

Centivo Participating Provider Manual



The way healthcare should be.

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1. Introduction

Welcome to the Focus Plan, administered by Centivo. The Focus Plan network is built exclusively around Triad HealthCare Network (THN) which includes Cone Health facilities and physician practices as well as a large number of independent and community physicians.

We are very pleased that you have contracted with THN as a key component of our commitment to provide an excellent healthcare experience for our mutual clients, beginning with Cone Health employees and their families.

We have prepared this Provider Manual to provide you with helpful administrative and other information relating to your important role with the covered Participants. We hope to minimize your administrative interaction and maximize your time with your patients.

This Manual is meant to supplement your THN PPO Participation Agreement; nothing in this manual is intended to alter the terms and conditions of your THN PPO Network Participation Agreement. The Agreement, along with state or federal law formally guide our relationship. Please note that if a provision in this Manual conflicts with state or federal law or the terms of the THN PPO Participation Agreement, the state or federal law or the THN PPO Participation Agreement takes precedence.

In addition to the obligations specified in your Agreement, this Manual provides information about contractual obligations for Focus Plan Participating Providers. While the terms of this Manual may be updated at the sole discretion of Centivo, it is Centivo's goal to review substantive changes with THN Leadership in advance of their release. Centivo will also provide thirty (30) days prior written notice to Provider. If you are contracted through a medical group or an IPA participation agreement, the medical group or IPA will notify you of changes to the Centivo Participating Provider Manual.

Unless otherwise defined herein, all capitalized terms shall have the same meaning as ascribed to them in the THN PPO Participation Agreement.

2. Centivo Information & Contact Information

Centivo Support is available Monday-Friday 8:00am to 8:00pm Eastern Time or any time at <https://provider.centivo.com>.

FOR ANY QUESTIONS, CONTACT CENTIVO SUPPORT:

Phone: 833-576-6491 | Email: providers@centivo.com

IMPORTANT LINKS:

Provider portal: <https://provider.centivo.com>

Focus Plan provider directory: Log in to provider portal to search or download

PBM prescriber portal: Link in provider portal



For questions regarding benefits, eligibility, claims status, or claims support:

Phone: 833-576-6491

Email: providers@centivo.com

Provider portal:

<https://provider.centivo.com>

For claims submissions:

Centivo electronic payer ID: 45564

Submit all claims to the following address:

Centivo

P.O. Box 211681

Eagan, MN 55121

For questions regarding utilization management (referrals and pre-authorizations) handled through Centivo Support:

Phone: 833-576-6491

Email: providers@centivo.com

For pharmacy support:

Contact MedImpact

Provider phone line: 844-401-2055

Fax: 858-790-7100

If you require additional communication or to send form and documents, you may:

- Fax to Centivo Support: 716-219-1946
- Mail to: Centivo Provider Support, 307 Cayuga Road, Suite 170, Buffalo, NY 14225
- Email Centivo Support: providers@centivo.com

3. About Centivo and the Focus Plan

Centivo is an administrator of health plans for self-funded employers committed to promoting the importance of primary care and engaging covered Participants to make well-informed decisions. The Focus Plan, administered by Centivo, is a new type of health plan serving Cone Health employees and their families, beginning in January 2019.

The Centivo model emphasizes the partnership between individuals and their primary care team as the proper model to coordinate healthcare needs. Centivo's provider partners have been selected based on their dedication to improving quality, affordability, access to care, and helping individuals more effectively navigate the healthcare system. Participants are rewarded for choosing high-value care and adhering to a health action plan, and supported through a state-of-the-art digital app and dedicated concierge team.

Centivo does not underwrite insurance plans and is not at risk for the payment of claims. Centivo administers its clients' benefit plans in accordance with the employer's applicable Plan Documents. Copies of Plan Documents and less detailed Summaries of Benefits and Coverage are available on the Provider Web Portal.

