Northwood Participating Provider Manual

For

Boston Medical Center HealthNet Plan Program

Effective November 1, 2020

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KEY CONTACTS DIRECTORY

Provider Relations	provideraffairs@northwoodinc.com
Claims	claims@northwoodinc.com
Utilization Management	northwoodUM@northwoodinc.com
Quality Assurance	qualityassurancegroup@northwoodinc.com
Compliance	compliance@northwoodinc.com **Anonymous FWA reporting at 833-770-0007 or** www.lighthouse-services.com/northwoodinc

OFFICE HOURS
FOR PROVIDER INQUIRIES:
Monday-Friday
8:30 a.m. – 5:00 p.m. (EST)

CLAIMS/INQUIRIES:
Northwood, Inc.
ATTN: BMCHP Claims
P.O. Box 510
Warren, MI 48090-0510

Provider Portal

https://providerportal.northwoodinc.com

Provider Inquiry Line:	**866-802-6471**
Provider Inquiry Fax:	**877-352-6551**
Member (BMCHP) Inquiry Line:	**866-802-6471**
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 Boston Medical Center HealthNet Plan (BMCHP).

The updated information contained herein replaces any previous Northwood Provider Bulletins and Manuals pertaining to BMCHP. (It also replaces those provisions in BMCHP's own Provider Manual having to do with BMCHP's management of DMEPOS.) The information contained in this Provider Manual will assist you when providing DMEPOS services to Boston Medical Center HealthNet Plan members.

Northwood's Participating Supplier Agreement and BMCHP Addendums 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 Fee Schedule
- Assignment for All Services Provided By Your Company
- Authorization
- Member Billing
- Claims Processing
- Quality of Service/Member Satisfaction
- Provider Allows Northwood/BMCHP to Use Provider's Performance Data
- 24-Hour Emergency Service

SECTION I - BENEFIT/COVERAGE CRITERIA

Northwood administers BMCHP's DMEPOS Program for members of all plan types in accordance with BMCHP benefits and the medical policy guidelines detailed below:

- Covered DMEPOS benefits for BMCHP's 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 <u>the most medically appropriate and cost-effective, standard item(s).</u> 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**.**

<u>PROVIDER RESPONSIBILITIES PRIOR TO RENDERING EQUIPMENT OR SUPPLIES</u>

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. (See plan guidelines.)
- 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 <u>emergency</u> 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 Boston Medical Center HealthNet Plan 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 Boston Medical Center HealthNet Plan 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. <u>Do not forward requests directly to Boston Medical Center HealthNet Plan or deny service to the member prior to case review.</u>

- It is the responsibility of the provider to inform the member that there are standard products available that meet BMCHP 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 (4) of the Addendum to the Participating Supplier Agreement for BMCHP.

OXYGEN EQUIPMENT

The following oxygen requirements apply for all BMCHP 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.

CPAP/BIPAP SUPPLIES

The following Positive Airway Pressure (PAP) requirements apply for all BMCHP 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 BMCHP. BMCHP makes all medical necessity denial determinations. Coverage is based upon the member's benefit document.

Prior authorization is required for all BMCHP 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 BMCHP provider line at 866-802-6471 during normal business hours (8:30 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.
  - BMCHP 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 applicable BMCHP product.

- 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 <u>on a monthly basis</u>.

- Neither Northwood nor BMCHP is responsible for payment of services provided to Members whose coverage has changed or terminated.

- Providers may verify member eligibility through:
  - For MassHealth members: WebEVS at www.mass.gov/masshealth/newmmis (providers will need to register for a username and password)
  - For MassHealth members: Automated Voice Response (AVR) – 1-800-554-0042
  - <u>For all members: Northwood's provider inquiry line at 1-866-802-6471</u>

- A Northwood authorization is not a guarantee of payment for service(s) provided.

<u>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 (4) OF THE ADDENDUM TO THE PARTICIPATING SUPPLIER AGREEMENT FOR BMCHP.</u>

<u>CHANGE TO INITIAL AUTHORIZATION</u>

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 fax or telephone to request review for a revised authorization. The following information must be included when requesting a review:

  - Current authorization number.
  - Patient name.
  - BMCHP 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 - 8:30 a.m. to 5:00 p.m. Monday thru Friday.

If a urgent request for services occurs after-hours or on weekends/holidays the provider should request an authorization within two (2) business days, or within thirty (30) calendar days for point-of-service providers (stock/bill, loan closets) identified by Northwood.

Urgent/Emergent and non-routine retrospective authorization requests must be made in writing and faxed 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 shall obtain authorization within the next two (2) business days.
- For MassHealth, provider staff should verify member eligibility through WebEVS and/or Automated Voice Response (AVR) Systems.
- Members should be informed of their potential financial responsibility for cost-sharing (co-payments, coinsurance and/or deductibles).

