



HOSPITAL FACILITY PROVIDER MANUAL

ADVANTAGE Health

Solutions, Inc.SM

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TABLE OF CONTENTS

INTRODUCTION	PAGE 3
IMPORTANT CONTACT INFORMATION	PAGE 3
ADVANTAGE PRODUCT SOLUTIONS	PAGE 4
IMPORTANT DEFINITIONS	PAGE 5
NETWORK PARTICIPATION	PAGE 8
CREDENTIALING	PAGE 9
RECOGNITION OF AUTHORIZED LOGOS	PAGE 10
UTILIZATION MANAGEMENT	PAGE 10
CASE MANAGEMENT	PAGE 11
PRIOR AUTHORIZATION REQUIREMENTS	PAGE 11
CLAIMS INFORMATION	PAGE 12
MODIFIERS	PAGE 13
FAILURE TO SUBMIT CLEAN CLAIMS	PAGE 18
COORDINATION OF BENEFITS	PAGE 18
BALANCE BILLING	PAGE 19
CLAIMS PAYMENT INQUIRIES	PAGE 19
PROVIDER APPEAL PROCESS	PAGE 19
APPENDIX A: ADVANTAGE AUTHORIZED LOGOS	PAGE 20
APPENDIX B: PROVIDER APPEAL POLICY AND PROCEDURE	PAGE 22
APPENDIX C: THIRD PARTIES	PAGE 24

INTRODUCTION

Thank you for your participation in the ADVANTAGE Health Solutions, Inc.SM (ADVANTAGE) provider network. ADVANTAGE contracts with providers throughout the State of Indiana to provide or arrange for health services covered under various ADVANTAGE products and benefit plans. This **ADVANTAGE 360^o** Facility Provider Manual is distributed to all healthcare facility providers that have entered into a contract directly with ADVANTAGE to participate in ADVANTAGE's proprietary provider network, **ADVANTAGE 360^o**. This Manual is referenced in the ADVANTAGE participating provider agreements, and it provides important information about ADVANTAGE's products, health plan rules, 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 ADVANTAGE, the state or federal law or your Agreement takes precedence.

ADVANTAGE 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 health care facility that is party to the Agreement with ADVANTAGE.

ADVANTAGE administers both fully-insured and 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 ADVANTAGE administers services and contracts with your facility to provide services.

IMPORTANT CONTACT INFORMATION

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

ADVANTAGE Health Solutions Inc.
9045 River Road, Suite 200
Indianapolis, IN 46240
www.advantageplan.com

General Questions, including eligibility, claims, benefits and medical management:

1-800-553-8933, Option #5

Provider Appeals or Contract matters, please contact:

317-573-6644

ADVANTAGE PRODUCT SOLUTIONS

ADVANTAGE is an Indiana-based statewide leader in health plan solutions. Our administrative services such as Provider and MEMBER Service and *Care-ADVANTAGE* medical management are performed in the Indianapolis office. We strive to meet or exceed accreditation standards for service, medical care management and outcomes, and ***we require very little administrative interface with the physicians' offices.***

ADVANTAGE HMO BENEFIT PLAN

ADVANTAGE markets several HMO benefit designs with optional out-of-network (Point of Service) benefits.

- Employees and their dependents can choose different Primary Care Physicians (PCPs)
- MEMBER pays a predictable co-payment or coinsurance for in-network services
- MEMBER may self-refer to any in-network specialist provider for consultation
- Disease Management and complex case management provided to all members along with outreach programs to encourage member engagement
- Brief list of procedures and services requiring prior authorization
- Total coordination of care and communication among medical and behavioral health providers

ADVANTAGE CHOICE BENEFIT PLAN

ADVANTAGE Choice Plans are a popular alternative to our HMO and POS plans and include the choice of selecting either the ADVANTAGE affiliated networks, or a preferred provider organization (PPO) network. Employers have the option of offering their employees more provider choice through a broader statewide network of providers.

EMPLOYER SPONSORED SELF-FUNDED PRODUCTS

ADVANTAGE offers a suite of self-funded product solutions:

- A combination of disease management and case management practices will be utilized including transitional care programs, in-home assessments, complex case management, and health coaches.

- For those individuals who want more provider choice and access, a wrap provider network is available
- While we can offer a PPO-like network access, we encourage employers to elect the Primary Medical Home model for complete coordination and integration of the overall patient health care. Participants can obtain “in-network” services from a broad representation of community and/or tertiary hospitals, home health care, specialty outpatient care, social services, rehabilitation, preventive care, health education and other forms of managed care without the requirement to obtain “permission.”

