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Privileged and Confidential
Letter from the CMO - Welcome to Teachers Health Trust

Dear Providers,

As we enter the new decade, Teachers Health Trust is more driven and more focused than ever on providing the highest quality of care for our members while allowing them to maximize their out-of-pocket costs. We believe in the power of collaborative health partnerships and our comprehensive network of quality providers is of the most essential key to our plan.

At Teachers Health Trust we hold ourselves accountable and only to the highest of standards and we share similar expectations from our Healthcare providers and facilities that are a part of our network. Our mission to deliver the best healthcare at affordable costs to a deserving community. This philosophy improves the quality of care while enhancing communication, engagement, experience, and member satisfaction.

To accomplish our goals for 2020 and to build our innovative and successful integrated community of providers, Teachers Health Trust is determined to provide you with the best practices, appropriate resources, clearest directions and real-time support that you may need in order to achieve the best outcomes for our members.

Our Provider Relations and Leadership teams are always here to help our members, as well as our providers, navigate through the health care continuum. On behalf of our entire team at Teachers Health Trust, I look forward to working closely with you. Thank you for choosing to be an integral part of our family.

Warmly,

Leslie Jacobs, M.D.
Chief Medical Officer
Teachers Health Trust
Plan Information

Welcome to Teachers Health Trust. Teachers Health Trust (THT) is a self-funded health plan, serving employees of the Clark County School District located in Southern Nevada.

The goal of this health plan is to meet the needs of our members. It is vital we strategically partner with innovative health professionals and leaders in the technology industry. Collectively, we seek to maximize the benefits offered to all members while controlling out of pocket costs. THT while promoting prevention and wellness, is committed to supporting members that need access care for serious health conditions. THT and our partners are committed to ensuring all members have access to quality care delivered by quality healthcare professionals.

Important Information

If there is a conflict between your Agreement and this care provider manual, use this manual unless your Agreement states you should use it instead. If there is a conflict between your Agreement, this manual and applicable federal and state statutes and regulations and/or state contracts, applicable federal and state statutes and regulations and/or state contracts will control. Teachers Health Trust Plan reserves the right to supplement this manual to help ensure its terms and conditions remain in compliance with relevant federal and state statutes and regulations. This manual will be amended as policies change.
Role of Third-Party Administrator (TPA)\(^1\)

Teachers Health Trust has contracted with a Third-Party Administrator (TPA) to provide certain administrative services for Teachers Health Trust’s plan(s), which includes claims processing, eligibility, verification, and benefits.
Key Contacts

For quick reference information about Teachers Health Trust Plan, providers can visit our website at https://www.teachershealthtrust.org/guides or log in to provider portal with https://www.askallegiance.com/THT/Login URL.

Note: Providers can call the following resources for more information

Teachers Health Trust Contacts

<table>
<thead>
<tr>
<th>Service</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teachers HealthTrust Direct Line/Member Services</td>
<td>702-794-0272</td>
</tr>
<tr>
<td>Contracting Team</td>
<td>702-780-1445</td>
</tr>
<tr>
<td>Provider Relations</td>
<td>702-780-1445</td>
</tr>
<tr>
<td>Compliance Hotline</td>
<td>844-936-0724</td>
</tr>
<tr>
<td>Pharmacy Claims &amp; Prior Authorization</td>
<td>1-877-330-3789</td>
</tr>
<tr>
<td>Specialty and Mail-Order Pharmacy</td>
<td>1-800-874-5881</td>
</tr>
</tbody>
</table>

Allegiance¹ Contacts

<table>
<thead>
<tr>
<th>Service</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical or dental claims</td>
<td>855-999-1050</td>
</tr>
<tr>
<td>Verification of benefits</td>
<td>406-523-3199</td>
</tr>
<tr>
<td>Pre-treatment review &amp; pre-certification</td>
<td>800-342-6510</td>
</tr>
<tr>
<td>Utilization Review</td>
<td>855-999-1050</td>
</tr>
<tr>
<td>Case Management</td>
<td>855-999-1050</td>
</tr>
<tr>
<td>Subrogation/Third Party Liability</td>
<td>855-999-1050</td>
</tr>
</tbody>
</table>

¹Allegiance is Teachers Health Trust’s Third-Party Administrator to process claims, provide eligibility and other related administrative services. For more information please refer to [page reference for TPA information]
Member Information

Eligibility Verification

All network providers are responsible for verifying a member’s eligibility at every visit.

Verification can be done by:

- Call Teachers Health Trust at 702-794-0272; Monday – Friday 8:00 am – 5:00 pm PST
- Visit AskAllegiance.com
- Ask to see the members ID Card. The member ID will have the member ID number, plan code, name, and effective date. Please note the card alone does not guarantee the customer is eligible

Member Identification Card
Member Rights

Teachers Health Trust Members have the following rights:

1. **The right to be treated with dignity and respect**

Members have the right to be treated with dignity, respect and fairness at all times. Teachers Health Trust must obey laws against discrimination that protect customers from unfair treatment. These laws state that Teachers Health Trust cannot discriminate against members because of a person’s race, disability, religion, gender, sexual orientation, health, ethnicity, creed, age or national origin. Members can file complaint by contacting Teachers Health Trust Compliance Officer at 844-936-0724. Please refer to Teachers Health Trust website for contact information.

2. **The right to protection of medical records and personal health information**

Federal and state laws are in place to protect the privacy of members medical records and personal health information. Teachers Health Trust keeps members health information private as required under these laws. Any information that a member provides to Teacher Health Trust is protected. Written permission must be obtained from authorized person(s) before members health information is given to anyone who is not involved in the member’s medical care (excluding exception required by law such as governmental agencies auditing quality of care).

