Northwood Participating Provider Manual

For

Well Sense Health Plan

New Hampshire Medicaid Care Management Program

February 1, 2018

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FOR PROVIDER INQUIRIES:
Monday-Friday
8:00 a.m. – 5:00 p.m. (EST)

CLAIMS/INQUIRIES:
Northwood, Inc.
ATTN: Well Sense NH Medicaid Care Management Program Claims
P.O. Box 510
Warren, MI 48090-0510

Provider Inquiry Line:	**866-802-6471**
Provider Inquiry Fax:	**877-552-6551**
Member (Well Sense) Inquiry Line:	**866-769-6884**
Business Line:	**586-755-3830**
Business Fax:	**586-755-3733**
Website:	**www.northwoodinc.com**

INTRODUCTION

Northwood, Inc. (Northwood) is the exclusive contracted administrator of Durable Medical Equipment (DME), Prosthetic and Orthotic (P&O) devices and Medical Supplies (DMEPOS) for Well Sense[1] New Hampshire Medicaid Care Management Program.

The information contained in this Provider Manual will assist you when providing DMEPOS services to Well Sense NH Medicaid Care Management Program members.

Northwood's Participating Supplier Agreement and Well Sense New Hampshire Medicaid Addendum to the Participating Supplier Agreement require network providers to adhere to Northwood's Policies and Procedures. Policies and Procedures include, but are not limited to:

- Northwood's New Hampshire Medicaid Care Management Program Fee Schedule
- Assignment for All Services Provided By Your Company
- Authorization
- Member Billing
- Claims Processing
- Quality of Service/Member Satisfaction
- Provider Allows Northwood/Well Sense to Use Provider's Performance Data
- 24-Hour Emergency Service

[1] Well Sense is trade name for the Boston Medical Center Health Plans, Inc. New Hampshire Medicaid Care Management product.

SECTION I - BENEFIT/COVERAGE CRITERIA

Northwood administers Well Sense's DMEPOS Program for New Hampshire Medicaid Care Management Program members in accordance with Well Sense's benefits and the medical policy guidelines detailed below:

- Covered DMEPOS benefits for Well Sense NH Medicaid Care Management Program members must be obtained from and provided by a Northwood contracted provider.

- Providers may not subcontract services to other providers without the consent of Northwood.

- Equipment and supplies provided under the program are based upon the most medically appropriate and cost-effective, standard item(s). For example, this includes prefabricated items versus those that are custom made.

- Shipping, handling, and sales tax are not eligible for separate reimbursement, nor can they be billed to the member.

- All services must be prior-authorized (except in emergencies as further set forth described herein).

- Providers should contact Northwood for medical criteria questions.

PROVIDER RESPONSIBILITIES PRIOR TO RENDERING EQUIPMENT OR SUPPLIES

Prior to providing equipment or supplies, the provider is responsible for obtaining and verifying all necessary information, including the following:

- Verify member eligibility for each date of service.

- Review for appropriateness and cost effectiveness.

- Documentation to support the medical need for customized services.

- Confirming that equipment is to be provided in the member's home or qualifying place of residence. With a few exceptions, this program does not generally cover equipment provided in a hospital or skilled nursing facility.

- Other Coordination of Benefits (COB) information (auto liability, workers compensation, etc.)

DELIVERY TIMELINES

Northwood requires providers to:

- Provide covered equipment (excluding custom fitting or design services) on the same day services are requested, unless the request is received after 12:00 PM EST.

- Provide orders received after 12:00 PM within 24 hours.

- Have on-call servicing available 7 days a week and 24 hours a day for respiratory and other necessary services.

- Deliver covered emergency services to member's place of residence (or hospital pending discharge) within 2 hours of receipt.

- Provide emergency services requested outside of Northwood's regular operating hours and obtain authorization within the next two (2) business days. (See Section II Authorization).

ASSIGNMENT – NONDISCRIMINATION

Northwood providers are required to:

- Provide covered equipment and supplies to Well Sense NH Medicaid Care Management Program members in the same manner, quality and promptness as services that are provided to other customers, including after-hours and emergency servicing.

- Accept assignment on covered equipment or supplies routinely provided by the provider to Well Sense NH Medicaid Care Management Program members.

- Render equipment and supplies in a manner consistent with professionally recognized standards of health care.

EQUIPMENT AND SUPPLIES NOT NORMALLY CONSIDERED A COVERED BENEFIT, INCLUDING DELUXE PRODUCTS/UPGRADES

- Member health care benefits are determined by the structure of their benefit package.

- A requested service normally considered "not a covered benefit" must be forwarded to Northwood for case review.

- All requests for services and medical review must be processed through Northwood. Do not forward requests directly to Well Sense or deny service to the member prior to case review.

- It is the responsibility of the provider to inform the member that there are standard products available that meet Well Sense's policy.

- If applicable based on the member's benefits/cost-sharing, a member must be advised of his/her estimated payment responsibility and the provider must obtain the member's signed consent indicating he or she has been informed of his or her responsibility for any outstanding balance.

    ° This must take place prior to ordering a product or before a product is delivered (refer to Northwood Waiver Form – Section XII).

There will be no payment to the provider by Northwood when the provider fails to follow the Case Review process detailed above. Additionally, members may not be charged for services when providers fail to follow the above process. Please see the "Hold Harmless" Section (5.5) of the Participating Supplier Agreement and Section (3) of the New Hampshire Addendum to the Participating Supplier Agreement for Well Sense.

OXYGEN EQUIPMENT

The following oxygen requirements apply for all Well Sense NH Medicaid Care Management Program members:

- The minimum manufacturer oxygen output concentration level at any flow rate must be 87%.

- The concentrator must have a built-in continuous flow analyzer feature with automatic sensor alarm.

- The concentrator must have, at a minimum, a five-year manufacturer warranty.

- Northwood expects a typical oxygen patient to use no more than five (5) portable fills per month. If a member requires more than five (5) fills in a given month, the provider should contact Northwood's Benefit Coordinator staff via Northwood's online authorization portal and request an individual consideration review for E0443.

CPAP/BIPAP SUPPLIES

The following Positive Airway Pressure (PAP) requirements apply for all Well Sense NH Medicaid Care Management Program members:

- The PAP device must include, as standard equipment, integrated heat and humidification. To further clarify, as a standard feature included under HCPCS E0601, the CPAP should incorporate in-built or all-in-one heat and humidification. Examples of such CPAPs are available upon request.

- The PAP device must have, at a minimum, a 2-year manufacturer warranty.

