2016

Adena Care Network Provider Manual

This manual is to help you learn more about Adena Health System’s employee medical plans and the Adena Care Provider Network

We hope you find this information and the enclosed documents useful to your office operation and in serving your patients – our members.

Adena Care
272 Hospital Road
Chillicothe, OH 45601
(740) 772-CARE (2273)
Fax: (740) 779-7845

OVERVIEW

What is the Adena Care Network?

The Adena Care Network (ACN) is a provider network created by Adena Care & Adena Health System to provide a local provider network for members of the Adena Health System Health Plan (AHSHP).

- AHSHP is self-funded through Adena Health System and is not a health insurance corporation.
- Adena Care provides the network for approximately 5,000 members on Adena Health System’s health plans.
- Providers in the Adena Care Network service area include the following counties:
  - Adams
  - Fayette
  - Highland
  - Jackson
  - Pickaway
  - Pike
  - Ross
  - Vinton

Main Office Location

Adena Care
272 Hospital Road
Chillicothe, OH 45601
(740) 779-CARE (2273)
Fax: (740) 779-7845
Office hours: 8:00AM – 4:00PM, Monday-Friday
Website: [https://www.adena.org/inside/adena-care/page.dT/about](https://www.adena.org/inside/adena-care/page.dT/about)

Our website provides the online convenience of a provider directory for referral ease, educational links, a preferred drug list, and information on Adena Care programs.
Provider Relations Department

Overseer of provider network, contracting, servicing, and educating providers. Contact our department in the following instances:

- If office has changes regarding Tax Identification Number, address, phone number, etc.;
- If additional providers join practice or if providers leave;
- Questions on fees, contracts, or credentialing; and
- Any other questions from staff or physicians.

Adena Care partners with the Medical Staff Services department of Adena Health System in order to ensure all providers within the network are fully credentialed per National Committee for Quality Assurance (NCQA) standards.

Provider Updates

Adena Care requires all changes or updates to your practice to be **put in writing** at the time of the change. Please mail or fax updates to the following address or fax number:

Adena Care  
272 Hospital Road  
Chillicothe, OH 45601

Fax: (740) 779-7845

**Tax Identification Numbers (TIN)**

If you have started a new practice or changed Tax Identification Numbers (TIN), Adena Care will need the update within 30 days of the change.

In-network providers will need to reapply for participation with Adena Care if notification has not been received within 30 days of the change. (Applies to changing practices or TIN changes).
MEDICAL PLANS

Adena Health System Medical Plans

PPO Plan

- In and out of network coverage (higher deductible & out of pocket maximum applies for Aetna or out of network providers)
- Care coordinated through Primary Care Provider (PCP)
- Deductible of $750 individual/$1500 per family (Adena Care Network)
- Preventative services covered at 100%
- Co-insurance: plan pays 90% for most services
- Copays: PCMH Office $10
  Non PCMH PCP $25
  Specialists: $40

Qualified High Deductible Health Plan 1

- In and out of network coverage (higher deductible & out of pocket maximum applies for Aetna or out of network providers)
- Care coordinated through Primary Care Provider (PCP)
- Deductible of $1,300 single coverage / $2,600 family coverage (Adena Care Network)
- Preventative services covered at 100%
- Co-insurance: plan pays 80% for most services
- Office visits are subject to deductible and coinsurance
- Select list of “preventative” prescription medications with a lower copay that aren’t subject to the deductible
  - See following page for list of “preventative” medications for 2016. List is subject to change without notice.

Qualified High Deductible Health Plan 2

- In and out of network coverage (higher deductible & out of pocket maximum applies for Aetna or out of network providers)
- Care coordinated through Primary Care Provider (PCP)
- Deductible of $2,000 single coverage/$4,000 family coverage (Adena Care Network)
- Preventative services covered at 100%
- Co-insurance: plan pays 90% for most services
- Office visits are subject to deductible and coinsurance
- Select list of “preventative” prescription medications with a lower copay that aren’t subject to the deductible
  - See following page for list of “preventative” medications for 2016. List is subject to change without notice.

*The information above does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member’s contract at time of service
Members of the Adena Health System Health Plan’s High Deductible Health Plans have a benefit that provides certain preventative maintenance medications at a lower cost. This list is subject to change.

