

**PARTICIPATING
PROVIDER
MANUAL**

November 2009



Dear Participating Provider:

Welcome to Beech Street, a Viant Network. We are pleased to offer you participation in one of the country's most recognized PPO networks. With over 50 years of reliable service in the healthcare industry, Beech Street can offer you access to approximately 16 million eligible individuals nationally. We constantly strive to improve our products and services to meet the needs of our clients and participating providers.

This Provider Manual is a reference tool designed to provide information regarding the administrative procedures, programs, and products that apply to your contract. Since the Manual is updated regularly, visit our website often at www.beechstreet.com to find current information. I encourage you to visit the website and review the online tools designed to further assist you.

We appreciate and thank you for your participation in the Beech Street network.

Sincerely,

Keith Vangeison
Executive Vice President
Beech Street
A Viant Network

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Please note that our Provider Manual is subject to applicable law. To the extent of any conflict between this Manual and applicable law, applicable law will control.

SECTION 1

PROVIDER CONTACT SHEET

DEPARTMENT/FUNCTION	SERVICE	CONTACT
Customer Service	General information, including participation status. Request a copy of your current contract. Credentialing questions.	E-mail: Customer.service@viant.com Phone: 800.877.1444
Provider Referrals	Referral to participating providers and facilities, including national (multi-state) contracts such as labs	E-mail: Customer.service@viant.com Phone: 800.877.1444
Claims Solutions and Investigations	Assistance on claims when payor has already been contacted; incorrect application of contracted rate (you must send HCFA/CMS or UB and EOB)	Email: Claimsappeals@viant.com Phone: 800.877.1444 Fax: 630.649.5416 Submit Appeals using the "Provider Claim Appeal Submission Form" located on website under Provider Tab
Physician Data Management (except see below for Physician/Provider Adds for Non-Delegated Providers)	Changes in physician/provider demographic information, including deletes, adds, changes to Tax Identification Numbers (TIN) (W-9 copies required for TIN changes), and NPI numbers.	Email: Network.Operations@viant.com Phone: 800.877.1444 Fax: 866.241.1644
Physician/Provider Adds for Non-Delegated Providers (Providers requiring the Beech Street credentialing process.)	Send credentialing application and accompanying documents via mail or email. Include W9.	Email: Nominations@viant.com Phone: 800.877.1444 Fax: 630.799.3050 Mail: Beech Street Corporation 25500 Commercentre Drive Lake Forest, CA 92630
Credentialing questions	Credentialing questions, including our current credentialing criteria.	Email: Credentialing@viant.com Phone: 800.877.1444
Facility Data Management	Changes in facility demographic information, including changes to billing information and Tax Identification Numbers (TIN) (W-9 copies required for TIN changes)	Email: Network.Operations@viant.com Phone: 800.877.1444 Fax: 866.241.1644
Copies of contracts	Copies of executed contracts. Please contact Customer Service.	Email: Customer.service@viant.com Phone: 800.877.1444
CPT Reimbursement Questions	Inquiry about fees. Please reference your Fee Schedule noted in your Agreement.	Email: Fee.Schedule@viant.com Phone: 800.877.1444 Fax: 866.241.1650
Precertification and Case Management Services	Refer to Patient ID card	
WEBSITE-ONLINE SERVICE	SERVICE	LOCATION
Claim Status Inquiry	Check the status of claims received by Beech Street in the last six months. Claim payment status must be checked with the payor or payor designee.	www.beechstreet.com Select "Providers" section and choose "Claim Status Inquiry"
Benefit Office Information & Claim Submission Addresses	Search function to provide information on claims submission addresses and benefit office phone numbers for information on benefits and eligibility.	www.beechstreet.com Select "Providers" section and choose "Benefits & Eligibility"
Client Listing(s)	Listing of Beech Street clients by network	www.beechstreet.com Select "Providers" section and choose "Client Listing"
Provider Manual	Reference Guide	www.beechstreet.com Select "Providers" section and choose "Provider Manual"
Online Features for Providers www.beechstreet.com	Apply to participate in the network, update your provider information, learn more about our network products, read the latest Beech Bulletin newsletter and more.	www.beechstreet.com Select "Providers" section and choose from the options on the left