- Northwood recognizes there are numerous PAP masks and nasal applications available on the market. As of the date this manual has been published, the following are examples of standard/basic PAP masks and nasal applications:

    - Respironics Comfort Gel Mask, Respironics Comfort Classic Mask, Respironics Simplicity Nasal Mask, Respironics Comfort Full Mask, Resmed Mirage Activa Mask, Resmed Mirage Vista Mask, Resmed Mirage Swift LT Nasal Mask, Respironics Comfort Select Nasal Mask, Resmed Mirage Swift Nasal Mask, Invacare Twilight Nasal Mask and other similar models.

Providers have 2 business days following delivery/set-up of PAP equipment to request a supply change to an initial set-up authorization. Such requests should include the specific code relative to the type of mask/nasal application supplied, if it was unknown prior to set-up.

SECTION II – AUTHORIZATION

Northwood must review all equipment and supply requests to determine coverage. Northwood makes all approval determinations. Any reviews that do not meet Northwood's clinical review criteria are referred to Well Sense. Well Sense makes all medical necessity denial determinations. Coverage is based upon the member's benefit document.

Prior authorization is required for all Well Sense NH Medicaid Care Management Program member services with the exception of equipment or supplies requested and provided after regularly scheduled Northwood business hours due to urgent/emergent situations (see After-Hours Retrospective Authorizations).

- Urgent/emergent situations are defined as situations where a member's physical condition is such that imminent or serious consequences could result to the member's health or, if in the opinion of the physician, the member would be subjected to severe pain if a DMEPOS request is processed within the routine decision-making time frame.

AUTHORIZATIONS - GENERAL

There are several ways you may request an authorization.

- **Online (required method for all routine requests) –** Providers are required to submit requests online at https://providerportal.northwoodinc.com and will receive a confirmation that a request has been submitted and received. For further information, please follow instructions outlined on webpage.

- **Phone (urgent emergent only)** - Call Northwood on the dedicated Well Sense Plan provider line at 866-802-6471 during normal business hours (8:00 a.m. to 5:00 p.m. EST, Monday through Friday), or within the next two (2) regularly scheduled business days if emergent/urgent services are provided.

- **Fax** (upon request from Northwood staff only)- Submit a completed Prior Authorization Fax Form to Northwood at 877-552-6551. If sent after-hours or on weekends, Northwood will respond on the next regularly scheduled business day.

The following information is required when requesting an authorization:

- Provider ID Number.
  - Member Name/Address/Telephone.
  - Provider Contact/Telephone.
  - Referral Source/Telephone.

- Well Sense ID Number.
- Other Insurance Information (if any).
- Diagnosis - ICD-10-CM Code and Description.
- Date of Service.
- Referring Physician.
- Primary Care Physician.
- Level II HCPCS Code.
- Description of Product/Service.
- Service Type (Purchase or Rental).
- Quantity.
- Duration of Need.

Authorizations for services will be provided:

- For equipment and supplies deemed to be covered benefits under the Well Sense New Hampshire Medicaid Care Management program.

- When use of the equipment or supply does not exceed the quantity limitation and medical necessity guidelines (monthly, yearly, replacement period, etc.).

- For medically supported over-quantity requests approved through case review.

- For the most appropriate, cost-effective, standard and basic equipment or supply.

Reimbursement will be limited to the authorized equipment or supply based upon the allowable fee for the procedure code(s) approved.

Payment consideration for equipment and supplies includes;

- Member eligibility at the date of delivery.

- Medical necessity clinical criteria are met and documented on the physician's written order.

- Most cost-effective standard and basic equipment or supply.

- Benefit coverage.

AUTHORIZATION TIMEFRAMES

Rental DME equipment is authorized based upon medical necessity and the appropriate duration of need for the diagnosis provided at the time of rental.

- Authorizations may be extended for up to 13 months, at which time the equipment rental may cap.

- A limited number of items cap in less than 13 months.
- Requests for quantities of supplies that exceed standard amounts are based on a review of medical documentation.
- Renewal authorizations for over-quantity amounts will require updated documentation.
- It is the provider's responsibility to verify member eligibility and cost-sharing (co-payments, coinsurance and/or deductibles) information for the effective period of an authorization or for continuing services, on a monthly basis. You can do so by visiting Northwood's online authorization portal at**https://providerportal.northwoodinc.com.**
- Neither Northwood nor Well Sense is responsible for payment of services provided to Members whose coverage has changed or terminated.
- A Northwood authorization is not a guarantee of payment for service(s) provided.

IF THE PROVIDER FAILS TO OBTAIN A REQUIRED AUTHORIZATION, THE MEMBER MAY NOT BE BILLED. SEE "HOLD HARMLESS" SECTION (5.5) OF THE PARTICIPATING SUPPLIER AGREEMENT AND SECTION (3) OF THE NEW HAMPSHIRE ADDENDUM TO THE PARTICIPATING SUPPLIER AGREEMENT FOR WELL SENSE.

CHANGE TO INITIAL AUTHORIZATION

Claims will be denied if the services provided do not match the authorization.

- If a change to an equipment item or supply originally authorized becomes necessary, contact a Northwood Benefit Coordinator via the Northwood online authorization portal/update feature to request review for a revised authorization. The following information must be included when requesting a review:
    - Current authorization number.
    - Patient name.
    - Well Sense ID Number
    - Documented reason for change of equipment or supply.
- Providers are responsible for maintaining the original authorization. Northwood will not provide duplicate copies of authorization for billing purposes or after payment has been made.

AFTER HOURS - RETROSPECTIVE AUTHORIZATIONS

Authorizations are provided during regular business hours - 8:00 a.m. to 5:00 p.m. Monday thru Friday.

If an urgent request for services occurs after-hours or on weekends/holidays the provider should request an authorization within Ten (10) business days for point-of-service providers (stock/bill, loan closets) identified by Northwood.

Urgent/Emergent and non-routine retrospective authorization requests must be submitted on line to Northwood along with supporting documentation for case review.

Retrospective authorizations will only be provided for after-hours service due to urgent/emergent situations or non-routine circumstances. Urgent/emergent situations are defined as situations where a member's physical condition is such that imminent or serious consequences could result to the member's health or, if in the opinion of the physician, the member would be subjected to severe pain if a DMEPOS request is processed within the routine decision-making time frame. The provider shall proceed as listed below:

- Under these conditions, the member should be serviced.

- The provider may obtain authorization within the next two (2) business days.

- Members should be informed of their potential financial responsibility for cost-sharing (co-payments, coinsurance and/or deductibles). The provider must maintain a signed agreement/member acknowledgement of the financial responsibility to include the cost-share amount. See attachment "Patient Advance Notice/Waiver o**f Liability** of Noncovered Services or Higher Grade/Deluxe Equipment or Supplies".

