



Grand Valley Health Plan
Partnering in health care!

Provider Manual November 2007

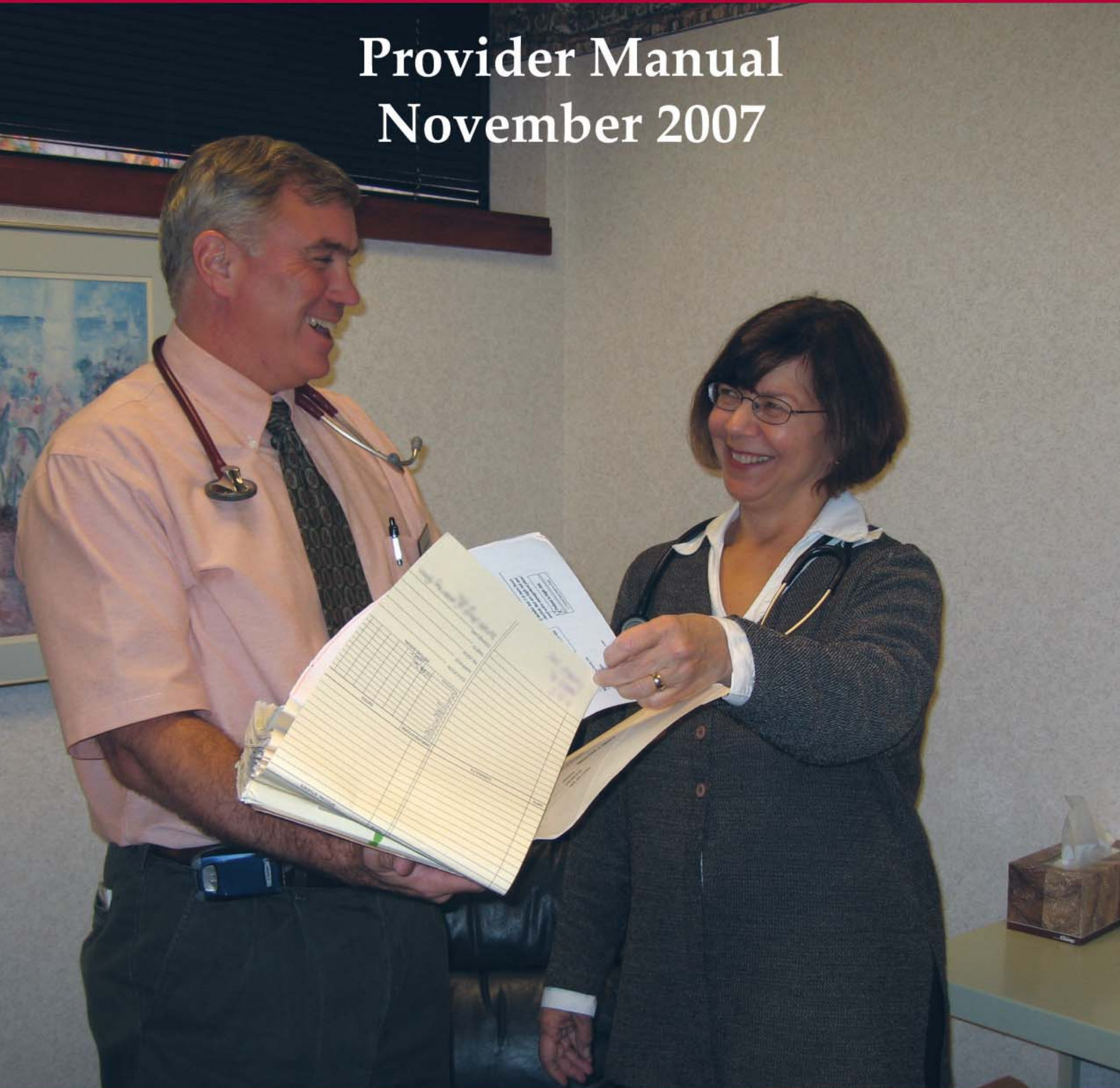


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INTRODUCTION

WELCOME TO GRAND VALLEY HEALTH PLAN

Dear Provider,

Welcome to Grand Valley Health Plan! We are excited that you have chosen to partner with us to help provide quality healthcare to our members. Our system is unique: combining integration of both insurance coverage and medical care. This integration makes seeking care less complicated for our members.

Here at Grand Valley Health Plan we believe that a strong partnership amongst health care providers—both at a primary care and specialty care level, creates a great opportunity to take a proactive approach to prevention and wellness. We are happy to be able to provide the services of quality specialists and facilities.

Thank you, again, for partnering with GVHP. If you have any questions or need additional information not found in this guide, please feel free to contact us at 949-2410.

PURPOSE STATEMENT

Grand Valley Health Plan (GVHP) is a regional health management organization dedicated to providing and managing the services, products and information that our customers value to maintain or optimize their health.

To accomplish this purpose, while providing great performance for our customers, it is essential that we develop and operate an integrated, coordinated health management system, whose culture can “walk the talk” with the following values:

- Focus on customer value
- Accept individual accountability for behavior
- Seek effectiveness in outcomes
- Develop partnering relationships
- Be creative during change
- Share team accountability for performance
- Produce a profitable result

We believe that:

- We can influence the qualitative well-being of humans
- Innovation is the only effective response to change
- The collective problems of individuals will only be resolved through the collective efforts of individuals
- The measure of quality is outcomes and that quantity is important only to the extent that it enhances or facilitates quality.

PHILOSOPHY

GVHP carries out its purpose through a philosophy or belief system that combines the values of cost, quality and service.

GVHP believes in having respectful relationships with our Members and health care professionals. We believe these relationships should be purposeful. They should be effective. They should result in quality health care and service.

GVHP believes in the value of keeping people healthy. We also believe in making them well. Prevention is the key. Programs and services that lower the risk of disease and illness are the “heart” of what we do at GVHP.

GVHP believes in the value of quality. We do this by credentialing our health care professionals. Credentialing is a review process health care professionals undergo. GVHP looks at their “Credentials” because we hold these professionals to high standards. We measure quality of care and customer satisfaction.

GVHP believes in quality-based health care. We believe in cost-effective health care. We do this by contracting with selected health care professionals. Our contracts address quality and service as well as cost.

GVHP believes in keeping our Members informed. We want Members to have information about how our health plans works. We want Members to know how our physicians and health care providers are paid. We want Members to know how resources are used and managed. This is called utilization management (UM). Finally, we want Members to know how these show and support quality of care.

GVHP believes that Members have the right to voice complaints. Members also have the right to appeal GVHP decisions. Finally, Members have the right to expect timely services and responses.

GRAND VALLEY HEALTH PLAN PRODUCTS AND PLAN DESIGNS

Grand Valley Health Plan is a regional Health Management Organization dedicated to providing and managing the services, products and information that our customers value to maintain or optimize their health. One of the ways that we accomplish this is by offering a diverse selection of plans and products to employer groups and Members at varying levels of flexibility in benefit coverage and provider access. In addition, Grand Valley Health Plan offers products directly to the general public. A summary of each product is listed below. For additional information please contact Customer Services at (616) 949-2410.

HMO

Grand Valley Health Plan provides benefits and coverage for a comprehensive set of health care service when provided, arranged, or authorized by a Grand Valley Health Plan Family Practice provider. Covered services are either covered in full or with a Member co-insurance, co-payment, and/or deductible when services are authorized. HMO Members have plans with varying levels of co-payments, co-insurance, and/or deductibles. The Member's employer group chooses the level of coverage. There is no coverage for out-of-network services except in the case of Emergency or Urgent care services.

Choice Plus POS Health Plan

Grand Valley Health Plan offers a Point-of-Service plan (Choice Plus) that offers both in-network and out-of-network benefits. This type of plan offers the Members the most flexibility in obtaining care and coverage. The Member will choose to receive services either in-network or out-of-network.

In-network services are services that are provided or arranged and authorized by a GVHP Family Health Center provider. In-network services are covered at a higher benefit level with minimal cost sharing.

Out-of-network services are sought when a Member chooses to self refer. The Member may be seeking services from either a GVHP participating or non-participating provider. Services are covered at a reduced benefit level and the Member incurs greater cost sharing. In addition, the Member is at risk for charges that exceed GVHP's reasonable and customary fee schedule.

Under the out-of-network benefit there is still a list of services that are only covered with prior-authorization. These services are listed on the back of the Member's Choice Plus Member identification card.

High Deductible Health Plan

This product is a high-deductible health plan offered with the Choice Plus benefit plan design that meets the requirements for Members to qualify for tax-favored contributions to a Health Savings Account (HSA) under the Medicare Prescription Improvement and Modernization Act of 2003. A Health Savings Account is a tax-exempt savings account for individuals with a high deductible health plan. Funds in the HSA can be used to pay for qualified medical expenses.

All Health Savings Accounts have a contract year deductible copay/coinsurance and out-of-pocket maximum that renews each year. The minimum amount of this deductible is \$1,000 per Member, including an adjusted Consumer Price Index (CPI) amount each year. The Member's deductible must be met in full before GVHP becomes responsible for payment. The only exception to this is in the case of preventative care services.

Specialist Directory

Conversion Health Plan

This plan is available to Members who lose Grand Valley Health Plan coverage through their employer-sponsored plan. Members must enroll and pay for coverage within 30 days from the loss of their employer-sponsored health plan. Members must live within the GVHP service area.

Individual Health Plan

This plan is offered once per year with open enrollment occurring in August with an effective date of September 1st. Members must live within the GVHP service area and be under 65 years of age upon enrollment. There is a pre-existing condition - waiting period for this plan.

PrimeCare

GVHP PrimeCare is not insurance, but prepaid family health center visits and services that are delivered at GVHP Family Health Center locations. This prepaid product is designed for people who desire the security of health care access at an affordable price. GVHP PrimeCare was created by Grand Valley Health Plan to help individuals and families who risk not having any, or have inadequate, health coverage.