SECTION 2

PROVIDER PROCEDURES OVERVIEW

Patient Identification

- As applicable under the eligible person's benefit plan, a patient identification card is issued to the eligible person by the client or payor.
- The information on the patient identification card identifies the client and/or payor and provides instructions regarding claims submission and other claim requirements.
- Beech Street, ppoNEXT, Viant or another Viant affiliate name will appear on the Explanation of Payment (EOP).
- Please complete all required patient information on the claim prior to submission for payment.
- Make a copy of the patient identification card, both front and back, for your records. For patients covered under one of our logo'd plans/products, Beech Street, ppoNEXT, Viant or another Viant affiliate name will appear on the patient identification card.
- Questions regarding claims procedures should be directed to the client or payor at the telephone number located on the patient identification card.
- The format and content of patient identification cards may vary by plan.

Key Client Information

The following key client information can vary by plan and can change periodically:

- Benefit Office Location
- Claims Payor
- Claims Mailing Address
- Employer Name
- Policy/Group Number

To facilitate claims processing, please review the patient identification card for information on these key items.

Eligibility and Benefit Verification

- Benefit designs, eligibility and payor information vary by plan and must be verified with the appropriate party as identified on the patient identification card/insurance materials.
- Beech Street does not have access to eligibility/benefit information and is not responsible for payment of claims.
- The payor is responsible for payment of claims and supplying information related to coinsurance, deductible, copayment, and plan design.

- Unless prohibited by law, the copayment amount, deductible, or coinsurance may be collected at time of service, when known.
- The website tools found at www.beechstreet.com can help you to locate benefit office information. You will need the name of the patient's employer or insurer.

Claims Submission Process

- Claims should be submitted on appropriate industry standard forms, such as a CMS HCFA-1500 form, UB-92 form, or other successor or standard industry form, 1) within ninety (90) days after providing services; 2) if payor is the secondary payor, within ninety (90) days of the explanation of payment from the primary payor; or 3) as otherwise required by applicable law.
- Unless otherwise required under applicable law, all requests for appeals or adjustments must be submitted within one hundred eighty (180) days from the date of the payor's payment or explanation of payment. Requests for appeals or payment adjustments submitted after this date will be denied, and you may not bill the payor or the patient for such denied services.
- As appropriate, the most recent versions of CPT-4 procedure codes (AMA Current Procedural Terminology), HCPCS (Healthcare Common Procedure Coding System) codes, revenue codes, DRGs, ICD-9 procedure codes or ICD-9 diagnostic codes (International Classification of Diseases, 9th Revision, Clinical Modification) should be utilized.
- Claims should be submitted to the location as directed on the patient identification card

Electronic Remittance Advice

- In an effort to streamline and expedite the claims submission and remittance process, many providers today are electing to utilize electronic claims submission technology or Electronic Remittance Advice (ERA). ERA is the electronic equivalent of the Standard Paper Remittance (SPR) and provides information to providers from payors regarding the payment of claims. In some cases, ERA may be a useful mechanism for receiving payment in a more expedited fashion and can allow providers the ability to quickly identify and reconcile accounts receivables. There are a number of clearinghouses that can be used by providers seeking to implement ERA.
- There are HIPAA regulated transaction fields within the ERA process that payors must comply with. For example, while paper Explanations of Benefits (EOB) and Explanations of Remittance (EOR) identify the network accessed to process the claim by name, HIPAA identifies the Network ID field on the ERA as a regulated field that can only be noted with a numerical identifier.
- This means that, if a provider elects to utilize ERA technology, Beech Street will be designated on the ERA through a numeric code when your Beech Street contract is applied to a claim. There is no provision for the Beech Street name to appear in the ERA. The following codes will be used in the Network ID field of the ERA to identify when your Beech Street contract was applied to a claim:

- Professional codes: 03495 and 03496
- Non-Professional codes: 03493 and 03494

Billing Requirements

Properly completed billing forms are an integral part of the claims submission process. The shaded areas on the following forms are required fields. The omission of any of the required fields may result in the delay of the processing or payment of claims. Information identifying the employer, payor, and policy number is required for payment. Use of the appropriate procedure codes and modifiers is also essential.

