Table of Contents
Provider Manual Overview ........................................................................................................................... 3
Introduction .................................................................................................................................................. 3
How NPN is Funded ...................................................................................................................................... 3
Delegation Defined ....................................................................................................................................... 3
Contact Information ...................................................................................................................................... 4
Credentialing ................................................................................................................................................. 5
Providers Joining Your Practice ................................................................................................................. 5
Types of Providers Credentialed ............................................................................................................... 5
Facilities Adding Location(s) .................................................................................................................... 6
Types of Facilities Credentialed ................................................................................................................ 6
Sub-Delegation of Credentialing ................................................................................................................. 6
Recredentialing ......................................................................................................................................... 6
Corrective Action ...................................................................................................................................... 6
Provider/Facility Rights ............................................................................................................................... 7
Changes to Your Practice/Facility ............................................................................................................... 7
Termination of Participation ....................................................................................................................... 7
Closing your Practice ................................................................................................................................. 8
Contracting .................................................................................................................................................... 9
Delegation by Plan .................................................................................................................................... 9
Rainier Health Network ............................................................................................................................ 9
  Medicare Shared Savings Program (MSSP) ............................................................................................ 10
Claims .......................................................................................................................................................... 10
  Reimbursement .................................................................................................................................... 11
  Charging Members ................................................................................................................................. 11
Releasing a Patient from your Practice .................................................................................................... 11
Compliance ................................................................................................................................................. 12
  Reporting Suspected or Detected FWA ............................................................................................... 12
  Conflicts of Interest ............................................................................................................................ 12
  Marketing ............................................................................................................................................. 12
    Medicare Advantage Do’s and Don’ts ............................................................................................... 13
Population Health ....................................................................................................................................... 13
Comprehensive Health Assessment Program (CHAPs) .......................................................... 13
Risk Adjustment Factor ........................................................................................................... 14
Coding and Documentation ..................................................................................................... 14
What does this mean to your practice? ................................................................................... 14
Opportunities and Services ....................................................................................................... 14
EMR Optimization .................................................................................................................... 15
Provider Quality Incentive Program (PQIP) ............................................................................ 15
Utilization Management ............................................................................................................. 16
  Referrals / Pre-Authorizations ............................................................................................... 17
  Physical Therapy ...................................................................................................................... 17
  Women’s Health ....................................................................................................................... 17
Care Management ..................................................................................................................... 18
Behavioral Health ...................................................................................................................... 18
Identifying NPN Members/Patients ........................................................................................... 18
Frequently Asked Questions ...................................................................................................... 19
  How do I check the status of a claim, authorization or member eligibility? ......................... 19
  Does NPN pay claims using Electronic Funds Transfer (EFT)? ............................................. 19
  How do I submit a referral? ...................................................................................................... 19
  How do I add/remove users to OneHealthPort? ..................................................................... 19
  How do I add/remove users to Clarity/SCI Solutions? ............................................................ 19
Appendix ..................................................................................................................................... 19
  Prior Authorization Guide ....................................................................................................... 20
  Prior Authorization Request Form Sample ................................................................................ 21
  Care Management Referral Form Sample ................................................................................ 22
  ID Card Samples ....................................................................................................................... 23
  Credentialing and Contracting Crosswalk ................................................................................ 25
  Delegation by Plan .................................................................................................................... 26
  Behavioral Health – Plan Resources ....................................................................................... 27

Issue date: March 2019
Provider Manual Overview
This Provider Manual is an extension of your participation agreement. It includes important information for providers, facilities and practice staff regarding policies, procedures, claims submissions and adjudication requirements, and guidelines used to administer plans. This Provider Manual replaces and supersedes any and all previous versions.

As per the Medicare Advantage Addendum in your participation agreement, all Providers and Facilities are to comply with health plan policies and procedures, including, but not limited to those listed herein. Please refer to health plan provider manuals for specific policies and procedures when applicable.

As policies and procedures change, updates will be issued via The Nibbler and/or Physician Alert and may be incorporated into the electronic version and subsequent paper versions of this Provider Manual.

Any requirements under applicable law, regulation or governmental agency guidance that are not expressly set forth in this Provider Manual shall be incorporated herein by this reference and shall apply to Providers, Facilities, health plans and/or NPN where applicable. Such laws and regulations, if more stringent, take precedence over this Provider Manual. Providers and Facilities are responsible for complying with all applicable laws and regulations.

Introduction
Northwest Physicians Network was founded in 1995 as an Independent Physicians Association (IPA). An IPA is a business entity organized and owned by a network of independent physician practices for the purpose of reducing overhead or pursuing business ventures such as contracts with employers, accountable care organizations (ACOs) and/or managed care organizations (MCOs).

Northwest Physicians Network was acquired by DaVita Medical Group (DMG) in November of 2017. DaVita Medical Group is an American managed care provider that operates practices in California, Colorado, Florida, Nevada, New Mexico and Washington. The company is a subsidiary of DaVita Inc. with approximately 74,500 employees and serves more than 1,700,000 patients worldwide.

Ultimately, NPN is projected to transition to Optum; which is currently in final regulatory proceedings of that acquisition. The network will adopt the Optum brand as we transition.

How NPN is Funded
NPN receives its funding through its contractual arrangements with the health plans. Revenue received from these arrangements are applied towards the cost of services (claims expenses) and general/administrative costs (operational expenses).

Delegation Defined
Delegation is the formal process or contract granting an enterprise authority to execute specific functions on behalf of an organization; in the case of NPN it refers to health plans. Ultimately, the health plan is the responsible party. As the delegating party, the health plan must remain apprised of the delegates actions; ensuring adherence to compliance standards.
In full delegation, this translates to providing services on behalf of the aforementioned plans to credential providers, provide care management services, administer utilization management and adjudicate claims. NPN has additional plan relationships that serve to delegate specific functions of health plan work. Please refer to the appendix for delegation by plan.

Please contact your Practice Support Advocate if you have additional questions.

