PROVIDER MANUAL FOR NEW HAMPSHIRE MINUTEMAN HEALTH PLANS

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INTRODUCTION

Minuteman Health, Inc. (www.minutemanhealth.org) is a member-governed, non-profit health maintenance organization (HMO) committed to removing inefficiencies from today's health insurance system to provide high-quality care, cut administrative costs and reduce premiums for individuals and businesses in Massachusetts and New Hampshire.

Minuteman offers HMO plans in New Hampshire that utilize the Minuteman New Hampshire network, as well as the Minuteman Massachusetts network, as In-Plan Providers. Minuteman also offers POS plans in New Hampshire which utilize the two aforementioned networks as In-Plan "Preferred" Providers, and the national First Health network as In-Plan "Non-Preferred" Providers. Please see the Minuteman Products and Benefits section of this manual for more information, and refer to the provider directories at www.minutemanhealth.org for a current listing of In-Plan Providers.

The New Hampshire (NH) provider community has a wide variety of clinicians including but not limited to: osteopathic physicians, chiropractors, podiatrists, nurse practitioners, optometrists, licensed professional midwifes, physical therapists, and behavioral health clinicians, including psychiatrists, licensed psychologists, licensed pastoral psychotherapists, advanced practice psychiatric nurses, licensed mental health counselors, licensed alcohol and drug counselors, licensed family therapists, licensed clinical social workers and licensed doctors of naturopathic medicine. Minuteman's directly contracted NH network is comprised of these and other clinicians who have decided to actively participate in our cost-effective network. All of these contracted clinicians, may practice without discrimination and within the scope of their practice as defined by New Hampshire law. They must however abide by Minuteman's NH coverage decisions, which are described in Minuteman's policies and procedures, including but not limited to Minuteman Member benefit structures, medical policies, Utilization Management (UM) policies, contractual and payment policies.

Minuteman also contracts with the national First Health network for our POS products, DentaQuest for pediatric dental benefits available under our "Patriot" or off exchange-only products, and OptumRx (formerly known as Catamaran) for pharmacy benefits.

This Provider Manual contains information about the guidelines and procedures which should be followed by providers when rendering medical service to Minuteman members. Some of the guidelines and procedures in this Manual are based on requirements of State and Federal law as well as accrediting organizations. Thus, the guidelines and procedures are subject to change if the requirements of the law or accrediting organizations change. Minuteman will notify providers in writing of modifications to this Manual that have a substantial impact on provider rights or responsibilities at least 60 days prior to the effective date of such modifications. Where there is a conflict between this edition of the Manual and a subsequent notification of a modification to a policy or procedure related to a change in the law, the information in the subsequent notification shall prevail.

Other (non-substantial) changes will be updated online with notice including an electronic list of changes and links to the amended sections, sent to the designated person in each provider organization.

If you have questions or suggestions regarding the information in this Provider Manual or wish to obtain a paper copy of the Manual, please contact Minuteman Provider Services at 855-644-1776. Representatives are available Monday-Friday from 8:00 am to 6:00 pm.

MINUTEMAN HEALTH - PROVIDER QUICK REFERENCE

Provider Web Portal at MinutemanHealthDirect.org

Providers can view up-to-date information on-line by using the Minuteman provider portal, including:

- Member eligibility, benefits information, and copay amounts
- Prior authorization request(s)
- Claims status
- Explanations of payment
- Network Provider/practice roster changes

Providers who have questions about this service or are interested in registering for the Minuteman provider portal should go to www.minutemanhealth.org to register.

Phone: Provider Services Phone: 855-644-1776 (Select Option 4)

To reach these departments within Minuteman Provider Services:	Dial 855-644-1776, select Option 4, then the following options:
Eligibility & Benefits	1
Provider Claims Servicing (Claims Status & Billing)	2
Minuteman Health Services (Prior Authorization and UM)*	3
For all other issues	4

***For Diagnostic Imaging Prior Authorization:** Contact eviCore/MedSolutions at 888-693-3211
***For Rx Prior Authorization:** Contact OptumRx (formerly known as Catamaran) at 855-838-3481
***For Pediatric Dental Claims/Benefits:** Contact DentaQuest at 855-264-0956 or dentaquest.com

Fax/Email:

Department	Fax/Email
Health Services (Prior Authorization)	413-233-2700
Provider Appeals	888-225-8716
Member Services	413-233-2655
Provider Relations (Contracting, Credentialing & Enrollment)	877-892-7621 or providers@providernetworkalliance.com

Mailing Address Information (including paper claims):

Correspondence –
Minuteman Health, Inc.
P. O. Box 120025
Boston, MA 02111

Claims -
Minuteman Health
c/o Health New England
One Monarch Place, Suite 1500
Springfield, MA 01144

Minuteman Payer ID for EDI Claims Submission: 01776

Member Eligibility and Identification Cards

Minuteman Members are issued an identification card (ID card) when they enroll or change plans. Members are instructed to present their ID card when seeking medical services. The ID card alone does not guarantee eligibility. You can verify eligibility and benefits by logging on to MinutemanHealthDirect.org. If you have not registered already, you can do so by going to www.minutemanhealth.org.

Refer to the Member's ID card to identify any Member copayment amounts for office visits, urgent/emergency care, prescriptions, etc. For more detailed information on members' cost-sharing and benefits please contact Provider Services. The Provider Network Alliance (PNA) logo is on the back of all ID cards because the Minuteman Health Massachusetts provider network is contracted via PNA. The First Health logo is also on the back of all cards since we are using First Health for our POS plans and in other limited circumstances.

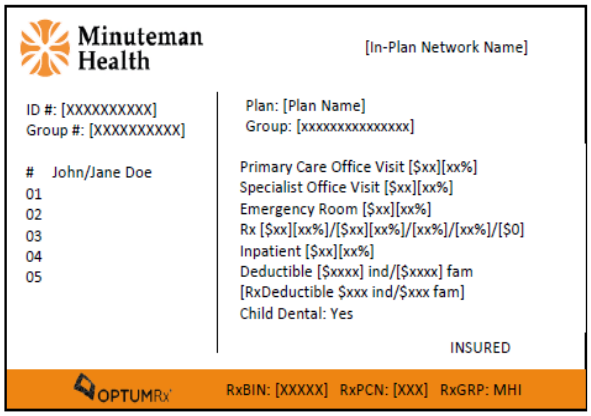
The In-Plan Network Name shown at the top of the front of the card will display as one of two ways for our New Hampshire members:

- Minuteman Health Network – NH IND (for members in individual or non-group plans)
- Minuteman Health Network – NH GRP (for member in group plans)

The group number on the ID Card contains important information. For our insured business, the first digit is (Z). For our insured individual and small group plans, the second digit identifies whether the plan is On Exchange (E) or Off Exchange (N), and the third digit identifies an Individual (I) or a Small Group (G) plan. For large group insured plans, the second and third digit will both be zeros.

For self-insured plans, the first and second digits will be SZ.

Sample ID card:



ADMINISTRATIVE PROCEDURES

Provider Record Changes

Please notify Minuteman Provider Relations of changes involving telephone numbers, addresses, hospital affiliations, tax identification numbers, coverage arrangements and panel status. Failure to provide timely notice of such changes may result in inconvenience to patients and possible delays in payment.

Mail	Minuteman Health, Inc. Attn: Provider Relations P.O. Box 120025 Boston, MA 02111
Phone/Fax	855-644-1776, select Option 4 / 877-892-7621
Email	providers@providernetworkalliance.com

Provider Address and Telephone Number Changes

Changes of address and telephone number must be communicated to Provider Relations, in writing no less than sixty (60) days from the effective date of the change. When informing of an address or telephone number change, providers should specify whether the change is for an office address or phone number, billing address or phone number, or both.

Physician Participation in PHOs or Medical Groups

Physicians that establish or terminate membership(s) in a provider organization (e.g. PHO, ACO, Medical Group), or enter into other arrangements that may affect participation status must notify Provider Relations, in writing not less than sixty (60) days prior to the effective date of the change. Such change in status may have an impact on payment terms and contractual obligations. The failure of physicians to properly notify Minuteman of such change in participation status may result in delayed, denied or incorrect payments.

Physician Primary Hospital Affiliation Changes/Additional Hospital Affiliations

If a physician would like to add, change or delete his or her primary hospital affiliation, the request must be submitted no less than sixty (60) days prior to such change. The notification should indicate the reason for the change and the effective date of the change.

Provider Tax Identification Number Changes

When a provider has a change in his or her Federal Tax ID number, Provider Relations must be notified in writing at least sixty (60) days prior to the change. When notifying Provider Relations of the change the following information must be provided:

- New Federal Tax ID number (W-9)
- The name to which checks should be made payable
- Billing address
- Billing phone number
- Effective date of change

Provider Coverage Arrangements

Minuteman requires all PCPs to make arrangements for care for Members listed on their panels twenty-four hours a day, seven days a week. When arranging for coverage, the covering practitioner will be bound by the PCP's agreement. If a physician does not properly maintain coverage arrangements, delayed or incorrect payments may result.

Member Assignment to Primary Care Panels

Minuteman requires all Members to select a PCP. Only physicians and registered nurse practitioners in primary care specialties (internal medicine, pediatrics and family practice) can be assigned as PCPs. Members may change their PCP either on the Member's request, provider request under certain circumstances (see below) or if the patient starts seeing a PCP from a different provider group.

PCP Panel Status Changes

PCPs may change their panel status by notifying Provider Relations in writing. PCPs may change the age restriction placed on their panels and may also change restrictions on accepting new patients. If a change places a greater restriction on the PCP's panel, the change must be made in compliance with the provider agreement and will be effective thirty (30) days from the date that Minuteman Provider Relations received the request. Any change that reduces or eliminates a restriction to a PCP's panel will be effective immediately upon receipt of the request. Categories of PCP panel status are described below:

ALL

Any Member who chooses this PCP will be added to the PCP's panel, provided the Member is within the age restrictions that the PCP has provided to Minuteman Provider Relations.

EXISTING

Only Members who are patients of this PCP at the time they became Minuteman Members will be added to the PCP's panel. All Minuteman Members are asked if they are an existing patient of the PCP that they have selected. A Member who answers "Yes" will be added to the PCP's panel. If the Member answers "No," the Member will not be added to the PCP's panel. The PCP's name will appear in the Minuteman Provider Directory and under the Accepting New Patients field "Has Restrictions" will be displayed.

CLOSED

No Members may be added to this PCP's panel. Neither new nor existing patients will be added to this PCP's panel. PCPs with a closed panel will not appear in the Minuteman Provider Directory. PCPs must not treat Minuteman Members differently from non-Minuteman Members with respect to closed panel status.

Removing a Member from a PCP's Panel

The physician-patient relationship is a personal one which may become unacceptable to either party. If this happens, the Member or the PCP may request that a Member be transferred to another PCP.

In order to remove a Member from his or her panel, the PCP must send a letter to the Member requesting that the Member choose another PCP, with a copy faxed to Minuteman Provider Relations. The letter must explain why the PCP is removing the Member from his or her panel. The PCP may not request a Member's transfer for discriminatory reasons, because of the amount of medical services required or because of a Member's physical or mental condition.

Once Provider Relations receives the letter, the Minuteman Member Services Department will contact the Member to assist them with selecting a new PCP. From the time Minuteman contacts the Member, the Member will have 30 days to select a new PCP. If they do not choose a new PCP within 30 days, Minuteman will assign them a new PCP. Minuteman will then send a letter to the Member advising them of the change. PCPs must continue to treat the Member during this transition period.

Member Rights and Responsibilities

Member Rights

Members of MHI have certain rights.

These are to**:**

- Receive information on MHI, its services, In-Plan Providers, policies, procedures, and Member rights and responsibilities. MHI will not release information that by law may not be given to Members or any third party. We will not disclose privileged information about In-Plan Providers.
- Be treated with respect and with recognition of the Members' dignity and right to privacy.
- Participate in health care decisions with their doctor or other health care providers.
- Expect that their doctor or other health care providers will fully and openly discuss appropriate, medically necessary treatment options, regardless of the cost or benefit coverage. It does not mean that MHI covers all treatment options. If Members are unsure about coverage, please contact the Member Services team.
- Contact us with a grievance or complaint about MHI or an In-Plan Provider.
- Refuse a treatment, drug, or other procedure recommended by their doctor or other health care providers as the law allows. Providers should tell Members about any potential medical effects of refusing treatment.
- Select an In-Plan Primary Care Provider (PCP) who is accepting new patients. For a list of PCPs, Members can search the Minuteman Health Provider Directory, visit the Provider & Pharmacy search tool at www.minutemanhealth.org, or call the MHI Member Services team.
- Change their PCP. Members may choose any In-Plan PCP, except those who have notified MHI that they no longer accept new patients.
- Have access, during MHI'S business hours, to the Member Services team who can answer Members questions and help resolve problems.
- Expect that their medical records and information on their relationship with their doctor will remain confidential, in accordance with state and federal law and MHI policies.
- Make recommendations regarding MHI'S member rights and responsibilities policies.

Because MHI is member-governed, Members have a number of additional Member rights. They may:

- Elect Members to the MHI Board of Directors (if they are age 18 or older).
- Participate in the annual Members' meeting.
- Have an opportunity to be nominated as a candidate to be elected to the MHI Board of Directors.

