Advanced Health Systems, Inc.

Innovations in Healthcare Technology

Attachment A

AHS State Network Provider Manual

Effective January 1, 2016

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Introduction

Advanced Health Systems, Inc. (AHS), a wholly owned subsidiary of Blue Cross & Blue Shield of Mississippi (BCBSMS), was contracted in 1999 by the State of Mississippi State and School Employees Health Insurance Management Board to manage a Provider Network for the Mississippi State and School Employees' Health Insurance Plan (Plan).

The goal of the AHS State Network is to provide a comprehensive network of high quality healthcare providers to the Plan participants of the Mississippi State and School Employees' Health Insurance Plan.

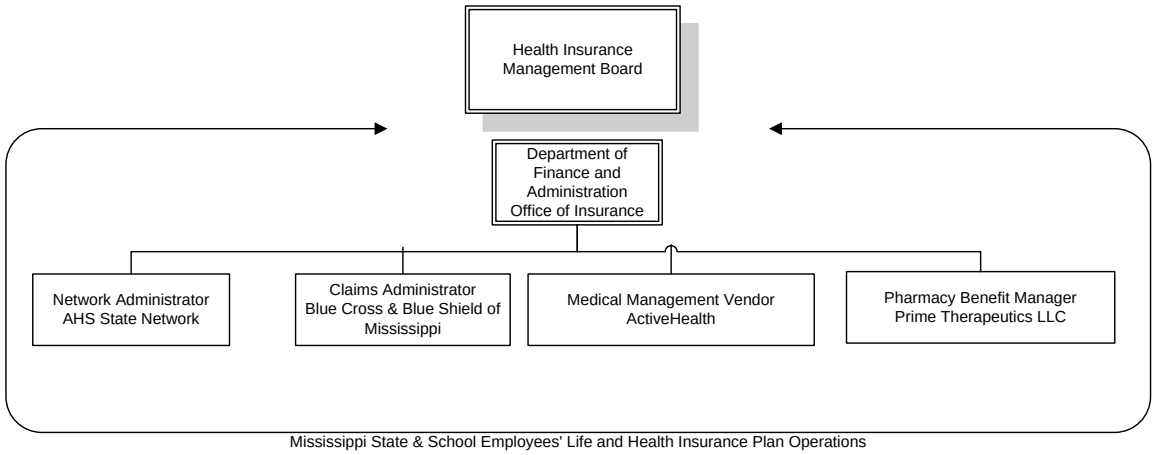
As a network provider with AHS, you must be familiar with the policies and procedures that are required when providing services to Plan participants. This AHS State Network Provider Manual, which is Attachment A to your State Network Healthcare Professional Agreement, will provide you with the necessary information to operate within the requirements of the AHS State Network.

If you have any questions related to the AHS State Network, you may contact us at 1-800-294-6307. A Provider Service Representative is available from 8:00 a.m. to 5:00 p.m., Monday through Friday, to assist you.

Plan Structure

The Mississippi State and School Employees' Health Insurance Plan is a self-funded health plan for employees of a department, agency, or institution of State government, public school district, community/junior college, institution of higher learning, public library, COBRA participants, retirees, and their dependents. At the direction of the Health Insurance Management Board, the Department of Finance and Administration has contracted with several companies for the administration and operational functions of their health plan.

Contact information for these organizations is located on the attached Quick Reference Guide. The vendors are subject to change. For the current vendor, see the website at http://knowyourbenefits.dfa.ms.gov. This website provides information related to the State of Mississippi State and School Employees' Health Insurance Plan to participants, providers, and other interested parties.



Mississippi State & School Employees' Life and Health Insurance Plan Operations

General Requirements

As a provider in the AHS State Network, 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.

- to adhere to the Utilization Management program requirements.

- to not bill Plan participants or AHS/the Plan for services that are not Medically Necessary as determined by the Medical Management and Utilization Review vendor or the Claims Administrator. Such services shall include those services that are not covered under the Plan's Wellness/Preventive Services benefit. Covered wellness services are listed on the Plan's website at http://knowyourbenefits.dfa.ms.gov.