IMPORTANT DEFINITIONS

ADVANTAGE means ADVANTAGE Health Solutions, Inc.SM, an Indiana corporation that is licensed with the State of Indiana to administer a full service health maintenance organization and provide third party administrator and network services.

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

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

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 UB04 or HCFA 1500 (or successor form), 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 ADVANTAGE 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 ADVANTAGE, 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 ADVANTAGE’s contract with the employer group preventing recovery.

COPAYMENT, COINSURANCE or DEDUCTIBLE means those charges if permitted under the Participant 's Plan Document, which may be collected directly by the Participating Provider from a Participant as additional payments for services. Copayments may be collected at the time services are rendered. However, Deductible amounts and coinsurance may not be collected until after ADVANTAGE has processed the claim for Covered Services.

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 or an individual who has entered into an individual contract directly with ADVANTAGE 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

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 lay person, 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 ADVANTAGE, to arrange health care services for its employees and, in some cases, retiree, 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.

FULLY FUNDED OR FULLY INSURED PLAN means a health plan arrangement where the employer has contracted with ADVANTAGE for ADVANTAGE to assume financial risk for the Member's medical claims and for all incurred administrative costs after any Deductibles, Copayments, and/or coinsurance are satisfied.

HOSPITAL means an acute care Hospital licensed by the Indiana State Department of Health which, unless otherwise approved by ADVANTAGE, 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 ADVANTAGE to provide and/or arrange for Covered Services to Participants.

MEDICALLY NECESSARY describes 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 ADVANTAGE'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 for 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.

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

PARTICIPATING PROVIDERS means licensed physicians and other health care professional, 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 ADVANTAGE 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 ADVANTAGE 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 ADVANTAGE or ADVANTAGE Clients remain proprietary to ADVANTAGE or the ADVANTAGE Client. This includes, but is not limited to, your Agreement and its terms, conditions, and negotiations, Contract Rates or fee information, ADVANTAGE 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.

PREFERRED FACILITY RESPONSIBILITIES AND REQUIREMENTS

As a Participating Provider in the **ADVANTAGE 360^o** 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 ADVANTAGE and ADVANTAGE Client requests for copies of a Participant's medical and billing records for those purposes which ADVANTAGE 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 ADVANTAGE or ADVANTAGE's Client; and
- Meeting the ADVANTAGE credentialing criteria, as referred to later in this section

CREREDENTIALING

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

ADVANTAGE 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 (AAAFF)
- 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.

RECOGNITION OF AUTHORIZED LOGOS

You agree to recognize each name and/or logo as “ADVANTAGE Authorized Logos” used as a means to identify Participants by identification cards, Explanation of Payment (EOP) forms or other forms of identification and evidence of ADVANTAGE's or Clients right to access your Contract Rates and facility(ies) as an **ADVANTAGE 360^O** Participating Provider. The list of ADVANTAGE Authorized Logos is included in **Appendix A** of this Manual. ADVANTAGE will provide you with a complete list of ADVANTAGE Authorized Logos, and will provide you with updated lists within 30 days of any addition or deletion, or in accordance with notification or approval requirements described in your Agreement with ADVANTAGE, whichever is earlier. Also, ADVANTAGE will be posting a current list of ADVANTAGE Authorized Logos on its website at www.advantageplan.com

UTILIZATION MANAGEMENT

You are required to cooperate with ADVANTAGE in the conduct and oversight of its Utilization Management program. You will be asked to provide ADVANTAGE with information that is reasonably necessary for ADVANTAGE to perform these functions. ADVANTAGE's Utilization Management program includes, but is not necessarily limited to:

- Applying ADVANTAGE or ADVANTAGE -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 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 ADVANTAGE;
 - concurrent review of inpatient admissions;
- Retrospective review of non-authorized admissions and selected pre-certified admissions and/or outpatient services;
- Prospective and/or retrospective review of selected high- dollar admissions, diagnostic tests and outpatient procedures, based on criteria acceptable to ADVANTAGE ;

If prior authorization is not possible, ADVANTAGE requires you to make best efforts to notify us within one (1) business day of any inpatient admission, outpatient surgery or complex case. ADVANTAGE may request other information as needed to perform utilization management and case management.