The laws that protect customer privacy give them rights related to accessing information and controlling how their health information is used. Teachers Health Trust is required to provide members with a notice that informs them of these rights and explains how Teachers Health Trust protects and privacy of their health information.

3. **The right to see Network Providers, get covered services and get prescription filled within a reasonable period of time**

Members have the right to receive full information from providers when medical care has been received, and the right to participate fully in treatment planning and decisions about their health care. Teachers Health Trust network providers must explain treatment options, planning and health care decisions in a way that members understand. Members have the right to know about all treatment options that are recommended for current conditions including all appropriate and medically necessary treatment options, regardless of the cost or whether they are covered by Teachers Health Trust current benefit plan. Members have the right to be told about all known risks involved with recommended treatment plans. Members must be informed in advance, in writing, if any recommended treatment plan is considered experimental or part of a research study.

__________________________________

2Compliance official’s contact information is also available on Teachers Health Trust’s website.
Members have the right to refuse treatment. This includes the right to leave a hospital or medical facility against medical advice. Members have the right to discontinue medications. Members that exercise this right accept responsibility for the results of refusing or discontinuing treatment.

4. **The right to use Advance Directives (Living Will or Power of Attorney)**

Members have the right to ask another person(s) to help with decisions regarding their health care. Members have the right to give their doctors written instruction mandating how to handle their medical care if they become unable to make decisions for themselves. Members must complete the legal documents such as “advance directive”, “living wills”, and “powers of attorney for health care” to execute their wishes.

Members can obtain advance directives for an attorney, social worker, hospital, online or other legal forms distributer. Once the legal document is signed, it is important for member to keep a copy at home and provide a copy to their provider and the person named as the ultimate decision maker.

5. **The right to make complaints**

Members have the right to make a complaint if they have concerns or problems related to their coverage or care. Members may file appeals, grievances, concerns and coverage determinations.

If members make a complaint or file an appeal or coverage determination, Teachers Health Trust is prohibited from discriminating against them because a complaint was made or filed an appeal. Teachers Health Trust should inform members how to file an appeal.

6. **The right to obtain information about their health care coverage and cost**

The Evidence of Coverage informs members what medical services are covered and what is the members responsibility. Members that need additional information can contact Teachers Health Trust. Members have the right to know how we pay our providers.

**Benefit Exclusions & Network Limitations**

Coverage under Teachers Health Trust plans may be subject to limitations and exclusions. Network providers should verify the availability of benefits before rendering services and inform the member of any potential payment responsibility.

Contact Customer Service to verify and obtain information on member benefits at 702-794-0272. Teachers Health Trust is not obligated to pay for services that are not covered benefits or in situations in which the applicable benefit has been exhausted, denied, or not authorized.
Member Confidentiality

Our members’ privacy is our highest priority. Teachers Health Trust respects and will protect our members personal information. Member information is not disclosed to anyone without consent from authorized person(s) unless permitted by law.

Teachers Health Trust has access to Protected Health Information (PHI). PHI, as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), is:

(i) information created or received by a health care provider, health plan, employer or health care clearinghouse, that relates to the past, present or future physical or behavioral health or condition of an individual, the provision of health care to the individual or the past, present or future payment for provision of health care to the individual;
(ii) identifies the individual, or with respect to which there is a reasonable basis to believe the information can be used to identify the individual; and
(iii) is transmitted or maintained in an electronic medium, or in any form or medium

For more details on HIPAA and PHI, please refer to http://www.hhs.gov/hipaa/

Access to PHI allows Teachers Health Trust to work with providers, to decide whether a service is a covered service and pay clean claims as contracted. Medical records and claims are generally used to review treatment and to conduct quality assurance activities but this information also allows Teachers Health Trust to understand how care is being delivered and identify opportunities to develop programs to improve the quality of care that Teachers Health Trust members receive and to help improve members’ quality of life.

Teachers Health Trust members have additional rights over their protected healthcare information (PHI). They have the right to:

- Send Teachers Health Trust a written request to see or get a copy of information about them
- To amend personal information that is believed to be incomplete or inaccurate.
- Request that we communicate with them about medical matters using reasonable alternative means or at an alternative address, if communications to address on file could endanger them
- Receive an accounting of Teachers Health Trust disclosures of their medical information, except when those disclosures are for treatment, payment, or health care operations, or the law otherwise restricts the accounting

As a Covered Entity under HIPAA, providers are required to comply with the HIPAA Privacy Rule and other applicable laws in order to protect members Personal Health Information. To discuss any breaches of the privacy of our members, please contact our Compliance Officer at 844-936-0724. Please refer to Teachers Health Trust website for contact information.
Cost-Sharing

Members may be required to pay a portion of the cost of their care as a deductible, co-payment, and/or co-insurance until they have paid their maximum out-of-pocket amount. A member whose plan benefits include a deductible must pay the entire cost of care up to a specified deductible amount. Members that must make co-insurance payments are responsible for paying a percentage of the cost of care prior to having spent the maximum out-of-pocket amount. Members that must make co-payment when visiting the doctor must pay fixed amount for each visit, up to the maximum out-of-pocket amount. Specific deductible, co-payment, and co-insurance amounts may vary depending on the member’s benefits.