Northwood may issue retrospective authorizations for urgent/emergent and non-routine circumstances. However, for routine requests retrospective authorizations will be denied for provider's failure to obtain authorization prior to delivery or completion of services.

SECTION III - MEMBER SERVICES

Covered DMEPOS benefits for Well Sense New Hampshire Medicaid Care Management program members must be obtained through Northwood's contracted providers and prior authorized by Northwood.

Members, referral sources, and providers may contact Northwood during regular business hours for questions and inquiries regarding:

- Provider locations.
- General benefits and/or coverage criteria.
- Financial responsibility.
- Appeal and grievance procedures.

Members may contact Northwood's dedicated Well Sense New Hampshire Medicaid Care Management program toll-free line at 1-866-769-6884. Members (non-English speaking) requiring language services may contact a Northwood Benefit Coordinator who will coordinate translation services.

Providers should utilize Northwood's online authorization portal.

MEMBER BILLING

- Northwood providers are bound by contract to accept assignment for all covered equipment and supplies rendered to Well Sense members.
- Members are only financially responsible, and may be billed, for applicable cost-sharing (co-payments, coinsurance and/or deductibles); retroactive eligibility terminations by Well Sense due to regulator/regulatory requirements or contractual standards; and for non-covered services in accordance with Northwood's Participating Supplier Agreement ("PSA") and New Hampshire Addendum to the PSA for Well Sense.

MEMBER HOLD-HARMLESS PROVISION

According to Northwood's Participating Supplier Agreement ("PSA") and the Addendum to the PSA for Well Sense New Hampshire Medicaid Care Management program, providers agree to abide by Northwood Policies and Procedures and to look solely to Northwood for payment of authorized covered equipment and supplies rendered under the Well Sense Program.

Members are financially responsible only for applicable cost-sharing (co-payments, coinsurance and/or deductibles) for equipment and supplies that have been approved by Well Sense and Northwood. Providers are prohibited from billing the member for any of the following:

- The difference between the provider's submitted charge and Northwood's fee.

- Reduced fee differential amounts on down-coded or adjusted items based upon medical necessity or the least costly alternative.
- When medical documentation provided conflicts with the information supplied during the authorization request.
- Provider's failure to obtain required authorization for covered equipment and supplies.
- Claims submitted past Northwood's filing limitations.
- Provider's failure to follow Northwood policies and procedures.

SECTION IV - PRESCRIPTION REQUIREMENTS

It is the provider's responsibility to obtain a valid prescription for requested equipment and supplies. Verbal orders are acceptable for initial set-up of equipment and supplies; however, a prescription must be obtained and provided to Northwood upon request. Providers must have a faxed, photocopied, original signed order or electronic prescription in their records before they can submit a claim for payment to Northwood. Providers must maintain valid prescriptions on file for equipment and supplies.

A valid prescription, paper or electronic, must include:

- Patient Name.
- Prescription Date (the original date of service must be within 30 days of the RX date).
- Item Description.
- Duration of Need.
- Diagnosis.
- Quantity.
- Physician Signature (stamped signatures are not valid).
- Physician Printed Name.
- Physician NPI.

PRESCRIPTION DURATIONS

- Most prescriptions are valid for 12 months but may vary according to medical necessity.

SECTION V - CLAIMS

FILING PROCESS

Northwood claims must be:

- Submitted electronically, primary or secondary, or on a CMS 1500 Claim Form.
- DMEPOS provider must have their National Provider Identifier (NPI) on all claims.
- ELECTRONIC claims must be completed according to HIPAA 837 transaction requirements detailed on Northwood's website **www.northwoodinc.com**.
- PAPER claims must be completed in entirety and include:
    - NORTHWOOD'S AUTHORIZATION NUMBER
    -
    - Remittance advice for secondary claims. Do not staple to claims.
    - Manufacturer's name, description, and product number documented in Box 19 of the CMS claim form for not otherwise classified (NOC) items.

As paper claims are scanned, please do not staple, fold or write on claims. Claims do not need to be sent with prescriptions or authorizations. When sending secondary paper claims, only the primary EOB/remittance advice is needed – but, please do not staple.

Claims submitted without the required information will be rejected and must be resubmitted within the filing limitation timeframe (see below).

CLAIMS FILING LIMITATIONS

- Claims for Well Sense New Hampshire Medicaid Care Management program members must be submitted to Northwood within 90 days from the date of service, unless you are awaiting a payment and or remittance advice from a primary payor via coordination of benefits.
- Other Party Liability claims must be submitted with an attached provider remittance advice within 90 calendar days of receipt of the remittance advice from the other insurance.
- Approved gradient compression surgical stockings for Medicare Primary/ Well Sense secondary members do not require submission to Medicare for denial; however, providers must obtain prior authorization and bill Northwood within the 90-day filing limitation.

- Filing limitations apply to all claims, including claims previously submitted and returned for missing or incomplete documentation.

- A claims status (claim denials or corrected claims) must be submitted within 90 days from date of service or primary payer's provider remittance advice; not to exceed 180 days.

- Submit paper claims to the following address:

NORTHWOOD, INC.
ATTN: WELL SENSE NH MEDICAID CARE MANAGEMENT PROGRAM CLAIMS
P.O. BOX 510
WARREN, MICHIGAN 48090-0510

CLAIMS PAYMENT CYCLE

- Northwood will process claims and remit payment for clean claims within 30 days of receipt.

- A clean claim consists of the following information:

    - Northwood Authorization Number.
    - Provider Name/Address/NPI Number.
    - Member Name/Address/Telephone.
    - Well Sense NH ID Number.
    - Date of Birth.
    - Other Insurance Information (if any).
    - Diagnosis (ICD-10-CM Code and Description).
    - Date of Service.
    - Referring Physician Name.
    - Referring Physician NPI and TIN.
    - Level II HCPCS Code.
    - Manufacturer name, description and product number for NOC items.
    - Service Type (Purchase or Rental).
    - Quantity
    - Duration of Need.
    - Modifier.
    - Provider Charge.
    - Other Payment.

- Claims payment shall be limited to Northwood's allowable fee less any member cost-sharing (co-payments, coinsurance and/or deductibles) or primary payment amount.

- Northwood maintains the right to request proof of delivery or hard copy prescription upon request. Payment will be suspended pending requested documentation.

- Payment is contingent upon provider's compliance with all applicable documentation requirements.