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 health care 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

Before completing the Certification process, always contact the Pre-Certification phone number listed on the Participant's identification card.

PRIOR AUTHORIZATION REQUIREMENTS

The following Covered Services require Prior Authorization when the Participant's identification card includes one of the ADVANTAGE Authorized Logos shown in Appendix A. You will be notified promptly when there is a change to ADVANTAGE's standard prior authorization requirements, or when ADVANTAGE's Client requires a modified list of prior authorization requirements.

- Inpatient hospitalization
- All outpatient surgical procedures- including **all** invasive procedures (for example- colonoscopy, endoscopy, biopsies - this excludes surgeries in an office setting)
- Nuclear Medicine Scans such as PET/SPECT (except MRI & CT)
- Durable Medical Equipment > than \$500 billed charges
- Home Health Care
- Home IV Therapy
- Hospice Care
- Skilled Nursing Facility
- Dialysis
- Chemotherapy/Radiation
- Cardiac & Pulmonary Rehab
- Physical Therapy, Occupational Therapy, Speech Therapy
- Corrective Appliances/Prosthesis

- Biotech Drugs : Envision Prior Authorization Phone – 877-684-0021 (This process may vary by Client. Please see the Third Parties section at the end of this manual for variations to this authorization process).
- Wound Treatment
- Sleep Study
- Pain Management
- Tertiary/ Out of Network Referrals

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

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 UB92 claim format. The National Provider Identifier (NPI) is a **required** identifier on all electronic health care transactions. ADVANTAGE 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 ADVANTAGE (or Client) may refuse payment.

CLAIMS REIMBURSEMENT

In exchange for Covered Services provided to Participants, ADVANTAGE or the Client will pay your facility in accordance with the Contract Rates and provisions specified in 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.

ADVANTAGE 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 ADVANTAGE or its Client is not paying Clean Claims in a timely manner, please contact the ADVANTAGE Provider Relations Department to discuss. ADVANTAGE 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, ADVANTAGE 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.

MODIFIERS

Unless otherwise defined in your Agreement, following is the ADVANTAGE 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 ADVANTAGE. If CPT/HCPCS and modifier combination is not on the Fee Schedule then payment will be default rate as defined in your Agreement with ADVANTAGE.

<i>Modifier</i>	<i>Description</i>	<i>Modifier Reimbursement</i>	<i>How will it pay?</i>									
26	Professional Component	100%	When procedure is billed with modifier 26 ADVANTAGE will pay 100% of applicable Fee Schedule or if not on the Fee Schedule ADVANTAGE will pay 100% of applicable default rate as defined in the contract.									
50	Bilateral Procedures	150%	<p>When procedure is billed with modifier 50 ADVANTAGE will pay 50% of applicable Fee Schedule or if not on the Fee Schedule ADVANTAGE will pay 50% of applicable default rate as defined in the contract.</p> <p>NOTE: In order to get proper reimbursement for the bilateral procedure provider should bill two lines as shown below</p> <table border="1"> <thead> <tr> <th>CPT/HCPCS</th> <th>Modifier</th> <th>Days or Units</th> </tr> </thead> <tbody> <tr> <td>64721</td> <td></td> <td>1</td> </tr> <tr> <td>64721</td> <td>50</td> <td>1</td> </tr> </tbody> </table> <p>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.</p>	CPT/HCPCS	Modifier	Days or Units	64721		1	64721	50	1
CPT/HCPCS	Modifier	Days or Units										
64721		1										
64721	50	1										

Modifier	Description	Modifier Reimbursement	How will it pay?
			<p>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.</p> <p>Total reimbursement for the bilateral procedure is 150%.</p>
51	Multiple Procedures	100% for Primary Procedure, then 50% for all additional Procedures	<p>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.</p> <p>Primary Procedure - ADVANTAGE will pay 100% of applicable Fee Schedule or if not on the Fee Schedule ADVANTAGE will pay 100% of applicable default rate as defined in the contract.</p> <p>Secondary Procedure - ADVANTAGE will pay 50% of applicable Fee Schedule or if not on the Fee Schedule ADVANTAGE will pay 50% of applicable default rate as defined in the contract for each Secondary Procedure.</p>
62	Two Surgeons	125%	<p>When procedure is billed with modifier 62 ADVANTAGE will pay 125% of applicable Fee Schedule or if not on the Fee Schedule ADVANTAGE will pay 125% of applicable default rate as defined in the contract.</p>
80 81	Assistant Surgeon Minimum Assistant Surgeon Assistant Surgeon(when qualified resident surgeon is	20%	<p>When procedure is billed with modifier s 80, 81, AS ADVANTAGE will pay 20% of applicable Fee Schedule or if not on the Fee Schedule ADVANTAGE will pay 20% of applicable default rate as defined in</p>