The maximum out-of-pocket for Teachers Health Trust Tier 1 is $6,850 individual/$13,700 family and for Tier 2 is $7,900 individual/$15,800 family.\(^3\)

Once the maximum out-of-pocket has been reached, the member is no longer responsible for any additional costs for the remainder of that year.

Network providers are required to verify the applicable member cost share at the time of service. Network providers are responsible for collecting any applicable cost share in accordance with the member’s benefits.

Network providers can find cost share information by:

<table>
<thead>
<tr>
<th>Paper Claims Submission</th>
<th>Electronic Claims Submission</th>
</tr>
</thead>
<tbody>
<tr>
<td>THT &amp; Dental Providers submit claims to: Allegiance PO Box 3018; Missoula, MT 59806</td>
<td>Payor ID: 81040</td>
</tr>
</tbody>
</table>

Member Held Harmless

Network providers are prohibited from balance billing Teachers Health Trust members, including but not limited to situations involving non-payment by Teachers Health Trust. The provider shall not bill, charge, collect a deposit or seek compensation or reimbursement from or have any recourse against members, pursuant to the providers’ contract. The provider is permitted to collect co-payments or coinsurances for covered services in accordance with the terms of the current benefit plan and as described above.

\(^3\) Please refer to Teachers Health Trust’s plan document available on Teachers Health Trust’s website to confirm the maximum out of pocket amount for your patient.
Provider Information

Provider Rights

- Teacher Health Trust encourages your feedback and suggestion on avenues to improve the services provided to both the provider and member
- The provider may request reconsideration on claims processing that the providers believe were not adjudicated in accordance with payment policy and/or contractual rates
- The provider may request an Appeal on any claims submission which was denied for services rendered
- The provider may request to discuss any referral request with the Allegiance (TPA) Medical Director before or after the decision is rendered

Provider Responsibilities

- The Provider must treat all Teacher Health Trust member the same as all other patients in your practice, regardless of the type or amount of reimbursement
- Primary Care Providers will make best efforts to provide follow-up care within seven (7) days, after discharge, to members that have been hospitalized
- Primary Care Providers are responsible for the coordination of routine preventive care along with any ancillary services necessary for completion
- Providers should code in accordance with CMS guidelines and adhere to state and federal laws. Providers are required to code to the highest level of specificity to accurately describe the members acuity level
- Specialists must provide specialty services and communicate in writing to the referring provider or PCP of record, the results of exam, treatment and recommended follow up

Providers Designated as Primary Care Physicians (PCPs)

Teachers Health Trust recognizes Family Medicine, General Practice, Geriatric Medicine, Internal Medicine, Obstetrics and Gynecology and Pediatric Medicine as Primary Care Providers (PCPs). This is inclusive of physician, nurse practitioners and physician assistants. All contracted credentialed providers participating with Teachers Health Trust are listed in the Provider Directory which is made available to the public.

The Role of the Primary Care Provider (PCP)

Each Teacher Health Trust member is encouraged to select a Primary Care Provider (PCP) at time of enrollment. The PCP is responsible for managing all the health care needs of Teachers Health Trust members as follows:

- Manage the health care needs of Teachers Health Trust members who have chosen the provider as their PCP
- Ensure that each member receives treatment as frequently as is necessary based on members condition
- Develop an individual treatment plan for each member
- Submit accurate and timely claims and encounter information for clinical care coordination
- Comply with Teachers Health Trust pre-treatment review and referral processes
- Refer members to appropriate in network providers
- Comply with preventive and screening clinical guidelines
- Refer members with chronic disease to Teacher Health Trust's appropriate Disease Management Program(s)
- Notify and collaborate with Teacher Health Trust case management team

Role of the Specialist Provider

Each Teachers Health Trust member is entitled to see a Specialist Provider for certain services required for the treatment of a given health condition. The Specialist Provider is responsible for managing all the health care needs of a Teachers Health Trust member as follows:

- Provide specialty health care services to customers as needed
- Collaborate with the members PCP to optimize the continuity of care and treatment
- Provide consultative and follow-up reports to the referring provider in a timely manner
- Comply with Teachers Health Trust pretreatment review (prior authorization) and referral processes
- Submit accurate and timely claims and encounter information for clinical care coordination
- Refer members to appropriate in-network providers
- Refer members with chronic disease to Teachers Health Trust’s appropriate Disease Management Program(s)
- Notify and collaborate with Teachers Health Trust case management team

Role of the Hospital/Facility Provider

Each Teachers Health Trust member may receive care from hospital and ancillary facilities consistent with plan benefit standards. Such facilities are responsible for managing the health care needs of Teachers Health Trust members as follows:

- Provide hospital or ancillary services, as applicable
- Cooperate and comply with the Teachers Health Trust pre-treatment review (prior authorization) and referral processes
- Determine primary and secondary carriers for members to coordinate benefits for members, as applicable
- Submit claims electronically
- Maintain appropriate licensure, insurance, and accreditation as appropriate and specified in the facility’s agreement with Teachers Health Trust, and in accordance with applicable NCQA, CMS, state, and federal guidelines
- Ensure that hospital-based physicians (e.g., emergency medicine, radiologists, pathologists) are credentialed
- Submit discharge summaries, when requested to Teachers Health Trust
Member Assignment to New PCP

Members can select a new PCP at any time. The change will be effective the first (1st) of the month, following the receipt of the request, unless circumstances require an immediate change. Teachers Health Trust network providers are to make all reasonable efforts to address members’ reason to request change to reduce disruption of continuity of care.