- to adhere to the AHS Electronic Business Model requirements

- 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 Plan will provide benefits for the patient's liability amount, as defined by the primary payor, not to exceed the AHS Allowable Charge.

- to accept, as the Allowable Charge, the lesser of Covered Charges or the amount established by AHS.

- to file claims within twelve months of the date on which the services were performed. The State Network Provider will hold the Plan Participant and AHS/the Plan harmless for any charges for which a claim is not filed within twelve months of the date of service.

- to ensure that any contracts with sub-contracted providers will be subject to the terms of the AHS State Network Agreement.

Electronic Business Model

The State Network Provider agrees to participate in the AHS Electronic Business Model for the electronic exchange of information as required by AHS. To assist with this Electronic Business Model, AHS offers a specialized and secure internet website for AHS State Network Providers 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 Electronic 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 participants 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 Plus, 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 Provider is required to complete an Authorization Agreement for Automatic Deposits to ensure that the State Network Provider 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.ms.gov to access the entire Plan Document for the State Health Plan which provides detailed benefits for Plan participants. Should

there be a need to speak to someone directly, please refer to the Quick Reference Guide attached to this Manual.

myBlueProvider also offers the following features to assist the State Network Provider in accessing and utilizing the AHS Electronic 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. These vouchers 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.

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

Quality Management

State Network Providers are expected to meet or exceed those standards of care set forth within their specific healthcare fields.

Quality of Care

AHS will monitor trends in ancillary services such as, but not limited to, the appropriateness and frequency of utilization of imaging, radiological and laboratory procedures, but will not be limited to such services.

State Network Providers should comply with the Healthcare Effectiveness Data and Information Set (HEDIS) measures, where applicable. HEDIS is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. Sample HEDIS measures include pneumococcal vaccination status for older adults, follow-up care for children prescribed ADHD medication, comprehensive diabetes care, and use of imaging studies for low back pain.

State Network Providers must submit biometric data on participants, as requested by AHS or Claims Administrator.

In the event AHS identifies a service provided to a Plan participant that results in a quality of care concern whereby the health outcome of the participant was impacted resulting in additional costs to the Plan or to the participant, AHS reserves the right to review the circumstances surrounding the service(s). Such review may result in a reduction in the reimbursement to the State Network Provider for any and all services rendered as part of this quality of care concern. AHS will notify the State Network Provider of the identified quality of care concern, and these identified services will be subject to clinical reviews by other physicians, AHS, ActiveHealth or any other entities that may provide professional support in the review of these situations.

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. State Network Providers agree to participate and cooperate in the Utilization Management Program.

Claims Administrator 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 Provider be familiar with these medical policies, including services that are considered not Medically Necessary and provide services based on these medical policies. The Claims Administrator's medical policies are available via *myBlueProvider.*

Medical Management and Utilization Review Program

ActiveHealth administers the Medical Management and Utilization Review program for the Mississippi State and School Employees' Health Insurance Plan.

The following services require certification by ActiveHealth:

- Inpatient Hospital Admission
- Inpatient Hospital Rehab
- Residential Treatment Facility
- Outpatient CAT Scan
- Outpatient MRI Scan
- Private Duty and Home Health Nursing Services
- Solid organ and bone marrow/stem cell transplants
- Home infusion therapy services
- Skilled Nursing Services
- Long Term Acute Care Facility
- Hospice Care Services
- Wound Vacuum Assisted Closure
- Diabetic Self-Management Training/Education
- Inpatient Bariatric Surgery Procedures
- Outpatient Bariatric Surgery Procedures
- Out-of-Network Reviews

State Network Providers cannot hold Plan participants or AHS/the Plan responsible 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 Medical Appeal process.

ActiveHealth performs out-of-network reviews. If a patient needs specialty services that are not available from participating providers, these services must be approved prior to the patient receiving the medical services.

ActiveHealth may be contacted at 1-866-939-4721, Monday-Friday, 7 am – 7 pm Central time.