Prior to submitting a claim for payment, please validate that all patient, provider and payor information has been completed appropriately.

Providers must bill payors using the provider's usual billed charge, which charge will not discriminate based upon the identity of the payor.

CMS – 1500

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA <input type="checkbox"/>		PICA <input type="checkbox"/>	
1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) <input type="checkbox"/> CHAMPVA (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BEN LUNG (SSN) <input type="checkbox"/> OTHER (ID) <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
CITY STATE		7. INSURED'S ADDRESS (No., Street)	
ZIP CODE TELEPHONE (Include Area Code) ()		CITY STATE	
8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		ZIP CODE TELEPHONE (Include Area Code) ()	
Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		11. INSURED'S POLICY GROUP OR FECA NUMBER	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____	
c. EMPLOYER'S NAME OR SCHOOL NAME		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____	
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17a. _____ 17b. NPI _____		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. _____ 3. _____ 2. _____ 4. _____		22. MEDICAID RESUBMISSION CODE _____ ORIGINAL REF. NO. _____	
23. PRIOR AUTHORIZATION NUMBER _____		24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSEDT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #	
1		NPI	
2		NPI	
3		NPI	
4		NPI	
5		NPI	
6		NPI	
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/>		26. PATIENT'S ACCOUNT NO.	
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. BALANCE DUE \$	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED _____ DATE _____		32. SERVICE FACILITY LOCATION INFORMATION a. NPI b. _____	
		33. BILLING PROVIDER INFO & PH # () a. NPI b. _____	

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

UB - 04

1 PATIENT NAME										2 PATIENT ADDRESS										3 PATIENT ID		4 STATE																																					
5 BIRTH DATE										6 SEX		7 DATE		8 ADMISSION		9 HR		10 TYPE		11 SEC		12 CHR		13 STAT		14		15		16		17		18		19		20		21		22		23		24		25		26		27		28		29		30	
31 OCCURRENCE CODE		32 DATE		33 OCCURRENCE CODE		34 DATE		35 OCCURRENCE CODE		36 DATE		37 OCCURRENCE CODE		38 DATE		39 OCCURRENCE CODE		40 DATE		41 OCCURRENCE CODE		42 DATE		43 OCCURRENCE CODE		44 DATE		45 OCCURRENCE CODE		46 DATE		47 OCCURRENCE CODE		48 DATE		49 OCCURRENCE CODE		50 DATE		51 OCCURRENCE CODE		52 DATE		53 OCCURRENCE CODE		54 DATE		55 OCCURRENCE CODE		56 DATE		57 OCCURRENCE CODE		58 DATE					
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82 REV CODE		83 DESCRIPTION										84 ICD9 / ICD10 / ICD9-CM CODE										85 DRG CODE		86 SERV UNITS		87 TOTAL CHARGE		88 NON-COVERED CHARGE		89																													
90 PAYER NAME		91 HEALTH PLAN ID										92		93		94 PRIOR PAYMENTS		95 EST. AMOUNT DUE		96		97 OTHER PAYER ID																																					
98 INSURED'S NAME										99		100 INSURED'S UNIQUE ID										101 GROUP NAME		102 INSURANCE GROUP NO.																																			
103 TREATMENT AUTHORIZATION CODES										104 DOCUMENT CONTROL NUMBER										105 EMPLOYER NAME																																							
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Requests for Adjustments/Claims Appeals

- For questions regarding payment of a claim, contact the payor or payor designee first at the number or address listed on the patient identification card. For questions regarding a network related issue, including situations where, after contacting the payor or payor designee, you believe there was an incorrect application of the contract rate, contact Beech Street.
- We strive to resolve issues raised by providers on initial contact whenever possible. If issues cannot be resolved on initial contact, we offer a one-level internal appeal process. Following the internal appeal process, arbitration may be used as a final resolution step.
- To initiate an appeal, please submit a written request for an appeal. Include a copy of the explanation of payment, billing, and any other pertinent information. Please submit appeals using the "Provider Claim Appeal Submission Form." The form can be found on the Beech Street website under the Provider tab. Appeals may be submitted:

By Fax: (630) 649-5416

By Mail: Beech Street, a VIANT Network
535 East Diehl Road, Suite.100
Naperville, IL 60563

- Unless otherwise required by applicable law, all requests for appeals or adjustments must be submitted within one hundred eighty (180) days from the date of the payor's original payment or explanation of payment. Requests for appeals or payment adjustments submitted after this date will be denied, and you may not bill the payor or the patient for such denied services.