Member Responsibilities

As Members of MHI, Members have certain responsibilities. These are to:

- Present their ID card at the time of receiving health care services.
- Provide, as much as possible, the information their providers need to care for them. This includes information on their present and past medical conditions, as they understand them, before and during any course of treatment.
- Follow the treatment plans and instructions for care that they have agreed on with their provider.
- Read MHI materials to become familiar with their benefits and services. If Members have any questions, please call the Member Services team.
- Follow all MHI policies and procedures.
- Treat providers and MHI staff with the respect and courtesy that they would expect for themselves.
- Arrive on time for appointments or give proper notice if they must cancel or will be late.
- Understand their health problems, which is an important factor in their treatment, and participate in developing mutually agreed upon treatment goals to the extent possible. If a Member does not understand their illness or treatment, they are responsible for talking it over with their doctor.
- Participate in decision-making on their health care.
- Inform MHI of any other insurance coverage they may have. This helps us process claims and work with other payers.
- Notify us of status changes (such as a new address) that could affect their eligibility for coverage.
- Help MHI and In-Plan Providers get prior medical records as needed. Members agree that MHI may obtain and use any of their medical records and other information needed to administer the plan.
- Consider the potential effects if they do not follow their provider's advice. When a service recommended by an In-Plan physician is covered, they may choose to decline it for personal reasons. For example, they may prefer to get care from out-of-plan providers rather than In-Plan Providers. In these cases, MHI may not cover substitute or alternate care that the Member prefers.

Medical Records and Document Retention

Minuteman Health and its designated agents shall have the right to inspect and audit transcripts of any provider's books, records and documents necessary for correct coding initiatives and fraud, waste and abuse activities. Providers are required to maintain the confidentiality of member records and information. Providers are required to maintain these documents for the Minuteman Performance Period which is Minuteman's CMS loan repayment period plus 10 years.

MINUTEMAN PRODUCTS AND BENEFITS

Minuteman provides insurance benefits to individuals and families as well as employer groups.

We also provide administrative services to health benefit plans sponsored and funded by employers themselves. We refer to these as "self-funded" plans. An easy way to identify a self-funded Member is by the group number which can be found on the Minuteman ID card. Self- funded group numbers always start with an "SZ".

It is important to know that our insured plans cover New Hampshire mandated benefits; however, self-funded plans may cover NH mandates at the Employer's discretion. Also, Minuteman's insured plans include many standard benefits. These benefits are not always standard among our self-funded groups. If you have any self-funded eligibility or benefit questions please see www.minutemanhealthdirect.org or call 855-644-1776.

Minuteman offers several types of products to both insured and self-insured groups. Below is a brief description of our products and selected benefits. Additional plan and benefit details are available through www.minutemanhealthdirect.org or by calling 855-644-1776.

Under our New Hampshire plans, In-Plan Providers include contracted Minuteman Health providers in both our New Hampshire network and our Massachusetts network. Minuteman also contracts with the national First Health network to support our POS products, with DentaQuest for pediatric dental benefits available under certain plans, and with OptumRx (formerly known as Catamaran) for pharmacy benefits. Links to the First Health online provider search and a list of In-Plan Dentists are available on MHI's website here: http://minutemanhealth.org/Resources#Provider.

HMO Plans

In New Hampshire, Minuteman sells HMO plans both on and off the Federal Exchange to individuals, families and small groups. We also sell plans to large groups. HMO member cost sharing may include copayments, deductibles and coinsurance. There may also be limits on the number of covered visits or services in a given calendar or policy year for certain categories of benefits. Additional benefit details are available through www.minutemanhealthdirect.org or by calling Provider Services at 855-644-1776 (Select Option 4).

Primary Care Provider – Our HMO plans require that each Member select a primary care provider (PCP). PCPs will either provide medically necessary care or direct the Member to a Minuteman specialty provider. Referrals to In-Plan Providers are not required. However, any direction to a non-participating provider requires prior approval by Minuteman if it is to be treated as a Covered Service; otherwise the claim may be denied. Only physicians, physician assistants and registered nurse practitioners in primary

care specialties (internal medicine, pediatrics and family practice) can be assigned as PCPs.

Specialty Care – Minuteman HMO Members may see participating specialists without being referred by their PCP. Specialists can also refer Members to other in-network specialists without a formal referral. However, any referral to a non-participating provider requires prior approval by Minuteman, otherwise the claim may be denied.

Prior Authorizations are required for some services. Failure to obtain a required authorization may result in a denial of coverage and non-payment. (See Utilization Management starting on Page 32.)

Point of Service (POS)Plans

Minuteman offers several types of POS plans to groups. Members may visit In-Plan Providers who have contracted with Minuteman either directly or indirectly via the First Health national provider network (except for emergency care, and urgent care obtained outside the Minuteman service area). Cost-sharing including copayments, deductibles and coinsurance, will vary depending on whether the Member visits a MHI-contracted provider ("Preferred") or a First Health provider ("Non-Preferred"). Services provided by Out-of-Plan providers, who do not contract with either the Minuteman Health Network of First Health, are not covered. Many of our POS plans include pediatric dental essential health benefits through our relationship with DentaQuest. Additional benefit details are available through www.minutemanhealth.org or by calling Provider Services at 855-644-1776 (Select Option 4).

Here is an overview of how our POS plans work:

MyDoc POS Plan Overview			
	In-Plan		**Out-of-Plan**
	Preferred	**Non-Preferred**	
Providers	Minuteman Health Network	First Health national network that includes hospitals, ancillary facilities and health care professionals	Any provider who does not participate in the Preferred Minuteman network or the Non-Preferred First Health national network
Medical Benefits & Cost-Share	Members incur the lowest out of pocket cost	Members have higher out of pocket costs, but providers must accept Minuteman's negotiated fees and cannot "balance bill"	**Not covered**

		Members	
PCP	Member must select a PCP	Not required	Not applicable
Referrals	Not required	Not required	Not applicable
Pharmacy Benefits	In-Network Pharmacy*		**Not covered***

***Benefit will be covered only if filled at an In-Network pharmacy.**

Primary Care Provider – The POS plans require that each Member select an In-Plan Preferred primary care provider (PCP) in order to receive the highest level of benefits (In-Plan Preferred level of benefits). POS members who live outside the MHI New Hampshire Service area may select In-Plan Non-Preferred providers from the First Health Network to act as their PCPs. PCPs will either provide medically necessary care or refer the Member to an In-Plan specialty provider. Only physicians, physician assistants and registered nurse practitioners in primary care specialties (internal medicine, pediatrics and family practice) can be assigned as PCPs.

Specialty Care - POS Members may be seen by In-Plan Preferred providers as well as In-Plan Non-Preferred Providers. No PCP referrals are required. POS Members do not have coverage if they see providers who do not participate in the Preferred Minuteman network or the Non-Preferred national network.

POS Members' benefits are greater with less out-of-pocket expenses when using In-Plan Preferred Providers. Please assist Minuteman POS Members whenever possible to use In-Plan Preferred Providers. Services from In-Plan Non-Preferred Providers are generally subject to higher copayments and coinsurance levels than those associated with In-Plan Preferred Providers.

As with our HMO plans, Prior Authorizations are required for some services under our POS plans. Failure to obtain authorizations may result in a denial or reduction of benefits.

Preventive Care

Minuteman covers a wide range of preventive services for children and adults with no member cost-sharing when they are rendered by In-Plan Providers. These include but are not limited to routine annual exams, immunizations, routine mammograms, routine colonoscopies, certain contraceptives and tobacco cessation products. A complete list of these services is available on our website here: http://minutemanhealth.org/Resources#Provider.

Emergency and Urgent Care

What is an Emergency Medical Condition?

An Emergency Medical Condition means the sudden and, at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy. NH RSA § 420-J:3 XV.

In the Minuteman Service Area

The Member always has coverage for care is that is considered an emergency. Minuteman encourages the Member to call their PCP first if possible. If a Member calls their PCP, the PCP may direct the Member to his/her office, an ER, or urgent care facility. Minuteman requires PCPs to provide on-call coverage 24 hours a day, seven days a week. The PCP (or the covering physician) should call the Member back as soon as possible if the Member reaches an answering service. Please remember that urgent care received inside the MHI New Hampshire service area must be rendered by In-Plan Providers.

Follow-up Care

Unless otherwise indicated in this Provider Manual, all emergency follow-up care must be coordinated by the Member's PCP. All Minuteman Members, including POS Members, have been instructed to contact their PCP within 48 hours of receiving care for the Emergency Medical Condition to coordinate all follow-up care.

Out of the Minuteman Service Area

The Member always has coverage for care that is considered an emergency, even when he/she is outside of the Minuteman New Hampshire service area. Follow-up care once an HMO Member is medically stable and able to return to the service area must be provided or coordinated by the PCP. Starting in 2016, Members will have coverage for urgent care received outside of the Minuteman New Hampshire service area. Please note: POS Members should be encouraged to follow up with their PCP. Out-of-network non-emergent services will result in higher Member cost share.

Emergency Inpatient Admissions

Emergency or urgent inpatient admissions must be reported to Minuteman within one business day by the hospital or the admitting physician. Please call Health Services at 855-644-1776 (Select Option 4, then Option 4).

- If a Minuteman HMO Member is admitted to an out-of-area hospital as a result of an emergency, Minuteman will cover the cost of services in that hospital only until the Member's medical condition allows for return to the service area and the care of the PCP. Please note: this does not apply to POS Members.
- If the Member is admitted to a hospital on an inpatient basis as the result of a medical Emergency, the ER copayment/coinsurance will be waived. Hospital deductibles and cost sharing will apply. The Member must pay a copayment/coinsurance for each ER visit if the visit does not

result in an admission.

Obstetrical and Gynecological Services

Minuteman Members do not need a referral or Prior Authorization to seek obstetric or gynecological services from an In-Plan Provider who specializes in obstetrics or gynecological care. This includes an In-Plan gynecologist, obstetrician, professional nurse midwife or family practitioner. All In-Plan Providers are required to follow Minuteman's policies and procedures for Prior Authorizations, as appropriate, for the services he or she provides.

Each female Minuteman Member is covered for one routine gynecological exam each calendar year. No referral is required. The annual gynecological exam may include a PAP smear and pelvic exam. The exam may be performed by the Member's PCP or any In-Plan participating gynecologist.

Family Planning Services

Minuteman covers Family Planning Services. This includes pregnancy testing and genetic counseling.

What is Covered:

- Outpatient contraceptive services. This includes consultations, exams, and medical services that are provided on an outpatient basis.
- Contraceptive methods approved by the Food and Drug Administration (FDA) and prescribed for a woman by her health care provider and subject to reasonable medical management.
- Nonprescription birth control preparations including but not limited to condoms, birth control foams and jellies, when prescribed by Provider.
- Counseling and diagnostic services for genetic problems and birth defects
- Family planning information and consultation
- Pregnancy testing
- Sterilizations
- Vasectomies
- Voluntary termination of pregnancy when allowed by New Hampshire law

Types of Things that are Not Covered:

- All infertility services, including infertility testing, treatment and procedures
- Reversal of voluntary sterilization
- Services related to achieving pregnancy through a surrogate (gestational carrier)
- Nonprescription birth control preparations including but not limited to condoms, birth control foams, jellies, and sponges, without a prescription from Provider.

Maternity Care

Only an In-Plan Provider can provide prenatal care. Also, an In-Plan Provider must arrange all inpatient care.

What is Covered:

- Prenatal visits and screening and postpartum care. This includes consultation for breast feeding support, equipment and counseling, screening for post-partum depression and parent education. There is no cost-sharing for routine prenatal visits and screening and postpartum care.
- Diagnostic tests
- Prenatal homemaker services for a woman who (1) is confined to bed rest or (2) whose normal functions of daily life are restricted. Services must be medically necessary, as determined by an In-Plan Provider, who shall consult with Minuteman's case manager, when applicable.
- Child Delivery, including a minimum of 48 hours of inpatient care following a vaginal delivery and a minimum of 96 hours of inpatient care following a caesarean section. Any decision to shorten the inpatient stay for the mother and her newborn child will be made by the attending physician and the mother.
- Routine nursery charges. These include services commonly given to healthy newborns. To have Minuteman cover the child of the Subscriber or the Subscriber's spouse after birth, you must enroll the child as a Member within 31 days of birth. Coverage will not be provided for a newly born child of a Dependent beyond 31 days.
- Newborn hearing screening
- Postpartum homemaker services, when medically necessary, as determined by In-Plan Provider, who shall consult with Minuteman's case manager, when applicable.

What is Not Covered:

- Routine maternity (prenatal and postpartum) care when you are traveling outside of the Minuteman Service Area.
- Delivery out of the Minuteman Service Area after the 37th week of pregnancy. Minuteman also will not cover delivery out of the Minuteman Service Area if the Member has been told that she is at risk for early delivery.

If the Member is pregnant, she may receive all of her pregnancy care and delivery, and one routine post-natal office visit from a participating obstetrician. The obstetrician must submit either the American College of Obstetricians and Gynecologists (ACOG) Antepartum Record Form or the Obstetrical Pre-Registration Form, following the Member's first prenatal visit, to Health Services. The form contains a section for Obstetrical High Risk/Pre-term Labor Assessment which is completed and submitted following the first prenatal visit and again following subsequent visit(s) if a risk factor is identified. Health Services will use the form to evaluate the need for Case Management services. Health Services will also confirm

that the delivery will take place in a network facility to minimize the Member's out-of-pocket costs.

The obstetrician is responsible for all obstetrical services and referrals related to the Member's pregnancy. The obstetrician may also provide routine medical services unrelated to the Member's pregnancy.

Any elective surgical procedures to be performed during the hospital admission and following delivery (i.e., planned tubal ligation) should also be communicated to Minuteman by submitting the ACOG form either at the initial or subsequent visits. These services do not require submission of a separate Standardized Prior Authorization Request Form. Please fax the ACOG Antepartum Record or Pre-Registration form to Minuteman Health Services at 413-233-2700.