GVHP has two packages:

The Primary Care package offers 12 visits that can be used throughout the year at one of Grand Valley Health Plan's six Family Health Centers:

- *Minor Fracture and Suture Care
- *Treatment of Minor Injuries
- *Sick Care (treatable in a Family Practice setting)
- *Simple Family Practice Office Procedures
- *Sports Physicals
- *Most Diagnostic Lab Services
- *Preventative Health Care
- *Health Education Classes
- *Discounted over-the-counter medications
- *X-rays
- *Routine Yearly Physicals
- *Most Pediatric Immunizations
- *Primary Care Disease State Management
- *Tests performed by GVHP Providers
- *GVHP Urgent Care Access
- *Health Coaching
- *24-hour Nurse Advice Line

GVHP PrimeCare URGENT is the second package offered. This package offers 6 Urgent Care visits to Grand Valley Health Plan's Urgent Care Center. The following services are provided exclusively at one of GVHP's Family Health Centers:

- *Minor Fracture and Suture Care
- *Treatment of Minor Injuries
- *Simple Family Practice Office Procedures
- *Tests performed by GVHP Providers
- *Sick Care (treatable in GVHP's Urgent Care setting)
- *Discounted over-the-counter medications
- *X-rays
- *Health Education Classes
- *Sports Physicals
- *Most Diagnostic Lab Services
- *24-hour Nurse Advice Line

Grand Valley Health Plan Family Health Centers

GVHP has six (6) Family Health Center locations, where Members receive their primary care, along with a Diagnostic Radiology Center, an Urgent Care Center and two full service Pharmacies. Listed below is the contact information for these locations. In addition, specific provider information can be found at Grand Valley's web site at www.gvhp.com.

FAMILY HEALTH CENTERS	TELEPHONE
Beckwith Family Health Center 2680 Leonard NW Grand Rapids, MI 49525	Phone (616) 224-1515 Fax (616) 224-2070 Call 24 hours a day
Jenison Family Health Center 529 Baldwin Drive Jenison, MI 49428	Phone (616) 457-3830 Fax (616) 457-8940 Call 24 hours a day
Kentwood Family Health Center 1142-44th Street SE Kentwood, MI 49508	Phone (616) 534-8323 Fax (616) 534-1570 Call 24 hours a day
Rockford Family Health Center 590 Ten Mile Road NE Rockford, MI 49341	Phone (616) 866-9568 Fax (616) 866-7760 Call 24 hours a day
Walker Family Health Center 650 Three Mile NW Walker, MI 49544	Phone (616) 784-4717 Fax (616) 784-7675 Call 24 hours a day
Wyoming Family Health Center 5251 Clyde Park SW Wyoming, MI 49509	Phone (616) 532-1100 Fax (616) 249-2246 Call 24 hours a day
Urgent Care Center 2680 Leonard NW Grand Rapids, MI 49525	Phone (616) 224-1515 Fax (616) 224-2070
Diagnostic Radiology Center 2680 Leonard NW Grand Rapids, MI 49525	Phone (616) 224-8686 Fax (616) 224-8687
Beckwith Pharmacy 2680 Leonard NW Grand Rapids, MI 49525	Phone (616) 224-1121 Fax (616) 224-3001
Wyoming Pharmacy 5251 Clyde Park SW Wyoming, MI 49509	Phone (616) 532-8882 Fax (616) 249-2269

GVHP Providers are available 24 hours a day, seven days a week. They can be reached by calling the Member's Family Health Center telephone number. If you have a question about a particular provider, please go to www.gvhp.com.

Specialist Directory

Communication Services for Providers

Staff is available to answer utilization questions from providers as they arise. GVHP provides a toll free number or staff who accept toll free calls regarding utilization issues. The toll free number is 1-800-335-1977.

GVHP provides the following services regarding both in-area and out-of-area UM issues to practitioners and Members:

- Availability of GVHP staff to discuss UM issues with Practitioners/Members on Monday-Friday from 8:00 a.m. to 5:00 p.m. (excluding holidays).
- Information requests may also be faxed to (616) 949-9948.
- GVHP staff is available after regular business hours to discuss urgent UM issues. Please call (616) 224-1515 and ask to speak with the GVHP Medical Director. Your call will be transferred by the after hours call staff.
- Follow-up communication about non-urgent conditions from GVHP staff regarding inquiries about UM issues will occur the next business day, during regular business hours.

II. ELIGIBILITY

Member Eligibility

Grand Valley Health Plan HMO Members are required to have services provided, arranged or authorized by a GVHP Family Health Center Provider. Services will be paid according to the Member's purchased benefits. All applicable deductibles, co-payments, co-insurances, and limitations apply.

Membership Cards

The GVHP HMO or Choice Plus Membership ID card is a key to medical services. It will identify the patient as a GVHP Member.

A new Member can use the "pink" copy of their GVHP Membership Change and Application Form until they receive their Membership card. If they do not have their pink copy, call the Customer Service team at (616) 949-2410 to ensure Membership.

Membership cards are issued to the subscriber, who is responsible for paying for GVHP coverage. The subscriber's spouse also gets a card. Both cards indicate the name of the subscriber. GVHP does not supply cards to dependents.

The front of the Membership card indicates the Member's family practice office, their coverage or benefit level, prescription drug co-payment (if applicable), and the employee group number.

The back of the Membership card indicates the address for claims submission and our partnership with the CuraNet/Multiplan network.

Grand Valley Health Plan Choice Plus Point of Service (POS) Member Card

Grand Valley Health Plan Choice Plus Point of Service (POS) plan, Members are covered for:

- In-network services
 - When they are provided, arranged, or authorized by a GVHP Family Health Center provider.
- Out-of-network services
 - Do not require pre-authorization by a GVHP Family Health Center provider.
 - Those that do require pre-certification are:
- Inpatient admissions and extended care including birth of newborns
- Skilled nursing facility confinement
- Hospice care
- Home health care
- Physical, occupational, and speech therapy services
- Inpatient mental health (only with rider)
- Inpatient and outpatient surgical services
- Hemodialysis
- Chemotherapy
- Pregnancy and maternity care for risk births (within 72 hours)

Members may be recognized by their Identification Card. Upon enrollment, Grand Valley Health Plan Choice Plus Membership cards are issued to the Member. The Member's spouse also gets a card. Both cards come in the name of the subscriber. GVHP does not issue cards to dependents. There are two sides to the GVHP Choice Plus (POS) Membership card. The front of the card gives information about the Member's GVHP Family Health Center office. To ensure up to date information, please visit our web site at www.gvhp.com or call Customer Service at (616) 949-2410.

The Back of the Choice Plus (POS) Card

The back of the Membership card indicates the address for claims submission and our partnership with the CuraNet/Multiplan network including what to do in case of an emergency. It also lists the out-of-network services that require pre-certification, including:

- Inpatient admissions (72 hours prior to admission) and extended care including birth of newborns,
- Skilled nursing facility confinement
- Genetic testing and counseling
- Kidney dialysis
- Chemotherapy
- Durable medical equipment
- Orthotics
- Physical, occupational and speech therapy services
- Inpatient mental health
- Inpatient and outpatient surgical services including pregnancy and maternity care for high-risk births.

Please call 1-888-921-GVHP (4847) for the Grand Choice Pre-Certification line.

III. CLAIMS PAYMENT RULES

Grand Valley Health Plan (GVHP) developed the Claims Payment Rules based on generally accepted insurance industry standards for billing medical services, including but not limited to Centers for Medicare and Medicaid (CMS) American Medical Association's Current Procedural Terminology (CPT) Guidelines, and various recognized Board Specialties. Our purpose is to have a reference document that could be shared and utilized by both GVHP staff and our contracted provider network on how claims are processed. We hope that you find the Claims Payment Rules helpful, and welcome your suggestions to improve the document, as it is revised periodically. Updates will be posted to our website, www.gvhp.com on a quarterly basis, or you may call Customer Services at (616) 949-2410.

SECTION 1: General Information

Claims must be received no later than 365 days from the date of service to meet timely filing rules. Claims that are greater than 365 days from the date of service are not reimbursable, and Members cannot be billed for untimely filing.

Grand Valley Health Plan regularly performs random audits to ensure accurate claims payment. Claims paid in error are subject to GVHP's Right to Recovery process, which extends 18 months from date of service. If an overpayment occurs, you have the option to send a refund, or GVHP can debit your next payment for the applicable amount. If GVHP has underpaid, we will adjust the payment amount and add the sum to your check.

SECTION 2: General Coding Requirements

The appropriate and most current year ICD-9-CM and CPT codes (including HCPC codes) must be used for all services. All current year CPT Codes will be implemented by January 1 of the year in which the codes become effective. After January 1, the previous year's CPT Codes will no longer be accepted for dates of service after January 1 and will be denied as invalid.

- All outdated and/or incorrect coding will be denied.
- Claims denied for incorrect and/or outdated coding must be resubmitted within 90 days of the denial provided that the 365 days from date of service submission requirement has been met. Claims submitted after the 30 days resubmission period are not payable and the Member may not be billed. Participating providers have Member hold harmless provisions in their contracts that support this policy and for non-contracted providers this is an industry standard and not unique to GVHP.
- Practitioners and providers are required to follow standard AMA and CMS approved coding guidelines.
- Practitioners and providers are required to use the most specific code available in the CPT, HCPC and ICD-9-CM coding systems.
- Miscellaneous/unlisted CPT codes will not be accepted unless the unlisted procedure code is the most accurate code to use and is accompanied with supporting documentation indicating details of the treatment or service.
- A valid code to describe the diagnosis and treatment performed does not guarantee payment.
- There is a quick reference table on page 43.

ICD-9-CM Diagnosis Codes must be submitted to the highest level of specificity, i.e. Diabetes Mellitus without complication is 250.01. For those diagnoses that are described to the fifth digit, five digits must be used.

Claims submitted by anesthesiologists for anesthesia services, excluding pain management procedures such as epidural injections, are to be billed with CPT surgical codes and not anesthesia administration codes (ASA codes).

Anesthesia claims submitted for reimbursement must be billed with a CPT surgical code and include the basic unit value along with start time, end time and total time. On the claim an indication must be made as to who is performing the work (i.e. Anesthesiologist or CRNA Certified Registered Nurse Anesthesiologist).