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 Boston Medical Center HealthNet Plan 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 Boston Medical Center HealthNet Plan toll-free line 1-866-802-6471. Members (non-English speaking) requiring language services may contact a Northwood Benefit Coordinator who will coordinate interpretation services.

Providers should utilize Northwood's online provider portal.

MEMBER BILLING

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

MEMBER HOLD-HARMLESS PROVISION

According to Northwood's Participating Supplier Agreement ("PSA") and the Addendums to the PSA for Boston Medical Center HealthNet Plan, 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 BMCHP 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 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 (this requirement is not applicable to custom wheelchair repairs for those chairs that were initially approved by Northwood/BMCHP. Providers are not required to obtain or maintain a prescription for repairs for custom wheelchairs that were initially approved by Northwood/BMCHP). 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.

<u>PRESCRIPTION DURATIONS</u>

- 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 (preferred method), 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**.

    - Northwood's national EDI Payer ID is: NWOOD
    - Northwood's Provider EDI Manual and Northwood EDI Insurance Plan Acronym List is located on Northwood's website at https://northwoodinc.com/northwood-providers/

- 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.

If a paper claim must be submitted, note they are scanned, so 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 BMCHP members must be submitted to Northwood within 150 calendar days from the date of service.

- Other Party Liability claims must be submitted with other payer information within 150 calendar days of receipt of the remittance advice from the other insurance.

- Approved gradient compression surgical stockings for Medicare Primary/BMCHP secondary members do not require submission to Medicare **for** denial; however, providers must obtain prior authorization and bill Northwood within the 150-day filing limitation.

- Filing limitations apply to all claims, including claims previously submitted and returned for missing or incomplete documentation. Northwood and the Plans are not responsible to provider for claims not submitted in a timely manner. In addition, provider may not bill, charge or seek remuneration from member for claims denied due to late submission.

- A claims status (claim denials or corrected claims) must be submitted to Northwood within the claim filing limitations noted above.

- Submit paper claims to the following address:

NORTHWOOD, INC.
ATTN: BMCHP CLAIMS
P.O. BOX 510
WARREN, MICHIGAN 48090-0510

<u>CLAIMS PAYMENT CYCLE</u>

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

- A clean claim consists of the following information:

  - Provider Name/Address/NPI Number.
  - Member Name/Address/Telephone.
  - BMCHP ID Number.
  - MMIS Number (MassHealth).
  - Date of Birth.
  - Other Insurance Information (if any).
  - Diagnosis (ICD-9-CM Code and Description).
  - Date of Service.
  - Referring Physician Name.
  - Referring Physician NPI and TIN.
  - Northwood Authorization Number.
  - 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 EOB 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).

- Northwood's payment for a service or supply as the secondary payor will be based on the difference between what the primary payor paid and what Northwood would have paid as the primary payor up to Northwood's allowed amount. If the primary payor'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 for all providers which is 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.

- All payments by ETF are payable to the bank account indicated during the credentialing period for network participation.

- Claim remittance notices are made available to providers via email (the preferred method), unless no provider remittance email address is on file. Provider remittances are also available for retrieval on Northwood's Provider Portal. Information regarding this is process can be found at www.northwoodinc.com.

- Providers must notify Northwood in writing, on company letterhead, of any changes to either their physical and/or email remittance address.

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

- Providers are responsible for maintaining the original Northwood claim remittance notices and providing copies to branch locations. Northwood is not responsible for re-issuing duplicate vouchers. Providers may view and retrieve remittances via Northwood's Provider Portal at https://providerportal.northwoodinc.com.

COORDINATION OF BENEFITS (C.O.B.)

- Providers are required to obtain all insurance information from the member.

- For MassHealth, BMCHP is the payer of last resort when any other type of insurance exists. For QHP/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 (see Section XII) within the claim filing limits noted above per business line 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 by going to Northwood's provider portal at https://providerportal.northwoodinc.com. If you do not see the claim on Northwood's portal, please resubmit.
- If you have not received a response within 45 days of submission, please make sure all information is correct and resubmit your claim.

Note: Ensure all payments are posted and resolve rejections prior to resubmitting claims to Northwood.

CLAIM PAYMENT RECOVERY

From time to time, Northwood may be required to request a refund from the provider for reasons such as: retroactive terminations, coordination of benefits (COB), eligibility changes, etc. Northwood will retract payments in those scenarios as provider level adjustments and providers will see the reason on their remittance advice.

ELECTRONIC FUNDS TRANSFER

Northwood maintains an all-electronic payment system. All disbursement will be made via Electronic Funds Transfer (EFT). To set-up electronic funds transfer (EFT), please visit the Northwood, Inc., website at www.northwoodinc.com.