OTHER PARTY LIABILITY CLAIMS

- Claims must first be submitted to the primary carrier and a hard copy of the provider remittance advice must be submitted with your hard copy claim to Northwood. If a secondary claim is submitted electronically to Northwood, primary payment information must be included pursuant to Northwood electronic claims submission procedures (available at www.northwoodinc.com).

- If providers receive information that indicates that the member is pursuing settlement from a liable party for accident and trauma claims the provider must notify Northwood immediately.

- Northwood's payment for a service or supply as the secondary payer will be based on the difference between what the primary payer paid and what Northwood would have paid as the primary payer up to Northwood's allowed amount. If the primary payer's payment is less than Northwood's allowed amount, Northwood will pay the difference not to exceed its allowed amount.

- Northwood does not reimburse for the difference between the billed and primary insurance allowable.

PROVIDER REMITTANCE ADDRESS

- Northwood maintains a primary address on file for all providers that will be used when processing claims for payment.

- All payments by check will be payable to the primary address supplied to Northwood during the credentialing period for network participation.

- It is important that each provider have one and only one primary remittance address.

- Providers need to notify Northwood in writing on company letterhead of any address changes to primary billing address.

- Providers must supply Northwood with an updated W-9 form for address changes.

- Providers are responsible for maintaining the original Northwood payment vouchers and providing copies to branch locations. Northwood is not responsible for re-issuing duplicate vouchers.

COORDINATION OF BENEFITS (C.O.B.)

- Providers are required to obtain all insurance information from the member, including Worker's Compensation insurance.

- For New Hampshire Medicaid Care Management Program, Well Sense is the payer of last resort when any other type of insurance exists. For Commercial Plans, as applicable, Northwood follows Coordination of Benefits guidelines from the National Association of Insurance Commissioners (NAIC) and applicable law.

- A claim may be rejected if a provider does not complete the section of the claim form regarding other insurance coverage.

HIPAA EDI CLAIMS INQUIRY

Electronic claim submitters may submit a HIPAA 276 transaction, Health Care Claim Status Request, for claims inquiry.

- Requests will be accepted in batch and can be uploaded using the same secure connection as with electronic claims.

- Northwood will respond with a HIPAA 277 transaction, Health Care Claim Status Response, which can be retrieved using the same secure connection that is used for electronic claim acknowledgements.

- Submitters will be notified by email when a new transaction batch is ready for download.

HIPAA EDI CLAIMS PAYMENT/ADVICE

Electronic claim submitters will receive HIPAA 835 transactions, Health Care Claim Payment/Advice, using the same secure connection that is used for electronic claim acknowledgements.

- Electronic payment /advice transactions will only apply to electronic claims.

- A payment/advice batch of transactions will be available on the day that Northwood prepares cash disbursements.

- Submitters will be notified by email when a new transaction batch is ready for download.

Please see the Northwood web site www.northwoodinc.com for the latest details related to HIPAA EDI transactions.

CLAIMS INQUIRY

A provider may make a claim inquiry under the following circumstances:

1. PAYMENT OTHER THAN ANTICIPATED

- If payment received is other than anticipated and not in accordance with the Northwood fee schedule, please submit a completed Claims Status Form in Section XII within 90 days from the date of service or primary payer's provider remittance advice; not to exceed 180 days and include the following;
  - Copy of the original claim.
  - Supporting documentation.
  - Northwood's remittance voucher.

2. NO RESPONSE TO CLAIMS SUBMISSION

- If you have not received a response to your original claim submission in accordance with Northwood's claim payment turnaround time, please verify that the claim was submitted to the correct address and resubmit.

- If a claim was correctly submitted and has not been responded to within 45 days (mailing, provider posting time, etc.) please copy the claim form and required documentation, write SECOND REQUEST at the top of the CMS claim form and resubmit.

Post payments and resolve rejections prior to resubmitting claims to Northwood.

CLAIM PAYMENT RECOVERY

From time to time, Northwood may be required to seek payment recovery from the provider for reasons such as; retroactive terminations, coordination of benefits (COB), eligibility changes, etc. Northwood provides a written notification with a payment recovery explanation, amount, check run, check date and amount paid.

Providers have up to 30 days to challenge the payment recovery from the date of notification. If no response, Northwood will deduct/retract the amount from future payments. Northwood may seek a provider refund in the event a deduction/retraction may not be timely or possible.

ELECTRONIC FUNDS TRANSFER

Electronic funds transfer (EFT) is available; please visit the Northwood, Inc. website www.northwoodinc.com to sign up.

SECTION VI - QUALITY

IT IS THE RESPONSIBILITY OF CONTRACTED PROVIDERS TO ENSURE THAT THEIR EMPLOYEES UNDERSTAND NORTHWOOD POLICIES AND PROCEDURES, INCLUDING SERVICING AND QUALITY ISSUES AS THEY MAY PERTAIN TO THE WELL SENSE PROGRAM.

Quality issues include but are not limited to:

- Substandard care.
- Deviations from standards and guidelines from generally accepted industry practices as they pertain to the provision of equipment and supplies in accordance with health plan provisions.
- Member discrimination related to plan coverage.
- Inappropriate behavior of staff, as perceived by the member, provider, Northwood or Well Sense.

PROVIDER COMPLAINT, APPEAL AND QUALITY IMPROVEMENT PROCESS

Northwood strives to provide quality service in a professional and timely manner. In the event a provider believes that Northwood has not satisfactorily resolved a problem or concern, providers may utilize Northwood's Complaint and Grievance Process.

- Providers may contact Northwood in writing regarding quality issues/concerns such as those outlined in the Quality Section of this Provider Manual.
- Northwood encourages providers to participate in the continuous quality improvement process by submitting quality concerns in writing.
- Periodically, Northwood will perform Provider Satisfaction Surveys to determine provider satisfaction with Northwood administrative services and to identify opportunities for improvement.
- A Provider may submit a provider appeal to Northwood, in writing, to request reconsideration of a previous decision. A provider appeal must be filed with Northwood within 90 calendar days from the date of denial. Written appeals should be submitted in letter format including any additional information or details deemed necessary. Appeals should be directed to:

Northwood, Inc.
P.O. Box 510
Warren, Michigan 48090-0510
Attn: Provider Appeals

- Provider appeals filed beyond the above-described timeframes will be denied and both Northwood and Well Sense will be held harmless. For more information on submitting a provider appeal, please contact Northwood at 1-866-802-6471. Appeal decisions are usually rendered within 30 calendar days of receipt of an appeal.

- If an initial provider appeal (Level I) as outlined above results in a denial, a provider may file a second (Level II) provider appeal. Providers shall follow the procedure described above and clearly indicate that their submission is a second (Level II) provider appeal. Second (Level II) provider appeal decisions are considered final.

