OSU HEALTH PLAN
PROVIDER MANUAL

THE OHIO STATE UNIVERSITY
HEALTH PLAN

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I. Background

The Ohio State University Health Plan (OSUHP) provides network management services for The Ohio State University and affiliate networks.

OSU Faculty and Staff Plan

OSUHP manages the healthcare benefits offered to faculty and staff of The Ohio State University and their dependents. Enrolling in self-insured coverage provided by the employer and administered by OSUHP grants access to not only a robust provider network but also a wide variety of health and wellness programs, benefits, and tools. OSUHP administers benefits for approximately 70,000+ OSU faculty, staff, and dependent members in all 88 Ohio counties. The medical plans are self-funded through The Ohio State University. OSUHP is not a commercial health insurance company.

OSU Student Health Franklin County Network

OSUHP delivers the Franklin County network in use by the OSU Student Health Insurance Benefit Plan.

Affiliate Networks

OSUHP also develops and maintains affiliate networks utilized by external employer groups. Your Provider Agreement will list your applicable Affiliate networks. **OSUHP does not administer the benefits for employer groups utilizing the affiliate networks. Providers should contact the administrator listed on the patient's ID card for claims and benefit inquiries.**

Ohio PPO Connect

Ohio PPO Connect (OPPOC) is a provider-owned, Ohio-based network with a local and regional approach to health care delivery. It brings the experience and expertise of the following networks to provide statewide coverage: Ohio Health Choice, Quality Care Partners, and OSUHP. *The Ohio PPO Connect network can be accessed by OSU Faculty and Staff Health Plan members ONLY for services rendered outside of Franklin County*. Ohio PPO Connect covers over 130,000 members. Ohio PPO Connect members will have the following logo on their card:

OHIO PPO CONNECT

Ohio Health Choice
Preferred Health Choice-Plus

Quality Care Partners Plus

OSU Health Plan

If you are providing care for a non-OSU Faculty and Staff Plan Ohio PPO Connect member, please check the following link https://www.ohioppoconnect.com/providerfaq.php for additional information to determine:

- Who to call for network status and which network contract applies
- How to determine benefits and eligibility
- How to interpret ID cards
- How to submit Ohio PPO Connect claims
- How to determine claim status and who handles claims

High Performance Health Network 'HPHN' including the Adena Employee Plan

High-Performance Health Network
Powered by Adena Health and Ohio State Health Plan Solutions

ADENA HEALTH | THE OHIO STATE UNIVERSITY HEALTH PLAN SOLUTIONS

Network providers are generally located in south central Ohio and Franklin County

North Central Ohio Area Network including the Avita Employee Plan

Network providers are generally located in Crawford, Richland, and Franklin Counties

Mary Rutan

OSUHP supplements Mary Rutan's network with providers generally located in Logan County.

II. Provider Directories

Please refer to the following links to find in-network providers for your patients:

OSU Faculty and Staff Plan
https://osuhealthplan.com/find-a-provider/osuhp/search

OSU Student Health Franklin County Network
https://osuhealthplan.com/find-a-provider/osushi/search

Affiliate Networks

Ohio PPO Connect
https://www.ohioppoconnect.com/providersearch.php

High Performance Health Network 'HPHN' including the Adena Employee Plan
https://osuhealthplan.com/find-a-provider/high-performance-health-network/search

North Central Ohio Area including the Avita Employee Plan
https://osuhealthplan.com/avita

Mary Rutan
https://osuhealthplan.com/find-a-provider/mr/search

III. Contracting and Credentialing

Contracting with OSUHP is a separate process from credentialing. Participation in one or more of our networks requires an executed contract **AND** approved credentialing status for each provider.

*1) **Initial Contracting***

To request a contract with OSUHP, providers must complete the ***Network Request Form***. This form can be found at https://osuhealthplan.com and the completed form can be faxed to (614) 292-1166 or sent via email to OSUHealthPlanPR@osumc.edu. A Provider Network Management Specialist who serves your specialty or provider group type will contact you once the completed form is received.

*2) **Adding/removing providers and demographic changes***

To avoid claim denials, timely updates to demographic changes are necessary. Providers must complete and submit a ***Provider Information Form*** (PIF) found at https://osuhealthplan.com.

i) If you are changing the group name and/or the remit address, include an updated W9 with the PIF.
ii) If adding a new provider to the practice, include a current malpractice face sheet along with the PIF.
iii) If a provider is changing their legal name, you need to include the request on company letterhead with the effective date of the name change.
iv) If you are changing Tax ID numbers or starting a new practice, you will need to go through the initial contracting process again. Send a network request form to the provider network services department at OSUHealthPlanPR@osumc.edu.

