ATTACHMENT A

STATE NETWORK HOSPITAL Policies and Procedures Manual

Inpatient / Outpatient Percent of Charge

Effective January 1, 2018

ATTACHMENT A

POLICIES & PROCEDURES

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Section 1 INTRODUCTION

STATE NETWORK HOSPITAL

State Network Hospitals are those hospitals which have entered into a State Network Hospital Agreement with Advanced Health Systems, Inc (AHS).

- The State Network Hospital is recognized in the State and School Employees' Health Insurance Plan as being a State Network Hospital. Plan Participants have benefit incentives in their Benefit Plan to utilize State Network Hospitals over non-State Network Hospitals.

- State Network Hospitals accept the payment as full compensation with the exception of deductible, co-insurance/co-payments, and non-covered services which are the Plan Participant's responsibility.

- The State Network Hospital accepts, as the Allowable Charge, the lesser of Covered Charges or the amount established by COMPANY.

- The State Network Hospital agrees to file claims within twelve (12) months of the date on which the services were performed. Should the State Network Hospital fail to submit a claim within this time period, the State Network Hospital will hold the Plan Participant and AHS harmless for any charges resulting from these services.

- The State Network Hospital is required to report anticipated charge increase(s) to AHS by September 1 of each year. If the State Network Hospital does implement a charge increase(s) during the term of the current Attachment B payment program, the State Network Hospital will provide sixty (60) days notice in advance to AHS.

- The State Network Hospital agrees to file claims with other carrier when the Mississippi State and School Employees' Health Insurance Plan is secondary in coordination of benefits. Under such circumstances, the Health Plan will provide benefits for the patient's liability amount, as defined by the primary payor, not to exceed AHS's Allowable Charge.

This State Network Hospital Policy and Procedure Manual, which is Attachment A to your State Network Hospital Agreement, contains the policies and procedures necessary for the effective operation of the reimbursement program, and provides specific explanations of the provisions of the State Network Hospital Agreement with Advanced Health Systems, Inc.

Section 2 DEFINITIONS

ActiveHealth
The medical management and utilization review vendor selected by the Health Insurance Management Board to perform medical management and utilization review services for the Health Benefit Plan.

Allowable Charge
Allowable Charge means the lesser of the submitted charge or the amount established by COMPANY, as provided in Attachments A and B of this Agreement.

Benefits
The amount that would be obligated to the Plan Participant to pay under the terms of the Health Benefit Plan for Covered Services in the absence of the State Network Hospital Agreement, and exclusive of applicable Deductible and Co-insurance/Co-payment amounts.

Billed Charges
Total charges made by the hospital for all services and supplies provided to the Plan Participant.

Claims Administrator
The vendor selected by the Health Insurance Management Board to process claims in accordance with the Health Benefit Plan.

Center of Excellence
A State Network Hospital that has met the minimum facility standards for bariatric surgery as certified by American College of Surgeons and the American Society for Metabolic and Bariatric Surgery.

Co-insurance, Co-payment
The portion of Covered Services, expressed as a percentage or dollar amount, for which the Plan Participant is financially responsible under the Health Benefit Plan.

Company
Advanced Health Systems, Inc. (AHS)

Coordination of Benefits
The act of determining primary/secondary/tertiary liability between and among various healthcare benefit programs and paying benefits in accordance with established guidelines when Plan Participants are eligible for benefits under more than one healthcare benefits program.

Covered Charges
Billed charges minus Non-Covered Charges.

Covered Services
Those Medically Necessary healthcare services and supplies for which Benefits are specified under Health Benefit Plan in its Master Plan Document.

Current Procedural Terminology (CPT)
CPT is a systematic listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians and other healthcare providers. It is a five digit coding system with three classifications: Category I codes (numeric), Category II codes (alphanumeric), and Category III codes (alphanumeric).

Deductible(s)
A specific amount of Covered Services, usually expressed in dollars, that must be incurred by a Plan Participant before the Health Benefit Plan is obligated to Plan Participant to assume financial responsibility for all or part of the remaining Covered Services under the Health Benefit Plan.

Diagnosis Related Groups (DRG)
DRGs are a grouping of diseases and disorders into medically meaningful sets as developed by CMS. Each inpatient claim is classified into one of the possible DRGs by a computer program known as the "DRG grouper." The DRG grouper assigns a DRG using:

1. Patient's principal diagnosis.
2. Patient's secondary diagnosis.
3. Surgical procedure(s) if applicable.
4. Patient's age.
5. Patient's sex.
6. Patient's discharge status.
7. Multiple diagnoses, complications or comorbidity.

These elements are recorded on the billing submitted by the hospital. Each grouping is assigned a DRG code.

NOTE: Advanced Health Systems, Inc., has adopted the CMS definitions and procedures for assigning DRGs for simplicity and systems compatibility. However, Advanced Health Systems, Inc. has developed outlier provisions that are specific to this reimbursement program.

Emergency
A sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably result in permanently placing a Plan Participant's health in jeopardy; causing serious impairment to body functions; causing serious and permanent dysfunction of any body organ or part; or causing other serious medical consequences.

HCPCS
A Level II alphanumeric procedure code developed and maintained by CMS Alpha-Numeric Editorial Panel. This code set primarily represents drugs, equipment, items and supplies not included in the CPT code set.

Health Benefit Plan
The State and School Employees' Life and Health Insurance Plan as authorized by Section 25-15-3 et seq. of the Mississippi Code.