- An anesthesia unit is defined as a 15-minute increment. Time greater than > 8 minutes will be calculated as a whole unit.
- Anesthesia reimbursement is as follows:
 - Physician performing services: 100% of the allowable rate per unit.
 - Physician overseeing a CRNA performing the work: 50% of the allowable rate.
 - CRNA performing services under physician supervision: 50% of the allowable rate.
 - CRNA combined with physician supervision charges will not be reimbursed above what an anesthesiologist alone would be reimbursed.
 - CRNA billing without anesthesiologist over-site: 85% of the allowable rate.
 - GVHP reimburses for anesthesiologists or CRNA's only.
- Anesthesia modifiers and qualifying circumstances codes are as follows:

There will be no additional payment for any of the modifiers and/or codes as noted below, on a routine processing basis.

Physical Status Modifiers

- P1- normal healthy patient
- P2- patient with mild systemic disease
- P3- patient with severe systemic disease
- P4- patient with severe systemic disease that is a constant threat to life
- P5- moribund patient who is not expected to survive without the operation
- P6- declared brain-dead patient whose organs are being removed for donor purposes

Qualifying Circumstances

- 99100 Anesthesia for patient of extreme age, under one year and over seventy
- 99116 Anesthesia complicated by utilization of total body hypothermia
- 99135 Anesthesia complicated by utilization of controlled hypotension
- 99140 Anesthesia complicated by emergency conditions

OB Services

- Global OB CPT Codes must be used if the services performed meet the AMA's coding guidelines. Separate CPT Codes will not be accepted for each service if they can be appropriately bundled into a global code.
- When billing global OB services, the date of the delivery is to be used as the date of service.
- When billing prenatal care only, use a date range indicating when the services were provided.

Specialist Directory

- Please reference CPT Coding Guidelines when billing maternity services that do not qualify under the global billing guidelines. For example, if one but not more than three antepartum visits were provided, E & M codes should be used to bill the service along with the appropriate ICD-9-CM Diagnosis code for pregnancy.

Provider Midlevel

- If a provider employs Certified Technical Surgical Assistants, Physician Assistants, and Certified Nurse Practitioners, GVHP requires that these services be prior authorized and that the claims be submitted on the same HCFA claim form as the physician; or if a separate HCFA form is generated, it must be attached to the physician claim.
- Certified Technical Surgical Assistants will not be reimbursed if the procedure does not support a surgical assistant. To determine coverage and reimbursement for use of Surgical Assistants, please contact Customer Services at (616) 949-2410. Denied services cannot be billed to GVHP Members.
- Based upon the recommendations of the American College of Surgeons and Medicare, GVHP will reimburse for surgical assistants only if the surgery is approved for a surgical assistant and is rendered by an authorized physician. Reimbursement is 20% of the allowable payment for physicians and 13% for CTSA's. All non-physician CTSA's must be employed by the surgeon performing the service and be credentialed by the hospital or freestanding surgical facility.

SECTION 3: Payment Rules Summary

GVHP follows CMS and CCI (Coding Compliance Initiative) rules for global packaging of procedure coding.

Procedure Unbundling

- A process whereby itemized or separate CPT Procedure Codes are billed in lieu of a single CPT Procedure Code
- Is all-inclusive for the procedures performed and is the most accurate CPT Procedure Code to use.
- GVHP follows the AMA guidelines and considers all supporting services necessary to accomplish a given procedure to be included in the primary procedure CPT descriptor. Although separate CPT Codes for some services may exist, GVHP considers billing for separate CPT Code unbundling. All procedures must be re-bundled into the most correct and comprehensive CPT Procedure Code.
- Payment will be denied for billing duplicate procedures, mutually exclusive procedures and incidental separate procedures.

Mutually Exclusive Procedures

If two or more CPT Procedure Codes are billed, which are not supported by industry standards of medical practice and should not be performed on the same patient, on the same date of service, the correct procedure will be identified for reimbursement and the other procedure(s) will be denied. GVHP considers all the services necessary to accomplish a given procedure to be included in the description of that procedure as advocated by the AMA's CPT Coding Guidelines.

For example, a vaginal hysterectomy (procedure code 58260) and total abdominal hysterectomy (procedure code 58150) are mutually exclusive. Only one procedure is performed, but not both. The appropriate code must be used based on the actual service provided.

Incidental Procedures

An “incidental procedure” is defined as a procedure that is performed at the same time as a more complex surgical procedure and is not part of the reason for surgery. It requires little additional physician resources and/or is not clinically integral to the performance of the primary procedure. All “incidental procedures” that are billed in addition to the primary procedure will be denied as included in the primary procedure for claims processing. We are not guaranteeing payment unless unusual and extenuating circumstances exist and for which prior authorization has been obtained.

For example, when a physician performs a transurethral incision of the prostate (procedure code 52450), the cystourethroscopy (procedure code 52000) is considered integral to the performance of the prostate procedure.

Most Extensive Procedures

When CPT descriptors designate several procedures of increasing complexity, the code describing the most extensive procedure performed should be submitted. In the following situations, the procedure viewed as the most complex would be billed:

- “Simple” and “complex” CPT codes performed: the simple procedure is bundled into the complex procedure.
- “Limited” and “complete” CPT codes performed: the limited procedure is bundled into the complete procedure.
- “Simple” and “complicated” CPT codes performed: the simple procedure is bundled into the complicated procedure.
- “Superficial” and “deep” CPT codes performed: the superficial procedure is bundled into the deep procedure.
- “Intermediate” and “comprehensive” CPT codes performed: the intermediate procedure is bundled into the comprehensive procedure.
- “Incomplete” and “comprehensive” CPT codes performed: the incomplete procedure is bundled into the complete or comprehensive procedure.
- “External” and “internal” CPT codes performed: the external procedure is bundled into the internal procedure.

With and Without Services

Specific CPT Code descriptors designate procedures performed “with”, “without” and “with or without” other services. Submit only the code that most accurately describes the service actually performed.

For example, if an MRI of the knee is performed without contrast material (procedure code 73721) and followed by contrast material (procedure code 73722) two codes would not be reported. The correct code to describe this service would be: MRI, any joint of lower extremity; without contrast material(s), followed by contrast materials(s) (procedure code 73723).

Gender Designation

Specific CPT Codes designate procedures performed exclusively for males or females. Check the CPT coding manual to ensure that the submitted code designation accurately reflects the gender of the patient. For example, use CPT code 53210 for total urethrectomy including cystostomy in a female as opposed to 53215 for the male.

Specialist Directory

Package Items

Physician Claims submitted with a surgical tray or HCPC codes that are already included in the surgical procedure will be denied as included in the primary procedure. Supplies associated with a surgical procedure, such as a surgical tray, are considered as part of the procedure and may not be billed separately. There are surgical procedures that require supplies over and above what is considered as part of a standard surgical package. Those supplies that are separately reimbursable are based on a limited list of procedures that are also consistent with industry standards.

Medical Visits on the Same Date of Service as a Procedure

All claims for an E & M service on the same date of service as a surgical procedure will be denied for payment as included in the global surgical payment unless documentation supports that a separately identifiable service was performed. (For information about billing with modifiers -25 and -57 see Section 4: “Modifier Requirements” below and reference your CPT Coding Book for guidance).

Pre- and Post-Operative Visits

The following evaluation and management services are considered part of the global package:

- Preoperative visits on the day before surgery
- Preoperative visits on the same day of surgical procedures
- Postoperative visits that fall within the Global Period for that procedure as defined by CMS guidelines.
- Miscellaneous services such as:
 - Dressing changes
 - Local incision care
 - Removal of operative pack
 - Removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints
 - Insertion, irrigation, and removal of urinary catheters
 - Routine peripheral intravenous lines
 - Nasogastric and rectal tubes
 - Changes and removal of tracheostomy tubes

SECTION 4: Modifier Requirements

Modifiers should only be used to further clarify or define a service(s). GVHP follows the AMA's CPT Coding Guidelines for modifiers. A complete list of modifiers and their definitions can be found in the most current edition of the CPT Manual.

Lists of the most common modifiers submitted to GVHP are defined as follows:

-21 Prolonged Evaluation & Management Services

When the service(s) being provided is significantly greater than that usually required for the highest level of evaluation & management services(s) within a specific category, modifier -21 might be added to the E & M service. Supporting documentation must be submitted along with the claim. Claims submitted with modifier -21 and without documentation will be denied. Modifier -21 is used only with E & M service codes.

-22 Unusual Procedural Services

This modifier is intended to be used to identify a service(s) that is greater than that usually required for a particular procedure. This modifier cannot be used with Evaluation & Management Codes, only surgical/diagnostic procedures that exceed the usual complexity and time necessary to perform the procedure. When the service provided exceeds these normal ranges, modifier -22 should be used in addition the surgical/diagnostic procedure code, and appropriate documentation must be attached to the claim. Claims submitted with modifier -22 and without supporting documentation will be denied.

-24 Unrelated Evaluation and Management Service By Same Physician During Postoperative Period

When a physician provides an E & M service during the postoperative period for reasons that are unrelated to the original procedure, modifier -24 should be used. Visits unrelated to the diagnosis for which the surgical procedure was performed should include the correct diagnosis code on the claim. Treatment for underlying conditions or an added course of treatment that is not part of normal recovery from surgery is appropriate for use with modifier -24. All claims submitted with modifier -24 require supporting documentation and the appropriate diagnosis. Claims submitted with modifier -24 and without supporting documentation will be denied.

-25 Significant, Separately Identifiable Evaluation & Management (E&M) Service by the Same Physician on the Same Day of the Procedure or Other Service

When the patient's condition requires a separately identifiable E & M service above and beyond the usual preoperative or postoperative care on the same day the procedure was performed, modifier -25 may be used. Supporting medical documentation must be submitted with the claim. Claims submitted with modifier -25 and without supporting documentation will be denied.

-26 Professional Component

Certain procedures are composed of a physician component (-26 Modifier) and a technical component (TC Modifier). The appropriate modifier -26 or TC must be used to identify which portion of the procedure the provider performed. If the global or total procedure is performed, the claim should be submitted with the procedure code and without the -26 and TC modifiers. Those procedures that are billed separately by two different providers (i.e. hospital and physician) must be approved, in advance.