4. Focus Plan – Plan Design

Participants have two different levels of coverage. Participants' out-of-pocket costs are determined by



their actions.

1. Coordinated – Participants who designate a primary care provider and receive referrals for specialty and ancillary care receive the highest level of benefits.
2. Uncoordinated – Participants who do not designate a primary care provider or who do not get referrals before seeing a specialist are covered at the reduced level and their care is subject to a deductible and co-insurance.
3. Out-of-Network – There is no out-of-network coverage, except for emergencies.

It is critical to note that Participants will not receive coverage for visits outside of the network. Please keep this in mind when recommending/referring other services. Ensure that you are referring patients to in-network providers by searching the provider directory via the Provider Portal or by calling Centivo Support at 833-576-6491.

5. Network Quality Assurance

The following is intended to provide clarification/additional information regarding your Participation Agreement's requirements for quality programs.

Nondiscrimination

You must not discriminate against any patient with respect to the delivery or accessibility of services. Your practice must maintain written policies and procedures related to non-discrimination. This includes discrimination based on:

- Type of health insurance
- Race
- Ethnicity
- National origin
- Religion
- Sex
- Age
- Disability
- Sexual orientation
- Claims experience
- Medical history
- Genetic information
- Type of payment

Quality and Patient Safety Activities

You are expected to support the quality improvement and patient safety activities and programs. Specifically:

- Providing timely access to medical records when requested.



- Providing timely responses to queries and/or completion of improvement action plans related to quality of care investigations.
- Support audits and data gathering, including site visits, medical record standards reviews, and Healthcare Effectiveness Data and Information Set (HEDIS®) record review.
- Allow use of practitioner and provider performance data.

Requirements for Primary Care Physicians

The following is intended to supplement and clarify the requirements for Primary Care Physicians under the Focus Plan program:

Focus Plan Primary Care Physicians have been selected for their superior performance and dedication to high quality, coordinated care. The role of a Focus Plan primary care provider is to deliver appropriate preventive and other primary care services within the scope of your practice. These services might include, but are not limited to:

- Accepting all attributed patients.
- Establishing and managing patient-specific care plans.
- Coordinating care among various health care practitioners and facilities.
- Delivering routine preventive care (e.g., wellness visits, immunizations, blood tests).
- Treating patients with routine sick care.

Call coverage/Off-hours access

Focus Plan PCPs are expected to provide coverage for Focus Plan Participants at any time. When a PCP is unavailable to provide services, the PCP must ensure they have coverage from either another participating primary care provider (preferred), or a provider that agrees to accept the same rates and ensure continuity of care. Hospital emergency rooms or urgent care centers are not substitutes for covering participating providers, unless Centivo approves a specific request for an exception by a provider.

All PCPs or their covering physicians must provide telephone access 24 hours a day, seven days a week so that you can appropriately respond to patients and other providers concerning after hours care. The use of recorded phone messages instructing patients to proceed to the emergency room or urgent care during off hours is not an acceptable level of care.

6. Provider Additions, Changes, Terminations, and Panel Closure

All provider adds, changes and termination requests must be submitted promptly in writing to THNPracticeRelations@conehealth.com.

Provider changes and updates include, but are not limited to the following:

- Change in practice location;



- Change in practice affiliation;
- Change of address, phone or fax number;
- Change in hours of operation;
- Retirement or leave of absence exceeding 30 days;
- Leaving network area

Any change to a provider's status should be communicated immediately to THN Practice Relations Department. All provider profiles are reviewed for credentialing requirements, including but not limited to the following:

- Provider specialty(ies) and credentials (e.g., MD, DO, MFT, etc.)
- Medical license number and expiration date;
- DEA number and expiration date;
- NPI number;
- Board Certification status;
- Professional liability insurance

A new provider may not submit claims for services until approval has been obtained from THN.

