This form is part of the credentialing procedure. Please complete and mail to AHO promptly.

Thank you

Mail form to:

Alternative Healthcare Options
P O Box 220395
Charlotte, NC 28222

- ❑ I have read my Provider Procedures for Group Health Plans Manual.
- ❑ I have placed the table tent in an area that can be view by all patients.
- ❑ I agree to follow the procedures outlined in my Provider Procedures for Group Health Plans Manual from Alternative Healthcare Options (AHO).

Provider's signature _____

Date _____

PPO Quick Reference Guide for Complementary and Alternative Medicine (CAM) Providers

The Natural Choice In Healthcare™

AHO providers mail claims to:
Alternative Healthcare Options
P O Box 220395
Charlotte, NC 28222

General Information

AHO is not an insurance company; therefore benefit design varies by employer group. Each ID card contains information specific to the subscriber. Look for the Alternative Healthcare Options logo to identify members of our PPO.

Eligibility

- Telephone: Refer to that number on the member's identification card.
- CAM benefits may vary by employer group; ask for specific information on CAM benefits.

Member Services

- Telephone: Refer to the number on the members identification card

Referral System

- AHO PPO is a direct access plan and no referral is required from a Primary Care Physician (PCP), except for massage therapy services and treatment.
- When referring for massage therapy services and treatment a referral form is required. Contact AHO by calling 877-203-3440 ext 310 for instruction if needed.
- When necessary to refer to another health provider, referrals within the network are strongly recommended. When available, refer to the provider directory or call 877-203-3440 ext 310.

Co-payment/Coinsurance Collection

- ***Collect the co-payment amount stated on the ID card.***
- ***Include a copy of the front and back of ID card in patients correspondence file.***
- Upon receipt of the EOB or remittance summary, provider may bill for any deductible or co-insurance up to the plans allowed amount.
- Provider may not balance bill for the discount amount on covered services.
- Non-covered services may be billed at the provider's normal charges.

Claims Submission

- Submit all claims to: Alternative Healthcare Options (AHO)
  P O Box 220395
  Charlotte, NC 28222

Claims Inquiries

- For tracing overdue claims (after 60 days), contact the payor listed on the member's ID card.
- Resubmit lost/missing claims through AHO.
- For questions relating to payment of a claim, contact the payor listed on the member ID card.
- Refer to your AHO fee schedule to confirm allowable amounts.

*Refer to your manual for details; this is only a summary of procedures.

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2013

PROVIDER PROCEDURES

FOR

GROUP HEALTH PLANS

Alternative Healthcare Options
P O Box 220395
Charlotte, NC 28222
1.877.203.3440

www.aho-network.com

Welcome to the
ALTERNATIVE HEALTHCARE OPTIONS
Preferred Provider Organization

INTRODUCTION

Alternative Healthcare Options (AHO) is a comprehensive, full-service Managed Care Organization based in Charlotte, North Carolina. The services we offer our clients include: PPO Network services, Utilization Management (Utilization Review and Case Management), Billing Services, Contract Negotiations and Loss Control. These managed care cost-containment services are offered in both the group health and workers' compensation arenas.

Alternative Healthcare Options is dedicated to providing its members with the highest quality (Alternative) health care in the marketplace at the most cost-effective price available. We are also dedicated to effectively managing the treatment of our members through the coordination of health care delivery and the continuous education of our members.

Participating providers are carefully selected and screened through a credentialing process. Continuous review and monitoring of care is provided to ensure necessity, reasonableness and appropriateness of levels of patient care.

OVERVIEW

AHO is not an insurance plan. Employers will retain their existing group health plans with insurance carriers while accessing the AHO Preferred Provider Network. The insurance company, third party administrator, HMO or employer must be contacted for eligibility and benefit information.

Health plans that incorporate the AHO Preferred Provider Network encourage the utilization of network providers through the implementation of plan benefit differentials. When the patient uses an AHO Preferred Provider, he or she, in most instances, will incur less out-of-pocket expenses. When patients use non-participating providers or hospitals, they may incur higher deductibles and/or co-payments resulting in greater out-of-pocket expenses.

The patient's freedom to choose his or her own provider is maintained through the use of the PPO. Because the PPO is tied into existing comprehensive insurance plans, the fee-for-service concept is preserved.