Health Insurance Management Board
The State and School Employees' Health Insurance Management Board as defined in Section 25-15-303 of the Mississippi Code, acting administratively through the Department of Finance and Administration.

Hospital Acquired Conditions (HACs)
Those conditions that are acquired during hospitalization (i.e. not present on admission) and are reasonably preventable by following evidence-based guidelines. A listing of HACs is as follows:

1. Object Left in During Surgery
2. Air Embolism
3. Blood Incompatibility
4. Pressure Ulcers
5. Catheter-Associated Urinary Tract Infections

6. Vascular Catheter-Associated Infections
7. Manifestations of Poor Glycemic Control
8. Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft
9. Surgical Site Infection Following Certain Orthopedic Procedures
10. Surgical Site Infection Following Bariatric Surgery for Obesity
11. Deep Vein Thrombosis and Pulmonary Embolism Following Certain Orthopedic Procedures
12. Hospital Acquired Injuries – Fractures, Dislocations, Intracranial Injury, Crushing Injury, Burns and Other Unspecified Effects of External Causes

In addition to the specific HACs listed above, AHS may review all claims and associated medical records to assess the quality of care rendered to Plan Participants. Certain conditions that occur in a hospital setting are deemed by AHS to be HACs or Hospital Quality-of-Care Conditions and the State Network Hospital shall not be reimbursed by AHS for any charges relating to or resulting from HACs or Hospital Quality-of-Care Conditions. AHS shall take into account the HAC or Hospital Quality-of-Care Condition when pricing the claim. In the event it is determined that circumstances or conditions acquired during hospitalization resulted in substantive clinical changes to the detriment of the Plan participant's health status, AHS will consider the claim to be a HAC related claim and will reimburse the State Network Hospital based on Rule 2: Inlier Involving HACs or Hospital Quality-of-Care Conditions located within Attachment A.

Hospital Service(s)
Those services and supplies provided by Hospital to Plan Participants and other patients. Hospital Services do not include services performed by an organization or facility not itself a general acute, psychiatric, or rehabilitation hospital.

ICD
Procedure Codes International Classification of Diseases, Ninth Revision, Clinical Modification, a classification system for diseases, procedures, conditions, and causes, etc.

Identification Card
The card issued to the Plan Participant identifying the Plan Participant as entitled to receive Benefits under a Health Benefit Plan for services rendered by healthcare providers and for such providers to use in reporting to State and Public School Health Benefit Plan Claims Administrator those services rendered to the Plan Participant by the provider. The Identification Card can be hard copy or Virtual and available through myBlue Provider.

Inlier
An Inlier is an inpatient hospital stay where:
1. A valid DRG code is assigned, and
2. The case does not exceed the charge outlier threshold.

Medical Management and Utilization Review
The program administered by the Health Benefit Plan medical management and utilization review vendor to perform utilization review and case management services for the Health Benefit Plan.

Medical Management and Utilization Review Vendor
The vendor selected by the Health Insurance Management Board to perform utilization review and case management services for the Health Benefit Plan.

Medically Necessary
Services, treatments, procedures, equipment, drugs, devices, items or supplies provided by a hospital, physician, or other provider that are required to identify or treat a Plan Participant's illness, injury or Nervous/Mental Conditions and which Claims Administrator determines are covered under the Health Benefit Plan. Such services or supplies must be:

a. consistent with the symptoms or diagnosis and treatment of the Plan Participant's condition, illness or injury; and
b. appropriate with regard to standards of good medical practice; and
c. not solely for the convenience of the Plan Participant, his or her physician, Hospital, or other provider; and
d. the most appropriate supply or level of care which can safely be provided to Plan Participant. When applied to the care of an inpatient, it further means that services for the Plan Participant's medical symptoms or condition require that the services cannot be safely provided to the Plan Participant as an outpatient.

NOTE: The Health Benefit Plan's Claims Administrator makes no payment for services, treatments, procedures, equipment, drugs, devices, items or supplies that are not documented to be Medically Necessary. The fact that the State Network Hospital, physician or other provider has prescribed, ordered, recommended or approved a service or supply does not, in itself, make it Medically Necessary. The State Network Hospital cannot bill Plan Participants or AHS for services that the Medical Management and Utilization Review vendor or the Claims Administrator has determined to be not Medically Necessary.

myBlueProvider
The secure AHS-designated website available solely for the usage by State Network Hospitals to provide information regarding AHS policies and procedures, patient information, reference tools and guides and various tools to promote the electronic exchange of information, such as electronic medical records, appeals, etc.

Non-Covered Charges
Hospital charges for Non-Covered Services.

Non-Covered Services
All healthcare or other services and supplies provided to Plan Participants other than Covered Services. Non-covered Services include, but are not limited to, the following:

Television, guest cots and guest meals, personal grooming items, and the like, and for other services and supplies specifically excluded by the Health Benefit Plan for preexisting conditions, cosmetic procedures, custodial care, and the like.

Outlier
An Outlier is an inpatient hospital stay that does not meet the definition of an Inlier where the covered charges exceed the charge threshold.

Outpatient
A patient who receives medical services or supplies in the Hospital setting, but is not admitted to the Hospital as an inpatient.

Outpatient Allowance
An amount payable to the Hospital for services provided to a Plan Participant, which is determined by the Outpatient Payment Rules.

Outpatient Differential
An agreed upon difference from Covered Charges

Outpatient Service
Any medically necessary service or supply required in the Outpatient treatment or diagnosis of a patient.

Payment Amount
The amount payable to the hospital for services to Plan Participants minus any deductible and co-insurance/co-payment. **NOTE:** The payment is determined by the payment processing rules.