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 BMCHP 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 BMCHP.

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

Timeframes for the 1st level appeal:

- Provider's must submit an appeal within 30 days from date of denial. Northwood will provide an appeal decision within 30 days from date of receipt of the appeal.

- The provider will receive a letter from Northwood if the appeal is denied. The letter will be mailed within 24 hours from date of decision and will not to exceed 30 days from date of receipt of the appeal.

- 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.

Timeframes for the 2nd level appeal:

- Provider's must submit a 2nd level appeal within 15 days from the date of the upheld denial.

- Northwood will provide an appeal decision within 15 days from the date of receipt of second appeal.

- If the denial is upheld, Northwood will mail a letter within 24 hours from date of decision; not to exceed 15 days from date of receipt of the 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.

<u>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 Boston Medical Center HealthNet Plan.</u>

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 1-866-802-6471 or Boston Medical Center HealthNet Plan Member Services at (888) 566-0010 (for MassHealth members), or at (855) 833-8120 (for QHP/ConnectorCare members) 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 BMCHP's Member Grievance and Appeal Rights information

SECTION VII - BOSTON MEDICAL CENTER HEALTHNET PLAN MEMBER GRIEVANCE and APPEAL RIGHTS

Boston Medical Center HealthNet Plan retains responsibility for the management of all member grievances and member appeals. The following describes BMCHP's processes:

MassHealth Members

The following Grievance and Appeal Rights are solely for use by BMCHP MassHealth members:

Standard internal appeal—Level one only Expedited internal appeal—Level one only

MassHealth Board of Hearings (BOH) appeal

An appeal of an Adverse 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 BOH. Member appeals must be submitted to the Plan within 60 calendar days of the notice of Adverse Action to the member. BMCHP may reject as untimely any Plan appeals submitted later than 60 calendar days after the notice of an Adverse Action.

How a member submits a Grievance or Appeal

- **The member or member's Authorized Representative may file an oral appeal or grievance by calling BMCHP's Member Services department at 1-888-566-0010 or 711 (TTY/TDD). Use of language services is free of charge to the member or member's Authorized Representative.**
- **The member or member's Authorized Representative may make oral inquiries by calling BMCHP's 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.**
- **The member or member's Authorized Representative may send written appeals and/or grievances to BMCHP at:**

  BMC HealthNet Plan
Member Appeals and Grievances
529 Main Street, Suite 500
Charlestown, MA 02129

- **The member or member's Authorized Representative may submit a grievance or appeal to a Plan representative in person at the Plan office location during normal business hours, 8:30 a.m. to 5 p.m., Monday through Friday (except holidays).**

- **The member or member's Authorized Representative may call a health benefits advisor at the MassHealth Customer Service Center. - The MassHealth Customer Service Center is available Monday through Friday, 8:00 a.m. to 5 p.m. (except holidays).**
- **The member or member's Authorized Representative may submit an external appeal request to the BOH after exhausting the Plan's internal appeal process and only if a final internal appeal decision has been rendered by the Plan.**
- **The member or member's Authorized Representative has 120 calendar days from the date of notice of the Adverse Action of the standard or expedited internal appeal to file an external appeal with the BOH.**

BMC HealthNet Plan will send written acknowledgement of the receipt of any grievance or internal appeal to members and/or Authorized Representatives, if applicable, within one business day of receipt by the Plan.

BMCHP will complete the resolution of grievances and send written notice to affected parties, no more than 30 calendar days from the date the Plan received the Grievance. BMCHP will complete the resolution of internal appeals and send written notice to affected parties, no more than 30 calendar days from the date the Plan received the Appeal, excluding any time required for an extension with permission from the member and/or Authorized Representative (if applicable).

BMCHP will provide instructive materials and forms to assist a member who submits a grievance or appeal. If the member requests it, the Plan will give him or her reasonable assistance completing the forms and following procedures applicable to the internal appeals process. This includes, but is not limited to, providing interpreter services free of charge and toll-free numbers with TTY/TDD and interpreter capability.

Standard Internal Appeal

The Plan offers one level of internal review for standard appeals. Reviews are conducted by healthcare professionals who have the appropriate clinical expertise in treating the medical condition, performing the procedure, or providing the treatment that is the subject of the Adverse Action, and who have not been involved in any prior review or determination of the particular internal appeal and who are not 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 BOH appeal process is included in any notice of an Adverse Action or denied internal appeal. Internal appeals must be filed by the member or member's Authorized Representative within 60 calendar days of

the notice of the Adverse Action. 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 Plan received the member's request for an internal appeal (unless the timeframe is extended).

BMCHP will allow a member or member's 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.