Providers may request a transfer of PCP if the patient-provider relationship is not beneficial to the members wellbeing or if:

- The member has exhibited repeated behavior that is disruptive, unruly or uncooperative, which seriously impairs the providers ability to provide services to the member or obtain new patients, if the behavior is not caused by physical or a mental health condition
- The member threatens physical harm to provider, staff or other patients
- Member known to have participated in fraudulent use of services or benefits
- Non-payment of required copays for services rendered

Access and Availability Standards for Providers

- A Primary Care Physician (PCP) office must be open five days a week for at least 32 hours
- PCP must ensure that members are able to schedule preventive and wellness appointments at least 6 months in advance
- A PCP must arrange coverage by an equally licensed and discipline provider, contracted with THT, during absences
- Primary Care Access Standard and Requirements:

<table>
<thead>
<tr>
<th>Appointment Type</th>
<th>Standard / Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent/Emergent</td>
<td>Same Day</td>
</tr>
<tr>
<td>Non-urgent Problem</td>
<td>Within 5 days</td>
</tr>
<tr>
<td>Routine and Preventative</td>
<td>Within 30 days</td>
</tr>
<tr>
<td>Wait time in Office</td>
<td>1 hour or less</td>
</tr>
</tbody>
</table>
Specialist Access Standard and Requirements

<table>
<thead>
<tr>
<th>Appointment Type</th>
<th>Standard / Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent / Emergent</td>
<td>Same Day</td>
</tr>
<tr>
<td>Non-urgent</td>
<td>Within 10 days</td>
</tr>
<tr>
<td>Elective</td>
<td>Within 30 days</td>
</tr>
<tr>
<td>Suspicion of Malignancy</td>
<td>Within 10 days</td>
</tr>
<tr>
<td>Waiting time in Office</td>
<td>1 hour of less</td>
</tr>
</tbody>
</table>

All contracted providers must return calls related to medical concerns. Emergency calls should be responded to immediately or directed to 911. Non-emergency calls should be returned within 24 hours.

Provision of Health Care Services

Provider Directory

Practices and providers sharing the same TIN will be listed in the Teachers Health Trust Providers Directory. The Provider Directory is located on the Teachers Health Trust website www.teachershealthtrust.org The Provider Directory will include at least the following:

- Practice name, address and phone number
- Provider name and credentials
- Specialty
- Gender
- Languages spoken

The directory is updated at least monthly, utilizing information provided from the practice. Teachers Health Trust must be notified in writing of any changes to the practice or provider no less than 60 days in advance of any changes or if advance notice is not possible, within 7 days of change.

Provider Participation

Providers new to Teachers Health Trust network must have an executed contract and be credentialed with Teachers Health Trust. If a provider leaves a practice and joins another
practice that is contracted, Teachers Health Trust must be notified in writing of the new group affiliation. Credentialing is still valid until recredentialing due date.\textsuperscript{4}

Communication Among Providers

- The PCP should provide the Specialist Provider with relevant clinical information regarding the member’s care
- The Specialist Provider must provide the PCP with context of member’s visit, determination, treatment plan and follow up in a timely manner
- The PCP must document in the member’s medical record, review of reports, labs or diagnostic test received from a Specialist Provider
- The PCP should document referrals to Teachers Health Trust case management and/or disease management programs, unless instructed otherwise

Plan Notification Requirements for Providers

Providers must provide written notice to Teachers Health Trust no less than 60 days in advance of any changes to their practice or if advance notice is not possible, within 7 days of change:

- Practice name or ownership (including mergers and/or acquisitions)
- Practice address or telephone number
- Billing Address
- Adding or closing locations
- Hospital affiliations
- Providers joining or leaving practice (including retirement or death)
- Provider name changes
- Providers taking extended leave of absence (greater than 12 weeks)
- Provider elects to stop accepting new patients (patient panel is considered closed)
- Tax ID (W-9 form required)
- NPI number changes
- Changes in practice office hours and practice limitations

Providing this information in a timely manner, will ensure the practice is listed correctly in the Provider Directory and prevent member inconvenience or dissatisfaction. Failure to provide up to date and correct information regarding demographic information regarding the contracted practice or providers, may result in the denial of claims.

Closing Patient Panels

If a provider elects to stop accepting new patients (patient panels is consider closed), it must apply to all patients regardless of insurance coverage. Providers may not discriminate against Teachers Health Trust members by closing their panels for Teachers Health Trust members only.

\textsuperscript{4} Please refer to the signed contract for the specific due date information
Providers that will no longer accept any new patients must notify Teachers Health Trust in writing no less than 60 days in advance.

Medical Record Standards

Teachers Health Trust requires the following items in the members medical records:

- Identifying information of the member
- Signed HIPAA Consent
- Identification of all providers participating in the member’s care and information on care provided by these providers
- A problem list, including chronic disease and psychological conditions
- Presenting complaints, diagnoses and treatment plans
- Prescribed medications, doses and dates of initial or refill prescriptions
- Information on advance directives
- Past medical history, physical examinations, necessary treatments, risk factors relevant to treatment

Also, copies of members medical records will be provided to Teachers Health Trust upon request at no cost.