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The Language of Managed Care and Organized Health Care Systems

SECTION I

IDENTIFICATION AND ELIGIBILITY

Member refers to any employee or family member of an employee who is eligible and enrolled in a plan utilizing AHO. The insured refers to the subscriber listed on the insurance plan.

Members have been asked to identify themselves as eligible for AHO Network services by showing their health insurance plan identification card. AHO services consist of covered benefits and discount programs from employer groups, HMOs, and insurance carriers. Insured members are issued identification cards through their employer with the AHO logo and/or name displayed. (See copy of card with logo) **It is important to make a copy of the patient's ID card.** This will help you in case necessary information may not have been obtained when the patient came into your office.

The ID card will contain the member's name, relationship to the insured (if member is a dependent), identification number, employer group number, and any special information regarding co-payments or other requirements. It is important that this information be recorded on your billing form. In addition, the card will list the phone number for eligibility/benefits, preferred provider information, and pre-certification.

Participating providers are encouraged to display the Alternative Healthcare Options participating provider sign to remind patients to show their ID cards when they seek treatment.

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SECTION II

PAYMENT AUTHORIZATION AND INFORMATION RELEASE FORM

AHO requires that the provider's office obtain authorization to release patient information and authorize payment.

***A copy of our form is shown on page 16. You may use this as a sample to generate additional copies.**

Your patient must sign an authorization when he/she makes the first visit to your office. The authorization form should be kept on file. If you use a similar form at this time, it is not necessary to have the patient sign both. Continue to use your own form.

COMPLETING THE CLAIM FORM

AHO has attempted to make billing as simple as possible. We request that you complete your HCFA-1500 claim form according to the following instructions:

1. For each procedure, submit your usual and customary charges (as shown on your fee schedule originally submitted to AHO).

2. All services must be coded in CPT-4.

3. All diagnoses must be coded in ICDM-9.

4. Mail the claim to:

   Attn: Claims Department
   Alternative Healthcare Options
   P O Box 220395
   Charlotte, NC 28222

COMPLETING THE CLAIM FORM-(continued)

All areas must be completed on the HCFA-1500 claim form but the following areas are especially important:

Item 1a: Insured's ID Number-enter the member's ID number from his/her identification card.

Item 4: Insured's Name- The insured is the member for whom the employer of insurance company provides coverage.

Item 11: Insured's Group Number-Enter the group number as it appears on the identification card.

Item 11b: Employer's Name-Enter the name of the insured's employer.

Item 11c: Insurance Plan Name-Enter the name of the Insurance Company. You may include AHO with the insurance company name for clarification but is NOT the actual insurance company.

Item 12: Information Release Authorization-AHO has provided a sample of the Release form on page 16. The release form should only be signed once for each member, so it is not necessary for the member to sign the bill.

Item 13: Benefits Payment Authorization-Since insured's signature has previously been obtained on the Payment Authorization and Information Release Form, simply stamp or type "signature on file".

Item 17: Referring Provider-Please enter the name of the other provider that has referred this patient to you.

Item 21: Diagnosis-Enter the associated ICDM-9 code. Claims which do not have the appropriate diagnostic codes may be delayed in processing or returned to your office for correct coding. The Prior Authorization Code must be entered in the appropriate space if hospitalization is required. This code is supplied by AHO during pre-admission certification.

Item 24-D: Medical Services Furnished-Please enter a CPT-4 code for each procedure listed. Claims which do not have the appropriate

procedural code may be delayed in processing or returned to your office for correct coding.

Item 24-F: Charges-Enter the charge for each procedure listed in Item24-D, as shown on your fee schedule which was originally submitted to AHO.

Item 31: Provider Signature-This item must be signed or stamped before the claim can be processed.

Item 32: Location Where Services Rendered-Fill in only if applicable.

Alternative Healthcare Options will make every effort to complete any missing information so that your payment will be expedited upon reaching the payor. If there is additional information needed, we will send a letter from our claims coordinator requesting the missing information. A sample of this letter is shown on page 17.

SECTION III

COLLECTION PROCEDURES

Using the AHO plan, the provider is always entitled to collect the lesser of his or her usual charge versus the AHO fee maximum. AHO fees are those fees agreed by AHO, the insurer and each participating provider. The member is responsible for any applicable co-payments (deductibles and coinsurance) and/or non-covered services as established by the member's Plan Contract.

Not all AHO PPO plans will contain the same benefits. You must contact the insurance company, third party administrator or employer to determine if it is a covered benefit. The name and phone number of these contacts will be on the ID card.