Contact Information

**NPN Main Number**
General information
Tel 253-627-4638
Fax 253-573-9511

**Website Address**
www.npnwa.net

**Customer Service**
Eligibility, claims/auth status,
Fax 253-573-9511
customerservice@npnwa.net

**Health Care Coordination**
Case Management
Tel 253-573-1880
Fax 253-627-4708

**NPN Directory Searches**
(Provider, Facilities)
www.npnwa.net/idirectory.php

**Credentialing**
Tel 253-682-4809
Fax 253-573-9511
credentialing@npnwa.net

**Contracting**
Tel 253-207-4335
Fax 253-573-9511
ycardenas@npnwa.net

**Network Development/Provider Relations**
Tel 253-627-3578
Fax 253-573-9511
providerrelations@npnwa.net

**Mailing Address**
Send general information to:
PO Box 2117
Tacoma, WA 98401
**Credentialing**

Credentialing refers to the process performed by NPN to verify and confirm that an applicant meets the established policy standards and qualifications for consideration in the NPN Network. Upon completion of the credentialing process, each applicant is presented to the Credentials Committee, which is comprised of physicians of various specialties, for review and recommendation. A complete copy of the NPN Credentials Program Manual may be provided upon request.

NPN performs credentialing activities on behalf of health plans for which a credentialing delegation agreement has been executed. This list is subject to change.

<table>
<thead>
<tr>
<th>Health Plan/Carrier</th>
<th>Lines of Business</th>
<th>Providers/Facilities Credentialed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna</td>
<td>All lines of business</td>
<td>Providers only</td>
</tr>
<tr>
<td>FirstChoice Health Network</td>
<td>All lines of business</td>
<td>Providers only</td>
</tr>
<tr>
<td>Humana</td>
<td>Medicare Advantage</td>
<td>All providers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>All facilities</td>
</tr>
<tr>
<td>Premera</td>
<td>Medicare Advantage</td>
<td>All providers</td>
</tr>
<tr>
<td></td>
<td>PersonalCare Plan</td>
<td>Ambulatory Surgery Centers</td>
</tr>
<tr>
<td>United Health Care</td>
<td>All lines of business</td>
<td>All providers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>All facilities</td>
</tr>
</tbody>
</table>

**Providers Joining Your Practice**

Unless the practice has a credentialing sub-delegation arrangement in place with NPN, all providers joining an existing practice must complete the credentialing process. Until such time as the provider has successfully completed the credentialing process and executed a Provider Agreement, claims may not be reimbursed appropriately and/or denied payment. Contact your Practice Support Advocate or NPN Credentialing prior to your new provider seeing patients to minimize any reduction or denial of payment.

**Types of Providers Credentialed**

NPN credentials the following provider types:

- MD
- DO
- DPM
- ARNP
- PA-C
- CNM
- RNFA
- OD
- PhD
- PsyD
- LMHC
- LMFT
- LSW
Facilities Adding Location(s)
Unless a credentialing sub-delegation arrangement is in place with NPN, all facility locations must complete the credentialing process. Until such time as the additional location has successfully completed the credentialing process, authorizations and claims payment may be denied. Contact NPN Credentialing prior to your new location seeing patients to minimize any denial of authorization or reduction in payment.

Types of Facilities Credentialed
- Ambulatory Surgery Centers
- Behavioral Health (facility)
- Birthing Centers
- Chemical Dependency Treatment Centers
- Durable Medical Equipment
- Home Health
- Home Infusion Therapy
- Hospitals
- Independent Diagnostic Testing Facility
- Laboratories
- Radiology (except therapeutic/interventional radiologists who are credentialed individually)
- Physical, Occupational or Speech Therapies
- Skilled Nursing Facilities
- Urgent Care Centers

Sub-Delegation of Credentialing
NPN may delegate specific credentialing and recredentialing responsibilities to healthcare entities. Determination of whether a group can be delegated is dependent on the successful results of a pre-delegation audit and execution of a credentialing sub-delegation agreement. Contact NPN Credentialing for additional information regarding eligibility and qualification.

Recredentialing
The recredentialing cycle occurs every three (3) years for Providers and Facilities. Non-response or failure to return a completed recredentialing application(s) and supporting documentation may be considered a voluntary termination of participation unless otherwise determined by the Executive Medical Director and/or Credentials Committee.

Exceptions to this may include active military assignment, maternity/paternity leave or sabbatical. Contact NPN Credentialing for additional information.

Corrective Action
Should NPN determine a provider or facility has failed to meet performance expectations pertaining to quality of care, patient services or established performance or professional standards, a corrective action plan may be implemented.
If a corrective action is not satisfactorily resolved within the designated period, the Executive Medical Director has authority to recommend extension of the corrective action plan or suspension/termination from network participation.

Providers/Facilities who are suspended or terminated have the right to appeal. Where an appeal is not reversed, NPN will notify the National Practitioner Data Bank and network affiliated entities (health plans) as required by law and contractual agreements.

The NPN Credentialing Program Manual may be available upon request for additional details regarding corrective action, suspensions, terminations, appeals.

Provider/Facility Rights
Providers and Facilities have the right to review information submitted in support of their credentialing application. However, this is limited to information obtained from any outside primary source such as malpractice insurance carriers, state license boards, and/or National Practitioner Data Bank (NPDB). Providers and Facilities have the right to correct erroneous information in the event credentialing information received from other sources conflicts with information provided by the Provider or Facility. Provider and Facilities have the right to appeal a decision made by the Executive Medical Director and/or the NPN Credentials Committee.

For detailed information regarding your rights, you may request a copy of the NPN Credentials Program Manual.

Changes to Your Practice/Facility
All changes to your Practice or Facility should be provided to NPN in accordance with the terms of your Participation Agreement or as soon as reasonably possible. This includes, but is not limited to:

- Change in address
- Change in ownership
- Change in Tax Identification Number (TIN)
- Additions
- Deletions
- Terminations
- Changes to licensure (actual or threatened) resulting in loss, suspension, or material limitation of a provider’s license
- Changes to staff membership or clinical privileges at any hospital
- Changes to formal disciplinary action, if any
- Change to any malpractice action filed against or decided adversely to provider

All changes should be sent to Credentialing@npnwa.net for processing. NPN Credentialing will notify health plans on a monthly basis for those plans which NPN has a delegated credentialing agreement in place.

Termination of Participation
Providers/Facilities are contractually required to provide adequate notice of termination of network participation. Please refer to your Provider or Facility Agreement.
Closing your Practice

Closing your practice due to retirement or business considerations is a complex undertaking. NPN would like to support you in locating resources for your transition and identifying actions needed. The process can be very different for Primary Care Providers and Specialists. The table should provide a start in preparing for such a change. Please utilize your resources with NPN by contacting your Practice Support Advocates, to assist in planning the logistics.