<i>Modifier</i>	<i>Description</i>	<i>Modifier Reimbursement</i>	<i>How will it pay?</i>
82 AS	not available) Physician Assistant in surgery		the contract.
TC	Technical Component	100%	When procedure is billed with modifier TC ADVANTAGE will pay 100% of applicable Fee Schedule
21	Prolonged E&M Services	100%	When procedure is billed with modifier 21 ADVANTAGE will pay 100% of applicable Fee Schedule
22	Unusual Procedural Services	100%	When procedure is billed with modifier 22 ADVANTAGE will pay 100% of applicable Fee Schedule or if not on the Fee Schedule ADVANTAGE will pay 100% of applicable default rate as defined in the contract.
23	Unusual Anesthesia	100%	When procedure is billed with modifier 23 ADVANTAGE will pay 100% of applicable Fee Schedule or if not on the Fee Schedule ADVANTAGE 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 ADVANTAGE will pay 100% of applicable Fee Schedule or if not on the Fee Schedule ADVANTAGE 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	100%	When procedure is billed with modifier 25 ADVANTAGE will pay 100% of applicable Fee Schedule or if not on the Fee Schedule ADVANTAGE will pay 100%

<i>Modifier</i>	<i>Description</i>	<i>Modifier Reimbursement</i>	<i>How will it pay?</i>
	or Other Service		of applicable default rate as defined in the contract.
47	Anesthesia by Surgeon	100%	When procedure is billed with modifier 47 ADVANTAGE will pay 100% of applicable Fee Schedule or if not on the Fee Schedule ADVANTAGE will pay 100% of applicable default rate as defined in the contract.
52	Reduced Service	80%	When procedure is billed with modifier 52 ADVANTAGE will pay 80% of applicable Fee Schedule or if not on the Fee Schedule ADVANTAGE will pay 80% of applicable default rate as defined in the contract.
54	Surgical Care Only	70%	When procedure is billed with modifier 54 ADVANTAGE will pay 70% of applicable Fee Schedule or if not on the Fee Schedule ADVANTAGE will pay 70% of applicable default rate as defined in the contract.
55	Postoperative Care Only	30%	When procedure is billed with modifier 55 ADVANTAGE will pay 30% of applicable Fee Schedule or if not on the Fee Schedule ADVANTAGE will pay 30% of applicable default rate as defined in the contract.
56	Postoperative Management Only	20%	When procedure is billed with modifier 56 ADVANTAGE will pay 20% of applicable Fee Schedule or if not on the Fee Schedule ADVANTAGE will pay 20% of applicable default rate as defined in

<i>Modifier</i>	<i>Description</i>	<i>Modifier Reimbursement</i>	<i>How will it pay?</i>
			the contract.
59	Distinct Procedural Service	100%	When procedure is billed with modifier 59 ADVANTAGE will pay 100% of applicable Fee Schedule or if not on the Fee Schedule ADVANTAGE will pay 100% of applicable default rate as defined in the contract.
66	Surgical Team	100%	When procedure is billed with modifier 66 ADVANTAGE will pay 100% of applicable Fee Schedule or if not on the Fee Schedule ADVANTAGE 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 ADVANTAGE will pay 100% of applicable Fee Schedule or if not on the Fee Schedule ADVANTAGE 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 ADVANTAGE will pay 100% of applicable Fee Schedule or if not on the Fee Schedule ADVANTAGE 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 ADVANTAGE will pay 100% of applicable Fee Schedule or if not on the Fee Schedule ADVANTAGE will pay 100% of applicable default rate as defined in the contract.
90	Reference (Outside)	100%	When procedure is billed with modifier 90 ADVANTAGE will pay 100% of

<i>Modifier</i>	<i>Description</i>	<i>Modifier Reimbursement</i>	<i>How will it pay?</i>
	Laboratory		applicable Fee Schedule or if not on the Fee Schedule ADVANTAGE will pay 100% of applicable default rate as defined in the contract.
99	Multiple modifiers	Reimbursement as Indicated for the Modifier Submitted	Reimbursement as Indicated for the Modifier Submitted

FAILURE TO SUBMIT A CLEAN CLAIM

If ADVANTAGE receives a claim that is not a Clean Claim containing all complete and accurate information required for adjudication, or if ADVANTAGE has some other stated dispute with the claim, ADVANTAGE will “soft-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

ADVANTAGE or Client is Primary

When ADVANTAGE or the Client is primary under the COB rules, ADVANTAGE or the Client pays for Covered Services according to the Participant’s Plan Document and pursuant to the Contract Rate.