BMCHP will also allow 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 timeframe for the standard appeal may be extended for up to fourteen calendar days if the member or member's Authorized Representative requests the extension, or the Plan can justify (to MassHealth, upon request) that:

- **The extension is in the member's interest; and**
- **There is a need for additional information, where there is a reasonable likelihood that receipt of this information would lead to approval of the request, if received; and this outstanding information is reasonably expected to be received within five calendar days.**

For any extension not requested by the member or member's Authorized Representative, the Plan will provide the member or member's Authorized Representative with written notice of the reason for the delay. The member or member's Authorized Representative has the right to file a grievance regarding an extension decision made by the Plan.

BMCHP will provide the member with continuing services, if applicable, pending resolution of the internal appeal, if the member submitted the request for the internal appeal within 10 calendar days of the date of the Adverse Action notice, unless the member specifically indicates that he or she does not want to receive continuing services. If the decision is to uphold the Adverse Action denial, the member may have to pay MassHealth for the cost of the continuing services.

Expedited Internal Appeal

A member or member's Authorized Representative may request an expedited internal appeal after receiving notification of an Adverse Action for urgent or time-sensitive care. BMCHP 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 appeal will be expedited if the Plan determines, a physician on behalf of a member asserts that, or based on a prudent layperson's judgment a member asserts, taking the time for a standard resolution, could seriously jeopardize the member's life or health, or the Member's ability to attain, maintain, or regain maximum function.

The Plan offers one level of internal review for an expedited appeal. The review is conducted by a healthcare professional that has the appropriate clinical expertise in treating the medical condition, performing the procedure, or providing the treatment that is the subject of the adverse action. A determination will be made within 72 hours of the receipt of the expedited internal appeal unless this timeframe is extended as outlined below.

BMCHP will allow 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 Plan will also remind a member or member's Authorized Representative of the limited time available for this opportunity in the case of an expedited appeal.

BMCHP may reject the request of a member or member's Authorized Representative 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 member's Authorized Representative oral notice of the denial of the request for expedited review, 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 that the request is unrelated to the member's health condition.

The timeframe for the expedited appeal determination may be extended for up to 14 calendar days if the member or member's Authorized Representative requests the extension, or if the Plan can justify to MassHealth, upon request that:

- **The extension is in the member's interest; and**
- **There is a need for additional information where there is a reasonable likelihood that receipt of this information would lead to approval of the request, if received; and this outstanding information is reasonably expected to be received within 14 calendar days.**

For any extension not requested by the member or member's Authorized Representative, the Plan will provide the member or member's Authorized

Representative with written notice of the reason for the delay. The member or member's Authorized Representative has the right to file a grievance regarding an extension decision made by the Plan.

BMCHP will provide the member with continuing services, if applicable, pending resolution of the expedited appeal if the member submitted the request for the expedited appeal within 10 calendar days of the date of the Adverse Action notice, unless the member specifically indicates that he or she does not want to receive continuing services.

BMCHP will notify the member, member's Authorized Representative (if applicable) and treating provider by telephone and in writing of our decision related to the expedited internal appeal. A member or member's Authorized Representative may submit an external appeal request to the BOH after the resolution of an expedited internal appeal with the Plan.

MassHealth Board of Hearings (BOH) Appeal

A member may request an external appeal review with the BOH after the Plan has rendered an internal appeal decision, standard or expedited. A BOH appeal must be requested within 120 calendar days of the date of the internal appeal decision notification. BMCHP will include the BOH Fair Hearing Application and other instructive materials that the member or member's Authorized Representative will need to complete to request a fair hearing with the BOH. BMCHP will assist the member in submitting the BOH appeal request and completing the BOH form if an external appeal is requested by the member or member's Authorized Representative.

If the member or member's Authorized Representative does not understand English and/or is hearing or sight impaired, the BOH will make sure that an interpreter and/or assistive device is available at the hearing.

The Plan will make best efforts to ensure that a provider, acting as an appeal representative, submits all applicable documentation to the BOH, the member and the Plan within five business days prior to the date of the hearing, or if the BOH appeal is expedited, within one business day of being notified by the BOH of the date of the hearing. Applicable documentation will include, but not limited to, any and all documents that will be reviewed upon at the hearing.

BMCHP will provide the member with continuing services, if applicable, pending resolution of the BOH appeal if the member or member's Authorized Representative submits the request for the BOH appeal within 10 calendar days from the date of the decision on the member's standard internal appeal or expedited internal appeal, unless the member specifically indicates that he or she does not want to receive continuing services. If the BOH appeal decision is to uphold the Plan's denial of coverage, the member may have to pay MassHealth for the cost of the continuing services.

BMCHP will allow a member or member's Authorized Representative access to the member's appeal files during the BOH appeal process and we will implement the BOH appeal decision immediately if our decision is overturned.

