



A division of CSG



Dear Physician/Provider:

Welcome to CHN PPO (CHN), a division of Consolidated Services Group, Inc. (CSG), one of the largest Preferred Provider Organizations (PPO) accredited by URAC in the Northeast region.

Your participation in CHN PPO unites you with a select network of medical institutions and professionals that our members have grown to trust and turn to with confidence. CHN PPO is committed to developing and strengthening relationships with you, our network providers, and your office staff.

This manual includes CHN PPO services, policies, procedures, contact information and guidelines and serves as an administrative guide for you and your office staff.

We encourage your comments and suggestions in order to solidify the success of our programs. You can contact us at 800-225-4CHN or on our web site at [www.CHN.com](http://www.CHN.com).

Thank you for participating in CHN PPO. Together we can provide our members access to the best healthcare available.

Sincerely,

---

William P. Anthony, MD  
Chief Medical Officer

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Cara Ianniello  
Vice President, Network Operations



**A Division of Consolidated Services Group, Inc.**

# **PROVIDER / FACILITY MANUAL**

**Hamilton, NJ    Cherry Hill, NJ    Glastonbury, CT    Lansdale, PA**



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## **PROVIDER / FACILITY MANUAL**

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THE CHN PPO NETWORK

The caliber of CHN PPO providers is an inherent strength that distinguishes CHN PPO from its competition. CHN contracts with physicians, hospitals and ancillary service providers to provide comprehensive, quality healthcare services.

As an organization committed to quality managed healthcare, CHN PPO places great emphasis on identifying and credentialing a wide array of healthcare providers. CHN PPO maintains full URAC accreditation for Health Network with Credentialing. All CHN PPO providers have met or exceeded CHN's rigorous credentialing criteria.

### **PRODUCTS**

**Preferred Provider Organization (PPO)** - Provides maximum access to the URAC accredited CHN PPO network, plus the flexibility to include or carve-out Utilization Management Services. CHN PPO is certified as an Organized Delivery System (ODS) by the New Jersey Department of Banking and Insurance.

**CSG's Managed Workers' Compensation Program** - Provides full-service management of workers' compensation claims from the time of injury to a successful Return-to-Work program. CSG utilizes a select panel of CHN PPO participating workers' compensation related specialists who are proficient in treating and managing workers' compensation injuries and focus on safe return to work programs. CSG is approved as a Workers Compensation Managed Care Organization (WCMCO) by the New Jersey Department and Banking Insurance

**CHN PPO Auto** - Provides maximum access to the URAC accredited CHN PPO participating provider network for the diagnosis and treatment of injuries sustained from a covered automobile accident.



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PATIENT BILL OF RIGHTS

The patient has the right to considerate, respectful care at all times and under all circumstances with recognition of his/her personal dignity. Providers have an obligation to protect and promote the rights of their patients, including the following rights:

**RESPECT AND DIGNITY** - Patients have the right:

- \* to be informed of the procedure they can follow to lodge complaints with the provider
- \* to know about the resolution of such complaints
- \* to voice their grievances without concern of discrimination or reprisal for having done so
- \* to receive information in clear and understandable terms

**CONFIDENTIALITY** - Patients have the right:

- \* to confidentiality with regard to information about their health, social and financial circumstances
- \* to expect the provider to release information only as required by law or authorized by the client

**FINANCIAL INFORMATION** - Patients have the right:

- \* to be informed of the extent to which payment may be expected from payor.
- \* to be informed of the charges for which the subscriber may be liable.
- \* to have access, upon request, to all bills for service the subscriber has received, regardless of whether the bills are paid out-of-pocket or by a payor or otherwise.

**QUALITY OF CARE** - Patients have the right:

- \* to receive high quality care and treatment and participate in the decision making process regarding their care and treatment.
- \* to have all medically related care and treatment provided according to physicians' orders
- \* to receive treatment without discrimination as to race, age, religion, sex, national origin or source of payment
- \* to refuse care or treatment to the extent permitted by law, and to be informed of the medical consequences of that action.



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CHN PPO Health Benefits

A traditional managed care plan with administrative and claims capabilities of a third-party administrator (TPA), self-insured employer, insurance company, or similar type payor. Patients are offered attractive cost-saving incentives to select participating providers. Patients may self-refer to any participating provider and still maintain a maximum level of benefits.

CHN's network of providers is marketed through TPAs, insurance carriers, brokers, and consultants and directly to self-insured employers in the Northeast.

### IMPORTANT NOTICE

#### For the CHN PPO Plan:

- Patients do NOT select a primary care physician
- There are NO referral authorizations
- There are NO withholds, application fees or subscriber dues
- Reimbursement is on a fee-for-service basis, utilizing a maximum allowable fee schedule.

#### **Here Are the Steps to Follow When a CHN PPO Member Visits Your Office:**

##### **Obtain the member's health insurance identification card...**

CHN's members are identified by the information contained on his/her insurance identification card. *Most patients* will have an ID card, which depicts the CHN PPO logo.

VERIFICATION OF ELIGIBILITY IS NOT A GUARANTEE THAT THE ELIGIBLE PERSON IS ENTITLED TO BENEFITS PURSUANT TO A PLAN.

##### **If a CHN PPO patient needs a specialist...**

Except in an emergency and within the dictates of good practice, Eligible Persons should be referred to another Participating Provider. Participating specialists can be found on the CHN website at [www.chn.com](http://www.chn.com). Referral forms are not required. If a network provider is not available, contact CHN's Customer Service Department at 800-225-4CHN prior to the referral, for assistance.

A Participating Provider shall not be penalized by the termination of their Participating Provider Agreement or otherwise, because the provider acts as an advocate for the Eligible Person in seeking Medically Appropriate health care services.

Participating Providers are encouraged to communicate openly with Eligible Persons regarding all appropriate diagnostic testing and treatment options.

**If a CHN PPO patient needs laboratory services...**

Except as noted below, the Eligible Person will receive maximum benefits pursuant to their Plan if laboratory services are provided by a CHN PPO participating laboratory. Check our web site at [www.chn.com](http://www.chn.com) for local participating laboratories.

**Please contact LabCorp at 800-631-5250 or Quest Diagnostics at 800-222-0027 for local patient service centers**

**EXCEPTIONS TO USING DESIGNATED LABORATORY:**

- Hospital pre-admission testing and any inpatient laboratory services that are performed at a participating hospital.

**CLAIMS SUBMISSION**

Claims must be mailed to the address on the patient's ID card. Claims should be submitted with your usual and customary charge, not the fee set forth in the CHN Fee Schedule.

**BILLING PROCEDURE**

Complete a billing form for each visit. The CMS-1500 or UB-04 or successor forms may be used.

**PAYMENT**

Claims will be paid by the appropriate Payor directly to you in accordance with the terms of your Participating Provider Agreement and applicable law. Reimbursement will be the lesser of your usual and customary Charges, the fees set forth in the current CHN Fee Schedule or any applicable state, federal or other mandated fee schedule, minus any co-payments or deductibles paid by the Eligible Person. Since claims are processed by the Insurance Company, Third Party Administrator and CHN, the application and acceptance of modifiers may vary in actual reimbursement values. Please see attached CHN PPO REPRICING GUIDELINES and contact CHN PPO customer service at 800-225-4CHN with any questions regarding your contracted fee schedule. You may request the reimbursement amounts for any CPT code(s) at any time by contacting CHN Customer Service at 1800-225-4CHN or by visiting the Provider Resources page of our website at [www.chn.com](http://www.chn.com).

**REMINDER: CSG/CHN PPO IS NOT A PAYOR AND IS NOT RESPONSIBLE OR LIABLE FOR ANY CLAIMS DECISIONS OR FOR THE PAYMENT OF ANY CLAIMS.**

The Eligible Person is responsible for the payment of any co-payment or deductibles in accordance with the terms of their Plan. Eligible Persons may be billed directly for any services that are not Covered Services. Any bills for co-payments, deductibles, or non-Covered Services should be forwarded to the Eligible Person after receipt of the Explanation of Benefits.

Please call the claims information number listed on the Eligible Person's identification card regarding submitted but unpaid claims. Any requests for claims review should be directed to the applicable Payor.

**BALANCE BILLING**

Eligible Persons cannot be billed for the difference between the billed charges and the CHN PPO Fee Schedule for Covered Services ("balance billing"), including but not limited to services deemed to be not Medically Necessary pursuant to the Utilization Management Program.



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CSG MANAGED WORKER'S COMPENSATION PROGRAM

CSG's Workers' Compensation Program is a managed care service designed to reduce medical and indemnity expenses of medically managed cases from the first report of injury. (CSG's Workers' Compensation Program utilizes the CHN PPO network.)

CSG's WORKERS' COMPENSATION PROGRAM EMPHASIZES:

- Early intervention
- Prospective diagnosis and treatment planning
- Concurrent Review and Case Management
- Early return to work with transitional duty status, as appropriate

**For the CSG Workers' Compensation Program:**

- Case Management occurs throughout the injured worker's care
- Any and all services must be authorized by the CSG Workers' Compensation Managed Care Department (800)293-9795.