The Explanation of Benefit (EOB) you receive from the payor will identify the payment as an AHO PPO participant and will clearly specify the amount of the fee maximum and PPO adjustment, as well as any ineligible amounts, applicable copays, or deductibles as determined by the plan.

All providers should:

1) Complete the appropriate claim form.

2) **Mail claims to:**

Attn: Claims Department
Alternative Healthcare Options
P O Box 220395
Charlotte, NC 28222

3) Alternative Healthcare Options will then re-price the claim based on the established fee schedule allowance and mail your claim to the insurance company/Payor for payment.

4) Benefits are applied by the insurance company and insurance payment is made. After insurance pays, bill the patient any remaining co-insurance up to the negotiated fee allowance (if this has not been collected at the time of service). **Please remember that you may not balance bill the patient for covered services as described in the Network Participating Provider Agreement, section 3.3.**

SECTION IV

UTILIZATION REVIEW PROGRAM

Purpose

Utilization review ("UR") examines, for claim purposes, the medical necessity of all schedule, non-emergency admissions by carefully evaluating the hospital admission of each person to prevent unnecessary hospitalizations and to shorten lengths of stay when it is practical to do so. Many times a less expensive, alternative treatment setting suites the needs of the patient just as well as, or better than, a hospital confinement.

Process

Each enrolled employee receives an employee orientation packet which contains an explanation of the UR Program and a special Identification Card. The special Identification card identifies them as an Alternative Healthcare Options member. When an employee or dependent visits the provider, and should the provider decide that massage therapy or special medical treatment is necessary, the patient gives the provider the AHO Identification Card. The provider or the employee then contacts the AHO UR office at 1-877-203.3440. The UR office hours are 8:30 a.m. -5:00 p.m., Monday through Friday. After hours and on weekends, voice mail is available and all messages are reviewed and calls returned the next work day.

The treatment and progress of each patient will be monitored during the on going treatment plan.

Patient Has Priority

It is important to keep in mind that UR operates in the interests of the employer and the employee. The patient is cared for by the provider of his or her choice and the doctor-patient relationship is not disrupted. While the goal of the UR Program is to reduce unnecessary medical treatment and thus reduce health care costs...UNDER NO CIRCUMSTANCE WILL THE HEALTH OR WELL-BEING OF THE PATIENT BE JEOPARDIZED to accomplish this! The professional UR staff works closely with the patient's provider to discuss the on going treatment plan. When medically advisable, alternative setting will be considered for treatment to promote cost savings and the comfort of the patient.

Claims

The UR Program does not disrupt the system an employer has developed for paying claims nor does UR determine coverage issues. The UR Nurse makes recommendations for the appropriate length of treatment based on the provider's diagnosis and recommendations, the patient's suitability for treatment in an alternative setting, and specific details of each case.

However, the determination of coverage for treatment beyond that certified by UR staff is a management decision based on the current group health plan and the plan sponsor's policy.

Essential Elements of The Utilization Review Program

The utilization and case management team is responsible for monitoring provider and member data to determine appropriateness of services utilized. In addition, the team has established the periodic review criteria for case management of high-risk areas.

The utilization and case management team collects and analyzes data pursuant to quality measurement guidelines. The guidelines include all three areas of utilization management; prospective, concurrent, and retrospective review. These guidelines shall be available to all providers and may be modified as necessary by the utilization and case management team.

Prospective review is a review method of authorizing elective services to assure that the services are necessary and are being provided in the most cost-effective manner. Prospective review is assisted by the use of treatment protocols and practice guidelines developed for chiropractic conditions. Reviews include but are not limited to; elective treatments, therapy, and referrals for consultation outside of the network.

Concurrent review is the ongoing assessment of any additional requests for services beyond the original plan but within the same episode of care. Concurrent review is vital and involves the examination of a patient’s medical record during the time of care to assess the medical necessity and appropriateness of continued care. If, at the time of review, predetermined criteria is not met, the UR/QA Team will discuss the case with the attending provider and the insuring company, as established in the procedures.

Retrospective review is the evaluation of care that has already occurred. This type of review includes evaluation of utilization statistics be it either general or case/physician specified, for educational and quality assurance purposes. This review will be accomplished by but not limited to electronic claims review utilizing ICD-9CM and CPT codes appropriate to the services to develop a provider profile database and the review of outcome management protocol (e.g., clinical, functional, satisfaction-related, and fiscal outcomes).

