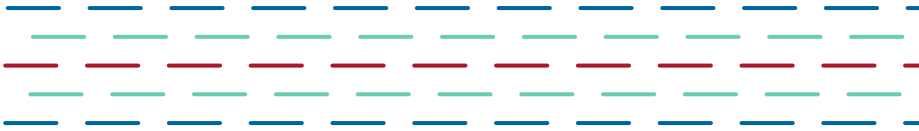
NHN NETWORK

POLICY MANUAL



Revised 12/22/2021

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INTRODUCTION

HOW TO USE THIS MANUAL

This NHN Network Policy Manual will assist NHN Network providers with understanding the terms of participation in the NHN Network participation agreements with payers. It sets forth the policies, rules and procedures applicable to be an NHN Network provider participating in payer contracts and other activities. All participants, including providers and facilities that participate in a PHO that have entered into a participation agreement with the NHN Network, will be referred to as "Network providers" throughout this manual.

This manual is an extension of the agreement entered into by NHN with PHOs, TPAs and other providers who participate in the Network. Notices of updates and revisions to this manual will be sent to participating NHN Network providers either directly or through their PHO and posted on the Nebraska Health Network website at NebraskaHealthNetwork.com.

This manual should assist you in answering questions about many aspects of the NHN Network agreements with payers. If you cannot locate the answer to your question in the manual, contact Nebraska Health Network at nhn@nebraskahealthnetwork.com or 402-559-6464.

We also want to hear from you. If you have any recommendations on how this manual can be expanded or improved to provide better clarity to help you administer NHN Network agreements, please let us know.

OVERVIEW

ABOUT US

The NHN Network is a regional network of physicians, advance practice providers, other health-care providers, hospitals and health-care facilities. Established in 2021, the NHN Network enables innovative partnerships with payers and employers and connects providers throughout Nebraska to work together to strengthen patient care.

Our goal is to provide high-quality, comprehensive and cost-effective health care. As members, our providers agree to perform health-care services at competitive fees, while working to improve quality, which lowers the out-of-pocket costs for patients receiving care within the Network. The NHN Network serves patients throughout Nebraska, Iowa and Kansas.

BACKGROUND OF THE NHN NETWORK

Our vision is to be the preferred network for network employer groups and other large employers in the communities we serve, bringing superior value to patients, employers, payers and providers. To accomplish this, we are focused on creating a regional network that is committed to creating a more cost effective, efficient and personal health-care experience.

As members of the NHN Network, providers are part of a coordinated and intentional effort to engage with payers and employers. Together, we will create product offerings that drive loyalty to each health system and provider group, and provide true value to local employers.

The NHN Network provides the best of both worlds by allowing NHN Network providers to retain their independence, yet benefit from centralized resources:

- NHN Network providers will have access to payer agreements and value-based arrangements not typically available to individual provider groups.
- The Nebraska Health Network will provide data, reporting and analytics to enable the provision of value-based care.

We will leverage the power of the entire network by working together to share best practices and expand our offerings. Together, members will be part of creating a better health-care offering for employers across our region. We seek to lower health-care plan administrative and claims costs and foster stronger relationships with local employers.

KEY STAKEHOLDERS

The NHN Network will evolve to become an "alliance" of regional health systems working together to bring innovation to employers through a network committed to high-value care. The following health systems are involved in this regional alliance.

Bryan Health

COLUMBUS COMMUNITY HOSPITAL

FAITH REGIONAL HEALTH SERVICES

Grand Island REGIONAL MEDICAL CENTER

Great Plains Health

KearneyRegional Medical Center

Mary Lanning HEALTHCARE

METHODIST

Nebraska Medicine

JOINING THE NETWORK

PHO MODEL

Health-care providers who wish to participate in the NHN Network will gain access to emerging payer products and direct-to-employer health plan offerings.

Providers wanting to join the NHN Network will join through a Physician Hospital Organization (PHO) that holds an participation agreement with the NHN Network.

Credentialing, a process that ensures that providers meet a set of membership standards, will be delegated by the third party administrator (TPA). NHN will be responsible to assure each NHN Participant and Provider is credentialed.

Non-Discrimination: Participation in the NHN Network shall not be denied on the basis of gender, sexual orientation, gender identity, age, race, religion, disability, ethnic origin, national origin or other factors unrelated to the criteria for participation and the ability to carry out responsibilities of the Participating Provider.

Confidentiality: Information collected by the PHOs during credentialing is considered confidential and is not discussed with anyone inside or outside the NHN Network or Nebraska Health Network except when required in the normal course of business or as required by law.

CONTACT

Nebraska Health Network,
NHN Network Administrator
9140 West Dodge Road, Suite 400
Omaha NE 68114

Ph. 402-559-6464
nhn@nebraskahealthnetwork.com
NebraskaHealthNetwork.com

Business Hours
8 a.m. to 5 p.m.
Monday to Friday

TERMS APPLICABLE TO NHN PROVIDERS

TERMS AND PARTICIPATION CRITERIA APPLICABLE TO NHN NETWORK PROVIDERS

All NHN Network providers must abide by the following terms, which have also been agreed to by PHOs in the agreement to participate in the Network:

SERVICES TO COVERED PERSONS

NHN Network provider agrees to provide to Covered Persons within the scope of their provider's license, practice or specialty, and consistent with accepted standards of medical care, all necessary Covered Services and to provide such services pursuant to office schedules and physical settings customarily provided by the provider; provided, however, nothing herein shall preclude the provider from refusing to accept a covered person as a new patient or from terminating a physician-patient relationship with an existing covered person.

NON-DISCRIMINATION

NHN Network provider shall not discriminate against covered persons based on race, color, sex, religion, married status, sexual orientation, disabilities, religion, national origin or other factors unrelated to the need for covered services or the NHN Network provider's ability to provide such covered services.

PAYMENT FOR COVERED SERVICES

NHN Network provider agrees to accept as payment in full for providing covered services to covered persons amounts specified in the Payer Notice (or as otherwise agreed between the Payer and provider). NHN Network provider may bill and collect from the covered person for non-covered services which NHN Network provider furnishes, but shall not bill or collect from or on behalf of the covered person for any covered services in excess of the amount established in the Payer Notice or other amount agreed to between the Payer and NHN Network provider.

RESPONSIBILITY FOR VERIFYING COVERED PERSON STATUS AND FOR BILLING AND COLLECTION

NHN Network provider shall be solely responsible for verifying the enrollment and eligibility status of a covered person with the Payer and for billing and collecting for covered services and non-covered services rendered to a covered person. Under no circumstances shall NHN be liable to the NHN Network provider for deductibles, co-pays or co-insurance amounts, the cost of non-covered services or any other costs of care.