One phone call to CSG's Workers' Compensation Program directs a worker to a credentialed CHN PPO Workers' Compensation provider for the diagnosis and treatment of work related injuries and immediately initiates a series of regular telephone interviews with the injured worker to obtain a medical profile and to monitor progress. Within the medical profile, the cause of injury, symptoms, diagnosis, treatment plan and the expected date of return to work are established.

**Here Are The Steps To Follow When a CSG Workers' Compensation Injured Worker Visits Your Office:**

- You will receive a call from a CSG Case Manager to arrange the initial appointment. An ID card is not necessary. The treatment plan form will be faxed directly to you prior to the employee's visit. Verify with the injured worker who directed them for treatment.
- After evaluating the injured worker, **complete the treatment plan form and fax it back to the CSG Workers' Compensation Case Manager within 1 business day to establish a treatment plan, address causality, receive authorization and set a target return-to-work date.**
- Periodic phone contact with the provider's office will be made by the CSG Case Manager to facilitate treatment. Please establish a return to work date at the end of **every** injured workers visit. Pre-authorization – All treatment plans, procedures, and referrals require pre-authorization through CHN.

No Participating Provider shall be penalized by the termination of their Participating Provider Agreement or otherwise because the provider acts as an advocate for the Eligible Person in seeking Medically Appropriate health care services.

Participating Providers are encouraged to communicate openly with Eligible Persons regarding all appropriate diagnostic testing and treatment options.

#### **CLAIMS SUBMISSION**

Please contact the Case Manager at (800)293-9795.

#### **BILLING PROCEDURE**

Complete a billing form for each visit. The CMS-1500 or UB-04 or successor forms may be used.

#### **PAYMENT**

Claims will be paid by the appropriate Payor directly to you in accordance with the terms of your Participating Provider Agreement and applicable law. Reimbursement will be the lesser of your usual and customary charges or the fee set forth in the current CHN Fee Schedule or any applicable state, federal or other mandated fee schedule. Please contact CHN PPO Customer Service at 800-225-4CHN with any questions regarding your contracted fee schedule. You may request the reimbursement amounts for any CPT code(s) at any time by contacting Customer Service at 800-225-4CHN.

**REMINDER: CSG/CHN PPO IS NOT A PAYOR AND IS NOT RESPONSIBLE OR LIABLE FOR ANY CLAIMS DECISIONS OR FOR THE PAYMENT OF ANY CLAIMS.**

The injured worker in NJ is not responsible for the payment of any co-payment or deductibles for treatment of Worker's Compensation injuries.. You may not bill injured workers in New Jersey directly for any services.

#### **BALANCE BILLING/New Jersey**

For Workers' Compensation, the injured worker cannot be billed for the difference between the provider's usual charge and the CHN PPO allowable rate.



## Workers' Compensation Managed Care

A Managed Care Program Administered by:  
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Hamilton, NJ 08619  
(800) 293-9795



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### PROVIDER INSTRUCTION SHEET

PROCEDURES REQUIRING IMMEDIATE CONTACT WITH WORKERS' COMPENSATION MANAGED CARE

**I. DECISION TO KEEP CLAIMANT OUT OF WORK MUST BE FORWARDED TO WCMC IMMEDIATELY BY PHONE OR FAX.**

**II. REFERRAL PROCEDURES/NETWORK STEERAGE**

**RADIOLOGY** - First x-ray appropriate at initial treatment facility only. X-rays beyond initial investigation to rule out fracture, MRI, CAT scan, Myelogram, etc. require review by WCMC. **Prescribing and review of MRI within 2 weeks of DOL supports early intervention and treatment plan management.**

**LAB** - All labwork except for PAT in the emergency surgery setting require review by WCMC.

**SURGERY/ADMISSION** - All procedures except for emergency situations to treat fractures, life-threatening injuries, burns and lacerations require review by WCMC.

**CONSULTS** - All except in emergency situations require review by WCMC.

**PT/OT** - All therapies require review by WCMC.

**DME** - All DME except for slings (arm), crutches or emergency induced equipment (e.g.Halo, brace) require review by WCMC.

In the event that you are requesting procedure or DME equipment that falls within the above list, contact a Workers' Compensation Managed Care representative at our toll free number 1-800-293-9795. Written referral requests must be forwarded on prescription format. After your request is reviewed, a network provider will be assigned for any referrals.

**III. PROCEDURES FOR REPORTING**

At the conclusion of your evaluation, fax the completed Quick Note within 24 hours to: 609-631-9732. Include claim number on all correspondence.

**IV. PROVIDER SPECIAL HANDLING**

*Critical Information:*

All treatment to be provided by a physician. Physician must clearly address and document causality to injury, prior history impact on current treatment needs.

Completion of Quick Note: Complete diagnosis, relatedness of diagnosis, clinical findings, treatment rendered, diagnostics rendered with results.

Return to Work Potential: Identify thirty-day treatment plan, follow-up visit. Transitional duty release requires completion of Physical and Functional Assessment form. Include claimant signature on return to work release date and transitional duty restriction paperwork. Provide claimant note regarding work status. Fax to Workers' Compensation Managed Care at 609-631-9732.



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**REFERRAL FORM**

Today's Date: \_\_\_\_\_ Time: \_\_\_\_\_

**Employee/Employer Information**

**Employee Information**

**Employer Information**

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
  
 DOB: \_\_\_\_\_  
 Home #: \_\_\_\_\_  
 Work #: \_\_\_\_\_  
 Cell Phone #: \_\_\_\_\_  
 Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Date of Injury: \_\_\_\_\_

Claim Number: \_\_\_\_\_

**Provider/Facility Referral To**

**Referral Information**

**Medical Information**

Facility:  
 Address: \_\_\_\_\_

Diagnosis: \_\_\_\_\_  
 Type Referral: \_\_\_\_\_

Phone: \_\_\_\_\_

Referral Reason: \_\_\_\_\_

FAX: \_\_\_\_\_

Treating Physician: \_\_\_\_\_

Comments: \_\_\_\_\_

**Scheduling Information**

**Appointment Information**

**Review**

Date: \_\_\_\_\_  
 Time: \_\_\_\_\_

WC Managed Care Rep.: \_\_\_\_\_  
 Review Date: \_\_\_\_\_

**Directions for Referral Provider/Facility**

**[Fax evaluation notes within 24 hours of visit to WC Managed Care at (609) 631-9732]**

**For important pre-certification requirements and directions please see attached form**

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IF YOU DO NOT RECEIVE ALL OF THE PAGES INDICATED ABOVE PLEASE CALL US AS SOON AS POSSIBLE  
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**QUICK NOTE**

Appointment Date: \_\_\_\_\_

Time: \_\_\_\_\_

CLAIM # \_\_\_\_\_

**EMPLOYEE INFORMATION**

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Street Address: \_\_\_\_\_

Occupation: \_\_\_\_\_

Second Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Location: \_\_\_\_\_ Work #: \_\_\_\_\_

Date of Injury: \_\_\_\_\_

Nature of Injury: \_\_\_\_\_

How Injury Occurred: \_\_\_\_\_

**MEDICAL SERVICES INFORMATION -**

Facility: \_\_\_\_\_

Treating Physician: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

Phone #: \_\_\_\_\_ Tax ID#: \_\_\_\_\_

Diagnosis & ICD-9 Codes: \_\_\_\_\_

Diagnosis - Causally related to work incident? Y \_\_\_ N \_\_\_

Causality: \_\_\_\_\_

Clinical Findings: \_\_\_\_\_

Chief Complaints: \_\_\_\_\_

Treatment Rendered: \_\_\_\_\_

Diagnostics: \_\_\_\_\_

Current Treatment Plan: \_\_\_\_\_

Projected Treatment Plan: \_\_\_\_\_

Referral Recommendation: \_\_\_\_\_

Return to Work Date: / / Check Item Which Applies: \_\_\_FULL \_\_\_\*TD \_\_\_RTW-No

\* If Transitional duty, please complete the Physical & Functional Assessment Form Attached

Follow-up visit: \_\_\_\_\_ Claimant advised of work status Yes \_\_\_ No \_\_\_

Discharge/Maximum Medical Improvement: Y \_\_\_ N \_\_\_ Date \_\_\_\_\_

Claimant Signature: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Fax completed form within 24 hours of visit to WCMC at 609-631-9732 for pre-certification.**



PHYSICAL AND FUNCTIONAL ASSESSMENT FORM



Name :

CLAIM #

Diagnosis: \_\_\_\_\_

\*\*Please indicate the highest level of the patient's physical capabilities\*\*

Can Patient Work an 8-hour day? Yes No If not, how many? \_\_\_\_\_

In an 8-hour day, patient can: (circle full hour capacity for each)

Sit	1	2	3	4	5	6	7	8	9	10	11	12	13
Stand	1	2	3	4	5	6	7	8	9	10	11	12	13
Walk	1	2	3	4	5	6	7	8	9	10	11	12	13