7. Utilization Management

Participating providers are required to observe the protocols of the Centivo Utilization Management Program, referred to as "UM". UM requirements may vary by Client or program, and may include, but is not limited to, prospective, concurrent, and retrospective review. UM programs may also include disease or condition management (referred to as "DM"), maternity management, and management of behavioral health conditions services.

Centivo may choose to employ Delegated Vendors for the administration of various UM programs. Contact Centivo Support to submit or track UM requests at 833-576-6491.

A list of the current services requiring pre-certification is included below **or can be found on the Provider Portal, <https://providers.centivo.com>, within the Resources tab.**

For Participants in the Focus Plan administered by Centivo in the State of North Carolina, Medwatch has been selected as a Delegated Vendor for UM services.

*Standard In/Out Patient Pre-Cert List ***

- Any services not available in the Cone/THN network being provided by a non-network provider
- Inpatient hospitalization
- Outpatient surgery in any setting
- Transplant candidacy evaluation and transplant (organ and/or tissue)
- Home Health Services
- Hyperbaric Oxygen Therapy (HBOT)



- Durable Medical Equipment, rental greater than two months, or purchase in excess of \$500 billed per date of service
- Residential Treatment Facility programs
- Skilled Nursing Facility stays
- Dialysis
- Use of implantable devices
- Infusion services
- MRI/PET/CT scans
- Bariatric Surgery (covered only at a Cone Health facility when rendered by an in network Physician)

**Our pre-cert is updated regularly as new procedures are introduced or abused.

8. Case Management

Plans administered by Centivo include case management services to patients with complex health conditions. The case manager will interact with patients and providers in ensuring that services are delivered effectively subject to the terms of the patient's self-funded Plan. This may include assistance in understanding the applicable health benefits and in navigating resources available to them. The complex case management program is a collaborative process among the Participant, the provider(s) and Centivo, as such, we will periodically report progress to a Participant's primary care physician. The goal of these programs is to achieve better health outcomes while managing health care costs.

Most case management will originate from UM programs and identification through medical and prescription drug claims. If you believe a patient is appropriate for Case Management, please contact the Centivo Support at 833-576-6491. Following your referral, the Case Manager will contact the patient, family members (if appropriate), and any related providers (if appropriate).

9. Eligibility/Participant ID Cards

The following are ways to identify whether a patient is a Focus Plan Participant:

Digital ID cards: Participants can access and view their digital ID cards after the effective date (listed on the card) using the Centivo app, or the Participant website at my.centivo.com. Patients can easily print replacement ID cards from these portals.

Participant ID cards: Participants should receive an ID card within 10 days of their effective date. At each visit, the office should ask to see the Participant's ID card and collect the appropriate copayment, if applicable. Note: Some covered Participants may only have digital ID cards. These Participants may present their mobile device or a printed copy when seeking health care services.



All Participants enrolled in the Focus Plan receive a Participant ID card. A sample ID card can be found below.



10. Patient Financial Responsibility and Collections

For specialist and other non-primary care practitioners, we anticipate that the vast majority of visits will be “Coordinated”, thus requiring a straightforward co-pay. However, it may not always be possible to confirm 100% whether a visit is “Uncoordinated” until the claim has been adjudicated. As such, we recommend that you either:

1. Collect the appropriate copay as outlined on the Participant ID card, assuming that the patient is covered at the “Coordinated” level for that visit, and bill for the remaining balance at a later time if applicable;
2. Wait to collect payment from the patient until the claim has been adjudicated.

We will be closely monitoring activity here and will quickly address any concerning trends through targeted patient education or other means. Contact Centivo Support to confirm benefits or address any questions: 833-576-6491.

11. Claims Submission



To be reimbursed for services rendered to a Focus Plan Participant, providers must submit a clean claim within the timely filing guidelines. Centivo request that providers file claims electronically for faster services. When submitting claims, please include all required information. Centivo requires that all claims be submitted on a UB-04 or CMS-1500 claim Form. Instructions for filing using either method are reflected below as well as on the reverse side of the Participant's ID card. When submitting electronic claims, use Centivo's clearinghouse payer ID*: 45564. If you are currently submitting paper claims via mail and would like to submit electronically, please call the Centivo Support and we will assist you.

