



MultiPlan Network Facility Handbook



Table of Contents

Introduction	3
Section One	
Important Definitions	4
Section Two	
Network Participation	7
Section Three	
MultiPlan Participation Requirements.....	11
Section Four	
Reimbursement and Billing Requirements.	13
Section Five	
MultiPlan Statement of Member Rights	17
Appendix A	18

Introduction

This Network Facility Handbook is the “Administrative Handbook” referenced in your Participating Facility Agreement, or may be applicable to the Participating Facilities covered under your Participating Health System Agreement. Please read it carefully and refer to it as questions arise. Please note that if a provision in this administrative handbook conflicts with state or federal law or the terms of your Participating Facility/Health System Agreement, the state or federal law or your Participating Facility/Health System Agreement takes precedence. The terms of this administrative handbook may be modified at the sole discretion of MultiPlan, Inc. In addition to the obligations specified in your Participating Facility/Health System Agreement, this administrative handbook provides information about contractual obligations for Network Facilities, including Network Facilities participating through a subsidiary of MultiPlan such as Private Healthcare Systems, Inc. (“PHCS”) or HealthEOS by MultiPlan, Inc. (“HealthEOS”).

When the word “you” or “your” appears in this administrative handbook, it means the Network Facility that is party to a Participating Facility/Health System Agreement with MultiPlan, Inc. or one of its subsidiaries, or is obligated directly or indirectly, to comply with the terms of a Participating Facility/Health System Agreement. When “MultiPlan” or “MultiPlan, Inc.” is referenced, it includes MultiPlan and its subsidiaries, including but not limited to, PHCS and HealthEOS. For questions regarding the Beech Street Network, the Texas True Choice Network, or True Choice USA, please refer to the Beech Street Provider manual available at BeechStreet.com

We are committed to positive relationships with our Network Providers, Clients and Users. To strengthen these relationships, we have a variety of information, including the most current version of this Network Facility Handbook and the most current Client list at www.multiplan.com or www.healtheos.com.

MultiPlan’s Network Products

PHCS Network

The PHCS Network is MultiPlan’s nationwide primary PPO. The PHCS logo is typically displayed on the front of a Participant’s identification. The PHCS name must be reflected on EOB/EOPs. Participants are directed to PHCS Network Providers through online and downloadable directories and a telephonic locator service. The PHCS Network is accredited by URAC and certified by NCQA in credentialing.

HEOS Network

The HealthEOS Network is MultiPlan’s primary PPO in Wisconsin. The HealthEOS logo is typically displayed on the front of a Participant’s identification. The HealthEOS name must be reflected on EOB/EOPs. Participants are directed to HealthEOS Network Providers through online and downloadable directories.

PHCS Savility®

PHCS Savility is MultiPlan's "virtual payer" primary PPO. PHCS Savility offers a number of features designed to behave to PHCS Savility Network Providers like a single payer network— a standard ID card format with the PHCS Savility logo in the upper left, a uniform claim submission process used by all Client/Users, one service line for all Clients/Users, and Client/User payment consolidated and forwarded to PHCS Savility Network Provider by MultiPlan. EOB/EOPs feature the PHCS Savility brand in the upper left corner.

MultiPlan Network

The MultiPlan Network is a complementary network. It is typically used as a secondary network to a Client's primary PPO. Participants can be directed to MultiPlan Network Providers through online and downloadable directories and a telephonic locator service. A MultiPlan name or logo may be placed on the front or back of the Participant's identification. The MultiPlan name must be reflected on EOB/EOPs.

ValuePoint® by MultiPlan

ValuePoint by MultiPlan is an access card network used in place of, or as a complement to, a member's health insurance plan. Participants are directed to ValuePoint Network Providers by their Program operators through online directories and a telephonic locator service. The ValuePoint logo must be displayed on the Participant's identification. The Participant's identification must also clearly state the Program is not insurance. For more information, visit www.multiplan.com/valuepoint.