CLAIMS

When submitting claims for covered persons, the NHN Network provider shall use appropriate procedure codes to identify services rendered to covered persons as defined by the latest version of CPT and/or ICD codes and shall comply with additional instructions stated in the NHN Network Policy Manual or the payer notice. NHN Network provider shall submit claims for covered services within the time frames and in accordance with the requirements specified in the NHN Network Policy Manual or an applicable Payer Notice.

BUSINESS ASSOCIATE SERVICES

NHN Network provider designates NHN to act as its business associate as that term is defined under HIPAA at 45 C.F.R. 164.101 for the purpose of conducting payment and health care operations on its behalf, including, but not limited to, analyzing and reporting claims and treatment data, introducing population health management tools, developing, communicating and evaluating performance under best practices developed by NHN in collaboration with PHO, de-identifying data and forming and maintaining the NHN Network. When conducting such services on behalf of NHN Network providers, NHN shall function in the capacity of a business associate of NHN Network providers and shall be subject to the business associate terms agreed to by PHOs in the NHN Network participation agreement.

PATIENT RECORDS

NHN Network provider shall make the Covered Person's medical record or requested clinical information available to NHN and to the Payer in their respective roles, subject to obtaining any necessary consent from the covered person (or business associate agreement) to do so.

EMERGENCY SERVICES

NHN Network provider agrees to provide emergency services to covered persons consistent with the site in which services are being provided regardless of their ability to pay or demonstrate financial responsibility for copayments or deductibles and without regard to any other criteria unrelated to medical need and the ability and resources of NHN Network provider to provide such emergency diagnosis and services. It is understood these services may be limited to first aid or temporary emergency intervention pending arrival of EMTs or transport to an appropriate emergency services provider.

INSURANCE

NHN Network provider agrees to carry professional liability insurance at its own expense in an amount not less than $1,000,000 per occurrence and $3,000,000 aggregate, through private insurance coverage or (if in Nebraska) through a combination of private insurance and qualification under and participation in the Nebraska Hospital Medical Liability Act, Nebraska R.R.S. §44-2801, et seq. Such coverage shall include coverage for providing covered services by NHN Network providers to covered persons. NHN Network provider will furnish a certificate from the insurance carrier attesting to the coverage upon request and will provide notice to PHO of any reduction in or termination of coverage. In addition to meeting any notice obligation to payers, NHN Network provider will upon request by the PHO or NHN notify PHO promptly whenever a covered person files a claim or notice of intent to commence action against NHN Network provider or a group physician in connection with covered services, and PHO shall immediately notify NHN. Upon request by PHO or NHN, NHN Network provider shall provide full details of the nature, circumstances, and disposition of such claims.

REFERRALS

If NHN Network provider determines that a covered person requires health services not customarily provided by NHN Network provider, including without limitation, services of hospitals, physicians, physician groups and other health care providers, NHN Network provider shall be guided by the covered person's best medical interest in referring, admitting or directing the covered person for such services. Subject to the foregoing, NHN Network provider shall exercise its best efforts to refer, admit, or direct the covered person to other NHN Network providers, except when the NHN Network provider's best medical judgment dictates otherwise or when the patient requests otherwise. When referring or admitting a Covered Person to other than a NHN Network provider, the provider shall notify the Covered Person that the service or admission may carry a higher deductible, co-pay or other cost to the Covered Person, unless the NHN Network provider reasonably believes that is not the case.

NHN NETWORK DIRECTORY

NHN Network provider agrees to allow NHN to list NHN Network provider's name, range of services provided, address and phone number in a directory of NHN Network providers to help promote the NHN Network with Payers, and to allow Payers to list similar information to help promote NHN Network providers with covered persons.

NHN NETWORK, NETWORK PARTICIPATION CRITERIA

NHN Network providers must comply with NHN Network provider participation criteria, which may be modified and communicated annually by NHN. The following participation criteria apply to NHN Network providers:

- Participate in all NHN contracts for each payer that utilizes the applicable NHN Network fee schedule and each agreement that complies with the NHN Standard Contract Parameters.
- Use ONC-certified electronic health record technology and be willing to share data with NHN to comply with payer and employer reporting, and evaluate and enhance performance.
- Participate in and comply with PHO's, NHN's, and each applicable Payer's quality improvement programs, including all required reporting, as adopted and amended from time to time.
- Participate in NHN educational activities and be available to meet with NHN or PHO staff to discuss quality and cost performance as requested.

CONTRACTING PROCESS OVERVIEW

STANDARD CONTRACT PARAMETERS

The Nebraska Health Network ("NHN") will adhere to the following contract parameters with payors, employers and third-party administrators ("Payor") for all agreements that utilize the NHN Network. Whenever a contract is with an Approved Payor, utilizes the reimbursement for that Approved Payor product and is consistent with these parameters, the PHO and PHO providers ("NHN Network Providers") shall participate in the Payor Contract in accordance with the Payor Notice.

Standard elements of Payor contracts utilizing the NHN Network:

BENEFIT PLAN DESIGNS

Payor products will include incentives in the benefit plan for beneficiaries to obtain Covered Services from NHN Network Providers. Such incentives may include reduction of deductibles, co-payments, coinsurance obligations, and/or maximum out-of-pocket payments, with the highest incentives reserved for NHN Network Providers.

- Certain payor products may provide greater benefit plan incentives for a subset of NHN Network Providers. This is allowed when a PHO Provider is using the network for their own employee benefit plan. In that event, all other NHN Network providers will remain in a benefit plan tier that provides incentives for use over non NHN Network providers.

PAYMENT

NHN will ensure that the Payor has policies to timely pay NHN Network Providers for all Covered Services pursuant to the following:

- NHN Network Provider's billed charge, minus the plan patient's responsibility under the applicable benefit plan, or in the event that the billed charge is in excess of amounts listed on the NHN Network Provider Fee Schedule, the Payor shall timely pay amounts pursuant to such schedule, minus the plan patient's responsibility under the applicable benefit plan.
- The reduction from a NHN Network Provider's billed charge due to application of the NHN Network Provider's fee schedule is the sole modification to the amount due for covered services to the NHN Network Provider by the Payor under these contracts. Outside of industry standard claims edits, payors shall not apply any other policy or edit based on reasonable and/or excessive charges, reference-based pricing, or other modification that would result in payment for covered services lower than the amount set out in the NHN Network Provider fee schedule.