<table>
<thead>
<tr>
<th>Asthma Related</th>
<th>Blood Pressure Related</th>
<th>Blood Pressure Related (continued)</th>
<th>Diabetes Related</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albuterol Sulfate</td>
<td>Acizolamide</td>
<td>Irbesartan/HCTZ</td>
<td>Acarbose</td>
</tr>
<tr>
<td>Cromolyn Sodium</td>
<td>Acebutolol HCL</td>
<td>Labetalol HCL</td>
<td>Glimepiride</td>
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<tr>
<td>Ipratropium Bromide</td>
<td>Amiloride HCL</td>
<td>Lisinopril</td>
<td>Glipizide</td>
</tr>
<tr>
<td>Levalbuterol</td>
<td>Amlodipine Besylate</td>
<td>Lisinopril/HCTZ</td>
<td>Glipizide ER</td>
</tr>
<tr>
<td>Levalbuterol HCL</td>
<td>Atenolol</td>
<td>Losartan</td>
<td>Glyburide</td>
</tr>
<tr>
<td>Montelukast Sodium</td>
<td>Benazepril HCL</td>
<td>Losartan/HCTZ</td>
<td>Metformin HCL (excl. 1000ER)</td>
</tr>
<tr>
<td>Proair HFA</td>
<td>Bisoprolol/HCTZ</td>
<td>Metoprolol Succinate</td>
<td>Pioglitazone HCL</td>
</tr>
<tr>
<td>Theophylline Anhydrous</td>
<td>Bumetanide</td>
<td>Metoprolol Tartrate</td>
<td>Prenatal Vitamins</td>
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<tr>
<td>Ventolin</td>
<td>Carvedilol</td>
<td>Nadolol</td>
<td>Prenaplex</td>
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<tr>
<td><strong>Blood Thinners</strong></td>
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</tr>
<tr>
<td>Chlorthalidone</td>
<td>Nifedipine</td>
<td></td>
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</tr>
<tr>
<td>Cilostazol</td>
<td>Chlorthalidone/Atenolol</td>
<td>Prazosin HCL</td>
<td>Prenatal 19</td>
</tr>
<tr>
<td>Clopidogrel Bisulfate</td>
<td>Clonidine/HCL</td>
<td>Propranolol HCL</td>
<td>Anti-Depressants</td>
</tr>
<tr>
<td>Warfarin</td>
<td>Diltiazem HCL</td>
<td>Quinapril</td>
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</tr>
<tr>
<td><strong>Cholesterol Related</strong></td>
<td>Doxazosin Mesylate</td>
<td>Ramipril</td>
<td>Bupropion HCL</td>
</tr>
<tr>
<td>Atorvastatin</td>
<td>Enalapril Maleate</td>
<td>Spironolactone</td>
<td>Bupropion HCL SR</td>
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<tr>
<td><strong>Fenofibrate</strong></td>
<td>Furosemide</td>
<td>Terazosin HCL</td>
<td>Citalopram Hydrobromide</td>
</tr>
<tr>
<td>Gemfibrozil</td>
<td>Guanfacine HCL</td>
<td>Timolol Maleate</td>
<td>Escitalopram Oxalate</td>
</tr>
<tr>
<td>Lovastatin</td>
<td>Hydralazine HCl</td>
<td>Triamterene HCTZ</td>
<td>Venlafaxine HCL</td>
</tr>
<tr>
<td>Pravastatin Sodium</td>
<td>Hydrochlorothiazide</td>
<td>Valsartan</td>
<td>Venlafaxine HCL ER</td>
</tr>
<tr>
<td>Simvastatin</td>
<td>Hydrochlorothiazide/Amiloride</td>
<td>Valsartan HCTZ</td>
<td>Amitriptyline HCL</td>
</tr>
<tr>
<td><strong>Osteoporosis Related</strong></td>
<td>Indapamide</td>
<td>Verapamil</td>
<td>Nortriptyline HCL</td>
</tr>
<tr>
<td>Alendronate Sodium</td>
<td>Irbesartan</td>
<td></td>
<td>Doxepin HCL</td>
</tr>
</tbody>
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**Psychotropics**
- Lithium Carbonate
- Risperidone
- Olanzapine
BILLING

CoreSource is the Third-Party Administrator that processes and pays claims for all Adena Health System medical plans.