MultiPlan Workers' Compensation Network

The MultiPlan Workers' Compensation Network is used by Clients that access the MultiPlan Network in conjunction with workers' compensation claims. The MultiPlan name must be reflected on EOB/EOPs.

MultiPlan Auto Medical Network

The MultiPlan Auto Medical Network is used by Clients that access the MultiPlan Network in conjunction with medical claims covered by auto insurance. The MultiPlan name must be reflected on EOB/EOPs.

Section One

Important Definitions

Depending upon the specific form of agreement you signed, the following terms may be utilized in your Participating Facility/Health System Agreement and are intended to be defined as provided for in your Participating Facility/Health System Agreement:

- (i) *Ancillary Provider* may be referred to as Vendor
- (ii) *Billed Charges* may be referred to as Regular Billing Rates;
- (iii) *Client* may be referred to as Payor or Company
- (iv) *Contract Rates* may be referred to as Preferred Payment Rates or Specified Rates;
- (v) *Covered Services* may be referred to as Covered Care;
- (vi) *Network Provider* may be referred to as Preferred Provider;
- (vii) *Participant* may be referred to as Covered Individual or Policyholder; and
- (viii) *Program* or *Benefit Program* may be referred to as Contract or Plan.

Authorized Logo(s) The names and/or logos indicated on Attachment A, entitled “Authorized Logos”.

Billed Charges The fees for a specified health care service or treatment routinely charged by a Network Provider regardless of payment source.

Benefit Program Maximum An instance in which the cumulative payment by a User has met or exceeded the annual or lifetime benefit maximum (e.g., dollar amount or service count) for a particular type of Covered Service rendered to a Participant in accordance with the terms of the Participant’s Benefit Program.

Certification The determination made by the Client’s or User’s Utilization Management program that the health care services rendered by a Network Provider meet the requirements of care, treatment and supplies for which payment is available by a Client or User pursuant to the Participant’s Program. Certification may also be referred to as “Precertification.”

Clean Claim Unless otherwise required by law, “Clean Claim” means a completed UB04 or HCFA/CMS 1500 (or successor form), as appropriate, or other standard billing format containing all information reasonably required by the Client for adjudication.

Clean Claim (PHCS Savility) Unless otherwise required by law, “Clean Claim” means a completed UB04 or HCFA/CMS 1500 (or successor form), as appropriate, or other standard billing format containing all information reasonably required for adjudication.

Client An insurance company, employer health plan, Taft Hartley fund, or other organization that sponsors or administers on behalf of a User, one or more Programs for the provision of health care services to Participants accessing the Network.

Concurrent Review Utilization Review conducted during a patient’s hospital stay or course of treatment.

Contract Rates The rates of reimbursement to Network Facility for Covered Services, as set forth in the Participating Facility/Health System Agreement.

Covered Service Health care treatment and supplies rendered by a Network Provider and provided to a Participant for which a User is responsible for payment pursuant to the terms of a Program.

Network An arrangement of Network Providers created or maintained by MultiPlan, Inc. or one of its subsidiaries, including PHCS and HealthEOS, under which such Network Providers have agreed to accept certain Contract Rates for Covered Services provided to Participants.

Network Provider A licensed facility or licensed, registered, or certified health care professional that agrees to provide health care services to Participants and that has been independently contracted for participation in the Network. Network Providers may be referenced in this handbook individually as “Network Facility,” “Network Ancillary Provider” or “Network Professional.”

Participant Any individual and/or dependent eligible under a Client’s Program that provides access to the Network.

Program Any contract, insurance policy, workers’ compensation plan, auto medical plan, government program, health benefit plan or other plan or program under which Participants are eligible for benefits. Program may also include the ValuePoint by MultiPlan Program or a Discount Card both of which are a non-insured business arrangements, where, in exchange for a fee or other consideration paid by Participant directly to Client, and upon presentation of an identification card bearing the *ValuePoint* logo or other MPI authorized name and/or logo, a Participant has the right to reimburse Network Providers directly at the Contract Rate as payment in full for health care services rendered.