When the Focus Plan is the primary payor, providers must submit claims for payment within ninety (90) days from the date of service or date of payment received by primary payer unless it is otherwise required by state or federal law or your THN PPO Network Participation Agreement.

The following information must be included on the claim:

- Current National Provider Identifier (NPI);
- Current Tax Identification Number (TIN);
- Participant's name, address, telephone number, gender, and date of birth;
- Focus Plan Participant ID number;
- Focus Plan Participant group number;
- Current CPT code for each procedure performed and any applicable modifiers;
- CMS coding for place of service and type of service;
- Revenue codes for Departmental revenue, when applicable;
- Diagnosis code number (ICD-10). Indicate appropriate symptoms or diagnoses for tests performed and submit up to four diagnosis codes.
- ICD-10 procedure and DRG codes for all UB-04 claims;
- Referral provider (indicate ordering provider on UB-04);
- Billing provider's name and remit address;
- Date of service;
- Current Coordination of Benefits (COB) information or other insurance information such as motor vehicle, worker's compensation or other third-party liability insurance information.

12. Provider Request for Reconsideration

In the event you disagree with the outcome of a particular claim, a utilization management determination, an erroneous payment adjustment, or other action by Centivo, you may request a reconsideration review. To request a reconsideration, please contact the Centivo Support at 833-576-6491. Note that all claims decisions are governed by the applicable plan document.

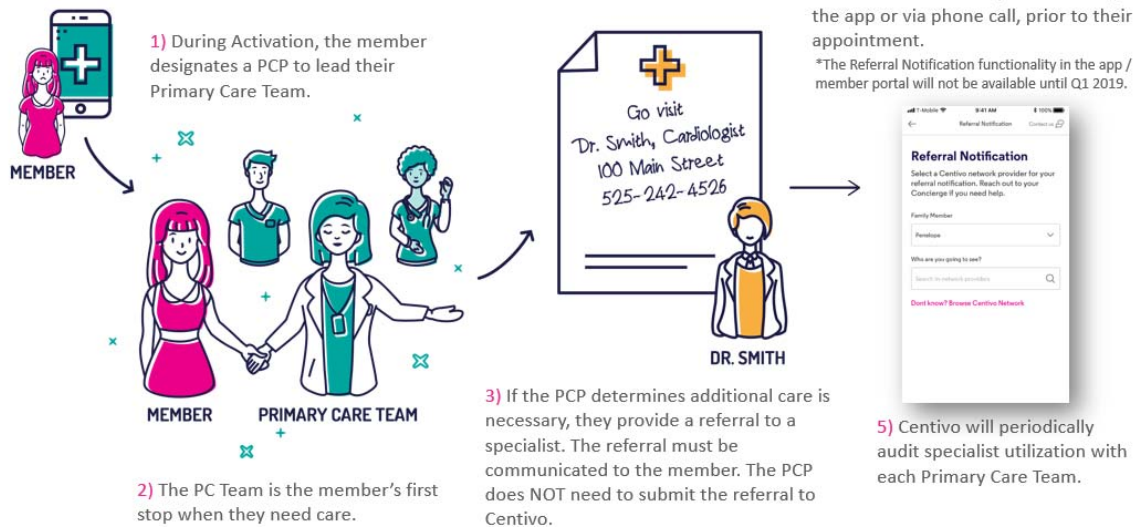
13. Referrals for Specialty and Ancillary Care

Focus Plan Participants must coordinate all their care needs with their Primary Care Provider to obtain



the best coverage and keep their out-of-pocket costs low. As such, Participants are required to get a referral from their Primary Care Team before going to any specialists (except obstetrics/gynecology and behavioral health) or facilities. The responsibility for notifying Centivo that a referral has been made rests with the Participant, not with the Primary Care Physician.