A copy of the Clinical Guideline for Uncomplicated Obstetric Care and forms may be obtained by calling Minuteman Health Services at 855-644-1776 (Select Option 4, then Option 4) or by referring to the website at www.minutemanhealth.org .

The obstetrician should also remind the pregnant Member to select a participating pediatrician to provide services to the newborn.

Mammograms

Routine screening mammograms are also covered as preventive services. A baseline mammogram may be obtained between the ages 35 and 39, then one mammogram is covered per calendar year for Members ages 40 and over. Non-preventive mammograms are covered as medically necessary and require member cost-sharing.

Routine Vision Exam

Each Minuteman adult Member in an insured plan is currently covered for one vision exam per 24 months each calendar year. Starting in 2016, adults will be covered for one routine eye exam every calendar year. Each child Member (under age 19) in a Minuteman New Hampshire plan is covered for one routine eye exam, a pair of frames from a designated MHI collection, eyeglass lenses (standard plastic up to 55 mm single vision, bifocal, trifocal, progressive), elective contacts in lieu of glasses and non-elective contacts for certain conditions in lieu of glasses, per calendar year. No referral is required. The exam may be performed by any participating optometrist or ophthalmologist.

Chiropractic Benefit

When chiropractic benefits are covered, they are limited to 12 visits in a calendar year. Minuteman Members may self-refer as medically necessary for up to all 12 visits to a chiropractor who is an In-Network

Provider. Please note**:** Minuteman does not cover X-rays when done in a chiropractic office. Chiropractors are directed to refer Members to their PCPs for coordination of these imaging services.

Outpatient Surgery

Some Minuteman HMO and POS plans include lower cost sharing for Members if they visit designated "Select" Minuteman contracted providers for Outpatient Surgery. See our online provider directory to identify "Select" providers in the MHI New Hampshire provider network.

Durable Medical Equipment (DME)

At Minuteman, the term "DME" is used to denote anything billed with an A, E, L, or K HCPCS code, with a few exceptions (e.g. certain drugs and pharmaceuticals). This includes standard durable medical equipment, high-tech or other specialized DME, medical and surgical supplies, ostomy supplies, oxygen and respiratory equipment and supplies, and orthotics and prosthetics.

Most DME is dispensed to Minuteman Members by contracted DME and orthotics & prosthetics vendors. However, certain DME products may be dispensed to Members by physicians at the time of the visit, by hospitals and by other contracted Minuteman vendors or manufacturers who dispense specialized products. Standard items will be dispensed unless the physician's order specifies a non-standard item.

DME Dispensed by Physicians

In-Plan Physicians may provide Members with therapeutic and medically necessary DME during an office visit, especially in instances where the dispensing of such DME items is essential to providing timely and effective care to the Member versus referring the Member to a DME vendor (e.g. splint). Minuteman will reimburse Minuteman In-Plan Physicians for such DME at its standard Physician Office Allowable DME Fee Schedule. (For POS members, Non-Preferred First Health DME providers will be reimbursed per the terms of their First Health Contracts.)

In instances where, in the physician's opinion, it is not medically necessary to dispense the DME from the physician's office, the physician's office should either contact an In-Plan DME vendor to have the item(s) delivered to the Member's home or give the Member a written order for the DME. The Member can either visit an In-Plan DME vendor or call to arrange for the items to be delivered to their home.

Certain equipment and supplies, for example, gauze, is included in the physician's office visit fee and will not be paid separately, nor is it covered when provided by the DME vendor.

Hearing Aids and Services:

Minuteman covers hearing aids to the extent required by New Hampshire law. A hearing aid is defined as

any instrument or device designed, intended or offered for the purpose of improving a person's hearing. Minuteman currently covers one hearing aid every sixty (60) months pursuant to New Hampshire law. Starting in 2016, Minuteman will cover hearing aids (including parts, attachments or accessories, including ear moldings) when medically necessary (i.e., each time a hearing aid prescription changes). No back-up hearing aids that serve a duplicate purpose are covered. Services necessary to assess, select, fit or service the hearing aid must be provided by an In-Plan Provider who is a licensed audiologist, hearing instrument specialist or licensed physician.

Laboratory Services

All laboratory testing must be medically necessary and related to an active treatment plan. The ordering physician must provide the Member with a written order if the test is not provided on site. The ordering physician must always direct the Member or Member's specimen to a Minuteman participating laboratory provider to ensure coverage. Members should also verify that the laboratory is a participating provider.

Blood specimens may be drawn in the physician's office. If testing is not performed in the office, only phlebotomy services may be billed. Minuteman does not allow pass through billing on laboratory exams.

Minuteman Physician Office Allowable Lab Tests

Subject to their provider contracts, Minuteman participating physicians may perform laboratory tests in their office for Minuteman Members and may bill and be reimbursed by Minuteman on a fee-for-service basis. The provider office laboratory (when applicable) must meet all local, state, and federal requirements relating to physician office laboratory standards and licensing.

"Select" Lab Providers

Some Minuteman HMO and POS plans include lower cost-sharing for Members if they visit "Select" laboratory providers. See our online provider directory to identify "Select" lab providers in the MHI New Hampshire provider network.

Behavioral Health Services

Mental Health Services

MHI will only cover mental health services when they are Medically Necessary. MHI covers all mental disorders that are described in the most recent edition of the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM).

Substance Abuse Services

MHI covers the diagnosis and treatment of substance abuse. The treatment can be inpatient and outpatient treatment. Outpatient treatment must be provided by a physician or psychotherapist who

spends a large part of his or her time treating substance abuse. MHI also covers Medically Necessary inpatient detoxification. All treatment must be Medically Necessary.

What is Not Covered:

- Educational services or testing, except services covered under the benefit for Early Intervention services
- Psychoanalysis
- Services for problems of school performance
- Faith-based counseling
- Social work for non-mental health care
- Christian Science practitioner and sanitarium stays
- Residential/custodial services (including residential treatment programs, sober houses and halfway houses)
    - Testing and treatment services at these facilities not covered

Miscellaneous Services including Pain Management, Biofeedback and Neuropsychological Testing

Minuteman insured plans cover Telemedicine furnished or approved by the PCP for Medically Necessary services that would be Covered Services if provided during an in-person consultation. Both the Network provider and Member must be present and participating.

Minuteman insured plans cover clinical trials if federally funded as part of an approved clinical trial (phases I-IV). Experimental devices and drugs that may be part of these trials are not covered by Minuteman.

Various types of providers including hospitals, mental health clinicians and anesthesiologists may provide pain management services. Copayments are applicable for pain management services, including an outpatient hospital copayment, if services are performed in the hospital.

Biofeedback is excluded from coverage for medical conditions other than urinary incontinence. Biofeedback for urinary incontinence requires prior approval. Biofeedback for mental health is treated like therapy and prior authorization from Minuteman Health Services is required. Biofeedback to treat ADHD and ADD is not a covered benefit.

Neurobiofeedback is not a covered benefit. Neurobiofeedback is a non-invasive technique that is used to teach patients how to stimulate and suppress brainwaves of specific frequencies.

Neuropsychological testing is covered. The physician office visit copayment applies. Prior approval from Health Services is required for Members.

Neuropsychological testing is not approved as a first assessment approach for Attention-Deficit/Hyperactivity Disorder.

Pediatric Dental Services

Under some of our plans, we cover pediatric dental essential health benefits for members under age 19 when provided by an In-Plan dentist who participates in the contracted DentaQuest dental network. Covered services under these plan types include the following:

Diagnostic & Preventive Services

- Topical fluoride treatment, once every 6 months (member cost-sharing does not apply for children up to age 5)
- Periodic oral exams, 2 per year
- Routine cleanings, once every 6 months
- Bitewing x-rays, 1 set every 6 months
- Panoramic x-rays, 1 image every 60 months

Minor Restorative Services

- Fillings
- Pre-fabricated stainless steel crowns, under age 15, 1 per tooth every 60 months
- Pre-fabricated porcelain crowns, primary, 1 per tooth every 60 months
- Simple tooth extractions
- Incisions and drainage of abscess
- Tissue conditioning
- Repair of crowns
- Palliative treatment of dental pain
- Adjustment of dentures

Complex Restorative Services

- Crowns, 1 per tooth every 60 months
- Root canals
- Periodontic services (limits vary)
- Endodontic services (limits vary)
- Onlay, metallic, 1 every 60 months
- Inlay, metallic, 1 every 60 months
- Dentures, 1 every 50 months
- Implants, 1 every 60 months

Orthodontic Services

Only medically necessary orthodontic treatment is covered. Members must have a severe and handicapping malocclusion. All orthodontic services (including interceptive orthodontic treatment) require prior authorization.

Provider questions about Minuteman's dental coverage, prior authorization, claims etc. should be directed to DentaQuest at 855-264-0145.

PHARMACY SERVICES

Note: *Pharmacy Prior Authorization Line (OptumRx):* 855-838-3481

Minuteman policies and benefits related to pharmacy are driven by Minuteman's pharmacy utilization and therapeutic intervention programs to help ensure that Members have access to quality care through clinically sound and cost-effective drug utilization. Our clinical pharmacists oversee the pharmacy and therapeutics program and work with **OptumRx** (formerly known as Catamaran), Minuteman's pharmacy benefits manager.

Pharmacy and therapeutics management consists of a formulary, generic drug substitution, targeted benefit restrictions, drug utilization review, prior approvals, step therapy, and a pharmacy network. Below are overviews of each program component. More detailed and current information can be found at www.minutemanhealth.org.

Prescription Benefit:
Most Minuteman Members are covered for prescription drugs obtained at participating pharmacies.

Drugs covered by Minuteman's closed New Hampshire formulary are organized into cost-sharing tiers as follows:

- Tier 1: Generics
- Tier 2: Preferred Brand-name
- Tier 3: Non-Preferred Brand-name
- Tier 4: Specialty
- Tier 5: ACA Preventive Drugs (no cost-sharing)

If Members have prescription drug coverage, this is noted at the bottom of the ID card *(for example, RX$10/20/35)*. The retail prescription drug benefit is normally limited up to a thirty (30)-day supply. Please see the Medications at Retail section below.

A Member can receive a ninety (90) day supply of maintenance medications either at a retail location or by mail order depending on the Member's plan. Please see the Medications at Mail Order section below. A Member who has taken a formulary drug for one year or more can be prescribed a ninety (90)-day supply, but any applicable prior authorization or UM programs would continue to apply. Controlled substances are not available in a ninety (90)-day supply.

Minuteman In-Plan Pharmacy Network:
Members can fill prescriptions at any of the more than 50,000 In-Plan Pharmacies that participate in our national network. Participating In-Plan Pharmacies include most major pharmacy chains as well as retailers such as Costco and Wal-Mart. In-Plan Pharmacies can be searched on the Minuteman website

at www.minutemanhealth.org.

Over the Counter Medications:
Minuteman covers a number of over-the-counter (OTC) medications with a prescription as required by the Affordable Care Act without a copay. Please refer to our formulary listings at www.minutemanhealth.org for additional detail.

Compounded Medications:
Copayments for compounds will vary based upon the ingredients. However, not all compounds are covered and some may be subject to prior authorization. For questions regarding coverage, please call Minuteman Member Services at 855-644-1776 (Select Option 4, then Option 4 again).

Maintenance Medications at Retail:
Minuteman's Access 90 program allows our Members to receive up to a ninety (90) day supply of maintenance medications and any other medications that are not a controlled substance that have been taken at participating retail pharmacies. A copayment will apply to each thirty (30) day supply. The Access 90 program does not apply to prescriptions filled at Minuteman's specialty vendor or if prohibited by law. For a listing of Access 90 participating pharmacies call Minuteman Member Services at 855-644-1776.

Maintenance Medications at Mail Order:
Members with the mail order benefit may obtain up to a ninety (90) day supply of maintenance medications through the mail.

- Please ensure that the Member has filled as least 2 refills at retail and has not had an adverse reaction before setting up mail order.
- Please verify that the medication is a maintenance medication as defined by Minuteman by visiting www.minutemanhealth.org.
- Please complete and submit the mail order profile available at www.minutemanhealth.org.
- For faster service our Members can order refills online at www.minutemanhealth.org as indicated on the invoice received from the mail order company. This only applies to prescriptions with refills and does not apply to any initial orders.

Specialty Medications:
Members being treated with specialty medications are required to use contracted specialty pharmacies to fill oral oncology and self-injectable medications with the exception of insulin products. Minuteman's specialty vendors supply all forms of injectable medications for Minuteman Members with a prescription benefit. Members without the benefit are covered only for medical injectables (i.e., administered by a medical professional) and are not covered for self-injectables. Order forms for specialty medications are

available on line at www.minutemanhealth.org or can be faxed to you by calling Minuteman Member Services at 855-644-1776 (Select Option 4).

Minuteman's specialty vendor will provide injectable drugs to Minuteman Members in the following settings:

- Private physician offices
- Hospital clinics
- Members' homes

This service is provided to both Members and providers. You can call Member Services at 855-644-1776 to request drug order forms.

Minuteman New Hampshire Formulary

The Minuteman New Hampshire formulary is a closed five tier formulary that is designed to meet Essential Health Benefit requirements. As part of the formulary evaluation process, Minuteman uses an algorithm based on safety, efficacy and cost. All formulary recommendations are discussed at the Minuteman Quality and Utilization Management Committee, which acts as our Pharmacy and Therapeutics Committee, providing a forum for clinician involvement. The Pharmacy and Therapeutics Committee reviews drug categories throughout the year evaluating requests for drug category additions as the category is reviewed. Recently approved drugs that fill a treatment void may be reviewed out of cycle. In general, newly approved drugs are not added to Minuteman's formulary right away. There is at least a six-month waiting period after the drug is approved called the Clinical Review Period (CRP). Minuteman does not cover the newly approved drugs during the Clinical Review Period.