Percent of Charge
Percent amount applied to inpatient claims. This amount is multiplied by the total Covered Charges to determine the allowed amount for an inpatient claim.

Plan Participant
Employees or individuals and their enrolled eligible dependents covered under the Health Benefit Plan who are entitled to receive healthcare benefits as defined in and pursuant to the Health Benefit Plan in its Master Plan Document.

Present On Admission (POA)
Diagnosis is present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including emergency department, observation or outpatient surgery, are considered present on admission.

Quality Management
The program designed by AHS to ensure the provision of high quality healthcare services for Plan Participants in an efficient, cost-effective manner which is consistent with nationally recognized standards of medical practice.

Quality-of-Care Condition
Those conditions, outside of defined HACs, that occur during hospitalization (i.e. not present on admission) and are reasonably preventable by following nationally recognized standards of medical practice, including circumstances or conditions acquired during hospitalization that resulted in substantive clinical changes to the detriment of the Plan Participant's health status.

Revenue Code
Three digit numeric code which identifies a specific accommodation and/or ancillary service billing calculation found on UB-04, Form Locator 42.

Serious Reportable Events (SREs)
Medical errors that should never happen in the hospital and can cause serious injury or death to the patient. Examples of these SREs are as follows:

1. Surgery Performed on the Wrong Body Part
2. Surgery Performed on the Wrong Patient
3. Wrong Surgical Procedure Performed on a Patient
4. Leaving a Foreign Object in a Patient
5. Injury Occurring Due to Lapse or Error in a State Network Hospital

State Network Hospital
A hospital which is licensed to provide general acute inpatient and outpatient hospital services and which is party to a State Network Hospital Agreement with Advanced Health Systems, Inc.

Utilization Management Program
The program administered by the Health Benefit Plan's Medical Management and Utilization Review vendor and the Claims Administrator to review and determine whether certain medical services provided, or to be provided, are Medically Necessary.

Visit
Outpatient Services provided to a Plan Participant for related diagnosis as to include pre-testing and post follow up care as defined in the Window of Service.

Window of Service
The period including the three days prior and three days subsequent to the day the Primary Outpatient Procedure (s) was performed.

Section 3 GENERAL REQUIREMENTS

As a State Network Hospital, you agree:

- to not discriminate in the treatment of Plan Participants on the basis of race, color, creed, sex, age, national origin, physical handicap, disability, religion, place of residence, source of payment or any other consideration made unlawful by federal and state laws.

- to comply with all state and federal laws and regulations relating to the confidentiality of protected health information of Plan Participants.

Section 4 PERCENT OF CHARGE PROGRAM

4.1 INPATIENT PAYMENT PROCESSING RULES

As indicated in the State Network Participating Hospital Agreement, the Participating Hospital shall accept the Plan's Payment Amount as payment in full, except for any non-covered charges, deductible, and co-insurance/co-payment amounts.

Only amounts related to deductible and co-insurance/co-payment must be deducted from the Percent of Covered Charge Amount to determine the amount of the Plan's payment. The amount and basis for calculation of the deductible, co-insurance and co-payment vary by Plan participant Contract/Certificate. The deductible, co-insurance or co-payment may be calculated based on covered charges, or the negotiated amount, which is based on a percent of covered charges.

The Plan pays the hospital generally as follows:

Covered Charge	+
Discount Percentage	x
Negotiated Amount	=
Deductible	-
Co-insurance/Co-payment	-
Payment Amount	=

In the event of HACs not being POA but listed as a secondary diagnosis at discharge, the Plan will pay a reduced payment on those claims involving HACs or Hospital Quality-of-Care Conditions, and the Plan participant will be held harmless for any amounts in excess of the allowed amount.

The Hospital collects non-covered charges, deductible and co-insurance/co-payment from the patient. The Hospital does not collect any amount in excess of the Negotiated Amount. The following pages detail the formulas for calculating the Percent of Covered Charge Payment Amount and the reduced payment for claims involving HACs or Hospital Quality-of-Care Conditions. Following is a summary of the Percent of Charge payment processing rules:

RULE	INPATIENT STAY	PERCENT of Charge AMOUNT
1	Inlier	Covered Charges X Discount Percentage
2	Inlier Involving HACs or Hospital Quality-of-Care Conditions	Covered Charges, less HAC or Hospital Quality-of-Care Condition related Charges, multiplied by Discount Percentage

The following pages detail the rules and formulas for calculating Percent of Charge payments for Inliers. An example of the Inlier calculation follows the rule and its corresponding formula. The field labels in each example represent the minimum record content needed to determine the payment amount.

4.2 INPATIENT PAYMENT COMPUTATION EXAMPLE

RULE 1: INLIER

The payment amount (I) is based upon the Negotiated Amount (F) minus amounts for Co-insurance/Copay/Deductible (G).