TIMELINESS

NHN will ensure that the Payor allows a minimum of one hundred eighty (180) days of the date the Covered Services were provided to submit charges for the services. NHN will ensure that the Payor has policies to provide payment on Clean Claims to NHN Network Providers as follows:

- Within thirty (30) calendar days of the Payor's acknowledged receipt of a Clean Claim of the Participating Provider for Covered Services rendered to Plan Patients.
- In the case of claims that are not initially submitted as Clean Claims, payment shall be made within thirty (30) calendar days after the determination of responsibility for payment or the Claims Administrator's acknowledged receipt of the Clean Claim of the Participating Provider, whichever is applicable.
- Payors shall not have the right to seek reimbursement for payments inappropriately made to Participating Provider for Covered Services or other expenditures after one (1) year has elapsed from the date of payment. This provision shall not apply to instances involving fraud. Retrospective audits within this time period are allowed subsequent to payment being made to NHN Network Provider. However, prospective audits prior to making payment to Participating Provider shall not delay the period for timely payment.
- Participating Providers have up to one (1) year from the date of payment to submit a claim reconsideration or appeal to Payors.

ELECTRONIC CLAIMS AND CONNECTIVITY

NHN will ensure that the Payor accepts electronic claims from NHN Network Providers. Payors will support and use electronic funds transfers (EFTs) as well as HIPAA-compliant standard transactions.

VALUE-BASED AGREEMENTS

Whenever possible, NHN will negotiate with Payors to include value-based components within products. These arrangements may include incentive payments or reimbursement in one of more of the following methods:

- Per member per month (PMPM) care management fees: These are prospective payments made by the Payor to the NHN for the purposes of providing resources to manage the health of the population.
- Quality bonus payments: These are payments, typically retrospective, are made by the payor to the NHN when the NHN Network Providers are successful in meeting or exceeding pre-defined quality metrics or benchmarks.
    - Quality measures included in value-based agreements will be focused and align with generally accepted national measures (such as those in the Physician Quality Reporting System (PQRS) or the Healthcare Effectiveness Data and Information Set (HEDIS)). Focus will be given to aligning a core set of quality measures across NHN value-based agreements.
- Shared savings payments: These payments, typically retrospective, are made by the Payor to the NHN when the total cost of care for managing a population is below a target budget or projected inflation rate.
- Program specific incentives: These are programs implemented by the NHN to address specific opportunities to enhance quality, decrease cost or enhance patient satisfaction. Examples would be initiatives to decrease hospital readmissions, improve generic prescribing rates, or reduce the use of imaging. These programs would include payments, typically retrospective, made to the NHN when the results of the program produce an outcome that positively impacts the issue being targeted, and exceeds performance benchmarks agreed to with the payor.

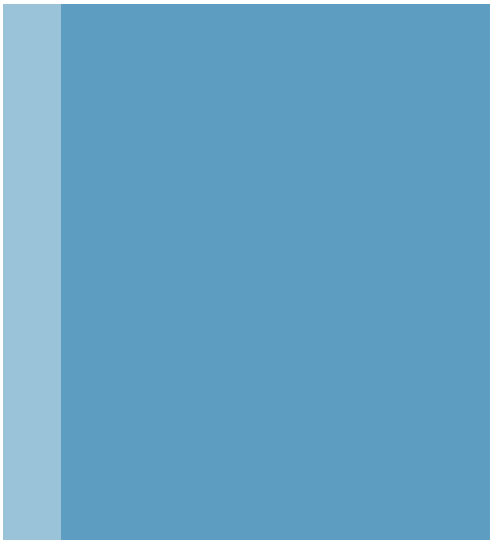
In the event a value-based agreement includes downside financial risk or a withhold of fee-for-service reimbursement, there will be a Payor Notice that provides NHN Network Providers with the ability to decline to participate.

DATA SHARING

Payors and third-party administrators will share claims and membership data with the NHN for the purposes of measuring and monitoring performance on financial and quality elements of Payor Contracts.

QUALITY MEASURES

Quality measures included in value-based agreements will be focused and align with generally accepted national measures such as those in the Physician Quality Reporting System (PQRS) or the Healthcare Effectiveness Data and Information Set (HEDIS). Focus will be given to aligning a core set of quality measures across NHN value-based agreements.



PARTICIPATION IN NHN PAYER CONTRACTS

The NHN will use the NHN Network in conjunction with payers that want to create products that provide preferential benefits to use NHN Network providers and in partnership with a Third Party Administrator(s) to provide health benefits for regional employer groups and individuals. If the Payer contract is consistent with the NHN Standard Contract Parameters and utilizes the NHN Provider Fee Schedule for an Approved Payer, then PHO and NHN Network providers shall participate in the Payer contract in accordance with the Payer notice.

If the Payer contract is not consistent with the NHN Network Contract parameters or does not utilize the NHN Network Provider Fee Schedule, then the NHN Network will deliver to the PHO a Payer notice describing the terms of the payer notice.

If PHO agrees to participate in the Payer Contract, PHO shall have forty-five (45) days following its notice to NHN that it will participate to communicate the applicable terms of the Payer notice to NHN Network providers and provide NHN with a notice listing all such NHN Network providers that have agreed to participate in the Payer contract. PHO may use an opt-in or opt-out methodology in determining which NHN Network providers have accepted and agreed to participate in a Payer contract. In the event that a NHN Network provider does not agree to participate in such Payer contract, such contract shall not take effect as to that NHN Network provider. Nothing herein shall preclude the PHO or NHN Network provider from negotiating directly with the payer in the event that the proposed fee schedule or other terms are unacceptable to PHO or NHN Network provider.

CREDENTIALING

CREDENTIALING

Provider credentialing is the process through which the educational qualifications and the clinical competence of the healthcare providers are analyzed and verified. From their professional school certificate to their latest professional training, each document of the provider is collected for verification. The credentialing process also verifies the DEA certificates and other federal requirements.

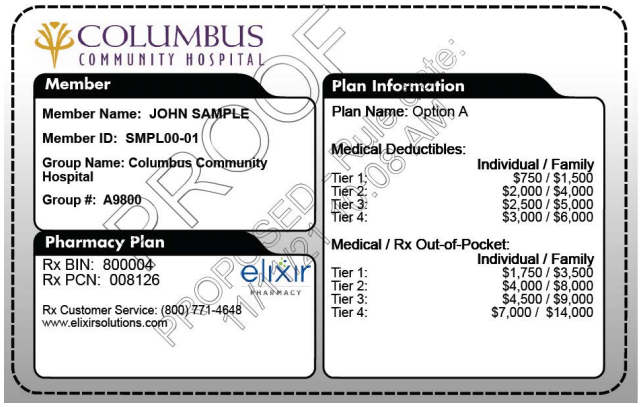
Each payer or third-party administrator has a thorough process to complete the collection and verification of documents for credentialing. The NHN shall be responsible for assuring each NHN Participant and NHN Provider is credentialed and meets the credentialing criteria of the payer or TPA.