Important Criteria:

- Drugs reviewed for addition must be FDA approved.
- Drugs under consideration will be compared to existing therapies and will be evaluated based on quality dimensions.
- If the drug under consideration is not similar to existing agents and is the only drug in its class, the evaluation will be made against existing therapies, including non-drug therapies.

The formulary is reviewed annually and as necessary throughout the year. Providers can receive a formulary listing upon request or on the website. Drugs added or deleted from the formulary during the year are communicated through periodic mailings to providers and Members, and are posted on www.minutemanhealth.org.

Minuteman, through OptumRx, maintains an expedited exceptions process, allowing Members to receive a decision on whether Minuteman will cover a non-formulary drug within 24 hours. To request a formulary exception, submit a request with a clinical rationale in accordance with the instructions on the OptumRx website. Minuteman allows "off label "drug use. In certain circumstances "off label" use may require a

prior authorization. The drug and the treatment methods must be recognized either in medical literature or in standard reference compendia.

Generic Drugs

Minuteman supports and encourages the use of FDA "AB" rated generic pharmaceuticals for Minuteman membership. Approved FDA "AB" rated generic drugs (Tier 1 cost-sharing) contain the same active ingredients as brand name drugs, are just as safe and effective and usually cost less. Pharmacists are permitted to substitute generic drugs unless the prescribing physician handwrites "medically necessary" on the prescription or, if ordering by telephone, specifies orally that the drug is medically necessary as written. Minuteman Members pay the lowest copayment for generic drugs.

When you prescribe a brand name medication and an approved FDA "AB" rated generic is available you will need to complete and submit a Prior Authorization Form, available at www.minutemanhealth.org. To assist in expediting your medication request make sure you complete all questions on the form. Provide your assessment of medical necessity for the brand product only. Include any documentation such as office notes, call log(s), action steps taken should the Member have experienced an adverse reaction, serious side effect, and/or lack of efficacy to the generic product. Minuteman encourages you to go to the FDA website and complete a Medwatch Adverse Event Reporting Form if the Member had a serious adverse event. Your request will be reviewed and a determination will be based on the information you provide.

Newly Approved Drugs

In general, new brand name drugs, or existing drugs with new treatment purposes, are not added to Minuteman's Formulary right away. There is a minimum six-month waiting period after they are approved by the FDA called the Clinical Review Period (CRP). This applies to all new drugs, including those dispensed at a retail pharmacy, from a specialty pharmacy, in the doctor's office or in an infusion suite.

Minuteman does not cover drugs during the CRP. You may ask us to make an exception. If we approve coverage of the drug during the CRP, the copay will be 50% of the cost of the drug. At the end of the CRP, Minuteman may decide not to cover the drug and add it to the exclusion list. If this happens, Minuteman will not cover the drug after the CRP. If Minuteman does decide to cover the drug, the copay will be the amount for the tier to which the drug is assigned.

After review, the drugs will be covered under tiers 2, 3 or 4 depending on their placement in the Minuteman formulary. This does not apply to newly approved generic drugs. Generic drugs are covered under the lowest copayment level (Tier 1).

Excluded Drugs

For the most current list of excluded drugs, please call Member Services at 855-644-1776.

Review Process

If a physician requests an FDA approved medication for a non-FDA approved disease state/condition, the criteria for its use will be based upon at least 3 peer-reviewed journal articles, national guidelines and current standard of care. If the use of the medication does not fall into any of these categories, Minuteman's Pharmacy Services Department will generally deny the request.

You can obtain a copy of the Clinical Review Period Benefit Exception form at www.minutemanhealth.org by searching the drug in question. The form will be available in the search results.

Medical /Pharmacy Benefit Drugs Requiring Prior Authorization

Minuteman continually monitors and evaluates new drug information, drug utilization and formulary compliance to meet our goal of providing high-quality pharmaceutical care. As part of this process, Minuteman limits quantities and use of certain drugs and requires prior authorization for others.

In order to obtain a supply of medication request forms or a list of any medical or pharmacy drugs that require approval, visit www.minutemanhealth.org or call Member Services at 855-644-1776 (Select Option 4). Complete the appropriate drug prior authorization form and fax it to the number on the form.

Our PBM, OptumRx, offers our providers the option to call in for prior authorization by calling 855-838-3481. The PBM will contact the provider if necessary and will notify you of all decisions. They also provide an opportunity for case discussion and reconsideration of adverse determinations.

Drugs with Quantity Limits

For the most current list of medications with quantity limits or quantity-based copayments, please call Member Services at 855-644-1776 (Select Option 4), or use the online drug search at www.minutemanhealth.org. Completed forms should be faxed to the number on the form. Only FDA maintenance indicator drugs are allowed through mail order.

Step Therapy Program

Step Therapy is an approach to medication management. Step Therapy is a program designed for certain conditions – diabetes, high blood pressure and high cholesterol. The Minuteman Step Therapy program is all about value. Most simply, that means getting a tried and true medication that is proven safe and effective for the condition and getting it at the lowest possible cost. This program is designed to have prescription drugs be more affordable. We will work with you to be certain that our Members are getting the appropriate drug for their condition. The use of samples does not satisfy the requirements of documented usage of a first or second line drug of medical necessity for a Step Therapy drug. If it is medically necessary for your patient to use a Step Therapy drug before trying a first and/or second line

drug, please contact Minuteman to request a pharmacy review. If you have any questions about the program please contact Member Services at 855-644-1776 (Select Option 4), or use the online drug search at www.minutemanhealth.org. Minuteman will not require failure on the same medication on more than one occasion for patients continuously enrolled in the plan.

Note: Some of these Step Therapies have 3 steps. Members must try the first line drug before Minuteman will cover the second line drug. Members must try the second line drug before Minuteman will cover the Step Therapy drug.

UTILIZATION MANAGEMENT

Prior Authorization Process

Minuteman Health Services Contact Information:

Phone: 1-855-644-1776 (Option 4, then Option 3)

Health Services FAX: 1-413-233-2700

Provider Portal: www.minutemanhealthdirect.org

For Diagnostic Imaging: Contact eviCore/MedSolutions at 888-693-3211

For Rx Prior Authorization: Contact OptumRx (formerly known as Catamaran) at 855-838-3481

IMPORTANT INFORMATION:

- Prior authorization is required for the elective admissions/services listed below whether they are administered in-plan or out-of-plan.
- The responsibility of obtaining prior authorizations from Minuteman Health is the sole responsibility of the provider. This responsibility includes, but is not limited to, drafting and submitting prior authorization forms. If a provider does not obtain prior authorization in accordance with Minuteman Health's policies and procedures, Minuteman Health will not pay the provider for these claims. Providers in Minuteman Health's network understand and agree that members are **not** financially liable for services obtained without the provider obtaining prior authorization and additionally agree that they will not balance bill members for services in accordance with New Hampshire law.
- All out-of-plan elective services require a prior authorization request from the PCP must be submitted to Minuteman for review if the service is to be treated as a Covered Service or, for Members enrolled in a POS plan, to be covered at an in-Network level of coverage.
- Behavioral health/substance abuse admissions do not require prior authorization, however, the facility must contact the Minuteman Health Services department within one business day to initiate continued stay review.
- Inpatient stays and ongoing services are reviewed concurrently.
- Submit request for prior authorization to Minuteman Health Services, by phone or fax prior to the scheduled admission/service.
- Requests may be submitted using the Standardized Prior Authorization Request Form available at www.minutemanhealth.org.
- Specific forms can also be found for requests for Behavioral Health and Enteral Nutrition can be found on our website.
- Provide complete, pertinent clinical information in order to avoid a delay in making a determination. When changes are made to this list, providers will be notified in writing 60 days prior to the change going into effect.

- Prior Authorization must be obtained even when another insurer may be primary.

Minuteman Health Prior Authorization List

Some treatments and services require Prior Authorization. These services and treatments are covered only if Minuteman Health, Inc. (MHI) authorized them in advance. If any non-authorized and/or non-covered service or treatment, such as a cosmetic procedure, is performed at the same time as the authorized services, MHI may deny the non-authorized and/or non-covered service or treatment. To get Prior Authorization, the treating doctor must contact MHI. The doctor can either send us a Prior Authorization Request Form or contact MHI by phone.

- Admissions to:
    - Acute care facilities
    - Skilled nursing facilities
    - Acute rehabilitation facilities
    - Hospice

- Transplants
    - Human organ
    - Bone marrow
    - Autologous chondrocyte

- Diagnostic Imaging* (Contact eviCore at 888-693-3211)
    - CT scans
    - MRA's
    - MRI's
    - PET's
    - Nuclear cardiac imaging performed in a physician's office or outpatient facility

*Imaging procedures performed while a patient is in the emergency room, observation, or is an inpatient, do not require prior authorization.

- Surgical Procedures
    - Abdominal panniculectomy
    - Bariatric surgery and surgical management of morbid obesity
    - Blepharoplasty
    - Cochlear implants
    - Endothelial keratoplasty
    - Gender reassignment surgery (MA)
    - Implantable Miniature Ocular Telescope (IMT) Prosthesis

- Infuse bone graft
- Mammoplasty, reduction
- Mobi C artificial cervical disc

- Obstructive sleep apnea corrective surgeries, involving palate, uvula, or related structures
- Orthognathic surgery
- Radiofrequency ablation for chronic spinal pain
- Removal of impacted teeth when performed in an outpatient facility (for both the facility and anesthesia)
- Rhinoplasty
- Sacroiliac joint fusion
- Stimulators
    - Bone growth
    - Gastric electrical
    - Sacral nerve
    - Spinal cord
- Stretta procedure
- Total ankle replacement (TAR)
- Total hip resurfacing
- Uvulopalatoplasty, laser-assisted

- Therapies
    - Speech

- Home Health Care
    - Skilled nursing
    - Infusion therapy
    - Perinatal monitoring
    - PT,OT, Speech Therapy
    - Hospice

- DME, Orthotics & Prosthetics**
    - Cardiac defibrillator, wearable
    - BIPAP, Pressure Support Ventilators
    - High cost equipment, including certain repairs and maintenance
        - Air fluidized beds
        - Bone growth stimulators
        - Cochlear implants
        - Continuous glucose monitoring systems
        - Voice synthesizers for monitors used by legally blind
        - Customized items and supplies
        - (Some)Diabetic equipment and supplies,

        - High frequency chest wall compression devices
        - Home use of oxygen
        - Inter-pulmonary percussive ventilation systems
        - Specialized beds/mattresses for wound care
        - Speech generating devices
        - Wheelchairs, power and other certain wheelchairs
        - Wound care supplies
        - Wound vac systems
    - Insulin pumps
    - Therapeutic shoes and orthotics
    - Prosthetic limbs
    - Facial prostheses (including artificial eyes)

- Infusion & Nutritional Support
    - IVIG
    - Formula and enteral nutrition
    - Lyme disease treatment

- Injectable drugs
    - For a list of injectable drugs covered under the medical benefit and prior authorization requirements, check the MHI Drug Formulary at www.minutemanhealth.org or call MHI Health Services at 1-855-644-1776 (Select Option 2, then Option 4).

- OB/GYN
    - Infertility Treatment (MA)
        - AI, IUI, IVF-EP, GIFT, ZIFT, FET, ICSI, assisted hatching, cryopreservation of eggs
        - Pre-implantation genetic diagnosis
    - Pregnancy
        - After first prenatal visit, fax pre-registration form from www.minutemanhealth.org to MHI Health Services at 413-233-2700, which will serve as prior authorization for admission on EDC
            - ACOG Antepartum Record Form may be used
        - Re-submit updated pre-registration form when a risk factor is identified at a subsequent visit

- Behavioral Health/Substance Abuse (* MA – certain services in Massachusetts cannot be subject to prior authorization but can require a notification requirement and subsequent concurrent review)
    - Acute residential treatment (ART)/Community Based Acute Treatment (CBAT)*
    - Applied Behavioral Health Analysis (In NH, prior authorization is not required. Two (2) visits for diagnosis followed by up to three (3) treatment visits in each contract year are covered without review. Subsequent visits with the contract year may be subject to utilization review. The treatment plan must be submitted.)

- Crisis Stabilization Unit (CSU)/Community Crisis Stabilization (CCS)
- Day treatment *
- Partial hospitalization program (PHP) *
- Family stabilization therapy (FST) *
- Intensive outpatient therapy (IOP) *
- Repetitive transcranial magnetic stimulation (rTMS)
- Neuropsychological testing
- Clinical Stabilization Services (CSS) /Community Stabilization Services (CSS) and Acute Treatment Services (ATS) (Covered in MA only – mandated coverage. In-plan provider notification required within forty-eight (48) hours and prior authorization required on day 15. Out-of-plan providers must have prior authorization.)

- Other
  - Ambulance, non-emergency, including air ambulance
  - Biofeedback
  - Cardiac monitoring
  - Chair van services
  - Cleft lip and palate treatment
  - Clinical trials
  - Dental procedures performed in a hospital setting
  - Dermal injections for the treatment of facial lipodystrophy syndrome (LDS)
  - Fecal microbiota transplant
  - Genetic testing
  - Hearing aids for members age 21 and younger
  - Hyperbaric oxygen treatment, outpatient (HBO)
  - Insulin pumps
  - Lyme disease treatment- IV antibiotics
  - Mandibular advancement device for treatment of sleep apnea
  - Oncogene typing associated with treatment of breast cancer
  - Proton beam therapy
  - Photochemotherapy (PUVA) and Phototherapy
  - Scleral lens
  - Sleep Studies

**Durable Medical Equipment (DME)

At MHI the term “DME” is used to denote anything billed with an A, E, L, or K HCPCS code, with a few exceptions of certain drugs and pharmaceuticals). This includes standard durable medical equipment, high-tech or other specialized DME, medical and surgical supplies, ostomy supplies, oxygen and respiratory equipment and supplies, and orthotics and prosthetics.