Patient can lift, carry: (please circle as appropriate)

	<u>Never</u>	<u>Occasionally</u>	<u>Frequently</u>	<u>No Restriction</u>
0-10 lbs.	Lift/Carry	Lift/Carry	Lift/Carry	Lift/Carry
11-25 lbs.	Lift/Carry	Lift/Carry	Lift/Carry	Lift/Carry
26-50 lbs.	Lift/Carry	Lift/Carry	Lift/Carry	Lift/Carry
51-100 lbs.	Lift/Carry	Lift/Carry	Lift/Carry	Lift/Carry
100+ lbs.	Lift/Carry	Lift/Carry	Lift/Carry	Lift/Carry

Patient can use upper extremities for repetitive (please circle as appropriate):

	<u>Simple Grasping</u>	<u>Firm Grasping</u>	<u>Fine Manipulation</u>	<u>Pushing/Pulling</u>	<u>Overhead Reaching</u>
Left	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
Right	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No

Patient can use lower extremities for repetitive movement such as foot control

Right Yes No Left: Yes No

Patient is able to: (Please check as appropriate)

	<u>Never (0%)</u>	<u>Occasionally (1-33%)</u>	<u>Frequently (34-66%)</u>	<u>No Restriction (67-100%)</u>
Balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crouch/Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Twist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use Foot (R <input type="checkbox"/> L <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Patient is able to operate: (Please check as appropriate)

	<u>Never</u>	<u>Occasionally</u>	<u>Frequently</u>	<u>No Restriction</u>
Car	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Small Truck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Large Truck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Automatic Transmission	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standard Transmission	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heavy Equipment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Physician's Comments: \_\_\_\_\_

Medications Prescribed: \_\_\_\_\_

Will medication affect physical functioning: Yes No

Employee is released to return to work as of (REQUIRED): \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Workers' Compensation Managed Care

A Managed Care Program Administered by:



## Occupational/Physical Therapy Guidelines

### Exams / Scheduling

- Initial evaluation to be scheduled within 24-48 hours of referral and outside work hours unless otherwise directed by the employer
- Case manager must be notified of date and time of the initial evaluation and facility location
- DME must be preauthorized by the case manager to ensure in network coverage
- Non-attendance of the initial evaluation by the claimant must be reported immediately to the case manager
- Reevaluation every two weeks by the therapist

### Documentation

- Initial evaluation report must be submitted to case manager within 48 hours
- Reevaluation with progress notes must be submitted every 2 weeks to case manager
- Progress note must be legible and include number of visits, no shows and cancellation dates; Progress note to include comparison of ROM and strength testing, deficits, goals, plan to achieve goals, recommendations and anticipated date of discharge from therapy
- Therapy home exercise program given to claimant and compliance with program must be documented in progress note

### When To Contact Case Manager

- Contact case manager at 1-800-246-7097 for reauthorization of therapy; Copy of prescription must be faxed to case manager at 609-631-9324
- Contact case manager for non-progression in therapy or change in claimant's condition requiring physician's notification
- Contact case manager for non-attendance of appointments by the claimant



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CHN PPO NEW JERSEY AUTO

Various automobile insurance carriers are Payors of CHN, and their insureds are Eligible Persons under the Participating Provider Agreement. Reimbursement will be the lesser of your usual and customary charges, the fee set forth in the current CHN PPO Fee Schedule or any applicable state, federal or other mandated fee schedule, minus any co-payments or deductibles paid by the Eligible Person.

When treating patients for injuries sustained in automobile accidents, New Jersey State law and the patient's automobile insurance policy may establish guidelines or requirements for the treatment of certain injuries. These include initial notification of the automobile insurance company (or the company's designee), Care Paths, Decision Point Review and Pre-certification.

For general information on utilization management or other requirements with regard to patients injured in automobile accidents, you may wish to contact the New Jersey Department of Banking and Insurance through the Department's web site at [www.njdobi.org](http://www.njdobi.org).

Providers treating patients injured in automobile accidents are responsible under State law for promptly notifying the patient's automobile insurance carrier of the commencement of treatment. At the time of notification, information on the patient's automobile insurance company's specific requirements can be obtained. The requirements vary from company to company.

#### **BILLING PROCEDURE**

Complete a billing form for each visit. The CMS-1500 or UB-04 or successor forms may be used.

#### **PAYMENT**

Claims will be paid by the appropriate Payor directly to you in accordance with the terms of your Participating Provider Agreement and applicable law. Reimbursement will be the lesser of your usual and customary Charges, the fees set forth in the current CHN Fee Schedule or any applicable state, federal or other mandated fee schedule, minus any co-payments or deductibles paid by the Eligible Person. Since claims are processed by the Insurance Company, Third Party Administrator and CHN, the application and acceptance of modifiers may vary in actual reimbursement values. Please see attached CHN PPO REPRICING GUIDELINES and contact CHN PPO customer service at 800-225-4CHN with any questions regarding your contracted fee schedule. You may request the reimbursement amounts for any CPT code(s) at any time by contacting CHN Customer Service at 1800-225-4CHN or by visiting the Provider Resources page of our website at [www.CHN.com](http://www.CHN.com).

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PROVIDER RELATIONS SERVICES

CHN's Network Operations Department supports network providers on a consistent basis. They can be reached at 1-800-225-4CHN or by emailing [Netops@CHN.com](mailto:Netops@CHN.com).

Our Provider Relations Team routinely provides in-services, orientations and training for providers and their office staff on CHN's policies and procedures. Providers can also call CSG/CHN's Customer Service Department at 800-225-4CHN with questions or inquiries relating to their participation, contracted fee schedule, client list, Provider Review Procedure, Appeals Process, any updated documents or to request an on-site service visit.

### HOURS OF OPERATIONS

MONDAY – FRIDAY 8:00AM – 4:30PM, Except on the following holidays:

New Year's Day  
Memorial Day  
Independence Day  
Labor Day  
Thanksgiving Day  
Day After Thanksgiving  
Christmas Day



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## QUALITY MANAGEMENT PROGRAM

**Quality Commitment Statement:** CSG/CHN PPO's Quality Management program is structured to assess the quality of service that is delivered to all customers to ensure it is in accordance with the philosophy of CHN PPO. The staff of CSG/CHN PPO is dedicated to the ongoing maintenance, support and expansion of the Quality Management program, providing the organization with an effective mechanism for assessment and response to potential or actual quality events.

The Quality Management program, whose content is designed from the standards established by URAC, is a comprehensive program conducted to assess that quality care is being rendered at all levels of service.

The Chief Medical Officer is responsible for the Quality Management program and for interfacing and communicating with participating providers on quality events.

The Quality Management Committee consists of, but is not limited to the following members of which there is representation of a non-employee participating provider:

- Chief Medical Officer
- Vice President, Network Operations
- Assistant Vice President, Quality Assurance
- Manager, Credentialing
- Clinical Representatives from Telephonic Case Management, Field Case Management and Utilization Management
- Other Professional Disciplines as needed
- Medical Advisory Panel in the following areas:
  - Internal Medicine
  - Cardiology
  - Chiropractic Medicine
  - Pediatrics
  - Physical Medicine & Rehabilitation
  - Behavioral Health

If the Quality Management Committee has identified a quality of care issue, the parties under review will be informed and afforded the opportunity to investigate the quality of care issue, and respond in writing to the Quality Management Committee. The Committee can initiate corrective action if appropriate, which can include any or all of the following:

- Focused monitoring of provider's activity
- Follow-up reviews to determine the effectiveness of the corrective action
- Non-reappointment to the Network
- Termination of agreement

Consumer and provider satisfaction is a top goal of CSG/CHN PPO. One method of assuring this satisfaction is our dedication and commitment to an ongoing Quality Management program.

## **PHYSICIAN INVOLVEMENT**

As a participating provider, you may be requested to, but are not required to, take part in the following activities:

- Participation on a CSG/CHN PPO Physician's Committee
- Participation in audit or monitoring activity
- Assist CSG/CHN PPO in grievance procedure reviews or review of a study appropriate to your specialty.

## **DISCLAIMER**

**CSG/CHN PPO IS NOT RESPONSIBLE FOR THE QUALITY OF CARE. QUALITY OF CARE REMAINS THE RESPONSIBILITY OF THE PARTICIPATING PROVIDER AND THE PATIENT. CSG/CHN PPO SHALL ONLY SEEK TO IDENTIFY QUALITY PROBLEMS TO THE BEST OF ITS ABILITY. CSG/CHN PPO DOES NOT GUARANTEE THE QUALITY OF THE SERVICES RENDERED BY PARTICIPATING PROVIDERS.**

## **PROVIDER DISPUTES**

Providers who have issues relating to their services that cannot be resolved may follow CHN PPO's Grievance Process.