ADVANTAGE or Client is Secondary

If ADVANTAGE or the Client is other than primary under the COB rules, ADVANTAGE or the Client will pay a reduced amount only after your facility has received payment from the primary plan. ADVANTAGE processes claims consistent with the National Association of Insurance Commissioners (NAIC) Model Regulation for Coordination of Benefits, or the coordination of benefits procedures adopted by the Client.

BALANCE BILLING

Please be sure to review the Explanation of Payment (EOP) form sent to you by ADVANTAGE or the Client. The EOP may be customized by Client, in which case, ADVANTAGE 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 IVR service at **1-800-553-8933** and select **Option #5**.

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. ADVANTAGE 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:

ADVANTAGE Health Solutions, Inc.
Provider Relations Department
9045 River Road, Suite 200
Indianapolis, IN 46240
(317) 573-2700, ext. 5

A copy of ADVANTAGE's provider appeal policy is included in this Manual in **Appendix B**.

APPENDIX A

ADVANTAGE AUTHORIZED LOGOS



The color or black-and-white ADVANTAGE corporate logo appears on all participant identification cards. The Participant could be enrolled in any one of ADVANTAGE's health products, either fully-insured or self-funded. If a Participant card has the ADVANTAGE corporate logo without any other ADVANTAGE logo listed below, the Participant is enrolled in an ADVANTAGE fully insured HMO product and eligible to receive services from ADVANTAGE's participating HMO network providers. Your facility may or may not be contracted to provide services to fully insured HMO participants. Please contact Provider Services at **1-800-553-8933 (Option #5)** if you are unsure of your participation status.



When you see this logo in the upper right-hand portion of the Participant's identification card, he/she may access services from any provider contracted in the **ADVANTAGE 360^o** network of providers, and you will be reimbursed pursuant to the Contract Rates described in your Agreement with ADVANTAGE.

SSFHS ADVANTAGE

When you see this logo in the upper right-hand portion of the Participant's identification card, he/she is covered through the **Sisters of St. Francis Health Services, Inc. Health Benefits**

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



When you see this logo and the **ADVANTAGE 360^o** on the participant's identification card, the participant is a participant of the Indiana Teamsters Health Benefit Fund. This is a self-funded benefit plan contracted to access your facility health care services and Contracted Rates with ADVANTAGE.

OTHER AUTHORIZED LOGOS

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



APPENDIX B**PROVIDER APPEAL POLICY AND PROCEDURE****POLICY:**

ADVANTAGE HEALTH SOLUTIONS, INC.SM (ADVANTAGE) ESTABLISHES A DUE PROCESS FOR CONTRACTED PROVIDERS TO APPEAL ANY CLAIM, DISPUTE, OR CONTROVERSY BETWEEN ADVANTAGE AND CONTRACTED PROVIDER ARISING OUT OF, OR RELATING TO, THE INTERPRETATION, PERFORMANCE OR BREACH OF CONTRACT. ADVANTAGE WILL ENSURE THAT ALL SUCH REQUESTS FOR APPEAL ARE RESPONDED TO IN A TIMELY AND FAIR MANNER.

PROCEDURE:**I. Request for Appeal**

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

**ADVANTAGE Health Solutions, Inc.
Provider Relations Department
9045 River Road, Suite 200
Indianapolis, IN 46240
(317) 573-6644**

II. Review of Provider Appeal

- A. Appeal resolutions are determined by:**
1. Appeals which are non-clinical in nature – Director of Provider Relations and Provider Relations Coordinator. Chief Operating Officer or Chief Executive Officer will participate in appeals related to breach of contract disputes.
 2. Appeals which are clinical in nature – Director of Provider Relations, Provider Relations Coordinator and an unbiased physician reviewer.
- B. Within five (5) business days of receipt of the provider's request to appeal, the Provider Relations Coordinator will:**
1. Acknowledge the provider's request in writing;
 2. Investigate the nature of dispute and determine if a favorable resolution can be reached without a formal hearing process.