Protected Health Information Individually identifiable health information that is transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium as defined by 45 C.F.R. 160.103.

Quality Management Program A program designed to promote quality assurance and improvement activities within an organization and assess the credentials of Network Providers and the quality of health care services rendered by each Network Provider. A Quality Management program may include a complaint investigation and resolution process.

Retrospective Review Utilization Review conducted after services have been provided to a Participant.

User The corporation, partnership, labor union, association, program employer or other entity responsible for the payment of Covered Services and entitled to receive access to the Contract Rates under the Participating Facility/Health System Agreement. A Client may also be a User. For purposes of the ValuePoint by MultiPlan Program or Discount Card Program, User shall mean an individual.

Utilization Management Program (Sometimes referenced as “Utilization Review.”) A program established by or on behalf of a Client or User under which a request for care, treatment and/or supplies may be evaluated against established clinical criteria for medical necessity, appropriateness and efficiency.

Section Two

Network Participation

Proprietary Information

All information and materials provided to you by MultiPlan, Clients or Users remain proprietary to MultiPlan, Client or Users. This includes, but is not limited to, your Participating Facility/Health System Agreement and its terms, conditions, and negotiations, any Program, rate or fee information, MultiPlan Client or User lists, any administrative handbook(s), and/or other operations manuals. You may not disclose any of such information or materials or use them except as may be permitted or required by the terms of your Participating Facility/Health System Agreement.

Preferred Facility Responsibilities and Requirements

As part of the Network, you are responsible for meeting certain requirements for Network participation. You have the responsibility for:

- The care and treatment of Participants under your care. You must ensure that all care is rendered in accordance with generally accepted medical practice and professionally recognized standards and within the scope of your applicable license, accreditation, registration, certification and privileges;
- Complying with any and all applicable state and/or federal laws related to the delivery of health care services and the confidentiality of Protected Health Information and taking all precautions to prevent the unauthorized disclosure of such Participant's medical and billing records;
- Complying with MultiPlan and Client and/or User requests for copies of a Participant's medical and billing records for those purposes which MultiPlan and/or its Clients or Users deem reasonably necessary, including without limitation and subject to any applicable legal restrictions, quality assurance, medical audit, credentialing, recredentialing or payment adjudication and processing;
- Cooperating with the Quality Management and Utilization Management programs of Client or Users;
- Meeting the MultiPlan credentialing criteria, as referred to later in this section; and
- Honesty in all dealings with MultiPlan, its Client and Users. As a Network Facility, you agree not to make any untrue statements of fact in any claim for payment, nor any untrue statements of material fact or any intentional misrepresentations of any fact in any statement made to MultiPlan or any Client or User.

In addition, you must meet the following requirements for Network participation:

- You may not engage in inappropriate billing practices, including but not limited to billing for undocumented services or services not rendered, unbundling, up-coding or balance billing.
- You may not be the subject of publicity that adversely affects the reputation of MultiPlan, as determined by MultiPlan. You may not commit professional misconduct that violates the principles of professional ethics.

- You may not engage in any action or behavior that disrupts the business operations of MultiPlan or any Client or User.
- Your responses to inquiries by MultiPlan shall be timely, complete and delivered in a professional manner.

Quality Monitoring Activities

The Quality Management Committee

The MultiPlan Quality Management Committee is a company wide council that provides support and oversight of quality management and improvement activities at MultiPlan. This integrated support and promotion of quality initiatives is vital to MultiPlan, and the Committee's objectives, listed below, reflect this:

- To strengthen the position of MultiPlan as an organization that continually strives to deliver services of optimal quality to its Clients, Users and their Participants;
- To promote company wide awareness of, and participation in, continuous quality improvement;
- To oversee activities throughout MultiPlan that contribute to quality and process improvement; and
- To assist MultiPlan with meeting national accreditation standards, state and federal mandates and Client and User expectations.