### **Grievance Process:**

1. A telephone call is made or a letter is sent to CHN PPO Customer Service Representative.
  - 300 American Metro Blvd, Ste 170, Hamilton, NJ 08619; (800) 225-4CHN
2. The concern is logged into the computer tracking system and then routed within five (5) business days to the appropriate CHN PPO department for investigation.
3. CHN PPO will respond to provider complaint within 30 days of receipt. CHN PPO response will include instructions for providers who are still not satisfied with the initial response.
4. If the Provider is not satisfied with the response, a letter with supporting documentation may be submitted to the Quality Management Committee. The Quality Management Committee meets quarterly. The Provider will be notified in writing of the Committee's decision.
5. If the provider still is not satisfied with the decision of the Committee, the provider may contact the state.

In New Jersey:

NJ Department of Banking and Insurance  
Consumer Protection Services  
Office of Managed Care  
P.O. Box 329  
Trenton, NJ 08625-0329

Toll Free – Complaint Hotline: 1-888-393-1062

Provider shall not be terminated or otherwise penalized because of complaints or appeals that the Provider files on his or her own behalf, or on behalf of a Covered Person, or for otherwise acting as an advocate for Covered Persons in seeking appropriate, medically necessary health care services covered under the person's health benefits plan.



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## CSG UTILIZATION MANAGEMENT PROGRAM

### **Purpose and Goal**

Utilization Management (UM) encompasses prospective, concurrent and retrospective review of health care services offered to Eligible Persons. Utilization Management criteria are used to determine if the clinical presentation of the Eligible Person satisfies the criteria. This process is used to evaluate the service provided to the Eligible Person and to determine what level of care is appropriate for the Eligible Person.

### **Methods**

An ongoing, formalized system of reviews takes place by the UM Review staff. This consists of concurrent, retrospective and prospective reviews. Patient Care service areas that will be reviewed are as follows:

- Inpatient
- Emergency Room
- Physician's Office
- Outpatient Surgery
- Laboratory
- Other ancillary services

CSG's Utilization Management Review System includes:

- Pre-admission Authorization
- Concurrent Review and Discharge planning
- Outpatient Surgery pre-authorization
- Outpatient Diagnostic Review
- Out-of-plan Referral Approval by CSG's Physician Advisor
- Feedback of Utilization Information of Physicians
- Appeal Process
- Retrospective Review

### **Review Process**

CSG or another Utilization Management Company may be providing utilization management. In either of these situations the assigned UM company's Medical Director supervises all utilization management activities and, along with the Review Staff, is also available to answer questions. Your participation and input in this process are essential to the success of the program.

Please direct any questions involving the Utilization Management programs to the appropriate UM company identified on the subscribers ID card. This may be identified on the reverse side of the subscriber's ID card. If utilization management is being performed by CSG, you may direct calls to 1-800-225-4CHN.

### **PRE-AUTHORIZATION**

The following services may require pre-authorization:

- All scheduled admissions (for any psychiatric admissions refer to the subscriber's ID card for benefits).
- Outpatient surgery and outpatient services, exclusive of physician's office.
- Referrals to non-participating providers
- PT/Chiropractic services

- Outpatient mental health services
- Radiological/Diagnostic testing i.e. MRI, CT, myelogram
- Home health care, rehabilitation facility or skilled nursing facility
- Durable medical equipment

To obtain pre-authorization or verify utilization management procedures, contact the Utilization Management company as identified on the member's ID card. You will be advised that a procedure is pre-authorized for treatment if the clinical presentation of the Eligible Person satisfies the utilization management criteria.

### **Confirmation**

A pre-authorization letter will be mailed to the treating provider, treatment/testing facility, and patient.

### **EMERGENCY SERVICES**

In a medical emergency, members are instructed to go immediately to the nearest emergency room or urgent care center and to notify the Utilization Management company on the back of their ID card.

In life-threatening situations, the PCP and/or patient or designee is required to notify the claimant's insurance carrier within 48 hours of admission at the number at the back of the ID card.

### **DISCLAIMER**

**CSG/CHN PPO DOES NOT PROVIDE UTILIZATION MANAGEMENT SERVICES FOR ALL PAYORS. PAYORS OF CSG/CHN HAVE THE ABILITY TO ENGAGE UTILIZATION MANAGEMENT COMPANIES ("UM COMPANIES") TO PROVIDE UTILIZATION MANAGEMENT ON A PROSPECTIVE, CONCURRENT AND RETROSPECTIVE BASIS. CSG/CHN SHALL NOT BE RESPONSIBLE OR HAVE ANY LIABILITY FOR ANY ACTIONS OF UM COMPANIES.**

**THE UTILIZATION MANAGEMENT SERVICES PROVIDED BY UM COMPANIES ARE PROSPECTIVE, CONCURRENT AND RETROSPECTIVE REVIEWS OF MEDICAL SERVICES RENDERED OR TO BE RENDERED BY PROFESSIONAL PROVIDERS. THE PURPOSE OF UTILIZATION MANAGEMENT IS TO ANALYZE PROPOSED MEDICAL SERVICES OR MEDICAL SERVICES WHICH HAVE BEEN PERFORMED, AND DETERMINE IF SUCH SERVICES SATISFY THE CRITERIA FOR MEDICAL APPROPRIATENESS AS DEFINED IN THE PARTICIPATING PROVIDER AGREEMENT. ONCE A UM COMPANY HAS DETERMINED WHETHER OR NOT MEDICAL SERVICES SATISFY THE CRITERIA FOR MEDICAL APPROPRIATENESS, THE UM COMPANY REPORTS THIS FINDING TO PAYORS. THE REPORTS TO PAYORS CONSIST OF INFORMATION, AND ARE NOT CLINICAL DECISIONS, AS THE CLINICAL DECISIONS ARE MADE ONLY BY THE PATIENTS AND THE PARTICIPATING PROVIDER. THE REPORTS BY THE UM COMPANY TO PAYORS ARE NOT DETERMINATIVE OF PAYMENT FOR MEDICAL SERVICES, AS THE ULTIMATE DECISION WITH RESPECT TO PAYMENT IS MADE BY THE PAYOR.**

**ALL CLINICAL DECISIONS REGARDING THE ADMISSION, TREATMENT AND DISCHARGE OF PATIENTS UNDER A PARTICIPATING PROVIDER'S CARE ARE SOLELY THE RESPONSIBILITY OF THE PATIENT AND THE PROVIDER, NOTWITHSTANDING THE RECEIPT BY THE PATIENT OR THE PROVIDER, WHETHER IN WRITING OR OTHERWISE, OF ANY DETERMINATION OF SATISFACTION OF CRITERIA OR NON-SATISFACTION OF CRITERIA FROM ANY UM COMPANY REGARDING ANY ADMISSION, PROPOSED ADMISSION, TREATMENT OR DISCHARGE WITH RESPECT TO ANY HOSPITALIZATION OR ANY PROCEDURE, TREATMENT OR MEDICAL CARE THAT MAY BE ISSUED PURSUANT TO THE UTILIZATION MANAGEMENT SERVICES PERFORMED BY A UM COMPANY.**



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**CSG UTILIZATION MANAGEMENT APPEALS PROCESS**

**When an employee, a patient, a patient’s representative, a facility, a provider or a provider who is acting on behalf of a patient disagrees with a determination made by CSG, the disagreeing party may initiate an appeal.**

**Expedited Appeal Process – Stage I**

An Expedited Appeal is a request by telephone, prior to or during the course of urgent or ongoing treatment, for an immediate review when the patient/member (or representative), attending physician or other ordering provider, and/or the facility rendering the service does not agree with the initial determination **not** to authorize or certify an admission, extension of stay, or other health care service. CSG will also process appeals made by the facility rendering care at the request of the patient/member, attending physician, or other ordering provider.

The appealing party may contact the appropriate department (utilization management, case management, customer service) by telephone to request an expedited appeal. Additional information will be accepted either via telephone conversation or facsimile and the appealing provider will be encouraged to share information with the reviewing consultant.

For UM appeals, CSG will identify the appropriate physician consultant and provide for reasonable access to him/her for such appeals. The physician consultant will speak with the treating provider or make mutually acceptable arrangements to facilitate a telephone conversation. The appealing provider will be notified of the determination by telephone, either at the time of the appeal conversation with the physician consultant, or as soon as possible.

The specialty consultant will be a licensed (non-restricted) board certified physician. The physician consultant will be of the same specialty or subspecialty as the appealing/treating provider, or of a specialty mutually agreed to by the involved parties. The physician consultant will be different from, and not subordinate to any of the consultants or advisors who may have rendered opinions not to certify the case under appeal.

The results of the review determination will be provided initially by telephone and then by written notification. Expedited appeals will be completed to include written notification of the appeal decision as soon as possible, and no later than 72 hours after the initiation of the appeal process.

CSG will provide the patient/member (or representative), appealing provider or other treating provider, the facility rendering the service, and the claims administrator written notification of the determination as soon as possible, and no later than 72 hours after the initiation of the appeal process. Expedited appeals that do not resolve a difference of opinion for continued treatment may be further appealed through the standard appeal process. Included in this notification will be the principal reasons the original determination was upheld and the method to initiate a standard appeal process. Upon request, CSG’s Utilization Management Service will make available in written form the specific clinical rationale that was utilized to render the determination.