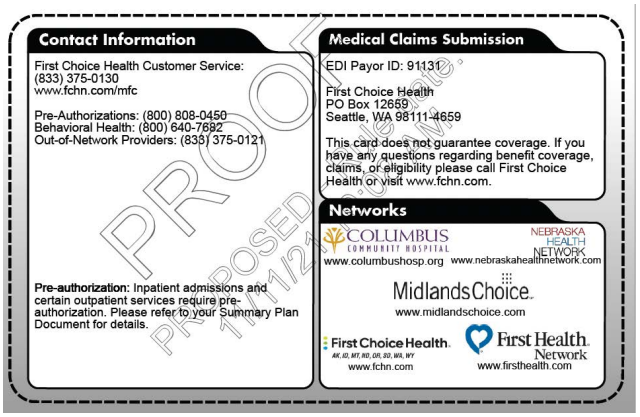
DIRECT TO EMPLOYER PRODUCTS

DIRECT TO EMPLOYER PRODUCTS

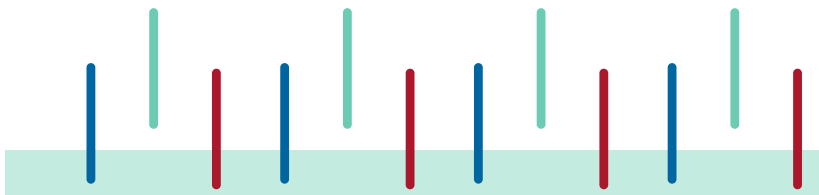
The NHN Network selected First Choice Health as its Third Party Administrator. Based in Seattle, Washington, First Choice Health is a physician and hospital owned organization. Please reference the First Choice Health provider manual found under Appendix One for additional information.

SAMPLE ID CARDS





MARKETING GUIDELINES



MARKETING GUIDELINES

NHN Network Providers may conduct general advertising using the NHN Network brand identity. All materials must receive prior written approval prior to production and should be directed to nhn@nebraskahealthnetwork.com.

BRANDING

The NHN Network Brand Identity Guidelines focus on the implementation of the NHN Network visual identity and brand by standardizing the use of logos, fonts, color and brand elements. Network members should review and share the guidelines with individuals focused on marketing efforts for their organization.

Network members are affiliates of the NHN Network. The NHN Network logo or name should always be used when promoting the Network. Affiliates should adhere to the branding guidelines when referencing the NHN Network. Additionally, the Affiliate partner name should always follow NHN Network when appearing in copy.

- Ex. NHN Network, Sample Hospital, Clinic or Health-Care System

Please note that the Network may elect to change its branding and name over time. At that time, we will provide additional guidelines and resources to assist with your communication strategy.

SOCIAL MEDIA GUIDELINES

The NHN Network will be responsible for managing the Network's social media channels. Affiliate organizations are encouraged to engage with the channels including liking, sharing and commenting on the posts.

RESOURCES

RESOURCES

The NHN Network has a number of online resources to support your needs.

PROVIDER EDUCATION

We believe in empowering our providers to deliver the highest quality of care. Our provider resource library features tools to help you communicate with patients, bill and code appropriately and understand population health trends impacting our entire network

PATIENT EDUCATION

We believe patient education is a key element in helping patients proactively manage their health. We offer a number of educational resources to guide patients in their health journey including: Chronic condition overviews and actionable resources such as Daily Self Checks, screening guides, medication trackers and more.

COMPLIANCE, FRAUD, WASTE AND ABUSE

COMPLIANCE, FRAUD, WASTE AND ABUSE

REGULATIONS AND GUIDELINES

NHN Network's fraud, waste and abuse policy was established to prevent, detect and correct fraudulent, wasteful or abusive practices perpetrated by employees, members, providers and facilities, including providers and facilities not contracted with the Network.

Compliance with this policy is the responsibility of each and every employee and anyone providing services to members of the NHN Network providers should ensure that all staff are thoroughly educated on state and federal requirements and that appropriate compliance programs are in place.

The NHN Network expects its first tier, downstream and related entities (FDRs) and its providers to operate in accordance with all applicable federal and state laws, regulations, and Medicare and Medicaid program requirements including, but not limited to the following:

HEALTH CARE FRAUD (18 U.S.C. §1347)

The Health Care Fraud statute makes it a crime for anyone to knowingly and willfully execute or attempt to execute a scheme to defraud any health care benefit program or to obtain by false or fraudulent pretenses, representations, or promises any of the money or property from a health care benefit program in connection with the delivery of or payment for health care benefits.

FEDERAL AND STATE FALSE CLAIMS ACTS (31 U.S.C. §§ 3729-3733)

The Federal False Claims Act (FCA) prohibits any person from engaging in any of the following activities:

- Knowingly submitting a false or fraudulent claim for payment to the United States government;
- Knowingly making a false record or statement in order to get a false or fraudulent claim paid or approved by the government;
- Conspiring to defraud the government in order to get a false or fraudulent claim paid or approved by the government; or
- Knowingly making a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the government.
- Federal Criminal False Claims Statutes (18 U.S.C. §§287,1001) Federal law makes it a criminal offense for anyone to make a claim to the United States government knowing that it is false, fictitious, or fraudulent. This offense carries a criminal penalty of up to five years in prison and a monetary fine.

ANTI-KICKBACK STATUTE (42 U.S.C. § 1320A-7B(B))

This statute prohibits anyone from knowingly and willfully receiving or paying anything of value to influence the referral of federal health care program business, including Medicare and Medicaid. Kickbacks can take many forms such as cash payments, entertainment, credits, gifts, free goods or services, the forgiveness of debt, or the sale or purchase of items at a price that is inconsistent with fair market value. Kickbacks may also include the routine waiver of copayments and/or coinsurance. Penalties for anti-kickback violations include fines of up to $25,000, imprisonment for up to five years, civil money penalties up to $50,000, and exclusion from participation in federal health-care programs.

THE BENEFICIARY INDUCEMENT STATUTE (42 U.S.C. § 1320A-7A(A)(5))

This statute makes it illegal to offer remuneration that a person knows, or should know, is likely to influence a beneficiary to select a particular provider, practitioner, or supplier, including a retail, mail order or specialty pharmacy.

PHYSICIAN SELF-REFERRAL ("STARK") STATUTE (42 U.S.C. § 1395NN)

The Stark Law prohibits a physician from referring Medicare patients for designated health services to an entity with which the physician (or an immediate family member) has a financial relationship, unless an exception applies. Stark Law also prohibits the designated health services entity from submitting claims to Medicare for services resulting from a prohibited referral. Penalties for Stark Law violations include overpayment/refund obligations, FCA liability, and civil monetary penalties. Stark Law is a "strict liability" statute and does not require proof of intent.

FRAUD ENFORCEMENT AND RECOVERY ACT (FERA) OF 2009

FERA made significant changes to the False Claims Act (FCA). FERA makes it clear that the FCA imposes liability for the improper retention of a Medicare overpayment. Consequently, a health care provider may now violate the FCA if it conceals, improperly avoids or decreases an "obligation" to pay money to the government.