For questions on Explanations of Benefits (EOB), call CoreSource at (855) 528-5607

- CoreSource accepts claims on a CMS 1500 claim form or electronically. If submitting electronically, call NGS CoreSource.
- 12-month filing limit (from date of service)
- Bill with Tax Identification Number, no suffix

NGS CoreSource
Claims/Eligibility: (855) 528-5607
Fax number: (586) 416-3001

Claims Mailing Address:
CoreSource
P.O. Box 2821
Clinton, IA 52733-2821
Member ID Cards

- Member is responsible for presenting ID card at time of visit.
- Member is responsible for co-payment at time of visit.
- ID card is not a guarantee of payment; providers must contact CoreSource to verify eligibility.
- Important information on ID card regarding coverage (see example of ID card).

Sample Medical ID Cards

Samples of the Adena Health System Employee Health Plan cards:

**PPO Card Sample:**

**HSA 1 Card Sample:**

**HSA 2 Card Sample:**
Referrals

Referrals are not required by the Adena Health System employee health plan; however, if a member needs to be seen by a specialist, you can help them receive the best benefit level available by recommending a specialist that is participating in the Adena Care Network.

Please see http://www.adena.org/inside/adena-care/page.dT/adena-care-providers for a listing of all participating hospitals.

If Adena Health System health plan members are referred to or self-refer to non-Adena Care Network providers, benefits may only be payable at the second or third tier benefit level.

Provider Credentialing

To comply with the guidelines established by the National Committee for Quality Assurance (NCQA), providers must be fully credentialed before our members can see them.

We ask that providers who are in the credentialing process refrain from seeing Adena Employee Health Plan members until they are notified of their effective date for Adena Care network participation.

Be assured that once we have received all appropriate documentation from the applicant, the credentialing process is typically completed in 45 days or less.

Adena Health System / Adena Care does not make credentialing decisions based on an applicant's race, ethnic/nationality, identity, gender, age or sexual orientation, or on type of procedure or patient (i.e., Medicaid) in which the practitioner specializes.
Provider Claims Appeals Process

A participating provider may submit an appeal to CoreSource for reconsideration of a claim denial for covered services if the covered plan member designates the provider as their authorized representative. This appeal should be submitted on behalf of an Adena Health System Health Plan member and should include verification that the member has authorized the provider to appeal on their behalf. A written letter of appeal, along with supporting documentation, should be sent to CoreSource, Attn: Appeals Department, P.O. Box 2821, Clinton, IA 52733-2821.

Appeals that are submitted to CoreSource must be received within 180 days** of the provider receiving the Explanation of Benefits (EOB). Appeals will be reviewed by NGS CoreSource. Review of the appeal will be completed by CoreSource within 60 days of receipt.

If reviewed by CoreSource and the denial is overturned, the claim will be reprocessed. If the denial is upheld, a letter will be sent to the provider, and if applicable to the member, upholding the initial denial.

If the denial stands and was based on medical judgment or experimental determination, the member has a right to request an external review. A member has four months from the receipt of the denial notification to file an external appeal request.

- CoreSource has 5 days to determine if the appeal meets their guidelines for an external appeal. If it meets the criteria, they send all applicable documents to an Independent Review Organization (IRO)
- The IRO has 45 days to appeal the case and respond to the member. The decision of the IRO is final unless there is a law that gives the member additional rights.

The Notice of Final External Review Decision from the IRO is binding on the covered person, the Plan and claims processor, except to the extent that other remedies may be available under State or Federal law.
MEDICAL GUIDELINES

Adena Health System Employee Plan Prior Authorization

All inpatient admissions, partial confinements, hospice care, outpatient diagnostic and surgical procedures as outlined below are to be certified by the Medical Management Department at CoreSource. Home health care and certain durable medical equipment (electric wheelchairs/scooters, CPAP/BiPAP, prosthetics and durable medical equipment with a cost greater than $1,000) must also be certified by CoreSource when provided by a non-Adena Care Network provider.

For non-urgent care, the covered person (or their authorized representative) must call CoreSource at least fifteen (15) calendar days prior to initiation of services. If CoreSource is not called at least fifteen (15) calendar days prior to initiation of services for non-urgent care, benefits may be reduced.