Billing and Coding Standards

Network providers must comply with the Teachers Health Trust’s billing and coding standards, which include:

- Accurately reporting, using the version of the ICD Code in effect at the time the service is provided, to the highest level of specificity
- Maintaining and submitting documentation that is complete, clear, concise, consistent and legible
- Appropriately documenting all conditions treated or monitored, services rendered, and any other required information
- Medical records should be signed and include provider credentials
- Medical records should identify a treatment plan for the member’s condition(s).
- Notifying Teachers Health Trust or its TPA of any erroneous data submitted and following the appropriate procedures to correct erroneous data
- Submitting claims in a timely manner, generally within thirty (30) days of the date of service (or discharge for hospital inpatient admissions)

Administrative, Medical and Reimbursement Policy Changes

Teachers Health Trust may amend, alter or clarify its polices. Specific Teachers Health Trust policies and procedures may be obtained by calling Teacher Health Trust at 702-794-0272. Teachers Health Trust will communicate changes to the Provider Manual by the following:

- Letter
- Email
• Website Portal Access

Providers are responsible for the review and inclusion of policy updates in the provider manual and for complying with these changes upon receipt of the notices.
Credentialing and Re-credentialing Program

Overview of Credentialing Process

All applicants to Teachers Health Trust must meet basic eligibility requirements and complete the credentialing process prior to becoming a participating provider.

Teachers Health Trust conducts secondary source verification of the applicant’s licensure, education and board certification, privileges, sanctions or other disciplinary action. Teacher Health Trust utilizes MedAdvantage for primary source verification. The credentialing process may take up to 90 days to complete. Once credentialing has been completed and applicant has been approved by the Credentialing Committee, the practitioner will be notified in writing of their effective date.

Providers are required to recredential every 3 years. Providers are required to update and re-verify through MedAdvantage every 3 years. Providers are required to submit recredentialing information in advance of their three-year credentialing anniversary date including the attestation signature date. Teachers Health Trust will make 3 separate attempts to obtain or verify required information via email, fax or telephone. Providers that fail to submit required information at least 45 days prior to their recredentialing anniversary date will be notified in writing of their termination from the network.

Note: Providers are responsible for notifying Teachers Health Trust for any change in their medical licensure status in licensing state.

Practitioner Selection Criteria

Providers who apply must meet basic credentialing and contract standards. At a minimum, but are not limited to:

- Hold appropriate, current and unrestricted licensure in the state of practice as required by state and federal entities
- Holds a current, valid and unrestricted federal DEA and State controlled-substance certificate as applicable
- Is board-certified/board-eligible or has completed appropriate and verifiable training in the requested practice specialty
- Maintains current malpractice coverage, commensurate with the state standard in which the provider practices
- Has a National Provider Identification Number
- Has admitting privileges at participating facilities or affiliations with providers who have admitting privileges

5 Please refer to Teachers Health Trust website for more information.
Application Process

Provider must have a fully executed contract with Teachers Health Trust on file with a completed and signed W-9.

A completed and signed Standard Nevada Credentialing Application with copies of the following documents:

- Current active medical licenses
- DEA certificate
- Proof of malpractice insurance with effective and expiration dates and policy term limits
- Clinical detail for all malpractice cases pending or resulted in settlement greater than $1500 within past 5 years
- Five years of work history (with explanation of any gaps exceeding 6 months)
- Professional Disclosure questions that are answered “yes”, with explanations
- Hospital affiliations
- Application must be signed and dated by applicant

Credentialing packets are processed by the date and order received, unless Teachers Health Trust determines a need to expedite the processing.

Once the entire application packet is completed it will be reviewed by Credentialing Committee. Provider will be notified of effective date in writing.

Non-discrimination Selection

Teachers Health Trust credentialing process is in accordance with National Committee for Quality Assurance (NCQA) guidelines. Teachers Health Trust ensure fair and impartial decision-making in the credentialing process and does not make credentialing decisions based on an applicant’s race, gender, age, ethnic origin, nationality, sexual orientation, gender identity or due to the type of patients or procedures in which the provider specializes.

Office Site Visits

Teachers Health Trust will conduct site visits and medical record keeping practice reviews as deemed necessary. Situations such as patient complaints, quality of care issue, or other state or federal regulations may also warrant a site visit.

Site surveys will include:

- Physical appearance and accessibility
- Patient safety and risk management
- Medical record management and security of information
- Appointment availability

If a provider fails to pass the area specific to a complaint, they will be required to submit a corrective action plan and make corrections within 60 days of the initial site visit.
Health Services

Wellness and Prevention Programs

Teachers Health Trust in collaboration with our providers and community partner’s goal is to maintain the healthiest lifestyle possible for our members and community. Providers are encouraged to promote and refer members to Teachers Health Programs.

To learn more about the wellness and prevention classes and activities to support healthier lifestyles for all members and their families. All Teachers Health Trust members are eligible to participate but those struggling with:

- Pre-diabetes
- Obesity
- Tobacco Use

To learn more about Teachers Health Trust recommended events, visit www.teachershealthtrust.org or call 702-794-0272.

Chronic Disease Management Programs

Teachers Health Trust has various health programs to support providers and members regain and maintain optimal health. Programs may include:

- Diabetes
- COPD/Asthma
- Cardiovascular Disease (CHF, Hyperlipidemia, Hypertension)
- Mental Health (Depression)

Providers are encouraged to notify Teachers Health Trust Health Programs Department by calling 702-794-0272 and share the following information:

- Member name and ID #
- DOB
- Diagnosis (existing or newly diagnosed)
- New medication(s), device or equipment prescribed
- Status: chronic stable, unstable, poor, non-adherent
- Referred to specialist? If yes who?

Teachers Health Trust nurse care coordination and management team member will work closely with providers and members to assess and identify barriers, educational needs and navigation of health services. Nurse case coordinator may refer members with complex conditions or high-risk circumstances to case management and/or other community resources, as well as communicate back to the primary care provider to ensure singularity in messaging to our members by all providers and coordinators.
Teachers health Trust encourages member education through multiple avenues on different disease states to promote overall wellness and good health. In addition to care coordination, therefore, our members also have the ability to sign up and request education material through Consumer Medical, our omnichannel partners in member services and advocacy.