Providers should submit requested changes 45 days prior to the expected effective date of the changes(s). Provider is responsible for obtaining confirmation that any changes were accepted. If you haven't received your confirmation within 30 days of sending the request, please contact us.

*3) **Credentialing***

To comply with the guidelines established by the National Committee for Quality Assurance (NCQA), providers must be fully credentialed prior to providing services to our members. Claims will NOT process as in-network until the provider's credentialing is complete. OSUHP does not make credentialing decisions based on an applicant's race, ethnic/national identity, gender, age or

sexual orientation, or on type of procedure or patient (i.e., Medicaid) in which the practitioner specializes.

i) Initial Credentialing

If you have a CAQH number, complete the CAQH Provider Data Form. You will need to give OSUHP permission to review. If you do not have a CAQH number, go to http://www.caqh.org to request a CAQH number and complete the information. You will need to give permission to OSUHP to review.

ii) Re-credentialing

Providers will be re-credentialed every three years. Make sure your CAQH is valid. CAQH must be re-attested every 120 days.

IV. Claims

Affiliate Networks

OSUHP is not an administrator of benefits for affiliate networks and does not pay claims or determine eligibility. You will need to refer to the member's ID card to identify the administrator of the benefit plan and direct inquiries regarding claims to the contact information listed on the card.

OSU Faculty and Staff Plan

1) Claims submission

Luminare Health is the Third Party Administrator that processes and pays claims for the OSU Faculty and Staff Plan. Claims can be submitted to Luminare Health by mail or electronically. Luminare Health accepts the following claim forms:

i) CMS 1500: AMA universal claim form also known as the National Standard Format (NSF) CMS Forms List
ii) CMS 1450: UB-04 (for hospitals)

Providers must bill Luminare Health for services with the most current coding available using HIPAA-compliant transaction and code sets. Claims must be legible and the information must be located in the appropriate fields on the claim form. Illegible claims and claims lacking required information will be denied as incomplete.

Claims submission mailing address:

ATTN: OSU Health Plan Claims
PO Box 4386
Clinton, IA 52733

Providers can also refer to the member's ID card for claim submission mailing address and the payor ID for electronic claims submission.

2) Provider Address

Accurate physical and remit addresses are required to process claims. For office-based claims, network status is based on the service location billed by the provider. If this location is not on the claim or does not match the address on file, the claim will be processed as non-network and denied if the member doesn't have out of network benefits. Providers are responsible for providing accurate and timely billing information (physical address, remit address, etc.). Please submit physical or remit address changes 45 days in advance of those changes by completing a ***Provider***

Information Form (PIF) found at https://osuhealthplan.com. A provider must receive confirmation their changes are approved prior to providing any services to members in new locations.

3) Timely filing

Original Claims

Claims for covered services must be received by Luminare Health no later than 12 months from the date of service. Claims submitted past the filing limit will be denied.

Claim Re-Submissions

Provider corrected claims follow timely filing of 12 months from the date of service. Claims resubmitted past this date will not be considered.

Appeals

Appeals follow the documented appeal process. Appeal rights are 180 days from remittance. Appeals submitted past this date will not be considered.

COB Claims

COB claims follow timely filing of 12 months from the date of service. Secondary claims should be submitted no later than 12 months from the date of service. Claims received past this date will be denied.

4) Claims Editing

OSUHP has a pre-payment auditing process to identify frequent coding billing errors including but not limited to bundling and unbundling coding errors, duplicate claims, and global billing. Coding edits are based on Current Procedural Terminology (CPT), industry standard National Correct Code Initiative (NCCI) policy and guidelines and industry payment rules and guidelines as specified by a defined set of indicators in the Medicare Physician Fee Schedule Data Base (MPFSDB). The National Correct Coding Initiative (NCCI) developed by CMS helps promote national correct coding methodologies for ensuring that claims are coded appropriately according to state and federal coding guidelines. The coding policies developed are based on:

i) Coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT) Manual
ii) National and local policies and edits
iii) Coding guidelines developed by national societies
iv) Analysis of standard medical and surgical practice
v) Waste and abuse

5) Claim Re-Submissions

Corrected Claims

Corrected claims need to be submitted directly to Luminare Health. Timely filing deadlines apply to re-submissions.

i) For institutional claims, the UB 04 claim should be submitted with a bill type of XX7 to replace the original claim and XX8 to void/cancel the original claim.
ii) For professional claims, the claims should be submitted through the original submission process marked as a corrected claim.