-50 Bilateral Procedures

A bilateral procedure is a procedure performed on both sides of the body (i.e., arms, hips, legs, eyes, etc.). Before billing for bilateral procedures refer to CPT to verify that the procedure code does not already include bilateral services. If the procedure includes bilateral services, no special reporting is required. However, if the procedure does not include bilateral services, report the first procedure with the CPT Code only and the second procedure with the CPT Code and modifier -50. Assign a separate charge to each line item. A bilateral procedure must be authorized; bilateral procedures not authorized will be denied. The GVHP payment rule for bilateral procedures is 150% of the GVHP allowable amount for the combined codes (First procedure paid at 100% of the allowable amount and the second procedure is paid at 50%). Bilateral services not billed on two lines as described above will be denied.

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-51 Multiple procedures

When multiple procedures are performed on the same day or at the same session, excluding E & M services, report the major (highest level procedure) without any modifier. Report additional procedures with modifier -51. Supporting documentation must be submitted with the claim or it will be denied. The GVHP payment rule for multiple procedures is 100% of the GVHP allowable amount for the primary procedure and 50% of the GVHP allowable amount for each subsequent procedure. Claims submitted without modifier -51 on procedures that are not modifier -51 exempt will be denied.

-52 Reduced Services

When a service or procedure is partially reduced or eliminated at the physician's discretion, modifier -52 should be used. Claims submitted without supporting documentation will be denied.

-53 Discontinued Procedures

When a surgical or diagnostic procedure is discontinued, modifier -53 should be used. In some circumstances, the claim may even be rejected for payment due to provider error. (Example: Patient required to be NPO for 12 hours prior to surgery and hospital gives patient breakfast, and this is not detected until patient is under going sedation, when the procedure must be stopped). Claims submitted without supporting documentation will be denied. Both facility and physician submissions will have the appropriate reduction applied.

-54 Surgical Care Only

When one physician performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding modifier -54 to the procedure code. Claims submitted without supporting documentation will be denied as unbundled.

-55 Postoperative Management Only

When one physician performs the preoperative care and evaluation and another physician has performed the surgical procedure, the postoperative component may be identified by adding modifier -55 to the unusual procedure number. Claims submitted without supporting documentation will be denied. Bills submitted from the same Group Practice will be denied.

-56 Preoperative Management Only

When more than one physician provides services that are included in the global surgical package, the sum of the amount approved for all physicians may not exceed what would have been paid if a single physician provides all services. Physicians who furnish only part of a global package must add the appropriate CPT modifier to the surgical procedure code as follows:

- Modifier -54 to report surgical care only
- Modifier -55 to report postoperative management only
- Modifier -56 to report preoperative management only

If a claim is submitted without modifier -54, -55, or -56 GVHP will process the claim as if he/she performed the entire global package. If a new claim reveals that an incorrect payment was made to the first physician

based on an inaccurate claim submission, the second physician will be paid according to the services performed and an overpayment will be collected from the first physician. Claims submitted without supporting documentation will be denied. Physicians billing under the same tax identification number must bill a global procedure code.

-57 Decisions for Surgery

When an evaluation & management service results in the decision to perform a major surgery either on the same day or the day prior to the procedure, modifier -57 should be billed along with the surgical procedure code. Do not report modifier -57 with a visit if the surgery was minor surgery, preplanned, or a prescheduled major surgery. Claims submitted without supporting documentation will be denied.

-58 Staged or Related Procedure or Service by the Same Physician During the Postoperative Period

When a patient has multiple surgeries performed at different operative sessions it is a staged procedure. If staged or related procedures are performed during the post-operative period of another surgical procedure because (a) it was planned prospectively at the time of the original procedure; or (b) more extensive than the original procedure; or (c) for therapy following a diagnostic surgical procedure, modifier -58 should be used. When the CPT code(s) includes multiple sessions or are otherwise defined as including multiple services or events, modifier -58 may not be billed. "Return to the OR" due to patient complications is not to be used with modifier -58. Claims must be submitted with the appropriate documentation when using modifier -58, or the claim will be denied.

-59 Distinct Procedural Service

A distinct procedural service occurs when, under specific circumstances, the physician provides a procedure or service that is clearly independent and distinct from other services performed on the same day. Modifier -59 should only be used when a more descriptive modifier is not available and/or the services are not generally reported together, but are appropriate under extenuating circumstances. Claims submitted without supporting documentation will be denied.

NOTE: Use of modifier -59 does not exempt the procedure from multiple procedure reduction. Unless the procedure is exempt, it is appropriate to use modifier -51 in conjunction with modifier -59. (The modifier that effects payment should always be used first.)

-62 Two Surgeons

When two physicians work together as primary surgeons performing separately identifiable parts of a single procedure at the same operative session, each physician must bill using modifier -62. For co-surgery, GVHP pays 120% of its global fee for the service, dividing the payment equally between the two surgeons (60% to each physician). Claims submitted without supporting documentation will be denied.

-76 Repeat Procedures by Same Physician

Modifier -76 should be used if a physician repeats a procedure or service subsequent to the original procedure or service. Documentation must accompany the claim in order to process it for payment. If the documentation is not submitted with the claim, the claim will be denied. Modifier -76 may not be used with two or more laboratory tests performed in the same 24-hour period. For lab tests, modifier -91 should be utilized.

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-77 Repeat Procedure by Another physician

If modifier -77 is used to bill a service, medical record documentation is required to process the claim for payment. If the documentation is not submitted with the claim, the claim will be denied.

-78 Return to the Operating Room for a Related Procedure During the Post-operative Period

If this modifier is used, medical record documentation is required in order for the claim to be processed for reimbursement. Claims submitted without supporting documentation will be denied

-79 Unrelated Procedures or Service by the Same Physician During the Postoperative Period

If this modifier is used, medical record documentation is required in order for the claim to be processed for reimbursement. Claims submitted without supporting documentation will be denied

-80 Assistant Surgeon

-81 Minimum Assistant Surgeon

-82 Assistant Surgeon (when a qualified resident surgeons are not available)

Not all procedures require an assistant surgeon. Assistant surgeons must be authorized to perform the procedure or the service will be denied. Those procedures that are not approved for assistant surgeons will not be approved and/or reimbursed by GVHP. The surgical assistant may be another qualified physician or an appropriately trained, licensed, credentialed and privileged mid-level provider rendering services at a participating facility. Providers submitting claims with modifiers -80, -81, or -82 must supply supporting documentation or the claims will be denied.

Surgical Assistant services performed by a certified and prior-approved mid-level providers should be submitted with the attending physician's name and tax ID number and billed with the modifier -81 as appropriate.

Surgical Assistant services performed by another physician should be submitted under the Assistant's name and tax ID number and billed with modifier -80 or -82 as appropriate.

GVHP reimburses 20% of the lesser of the primary surgeon's allowable charges or the GVHP fee schedule for a physician assistant surgeon and 13% of the lesser of primary surgeon's allowable charges or the GVHP fee schedule for Certified Technical Surgical Assistants (CTSA) and Physician's Assistants (PAC).

-91 Repeat Clinical Diagnostic Laboratory Test

Used when it is necessary to repeat the same laboratory test(s) on the same day to obtain multiple test results required in the course of treatment. Modifier -91 may not be used when another CPT code(s) already describes a series of tests. It is important to link the appropriate diagnosis with the correct lab test. Documentation is not required unless specifically requested.

SECTION 5: Claims Submission for Professional Services

Standard medical billing forms in use nationwide are part of the streamlining of systems for more efficient, cost-effective health care. Using the same forms as required by other insurance companies helps eliminate unnecessary paperwork.

The practitioner or provider is ultimately responsible for the accuracy of claims filed for services. Accuracy of claims submission can be achieved by following these guidelines.

- Use only standard forms. The following are acceptable claim forms:
 - CMS-1500
 - CMS-04
- Submit claims to the following address:

Claim Services
Grand Valley Health Plan
829 Forest Hill Ave SE
Grand Rapids, MI 49546

Note: All services performed on the same date of service must be billed on one CMS form. If maximum lines are exceeded, an additional claim form may be used. If multiple services are billed separately, the claim will be denied for resubmission with the claims billed on one form.

Claims submitted with incorrect Member numbers, procedure codes, diagnosis codes, charges and/or with missing modifiers or units will be rejected. The practitioner or provider must resubmit the claim with the correct information within the time limit for claims submission.

SECTION 6: Provider Appeals

There are two kinds of provider appeals, claims payment and clinical decision making.

When the practitioner or provider is dissatisfied with a medical decision on a claim(s), he or she has the right to appeal the decision. The appeal process does not apply to benefit design, and must be accompanied by supporting documentation.

The appeal must be requested in writing. The practitioner or provider has 30 days to appeal the denial in writing. The written request should contain all pertinent information necessary to render a decision. A copy of the claim should accompany the appeal request. The request should be sent to:

Provider Appeals
Grand Valley Health Plan
829 Forest Hill SE
Grand Rapids, MI 49546

GVHP will render a decision fifteen days from receipt. In most cases, a written response will be mailed to the practitioner or provider within fifteen days of the decision.

SECTION 7: HCPCS Codes in Special Circumstances

REIMBURSEMENT FOR SURGICAL TRAYS (A4550)

Payment for surgical trays is generally included in the payment amount for the surgical procedure performed. However, GVHP does recognize that certain specified surgical procedures require medical supplies over and above the standard surgical tray, and thus will follow AMA and CMS guidelines to allow

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separate, additional payments in qualifying circumstances, at the GVHP allowable amount.

UNLISTED J CODES

Unlisted J codes must include the following:

- Drug name
- Strength
- Dosage
- Method of administration

SECTION 8: Non-Covered CPT Codes

CODE 92015

Refraction examinations generally are not covered under the Grand Valley Health Plan Certificate of Coverage.

CPT CODE 99070

GVHP does not recognize CPT Code 99070 for billing supplies. Please refer to the appropriate CPT or HCPCS code book to select a more accurate description of the supplies used in patient care.

CODES 99361 – 99362

GVHP does not generally reimburse for CPT codes 99361 or 99362 for Physician Team Conference. These codes are considered to be included in the evaluation and management, and are not reimbursed separately. The Member cannot be billed for these services.