Case Management

Inpatient and outpatient case management is available to assist providers with members that have complex conditions. Teachers Health Trust will actively monitor member’s health care utilization, demographic data, epidemiologic data and survey data to select care management objectives, activities and evaluations.

The sole focus of our case managers is to support the member and care givers, promote continuity of care, coordination of care, remove barriers to care, prevent complications and improve member quality of life. Disease management is a component of the case management continuum. Our Case management team assesses the needs of individual members that agree to participate. Case management interventions and disease management outreach are based on a collection of health risk assessment surveys, eligibility data, retrospective claims data, and diagnostic values.

Pre-Treatment Review (Prior Authorization)

Pre-Treatment Review (prior authorization) may be requested at any time if the treatment plan requires clarification of medical necessity. This excludes emergency treatment.

Providers can initiate Pre-Treatment Review by visiting: https://www.askallegiance.com/THT/ForProviders

Also, providers can submit Pre-Treatment (Prior Authorization) Review requests via fax at 866-201-0522 and provide the following information via mail to Plan Supervisor at PO Box 3018, Missoula, MT 59806-3018.

If pre-treatment review is not obtained, Teachers Health Trust may deny payment. Teachers Health Trust may deny payment for a service rendered following an approved prior authorization if such service is found to not be medically necessary or to be otherwise excluded by the plan.

Pre-treatment (prior authorization) review must be submitted before 7 days of requested treatment. Allegiance will perform a retrospective review of service for reviews submitted after the treatment. Providers will receive a response with 3-5 business days.

Please submit the following with your pre-treatment (prior authorization) review to the Plan Supervisor at Allegiance:

1. A complete description of the procedure(s) or treatment(s) for which review is requested
2. A complete diagnosis and all medical records regarding the condition that supports the requested procedure(s) or treatment(s) including, but not limited to, informed consent form(s), all lab and/or x-rays, or diagnostic studies
3. An itemized statement of the cost of such procedure(s) or treatment(s) with corresponding CPT or HCPCS codes
4. The attending Physician’s prescription, if applicable
5. A Physician’s referral letter, if applicable
6. A letter of Medical Necessity
7. A written treatment plan and
8. Any other information deemed necessary to evaluate the request for Pre-treatment (Prior Authorization) review
9. Upon receipt of all required information, the Plan will provide a written response to the written request for Pretreatment (Prior Authorization)
10. Review of services

Pre-Treatment Review (Prior Authorization) Exceptions Process

Teachers Health Trust will grant an exception to the Pre-Treatment (prior authorization) review process in the case of extenuating circumstances. In certain situations, claims will not be automatically denied for lack of pre-treatment (prior authorization) review and approval, as long as the services are covered under the member’s benefit plan and meet Teachers Health Trust’s criteria for medical necessity. These circumstances may include emergency services for which there was no time to obtain prior authorization or cases in which the member was unable to tell the provider about their coverage (e.g., an unconscious patient, minor dependent), etc.

In such cases, network providers should submit a pre-treatment (prior authorization) review request retroactively, with an explanation of the circumstances which prevented the request prior to treatment being rendered.

Note: Medical necessity criteria and benefit coverage must be met, even in cases of exceptional circumstances. An application for a pre-treatment (prior authorization) review exception is not a guarantee of payment.

Referral Guidelines
Referrals to specialty providers and radiology is not required at this time. Teachers Health Trust strongly recommends referrals be provided to assist members and specialty service providers and facilities to ease the scheduling process.\(^6\)

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\(^6\) This is subject to change. Please refer to Teachers Health Trust website or call us for most recent information.
Home Health Services

Home health services are available in accordance to the plan benefits if ordered by member’s provider. Specific services, equipment and supplies must be ordered by the provider. Start and end date or re-evaluation dates must be included in all home health services.

Readmissions

Readmission to the hospital with the same or related diagnosis (DRG – Diagnosis Related Group) within 30 days of discharge must be reported to Teachers Health Trust case management team within 48 hours of readmission.
Claims Submission

Claims may be submitted either electronically or via paper.

- Electronic submission of claims is preferred
- Electronic Payer ID is 81040
- Paper claims should be sent to

  Allegiance Benefit Plan Management
  P.O. Box 3018
  Missoula, MT  59806

Clean Claim Standards

Teachers Health Trust endeavors to make timely payment of all clean claims. A claim is considered to be a clean claim when it contains an itemized statement of billed charges submitted to Teachers Health Trust or its TPA for covered services performed by a network provider, contains no defects, and is not missing any documentation that would delay adjudication. Clean claims must consist of the UB04 or CMS 1500 data set, or its successor form, with entries stated as mandatory by the National Uniform Billing Committee or its successor. With respect to electronic claims, a claim must be in the format and include the data required by HIPAA, as amended from time to time, or as required by other applicable law, in order to be considered a clean claim. A claim that does not include all the required information is not a clean claim until Teachers Health Trust or its TPA receives the required additional information. Clean claims must also comply with any additional requirements under applicable state law.

Please refer to your claims form for directions regarding clean claims requirements.

Note: Failure to include all necessary information may delay the processing and payment of a claim. The form will be returned for any missing information.

For further instructions, please refer to the CMS website (www.cms.hhs.gov) for manuals regarding completing both the CMS 1500 and CMS 1450(UB04).