Qualified Health Plans (QHP) and ConnectorCare Plans

The following Grievance and Appeal Rights are solely for use by BMCHP Qualified Heatlh Plan members (including ConnectorCare):

A grievance is a formal complaint by a member or member's Authorized Representative about:

- **Plan Administration (how the plan is operated): any action taken by a plan employee, any aspect of the plan's services, policies or procedures, or a billing issue.**
- **Attitude/Service of a network provider and/or network provider's staff member;**
- **Access to services/supplies;**
- **Billing/Financial issues of a network provider;**
- **Quality of Care: The quality of care a member received from a plan network provider;**
- **Quality of a Practitioner's Office Site**

Note: The Internal Grievance Process is not used to resolve complaints about a denial of coverage (either Benefit Denials or Adverse Determinations). These types of complaints are addressed through the Appeals Process.

Standard Internal Appeals Process

An appeal is a request for coverage of services/supplies by a member or member's Authorized Representative. There are two types of coverage denials:

- **Benefit Denial – a Plan decision, made before or after the member has obtained services, to deny coverage for a service or supply that is specifically limited or excluded from coverage as outlined in the member's Evidence of Coverage.**

- **Adverse Determination – a Plan decision, based on a review of information provided, to deny, reduce, modify, suspend or terminate an admission, continued inpatient stay or the availability of any other healthcare services, for failure to meet the requirements for coverage based on medical necessity, appropriateness of healthcare setting and level of care, or effectiveness. These are often known as medical necessity denials because in these cases the Plan has determined that the service is not medically necessary.**

The preferred way for a member or member's Authorized Representative to file a grievance or an appeal is to put it in writing and send it to the Plan by postal mail or electronically by fax. Appeals and grievances may also be delivered in person to the Plan's office location or may be submitted orally by calling the Member Services department at 1-855-833-8120or 711 for TTY/TDD. The Plan will send an acknowledgment letter upon receipt of a grievance or appeal at the Plan. This letter will serve as confirmation the Plan has received the grievance or appeal.
Written grievance or appeals should include the member's name, address, Plan ID number, daytime phone number, detailed description of the grievance or appeal (including relevant dates and provider names), any applicable documents that relate to the grievance or appeal, such as billing statements, and the specific result that has been requested. Written grievances or appeals can be faxed to 617-897-0805 or mailed to:

BMC HealthNet Plan
Member Appeals and Grievances
529 Main Street, Suite 500
Charlestown, MI 02129

A grievance must be filed within 60 calendar days of the issue being grieved and an appeal must be filed at any time within 180 calendar days of the date of the notification of Plan's initial denial. The Plan encourages members and their Authorized Representatives to file any grievances or appeals as soon as possible.

Release of medical records: If the grievance or appeal requires the Plan to review medical records, a signed Authorization to Release Medical Records Form must be submitted to us. This form authorizes providers to release medical information to the Plan. It must be signed and dated by the member or member's Authorized Representative. A copy of this form will be sent by the Plan with acknowledgment letters. When the form is signed by an Authorized Representative, appropriate proof of authorization to release medical information must be provided. If the Plan does not receive this form within 30 calendar days of the date of receipt of the grievance or appeal, the Plan may respond to the grievance or appeal without having reviewed relevant medical information. In addition, if the Plan receives the form but a provider does not give the medical records to the Plan in a timely fashion, the Plan will ask the member to agree to extend the time limit for a response.

All grievances and appeals will be processed by an Appeals and Grievances Specialist. Reviews will be performed by appropriate individuals who are knowledgeable about the issues relating to the grievance or appeal. Appeals regarding adverse determinations will be reviewed by health care professionals who have the appropriate clinical expertise in treating the medical condition, performing the procedure, or providing the treatment that is the subject of the Adverse Determination, who have not been involved in any prior review or determination of the particular appeal and who are not 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 deliver the treatment involved in the appeal. Decisions will be based on the terms of the member's Evidence of Coverage document, the opinions of the member's treating providers, the opinions of the Plan's professional reviewers, applicable records provided by the member or providers, and any other relevant information available to the Plan.

BMCHP will send a written response within 30 calendar days of receipt of the grievance or standard appeal at the Plan. The 30 calendar day period begins as follows:

- **If the grievance or standard appeal requires the Plan to review a member's medical records, the 30 calendar day period does not begin until the Plan receives a signed Authorization to Release Medical Information Form.**

- **If the grievance or standard appeal does not require the Plan to review a member's medical records, the 30 calendar day period begins on the next working day following the end of the three working day period for processing inquiries through the internal inquiry process, if the inquiry was not addressed within that time period, or on the day the Plan was notified that the member was not satisfied with the response to the inquiry.**

These time limits may be extended by mutual written agreement. Any extension will not exceed 30 calendar days from the date of the mutual agreement.