In addition to the Quality Management Committee, the MultiPlan commitment to quality includes maintaining provider credentialing, recredentialing and Quality Management programs. Specifics of these programs follow.

Credentialing

We apply rigorous criteria when we credential (facility) providers in our Network. MultiPlan has established and periodically updates credentialing criteria for all categories of providers it accepts into its Network.

The credentialing criteria include but are not limited to the following as appropriate:

- Accreditation by The Joint Commission (JC) to a level of "Accredited" or "Provisional Accreditation;" or
- Certification by the Centers for Medicare & Medicaid Services (CMS) as a Medicare Participant; or
- Certification by the Healthcare Facilities Accreditation Program (HFAP); or
- Accreditation by the American Osteopathic Association; or
- Accreditation by the Commission on Accreditation of Rehabilitation Facilities ("CARF"); or
- Accreditation by the Accreditation Commission for Healthcare ("ACHC"), or
- Accreditation by the Accreditation Association for Ambulatory Healthcare ("AAHHC") if Facility is an ambulatory surgery center; or
- Satisfactory completion of the MultiPlan Request for Information for "Acute Inpatient Facilities that are not accredited by JC or certified by CMS;" and

Section Two: Network Participation

- Professional liability insurance of \$1 million/occurrence and \$5 million in aggregate; and
- Adequate General liability insurance.

The MultiPlan Credentials Committee makes all decisions regarding provider participation in the MultiPlan Network in accordance with MultiPlan credentialing criteria.

Credentialing criteria vary by provider type. To obtain a copy of the MultiPlan credentialing criteria, please contact Service Operations at (800) 950-7040.

Recredentialing

MultiPlan recredentials Network Facilities on a set schedule in accordance with state and federal law and national accreditation standards. MultiPlan reviews accreditation/certification databases as appropriate to confirm that accredited or certified status is current. Recredentialing activities may also be triggered as a result of quality management investigations or information received from state or federal agencies.

Quality Management Program

MultiPlan maintains a Quality Management program that is responsible for the management of complaints originating from various sources, including Participants, Clients or Users. The Quality Management program acknowledges tracks and investigates complaints about Network Providers, and manages their resolution through a standard process. Complaints may include but are not limited to perceptions of:

- Unsatisfactory clinical outcome
- Inappropriate, inadequate, over-utilized or excessive treatment
- Unprofessional behavior by Network Provider or office staff
- Inappropriate billing practices

As part of your participation in the Network, you are responsible for participating in, and observing the protocols of the MultiPlan Quality Management program. The MultiPlan Quality Management program consists of the following:

Investigation Process

MultiPlan facilitates the complaint investigation process by gathering information from various parties (including the Network Facility involved) to determine the circumstances surrounding the complaint. Requests for information from Network Facilities may include a patient's medical and/or billing records. MultiPlan recognizes that the Network Facility's participation in the investigation process is critical. When requesting information, MultiPlan reports the complainant's concerns and affords the Network Facility an opportunity to respond to the complaint.

While complaints are investigated in a timely fashion, it is important to note that timeframes are predicated upon the receipt of information necessary to complete the investigation. Depending upon the nature of the complaint, it may be thirty to sixty (30-60) days before an initial determination is reached. MultiPlan conducts the investigation process with strict confidentiality. If the complaint is of a clinical nature, MultiPlan clinical staff (including a MultiPlan Medical Director) participates in the investigation process.

Outcome of Investigation

Investigation outcomes vary based on the type and severity of the complaint and the complaint record of the Network Facility. Based upon the outcome, complaints may be categorized as “No Incident,” or in levels ranging from “Patient Dissatisfaction” to “Termination.” If the investigation reveals the presence of imminent danger to Participants, termination may be immediate.