FORMULA: PAYMENT = [NEGOTIATED AMOUNT - (CO/DED)]
OR
I = [F – G]

		EXAMPLE #1	EXAMPLE #2
A	COV DAYS	1	4
B	TOTAL CHARGES	$1,000.00	$5,000.00
C	NON-COV CHARGES	$ 100.00	$ 200.00
D	COVERED CHARGES	$ 900.00	$4,800.00
E	DISCOUNT PERCENTAGE	.20	.20
F	NEGOTIATED AMOUNT	$ 720.00	$3,840.00
G	CO/DED	$ 72.00	$ 150.00
H	BENEFIT AMOUNT	$ 648.00	$3,690.00
I	PAYMENT AMOUNT	$ 648.00	$3,690.00

RULE 2: INLIER INVOLVING HACs OR HOSPITAL QUALITY-OF-CARE CONDITIONS

If any of the HACs or Hospital Quality-of-Care Conditions listed in this manual was not present on admission but was listed as a secondary diagnosis at discharge, then the payment will be based upon the total charges incurred by the plan participant up to the day prior to documentation of the HAC or Hospital Quality-of-Care Condition. The Claims Administrator or its designee will contact the hospital to request medical records and a detailed bill required for any audit used in the determination of the HAC or Hospital Quality-of-Care Condition. Any HAC or Hospital Quality-of-Care Condition related charges will be removed from the total charges. Final covered charges will be multiplied by the Discount Percentage and will be the Negotiated Amount, and the plan participant will be held harmless for any amounts in excess of the Negotiated Amount.

4.3 SPECIAL PAYMENT PROVISIONS

Billing for Pre-Admission Testing - All outpatient pre-admission testing/services provided within 72 hours or three business days prior to admission as an inpatient are included in the DRG Amount for the inpatient stay and must be billed as part of the inpatient claim. This provision applies only to outpatient services related to the inpatient stay and performed at the same (or related) facility where the patient is subsequently admitted.

Billing for Re-admission with Same or Similar Diagnosis – All re-admissions within 48 hours of a previous discharge with the same or similar diagnosis must be billed on the same claim as the prior admission, with the exception of inpatient rehab. Inpatient rehab may be billed under a separate provider number assigned by AHS, provided the State Network Hospital is accredited under CARF's Medical Rehabilitation Program.

AHS will review re-admissions and, as deemed necessary by AHS, conduct quality-of-care reviews on behalf of the Plan Participant as referenced within Section 6.5 – Quality Management. AHS will also review re-admissions for the same diagnosis or condition for medical necessity. State Network Hospitals will be required to share clinical information regarding re-admissions, including treatment plans, discharge plans, risk of re-admission assessments and a clinical explanation as to why re-admissions occur. State Network Hospitals may be subject to a reduction in payment, dependent upon if the re-admission diagnosis or condition is directly related to the initial admission.

ICD-10 – Claims filed using ICD-10 procedure codes will be monitored for abnormal variances in reimbursement and adjustments may be made to ensure appropriate reimbursement for services.

Outpatient Services – State Network pays for outpatient services based on the provisions of the Network Hospital's Payment Program – Attachment B.

The Network Hospital's outpatient department must clearly state that it is an outpatient department of the Network Hospital, and there can be no references to a clinic within the outpatient department, including, but not limited to, signage, forms, advertising and/or reading material.

Any reference to a clinic within the Network Hospital would require that location to be considered a clinic, and claims shall be filed using a CMS-1500 claim form with appropriate Place of Service.

Provider Based Physicians – Percent of Charge reimbursement includes all Network Hospital medical directorships and all activities associated with them including, but not limited to, the selection of instruments, quality of results of tests and quality control activities, responsibility for the results of the section(s), surveys and accreditation activities, and other quality control processess. Network Hospital will assure that Provider-Based Physicians will follow all Blue Cross medical and coding policies.

All provider-based physicians utilized by the State Network Hospital must be AHS network providers. State Network Hospitals are responsible for all provider-based physician services rendered and will ensure that all services performed are performed by AHS network providers. If a service is provided by a non-network physician/provider within a State Network Hospital, the State Network Hospital will ensure that the Plan Participant's claim is treated as a network claim by any non-network providers, and the Plan participant will not be billed by any non-network providers.

Transfers Out - Transfers Out are subject to Medical Necessity Review.

Transfers In - Transfers In are treated as regular admissions, but are subject to Medical Necessity Review.

SRE – Do not submit claims to BCBSMS for services related SREs. Under no circumstances will there be reimbursement for SREs or any related, subsequent procedures, and the Plan Participant will be held harmless for any charges relating to these SREs.

4.4 MONITORING

Diagnosis and Procedure code editing: The Claims Administrator will edit the hospital's coding upon claims submission for accuracy and internal consistency. Such editing may require the Claims Administrator to return the claim to the hospital for correction of the coding.

Auditing procedures: The Claims Administrator or the Claims Administrator's designated representative may conduct on-site or off-site audits at the sole discretion of the Claims Administrator during the State Network Hospital's regular business hours. These audits may consist of verification of medical necessity of services, coding accuracy, abstract verification, financial or claims verification, and charge audits. State Network Hospitals shall provide all necessary information for the completion of such audits without charge.

Section 5 OUTPATIENT PAYMENT PROGRAM

5.1 OUTPATIENT PAYMENT METHODOLOGY

As indicated in the Participating Hospital Agreement, the Participating Hospital shall accept the Plan's Payment Amount as payment in full, except for any non-covered charges, deductible, and co-insurance/co-payment amounts.

Only amounts related to deductible and co-insurance/co-payment must be deducted from the Percent of Covered Charge Amount to determine the amount of the Plan's payment. The amount and basis for calculation of the deductible, co-insurance and co-payment vary by Plan participant Contract/Certificate. The deductible, co-insurance or co-payment may be calculated based on covered charges, or the negotiated amount, which is based on a percent of covered charges. The Plan pays the hospital generally as follows:

Covered Charge	+
Discount Percentage	x
Negotiated Amount	=
Deductible	-
Co-insurance/Co-payment	-
Payment Amount	=

The Hospital collects non-covered charges, deductible and co-insurance/co-payment from the patient. The Hospital does not collect any amount in excess of the Negotiated Amount. The following page details the formula for calculating the Percent of Covered Charge Payment Amount.