3. If a formal hearing process is necessary, then schedule a date to convene the appropriate participants (Panel) described above.
 4. Review additional information (if any) provided by the provider and include with review material to be used by the Panel during the hearing. Include all information that was used in the initial adverse decision.
 5. Schedule a representative of the appealing provider to participate in the hearing (either in person or via conference call).
- C. Panel convenes as soon as possible but no later than 14 calendar days from the date of receipt of the network appeal. The Panel's decision will be communicated to the provider within one business day of the decision.
- D. If the decision of the Appeal Panel is not favorable to the provider, the provider may elect to submit the dispute to binding arbitration in accordance with the contract between ADVANTAGE and the provider.

APPENDIX C THIRD PARTIES

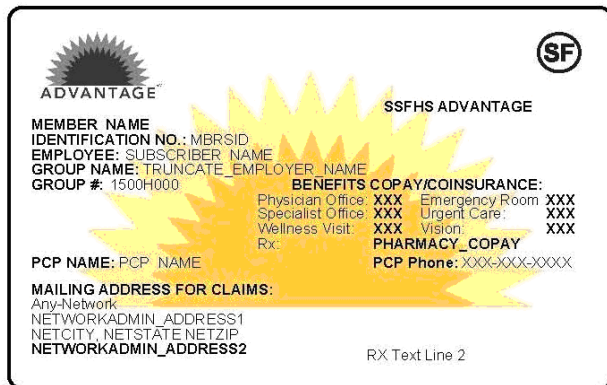
THIRD PARTY ACCESS – APPROVED BY YOUR FACILITY

1. SISTERS OF ST. FRANCIS HEALTH SERVICES, INC.

SSFHS ADVANTAGE

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

SAMPLE ID CARD



AUTHORIZATION REQUIREMENTS: The Sisters of St. Francis Health Services, Inc. follow the authorization requirements found on page 11 of this manual.

CLAIMS ADDRESS: P.O. Box 503486, Indianapolis, IN 46250

EDI Payer ID: 35199

Precertification: (888)-824-0391

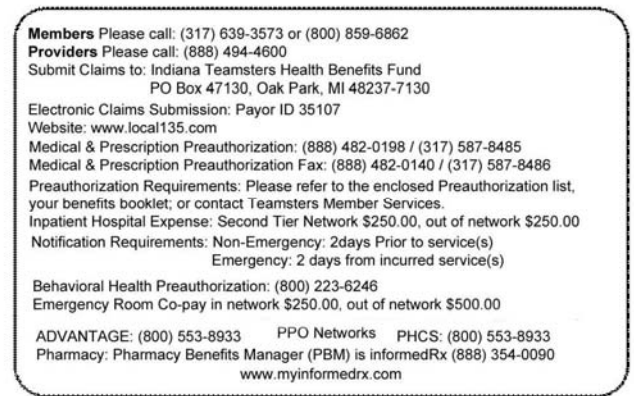
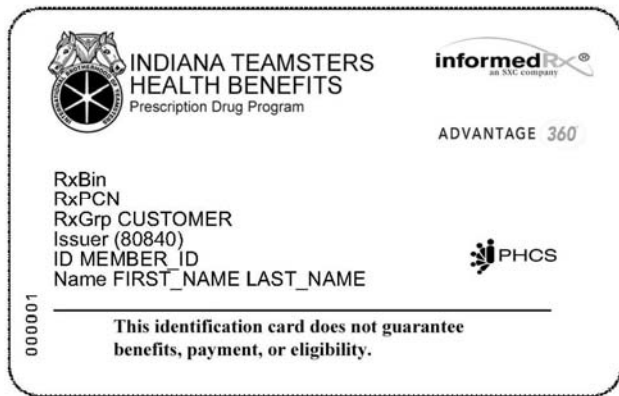
Claims Inquiries: (317) 573-2726

2. INDIANA TEAMSTERS HEALTH BENEFIT FUND.



This is a self-funded benefit plan contracted to access your facility health care services and Contracted Rates with ADVANTAGE.

ID Card Sample:



AUTHORIZATION REQUIREMENTS: The Indiana Teamsters Health Benefit Fund follows the authorization requirements found on page 11 of this manual.

CLAIMS ADDRESS: P.O. Box 47130, Oak Park, MI 48237

EDI Payor ID: 35107

Precertification: (888) 482-0198

Claims Inquiries: (800) 553-8933