Note: See Section VII for information regarding member appeals. Appeals filed by a member or by a member's Authorized Representative should be directed to Well Sense.

Northwood monitors the quality and performance of its network providers through its Member Satisfaction Surveys and complaint processes.

- Northwood routinely performs Member Satisfaction Surveys**.**

MEMBER COMPLAINTS

- Member complaints may be received through the survey process, provider, referral source, health plan, member or patient advocate.

- Members should be directed to contact Northwood at 1-866-769-6884 or Well Sense Health Plan Member Service department at 1-877--957-1300 (1-866-765-0055 TTY/TDD) or New Hampshire Medicaid to register a complaint or concern.

- Members are encouraged to discuss their concerns with their Northwood provider who often can correct the situation to the member's satisfaction.

- Providers are required to notify Northwood of all member complaints to ensure activation of the Member Complaint and Grievance Process.

- See Section VII, below, for Well Sense's Member Grievance and Appeal Rights information

SECTION VII – Well Sense GRIEVANCE and APPEAL RIGHTS

APPEALS, INQUIRIES AND GRIEVANCES

MEMBER GRIEVANCES AND APPEALS

Overview
The Plan has an efficient process in place to resolve member grievances, and address member appeals in a timely manner. If a member is inquiring about a medical necessity or service coverage issue, the Plan offers assistance and informs the member of the appeals process. Providers may assist in resolving a member issue by furnishing documentation and other information the Plan requests, and may be appointed as an authorized representative by the member to act on their behalf regarding an internal appeal or DHHS State Fair Hearing appeal. The member must give written permission for a provider to act as their representative for Standard Internal Appeals and DHHS State Fair Hearing appeals.

A member or authorized representative may submit three types of appeals for Actions related to medical/surgical and/or pharmacy services:

- Standard internal appeal
- Expedited internal appeal
- DHHS State Fair Hearing appeal (External)

An appeal of an Action is a standard internal appeal or an expedited internal appeal filed with the Plan by a member or member's authorized representative. An external review appeal is directed to the DHHS. Member appeals must be submitted to the Plan within 60 calendar days of the notice of Action to the member. The Plan may reject as untimely, any Plan appeals received later than 60 calendar days after the notice of an Action.

How a member submits a grievance or appeal
When a member has a concern about the care, service or access to service provided by the Plan or a participating provider, the member or authorized representative may inquire about that care or may file a grievance or appeal in any of the following ways:

- File an oral appeal (which must be followed by a written and signed appeal request unless the appeal is expedited) or grievance by calling the Plan's Member Services department at 1-877-957-1300 for English and other languages, or 1-888-566-0012 for Spanish or 711 for TTY/TDD services. The Plan offers free language services to the member or member's authorized representative.
- Make oral inquiries by calling the Member Services department as well.
- If a minor is able, under law, to consent to a medical procedure, that minor can request an appeal of the denial of such treatment without parental/guardian consent.

- Send written appeals and/or grievances to:

  Well Sense Health Plan
  Member Appeals and Grievances
  529 Main Street, Suite 500
  Charlestown, MA 02129
  Fax 617-897-0805

- Submit a grievance or appeal to a Plan representative in person at a Plan office location noted below during regular business hours, Monday through Wednesday between the hours of 8:00 a.m. and 8:00 p.m. or Thursday through Friday between the hours of 8:00 a.m. and 6:00 p.m. (except holidays).

  Well Sense Health Plan
  529 Main Street, Suite 500
  Charlestown, MA 02129

  Well Sense Health Plan
  1155 Elm Street
  Manchester, NH 03104

- Submit an external appeal request to the DHHS after exhausting the Plan's internal appeal process and only if an internal appeal decision has been rendered by a Plan Physician Reviewer. An overview of the DHHS appeals process is outlined in DHHS State Fair Hearing Appeal.

The Plan provides written acknowledgement for any grievance or internal appeal it receives to members and/or authorized representatives, if applicable, within one business day of receipt by the Plan.

The resolution of grievances are completed and written notice is sent to affected parties no more than 30 calendar days from the date the Plan received the Grievance, unless the grievance is extended upon mutual agreement between the member or authorized representative and the Plan. In some cases, grievances may be extended for up to 15 calendar days. See Standard, Expedited and DHHS State Fair Hearing Appeals section for notice of resolution for appeals.

The Plan provides instructive materials and forms to assist members submitting an appeal. Upon a member's request, the Plan will provide reasonable assistance in completing the forms and following procedures applicable to the internal appeals process. This includes, but is not limited to, providing free interpreter services and toll-free numbers with TTY/TDD and interpreter capability. Members are entitled to free access to and copies of any of their medical information related to their appeal that is in the Plan's possession and under the Plan's control.

Monitoring member appeals

The Plan maintains reports of all member appeals (including external appeals submitted to the DHHS), which include the following information:

- Type and nature of the appeal
- How each appeal was addressed
- Outcome of the appeal
- What, if any, corrective action was taken related to the appeal
- The provider involved in the appeal
- If the service was denied or approved after review of the appeal

On an annual basis, the Plan reviews the data and the appeals policies and makes any necessary modifications or improvements.

Standard Internal Appeal

The Plan offers one level of internal review for standard appeals, which are performed by healthcare professionals with appropriate clinical expertise in treating the medical condition, performing the procedure, or providing the treatment that is the subject of the Action. Additionally, the individual has not been involved in any prior review or determination of the particular internal appeal or is the subordinate of someone who was involved. During the appeal review process, the Plan will consult, if appropriate, with same or similar board-certified specialty providers who typically treat the medical condition, perform the procedure or provide the treatment involved in the appeal. Information regarding the internal appeal process and the DHHS appeal process is included in any notice following the denial of an Action or internal appeal. Appeals must be filed by the member or authorized representative within 60 calendar days of the notice of the Action or notice of the Plan's decision. The Plan will not take punitive action against providers who support a member's internal appeal.

The Plan's standard internal appeal process and written notice to affected parties will conclude no more than 30 calendar days from the date the request for a standard internal appeal is received (unless the timeframe is extended).

The Plan allows a member or authorized representative, before and during the internal appeals process, the opportunity to examine the member's case file, including medical records, and any other documentation and records considered during the internal appeals process. Additionally, the Plan allows reasonable opportunity for a member or member's authorized representative to present evidence and allegations of fact or law in person as well as in writing.