MultiPlan communicates investigation outcomes and resulting actions directly to the Network Facility involved. If the quality of care rendered at the Network Facility is below acceptable standards, MultiPlan will work with the Network Facility to develop a corrective action plan. If the corrective action plan does not result in acceptable standards of care, MultiPlan may terminate the relationship with the Network Facility. If a Network Facility is terminated from participation in the MultiPlan Provider Network, the Network Facility will be notified in writing and informed of the right to appeal. All complaint records are maintained confidentially and reviewed during the recredentialing process. Data obtained from analysis of complaint records may also be used in aggregate form to support other initiatives, including provider education.

HealthEOS by MutliPlan CareEngine Services. In addition to the above, the HealthEOS Network also utilizes CareEngine[®] Services, which is intended to support improvement of the overall quality of healthcare provided to Participants, and to lower the overall costs of such healthcare.

Recognition of Authorized Logos

As a Network Facility, you agree to recognize each name and/or logo identified as an Authorized Logo when displayed on identification cards, Explanation of Benefits (EOB) forms or other forms of identification and evidence of the Client or User’s right to access Network Facility and to reimburse Network Facility at the Contract Rates for Covered Services rendered to Participants. MultiPlan may update the list of Authorized Logos included on Appendix A of this handbook by posting such modifications to the MultiPlan website; however Network Facility should refer to his/her Participating Facility Agreement for specific access.

Identification of Participants

Clients and Users furnish Participants with a means of identifying themselves as covered under a Program with access to the Network. Such methods of identification include, but are not limited to, affixing an Authorized Logo on an identification card; a MultiPlan phone number identifier, written notification by Client of an affiliation with MultiPlan at the time of benefits verification, a MultiPlan Authorized Logo on the explanation of benefits form, or other means acceptable to MultiPlan and the Network Provider. Clients and Users will also furnish a telephone number to call for verification of the Participant’s eligibility. Always contact the Client or User to obtain eligibility and benefit information before rendering services. Please note that confirmation of eligibility does not guarantee payment. Program restrictions and limitations may apply. MultiPlan does not determine benefits eligibility or availability for Participants and does not exercise any discretion or control as to Program assets, with respect to policy, payment, interpretation, practices, or procedures. Be sure to notify Participants of restrictions and/or limitations identified after contacting the Client or User.

Section Three

MultiPlan Participation Requirements

Utilization Management

You are required to participate in and observe the protocols of Client or User's Utilization Management programs for health care services rendered to Participants. Utilization Management requirements may vary by Client or User, and by the Participant's Program and may include, but is not limited to, pre-certification, concurrent review, and retrospective review. Utilization Management programs may also include case management, disease management, maternity management, and mental health management services.

Certification

Most Utilization Management programs used by Clients or Users require Certification. Please verify any certification or other Utilization Management requirements at the time you verify benefits and eligibility. As part of the Certification process, please be prepared to provide the following information by telephone, facsimile, or through any other method of communication acceptable to the Client or User's Utilization Management program:

- Client or User name
- Group policy number or name
- Policyholder's name, social security number and employer (group name)
- Patient's name, sex, date of birth, address, telephone number and relationship to policyholder
- Network Professional's name and specialty, address and telephone number
- Facility name, address and telephone number
- Scheduled date of admission/treatment
- Diagnosis and treatment plan
- Significant clinical indications
- Length of stay requested

You may be required to obtain Certification from the Utilization Management or Utilization Review program for the following:

- **Inpatient admissions, outpatient surgery and other procedures identified by the Client or User's Utilization Management program** To obtain Certification for these procedures, call the telephone number provided by the Participant or the Client or User prior to the date of service to the Participant. You may be required to obtain separate Certifications for multiple surgical procedures. To facilitate a review, be sure to initiate the Certification process a minimum of seven to ten (7-10) days before the date of service.
- **Emergency admissions** Certification of all admissions following an emergency room visit is usually required within forty-eight (48) hours after the admission.

- **Length of stay extensions** In the event a length of stay extension is required for those health care services initially requiring Certification, you may be required to obtain additional Certification from the Utilization Management program prior to noon of the last certified day.