## Standard Appeal Process – Stage II

The purpose of the Standard Appeal Process is to facilitate data collection when time constraints are not so critical as would be the case for an Expedited Appeal. The patient/member or representative, treating physician or other ordering provider, and the facility rendering the service, have 180 days from the date of the determination in question to file a Standard Appeal. CSG will also process appeals made by the facility rendering care at the request of the patient/member, attending physician, or other ordering provider.

The appealing party may contact the appropriate department (Utilization Management, Case Management) to request a standard appeal. CSG will allow for standard appeals to be made in writing and/or by telephone. An appeal may be requested for pre-certification/pre-authorization reviews, concurrent reviews, retrospective reviews, and case management determinations not to certify. The standard appeal must include additional information. CSG may require copies of part or all of the medical record or a written statement from the health care provider. The appealing provider will be encouraged to share information with the reviewing consultant.

CSG conducts a review of such documentation by a licensed (non-restricted) board certified physician. The physician advisor will be of the same specialty or subspecialty as the appealing/treating provider, or of a specialty mutually agreed to by the involved parties. The physician advisor will be different from, and not subordinate to any of the consultants or advisors who may have rendered opinions not to certify the case under appeal. When the initial determination not to approve was based on lack of necessary information, the physician who made the original determination may review the case.

CSG Utilization Management Services and/or carrier will notify, in writing, the patient/member (or representative), the attending physician or other ordering provider, facility rendering the service, and claims adjuster of its determination on appeal. This will be done within thirty (30) days of the initiation of the appeal process and receipt of the required documentation necessary to conduct the appeal. Included in this notification will be the principal reasons the original determination was upheld. Upon request, CSG's Utilization Management Service will make available in written form the specific clinical rationale that was utilized to render the determination. Standard appeals that do not resolve a difference of opinion may be further appealed through the Independent Healthcare Appeals Program (IURO).

The patient/member or representative, treating physician or other ordering provider, and/or the facility may initiate an appeal through the New Jersey Department of Banking and Insurance's Independent Healthcare Appeals Program, within 60 days of the carrier's final determination. For additional information refer to [www.state.nj.us/dobi](http://www.state.nj.us/dobi). The appeal application should be mailed to:

Department of Banking and Insurance  
Consumer Protection Services  
Office of Managed Care  
PO Box 325  
Trenton, NJ 08625-0325





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## REIMBURSEMENT APPEAL PROCESS

An appeal is any dispute or inquiry from a provider, adjuster or attorney requesting reconsideration of an organizational determination. Providers may initiate an appeal on or before the 90<sup>th</sup> calendar day following receipt by the healthcare provider of the payor's claim determination. CHN PPO will respond to an appeal on or before the 30<sup>th</sup> calendar day following receipt of appeal request.

Upon receipt of an appeal the following process will be undertaken:

### 1. First Level-

Bill Review Department will review the issue. If the issue can be resolved with the support of coding guidelines or documentation from established medical organizations then clinical review is not necessary.

A. For Contract issues, Usual & Customary (U & C) disputes, and NJ PIP fee schedule disputes, the bill review staff will:

- Verify information on the provider and facility
- Obtain written documentation that is required for the resolution of a contract issue
- Upon verifying that the U & C rates are correct, respond to provider, adjuster or attorney with letter that explains origin of U & C rates
- Compare date of service with PIP book for actual regulations and fee schedules (Periodic changes to the fee schedule and regulations are noted by the effective date)

B. Disputes Requiring Clinical Review: The bill review staff will:

- Request that provider submit written request specifying issue for appeal
- Utilize available AMA, AANEM, AAOS or supporting documentation from other appropriate source and/or guidelines to address specific issue.
- In the instances where the documentation supports the decision on the issue in dispute, notify the provider in writing of the determination on or before the 30<sup>th</sup> calendar day of receipt of the appeal. The information used to support the decision will be made available to the provider. The adjuster will receive a copy of the correspondence, if appropriate
- In the instances where the supporting documentation recommends an adjustment to the claim in dispute, notify the insurance carrier/payor in writing of the recommendation.

C. Disputes Requiring Physician Review: The bill review staff will:

- Forward all necessary documentation to CSG's Physician Advisor for review. Provider will receive written notification regarding outcome of Physician Advisor review.

## 2. Second Level

Should the provider continue to disagree with the determination and request a second appeal, another analyst or physician advisor other than the original analyst or physician advisor, who rendered the decision, will be selected to review and render a decision on the issue on or before the 30<sup>th</sup> calendar day of receipt of the second appeal. The complainant will be notified in writing of the outcome of the second determination. If after two reviews performed by two physician advisors, the provider continues to disagree with the determination; the provider may submit an appeal request to the arbitration organization contracted by the Commissioner for the New Jersey Department of Banking and Insurance. For additional information refer to [www.state.nj.us/dobi](http://www.state.nj.us/dobi).



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**CHN PPO PROVIDER INFORMATION UPDATE**

Any change to the provider profile that was supplied on the original application must be reported immediately to CHN PPO in writing or electronically in accordance with the Participating Provider Agreement. Below are important changes that need to be immediately supplied to CHN:

- New / Change of Address
- New / Change or Additional Tax ID (Requires copy of completed W-9 form, which can be accessed at [www.irs.gov](http://www.irs.gov))
- New / Change of Telephone or Fax Number
- Additional Office Location
- Provider Leaves or Joins Practice
- Specialty Changes
- Addition / Change of NPI number

**YOU CAN NOTIFY CHN PPO IN SEVERAL WAYS**

• **Via Mail:**

CHN PPO  
Data Quality Department  
300 American Metro Blvd., Suite 170  
Hamilton, NJ 08619

• **Via Fax:**

Attention: Data Quality  
609-631-0476

• **Via Email:**

[Provider.update@chn.com](mailto:Provider.update@chn.com)

• **Via Our Website:**

[www.CHN.com](http://www.CHN.com) or [www.csg-inc.net](http://www.csg-inc.net)

If further assistance is required, please contact our Customer Service Department at: 800-225-4CHN.



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## CHN PPO REPRICING GUIDELINES

These Re-pricing Guidelines are intended as a guide for re-pricing claims submitted by participating providers. These Re-pricing Guidelines shall not supersede applicable laws, rules and regulations governing re-pricing or payment of claims. Payor and/or Payor's re-pricing agent shall be responsible for paying claims in accordance with applicable laws, rules and regulations.

The New Jersey Administration Code provides that an insurer's limit of liability for medically necessary expenses under personal injury protection (PIP) coverage is the lesser of the provider's usual, customary and reasonable fee or the amount set forth in the PIP medical fee schedules. As CHN has negotiated a fee schedule with the participating providers that may be lower than the PIP medical fee schedules, bills may be re-priced in accordance with the CHN fee schedule.

**USING MODIFIERS** - For a complete list of modifiers and their descriptions, please refer to current CPT reference materials. CHN PPO recommended reimbursement methodologies for modifiers are based on AMA guidelines.

### **MODIFIER -22 Unusual Procedural Services:**

An additional 20% of the CHN fee schedule amount shall be added to the amount in the CHN fee schedule where this modifier is presented and verified by report.

### **MODIFIER -25 Significant, Separately Identifiable E & M Service:**

An additional 20% of the CHN fee schedule amount shall be added to the amount in the CHN fee schedule where this modifier is presented and verified by provider office notes.

### **MODIFIER -50 Bilateral Procedures:**

Modifier -50 should be used to identify the second (bilateral) procedure in addition to the appropriate CPT code describing the first procedure unless there is an appropriate CPT code that indicates "Bilateral". Reimbursement should be 150% of the amount set forth in the CHN fee schedule. (100% for the first side and 50% for the second – CHN recommends breaking out the charges on to two lines so PPO application is correct) MPR applies to any applicable subsequent procedures.

### **MODIFIER -51 Multiple Procedures (surgery):**

Modifier -51 is used to identify multiple procedures performed on the same day by the same provider. The primary procedure may be reported as listed and the additional procedures identified with the modifier -51.

**Heath Benefits/Workers' Compensation** -The primary procedure is re-priced at 100% of the amount set forth in the CHN fee schedule. The second and subsequent surgical procedures shall be re-priced at 50% of the amount in the CHN fee schedule.

**Auto (PIP)** - The primary procedure is re-priced at 100% of the amount set forth in the CHN fee schedule. The second procedure is re-priced at 50% of the amount set forth in the fee schedule. The third and subsequent procedures are re-priced at 25% of the amount set forth in the CHN fee schedule.

There are “add on” surgical CPT codes defined by the AMA which are an exception to this rule. The CPT code description will read that it is secondary to the major procedure therefore do not apply modifier 51.

A summary of CPT codes exempt from Modifier - 51 can be found in the latest CPT book.

### **MODIFIER – 57 Decision for surgery:**

An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of E/M service.