Referrals

In order for members to receive their full benefits, members should be encouraged to see providers participating in the Alternative Healthcare Options network. Self-referral is allowed in most of the AHO PPO plans. To obtain participating provider information, please call the Alternative Healthcare Options toll free number at 1-877.203.3440 and ask for the Provider Relations Department.

Referrals to a non-participating provider may result in increased out-of-pocket expenses to your patient. Referrals are appropriate to non-participating providers in emergency of other situations when such services are not reasonably available within the network.

The patient always has the choice not to use Alternative Healthcare Options providers; whereby the provider is not responsible if the patient self-refers. However, the patient should be made aware that he/she may be responsible for higher out-of-pocket cost.

Utilization Review Procedures:

Precertification will be needed for:

1. All Massage Therapy Services.
2. Any Special Treatment or Procedures.

- Please call the Member Services Department at Alternative Healthcare Options to verify if pre-certification is necessary when in question:

ph 1.877.203.3440

SECTION V

GRIEVANCE PROCEDURES

Formal Complaint

If a member or provider is not satisfied with a denial decision made in the Utilization Review Program or with any aspect of the services provided by AHO, the member or provider may file a formal complaint with AHO. A formal complaint must be made in writing and should describe the decision which is under complaint and the reason for your objection. It should also contain all available medical and clinical information relating to the case.

A formal complaint must be filed with AHO within ninety (90) days of the decision which is under complaint. The AHO Medical Director will refer the complaint to an Ad Hoc Utilization Management panel. This panel will investigate the formal complaint, reach a decision, and report the decision to the member and provider in writing with supporting medical reasons within (30) days of the date of the appeal and no later than 5 business days after the decision.

SECTION VI

CREDENTIALING

Professional Requirements for PPO Provider Participants

It is mutually agreed that each participating provider will be a member of their Association, respectively, in the state where practicing medicine. All participating providers will adhere to the following requirements in connection with professional credentials and that failure to maintain any of these requirements is grounds for immediate termination of the Provider Participation Agreement.

1. Participating provider shall be duly licensed or have authorization duly issued in accordance with the laws of the state in which to practice medicine. Evidence of such licensing or authorization shall be submitted to AHO upon request and participating provider shall notify AHO of the limitation and /or revocation of such license within fifteen (15) days from date of same.

2. Participating provider must meet all qualifications and standards set forth in the Credentialing Policies and Procedures of AHO for membership as a provider in the AHO Network.

3. Participating provider shall maintain provider's professional liability (malpractice) insurance coverage no less than the amount of one million dollars ($1,000,000) per claim and three million dollars ($3,000,000) in aggregate, and further agrees that AHO shall be given thirty (30) days prior written notice of any modification, cancellation, or termination of the above-referenced policy.

Confidentiality

All utilization review and quality assurance data, worksheets, and reports will be maintained respecting strict patient confidentiality of information.

Provider Compliance with Alternative Healthcare Options Policies

As previously mentioned, provider compliance with AHO's Quality Assurance and Utilization Management policies is crucial to the success of AHO. Providers must follow procedures for referrals, hospitalization, and billing for AHO to provide employers with cost control mechanisms necessary to market the PPO plan.

SECTION VII

Summary

(1) The TPA/Payor issues the plan identification card which contains the Alternative Healthcare Options PPO(AHO) logo and/or name.

(2) Copayment/deductible information is verified by the plan's TPA/Payor. The plan's I.D. card provides the necessary telephone numbers

(3) Claims **MUST** be mailed to Alternative Healthcare Options.

Attn: Claims Department
Alternative Healthcare Options
P O Box 220395
Charlotte, NC 28222

Phone: 1.877.203.3440

(4) AHO does not pay claims. We review claims for our patients, collect data, and complete any missing information in order to expedite the claim. In all instances, payment is made by the Insurance Company, HMO or Third Party Administrator (TPA) to AHO and we pass this payment on to the provider minus any administrative fee.

(5) If you have a question about an employer or other questions, please call the Provider Relations Department:

In Charlotte: 704.523.3440
Outside: 1.877.203.3440

PAYMENT AUTHORIZATION AND INFORMATION RELEASE FORM

Employer Name_____

Insured Member Name_____

Dependent Members Covered by the Plan:_____

_____

_____

PAYMENT AUTHORIZATION

I authorize payment of medical benefits to the provider or clinic named below for services rendered pursuant to an agreement with Alternative Healthcare Options (AHO).
This authorization shall remain valid for any service provided pursuant to said agreement.