<table>
<thead>
<tr>
<th>Considerations</th>
<th>PCP</th>
<th>Specialist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notify NPN via letter or email to <a href="mailto:Credentialing@nnpwa.net">Credentialing@nnpwa.net</a></td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Letter Notifying Patients of change</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Communicate how patient may obtain their records</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Recommendations for new providers</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>How to contact the office during and after the transition</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Communicate changes to non-NPN Health Plans</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Instruct patients to contact the Health Plan regarding a PCP change</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Close patient panel</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Identify patient currently in Care Management</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Provide access to medical records to NPN (current year)</td>
<td>✔</td>
<td>✔</td>
</tr>
</tbody>
</table>
Contracting

NPN’s Provider and Facility Participation Agreements allow NPN to contract with health plans as an arranger of care. Please refer to your Agreement for specifics. Please refer to the Credentialing section to determine eligibility to participate.

NPN holds the following contracts:

<table>
<thead>
<tr>
<th>LINE OF BUSINESS</th>
<th>PAYOR</th>
<th>PAYOR PLAN</th>
<th>EFFECTIVE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEDICAID</td>
<td>United Healthcare</td>
<td>Medicaid - Community Plan (Apple Health)</td>
<td>7/1/2012</td>
</tr>
<tr>
<td>MEDICARE ADVANTAGE</td>
<td>United Healthcare</td>
<td>Medicare Advantage - HMO Plans</td>
<td>12/1/2013</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medicare Solutions Dual Complete Medicare Advantage</td>
<td>1/1/2019</td>
</tr>
<tr>
<td></td>
<td>Humana</td>
<td>Medicare Advantage HMO Plans</td>
<td>1/1/2016</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medicare Advantage PPO Plan</td>
<td>1/1/2016</td>
</tr>
<tr>
<td></td>
<td>Premera</td>
<td>Medicare Advantage Plans - HMO Plans</td>
<td>1/1/2014</td>
</tr>
<tr>
<td>RAINIER HEALTH NETWORK</td>
<td>CMS</td>
<td>Medicare Shared Savings Program - Fee For Service</td>
<td>6/7/2012</td>
</tr>
<tr>
<td></td>
<td>Aetna</td>
<td>Whole Health (specific commercial product)</td>
<td>7/1/2015</td>
</tr>
<tr>
<td></td>
<td>BCBS of IL/Regence</td>
<td>CHI Employee Plan</td>
<td>1/1/2015</td>
</tr>
<tr>
<td></td>
<td>United Healthcare</td>
<td>Commercial plans</td>
<td>1/1/2016</td>
</tr>
<tr>
<td>COMMERCIAL SHARED SAVINGS</td>
<td>Aetna</td>
<td>Commercial Shared Savings - Commercial</td>
<td>7/1/2013</td>
</tr>
<tr>
<td></td>
<td>Cigna</td>
<td>Commercial Shared Savings - Commercial</td>
<td>4/1/2013</td>
</tr>
<tr>
<td></td>
<td>Premera</td>
<td>Personal Care Partner - Commercial (PCP assigned)</td>
<td>1/1/2016</td>
</tr>
</tbody>
</table>

This list is subject to change. In some cases, a Provider/Facility must also hold a direct contract with the health plan for participation and/or reimbursement purposes. In some cases, NPN has negotiated the reimbursement rate with the health plan. See also the Credentialing and Contracting Crosswalk in the Appendix or contact your Practice Support Advocate for details.

For NPN attributed members, your NPN Participation Agreement will supersede your direct health plan agreement in some cases.

Delegation by Plan
Please see appendix for delegation by plan matrix.

Rainier Health Network
Rainier Health Network (RHN) is an Accountable Care Organization (ACO) owned by CHI Franciscan Health and not a health plan.
NPN is a participating network provider in RHN and you are included as part of NPN’s network arrangement. Additionally, you will need to have underlying health plan contracts.

Please refer to NPN Credentialing and Contracting Crosswalk in the appendix for further details or contact your Practice Support Advocate.

Medicare Shared Savings Program (MSSP)

To participate in the RHN MSSP contract, you must sign an agreement directly with RHN. NPN, as a network, does not participate, manage or administer this plan. For more information or how to participate, please contract RHN directly at rhn@chifrancscan.org or 253-428-8444.

Claims

NPN is delegated to adjudicate and pay claims for some health plans. Please refer to the grid below.

Provider and Facilities are responsible for verifying patient eligibility, benefits and obtaining referral/authorization, if applicable, prior to services rendered. Claims should be submitted electronically to NPN11. Paper claims will not be accepted and will be returned.

<table>
<thead>
<tr>
<th>Health Plan / Product</th>
<th>Submit to</th>
<th>Claims Submission Information</th>
</tr>
</thead>
</table>
| **United Healthcare - MA** | NPN | Electronic Claims: Payer ID# NPN11  
Clearing House: Availity  
Paper Claims: Not accepted |
| • AARP Medicare Complete  
  ○ Plan 1 (HMO-MAPD Plan)  
  ○ Plan 2 (HMO-MAPD Plan)  
  ○ Plan 3 (HMO-MAPD Plan) | | |
| **United Healthcare - Medicaid** | NPN | Electronic Claims: Payer ID# NPN11  
Clearing House: Availity  
Paper Claims: Not accepted |
| • Community Plan  
  • SCHIP | | |
| **Humana** | NPN | Electronic Claims: Payer ID# NPN11  
Clearing House: Availity  
Paper Claims: Not accepted |
| • Gold Plus HMO-MAPD Plan | | |
| **United Healthcare - Duals** | UHC | Electronic Claims: Payer ID# 95959  
Paper Claims: PO Box 31362 |
| • Medicare Solutions Dual Complete Medicare Advantage | | |
| **Humana – Duals** | Humana | Electronic Claims: Payer ID# 61101  
Clearing House: Availity  
Paper Claims: PO Box 14601  
Lexington, KY 40512 |
| • HumanaChoice PPO Gold Plus – SNP-DE | | |
| **Premera Blue Cross Medicare Advantage** | Premera | Electronic Claims: Payer ID# 00934  
Clearing House: Availity  
Paper Claims: PO Box 91059  
Seattle WA 98111 |
| • Medicare Advantage (HMO-MAPD Plan)  
  • Medicare Advantage Classic (HMO–MAPD Plan)  
  • Medicare Advantage Classic Plus (HMO-MAPD Plan)  
  • Soundpath Health Alpine (HMO-MA Only Plan)  
  • Soundpath Health Peak + Rx (HMO-MAPD Plan)  
  • Soundpath Health Sound + Rx (HMO-MAPD Plan)  
  • Soundpath Health Charter + Rx (HMO-MAPD Plan) | | |
<table>
<thead>
<tr>
<th>Health Plan / Product</th>
<th>Submit to</th>
<th>Claims Submission Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Premera PersonalCare Partner Systems</strong></td>
<td>Premera</td>
<td>Premera</td>
</tr>
<tr>
<td>• Gold</td>
<td>Electronic Claims: Payor ID# 00934</td>
<td></td>
</tr>
<tr>
<td>• Silver</td>
<td>Clearing House: Availity</td>
<td></td>
</tr>
<tr>
<td>• Bronze</td>
<td>Paper Claims: PO Box 91059</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Seattle WA 98111</td>
<td></td>
</tr>
<tr>
<td><strong>Rainier Health Network</strong></td>
<td>Health plan as applicable</td>
<td>Refer to patient ID card for appropriate health plan claims submission information.</td>
</tr>
<tr>
<td>• Aetna Whole Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• BCBS of Illinois (CHI Employee Plan)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Regence (CHI Employee Plan – Kitsap only)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• United Healthcare</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Reimbursement**