Claim Submission Timeframes

The standard timeframe for claim submission is 12 months from date of service unless specified otherwise in your contract. Claims submitted outside of the standard timeframe will be denied.

Incorrect Claims Payment

When a network provider identifies an incorrect claims payment, it must notify Teachers Health Trust or its TPA within 180 days by doing one of the following:

1. Call Allegiance on 855-999-1050. Teachers Health Trust will make any necessary corrections in the provider’s next payment
2. With respect to overpayments, write a refund check to Allegiance for the exact overpayment amount within the timeframe specified in the applicable provider agreement. Attach a brief note explaining the error.

Mail to:

Allegiance
PO Box 3018
Missoula, MT 59806

If Teachers Health Trust does not receive the overpayment refund within the timeframe specified by the applicable provider agreement, Teachers Health Trust or its TPA may deduct the refund amount from future payments.

Cash Payment Process

All claims will be processed by Allegiance and paid via Zelis.

- All payments will be made via EFT/835
- If providers prefer to receive payments via check, they can opt out of Zelis by:
  - Calling 877-828-8770
  - Visiting www.zelispayments.com

Claims Adjustments/Corrections

A provider may submit a corrected claim through the following procedures:

<table>
<thead>
<tr>
<th>Paper claims:</th>
<th>Underpayment error:</th>
</tr>
</thead>
</table>
| Allegiance Benefit Plan Management  
P.O. Box 3018  
Missoula, MT  59806 | If an underpayment is discovered, the provider can submit a request in writing for Allegiance to review. The request needs to include the claim information:  
- Member ID  
- Claim number  
- Expected allowed amount |

Electronic claims (CMS-1500) & (UB-04):  
Electronic Payer ID is 81040
Reconsiderations, Denials and Appeals
Utilization Management team is authorized to render a denial decision based on contractual terms, benefits or eligibility. Medical Directors make every effort to obtain all necessary clinical information from the treating provider to make appropriate determination.

Notification of denials are issued to providers, facilities and members. The denial notification will include the original request that was denied and any alternative service, along with a detailed process for appeal.

Providers may submit requests for reconsideration or appeals, if they have additional information to provide to the reviewing Medical Director or Appeals Committee. The provider must be responding to an official denial from the third-party administrator, to request a reconsideration or appeal.

Appeals Process

All telephonic inquiries received by Teachers Health Trust will be resolved on an informal basis, except for inquiries that involve “Appealable” issues. Appealable issues will be handled by our appeals team. Appeals are resolved within 30 days of receipt for services not yet received and within 60 days for services that have been provided prior to submitting the appeal. In situations where a customer is not in agreement with the informal resolution, the customer must submit a written request for appeal.

Written requests for appeal should be sent to:

Allegiance
Attn: Appeals & Grievances
PO Box 3018
Missoula, MT 59806

All other written correspondence received by Teachers Health Trust will be documented and routed through the appropriate Appeal channels.

Teachers Health Trust members have the right to appeal any decision about Teachers Health Trust’s failure to provide what they believe are benefits contained in the benefit package. These include:

- Reimbursement for urgently needed care outside of the service area or Emergency Services worldwide
- A denied claim for any health services furnished by a non-participating provider or supplier they believe should have been provided, arranged for, or reimbursed by Teachers Health Trust
- Services not received but believed to be the responsibility of Teachers Health Trust
- A reduction or termination of a service a customer feels is medically necessary
In addition, a member may Appeal any decision related to a hospital discharge. In this case, a notice will be given to the customer with instructions for filing an Appeal. The member will remain in the hospital while the Appeal documentation is reviewed. The member will not be held liable for charges incurred during this period, regardless of the outcome of the review. Please contact Teachers Health Trust for more information.

Request for reconsideration or appeals must be sent to

Allegiance
PO Box 3018
Missoula, MT 59806

Time frames for notifications of denials:

<table>
<thead>
<tr>
<th>Non - Urgent</th>
<th>Pre-service decisions</th>
<th>Within 14 calendar days of the request</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent</td>
<td>Pre-service decisions</td>
<td>Within 72 hours / 3 calendar days of request</td>
</tr>
<tr>
<td></td>
<td>Concurrent decisions</td>
<td>Within 24 hours of the request</td>
</tr>
<tr>
<td></td>
<td>Post-service decisions</td>
<td>Within 30 calendar days of request</td>
</tr>
</tbody>
</table>

Time frames for submission of:
- Reconsiderations is 180 days from date of denial
- Appeals is within 60 days of the original decision

Coordination of Benefits

Coordination of Benefits (COB) is the process through which health plans determine the order in which benefits are paid and the amounts that are payable when a patient is covered under multiple plans. COB prevents duplication of benefits. Teachers Health Trust COB standards are defined in your provider contract. Network providers are responsible for determining the primary payer and for billing the appropriate party or network providers must submit sufficient information for Teachers Health Trust to determine the primary payer.

- If Teachers Health Trust is not the primary payer, then the network provider should first submit the claim to the primary payer
- When Teachers Health Trust is the secondary payer, the primary payer payment must be specified on the claim
Pharmacy

Drug Formulary

Teachers Health Trust uses a formulary based on clinical evidence with respect to safety, efficacy, and cost. Drug benefits may vary by plan. Network providers must follow the plan formulary when prescribing medications to members. Network providers may access information about Teachers Health Trust formularies and formulary policies at www.teachershealthtrust.org/pharmacy.