Provider Termination Appeals

On occasion, a provider's participation in our network may be terminated. To initiate a first-level appeal of a provider termination, submit the following information in writing within 30 calendar days of the date of the provider termination notice:

- Provider termination appeal letter indicating the reason for the appeal;
- A copy of the original termination notice; and
- Supporting documentation for reconsideration

Provider termination appeals should be submitted to the following address:

By Mail: Beech Street Corporation
Attention: Chief Medical Officer
6116 Shallowford Road, Suite 109B
Chattanooga, TN 37421

Requests for appeals relating to a provider termination submitted after the 30 calendar day timeframe will not be considered. The provider termination letter will outline the process for the appeal or, if not included in the termination letter, a description of the appeal process is available upon request.

Arbitration

Payment or termination disputes that are not resolved through the above appeals processes and any other disputes between the parties regarding the performance or interpretation of the provider agreement will be resolved through arbitration in accordance with the arbitration provision in the provider contract. To the extent permitted under applicable law, with respect to a payment or termination dispute, providers must submit a request for arbitration within 12 months of the date of the letter communicating the final decision under the above internal appeal process or the claim will be waived.

Coordination of Benefits

- Coordination of benefits is defined by the benefit plan.
- In accordance with our contract, payors will not be required to pay more than the contract rate.

Patient Billing

- Your contract rate with Beech Street is payment in full for services rendered to eligible persons. Payment for covered services will be made net of applicable copayments, coinsurance and, deductibles which are the responsibility of the patient.
- Do not bill the patient for amounts in excess of the contract rate.
- The Explanation of Payment (EOP) sent by the payor or payor designee should identify the amount billable to the patient. Any questions regarding the EOP or patient responsibility should be directed to the payor or payor designee.
- In addition to collecting the applicable copayment, coinsurance, or deductible amount, providers may bill patients for services not covered by the patient's benefit plan if the patient has agreed in writing to pay for those services prior to the receipt of services.

Diagnostic Radiology and Laboratory

- Participating providers are required to refer patients to participating diagnostic radiology and laboratory providers for services that are not performed in the office. A list of participating radiology and laboratory providers can be found at our online provider directory at <http://www.beechstreet.com>.
- Industry standard billing guidelines will apply to these services.

Client List

Beech Street clients include insurance companies, self funded employer sponsored plans, labor trust funds, third party administrators, regional PPOs, and large managed care or other health plans.

- Access to a list of Beech Street's clients may be obtained at our website at www.beechstreet.com and by calling Customer Service at 800.877.1444 if a client is not listed on the website. Our client listing is subject to change.
- Some of the clients listed access our network in limited geographies or for select payors or plans only. This means that not all plans administered by a client on our client list access our network. For questions about a particular client, please call Customer Service at 800.877.1444.
- Benefit levels are determined by the applicable plan. Claims for Covered Services will be reimbursed at an in-network or out-of-network benefit level as applicable under the particular plan.
- Clients listed on our website may choose not to access the Beech Street network in certain circumstances. The Explanation of Payment or ERA will indicate when the Beech Street network contract rate has been applied to payment of a claim.
- The client list is considered confidential and proprietary information as defined in the contractual agreements. Unauthorized use is prohibited.

Beech Street Participating Provider Listing

- Access to a current list of participating providers in the Beech Street network may be obtained at our web site, www.beechstreet.com.
- Information includes the names, addresses, telephone numbers and specialties of participating providers.

Please see Section 7 of this Manual for the appropriate procedures for submission of changes to your demographic information.

SECTION 3

BILLING AND REIMBURSEMENT GUIDELINES

Services should be billed in accordance with industry standard coding guidelines.

Group Billing Guidelines

- When billing under a group name and TIN, both the group name and TIN, as well as the rendering provider name, must be identified on the billing form. Claims from providers that bill using a contracted group name and TIN will be processed in accordance with the contract rate applicable to that contracted group. Individual providers that are part of a contracted group but that have elected not to participate with Beech Street must bill using their individual name and TIN or the group contract rate will apply.