Claim Appeals

Appeals may be submitted by the member or on behalf of an OSUHP member. Member authorization/signature is required. Adverse benefit determination appeals must be submitted to Luminare Health within 180 days of receipt of the explanation of benefits (EOB). A written letter of appeal along with all supporting documentation should be sent to Luminare Health at:

ATTN: Appeals Department
PO Box 4386
Clinton, IA 52733

If the denial is overturned, the claim will be reprocessed. If you disagree with the decision you can submit a Claim Reconsideration Form found at https://osuhealthplan.com/ to OSUHealthPlanPR@osumc.edu within 60 days of Luminare Health denying your appeal.

6) Coordination of Benefits (COB)

Please refer to the Faculty and Staff Health Plan Specific Plan Details Document (osu.edu) for details on COB.

7) Balance Billing

Contracted providers may not balance bill a member for the difference between the total billed charges and the plan allowed amount. If a provider receives a reduction in pay due to failure to obtain a prior authorization timely, the provider may not bill the member for the difference.

8) Overpayment Refunds

In the event there is an overpayment on a claim or necessary recoupment, a letter requesting the refund will be mailed to the provider. Details regarding the refund will be listed on the letter. Luminare Health will seek recovery from the provider by offsetting future payments when the provider does not send in the refund within 90 days.

9) ERA/EFT

Providers can submit ERA/EFT enrollments via email edi@echohealthinc.com, fax 440-835-5656 or via their portal: https://edi.echohealthinc.com.

V. Benefit Plans, Covered Services, and Limitations

OSU Faculty and Staff Plan

OSUHP administers several benefit packages for The Ohio State University. The medical benefit networks for each plan have been arranged into a Premier and a Standard network. Members may choose to use providers in either network at any time.

Information on medical benefits can be found here: https://hr.osu.edu/benefits/medical/

Information on pharmacy benefits can be found here: https://hr.osu.edu/benefits/prescription/

The Ohio State University Faculty and Staff Health Plan Specific Plan Detail (SPD) document can be found here: Faculty and Staff Health Plan Specific Plan Details Document (osu.edu)

OSU Student Health Franklin County Network

Please refer to the member's ID card to identify the administrator of benefit plan and direct inquiries regarding benefit plans, covered services, and limitations to the contact information listed on the card.

Affiliate Networks OSUHP is not an administrator of benefits for affiliate networks. Please refer to the member's ID card to identify the administrator of the benefit plan and direct inquiries regarding benefit plans, covered services, and limitations to the contact information listed on the card.

VI. Referrals

Affiliate Networks

OSUHP is not an administrator of the member's benefits for affiliate networks. Refer to the member's ID card to identify the administrator of the benefit plan and direct inquiries regarding referrals to the contact information listed on the card.

OSU Faculty and Staff Plan

1) In Network Referrals

OSUHP does not require members to obtain referrals for services. However, some providers may require a referral to accept the patient. When providing a referral for an OSUHP member, you must refer the member to another provider within the OSUHP network. Any consult form or other means of communication between you as the referring provider and the chosen consulting provider is acceptable. It is not necessary to send a copy of the referral to OSUHP. To verify whether a provider is participating in the OSUHP network, contact us at 614-292-4700 / 800-678-6269 or view https://osuhealthplan.com/find-a-provider/osuhp/search for a listing of all participating providers.

2) Out of Network Referrals

If members in network only plans are referred to or self-refer to non-participating hospitals or specialists, there is NO coverage. The only exception is emergency services. If services are unable to be provided in-network, services must be prior authorized through Medical Case Management at OSUHP. To verify whether a provider is participating in the OSUHP network, contact us at 614-292- 4700 / 800-678-6269 or view https://osuhealthplan.com/find-a-provider/osuhp/search for a listing of all participating providers.

3) OSU Consult Line

If you are interested in referring a patient to or talking with a physician at The Ohio State University Hospitals or The James Cancer Hospital, call the OSU Consult Line at 800-824-8236.

VII. Prior authorization and Medical Necessity Review

Affiliate Networks

OSUHP is not an administrator of the member's benefits for affiliate networks. Refer to the member's ID card to identify the administrator of the benefit plan and direct inquiries regarding prior authorizations and medical necessity review to the contact information listed on the card.