No grievance or appeal will be considered received by the Plan until it is actually received by the Plan at the appropriate address or telephone number listed above.

Written responses to Adverse Determinations will explain further avenues of appeal for the member, such as the member's right to request an External Review from an Independent External Review Agency through the Commonwealth of Massachusetts Health Policy Commission/Office of Patient Protection.

If the Plan doesn't respond to the appeal within the timeframes described in this section, including any mutually agreed upon written extension, the appeal will be deemed decided in the member's favor. 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.

Expedited Internal Appeals Process

An expedited appeal is a faster process for resolving an appeal. This faster process can be used when there has been a denial of coverage involving immediate or urgently-needed services. Examples of appeals that are eligible for the expedited appeals process are appeals involving substantial risk of serious and immediate harm; inpatient care; durable medical equipment; and terminal illness. Expedited appeals will not be used to review a benefit denial, which is a denial of coverage for a service or supply that is specifically limited or excluded as outlined in the member's Evidence of Coverage. A determination will be made within 72 hours of the receipt of the expedited internal appeal.

An expedited appeal will be reviewed and resolved within 72 hours if the Plan determines, a physician on behalf of a member asserts that, or based on a prudent layperson's judgment a member asserts, taking the time for a standard resolution, could seriously jeopardize the member's life or health, or the Member's ability to attain, maintain, or regain maximum function. The Appeals and Grievances Specialist will make reasonable attempts to notify the member, member's Authorized Representative, and treating provider orally of decisions involving expedited appeals. The Appeals and Grievances Specialist will also send written resolution to the member and/or member's Authorized Representative within 72 hours of the request.

Durable Medical Equipment (DME) needed to prevent serious harm: The appeal will be expedited if the Plan determines, a physician on behalf of a member asserts that, or based on a prudent layperson's judgment a member asserts, taking the time for a standard resolution, could seriously jeopardize the member's life or health, or the Member's ability to attain, maintain, or regain maximum function. The certification must also specify a reasonable time period, not less than 24 hours, in which the Plan must provide a response. This means the Plan will review and decide the expedited appeal and send a written decision within less than 72 hours of receipt of this certification. The Appeals and Grievances Specialist will also make reasonable attempts to orally notify the member, member's Authorized Representative, and treating provider.

If the Plan does not respond to the expedited appeal within these timeframes, including any mutually agreed upon written extension, the expedited appeal will be deemed in the member's favor.

If an appeal concerns the termination of ongoing coverage or treatment, the disputed coverage remains in effect at the Plan's expense through the completion of the standard internal appeals process or expedited internal appeals process (regardless of the outcome of the process) if all of the following are true:

- **the appeal was filed on a timely basis,**
- **the services were originally authorized by the Plan prior to the member or member's Authorized Representative filing an appeal**

(except for services sought due to a claim of substantial risk of serious and immediate harm),

- **the services were not terminated due to a specific time or episode related exclusion in the member's Evidence of Coverage,**
- **the member continues to be an enrolled member.**

Reconsideration of a Final Adverse Determination

The Plan may offer the member or member's Authorized Representative the opportunity for reconsideration of its final appeal decision on an Adverse Determination. The Plan may offer this when, for example, relevant medical information was received too late for the Plan to review it within the 30 calendar day time limit for standard appeals, or was not received but is expected to become available within a reasonable time following the Plan's written decision on the member's appeal. If the member or member's Authorized Representative requests reconsideration, the member or member's Authorized Representative must agree in writing to a new review time period not to be more than 30 calendar days from the agreement to reconsider the appeal.

Independent External Review Process

The external review process allows the member to have a formal independent review of a Final Adverse Determination made by the Plan. Only Final Adverse Determinations are eligible for external review. Benefit Denials (i.e., coverage limitations and specific exclusions) are not eligible for external review. External reviews are performed by an independent organization under contract with the Office of Patient Protection ("OPP") of the Commonwealth of Massachusetts Health Policy Commission (HPC).

Members can request the external review or can ask for an Authorized Representative, including a healthcare provider or attorney, to act on the member's behalf during the external review process. A member may be represented by anyone he or she chooses, including an attorney.

An Authorized Representative may be a family member, agent under a power of attorney, healthcare agent under a healthcare proxy, a healthcare provider, attorney or any other person appointed in writing to represent the member in a specific grievance or appeal.