Name of Provider or Clinic: _____

_____

Insured Member or Spouse Signature **Date**

AUTHORIZATION TO RELEASE PATIENT INFORMATION

You are authorized to permit AHO representatives/agents to obtain or review records regarding the examination , treatment, history, and medical expenses of the Members listed above.

As an employee/dependent of an employer who participates in AHO, I hereby authorize any hospital or provider office at which the patient may be treated to release to AHO any medical and related information concerning that treatment.

I understand that this information is confidential and will not be released by AHO in identifiable form.

*The patient is entitled to receive a copy of this authorization upon request.
A photocopy of this signed form shall be as valid as the original.

_____

Employee or Spouse Signature **Date**

This authorization shall remain valid for the period during which any service is provided pursuant to said agreement with AHO and for a reasonable time thereafter.

Incomplete Information Form

From: **Attn: Claims Department**
Alternative Healthcare Options
P O Box 220395
Charlotte, NC 28222

Date: _____

To: _____ **Re:** _____
_____ **(patient)**
_____ **Acct #**_____
_____

In order for us to properly re-price this claim, we will need the following information:

____ This claim is not ours, please verify proper claims handler.
_____ Federal Tax No.
_____ Statement covers period
_____ Patient control No.
_____ ICD-9 (Diagnosis code)
_____ CPT Code
_____ Resubmit on proper form or HCFA1500.
_____ Insured's ID Number
_____ Insured's Name
_____ Insured's Group Number
_____ Employer's Name
_____ Insurance Plan Name.
_____ Referring Provider
_____ Charges
_____ Provider Signature
_____ Location Where Services Rendered

Other_____
_____
_____

Please return the claim and/or information requested to:
Attn: Claims Department
Alternative Healthcare Options
P O Box 220395
Charlotte, NC 28222

If you have any questions, please feel free to call the Claims Department at 1.877.203.3440

Alternative Healthcare Options

Request for Authorization

Date:_____	**Sent by:**_____
Phone:_____	**Fax #:**_____

Patient Name: _____
DOB:_____
Patient ID: _____ **PCP Name:**
_____

Diagnosis: Primary _____ ICD9 _____
Secondary _____ ICD9 _____

Procedure(s): CPT _____ CPT _____
CPT _____ CPT _____

Comments: _____
_____

Referred To: Provider _____ Phone # _____
Facility _____ Phone # _____
Other _____ Phone # _____

Initial Date of Service _____ # of visits req'd _____

You must receive **prior** authorization before procedures are initiated. Medical information may be requested to evaluate the medical necessity of a referral or procedure. A decision will be rendered within 2 business days of receipt. **AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT. COVERED SERVICES ARE BASED ON MEMBER'S ELIGIBILITY AND BENEFIT LIMITATIONS AT THE TIME SERVICES ARE RENDERED.**

Please fax to : Alternative Healthcare Options (704) 847.3014 Fax

For AHO Office Use:
Auth #: _____ **By:** _____
Date: _____ **# Visits approved:** _____
Comments: _____

The Natural Choice In Healthcare. ™
P O Box 220395, Charlotte, NC 28222
1.877.203.3440 Bus 704.847.3014 Fax

A Glossary of Terms

The Language of Managed Care and Organized Health Care Systems

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(ACR) Adjusted Community Rating - community rating impacted by group specific demographics and the group's prior experience. Also known as *prospective rating*.

(ADS) Alternative Delivery Systems - a catch-all phrase used to cover all forms of health care delivery except traditional fee-for-service, private practice. The term includes HMOs, PPOs, IPAs and other systems of providing health care.

(ALOS) Average Length Of Stay - the average number of days in a hospital for each admission. The formula for this measure: total patient days incurred divided by the number of admissions and discharges during the period.

(APT) Admissions Per 1000 - the number of hospital admissions per 1,000 health plan members. The formula for this measure is: (# of admissions/member months) x 1,000 members x # of months.

(ASO) Administrative Services Only - a service requiring a third party to deliver administrative services to an employer group and requiring the employer to be at risk for the cost of health care services provided. This is a common arrangement when an employer sponsors a self-funded health care program.