Concurrent Review

Network Facilities must participate in the Utilization Management program of Concurrent Review. A nurse reviewer performs Concurrent Review to document medical necessity and facilitate discharge planning.

Case Management

Case management identifies those Participants whose diagnoses typically require post-acute care or high level and/or long-term treatment. The case manager works with providers and family members to formulate a plan that efficiently utilizes health care resources to achieve the optimum patient outcome. Case management services are provided for Participants who may benefit from:

- Change in facility or location of care
- Change in intensity of care
- Arrangements for ancillary services
- Coordination of complex health care services

Before completing the Certification process, always contact the Client or User to obtain eligibility information.

In cases where multiple procedures are performed, be sure to confirm benefit eligibility from the Client or User for each procedure.

Referrals to Other Network Providers

To help Participants avoid a reduction in benefits, you are required to use your best efforts to refer Participants to Network Providers within the same respective Network, when medically appropriate and to the extent these actions are consistent with good medical judgment. For assistance in finding other providers participating in the MultiPlan Network for referral purposes, contact Service Operations at (800) 950-7040.

Appeals Process for Care Management Decisions

The appeals process may vary by the Client or User's Utilization Management program and/or as mandated by state or federal law. In the event you or a Participant do not agree with a noncertification determination made under the Utilization Management program, you or the Participant has the right to appeal the determination in accordance with the Client or User's Utilization Management program appeals process. To obtain details of the Client or User's Utilization Management program appeals process, please contact the appropriate Client or User.

Failure to observe the protocols of the Utilization Management program may also result in a reduction of benefits to the Participant. You are responsible for notifying the Participant of any potential financial implications associated with failure to observe the Utilization Management Program protocols.

Section Four

Reimbursement and Billing Requirements

Timely Payment of Claims

Clients understand the importance of timely payment of Clean Claims. Please refer to your Participating Facility/Health System Agreement for specific requirements regarding timely payment of Clean Claims. Any payments due by Client shall be reduced by applicable Co-payments, Deductibles, and/or Co-insurance, if any, specified in the Participant's Benefit Program and/or any service for which the Participant's Benefit Program does not provide coverage. Payment by Client or User shall be subject to industry standard coding and bundling rules, if any.

Note: MultiPlan is not an administrator, insurer, underwriter, guarantor, or payer of claims and is not liable for any payment of claims for services under Programs submitted by the Network Facility to MultiPlan or any Client or User.

Submission of Claims

Claims should be sent as usual by following the instructions on the back of the member's ID card. As a Network Facility, you agree to submit claims for payment within at least ninety (90) days of furnishing healthcare services (or as otherwise required by state or federal law or your Participating Facility/Health System Agreement).. All claims should be submitted using your Billed Charges and the appropriate procedure code per American Medical Association (AMA) and Center for Medicare and Medicaid Services (CMS) standards.

Submitting Claims by Mail

Claims must be submitted to the address found on the Participant's ID card using a UB92 claim form. Clean Claim that are mailed shall be deemed to have been received by the Client or User five (5) calendar days following the deposit of such Clean Claim in the U.S. Mail, first class postage prepaid and addressed to the Client or User at such address set forth on the Participant's identification

Submitting Claims Electronically

All claims may be submitted electronically through transaction networks and clearinghouses in a process known as Electronic Data Interchange (EDI). This method promotes faster, more accurate processing than paper claims submitted by mail, and is required by federal benefit plans. We encourage you to exercise your best efforts to implement electronic claims submission capability as soon as reasonably practicable. Clean Claims that are transmitted electronically shall be deemed to have been received by the Client or User on the date that such Clean Claim is transmitted to the Client or User.

The National Provider Identifier (NPI) is a required identifier on all electronic health care transactions. MultiPlan recommends that you submit your NPI information as part of your standard submission of practice information updates. MultiPlan supplies this information to MultiPlan Clients and Users for use in electronic transaction processing.