OSU Faculty and Staff Health Plan

1) Medical Necessity

For a service to be considered medically necessary a covered service must:

- Be rendered in connection with an injury or sickness;
- Be consistent with the diagnosis and treatment of your condition;
- Be in accordance with the standards of good medical practice;
- Not be for your convenience or your physician's convenience and
- Not be considered experimental or investigational

2) Inpatient Admission Review

Utilization Review is required for all inpatient admissions including elective admissions, extended care facilities, hospice care, medical rehabilitation, surgical, and urgent/emergent admissions. For elective admissions clinical documentation must be sent in ≥10 days prior to the admission. For urgent or emergent admissions notification with medical documentation is required to be submitted to the Medical Management Department within 48 hours of admission. You can contact the Medical Management Department at 614-292-4700 or 800-678-6269. Supporting clinical documentation can be faxed to 614-292-2667.

When faxing provider must include:

- Procedure requested;
- Diagnosis;
- Physician and Facility;
- Date of Service; and
- Medical record documentation to support medical necessity (such as patient history, progress notes, conservative treatment(s) failed, etc.).

3) Outpatient Observation Policy

The outpatient observation policy is available at osuhealthplan.com for review.

4) ***Prior Authorization*** A complete list of services/procedures/treatments requiring prior authorization is available at osuhealthplan.com for review. The list is updated quarterly with new codes.
   - **a)** Prior authorization must be requested ≥10 days prior to rendering services. If not obtained, claims for these services may be denied or a penalty applied consisting of 20% of the fee, up to $1,000 per admission or service. Prior authorization penalties do not apply toward the annual deductible or annual out-of-pocket limit.
   - **b)** If the covered person visits a network provider, the network provider is responsible for obtaining the prior authorization.
   - **c)** If the covered person is enrolled in a non-network medical plan or uses an out-of-network provider, it is the covered person's responsibility to obtain prior authorization and to inform the providers that he/she is enrolled in a medical plan that has prior authorization requirements.

5) ***Criteria for Review***

The criteria utilized in the review process will include:

- The terms of the definition of Medical Necessity as contained in Provider Agreement and as periodically updated by OSUHP
- Peer-reviewed, published medical journals
- A review of available studies on a particular topic
- Evidence-based consensus statements
- Expert opinions of health care professionals
- Guidelines from nationally recognized health care organizations

6) ***Peer-to-Peer Review and Appeals process***

The OSUHP will provide the opportunity to discuss the Adverse Benefit Determination with the clinical peer reviewer making the initial determination. If a peer-to-peer conversation or review of additional information does not result in a certification, OSUHP informs the provider and consumer of the right to initiate an appeal and the procedure to do so. Peer-to-peer review following a Final Adverse Benefit Determination is not available unless new medical record documentation has been submitted for review. The member and provider appeals process can be found at: https://osuhealthplan.com/sites/default/files/2022-05/member_or_provider_appeals_process_1.pdf

*Please note that the appropriate appeals form will be provided to member and provider on denial of service

7) Pharmacy

Express Scripts, Inc. (ESI) is the Pharmacy Benefit Manager (PBM) for the OSU Faculty and Staff Health Plan. Providers can contact Express Scripts, Inc. at 800-417-8164. The OSUHP Formulary can be found under the forms and downloads section of the provider website at https://osuhealthplan.com.

VIII. Quality Improvement

The OSUHP Quality Improvement program includes specific areas requiring Provider participation and compliance:

1) Credentialing Program

Includes completed contracting, application for membership, and site survey information. OSUHP shall provide all written/electronic materials and arrange for the practice site visit if required by the credentialing policy. Provider shall provide all needed information and shall accommodate the site review (if required) in a reasonable and timely manner.

2) Access Standards

OSUHP has adopted access guidelines by specialty type. All participating Primary Care Providers (PCP) and Specialists are expected to adhere to these access standards for appointment scheduling.

- Appointment Scheduling: at initial call or within same business day call back by office
- Telephone Access: 24-hour accessibility, phones busy <50% of office operating hours
- Hold time ≤2minutes, phone answered ≤45 seconds, abandonment rate ≤5%
- Waiting Room Wait Time: ≤20 minutes if arrival within five minutes of scheduled time
- Exam Room Wait Time: ≤10 minutes
- Office hours: Must maintain office hours ≥ 4 full days weekly with arrangements for 24-hour coverage. For group practices, the presence of one participating physician at least four days weekly will fulfill this requirement.