Reimbursement for services terms are defined in your Provider/Facility Agreement. However, your reimbursement is affected not only by the terms of your Agreement, but also the following:

- Patient’s eligibility at the time of the service
- Whether services provided are covered services under the patient’s health plan
- Whether services are medically necessary as required by the patient’s health plan
- Whether services were without prior approval/authorization, if authorization is required
- Patient copayments, coinsurance, deductibles and other cost-share amounts due from the patient and coordination of benefits with third-party payors as applicable
- Adjustments of payments based on coding edits described above

All services must comply with all federal laws, rules and regulations applicable to individuals or entities receiving federal funds, including without limitation Title VI of the Civil Rights Act of 1964, Age Discrimination Act of 1975, Americans with Disability Act, and Rehabilitation Act of 1973. Please refer to your Provider/Facility Agreement for additional terms.

Nothing contained in the Agreement or Provider Manual are intended to be a financial incentive or payment which directly or indirectly acts as an inducement for Providers/Facilities to limit medically necessary services.

**Charging Members**

Practices and Facilities are responsible for verifying patient eligibility and benefits prior to services, including but not limited to, obtaining authorization for services. Practices and Facilities are responsible for the collection of copays, co-insurance and/or deductibles as applicable. Please refer to WAC 284-170-421 regulations in your Participation Agreement for additional details.

Additionally, per your NPN Participation Agreement, Practices and Facilities shall not charge a Medicare Advantage patient for non-covered services under the Patient’s plan unless the Patient has received a pre-service organization determination notice of denial from NPN or health plan before any such services are rendered. Please refer to your Participation Agreement for complete language.

**Releasing a Patient from your Practice**

Please refer to health plan specific provider manuals for releasing a patient from your practice.
Compliance
All contracted Practices and Facilities are required to comply with applicable laws, regulations, accreditation standards and health plan policies and procedures, including but not limited to Fraud, Waste and Abuse (FWA) regulations, maintaining an effective compliance program and training. Please refer to your Participation Agreement and health plan specific provider manuals for specifics.

Reporting Suspected or Detected FWA
All contracted Practices, Facilities and their employees are required to report any potential, suspected or detected non-compliance of Fraud, Waste and Abuse to either:

- NPN Compliance Officer – Olivia Smith at osmith@npnwa.net
- DaVita Medical Group Compliance Department via the Compliance Hotline at 855-236-1448 or at CorporateCompliance@davitamedicalgroup.com

Individuals and entities who report suspected or detected false claims violations are protected from retaliation under 31 U.S.C. 3730(h) for False Claims Act compliance. NPN and health plans have policies of non-retaliation against those in good faith report suspected or detected violations.

Conflicts of Interest
All Practices, Facilities and their employees are required to avoid conflicts of interest. Practices and Facilities should never offer or provide anything of value, including but not limited to, cash, cash-equivalents, bribes or kickbacks.

Practices and Facilities should obtain conflicts of interest statements from their employees. The statement should certify that the employee is free from any conflict of interest which would prevent them from administering, delivering or arranging Medicare/Medicaid benefits or services. If a potential conflict of interest arises, the Practice or Facility is responsible for removing the conflict, or if appropriate, obtaining approval from affected parties to continue work despite the conflict.

Marketing
For the purposes of this Provider Manual, “marketing” includes any information, whether oral or written, that is intended to promote or educate current or prospective Medicare beneficiaries about any Medicare plans, products or services.

All contracted Practices and Facilities are required to comply with all current CMS regulations regarding marketing. As of January 2019, CMS has clarified that providers may interact with their patients regarding plan options when relevant to the course of treatment or at the patient’s request. A summary of the rules are as follows, however please refer to https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Guidance.html for the most current and in-force information.
Medicare Advantage Do’s and Don’ts

| Providers and office staff MUST always: | • Remain neutral when discussing health plan options  
• Consider patients' needs when discussing health plan options (such as transportation benefits, certain drug benefits, mental health benefits, enhanced care coordination for chronic conditions, etc.) |

| Providers and office staff MAY NEVER: | • Steer patients towards a particular plan based on any financial or any other interest of the provider, staff member or office  
• Offer patients anything of value to encourage patients to enroll in a particular plan or select a particular organization or provider  
• Distribute plan marketing materials or applications where care is delivered (in the exam room or other treatment areas)  
• Selectively display or distribute marketing materials in common areas/waiting rooms for only one or a few plans |

| Providers MAY do the following in the exam room when relevant to treatment or at the patient’s request: | • Answer questions or discuss the merits of a plan or plans, including cost sharing and benefit information  
• Refer to and distribute materials created by CMS, including “Medicare & You” and “Medicare Options Compare” |

| Providers and office staff MAY do the following in common areas/waiting rooms: | • Provide names of plans that the provider is contracted  
• Refer patients to: State Health Insurance Assistance Programs (SHIP), plan marketing representatives, Local State Medicaid and Social Security offices, CMS’s website (medicare.gov), or 1-800-MEDICARE  
• Refer patients to and/or make available plan marketing materials, where all contracted health plans have had the same opportunity to submit marketing materials  
• Provide information and assistance in applying for LIS (Low Income Subsidy) |

Population Health

NPN has developed programs and resources in concert with health plans to support your Practice around population health management. These programs and resources include, but are not limited to, complex care management, Comprehensive Health Assessment Programs (CHAPs) and electronic medical record (EMR) optimization.