CODES 99371 – 99373

CPT codes 99371 – 99373, Telephone calls by a physician to patient or for consultation or medical management or for coordinating medical management with other health professionals, is not reimbursable by GVHP and Members cannot be billed for this service.

CODE 36415

CPT code 36415, routine venipuncture or finger/heel/ear stick for the collection of specimens, is not separately reimbursable by GVHP because it is included with the test code and/or office visit. Routine specimen collection at the time of an office visit is considered an integral part of the services rendered under the E & M service. It is acceptable to direct the GVHP Member back to their designated family health center to have a specimen collected. Please note that if laboratory testing is required at the time of an office visit, the laboratory testing must be prior authorized by the Member's family health center. Prior authorized specimens must be directed to a Quest Clinical Laboratory.

GVHP will not reimburse for laboratory tests mistakenly sent to a non-participating laboratory, nor is the GVHP Member financially responsible for this error. The provider directing the sample to the incorrect laboratory will be held responsible for the error.

CODE 99000

CPT code 99000, specimen handling and/or conveyance to a laboratory for testing, is not reimbursable by GVHP.

SECTION 9: Prudent Layperson

The Prudent Laypersons Act states that an HMO shall not deny payment for emergency health services up to the point of stabilization of the patient based on either the final diagnosis or the fact that prior authorization was not given. GVHP covers emergency services necessary to screen and stabilize Members without pre-certification in cases where a prudent layperson, acting reasonably, would have believed an emergency condition existed. GVHP reserves the right to transfer a patient after stabilization occurs should the member be admitted to a hospital.

SECTION 10: Member Financial Responsibility

No Show

GVHP does not reimburse for Member's missed appointments. If a Member fails to keep his/her appointment, the practitioner or provider may bill the Member if the office has an established policy.

Co-payments

Co-payments should be collected at the time of service. If the practitioner or provider has been unsuccessful in collecting the co-payment, he/she may follow his/her established office policy for obtaining the co-payment.

Deductibles

Claims are processed in the order in which they are received. Depending on the individual providers' office policy for collection of payment at the time of service, a deductible may be required to be paid by the Member. However, due to claims being processed on a daily basis, a deductible paid by the Member at the time of service could result in an overpayment, as all claims are date stamped and processed by GVHP in the order in which they are received.

Should a Provider collect a deductible resulting in an overpayment on the account, the Provider is responsible for Member reimbursement. A Remittance Advice will provide notification of patient responsibility.

When to Bill Members

The following services can be billed to the Member:

- (a) Non-covered services
- (b) Policy exclusions (unbundled vs. non-covered code)
- (c) Self-referred visit
- (d) Co-payments and deductibles
- (e) Missed appointments

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Prior-Authorization

The practitioner or provider is required to obtain prior-authorization for all scheduled, non-emergent services from the Member's family health center. If the practitioner or provider has not obtained a prior-authorization number and an emergency situation did not exist, the practitioner may not bill the Member for the service and GVHP will not reimburse the practitioner/provider. Retro-authorization will not be given by the Member's family health center unless the service was urgently needed and a time delay could be harmful to the Member's health. Services must be prior-authorized and the authorization number must be documented on the claim form.

SECTION 11: Home Health Care Claims & DME Services

Not all home health care and DME services are covered. Always call for prior authorization to determine coverage. Home Health Care and DME services require preauthorization by a GVHP Primary Care Provider (PCP). DME Services not authorized will be denied by GVHP. Service codes preauthorized must match the codes submitted on the claim form or the services will be denied.

SECTION 12: Facility Billing

GVHP follows CMS billing guidelines for the submission of facility claims (inpatient and outpatient). Providers should submit claims according to these rules. Claims may be rejected for not containing the required information to appropriately adjudicate a submitted claim.

SECTION 13: Observation Stays

Observation stays will be paid if it is part of the facility's contractual agreement. Hospital observation charges for outpatient surgery, myelograms, colonoscopies, or other diagnostic procedures are not routinely payable. Also, observation charges are not payable when billed with other services such as false labor treatment or IV therapy. Observation bed claims that do not meet GVHP guidelines remain the hospital's liability, and the Member may not be billed. Observation is only payable following emergency room care or a referral from a physician or skilled nursing facility with a medical emergency or emergency first aid diagnosis.

Any patient who remains hospitalized for 24 hours or more will be considered an inpatient, and the claim will be processed accordingly.

IV. COMPLIANCE PROGRAM POLICY

Grand Valley Health Plan's company wide compliance program instills a corporate culture of compliance with the law and the highest standards of health care delivery and insurance services. It has the added benefit of preventing fraud and abuse from occurring, which will minimize adverse liability.

Grand Valley Health Plan is committed to establishing and maintaining an atmosphere of honesty, integrity, courtesy, respect, and concern for all Members, visitors, vendors and staff. To meet this commitment and assure safe, efficient, and responsive operations, Grand Valley Health Plan staff are expected to demonstrate professional behavior and conduct in the workplace in general, and with both internal and external customers. Violations, which the company feels, reflect adversely on the employee or the company may result in corrective action, up to and including discharge.

The purpose of the program, which includes our Code of Conduct and Employment Practices, Ethics, reflects our mission and how we conduct business is to have a formally documented and consistent compliance program to prevent, detect and correct possible deficiencies. Some of the areas that are pertinent to our partners in health care are reflected in the following areas and which meet all local, State, federal and regulatory requirements:

- Improper payments and claims submissions practices
- Payments for services that fail to meet professionally recognized standards of care
- Care that is not medically necessary
- Patient safety
- HIPAA Program and Confidentiality

Grand Valley has established a 24/7 hot line to report potential deficiencies regarding any aspect of the Corporate Compliance Program. The hot line number is 1-800-335-1977.

V. REFERRALS AND AUTHORIZATIONS

Referrals

Referral services, including but not limited to, are as follows:

- Office visits
- Consultations
- Testing
- Therapeutic services
- Surgical procedures

All referrals require authorization by a GVHP Primary Care Provider (PCP). Copays and deductibles will apply (see Billing section). When a Member is referred for consultation, the GVHP Provider continues to monitor and manage the care of their patients. Specialty providers must be in regular communication with the Member's Family Health Center to keep them informed of the Member's progress. For each visit, consult letters are expected and valued for continued management in Primary Care. The GVHP PCP is responsible for communicating to the participating specialist pertinent information that will assist the specialists in the consultation, determining the diagnosis and recommending ongoing treatment. A specialist referring a GVHP Member, to other specialists or for other health services outside their office, without prior approval from the Member's PCP could result in denial of payment for services.

Patient Referral/Authorization Form

GVHP Consultation Request forms are faxed to the specialist office from the Member's family health center and a copy is provided to the Member. Each Consultation form provides a start date, an end date, and if pertinent a specific number of visits. If testing or procedures are preauthorized, the appropriate fields will

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be marked. If Consultation only has been authorized this will be the only reimbursable service. If services are provided beyond the end date of the authorization, payment will be denied automatically.

Grand Valley Health Plan Consultation Request

CONSULTATION INFORMATION				
Date submitted:	A. Authorization #:			
Patient name:	Last	First	Med Record #	
Member ID#:	DOB:			
Group #:				
Check if applicable:	<input type="checkbox"/> Worker's Compensation	<input type="checkbox"/> Auto Accident	<input type="checkbox"/> Other COB	
REFERRED BY:				
PCP Name:	Location:			
Phone #:	Fax #:	Tax ID#:	38-2396958	
REFERRED TO:				
Group/Facility:	Specialty:			
Phone #:	Fax #:			
SERVICES REQUESTED				
ICD-9 DX Code:	B. Start Date:	End Date:	C. # Visits:	
<input type="checkbox"/> Consult Only D.	E. <input type="checkbox"/> Consult & /or Testing & /or Treatment		F. <input type="checkbox"/> Testing Only	
* Use Quest Diagnostics Laboratory and/or GVHP Diagnostic Radiology Center only				
<input type="checkbox"/> Diagnostic Lab/Pathology	<input type="checkbox"/> Audiology / Evaluation	<input type="checkbox"/> Ophthalmologic Services		
<input type="checkbox"/> Radiology / Imaging	<input type="checkbox"/> Cast/Fracture Care	<input type="checkbox"/> Diabetic Eye Exam		
<input type="checkbox"/> Diagnostic / Therapeutic Studies	<input type="checkbox"/> Oncology Services	<input type="checkbox"/> Pain Management		
<input type="checkbox"/> Allergy	<input type="checkbox"/> Dialysis	<input type="checkbox"/> OB		
<input type="checkbox"/> Surgery/Procedure	Surgical/Procedure CPT Code(s): _____			
Description of Surgery/Procedure _____				
Therapy :	<input type="checkbox"/> Physical	<input type="checkbox"/> Occupational	<input type="checkbox"/> Speech	<input type="checkbox"/> Cardiac
APPOINTMENT INFORMATION				
Appointment Date :	Appointment Time:	<input type="checkbox"/> No Show <input type="checkbox"/> Reschedule		
Physician/Facility:				
Street Address:				
City:	State:	Zip:		

Comments:

This consultation request does not guarantee payment. Please contact GVHP to verify Member eligibility and covered benefits.

With the acceptance of this consult, Provider agrees to accept the Grand Valley Health Plan fee schedule for all services and shall look only to the HMO for compensation for services authorized by or on behalf of the HMO. Provider agrees not to bill, charge, collect a deposit from, seek compensation from, seek remuneration from, surcharge or have any recourse against Member or persons acting on behalf of Member (other than HMO), except for copays, deductibles, and/or non-covered services.

- A. Authorization number – Needed for Payment
- B. Start date and end date – Time frame for Authorization
- C. # Of Visits - # of visits pre-authorized
- D. Consult only – Requests a medical opinion and excludes testing and treatment
- E. Consult, testing, and/or treatment – Authorized for office setting only with the exception of diagnostic X-ray and lab testing
- F. Testing only – Authorization for in office testing only. Excludes consultation. Please keep in mind that when additional services are being requested, a written consultation letter must be received by the Family Health Center prior to approval. This includes follow-up appointments, testing and procedures.