COMPLIANCE REPORTING

Medicare beneficiaries, health-care providers, contractors, suppliers or team members with ethical, legal or compliance-related concerns or questions, may report concerns via our website at NebraskaHealthNetwork.com/compliance.

Emails generated by the form are treated with strict confidentiality. Individuals who submit concerns are protected from retaliation for reporting an issue in good faith. Submissions may include contact information or remain anonymous.

HIPAA PRIVACY AND SECURITY

Nebraska Health Network is HIPAA compliant. We take great pride and care to protect patient health information.

It is the policy of the NHN Network to comply with all applicable federal and state regulations governing privacy and confidentiality, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA). It is the policy of the NHN Network to protect privacy and confidentiality through the appropriate acquisition, storage, maintenance, use, and destruction of information gathered in the course of population health management and other activities of the NHN Network or entrusted to the NHN or patient care or administrative purposes. Information created or received in the course of NHN Network operations is a valuable asset of the NHN Network and belongs to the NHN Network. NHN Network workforce and business associates with access to private and/or confidential information will be held accountable for maintaining confidentiality.

Breach of confidentiality may result in sanctions, civil or criminal prosecution and penalties, and/or employment/academic corrective action, which could lead to dismissal or, as it relates to health care professionals associated with the NHN Network, suspension or revocation of all access privileges or removal from the NHN Network.

The NHN Network workforce has a duty to protect confidential information. Breach of this duty includes but is not limited to the following:

- Accessing confidential information, in any form, without a "need to know" to perform assigned duties.
- Disclosing confidential information to individuals who do not have a "need to know" to perform assigned duties.
- Disclosing confidential information without proper authorization (see Use & Disclosure of Protected Health Information Policy).
- Leaving confidential information unattended in a non-secure area.
- Improper disposal of confidential information.
- Using another person's user ID, password, or other security codes.
- Assisting an unauthorized user to gain access to a secured information system.
- Using confidential information developed or received for NHN Network purposes for other external or outside purposes (other than NHN Network functions).
- Disclosing confidential information on social media (even if a patient's name is not used, any information disclosed that may identify the patient constitutes a HIPAA violation).
- Violation of NHN Network privacy or security policies.

Individuals who know or suspect that a privacy or security incident has occurred by another person or persons have a responsibility to report the incident to the Privacy and Security Officer of the NHN Network. All individuals are to cooperate fully with those performing an investigation pursuant to the policy.

APPENDIX ONE: FIRST CHOICE HEALTH PROVIDER MANUAL

First Choice Health®

Provider Manual

Provider Policies & Procedures

v.2021.2

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Chapter One: First Choice Health Information

Introduction

The purpose of this manual is to provide the basic information you and your office staff need when you see NHN Network members that utilize First Choice Health. This manual provides direction and clarification regarding your obligations as a NHN Network provider.

General Information

First Choice Health is a Seattle-based, physician and hospital owned company that has been serving customers since 1985. First Choice Health provides Health Plan Administration services to the NHN Network. First Choice Health also offers Medical Management services and an Employee Assistance Program (EAP).

How to Contact Us

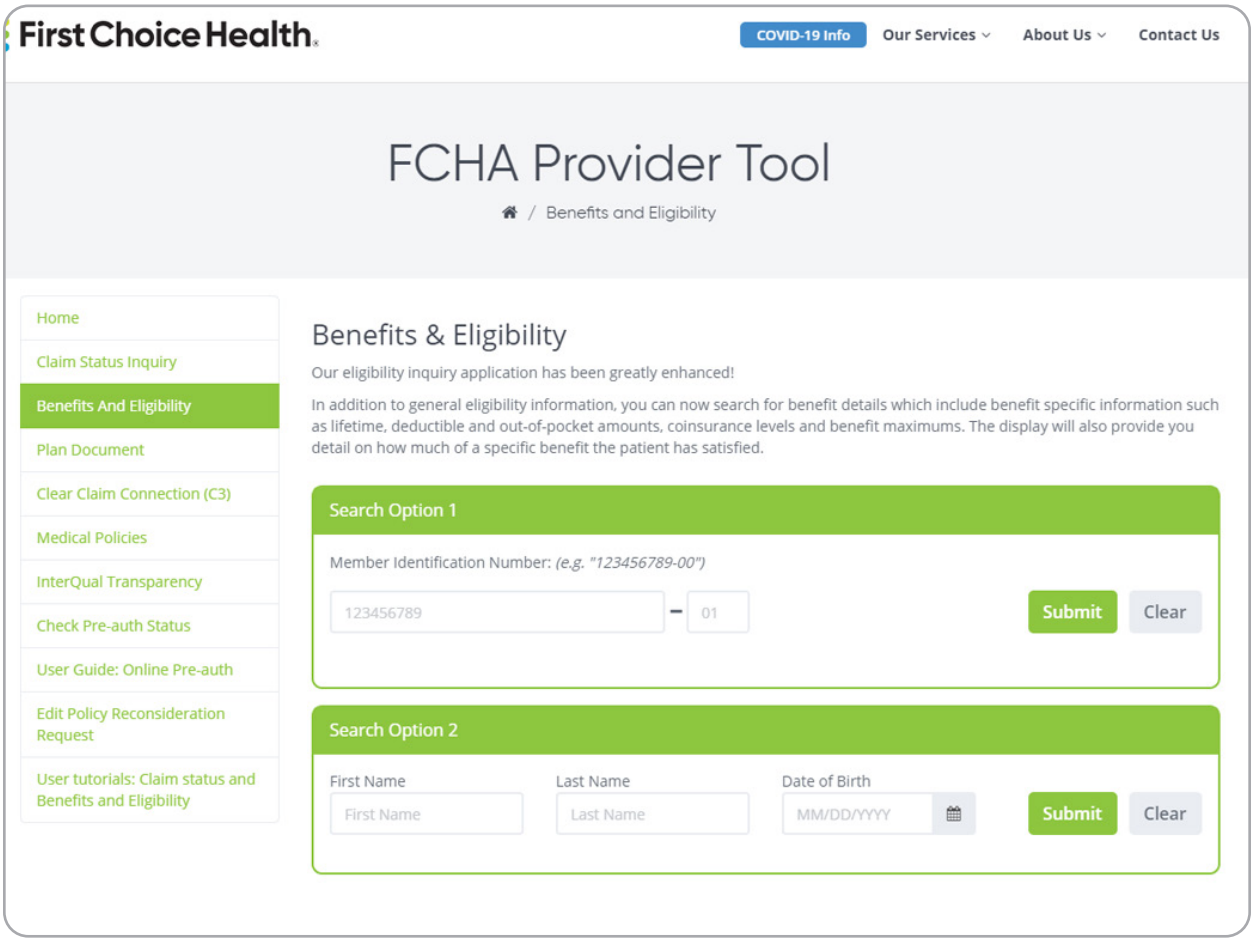
For assistance regarding your fee schedule allowed amounts, contact Provider Relations via email at ProviderRelations@fchn.com. For claims processing assistance, contact our Customer Care Team via phone at (800) 517-4078.