New Patient Appointments	
PCP/Specialist/Behavioral Health	Within 4 weeks
Routine Follow Up Appointments	
PCP	Within 2-3 weeks
Specialist	Within 4 weeks
GYN Annual Visit	Within 8-12 weeks
Other	
Urgent Care	Within 24 hours
Emergent Care	Immediately

3) Quality of Care and Service Complaints

Quality of Care and Service concerns are related to the quality of medical care and service a member receives from a network provider (physician, hospital, home health, ancillary company etc.). This not only encompasses medical care members receive, but also refers to such issues as accessibility of care, potential underutilization or overutilization of services and professional conduct of a provider or their staff. If a complaint is made, a request is sent to the provider requesting clarification or additional information regarding events of the case. The provider will have 15 business days to respond. Documentation of actions taken, including provider education and corrective actions plans must be provided by the provider to OSUHP.

4) Compliance with Medical Case Management Directives

OSUHP reserves the right to monitor compliance, assess best practices, and develop guidelines appropriate for the care of Covered Members.

5) Compliance with Requests for Information for Quality Improvement Purposes

Network providers are expected to maintain adequate clinical, financial, and administrative records related to services rendered as part of the provider's contractual agreement, including claims records, for a minimum of 6 years following the end of the calendar year the services are provided, unless a different retention period is required by applicable law.

Providers must provide access to these records to OSUHP or its designees if requested in connection with utilization/case management programs, quality assurance and improvement programs, or for claims payment or other administrative obligations, including reviewing compliance with the terms and provisions of the provider's contractual agreement. Providers must provide access during ordinary business hours within ten days after a request is made, except in cases of an audit involving a fraud investigation or the health and safety of a patient (in which case access shall be given within 48 hours after the request) or of an expedited patient appeal or grievance (in which case access shall be given so as to reasonably meet the timelines for determining the appeal or grievance)

Provider must cooperate with OSUHP or its designees on a timely basis in connection with any audit request.

6) Provider's Participation, written confirmation of understanding and intent to comply

Provider will comply with corrective action plans designed to address areas identified by OSUHP as problem areas requiring correction to maintain participation in the Network.

IX. Health and Wellness Programs

Affiliate Networks

OSUHP is not an administrator of the member's benefits for affiliate networks. Refer to the member's ID card to identify the administrator of the benefit plan and direct inquiries regarding any health and wellness programs to the contact information listed on the card.

OSU Faculty and Staff Health Plan

Your Plan for Health (YP4H) is The Ohio State University's approach to fostering a culture of well-being and optimal performance. YP4H provides programs and resources to empower benefits-eligible faculty, staff, or family members to pursue a life of health and wellness. The focus of the initiative is to help members reach the healthiest state possible by offering programs and incentives for identifying and acting on health conditions, promoting smart, cost-efficient choices based on individual needs, and taking control of health-care spending. The cornerstone of this initiative is the Personalized Health and Well-Being Assessment (PHA), a questionnaire that, coupled with a biometric health screening numbers, establishes a health baseline and sets a direction for employees to pursue health, wellness, and disease management. Additional services include educational programming, health fairs, flu vaccinations, personal health coaching, and care coordination.

- **Dedicated Support**
- **Prime Access**
- **Biometric Health Screenings**
- **Personal Health and Well-Being Assessment**
- **Educational Programming**
- **Personal Health Coaching Services**
- **Chronic Condition/Disease Management/Care Coordination**
- **Buckeye Baby**
- **Ohio State Employee Assistance Program**

X. Contact Us

OSUHP's network management department administers provider networks, including but not limited to: contracting, credentialing, servicing, and educating providers. Contact our team for:

- Inquiries on contract language, fee schedules, or credentialing
- Changes regarding Group Name or Tax Identification Number
- Changes regarding physical address, remit address, phone number, etc.
- If providers join or depart the provider group

Contact Us at OSUHealthPlanPR@osumc.edu

OSU Health Plan Inc. 700 Ackerman Road, Suite 1007 Columbus, OH 43202
Customer Service Phone: (614) 292 4700
Clinical Fax: (614) 292 2667 (Clinical Authorizations for OSU Faculty and Staff Plan patients only)
Provider Network Management Fax: (614)292 1166 (Contracting and Credentialing Information)
Office hours: 7:30AM 5:00PM, Monday Friday
Website: www.osuhealthplan.com

For inquiries regarding specific claims, please contact the member's third party administrator.

Third Party Administrator: OSU Faculty and Staff Plan

Luminare Health PO Box 4386 Clinton, IA 52733
Phone: 866 893 4472 ▪ 866 442 8257
Website: myluminarehealth.com

Third Party Administrator: Affiliate Networks

Please use the TPA contact information listed on the patient's ID card. OSUHP is not an administrator of the member's benefits for affiliate networks and does not pay claims or determine eligibility.