### **MODIFIER - 62 Two Surgeons:**

#### **Health Benefits/Workers’ Compensation**

Co-surgeon charges will be re-priced at 60% of 120% of the amount set forth in the CHN fee schedule. Second and subsequent procedures shall be re-priced at 50% of the reduced amount set forth in the CHN fee schedule (refer to modifier 51).

#### **Auto (PIP)**

Co-surgeon charges will be re-priced at 75% of the amount set forth in the CHN fee schedule ( i.e. 50% of 150% of the amount set forth in the CHN fee schedule). Re-price second procedure at 37.5 % of the amount set forth in the CHN fee schedule (i.e. 50% of the percentage for the primary procedure). Reprice the third and subsequent procedures at 18.75% of the amount set forth in the CHN fee schedule (i.e. 25% of the percentage for the primary procedure). \*Refer to Modifier 51

### **MODIFIER - 80 Assistant Surgeon:**

Re-priced at 20% of the amount in the CHN PPO fee schedule of the primary physician’s fee in accordance with the CHN PPO fee schedule.

Surgeons that assist in multiple procedures are re-priced at 20% of the multiple procedures in the following manner:

#### **Health Benefits/Workers’ Compensation**

- ⤴ 1st or major procedure = 20% of the amount set forth in the CHN fee schedule
- ⤴ 2nd or minor procedures = 20% of the reduced amount set forth in the CHN fee schedule (refer to modifier 51)

#### **Auto (PIP)**

- ⤴ 1st or major procedure = 20% of the amount set forth in the CHN fee schedule
- ⤴ Subsequent procedures = 10% of the amount set forth in the CHN fee schedule (i.e. 50% of the percentage for the primary procedure) \*Refer to modifier 51

### **MODIFIER – 82 Minimal Assistant Surgeon:**

Surgery assisted by a PA (Physician Assistant) should be reimbursed at 10% of the amount in the CHN PPO fee schedule of the primary physician’s fee in accordance with the CHN PPO fee schedule.

#### **Health Benefits/Workers’ Compensation**

- ⤴ 1st or major procedure = 10% of the amount set forth in the CHN PPO fee schedule
- ⤴ 2nd or minor procedures = 10% of the reduced amount set forth in the CHN PPO fee schedule (refer to modifier 51)

#### **Auto (PIP)**

- ⤴ 1st or major procedure = 10% of the amount set forth in the CHN fee schedule
- ⤴ Subsequent procedures = 5% of the amount set forth in the CHN fee schedule (i.e. 50% of the percentage for the primary procedure) \*Refer to modifier 51

\*Surgical procedures performed by a Physician Assistant in an office shall be re-priced at 70% of the amount set forth in the CHN PPO fee schedule.

## **OFFICE VISITS**

Office visits billed by a Physician Assistant, Nurse Practitioner or Registered Nurse should be reimbursed at 70% of the amount set forth in the CHN PPO fee schedule.

## **PROFESSIONAL COMPONENTS / TECHNICAL COMPONENTS**

The amount set forth in the CHN PPO fee schedule is the global fee, which is the sum of the professional and technical components. Professional and technical components shall be re-priced as follows:

### **Health Benefits/Workers' Compensation**

- ⤴ For radiology – professional components, modifier 26 (70000 – 79999) and other diagnostic testing (92000 - 95999) –re-priced at 35% of the amount set forth in the CHN PPO fee schedule. Technical components-modifier TC –re-priced at 65% of the amount set forth in the CHN PPO fee schedule.
- ⤴ For pathology – professional components, modifier 26 (80002 - 89399) –re-priced at 65% of the amount set forth in the CHN PPO fee schedule. Technical components-modifier TC –re-priced at 35% of the amount set forth in the CHN PPO fee schedule.

### **Auto (PIP)**

- ⤴ Professional Components/Modifier 26 –Re-price at 40% of the amount set forth in the CHN fee schedule
- ⤴ Technical Components/Modifier TC – Re-price at 60% of the amount set forth in the CHN fee schedule

## **UNLISTED PROCEDURE CODES –'99**

CPT codes described as “unlisted procedures”, usually ending in 99 are to be considered on a by report basis. Whenever a claim is received for an unlisted procedure code, each payor shall contact the provider of the service and request a copy of the operative report or office notes related to the procedure(s) performed. The report should be reviewed by medical personnel and an appropriate allowable fee should be determined.

## **ANESTHESIA**

The following formula is used to determine anesthesia fees:

Number of base units (Refer to the RVS) plus the number of time units (1 unit per 15 minutes or any part beyond 5 minutes). Multiply the sum of the units by the appropriate conversion factor, the result is the CHN PPO fee amount. If additional units are billed, review to be sure that payment for additional units conforms to the utilization management criteria.

Physical status modifiers shall be re-priced as follows:

- ⤴ P1 and P2 – no additional units
- ⤴ P3 – 1 unit
- ⤴ P4 – 2 units
- ⤴ P5 – 3 units

Services billed with the following CPT codes in an emergency situation shall be re-priced as follows:

- ⤴ 99100 – 1 unit
- ⤴ 99116 – 5 units
- ⤴ 99135 – 5 units
- ⤴ 99140 – 2 units

## **ANESTHESIA MODIFIERS**

If anesthesia is billed with modifier QK, QX or QY re-pricing should be as follows:

### **Health Benefits/Workers' Compensation**

- ⤴ QK, QY - the charges shall be re-priced at 60% of the applicable PPO rate
- ⤴ QX - the charges shall be re-priced at 40% of the applicable PPO rate

### **Auto (PIP)**

- ⤴ QK - Charges shall be re-priced at 50% of the applicable PPO rate
- ⤴ QY - Charges shall be re-priced at 50% of the applicable PPO rate
- ⤴ QX - Charges shall be re-priced at 50% of the applicable PPO rate
- ⤴

### **NEW MISSING CODES**

Codes not existing in the CHN PPO fee schedule shall be re-priced to 75% of billed charges or the usual and customary charges of the provider's geographic area.



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## CHN PPO PROVIDER REVIEW PROCEDURE

### 1. Definitions.

- 1.1 Provider. “Provider” means healthcare providers eligible to enter into Participating Provider Agreements with CHN PPO (“Provider Agreement”).
- 1.2 Participating Provider. “Participating Provider” means a provider who has entered into a Provider Agreement either directly or indirectly with CHN PPO.
- 1.3 Credentialing Criteria. “Credentialing Criteria” means the criteria established by CHN PPO for the credentialing and re-credentialing of Participating Providers which may be amended from time to time by CHN PPO in its sole discretion. The Credentialing Criteria pertaining to Provider are set forth in the contract.
- 1.4 Review. “Review” means the reconsideration of a determination by CHN PPO that a Provider:
  - 1.4.1 did not satisfy the Credentialing Criteria of CHN PPO which has resulting in (i) the rejection of the Provider from the CHN PPO Network; (ii) the termination of the Provider as a Participating Provider; or (iii) the suspension of the Provider or other disciplinary action by CHN PPO; or
  - 1.4.2 did not comply with the policies, procedures, rules and regulations of CHN PPO which has resulting in” (i) the rejection of the Provider from the CHN PPO Network; (ii) the termination of the Provider as a Participating Provider; or (iii) the suspension of the Provider or other disciplinary action by CHN PPO.
  - 1.4.3 The Review shall not be a reconsideration of the Credentialing Criteria or the policies, procedures, rules and regulations of CHN PPO.
  - 1.4.4 The Review shall be conducted pursuant to the procedures provided in this Provider Review Procedure.
- 1.5 Review Request. “Review Request” means a written request by a Provider for a Review pursuant to this Provider Review Procedure due to (i) a rejection of the Provider based upon an initial application to become a Participating Provider; (ii) the termination of the Provider as a Participating Provider; (iii) the suspension of the Provider or other disciplinary action by CHN PPO. The Review Request shall include a release signed by the Reviewed Provider to Permit CHN PPO to disclose confidential information to the Provider Panel and other participants in the Provider Review Procedure.
- 1.6 Reviewed Provider. “Reviewed Provider” means a Provider submitting a Review Request pursuant to this Provider Review Procedure.

1.7 Provider Panel. “Provider Panel” means a panel of Participating Providers appointed by CHN PPO to provide recommendations to CHN PPO with respect to the Review Request submitted by the Reviewed Provider. A Provider Panel shall consist of at least three qualified individuals, of which one must be a Participating Provider who is not otherwise involved in management of the CHN PPO Network and who is in the same or similar vocation or specialty as the Reviewed Provider.

2. Review Based Upon Initial Application.

2.1 Notice of Rejection. If a Provider is not accepted for participation as a Participating Provider (“Rejected Provider”) in the CHN PPO Network, CHN PPO shall provide the Rejected Provider with written notice of rejection (“Rejection Notice”). The Rejection Notice shall reference the sections of the Credentialing Criteria which are the reasons for rejection and shall be sent within ten (10) business days after the decision by CHN PPO to reject the Provider. The Rejection Notice shall inform the Rejected Provider of this Provider Review Procedure.