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

- Patient name, ID number, date of birth, address and phone number
- Diagnosis/ICD Codes
- Procedure/CPT Codes
- Name of Facility where Procedure/Admission will Occur
- Date of Admission
- Anticipated Date of Discharge
- Adequate Clinical History

ActiveHealth also provides the following services:

- Case management
- Disease management for diabetes, asthma, congestive heart failure and coronary artery disease
- Maternity program
- 24/7 nurse line
- Clinical alerts called Care Considerations
- Weight Management Enhancement Program
- Health and Wellness Programs

ActiveHealth will contact patients who could benefit from the case management, disease management, weight management or maternity programs. They also welcome your referrals. To refer a patient to ActiveHealth, please call **1-866-939-4721**.

ActiveHealth identifies clinical alerts from evidence-based guidelines and patients' medical, prescription, and laboratory test data. Here is what to expect:

- The alerts are individualized to each patient.
- Most alerts are sent by fax or mail, but if it is a potentially life-threatening issue, ActiveHealth will call the provider's office
- The alerts may provide information not otherwise available to the provider, such as treatment by other physicians or patient non-compliance (e.g. patient didn't fill a prescription)
- Each alert asks for feedback. By responding and including detail not available from claims (e.g. medication intolerance), the provider can help increase the accuracy of future alerts

If you have any questions about an alert, please call 1-800-319-4454 and ask to speak with an ActiveHealth physician.

Pharmacy Benefits – Prior Approval

Prime Therapeutics is the pharmacy benefit manager for the Mississippi State and School Employees' Health Insurance Plan.

Certain prescription drugs require prior approval. The prescribing physician must contact Prime and provide appropriate documentation of Medical Necessity.

The quantity of some prescription drugs may be limited based on medical necessity. If the quantity of a covered prescription drug is not approved by Prime, the physician must contact them for approval of additional quantities.

You may contact Prime at 1-855-457-0408 for prior authorization or you may visit their web site for Prior Authorization Form instructions. The web site address is www.primetherapeutics.com. Click on Providers at the top of the screen to access the Health Care Professionals page to see Prior Authorization Form instructions.

AHS Professional Allowance Schedule

The AHS State Network professional allowance schedule is based upon a modified version of Resource Based Relative Value Scale (RBRVS). The professional allowance schedule is reviewed in the fall of each year and, if necessary, adjustments are made effective on January 1.

To check the allowance for a specific procedure, you may utilize *myBlueProvider* to obtain access to the AHS State Network Professional Fee Inquiry tool.

AHS Allied Provider Allowance Schedules

The allowance schedule for DME and Prosthetic/Orthotic providers is based upon a modified version of national pricing models.

The allowance schedules for Home Infusion, Renal Dialysis, Skilled Nursing, Hospice and Ambulatory Surgical Center providers is specific for each provider type and is specified within their contracts.

The allowance schedule for all other allied provider types is based on the AHS State Network professional allowance schedule.

To check the allowance for a specific procedure, you may utilize *myBlueProvider* to obtain access to the AHS State Network Professional Fee Inquiry tool.

Provider Suggestions

The AHS State Network Quality Improvement Committee oversees the AHS State Network's Quality Management Program. This Committee is comprised of network management staff as well as network providers who administer the Network's Quality Improvement Plan.

If you would like to send any concerns or suggestions to the Committee's attention, please write to:

AHS State Network
Attn: Manager, Provider Contracting
P.O. Box 23070
Jackson, MS 39225-3070