Chapter Two: Provider Portal Tools

Benefits and Eligibility

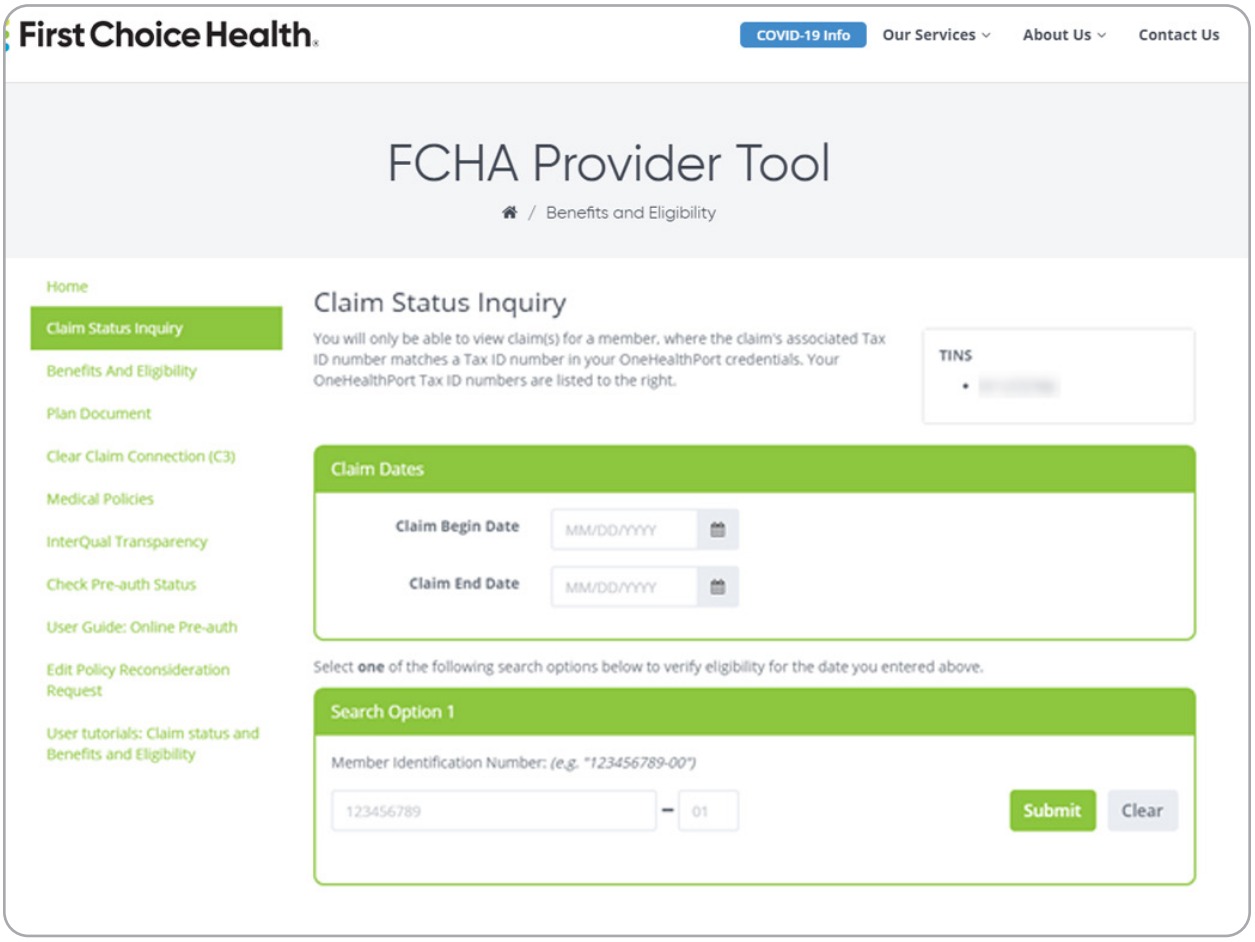
To assist providers, we have a dedicated Provider Portal available at www.fchn.com/TPAProviders/Home/BenefitsEligibility. This web page displays information regarding member benefits and eligibility, as well as claims status.

This is a secured web page and requires registration with OneHealthPort (OHP) in order to access the page. Use of OHP is free to providers entering their data.



Claims Status

First Choice Health offers third party administration for the NHN Network including adjudicating claims. To check the status of your claim, use our online web tool at www.fchn.com/TPAProviders/Home/ClaimStatusInquiry. This is a secured web page and requires registration with OneHealthPort in order to access the page.