2.2 Request for Review.

2.2.1 A Rejected Provider shall have thirty (30) days after the effective date of the Rejection Notice to submit a Review Request to CHN PPO. Failure to submit a Review Request within such period shall constitute a waiver of the right to a Review and the rejection of Provider shall be final, conclusive and binding and the Rejected Provider shall have no further right to contest the rejection.

2.2.2 A Rejected Provider shall include any statement or additional information in the Review Request. Such statement or additional information shall be limited to information relating to the reason for rejection as stated by CHN PPO in the Rejection Notice and shall not include any disagreement with the Credentialing Criteria or the policies, procedures, rules or regulations of CHN PPO. Provider shall have no further right to submit information to CHN PPO. Provider shall have no right to an attorney, to appear in person or to provide any testimony to the Medical Director of CHN PPO or the Provider Panel other than in the Review Request.

2.3 Rejection Without Review. Notwithstanding anything contained herein to the contrary, a Provider shall not be entitled to a Review if the reason for rejection is based upon the determination by CHN PPO (i) that the CHN PPO Network has sufficient Participating Providers in a specialty for a geographic area; (ii) Provider was previously not accepted by CHN PPO for the same or a substantially similar reason; or (iii) to withdraw the CHN PPO Network from the relevant service area, as determined by CHN PPO in its sole discretion.

3. Review Based upon Termination, Suspension, or Action of CHN PPO.

3.1 Notice of Termination. If the Provider Agreement of a Participating Provider is terminated, if CHN PPO provides notice of non-renewal, if a Participating Provider is suspended by CHN PPO, or if CHN PPO takes an action related to the Participating Provider’s professional competency or conduct, CHN PPO shall provide the Participating Provider (“Terminated/Suspended/Affected Provider”) with written notice of termination, suspension or action (“Termination/Suspension/Action Notice”) referencing the sections of the Credentialing Criteria which are the reasons for termination, suspension or action. The Notice shall be sent within ten (10) business days of the decision by CHN PPO. The Termination/Suspension/Action Notice shall inform the Terminated/Suspended/Affected Provider of this Review Procedure including the right of the Terminated/Suspended/Affected Provider to request a Review with a hearing within ten (10) business days following the date of receipt of termination notice or a Review without a hearing.

### 3.2 Review Request.

- 3.2.1 A Terminated/Suspended/Affected Provider shall have thirty (30) days after the effective date of the Termination/Suspension/Action Notice to submit a Review Request to CHN PPO. Failure to submit a Review Request within such period shall constitute a waiver of the right to a Review and the termination or Provider shall be final, conclusive and binding and the Terminated/Suspended/Affected Provider shall have no further right to contest such termination.
- 3.2.2 A Terminated/Suspended/Affected Provider shall include any statement or additional information in the Review Request. Such statement or additional information shall be limited to information relating to the reason for the termination, suspension or action and shall not include any disagreement with the Credentialing Criteria or policies, procedures, rules or regulations of CHN PPO. Subject to Section 3.2.4, the Review Request shall inform CHN PPO if the Terminated/Suspended/Affected Provider is requesting a Review with a hearing or a Review without a hearing.
- 3.2.3 A Terminated/Suspended/Affected Provider requesting a Review without a hearing shall have no further right to submit information to CHN PPO. A Terminated/Suspended/Affected Provider requesting a Review without a hearing shall have no right to an attorney to appear in person or to provide testimony to the Medical Director of CHN PPO or the Provider Panel other than in the Review
- 3.2.4 Notwithstanding anything elsewhere in this Procedure to the contrary, a Terminated/Suspended/Affected Provider requesting a panel Review shall have the right to a panel Review if there is no: (i) immediate or serious danger to members' health or safety, or any action by a state medical board, medical licensing board, other licensing board, or any other government agency, that effectively impairs the Provider's ability to practice medicine; or (ii) any case of fraud, malfeasance, or incarceration. Panel Reviews shall be conducted as determined by CHN PPO in accordance with applicable law.

### 3.3 Expedited Review.

- 3.3.1 If the termination of the Participating Provider is effective immediately, including without limitation immediate termination based upon imminent harm to patient care as determined by CHN PPO in its sole discretion, or if a Participating Provider is suspended from CHN PPO pending an investigation, the Terminated/Suspended/Affected Provider may include a request for an expedited review in the Review Request ("Expedited Review Request"). If a Terminated/Suspended/Affected Provider shall provide CHN PPO with an Expedited Review Request, CHN PPO shall conduct the initial Review within ten (10) business days of the receipt by CHN PPO of the Expedited Review Request.
- 3.3.2 If a Terminated/Suspended/Affected Provider shall provide CHN PPO with an Expedited Review Request for a First-Level Appeal Review without a hearing, CHN PPO shall use best efforts to cause the Provider Panel to provide CHN PPO with a recommendation within ten (10) business days of receipt of the Expedited Review Request. An expedited review shall not be available for a First-Level Appeal Review with a hearing.

### 3.4 Certain Other Terminations Subject to Review. Notwithstanding anything contained herein to the contrary, a Participating Provider shall not be entitled to a Review if the reason for termination is based upon withdrawal of the CHN PPO Network from the relevant service area, as determined by CHN PPO in its sole discretion, [a determination of fraud, or a final

disciplinary action by a state licensing board or the governmental agency that impairs the ability of the Terminated/Suspended/Affected Provider to practice].

4. Review by the CHN PPO Medical Director. Upon receipt of a Review Request by a Reviewed Provider, a Review shall be conducted as follows:
  - 4.1 Review by the Medical Director of CHN PPO. The Medical Director of CHN PPO shall review the Review Request and the file and make a review determination regarding the application or termination of the Reviewed Provider.
  - 4.2 Review Determination by the Medical Director. After review of the application or termination of the Reviewed Provider, the Medical Director shall issue a determination with notification to the Quality Committee.
  - 4.3 Notification of Provider. CHN PPO shall provide a notice of the Medical Director's review determination to the Reviewed Provider within ninety (90) days after receipt for the Request for Review ("Determination Notice").
5. Request for First-Level Appeal Review by a First-Level Provider Panel:
  - 5.1 A Reviewed Provider may request a first-level appeal of the determination issued by the Medical Director ("First-Level Appeal Review"). A Reviewed Provider shall have thirty (30) days after the effective date of the Determination Notice to submit a Review Request for a First-Level Appeal Review ("First-Level Appeal Review Request"), including the right to a review by an authorized representative of CHN PPO not involved in the initial decision that is subject of the dispute. Failure to submit a First-Level Appeal Review Request within such period shall constitute a waiver of the right to a First-Level Appeal Review and the decision of CHN PPO shall be final, conclusive and binding and the Reviewed Provider shall have no right to further review.
  - 5.2 The First-Level Appeal Review Request shall include any statement of additional information. Any statement or additional information submitted with the First-Level Appeal Review Request shall be limited to information relating to the reason for the rejection, termination, suspension or action and shall not include any disagreement with the Credentialing Criteria or policies, procedures, rules or regulations of CHN PPO. Subject to section 5.2.1, First-Level Appeal Review Request submitted by a Terminated/Suspended/Affected Provider shall inform CHN PPO if Terminated/Suspended/Affected Provider is requesting a First-Level Appeal Review with a hearing or a First-Level Appeal Review without a hearing. A Rejected Provider shall not have the right to a First-Level Appeal Review with hearing.
    - 5.2.1 Notwithstanding anything elsewhere in this Review Procedure to the contrary, a Terminated/Suspended/Affected Provider requesting a panel Review shall have the right to a panel Review if there is no: (i) immediate or serious danger to members' health or safety, or any action by a state medical board, medical licensing board, other licensing board, or any other government agency, that effectively impairs the provider's ability to practice medicine; or (ii) any case of fraud, malfeasance, or incarceration. Panel Reviews shall be conducted as determined by CHN PPO in accordance with applicable law.
6. First-Level Appeal Review Without a Hearing. Upon receipt of a First-Level Appeal Review Request by CHN PPO from a Reviewed Provider not requesting a hearing, the First-Level Appeal Review shall be conducted as follows:
  - 6.1 First-Level Provider Panel. CHN PPO shall utilize its Credentialing Committee as the First-Level Provider Panel which shall consist of at least three qualified individuals, who do not compete with the Reviewed Provider, of which one must be a Participating Provider who is not otherwise involved in management of the CHN PPO Network and who is in the same or

similar vocation or specialty as the Reviewed Provider. When requested in the First Level Appeal Review request, CHN PPO shall utilize a participating peer review provider or authorized representative of CHN PPO not originally involved in the initial decision that is subject of the dispute.

## 6.2 Review by First-Level Provider Panel.

6.2.1 CHN PPO shall provide each First-Level Provider Panel member with: (i) a copy of the pertinent portions of the file of Reviewed Provider relating to the reason for rejection, termination, suspension or action; (ii) the portions of the Review Request and the First-Level Appeal Review Request relating to the reason for rejection, termination, suspension or action; and (iii) other material relating to the Reviewed Provider during the Review.