- MHI does require DME vendors to receive a prescription from a physician or ordering practitioner prior to dispensing an item to ensure that it is medically necessary.

- The vendor is not required to submit the prescription to be reimbursed, however, MHI may request to see the physician's prescription order.
- Very few DME items require prior approval by Health Services prior to dispensing. For information on member responsibility as well as requirements for prior authorization please call MHI Member Services at 855-644-1776 (Select Option 4).

New Technology and Procedures

Providers who intend to implement the use of a new service, technology or procedure, or implement a new use for an existing technology or procedure, must provide written notification to Minuteman Health not less than (60) days prior to such implementation for approval. Minuteman Health will determine coverage and reimbursement guidelines, including but not limited to payment rates and authorization requirements for such new technology or procedure for the intended site of service. If a provider does not obtain such approval, Minuteman Health will not pay claims for these services. Additionally, members will have no financial liability for new services provided without Minuteman Health's expressed approval.

These requests should be faxed to Minuteman Health Services at 413-233-2700.

UM Decision Process

All UM decisions are made in accordance with the terms of the Member's Evidence of Coverage (EOC) document in a fair and consistent manner. When making a determination of coverage based on medical necessity or appropriateness, Minuteman will render the decision in accordance with defined UM criteria and will evaluate all relevant clinical information, including the individual Member's particular health care needs and the capability of the local delivery system. Written criteria govern all decision-making.

The Minuteman UM Decisions policy sets forth the timeframes for UM decision-making and the process for notification of UM decisions. It is Minuteman's policy to meet both state and federal regulatory requirements as well as to meet or exceed NCQA standards and requirements. At a minimum, this policy is updated on a biannual basis. Minuteman will notify providers in writing of changes or modifications to the UM program that have a substantial impact on the rights or responsibilities of the providers and the effective date of such modifications. If providers would like a copy of Minuteman's most recent UM Decisions policy or UM Criteria, providers may request a copy by calling Health Services at 855-644-1776 (Option 4, then Option 4).

Physician Reviewers

The Chief Medical Officer and/or appropriate specialists and clinical practitioners are consulted for cases that do not meet medical necessity criteria. Program staff may not make denial of service determinations for medical necessity. The Chief Medical Officer or his or her designee is the final decision-maker for any denial based on medical necessity.

Utilization Management decision making is based only on the appropriateness of care and service and existence of coverage. MHI does not specifically reward practitioners or other individuals for issuing denials of coverage. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

Criteria and Medical Necessity

Consistent with generally accepted principles of professional medical practice and in consultation with the Member, the physician treating a Member makes all clinical decisions regarding medical treatment to be provided to the Member, including the provision of durable medical equipment and hospital lengths of stay. Nothing in this section shall be construed as altering, affecting or modifying either the obligations of any third party or the terms and conditions of any agreement or contract between either the treating physician or the Member and any third party.

In reviewing requests for prior approval, Minuteman may consider whether the service:

- Is a covered benefit or service
- Is medically necessary
- Is being provided in the appropriate setting
- Follows generally accepted medical practice
- Is available within the Minuteman network
- Meets Minuteman's clinical criteria for coverage

Minuteman utilizes commercially purchased criteria sets, (Interqual), to assist with making level of care determinations. Minuteman's commercially-purchased criteria sets are licensed criteria sets, which are the PROPRIETARY and CONFIDENTIAL property of the licensing company. Minuteman has a contractual obligation to protect the confidentiality of these licensed criteria. Minuteman makes available to the treating provider and the Member the specific portion of the criteria used where required by law or by applicable accreditation requirements.

Minuteman also utilizes internally-developed criteria that are used as a guideline when applying the standard of medical necessity for select procedures, treatments, and services. Providers who would like a copy of the internally-developed clinical criteria that are used to make UM determinations should

contact Health Services at 855-644-1776 (Select Option 4, then Option 3) or can access the criteria at www.minutemanhealth.org.

The internally-developed medical necessity guidelines utilized by Minuteman in making coverage determinations are:

- Developed with input from practicing physicians.
- Evidence-based and developed in accordance with the standards adopted by national accreditation organizations.
- Updated at least annually as new treatments, applications and technologies are adopted as generally accepted professional medical practice.

In applying such guidelines, Minuteman considers the individual health care needs of the Member. In addition, Minuteman will notify Members and providers sixty (60) days prior to the effective date of any material changes to Minuteman's criteria.

With respect to a Member enrolled in a health benefit plan under which Minuteman only provides administrative services (i.e., for Members enrolled in a Self-Funded plan), the payer may reserve the right to decide certain appeals of benefit denials. If so, Minuteman's role with respect to payment is limited to the benefit coverage recommendation of the payer.

Minuteman defines "medically necessary" in accordance with New Hampshire law as follows: health care services or products provided to a Member for the purpose of preventing, stabilizing, diagnosing or treating an illness, injury or disease or the symptoms of an illness, injury or disease in a manner that is:

- Consistent with generally-accepted standards of medical practice;
- Clinically appropriate in terms of type, frequency, extent, site and duration;
- Demonstrated through scientific evidence to be effective in improving health outcomes;
- Representative of "best practices" in the medical profession; and
- Not primarily for the convenience of the Member or physician or other health care provider.

Of note, medical care should not be performed in a way that financially benefits the provider at the expense of Minuteman Members.

Inquiring About the Status of a UM Decision

Practitioners have direct access to UM staff regarding specific cases and discussion of UM decisions. In general, if a provider requests a service that requires Minuteman's prior approval and would like to know its status or outcome, the provider should contact Health Services at 855-644-1776 (Option 4, then Option 4), between 8:00 a.m. and 6:00 p.m., Monday through Friday.

Practitioners may also call Minuteman UM Departments at delegated entities directly as follows:

- High Cost Radiology and Imaging – **Call eviCore/MedSolutions at 888-693-3211**

- Pharmacy Issues – **Call OptumRx at 855-838-3481**

Submitting Additional Information in the Case of an Adverse Determination
When a provider has received an adverse determination and has additional information that may influence the decision, the provider or his/her office staff should contact the Minuteman Nurse Case Manager so that the request is reviewed again based on this new information. The Nurse Case Manager will review the new information and refer to a physician if unable to reverse the adverse determination.

Reconsideration of an Adverse Determination
If an adverse decision is based on medical necessity and appropriateness, the provider may request a reconsideration from a clinical peer reviewer. A provider who is treating a Member has the right to seek reconsideration of an adverse determination from a clinical peer reviewer in any case involving an initial determination or a concurrent review determination. This reconsideration process shall be initiated within one business day of the receipt of the request. It will be conducted between the provider and the clinical peer reviewer or a clinical peer designated by the clinical peer reviewer if the reviewer cannot be available. If the adverse determination is not reversed by the reconsideration process, the Member or the provider on behalf of the Member, may pursue the grievance process established pursuant to New Hampshire RSA 420-J:5. The reconsideration process allowed herein shall not be prerequisite to the formal internal grievance process or an expedited appeal required by New Hampshire RSA 420-J:5.

Arranging a Telephone Conference for a Case Discussion or Reconsideration
To arrange a telephone conference time for a reconsideration, the requesting physician should call Health Services at 855-644-1776 (Select Option 4, then Option 4). Health Services will obtain the relevant plan information for the case and arrange a teleconference between the requesting physician and the Minuteman physician reviewer or clinical peer reviewer.

Care Management

Minuteman's Care Management Program is designed to offer physicians and Members a Nurse Care Manager to facilitate care coordination. Each Care Manager is responsible for performing utilization review and coordinating follow-up care. Care Management is provided for the ambulatory, outpatient and inpatient settings, as needed. Providers may refer a Member for Care Management Services by calling Minuteman Health Services at 855-644-1776 (Select Option 4, then Option 4).

Minuteman provides an After Hours On-Call Program. A Minuteman Care Manager is available to providers and Members to assist in care coordination that occurs outside of Minuteman's usual business hours. The After Hours On-Call Program functions include:

1. Assisting providers in transitioning Members from one level of care to another appropriate level of care

2. Assisting in disposition planning for hospitalized Members on weekends or holidays where a delay may otherwise be experienced
3. Being available to Members/families and providers during transitions in care to answer questions

Complex Case Management

Complex Case Management is provided for those Members who have a high risk of hospitalization or require multiple health care services. The goal of Complex Case Management is to improve the Member's functional status, reduce hospital admissions, and reduce medical costs. If providers have questions or would like to refer a Member to this program, providers may contact Health Services by calling 855-644-1776 (Option 4, then Option 4).

Chronic Condition Management

Minuteman is committed to helping our Members with chronic health conditions live healthy lives. As part of this commitment, we offer Chronic Condition Management programs for Members with:

- Diabetes
- Asthma
- Coronary artery disease
- High-risk pregnancy
- COPD
- Heart Failure
- Depression
- Hypertension

Minuteman partners with physicians in support of the plan of care. The overall goal of this collaborative effort is to help Members achieve and maintain control of their condition by improving self-management skills. Minuteman programs provide Members with education and support to help improve their ability to manage their health condition on a day-to-day basis.

Claims and encounter data are reviewed, using an algorithm, to identify Members with chronic conditions and stratify them into low-, medium-, and high-risk categories, based on the level of control of their condition. Minuteman provides interventions based on a Member's stratification level. Interventions include:

- Educational materials
- Questionnaires
- Health diaries
- Tracking tools

- Telephonic assessment performed by a registered nurse

If providers have questions or would like to refer a Member for chronic condition management, contact Health Services at 855-644-1776 (Select Option 4, then Option 4).

If a provider would like more information regarding disease management, case management or other medical management functions please call Health Services at 855-644-1776 (Option 4, then Option 4).

Health Information Line (HIL)

The HIL provides health information and resources to Minuteman Members 24 hours a day, 7 days a week. HIL, also known as the Nurse Advice Line, is not intended to replace or question the diagnosis of a physician or health care provider, nor provide specific follow-up care for treatments prescribed. For triage situations, the nurse directs the Member to the type of care most appropriate based on the symptoms and situation conveyed by the Member. The HIL vendor notifies Minuteman about Member activity for quality and utilization purposes. The HIL is accessible through Minuteman's main telephone number 855-644-1776 or by dialing direct to 866-389-7613.

Behavioral Health

Covered Services with Prior Authorization

Minuteman covers the following services with prior authorization from Health Services. Health Services conducts concurrent reviews of ongoing hospitalization services to ensure continued medical necessity.

- Behavioral Health/Substance Abuse
    - Acute residential treatment (ART)
    - Applied Behavioral Health Analysis
    - Crisis Stabilization Unit
    - Day treatment
    - Partial hospitalization program (PHP)
    - Family stabilization therapy (FST)
    - Intensive outpatient therapy (IOP)
    - Repetitive transcranial magnetic stimulation (rTMS)
    - Neuropsychological testing
    - Clinical Stabilization Services (CSS) and Acute Treatment Services (ATS)

Members who are denied coverage because of the absence of medical necessity will be notified in writing. They will have the option to appeal through Minuteman's Grievance Process, and will have the opportunity to continue their treatment at their own expense with either their Minuteman therapist or someone else of their choosing. If their Grievance is successful, the Medically Necessary treatment, including

the treatment received during the Grievance process, will be covered. Should the clinical condition change, a new determination of medical necessity can be arranged by contacting Health Services. Providers will not be penalized or terminated from the network for advocating in favor of coverage for a service or supply in accordance with the terms of the Grievance process.

What is Not Covered:
Services that are not covered under the mental health/substance abuse benefit include:

- Educational services or testing, except services covered under the benefit for Early Intervention Services
- Psychoanalysis
- Services for problems of school performance
- Non-licensed pastoral counseling/faith-based counseling
- Social work for non-mental health care
- Christian Science practitioner and sanitarium stays
- Services that a third party or court order requires, unless Minuteman determines that the service is Medically Necessary
- Hypnosis
- Telephone Therapy
- In-Home Therapy
- Residential/custodial services (including residential treatment programs, sober houses and halfway houses)
    - Testing and treatment services at these facilities are not covered

Diagnostic Imaging Management Program

eviCore/MedSolutions performs utilization management services for outpatient imaging services on behalf of Minuteman. Certain radiological services require prior authorization. This prior approval policy **affects outpatient services only**; emergency room, observation and inpatient imaging procedures do not require prior authorization. **Failure to obtain prior approval may result in denial of payment**. This policy is applicable to all Minuteman Products.

Procedures that Require Prior Authorization and are required to be obtained within the Minuteman Network:

- CT Scan
- MRI/MRA
- PET Scan

- Nuclear cardiac imaging (in office only)

Prior Authorization Process: Visit eviCore/MedSolutions website below or call 888-693-3211.

- The **ordering physician** is responsible for obtaining the prior authorization from eviCore/MedSolutions for the study requested. Patient symptoms, past clinical history and prior treatment information will be requested and should be available at the time of the call. eviCore/MedSolutions also has the ability to receive your requests online via a secure web application at www.medsolutionsonline.com.
- The **facility providing radiological services** is responsible for ensuring that authorization has been obtained prior to rendering service. Facility providers may confirm authorizations by visiting eviCore/MedSolution's website at www.medsolutionsonline.com. Providing services without prior authorization may result in denial of payment.
- **Call center hours of operation are Monday through Friday, 8:00 a.m. to 9:00 p.m. EST**. Providers may obtain prior approval by calling 888-693-3211. (Studies ordered after normal business hours or on weekends should be conducted by the rendering facility as requested by the ordering physician. However, the ordering physician must contact eviCore/MedSolutions within 48 hours of the next business day to obtain proper approval for the studies, which will still be subject to medical necessity review.)