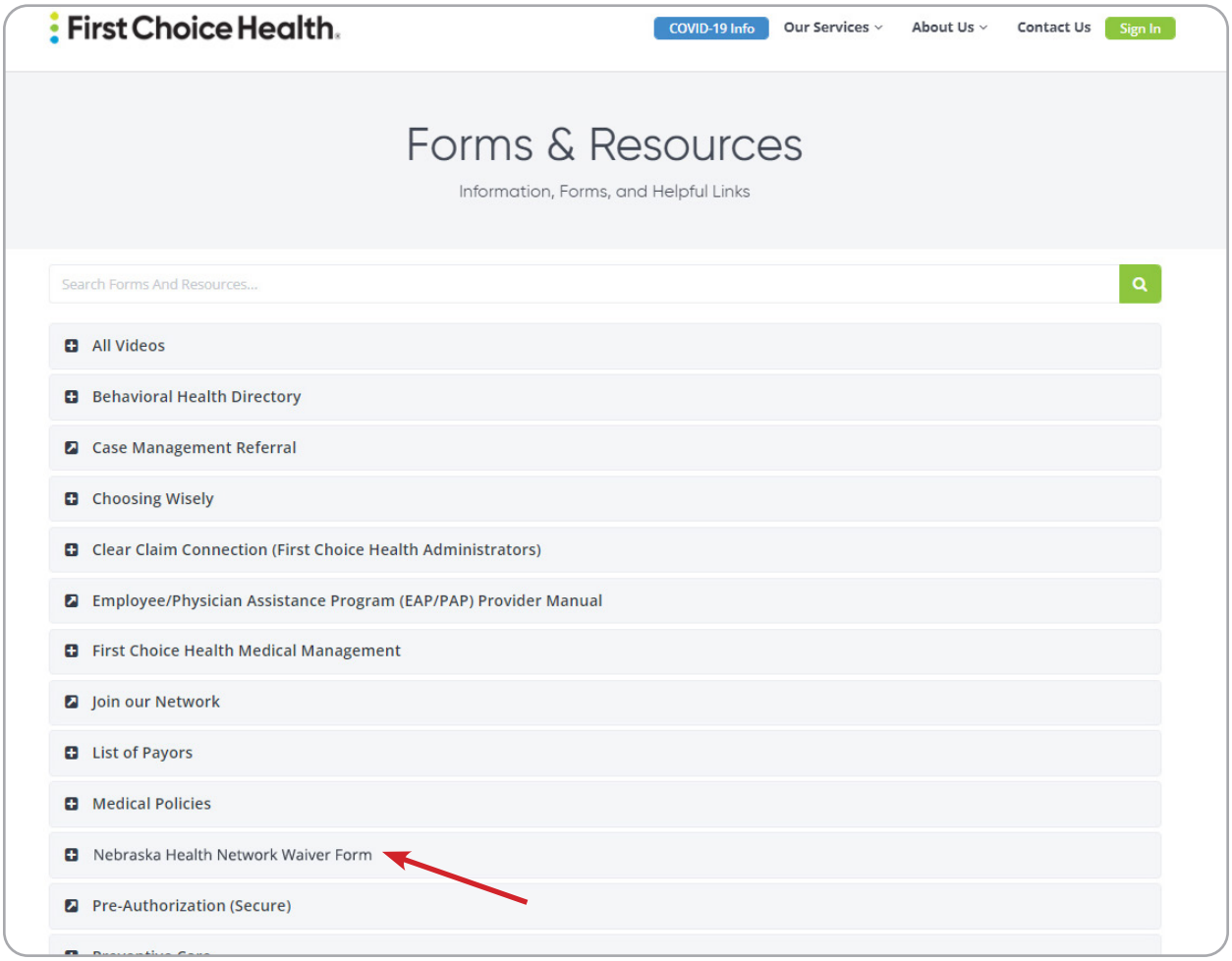


NHN Waiver Form

The Nebraska Health Network waiver form is an opportunity for providers participating in the Nebraska Health Network to submit a request for enrolled members to see an Out of Network provider at In-Network Tier 2 pricing. The requesting provider must complete and sign the form, then email it to casemanagement@fchn.com. If the request is approved, any other requests, such as prior authorization, also need to be submitted to First Choice Health. Once a decision is made, First Choice Health will notify both the member and provider of the decision by letter.

The Nebraska Health Network (NHN) Waiver Form can be found on our website at www.fchn.com/FormsResources?cat=P. This form is not secured and does not require a sign on.

Contact us at (800) 808-0450 or email casemanagement@fchn.com if you have any questions.



Chapter Three: Claims and Billing

Where to Send Claims and Claim Payments

Refer to the member's ID card for the claims address. Electronic claims submission is the fastest, most efficient route to submit claims for processing.

- EDI Payor number is 91131
- Claims mailing address is PO Box 12659, Seattle, WA 98111-4659

Physicians and healthcare providers are required to use only a street address as the billing provider address under the Version 5010 transactions. The billing provider address is reported in the billing provider loop (2010AA, N3S01, and N302) of the 837 claim transaction.

First Choice Health uses both Group ID and Group Name information to match claims appropriately. Without the presence of valid group information, we will be unable to accurately associate the claim.

Pay-To (Remittance) Address

First Choice Health rejects EDI claims transactions that are submitted with a post office box in the billing provider address field to comply with HIPAA. **Providers who want payments to be sent to PO boxes or lockboxes need to report this address in the "pay-to" address field on the EDI transaction (Loop 2010AB).**

HIPAA requires that all 5010 transactions are billed with extended zip codes (ZIP+4) in the billing provider (Loop 2010AA N403). First Choice Health requires all transactions to include a complete address (a complete address is defined as including the full 9-digit ZIP code—the traditional five digits plus the extra four digits for localized mail delivery).

Interim Claims

First Choice Health does not have the ability to price interim claims. If an interim claim is received, it will be rejected and returned to the submitter. The rejection code 'C12' (*interim bills cannot be processed*) can be found on the pricing worksheet. The claim must be submitted as final for First Choice Health to price. The exception to this pricing rule is if your contract is based on a percentage of billed charges.

Chapter Four: Payment Overview

This section of the provider manual covers any type of service where the provider's contractual allowance is affected by certain billing methodologies.

Anesthesia Claims

Anesthesiology services are calculated using base units plus time units. The procedure for re-pricing anesthesia claims by First Choice Health is as follows:

- All claims for anesthesia services require the total time of the procedure, with the exception of codes 01953, 01995, and 01996, which do not require time units. The time billed is then converted into "time units." Time units are calculated in fifteen (15) minute increments or four (4) time units per hour.
- All claims for maternity related anesthesia claims billed with CPT code 01967 are calculated at 15 minute increments for the first hour (4 units) and 60 minute increments for subsequent hours (1 unit).
- Any value of time up to the first 15 minutes is considered one time unit. For time billed beyond the initial time unit, FCH applies a seven (7) minute rule when calculating time units. The first seven minutes reported after the first time unit will be rounded down to the previous 15-minute increment. Any time reported after seven minutes will be rounded up to the next 15-minute increment.
- All applicable codes are assigned base units on each fee schedule. Total anesthesia units are calculated by adding the calculated time units to the specific base anesthesia units that are listed on the fee schedule for the CPT code billed.
- CPT codes ranging from 0019T-0042T are Category III codes and are considered temporary (anesthesia logic does not apply). These codes will be priced at the Default Discount for each fee schedule when payable.
- First Choice Health will not accept CPT codes billed with time units for contracted anesthesia providers.
- Only bill appropriate CPT anesthesia codes (00100-01999).
- Every anesthesia procedure billed must include one of the following anesthesia HCPCS modifiers:

Modifier	Modifier Denotes
AA	Anesthesia services performed personally by anesthesiologist or when an anesthetist assists a physician in the care of a single patient
QY	Medical direction of one qualified non-physician
QK	Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals
AD	Medical supervision by a physician: more than four concurrent anesthesia procedures
QX	Qualified non-physician anesthetist service: with medical direction by a physician
QZ	Qualified non-physician anesthetist service: without medical direction by a physician

Baby's Birth Weight

When billing Newborn Inpatient claims on the UB04, use Value Code 54 - Enter this code in the code field with the newborn birth weight in grams in the amount field (no decimals). Right justify the weight in grams to the left of the dollars/cents delimiter. (If billing software requires the decimal in the "Value Code" field, enter the weight in grams then decimal point 00 e.g., 2499.00). Baby's birth weight should be billed in EDI Loop 2300.