Appeal Process

Medical Appeals

If you believe that the Claims Administrator incorrectly denied all or part of a claim, you may submit an appeal via our online submission of appeals process located on *myBlueProvider*. The appeal will be reviewed and the status of the appeal will be placed on *myBlueProvider* for you to review. If you still disagree with the decision, you may submit a final appeal in writing to the Department of Finance and Administration, Office of Insurance. You must include a copy of the Claims Administrator's review decision and all pertinent information related to the claim. The decision of the State Insurance Administrator with the Department of Finance and Administration, Office of Insurance is final and concludes all internal levels of appeal. Within four months after the date of receipt of a final internal denial of a claim, you 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 request must be made through the Office of Insurance and must include all information pertinent to the denied claim. An external review decision is binding except to the extent of other remedies available under applicable federal or State law. For any appealed claims where the services were determined to be not Medically Necessary and the Medical Appeal Process upheld the denial due to Medical Necessity, the State Network Provider cannot hold Plan participants or AHS/the Plan responsible for these denied services and will hold both AHS/the Plan and the Plan participant harmless for these denied services.

Prescription Drug Appeals

If you believe that all or part of a prescription drug claim or service was denied incorrectly, contact the pharmacy benefit manager, Prime, for information to submit an appeal. The phone number is 1-855-457-0408.

Utilization Review Appeals

If you believe that the Utilization Review vendor, ActiveHealth, incorrectly denied all or part of a medical service, you may contact ActiveHealth to discuss any findings of "not medically necessary". An ActiveHealth staff physician will determine if the original decision should be affirmed or amended. You will be notified in writing of this decision.

If you do not agree with this decision, you may submit a written request for review to ActiveHealth, outlining the reason for the request. A decision will be made based on a thorough review and discussion of medical records and other supporting documentation. You will be notified in writing of this decision.

If you do not agree with the second decision, you may request an independent review by an independent physician under contract with ActiveHealth. The decision of the independent physician is final and not subject to further reconsideration.

For any appealed claims where the services were determined to be not Medically Necessary and the Utilization Review Appeal Process upheld the denial due to Medical Necessity, the State Network Provider cannot hold Plan participants or AHS/the Plan responsible for these denied services and will hold both AHS/the Plan and the Plan participant harmless for these denied services.

The phone number for ActiveHealth is 1-866-939-4721.

Please note:

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

- The AHS State Network reviews appeals on claims pricing/allowances that are referred by the Claims Administrator. If it is determined that a claim appeal is concerning the pricing or allowed amounts for a claim or procedure, the Claims Administrator will request that the AHS State Network staff review it. Once the appeal has been finalized, the Claims Administrator will communicate the determination to you in writing.

Complaint Process

Any complaints regarding the AHS State Network should be reported to the Provider Service Representative, State Network, at 1-800-294-6307. You may send a complaint to the following address:

AHS State Network
Attn: Manager, Provider Contracting
P.O. Box 23070
Jackson, MS 39225-3070

The AHS State Network's goal is to provide quality services and to continuously improve the Network management's performance. All complaints reported to the Network will be handled promptly.

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 resolution mechanism is available.

The Dispute Resolution Process consists of a two-level review that a State Network 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 State Network 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.

The Dispute Resolution Process for administrative disputes does not involve a second level review.

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 a Dispute Resolution Process Form, 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 39225-3070

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.)

MISSISSIPPI STATE AND SCHOOL EMPLOYEES' HEALTH INSURANCE PLAN
QUICK REFERENCE GUIDE

Contract Issues or Provider Issues	**Advanced Health Systems, Inc. www.myBlueProvider.com**	**1-800-294-6307**	**8:00 a.m. – 5:00 p.m. Monday - Friday**
Benefits, Eligibility Claims Status	**Blue Cross & Blue Shield of Mississippi www.myBlueProvider.com**	**1-800-709-0973**	**Automated Service Available 24 hours 7 days a week Provider Reps 8:00 a.m. – 5:00 p.m. Monday - Friday**
Medical Management/ Utilization Review	**ActiveHealth www.activehealth.com**	**1-866-939-4721**	**7:00 a.m. – 7:00p.m. Monday – Friday**
Pharmacy Benefits, Questions	**Prime Therapeutics LLC www.primetherapeutics.com**	**1-855-457-0408**	**8:00 a.m. – 5:00 p.m. Monday - Friday**

NOTE: For the most current information, please check the plan participant's web site at http://knowyourbenefits.dfa.ms.gov.