Prescription Drug Monitoring Programs

Teachers Health Trust requires all providers to register and utilize the Nevada Prescription Monitoring Program (NV PMP). NV PMP is a database of information regarding the controlled substance prescriptions that were dispensed to patients in Nevada. The database is an online tool that allows prescribers and dispensers access to a patient’s controlled substance prescription medication history. The PMP also aids regulatory and law enforcement agencies in the detection and prevention of fraud, drug abuse and the criminal diversion of controlled substances.

**Teachers Health Trust mandates following the guidelines set forth by the Nevada State Board of Pharmacy.**

Drug Utilization Review

Teachers Health Trust and our pharmacy partners utilize concurrent, retrospective and prospective reviews.

Concurrent DUR Program

Concurrent DUR uses innovative information technology to proactively warn the dispensing pharmacist of potential drug problems. The concurrent DUR system operates in an on-line, real-time environment. The Clinical Decision Support System SM (CDSS) checks all incoming prescriptions to prevent the patient from experiencing inappropriate drug prescribing or consumption, medical conflicts or potentially dangerous interactions.

Concurrent DUR enables mail service managed care and retail network pharmacists to avert many therapeutic problems since changes in dosing, duration, or product selection are made prior to dispensing.
Retrospective DUR Program

Please check back later. This section will be updated by May 10, 2020.

Prospective DUR Program

Prospective Drug Use Review (DUR) occurs before the patient receives the drug. Prospective management for specific drugs or therapeutic classes occurs in the Prior Authorization (PA) Program. PA criteria are unique to the target drug or therapeutic class and address the key areas of DUR.

- Therapeutic Appropriateness: PA criteria may check for diagnosis, history of adverse effects, and clinical response to therapy.
- Over and Under Utilization: Limitations for patient use of targeted drugs such as overuse of headache medications and under use of drugs to treat opioid addiction.
- Generic Use: PA criteria often request that the member use a generic product before approving the brand drug.
- Therapeutic Interchange: If the health plan has such a program, these PA criteria allow for substitution of a therapeutically equivalent product where appropriate.
- Duplication of Therapy: The PA criteria ask about similar therapy and does not allow for multiple drugs that produce the same clinical outcome.
- Drug-Disease Contraindications: The PA review process uses criteria to check for specific drug-disease conflicts.
- Drug-Drug Interactions or Drug-Allergy Interactions: The PA criteria screens for allergies and other concurrent drugs that may pose a medication safety issue.
- Drug Dosage: PA criteria may ask for the drug dosage and deny for greater than the maximum recommended dose. Additionally, PA criteria may screen for too low a dose. The PA criteria may request the patient’s height and weight to check the appropriate dosing.
- Duration of Treatment: Some PA approvals may be for only the appropriate duration of therapy, such as less than six months for the use of hypnotics to treat sleep disorders.
- Clinical Abuse or Misuse: Drugs that are frequently abused or misused may require more frequent review of adverse effects and clinical outcomes. Often, the approval period is for a limited time.
- Drug-Age Precautions: The PA criteria will ask for the patient’s age for certain drugs and deny for use if an inappropriate age for the drug.
- Drug-Gender Precautions: The PA criteria may deny for use of certain drugs inappropriate based on the patient’s gender.
- Pregnancy Precautions: For certain drugs known to cause fetal or reproductive harm, the PA criteria may require either attestation that the woman is not pregnant and/or is using the means to prevent pregnancy while being treated with the requested drug.
- Regulatory Limitations: Some PA criteria may include questions to meet state or federal regulations.
Benefit Design: Administrative PA criteria provide guidelines making non-formulary exceptions, and coverage of off-label use of a drug.
Exchange of Electronic Data

HIE is concerned with electronic movement of health-related information among organizations according to nationally recognized standards. HIE is necessary to facilitate access to and retrieval of clinical data to provide safer, timelier, more efficient, effective, equitable, and patient-centered care. HIEs need to support and provide the capability to electronically move clinical information between disparate healthcare information systems while maintaining the meaning of the information being exchanged. An HIE also provides an infrastructure for secondary use of clinical data for purposes such as public health; clinical, biomedical, and consumer health informatics research; and institutional and provider quality assessment and improvement.

In order to provide the most value to clinicians, HIE technology solutions must be able to exchange data with each other in a manner that not only preserves the meaning of the data, but also harmonizes with the clinician’s workflow. Often times, technologies get in the way of workflow and creates extra work on the part of the end user.

Transmission of Lab Results

The Privacy Rule allows covered health care providers to share protected health information for treatment purposes without patient authorization, as long as they use reasonable safeguards when doing so. These treatment communications may occur orally or in writing, by phone, fax, e-mail, or otherwise with any member of the treatment team.

Providers and representatives must utilize reasonable safeguards when making these communications to protect the information from inappropriate use or disclosure. These safeguards may vary depending on the mode of communication used. For example, when faxing protected health information to a telephone number that is not regularly used, a reasonable safeguard may involve a provider first confirming the fax number with the intended recipient. Similarly, a covered entity may pre-program frequently used numbers directly into the fax machine to avoid misdirecting the information. When discussing patient health information orally with another provider in proximity of others, a doctor may be able to reasonably safeguard the information by lowering his or her voice.
Quality Assurance & Quality Improvement

Teachers Health Trust is committed to improving the quality and safety of clinical care delivery to its members. A robust Quality Assurance and Quality Improvement program is essential to assess and improve the quality and safety of clinical care delivery. Teachers Health Trust will be updating this section over the next few weeks to assure demonstrable and sustainable improvements in the health status of its members.