Important Notes:

- If the ordering provider is not satisfied with eviCore/MedSolutions' decision, the provider may request a reconsideration of the pre-service denial. The provider may request a reconsideration by contacting eviCore/MedSolutions at 888-693-3211. The reconsideration will be conducted within one business day of the request by the physician reviewer. If the provider is still not satisfied with the outcome after a reconsideration, the provider may initiate a Member appeal on behalf of the Member by contacting Minuteman's Member Services Department at 855-644-1776 (Select Option 4, then Option 4). The Member must consent to the initiation of the Member appeal.
- The provider may submit a provider appeal for post-service denials.

Accreditation Requirements for Advanced Diagnostic Imaging Facilities

Suppliers of the technical component of advanced diagnostic imaging services must be accredited.

For all lines of business, Minuteman follows the Centers for Medicare and Medicaid Services (CMS) accreditation requirements for suppliers that provide the technical component of advanced diagnostic imaging. CMS defines advanced diagnostic imaging procedures as including magnetic resonance imaging

(MRI), computed tomography (CT), and nuclear medicine imaging such as positron emission tomography (PET). This requirement only applies to the suppliers that furnish the technical component (TC) of advanced diagnostic imaging services, not to the physicians interpreting them. Providers subject to this requirement include physicians, non-physician practitioners, and Independent Testing Facilities. Hospitals are excluded from this requirement.

Clinical Transition Program

Minuteman has established a Clinical Transition Program to ensure the continuity of care for:

- New Members to Minuteman;
- New Members to Minuteman who are actively receiving mental health services in accordance with NH Admin Code INS §2201.10(b);
- Members who have reached their benefit maximum for coverage;
- Continuation of coverage following provider disenrollment; and
- Departing Members without new coverage.

If providers have questions concerning program requirements and transitional coverage available, providers should contact Minuteman Health Services by calling 855-644-1776 (Option 4, then Option 4).

Appropriateness of Care Statement

It is the policy of Minuteman that decisions regarding patient care are made based upon medical necessity, the appropriateness of care, and the services rendered. If a service is not medically necessary or is not a covered benefit, coverage may be denied. In cases where services are covered but are not being provided, such as preventive care services and prenatal care, it is Minuteman's policy to encourage appropriate treatment.

Both approval and denial of coverage are based on appropriateness, medical necessity, and the scope of Minuteman's contractual obligations to its Members. Minuteman does not offer incentives to its staff or to physician reviewers to encourage coverage denials, nor is compensation tied to such denials.

Medical Technology Assessment Program

Minuteman uses Hayes Health Technology assessments to ensure that Members have equitable access to safe and effective care through the evaluation of developments in new technology and new applications of existing technology.

Technology evaluation criteria, in general terms, include the following:

- Approval from appropriate regulatory bodies
- Scientific evidence must permit conclusions concerning the effect of the technology on health outcomes

- The technology must improve the net health outcomes
- The technology must be beneficial as an established alternative
- The improvement must be attainable outside investigational settings

If providers have questions about this program or would like Minuteman to consider coverage for a new or existing technology, providers should contact Minuteman's MTAC Process Coordinator, at 855-644-1776, ext. 3457.

HIPAA Privacy Requirements and Patient Information Needed for Utilization Management, Case Management and Care Coordination

Minuteman conducts utilization review, case management and care coordination activities for payment and health care operations purposes. In order to perform these activities, Minuteman often needs patient information such as office notes, diagnostic results, and treatment plans.

Some physicians have expressed concern about whether they may disclose medical record information to Minuteman in light of the Privacy Rule requirements of the Health Insurance Portability and Accountability Act (HIPAA). HIPAA allows covered entities, which includes physicians and health plans, to use or disclose protected health information (PHI) without an individual authorization from the patient for treatment, payment and some health care operation purposes, and for certain other specific purposes outlined by the HIPAA Privacy Rule.

Covered entities may disclose PHI to other covered entities for the other covered entity's treatment, payment and health care operation purposes, as defined by the Privacy Rule, as long as the request relates to current or former patients or Members.

Minuteman's utilization review activities are included under payment, and case management and care coordination activities are included within the limited health care operation. **Therefore, the disclosure of health information by a physician to Minuteman for these purposes is permissible without an individual authorization from the patient under the HIPAA Privacy Rule.**

Minuteman recognizes that health care providers are committed to complying with applicable privacy laws. Minuteman shares that same commitment and as a company will proceed only in a manner that is consistent with applicable laws, as outlined above. Providers should contact the Minuteman Compliance Officer at 857-265-3217 if they have additional questions or concerns.

CLAIMS SUBMISSION AND REIMBURSEMENT

Scope of Services

The scope of services for which a provider will be reimbursed is limited by the type of provider agreement and the terms of that agreement. Reimbursement may be restricted to services within the provider specialty, to services provided at a specific location, and to services specified in a particular Minuteman product's Evidence of Coverage (EOC).

The scope of covered services provided by physicians and allied health providers is limited to the provision of professional services, unless otherwise specified in the provider agreement and Minuteman payment policy (please see Minuteman website for most up to date details). Thus, providers will only be paid for the professional component of their services, unless the provider agreement expressly authorizes payment for technical or other services. Physicians and allied health providers may request an expansion for the provision of additional covered services by sending a letter of interest to Minuteman (please refer to www.minutemanhealthdirect.org for contact information). The request will be reviewed in consideration of the needs of Membership for such services in the provider's geographic area, site of service, and the existing availability of similar services in that area. The approval for expansion of scope of services will be made at the discretion of Minuteman and is subject to change with not less than sixty (60) days prior notification to the provider.

Claims Procedure

All claims must be submitted to Minuteman on either a CMS-1500 form (formerly HCFA-1500 form) or a UB-04 form (formerly UB-92). All health care providers and facilities must submit itemized claims to the Minuteman Claims Department, and claims will be subject to CMS processing guidelines including Correct Coding Initiative (CCI) edits.

Claims must be submitted to Minuteman within one (1) year of the date of service or date of discharge from a facility (or, in the case of a claim subject to COB with another payer, within six months of the date of payment or denial by the primary carrier) or within the time period specified by contract. If a bill is not received by Minuteman within the specified time period, it will be denied for exceeding the claims filing limit. Providers may not bill Members for services that were denied payment for untimely submission.

The filing limit also applies to the resubmission of claims. If a claim is denied for incorrect code, etc., and the provider resubmits the claim with the correct information, it must be received at Minuteman within the filing limit of the original date of service. Providers also should be aware that the filing limit applies when utilizing the services of a billing agent.

Claims Xten Edits

Minuteman processes all claims using the claim editing software Claims Xten from McKesson, which reviews claims in a payable status and applies recommended modifications based on common coding guidelines established by the Centers for Medicare and Medicaid Services (CMS). If a service is edited, Minuteman will provide an adjustment code with the Explanation of Payment.

Important Information Regarding All Claims

All claims must include this information:

- Patient name (as it appears on the Member's Minuteman ID card)
- Minuteman Member ID number (including applicable letter prefix and two-digit number suffix as it appears on the Member's Minuteman ID card)
- Most current ICD-9-CM codes, using appropriate 3, 4 or 5 digit codes (If there is more than one diagnosis, it is important to include all appropriate ICD-9-CM codes.)
- Date(s) of service
- Standard place of service code
- Description of service(s), using, as appropriate, the most current CPT procedure code(s), UB-92 revenue code(s), HCPCS code(s), or unique codes previously agreed upon by Minuteman
- Provider name, payment address, Minuteman Provider number (if possible), provider signature, and provider federal tax identification number and Provider NPI number
- Information regarding other insurance coverage
- Name of the referring or ordering physician
- Units
- Amount billed for each procedure
- Total of all amounts billed
- Reports (if applicable to describe unusual services or services for which a coding methodology does not exist)

Minuteman will accept claim submission in the following formats:

Electronically:

- HIPAA compliant professional (CMS1500)
- HIPAA compliant institutional (UB-04)

Paper claim:

- CMS 1500 for professional

- UB-04 for facility or technical

EDI Claims Submission

The following information must appear on all electronic claims:

- The correct Minuteman Provider 5 digit number in the PIN field
- The correct Minuteman Member 11 digit ID number
- The Minuteman Payer Number: 01776

For more detailed information, please go to: http://minutemanhealth.org/Resources#Provider.

Place of Service Codes

Code	Description	Code	Description
11	Office	41	Ambulance – Land
12	Home	51	Inpatient Psych Facility
21	Inpatient Hospital	52	Psychiatric Facility/Partial Hospitalization
22	Outpatient Hospital	53	Community Mental Health Center
23	Emergency Room - Hospital	54	Intermediate Care Facility/Mentally Retarded
24	Ambulatory Surgical Center	61	Comprehensive Inpatient Rehab Facility (CIRF)
25	Birthing Center	65	End Stage Renal Disease
31	Skilled Nursing Facility	71	Public Health Clinic
32	Nursing Facility	81	Independent Lab
34	Hospice	99	Other

The above table is a partial listing of the code set referenced under HIPAA. The most recent version of this code set can be found on-line at www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html

Non-participating providers can use any valid place of service code. Contractual agreements with participating providers may include/exclude codes from this code set.

Paper Claims

Minuteman prefers that all claims be submitted electronically. In instances where paper must be used, Minuteman uses an imaging and capture process for paper claims. To ensure accurate and timely claims imaging, please follow the rules below:

- Type all fields completely.
- Submit all claims on an original red and white form.
- Complete all claims in black or blue ink only.
- Include the word 'continue' when submitting a multi-page paper claim with the total amount on the last page. (Do not 'sub-total' the first page).
- Do not use highlighter on any claim form field.
- Do not submit photo-copied claim forms.
- Do not submit claim forms via fax.
- Do not submit unnecessary attachments.

Paper Claims need to be submitted to the following address:

Minuteman Health
C/o Health New England
One Monarch Place, Suite 1500
Springfield, MA 01144

Clean Claim Requirements

The following fields are required for UB-04 & CMS-1500 claim forms.

CMS-1500 (Physician Claims)

Patient's Name		Service Date(s): To and From
Patient Minuteman ID Number		Place of Service (CMS Codes)
Patient's DOB and Gender		Procedure Code (CPT-4; HCPCS - Current, valid codes)
Patient's Address		Diagnosis Codes (ICD-9-up to 5th digit if applicable – Current, valid codes)
Other Insurance / Workers' Compensation / MVA		Units
Insured's Policy Group or Number		Amount Billed for Each Procedure
Insured's Name and Address		Attending Physician
Provider's Name & Provider ID Number		Patient Account Number (optional)
Provider's Address		Total of All Amounts Billed
Practice Tax ID Number (EIN)		Provider's Telephone Number

Provider's NPI Number		Modifier Codes (CPT-4, HCPCS - Current, valid codes)

UB-04 (Facility Claims)

Patient Name		Service Date(s): To and From for Entire
Patient Minuteman ID Number		Service Date(s) for Each Service Outpatient
Patient's DOB and Gender		Revenue Codes (Current, valid codes)
Patient's Address		Procedure Code (CPT-4; HCPCS - Current valid codes) Outpatient Only
Other Insurance / Workers' Compensation /MVA		Units Anesthesia Claims require Minutes
Insured's Policy Group or Number		Amount Billed for Each Service
Insured's Name and Address		Total of All Billed Amounts
Date		Principal Diagnosis Code (ICD-9-up to 5th digit if applicable) (Current, valid codes)
Provider's Name, Provider ID Number		Secondary/Other Diagnosis Code(s) (ICD-9-up to 5th digit if applicable) (Current, valid codes)
Provider's Address		Attending Physician
Provider's Telephone Number		ICD-9 Procedure Code(s)—Principal and All Other Applicable Codes
Practice Tax ID Number (EIN)		Admission Date (optional for outpatient; required for inpatient)
Type of Bill		Admission Hour (optional for outpatient; required for inpatient)
Claim Statement Dates		Discharge Hour
Provider's NPI Number		Discharge Status
POA Indicators		

Minuteman Provider Collection Policy

Minuteman recommends that the provider submit the bill to Minuteman prior to collecting any portion of a Member's deductible and coinsurance. If a provider collects from the Member prior to submitting a bill to Minuteman, we expect providers and Members to coordinate mutually acceptable terms for collection of a Member's deductible and coinsurance obligations.

In no event may a provider collect payment from a Minuteman Member for a Minuteman covered service for more than the Member's current estimated remaining deductible obligation as of the date of service.

In the event that an amount in excess of a Member's actual obligation is inadvertently collected, the provider or facility must promptly remit such excess amount to the Member upon verification from the provider's or facility's EOP or Member's EOB.

Minuteman supports the use of standardized disclosure and authorization forms to facilitate dialogue between providers and Members regarding financial responsibility and to establish expectations and facilitate collection of Member deductible and coinsurance payments. In all cases, Minuteman expects providers or facilities to apply collection practices that are no more restrictive to Minuteman Members than those applied to Members of any other commercial payers.