REFERRAL PROCESS



Role of the Primary Care Provider:

- Ensure that you are referring patients to an in-network provider. Please note that patients do not receive benefits for out-of-network care (other than for emergencies). Please ensure that you are referring patients to in-network providers by searching the provider directory via the Provider Portal or by calling Centivo Support.
- Communicate that provider's information to the patient, including provider or practice name and specialty.
- Keep a record of any referrals.

Role of the Participant:

- Obtain referral from primary care team.
- Notify Centivo (via phone, app, or web) of any referral at least 24 hours prior to receiving care.
- In case of emergencies, Participant must contact the PCP within 72 hours (ER / Urgent Care).

Other Referral Guidelines:

- Each referral will be valid for 120 days for that specialist provider.
- There is no referral requirement for obstetrics/gynecology and behavioral health providers.
- In the event of emergency or urgent care, Participants have 72 hours after they receive care to contact their Primary Care Team and submit the referral notification.



14. Pharmacy Management

Centivo will follow the pharmacy benefits set forth in the applicable Health Benefit Plan and plan document. Such benefit plans/plan documents may utilize a prescription drug formulary to help maintain access to quality, affordable prescription drug benefits for your patients. For more information on a Participant's pharmacy benefits, please follow the instruction on the Participant's ID card.



EXHIBITS

EXHIBIT A – Important Definitions

The following terms shall have the meanings as ascribed to them or referenced below (such terms shall be equally applicable to both the singular and plural forms of the terms defined):

1. "Client(s)" means any employer group, Plan Administrator, health plan, or insurance company that has an agreement with Centivo.
2. "Claim" means a request for payment for Covered Services rendered to a Participant submitted in accordance with the terms of your Agreement and applicable Health Benefit Plan.
3. "Clean Claim" means a completed UBo4 or HCFA/CMS 1500 (or successor form), as appropriate, or other standard billing format containing all information reasonably required by the Client for adjudication, including but not limited to the submitting provider's National Provider Identifier (NPI) number.
4. "Coordination of Benefits" means a method of sequentially assigning responsibility for the payment for health care services rendered to a Participant among two or more insurers.
5. "Covered Services" means those medical and hospital services, for which benefits are available to Participants in accordance with the terms of the applicable Health Benefit Plan.
6. "Delegated Vendor" means any person or organization appointed by Centivo to administer managed care, utilization management, claims processing or other programs for its Health Benefit Plan.
7. "Health Benefit Plan" means the Health Benefit Plan of a Centivo Client which describes the costs, procedures, benefits, conditions, limitations, exclusions and other obligations to which Participants are subject thereunder.
8. "Medical(ly) Necessity(ary)" means those services determined to be (a) preventative, diagnostic, and/or therapeutic in nature, (b) specifically related to the condition which is being treated/evaluated, (c) rendered in the least costly medically appropriate setting (e.g., inpatient, outpatient, office), based on the severity of illness and intensity of service required, and (d) not primarily for the Participant's convenience or that of his or her physician.
9. "Network" means those Participating Providers, preferred provider organizations, specialty networks or other organizations that arrange for the delivery of health care services that contract with Centivo and/or THN to arrange for the provision of health care services to Participants.
10. "Non-Covered Services" means those medical and hospital services, supplies, products and accommodations provided to Participants that are not designated as benefits to Participants under the terms of the applicable Health Benefit Plan.
11. "Participant" means any person who is eligible to receive benefits under a particular Health Benefit Plan as set forth in the applicable plan document
12. "Participant Responsibility" means deductibles, coinsurances, co-payments or other amounts for which Participants are responsible to Participating Providers under the terms and conditions of the applicable Health Benefit Plan.



13. "Participating Provider" means a health care provider that is considered in-network under the terms of the applicable Health Benefit Plan.