Guidelines for Coding and Bundling of Claims

- Beech Street and payors have the right to establish coding guidelines generally based on the Current Procedural Terminology (CPT), as published by the American Medical Association and updated annually by the organization.
- In addition to CPT guidelines, guidelines adopted by the Centers for Medicare & Medicaid Services (CMS), industry standard guidelines and other coding and bundling guidelines may also be applied.
- Providers must comply with payor claim payment guidelines and the Utilization Management Program selected by the payor.
- Claims may be reviewed to identify services/items that are not in compliance with guidelines. No allowance for reimbursement will be made for services/items found not to be in compliance with such guidelines.
- In instances where the payor has reimbursed a provider for items not in compliance with such guidelines, the provider may be required to refund to the payor the amount of the overpayment.
- Review of provider claims for coding and billing may occur at the time of claims processing or may occur retrospectively.

Fragmentation (Unbundled Billing)

Individual CPT codes may include more than one associated procedure. It is inappropriate to bill separately for any of the procedures included in the value of another procedure.

SECTION 4

REIMBURSEMENT Place of Service

Place of Service (POS) codes are two-digit codes placed on healthcare professional claims to indicate the setting in which a service was provided. The Centers for Medicare & Medicaid Services (CMS) maintain POS codes used throughout the healthcare industry.

- Reimbursement is based on the Place of Service as listed in box 24b of the CMS 1500 form.
- Professional services are processed using the Facility Allowed Amount defined by CMS for claims submitted with the following Place of Service Codes:

Place of Service Code	Description
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room Hospital
24	Ambulatory Surgical Center
26	Military Treatment Facility
31	Skilled Nursing Facility
34	Hospice
41	Ambulance – Land
42	Ambulance – Air or Water
51	Inpatient Psychiatric Facility
52	Psychiatric Facility – Partial Hospitalization
53	Community Mental Health Center
56	Psychiatric Residential Treatment Center
61	Comprehensive Inpatient Rehabilitation Center

- All other Place of Service Codes submitted on a professional claim will be processed based on the Non-Facility Allowed Amount.
- If the place of service is not indicated on a professional claim, reimbursement will be made based on the value assigned to services rendered in the provider's office.

Ambulatory Surgery Center

- Multiple Surgical Procedures – Standard reimbursement for multiple surgical procedures is 100% of the contract rate for the highest valued procedure and 50% of the contract rate for all subsequent procedures.
- Grouper – Standard ASC groupers as adopted by CMS are applied as appropriate.

Modifiers

The standard reimbursement level for specific modifiers is as follows:

Modifier	Description	Percentage
26	Professional Component	Based on RBRVS
TC	Technical Component	Based on RBRVS
80	Assistant Surgeon	20% of the allowed amount for the surgical procedure
81*	Minimum Assistance Surgeon	10% of the allowed amount for the surgical procedure
82	Assistant Surgeon (when qualified resident surgeon not available)	20% of the allowed amount for the surgical procedure
50	Bilateral Procedure	150% of the global allowed
51	Multiple Surgical Procedures	100% of the highest allowance, 50% of all subsequent procedures
54	Surgical Care Only	70% of the global allowed
55	Postoperative Management Only	30% of the global allowed
56	Preoperative Management Only	10% of the global allowed
59	Distinct Procedural Service	100% of the global allowed
62	Two Surgeons	62.5% of the global allowed
AS*	Non surgeon assistant	10% of the global allowed
QK	Medical Director 2-4 concurrent anesthesia procedures	50% of global allowed
QX	CRNA with MD	50% of global allowed
QY	Medically directed CRNA	50% of global allowed
QZ	CRNA without MD	100% of global allowed

* Effective 1/1/2010

The above standard reimbursement levels for the referenced modifiers are subject to change.

Provider Contract and Applicable Plan

As always, reimbursement is subject to the terms of the provider contract and the applicable plan.

SECTION 5

MEDICAL MANAGEMENT

Beech Street requires that network providers participate in and cooperate with the Medical Management programs selected by the client, payor, or health plan. Utilization Management is a Medical Management program which may include, but is not limited to, pre-certification, concurrent review, and retrospective review. Medical Management programs may also include case management, disease management, maternity management, and mental health management services.