State Network Hospitals cannot bill Plan Participants or AHS for services that the Medical Management and Utilization Review vendor or the Claims Administrator has determined to be not Medically Necessary.

5.2 OUTPATIENT PAYMENT COMPUTATION EXAMPLE

PERCENT OF COVERED CHARGE PAYMENT FORMULA
The payment amount is based upon the Negotiated Amount (E) minus amounts for Co-insurance/ Copay/Deductible (F).

FORMULA: PAYMENT = [NEGOTIATED AMOUNT - (CO/DED)]
OR
H = E – F

		EXAMPLE
A	TOTAL CHARGES	$1,000.00
B	NON-COV CHARGES	$ 100.00
C	COVERED CHARGES	$ 900.00
D	DISCOUNT PERCENTAGE	.20
E	NEGOTIATED AMOUNT	$ 720.00
F	CO/DED	$ 72.00
G	BENEFIT AMOUNT	$ 648.00
H	PAYMENT AMOUNT	$ 648.00

5.3 COVERED SERVICES FURNISHED UNDER ARRANGEMENT

The Hospital may furnish or may be deemed to have furnished Outpatient Services under arrangement with outside suppliers, including other hospitals or facilities and professional services rendered by physicians and other professional providers under arrangement.

The amount charged by the outside supplier must be paid directly by the Hospital. Each Outpatient Service provided by the outside supplier must appear as line items on the claim submitted to AHS. AHS's payment to the Hospital for that Outpatient Service is based on the Hospital's Outpatient Allowance as specified on Attachment B for that Outpatient Service, and Outpatient Services furnished under arrangement are treated as if furnished directly by the Hospital. If a related Covered Service (e.g., a radiological or laboratory service provided and billed by a non-Hospital provider), is rendered in connection with (Covered) Outpatient Services and are billed by a provider that is not the Hospital, the Outpatient Services and non-Hospital Covered Services may be consolidated and reimbursed, solely to the Hospital at the Outpatient Allowance. AHS will not reimburse the Hospital or the outside supplier for any Outpatient Services for which the Hospital is not in compliance with the provisions of this Paragraph.

Services rendered by Hospital Based physicians and/or contracting providers will be reimbursed based upon AHS' professional fee allowance schedule and medical necessity requirements. HOSPITAL agrees to ensure that the Plan participant receives hold harmless for any services that are determined to be not medical necessary and that these providers do not balance bill the Plan Participant for the difference between the total charges and AHS' allowed amounts.

Section 6 ADMINISTRATIVE POLICIES AND PROCEDURES

6.1 SUBMISSION OF CLAIMS

State Network Hospitals must submit claims for services provided to Plan Participants using the Electronic Submission of Claims (ESC) system. Reference should be made to the UB-04 Manual for specific instructions on claims preparation. The State Network Hospital is responsible for providing all information necessary to adjudicate the claim including CPT/HCPCS codes for outpatient claims. Following are some key rules for billing:

1. Include on inpatient billings any charges for hospital services obtained from another organization (related or unrelated) while an inpatient at your hospital. A patient cannot be considered an inpatient and an outpatient at the same time. Professional components of these services may be billed separately for covered services under a professional provider number. For any durable medical equipment devices used within a hospital setting and then discharged home with the Plan Participant, these charges are to be included on the hospital claim.

2. All claims must indicate if work-related injuries or illnesses are involved, if the services are related to an accident, and if the Plan Participant has other coverage and, if so, the identity of the other carrier or plan.

3. In computing the number of inpatient days of care provided to a Plan Participant, count the day of admission, but not the day of discharge. No charge will be allowed for a fractional part of a day, except that a charge may be made directly to a Plan Participant who elects to remain beyond the hour of discharge designated by the attending physician or hospital. This is a non-covered charge under the Plan Participant's Health Benefit Plan.

4. The hospital cannot require any Plan Participant (before or after the rendering of a service) to pay any amount in excess of any deductible, co-insurance/co-payment and charges for non-covered services. The hospital shall look only to the Claims Administrator for payment of covered charges except for the deductible, co-insurance/ co-payment and charges for non-covered services. The hospital cannot bill the Plan Participant for covered charges in excess of the DRG Amount.

5. The Claims Administrator will inform the hospital of services not included as covered services under the Plan Participant Health Benefit Plan. The Claims Administrator will also identify the amounts for these services that the hospital can bill directly to the Plan Participant. However, the hospital must include all such charges on the claim submitted.

6. The State Network Hospital cannot bill Plan Participants or AHS for services that the Medical Management and Utilization Review vendor or the Claims Administrator has determined to be not Medically Necessary.

7. The hospital cannot submit interim billings for inpatient services.

8. The hospital must submit separate billings for mothers and newborns.

9. The hospital is required to file a POA indicator on all primary and secondary diagnosis codes submitted on all inpatient hospital claims. Claims submitted without a POA Indicator will be rejected. Refer to the UB-04 Data Specifications Manual and the ICDCM Official Guidelines for Coding and Reporting (or most current guidelines) to facilitate the assignment of the POA indicator. Below are the five values that BCBSMS will accept as valid POA indicators.

    A. 1 – Exempt from POA Reporting
    B. Y – Yes, present at the time of inpatient admission
    C. N – No, not present at the time of inpatient admission
    D. U – Insufficient documentation to determine if present on admission
    E. W – Clinically unable to determine if present on admission

10. Claims for services related to SREs shall not be submitted to the Claims Administrator. If attempting to submit, the Claims Administrator will not accept these claims, and they will be returned to the State Network Hospital. The Plan Participant will also be held harmless for any charges related to the SREs.