6.2.2 The First-Level Provider Panel shall review the file solely with respect to the reason for rejection, termination, suspension or action of the Reviewed Provider and shall disregard any other statements or information which do not pertain to the reason for rejection, termination, suspension or action. The First-Level Provider Panel shall not review or provide recommendations with respect to the Credentialing Criteria or the policies, procedures, rules or regulations of CHN PPO.

6.2.3 The First-Level Provider Panel shall not communicate with the Reviewed Provider regarding the First-Level Appeal Review.

6.2.4 The First-Level Provider Panel shall not confer with the other First-Level Provider Panel members. Upon review of the file of the Reviewed Provider, each First-Level Provider Panel member shall render an individual recommendation to CHN PPO in the manner prescribed by CHN PPO. CHN PPO shall review and tabulate the recommendations of the First-Level Provider Panel

## 6.3 Notification of Reviewed Provider.

6.3.1 CHN PPO shall provide Reviewed Provider with notice of the determination of CHN PPO based on the results of the First Level Provider Panel within ninety (90) days after receipt of the First-Level Appeal Review Request ("First-Level Appeal Determination notice"). The First-Level Appeal Determination Notice shall not inform the Reviewed Provider of any further rights.

6.3.2 CHN PPO shall provide an explanation of the CHN PPO decision upon the written request of the Reviewed Provider. If the Reviewed Provider fails to request such explanation with thirty (30) days after the effective date of the notice of determination CHN PPO, CHN PPO shall have no further obligation to provide such explanation.

6.4 Final Review. Review by CHN PPO pursuant to this Review Procedure shall be the final Review and the Reviewed Provider shall have no further recourse upon the conclusion of the Review Procedure.

7. First-Level Appeal Review with a Hearing. Subject to Section 7.4.3, upon receipt of a First-Level Appeal Review Request from a Terminated/Suspended/Affected Provider requesting a hearing, the First-Level Appeal Review shall be conducted as follows:

7.1 Notice of Hearing Date. CHN PPO shall set a date for the hearing to occur within thirty (30) days following receipt of the written request for a hearing by the Terminated/Suspended/Affected Provider.

- 7.2 First-Level Provider Panel. CHN PPO shall utilize its Credentialing Committee as the First-Level Provider Panel which shall consist of at least three qualified individuals, who do not compete with the Reviewed Provider, of which one must be a Participating Provider who is not otherwise involved in management of the CHN PPO Network and who is in the same or similar vocation or specialty as the Reviewed Provider. When requested, in the First Level Appeal Review request, CHN PPO shall utilize a participating peer review provider or authorized representative of CHN PPO not originally involved in the initial decision that is subject of the dispute.
- 7.3 Review by First-Level Provider Panel.
- 7.3.1 CHN PPO shall provide each First-Level Provider Panel member with: (i) a copy of the pertinent portions of the file of Terminated/Suspended/Affected Provider relating to the reason for rejection, termination, suspension or action; (ii) the portions of the Review Request and the First-Level Appeal Review Request relating to the reason for rejection, termination, suspension or action; and (iii) other materials relating to the Terminated/Suspended/Affected Provider during the Review.
- 7.3.2 The First-Level Provider Panel shall review the file and, if required by applicable law, hear any testimony of the Terminated/Suspended/Affected Provider solely with respect to the reason for termination, suspension or action and shall disregard any other statements or information which do not pertain to the reason for rejection, termination, suspension or action. The First-Level Provider Panel shall not review or provide recommendations with respect to the Credentialing Criteria or the policies, procedures, rules or regulations of CHN PPO.
- 7.3.3 The First-Level Provider Panel shall render a decision to CHN PPO in the manner prescribed by CHN PPO.
- 7.4 Notification of Terminated/Suspended/Affected Provider.
- 7.4.1 Based on the results of the First Level Provider Panel, CHN PPO shall provide the Terminated/Suspended/Affected Provider with notice of the determination of CHN PPO within ninety (90) days after receipt of the First-Level Appeal Review Request ("First-Level Appeal Determination Notice"). The First-Level Appeal Determination Notice shall inform the Terminated/Suspended/Affected Provider of his or her further rights regarding a second-level appeal.
- 7.4.2 CHN PPO shall provide an explanation of the CHN PPO decision upon the written request of the Terminated/Suspended/Affected Provider. If the Terminated/Suspended/Affected Provider fails to request such explanation within thirty (30) days after the effective date of notice of determination, CHN PPO shall have no further obligation to provide such explanation.
- 7.4.3 Notwithstanding anything elsewhere in this Review Procedure to the contrary, a Terminated/Suspended/Affected Provider requesting a panel Review shall have the right to a panel Review if there is no: (i) immediate or serious danger to members' health or safety, or any action by a state medical board, medical licensing board, other licensing board, or any other government agency, that effectively impairs the provider's ability to practice medicine; or (ii) any case of fraud, malfeasance, or incarceration. Panel Reviews shall be conducted as determined by CHN PPO in accordance with applicable law.

8. Request for Second-Level Appeal Review by a Second-Level Provider Panel:

- 8.1 A Reviewed Provider may request a second-level appeal of the determination issued by the First-Level Appeal Panel (“Second-Level Appeal Review”). A Reviewed Provider shall have thirty (30) days after the effective date of the Determination Notice to submit a Review Request for a Second-Level Appeal Review (“Second-Level Appeal Review Request”), including the right to a review by an authorized representative of CHN PPO not involved in the First-Level Appeal decision that is subject of the dispute.. Failure to submit a Second-Level Appeal Review Request within such period shall constitute a waiver of the right to a Second-Level Appeal Review and the decision of CHN PPO shall be final, conclusive and binding and the Reviewed Provider shall have no right to further review.
- 8.2 The Second-Level Appeal Review Request shall include any statement of additional information. Any statement or additional information submitted with the Second-Level Appeal Review Request shall be limited to information relating to the reason for the rejection, termination, suspension or action and shall not include any disagreement with the Credentialing Criteria or policies, procedures, rules or regulations of CHN PPO. Subject to section 8.2.1, Second-Level Appeal Review Request submitted by a Terminated/Suspended/Affected Provider shall inform CHN PPO if Terminated/Suspended/Affected Provider is requesting a Second-Level Appeal Review with a hearing or a Second-Level Appeal Review without a hearing. A Rejected Provider shall not have the right to a Second-Level Appeal Review with hearing.
- 8.2.1 Notwithstanding anything elsewhere in this Review Procedure to the contrary, a Terminated/Suspended/Affected Provider requesting a panel Review shall have the right to a panel Review if there is no: (i) immediate or serious danger to members’ health or safety, or any action by a state medical board, medical licensing board, other licensing board, or any other government agency, that effectively impairs the provider’s ability to practice medicine; (ii) or any case of fraud, malfeasance, or incarceration. Panel Reviews shall be conducted as determined by CHN PPO in accordance with applicable law.
- 8.3 The Second Level Appeal Review shall be conducted pursuant to the same process, procedure and timeframes as specified for the First Level Appeal Review. The Second Level Provider Panel shall consist of at least three qualified individuals, not part of the CHN PPO Credentialing Committee, that were not involved with the First-Level Provider Panel, who do not compete with the Reviewed Provider, of which one must be a Participating Provider who is not otherwise involved in management of the CHN PPO Network and who is in the same or similar vocation or specialty as the Reviewed Provider.

9. Notification of Reviewed Provider of Second Level Appeal Review.

- 9.1 CHN PPO shall provide Reviewed Provider with notice of the determination of CHN PPO within ninety (90) days after receipt of the Second-Level Appeal Review Request (“Second Determination notice”). The Second Determination Notice shall not inform the Reviewed Provider of any further rights.
- 9.2 CHN PPO shall provide an explanation of the CHN PPO decision upon the written request of the Reviewed Provider. If the Reviewed Provider fails to request such explanation with thirty (30) days after the effective date of the notice of determination CHN PPO, CHN PPO shall have no further obligation to provide such explanation.
- 9.3 Review by CHN PPO pursuant to this Review Procedure shall be the final Review and the Reviewed Provider shall have no further recourse upon the conclusion of the Review Procedure.

10. Miscellaneous.

- 10.1 Notices. Notices shall be written and personally delivered or delivered by facsimile, effective on delivery, or sent by United States mail, postage prepaid, effective upon delivery, receipt by fax or on the third (3<sup>rd</sup>) day following the date deposited in the mail, addressed to parties' last known address, or to any other address specified in writing by such party.
- 10.2 Compliance with Terms. Failure to insist upon strict compliance with any of the terms herein (by way of waiver or breach) by either party hereto shall not be deemed to be a continuous waiver in the event of any future breach or waiver of any condition hereunder.
- 10.3 Benefits. This Review Procedure shall be binding upon, and shall insure to the benefit of, the parties hereto and their respective heirs, personal representatives, executors, administrators, successors, and assigns.
- 10.4 Governing Law. This Review Procedure shall be governed by the laws of the state in which the offices of Provider are located without giving effect to its conflicts of law provisions.