The standard appeal timeframe may be extended up to 14 calendar days if the member or member's authorized representative requests the extension, or the Plan can justify that:

- the member requests an extension orally or in writing; or
- there is a need for additional information; and
- the extension is in the member's best interest

The Plan will continue to provide benefits to the member, pending a resolution, as long as the request for an internal appeal is submitted within 10 calendar days of the Action

unless a member or member's authorized representative specifically requests not to receive continuing services.

Expedited Internal Appeal
A member or authorized representative may request an expedited internal appeal after receiving notification of an Action for urgent or time-sensitive care. The Plan does not require written permission from the member for providers to file expedited appeals on the member's behalf, and the Plan will not take punitive action against providers who request an expedited resolution on behalf of a member.

An expedited review is conducted by a healthcare professional who has the appropriate clinical expertise in treating the medical condition, performing the procedure, or providing the treatment that is the subject of the action. During the expedited appeal review process, the Plan will consult, if appropriate, with same or similar board-certified specialty providers who typically treat the medical condition, perform the procedure or provide the treatment involved in the appeal. A determination is made within 72 hours of receiving the expedited internal appeal.

The Plan allows reasonable opportunity for a member or authorized representative to present evidence and allegations of fact or law in person as well as in writing. The Plan also reminds a member or authorized representative of the limited time available for this opportunity in the case of an expedited appeal.

The Plan may reject a member or authorized representative's request for an expedited appeal. In the event the request is rejected, the Plan will:

- Transfer the internal appeal to the timeframe for standard internal appeal resolution, and
- Make reasonable efforts to give the member or authorized representative oral notice of the denial, and will send written notice within two calendar days.

The Plan may only reject a provider's request on behalf of a member for an expedited appeal if the Plan determines the request is unrelated to the member's health condition, and the member has the right to file a grievance regarding the denial of an expedited appeal request.

The Plan will continue to provide benefits to the member, pending a resolution, as long as the request for an internal appeal is submitted within 10 calendar days of the Action.

The Plan notifies either the member or authorized representative and treating provider of the decision to expedite the appeal by telephone and in writing. After the resolution of the expedited appeal with the Plan, a member or authorized representative may submit an external appeal request to the DHHS.

DHHS State Fair Hearing Appeal
A State Fair Hearing through the New Hampshire DHHS is an independent review by the State of a Member's request for coverage of denied or partially approved services through the Plan. A Member may be eligible for a State Fair Hearing Appeal only after

they have exhausted the Plan's Standard or Expedited Appeals Process and have received a denial or partial approval. If a Member and/or Authorized Representative wish to request a State Fair Hearing, they must do so within 120 calendar days of the date of the Plan's denial or partial approval Appeal letter.

A Member may be eligible to receive Continuing Services throughout the State Fair Hearing process if the Member and/or Authorized Representative request a hearing within ten (10) calendar days of receiving the Plan's Appeal denial or partial approval letter. However, the Member may be required to pay the cost of services received if the State Fair Hearing decision results in an uphold of the Plan's denial or partial approval. Members are notified of this in the Member Handbook and the Notice of Rights for Standard, Expedited and State Fair Hearing Appeals insert which accompanies Action and Appeal correspondence from the Plan.

Members and/or Authorized Representatives may file a request for a State Fair Hearing Appeal in writing. Written requests for Appeal may be sent to:

New Hampshire Administrative Appeals Unit
105 Pleasant Street
Main Building
Concord, New Hampshire 03301-6521

DHHS SHIP program
In the event the Plan determines that a dual-eligible Member's Appeal is solely related to a Medicare service, the Plan shall refer the Member and/or Authorized Representative to New Hampshire's SHIP program.

The State Health Insurance Assistance Program, or SHIP, is a Federal grant program that helps States enhance and support a network of local programs, staff, and volunteers. Through one-on-one personalized counseling, education, and outreach, this network of resources provides accurate and objective information and assistance to Medicare beneficiaries and their families. This allows the recipients to better understand and utilize their Medicare benefits.

SHIP is currently administered by ServiceLink Aging and Disability Resource Center. Members and/or Authorized Representatives will be informed that they may contact the SHIP program toll free at 1-866-634-9412 or by accessing their website at www.servicelink.org. Members and/or Authorized Representatives may also send Appeals to:

New Hampshire Department of Health and Human Services
Bureau of Elderly and Adult Services
129 Pleasant Street
Governor Hugh Gallen State Office Park
Concord, New Hampshire 03301-3857

Grievance Process
Grievances are categorized as follows:

- **Administrative Grievances**; Grievances related to billing issues, provider office condition or staff, attitude/service of a provider, or a member's dissatisfaction with Plan staff, policies, processes or procedures.
- **Clinical Grievances** (Quality of Care Grievances): Grievances related to the healthcare and/or services a member has received or is trying to receive from a participating Plan provider.
- **Expedited Clinical Grievances** (Expedited Quality of Care Grievances): Grievances relating to clinical issues such that a delay in the review process might seriously jeopardize:
    - the life and/or health of the member, and/or
    - the member's ability to regain maximum functioning, or is an issue that poses an interruption in the ongoing immediate treatment of the member

Members or an authorized representative can file a grievance in writing and send it via mail, fax, deliver in person to the Plan's office, or orally by calling the Member Services department at 1-877-957-1300. If the grievance is filed orally, the Appeals and Grievances Specialist will write a summary of their understanding of the grievance in an acknowledgment letter and send a copy to the member or authorized representative within one business day of receipt at the Plan. This summary will serve as both a written record of the grievance as well as an acknowledgment of receipt of the grievance.

Written grievances should include name, address, Plan ID number, daytime telephone number, detailed description of the grievance (including relevant dates and provider names), and any applicable documents that relate to the grievance (such as billing statements). Written grievances should be faxed to the Appeals and Grievances Department at 617-897-0805 or mailed to:

Well Sense Health Plan
Member Appeals and Grievances Specialist
529 Main Street, Suite 500
Charlestown, MA 02129

Once the written grievance is filed, the Plan sends a letter within one business day to the member or authorized representative to acknowledge receipt of the grievance.

All grievances are processed by an Appeals and Grievances specialist with reviews performed by appropriate healthcare professionals who are knowledgeable about the type of issues involved in the grievance. Responses will be based on the Plan's clinical policies and guidelines, the opinions of the treating providers, the opinions of the Plan's professional reviewers, applicable records provided by providers, and any other relevant information available to the Plan.

A written response is sent to the member or authorized representative within 30 calendar days of receipt of the grievance unless the grievance is extended. The Plan may extend the grievance up to 15 calendar days, if necessary.