Utilization Management Programs may require that you obtain pre-certification for specific services prior to rendering the services. The patient's identification card typically provides a telephone number for questions regarding the applicable Utilization Management program. Please verify any pre-certification or other Medical Management requirements at the time you verify benefits and eligibility.

Medical records requested by the payor, Beech Street or their designee in connection with Utilization Management or other Medical Management programs must be provided at no charge and within the time frame requested which time frame must be reasonable under the circumstances.

Payment may be denied for failure to comply with Medical Management requirements, and providers cannot bill payors or patients for any such denied payments.

Appeals of Medical Management determinations will be handled in accordance with the procedures defined by the applicable payor or plan.

SECTION 6

CREDENTIALING AND QUALITY MANAGEMENT PROGRAMS

Credentialing Program Introduction

Beech Street promotes the provision of quality care by requiring that primary network candidates participate in a credentialing process that validates and examines the provider's professional education, training, and experience. Beech Street examines these factors in the evaluation of the provider in order to make an informed decision regarding the request for network membership and/or continued participation in the network. To inquire about our current credentialing/recredentialing criteria, please contact us at 800.877.1444.

Credentialing Committee

The Credentialing Committee, in its role as a peer review body, is responsible for evaluating the providers that apply for participation in the Beech Street primary network or that are recredentialed against our standards for participation in the Beech Street provider network. Committee meetings are scheduled with a frequency that is aimed at ensuring that credentialing decisions are made in a timely fashion.

Confidentiality

Credentialing activities, files, documents, data, reports or other material that involve peer review, member, or provider information are confidential and will be only be used as required in connection with our Credentialing Program.

Non Discrimination

Beech Street will not discriminate against any provider based on age, race, sex, color, religion, national origin, disability, veteran status, sexual orientation, status with respect to public assistance or any other characteristic protected under state, federal or local law.

Notification

Once approved by the Credentialing Committee, providers who meet criteria are notified in writing. Only initial applicants are notified of their approval. Notification of completed recredentialing is not routinely sent unless an adverse determination is rendered. Providers whose initial or recredentialing applications do not meet Beech Street's criteria for participation are sent a letter that outlines the rationale for the determination.

Provider Rights

Providers have the right to:

- be informed of their rights during the credentialing process
- correct erroneous information received by Beech Street in the course of the credentialing process
- review information received by Beech Street in the course of the credentialing process
- be informed of the status of their application through either a telephonic or written request to our Customer Service department.

Reconsideration/Appeal Process/Fair Hearing

Network providers who are subject to an adverse recredentialing determination may request a reconsideration of the adverse decision. Requests and additional information in support of the network provider must be submitted, in writing, to the Chief Medical Officer within thirty (30) days of the provider's receipt of the explanatory letter, unless otherwise mandated by state law. The provider will be notified of the Committee's decision within sixty (60) days of Beech Street's receipt of the request for reconsideration, unless otherwise mandated by state law. If the provider is not satisfied with the determination of the Committee after this reconsideration review, he/she may request a second level review. Details for requesting this process will be included in the reconsideration determination letter.

Quality Management Program

Introduction

Beech Street requires that network providers participate in and cooperate with our Quality Management Program. The primary focus of the Quality Management program is to assure that processes are in place to evaluate, track, and identify opportunities for improvement and improvement interventions.

Continuous Quality Management Committee/Medical Advisory Panel

The Continuous Quality Management Committee (CQMC) and Medical Advisory Panel, in their role as peer review bodies under the direction of the Chief Medical Officer, meet as required to evaluate and address quality of care and service issues, license sanction, and other adverse license activity between recredentialing cycles.

Complaint & Grievance (C&G) Review

Beech Street's C&G Program tracks and trends serious or unresolved complaints and grievances pertaining to either quality of care or services. The intake and resolution of complaints pertaining to inappropriate handling or use/disclosure of Protected Health Information (PHI) has been incorporated into the Corporate Complaint and Grievance process to ensure compliance with regulatory requirements.