Modifiers

FCH recognizes all valid CPT/HCPCS modifier codes, although not every modifier code will affect a NHN negotiated allowable. There may be modifiers billed that do not impact pricing. Payment adjustment may be necessary based on the payor's medical payment policy. The following modifier table is not inclusive of all modifiers that may or may not warrant a change in reimbursement. The modifiers on the following pages are only applied to professional claims unless otherwise noted in your contract. Adjustments applied to codes billed with modifiers will be limited to the charge line in which the code and modifier were billed.

Modifier Pricing Hierarchy

The following guidelines will be used by FCH to ensure correctly priced modifiers:

- Modifiers that alter the contract allowed amount due to the provider agreement should always be priced according to that agreement first.
- Modifiers that result in an allowed amount greater than the contract allowed amount are priced next.
- Modifiers that result in an allowed amount less than the contract allowed amount are priced next.
- Modifiers that do not alter the contract allowed amount are informational only.

Additional Modifier Information

Modifier	Modifier Denotes	Description
AA	Anesthesia component	The allowable amount is based on the start and end times of the procedure, and is calculated in conjunction with the predetermined base units.
AD	Anesthesia component	Reduce allowable by 50%.
AS	PA services for assistant at surgery	Reduce allowable by 80%.
NU	New DME	The allowable amount is contractually predetermined.
P3	A patient with severe systemic disease	One base unit will be added.
P4	A patient with severe systemic disease that is a constant threat to life	Two base units will be added.

Modifier	Modifier Denotes	Description
P5	A moribund patient who is not expected to survive without the operation	Three base units will be added.
QK	Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals	Reduce allowable by 50%.
QX	CRNA service: with medical direction by a physician	Reduce allowable amount by 50%.
QY	Medical direction of one Certified Registered Nurse Anesthetist (CRNA) by an anesthesiologist	Reduce allowable amount by 50%.
RR	Rental DME	The allowable amount is contractually predetermined.
RT	Procedure done on the right side of the body	100% of allowable
LT	Procedure done on the left side of the body	100% of allowable
TC	Technical component	The allowable amount is contractually predetermined.
UE	Used DME	The allowable amount is contractually predetermined.
22	Unusual procedural services	Upon medical review by payor, if determined appropriate, recommended reimbursement is to increase to 125% of allowable.
24	Unrelated evaluation and management service by the same physician during a post-operative period	100% of allowable
25	Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service	100% of allowable
26	Professional component	The allowable amount is contractually predetermined.
50	Bilateral procedure	150% of allowable
51	Multiple procedure	Reduce allowable by 50%.
52	Reduced services	Upon medical review by payor, if determined appropriate, recommended reimbursement is to reduce allowable by 25%.
53	Discontinued procedure	Upon medical review by payor if determined appropriate, recommended reimbursement is to reduce allowable by 50%.
54	Surgical care only	Reduce the contract allowed by 20% per applicable charge line.
55	Post-operative management only	Reduce allowable by 80%.
56	Pre-operative management only	Reduce allowable by 90%.

Modifier	Modifier Denotes	Description
58	Staged or related procedure or service by the same physician during the post-operative period	100% of allowable
59	Distinct procedural service	It may be appropriate to review supporting documentation for this distinct procedural service.
62	Two surgeons	Reduce allowable by 37.5% for a surgical procedure.
73	Discontinued outpatient hospital/ ambulatory surgery center (ASC) procedure prior to the administration of anesthesia	Upon medical review by payor, a determination is made on how much of the procedure was not done. It is then reduced by 25%, 50%, or 75%.
74	Discontinued outpatient hospital/ ambulatory surgery center (ASC) procedure after the administration of anesthesia	Upon medical review by payor, a determination is made on how much of the procedure was not done. It is then reduced by 25%, 50%, or 75%.
78	Return to the operating room for a related procedure during the post-operative period	Reduce allowable by 20% for a surgical procedure.
80	Assistant surgeon	Reduce allowable by 80%.
81	Minimum assistant surgeon	Reduce allowable by 80%.
82	Assistant surgeon (when qualified resident surgeon not available)	Reduce allowable by 80%.

Bilateral Procedures

A valid bilateral adjustment as indicated by CMS, should be billed on one line with modifier 50. These are procedures with a Medicare Physician Fee Schedule Database (MPFSDB) bilateral indicator of one (1). If a bilateral procedure is eligible for bilateral adjustment, it should be processed with one (1) unit of service and reimbursed at 150% of allowed charges, not to exceed billed charges.

For ASCs, bilateral procedures billed on one line with modifier 50 and one (1) unit, will be reimbursed at 150% of allowed charges. Bilateral procedures may also be billed on two lines with RT and LT modifiers on each and will be reimbursed for the first line at 100% of allowed charges, and for the second line at 50% of allowed charges.

Observation and Inpatient Admission Policy

A patient admitted to observation and then admitted to inpatient status on the same day should be billed using inpatient admission codes only.

A patient admitted to observation and then admitted to inpatient status on a different day may be billed with both the initial observation codes and also hospital admission codes on the subsequent day. Any observation hours exceeding 48 hours should be billed in the non-covered column.

Claims Editing

Claims may be subject to standard claims editing software by payors to detect bundling and unbundling as well as incorrect billing.

Sales Tax

HCPCS code S9999, which bills for sales tax, will appear on FCH re-pricing worksheets with an allowed amount of $0.00 as FCH does not have the authority to dictate payment on sales tax. Sales tax is reimbursable at NHN's discretion.

Chapter Five: Quality

First Choice Health product performance is measured by identifying and implementing a set of organizational quality standards designed to meet and exceed customer and regulatory requirements.

First Choice Health tracks, trends, and looks for opportunities to improve services across all divisions and departments. Measures are tracked daily and reported weekly, monthly, and quarterly to appropriate corporate and quality committees.

Metrics Monitored at a Corporate Level

- Customer Service and Provider Relations call statistics
- Average answer time
- Abandonment rates
- Claims processing metrics
- Claims pricing turnaround times
- Days on hand
- Payor pricing
- Active providers
- Provider files

Receiving and Tracking Complaints

First Choice Health has a process for tracking any written or verbal concerns from any customer who accesses care and services through a participating FCH provider.

Complaints regarding providers: Any issue, verbal, or written statements, regarding perceptions of sub-standard care, administrative service, or office environment of a provider. Complaints fall under two categories:

1. Perceived Service Quality Concern: Any non-clinical issue, raised verbally or in writing, regarding the administrative service or office environment of a participating FCH provider. Service quality includes perceived friendliness and courtesy of staff.
2. Perceived Quality of Care (PQOC) Concern: Any verbal or written concern about the perceived quality of clinical care provided or actions taken by a healthcare provider. Either the participant or his/her designated representative, a provider, FCH Medical Management staff, or a client may submit a perceived quality of care concern.

Perceived quality of care concerns are initially reviewed by the Chief Medical Officer or medical director designee. As part of the review, patient medical records may be requested. The final review of the complaint may be submitted to the Credentialing Department.