Comprehensive Health Assessment Program (CHAPs)

CHAPs includes, but is not limited to, provider training related to Medicare Advantage documentation requirements and coding to the highest level of specificity, patient outreach/engagement to close quality gaps, and providing tactical support for meeting CMS STAR/quality measures.

All contracted providers are required to allow NPN access to patient charts for NPN attributed patients as part of supporting quality initiatives. An essential part of ensuring all data is captured and reported to health plans, NPN deploys Chart Abstractors, whether to your practice or via remote access to your
EMR. Data for only your NPN attributed patients is reviewed and processed. The chart abstraction process can capture documentation to close care gaps and potential coding trends.

Risk Adjustment Factor
Risk Adjustment Factor or RAF score is based on health conditions a patient may have (specifically those that fall within a Hierarchical Condition Category or HCC), as well as demographic factors such as Medicaid status, gender, age/disabled status and whether the patient lives in an institution (for 90 days or longer) or not.

The RAF is a relative measure of probable costs to meet the healthcare needs of the individual. The RAF is used by Centers for Medicare and Medicaid Services (CMS) to adjust capitation payments to payors and thus to NPN for each Medicare Advantage (MA) member. As such, complete and accurate reporting of patient data is critical.

CMS requires providers to identify all conditions that may fall within an HCC at least once, each calendar year. Documentation in the patient’s medical record must support the presence of the condition and indicate the provider’s assessment and treatment plan.

Coding and Documentation
Documentation, coding and ensuring compliance takes education, communication and understanding by all the members of your clinic staff. As more and more of our work and payments structures are measured by data it has become increasingly important that we educate and prepare ourselves and our systems to capture the complexity of the work we do.

Northwest Physicians Network has a team to help your clinic stay up to date and able to report. The Coding and Compliance Educator will help providers with diagnostic coding issues, medical record review, documentation standards, and education opportunities that support the ever-changing work in healthcare. NPN’s goal is to help promote the highest quality of care to our patients.

What does this mean to your practice?
- NPN will provide coding knowledge to you as a provider and to your clinic staff to support ongoing development of risk adjustment coding and quality metric recognition coding (CPT Category II)
- Our Certified Professional Coder will evaluate documentation and coding behavior and identify recommendations for improvement.
- We will provide consultation and education to help our providers improve their systems to impact risk adjustment and quality reporting.

Opportunities and Services
- We will perform reviews of medical documentation to ensure that all offices capture chronic HCC (Hierarchical Condition Categories) that would affect the Medicare Risk Adjustment reimbursement.
- NPN analyzes data from inpatient hospitalizations, diagnostic testing, outpatient procedures and services, home health care services, durable medical equipment, rehabilitative therapies, and pharmacy reviews for the possibility of chronic codes missed.
• The coder will prepare feedback and training materials to educate the providers and staff on any audit outcomes and will help with accurate coding procedures. The coder will help the staff implement any changes that are needed.
• NPN will communicate with the managers of possible coding trends and help implement correct diagnosis reporting.
• NPN will perform routine audits of documentation and coding in accordance with Compliance Policies and Procedures and communicate the results to the offices.
• We will follow up with written and verbal education regarding coding and compliance to physicians, clinical staff, and non-clinical staff. You will also be able to request the coder to come to your clinics and help with any coding or documenting issues.
• The coder will remain apprised of the latest guidelines and relay that information to the clinics and staff. We will provide any updates of new codes or coding issues. NPN will send emails with free webinars, coding materials, and any other education needed.
• NPN will identify members with high risk CMS Hierarchical Condition Categories (HCC) and speak with the particular clinics regarding the documenting and reporting of care and how this will help the provider’s income.

EMR Optimization
NPN has a full-time EMR Optimization Specialist who can assist your practice in utilizing your system more efficiently to maximize data collection and reporting opportunities. For more information, contact your Practice Support Advocate.

Provider Quality Incentive Program (PQIP)
In an effort to support sustainable private practice, NPN implemented the Provider Quality Incentive Program in January 2018 to reward quality, activities that drive quality outcomes, exclusivity, access and the time commitment to learn about population health management.

PQIP is currently only available to eligible Primary Care Providers (PCPs) seeing Medicare Advantage patients under NPN’s UHC and Humana HMO plans. Unless otherwise noted, PQIP related payments are made payable to the practice and a completed IRS Form W-9 must be on file with NPN.

PQIP has 4 components, rates are subject to change via amendment notification:

<table>
<thead>
<tr>
<th>Component</th>
<th>Expectation</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per Member Per Month (PMPM)</td>
<td>• Provide timely access</td>
<td>• 1st year rate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Subsequent years - amount may vary based on YE 2018 STAR performance</td>
</tr>
<tr>
<td>Annual Comprehensive Visit Incentive (ACV)</td>
<td>• Conduct ACV for attributed MA members</td>
<td>• Gate 1 - Per member per year amount OR</td>
</tr>
<tr>
<td></td>
<td>• Gate 1 - 75% ACV completion by 9/1 OR</td>
<td>• Gate 2 – higher per member per year amount</td>
</tr>
<tr>
<td></td>
<td>• Gate 2 - 90% ACV completion by 12/13</td>
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<tr>
<td>Component</td>
<td>Expectation</td>
<td>Rate</td>
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<tr>
<td>----------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>Patient Profile From</td>
<td>• In a timely, complete and accurate fashion, complete and submit an annual comprehensive visit form</td>
<td>• Per member per year amount</td>
</tr>
<tr>
<td>CHAPs training</td>
<td>• Attend and actively participate in period provider training sessions/activities</td>
<td>• Hourly rate (Provider level)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Hourly rate (Support staff)*</td>
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</table>

*Support staff is limited to 1 per practice and for select trainings only.

**Utilization Management**

NPN’s Utilization Management (UM) Team works in concert with PCPs, Specialists and ancillary providers of care around the appropriate and efficient use of healthcare resources. The UM Team works collaboratively with discharge planners in hospitals and skilled nursing facilities to ensure positive patient outcomes.