(ASR) Age/Sex Rates - a set of rates for a given group product in which there is a separate rate for each grouping of age and sex categories. One overall table serves a defined group or product. These rates are used to calculate premiums for group billing purposes. This type of premium structure is often preferred over single and family rating in small groups because it automatically adjusts to demographic changes in the group.

(Cap) Capitation - in the strictest sense, a stipulated dollar amount established to cover the cost of health care delivered for a person. The term usually refers to a negotiated per capita rate to be paid periodically, usually monthly, to a health care provider. The provider is responsible for delivering or arranging for the delivery of all health services required by the covered person under the conditions of the provider contract.

(COB) Coordination Of Benefits - a provision in a contract that applies when a person is covered under more than one group medical program. It requires that payment of benefits will be coordinated by all programs to eliminate over-insurance or duplication of benefits.

(COBRA) Consolidated Omnibus Budget Reconciliation Act - a federal law that, among other things, requires employers to offer continued health insurance coverage to certain employees and their beneficiaries whose group health insurance coverage has been terminated.

(COC) Certificate Of Coverage - a description of the benefits included in a carrier's plan. The certificate of coverage is required by state laws and represents the coverage provided under the contract issued to the employer. The certificate is provided to the employee.

(CPT) Physician's Current Procedural Terminology - a list of medical services and procedures performed by physicians and other providers. Each service and/or procedure is identified by its own unique 5-digit code. CPT has become the health care industry's standard for reporting of physician procedures and services, thereby providing an effective method of nationwide communication.

(CRC) Community Rating By Class - the practice of community rating impacted by the group's specific demographics. Also known as *factored rating*.

(DC) Dual Choice - a term used to describe a situation in which only two carriers are contracted by a specific group. For example, an employer offers its employees one HMO and one indemnity plan, or two HMOs and no indemnity plan.

(DCI) Duplicate Coverage Inquiry - a request to an insurance company or group medical plan by another insurance company or medical plan to find out whether other coverage exists for the purpose of coordination of benefits.

(DME) Durable Medical Equipment - equipment which can stand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness or injury, and is appropriate for use at home. Examples of durable medical equipment include hospital beds, wheelchairs and oxygen equipment.

(DOS) Date Of Service - the date on which health care services were provided to the covered person.

(DRGs) Diagnosis Related Groups - a system of classification for inpatient hospital services based on principal diagnosis, secondary diagnosis, surgical procedures, age, sex and presence of complications. This system of classification is used as a financing mechanism to reimburse hospital and selected other providers for services rendered.

(EDI) Electronic Data Interchange - the computer-to-computer exchange of business or other information between two organizations (trading partners). The data may be in either a standardized or proprietary format.

(EOB) Explanation Of Benefits - the statement sent to covered persons by their health plan listing services provided, amount billed, and payment made.

(EOI) Evidence Of Insurability - proof presented through written statements (e.g., an application form) and/or a medical examination that an individual is eligible for a certain type of insurance coverage. This form is required for eligibles who do not enroll during the open enrollment period (generally a 31-day period), or who apply for excess amounts of group life
insurance. Also known as *evidence of good health*.

(EPO) Exclusive Provider Organization - a term derived from the phrase preferred provider organization (PPO). However, where a PPO generally extends coverage for non-preferred provider services as well as preferred provider services, an EPO provides coverage only for contracted providers. Technically, many HMOs also can be described as EPOs.

(ERISA) Employee Retirement Income Security Act of 1974, Public Law 93-406 - this law mandates reporting and disclosure requirements for group life and health plans.

(FFS) Fee-For-Service *reimbursement* - the traditional health care payment system, under which physicians and other providers receive a payment that does not exceed their billed charge for each unit of service provided.

HCFA 1500 - a universal form, developed by the government agency known as Health Care Financing Administration (HCFA), for providers of services to bill professional fees to health carriers.

(HCPCS) HCFA Common Procedural Coding System - a listing of services, procedures and supplies offered by physicians and other providers. HCPCS includes CPT (Current Procedural Terminology) codes,

national alpha-numeric codes and local alpha-numeric codes. The national codes are developed by HCFA in order to supplement CPT codes. They include physician services not included in CPT as well as non-physician services such as ambulance, physical therapy and durable medical equipment. The local codes are developed by local Medicare carriers in order to supplement the national codes. HCPCS codes are 5-digit codes, the first digit a letter followed by four numbers. HCPCS codes beginning with A through V are national; those beginning with W through Z are local.