11. The State Network Hospital is required to file a timely, accurate and complete electronic claim. A corrected claim should only be submitted when there will be a change in the allowable amount or payment amount. If the State Network Hospital needs to submit a corrected claim, the State Network Hospital must submit a corrected claim within twelve (12) months after payment of the original claim. Only one corrected claim will be accepted.

12. The State Network Hospital will file claims electronically as soon as possible and will not withhold submission of claims for any reason other than the lack of an accurate and complete claim. All claims are subject to the timely filing requirement of the Plan Participant's contract.

13. The State Network Hospital shall not bill nor attempt to seek reimbursement from either AHS or the Plan Participant for any services resulting from a manufacturer's device malfunction. This includes any resulting hospital-based provider services that may otherwise be billed separately from the State Network Hospital. Examples of such manufacturer's device malfunctions are defibrillators, neurostimulators, stents, implants, etc.

6.2 AUDIT PROVISIONS

AHS reserves the right to audit any and all claim payments on an individual or aggregate basis, regardless of whether such payment or payments have already been made and may make adjustment to such claims payments, including but not limited to the following:

1. Medical necessity or lowest cost setting determinations.

2. Bill/claim validation determinations of coding accuracy.

3. Fragmentation pursuant to the Payment Processing Rules Section of this Exhibit.

4. Adjustments required for failure to comply with submission of claim instructions or requirements of AHS.

6.3 UTILIZATION MANAGEMENT PROGRAM

The Utilization Management Program consists of the Medical Policy Program administered by the Claims Administrator and the Medical Management and Utilization Review Program administered by ActiveHealth. The State Network Hospital agrees to participate and cooperate in the Utilization Management Program.

Medical Policy

The Claims Administrator administers the Medical Policy Program for the Mississippi State and School Employees' Health Insurance Plan. It is expected the State Network Hospital must be familiar with these medical policies, including those that are considered not Medically Necessary and provide services based on these medical policies. All medical policies are available via *myBlueProvider.*

Medical Management and Utilization Review

ActiveHealth administers the medical management and utilization review program for the Health Benefit Plan. **The State Network Hospital must contact the Health Benefit Plan's Medical Management and Utilization Review vendor for utilization management functions.**

The following services require certification by ActiveHealth:

1. Inpatient Hospital Admission
2. Inpatient Hospital Rehab
3. Residential Treatment Facility
4. Outpatient CAT Scan
5. Outpatient MRI Scan
6. Private Duty and Home Health Nursing Services
7. Solid Organ and Bone Marrow/Stem Cell Transplants
8. Home Infusion Therapy Services
9. Skilled Nursing Services
10. Long Term Acute Care Facility
11. Hospice Care Services
12. Wound Vacuum Assisted Closure
13. Diabetic Self-Management Training/Education
14. Inpatient Bariatric Surgery Procedures
15. Outpatient Bariatric Surgery Procedures
16. Out-of-Network Reviews*

State Network Hospitals cannot bill Plan Participants or AHS for services that the Medical Management and Utilization Review vendor or the Claims Administrator has determined to be not Medically Necessary, including those services that have gone through the Utilization Management or Reimbursement Appeal process.

To request certification of inpatient hospital admissions, inpatient hospital rehab, and certain outpatient services, call ActiveHealth at **1-866-939-4721**, Monday-Friday, 7 am – 7 pm Central time. ActiveHealth must be contacted in advance of any anticipated non-emergency hospital admission and immediately following an emergency admission. **Failure to comply with notification requirements will result in financial penalties, reduction of benefits or denial of benefits.**

Please have the following information ready when you call ActiveHealth to expedite your reviews for medical necessity:

- Patient name, date of birth, address and phone number
- DX/ICD Code
- Procedure/CPT Codes

- Name of Facility where Procedure/Admission will Occur
- Date of Admission
- Anticipated Date of Discharge
- Adequate Clinical History (see below)
    - Indication for Admission/Procedure
    - Brief History - Pertinent presenting symptoms or signs leading to hospitalization
    - Diagnosis/Diagnoses
    - Co-morbidities - e.g. Diabetes, CHF, COPD, CAD, Psychosis, Metastatic Disease/ Malignancy
    - Vital Signs - Include any supplemental oxygen requirement # liters and route of administration: NC, NRB, Vent, tracheostomy /Collar etc.
    - Exam - Brief Pertinent Positives/Negatives (e.g., Chest tubes, Drains etc.)
    - Current Clinical - Include information related to patient's current activity level (e.g., obtunded, ambulatory, OOB with assist only, Rolling Walker)
    - Include patient's intake - NPO, Clear fluids, taking regular diet, etc.
    - Treatments - Conservative or Otherwise (e.g., PT, OT)
    - Medications - Particularly IV meds, PCA pumps, IV hydration, etc.
    - Consults - Include notes, impressions, recommendations
    - Procedures/Relevant Imaging Studies or Testing (e.g., Ekg, Echo, Stress Tests, Ultrasounds, catheterization results, Doppler studies, CT/MRI's)
    - Relevant abnormal/normal labs: (e.g., Hypokalemia, hyponatremia, troponins, hemoglobin/hematocrit)
    - Discharge Plans: Include anticipated discharge needs (e.g., home health, rehabilitation, etc.)