Sample Statement of Understanding

Note: *Use the following Statement of Understanding form for services that Minuteman will not cover and for which the Member intends to accept full financial liability. If your office uses a different Statement of Understanding, it should be substantially similar to the form below. This form should only be used in one of the four circumstances described on the form below.*

Member Assumption of Financial Responsibility for Medical Services
Statement of Understanding

I understand that a Minuteman provider may not require me to sign this Statement of Understanding as a condition of receiving services unless one or more of the following conditions exist on the date below (date services provided):

1. These services are normally provided by my primary care provider and I have decided to request services from the below named provider who is not my primary care provider, or
2. These services exceed my benefit limitation, or
3. These services are not covered services under my Plan, or
4. These services have not received prior approval.

I acknowledge that I have voluntarily sought the services of (name of provider) _____ who is a Minuteman participating provider. I accept full responsibility for paying for these services provided today by the above named provider. I understand that Minuteman will not pay the provider, or reimburse me, for the cost of today's services, or any subsequent or ancillary medical services that the provider may order today on my behalf as a result of today's visit.

I understand that this Statement of Understanding is not an acceptance of financial responsibility for any services other than those services provided or ordered today.

_____ _____
Patient's Name (please print or type) Patient's Minuteman Member ID Number

_____ _____
Patient's Signature Today's Date

_____
Parent/Guardian Signature (if under 18 years of age)

Coordination of Benefits

Coordination of Benefits (COB) occurs when Minuteman arranges for payment from an alternative insurance, which may either be "primary" or "secondary" for the claim. When a Member is covered under two different plans, Minuteman coordinates benefits under each plan according to rules used throughout the insurance industry or as required by law.

Explanation of Payment (EOP)

These reports can be found on the Minuteman provider portal at www.minutemanhealthdirect.org. Paper EOP's will now be accessed through the provider portal for our In-Plan Providers.

DME Billing Guidelines and Procedures

DME Vendors Only – Modifiers

Every DME item billed with an A, E, L, or K HCPCS code must be billed with a modifier.

- "NU" is required for items which are purchased and are never rented
- "RR" is required for any item that is rented for the billed period
- "NR" is required for any item that has been rented previously for the designated number of rental periods and is being purchased in the current billed period

If a DME item is billed by a DME or orthotics and prosthetics vendor without a modifier, the claim will be denied.

DME Vendors Only – "SC" Modifier

Minuteman will reimburse higher than the standard rate for covered, non-standard, medically necessary items when the Member presents a prescription for the non-standard item. The vendor should bill the HCPCS code corresponding to the standard item and attach an "SC" modifier. Rather than the standard reimbursement, Minuteman will reimburse the vendor a percent of the billed charge based upon the default percent of charge listed in the vendor's contract. Minuteman reserves the right to audit the vendor's prescriptions for any item which Minuteman has been requested to reimburse.

Please note: When an "SC" modifier is used with HCPCS code E1399 (Miscellaneous), reimbursement will be according to the E1399 guidelines below, which apply to DME vendors only:

When should a DME item be billed with HCPCS code E1399?
The HCPCS Manual describes E1399 as "Durable medical equipment, miscellaneous." Therefore, this code should only be used to bill for DME for which no presently active HCPCS code accurately describes the DME item.

When will Minuteman provide reimbursement for a DME item billed with E1399?

Minuteman will provide reimbursement for a DME item billed with E1399 when the item is covered under the vendor's contract, is covered by the Member's benefit, and is medically necessary or otherwise authorized by Minuteman Health Services in advance.

What are the guidelines for processing DME items billed with E1399?

- The DME item will be denied as "billed incorrectly" if it is billed with E1399 when a more precise, descriptive HCPCS code exists.
- A DME item billed with E1399 for a total charge (including multiple units) of less than or equal to $300 will be reimbursed at the provider's contracted default discount rate.
- If a DME item with total charges (including multiple units) greater than $300 for code E1399 is submitted on a claim, it must be accompanied by an invoice. The claim and invoice will be reviewed and a payment determination made.
- Special Instructions for DME Vendors Who Bill Electronically: DME vendors who bill electronically must submit paper claims with an invoice for any DME items billed with E1399 for total amounts greater than $300, otherwise the claim will be denied as billed incorrectly.

Physicians Only – Modifiers
There are no modifier requirements for physicians billing for DME.

Minuteman's Vaccine Policy

State Supplied Vaccines in General:

- All State Supplied Vaccines are configured in our system for specific age ranges.
- Claims for Members receiving a vaccine on the State Supplied list whose age is outside of the State-specified age range will be pended for review. Minuteman will contact the provider to confirm the fact that the vaccine was purchased and not supplied free from the State.

IN ALL OTHER INSTANCES, STATE SUPPLIED VACCINES ARE NOT COVERED:

- Minuteman expects providers to get these from the State.
- Minuteman expects providers to give the State Supplied vaccines on the approved schedule (CDC and AAP).

Other Vaccines:
Minuteman will cover supplied vaccines for Minuteman Members under the following conditions:

- The physician must bill for the vaccine using the appropriate J-code or CPT code (this allows vaccines to be considered a preventive service for High Deductible Health Plans).
- The physician may purchase the vaccine through any supplier **(as long as it is not State Supplied).**
- Minuteman will reimburse the physician using the Minuteman fee schedule, which is updated quarterly.

HEDIS reports for providers

The Health Plan Employer Data and Information Set (HEDIS) is the most widely used set of performance measures in the managed care industry. HEDIS is designed to ensure that purchasers and consumers have the information they need to compare the performance of managed care plans. Minuteman requires all providers to cooperate in the collection of data for HEDIS reporting.

HEDIS contains 61 measures across 8 domains of care:

- Effectiveness of Care
- Access/Availability of Care
- Satisfaction with the Experience of Care
- Health Plan Stability
- Use of Services
- Cost of Care
- Informed Health Care Choices
- Health Plan Descriptive Information

Payment Policies

Minuteman's payment policies are intended to help with the claim submission process by detailing accurate coding and benefit coverage. Minuteman's payment policies are located at: http://minutemanhealth.org/Resources#Provider.

PROVIDER APPEAL GUIDELINES

Note: These guidelines do not apply to the submission of an amended claim to a previously processed claim within 180 days from date of service. An amended claim submitted within 180 days is an 'On Time Corrected Claim' and not a Provider Appeal. Please note on the claim form that it is an On Time Corrected Claim and mail it to: Minuteman Claims Department, One Monarch Place, Suite 1500, Springfield, MA 01144. On Time Corrected Claims cannot be accepted via fax.

Please fax Provider Appeals to Minuteman at: 888-225-8716

Provider Appeal Guidelines:

- Providers have the right to file a Provider Appeal if they disagree with how Minuteman processed a claim.
- Provider Appeals must be submitted within one year from the date of service. An appeal submitted after the one-year deadline will be denied.
- A Provider Appeal must be submitted on the Request for Claim Review form, which can be found on the following page and under the "Provider Forms" section on the Minutemen website.
- The control number—the 12-digit number on the Minuteman Explanation of Payment (EOP)—must be listed on the Request for Claim Review form.

Please include with your appeal:

- The EOP and all supporting documentation, such as operative and office notes, authorizations, invoices, and other information which would be pertinent to the review process, rationale for appeal, and desired resolution.
- PLEASE NOTE: If you are disputing a denial of a Prior Authorization Request and the service has not yet been rendered, your appeal will be treated as a Member Appeal and processed in accordance with Minuteman's Member Appeal Guidelines.

Appeal Types:

Provider Contractual Appeals, such as

- Claim denied for no authorization
- Claim denied past filing limit
- Claim denied as billed incorrectly
- Claim denied as duplicate claim
- Claim reimbursement issue, e.g. CPT code(s), disagreement about payment methodology

Provider Adverse Determinations (relates to decisions made during the prior authorization process that impact how a claim has been processed), such as

- Claim denied for not being medically necessary
- Claim denied as experimental/investigational

MINUTEMAN CLINICAL GUIDELINES AND STANDARDS

Clinical Guidelines and Standards

The Minuteman Quality and Utilization Management Committee (QUMC) is responsible for developing, disseminating and coordinating activities intended to define good medical practice and develop improved quality. Activities include establishing and maintaining a criterion-based system including standards and guidelines in relation to patient care and developing pre-treatment and pre-admission medical protocols.

Clinician participation plays an important role in the development of clinical guidelines and standards. Participating clinicians serve on the QUMC, and Minuteman welcomes and invites the comments of other participating clinicians. If providers have comments, questions, or concerns about a clinical guideline or standard, they should contact the Minuteman Director of Quality & Medical Management at 857-265-3332.

Providers are required to cooperate with all Quality Improvement and Assurance activities to improve the quality of care, services and member experience. This includes allowing the collection and evaluation of provider data.

Unless new scientific evidence or revised national standards warrants review and update sooner, clinical guidelines are reviewed biennially. Preventive health recommendations are reviewed annually.

All clinical guidelines, standards, quality program and criteria used for rendering decisions regarding the appropriateness of medical services are available to participating providers upon request by calling Health Services at 855-644-1776 (Select Option 2 then Option 4). In addition, internally developed clinical guidelines are available on the Minuteman website at www.minutemanhealth.org.

Medical Record Standards and Reviews

The following minimum medical record standards will be used for quality assurance purposes:

MEDICAL RECORD DOCUMENTATION GUIDELINES / BENCHMARKS

Criteria	Benchmark
1. Each page in the record contains the patient's name or ID number.	95%
2. Personal biographical data include the address, employer, home and work telephone numbers, and marital status.	95%
3. All entries in the medical record contain author identification. Author identification may be hand written, stamped, or electronic.	95%
4. All entries are dated.	95%
5. The record is legible by someone other than the writer. A second surveyor examines any record judged to be illegible by one physician surveyor.	95%
6. Significant illnesses and medical conditions are indicated on the problem list.	95%
7. Medication allergies and adverse reactions are prominently noted in the record. If the patient has no known allergies or history of adverse reactions, this is appropriately noted in the record.	100%
8. Past medical history (for patients seen three or more times) is easily identified and includes serious accidents, operations, and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations, and childhood illnesses.	95%
9. For patients 14 years and older, there is appropriate notation concerning the use of cigarettes, alcohol, and substances (for patients seen three or more times, query substance abuse history.)	95%
10. The history and physical exam records appropriate subjective and objective information pertinent to the patient's presenting complaints.	95%
11. Laboratory and other studies are ordered as appropriate.	100%
12. Working diagnoses are consistent with findings.	100%
13. Treatment plans are consistent with diagnoses.	100%
14. Encounter forms or notes have a notation, when indicated, regarding follow-up care, calls, or visits. The specific time of return in noted in weeks, months, or as needed.	95%
15. Unresolved problems from previous office visits are addressed in subsequent visits.	100%
16. Review for under- and over-utilization of consultants.	95%
17. If a consultation is requested, is there a note from the consultant in the record?	95%
18. Consultation, lab, and imaging reports filed in the chart are initialed by primary care practitioner to signify review. If the reports are presented electronically, or by some other method, there is also representation of practitioner review.	100%
19. Consultation, abnormal lab, and imaging study results have an explicit notation in the record of follow-up plans.	100%
20. There is no evidence that the patient is placed at inappropriate risk by diagnostic or therapeutic procedure.	100%
21. An immunization record for children is up to date, or an appropriate history has been made in the medical record for adults.	95%
22. There is evidence that preventive screening and services are offered in accordance with the organization's practice guidelines.	100%
23. Advance Directive documented in chart	100%

Credentialing/Recredentialing

Credentialing is a fundamental component of quality management.

The process scrutinizes the qualifications and clinical competency of healthcare professionals. Minuteman, or its contracted credentialing vendor, utilizes a credentialing and re-credentialing process to select and evaluate the providers who apply to be Members of its provider network.

The credentialing and re-credentialing process and policies are structured to be in compliance with the National Committee for Quality Assurance (NCQA) and NH regulations when applicable.

Providers have the right to review information submitted to support credentialing application, review the status of credentialing or re-credentialing application on request and correct erroneous information.

CREDENTIALING CRITERIA FOR MEDICAL PROVIDERS:

Credentialing these individuals is to assure that only qualified providers who can demonstrate current clinical competence are authorized to provide services to the Members, to protect them from unethical or untrained providers and to match desired service and skills with qualifications and competence of providers.

Applicants must meet minimum credentialing criteria/standards:

- Board certification (when applicable)
    - Primary source verification from appropriate specialty board
- Current malpractice liability insurance
    - Primary source verification from malpractice liability carrier including dates and coverage amounts
- Current valid license
    - Primary source verification from appropriate licensing board
- Department of Health and Human Services Medicare/Medicaid status
    - Primary source verification through the Department of Health and Human Services (DHHS)
    - Cumulative Sanctions Report or the National Practitioners Data Bank (NPDB)
- Graduation from medical school and completion of a residency
    - Primary source verification from medical school and residency institution
- Professional liability claims history
    - National Practitioner Data Bank report or
    - Primary source verification from malpractice liability carriers
- Staff affiliation at primary admitting facility
    - Primary source verification from medical staff office of health care entity

- Valid Drug Enforcement Agency (DEA) certificate/Controlled Dangerous Substance (CDS) certificate
    - DEA record of certification through National Technical Information Service (NTIS) database or certificate. CDS record of certification through respective state agency or certificate.

Provider Review and Corrective Action Policy

The purpose of this policy is to create a framework to address provider actions which affect the administration of a Minuteman Health plan or the quality of health care services provided to Minuteman Members. This policy applies when Minuteman becomes aware of information concerning a provider (or the office staff working on behalf of the provider) that warrants further review and possible corrective action, including both non-disciplinary and disciplinary action.

In the event that a provider engages in conduct which affects the perceived quality of the Minuteman Provider network, the Minuteman Chief Medical Officer shall decide, in his or her discretion, whether to proceed under this policy, the credentialing policy or both, if appropriate. Such decisions shall take into account the nature and severity of the offense and the particular circumstances of the case.