However, NPN is not delegated for Utilization Management for all plans. Please refer to the table below:

<table>
<thead>
<tr>
<th>Health Plan</th>
<th>UM Managed by</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>UHC – Medicare Advantage (HMO)</td>
<td>NPN</td>
<td>Phone: 253-573-1880</td>
</tr>
<tr>
<td>• AARP Medicare Complete</td>
<td></td>
<td>Fax: 253-627-4708</td>
</tr>
<tr>
<td>• Plan 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Plan 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Plan 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>UHC – Medicare Advantage (Dual)</td>
<td>UHC</td>
<td>Phone: 877-842-3210</td>
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<td>• Medicare Solutions Dual Complete</td>
<td></td>
<td></td>
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<tr>
<td>UHC – Medicaid</td>
<td>NPN</td>
<td>Phone: 253-573-1880</td>
</tr>
<tr>
<td>• Community Plan</td>
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<tr>
<td>• SCHIP</td>
<td></td>
<td></td>
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<tr>
<td>Humana – Medicare Advantage (HMO)</td>
<td>NPN</td>
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<tr>
<td>• Gold Plus HMO-MAPD Plan</td>
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<td></td>
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<tr>
<td>• HumanaChoice PPO</td>
<td></td>
<td>Phone: 800-457-4708</td>
</tr>
<tr>
<td>• Gold Plus – SNP-DE</td>
<td></td>
<td>Phone: 800-457-4708</td>
</tr>
<tr>
<td>Premera – Medicare Advantage (HMO)</td>
<td>NPN</td>
<td>Phone: 253-573-1880</td>
</tr>
<tr>
<td>• Medicare Advantage (HMO-MAPD Plan)</td>
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<td>Fax: 253-627-4708</td>
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<tr>
<td>• Medicare Advantage Classic (HMO–MAPD Plan)</td>
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</tr>
<tr>
<td>• Medicare Advantage Classic Plus (HMO-MAPD Plan)</td>
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</tr>
<tr>
<td>Health Plan</td>
<td>UM Managed by</td>
<td>Contact Information</td>
</tr>
<tr>
<td>------------</td>
<td>---------------</td>
<td>---------------------</td>
</tr>
</tbody>
</table>
| • Soundpath Health Alpine (HMO-MA Only Plan)  
• Soundpath Health Peak + Rx (HMO-MAPD Plan)  
• Soundpath Health Sound + Rx (HMO-MAPD Plan)  
• Soundpath Health Charter + Rx (HMO-MAPD Plan) | Premera | Referrals & Prior Authorizations:  
Phone: 855-339-8127  
Fax: 800-989-7479  
Clear Coverage Link:  
https://identity.onehealthport.com/Em powerIDIDPForms/ssoservice.aspx?SSO Connect=6c5a1b84-6649-4cfd-a2a7-8c24c542bf56&RelayState=PRMA_000  
Case Management:  
Phone: 855-339-8127 |

**Premera – Personal Care Plan**  
• Gold  
• Silver  
• Bronze |

**Referrals / Pre-Authorizations**

As a managed care network, patients assigned to us are required to use providers/facilities from within our network for care. Keeping services in-network works to minimize some administrative burden and keep costs contained. We have a diverse group of Specialists and Facilities within our network, but are continuously working to grow and expand our reach in the community. If your patient requires a Specialist or Facility that is **not** within the NPN Network then we recommend that the specialist/facility is contracted with the patient’s health plan. If the specialist/facility is not contacted with the plan, prior authorization is required. Note: some plans may not have out-of-network benefits.

**In-Network (Office Visits)** (Tier 1):  
NPN PCP to NPN Specialist referrals do **not** require precertification  
NPN Specialist to NPN Specialist do **not** require precertification  

**Out of Network Referral** (Tier 2): Requires prior authorization from NPN

**Physical Therapy**

Please note that authorization is not required for Humana MA HMO or United Healthcare MA and Community Plan. However, there is a 24 visit limit for United Healthcare Community Plan (Medicaid) members.

**Women’s Health**

A referral from the PCP is not required for covered Women’s Health Care Services when the services are provided by a Women’s Health Care Provider. However, the member must self-refer within her contracted plan’s network. Female-related diagnosis, urinary tract infections and disorders of the breast will be allowed under women’s self-referral for women on a NPN plan.
If you have further questions, please contact your Practice Support Advocate (PSA). If a provider falls outside of both tiers and you believe their inclusion in the network would be beneficial, please alert Network Development at NPN and we will research the opportunity.

Please refer to the Appendix for sample forms and additional information. Please visit https://www.npnwa.net/FAQsProviders.aspx for a link to an electronic version of the authorization request form.

**Care Management**
NPN’s Care Management team consists of Registered Nurses certified in Care Management, a Licensed Mental Health Counselor, and a Care Coordinator. Primary Care offices are able to refer patients with complex care needs by referral, but we can also capture these referrals from pre-authorization trends, transitions (i.e. Hospital to Skilled Nursing), and Members can also self-refer.

Care Management has oversight of the following programs:

- Transition Management
- Complex Care Management (Medical/Behavioral Health)
- Disease Management/Condition Support
- Emergency Department Reduction Program
- Behavioral Health

For additional information, please contact your Practice Support Advocate.

**Behavioral Health**
NPN manages behavioral health authorizations and adjudicates claims for Humana MA HMO line of business only. Please refer to Behavioral Health Plan Resources in the Appendix for additional information.

**Identifying NPN Members/Patients**
Health plans utilize an attribution model based on Primary Care Provider (PCP) selection. In most cases, an identifier can be found on the patient’s health plan identification card listing NPN as the “Provider Group” or by Payer ID (NPN11). Please refer to the health plan identification card samples in the appendix. Additionally, Providers and Facilities should verify eligibility using OneHealthPort or the health plan’s portal.

Please see ID card samples in the Appendix.
Frequently Asked Questions

How do I check the status of a claim, authorization or member eligibility?
Log on to [www.onehealthport.com](http://www.onehealthport.com) for claims status, authorizations and member eligibility. If you are unable to locate the claim or authorization, please contact NPN's Contact Center at 253-573-1880 Monday through Friday 8am – 5pm (closed 12pm – 1pm for lunch).

Does NPN pay claims using Electronic Funds Transfer (EFT)?
Yes, NPN utilizes InstaMed for electronic funds transfer (EFT) and electronic remittance advice (ERA). Funds are deposited directly into your designated bank account and include the TRN Reassociation Trace Number, in accordance with CAQH CORE Phase III Operating Rules for HIPAA standard. To register, please go to [www.instamed.com/eraeft](http://www.instamed.com/eraeft).