If a member or member's Authorized Representative is filing a request for an expedited appeal, the External Review option may be available to them if the adverse determination was based upon medical necessity. The request for an expedited External Review must be made to the HPC/OPP and shall contain a certification, in writing, from a health care professional responsible for the treatment or proposed treatment that delay in the provision or continuation of health care services that are the subject of a final adverse determination,

would pose a serious and immediate threat to the health of the insured. Please be advised that a member or member's Authorized Representative may file a request for an Expedited External Review either (1) after receipt of the plan's final written decision on the Expedited Internal Appeal; or (2) at the same time as the member or member's Authorized Representative files a request for an Expedited Internal Appeal. A member or member's Authorized Representative does not need to await the outcome of an Expedited Internal Appeal before filing a request for an Expedited External Review.

How to request an external review:

To request external review, the member or member's Authorized Representative must file a written request with the HPC/OPP within four (4) months of receipt of the Plan's written notice of the final standard internal appeal decision. A copy of the HPC/OPP external review forms and other information will be enclosed with the notice of a decision to deny a member's initial prior authorization request and internal appeal.

Expedited external review:

The member, or member's Authorized Representative, can request an expedited external review. If the member is filing a request for an expedited appeal, the External Review option may be available to the member if the adverse determination was based upon medical necessity. Please be advised that the member or member's Authorized Representative may file a request for an expedited external review at the same time as the member files a request for an expedited internal review or upon receipt of the notice of the Plan's decision to deny the expedited internal appeal.

To file an expedited external review, a written certification must be submitted from a physician explaining that a delay in providing or continuing the health services that are the subject of the final appeal decision would pose a serious and immediate threat to the member's health. If the HPC/OPP finds that such a serious and immediate threat to the member's health exists, it will qualify the request as eligible for an expedited external review.

Requirements for an external review:

- **The request must be submitted on the HPC/OPP application form called "Request for Independent External Review of a Health Insurance Grievance." The Plan will send the form with both the initial prior authorization denial and internal appeal denial response letters. Copies of this form may also be obtained by calling the Member Services department at 1-855-833-8120, by calling the HPC/OPP at 1-800-436-7757, or from the HPC/OPP website:**

  www.mass.gov/hpc/opp

- **The form must include the member or member's Authorized Representative's signature consenting to the release of medical information.**
- **A copy of the Plan's final appeal decision or the Plan's initial prior authorization denial if requesting simultaneous expedited internal and external reviews must accompany the form.**

Coverage during the external review period:

If the subject of the external review involves termination of ongoing services (outpatient or inpatient), the member or member's Authorized Representative may apply to the External Review Agency to seek the continuation of coverage for the service(s) during the period the review is pending. Any request for continuation of coverage must be made to the review panel before the end of the second working day following the receipt of the Plan's final decision about the appeal. The review panel may order the continuation of coverage if it finds that substantial harm to the member's health may result from termination of the coverage or for such other good cause as the review panel shall determine. The continuation of coverage will be at the Plan's expense regardless of the final external review decision.

Access to information:

The member or member's Authorized Representative may have access to any medical information and records related to the external review that are in the Plan's possession or under the Plan's control.

Review process:

The HPC/OPP will screen requests for external review to determine whether the member's case is eligible for external review. If the HPC/OPP determines that the case is eligible for external review, it will be assigned to an External Review Agency that contract with the OPP. The OPP will notify the member, the member's Authorized Representative and the Plan of the assignment. The External Review Agency will make a final decision and send it in writing to the member, member's Authorized Representative, and to the Plan. For non-expedited external reviews, the decision will be sent within 45 calendar days of receipt of the case from the OPP (unless extended by the External Review Agency). For Expedited External Reviews, the decision will be sent within 72 hours from receipt of the case from the OPP. The decision of the External Review Agency is binding on the Plan.

If the HPC/OPP determines that a request is not eligible for external review, the member or member's Authorized Representative will be notified within 10 working days of receipt of the request or, in the case of requests for expedited external review, within 72 hours of the receipt of the request.

How to reach the Office of Patient Protection (OPP):

Health Policy Commission
Office of Patient Protection
50 Milk Street, 8th Floor
Boston, MA 02109
Telephone: 1-800-436-7757
Fax: 1-617-624-5046
Website: www.mass.gov/hpc/opp

SECTION VIII - CONFIDENTIALITY

CONFIDENTIALITY OF MEDICAL RECORDS

In accordance with applicable state and federal laws and regulations, Boston Medical Center HealthNet Plan, Northwood and Northwood contracted providers shall not:

- Disclose medical records or information except to an authorized representative of Boston Medical Center HealthNet Plan, Northwood or to a properly identified and authorized government agent and as otherwise specifically provided in the Northwood Participating Supplier Agreement and the Addenda to the Participating Supplier Agreement for Boston Medical Center HealthNet Plan.