6.4 ELECTRONIC BUSINESS MODEL

The State Network Hospital agrees to participate in AHS's e-Business Model for the electronic exchange of information as required by AHS. To assist with this e-Business Model, AHS offers a specialized and secure internet website for AHS State Network Hospitals called *myBlueProvider.* This website provides a key component to practice efficiency with AHS and can be accessed 24 hours a day, 7 days a week via www.myblueprovider.com. Examples of the e-Business Model requirements include, but are not limited to, the following:

Electronic Claims Submission

Blue Cross & Blue Shield of Mississippi is the Claims Administrator for the Mississippi State and School Employees' Health Insurance Plan. When filing claims for services provided to members covered under the Mississippi State and School Employees' Health Insurance Plan, you should use your Blue Cross & Blue Shield of Mississippi provider identification number. All claims are required to be submitted electronically.

To assist in submitting your claims electronically, AHS offers EMC PLU$, a Windows PC-based software product designed for the entry and filing of CMS-1500 claims.

You are required to submit a timely, accurate and complete electronic claim. A corrected claim should only be submitted when there will be a change in the allowable amount or payment amount. If the State Network Provider needs to submit a corrected claim, the State Network Provider must submit a corrected claim within twelve (12) months after payment of original claim. Only one corrected claim will be accepted.

For more information, you may contact us at EDIServices@bcbsms.com or 1-800-826-4068. The local number is 601-664-4357.

Electronic Receipt of Claim Payments

The State Network Hospital is required to complete an Authorization Agreement for Automatic Deposits to ensure that the State Network Hospital receives claims payments electronically via Automated Clearinghouse (ACH).

Electronic Access to Benefits

If you have a question about a Plan Participant's benefits or coverage, please refer to *myBlueProvider* where you will be able to access online information that you need to manage the Plan Participants' accounts. You can also refer to http://knowyourbenefits.dfa.state.ms.us to access the entire Plan Document for the State Health Plan which provides detailed benefits for Plan Participants.

myBlueProvider also offers the following features to assist the State Network Provider in accessing and utilizing our e-Business Model:

Verification of patient eligibility and benefits
You will be able to verify your patient's policy coverage dates, deductible and out-of-pocket accumulations, medical benefits and any applicable benefit limitations.

Medical Policy Guidelines
You will have access to the most current medical policies, including which procedures are covered under medical policy guidelines.

Verification of claims status
You will be able to view the status of all claims filed to the Claims Administrator.

Retrieval of electronic remittance advices
You will be able to identify and select specific vouchers to review which will provide you with payments, patient liability amounts and type codes.

Electronic Submission of Appeals
You will be able to submit appeals electronically and also attach any medical documentation required.

Usage of Contact Blue for inquiries
You will be able to submit questions that will be routed to the appropriate department for response.

Usage of reference tools for policies and procedures manuals, including coding and other operational guidelines
You will be able to access current coding guidelines as well as download current manuals to assist you in meeting the requirements of a State Network Provider.

Usage of informational articles relevant to the operations of the State Network Provider
You will be able to view news articles regarding the AHS State Network as soon as they are published and will also be able to retrieve at later dates.

For more information regarding *myBlueProvider* or password questions, contact our EDI Services department at ediservices@bcbsms.com or 601-664-HELP.

6.5 QUALITY MANAGEMENT

AHS shall engage in, and the State Network Hospital shall cooperate in, Quality Management/ Improvement programs designed to ensure the provision of high quality health care services for Plan Participants.

Quality Management/Improvement shall include but not be limited to:

(a) Quality Care Review. AHS may conduct quality of care reviews of the State Network Hospital Services provided to Plan Participants related to potential quality of care concerns; focused quality of care studies; generic quality indicators; Plan Participant complaints/grievances; and an annual, random sampling review of inpatient records. AHS may also coordinate conference calls with Network Hospital Quality Management, Risk Management, Chief Medical Officer, Health Benefit Plan's Utilization Management vendor or other applicable staff to review questionable quality of care events to determine if an event is a HAC or a Quality-of-Care Condition. Additionally, external, independent physician reviewers may be utilized to render an opinion regarding quality of care when the Network Hospital appeals the HAC or Quality-of-Care Condition determination

AHS may also review, as deemed necessary by AHS, any claims and associated medical records to assess the quality of care rendered to Plan participants.

(b) Development/Implementation of quality improvement plans. AHS may request the State Network Hospital to develop/implement quality improvement activities based on the identification and confirmation of quality of care and/or service issues.

(c) Clinical Data. AHS may request the State Network Hospital's cooperation with provision of inpatient and outpatient clinical data related to AHS' Disease Management and/or Quality Management initiatives.

(d) Transparency. AHS may make available episode of care costs and quality ratings for certain hospital services to ensure Plan participants are provided with appropriate information to make informed decisions on their health care services.

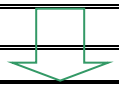
6.6 APPEAL PROCEDURES

Utilization Management Appeals
If a Plan Participant or provider believes that ActiveHealth incorrectly denied all or part of a medical service, he may initiate the appeals process. The chart below outlines the process.

Step 1
The attending physician contacts ActiveHealth to discuss any findings of "not medically necessary" with the physician who initially made the determination. If the physician is not available, another physician will be made available. Based on that discussion, the ActiveHealth staff physician will determine whether the original decision should be affirmed or amended. The enrollee and attending physician will be notified in writing of the results of this review.