VI. GVHP ANCILLARY (VALUE ADDED) SERVICES

Surgical Center

Grand Valley Surgical Center, LLC is the preferred provider for outpatient surgeries. The innovative surgical center focuses on the highest quality care for patients and families. Grand Valley Surgical Center is a freestanding Ambulatory Surgical Center (ASC) located on the northeast side of Grand Rapids. The center is licensed by the State of Michigan, certified by the Health Care Financing Administration for Medicare Part B and fully accredited by the Accreditation Association for Ambulatory Health Care (AAAHC).

The Surgical Center features six operating rooms and a friendly, inviting atmosphere with personal touches to make the time there positive. More than 200 well-known physicians, performing procedures in the following areas, staff the surgical Center:

- Gynecology
- Hand/Plastic Surgery
- Neurosurgery
- Ophthalmology
- Orthopedic
- Otolaryngology
- Pain Management
- Podiatry
- Urology

GVHP's Well Woman Center

GVHP offers its female Members an added-value service. We now offer appointments for pap, pelvic and breast exams at our Well Woman Center. This is located at 2680 Leonard NE. This is the same location as GVHP's Beckwith Family Health Services. Appointments at the Well Woman Center are with female mid-level providers. The Well Woman Center is open on selected Saturday's.

For information about the services of the Well Woman Center, please call your GVHP family health center or GVHP Customer Services at (616) 949-2410.

GVHP's OB Center of Excellence

GVHP's OB Center of Excellence, 2680 Leonard NE (same location as Beckwith Family Health Services) provides individualized, personal care.

The OB Center of Excellence has a team of professionals who specialize in OB care. This team includes family physicians, obstetricians, nursing staff and a perinatologist. The hospital utilized by the OB Center of Excellence is Spectrum Health-Butterworth.

Radiology

GVHP offers a full range of X-ray services at our Diagnostic Radiology Center located in the same building as Beckwith Family Health Services. The services provided by the Diagnostic Radiology Center include mammography, ultrasound, and x-ray services. The GVHP Diagnostic Radiology Center is located at 2680 Leonard NE, Grand Rapids, MI. To arrange for radiology services, call the GVHP Diagnostic Radiology Center at (616) 224-8686.

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Laboratory Services

GVHP offers a full range of laboratory services through Quest Diagnostics Laboratories. Laboratory specimens can be collected either at a Member's Family Health Centers, a specialty physician's office served by Quest or at a Quest collection site.

Pharmacy

Grand Valley Health Plan has two full service pharmacies located at Beckwith Family Health Services and the Wyoming Family Health Center. In addition, GVHP offers prescription services at all six Family Health Centers. GVHP prefers that Members fill their prescriptions at a GVHP Pharmacy. Prescriptions can be faxed directly to either GVHP pharmacy.

Benefits of using a GVHP Pharmacy include lower co-payments and a 90-day supply on many maintenance medications, which helps our Members decrease out of pocket costs.

The two full service pharmacies are:

Beckwith Pharmacy 2680 Leonard, NE Grand Rapids, Michigan 49525 Phone: (616) 224-1121 Fax: (616) 224-3001	Wyoming Pharmacy 5251 Clyde Park, SW Grand Rapids, Michigan 49509 Phone: (616) 532-8882 Fax: (616) 249-2269
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Disease Management Programs

Disease management is a multi-disciplinary, continuum-based approach to health care that proactively identifies populations with, or at risk for, chronic medical conditions. Disease management includes the following elements in its approach to improving overall health:

- Supports the practitioner-patient relationship and plan of care
- Emphasizes the prevention and further complications of the disease
- Uses evidence based practice guidelines
- Maximizes patient empowerment strategies to enhance patient self management
- Treats disease from a "whole person" perspective
- Continually evaluates clinical, humanistic, and economic outcomes
- Determines interventions based on stratification
- Engages the Member in a team approach to care (multidisciplinary) that includes the primary care provider and other involved providers such as the health and wellness coach
- Provides pro-active condition monitoring, tracking of patient adherence to the treatment plan, and addressing of lifestyle issues that may exacerbate the disease

GVHP offers a number of disease management programs including:

- Diabetes, which has been nationally recognized
- Asthma Disease Management, also which has been nationally recognized
- High Risk for Cardiovascular Event (HRCVE) Program
- Oncology Risk Reduction/Disease Management Program
- Healthy Self Program designed to manage Members that have co-morbidity and poly pharmaceutical use.

Members do not have to enroll in these programs. They are automatically enrolled upon diagnosis or when meeting key risk indicators. As a provider of GVHP, if you desire to enroll a Member into one of the disease management programs, please initiate this by contacting the Member's Family Health Center.

Once a Member is enrolled, the program will provide the following services:

- Support from our family health center staff to ensure that the Member understands
- How to best manage their condition and periodically evaluate their health status
- Periodic newsletters to keep the Member informed of the latest information on their disease
- Educational and informational materials that can assist the Member in understanding and managing the medications prescribed, how to effectively plan for primary care provider visits, and reminders as to when those visits will occur
- Information about upcoming events such as health fairs

GVHP believes in a holistic, continuum of care, multi-disciplinary approach to disease management and will continue to implement innovative programs that approach care from this perspective.

VII. POLICIES

Member Co-Payment, Deductible, and Co-insurance Policy

Grand Valley Health Plan educates Members that office visit co-payments are due at the time of service. The Members office visit co-payment is listed on their GVHP Membership Identification card. It is the responsibility of your office to collect the Member's applicable co-payment, deductible and/or co-insurance. For all submitted claims, the Member's financial responsibility will be listed on the provided remittance advice. For verification of Member's co-payments, deductibles and co-insurances please review the Member's GVHP identification card or contact Customer Services at (616) 949-2410.

VIII. PROVIDER RESPONSIBILITIES

GVHP's Primary Care Provider (PCP) Responsibilities

The PCP is responsible for communicating to the Grand Valley Health Plan participating specialist pertinent information that will assist the specialist in the consultation, determining the diagnosis, and recommending ongoing treatment. PCP's should only refer to participating specialists and facilities.

Specialty Provider Responsibilities

Specialty providers are valuable team members in delivering care to GVHP Members, and are responsible for:

- Rendering services requested and authorized by Primary Care Providers
- Communicating all findings surrounding a case to the PCP to ensure that the PCP is informed of the Members status
- Obtaining approval from the PCP prior to rendering additional services not requested on initial referral

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Coordination of Care

Grand Valley Health Plan Members select a Primary Care Physician (PCP) who is responsible for coordinating all aspects of the Member's care. PCP's are responsible for requesting information from contracted Providers, as necessary, to provide care. When a Member is referred to a contracted specialist or other provider, the specialist or provider is required to send a medical report for that visit to the PCP, to ensure that the PCP is informed of the Member's status.

Open Communication Policy

GVHP values open communication between the participating provider and the Member seeking treatment, regarding appropriate treatment alternatives, and the medical necessity and appropriateness of care of the alternative(s) with the Member, without penalty to the participating provider.

Follow-up and Self-care

Contracted providers must ensure that Members are informed of specific health care needs requiring follow-up and receive, as appropriate, training in self-care and other measures the Member may take to promote their own health. Providers must communicate by way of written progress notes with the Member's Family Health Center to keep them informed of the Member's progress.

Professional Standards and Federal Law

Contracted providers must provide all covered services in a manner consistent with professionally recognized standards of health care.

Contracted providers must meet the requirements of all other applicable laws and regulations, including, but not limited to Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, the Rehabilitation Act of 1973, and all the laws applicable to recipients of Federal funds such as Medicare and Medicaid.

Cultural Competency

Grand Valley Health Plan's contracted providers must offer quality services to existing Members in a culturally competent manner to ensure all Members are able to fully participate in GVHP programs, activities, and benefits. This includes recognizing and accommodating Members with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, and physical or mental handicaps. Grand Valley Health Plan's contracted providers may not exclude or limit Member participation or access to programs and services on the basis of race, color, national origin, education, physical or mental disability, socioeconomic status, or sexual orientation.

Non-Discrimination Based on Health Status

Contracted providers may not deny or limit benefits or coverage on the basis of any factor related to health status. Contracted providers are not to encourage Members to disenroll from Grand Valley Health Plan or change providers based on expected health care costs. Contracted providers and the Plan may not discourage enrollment of certain individuals.

Billing Members

- Covered Services – Specialty Providers shall look only to Grand Valley Health Plan for compensation for covered services, and agree not to bill or attempt to collect from Members except for applicable co-payments or deductibles for covered services. Providers shall accept compensation as set forth in the provider agreement as full compensation for providing covered services to Members. Providers agree not to maintain any action at law or in equity against Members to collect sums that are owed by Grand Valley Health Plan, even in the event Grand Valley Health Plan fails to pay, or becomes insolvent.
- Non-Covered Services – A Specialty provider may bill the Member for non-covered services only if the provider obtains the prior written authorization of the Member. Members may file a written appeal with Grand Valley Health Plan if prior written authorization has not been obtained.
- Signed Waiver – In obtaining a written authorization, Grand Valley Health Plan requires that providers explain to the Member in writing that the service is not a covered benefit and the actual cost of the service the Member will be expected to pay. To be a valid written authorization, the provider must obtain the Member's signature as acknowledgement prior to providing non-covered services. A written authorization is specific to a single visit or procedure, specifying date, provider, and non-covered services.

IX. MEMBER RIGHTS AND RESPONSIBILITIES

As practitioners treating Grand Valley Health Plan Members you should be aware of a Member's rights and responsibilities, as listed below.

Member Rights

- The right to receive information about Grand Valley Health Plan, its services, its practitioners and providers, and their rights and responsibilities.
- The right to have timely and appropriate medical care delivered in the appropriate setting.
- The right to be satisfied with their choice of Family Health Center and to have a choice within the health plans of practitioners and providers who meet high standards of professional training and experience.
- The right to be cared for by health care professionals who are accountable for quality and confidentiality of the services they provide and for the satisfaction of their patients.
- The right to participate with their Family Health Center team in decision making regarding their health care.
- The right to discuss appropriate or medically necessary treatment options for their condition, regardless of cost or benefit coverage.
- The right to voice a complaint or appeal about GVHP or the health care provided.
- The right to be treated with respect and dignity and to have their right to privacy maintained.
- The right to make recommendations regarding Grand Valley Health Plan's Members' rights and responsibilities policies.