Provider Sanction Monitoring/Ongoing Review

As an integral part of our Quality Management program, Beech Street has developed a License Sanction Monitoring program to periodically review for state and federal sanctions imposed on contracted providers. Severe sanctions, such as loss of license, can subject a provider to immediate termination procedures. Other restrictions of practice, such as license probations, are reviewed by our Chief Medical Officer for a determination and course of action, as appropriate, which may include peer review by the CQMC.

Although recredentialing is performed in a formal and scheduled process, Beech Street reserves the right to review and investigate any issue that presents itself that may indicate that a provider no longer meets one or more of Beech Street's criteria for participation.

Any one of the following items once known to Beech Street will be reviewed with possible action, up to and including termination, as determined by the Chief Medical Officer:

- ❖ Status of a Provider's license changes
- ❖ Status of a Provider's DEA/CDS changes
- ❖ Status of a Provider's Medicare/Medicaid sanction history changes
- ❖ Status of Provider's malpractice claims history changes

Potential issues are reported to the Quality Management Department that, in turn, primary source verifies the issue and presents the issue to the Chief Medical Officer and/or Credentialing Committee for a final determination, as the condition warrants and policy/procedure dictate.

Section 7

DEMOGRAPHIC CHANGES

Any change to the provider profile that was supplied on the original application for participation must be reported in writing or electronically submitted to Beech Street. All notices must contain both the old and new information in order to help ensure the information is processed correctly. The written notification must be on letterhead and signed by the provider or group administrator. It is vital that all written notices be as clear and precise as possible. This can help ensure accuracy and allow for changes to be completed in a timely manner.

The following are the types of changes that must always be reported as soon as possible to Beech Street:

- New address. Please indicate whether this is an additional address, or a replacement to an address previously supplied
- New telephone or facsimile number: Indicate which address(es) correspond to each phone number
- Additional office location: Please include Phone, Fax, and TIN for each office location provided
- Provider joins or leaves practice. Please include Specialty, Add/Term Effective Date, TIN, etc for each provider
- New ownership of practice
- New tax identification number (with effective date and copy of the W-9 form). Please indicate whether this is an additional TIN or a replacement to a TIN previously supplied
- Change in hospital affiliation. Please indicate new affiliation, in addition to the old affiliation, and whether the old affiliation needs to be removed
- Change in board certification status
- Change in liability coverage
- Change in practice limitations

The following data changes require written notification to our Network Administration Department and must be submitted on your office stationery. The chart below outlines the options available for submitting the changes.

Type of Change	Method of Submission		
	Facsimile:	Email:	Mail:
	(866) 241-1644	network.operations@viant.com	PO Box 22968 Chattanooga, TN 37421
Tax Identification Number (TIN) name and number addition or change (Note: must include copy of W-9 form)	X	A scanned copy of the W-9 form must be attached	X
Tax Identification Number (TIN) removal	X	X	X
Retirement	X	X	X
Disenrollment	X	X	X
Deceased provider	X	X	X
Malpractice changes on the malpractice face sheet	X	X	X
Type of Change	(630) 799-3050	nominations@viant.com	25500 Commercentre Drive Lake Forest, CA 92630
Adding a new provider to an existing <i>non-delegated group</i> agreement - The signed application and all required documents listed below must be attached (use the Add-To-Group form)	X	X	X

NON-DELEGATED GROUP ADD-ON FORM
(Existing Group Only)

Please submit the Beech Street **Provider Application or State Mandated application** for **each provider** you are adding to your group practice. Please ensure the following Credentialing data elements are included with each application:

1. Current Curriculum Vitae (CV) or resume
2. W9 IRS Form, including signature and date, if applicable
3. State Controlled Substance Certificate (CDS, BNDD, etc.) – required for the following states: AL, CT, DC, HI, ID, IL, LA, MD, MO, NV, RI, SC
4. Completed, signed and dated Attachment II for every malpractice case occurring in the last 5 years or any pending claim which involves the death of a patient.

You may submit your provider's application to us via:

- Fax @ 630-799-3050
- Email @ nominations@viant.com
- Or you may mail your request to:

Viant, Inc.
Attention: Contract Support – Beech Street Network
25500 Commercentre Drive
Lake Forest, CA 92630

Please fill out the following information for each provider you are adding to the group.