SECTION VIII - CONFIDENTIALITY

CONFIDENTIALITY OF MEDICAL RECORDS

In accordance with applicable state and federal laws and regulations, Well Sense, Northwood and Northwood contracted providers shall not:

- Disclose medical records or information except to an authorized representative of Well Sense, Northwood or to a properly identified and authorized government agent and as otherwise specifically provided in the Northwood Participating Supplier Agreement and the Well Sense New Hampshire Medicaid Addenda to the Participating Supplier Agreement for Well Sense.

- Both Northwood and Northwood contracted providers are required to maintain accurate and timely medical records for members describing covered equipment and services and related financial records. These records must be kept for at least six (6) years (children's records must be retained up to age of majority) from the last date of provision of covered equipment, or longer if required by law, regulation or applicable contract. Such records must be kept in a manner that safeguards the privacy of any information that may identify a particular member.

- Northwood and Well Sense have the right to inspect and obtain, at no additional charge, copies of all medical records of members.

In addition to the above, Northwood providers shall:

- Have a central file location where records are stored in an adequate filing space and patient records are available and retrievable.

- Ensure patient records are stored and accessed according to the Health Insurance Portability and Accountability Act (HIPAA).

- Store patient records securely in a separate area or room that is accessible only to authorized personnel. If feasible, records area should be locked.

CONFIDENTIALITY OF BUSINESS INFORMATION

In accordance with Northwood's Participating Supplier Agreement ("PSA") and Well Sense New Hampshire Medicaid Addenda to the PSA, Northwood providers are bound to hold all confidential or proprietary information or trade secrets of each other in trust and confidence and agree that such information shall be used only for the purposes contemplated in the above named agreements.

SECTION IX - PARTICIPATION REQUIREMENTS AND CREDENTIALING

PROVIDER CRITERIA

Northwood requires its providers to meet the following minimum requirements for participation in its network:

- Centers for Medicare and Medicaid Services (CMS) approval/supplier number.
- Accreditation by an independent accrediting organization adopted by CMS.
- National Provider Identifier (NPI)
- State required licensure (if applicable).
- Any required DMEPOS licensure (if applicable) must be in good standing.
- Enrolled in New Hampshire Medicaid.
- Liability insurance minimums of $1,000,000 per occurrence/$2,000,000 annual aggregate.
- Notification to Northwood of changes or termination of such insurance.
- Sound financial standing.
- Possession of manufacturer's warranties on equipment.
- Ability to service equipment according to warranty specifications.
- Available skilled and/or credentialed staff to support services provided.
- Appropriately staffed business hours (8 hours per day).
- Staff available twenty-four hours per day, seven days per week for emergency services.
- After-hours answering service/paging system.
- Providers must use the OIG List of Excluded Individuals Entities (LEIE) upon initial hiring and on an ongoing monthly basis to screen employees to determine if any are excluded from participation in federal health care programs.

- Not currently excluded, terminated or suspended from participation in New Hampshire Medicaid.

    - Under its contracts, if Northwood receives a direct notification from Well Sense (via New Hampshire Medicaid) to suspend or terminate a provider, Northwood is required to suspend or terminate the provider from its network if the provider contracts with Northwood for Well Sense New Hampshire Medicaid Care Management program members. (Northwood is not permitted to authorize any providers terminated or suspended from New Hampshire Medicaid to treat members and must deny payment to such providers.)

- Provider has a formal policy that states it does not compensate employees/consultants/contractors or healthcare providers in bonuses, reimbursement or incentives, based on member utilization of health care services. During orientation of new staff and annually, provider reviews potential scenarios that may result in conflict of interest or ethical situations, including those involving financial incentives of staff.

- Participation in quality assurance/utilization review programs, including reviews involving;

    - Determination of appropriate equipment,
    - Complete and detailed member treatment records, available to Northwood/Well Sense for review,
    - Emergency visits to member's home/place of residence,
    - Two-hour provision for emergency equipment/service delivery,
    - Member education, including written patient instructions on proper use and maintenance of equipment.
    - Physician contact when necessary to review prescriptions and changes in patient's conditions.
    - Scheduled follow-up visits to member's home or by appointment in provider's facility.
    - Integrity and ethical business practices.
    - Solid community standing.

PROVIDER CREDENTIALING

Providers must submit and update the following credentialing information to Northwood during the initial credentialing process:

1. A copy of your National Supplier Clearinghouse (NSC) document indicating CMS's approval and assignment of your Medicare supplier number(s);
2. A copy of your accreditation letter or certificate for Durable Medical Equipment issued by an independent accrediting organization adopted by CMS (e.g., Joint Commission);

3. A copy of your Prosthetic/Orthotic certification/accreditation (e.g., ABC) if applicable;
4. A copy of your state license, i.e. limited retail drug license (if applicable);
5. A copy of your Business License;
6. A copy of your Certificate of Liability Insurance with Northwood named as a Certificate Holder
7. A complete copy of your current liability insurance certificate or declaration page (face sheet) of your insurance policy. The document should include the name of the company, name of applicant, policy number, dates of coverage and amounts of coverage (with a minimum of coverage outlined in Section X Liability Insurance Requirements);
8. A copy of your National Provider Identifier (NPI) notification;
9. A copy of your Sales Tax License (if applicable);
10. Copies of any other certifications held.

Northwood provides an annual summary of provider demographics and other information it maintains in the provider database. Providers must review and make any changes to data, provide certificates or other information as requested and return to Northwood by the return date indicated on the form.

RE-CREDENTIALING PROCESS

It is the responsibility of the provider to notify Northwood in writing of any changes to the information initially supplied on the Northwood Participating Provider Application including;

- Additions or deletions to locations.
- Address changes, phone, fax, key personnel.
- Changes to remittance address.
- Changes to ownership.
- Insurance coverage changes.
- Federal Tax ID numbers.

Northwood will make its best efforts to accommodate the addition of newly added locations of the provider. Requests should be directed to the Northwood Provider Affairs Manager.

Changes to ownership will require reapplication into the network.
Upon notification from Northwood, providers will be required to submit a completed re-credentialing application and all requested supporting documentation.

Failure to respond to the credentialing notice may result in termination from Northwood as a contracting DMEPOS services provider.