Step 2

The attending physician or participant may submit a request for appeal, outlining the reason for the request, within 180 days of the initial denial decision. A thorough review and discussion of medical records and other supporting documentation will be undertaken by a specialist with experience in the condition or procedure requested. Based on this review, a decision affirming or amending the original decision will be rendered and provided in writing to the enrollee and the attending physician. The physician may also request an expedited internal appeal at the same time as an expedited external review if the physician believes that the patient's life could be in jeopardy waiting the timeframe to complete a standard internal appeal.



Step 3

Within four months after the date of receipt of an adverse determination or a final internal denial of a claim, the participant may file a request for an external review. An external review is available when the final denial involves an issue of medical necessity, appropriateness, health care setting, level of care, or effectiveness. The participant will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision on the external review. The request must be made through ActiveHealth. An external review decision is binding on the participant except to the extent the participant has other remedies available under application of Federal or State law.

Failure to request a review in accordance with the procedures above will result in the Plan Participant's right to an appeal and rights to sue being forfeited.

For any appealed claims where the services were determined to be not Medically Necessary and the Utilization Management Appeal Process upheld the denial due to Medical Necessity, the State Network Hospital cannot bill Plan Participants or AHS for these denied services and will hold both AHS and the Plan Participant harmless for these denied services.

Out-of-network reviews are not subject to the utilization review appeals process. A denial of an out-of-network approval may be appealed directly to the Department of Finance and Administration, Office of Insurance.

Reimbursement Appeals

The State Network Hospital may appeal the pricing of a claim if it feels the payment on the Remittance Statement is incorrect based upon the appropriate rates and related time period. The State Network Hospital must notify the Claims Administrator, as directed by the Claims Administrator, within one year of the original process date for the disputed claim. This appeal will be reviewed by the Claims Administrator and its decision shall be final.

6.7 INFORMATION REQUIREMENTS

Information deemed necessary in the sole discretion of AHS to carry out the terms of the State Network Hospital Agreement shall be provided by the State Network Hospital at no charge to AHS, AHS's designated representative or its Plan Participants. Likewise, AHS shall furnish any such information at no charge to the State Network Hospital. If additional copies of records are required, the State Network Hospital may charge AHS reasonable copying charges.

AHS may require the State Network Hospital to provide information in a format designated by AHS, including but not limited to:

1. Financial statements, ledgers, billings, itemized statements, price lists, invoices, patient ledgers and other financial records of the hospital.

2. Medical records and medical record abstract information. When requested, the State Network Hospital shall make available complete medical records or medical record abstracts in a format which AHS personnel can utilize.

3. A listing of new services being performed at the State Network Hospital. The State Network Hospital will notify AHS sixty (60) days in advance of beginning any new services. Failure on the part of the State Network Hospital to notify AHS of any new services within the proper timeframe will result in denial of any such new services with a hold harmless to the Plan Participant and AHS.

3. The State Network Hospital is required to report anticipated charge increase(s) to AHS by September 1 of each year. If the State Network Hospital does implement a charge increase(s) during the term of the current Attachment B payment program, the State Network Hospital will provide sixty (60) days notice in advance to AHS.

6.8 SERVICES FURNISHED UNDER ARRANGEMENT

The State Network Hospital may furnish or may be deemed by AHS in its sole discretion to have furnished services or supplies to a Plan Participant under arrangement with outside suppliers or service providers. Such supplies/services include the provision of facilities, professional services rendered by physicians and services/supplies provided by professional providers outside of Provider-Based Physicians. Under any and all circumstances, the Hospital will assure that these supplies/services shall be rendered by network providers, reimbursed based upon AHS's allowed amounts and be subject to AHS's medical necessity requirements and Benefits. The State Network Hospital may also include these supplies/services as a part of the hospital claim. The State Network Hospital will ensure the Plan Participant will be held harmless for any amounts in excess of the allowed amount and shall not be billed for any services deemed not medically necessary.

6.9 DISPUTE RESOLUTION PROCESS

The AHS State Network provides two tracks for providers with Network disputes. One track is for disputes related to the provider's status in the Network or any action related to the provider's professional competency or conduct while, for all other types of disputes, an administrative dispute resolution mechanism is available.

The Dispute Resolution Process consists of a two level review that a participating provider can initiate by written request. If the dispute is not resolved to the provider's satisfaction by the first-level review, the provider will have the option of submitting the dispute to a second level of review. A participating provider(s) of the same specialty as the provider that filed the dispute, who is not otherwise involved in network management, will be on each of the review panels. Each level of dispute should be finalized within 30 days of receipt of the provider's request to initiate the Process. All results of the review will be communicated to the provider in writing.

To initiate the Dispute Resolution Process, complete the AHS Dispute Resolution Form that is attached and mail to the AHS State Network as directed on the form.

To request additional Dispute Resolution Process Forms, please call 1-800-294-6307.

ADVANCED HEALTH SYSTEMS, INC.

AHS State Network
Dispute Resolution Form

Please complete the information below to request the Dispute Resolution Process. Your dispute will be referred to a first level review panel. Results or status of the review will be sent to you in writing within thirty (30) business days of receipt of this form. If you have any questions, please call 1-800-294-6307.

Mail form to: AHS State Network
Attn: Manager, Provider Contracting
P.O. Box 23070
Jackson, MS 39225

Date

Name

Address

Provider Number(s) and location(s)

ADVANCED HEALTH SYSTEMS, INC.

AHS State Network
Dispute Resolution Form

Nature of Dispute (Give detailed explanation.) (Attach any additional documentation.)

AHS Staff Contacted to Resolve Dispute (List all names and briefly describe any actions to resolve dispute.)