(HEDIS) Health Plan Employer Data and Information Set - a core set of performance measures to assist employers and other health purchasers in understanding the value of health care purchases and evaluating health plan performance.

(HIPC) Health Insurance Purchasing Cooperatives - purchasing pools which would be responsible for negotiating health insurance arrangements for employers and/or employees. Alliances would use their leverage to negotiate contracts that would ensure care is delivered in economic and equitable ways. (Also referred to as *health insurance purchasing cooperatives, health plan purchasing cooperatives, health alliances* or *regional health alliances).*

(HMO) Health Maintenance Organization - an entity that provides, offers or arranges for coverage of designated health services needed by plan members for a fixed, prepaid premium. There are four basic models of HMOs: group model, individual practice association, network model and staff model.

Under the Federal HMO Act, an entity must have three characteristics to call itself an HMO:
1. An organized system for providing health care or otherwise assuring health care delivery in a geographic area,
2. An agreed upon set of basic and supple-mental health maintenance and treatment services, and
3. A voluntarily enrolled group of people.
See also *group model, individual practice association, network model and staff model.*

(HSA) Health Service Agreement - the detailed procedure and benefit description given to each enrolled employer. This agreement is the basis for discussion and/or explanation between the employer and the health plan on enrollment, eligibility limitations, benefit descriptions, etc.

(ICD-9-CM) International Classification of Diseases, 9th Edition (Clinical Modification) - a listing of diagnoses and identifying codes used by physicians for reporting diagnoses of health plan enrollees. The coding and terminology provide a uniform language that can accurately designate primary and secondary diagnoses and provide for reliable, consistent communication on claim forms.

(IPA) Individual Practice Association Model HMO - a health care model that contracts with an entity, which in turn contracts with physicians, to provide health care services in return for a negotiated fee. Physicians continue in their existing individual or group practices and are compensated on a per capita, fee schedule, or fee-for-service basis.

(IME) Independent Medical Evaluation - an examination carried out by an impartial health care provider, generally board certified, for the purpose of resolving a dispute related to the nature and extent of an illness or injury.

(ISN) Integrated Service Network - proposed networks of providers and payers which would provide care and compete with other systems for enrollees in their region. Systems could include hospitals, primary care physicians, specialty care physicians, and other providers and sites that could offer a full range of preventive and treatment services. Also referred to as accountable health plans (AHP), coordinated care networks (CCN), community care networks (CCN), integrated health systems (IHS), and organized delivery systems.

(JCAHO) Joint Commission on Accreditation of Health Care Organizations - a private, not-for-profit organization that evaluates and accredits hospitals and other health care organizations providing home care, mental health care, ambulatory care, and long term care services.

(LOS) Length Of Stay - the number of days that a covered person stayed in an inpatient facility.

(Medsupp) Medicare Supplement Policy - a policy guaranteeing that a health plan will pay a policyholder's coinsurance, deductible and co-payments and will provide additional health plan or non-Medicare coverage for services up to a predefined benefit limit. In essence, the product pays for the portion of the cost of services not covered by Medicare. Also called *Medigap* or *Medicare wrap.*

(MSO) Management Service Organization - a legal entity that provides practice management, administrative and support services to individual physicians or group practices. An MSO may be a direct subsidiary of a hospital or may be owned by investors.

(Non-par) Non-participating Provider - a term used to describe a provider that has not contracted with the carrier or health plan to be a participating provider of health care.

(OA) Open Access - a self-referral arrangement allowing members to see participating providers for specialty care without a referral from another doctor. Typically found in an IPA HMO. Also called *open panel.*

(OOA) Out-Of-Area - coverage for treatment obtained by a covered person outside the network service area.

(OOPs) Out-Of-Pocket costs/expenses - the portion of payments for health services required to be paid by the enrollee, including copayments, coinsurance and deductibles.

(OTC) Over-The-Counter Drug - a drug product that does not require a prescription under federal or state law.

(PAC) Pre-Admission Certification - a review of the need for inpatient hospital care, done prior to the actual admission. Established review criteria are used to determine the appropriateness of inpatient care.

(Par) Participating Provider - a provider who has contracted with the health plan to deliver medical services to covered persons. The provider may be a hospital, pharmacy or other facility or a physician who has contractually accepted the terms and conditions as set forth by the health plan.

(PCN) Primary Care Network - a group of primary care physicians who have joined together to share the risk of providing care to their patients who are covered by a given health plan.