Contract Entity (CE) #: _____	
Group/DBA Name: _____	State: _____
Practice/Institution: _____	
Group Primary TIN#: _____	
<input type="checkbox"/> Individual Provider Add	<input type="checkbox"/> Multiple Provider Add
FOR BEECH STREET USE ONLY:	
Group's Credentialing Status: _____	CE#: _____

Electronic Demographic Updates for Delegated Provider Groups and Facilities

We encourage delegated provider groups and facilities to submit updates in our standard electronic format. The file layout is found in the provider section of our website at www.beechstreet.com. Updates can be sent in both Excel or Access data base files. Updates are generally processed within 30 business days of the date we receive all required information. The standard file layout contains the requirements for groups and facility providers

Please send delegated group demographic updates via email to network.operations@viant.com. If you have questions regarding the process, please call our Customer Service department at 1.800.877.1444.

Section 8

PRODUCT GRID

Beech Street Program	Features
Beech Street Primary Network	<ul style="list-style-type: none"> • A network that is accessed by patients on a primary basis where Covered Services are payable at the highest or in-network benefit level available under the patient's plan. • Patients can access our provider directory to verify provider participation. • Our customers recognize the importance of timely payment for services. • Patient identification cards identify Beech Street or a Beech Street affiliate and provide customer contact information, including where to send claims. • Explanations of payment clearly identify Beech Street or a Beech Street affiliate.
Beech Street Complementary Network	<ul style="list-style-type: none"> • A network that extends provider access to patients who would like to receive medical care from providers that do not participate in their health plan's primary network. • Benefits apply at the in-network or out-of-network benefit level, based on the patient's benefit plan. • Patients can access our provider directory to verify provider participation. • Our customers recognize the importance of timely payment for services rendered. • Patient identification cards identify Beech Street or a Beech Street affiliate and provide customer contact information, including where to send claims. • Explanations of payment clearly identify Beech Street or a Beech Street affiliate. • Since customers direct payment of covered services to the provider instead of to the patient, patient accounts receivable amounts can be reduced.
Beech Street Supplemental Network (also referred to as Expedited Claim Services Program)	<ul style="list-style-type: none"> • A network that extends provider access to patients who would like to receive medical care from providers that do not participate in their health plan's primary network. • Benefits typically apply at the out-of-network benefit level, based on the patient's benefit plan. • Our customers recognize the importance of timely payment for services rendered. • Since customers direct payment of covered services to the provider instead of to the patient, patient accounts receivable amounts can be reduced. • Potential for reduced administrative expenses with fewer individual claim negotiations. • Patient identification cards provide payor contact information, including where to send claims. Identification cards do not include the Beech Street or Beech Street affiliate name, but providers can access a list of customers that access the Supplemental Network on the Beech Street website. • Explanations of payment clearly identify Beech Street or a Beech Street affiliate. • Some plans accessing the Supplemental Network and Expedited Claims Services Program do not include direction mechanisms.
Consumer Card	<ul style="list-style-type: none"> • Patients can access our provider directory to verify provider participation. • Patient identification cards identify Beech Street or a Beech Street affiliate. • Patient identification cards also provide contact information, including how to determine the network contracted amount and verify patient participation. • The patient is responsible for payment of services at the contract rate, and payment may be collected from the patient at the time of service.
Workers' Compensation Network	<ul style="list-style-type: none"> • Network access for services subject to a customer's workers' compensation program. • Adjusters and patients can access our provider directory to verify provider participation. • Explanations of payment clearly identify Beech Street or a Beech Street affiliate.
Auto Medical	<ul style="list-style-type: none"> • Network access for health care services rendered under a customer's auto medical program. • Patients can access our provider directory to verify provider participation. • Explanations of payment clearly identify Beech Street or a Beech Street affiliate.

The above is a summary of our standard product portfolio. Some of the above listed products may not apply to your agreement. Our product portfolio is subject to change. Access to a list of our customers may be obtained at our website: www.beechstreet.com.

If you have any questions about participation in these products, please feel free to contact our Provider Services Department at the numbers listed below:

- Primary/Complementary/Supplemental 800.432.1776
- Consumer Card 800.432.1776
- Workers' Compensation 800.877.1333
- Auto Medical 800.877.1909