimbursed pursuant to the Contract Rates in your Agreement with AdvantUs.

ID CARD SAMPLE(S):

Marian University

KEY BENEFIT ADMINISTRATORS
MARIAN UNIVERSITY Indianapolis

Member
MARIAN UNIVERSITY Indianapolis
Employee: JOHN SAMPLE
Member ID: SMPL0001
Group #: ADV0002

Plan Information
AdvantUs
Franciscan HEALTH

Pharmacy Plan
RxBIN: 004336
RxPCN: ADV
RxGRP: Rx1461
RxISSUER: 80840
CVS/caremark
Pharmacy Provider Support: 877-860-6415
www.caremark.com

Rx Copay
Generic: $10.00
Brand Formulary: $30.00
Brand Non-Formulary: $60.00
Specialty: $60.00

Office Copay
Primary Care Physician: $20.00
Specialist Physician: $35.00
Emergency Room: 20%; after deductible
Urgent Care: $50.00

Benefits
Deductible:
Individual: $750.00 Per calendar year
Family: $2,250.00 Per calendar year
Out-of-Pocket:
Individual: $3,250.00 Including deductible
Family: $9,750.00 Including deductible

Customer Service
To verify benefits and eligibility, contact KBA at 800-331-4757 or visit our website at www.kbasolution.com.

Pre-Certification
American Health Data Institute (AHDI)
800-831-1854 or 317-284-7140
You must call AHDI for precertification prior to a scheduled admission or within 48 hours after an emergency admission. Some services require prior authorization. Please refer to your Plan Document.
NON-COMPLIANCE PENALTY for NON-NETWORK Providers: Subject to a 10% per-admission penalty in addition to any deductible that might apply.
This card does not guarantee eligibility or payment.

Claims Submission
Send all claims to:
Key Benefit Administrators
P.O. Box 3252
Milwaukee, WI 53201-3252
WebMD payer ID # 37217
SAG1229 (HCFA11C/UB50)
KEY BENEFIT ADMINISTRATORS
SAGAMORE
MultiPlan

2. LEVEL FUNDED

AdvantUs
Changing the way businesses offer health benefits

Member
Employee: JOHN SAMPLE
Member ID: SMPL0001
Group #: AdvantUs
Plan Name

Plan Information
AdvantUs
To verify benefits, eligibility, claim status, or receive a fax back, please contact AdvantUs at 855-744-3596. To receive maximum plan benefits, use only network providers. Visit **advantusnetwork.com** for the Tier 1 provider directory.

Pharmacy Plan
RXBIN: 018737
RXPCN: NEX
RXGRP: HCHRX
CERPASSRX
Member Services: 877-986-4666
www.cerpassrx.com

Rx Copay
Generic: $00
Brand Formulary: $00
Brand Non-Formulary: $00
Specialty: 00%

Office Copay
Primary Care Physician: $00
Specialist Physician: $00
Emergency Room: $00
Urgent Care: $00

Benefits
Deductible:
Individual: $000 Per calendar year
Family: $0,000 Per calendar year
Out-of-Pocket:
Individual: $0,000 Including deductible
Family: $0,000 Including deductible

Online Services
Please visit **advantusnetwork.com** to locate providers and register to view claim status, eligibility, summary of benefit coverage, and plan documents.

Pre-Notification
American Health Data Institute (AHDI)
800-831-1854 or 317-284-7140
You must call AHDI for pre-notification prior to a scheduled admission or within 48 hours after an emergency admission. Some services require prior authorization. Please refer to your Plan Document.
NON-COMPLIANCE PENALTY: $250.00 reduction in benefits

Claims Submission
Send all claims to:
Key Benefit Administrators
P.O. Box 3252
Milwaukee, WI 53201-3252
WebMD payer ID # 37217
SAG1229 (HCFA11C/UB50)
KEY BENEFIT ADMINISTRATORS
SAGAMORE
MultiPlan