(PCP) Primary Care Physician - a physician the majority of whose practice is devoted to internal medicine, family/general practice and pediatrics. An obstetrician/gynecologist may be considered a primary care physician.

(PCR) Physician Contingency Reserve - the "at-risk" portion of a claim that is deducted and withheld by the health plan before payment is made to a participating physician as an incentive for appropriate utilization and quality of care. This amount - for example, 20% of the claim - remains within the plan and is credited to the doctor's account. The PCR can be used in instances where the plan needs additional funds to pay for claims. The withhold may be returned to the physician in varying levels which are determined based on analysis of his/her performance or productivity compared against his/her peers. Also called *withhold.*

(PEC) Pre-Existing Condition - any medical condition that has been diagnosed or treated within a specified period immediately preceding the covered person's effective date of coverage under the master group contract.

(PHO) Physician-Hospital Organization - a legal entity formed and owned by one or more hospitals and physician groups in order to obtain payer contracts and to further mutual interests. Physicians maintain ownership of their practices while agreeing to accept managed care patients under the terms of the PHO agreement. The PHO serves as a negotiating, contracting and marketing unit. See *integrated delivery system.*

(PMPM) Per Member Per Month - the unit of measure related to each effective member for each month the member was effective. The calculation is: # of units/member months (MM).

(POS) Point-Of-Service Plan - a health plan allowing the covered person to choose to receive a service from a participating or non-participating provider, with different benefit levels associated with the use of participating providers. Point-of-service can be provided in several ways:

- an HMO may allow members to obtain limited services from non-participating providers;
- an HMO may provide non-participating benefits through a supplemental major medical policy;
- a PPO may be used to provide both participating and non-participating levels of coverage and access; or
- various combinations of the above may be used.

(PPO) Preferred Provider Organization - a program in which contracts are established with providers of medical care. Providers under such contracts are referred to as preferred providers. Usually, the benefit contract provides significantly better benefits (fewer co-payments) for services received from preferred providers, thus encouraging covered persons to use these providers. Covered persons are generally allowed benefits for non-participating providers' services, usually on an indemnity basis with significant co-payments. A PPO arrangement can be insured or self-funded. Providers may be, but are not necessarily, paid on a discounted fee-for-service basis.

(QA) Quality Assurance - a formal set of activities to review and affect the quality of services provided. Quality assurance includes quality assessment and corrective actions to remedy any deficiencies identified in the quality of direct patient, administrative and support services.

(R&C) Reasonable and Customary - a term used to refer to the commonly charged or prevailing fees for health services within a geographic area. A fee is considered to be reasonable if it falls within the parameters of the average or commonly charged fee for the particular service within that specific community.

(RBRVS) Resource Based Relative Value Scale - a fee schedule introduced by HCFA to reimburse physicians' Medicare fees based on the amount of time and resources expended in treating patients, with adjustments for overhead costs and geographical differences.

(SPD) Summary Plan Description - a description of the entire benefits package available to an employee as required to be given to persons covered by self-funded plans.

(TPA) Third Party Administrator - an independent person or corporate entity (third party) that administers group benefits, claims and administration for a self-insured company/group. A TPA does not underwrite the risk.

(UB-92) Uniform Billing Code of 1992 - a revised version of the UB-82, a federal directive requiring a hospital to follow specific billing procedures, itemizing all services included and billed for on each

invoice, which was implemented October 1, 1993.

(UCR) Usual, Customary and Reasonable - a term used to refer to the commonly charged or prevailing fees for health services within a geographic area. A fee is considered to be reasonable if it falls within the parameters of the average or commonly charged fee for the particular service within that specific community. Also called *reasonable and customary*.

(UM) Utilization Management - a process of integrating review and case management of services in a cooperative effort with other parties, including patients, employers, providers, and payers.

(UR) Utilization Review - a formal assessment of the medical necessity, efficiency, and/or appropriateness health care services and treatment plans on a prospective, concurrent or retrospective basis.

(URAC) Utilization Review Accreditation Commission - a Washington-based, not-for-profit corporation formed in 1990 and dedicated to improving the quality of utilization review in the health care industry by providing a method of evaluation and accreditation of utilization review programs.

(UR/QA) Utilization Review/Quality Assurance - a formal assessment of the medical necessity, efficiency, and/or appropriateness of health care services and treatment plans on a prospective, concurrent or retrospective basis.