How do I submit a referral?
Complete an authorization request form (available electronically on NPN’s website) with all member information, specialist and/or facility information and requested service information, including diagnosis (ICD-10-CM), service or procedure (CPT or HCPCS) being requested. Alternative care (acupuncture, chiropractic, massage and naturopathic) may not be a benefit under the Member’s plan and may require prior authorization from NPN or the health plan network. All completed request forms can be faxed to 253-627-4708 or submitted electronically via SCI Solutions.

Please allow 2 days before calling or resubmitting referral requests.

How do I add/remove users to OneHealthPort?
Contact your OneHealthPort admin to add or remove authorized users. If you continue to require assistance, please contact OneHealthPort at [www.onehealthport.com](http://www.onehealthport.com).

How do I add/remove users to Clarity/SCI Solutions?
Contact your Clarity/SCI Solutions admin to add or remove authorized users. If you continue to require assistance, please contact SCI Solutions at [www.scisolutions.com](http://www.scisolutions.com)

Appendix
2018 Prior Authorization Guide for NPN Contracted Providers and Facilities

NOTE: All urgent/emergent inpatient admissions require notification within 48 hours of the admission. Planned and/or elective inpatient admission should be pre-authorized in order to be covered. The medical care and procedures below require prior authorization in all settings. If you have questions be contact Customer Service at 253-573-1880.

URGENT or EXPEDITED REQUEST DEFINITION: care or treatment where the passage of time could seriously jeopardize the life or health of the patient, seriously jeopardize the patient’s ability to regain maximum function, or in the opinion of the physician with knowledge of the patient’s medical condition, would subject the patient to severe pain that cannot be adequately managed without care or treatment that is subject of the request (WAC 284-43-0160)

ALL SERVICES OUT OF THE NPN NETWORK - HOSPITALS, SURGERIES, PROCEDURES, REFERRALS, EVALUATIONS, SERVICES AND OR TREATMENT REQUIRE PRIOR AUTHORIZATION

TRANSPORT
• Non-emergent Air Transport
• Non-emergent Facility to Facility Transport (WA Apple Health Only)

INPATIENT & INSTITUTIONAL SERVICES
• Elective Scheduled Admission
• Acute Rehabilitation (IPR)
• Subacute Admissions (TCU)
• Skilled Nursing Facility (SNF)
• Hospice (Washington Apple Health only)
• Long Term Acute Care (LTAC)

SURGICAL PROCEDURES
• Bariatric Surgery
• Cochlear & Other Auditory/implants
• Orthognathic Surgery
• Sleep Apnea Procedures
• Cosmetic & Reconstructive Procedures (blepharoplasty, brow ptosis repair, breast reconstruction, panniculectomy, gynecomastia, nasal reconstruction, FEES (functional endoscopic sinus surgery)
• Septoplasty/Rhinoplasty/Turbinate Resection
• Spinal Stimulator for Pain Management
• Vagus Nerve Stimulation
• Ventricular Aechoo Dovio (VAD)
• Gender Dysphoria Treatment

DURABLE MEDICAL EQUIPMENT
• DME greater than $1000 in retail cost whether purchase or rental
• Prosthetics & Orthotics greater than $1000 billed charges per device (CPAP/BIPAP do NOT require authorization)
• Power Mobility Devices
• Lymphedema and Pneumatic Compressors
• Wound Vac
• Bone Growth Stimulators

RADIOLOGY
• SPECT Scan: Heart (MRI), Brain, Tumor Imaging, localization of inflammatory process
• PET Scan

OUTPATIENT SERVICES/TREATMENT
• Home Health (Skilled Nursing, Physical, Occupational, Speech, Respiratory)
• Home Enteral Nutrition & Infusion
• Dental: Comprehensive (anesthesia & facility covered if criteria met – medical services only for WA Apple Health
• Genetic Testing
• Chiropractic (WA Apple Health age 20 and under, no benefit for members older than 20)
• Radiation Therapy – IMRT, SRS, SBRT, Proton Beam Therapy only

MEDICATIONS
• Botox (botulinum toxin)
• IVIG (Immune Globulin)
• Spinraza (nusinersen)

NEW TECHNOLOGY
• Potentially Unproven Services
• Experimental or Investigational Services
• Transplants: BMT & Solid Organs

Inclusion of items/services on this list does NOT indicate benefit coverage. Please verify benefits prior to requesting authorization.
Prior Authorization Request Form Sample

Prior Authorization Request
*YOU MUST SUBMIT CLINICAL DOCUMENTATION TO SUPPORT YOUR REQUEST

DATE: 06/19/2018
Authorizations (253) 573-1880 #2  Fax (253) 627-4708
Customer Service (253) 573-1880 #3  Fax (253) 573-9511
Case Managers (253) 573-1880 #2  Fax (253) 627-4708

☐ United Healthcare AARP West
☐ United Healthcare Community and State
☐ Premera Medicare Advantage
☐ Humana Medicare Advantage

☐ Routine  ☐ Urgent  ☐ Post-Service

*Urgent is defined as a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity such that if services are not received within 24 hours of the request the person’s situation is likely to deteriorate to the point that emergent services are necessary.

Patient Name:  
Member ID:  
DOB:  
Phone Number:  

*If referring Out of Network, please provide documentation to support medical necessity

Requesting Provider:  
Servicing Provider:  
Phone:  
Phone:  
Fax:  
Fax:  

☐ Inpatient  ☐ Outpatient

Diagnosis and ICD-10 code(s):  
Date of Service:  
CPT Code(s):  
Facility Information:  
Comments:  

PLEASE NOTE: This Authorization does not ensure payment of services. All claims are subject to normal policy limitations, current eligibility, and plan requirements. AUTHORIZATION NUMBERS WILL BE FAXED TO PCP & SPECIALIST THE DAY AFTER PROCESSING.