Member Responsibilities

- The responsibility to hear how to use their Family Health Center.
- The responsibility to call their primary Family Health Center to get approval for any service.
- The responsibility to ask questions, when they think it is necessary, about their agreed upon treatment plan and then follow through on the treatment plans and instructions given them.

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- The responsibility to ask questions to understand their health problem, participate in developing an agreed upon treatment plan and then following the treatment plan and instructions given them.
- The responsibility to use the Helping You Help Yourself Handbook.
- The responsibility to be open and honest with their Family Health Center team and supply any information to the best of their ability that GVHP's Practitioners and providers may need in order to provide care.
- The responsibility to understand their health problems and to participate with the Family Health Center team in developing mutually agreed upon treatment goals.

X. PROVIDER AGREEMENTS

Terms and Conditions

Providers participate with Grand Valley Health Plan through direct agreements.

Provider agreements define the terms and conditions of all parties regarding compensation, confidentiality, the terms of the agreement, termination, and other contract issues that are in addition to the terms and conditions set forth in this manual. All parties affiliated with an agreement are responsible for the terms and conditions set forth in that agreement and in this Manual.

Subject to the terms of your provider agreement, the most recent information, whether in this manual or the contract, shall control in the event that an inconsistency arises between the languages.

Notification of Provider Change In Information

As a Grand Valley Health Plan provider, it is your responsibility to provide written notification on office letterhead to Grand Valley Health Plan Provider Relations Department 30 days prior to any change in:

- Address
- Phone Number
- Tax ID (including a copy of the W-9)
- Practice limitations (i.e. patient age, existing patient only, etc)
- License Status
- Certification Status
- Professional liability coverage if it drops below \$100,000/\$300,000
- Medicare and/or Medicaid participation status
- Information provided to GVHP on the credentialing/re-credentialing application

Telephone requests for changes will not be accepted.

If you make a change to one of the above items, include with your written documentation to Grand Valley Health Plan, the full names for all providers affected by the change. This is important to insure you receive your Grand Valley Health Plan payment timely and accurately.

If your tax ID number is changing, you must provide a copy of your W-9. Tax ID numbers can only be changed up to 30 days preceding the receipt of the request to change. If you are moving, indicate your old and new addresses in the written communication to Grand Valley Health Plan.

Submission of Changes

Submit information changes to:

Grand Valley Health Plan
829 Forest Hill Avenue SE
Grand Rapids, Michigan 49546
Fax: (616) 949-9948
Attention: Provider Relations
(Please confirm successful transmission)

XI. QUALITY MANAGEMENT

GVHP Believes in Quality

We believe quality should be part of our health care delivery. We also believe it should be part of the service we offer our Members. GVHP shows quality. Here are a few ways we do this.

- GVHP goes through an accreditation process. This means we must undergo a thorough review process. Some managed care organizations choose to go through this process to demonstrate quality. The National Committee on Quality Assurance (NCQA) is a nationally recognized organization. NCQA “gives a seal of approval” to managed care organizations on how well they “do quality.” GVHP has gone “under the microscope,” so to speak. This is one way we can demonstrate quality.
- We are authorized by the Office of Financial and Insurance Services (OFIS). We report regularly to them about our quality, service and delivery measures. GVHP must meet OFIS standards on a regular basis.

GVHP Measures Quality

We do this in several ways. GVHP participates in the Health Employer Data Information Set (HEDIS). On an annual basis, GVHP measures the effectiveness of its care. We measure such things as immunizations and well child visits. Prenatal and postnatal care as well as breast and cervical screenings are also reviewed. Some other things we measure include diabetic eye exams and Member satisfaction. HEDIS information is reported locally and nationally. GVHP consistently performs well in meeting HEDIS and quality performance standards.

GVHP Has A Quality Program

This program is measured and evaluated by the GVHP Performance Improvement Committee. This Committee reviews quality indicators for care and service on a regular basis. Annually, we report the results of our program to our Board of Directors. We give this information to the Office of Financial and Insurance Services. Members and practitioners may review our annual Quality Program evaluation.

For more information, please call GVHP Customer Services at 616-949-2410 or visit our web site at www.gvhp.com.

XII. CREDENTIALING PROCESS

Practitioner Credentialing/Re-credentialing

Initial credentialing and re-credentialing includes the primary verification of pertinent information provided on the application as part of the process for seeing GVHP Members. Practitioner re-credentialing occurs every three years.

Practitioners have the right to review information submitted in support of their credentialing application and the right to correct erroneous information submitted by another party. This includes information submitted by any outside primary source.

Grand Valley Health Plan certifies that the practitioner participates with Medicare (excluding Pediatricians and behavioral health providers) and has not been convicted of a felony or Medicaid or Medicare fraud, excluded or debarred from the Medicaid or Medicare program.

Grand Valley Health Plan verifies the history of all past and present issues regarding the loss or limitation of clinical privileges at all facilities or organizations with which he/she has had privileges (if recredentialing, then only from the time of the last credentialing.)

Grand Valley Health Plan verifies that the practitioner has an absence of excessive substantive malpractice claims for area and type of practice (as determined by the Credentialing Committee.)

Grand Valley Health Plan verifies the absence of sanctions against the practitioners' license to practice.

Grand Valley Health Plan's Credentialing Committee led by Vice President For Medical Affairs reviews and approves or denies the credentials of practitioner candidates for affiliation and continued affiliation. Grand Valley Health Plan will notify the practitioner within 30 days of the Credentialing decision.

Upon completion of the credentialing process, the practitioner will be added to the Grand Valley Health Plan practitioner referral directory.

Grand Valley Health Plan will not discriminate against health care professionals on the basis of race, color, national origin, education, physical disability, socioeconomic status, sexual orientation, or to those who serve high-risk populations, or who specialize in treatment of costly conditions.

The Credentialing Committee includes participation from a range of specialty participating practitioners.

Scope of the Credentialing Policy

This policy applies to all primary care, specialty care, physician assistants, nurse practitioners, physical therapists, occupational therapists, speech therapists, and behavior health practitioners for whom Grand Valley Health Plan has direct credentialing and recredentialing responsibility. Primary care practitioners include the following specialties: family practice, gynecology and pediatrics.

Grand Valley Health Plan is required to credential and recredential practitioners with whom it has an independent relationship. This includes practitioners who see Members outside of the inpatient hospital setting and/or outside of a freestanding facility.

Procedure for Practitioners

Practitioner must meet the following Grand Valley Health Plan criteria in order to be offered affiliation:

- Possess and maintain, at all times, a current, valid, unrestricted license to practice as an MD, DO, DPM, DDS, PhD, LLP, PA-C, NP, or MSW/CSW, and LSW in the state of Michigan.
- If applicable, be board-certified in a designated specialty whose board is a Member of the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA), the board of American Board of Professional Psychology (ABPP), the American Board of Podiatric Surgery (ABPS), the American Board of Podiatric Orthopedics and Primary Podiatric Medicine (ABPO PPM), the American Council of Certified Podiatric Physicians and Surgeons (ACCPPS). Special exceptions to this requirement may be granted in certain situations. Practitioners must achieve board certification within the timeframes allotted by the respective specialty board. The Vice President Medical Affairs and the Credentialing Committee approves all special exceptions.
- Each case is reviewed on an individual basis and the Credentialing Committee may request additional information. The Credentialing Committee also looks specifically at the type of medical training completed including residency training.
- Practitioners whose board certification requires renewal must be appropriately recertified in their specialty according to the rules of the appropriate specialty board.
- If applicable, maintain full, admitting clinical privileges in good standing, as appropriate to their specialty, on the medical staff of a Grand Valley Health Plan participating hospital.
- If applicable, possess and maintain a current, valid, unrestricted DEA Certification and Michigan Controlled Substance License.
- Possess and maintain professional liability insurance in amounts not less than \$100,000 per claim or occurrence and \$300,000 individual annual aggregate. (Note: In some instances contractual requirements may be higher.)
- Meet all requirements as outlined in the credentialing application.
- All PCP offices, obstetric/gynecology offices, and high volume behavioral health providers must show satisfactory completion of a facility site review. Credentialing site reviews are conducted annually.
- Practitioners rendering medical care and/or behavioral health services to Grand Valley Health Plan Members shall be recredentialled by Grand Valley Health Plan at least every three years.
- Maintain satisfactory performance related quality management and utilization management activities as determined by peer review, Member complaints and utilization analysis.

Action on Credentialing and Re-credentialing

The Grand Valley Health Plan Credentialing Committee shall:

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- Review the applicant grid prepared by the credentialing coordinator of all practitioner candidates that meet Grand Valley Health Plan credentialing criteria.
- Conduct more substantive review of candidates requiring special consideration:
 - Lack of professional liability insurance
 - Lack of specialty board certification
 - Excessive malpractice claims
 - Concerns in the area of quality
 - Utilization review
 - Member complaints
 - State sanctions
 - Restrictions on licensure
 - Limitations on scope of practice
 - Medicare and Medicare sanctions.
- Determine the disposition of each application as follows:
 - Approval
 - Approval with conditions or contingencies as defined by the Credentialing Committee
 - Denial

Organizational Credentialing/ Re-credentialing

This policy applies to all organizational providers with which Grand Valley Health Plan decides to contract. Organizational providers include, but are not limited to, the following:

- Hospital
- Home health care agency
- Skilled nursing facility (SNF)
- Urgent care center
- Ambulatory surgery center
- Hospice
- Durable medical equipment (DME)
- Home infusion
- Laboratory
- Radiology/diagnostic center
- Ambulance
- Physical therapy/occupational therapy/speech therapy (PT/OT/ST)
- Sleep laboratories
- Psychiatric clinics
- Addiction disorder clinics.

Credentialing Procedure for Organizational Providers

Organizational providers must meet the following criteria in order to be offered participation with Grand Valley Health Plan:

- Possess and maintain professional and general liability insurance in amounts as specified by Grand Valley Health Plan.
- Possess and maintain all licenses and/or certifications necessary to operate in the state of Michigan as required.
- Maintain certification by the Centers for Medicare and Medicaid Services (CMS) and/or other certification as deemed necessary (except for behavioral health).