- 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 BMCHP 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 Addenda to the PSA for Boston Medical Center HealthNet Plan, 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.
- 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.
- Any required DMEPOS licensure (if applicable) must be in good standing.
- Providers must use the OIG List of Excluded Individuals Entities (LEIE) and SAM Excluded Provider List (EPLS) 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. All exclusion list checks must be performed in a manner that is verifiable and verification must be available upon request.
- Not currently excluded, terminated or suspended from participation in MassHealth or the Connector.
    - Under its contracts, if Northwood receives a direct notification from BMCHP (via MassHealth, the Connector, or other regulatory agency) 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 all BMCHP plan/product types. (Northwood is not permitted to authorize services for any providers terminated or suspended from MassHealth 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/BMCHP 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 Medicaid approval/supplier number (indicate which states and list by state);
3. A copy of your accreditation letter or certificate for Durable Medical Equipment issued by an independent accrediting organization adopted by CMS (e.g., JCAHO);
4. A copy of your Prosthetic/Orthotic certification/accreditation (e.g., ABC);
5. A copy of your state license (as applicable);
6. A copy of your Business License (any one of the below is acceptable):
   a. Manufacturer Wholesaler License
   b. Pharmacy License

c. Articles of Incorporation
d. Business Corporation
e. Sales Tax License
f. DEA

7. A complete copy of your current liability insurance certificate or declaration page (face sheet) of your insurance policy (provider must name Northwood as a certificate holder so renewal certificates will be sent directly to Northwood). 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;
11. Copy of Ownership Disclosure form.

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 Provider Relations department.

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.

RE-CREDENTIALING PROCESS

Northwood re-credentials its contracted providers biennially.

As part of the re-credentialing process, providers are requested to send updated documents that were utilized for the initial credentialing process to Northwood by the date indicated on the re-credentialing form. The re-credentialing documents include, but are not limited to:

1. Center for Medicare (CMS) approval/supplier number
2. Medicaid approval/supplier number (indicate which States and list by State)

3. Copy of Accreditation certificate
4. Copy of NPI notification information
5. Copy of General Liability coverage with minimum limits of $1,000,000 and Products/Completed Operations Liability coverage with minimum limits of $2,000,000
6. Copy of W-9
7. Copy of state license (as applicable)
8. Copy of Business License (any one of the below is acceptable):
    i. Manufacturer Wholesaler License
    ii. Pharmacy License
    iii. Articles of Incorporation/Organization
    iv. Business Corporation
    v. Sales Tax License
    vi. DEA
9. Copy of Ownership Disclosure form from you CMS 855S Application
10. Complete Fraud, Waste and Abuse Questionnaire

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

SECTION X - LIABILITY INSURANCE REQUIREMENTS

The following insurance minimums are required for contract participation in accordance with Northwood's agreements with Boston Medical Center HealthNet Plan:

- 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/Boston Medical Center HealthNet Plan, 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/Boston Medical Center HealthNet Plan.

- 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. **PATIENT ADVANCE NOTICE/WAIVER OF LIABILITY OF NONCOVERED SERVICES OR HIGHER GRADE/DELUXE EQUIPMENT OR SUPPLIES**
2. **NORTHWOOD CLAIM STATUS FORM**
3. **RETROSPECTIVE AUTHORIZATION FORM**
4. **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 □ Higher Grade/Deluxe Equipment
□ Reason not covered_________________ □ 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

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: BMCHP Claims
P.O. Box 510
Warren, MI 48090-0510
1-866-802-6471

BMCHP CL-04
06-28-11

RETROSPECTIVE AUTHORIZATION REQUEST FORM
FOR URGENT/EMERGENT DMEPOS REQUESTS

PROVIDER NAME ______________________________ NW PROVIDER #________________

PROVIDER CONTACT NAME____

PHONE #__________________________FAX # ____________________________________

DATE OF REQUEST____________________DATE OF SERVICE_______________________

MEMBER NAME____

CONTRACT/ID NUMBER ____

DIAG.CODE(S) ____

EQUIPMENT/SUPPLIES DISPENSED____

____

HCPCS CODE(S)
____

QUANTITY____

REASON FOR NOT OBTAINING PRIOR AUTHORIZATION

____

____

ABOVE INFORMATION MUST BE COMPLETE AND SUBMITTED WITH ANY SUPPORTING DOCUMENTATION TO BE CONSIDERED FOR RETROSPECTIVE AUTHORIZATION.

RETROSPECTIVE AUTHORIZATION REQUESTS MUST BE SUBMITTED WITHIN THE NEXT TWO (2) SCHEDULED BUSINESS DAYS, OR WITHIN FIVE (5) BUSINESS DAYS FOR POINT-OF-SERVICE PROVIDERS (STOCK/BILL, LOAN CLOSETS) IDENTIFIED BY NORTHWOOD.

BMCHP CSR-01
01-18-11

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