Submit Claims to: Northwest Physicians Network
Electronic ID: NPN11
Clearinghouse: Availity

PAYMENT SUBJECT TO CURRENT ELIGIBILITY AT THE TIME OF SERVICE

Effective 6/2016
**Care Management Referral Form Sample**

<table>
<thead>
<tr>
<th>Date:</th>
</tr>
</thead>
</table>

**Member Information**

| Member Name: |  |
| Health Plan ID#: |  |
| Phone #: |  |

If primary contact is other than member please include Contact name, relationship and Phone Number:

| Name: | Relationship: | Phone: |

**Referred By**

| Name | Title | Phone |

**Line of Business**

- [ ] Aetna
- [ ] United Health Care Healthy Options (Community Plan)
- [ ] United Health Care Medicare Advantage (AARP)
- [ ] Medicare FFS ACO
- [ ] Cigna
- [ ] Premera MA
- [ ] Premera PPO
- [ ] Humana MA

**Primary Care Provider Information (if known)**

| Name: | Address: | Phone: |

**Diagnosis and Reason for Care Management Referral**

| Diagnosis(s): |  |

Reason of Need for Assistance:

**Projected Outcome form Care Management**

Please list any specific outcomes or goals you have for the member you are referring:

**Instructions for Referral Submission:**
Complete this referral form and fax to 253-627-4708 or Submit referral directly through Clarity
ID Card Samples

Medicaid

Health Plan – United Healthcare Community Plan/Apple Health

Medicare

United Healthcare MA-HMO

Humana MA- HMO

Individual MAPD HMO

Humana MA – PPO

Individual MAPD PPO
## Credentialing and Contracting Crosswalk

<table>
<thead>
<tr>
<th>LINE OF BUSINESS</th>
<th>PAYOR</th>
<th>PAYOR PLAN</th>
<th>Credentialing</th>
<th>Contract Required?</th>
</tr>
</thead>
<tbody>
<tr>
<td>MEDICAID</td>
<td>United Healthcare</td>
<td>Medicaid - Community Plan (Apple Health)</td>
<td>Yes through NPN</td>
<td>No through NPN</td>
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<tr>
<td>MEDICARE ADVANTAGE</td>
<td>United Healthcare</td>
<td>Medicare Advantage - HMO Plans</td>
<td>Yes through NPN</td>
<td>No through NPN</td>
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<tr>
<td></td>
<td></td>
<td>Medicare Advantage - Duals</td>
<td>Yes through NPN</td>
<td>No through NPN</td>
</tr>
<tr>
<td></td>
<td>Humana</td>
<td>Medicare Advantage HMO Plans</td>
<td>Yes through NPN</td>
<td>No through NPN</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medicare Advantage PPO Plan</td>
<td>Yes through NPN</td>
<td>No through NPN</td>
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<tr>
<td></td>
<td>Premera</td>
<td>Medicare Advantage Plans - HMO Plans</td>
<td>Yes through NPN</td>
<td>No through NPN for Providers &amp; ASCs; all others need a direct Premera contract</td>
</tr>
<tr>
<td>RAINIER HEALTH NETWORK</td>
<td>CMS</td>
<td>Medicare Shared Savings Program - Fee For Service</td>
<td>No through CMS</td>
<td>YES - need to contact RHN to contract specifically for MSSP</td>
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<tr>
<td></td>
<td>Aetna</td>
<td>Whole Health (specific Commercial Product)</td>
<td>Yes through NPN</td>
<td>YES, an underlying agreement for Aetna commercial required</td>
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<tr>
<td></td>
<td>Regence / BCBS of IL</td>
<td>CHI Employee Plan</td>
<td>No - through Regence or BCBS</td>
<td>YES, an underlying agreement for Regence/BCBS commercial required</td>
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<tr>
<td></td>
<td>United HealthCare</td>
<td>Commercial plans</td>
<td>Yes through NPN</td>
<td>YES, an underlying agreement for UHC commercial required</td>
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<td>COMMERCIAL SHARED SAVINGS</td>
<td>Aetna</td>
<td>Commercial Shared Savings - Commercial</td>
<td>Yes through NPN</td>
<td>YES, an underlying agreement for Aetna commercial required</td>
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<td></td>
<td>Cigna</td>
<td>Commercial Shared Savings - Commercial</td>
<td>No, you must go through Cigna's credentialing, However, we do report that you are in the NPN network</td>
<td>YES - you must have an agreement with Cigna. However, you will be attributed to NPN's network for their CAC product unless you elect otherwise in writing</td>
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<tr>
<td></td>
<td>Premera</td>
<td>Personal Care Partner - Commercial (PCP assis)</td>
<td>Yes through NPN</td>
<td>YES - you must have an underlying Premera agreement for claims payment</td>
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## Delegation by Plan

<table>
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<tr>
<th>Delegation by Plan</th>
<th>Humana MA HMO</th>
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<th>UHC MA HMO</th>
<th>UHC Medicaid</th>
<th>UHC MA - Duals</th>
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<th>FirstChoice Health Network</th>
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<td>Case Management for Transplants</td>
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<td>Providers and ASCs only</td>
<td>Providers; All Facility Types</td>
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<td>Providers; All Facility Types</td>
<td>Providers only</td>
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<td>Behavioral Health/Substance Use</td>
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<td>DSNP</td>
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Behavioral Health – Plan Resources

United Healthcare Community Plan (Medicaid)
Behavioral Health Claims and Authorizations 1-877-542-9231

United Healthcare Medicare Advantage
Behavioral Health Claims and Authorizations 866-673-6315

Humana Medicare Advantage
Behavioral Health Provider Assistance **1-866-900-5021 - Non-patient facing number.** 8 a.m. – 6 p.m., Eastern time. Patients may call the number on the back of their Humana member ID card.
Behavioral Health Claims and Authorizations - **NPN Utilization Management**

Premera Medicare Advantage
Find a Behavioral Health Provider [https://www.premera.com/wa/visitor/find-a-doctor/doctor-dentists-and-more/](https://www.premera.com/wa/visitor/find-a-doctor/doctor-dentists-and-more/)
Behavioral Health Claims and Authorizations 1-800-711-4577

Premera PersonalCare Plan
Find a Behavioral Health Provider [https://www.premera.com](https://www.premera.com)
Behavioral Health Authorizations and Claims 1-877-342-5258 Claims Option #3, Authorizations Option #4

Cigna
Provider Finder [https://my.cigna.com/web/public/guest](https://my.cigna.com/web/public/guest)
Behavioral Health Authorizations and Claims 1-800-926-2273

Aetna
Behavioral Health Provider Finder 800-962-6842
[https://www.aetna.com/individuals-families/find-a-doctor.html](https://www.aetna.com/individuals-families/find-a-doctor.html)
Behavioral Health Authorizations and Claims 888-632-3862 Option 3