Disputing a Claim

As a Network Provider you and the Client have the right to dispute a claim. When a problem arises, contact MultiPlan Service Operations at (800) 950-7040 as soon as possible, as required by your Participating Facility/Health System Agreement, and provide all information pertinent to the problem. If the issue can't be resolved on the call, it will be escalated to a provider service representative who will conduct an inquiry, contacting the Client/User and/or regional provider relations specialist as appropriate.

Erroneous Claim Submission

If you discover that a claim you sent to a Client was meant for another Client or the claim had incorrect information, please notify the Client.

Failure to Submit a Clean Claim

If a Client or User receives a claim that is not a Clean Claim containing all complete and accurate information required for adjudication or if the Client has some other stated dispute with the claim, they will provide you with written notification prior to payment of the claim. The Client will pay, or arrange for User to pay, you at the Contract Rate(s) for all portions of the claim not in dispute. Please provide complete and accurate information requested within thirty (30) business days of the Client or User's request (unless otherwise specified in your Participating Facility/Health System Agreement).

Timeframe for Disputing a Claim

Following your receipt of payment from the Client or User, you may challenge payments made to you during the timeframe as specified in your Participating Facility/Health System Agreement (unless otherwise required by law), otherwise such payment shall be deemed final.

Coordination of Benefits

Participants are sometimes covered by more than one insurance policy, benefit plan or other health plan or program. In that instance, the Client or User uses the following rules for the Coordination of Benefits (COB) with regard to payment:

MultiPlan Client or User is Primary

When a MultiPlan Client or User is primary under the COB rules, the Client will pay, or arrange for User to pay, for Covered Services according to the Participant's Program (e.g., 90%, 80%, or any other percent based on the Participant's coinsurance amount) and pursuant to the Contract Rate.

MultiPlan Client or User is Secondary

Except as otherwise required by law or the Participant's Program, if a Client or User is other than primary under the COB rules, the Client will pay, or arrange for User to pay, a reduced amount only after the Network Facility has received payment from the primary plan. Please refer to your Participating Facility/Health System Agreement for the specific terms related to payment when a Client or User is other than primary under the COB rules.

As a Network Facility, you are required to cooperate fully with MultiPlan and/or Clients or Users in supplying information about other entities providing primary medical coverage or otherwise

Section Four: Reimbursement and Billing Requirements

having payment responsibility for services rendered to Participants, and in all other matters relating to proper coordination of benefits.

Note: Payment may vary based on state or federal law when Medicare is a primary or secondary payer.

Balance Billing

Please be sure to review the Explanation of Benefits (EOB) form sent to you by the Client or User to determine the amount billable to the Participant. At the time of the visit, you may collect any co-payment or encounter fee specified in the Participant's Program. Following the receipt of an EOB, you may also bill for deductibles and co-insurance, if any, as specified in the Participant's Program, and/or payment for non-Covered Service. In the event that you collect fees from the Participant that exceeds the Participant's responsibility, you must refund those fees to the Participant promptly upon notice of overpayment.

As specified in the Participating Facility Agreement, Participants cannot be billed for the difference between your Billed Charges and the Contract Rate.

Benefit Maximums

As previously mentioned, Participants cannot be billed for the difference between Billed Charges and the Contract Rate for Covered Services, whether the Client or User is primary or secondary. In instances where the cumulative payment by a Client or User has met or exceeded an annual or lifetime benefit maximum for a particular type of Covered Service rendered to a Participant, Network Providers may not "balance bill" Participants for the difference in billed charges and the Contract Rates. However, you may bill the Participant for the Contracted Rate once the Participant has reached the Benefit Program Maximum.

A benefit maximum limits the Client or User's cumulative responsibility for payment of a select set of services to some annual or lifetime dollar amount or service count. This prohibition will remain in effect as long as the patient remains a Participant under a Program. When a particular type of care, treatment or supply is considered a "major medical exclusion" pursuant to the Program and/or does not qualify under any circumstance as a Covered Service for the Participant, Network Providers may bill the Participant at the Network Provider's Billed Charges for the "excluded" service.