- Maintain accreditation by the appropriate body, as specified by Grand Valley Health Plan. If not accredited, demonstrate satisfactory completion of a site review and approved corrective action plan, as necessary, by the Center for Medicare and Medicaid Services (CMS) and Michigan Department of Community Health (MCDH) or show satisfactory completion of a facility site review, applying criteria as developed by Grand Valley Health Plan and as required for HMO providers by the Michigan Department of Community Health (MCDH) and in accordance with the Michigan statutes governing HMO's and other external review agencies, as necessary.

Confidentiality

All information, which is compiled in the process of credentialing and recredentialing practitioners and organizational providers, is kept confidential, protected by applicable state and federal laws. Release of this information to third parties, whether verbal or written, requires written authorization from the person to whom it pertains unless reporting of the information is required by law.

Access to information is restricted to certain persons or entities that have a legitimate need to use the information in the course of their assigned Grand Valley Health Plan activities.

Denial Process

In the event the practitioner's application for affiliation is denied based on administrative reasons, the practitioner will be notified, in writing, of the decision of the Credentialing Committee. The practitioner will have 30 business days from the date of Grand Valley Health Plan's denial letter to submit supplemental information if he/she believes the information that was reviewed by the Credentialing Committee is erroneous or misleading.

In the event that the practitioner was denied continued affiliation (rec credentialing) for excessive substance malpractice claims, he/she will have appeal rights as described in Professional Review Action and Appeals, below.

Professional Review Actions and Appeals

Grand Valley Health Plan will take professional review actions against a provider when it is determined that the provider does not meet Grand Valley Health Plan standards of quality, utilization, Member satisfaction, credentials, or professional standards. As a result of such professional review activity, Grand Valley Health Plan may deny, suspend, reduce, terminate, or otherwise alter a provider's participation status.

Providers have the right to appeal professional review action(s) based on competence, malpractice claims history, or professional conduct. Grand Valley Health Plan notifies provider via certified letter if professional review actions are initiated, and of their right to appeal.

XII. UTILIZATION MANAGEMENT

Utilization Management Program

Grand Valley Health Plan is committed to providing necessary and effective health care services to its Members. To this end, GVHP encourages its practitioners to make appropriate medical decisions and manage utilization of care.

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Because of this, all Grand Valley Health Plan employees that make medical necessity determinations are aware of and practice consistent with the following GVHP policies:

- Utilization management decision-making is based only on appropriateness of medical care and service and existence of coverage.
- Grand Valley Health Plan does not provide its utilization review staff any rewards or incentives for denying necessary services.
- Grand Valley Health Plan does not provide financial incentives that would encourage decisions that would result in under utilization of services or use of inapplicable services.
- Any denials for care or services are rendered in accordance with GVHP's Medical Opinion Review Process. All requests are carefully reviewed according to GVHP's Utilization Management Policies and Certificates of Coverage.
- In the event of a denial, the provider has the option to contact the Vice President for Medical Affairs or the Medical Director to discuss the denial.

Grand Valley Health Plan also has many additional utilization management procedures. These procedures outline how Grand Valley Health Plan makes decisions based on sound clinical evidence. These procedures include: primary care and secondary care management, pharmaceutical (if applicable), and counseling and wellness to name a few. If you are interested in receiving a copy of any of these utilization procedures please call Customer Services at (616) 949-2410

Milliman Care Guidelines

Grand Valley Health Plan uses Milliman Care Guidelines to identify benchmark patient care and recovery as one means of enhancing the delivery of healthcare services and resource management. The Optimal Recovery Guidelines (ORGs) describe recovery and treatment plans that generate the most favorable outcomes and assume optimal recovery, decision making, and care. Optimal recovery occurs in the patient who:

- Recovers as well as can be expected from his or her primary condition
- Has no complications or co-morbidities
- Has no barriers to recovery such as noncompliance
- Receives optimal care from his or her healthcare provider
- Receives optimal services from Grand Valley Health Plan


The status of the patient on any day determines whether that particular patient meets the Care Guidelines for optimal recovery. The guidelines are not inflexible expectations for all patients. Instead, they are considered guides to quality care that often is attainable.

XIV. MEDICAL RECORDS

Guidelines for Physician Office Medical Record Documentation

Grand Valley Health Plan is committed to the keeping of medical records that facilitate communication, coordination, and continuity of care while promoting efficient and effective treatment. GVHP uses an electronic medical record for documentation of medical information. All medical records are to be kept in accordance with NCQA's Standards for Medical Record Documentation and HIPAA Regulations. All offices will adhere to the following medical record documentation standards:

- Kept confidential by being stored securely, having only authorized personnel gain access and staff receiving periodic training in the confidentiality of protected health information

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- Kept organized and stored in a manner that allows easy retrieval by authorized personnel but secure from public access areas
 - Include documentation of personal medical history, family history and results of physical examinations, allergies and adverse drug reactions, medical problem list, medications, smoking and substance abuse information, and immunization records
 - Include documentation of reason for visit, clinical findings and evaluation for each visit
 - Include documentation of preventive services and risk screening
 - Include documentation of all services provided directly by the primary care provider
 - Include documentation of all ancillary services and diagnostic tests ordered by the PCP
 - Include documentation of all diagnostic and therapeutic services for which a Member was referred by the PCP such as home health nursing, specialty physician reports, hospital discharge reports, and physical therapy reports

XVI. DEFINITIONS/ACRONYMS

Frequently Used Acronym's

Acronym	Definition	Acronym	Definition
ALOS	Average length of stay	MEDIGAP	Medicare supplement Insurance
APR	Average payment rate	MH/CD	Mental health/chemical dependency
ASO	Administrative Services Only	MRA	Magnetic resonance angiography
CAP	Capitation	MRI	Magnetic resonance imaging
CMS	Centers for Medicare & Medicaid (formerly HCFA)	NCQA	National Committee for Quality Assurance
COB	Coordination of Benefits	NON-PAR	Non-participating provider
COC	Certificate of Coverage	NPN	Non-par not approved
CPT	Current Procedural Terminology	OOA	Out-of-area
CQI	Continuous quality improvement	OOPS	Out-of-pocket expenses
DME	Durable medical equipment	OSHA	Occupational Safety and Health Administration
DO	Doctor of osteopathy	OTC	Over-the-counter
DOB	Date of birth	PAC	Pre-admission certification
DOS	Date of service	PAR	Participating provider
DPT	Days per thousand	PCP	Primary care provider
DRG	Diagnosis related group	PEC	Per-existing condition
DSS	Department of Social Services	PHO	Physician hospital organization
DX	Diagnosis code...may be diagnosis	PMPM	Per Member per month
EDI	Electronic data exchange	PO	Physician organization
EOP	Explanation of benefits	PPO	Preferred provider organization
ESRD	End stage renal disease	PRO	Professional (or peer) review organization
FFS	Fee-for-service	U&C	Usual and customary
HEDIS	Health plan Employer Data Information Set	QA	Quality assurance
HCPCS	HCFA Common Procedural Coding System	QI	Quality improvement
HDHP	High-deductible health plan	QIC	Quality improvement committee
HHA	Home health agency	QM	Quality management
HIPAA	Health Insurance Portability and Accountability Act	QMB	Qualified Medicare beneficiary
HMO	Health maintenance organization	R&C	Reasonable & customary
HRA	Health risk assessment	RVRBS	Resource-based relative value scale
HSA	Health savings account	TPA	Third party administrator
ICD-9-CM	International Classification of Diseases, 9th edition (Clinical Modification)	TPP	Third party (other coverage) payment
ICF	Intermediate care facility	U&C	Usual and customary
IPA	Individual practice association	UB-92 UB04	Uniform Billing Code of 1992, used to bill facility services
IRA	Individual Retirement Account	UM	Utilization management
LOS	Length of stay	UR	Utilization review
MDCH	Michigan Department of Community Health		

XVII. GVHP MODIFIER CHART

Modifier	Description	Usage	Notes	Example	Comments
-25	Unusual Procedural Service	Most commonly used with E&M codes (office visits, consultations, inpatient care, etc...) and in conjunction with a surgery code.	N	99214-2511100	Without modifier -25 the E&M code would be denied.
-26	Professional Component	Indicates only the professional component was provided by the physician. Typically used with radiology or diagnostic testing.	N	71010-26	Payment is affected by use of this modifier.
-50	Bilateral Procedure	Indicates procedure is performed during the same operative session and anatomical site. **GVHP requires claims be billed as two lines for bilateral procedures.	N	2744727447-50	GVHP pays 100% of allowable for the first line and 50% of allowable for the -50 line for a total of 150% of the allowable on the bilateral procedure. NOTE: When multiple bilateral procedures are submitted, modifier -50 should be used in conjunction with modifier -51. Multiple bilateral procedures will be reduced by an additional 50% of the allowable fee.
-51	Multiple Procedures	More than one surgical procedure performed during the same operative session.	N	4310043219-51	GVHP allows 100% for the primary procedure and 50% of allowable for subsequent procedures. **Not all surgical procedures are subject to the multiple procedure reduction.
-59	Distinct Procedural Service	Indicates the procedure is separate from another procedure performed at the same operative session or performed on the same date of service.	Y	2718626160-59	Modifier -59 does not reduce payment. Notes are required when -59 is added to the procedure. ***Use of -59 DOES NOT bypass or exempt a procedure from the multiple procedure reduction (-51). It is appropriate to affix both modifier -51 and -59 to a line item (when appropriate).
-76	Repeat Procedure-Same Physician	Service was repeated more than once on the same date and by the same physician. Indicates that the service is not a duplicate.	N	71010-76	Payment is not reduced.
-77	Repeat Procedure-Different Physician	Service was repeated more than once on the same date and by another physician. Indicates that the service is not a duplicate.	N	93010-77	Payment is not reduced.
-80	Assistant Surgeon	Describes a qualified surgical assistant on procedures eligible for the services of an assistant surgeon.	N	62100-80	GVHP reduces these services to 20% of the allowed amount for an MD or DO and 13% of the allowed amount for PAC or TSA.

*GVHP reserves the right to request medical records and/or operative reports for all claims submitted.



Grand Valley Health Plan