The provisions of this policy are incorporated into the contract between Minuteman and the provider (or the PHO) through which the provider is contracted with Minuteman ("Minuteman Agreement"). The policy is required as part of the plan's Quality Management program to ensure that a process is in place to assure the timely and consistent approach to activities which might adversely impact patients. If the provider engages in conduct which constitutes a breach of the Minuteman Agreement, Minuteman's action or inaction pursuant to this policy shall not affect Minuteman's rights to enforce the Minuteman Agreement and shall not be construed as a waiver of that contract.

With respect to Utilization Management and Quality of Care Issues, the intent of this policy is to resolve the issues through discussion and cooperation between Minuteman and the provider and to assure that at each stage of the process the provider has the right to appeal. Where Disciplinary Issues arise, this policy is intended to ensure that the quality of care provided to Members is not compromised and to address the improper provider action promptly and effectively.

Serious Reportable Events and Never Events

The purpose of this Minuteman policy is to increase patient safety and promote cost-effective, high-quality health care by utilizing national and regional guidelines for the reporting, payment and treatment of Serious Reportable Events and Never Events.

Definitions: (for purposes of this policy, the following definitions apply);

- **Serious Reportable Event-**(i) An event that results in a serious adverse patient outcome that is clearly identifiable and measurable, reasonably preventable, and caused by care management (rather than the underlying disease) or (ii) errors that occur from failure to follow standard care or institutional practices and policies. They are also known as Adverse Events.
- **Never Event-**Any wrong procedure(s) performed on the wrong side, wrong body part, or wrong person. These never events are not medically necessary as they are not required to diagnose or treat an illness, injury, disease or its symptoms, and are not consistent with generally accepted standards of medical practice. All never events involving a wrong procedure performed on the wrong side, wrong body part, or wrong person are considered not medically necessary.

The National Quality Forum (NQF), a not-for-profit membership organization created to develop and implement a national strategy for health care quality measurement and reporting, has identified a list of Serious Reportable Events and Never Events in 1 of 7 categories: surgical, product or device, patient protection, care management, environment, radiologic and criminal. A list of these events is below (as of October 31, 2013, and subject to NQF updates) and the most current list can be found at www.qualityforum.org/Topics/SREs/List_of_SREs.aspx. In New Hampshire this list also includes the exposure of a patient to a non-aerosolized blood borne pathogen by a health care worker's intentional, unsafe act.

National Quality Forum List of Serious Reportable Events and Never Events
Surgical Events
Surgery or other invasive procedure performed on the wrong site
Surgery or other invasive procedure performed on the wrong patient
Wrong surgical or other invasive procedure performed on a patient
Unintended retention of a foreign object in a patient after surgery or other invasive procedure
Intraoperative or immediately postoperative/post procedure death in an ASA Class 1 patient
Product or Device Events
Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided in the healthcare setting by the healthcare facility
Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended
Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a healthcare setting
Patient Protection Events
Discharge or release of a patient/resident of any age who is unable to make decisions, to other than an authorized person

Patient death or serious injury associated with patient elopement (disappearance)
Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a healthcare setting
Care Management Events
Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration)
Patient death or serious injury associated with unsafe administration of blood products
Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a healthcare setting
Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy
Patient death or serious injury associated with a fall while being cared for in a healthcare setting
Any Stage 3, Stage 4, and unstageable pressure ulcers acquired after admission/presentation to a healthcare setting
Artificial insemination with the wrong donor sperm or wrong egg
Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen
Patient death or serious injury resulting from failure to follow up or communicate laboratory, pathology, or radiology test results
Environmental Events
Patient or staff death or serious injury associated with an electric shock in the course of a patient care process in a healthcare setting
Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or are contaminated by toxic substances
Patient or staff death or serious injury associated with a burn incurred from any source in the course of a patient care process in a healthcare setting in a healthcare facility
Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a healthcare setting
Radiologic Events
Death or serious injury of a patient or staff associated with the introduction of a metallic object into the MRI area
Criminal Events
Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed healthcare provider
Abduction of a patient/resident of any age
Sexual abuse/assault on a patient or staff Member within or on the grounds of a healthcare setting
Death or serious injury of a patient or staff Member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare setting

Reporting

- All facilities are required to report a Serious Reportable Event or Never Event to Minuteman when the event involves a Minuteman Member. The facility shall accomplish this reporting requirement by faxing a report to the Minuteman Chief Medical Officer at fax number 888-225-8716.
- In order to identify inefficient care and preventable conditions, all facilities must provide Present on Admission (POA) indicators on all inpatient claims. Failure to indicate POA conditions on an inpatient claim may result in delayed reimbursement or denial of the claim.
- Minuteman will not publicly disclose information reported under this section unless otherwise required to do so by law, statute, or regulation.

Reimbursement

Minuteman will **not** reimburse for services associated with Serious Reportable Events or Never Events. These events are based on nationally acceptable definitions. This list may be amended from time to time and the most current list can be found at www.qualityforum.org/Topics/SREs/List_of_SREs.aspx.

Providers shall not bill Minuteman Members for charges associated with the Serious Reportable Events and Never Events for which Minuteman denies reimbursement, and for any subsequent care needed to address the events. Providers shall waive any copayment or deductible due from the Minuteman Member for the admission during which the Serious Reportable Event or Never Event occurred.

Minuteman shall retract payment for any services after payment has been made if the claim is identified to have met the requirements for non-reimbursement as a Serious Reportable Event or Never Event.

Scope

This policy will be in effect for all facilities, such as hospitals, acute rehabilitation centers, skilled nursing facilities, visiting nurse associations, same day surgery centers, offices, and outpatient locations, both in-network and out-of-network and all clinical providers. Notwithstanding the foregoing, upon notification of a Serious Reportable Event or Never Event to Minuteman's Chief Medical Officer or the discovery of a Serious Reportable Event or Never Event by Minuteman, the claim(s) may be reviewed to determine whether to extend non-payment to other service professionals (nurse practitioners, anesthesiologist, etc.) involved in the services of said event.

HEDIS

Health Plan Employer Data and Information Set (HEDIS) is the most widely used set of performance measures in the managed care industry. HEDIS is developed and maintained by the National Committee for Quality Assurance (NCQA), a not-for-profit organization committed to assessing, reporting on and

improving the quality of care provided by organized delivery systems. HEDIS was originally designed for private employers' needs as purchasers of health care. It has since been adapted for use by public purchasers, regulators, and consumers.

Quality improvement activities, health management systems and provider profiling efforts have all used HEDIS as a core measurement set. HEDIS also is used as an element of NCQA accreditation, and is considered the consumer report card for managed care organizations.

Minuteman collects HEDIS data from three major sources. The first source is administrative data gathered from claims, encounter and enrollment systems. The second source is the medical record. Minuteman generally requests copies of medical records for HEDIS reviews. The third source is survey information. For some measures, administrative and medical record data are commonly combined in a standardized manner known as the hybrid method. Data derived purely from administrative sources reflect rates that consider every eligible Member and occurrence. All other data are based on samples of Members and services. These samples must be drawn in a systematic fashion that has been specified by NCQA.

Providers are required to cooperate with all Quality Improvement and Assurance activities to improve the quality of care, services and member experience. This includes allowing the collection and evaluation of provider data.

NCQA publishes summary data in its annual State of Health Care Quality report, which can be found on its website: www.ncqa.org.

NCQA Accreditation

Minuteman is an NCQA accredited health plan. Minuteman providers are required to comply with requests for information needed for NCQA accreditation and HEDIS metrics.

NCQA's primary focus is to assess the organization's quality improvement structures and processes utilizing more than 50 standards in 5 categories:

- Quality Management and Improvement
- Credentialing and Re-credentialing
- Utilization Management
- Members' Rights and Responsibilities
- Member Connections

Accreditation also includes an assessment of the care and service that plans are delivering in important areas measured through HEDIS, such as immunization rates, mammography rates and Member satisfaction.

MINUTEMAN CORPORATE COMPLIANCE PROGRAM (INCLUDING FRAUD, WASTE, AND ABUSE PREVENTION PROGRAM)

Compliance Statement and Code of Conduct

It is Minuteman's policy to conduct its business in compliance with the applicable laws and regulations of the United States and the state of New Hampshire and to assure that Minuteman operates in a manner consistent with the letter and the spirit of the law.

Minuteman is committed to compliance with such laws and regulations and intends to assure that Minuteman's activities and operations, as carried out by the employees and other agents of Minuteman, are conducted in compliance with such laws and regulations. In recognition of this commitment, Minuteman has developed a Corporate Compliance Program that has been adopted and endorsed by the Minuteman Board of Directors.

Scope

The scope of the Minuteman Compliance Program covers all employees, temporary employees, volunteers, and agents, including participating providers (first tier and downstream entities) and delegates (contractors and subcontractors, both first tier and downstream entities), including any related entities, of Minuteman and its subsidiaries, promoting compliance with applicable federal and state law and regulations while adhering to the highest ethical standards. The Minuteman Compliance Program also includes the Minuteman Privacy and Security Program, promoting the confidentiality, privacy and security of Member protected health information, as well as the Minuteman Fraud, Waste, and Abuse Prevention Program.

Code of Conduct

Part of Minuteman's mission is to be a leading corporate citizen. This means that Minuteman, and all Minuteman associates and agents, should follow these three rules when conducting business on behalf of Minuteman:

- Act ethically and responsibly
- Obey the law
- If you learn that someone connected with Minuteman is breaking either of the first two rules, report the problem, and do your best to put things right or find someone who can

All employees and agents of Minuteman are advised as follows:

- No employee or agent of Minuteman has any authority to act contrary to the provisions of the Code of Conduct (Code), or to authorize, direct or condone violations by any other employee or agent of Minuteman.

- Any employee or agent of Minuteman who has knowledge of facts or incidents that he or she believes may violate the Code has an obligation to promptly report the matter.

- Any employee or agent who violates the Code, or who orders or who knowingly permits a subordinate to violate the Code, shall be subject to appropriate disciplinary action which may include discharge or termination of his/her relationship with Minuteman.
- Minuteman will make full, fair, timely, and understandable disclosures in the periodic reports required by law.

Reporting Your Concerns

Please tell us if you have a compliance concern. When making a report, please provide as much detail as possible. Names, dates, and a description of the issues in question are helpful. For example, you may wish to describe why you think an activity is a cause for concern. If possible, please include your name and telephone number so that we can contact you if we have any questions during our investigation.

You can call our toll-free anonymous compliance hotline, email us, or send us a letter via fax or mail:

Phone	English 855-400-0098 Spanish 800-216-1288
Fax	215-689-3885 (must include company name with report)
Online	www.lighthouse-services.com/minutemanhealth, OR mailto:reports@lighthouse-services.com (must include company name with report)
Mail	Minuteman Health, Inc. Attn: Compliance Officer P.O. Box 120025 Boston, MA 02111

Reasonable efforts will be made to protect the confidentiality of those who are reporting. However, confidentiality cannot be guaranteed and will not be possible in some circumstances. Compliance issues will be discussed only with persons with an absolute "need to know." Minuteman will not discriminate or retaliate against any employee or agent of Minuteman for reporting a compliance concern or for cooperating in any government or law enforcement authority's investigation or prosecution.

All reports will be taken seriously and, if warranted, investigated by the Minuteman Compliance Officer. Reports of suspected fraud, waste, or abuse are investigated by Minuteman. Minuteman takes appropriate actions to mitigate any harmful effects and works to identify opportunities for improvement and corrective actions designed to correct any underlying problems.

Privacy and Security Program

Minuteman has established a comprehensive Privacy and Security policy to protect Minuteman Members from inappropriate use or disclosure of their protected health information (PHI). Under this policy, Minuteman has implemented appropriate administrative, physical, and technical safeguards to ensure the security of electronic PHI. For more information, review the Minuteman Notice of Privacy Practices, which is posted on www.minutemanhealth.org. A copy of the notice is also available upon request.

Fraud, Waste, and Abuse Prevention Program

Minuteman has established a Fraud, Waste, and Abuse (FWA) Prevention policy to prevent, detect, and correct fraud, waste, and abuse by employees, Members, employers, brokers, providers, contractors, and subcontractors of Minuteman.

Under this program, Minuteman works to promote a sense of integrity and vigilance. This program also provides procedures for prevention, detection, auditing, monitoring, investigation and follow-up. If you suspect fraud, waste or abuse please report this to Minuteman, either through the toll-free anonymous hotline or to Minuteman's Compliance Officer. Upon receipt of an FWA issue, Minuteman will thoroughly investigate the issue and mitigate as appropriate. Please note that Minuteman encourages reporting FWA and thus adheres to a non-retaliation policy for reporting any potential or actual FWA. Minuteman may disseminate FWA educational materials either via mail or on www.minutemanhealth.org.

Please notify Minuteman of potential FWA. You can call our toll-free, anonymous compliance hotline, email, or send us a letter via fax or mail. (See Section XIII.B of the Minuteman Provider Manual for details on reporting a concern to the Minuteman Compliance Program.)

You may also report fraud directly to the Department of Health and Human Services (HHS) Office of Inspector General (OIG) Hotline.

Contacting the HHS OIG Hotline
Phone: 800-HHS-TIPS (800-447-8477)
Fax: 800-223-8164
E-Mail: HHSTips@oig.hhs.gov
Website: https://forms.oig.hhs.gov/hotlineoperations/
TTY: 800-377-4950

Mail:
Office of Inspector General
Department of Health and Human Services
Attn: HOTLINE PO Box 23489
Washington, DC 20026