Reimbursement Policies

Administrative/Facility Fees

When fees are negotiated for care, treatment and supplies pursuant to the MultiPlan Participating Facility/Health System Agreement, it is recognized that such services may include an administrative and maintenance component. As a result, the fees paid for health care services pursuant to the MultiPlan Participating Facility/Health System Agreement include payment for administrative, oversight, overhead and/or similar charges related to the provision of any service rendered. You may not separately bill or collect from the Participant or the Client or User any additional amount for administrative, oversight, overhead and/or similar charges related to the provision of such services.

Multiple Procedures

In a case where multiple surgical procedures are planned, be sure to obtain information from the MultiPlan Client or User with regard to benefit coverage for each procedure. Unless otherwise specified in your MultiPlan Participating Facility/Health System Agreement, reimbursement for multiple procedures may vary by the Client or, and may be reduced when performed during a single encounter (e.g. 100% of the negotiated rate for the primary procedure, 50% of the negotiated rate for the secondary procedure, etc.).

Assignment of Benefits and Release of Medical Information

Clients can pay or arrange to pay Network Facilities directly only when the Participant has approved the assignment of benefits. Participants should present a signed form for this purpose during the first visit to you. If the Participant does not have an appropriate form from the Client or User, you may obtain an assignment using your standard form. Signatures need only be provided once and can be filed with the Participant's record. All claims submitted should indicate that signatures for assignment of benefits are "on file."

For some types of treatment, Clients or Users may require the Participant's consent (and possibly the consent of family members) to release Protected Health Information. These signatures should be kept on file with the Participant's record.

Section Five

MultiPlan Statement of Member Rights

MultiPlan is committed to preserving and respecting member rights. Below is our statement recognizing member rights and protections. We expect our Network providers, including individual practitioners, to support and act in accordance with these rights.

1. Members have the right to receive accurate, easily understood information about MultiPlan, the services we provide, the providers in our networks, the rights of members and MultiPlan and PHCS Network providers, and how to contact us regarding concerns about MultiPlan services or networks.
2. Members have the right to be treated with respect and recognition of their dignity and the right to privacy. This right includes protecting the confidentiality of medical and other personal information. It also includes members' rights to review their medical and personal information on file at MultiPlan, as required by applicable state and federal law.
3. Members have the right to communicate with providers in making decisions about their healthcare without interference from MultiPlan.
4. Members have the right to register complaints about MultiPlan, our services, determinations, or the care provided by a MultiPlan or PHCS Network provider. This includes the right to have complaints addressed in a timely manner through formal procedures appropriate to the nature of the complaint.
5. Members have the right to a choice of healthcare providers from the MultiPlan and/or PHCS Network, consistent with the terms of their health benefit plans and applicable state and federal law.
6. Members have the right to receive healthcare services without discrimination. MultiPlan and/or PHCS Network providers are precluded by contract from differentiating or discriminating against members in the provision of healthcare services due to certain member characteristics, and are required to render such services to all members in the same manner, in accordance with the same standards, and with the same availability as offered to the Network provider's other patients.

MultiPlan uses its best efforts to assure that all members are afforded these rights. If you feel that your rights as a member have not been met, you may voice your concern through the MultiPlan complaint resolution process. The complaint resolution process is the formal mechanism by which MultiPlan addresses members' concerns about their health care from our Network providers. To begin the complaint resolution process, kindly document the complaint in writing and send it to:

MultiPlan

1100 Winter Street

Waltham, MA 02451-1227

Attn: Corporate Quality Management

MultiPlan Clients use the following names or logos on Participant identification. Refer to your Participating Professional Agreement for specific access.

Primary Network Names and Logos



(Beginning January, 2011, the logos below will replace the ones above)



(WI, MI, MN)

Complementary Network Names and Logos