For urgent care, the covered person (or their authorized representative) must call CoreSource within forty-eight (48) hours or the next business day, whichever is later, after the initiation of services. Please note that if the covered person needs medical care that would be considered as urgent care, then there is no requirement that the Plan be contacted for prior approval.

Covered persons shall contact CoreSource’s Medical Management Department by calling: 1-866-884-6819

When a covered person (or authorized representative) calls CoreSource, he or she should be prepared to provide all of the following information:

1. Employee’s name, address, phone number and CoreSource Member Identification Number.
2. Employer’s name.
3. If not the employee, the patient’s name, address, phone number.
4. Admitting physician’s name and phone number.
5. Name of facility, home health care agency or hospice.
6. Date of admission or proposed date of admission.
7. Condition for which person is being admitted.
8. Notification of the following outpatient diagnostic and surgical procedures:
   a. Imaging (non-emergency): CT Scan, MRA, MRI, Nuclear Stress Test, PET Scan.
   b. Adenoidectomy
   c. Arthroscopy of the Knee
   d. Bunionectomy with or without Osteotomy
   e. Cardiac Catheterization and Coronary Angioplasty
   f. Carpal Tunnel Release
   g. Cataract Extraction with or without Intraocular Lens Implant
   h. PTCA (Percutaneous Transluminal Coronary Angioplasty) with or without Stent Placement
   i. Cholecystectomy
   j. D & C (Dilatation and Curettage)
   k. EGD (Esophagogastroduodenoscopy)
   l. ERCP (Endoscopic Retrograde Cholangiopancreatography)
   m. Hemorrhoidectomy
   n. Vaginal Hysterectomy
   o. Laminectomy
   p. Lithotripsy (EWSL Extracorporeal Shock Wave)
   q. Myringotomy and Tympanostomy tubes
   r. Septoplasty
   s. Tonsillectomy
   t. Organ or Tissue Transplant
   u. Rhinoplasty
   v. Chemotherapy
If the covered person (or authorized representative) fails to contact CoreSource prior to the hospitalization and within the timelines detailed above, the amount of benefits payable for covered expenses incurred shall be reduced by $750 for the purpose of determining benefits payable. If the Medical Management Department at CoreSource declines to grant the full pre-certification requested, benefits for days or services not certified as medically necessary by the Medical Management Department shall be reduced by fifty percent (50%). All other services requiring pre-certification, as listed above, shall be reduced by fifty percent (50%) for the purpose of determining benefits payable if not pre-certified as required. The patient shall not be responsible for pre-certification penalties applied to home health care services and durable medical equipment provided by Adena Care Network preferred providers.
PHARMACY

EnvisionRx Options is the Pharmacy Benefit Manager (PBM) for the Adena Health System employee medical plans.

Adena Health System EnvisionRx Contact List

<table>
<thead>
<tr>
<th>Member or Provider Help</th>
<th>1-800-361-4542</th>
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<tbody>
<tr>
<td></td>
<td>or</td>
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<td></td>
<td><a href="https://www.envisionrx.com/">https://www.envisionrx.com/</a></td>
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</tbody>
</table>

PRIOR AUTHORIZATIONS OF PRESCRIPTION DRUG CLAIMS

EnvisionRxOptions has been retained by the plan administrator to provide prior authorization services for a particular set of drugs. The Plan has approved a predetermined set of criteria to be applied to this prior authorization process. In order for a drug which is subject to prior authorization to be covered by this Plan, the prescribing physician must call the EnvisionRxOptions Customer Service Help Desk at 1-800-361-4542, to obtain prior authorization before the drug is purchased. EnvisionRxOptions will determine whether or not the drug will be a covered expense, based upon the predetermined set of criteria and the information supplied by the physician. EnvisionRxOptions will notify the physician who submitted the request for prior authorization that the drug is or is not covered by the Plan. The request for prior authorization is considered to be a pre-service claim as described in the U.S. Department of Labor Regulations 2560.503-1 (issued November 21, 2000).

Please refer to the list below for a list of most medication classifications that will require a prior authorization.

- Chemotherapy Medications
- Medications used for Multiple Sclerosis
- Medications used for Osteoporosis
- Growth Hormones
- Medications for Hepatitis C
- Medications used for Rheumatoid Arthritis
- Medications for Acromegaly, Profuse Diarrhea
- Certain medications used for Asthma
- Oncology Pain Management medication