SECTION X - LIABILITY INSURANCE REQUIREMENTS

The following insurance minimums are required for contract participation in accordance with Northwood's agreements with Well Sense:

- General/professional liability insurance and products and completed operations liability insurance, each with minimum annual limits of $1,000,000 per incident and $2,000,000 in the aggregate.
    - Such coverage shall include provider, its employees and agents at all sites and for all activities related to provision of covered equipment.
- Provider is required to promptly notify Northwood:
    - Upon discovery of any loss, or impairment of required coverage, or;
    - When more than half of any required annual limits have been exhausted or reserved by the applicable insurance carrier;
    - And, submit annually a listing of all Products/Completed Operations losses incurred by provider, including those reported to provider's insurers regardless of whether any such losses have been paid.
- If liability coverage is secured on a "claims made" policy:
    - Provider must purchase a "tail" policy covering a period of not less than five (5) years following termination of the coverage or termination of your agreement with Northwood/Well Sense, whichever is later, or;
    - Agree to continue to provide the certificate of insurance as outlined in this request for a period of five (5) years after termination of your agreement with Northwood/Well Sense.
- Providers are required to name Northwood as a certificate holder and immediately notify Northwood in writing of any lapse or change in coverage. Failure to do so may result in termination from network participation.

SECTION XI – FINANCIAL INCENTIVE POLICY

Northwood does not reward practitioners, providers, or employees who perform utilization reviews for not authorizing health care services. No one is compensated or provided incentives to encourage denials, limited authorization or discontinue medically necessary covered services. Denials are based on lack of medical necessity or because a benefit is not covered. Northwood does not make decisions about hiring, promoting, or terminating practitioners or other staff based on the likelihood or the perceived likelihood that the practitioner or other staff member supports, or tends to support, "denial of benefits".

SECTION XII - FORMS

1. NORTHWOOD WAIVER OF LIABILITY
2. NORTHWOOD CLAIM STATUS FORM
3. FEE SCHEDULE / POLICY UPDATE ACKNOWLEDGMENT FORM

Northwood

PATIENT ADVANCE NOTICE/WAIVER OF LIABILITY OF NONCOVERED SERVICES OR HIGHER GRADE/DELUXE EQUIPMENT OR SUPPLIES

Provider Name:	NPI:
Member Name:	Contract/ID #:
Health Plan:	Date of Service:

Equipment/Supply Requested:

HCPCS Codes:

The equipment/supply being prescribed and requested will probably not be covered by your health plan because it is a:

□ Noncovered item
□ Reason not covered_____
□ Higher Grade/Deluxe Equipment
□ Standard Equipment:_____

Provider Charge: $.	Expected Insurance Payment: $.	Expected Member Liability: $.

Northwood Benefit Coordinator Name: Date Contacted:

If you believe a service will not be covered, you will need to contact Northwood and speak to a Benefit Coordinator.

This notice gives an opinion regarding nonpayment or noncoverage for equipment or supplies by your health plan. It is not an official decision by your plan. If you would like to receive an official decision from your health plan prior to receiving and paying for the prescribed and requested equipment/supply we can contact your health plan.

By signing and dating below, I understand that my insurance may not pay for the equipment/supplies I am receiving today or they may not pay the full amount (less any applicable deductibles, coinsurance, co-pays, etc. which are member responsibility). It is my decision to receive the equipment/supply irrespective of its coverage and that the charges will be my responsibility.

_____

Print Name Signature Date

If you have questions about this notice or about your plan billing or coverage, please call your health plan's customer service number.

PA-13
05-17-2013

FORM INSTRUCTIONS:

In order to bill a member for noncovered or deluxe equipment, the provider must first obtain a signed, appropriate advanced notice/waiver of liability. This form may be used to obtain the member's advanced permission to bill the member for noncovered/deluxe equipment.

If a provider believes that an equipment/service will not be covered, or is a higher-grade/deluxe item, Northwood must be contacted to verify benefits. If the determination is that the equipment is noncovered or deluxe, the member may choose to have the item dispensed without receiving a formal health plan determination/decision. Prior to dispensing the noncovered or deluxe equipment, the member must acknowledge liability in writing by signing an advance notice/waiver of liability. If a provider will be billing a member for noncovered or deluxe equipment, the provider must inform the member before services are rendered and the member must agree in writing to the arrangements regarding the cost of the equipment/service and payment terms.

This form must be filled out in its entirety. When indicating that the item is noncovered, providers must state a reason for noncoverage; i.e. not medically necessary, experimental/investigational, etc. Also, in the boxes provided fill in the equipment (including HCPCS codes) being provided, the charge for the equipment, any anticipated health plan payment and the potential amount of member liability. Document the name of the benefit coordinator that was contacted at Northwood and indicated that the item was noncovered/deluxe.

After completely filling out all the fields on the document - have the member print their name, sign, and date the document. After the member signs, give a copy of the signed notice/waiver to the member and keep the original on file in the Member's record.

OTHER INSTRUCTIONS:

If it is determined by Northwood that the item is noncovered or deluxe, a Member may be given the option to receive a formal decision from their health plan or continue with obtaining the equipment/service by signing an advanced notice/waiver. If the member chooses to receive a formal health plan decision, the provider must submit the request to Northwood and include supporting documentation, i.e. prescription, LOMN, etc.

PA-13
05-17-2013

Northwood

CLAIM STATUS FORM

Date of Status_____ Provider Contact/Statuses: _____

Provider Name and Tax ID: _____

Health Plan _____

Patient Name: _____

Contract/ID Number: _____

Claim Number _____

Procedure Code(s) Status: _____

Usual and Customary Charge(s): $_____

Date of Service: _____

Authorization Number: _____

Date of First Submission: _____

Reason for Claim Status: _____

_____

Additional Documentation Submitted (YES) _____ (NO) _____

Additional Comments:

_____

_____

Status forms are to be used for underpayment or rejected claims only.

Mail to: Northwood, Inc.
Attn: Well Sense NH Medicaid Care Management Program Claims
P.O. Box 510
Warren, MI 48090-0510

WELL SENSE CL-04
06-28-11

FEE SCHEDULE/POLICY UPDATE ACKNOWLEDGEMENT FORM

Dear Northwood Provider,

Please review the enclosed Fee Schedule, Provider Manual Revisions and/or Policy Updates. One copy of the Fee Schedule, Provider Manual Revisions or Policy Updates has been mailed to the primary location listed on the contract agreement between Northwood, Inc. and the provider. Please copy and distribute to other branch locations as needed.

Northwood's Provider Relations Department requests that you acknowledge your receipt of the above referenced materials dated _____. Please sign, date and return a copy of this form via mail (P.O. Box 510, Warren, MI 48090) or fax (586 755 3733).

Acknowledgement of Receipt

I, _____ the _____of
Authorized Company Representative (Printed Name) *(Title)*

_____acknowledge receipt of the
Company Name

Northwood Fee Schedule effective _____

Northwood DME Manual or Policy Update effective _____

Signature: _____ Date: _____
Authorized Company Representative

PA-9
02-01-10